Camden Domestic Homicide Review

Executive Summary of report into the death of Magda Eriksen[1]

Hilary McCollum, Independent Domestic Homicide Review Chair and Report Author

Report Completed: October 2015

[1] Not her real name

SUMMARY OF THE CASE

Name	Age at the point of the murder	Relationship	Known addresses
Magda ERIKSEN	67	Victim	Address 1 (Magda's flat)
Thomas ERIKSEN	44	Son / Perpetrator	Address 1 and Address 2 (Thomas's flat)

1. This Domestic Homicide Review Summary Report examines agency responses and support given to Magda Eriksen, an adult resident of Camden, and her son, Thomas Eriksen, also of Camden. The report covers the period between 1 January 2000 and the death of Magda Eriksen on 9 May 2014. A number of earlier events are included where relevant.

2. The findings of this review are confidential and all parties have been anonymised. For ease of reading, the victim and perpetrator have been allocated alternative names.

3. Magda Eriksen was a Russian woman in her sixties who had lived in London since the early 1970s. She was a Russian language journalist. She lived alone in a privately owned flat in Camden (Address 1). Magda was described by friends and neighbours as a colourful, independent and somewhat eccentric woman. She could be difficult and challenging, both with neighbours and health services.

4. Magda's son, Thomas Eriksen, lived at Address 2, a one-bedroom council flat. He was a long-term user of mental health services. His first contact was in early 1994 when he was formally admitted to a psychiatric hospital under the Mental Health Act.[2] He had eleven admissions, both formal and informal, between 1994 and 2002 and was diagnosed with paranoid schizophrenia.

5. In December 2001, Thomas was voluntarily admitted to psychiatric care after fearing that he might stab a neighbour. He again asked for admission in November 2002 as he was not coping and was hearing voices calling him the devil. This was agreed. This was his last admission until after his mother's death.

6. From 2002 until 2014, Thomas was supported in the community by Camden & Islington NHS Foundation Trust (and its predecessor organisations) but he frequently disengaged from services. With the encouragement of his mother, he did not take medication for his psychosis. He had little contact with services other than community mental health, although he was arrested in 2007 after smashing nine

[2] The Mental Health Act 1983 makes provision for people to be admitted, detained and treated in hospital without their consent because they are considered by mental health professionals to be a danger to themselves and/or others. Admissions under the Act are referred to as 'formal' admissions. Individuals may also voluntarily agree to be admitted to psychiatric care. These are referred to as 'informal' admissions.

panes of glass with a hammer at Horse Guards Parade. He was fined and served a one-day imprisonment.

7. Thomas's clinical records report a difficult relationship between mother and son. Magda told mental health services that Thomas had been violent to her and threatened her on several occasions. Magda, in turn, would belittle and shout at him in public. Despite the difficulties, Magda was very committed to Thomas and he relied on her for support. He would intermittently stay with her at Address 1 when he was struggling with his mental health. His last stay began in late March/early April 2014.

8. One morning in May 2014, Magda phoned South Camden Rehabilitation and Recovery Team asking for Thomas to be admitted to hospital. She explained that she was in fear of her son attacking her and that he had threatened her. She reported that he had put his hands around her throat in the past. A social worker spoke to Thomas by phone and he said that he needed to go to hospital as he was not well, was hearing voices and believed he may become aggressive towards his mother if he remained where he was.

9. Thomas and Magda saw a trainee mental health worker at the Rehabilitation and Recovery Team offices that afternoon. Thomas again requested a hospital admission. An informal admission was agreed in principle but there were no beds available in the Trust at that time and it was not considered necessary to source one in the private sector. Following a face-to-face assessment by the Clinical Team Manager, Thomas returned to his mother's flat with Crisis Team support and anti-psychotic medication. This was supposed to be a short-term arrangement while they waited for a bed to become available but this was not documented on the electronic record. When the bed manager checked Thomas's electronic records later that afternoon, he noted that the Clinical Team Manager had assessed Thomas and decided that he was appropriate for home treatment. As a result the bed manager stopped the search for a bed for Thomas.

10. A member of the Crisis Team and Thomas's care coordinator visited Thomas the following morning. Magda again requested a psychiatric admission and Thomas asked on a number of occasions if he was going to be admitted. The outcome of the assessment was that Thomas would be supported by home treatment. A home visit from the Crisis Team and team doctor was agreed for the following day. His care coordinator suggested meeting him at the Recovery and Rehabilitation Team offices later that day. Thomas did not attend. The panel was unable to establish whether this had been a formal appointment, where non-attendance would have been expected to result in follow-up action.

11. In the early hours of the following day, London Fire Brigade was called to a fire at Address 1. The Fire Brigade entered Magda's flat and found her body. She had multiple stab wounds. London Ambulance Service also responded to the call and commenced CPR but life was pronounced extinct shortly afterwards. Police were called to the scene and a murder investigation was launched. The suspect was identified as Thomas Eriksen.

12. Later that day Thomas presented to Royal Free Hospital's Accident and Emergency department where he was recognised. The police were notified and Thomas was

arrested. Whilst in police detention he was assessed by mental health professionals and deemed unfit for interview. He was subsequently charged with murder. Thomas pleaded guilty to manslaughter on the grounds of diminished responsibility when the case came before the Central Criminal Court in November 2014. He also pleaded guilty to arson. The judge imposed hospital orders and he was sent to a secure hospital for an indeterminate time.

13. The inquest was opened and adjourned by St Pancras Coroners Office and Court in June 2014 and resumed in April 2015. The coroner made a narrative determination that Magda was unlawfully killed and issued a prevention of future death report.

