NHS
North East

REPORT TO THE NORTH EAST STRATEGIC HEALTH AUTHORITY OF THE INDEPENDENT INVESTIGATION INTO THE HEALTH CARE AND TREATMENT OF DAVID BRADLEY

August 2011

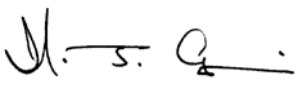
The panel

The members of the panel were:

- Mr Euan Duff – Barrister (Chairman)
- Prof Malcolm Peet – Consultant Psychiatrist at Rotherham, Doncaster & South Humber Mental Health NHS Foundation Trust and Honorary Professor, University of Sheffield.
- Mr Harry Cronin – Former Executive Director of Nursing, Psychology and Allied Health Professionals, Tees, Esk & Wear Valley NHS Foundation Trust.

Mr Euan Duff 

Prof. Malcolm Peet 

Mr Harry Cronin 

Acknowledgement

The investigating panel wishes to express its gratitude to the panel coordinator, Mr Richard Smith, for all of his hard work and assistance in the administration of the investigation.

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1. Introduction

On the night of 8 to 9 July 2006, over a period of about four hours, David Bradley shot and killed his uncle, aunt and two cousins; Peter, Josie, Keith and Glen Purcell at the family home in Newcastle upon Tyne. He first of all killed his cousin Keith. This was apparently after Keith had remonstrated with David Bradley who had smashed up his own room and was causing a disturbance. Immediately thereafter he killed Peter Purcell and, when they later returned to the house separately, Josie and Glen Purcell. At 5.55 am on 9 July David Bradley went to the West End Police Station with the pistol that he had used to kill his victims and other weapons and informed the police of what he had done.

David Bradley was 41 years of age at that time. He had no previous criminal convictions.

In due course David Bradley appeared at Newcastle upon Tyne Crown Court and, on 27 January 2007, pleaded guilty to four counts of manslaughter on the basis of diminished responsibility. His pleas were accepted and on 9 April 2008 he was sentenced to life imprisonment with a minimum term of 15 years to serve. Thereafter he was transferred to Rampton Special Hospital where he remained detained at the time of the commissioning of this report.

At the time of the killings David Bradley was under the care of the secondary mental health services provided by Northumberland Tyne and Wear NHS Trust (NTW), having been referred to Newcastle, North Tyneside and Northumberland NHS Trust (3Ns), by his general practitioner on 23 March 2006. NTW was created on 1 April 2006 following a merger of 3Ns with Northgate & Prudhoe NHS Trust and South of Tyne and Wearside Mental Health NHS Trust. That was the third occasion on which he had been involved with the secondary mental health services. Under the terms of Health Service Guidance (94)27 (as amended 2005), the North East Strategic Health Authority commissioned this independent investigation into David Bradley's health care and treatment with the terms of reference set out hereinafter.

The panel met on 33 occasions between 25 November 2009 and 19 April 2011. It had access to all of the documentation listed in the bibliography at the end of this report. The panel interviewed ten witnesses who were requested to attend and did so willingly. A further witness made a written submission but was not interviewed. The panel wished to interview one witness, who had been involved with David Bradley as a community psychiatric nurse (CPN), who declined to attend.

The panel also wished to interview David Bradley to obtain his view of the care and treatment that he had received, but he declined that request.

The interviews of all witnesses were contemporaneously recorded and they were provided with transcripts of the interviews and given the opportunity to amend any matter on the record which they regarded as inaccurate.

The panel was acutely conscious that it was in the uniquely advantageous position of being able to consider the care and treatment of David Bradley without the pressures of the day-to-day management of numerous patients for whom clinicians and other professionals have responsibility. The panel has attempted to guard against the wisdom of hindsight.

The panel considered the entire history of David Bradley's involvement with the secondary mental health services, which fell into three separate episodes and which was ongoing at the time of the killings.

2. Terms of reference

To examine the circumstances of the surrounding health care and treatment of David Bradley, in particular:

- The quality and scope of his health care and treatment, in particular the assessment and management of risk

- The appropriateness of his treatment, care and supervision in relation to the implementation of the multi-disciplinary care programme approach and the assessment of risk in terms of harm to himself or others. This should take into consideration other family members in receipt of services, as well as those who may be in a carer role

- The standard of record keeping and communication between all interested parties

- The extent to which his care corresponded with statutory obligations and relevant guidance from the Department of Health

- Prepare a report of the findings of that examination for, and make recommendations to, the North East Strategic Health Authority.

3. Narrative chronology

Early life

David Bradley was born on 12 February 1965. He had a troubled childhood and was later to describe frequent arguments in the home and some violence between his parents. They separated when he was aged 11 and at first he lived with his father but, after about two years, went to live with his mother, even though he did not get on with her. This led to significant difficulties between David Bradley and his mother. He claims that she frequently lost her temper with him and often hit him. He, in turn, was violent to her on at least one occasion in 1982 when, after a particularly severe argument, he struck her. He left her home at that point and, after staying briefly with a paternal uncle, took up residence with the Purcell family, who were ultimately to be his victims.

David Bradley is reported to have described being unhappy and bullied at school, from where he often truanted after the age of about 14. He is said to have had no real friends and no particular interests or hobbies.

Commentary

The panel is unable to say what, if any, influence these early experiences had on David Bradley's later behaviour. It is highly likely that they played a significant part in the formation of his character and contributed to some of his later problems, but they are not immediately relevant in relation to his later treatment.

Employment and army life

David Bradley is said to have attempted to join the army at the age of 16 but to have been rejected on at least one and possibly two occasions. He joined the Territorial Army at the age of 18 and, after having some civilian jobs, all held for relatively short periods of time, he was eventually accepted into the army in 1987 at the age of 22. He served in the Royal Artillery. He had various postings in Germany, Cyprus, the Gulf (during the Gulf War in 1991), Northern Ireland, Bosnia and Canada. He was not engaged in direct combat in any of those postings but was later to describe to Consultant Forensic Psychiatrist 1, who reported for the criminal proceedings, that in Northern Ireland he had stones thrown at him whilst on patrol and that shootings took place around him. He described a particularly distressing incident in which, whilst on guard in the Shankill area of Belfast, he saw a loyalist protester intending to throw a grenade that exploded in his hand before he could throw it. He recalled seeing the man's hand lying on the ground. He was later to say that it was during his time in the army that he began to abuse cannabis in order to help him cope with his experiences, particularly those in Northern Ireland.

Throughout his time in the army he received satisfactory work reports although he was described as a "loner" and it is clear from what he was later to say that he had little regard for his fellow soldiers.

His medical report on discharge from the army dated 2 June 1995 gives no hint of any difficulty at that stage, save for some slight knee problem, and provides no insight into his mental state. There is no hint of any abnormality. His discharge report recorded that he had been of exemplary conduct.

Commentary

It seems clear that David Bradley's experiences in the army formed a significant part of the background to the problems that led up to the shooting of the Purcells and that those experiences, combined with his troubled childhood, were a contributing factor to the mental health problems that he suffered.

Life after discharge from the army

After he left the army David Bradley returned to live with the Purcells. At that time it seems that only Mr and Mrs Purcell were living permanently in the house, although Glen Purcell is reported to have spent considerable periods of time there and to have regarded the house as his true home. David Bradley obtained work with a local hire company but reported that he found that job to be mundane and, in 1997, he worked briefly as an installer for a telecommunications company but left the job because he did not like it. It was at about this time that his mental health problems first became apparent and he sought help for them. From this time onwards he appears to have lived a particularly isolated life and, although sharing a home with the Purcells, is reported to have had little interaction with them and to have spent increasing amounts of time in his bedroom.

First contact with mental health services (29 October 1997 – 15 May 1998)

On 28 October 1997 David Bradley registered with GP1's practice in Newcastle. The next day GP1 referred him to the community mental health centre. The referral letter comments that David Bradley had recently felt extremely tense and describes him as visibly shaking during the consultation. David Bradley had said that he had feelings that he was going to explode in violent outbursts or attack someone. He is described as socially isolated, never seeing his family and never going out. GP1 saw David Bradley as having depression with prominent feelings of anxiety and agitation and prescribed paroxetine (an antidepressant).

He was again noted as having depression on 11 November 1997 in his GP notes and, on 25 November 1997, he was given a medical certificate for two weeks on that basis. He was also noted, on 9 December 1997, to be suffering from alopecia totalis (total loss of head hair).

Following the referral by GP1, David Bradley was seen, on 12 December 1997, by Consultant Psychiatrist 1 together with a junior doctor, Senior House Officer 1, as an outpatient at Newcastle General Hospital. Because of his aggressive manner this was on a ward rather than in the outpatient clinic. It was noted that he was "tense", "wound up", not sleeping and couldn't stand being around people. He said that he wanted to kill somebody and felt like he was still patrolling the streets. He said that he had felt like that for years but things had been worse since he had come out of the army two years previously. He said that he was kept awake at night by thoughts of devious ways in which to kill people. He did not have any specific target in mind. A fairly comprehensive history was taken from him dealing with his childhood, army history and then current situation. He denied using drugs or alcohol. He was noted to have good insight into his condition and it was said that there was no evidence of affective (mood related) or psychotic (delusions and/or hallucinations) illness. He was thought to have antisocial personality traits, was prescribed clopixol (an antipsychotic) and was to be reviewed by Consultant Psychiatrist 1 on 23 January 1998.

A fairly detailed report, dated 15 December 1997, was sent by Senior House Officer 1 under the supervision of Consultant Psychiatrist 1 to GP1, setting out the history that David Bradley had given, his presentation, a possible preliminary diagnosis and the treatment plan of prescribed medication and a review on 23 January 1998.

Commentary

The panel noted that there was no copy of an appointment letter in the records. Whilst this was not an urgent referral the panel noted that the first appointment did not take place for six weeks. The medical notes begin by stating that David Bradley was seen by the two doctors on a ward because of his aggressive manner. That was because of the reference to violence in the referral letter. The panel notes that despite it being said that there was no evidence of psychotic illness he was prescribed clopixol (an antipsychotic). This was given as a tranquilliser. The appropriateness of this prescription is questionable but the panel noted that Consultant Psychiatrist 1's options were very limited. It was clear from the report to GP1 that David Bradley's problems were long standing. The letter of 15 December 1997 to the GP noted the history of violence against his mother but the subsequent risk assessment form completed by Consultant Psychiatrist 1 recorded no history of known violence.

