Camden Domestic Homicide Review

OVERVIEW 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

CONTENTS

Appendices

Section One: PREFACE

1. This Domestic Homicide Review (DHR) report examines agency responses to Magda Eriksen[2] and her son, Thomas Eriksen[3], both residents of Camden, up to the point of Magda's death in May 2014.

2. Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be:

   'A review of the circumstances in which the death of a person aged 16 years or over has, or appears to have resulted from violence, abuse or neglect by –
   a) A person to whom (s)he was related or with whom (s)he was or had been in an intimate relationship or
   b) a member of the same household as himself/herself'

3. The key purposes for undertaking DHRs[4] are to:

   - Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
   - Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
   - Apply these lessons to service responses including changes to policies and procedures as appropriate; and
   - Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

4. This review was initiated by the Chair of the Camden Community Safety Partnership in compliance with the legislation. The review process followed the Home Office statutory guidance.

5. The Independent Chair and DHR Panel extend their thanks to everyone who has contributed to the deliberations of the Review.

6. The Chair of the Review thanks all of the members of the Review Panel and Individual Management Review (IMR) authors for the professional manner in which they have conducted the Review.

7. The Independent Chair and the DHR Panel members offer their deepest sympathy to all who have been affected by the death of Magda.

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[2] Not her real name
[3] Not his real name
[4] Home Office, 2011, Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, p6, https://www.gov.uk/government/publications/statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

Section Two: INTRODUCTION

8. This Overview 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 in May 2014 for both Magda and Thomas. A number of earlier events are included where relevant.

9. The table below sets out the family members involved in this review.

Name	Age at the point of the murder	Relationship
Magda ERIKSEN	67	Victim
Thomas ERIKSEN	44	Son / Perpetrator

10. Address 1 is the privately owned flat in Camden where Magda had lived for more than two decades. Thomas had spent part of his childhood there and would come and stay with his mother when he was struggling with his mental health. He was living there at the time of the homicide. Address 2 is the council flat in Camden where Thomas lived on his own.

ABOUT CAMDEN

11. Camden is an inner London borough with a population of approximately 220,000[5]. It includes the areas of Holborn, Kentish Town, Camden Town, Belsize Park and Hampstead among others. It is composed of commercial and residential land and has 39 conservation areas, covering half the borough. It includes a number of cultural and leisure attractions within its boundaries including the British Library, British Museum, London Zoo, Hampstead Heath, Camden Market and parts of Covent Garden. It is an ethnically diverse area and more than 40% of the population was born outside the UK[6]. Camden has one of the highest rates of child poverty in London[7].

12. The crime rate in Camden is one of the highest in London[8]. In 2014, when Magda was killed, there were a total of 3066 domestic violence reports made to the Metropolitan Police in Camden. Of these, 1393 were recorded as crimes with the remaining 1673 logged as non-crime domestic incidents. This was below the London average (based on the total number of domestic incidents and offences recorded by the Metropolitan Police divided by 32 (boroughs covered)). In common with many local areas, Camden has a MARAC and an IDVA service.

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[5] http://www.londonspovertyprofile.org.uk/indicators/boroughs/camden/
[6] http://www.cscb-new.co.uk/downloads/reports_research/2011_Census_Key_Stats_and_Quick_Stats_for_Camden[1].pdf
[7] http://www.endchildpoverty.org.uk/london/poverty-in-your-area/camden-20/
[8] http://maps.met.police.uk

13. The proportion of people registered with their GP as having a serious mental illness (via the Quality and Outcomes Framework) is significantly higher in Camden than the London and England averages, and the third highest across England. In 2012, 3400 people were recorded on QOF registers for serious mental illness, representing 1.3% of the population.

SUMMARY OF THE CASE

14. Magda Eriksen was a Russian woman in her sixties who had lived in London since the early 1970s. She lived alone in a privately owned ground floor flat in Camden (Address 1). Her son, Thomas, would come and stay with her when he was struggling with his mental health. She was described by friends and neighbours as a colourful, independent and somewhat eccentric woman who was very much part of the local community. She had a keen interest in alternative health practices. She could be difficult and challenging, both with neighbours and health services.

15. Magda was born in the Soviet Union in 1946 and was raised there during the communist era. She met her husband, a Danish national, in the Soviet Union during the 1960s and moved with him to Denmark. Their son, Thomas, was born in Denmark in 1970. The family moved to London around 1973, where Mr. Eriksen built a successful business.

16. Magda and her husband separated and divorced when Thomas was ten years old, with Thomas remaining with his mother. Mr. Eriksen subsequently relocated to Spain and had little contact with his son.

17. Magda worked as a Russian language journalist and for a national broadcaster, helping to identify locations for filming in Russia. She owned properties in St. Petersburg and Moscow from which she derived rental income.

18. Thomas Eriksen 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.[9] He had eleven admissions, both formal and informal, between 1994 and 2002 and was diagnosed with paranoid schizophrenia. His relapses tended to follow a pattern of him spending large amounts of time listening to loud music, increasing his use of alcohol and illicit substances and becoming aggressive, hostile and irritable.

[9] 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. The rights of people are different depending whether they have been admitted formally or informally. Less than half of people in psychiatric wards are formally detained. (MIND suggest about 25% of patients are formally detained http://www.mind.org.uk/information-support/legal-rights/mental-health-act-the- mind-guide/#.VCGC_ZRdWO0. Figures from the Health and Social Care Information Centre (2013 Bulletin) show that around 45% of patients whose records were in Mental Health Minimum Dataset returns were formally detained during the 2012/13 reporting year. http://www.hscic.gov.uk/catalogue/PUB12745).

19. In 1996, he smashed all the windows at Magda's flat. In 2000, he was arrested and remanded in custody after threatening a psychiatrist with a combat knife. The charge was withdrawn at court on the grounds of Thomas's mental health.