CONDOLENCES

14. The Panel wishes to express its condolences to the family members and friends of Magda. May she rest in peace.

THE REVIEW PROCESS

15. The Camden Domestic Homicide Review Panel was initially convened on 29 July 2014. The panel consisted of senior officers from statutory and non-statutory agencies that potentially had contact with Magda and Thomas prior to the homicide: LB Camden (Adult Safeguarding, Community Safety, Housing Management), Camden and Islington NHS Foundation Trust, Metropolitan Police, Camden Clinical Commissioning Group, NHS England and Camden Safeguarding Adults Partnership Board. In the latter stages of the review, University College London Hospital Foundation Trust joined the panel when it emerged that they had had contact with the family. None of the members of the Panel had any direct contact with the family. The first meeting agreed the scope and Terms of Reference for the review, which can be found in the main report (Appendix 1).

16. Six meetings of the review panel were held. The DHR took place in parallel with the criminal trial process, with agreement from the Senior Investigating Officer from the Metropolitan Police.

17. The following agencies that had had contact with Magda and Thomas prior to the homicide were asked to give chronological accounts and to complete an Individual Management Review (IMR) in line with the format set out in the statutory guidance - Metropolitan Police; LB Camden Housing; University College London Hospital (UCLH). Each IMR included a chronology of interaction with the victim, perpetrator and/or the children; what was done or agreed; whether internal procedures and policies were followed; whether staff have received sufficient training to enact their roles; analysis using the terms of reference; lessons learned; recommendations. The Chair agreed to accept the Serious Incident Investigation report from Camden & Islington NHS Foundation Trust instead of an IMR but asked for further information in a number of areas to ensure that the terms of reference of the DHR were addressed. Fitzrovia Medical Centre and Caversham Group Practice, who provided GP services to

Thomas and Magda respectively, and the Royal Free Hospital each provided a chronology. Each IMR and chronology was scrutinised at a panel meeting.

CONTRIBUTORS TO THE REVIEW

18. All Panel members regularly attended and contributed to Panel meetings.
19. Other than Thomas, Magda had no family members in this country. The Chair contacted her brother and nephew who both live abroad but received no response.
20. The Chair conducted interviews with Thomas and with a neighbour of Magda's.
21. The Chair would like to thank everyone who contributed to the Review.

PARALLEL INVESTIGATIONS

22. Other than the criminal case against Thomas and the inquest, there were no other parallel investigations.
23. The Local Safeguarding Adults Board has agreed to consider the report and its recommendations when it can be disseminated.

INDEPENDENCE

24. Both the summary report and the overview report were written on behalf of the DHR panel by the Independent Chair of the Review, Hilary McCollum.

SUMMARY OF AGENCY CONTACT

25. Edited highlights of the most significant events in terms of agency involvement with Magda and Thomas are set out below. More detail is contained in the main report, which includes a narrative chronology of relevant agency involvement.

1993-2002
Emergence of Thomas's Mental Health Issues and Repeated Admissions to Psychiatric Care

26. In December 1993, when he was 23, Thomas's serious mental health problems began to emerge. In February 1994, he was admitted to a psychiatric ward under Section 2 of the Mental Health Act 1983. He self-discharged a month later after the assessment and treatment order expired.
27. This was the first of eleven admissions to psychiatric care over the next eight years (February 1994, section 2, 1 month; April 1995, section 3, 1 month; June 1995, section 3, 1 month; May 1996, section 3, 1 month; August 1996, section 3, 1 month; 1997, informal, 3 months; May 1998, section 2, 3 months; February 1999, informal, 4 months; April 2000, section 3, 2 months; December 2001, informal, 1 month; November 2002, 12 days, informal).
28. On a number of occasions, his formal admissions were linked to violence or threats of violence including threatening to stab his father (April 1995) and smashing Magda's windows (August 1996). In April 2000, Thomas threatened a psychiatrist with a knife. He absconded from the hospital where he was being examined and

was reported as a missing person. Later the same day, he voluntarily attended Hammersmith Police Station still in possession of the knife and was arrested and charged. He was subsequently detained under the Mental Health Act following an appearance at the magistrate's court. He was discharged two months later after making good progress as an inpatient.

29. On 31 July 2000, a record was placed on Thomas's GP notes that he should have appointments with male doctors and that no female doctors should see him. The reasons are not recorded but may have been linked to him threatening the consultant psychiatrist with a combat knife in April 2000.

30. Thomas's tenth admission was on 24 December 2001 after presenting at A&E at University College London Hospital. He had stopped taking his medication and was feeling persecuted by neighbours. He was concerned that he would lose his temper with a neighbour and stab him and wanted admission to prevent this happening. He was initially admitted informally to a psychiatric ward at St. Pancras Hospital but was subsequently formally detained. He was discharged on 28 January 2002 with a plan for outpatient follow up and treatment with olanzapine, an anti-psychotic medication.

31. On 18 March 2002, Magda attended her GP with a cat bite. She declined antibiotics and a tetanus injection and was noted to be "not keen on conventional treatment".

32. On 27 June 2002, Thomas and Magda met with his new community Consultant Psychiatrist (psychiatrist 2) for the first time in psychiatric outpatients. The psychiatrist commented that Magda's presence made the session difficult and suggested that Thomas came alone in future.

33. On 13 November 2002, Thomas was admitted to a Trust inpatient unit after presenting to A&E at UCLH requesting admission as he was not coping and was hearing voices calling him the devil. He was frightened he would harm someone in the street out of anger. This was an informal admission, which lasted for 12 days. This was Thomas's last admission to inpatient care until his arrest in connection with Magda's death.

January 2003 – August 2005
Thomas is supported by community mental health services

34. From the time of his first admission, Thomas had contact with community based mental health services. From 2002 onwards, he was supported in the community without being admitted to psychiatric care. He neither requested admission during this time nor was he formally detained. He did not take medication to manage his illness during most of this period and said he managed his symptoms by keeping busy. He would also go on (sometimes lengthy) holidays, often with Magda.

35. Thomas completed ten sessions of cognitive behaviour therapy in 2003. He attended six monthly appointments with his psychiatrist (psychiatrist 2) in 2003 and 2004 and was described as stable and making good progress. He was compliant with medication.

36. In September 2004, Thomas had a health review with his GP. He said that he wanted to reduce his involvement with the community mental health team. This was his last recorded face-to-face contact with his GP. He was deregistered in 2007 when the GP was unable to make contact with him.