On 8 January 1998, prior to his being reviewed by the consultant psychiatrist, David Bradley was seen again by GP1 who noted that he was suffering from alopecia universalis (loss of all body hair). He was referred to the Royal Victoria Infirmary, Newcastle, for this condition with a history of a depressed mood and feeling frustrated by his circumstances. His hair loss exacerbated his problems.

David Bradley was actually seen by the consultant psychiatrist on 14 January 1998 rather than 23 January. It is not clear from the records why the date of that appointment changed. He was seen on that occasion by Consultant Psychiatrist 1 alone and it is noted that he was "feeling a lot better and getting out a lot more" but had only taken clopixol for one day as he did not feel it had done much good and did not like taking tablets. His notes also record that he "now has a car goes out for a drive when feels tense, or goes to room, or out with friends". At that stage an electroencephalogram (EEG - recording of the electrical activity of the brain) was arranged.

Following that appointment Consultant Psychiatrist 1 reported, on 20 January 1998, to GP1 the results of the consultation and that she had referred him for an EEG to make sure that he did not have temporal lobe epilepsy, even though she regarded that as most unlikely. She stated that she had arranged to see David Bradley again when she had the results of the EEG. The EEG examination was carried out on 2 February 1998 and did not show any significant abnormality. David Bradley was reported to have been decidedly "prickly", although compliant, during the investigation.

On 6 March 1998 Consultant Psychiatrist 1 again saw David Bradley with the results of the EEG test. She noted that his mood had worsened over the last few weeks. She wondered about the possibility of a rapid cycling mood disorder. She concluded that the most likely diagnosis still appeared to be an antisocial personality but David Bradley agreed to try a mood stabiliser and was prescribed sodium valproate (an anti-epileptic drug that is used as a mood stabiliser).

On that date a Care Programme Approach Client Registration form and a Risk Assessment Form were completed by Consultant Psychiatrist 1. The only risk indicator noted on the latter form was a history of known threats of violence or assault against others. Consultant Psychiatrist 1 reported back to GP1 on 12 March 1998 her view of the situation at the time and stated that she had her doubts as to whether David Bradley would take the medication that she had prescribed. She took the view that if that medication was not effective then there was not a lot more that she could do for him and that she would discharge him back to GP1's care, but that he would be seen again in two months time.

On 19 March 1998 David Bradley was seen at the Dermatology Department of the Royal Victoria Infirmary and a report was sent back to GP1 on 24 March 1998. The diagnosis of alopecia universalis was confirmed and it was said that it had been explained to David Bradley that his hair might well not regrow and that he seemed to have accepted that quite well.

On 15 May 1998 David Bradley was again seen by Consultant Psychiatrist 1 in an outpatient setting. He said that he was feeling much better and had been trying to get out more. He had only taken the sodium valproate for a couple of weeks as he didn't want to take tablets. Consultant Psychiatrist 1 suggested some self-help reading material to him and David Bradley asked to see his notes. This was agreed to, as they contained no adverse material. Consultant Psychiatrist 1 recorded that she was unable to offer further help at that stage and discharged him back to the care of GP1. In the discharge letter she commented that unfortunately they had no access to an anger management course at that time, which she thought would probably be of the most help to David Bradley. She said that they had found no organic cause for his difficulties and that he was unwilling to take medication. On that day she completed a Care Programme Approach Change of Circumstances form noting that he no longer required follow-up. This was the conclusion of the first recorded treatment episode for David Bradley's mental health problems.

Commentary

David Bradley was seen by Consultant Psychiatrist 1 alone on the second occasion as her assessment of him on the first made her feel that it was safe to do so. The record of that appointment makes no reference back to David Bradley's earlier thoughts about wanting to kill people. The risk issues ought to have been re-visited and the conclusions recorded before he was discharged back to his GP. The history of actual violence (towards his mother) was not recorded in the risk assessment. The investigation for temporal lobe epilepsy was performed even though Consultant Psychiatrist 1 regarded this as a most unlikely diagnosis. The prescribing of sodium valproate as a mood stabiliser was recognized by Consultant Psychiatrist 1 as having little chance of being effective. Once again Consultant Psychiatrist 1 was attempting to provide medical solutions as there were no more appropriate options for his care available at that time. In particular there was no access to anger management which Consultant Psychiatrist 1 thought would be of the most help. The Care Programme Approach Client Registration form was not completed until 6 March 1998, although David Bradley had been referred in October 1997. The reports back from Consultant Psychiatrist 1 to GP1 were sent in a timely manner. Consultant Psychiatrist 1 used medical interventions that had minimal chance of success and this may have had an adverse effect on David Bradley's confidence in and future concordance with medication.

Period between involvements with secondary mental health services

For the next four years David Bradley had no involvement with the secondary mental health services. He continued to be seen from time to time by GP1 and on 18 May 1999 is recorded as having a depressive disorder. At that time he applied for benefits on the basis of his inability to work, because of his mental health problems. His application was initially refused but later allowed and by 15 September 1999 he was in receipt of benefits and GP1 was sent a letter saying that he need no longer supply medical certificates. Thereafter there are no entries in the GP records for the latter part of 1999 or the year 2000. The next entry that appears relates to 3 April 2001 when there is an entry in the GP records stating "hair loss". It is not clear what lifestyle David Bradley was pursuing during this period or whether he was experiencing any mental health problems.

Second episode of involvement with secondary mental health services (15 November 2002 – 25 February 2003)

In May 2002 the benefits agency reconsidered David Bradley's eligibility for incapacity benefit and he was medically examined on 10 June 2002. As a result of that examination a decision was taken that he was no longer incapable of work and his entitlement to benefit was terminated. It was this event which was the precipitating factor for David Bradley's second episode of involvement with the secondary mental health services, after he consulted the Citizens Advice Bureau (CAB) in an attempt to have his benefits restored. On 14 August 2002 GP1 was written to by the Tribunal Assistance Scheme of the CAB enclosing medical report forms from the Benefits Agency dated 13 September 1999 and 10 June 2002 (the former assessing him as unfit and the latter as fit for work) and asking whether GP1 was of the view that David Bradley's mental health had improved during that period. GP1 wrote back on 20 August 2002, reporting that David Bradley had not consulted him about his mental health since May 1999 and that, accordingly, he did not have any relevant information in relation to his eligibility for benefits.

On Friday 15 November 2002 David Bradley went to the CAB in connection with his benefits and was seen there by Consultant Forensic Psychiatrist 2, who was carrying out voluntary work at the CAB. He was so concerned about David Bradley's presentation that he contacted GP1 by mobile telephone. He reported that David Bradley was severely depressed with persecutory delusions and that he found his mental state worrying and quite frightening. David Bradley had reported to Consultant Forensic Psychiatrist 2 that he kept a knife under his pillow in case he was attacked and carried it with him when he went out of the house. Between them Consultant Forensic Psychiatrist 2 and GP1 arranged for David Bradley to attend at GP1's surgery later in the day and he duly did so. GP1 found David Bradley to be feeling very stressed, "hearing voices and getting other intrusive delusions". David Bradley was reluctant to elaborate on the nature of the symptoms. GP1 described his affect as bizarre and inappropriate, with laughing and giggling without reason. During the consultation David Bradley said that he was feeling agitated and wanted to go home, which he did.

GP1 then contacted the crisis assessment and treatment (CAT) service who told him that they were of the opinion that David Bradley would best be assessed at the accident and emergency department. When GP1 tried to contact him, it transpired that the telephone number David Bradley had provided was incorrect. In view of the fact that David Bradley had not expressed any suicidal intent GP1 decided to leave the matter until the next working day, Monday 18 November 2002, when he faxed an urgent letter of referral to the community mental health team (CMHT) at Clifton Mount. The letter asked that David Bradley be assessed urgently and pointed out that there might be an element of risk with him in view of the fact that he suffered from paranoid delusions and kept a weapon to defend himself. GP1 commented that in the past David Bradley had responded very well to treatment, but had not been on any medication for over a year as far as he could tell.

CPN1, the team leader of the CMHT, wrote that day to David Bradley offering him an appointment for Wednesday 20 November 2002 at the Clifton Mount office. David Bradley duly attended that appointment. At the appointment David Bradley was assessed by CPN1 alone. The Care Coordination Assessment form completed by CPN1 was a full and detailed document drawing upon information supplied by David Bradley himself, the contents of GP1's referral letter and CPN1's observations. It records that David Bradley felt that he was losing control, was frightened and had no life. He stated that he only went out early in the morning as he felt unsafe later in the day and might attack somebody if they looked at him. He also said that he had been sent for an EEG in the past as a result of self-reporting that he had epilepsy and had got angry during the test in order to 'fake' the result. He claimed that he had been prescribed anti-epileptic medication but had not taken it. David Bradley reported that he lived with friends of his family but hated it and wanted to move. He also said that he smoked cannabis on some or most days, usually to help him sleep and that although he had drunk alcohol heavily in the army he did not drink at that time. He was not sure what his expectations from the mental health services were but was willing to see someone. CPN1 was not sure if he had a psychosis, personality disorder or anxiety disorder. It was recommended that he see Consultant Psychiatrist 1 for a diagnostic assessment and for the prescribing of any necessary medication, after which it was thought that there might be a necessity for input by a CPN. David Bradley's case was to be discussed by the team and it was noted that he should be seen in the morning as he would not attend late appointments.

The next day, Thursday 21 November 2002, David Bradley's case was discussed at the CMHT meeting at which stage the appropriate diagnosis and tier (level of complexity) were recorded as being unclear. An outpatient appointment with Consultant Psychiatrist 1 and CPN1 was arranged for 5 December 2002 at the Hadrian Clinic. The following day a letter was sent to David Bradley offering him an appointment at 9.15 am on 5 December 2002, which letter was copied appropriately to GP1 and Consultant Psychiatrist 1.