20. In December 2001, he was voluntarily admitted 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.

21. Thomas did not request another admission to a psychiatric ward until two days before he killed his mother in May 2014. Neither was he compulsorily detained during this period. From 2002 until 2014 he was supported in the community by mental health services provided by Camden & Islington NHS Foundation Trust.[10] He was living by then at Address 2, a one-bedroom council flat in a busy area of central London. He frequently disengaged with services. With the encouragement of his mother, he did not take medication for his psychosis. In interview for this review, he said that he managed by keeping busy and visiting the British Museum and art galleries.

22. He had little contact with services other than community mental health throughout this period, although he was arrested in 2007 after smashing nine panes of glass with a hammer at Horse Guards Parade. He was not referred to or assessed by mental health services regarding this offence. He was fined and served a one-day imprisonment.

23. 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 Thomas in public, shouting at him and placing her face very close to his.

24. Despite the difficulties, Magda was very committed to Thomas and he relied on her for support. Throughout the period 2002-14 he would intermittently come and stay with her at Address 1 when he was struggling with his mental health. His last stay began in late March/early April 2014.

25. On the morning of Wednesday 7 May 2014, Magda contacted South Camden Rehabilitation and Recovery Team, where Thomas's care co-ordinator was based. She was concerned that her son would harm her, as he was not well. The care coordinator, a social worker within the Rehabilitation and Recovery Team, was off duty and initially Magda spoke with another social worker who said she would call back after getting some background information.

26. Ten minutes later, Magda called again and told another member of the team that Thomas needed to be admitted immediately. The social worker returned Magda's call and spoke to both Thomas and Magda on the phone. Thomas 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.

[10] Camden & Islington NHS Foundation Trust was established in 2008. It provides mental health and substance misuse services and care for people with learning disabilities. Its predecessor, Camden & Islington Mental Health and Social Care Trust, was formed in 2002.

27. Thomas and Magda saw a trainee mental health worker at the Rehabilitation and Recovery Team offices at around 14:19[11]. Thomas again requested a hospital admission. The trainee mental health worker contacted the Crisis Team who documented that they would complete 'gatekeeping'[12] for an informal admission on the basis of Thomas's chaotic behaviour, his request for admission (which was unusual for him) and his poor self-care. The Crisis Team did not plan to meet with Thomas for a face-to-face assessment prior to agreeing the admission, which is permitted under the Trust's Bed Management Policy.

28. Following completion of the gatekeeping process, the trainee mental health worker from the Rehabilitation and Recovery Team contacted the bed manager to arrange for Thomas to be admitted but there were no beds available in the Trust at that time.[13]

29. The case was handed over to the Clinical Team Manager at around 15:00. He conducted a face-to-face assessment of Thomas and documented that Thomas was safe to go home with Crisis Team support. In interview for the Serious Incident Investigation, the Clinical Team Manager said he saw this as 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[14] (an anti-psychotic medication which Thomas had been prescribed previously) for five days. 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.

30. The Crisis Team contacted Magda by phone that afternoon and arranged to conduct a home visit the next day. Magda reported that Thomas had said he was having thoughts about wanting to hurt her; however he had no plan or intent to act on these thoughts. 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 and he could be reviewed by the Mental Health Liaison Team. However Magda was concerned about the envisaged waiting times at A&E.

31. Meanwhile, the Clinical Team Manager from the Rehabilitation and Recovery Team 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

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[11] Timings given for contact between C&IPFT and Thomas/Magda are based on when entries were made on the electronic records system. They do not necessarily reflect the exact time that events took place.

[12] The Trust's gatekeeping process requires that all admissions must be processed through the Crisis Team (as is national policy). Whilst the Crisis Team may have limited involvement with some admissions, they will always be contacted to perform the gatekeeping function.

[13] When this happens, a bed can be sought in the private sector should one be considered necessary.

[14] Olanzapine is an anti-psychotic medication. The rapidity of its effect is uncertain, varying from individual to individual. Alcohol use has an unpredictable negative impact on olanzapine's effectiveness. Both alcohol and olanzapine are sedating and it can be risky to take both.

appropriate for home treatment. At that point any action to identify a bed and progress an admission stopped. The Clinical Team Manager believed that a bed was still needed but there was no contact between the bed manager and Clinical Team Manager or with the matron (who would have been contacted by the bed manager to authorise use of a private bed) to confirm whether or not a bed was still needed.

32. At 10:00 on Thursday 8 May 2014, a member of the Crisis Team visited Thomas, accompanied by Thomas's care coordinator, who had known Thomas for more than five years. Magda again said that she wanted him to be admitted to a psychiatric ward and Thomas asked on a number of occasions if he was going to be admitted. Magda said that he had refused to take the olanzapine that day but he did take it in the presence of the assessors. Potential risks to Magda were explored and she was advised to phone emergency services if necessary. 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 and his non-attendance did not trigger any follow-up or attempts to contact him 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. Even if the arrangement were informal, follow-up action would have been prudent given the events of the preceding 24 hours.

33. In the early hours of Friday 9 May 2014, London Fire Brigade was called to a fire at Address 1. Several occupants of the building had taken refuge from the fire on the roof of the building and were rescued. 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 shortly after a murder investigation was launched.

34. The suspect was identified as Thomas Eriksen, the victim's son, who had been staying with her recently. Later that day Thomas presented to Royal Free Hospital's Accident and Emergency department where he was recognised, following Camden & Islington NHS Foundation Trust alerting other services and the police having released his details. The police were notified and attended the hospital. Thomas was arrested on the evening of 9 May 2014. Whilst in police detention he was assessed by the on call consultant and senior manager and was deemed unfit for interview. He was subsequently charged with murder on 10 May 2014.

POST MORTEM

35. On 10 May 2014, a Home Office pathologist, Dr Fegan-Earl, conducted a post mortem examination on Magda's body at Whittington Hospital Mortuary. The cause of death was stab wounds to the neck and chest, shock and haemorrhage. There were defence wounds to both hands and fatal injuries to her torso and neck. Blunt trauma injuries were also noted to the rear of her head. The lungs showed no presence of smoke indicating that she had been dead prior to the fire being started.