37. In August 2005, Thomas and Magda attended an appointment with psychiatrist 2. The review stated that Thomas had experienced no psychotic symptoms in the past six months. The main problem identified was a lack of social confidence. A week later Thomas was discharged from the Care Programme Approach**,** which he had been on for some years, as he was thought to need outpatient appointments only.

December 2005 – April 2010
Thomas disengages from community mental health support; Thomas is arrested for smashing windows with a hammer; Magda is concerned about Thomas's mental health but he continues to disengage from services; Magda has a number of health concerns

38. Thomas did not attend his outpatient appointment with psychiatrist 2 in December 2005 and also missed his appointments in 2006 and in 2007. This was contrary to the plan for his care after he was discharged from the CPA. Psychiatrist 2 referred him back to the community mental health team. In July 2007 Magda reported that Thomas was well at the moment and agreed to contact the team if he became psychotic.

39. In September 2007, Thomas was arrested for smashing panes of glass with a hammer at Horse Guards Parade. He was noted to be drunk. It appears that no mental health assessment was conducted. Thomas was discharged from care co-ordination by the community mental health team a few days later after he stated that he wanted no further contact. The Community Mental Health Team was not aware of his recent arrest. His case was still open to outpatient care and he was expected to see a psychiatrist twice a year.

40. In October 2007, Magda attended her GP with the results of an ultrasound scan that she had had in Russia. She was noted to be unhappy that the GP could not interpret the ultrascan and became aggressive. She was referred to a gynaecologist at the Royal Free Hospital and attended three appointments before having a laparoscopy in December 2007.

41. In November 2007 and on a number of occasions during 2008, 2009 and 2010, Magda contacted her GP with concerns that she may have various forms of cancer. Tests proved normal.

42. In January 2008 Thomas appeared at Horseferry Road Magistrates in connection with the criminal damage at Horse Guards Parade the previous September. He was found guilty. He served one-day imprisonment after failing to surrender and pay his fine. Magda contacted the community mental health team and said that she was concerned that Thomas was becoming unwell. He was becoming 'increasingly hostile' towards her. They had argued the previous day and she feared Thomas would attack her. In a phone call he had threatened to kill her. The community mental health team contacted Thomas who said that his hostility to Magda was intended to reduce the frequency of contact between them as he found her 'overbearing' and 'intrusive'. He declined further support from the team. In March 2008, Magda phoned the community mental health team to report that Thomas had 'assaulted her in Cape Town following drinking large quantities of alcohol.'

43. A new care co-ordinator (care co-ordinator 1) was allocated to Thomas in August 2008 and remained in this role until Magda's death. Thomas did not attend his psychiatric outpatients appointments in 2008 or 2009. His psychiatrist (psychiatrist 2) contacted the community mental health team in March 2009 highlighting non-engagement as a risk factor for Thomas and stating this should lead to an assertive outreach approach from the community mental health team. A home visit was attempted but there was no answer at his address.

44. On 16 March 2009, Thomas twice attended A&E at UCLH, first at 05:20 with a rash, and again at 22:12 feeling sick, in pain and with a rash. He denied mental illness and substance and alcohol misuse but said he was having hallucinations and was seeing vapours that were poisonous. He was discharged after treatment and advised to see his GP for follow up.

45. In January 2010, the Community Mental Health Team discussed Thomas's care and agreed that he should be kept on CPA, that a review should be arranged and a care plan devised, bearing in mind Thomas would not engage.

April 2010 – December 2012
Thomas's (limited) re-engagement with community mental health services; Magda frequently visits GP, linked to development of rheumatoid arthritis; Magda and Thomas's relationship fluctuates, with Thomas sometimes avoiding contact, at other times spending most of his time with his mother

46. During 2010 to 2011, Magda had 103 contacts with University College London Hospital. Investigations were centred around parathyroidsm and bilateral carpal tunnel syndrome. She was in considerable pain. The Rheumatology team recorded that Magda was rude and would shout them down. One put in a formal complaint for an "abusive" phonecall. A left shoulder injury was identified in March 2011, based on a previous ultrasound. She did not offer any explanation of how this was caused. An orthopaedic referral was offered but she did not attend the appointment.

47. Magda contacted the Community Mental Health Team on several occasions during April 2010. Thomas had stopped communicating with her and she was also concerned about his financial situation and isolation. When Care Co-ordinator 1 spoke with Thomas he described his mother as over-bearing and said that he had no privacy. He agreed to meet Care Co-ordinator 1 once a week.

48. In May 2010, Magda told the Community Mental Health Team Manager that Thomas had said she (Magda) was "dead and buried." This frightened her. She said that when Thomas was drinking he was a different person, more unpredictable and dangerous. He was sleeping with a hammer and screwdriver under his bed. There is no record of how Thomas's reported "dead and buried" comment was addressed.

49. Thomas met with Care Co-ordinator on several occasions during May 2010. He was supported to access welfare rights advice, which eventually led to a debt relief order being obtained. By the end of May, Thomas felt his relationship with his mother had improved as his debts were being looked into and so she was "less intrusive." Contact with Care Co-ordinator 1 became more intermittent from June 2010 and he

did not attend his CPA Review in September 2010. He did not attend outpatient appointments with his psychiatrist in 2010.

50. Magda was admitted to emergency hospital care in October 2010. It was initially thought that she had TB but the eventual diagnosis was rheumatoid arthritis. Magda had regular contact with her GP over the next eighteen months linked to her rheumatoid arthritis. She explored alternative therapies to treat her symptoms and initially rejected conventional approaches. In December 2010, Magda was noted to be abusive to the reception team at the GP surgery and was advised she would be removed from the list if she was rude again.