On 5 December 2002 David Bradley duly attended and was seen by Consultant Psychiatrist 1 and CPN1. Detailed notes were made by Consultant Psychiatrist 1 and later in the day his case was discussed at a CMHT team meeting. It was noted that he lived with his aunt and sometimes got irritated with her and felt that he wanted to hit her, but that he had not done so. It was also noted that when he had been prescribed medication in the past he had not taken it. He admitted that he had used cannabis for the last two years and said that he did so every day. In the course of discussions about his army past David Bradley denied that he had access to guns at the time of the appointment. It was recorded that he had partial insight into his problems and was aware that he had difficulties but could not express them. Consultant Psychiatrist 1 noted that she was unsure what sort of help the team could give him. He said that he would try medication, but Consultant Psychiatrist 1 put a question mark over whether he would comply. She noted possible diagnoses of schizophrenia, antisocial personality disorder and a drug induced psychosis. The plan formulated at that time was to commence David Bradley taking olanzapine (an antipsychotic), for CPN1 and CPN2 to visit him at his home, to try to build a relationship with him, to obtain information from his aunt, the GP and David Bradley himself and to see him again in three weeks time. No formal care coordination care plan was prepared at that stage.

At the end of the record of the CMHT discussion it is noted that during the appointment in the morning when it had been suggested that he had medication and come into hospital David Bradley's whole demeanour had changed. It was said that he would see CPN1 again but did not trust Consultant Psychiatrist 1. CPN1 also created a typed note which went into the CMHT records. In the note he recorded that both he and Consultant Psychiatrist 1 felt that there was "a marked psychotic feel" to David Bradley's presentation and that there might well be "a forensic element". He also recorded David Bradley's anger with Consultant Psychiatrist 1 for raising the possibility of inpatient treatment.

The next day a letter was sent by the CMHT administration to David Bradley stating that his appointment with CPN1 had been changed from Wednesday 11 December 2002 to Tuesday 10 December 2002 and apologising for any inconvenience. On the same day GP1 responded to a letter from Consultant Forensic Psychiatrist 2, dated 28 November 2002, concerning David Bradley's ongoing benefits appeal and which also referred to David Bradley's worrying revelations. GP1 informed Consultant Forensic Psychiatrist 2 that he had not received any correspondence from the CMHT and suggested that Consultant Forensic Psychiatrist 2 might liaise directly with them, but assured him that he would forward on any correspondence.

Commentary

The panel concluded that the attempt to involve the CAT service recognised the urgency of the situation and that ultimately the deferral of the matter over the weekend owing to the incorrect telephone number having been given to GP1 was reasoned and reasonable. David Bradley's account during the assessment of cannabis use was the first time this had been mentioned but he was later to reveal that this had begun when he was in the army, continued on his return to Newcastle and had become a daily habit about two years before the assessment. It was made clear in the later forensic psychiatric assessments prepared for the criminal proceedings that David Bradley's use of cannabis may have been a significant factor in his worsening mental health. The care coordination assessment was as detailed and thorough as could be expected from an initial assessment carried out in the setting of a CMHT base but the panel is of the view that a requirement to obtain full information about his social circumstances by means of a prompt home visit should have been identified as a further action. The psychiatric outpatient appointment of 5 December 2002 was as rapid as one could reasonably expect. In view of the fact that this was the first occasion when David Bradley was prescribed olanzapine and there was a known history of non-concordance with medication the panel was concerned that this was not highlighted as a problem and no strategy was put in place to address this. At the commencement of this episode there were clearly identified risks and hospital admission was suggested during the appointment of 5 December 2002. In the management plan that resulted from this consultation (set out in the letter to the GP dated 23 December 2002) those risks were not addressed, nor was the discussion of possible hospital admission recorded.

On 9 December 2002 notification was sent to David Bradley that his appeal against the decision to terminate his benefits had been allowed and his benefits were re-instated. On 10 December 2002 CPN1 and CPN2 visited David Bradley at his home. CPN2 talked to David Bradley's aunt who confirmed his army life and the solitary nature of David Bradley's lifestyle and that he had no contact with his mother or siblings. CPN1 spoke to David Bradley in his room, which he noted as being dark and with everything boxed up. David Bradley was said to be very anxious and not communicative. When CPN2 joined them David Bradley became stressed and asked them to leave.

On 19 December 2002 CPN1 attempted a home visit that the panel was informed had been agreed orally on 10 December 2002. There was no answer when CPN1 called but it is recorded that at 10.35 that morning David Bradley telephoned saying that "the stupid fucker downstairs didn't open the door!" and that he had seen CPN1 from his window but would not come down as he "doesn't do that". He agreed to meet CPN1 on 2 January 2003 at the outpatients department and reported that he was not taking his olanzapine, but would not talk further on the telephone.

Commentary

The panel was informed that on 10 December 2002, although David Bradley's aunt was spoken to by CPN2, the conversation lasted only two or three minutes and it seems that very little information was obtained from her. The only things noted were confirmation of David Bradley's army past, his solitary life style and his lack of contact with his mother and siblings. The panel was informed that the entire visit lasted 15 minutes at most and little effort was made to engage with the aunt in depth. One element of the plan, devised between Consultant Psychiatrist 1 and CPN1 had been "to obtain further information from David Bradley's carer". Consultant Psychiatrist 1 intended this to refer to David Bradley's aunt although she was not a formal carer. This was a missed opportunity to put that aspect of the plan into operation. The panel was informed that the purpose of the visit was to engage with David Bradley, which was achieved only to a very limited extent and no other advance was made in the potential management of his case. Had a good rapport been established with the aunt on the first visit, that may have facilitated a successful visit on 19 December. No arrangements had been made with David Bradley's aunt for future communication. In the telephone conversation on 19 December 2002 David Bradley said that he was not taking his olanzapine; it was predictable that he would not take the medication, which was considered to be necessary at that time. The medication was a core part of the care plan and his non-concordance was a significant problem which ought to have been addressed.

On 23 December 2002 Consultant Psychiatrist 1 wrote to GP1 reporting the outcome of the consultation of 5 December 2002. That was a full letter and ended by setting out the proposed management plan for David Bradley.

On 2 January 2003 David Bradley attended his outpatient appointment and was seen by Consultant Psychiatrist 1 and CPN1. The medical notes record a discussion between Consultant Psychiatrist 1 and CPN1 as to what had happened since the last outpatient appointment and then the meeting with David Bradley himself. He said that he had been using cannabis regularly, which he thought helped him cope. He was expressing a desire to live in the country away from people and mentioned that he used to enjoy hill walking and fishing but had done neither since 1995. He admitted that anxiety was a big problem and that he never answered the front door. He said that he had taken olanzapine every few days but that it had made him feel weak, although he slept better. Consultant Psychiatrist 1 explained that it needed to be taken every night in order to be effective and it was agreed to reduce the dose to 5 mg per night. It was planned that CPN1 would see David Bradley to discuss anxiety management techniques. The aim was still to build rapport and trust and monitor his mental state. The possibility of his becoming involved with a men's group that was about to be formed was noted.

CPN1's notes of that appointment record David Bradley arriving early, being anxious but less aggressive than at the previous outpatient appointment. He said that olanzapine tired him, but he had agreed to take a reduced dose. He was not deluded but clearly more anxious. It is also recorded that he did not want to see Consultant Psychiatrist 1 and therefore no new appointments had been arranged with her but that he would see CPN1 at Clifton Mount for anxiety management.

On 3 January 2003 Consultant Psychiatrist 1 wrote to GP1 reporting on events since her last letter and concluding by stating that at that time the aim was still to build rapport and trust with David Bradley and to monitor his mental state. She reported to GP1 that she would keep him informed of her involvement.

Commentary

This series of events and in particular the outpatient appointment of 2 January 2003 give a number of clues to David Bradley's problems and possible solutions. In the opinion of the panel, it is clear that he was expressing a wish to be re-housed which should have led to the housing situation being looked at as a part of the overall social circumstances assessment and as an ideal means of engaging with him. Arrangements should have been made to get access to David Bradley in his home setting. The letter of 3 January 2003 contained no reference to his earlier delusional state. There seems to have been something of a shift in the perspective as to what the principal issue in David Bradley's case was. The issue of concordance with medication clearly remained a problem. It is not clear when David Bradley had said that he did not wish to see Consultant Psychiatrist 1 again and there is no hint of that in the letter to GP1. No further outpatient appointment was made but Consultant Psychiatrist 1 indicated to GP1 that she would keep him informed of her involvement. The nature of this involvement is not apparent but no reference is made to his being discharged from the clinic.

On 6 January 2003 documentation was completed by CPN1. This was a Care Coordination Registration and Front Sheet, a Functional Assessment of Care Environments (FACE) Triage Risk Assessment and a Health of the Nation Outcome Scale (HONOS) Client Score Sheet. There is also a Care Co-ordination Care Plan that is undated, but which the panel was informed was completed on the same date. That documentation was based upon contacts with David Bradley up to and including 2 January 2003. He was not actually seen on 6 January. The FACE assessment recorded that there was a provisional diagnosis of "Psychosis/Personality Disorder/Anxiety". David Bradley was described as an "isolated man with fantasy or delusion of paranoid nature". He said that he carried a knife when out of the house and felt "got at". He was recorded as having no social skills, no social contact, drinking four cans of lager daily and smoking cannabis. The HONOS sheet noted a primary diagnosis of "personality or neurosis/anxiety".

Commentary

The panel is of the opinion that the HONOS form contained contradictions in that the primary diagnosis of "personality" or "neurosis/anxiety" did not reflect the record that hallucinations and delusions were present. The FACE triage assessment ought to have been completed within 72 hours of David Bradley having been seen. In contrast to the HONOS assessment, psychosis was indicated in the FACE provisional diagnosis. The panel was informed by CPN1 that he had entertained doubts as to whether David Bradley had actually been in the army. When the aunt confirmed that he had been in the army he no longer regarded this as a possible fantasy or delusion. David Bradley was rated on the FACE assessment as having a score of two (moderate) under the heading of "Delusions" and as constituting a "significant risk" to others but the panel is of the opinion that the net result of the visit of 10 December 2002 and the outpatient appointment of 2 January 2003 was that concern about the severity of his delusions was reduced and his case regarded as being less serious, which was reflected in his level of need being assessed as standard under the care coordination policy.

On 13 February 2003 David Bradley's case was discussed at the CMHT meeting. Later correspondence indicated that an earlier meeting had taken place at Clifton Mount between CPN1, CPN2 and David Bradley when David Bradley had walked out after ten minutes. At the CMHT meeting Consultant Psychiatrist 2, a locum, was in attendance, Consultant Psychiatrist 1 having transferred to another part of the service by that time. Consultant Psychiatrist 2 had assumed responsibility for Consultant Psychiatrist 1's caseload. CPN1 was not in attendance at that meeting and CPN2 was the only person there who had had any direct dealing with David Bradley. The notes of that meeting record that Consultant Psychiatrist 1 had discharged David Bradley from the clinic and that CPN1 had planned to hand his case over to CPN2. It was recorded that David Bradley was not willing to engage in any work and that he regarded the solution to his problems as relocation to the country. The plan was to discharge David Bradley to the care of his GP and he was assessed as being at tier two (low priority).