INQUEST

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

COURT DATES

37. Thomas pleaded guilty to manslaughter on the grounds of diminished responsibility when the case came before the Central Criminal Court on 3 November 2014. He also pleaded guilty to arson. The prosecutor accepted the doctors' assessment that his ability to form any rational judgment was severely impaired at the time of the offences through mental illness. The judge imposed hospital orders in respect of the two counts Thomas had admitted and he was sent to a secure hospital for an indeterminate time.

Section Three: THE REVIEW PROCESS

DECISION TO HOLD A REVIEW

38. When Camden Community Safety Partnership was notified of Magda's death, records were secured and, in consultation with partners, a decision was made to instigate a DHR. The Home Office was duly notified on 5 August 2014. *(Author's Note: this followed the initial meeting of the panel. Camden Community Safety Team have decided to develop a DHR checklist to ensure that actions are taken promptly in the event of another domestic homicide.)*

39. In June 2014, the AVA project[15] was appointed to conduct the review with Hilary McCollum as the Independent Chair and Report Writer. Hilary has worked for more than twenty-five years within the public and voluntary sectors on issues related to violence against women and girls. She does not have any connection with the agencies to which the report relates or with the families of the victim or perpetrator.

CONVENING THE PANEL

40. The first meeting of the review panel was held on 29 July 2014. The panel consisted of senior officers from statutory and non-statutory agencies as listed below. None of the members of the Panel have had any direct contact with Magda or Thomas.

Name	**Organisation**
Hilary McCollum	Independent Chair and Report writer
Head of Community Safety	LB Camden
Safeguarding Manager	Camden and Islington NHS Foundation Trust
Detective Sergeant	Metropolitan Police
Detective Chief Inspector	Metropolitan Police
Director of Quality and Effectiveness	Camden CCG
Patient Safety Lead / Clinical Quality Manager	NHS England
Safeguarding Development Officer	LB Camden, representing Camden Safeguarding Adults Partnership Board

[15] AVA is a second tier charity that provides a range of services to organisations and agencies in the voluntary and statutory sector working on violence against women and girls. http://www.avaproject.org.uk

Name	Organisation
Assistant Director Adult Social Care and Joint Commissioning	LB Camden
Assistant Director Housing Management	LB Camden
Trust Lead Safeguarding Adults & the Mental Capacity Act	University College London Hospital Foundation Trust

SCOPE AND TERMS OF REFERENCE

41. The first meeting agreed the scope and Terms of Reference for the review. Thomas's serious mental health issues first emerged in 1993. Between 1994 and 2002 he had a number of admissions to inpatient psychiatric care. From 2002-14, his mental illness was managed in the community. In order to capture both the period of admissions and the period of community care, the beginning of 2000 seemed an appropriate point at which to set the start of the scope for participating agencies in relation to Thomas. The Panel considered whether a more limited time frame would be appropriate for Magda but, given the potential impact of Thomas's illness on her, decided that the beginning of 2000 would be an appropriate period for her too. Each agency was asked to include a summary of any relevant contact prior to 1 January 2000.

42. The areas for the review to consider included:

- Accessibility, availability and responsiveness of services;
- Each agency's involvement with the victim and alleged perpetrator from 1 January 2000 until the death of Magda Eriksen on 9 May 2014:

Communication and information sharing between services

- Compliance with policy, procedures, protocols and professional standards, particularly in relation to domestic violence and safeguarding adults;
- Responses to any referrals;
- The quality of assessments and risk assessments;
- Thresholds for intervention;
- Whether adult-focused services ensured that the welfare of any children was promoted and safeguarded and vice-versa and how this was done;
- Whether services took account of the wishes and views of members of the family in decision-making and how this was done;
- Sensitivity and responsiveness of agencies to issues of identity and additional needs;

- Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner;
- The impact of organisational change;

43. The full terms of reference for the review are attached as Appendix 1.

INDIVIDUAL MANAGEMENT REPORTS AND CHRONOLOGIES

44. At the start of the review process, Camden Community Safety Team contacted a number of statutory and non-statutory organisations that potentially could have had contact with the victim or the suspect. All organisations were asked to indicate whether or not they had had any contact.

45. The first meeting of the Panel considered information from the initial returns. On the basis of this information and discussion at the meeting, the following agencies were asked to give chronological accounts of their contact with the victim and suspect prior to the murder and to complete an Individual Management Review (IMR) in line with the format set out in the statutory guidance:

    - Metropolitan Police
    - London Borough of Camden Housing
    - Camden and Islington NHS Foundation Trust

46. IMRs were completed by the Metropolitan Police and LB Camden Housing. 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. Each of the reports covered the following:

- 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 of the above using the terms of reference
- Lessons learned
- Recommendations

47. The first meeting of the Panel also agreed that the Chair would write to the GPs for both Magda and Thomas, requesting a brief summary of any relevant contact. On the basis of the information provided, the Panel would decide whether an IMR was required.

48. Thomas's GP practice, Fitzrovia Medical Centre, responded promptly to the initial request and said that they had not had any contact with him since 2004. As a result, he had been discharged from the practice. The Panel requested a chronology for all contact the GP practice had with Thomas from 1 January 2000 until the point of his deregistration, including a note of any correspondence or phone calls received from

other agencies and how these were responded to. Thomas's GP was also asked to clarify:

- when Thomas had been deregistered, as NHS England records indicated that he was registered with the GP practice until January 2014;
- what correspondence, if any, the GP had received from Camden & Islington NHS Foundation Trust during the time that Thomas was registered as a patient with the practice (including invites to Care Programme Approach (CPA) meetings and the outcomes of any such meetings etc);
- whether the GP was aware that they should have conducted annual physical health checks as part of his care plan.

49. After a long delay, Fitzrovia Medical Centre provided a chronology and statement about their contact with Thomas.

50. The initial response from Magda's GP practice, Caversham Group Practice, indicated that Magda had never raised any issues around abuse or stress with the GP. However they did have fairly frequent contact with her and the Panel requested a full chronology and IMR to identify any significant events that would otherwise be unknown to the panel and whether there were any opportunities to intervene that had been missed.

51. After some discussion with the Chair, Caversham Group Practice provided a chronology for the period from 1 January 2000 until Magda's death. This was produced by the GP who had most contact with Magda. The Chair also conducted a telephone interview with the GP to explore their contact with Magda. An IMR was not produced.