51. In January 2011, Thomas's mental health was stable and he told Care Co-ordinator 1 that his relationship with Magda was improving but in February 2011, Magda reported that Thomas had recently locked her out of her flat. Care Co-ordinator 1 visited Thomas at home again in March 2011. He seemed more stable but his relationship with Magda was noted to be difficult. By May 2011 his relationship with Magda had improved again. In June 2011, Magda called Care Co-ordinator 1 to say that Thomas was unwell and self-medicating. Care co-ordinator 1 saw Thomas the same day. He was highly agitated and said that he wanted the care co-ordinator to stop Magda from visiting him. He was noted to be calmer a few days later but said that he did not want Magda coming to his flat without notice. He declined the offer of family therapy.

52. In July 2011, Magda called the Community Mental Health Team. She said Thomas raised his arm as if to hit her, though he did not hit her. In August 2011, Thomas told Care Co-ordinator 1 that the main problem he had was Magda's intrusive behaviour. Thomas's mental state was recorded as 'stable', which remained the case through further visits between September and December 2011. He did not attend outpatient appointments with his psychiatrist throughout 2011.

53. Between September 2011 and August 2012, Magda attended GP and hospital appointments relating to concerns about her digestive system, thyroid, wrist pain, shingles and dizziness. In February 2012 she had a thyroidectomy at a private hospital. In August 2012 she told her GP that she was no longer attending the hospital rheumatology clinic, as she did not agree with their treatment.

54. In March 2012, Care Co-ordinator 1 made a home visit. Thomas said that he had not seen his mother for some time. His mental health appeared stable. The Community Mental Health Team then struggled to make contact with Thomas for some months. After a gap of five months, Care Co-ordinator 1 met Thomas in August 2012. He was reported as managing well and spending a lot of time at Magda's house. This remained the case for the rest of the year.

55. Thomas did not attend psychiatric outpatients appointments during 2012. Following a service reorganisation in July 2012, Thomas was reallocated to a new Consultant Psychiatrist (psychiatrist 3) in the newly formed Rehabilitation and Recovery (R&R) Team. Patients were categorized under a Red, Amber, Green system. Thomas was given a green rating, the lowest level of risk, despite his history of repeated non-engagement, previous violence and threats of violence and noted difficult relationship with his mother who was his main form of support.

January 2013 – 6 May 2014

Thomas reported to be largely stable; Thomas staying with Magda at the end of 2013; Thomas has no recorded contacts with mental health services between January 2014 and April 2014

56. During 2013, Magda missed many outpatient appointments at UCLH.

57. In February 2013, Care Co-ordinator 1 noted that Thomas was quite agitated but appeared to be coping well. A risk assessment, conducted by the South Camden Recovery and Rehabilitation Team in April 2013, stated that, "there is little need for Magda to express the level of concern she does about Thomas." Thomas, Magda, psychiatrist 3 and Care Co-ordinator 1 attended a CPA Review Meeting in May 2013. This was the first time that Thomas's new consultant psychiatrist had met him. The formulation that psychiatrist 3 arrived at was:

    - Thomas was somebody with continuous psychotic symptoms that were not always very apparent;
    - Thomas experienced lots of negative symptoms – self-isolating, loss of motivation and drive;
    - His social isolation may have been related to paranoid delusions that he was not always talking about;
    - It was difficult to understand why Thomas had a period of being more stable – this may have been related to reduced substance use, but there was little independent evidence about this;
    - If he had been willing, Thomas should have taken long term antipsychotic medication;
    - Thomas did not reach a point of having compulsory treatment in hospital as his management plan seemed to have been working in preventing severe relapses;
    - Thomas was quiet, mildly self-neglected, psychotic, very guarded and interested in a structured psychological therapy.

58. The outcome of the review was to refer Thomas for a psychological therapy assessment and to continue monitoring Thomas's mental state. In August 2013, Magda contacted Care Co-ordinator 1 as she felt that Thomas was deteriorating. When the care coordinator visited Thomas in September 2013, he found him to be slightly anxious but stable. In December 2013 Thomas was referred for a psychology assessment with the aim of providing coping mechanisms for him. This was seven months after Thomas's CPA review agreed to the referral.

59. Magda was seen by the outpatient clinic at UCLH on 24 December 2013. She had not attended scheduled appointments over the previous year and had stopped all her prescribed medication. She said that she had had all her amalgam fillings removed and was having Vitamin C infusions, which had helped her rheumatoid arthritis. She missed follow up appointments in April 2014.

60. Care co-ordinator 1 made another entry on 30 December 2013 stating that Thomas's mental state remained consistent. Thomas said that the area around his own flat was crowded and he felt safer staying with his mother.

61. In February 2014, a Housing Officer from LB Camden wrote to Thomas following complaints from his neighbours regarding very loud music being played at night and at unsocial hours. He was advised that if the Housing Department received further complaints, the matter would be investigated further.

62. Under Thomas's care plan, Care Co-ordinator 1 was expected to visit him once every two-four weeks to provide support and monitor his mental health. There are no contacts recorded on the RiO system between Thomas and any community mental health service between January 2014 and April 2014. However it appears that Care Co-ordinator 1 saw him on 24 April 2014 as a contact on that date is recorded in his diary.

May 2014

Magda and Thomas request that he is informally admitted, agreed in principle but no beds available within Trust; Thomas sent home after assessment; Crisis Team visits Thomas the next day, Magda and Thomas ask about admission but told it is not indicated; home treatment plan put in place; Thomas kills Magda the following morning

63. In late March/early April 2014, Thomas came to stay with his mother as he was struggling with his mental health. One morning in May 2014, Magda phoned South Camden Rehabilitation and Recovery Team. She was concerned that Thomas would harm her, as he was not well. His care coordinator was off duty and Magda spoke with two other members of the team in separate calls. She said that Thomas needed to be admitted immediately. A social worker spoke to Thomas by phone and he said that he needed to go to hospital as he was not well, was hearing voices and believed he may become aggressive towards his mother if he remained where he was. He agreed to come to the Rehabilitation and Recovery Team offices a few hours later. Magda phoned again later that morning and reported that Thomas had put his hands round her throat in the past.