On 24 February 2003 CPN1 wrote a letter to GP1, copied to Consultant Psychiatrist 2, stating that he was sorry to report that David Bradley had walked out of his last meeting with himself and a CPN colleague after ten minutes, strongly indicating that he did not wish to see them or anybody else from the CMHT again. He reported that he had seen David Bradley twice with CPN2, twice with Consultant Psychiatrist 1 and once by himself. The letter stated that initially CPN1 had leaned towards a formulation that David Bradley had a psychotic illness, characterised by "delusional fantasies and vague hallucinations". He now stated that, whereas the diagnosis of schizophrenia had not been completely discounted, it seemed more likely that David Bradley had an anxiety-based disorder with some personality disorder traits. The letter stated that the precipitating factor causing David Bradley to terminate the last meeting had been his being told that the CMHT "would be unable to rehouse him in a cottage *in the* country". It was said that the team had tried to encourage attendance at the weekly men's group but that this had been rejected and other suggestions for exercise

or activity, building upon his expressed past interests, had been ridiculed by David Bradley. It was said that after the last CMHT discussion it had been decided not to continue to offer appointments but that David Bradley would be written to on the basis that he could contact the CMHT at any time if he wished for an appointment. The letter concluded by inviting GP1 to contact the CMHT if David Bradley presented at the surgery or if his aunt reported deterioration.

On 25 February 2003 a letter was written to David Bradley by CPN1 stating that, after the last meeting, he had not arranged any further appointments but suggesting that David Bradley could contact the team at any time to request one. The letter also pointed out that the team could only help with certain things: "your feelings of anxiety, medication, or activities available to you but cannot help with other needs". It stated that the team could try to put David Bradley in touch with people who could help with those needs. This represented the end of David Bradley's second episode of involvement with the secondary mental health services. Although there is an entry in the medical records dated 3/12/03 which reads "Discuss at CMHT", it is highly likely that the date is inaccurate and ought to read 13/2/03 referring to the CMHT meeting that took place on that date.

Commentary

The panel is of the opinion that this ending to the second episode of involvement with the secondary mental health services was unsatisfactory. The letter of 24 February 2003 refers retrospectively to the meeting between David Bradley, CPN1 and CPN2 at which David Bradley was said to have walked out. This was the crucial factor in the team deciding to terminate its involvement. There is no contemporaneous record of that meeting in the CMHT notes or elsewhere. The CMHT seems to have focused upon David Bradley's desire to move to the country and to have failed to recognize that this may well have been his way of indicating the desire to be re-housed, which he had previously stated explicitly and in strong terms. The letter to the GP referred to David Bradley having had an expressed past interest in cycling but the panel was informed that this was actually an interest of CPN2 rather than David Bradley. The notes of the CMHT meeting of 13 February 2003 contain the statement that Consultant Psychiatrist 1 had discharged David Bradley from the outpatient clinic. Consultant Psychiatrist 1 informed the panel that she had not discharged him and there is no record by her of any such discharge. The panel notes that Consultant Psychiatrist 2 had no prior knowledge of David Bradley and that he had taken over responsibility for Consultant Psychiatrist 1's case load of approximately 300 cases. Consultant Psychiatrist 2 was in no position to make any informed contribution to the discussion regarding the discharge of David Bradley from CMHT care. The entire situation had been downgraded quite significantly from the position that existed when David Bradley had been urgently referred to the CMHT only some three months previously. This disengagement from David Bradley's case was premature and based upon a failure to grasp his true situation and needs. It is clear from later reporting by David Bradley to GP1 that the way in which this episode ended adversely affected his view of what assistance the CMHT might be able to give him.

Period between second and third episodes

There are no entries at all in any records relating to the period of 15 months after David Bradley's discharge from the care of the CMHT in February 2003. The next entry that appears relates to 10 May 2004 when he attended GP1 in his surgery for a mental health review, at which time it was recorded that his sleep was poor and that he felt less settled at that time, which tended to happen in summer. He had not been on any medication. It was noted that he was started on olanzapine, "as per CMHT" and he was advised to limit his cannabis use. He was to be seen again in three weeks time. The next appointment was, in fact, on 14 June 2004 when the entry reads "Depressive disorder NEC with agitation". He was said to be more settled and it was reported that he had walked out of the CMHT because they were "no use to me". David Bradley saw GP1 again on 19 July 2004 when he complained of insomnia and GP1 changed his medication to trazodone (a sedative antidepressant). He was to be seen again in three weeks time. On 24 August 2004 GP1 saw him again and recorded that his condition had improved and he was to stay on current medication.

On 13 October 2004 David Bradley returned to GP1's surgery complaining of an unrelated physical problem and no issues relating to his mental health were recorded at that time.

On 22 July 2005 David Bradley was asked to attend the GP's surgery for a routine mental health review. An entry for 29 July 2005 shows that he was seen by GP1 and reported that he stayed in all of the time, had poor sleep, recurring bad dreams and high alcohol and cannabis use. GP1 decided to try an increase of the olanzapine and advised him to reduce his alcohol and drug intake. He planned to review the position in one month's time but David Bradley did not return at that time.

From 30 November 2005 through to 18 January 2006 there are a number of entries relating to a hand injury, the possible relevance of which is discussed in the chapter relating to the involvement of Keith Purcell. There is no further mention of his mental health until 23 March 2006.

Third and final involvement with secondary mental health services (23 March 2006 - 9 July 2006)

23 March 2006 David Bradley attended at GP1's surgery and it was recorded "Referral to mental health team, crisis point, feels very desperate, is unable to sleep, aggressive/ on edge, has violent impulses, using cannabis, valium, analgesics and alcohol. Would like psych."

GP1 referred him urgently to the CMHT at Clifton Mount. His letter, sent by fax, asked for an urgent assessment of David Bradley stating that he was suffering from severe depression with agitation for the last nine years since he had left the army and that he felt at his worst ever and could not go on. He was drinking one bottle of wine daily and frequently taking cannabis and illicit diazepam. GP1 was concerned about the risk of self harm and reported that David Bradley was very keen to receive psychiatric help. He enquired if he could be seen the following day.

It is apparent from the notes that CPN2 telephoned GP1 to get further information from him the same day. As a result of that conversation it was recorded by CPN2 that David Bradley was feeling increasingly angry and had recently fractured a knuckle when hitting someone. It was also noted that GP1 felt that David Bradley was currently motivated to seek help. CPN2 arranged an urgent appointment for Monday 27 March 2006 and planned to do a joint assessment with the duty worker. He noted that he had dealt with David Bradley previously.

On 23 March 2006 two separate appointment letters were sent out, one for 27 March 2006 and the other for 3 April 2006, both in similar terms save for the dates. There is no further information about the appointment offered for 27 March but David Bradley kept the appointment of 3 April 2006 when he was seen by Social Worker 1 and Approved Social Worker 1. A care coordination assessment was carried out, which was reasonably detailed and began by stating that the referral was due to severe depression/agitation. The history that David Bradley gave was recorded and his previous involvement with the secondary mental health services in 1998 and 2002 was noted. It was stated that he had a history of assault and that the last incident had occurred in November 2005 when he had punched someone with whom he had argued over a drugs deal. He said that he had twice broken his hand due to punching people. He used to carry a knife with him when he went out but had stopped doing that after being cautioned by the police. It was said that he would like to become more independent and gain his own tenancy. In contrast to what was reported by GP1, it was recorded that David Bradley did not drink on a daily basis but drank heavily on occasions. The only drug that he was recorded as ever having used was cannabis; he was recorded as stating that he had not used Valium (diazepam). It was noted that on several occasions during the assessment David Bradley appeared to stare into space and, when he was brought back into the discussion, appeared to be genuinely disorientated. At the conclusion under "Further action" it was stated that there should be a further assessment in the outpatient department, consideration should be given to the use of Plummer Court (the substance misuse service) and that David Bradley appeared to have a significant risk history of violence and should be seen by two workers at interview until further assessment had taken place. It was recorded that he was accepted for care coordination at the enhanced level.

David Bradley signed a consent form in relation to the sharing of information. His signature is not dated but that of Social Worker 1 is recorded on 5 April 2006.

On 13 April 2006, following the initial assessment, Social Worker 1 wrote to David Bradley offering him a further appointment with herself and Consultant Psychiatrist 3 on 18 May 2006 at Clifton Mount. On that date David Bradley attended his outpatient appointment and was seen by Consultant Psychiatrist 3 and Social Worker 1. He said that he had poor sleep with three to four hours maximum; he woke up at 4 am then had a drink to help him sleep, with variable success; his appetite was erratic and he had no interest in food; he felt frustrated a lot of the time with his situation; he isolated himself and did not have any social contacts. His mood was variable and he had spells of feeling upset, which were triggered by memories of past events, although he was unwilling to discuss those in detail. He was using cannabis daily which he felt helped him to deal with those thoughts and he was often "too stoned" to do anything else in the day. He was still prescribed 5 mg of olanzapine daily but said that he forgot to take it most nights. He did not like where he lived as it held too many reminders of his abusive childhood. He was hearing voices both inside and outside of his head that had conversations with him but they were not commanding in nature. He stated that, for some time, he had not been carrying a knife with him when he went out and had not been getting into fights lately. He denied thoughts of suicide or of harming others and was very clear that he was not depressed. Consultant Psychiatrist 3 noted that he had variable eye contact, that it was difficult to establish rapport with him, he was very guarded and did not spontaneously volunteer much information. Even on questioning he was guarded about details and after a while had become tense and asked to leave the room, which he did for a few minutes. He smiled inappropriately on being asked many questions. Consultant Psychiatrist 3 noted that he had partial insight into his condition and noted possible diagnoses as schizophrenia/post-traumatic stress disorder (PTSD) and antisocial personality disorder.

Under the heading "Plan" there were four entries which were: 1 - patient reluctant to consider any intervention especially by Plummer Court; 2 - continue olanzapine 5 mg daily; 3 – waiting list - CMHT- housing and other issues; 4 - review in one month's time.

On 24 May David Bradley's case was discussed at the weekly CMHT meeting when it was noted that he had been placed on the waiting list for allocation, that he was to be seen again by Consultant Psychiatrist 3 in the Thursday clinic for a joint assessment with the care coordinator, who was to be allocated by that time.