52. The issue of GP contributions to DHRs is discussed further in the Analysis section.

53. At the time of the inquest, there was a suggestion in a media report that London Ambulance Service had been called to the address on the day before the homicide. The Chair wrote to London Ambulance Service who checked their records and established that this was not the case. At this time it came to light that not all statutory health agencies had been contacted during the initial trawl following the homicide. As a result, the Chair contacted University College London Hospital (UCLH), the Royal Free Hospital and the Whittington Hospital seeking information about their contact with the victim and/or perpetrator. The Whittington had no record of contact with either Magda or Thomas but the two other institutions did. Both the Royal Free and UCLH provided chronologies and UCLH was requested to produce an IMR, which they agreed to do.

54. The IMRs, Serious Incident Investigation Report and information provided by the GPs and hospitals were scrutinised at meetings of the Panel. In some instances, additional recommendations were made which have been included in the action plan at Appendix 2. A combined chronology was also produced and considered by the panel.

TIMESCALES

55. This review began on 29 July 2014. Six meetings of the DHR Panel took place with the final meeting on 20 July 2015. The report was concluded in October 2015 when the final action plans were received.

56. The review began within twelve weeks of Magda's death and continued in parallel with the criminal investigation. The decision not to suspend the review process pending the criminal trial was made by the Chair in conjunction with the Senior Investigating Officer as it did not appear from the initial meeting that the continuation of the review would prejudice the trial.

PARALLEL INVESTIGATIONS

57. As well as the criminal case against Thomas and the Inquest, Camden & Islington NHS Foundation Trust conducted a Serious Incident Investigation. The report of the Serious Incident Review was available to the Panel.

CONTRIBUTORS TO THE REVIEW

58. All Panel members regularly attended and contributed to Panel meetings.

59. Other than her son, Magda had no family members in this country. The Chair wrote to Magda's twin brother and to her nephew, who both live in the USA. Unfortunately, neither of them responded.

60. The Chair wrote to Thomas via his psychiatrist requesting his involvement in the review and Thomas responded positively. The Chair conducted an interview with Thomas, who provided useful background information about his mother as well as about his experience of services.

61. The Chair also interviewed one of Magda's neighbours who passed on information about Magda from two other neighbours. She also shared her recollections of Magda's funeral, which had been attended by Magda's brother and nephew.

DISSEMINATION

62. DHR Panel members (see list at paragraph 39), the Borough Solicitor at LB Camden and the Chair of Camden Community Safety Partnership have all received a copy of this report. The Chair wrote to Magda's brother and her nephew offering to send them a copy of the report and brief them on the contents. A copy has also been offered to Thomas via his psychiatrist.

CONFIDENTIALITY

63. 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.

64. Information has only been made available as described above. The report will not be published until permission has been given by the Home Office to do so.[16]

INDEPENDENCE

65. This report was written on behalf of the DHR panel by the Independent Chair of the Review, Hilary McCollum. Hilary has worked for more than twenty-five years within the public and voluntary sectors on issues related to violence against women and girls. She has been a specialist adviser to the Cabinet Office and developed the draft London Violence against Women Strategy, *The Way Forward*, for the London Mayor. She was a member of the Metropolitan Police Force's Domestic Homicide Review Group, the London Domestic Violence Steering Group and the London Safeguarding Children Board. Hilary has also worked on hate crime and led the formal inquiry into disability harassment for the Equality and Human Rights Commission, including preparing the final report, *Hidden in Plain Sight*.

66. The Chair had no connection with the attending agencies.

67. This report was written between February and October 2015. It was considered in detail at three Panel meetings. It is based on:

- the Individual Management Reviews undertaken by:
  - Metropolitan Police
  - LB Camden Housing
  - University College London Hospital
- the Serious Incident Investigation Report and additional information provided by Camden & Islington NHS Foundation Trust;
- the chronology and information provided by Magda's GP, Caversham Group Practice;
- the chronology and information provided by Thomas's GP, Fitzrovia Medical Centre;
- the chronology and information provided by the Royal Free Hospital;
- interviews with Thomas and with a neighbour of Magda's.

68. The IMR report writers and Serious Incident Investigation Report writer had not had any contact with the victim or perpetrator and were not line managed by anyone who did. Each of the reports was signed off by a senior manager within the organisation. DHR Panel members were similarly independent. Magda's GP also provided information for the review. She had known her for some years.

EQUALITY AND DIVERSITY ISSUES

[16] The Chair of the Home Office Quality Assurance Panel wrote to Safer Camden on 5 April 2016, giving permission for the report to be published. The letter is attached to this report as Appendix 5.

69. All nine protected characteristics in the 2010 Equality Act were considered by both IMR authors and the DHR Panel and several were found to have potential relevance to this DHR. These were:

Age: Thomas's mental health issues emerged when he was 23 years old, which is within the usual age range for onset of paranoid schizophrenia. When he killed Magda, he had been living with ongoing mental health issues for more than 20 years, mostly without medication. In interview for the review, he said that although he was in his forties, he still felt like a teenager in some ways.

Magda was 67 years old when she died. She had been supporting Thomas for a long period of time. From 2010, she was increasingly facing her own health issues, with a diagnosis of rheumatoid arthritis.

Religion and belief: Magda's funeral was conducted by a Greek Orthodox priest as a Russian Orthodox priest was not available. It is not clear whether Magda had an active religious belief.

Thomas's religion is recorded as 'other religions' within his health records. During one of his admissions, he described paranoid ideas of feeling threatened by people belonging to different religions.

Ethnicity: Magda was born and raised in Soviet era Russia. She spoke English well and had lived in London since the early 1970s.

Thomas was born in Denmark of Danish and Russian parents. He had lived in England since he was a young child.

Sex: women are more likely to experience domestic violence than men.[17] Magda was described as a petite woman. Thomas was physically much taller and bigger than her.

Disability: Thomas had serious, ongoing mental health issues, which impacted on his life. He had a number of brief periods of employment during his twenties, predominantly in summer jobs. He had been unemployed since 1997 and was dependent on benefits. At times he had felt discriminated against because he had a mental illness.