64. Thomas and Magda saw a trainee mental health worker at the Rehabilitation and Recovery Team offices that afternoon. Thomas again requested a hospital admission. He did not want to go to his flat or to Magda's. An informal admission was agreed via the Crisis Team (who perform a gatekeeping function) on the basis of Thomas's chaotic behaviour, his request for admission (which was unusual for him) and his poor self-care. The trainee mental health worker contacted the bed manager to arrange for Thomas to be admitted but there were no beds available in the Trust at that time.

65. The case was handed over to the Clinical Team Manager who met with Thomas and Magda and carried out a detailed assessment of Thomas. He noted that, "[Thomas] admitted to auditory hallucinations, outside his head, he made reference to voices telling him to kill but said that there was no one specific." Thomas then said that, "at times the voices tell him to hurt his mother." Thomas said that he was experiencing visual hallucinations and reported anxiety and that he was not sleeping and not eating. He concluded that an informal admission would be most appropriate. The Clinical Team Manager contacted the bed manager but there were no beds available. Under the Trust's bed management policy, if no beds are available in the Trust and a bed is required, a bed in a private hospital will be

sourced. This requires authorisation at a senior level[3]. The Clinical Team Manager was aware of the process to follow if he considered a bed was urgently needed.

66. The Clinical Team Manager documented that Thomas was safe to go home with Crisis Team support. He identified several protective factors: Thomas seeking help and agreeing to take medication; referral to the Crisis Team for an assessment. This was supposed to be a short-term arrangement while they waited for a bed to become available but this was not documented on the electronic record. The Clinical Team Manager prescribed Thomas olanzapine (an anti-psychotic medication). Both Magda and Thomas left the Rehabilitation and Recovery Team offices and returned home. They were unhappy that a bed was not available at that time.

67. The Crisis Team contacted Magda by phone that afternoon and arranged to conduct a home visit the next day. Magda was upset that there were no beds to facilitate an admission She said that Thomas was staying with her because he was too scared to stay in his own flat. She reported that Thomas had said he was having thoughts about wanting to hurt her. The Crisis Team advised her that if she was feeling unsafe then Thomas should attend A&E and/or she should make contact with emergency services.

68. Meanwhile, the Clinical Team Manager again contacted the bed manager who reported there were still no beds available but that he was aware that a referral had been made for an admission for Thomas. The bed manager checked Thomas's electronic records soon after and noted that the Clinical Team Manager had assessed Thomas and decided that he was appropriate for home treatment. At that point any action to identify a bed and progress an admission stopped.

69. A member of the Crisis Team and Thomas's care coordinator (referred to below as the assessors) visited Thomas the following morning. Magda again requested a psychiatric admission and Thomas asked on a number of occasions if he was going to be admitted. The assessors explained to him that he did not need to go to hospital. Thomas attributed his symptoms to his alcohol intake. There was no evidence during the assessment that Thomas was distracted by voices or any hallucinatory phenomenon though he appeared not to understand or fully take in everything and would intermittently ask, "so am I going into hospital?" Thomas said he was drinking four or five cans of beer a day and Magda said that Thomas threatened her when he had been drinking. The assessors advised Magda not to let Thomas into the flat if he was drunk or behaving in a threatening manner and to contact emergency services if she felt unsafe. Thomas denied thoughts or intent to harm his mother and said that he would walk out if she nagged him. The assessors encouraged Thomas to return to his own flat but neither Thomas nor Magda agreed to this.

70. The outcome of the assessment was that Thomas would be supported by home treatment. A home visit from the Crisis Team and team doctor was agreed for the following day. Thomas was encouraged to see Care Co-ordinator 1 at the Recovery

[3] The policy states that, "No admission should be made to private hospitals other than in situations of extreme emergency and with the authorisation of the Chief Operating Officer (COO) or their nominated deputy, during working hours. For out of hours authorisation the On Call Director must be contacted."

and Rehabilitation Team offices later that day. Thomas did not attend and there was no follow-up of his non-attendance, such as contacting Thomas or Magda. The panel was unable to establish whether this had been a formal appointment, where non-attendance would have been expected to result in follow-up action.

71. The exact events following the home assessment are not clear. Thomas was not well enough to be interviewed by the police at any point from his arrest in May 2014 until the trial in November 2014. He is known to have left Address 1 at around 04:40 on the morning following the home assessment. He walked to a shop about 500 yards away where he bought firelighters and olive oil. Then he returned to Address 1. At about 05:00, one of the neighbours heard an intense scream. Another neighbour heard a door slam about ten minutes later. Soon after, the London Fire Brigade was called to a fire at Address 1. The Fire Brigade entered Magda's flat and found her body in the lounge area. She had multiple stab wounds. London Ambulance Service also responded to the call and commenced CPR but life was pronounced extinct shortly afterwards.

72. Police were called to the scene and a murder investigation was launched. On examination of the crime scene, four separate seats of fire were discovered. A large knife was found on a coffee table, which was consistent with the injuries to Magda. The suspect was identified as Thomas Eriksen.

73. Thomas presented to A&E at the Royal Free Hospital that evening. Staff recognized him from information shared by Camden & Islington NHS Foundation Trust. The police were called and he was arrested. He was taken to a Camden Town Police Station where he was assessed by a consultant from Camden Mental Health team who deemed he was not fit for interview either now or in the near future. He was charged with murder and admitted to a secure hospital via Highbury Magistrates Court. Thomas admitted manslaughter on the grounds of diminished responsibility and arson at his trial in November 2014 and was sentenced to a hospital order. He is currently detained in a secure hospital with an indeterminate sentence.

SUMMARY OF FINDINGS

74. It should be noted when reading the findings below that they relate to circumstances in place at the time of Magda's death. A number of changes have already been implemented with further actions planned.