On 26 May 2006 Consultant Psychiatrist 3 wrote to GP1 reporting on that outpatient consultation. In the final paragraph of that letter, before the treatment plan was outlined, Consultant Psychiatrist 3 reported "In the past it has been questioned whether David has a history of antisocial personality disorder or not. It does appear that there is some suggestion that he may be having a psychotic illness of a schizophrenic nature. It is also likely that he has post-traumatic stress disorder because of his experiences in childhood and those during his tenure with the army. However, we have not established a relationship enough to explore these in any great detail. It also appears that his psychotic processes may be driven by his drug use."

David Bradley was not seen by anyone from the secondary mental health services after that initial consultation with Consultant Psychiatrist 3 prior to 8 July 2006 when, over the space of a few hours, he shot and killed his uncle, aunt and two cousins.

It is recorded in the notes of the outpatient appointment of 18 May 2006 that his case was to be reviewed in one month's time and stated in the letter to GP1 of 26 May 2006 that it had been arranged that David Bradley would be reviewed in one month's time. There is no record of any such appointment being made or of any further step being taken by the secondary mental health services prior to the shooting of the four victims in this case on the night of 8 to 9 July 2006.

Commentary

The initial response to GP1's urgent referral was prompt and appropriate. However, the panel is of the opinion that his subsequent care fell below acceptable standards and that there are a number of areas of concern.

These are:

- *nobody took responsibility for the management of David Bradley's case*
- *there was undue delay in David Bradley being seen in the outpatient clinic after the initial assessment*
- *David Bradley was not seen after the outpatient appointment of 18 May 2006*
- *there is no record of any follow up after David Bradley was seen on 18 May.*

The initial assessment concluded that his case was complex and that "there was a significant risk history of violence" but no FACE risk assessment was completed. David Bradley was accepted for enhanced care coordination. That ought to have resulted in the allocation of a care coordinator. Neither Social Worker 1 (the assessor) nor the team manager was aware that the care coordination policy then in force imposed upon the assessor responsibility for putting in place care arrangements for the urgent clinical needs of David Bradley. This is fully detailed in the chapter on Policy and Practice.

The panel noted that neither Social Worker 1 nor the CMHT manager nor Consultant Psychiatrist 3 was clear as to upon whom responsibility for David Bradley's case fell before the formal appointment of a care coordinator. After the outpatient appointment at which it was confirmed that David Bradley required enhanced care coordination both Social Worker 1 and Consultant Psychiatrist 3 were of the view that Social Worker 1 no longer had any responsibility for the patient but equally Consultant Psychiatrist 3 was clear that he would not, under any circumstances, be the care coordinator for a patient on enhanced care coordination. As a result nobody carried responsibility for care co-ordinating David Bradley's case in the period between the outpatient appointment and the killing of David Bradley's family.

There was a gap of over six weeks between the initial assessment and the outpatient appointment which was regarded as necessary to complete the assessment of David Bradley. The panel was informed that before patients could be placed upon the waiting list for enhanced care coordination they had to be assessed by a consultant psychiatrist. The panel is of the view that this was not a requirement of the trust's policy and it is not good practice to require it in every case. David Bradley needed to be seen by a psychiatrist, because of the complexity of diagnosis, but that ought to have occurred much more rapidly than was the case. The panel was informed by Consultant Psychiatrist 3 that the urgency of David Bradley's case had been recognised at the team meeting and that a more rapid appointment could have been offered. The panel considers that the delay of over six weeks between the assessment and the outpatient appointment was unacceptable.

After the outpatient appointment Consultant Psychiatrist 3 agreed that David Bradley's case was complex and that he required enhanced care coordination, for which he was placed on a waiting list. The care coordination policy in operation had no provision for a waiting list. The panel was informed that the waiting list existed because of lack of resources and workload pressures. The arrangements for the management of the waiting list were informal and unclear. As someone who had been recognised as having complex needs, requiring enhanced care coordination and in whose case there was an element of risk, the panel was of the opinion that putting David Bradley on a waiting list was inappropriate and that a care coordinator ought to have been allocated promptly. The delay in giving an outpatient appointment and the use of a waiting list for allocation of a care coordinator resulted in David Bradley's care not being managed.

The final entry on the clinical notes in relation to the appointment of 18 May 2006 states "review in one month's time". This was confirmed in the letter to GP1, which was the first feedback that he had received since his urgent referral on 23 March 2006. The panel was informed, by Consultant Psychiatrist 3, that an appointment had been made for David Bradley for 15 June 2006 and that he failed to attend that appointment. Consultant Psychiatrist 3 informed the panel that his usual practice was to record appointments himself in his work diary and that he had issued an appointment card to David Bradley. That diary was provided to the panel but contained no record of any appointment for David Bradley and there was no other record of any such appointment. The medical notes contained no record of David Bradley's failure to attend any appointment after the outpatient appointment of 18 May 2006 nor is there any other record of such a failure.

There is no record of any further step being taken by Consultant Psychiatrist 3, although he informed the panel that after the failed outpatient appointment he was considering a home visit but rejected that idea because David Bradley had reacted negatively to such a visit previously. The only home visit that had occurred in this case was on 10 December 2002, some three and a half years previously. No further action was taken by any other member of the team.

From the information given to the panel it is clear that there was a failure in record keeping and to ensure that follow up took place.

The panel is of the opinion that there was an overall failure actively to manage David Bradley's case after the initial assessment and that this was particularly so in view of the urgency of the referral by GP1 and David Bradley's documented desire for psychiatric assistance and willingness to engage at that time. Had ownership of David Bradley's case been taken, the panel would have expected a number of areas to have been addressed in a timely fashion. These should have included a full and detailed risk assessment and a full social circumstances assessment which would have addressed housing needs, a subject that David Bradley had consistently raised and which would have been an ideal way to engage with him and to have encouraged him to cooperatewith an active management and treatment plan. The social circumstances assessment would have clarified the situation relating to other family members. Other areas that should have been addressed were a further assessment of his PTSD symptoms which might have led to a referral to psychology services and attention to his known poor compliance with medication. Medical review should have been assured.

4. Relevance of Keith Purcell's situation

Keith Purcell, David Bradley's first victim, was himself a patient of the same mental health service. In the mental health records of Keith Purcell it is recorded, in an entry dated 8 August 2005, that he had lost his flat and was now living with his mother. It is not clear precisely when Keith Purcell moved back in with his mother, into the same address as David Bradley, but assuming that entry to be correct it had occurred by that date. This event may have been of the very greatest significance. It is not necessary or appropriate to consider the records of Keith Purcell other than in relation to how they impact upon the case of David Bradley; it suffices to say that he clearly had very significant mental health issues of his own and had a prolonged history of involvement with the secondary mental health services.

At 5.57 am on Wednesday 30 November 2005 Keith Purcell telephoned the police using the 999 emergency number, stating that three men, named as Glenn Purcell, David Bradley and another unnamed person were in the family home in Newcastle and had shotguns. The police acted in response to that call, but Keith Purcell's mental health problems and previous spurious phone calls had been noted in police records and, since checks revealed no trace on David Bradley nor any information relating to firearms at that address, telephone contact was made with Keith Purcell who stated that "someone had been rewiring his house". The police therefore took the view that no firearms were involved and a police sergeant gained entry to the house by himself, being admitted by Keith Purcell, who was in an agitated state. Keith Purcell indicated to the sergeant that "they were upstairs" at which point David Bradley came downstairs, in an annoyed state, and said that Keith Purcell was mad and was talking rubbish. Josie Purcell told the police sergeant that there was nothing wrong in the house, definitely no firearms there and that the only people in the house were herself, her husband, Keith Purcell and David Bradley. She was frustrated with the behaviour of Keith Purcell and said that he had been keeping people awake for most of the night. Mrs Purcell stated that she had been having a lot of problems with Keith owing to his deteriorating mental state and needed some professional help. During the visit Keith Purcell is described as "speaking unintelligible nonsense". David Bradley was recorded as showing no obvious cause for concern other than annoyance at the fact that Keith Purcell's actions were preventing him from sleeping. The sergeant attended Hadrian Clinic and spoke to staff who indicated that they would contact the duty CAT team and ask them to attend the address in the morning. The matter appears to have been dealt with appropriately so far as the care of Keith Purcell was concerned.

There is no reference in the police record of the incident that David Bradley had any injury of note. It is clear from hospital records, however, that David Bradley had attended the accident and emergency department at Newcastle General Hospital at 2.12 am on 30 November 2005 with an injury to his right hand. He is recorded as saying that he had had a fall and also that he had struck a wall.

A letter, dated 7 December 2005, from a consultant orthopaedic surgeon at Newcastle General Hospital to GP1 states that David Bradley had allegedly fallen on his hand "yesterday" (6 December 2005) and had initially been seen at the accident and emergency department where a fracture of the hamate (a bone in the wrist) was diagnosed and he was referred to the hand clinic, and then referred back to the fracture clinic. Another letter, dated 8 December 2005, from the Department of Plastic and Reconstructive Surgery confirmed that history. The true cause of this hand injury to David Bradley is not clear from the available records. He was later to tell Consultant Forensic Psychiatrist 1 (who reported for the criminal proceedings) that the injury had been caused when he struck Keith Purcell. A relative also reported in a later witness statement that, two weeks prior to the shooting of the victims in this case, David Bradley had "tried to wrap a crutch round Keith's neck and had to be stopped". None of this appears to have been volunteered to the police or to any mental health worker involved with either David Bradley or Keith Purcell.

On 24 March 2006 CPN3, Keith Purcell's care coordinator, visited him at his home. He had recently undergone a hip operation, which had been complicated by an infection. In a full note dealing with Keith Purcell's problems she noted that "David who lives with them was a stress factor". In a later letter, dated 21 April 2006 she reported to Consultant Psychiatrist 3 that, in relation to Keith Purcell's mental health problems just prior to Christmas 2005, he had identified stress at that time "in relation to a family friend (David) who lives with Keith and his parents". She reported that Keith had said that David had mental health problems of his own and was a stressful factor in the house for both him and his mother. She also said that on previous occasions she had spoken to David on the phone and once at the front door when trying to make contact with Keith, and had found him to be obstructive and unhelpful.