Magda was diagnosed with rheumatoid arthritis in 2010 which caused ongoing pain and swelling in her joints. It is not clear how severe the level of impairment was and how it impacted on her life.

INVOLVEMENT OF FAMILY AND FRIENDS

[17] *Intimate Personal Violence and Partner Abuse*, Office for National Statistics, 2014, http://www.ons.gov.uk/ons/dcp171776_352362.pdf

70. Magda was born and raised in Soviet era Russia. Thomas was her only relative in Britain. Her twin brother and his son live in USA. Attempts were made to involve them in the review but without success.

71. An interview was conducted with Thomas and with a neighbour of Magda's, who also passed on input from other neighbours.

ACKNOWLEDGMENTS

72. The Chair of the Review would like to thank all members of the Review Panel for the professional manner in which they conducted the Review. The Chair also extends her thanks to the Individual Management Review (IMR) authors for their honesty and transparency in reviewing the conduct of their individual agencies. The Chair would like to thank all those who agreed to participate in this review.

CONDOLENCES

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

Section Four: THE FACTS

PEN PORTRAITS

Magda Eriksen

74. Magda was born in Leningrad (now St. Petersburg) in 1946 during the Soviet era. She was one of twins. She grew up at the height of the Cold War.

75. In the sixties, she met her future husband in Russia. He was a Danish national and she moved with him to Denmark. In 1970, she gave birth to their only child, Thomas, in Denmark. A few years later the family relocated to London, where Mr. Eriksen established a successful business.

76. Thomas described his parents' relationship as difficult. His father drank a lot and his parents were "always fighting". They argued constantly and this was "occasionally physical."

77. Magda and Mr. Eriksen separated in 1980 and subsequently divorced. Thomas remained with his mother. It is unclear whether Magda and Thomas had lived with Mr. Eriksen at Address 1, a flat in Kentish Town, or whether they moved there after the separation. Neighbours said that she had lived in the street for decades and recalled Thomas growing up there.

78. Magda worked as a Russian language journalist. She spoke English well. According to Thomas, she also worked for a national broadcaster, identifying film locations in Russia, and as a personal assistant for a wealthy American woman. Following the collapse of the communist regime, Magda bought a number of properties in Russia from which she derived rental income. She travelled frequently to Spain and South Africa. She was noted by University College London Hospital to enjoy swimming.

79. Thomas described Magda as a "sixties mother" with liberal attitudes but she was also a strong woman and quite tough.

80. She was described by neighbours as a "Russian eccentric". She was a colourful, free-spirited, independent woman who was cared for and appreciated on her street and by friends across the world. She was caring, generous and full of life. She was part of the community and her neighbours liked her. She was a friend as well as a neighbour and looked after one neighbour's baby on occasions. She was very interested in alternative health approaches and looked younger than she was.

81. Magda could also be a difficult person. She complained to her neighbours about noise and about splitting communal bills. She seems to have been particularly difficult with health professionals, both those treating her and her son. She would often be agitated during GP appointments and would rarely sit down. She largely rejected conventional medicine and would present to her GP demanding interventions that were not available through conventional medicine.

82. Magda had contact with the Royal Free Hospital between 2007 and 2009. At one attendance at the emergency department in August 2009, she was noted to spend ten minutes repeatedly washing her hands. Magda had extensive contact with a number of specialist departments at University College London Hospital, particularly during the last five years of her life when she was being investigated for various

ailments. In 1984, the medical team at UCLH identified that she had a fraught relationship with them. She was described as “difficult”, “extremely angry & anxious”, “demanding”, “aggressive” and ”confrontational”. The team made many mentions of having “difficult” consultations with her up till 2013.

83. Magda did not talk about Thomas or disclose any concerns about him to her GP or to staff at the Royal Free or UCLH.

84. Community mental health services also found Magda difficult to deal with. She disputed Thomas’s diagnosis of paranoid schizophrenia and encouraged him not to take conventional medicines to treat it. Thomas’s care co-ordinator believed that contact with Magda made Thomas’s mental health state worse. Nevertheless, he would go and stay with her when he was feeling unwell and when he could not cope or felt unsafe in his own flat. Magda reported to mental health services that Thomas had been violent to her on several occasions. It was noted that these were not substantiated and “often occur where Thomas feels intimidated by his mother.” There were incidents when he smashed all of the windows in her flat, where he openly threatened her and where he stated that he was frightened he may harm her. His risk to her appears to have been largely unexplored by community mental health services. In May 2013, the community mental health team recorded that “there is little need for Magda to express the level of concern she does about Thomas.” However staff also acknowledged that Magda wanted the best for Thomas.

85. It appears that Magda lived alone at Address 1 after Thomas left home to go to university in the late 1980s although he may have returned to live with her for a time after he dropped out of university. By 1998, Thomas had his own council flat, Address 2, but would come and stay with Magda at Address 1 when he was struggling with his mental health. The last occasion that he came to stay was in late March/early April 2014. From 7 May 2014 his mental health deteriorated. Magda contacted Camden & Islington NHS Foundation Trust asking for him 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. At the same time, Thomas was stating that he was hearing voices and having feelings that he was going to hurt his mother if he remained living with her. An admission was agreed in principle but no bed was available at that time. Following a face-to-face assessment, Thomas returned to his mother’s flat with Crisis Team support as he felt too scared to go to his own flat. The Crisis Team visited on 8 May 2014 with Thomas’s care co-ordinator. Thomas and Magda again asked that he be admitted but a home treatment plan was put in place instead. In the early hours of the following morning, Thomas stabbed Magda to death. She was 67 years old.

Thomas Eriksen

86. Thomas Eriksen was born in Denmark in 1970. His father was Danish, his mother Russian. He moved to London with his parents when he was approximately three years old.