Quality of risk assessment

75. The Clinical Team Manager who assessed Thomas in May 2014 was aware that:

- Thomas had not been admitted formally or informally to inpatient care since November 2002 and neither had he requested admission;
- In his two most recent admissions (in December 2001 and November 2002) he had requested informal admission because he was worried he might hurt someone. On both occasions his request had been granted;
- Thomas was worried that he might hurt his mother;
- Magda was worried that Thomas might hurt her;

- Magda had reported that Thomas had previously attempted to strangle her;
- Thomas was staying at Magda's flat;
- Thomas's symptoms could worsen when he was drinking and that he admitted he had been drinking recently;
- Magda was viewed by Thomas's care co-ordinator as exacerbating his symptoms.

76. Given Thomas's tendency to avoid contact with services, his request for admission should have been given greater weight. The request was out of the ordinary and was accompanied by fears that he was going to hurt Magda and/or kill someone. An informal admission was agreed but the Clincial Team Manager then decided that Thomas should be treated at Magda's home rather than requesting authorization of a private bed when a Trust bed was not available. No DASH risk assessment was undertaken to assess the risk to Magda.

77. Likewise, the assessors on 8 May 2014 were aware of all of the above factors. In addition, Care Co-ordinator 1 was aware that Magda had made previous allegations that Thomas had abused her and made threats to kill her. Again, a DASH risk assessment was not conducted.

78. Camden & Islington NHS Foundation Trust should review the quality of its risk assessment processes in situations where previous allegations of abuse have been made.

Crisis treatment at the home of person who has been threatened

79. Following the assessment in May 2014, Thomas was considered safe to go home with Magda with crisis support. The risk assessment and home treatment plan did not explicitly address Thomas and Magda's reported concerns that he might harm her nor the previous history of allegations that Thomas had been violent, abusive and threatening to Magda. Magda had previously been seen as having a negative impact on Thomas's mental health and their relationship was considered to be difficult but this was not considered a risk either.

80. Thomas was assessed again the following day, this time by a member of the Crisis Team and Care Co-ordinator 1. Although he said that he was not planning to hurt anyone the assessors did not explore his reports of the previous day that he was worried he would harm Magda or that voices were telling him to kill. The assessment does not appear to have considered Magda's previous reports of Thomas's threats and violence to her. The possibility of a hospital admission does not appear to have been considered, with Thomas being told he did not need to go to hospital when he asked a number of times if he was going to hospital. The fact that Thomas was requesting an admission for the first time in more than eleven years was not explored or given weight.

81. There was some recognition of the potential for conflict between Thomas and Magda and Care Co-ordinator 1 attempted to persuade Thomas to return to his flat. He was reluctant to do so and Magda was opposed to this happening.

82. Camden & Islington NHS Trust should review its approach to crisis treatment and seek to avoid putting in place treatment plans at the home address of someone who has made allegations of abuse against the service user or who has reported threats or fears of violence. A full assessment of the potential risks to the person who has made allegations of abuse should be conducted and appropriate safety plans put in place.

No beds available

83. There was confusion over the meaning of no beds being available. Thomas was initially assessed by the Rehabilitation & Recovery Team as meeting the criteria for admission. The Rehabilitation & Recovery Team contacted the Crisis Team who completed the gatekeeping process required to authorise the admission. The Rehabilitation & Recovery Team then contacted the bed manager who advised that no bed was available.

84. Trust policy at the time was that if admission was required and no bed was available immediately within the Trust, authorisation would be sought and given for a bed outside of the Trust to be located by the bed manager. The bed manager was responsible for escalating this and seeking authorisation for a private bed to be used. The Trust's bed management policy stated that, "No admission should be made to private hospitals other than in situations of extreme emergency and with the authorisation of the Chief Operating Officer (COO) or their nominated deputy, during working hours." The policy did not set out criteria for judging what constituted an extreme emergency or who should make that judgement. Nor did it identify what should happen when a bed was not available in situations that were not considered an "extreme emergency".

85. In Thomas's case, when the Rehabilitation & Recovery Team was advised that no bed was available, he was assessed by the Clinical Team Manager and considered as safe to go home with Crisis Team support. The Recovery & Rehabilitation Team saw this as a temporary solution while waiting for a bed to become available. This was not clearly documented on RiO (the electronic records system). The bed manager understood the RiO note to mean a bed was no longer required. From this point the bed manager effectively stood down the search for a bed for Thomas as the RiO notes stated that he was now to be assessed the following day by the Crisis Team. The bed manager would only have recommenced a search for a bed if the Crisis Team had contacted him following their further assessment the following day.

86. Failure to locate a bed for Thomas had catastrophic consequences for both Magda and him. Bed management policy has since been changed to ensure that a search for a bed cannot be stood down without communication with the clinical team that requested it.

87. The Rehabilitation & Recovery Team offices are not open 24 hours a day and when there are delays in finding a bed for an admission it is not possible to provide a place for a person to wait out of hours. Thomas and Magda were advised that they could go and wait in A&E but they did not wish to do so and instead returned home. There are no time limits on securing a bed within Camden & Islington NHS Foundation Trust's bed management policy. Admissions via A&E are subject to time escalations linked to A&E waiting times which require that at least 95% of patients attending

A&E must be seen, treated, admitted or discharged within four hours. There are no such time escalations for beds requested by the Rehabilitation & Recovery Team. As part of the Serious Incident Investigation, senior staff suggested that this is where the person seeking informal admission is at a disadvantage to those who are detained under the Mental Health Act where there is a legal requirement to find a bed.

88. Since Magda's death, the Trust has put in place a new bed management policy which seeks to improve bed management and provide greater clarity on:

- the gatekeeping process from all avenues of referral;
- who makes contact with the bed manager;
- time limits for securing a bed;
- the role of the bed manager; and
- the process for standing down the search for a bed.