Commentary

According to what David Bradley said to the police after killing his relatives, the incident began when he had smashed his room up and was then causing a disturbance in an upstairs passageway. Keith Purcell remonstrated with him which resulted in David Bradley running downstairs, assaulting him and then going back upstairs and getting a gun. Keith Purcell was the first of the four people that David Bradley killed. A review of all of the evidence demonstrates that David Bradley and Keith Purcell living in the same household was problematic. It is not clear whether the injury to David Bradley's hand on 30 November 2005 was caused in any incident with Keith Purcell and that was certainly never suggested when the police were in attendance. David Bradley did, however, later admit to hitting Keith Purcell. It is clear that at the very time that GP1 was making his final urgent referral in relation to David Bradley's mental health problems it was being noted by Keith Purcell's CPN that David Bradley's presence in the same household was a source of stress to both Keith Purcell and his mother.

According to what David Bradley said to the police after killing his relatives, the incident began when he had smashed his room up and was then causing a disturbance in an upstairs passageway. Keith Purcell remonstrated with him which resulted in David Bradley running downstairs, assaulting him and then going back upstairs and getting a gun. Keith Purcell was the first of the four people that David Bradley killed. A review of all of the evidence demonstrates that David Bradley and Keith Purcell living in the same household was problematic. It is not clear whether the injury to David Bradley's hand on 30 November 2005 was caused in any incident with Keith Purcell and that was certainly never suggested when the police were in attendance. David Bradley did, however, later admit to hitting Keith Purcell. It is clear that at the very time that GP1 was making his final urgent referral in relation to David Bradley's mental health problems it was being noted by Keith Purcell's CPN that David Bradley's presence in the same household was a source of stress to both Keith Purcell and his mother.

It is clear that there was no marrying up of the management of Keith Purcell and of David Bradley. Given that the same CMHT was involved with both individuals and that they had the same address registered in the records and, indeed, ultimately the same consultant psychiatrist, the panel was surprised that this situation was not identified. That is particularly so when David Bradley had repeatedly referred to the situation in which he was living as being one of his perceived problems and had wanted to be re-housed for a considerable period. The panel is of the view that in a properly functioning CMHT there would be an awareness of the social circumstances of each patient and that any proper assessment of those circumstances would have identified that situation. This highlights the failure to carry out any timely and adequate assessment of family and social circumstances in relation to David Bradley.

It is impossible to say what would have happened had the CMHT realised that two patients were residing in the same household and that each one was a stress factor in relation to the other. It is clear, however, that it would have been an important piece of knowledge in relation to the assessment of risk and the management of each patient.

5. Overview of psychiatric care

The psychiatric treatment of David Bradley falls into three discrete episodes. This summary will begin with an outline of David Bradley's personal history prior to his first psychiatric care. Then each episode of treatment will be discussed, followed by concluding comments.

The period prior to first psychiatric referral

David Bradley was first seen by the psychiatric services in December 1997 when he was aged 32 years. There is nothing in his general practice notes or in his army medical records to suggest that he suffered from any serious psychiatric disorder prior to that referral. According to his general practitioner notes he suffered from nightmares at the age of four, for which he was prescribed the sedative medication phenergan. Later that year he is recorded as having developed a torticollis (a twisting of the neck). This can be a side effect of phenergan, but his general practitioner regarded it as a traumatic injury and prescribed a support collar. Shortly before his fifth birthday he was recorded as having behavioural problems, the nature of which was not specified, and he was again prescribed phenergan. He later gave a history of arguments and violence between his parents during his childhood. He also gave a history of having been bullied at school and frequent truanting from the age of 14. He said that he had no real friends and was never able to "connect with people".

His parents separated when he was 11 years old and he stayed first with his father and then with his mother until the age of 17. He and his mother frequently argued and he said that she used to hit him. Eventually he hit her back and then left home at the age of 17 to live with the Purcells until he joined the army at the age of 22.

Whilst in the army he had a variety of postings, and although he was not involved directly in combat he was later to describe stressful and distressing incidents that took place whilst he was on patrol in Northern Ireland. He began using cannabis in order to help him cope with these experiences.

In summary, his history prior to the first psychiatric referral provides indications of a troubled childhood, bullying and truanting at school, emotionally traumatic experiences whilst on patrol with the army in Northern Ireland, and the use of cannabis as a way of coping with these experiences.

First episode of psychiatric care

David Bradley was first seen in the psychiatric outpatient clinic in December 1997 following referral by his general practitioner. He gave a history of feeling extremely tense and agitated. He felt that he was on patrol in the streets, as he had been when in the army. He was finding people so irritating that he was isolating himself in his room. During the interview he was agitated and tense, pacing the room and shaking. His mood was labile and irritable. He complained of feeling extremely tense and felt as though he wanted to kill somebody. He said that he had felt worse since leaving the army. No symptoms of psychosis were identified. He denied drug abuse. He was regarded as suffering from antisocial personality traits and was prescribed clopixol to reduce his level of arousal.

He was reviewed again in the outpatient clinic in January 1998. He had taken the clopixol for only one day and said that he did not like taking tablets. Nevertheless he reported that he felt much better. The consultant arranged an electroencephalogram (EEG) to exclude temporal lobe epilepsy.

In March 1998 he was seen again by the consultant in the outpatient clinic. His EEG had been reported as normal. He said that his mood had worsened over the last few weeks. The psychiatrist, although believing that the primary diagnosis was antisocial personality disorder, decided on a therapeutic trial of sodium valproate as a mood stabiliser. This was prescribed because of the remote possibility that he was suffering from a rapid cycling mood disorder even though the psychiatrist believed that the evidence for this was tenuous. On his next and final outpatient appointment in May of the same year he again reported feeling much better although he had taken the sodium valproate for only one or two weeks. He again expressed reluctance to take medication. The consultant wanted to refer him to an anger management group but none was available. In the circumstances, the consultant felt that there was nothing more that could be done and he was discharged back to the care of his general practitioner.

Second episode of psychiatric care

David Bradley was referred back urgently to mental health services in November 2002. The referral had been precipitated by concerns expressed by a psychiatrist who was doing voluntary work for the CAB which David Bradley had attended. The letter to the CMHT from the general practitioner refers to David Bradley expressing delusions, hearing voices and carrying a knife. David Bradley was seen in the psychiatric outpatient clinic in December 2002, by the consultant psychiatrist together with the CPN who had carried out the initial assessment. The psychiatrist working with the CAB in a voluntary capacity was a consultant in learning disability with a background in forensic psychiatry. This added gravity to the concerns that he had expressed, but the assessing consultant in the outpatient clinic was not aware of that background.

When seen in the outpatient clinic David Bradley complained of being tense with sleep disturbance, social isolation and feelings of irritation towards his aunt leading to thoughts of physical aggression, though no actual violence had occurred. He also felt irritable when other people looked at him and feared that he might lose control. The psychiatrist noted paranoid delusions and auditory hallucinations, but when interviewed by the panel said that the paranoid ideas might not have reached delusional intensity. At the interview the psychiatrist also mentioned that David Bradley exhibited some features of PTSD, although this was not explored in depth at the time of the original outpatient consultation. The differential diagnosis given at that time was between schizophrenia, drug induced psychosis and antisocial personality disorder. A prescription was given for olanzapine 10 mg at night, and the management plan included a home visit, obtaining further information from his carer, an ongoing attempt to build a therapeutic relationship, and a review in the outpatient clinic in three weeks time.

When reviewed in the outpatient clinic in January 2003 David Bradley reported that he had not been taking his olanzapine regularly. The letter to the general practitioner recording that visit makes no mention of the apparent psychotic symptoms and the aggressive feelings that were noted on the first visit. He was encouraged to take the olanzapine in a reduced dose, because he had complained of side effects, and consideration was given to him joining a men's group that was due to start shortly thereafter. The differential diagnosis was modified to lie between schizophrenia, drug induced psychosis and anxiety.

Subsequently the consultant left that part of the service and therefore did not see the patient again. A different consultant psychiatrist joined the team as a locum. At a team meeting in February 2003 it was said that the previous consultant had discharged this patient from the outpatient clinic, and it was planned that he should be discharged to the general practitioner. The meeting was attended by the locum consultant, who had no prior knowledge of David Bradley. When interviewed, the original consultant said that David Bradley had not been discharged from the outpatient clinic, and it is not clear to the panel how this misunderstanding had arisen. In the discharge letter to the general practitioner, the CPN, having previously discussed the matter with the original consultant ,offered the opinion that although a diagnosis of schizophrenia had not been completely discounted it was more likely that the patient was suffering from an anxiety based disorder, possibly with some traits of personality disorder.

Third episode of psychiatric care

In March 2006 the general practitioner again requested an urgent assessment of David Bradley who was considered to be severely depressed and agitated, drinking heavily and abusing cannabis and diazepam. He was seen by a consultant psychiatrist, in the outpatient clinic in May 2006, together with a CMHT member who was one of two who had done an initial assessment. He complained of sleep disturbance, feelings of frustration, social isolation, and of being upset by recollections of past events that were triggered, for example, by some television programmes and noise outside the house. He was maintaining a state of intoxication with cannabis and was seldom taking the olanzapine that was still being prescribed. He reported feeling under threat and hearing voices, though it was not clear to the consultant whether these were true hallucinations or pseudohallucinations. It was also reported that he appeared to have delusions of persecution which led him to bolt the door of his room at night. He denied carrying weapons or having had episodes of violent behaviour.

The consultant thought it possible that David Bradley was suffering from psychosis of a schizophrenic nature, perhaps driven by his cannabis use. The letter to the general practitioner does not indicate any concerns about risk. It was also thought likely that he suffered from PTSD resulting from experiences in childhood and in the army. It was noted that he was quite guarded, gave minimal cooperation and that he was reluctant to consider any intervention, especially with Plummer Court. He was encouraged to continue taking the olanzapine and placed on the waiting list for allocation of a care coordinator to help with housing and other issues. It is recorded that an outpatient review had been arranged in one month's time. No psychiatrist from secondary services saw David Bradley again prior to the incident.

Commentary

This was a complex and multifaceted case which presented difficulties both in diagnosis and in management. The essential approach to such cases is a comprehensive, coherent and well executed package of multidisciplinary care. There were plainly deficiencies in the care package that was provided for David Bradley.