87. As mentioned above, Thomas said his parents “would argue constantly.” Thomas said, “I got really nervous when I heard them arguing.” He recalled arguments that became violent and said that on one occasion, when he was eight, he had tried to

intervene between his parents using a tennis racket. He said that on at least one occasion the police were called. *(Author's note – the police records for this period are no longer available to confirm this or establish the circumstances).*

88. His parents separated when Thomas was ten years old and Thomas remained with his mother. Mr. Eriksen subsequently relocated to Spain and had little contact with his son. Thomas felt that after the separation, "my dad seems to have melted away."

89. Thomas was privately educated at prep school and then day boarding until he was 16. He attended a state sixth form college to study for his 'A' levels. In interview for this review, Thomas said that his parents had money and he was "spoilt in that sense."

90. When he was 19, Thomas went to university to undertake a degree in Soviet studies. Thomas had started smoking cannabis at the age of fourteen and had become a heavy user. His use of illicit drugs, including LSD (30 or 40 times), ecstasy and amphetamines, increased at the start of his university life. He stayed for two years before being asked to leave due to poor attendance and poor achievement.

91. He returned to London where he continued his illicit drug use, including taking cocaine and smoking heroin on a number of occasions. He also abused a number of prescription drugs and drank alcohol regularly to excess. He tried again to pursue academic study, starting the same course on three separate occasions, but failed to complete due to his drug use.

92. In interview for this review, Thomas said he had started taking drugs "for the buzz." He feels he was "brought up to be quite wild." He was "into football, music, drugs – the carnival life." Neighbours who had known Thomas as a teenager reported that they felt that drugs had changed him.

93. Thomas went to Denmark to study but discontinued after six months. He said that during spells living in Denmark, he would buy jazz music and smoke hash, which was legal to buy for personal use. After Thomas's return to London, there followed a number of brief periods of employment in predominantly summer jobs.

94. In December 1993, Thomas's serious mental health problems began to emerge. In February 1994, he was admitted to a private hospital under Section 2 of the Mental Health Act 1983.[18] He had started thinking he was Jesus and that his mother was Mary. He spoke of telepathy, secret organisations, conspiracy theories and '"God trips." He self-discharged a month later after the assessment and treatment order expired.

95. 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).

[18] A brief summary of the Mental Health Act is included as Appendix 4

96. On a number of occasions, his admissions were linked to violence or threats of violence including threatening to stab his father (April 1995); smashing Magda's windows (August 1996); and threatening a psychiatrist with a combat knife (April 2000). In December 2001, Thomas was informally admitted at his own request because he was concerned he would stab a neighbour.

97. In February 1994, police were called to the psychiatric ward to assist after Thomas barricaded himself into his room. Police were involved in his admission in April 1995, when they escorted him to hospital. Police were involved again in April 2000, after 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.

98. From the time of his first admission, Thomas had contact with community based mental health services. He attended a programme of ten sessions of cognitive behavioural therapy in 1999. Thomas's last admission prior to his mother's death was in 2002. 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 this period and said he managed his symptoms by keeping busy. The British Museum was five minutes away and he would go there a lot. He was interested in mythology, especially Ancient Greece and Ancient Rome. He would go to the Tate and the National Gallery. He continued his interest in jazz music and art films. He would also go on sometimes lengthy holidays, often with Magda.

99. Thomas was supposed to see his care co-ordinator monthly but at times it was difficult to engage with him. Magda often contacted the Community Mental Health Team (now the Rehabilitation and Recovery (R&R) Team), concerned that Thomas was unwell. As mentioned elsewhere, the team's view was that "there is little need for Magda to express the level of concern she does." On a number of occasions, Thomas complained to his care co-ordinator that his mother was interfering in his life and that she was intrusive. The care co-ordinator's view was that Thomas's mental health could deteriorate following Magda visiting him. Nevertheless, Thomas spent much of his time at his mother's house and would go and stay with her when he was not managing on his own. They were offered family therapy on more than one occasion but both turned it down. Thomas attended a programme of ten sessions of cognitive behavioural therapy in 2003 and was referred to Psychology again in Dec 2013.

100. Thomas was unemployed from 1997 onwards. He told his care coordinator that at times he had felt discriminated against because he had a mental illness. He was in receipt of benefits and was not financially dependent on Magda. At times he would use his benefits to get drunk but he was no longer engaging in illicit drug use.

101. In 2007, Thomas was arrested and charged with criminal damage after smashing nine panes of glass with a hammer at Horse Guards Parade. He was found guilty, fined and served a day in prison.

102. In interview for this review, Thomas said that he had had a few arguments with people in the street and with someone in a shop over the years of living in the community. However no agencies were involved on these occasions.

103. As set out above, around a month before Thomas killed Magda, he came to stay with his mother. His mental health was deteriorating and on 7 May 2014 Magda contacted the South Camden Rehabilitation and Recovery Team at Camden & Islington NHS Foundation Trust, asking for him to be admitted. Thomas spoke to a member of the team on the phone and in person and also requested to be admitted. This was his first request for admission since November 2002. An admission was agreed in principle but no bed was available in the Trust at that time. A face-to-face assessment was then carried out with Thomas and he was sent home with anti-psychotic medication and an appointment to see the Crisis Team the following day. On 8 May 2014, Thomas again asked if he would be going to hospital but a home treatment plan was put in place instead. In the early hours of the following day, he stabbed his mother to death and set the flat on fire. He was 44 years old at the time.

104. In interview for this review, Thomas reported feeling "horrendous" in the days before killing Magda, experiencing auditory and visual hallucinations and convinced that he was going to hell and that spirits were taking over. After he killed Magda, he left the flat and went to Highgate Woods. He tried to burn down trees in the woods and had thoughts in Danish about burning down churches. He presented to A&E at the Royal Free Hospital on the evening of 9 May 2014. Staff recognized him from information shared by Camden & Islington NHS Foundation Trust. The police were called and he was arrested. He was charged with murder the following day. He was not deemed mentally fit to be interviewed by the police either at the time of his arrest or up until the point of his trial. He 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.

NARRATIVE CHRONOLOGY

105. A comprehensive chronology of agency involvement was prepared and considered by the Review Panel. All relevant events are set out in the Narrative Chronology below.