Availability of Beds

89. There have been widespread concerns across England and Wales in recent years about the availability of inpatient psychiatric care. In February 2015, the Royal College of Psychiatrists launched an independent Commission to review the provision of inpatient psychiatric care for adults in England, Wales and Northern Ireland.[4] Its interim findings were published in July 2015.[5]

90. There were pressures on beds in Camden & Islington NHS Foundation Trust at the time of Thomas's requested admission in May 2014. During 2013/14 bed occupancy levels excluding leave in Camden & Islington NHS Foundation Trust averaged 97%. If leave were to be included, the bed occupancy levels would be more than 100%. The Royal College of Psychiatrists recommends an average occupancy level of 85%.[6] Despite these pressures, beds were located for four other patients on the day that Thomas requested admission. Three were formal admissions under the Mental Health Act where there was no option but to find a bed. The fourth was an informal admission. It is not known whether these admissions were made before or after the time when Thomas had requested a bed.

91. There is currently no pan-London planning for inpatient mental health beds. NHS England are currently looking at demand and capacity for psychiatric beds within London. This should incorporate the potential for pan-London planning to increase the availability of in-patient care.

Response to reports of violence and abuse

---

4 https://www.rcpsych.ac.uk/mediacentre/pressreleases2015/independentcommissionlaunch.aspx

5 *Improving acute inpatient psychiatric care for adults in England: Interim report* http://www.caapc.info

6 *Do the right thing: how to judge a good ward. Ten standards for adult in-patient mental healthcare*, 2011, http://www.rcpsych.ac.uk/pdf/OP79_forweb.pdf

92. Magda told Camden & Islington NHS Foundation Trust that Thomas had threatened her, broken her windows, stolen from her and been violent to her. On at least two occasions, in January 2008 and in May 2014, she reported that she was frightened that he would attack her. In May 2014 she reported that he had put his hands around her throat in the past. There was limited information about how these allegations were investigated. A social worker discussed Thomas's alleged threat to kill Magda with him in January 2008. He reported that he was hostile to his mother to try to prevent her intruding into his life.

93. Magda should have been referred to specialist domestic violence services but this did not happen. She was offered a carer's assessment, which she refused. Care Co-ordinator 1 recorded that Magda's reports were "unsubstantiated" and that they followed verbal attacks by Magda on Thomas. Care Co-ordinator 1 noted in 2013 that Magda was "overly concerned about Thomas."

94. Magda and Thomas's relationship was often difficult. As well as Magda's reports of violence and abuse from Thomas, she was noted to belittle him in public, to shout at him and place her face very close to his in a threatening manner. Thomas viewed her as intrusive and overbearing but he also turned to her for help when he was struggling with his mental health and spent a great deal of time at her flat. They were offered family therapy, which they refused.

95. No safeguarding alerts were made in relation to either Magda or Thomas. Magda might not have met the threshold in place at the time of an "adult at risk" which underpins safeguarding adults policy. The Care Act 2014 has extended safeguarding responsibilities in relation to carers and under the definition of an "adult at risk" now in place, it would be expected that a safeguarding alert would be raised for Magda.

96. Thomas's mental health issues mean that he probably would have met the defintion in place at the time of Magda's noted belittling of him, as well as the updated definition. A safeguarding assessment might have triggered actions to address the ongoing difficulties and may also have led to an appropriate referral for Magda in relation to domestic abuse.

Disengagement from services

97. Thomas was expected to see his consultant psychiatrist twice a year but there is no record of him attending an outpatient psychiatric appointment from August 2005 until May 2013. In 2009, Thomas's psychiatrist suggested that the Community Mental Health Team put in place an assertive outreach approach and there is some evidence that this was put in place during 2010 and 2011. Contact was more intermittent in 2012 and 2013 and there was no recorded contact in 2014 prior to the crisis in May although Care Co-ordinator 1 has stated that he did see Thomas on 24 April 2014. Thomas had lengthy periods on holiday out of the country, which hampered efforts to engage with him.

GP Role in Care Plan

98. Fitzrovia Medical Centre did not notify Camden & Islington NHS Foundation Trust when Thomas was deregistered in 2007. He was reregistered in September 2013 but deregistered again in January 2014. As a result of deregistration, Thomas did

not have the annual health check ups that were required under his care plan. Commissioners of GP services should ensure that people with a care plan are not deregistered from their GP without contacting Adult Social Care and/or the Mental Health Trust first.

Police assessment and referral of mental health issues

99. The Metropolitan Police were aware of Thomas's mental health problems during his arrest in April 2000 but there is no evidence that an assessment under the Mental Health Act took place when he was arrested in September 2007 after smashing nine panes of glass with a hammer at Horse Guards Parade. Given the outcome of his previous arrest (the charge was withdrawn on mental health grounds) and the circumstances of the 2007 offence, a mental health assessment should have taken place. Camden & Islington NHS Foundation Trust were not made aware of the offence. They discharged Thomas from his Care Programme Approach five days after the offence.

Additional Issues Arising from Analysis Against the Terms of Reference

100. The key issues are set out above. In addition the following issues have been identified in the analysis against the terms of reference.

Communication and information sharing

101. There were examples of good communication and information sharing. For example between Magda's GP and UCLH regarding referrals and the outcome of any assessments. However there were also gaps as set out previously, particularly in relation to: the search for a bed for Thomas in May 2014; deregistration of Thomas from Fitzrovia Medical Centre; and police contact with Thomas in 2007.

102. Following the inquest into Magda's death, the Coroner sent a Prevention of Future Deaths Report to Camden & Islington NHS Trust. It raised gaps in communication as a matter of concern. Camden & Islington NHS Trust have implemented a number of actions to address these concerns.

Delivery of services

103. There were elements of the NICE guidelines not covered in Thomas's care plan including addressing his physical health needs; providing peer support and a manualised self-management programme; considering other occupational or educational activities; routine recording of daytime activities. Thomas's lack of engagement with services made it more difficult to address some of these elements.

104. As set out previously, Magda's reports to Camden & Islington NHS Trust of threats and violence should have been fully investigated. She should have been referred to a specialist domestic violence service. A safeguarding alert should have been considered for both Magda and Thomas. There is a gap in Trust policy and practice regarding the appropriateness of home treatment at the home of a person that the patient is alleged to have abused.