In the first episode, an attempt was made to help David Bradley by means of a purely medical approach in the outpatient clinic. There was no clear indication for requesting an EEG or for the prescription of either clopixol or sodium valproate. In the view of the panel the possibility that either of these drugs would help him was remote. The panel was informed by the consultant that a CMHT was in existence which included a psychologist. Those resources were not utilised as the complexity of David Bradley's presentation was not considered sufficient to warrant full CMHT involvement, although referral to a psychologist might have been considered. The medical approach was ineffective in dealing with David Bradley's underlying problems.

The second episode raises several issues. At his initial interview, David Bradley was regarded as probably suffering from psychosis with sufficient confidence to justify the prescription of an antipsychotic medication. He had a known history of non-compliance with medication, yet no active steps were taken to address this. The possibility of PTSD was not explored and the need to assess this was not recorded as part of his future care needs. The manner in which he was discharged by the team was unsatisfactory, because the only medical involvement was through second-hand information which was incorrect. The consultant who was present at the team meeting where this decision was made had no knowledge of the patient beyond what was said at the meeting. Overall, there appears to have been a downgrading of the seriousness of this patient's presentation, which started with probable psychosis and reports of aggressive impulses, and ended with non-psychotic diagnoses and no further mention of aggression. The evidence upon which this downgrading of severity was based is unclear.

In relation to the third episode yet again, no systematic attempt was made to enhance compliance with his antipsychotic medication. No arrangement was made for a more detailed assessment of possible PTSD, though the consultant was to say later that this had been his intention. It is plain that, significantly, something went wrong with the follow up outpatient appointment so that it did not occur and no further action was recorded in relation to it at that time. Because there was no care coordinator, there was nobody taking an overview of the care of this patient. If there had been, then the failure of medical follow-up ought to have been noted and dealt with. Whilst this does not absolve the consultant involved from responsibility for ensuring proper medical follow-up, it does mean that an important safeguard was not in place. The lack of a care coordinator also contributed to other deficiencies in the overall care of David Bradley.

At the time of each episode, consultants were working with CMHTs, but they were not fully embedded within the teams and maintained separate outpatient clinics. This can be seen as directly relevant to the problems that arose with David Bradley's care. In each episode, medical involvement was in practice limited to a diagnostic formulation and the prescription of medication. Significantly, confusion regarding the consultant's opinion on whether he should be discharged after the second episode might have been avoided in a more integrated team.

Three documents have been produced that focus on the way in which mental health teams should be organised in order to provide a modern mental health service. These are New ways of working for psychiatrists: Enhancing effective, person- centred services through new ways of working in multi-disciplinary and multi-agency contexts *(Department of Health, October 2005);* Creating Capable Teams Approach (CCTA) *(Department of Health, April 2007)* and Mental Health: New Ways of Working for Everyone *(Department of Health, October 2007). The guidance contained within these documents provides a framework for a service model that would help to avoid many of the issues that arose in the management of David Bradley.*

New Ways of Working for Everyone contrasts an old style of working, in which the consultant is described as the "'boss'" but "semi-detached" from the team and as having many other responsibilities such as large outpatient clinics and ward rounds, with a new type of service. Under the old system, consultants carry large caseloads typically of more than 300 patients, generally seen in an outpatient clinic. Under New Ways of Working, the consultant and other medical staff are fully integrated into teams. In these "new" teams, responsibility for different aspects of care is taken by whichever team member is most expert in that area, and patients with multiple needs have a designated care coordinator to ensure that all aspects of care are assessed and managed. Consultants should focus on patients with the most complex needs for whom their particular expertise would be needed. It is emphasised that care should be "patient-focused", taking the expressed wishes of the patient into account as a matter of priority. It is also emphasised that the team should have a clear and transparent caseload management system in place, and that all team members, including the psychiatrists, should be open to challenge about their case-mix.

- *It is plain that application of these principles would have mitigated some of the problems that arose in David Bradley:*

- *during the first episode, David Bradley as he then presented would not have been regarded as primarily requiring the skills of a consultant psychiatrist, and so his care would not have been dealt with on a purely medical basis*

- *there would have been the opportunity for an effective handover of David Bradley's case between consultants at the end of the second episode as the consultant case load would have involved only a relatively small number of complex cases*

- *the team approach, led by the care coordinator, would have ensured that all aspects of patient care were properly addressed*

- *the skill sharing that is a necessary part of this form of team working would have enhanced the likelihood that other team members would have taken responsibility for ensuring concordance with medication, instead of this being seen as solely a medical responsibility*

- *other aspects of this guidance, such as the need for a clear caseload management system, effective leadership, good communication and patient focused care are all also relevant to the care of David Bradley though not specifically in relation to his psychiatric care.*

6. Policy and practice issues

First episode
(29 October 1997 – 15 May 1998)

David Bradley was referred on 29 October 1997 by his general practitioner to Wesley House Community Mental Health Centre. He was seen by a consultant psychiatrist and a senior house officer in the outpatient clinic at Hadrian Clinic on 12 December 1997.

The panel did not have access to the local care programme approach (CPA) policy for the above dates. The local CPA policy was that used by the Newcastle City Health NHS Trust. However, following a series of trust mergers that trust became part of NTW.

The national policy guidance in force at that time was issued in 1990 as the Department of Health Circular HC (90) 23: *"Caring for People" The care programme approach for people with a mental illness referred to the specialist psychiatric services.*

By the time of this episode, in furtherance of the implementation of CPA, the trust was using documentation that indicated levels of complexity of assessed client needs as "minimal", "more complex" and "full multi-disciplinary".

The consultant psychiatrist assessed David Bradley as needing minimal CPA and therefore took on the role of key worker. The records show that David Bradley was registered on CPA on 6 March 1998, when a tick-box risk assessment form was also completed. The ticked boxes record that the patient had a history of a threat of violence but no actual violence or current risk of violence.

Commentary

David Bradley was seen as an outpatient with no complex needs and as such was on the minimal level of CPA which fitted with his presentation at that time.

Although referred in October 1997, David Bradley was not registered onto CPA until March 1998.

The CPA risk assessment tool noted that David Bradley had a history of a known threat of violence. The consultant psychiatrist noted, in relation to David Bradley's mother, that he had "beat her up" but did not record that in the risk assessment under the domain of "known violence".

Second episode
(18 November 2002 – 23 February 2003)

By the time of the second episode the circular HC (90) 23 had been supplemented, in 1999, by a policy booklet published by the Department of Health entitled *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach*. Its four main elements were:

- "Systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services
- The formation of a care plan which identifies the health and social care required from a variety of providers
- The appointment of a key worker to keep in close touch with the service user and to monitor and coordinate care and
- Regular review and, where necessary, agreed changes to the care plan."

The policy identifies two levels of care coordination; "Standard" and "Enhanced" and states:

"The characteristics of people on standard CPA will include some of the following:

- they require the support or intervention of one agency or discipline or they require only low key support from more than one agency or discipline;
- they are more able to self-manage their mental health problems;
- they have an active informal support network;
- they pose little danger to themselves or others;
- they are more likely to maintain appropriate contact with services.

People on enhanced CPA are likely to have some of the following characteristics:

- they have multiple care needs, including housing, employment etc, requiring inter-agency co-ordination;
- they are only willing to co-operate with one professional or agency but they have multiple care needs;

- they may be in contact with a number of agencies (including the Criminal Justice System);

- they are likely to require more frequent and intensive interventions, perhaps with medication management;

- they are more likely to have mental health problems co-existing with other problems such as substance misuse;

- they are more likely to be at risk of harming themselves or others;

- they are more likely to disengage with services."

The policy stipulates that service users are to be given full information about the CPA process and a copy of the agreed care plan.

The earliest care coordination policy the panel had access to was the 3Ns policy dated March 2003. However the documentation used in the care of David Bradley was clearly headed "Care Co-ordination Policy" and staff interviewed by the panel confirmed that care co-ordination was the care system in use in 2002/2003.

The local operational guidelines (OGs) which were in use at that time referring to care coordination for the Newcastle CMHTs in the 3Ns Trust state that "all appropriate referrals will be offered a comprehensive health and social care assessment of need, using the Care Co-ordination Assessment format, including FACE risk assessment, and discussed at the MDT (multi-disciplinary team)". Urgent referrals will be seen within four working days by a CMHT worker and "Following assessment presentation, the MDT chair will confirm the following:

- Current diagnosis and needs identified.

- Risk Assessment and Management Plan.

- Priority for allocation, using the Northumberland Tiered approach. Highest priority users (tier 4) will be allocated immediately, middle priority (tier 3) will be allocated promptly and low (tier 2) may be placed on a waiting list.

- Name of Care Co-ordinator and level either standard or enhanced.

- Recommendations about any Care Plan or advice to referrer if not assessed for allocation (tier 1)."

The final stage in the assessment process as per the OGs is that the assessor will inform the referrer of the outcome of the assessment within one week of the MDT discussion and an up to date care coordination assessment will be forwarded.

The then current operational policy for the CAT team states that "Criteria for the CAT service are:

- The person must be presenting with significant risk of self-harm or harm to others.
- That Inpatient admission is being considered or
- That the person needs to be seen within the next 24 hours.".

Commentary

The advice from the CAT service to the general practitioner that David Bradley would be best assessed at accident and emergency was appropriate and in accordance with their policy.

David Bradley was seen within four days of the referral on 18 November 2002 by the GP to the CMHT which was in accordance with the OGs for urgent referrals then in place.

No time scales are given for the completion of the care coordination assessment process in the OGs but in the case of David Bradley they were not completed until 6 January 2003, and even then there was no comprehensive social care assessment. There is no record of David Bradley agreeing his care plan or being given a copy of it. The follow up appointment on 5 December with the team consultant psychiatrist and CPN was agreed at the MDT as per the OGs.

The consultant psychiatrist and CPN thought the Care Co-ordination Assessment form was sent to the general practitioner. However the general practitioner did not receive the assessment and the first information he received was from the assessment letter sent to him by the team consultant psychiatrist in the letter dated 23 December 2002, five weeks after making the urgent referral. The OGs state that the referrer will be informed of the assessment outcomes within one week. The general practitioner informed the panel that he would not wish to receive the full care coordination assessment but a timely and concise summary of the findings and care plan would be helpful.

The management plan for David Bradley contained in the letter to the general practitioner from the team consultant psychiatrist indicated a number of actions that were not included in the care plan recorded in the CMHT meeting notes, in particular the need to obtain further information from the aunt and David Bradley's general practitioner.