1994-1999
Emergence of Thomas's Mental Health Issues and Repeated Admissions to Psychiatric Care

106. On 20 February 1994, Thomas was admitted to a private hospital under Section 2 of the Mental Health Act 1983 after experiencing paranoid delusions. He was treated with psychotropic medication. He self-discharged a month later after the Section 2 assessment and treatment order lapsed.

107. Thomas was admitted for a second time on 26 April 1995 to another private hospital (Priory Hospital, Roehampton) under Section 3 of the Mental Health Act. He stayed in hospital for a month. He had paranoid delusions and delusional beliefs of a

religious content. He was aggressive and threatening. His illicit drug use was noted to have been heavy, particularly of cannabis and ecstasy. He was treated with both anti-psychotic and anti-anxiety drugs and referred to a drug treatment programme.

108. Thomas did not attend the drug treatment programme and was subsequently re-admitted in June 1995 to the Priory Hospital, under Section 3 of the Mental Health Act 1983. During this third admission he had religious delusions and described visual and auditory hallucinations. He was verbally aggressive. He believed that "other people's minds would be speaking in my mind". He was subsequently discharged after a month, on several anti-psychotic drugs to be taken on a daily basis. *(Author's Note: at the time there was no way to enforce compliance with medication in the community. This is now possible through a Community Treatment Order following amendments to the Mental Health Act).*

109. In August 1995, it appears that Thomas attended the outpatient department at a hospital in North Yorkshire. He described ideas of reference[19] and feeling paranoid. He complained about the side effects of chlorpromazine, one of the drugs he had been prescribed, but agreed to continue with other medication.

110. In 1996, Magda reported to police that Thomas had thrown a rubbish bin against her window causing damage. She did not wish to pursue the allegation but wanted her son found to ensure that he underwent a mental health assessment.

111. Thomas's fourth admission was via a presentation to University College London Hospital. This resulted in admission to a psychiatric hospital from 22-30 May 1996. He was admitted with a diagnosis of schizophrenia and detained under Section 3 of the Mental Health Act 1983. Magda had alerted Social Services as she felt he had been ill over the previous week. He had poor self-care and had slept rough in Regents Park. He was described as having delusional mood with religious references but no firm delusional ideas and may have been experiencing auditory hallucinations. At the point of admission he was not taking any regular medication on Magda's advice, as she felt it would not do him any good. During the admission Magda was noted to be overly involved in her son's care and subsequently discharged him from the hospital.

112. Thomas's fifth admission occurred on 8 August 1996 and lasted until 25 September 1996. He was admitted to a private hospital (under Section 3 of the Mental Health Act 1983) and transferred to an NHS facility on 29 August 1996. Thomas had been aggressive at home and smashed all the windows at Magda's flat. He had been drinking and it was noted that his relapses tended to follow a pattern of him listening to loud music, increasing his use of alcohol and illicit substances and becoming aggressive, hostile and irritable. On this occasion he was verbally abusive and physically threatening towards Magda. He claimed that he was angry with her as he felt she had treated him badly as a child. He had also been thinking about World War II, the holocaust and paedophilia. He believed the end of the world was approaching and he was to play a major part.

[19] Delusions of reference are beliefs caused by a mental illness that ordinary events, objects, or behaviours of others have particular and unusual meanings specifically for oneself.

113. On admission Thomas was not on regular medication and was treated with anti-psychotic medication. In view of his previous history of annual admissions and poor compliance with medication, a depot injection[20] was discussed and subsequently commenced. He was discharged on the basis of monthly injections of an anti-psychotic drug as well as daily tablets of another drug. However, Thomas was due to travel to Denmark to attend a detoxification programme and it was agreed that he would be sent with a two-month supply of medication. The depot medication approach was not followed on his return to London.

114. Thomas was informally admitted to St. Luke's Hospital[21] for three months in September 1997. There are no further details available about this admission.

115. On 27 May 1998, Magda reported that she believed that Thomas had broken a window at her address on 22 May 1998 and stolen her Social Security book. Thomas admitted breaking the window but Magda declined to substantiate the allegation as he was by then being detained at St. Luke's Hospital having been formally detained under the Mental Health Act. He was admitted to St. Luke's with drug-induced psychosis. There are no further details available about this admission.

116. Thomas's eighth admission was in February 1999 when he was informally admitted for four months to St. Luke's. He had presented to A&E complaining of feeling unsafe and afraid that people would harm him. He described paranoid ideas of feeling threatened by people belonging to other religions. He was admitted informally and settled on medication. He was discharged in his absence, as he had left the ward without leave on 30 June 1999.

117. During 1999, Thomas attended a ten-week course of cognitive behavioural therapy.

January 2000 – December 2002
Thomas threatens psychiatrist with combat knife; Thomas's continued admissions

118. On 18 April 2000, Thomas attended an urgent outpatient appointment at Tottenham Mews Community Resource Centre (where the Community Mental Health Team was based) following concerns from his Community Psychiatric Nurse and Magda about his disengagement from services and suspected non-compliance with medication. He saw a Consultant Psychiatrist. He was described as highly aroused and suspicious and accused the interviewers of laughing at him and threatening him with admission to hospital under the Mental Health Act. He talked about murder and death. During the interview he wandered around the room and at one point stood behind the psychiatrist's chair for a considerable period. The psychiatrist suggested Thomas go outside and have a cigarette and then suggested Thomas come into hospital informally. At this point Thomas brandished a combat knife and repeatedly

[20] A depot medication is an injection of antipsychotic medication that is slowly released over 2-4 weeks. Patients have injections administered by a nurse and don't need to take tablets every day. It is useful for patients who forget to take oral medication and for patients subject to community treatment orders who would otherwise not comply with treatment.
[21] St Luke's Hospital provided both outpatient and inpatient psychiatric services until 2011 when inpatient services were closed. It was managed by Camden & Islington NHS Foundation Trust.

said, "Section me," and “Call the police.” The police were called but Thomas had already left the resource centre and did not return home.

119. At one o'clock the following morning Thomas self-presented to Hammersmith Police Station dressed in a balaclava and brandishing a knife. He subsequently handed over a black handled combat style knife with a six inch blade and was arrested and charged with possession of an offensive weapon. He was remanded to HMP Brixton but the case was charges were dropped at Horseferry Road Magistrates Court due to concerns about his mental health.