Referrals and Assessments

105. As set out above, Magda should have been referred by Camden & Islington NHS Foundation Trust to a domestic abuse service but was not. A safeguarding alert

should have been considered by Camden & Islington NHS Foundation Trust in relation to Thomas but was not. The risk assessments of May 2014 did not explicitly address Magda and Thomas's expressed fears that he might harm his mother.

Thresholds for intervention

106. In May 2014, Thomas was assessed as requiring informal admission. The threshold appears to have been appropriately set. However when no bed was available within the Trust, Thomas was assessed and considered safe to go home. As set out above, insufficient weight appears to have been given to his and Magda's fears that he might harm her and to the previous history of allegations of threats and violence.

Identity and diversity issues

107. All nine protected characteristics in the 2010 Equality Act were considered by both IMR authors and the DHR Panel. No specific recommendations for changes in practice were identified in relation to these issues.

Escalation to senior management or other organisations/professionals

108. As set out previously, there was confusion over the meaning of no beds being available. Referrals to domestic violence services and a safeguarding alert should have been considered but were not.

The impact of organisational change

109. As set out previously, the reduction in the numbers of inpatient psychiatric beds has created pressures on bed availability. The average bed occupancy rate excluding leave in Camden & Islington NHS Foundation Trust was 97% in 2013/14 rather than the 85% level recommended by the Royal College of Psychiatrists.

Additional Lessons Learnt

110. It took some time to obtain information from both Magda and Thomas's GPs. The changing structures of the NHS mean that increasingly it is GP surgeries themselves who are responsible for producing the required information for the domestic homicide review. It can be difficult to get GPs to engage with the process.

111. There were issues about a number of aspects of the Serious Incident Investigation report including:

- a lack of detail about Magda's reports of violence, threats and abuse and how these were investigated;
- information provided in the report was subsequently contradicted on further investigation during this review.
- it concluded that the homicide could not have been prevented and did not acknowledge that if Thomas had been admitted in May 2014, he would not have been in a position to attack Magda at her home.

112. There were gaps in Safer Camden's initial organisation of this domestic homicide review, with the Home Office not being notified until alerted to do so by the Chair and an incomplete initial trawl of statutory health agencies being carried out. Safer Camden have agreed to draw up a checklist for conducting domestic homicide reviews to address these issues.

CONTRIBUTORY FACTORS AND ROOT CAUSES

113. A number of overarching issues emerge from the analysis:

- there was insufficient involvement of primary care services in Thomas's care;
- Thomas was at times difficult to engage. This hampered the consistent delivery of care;
- agencies found Magda difficult to deal with. This appears to have influenced their perceptions of her risk of being a victim;
- Magda's allegations of violence and abuse were not properly investigated at the time that they were made and were not sufficiently taken into account in risk planning in May 2014;
- the degree of risk that Thomas posed to Magda was not recognised and managed in May 2014 and the home treatment plan did not adequately consider her safety;
- there was confusion about the meaning of "no bed available" and the appropriate course of action to take in such circumstances;
- there was a lack of communication between the Rehabilitation & Recovery Team, bed manager and Crisis Team regarding whether a bed was still required or not.

114. The following contributory factors and root causes were identified:

- There was a lack of recognition of Magda as a potential victim and of Thomas as a potential perpetrator;
- There was a lack of focus on dealing with Thomas's drinking and its interaction with his mental health issues;
- Risk assessments were inadequate;
- High occupancy rates of inpatient psychiatric beds contributed to no bed being available within the Trust for Thomas. The process for dealing with there being no bed available was confused.

115. These issues have been considered above and are addressed within the recommendations and action plan. Areas for action include:

- Risk assessment and risk management
- Bed Management
- Domestic abuse guidance
- Safeguarding awareness
- Patient care
- Carers' needs
- Deregistration of people with care plans from GP services
- Conduct of domestic homicide reviews

116. The action plan will be monitored and reviewed by Camden Community Safety Partnership Board.

WAS THIS HOMICIDE PREVENTABLE?

117. In interview for this review, Thomas was asked what he thought would have prevented Magda's death. He said, "If they'd sectioned me or if I'd been able not to drink." However he said that he couldn't stop drinking himself as he "just couldn't cope anymore." He was aware that drinking made his mental health worse and in hospital he would not be able to drink. Thomas had been worried about hurting Magda and about hurting himself. He felt that he should have been sectioned when he needed it as had happened on previous occasions.

118. Both Thomas and Magda asked that he be admitted in May 2014. He was assessed by the Rehabilitation & Recovery Team who agreed that he needed to be admitted. Had a bed been available, Thomas would have been admitted. As a result, he would not have been living at Magda's flat and would not have been in a position to kill her less than two days later.

119. However no bed was available within the Trust, a bed was not sought outside the Trust and a home treatment plan was put in place following an assessment. In developing this plan, insufficient weight was given to Magda's previous reports of threats and violence and to both Thomas and Magda's expressed concerns of May 2014 that he might hurt her. Had these been explicitly addressed, a home treatment plan might not have been considered appropriate. This in turn might have resulted in the search for a bed being escalated and authorisation being sought to obtain a bed outside the Trust if necessary.

120. As it was, the bed search was stepped down due to a lack of communication between the bed manager and the Rehabilitation & Recovery Team. Had the search not been stepped down, it is possible that a bed would have been found and Thomas admitted before the time when he attacked his mother.

121. A further opportunity to initiate a bed search was presented the following day when an assessment was carried out by a member of the Crisis Team and Thomas's Care Co-ordinator. However, again previous reports of threats and violence and Thomas and Magda's expressed concerns of May 2014 that he might hurt her were not explicitly addressed. Instead a home treatment plan was confirmed.

122. Thomas was asked to attend the Peckwater Centre that afternoon. The panel was not able to establish whether this was a formal appointment or an informal arrangement. He did not attend and his non-attendance did not trigger any contact with Magda or Thomas to identify whether the situation had deteriorated further.

123. Had these responses been different, it is possible that this homicide might have been prevented.

124. The Panel wishes to express its condolences to the family and friends of Magda. May she rest in peace.