The CMHT meeting notes make no reference to care coordination. They note priority for allocation using the Northumberland tiered approach. David Bradley was not assessed according to the criteria set out in the national policy guidance for allocation to standard or enhanced care coordination. The national guidance policy is focused on patient needs whereas the panel was informed that the use of the tiered approach was resource driven and was not compatible with care coordination. In the view of the panel the national guidance should have been followed.

Third episode
(23 March 2006 onwards)

In March 2006, immediately before the creation of NTW, a briefing paper went to all staff instructing them to use all existing polices until the new trust had approved or revised policies. In April 2006, following the creation of NTW, an interim care coordination and care programme approach process policy document was issued confirming that local policies would continue to apply. The panel has used the 3Ns care coordination policy as its reference source for the application of care coordination in the period April to May 2006.The policy makes reference to the 1999 *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach and the Mental Health National Service Framework*. The policy states that there will always be a named care coordinator. The policy also outlines the assessment process including the following:

- systematic assessment of health and social care needs

- assessments of risk to be integral to initial assessments

- that once a service user has received an assessment, or part of the assessment process where two or more sessions are required, the service assumes some responsibility for the person. The policy states that "in practice, this means that the assessing clinician needs to put in place care arrangements that meet any urgent clinical need". This was designed to ensure that service users will not fall into gaps in services at transition points

- that decisions following assessment cannot be made collectively by team meetings. "This responsibility rests with the professional carrying out the assessment"

- reference to the two levels of care coordination; Level 1 (Standard) and Level 2 (Enhanced)

- the responsibilities of the care coordinator.

The same OGs described in the second episode were still in place for CMHTs at the time of the third episode. The notes of the CMHT weekly meeting of 5 April 2006 state that the assessing social worker would arrange an appointment with the consultant psychiatrist. The notes of the CMHT weekly meeting of 24 May 2006 state that David Bradley had been seen by the consultant psychiatrist, but the assessment had been inconclusive and he was to be seen in the Thursday clinic and a care coordinator appointed by that time. There is no reference to a tier of complexity being agreed or a level of care coordination.

After the outpatient appointment at which it was confirmed that David Bradley required enhanced care coordination both the assessor and the consultant psychiatrist were of the view that the assessor no longer had any responsibility for the patient but equally the consultant was clear that he would not, under any circumstances, be the care coordinator of a patient on enhanced care coordination. As a result nobody accepted responsibility for managing David Bradley's case. The clinical manager and the divisional manager expressed the view that, prior to formal allocation, the responsibility was that of the team manager, but that was not something that the team manager recognised nor was it in the trust policy.

The team manager stated that a patient referred to the CMHT would have to be seen by a consultant psychiatrist before he could be registered as needing enhanced care coordination. That step in the assessment process is not supported by the care coordination policy.

During this episode the trust had a policy *Non Attendance (Did Not Attend) 3NTW(C) 28 – Issue 2*. That policy was to be read in conjunction with the care coordination policy of the trust. The policy covered the actions to be taken if a service user did not attend for a scheduled appointment. The policy states "this would apply to any appointment with care coordinators/clinicians, not just medical outpatients".

The policy sets out a variety of responses, depending upon the severity of mental illness and level of risk, in relation to a patient who fails to attend, including; contacting the GP, contacting the user, sending a further appointment, discussion with the MDT and arranging a domiciliary visit.

Section 6 is headed "Recording of 'Did Not Attends'?". This section deals with cancelled appointments and also states that "All 'DNAs' will be collated by the team administrator/secretary, following locality procedures". There is no other guidance or requirement in relation to what should be recorded following a DNA.

Commentary

David Bradley was seen seven working days after referral rather than within four as required by the OG.

Although within the care coordination assessment document mention was made of David Bradley having been violent, the FACE risk assessment had not been initiated and there was no indication of tier level. No assessment of social care needs was carried out nor was a care coordinator appointed although the assessing social worker had identified David Bradley as needing enhanced care coordination. The housing issues were not explored in the assessment or care planning process even though these were a consistent theme in David Bradley's presentation.

The practice of the CMHT was not in accordance with the OGs. The team manager in evidence stated that it was only after the patient had been seen by the consultant psychiatrist that he could be registered as needing enhanced care coordination. That is not written into either the OGs or the care coordination policy.

The letter of 26 May 2006 was the first communication of the assessment outcome that the referrer had received from the secondary mental health services following the urgent referral on 23 March 2006.

At no time during the episode was David Bradley allocated a care coordinator. There was confusion within the team as to who carried ongoing responsibility for David Bradley until he had been formally allocated a care coordinator.

There is no record of David Bradley's DNA or of any step that was taken following that DNA, although the policy on what should have been recorded is very unclear.

It was noteworthy that as between the divisional manager, clinical manager, team manager, consultant psychiatrist, and the initial assessor there was no common understanding about the practical application of the care coordination policy with the result there was confusion about who carried responsibility for the patient. This was compounded by the conflict between the OGs which used the tier approach and the policy requiring patients to be assessed as needing either standard or enhanced care coordination.

Subsequent to these events the Department of Health issued policy and practice guidance "Refocusing the Care Programme Approach" in March 2008. That document updates guidance and highlights good practice. It emphasises the need for a focus on delivering person-centred mental health care and also repeats that crisis, contingency and risk management are an integral part of the assessment and planning processes. Adhering to that guidance would address a number of the issues highlighted in this report.

7. Conclusions and recommendations

Conclusions

The final catastrophic outcome in this case involving David Bradley killing four members of his family is not something which was in any way predictable. During his involvement with mental health services David Bradley had been recognised as constituting a risk to others and had, in the first episode, expressed thoughts of killing people and, in the second episode, described feelings of aggression towards his aunt. He had at times carried a knife and had used physical violence. It is evident, therefore, that whilst the final outcome is not something which could have been within the contemplation of any professional involved in the care of David Bradley there were a number of clear indicators that there was a risk of violence on his part.

There were a number of shortcomings in David Bradley's care at various stages, particularly in the final episode. If none of those shortcomings had occurred and all appropriate steps had been taken then measures may well have been put in place which would have altered the sequence of events and which might have produced a different outcome.

The first episode of care was managed through the outpatient clinic with sole input from a consultant psychiatrist. As a result, David Bradley's care was approached from a purely medical perspective. Given that approach and the resources in place at that time the management was reasonable. It is possible that the prescribing of medication that had a minimal chance of success might have sown the seeds of his poor compliance with medication in later episodes. The risk issue, although recognised, was not fully explored and addressed.

The second episode of care, which began with an urgent referral describing a worrying situation, lasted for some three months. The initial assessment and early management were appropriate and the foundations of a comprehensive care plan were laid. However those foundations were not built upon so that there was never a comprehensive social circumstances investigation. The professionals involved with David Bradley never addressed his overall situation, particularly in relation to his housing concerns. The risk issues, clearly identified at the start of the episode, were yet again minimised and not adequately addressed. The conclusion of the episode was unsatisfactory and left David Bradley disillusioned with the service that he had received.

The third and final episode of care began with David Bradley being referred on an urgent basis and very keen to receive psychiatric help. Risk issues were again identified at the initial assessment. From the records the only care that David Bradley received during the fifteen week period leading up to the killings was an initial assessment and a single outpatient appointment with a consultant psychiatrist. Although it is recorded that David Bradley was to be offered a follow up outpatient appointment, which the panel was informed had been made and that he failed to attend, there is no record of this nor of any action being taken in relation to a failure to attend such an appointment. Having been assessed as requiring enhanced care coordination at the initial assessment and the subsequent outpatient appointment no care coordinator was identified prior to the shootings.

From the above and addressing the terms of reference for this investigation, the panel concluded that:

- at times and viewed overall there were shortcomings in David Bradley's health care and treatment. In each of the episodes risk issues were identified but these were never dealt with in any systematic way

- David Bradley's treatment could not be said to be in accordance with the multi-disciplinary care programme approach in several respects and in particular there were failures adequately to assess his social circumstances, substance misuse and non-compliance with medication. There was neither proper assessment of the role of his aunt nor any adequate attempt to obtain information from her. David Bradley's care did not recognize or deal with the fact that Keith Purcell was also in receipt of services

- there were clear shortcomings in relation to record keeping and a lack of adequate communication at times

- the care provided to David Bradley did not correspond to the Department of Health guidance in relation to care coordination.

Recommendations

The panel concluded that in order to address these shortcomings, the strategic health authority should ensure the following recommendations are implemented:

- There should be a clear three stage approach to the question of clinical risk; first the identification of any risk, second a detailed assessment of any such risk and third a clear plan for the management of that risk.

- A full social circumstances assessment must take place in any case in which issues in that area have been identified.

- Engagement with patients ought to be achieved by acknowledging their expressed needs and developing an agreed care plan based on those needs.

- There ought to be a programme of training in the use of clinical assessment tools to ensure that they are used accurately and applied appropriately.

- There should be a clear system for identifying an individual who carries responsibility for the care of each patient at each stage of involvement with the mental health services.

- If a patient with complex needs and identified risk issues requires a medical assessment, then that should occur promptly.

- The trust must ensure that the NICE guidance for the assessment and management of PTSD is followed.

- The trust ought to ensure that the prescribing of anti-psychotic medication accords with NICE guidelines.

- In any case in which there is a known history of non-concordance with medication, specific interventions should be put in place to address that issue.

- Where there is recognition of a substance misuse problem then there should be a clear and continuing strategy of intervention.

- A system must be devised and introduced to ensure that if there is more than one patient at any particular address that fact is recognised and brought to the attention of all secondary mental health workers involved.

- Patient records should be maintained electronically with one core record to which all team members should have access and onto which entries by all mental health workers (including medical staff) relating to the patient must be added.

- The outcome of discussions about individual patients at team meetings should go into their electronically maintained records.

- A robust system must be put in place to ensure that appropriate action is taken to respond to failed appointments. Primary responsibility for this should remain with the individual with whom the appointment was scheduled. The care coordinator or, if none has been appointed, the team manager, must be informed of failed appointments and that person must ensure that appropriate action is taken. Ideally the system would incorporate an automated electronic flagging system.

- The policies in force should be reviewed to ensure that they are coherent, not in conflict and in accordance with good practice.

- There should be an ongoing training programme in relation to the policies in force to ensure that all staff are familiar with the requirements, and appropriate supervision to ensure that there is compliance with such policies.

- The structure and functioning of all mental health teams should be reviewed and, where necessary, revised to ensure that they are in accordance with the guidance set out in *New Ways of Working and Refocusing the Care Programme Approach*.

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