120. Thomas was taken to St. Luke’s hospital where he was assessed by a Specialist Registrar in Forensic Psychiatry. The assessment noted that Thomas tended to disengage with services, become non-compliant with medication and lose insight rapidly. The Specialist Registrar suggested intervention for drug and alcohol misuse to prevent further relapse and the use of a depot medication, which Thomas was prepared to accept although he would have preferred oral anti-psychotic medication. He was admitted to an inpatient ward at St. Luke’s, detained under Section 3 of the Mental Health Act 1983, where he remained for two months.

121. In May 2000, Magda attended the GP twice with minor ailments.

122. After making good progress as an inpatient, Thomas was discharged on 6 July 2000 to the care of a different community team than the one in which he had threatened the psychiatrist, which had led to his admission. The suggestion of a depot medication was not followed up on discharge and there is no further mention of it in the clinical notes.

123. 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.

124. On 8 May 2001, Thomas attended the GP surgery. He reported that he had recently undertaken an alcohol/drugs rehabilitation in South Africa at the behest of his parents.

125. On 3 October 2001, Thomas attended A&E with his mother after being stung by a wasp. He was noted to be very rude and verbally abusive to a doctor. Magda complained about the length of wait and said NHS care was terrible. He was treated and discharged.

126. Thomas’s tenth admission was on 24 December 2001 after presenting at A&E at University College London Hospital. He had stopped taking medication and was feeling persecuted by neighbours. He thought people wanted to kill him. 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 placed on section 5(2) of the Mental Health Act on 26 December 2001, then on section 3. He was discharged on 28 January 2002 with a plan for outpatient follow up and treatment with olanzapine, an anti-psychotic medication.

127. On 18 March 2002, Magda attended her GP with a cat bite. She was worried about feline AIDS. She declined antibiotics and a tetanus injection and was noted to be

"not keen on conventional treatment". She also requested a hormone test as she believed she was menopausal and wanted to "treat herself".

128. 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. Thomas expressed his interest in re-engaging with psychology at this session.

129. 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 felt he would "explode soon" and was frightened he would harm someone in the street out of anger. He was noted to be experiencing some 'command hallucinations'[22] but was able to resist them. 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; Magda contacts police about offences unconnected to Thomas; Magda attends GP with a variety of health concerns

130. Magda attended her GP on 16 January 2003 with a spot on her upper lip, which she had been treating herself. She wanted to see a private dermatologist and also thought she may have a food intolerance. She requested blood tests and the results were normal.

131. Thomas met with a Clinical Psychologist on 16 March 2003 and agreed to ten sessions of CBT (he had previously attended ten sessions in 1999).

132. On 10 June 2003 and 10 December 2003, Thomas met with psychiatrist 2. On both occasions he was described as making excellent progress and was compliant with medication. There is no record of Magda attending either appointment.

133. On 29 July 2003, Magda made an allegation of criminal damage to the police. She had returned from holiday and found that her front window had been damaged. Local youths were believed to be responsible.

134. Thomas completed his course of CBT with the Clinical Psychologist on 13 August 2003. He was offered a follow up session in December 2003 but cancelled the appointment, as he felt he could manage without it.

135. On 9 February 2004, Magda attended the GP with a spot on her eye. She wanted an immediate referral immediately and was advised that this was not necessary. However she insisted on attending casualty at Moorfields eye hospital. On the same day, Magda made an allegation of common assault to the police after being verbally abused and assaulted by a passenger on a bus. She attended the GP two days

[22] Command hallucinations are hallucinations in which a person perceives they are being given orders, either as auditory commands or inside the person's mind and/or consciousness.

later with bruising on her face resulting from the assault and was noted to be distressed.

136. On 16 April 2004, Thomas attended an outpatient appointment with psychiatrist 2, accompanied by Magda. The assessment states that Thomas's psychotic illness was under control but that he was experiencing symptoms of social phobia. Psychiatrist 2 agreed to refer Thomas to the Clinical Psychologist. It is not known if this referral was made.

137. On 17 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.

138. Thomas attended an outpatient appointment with psychiatrist 2 on 24 November 2004 and was described as very stable.

139. Magda attended her GP on 22 December 2004 for a smear test but it was not possible to carry out the procedure due to pain. Magda insisted on a gynaecology referral.

140. On 9 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. On 15 August 2005, 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. The community team social worker reported that Thomas's mental state had been stable for 2.5yrs. He had had minimal contact with his care coordinator. This had been planned as Thomas had wanted to ascertain how well he could monitor and maintain his own mental health. Thomas was described as very successful in doing this.

141. On 24 October 2005, Magda attended the GP for smoking cessation advice. She also requested a bone scan and colonoscopy. The bone scan was undertaken on 5 January 2006 and was reported as normal.

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 further health concerns

142. Thomas did not attend his outpatient appointment with psychiatrist 2 on 6 December 2005.

143. On 2 February 2006, Thomas's GP noted that Thomas had not been attending his psychiatric appointments. The GP tried to contact Thomas without success. As a result Thomas's medication was taken off repeat prescription and a note was made that he must see a doctor if he attended requesting medication. There are no further GP records relating to Thomas. He was deregistered in 2007.

144. On 12 April 2006, Magda was again noted to prefer alternative treatments when she attended her GP. On 21 April 2006, she told the GP she was now reluctant to have

a colonoscopy. She thought she might have wheat intolerance but tests proved negative.

145. Thomas did not attend any psychiatric outpatient appointments throughout 2006. This was contrary to the plan for his care after he was discharged from the CPA.

146. On 12 January 2007, a Housing Officer at LB Camden wrote to all residents of Address 2 regarding noise in the communal areas. The source of the noise was unknown and all residents were asked to be considerate toward their neighbours.

147. On 23 January 2007**,** Thomas again failed to attend a planned appointment with psychiatrist 2 who referred him back to the community mental health team. Magda said that whilst Thomas was well at the moment, he was taking no medication and distancing himself from mental health services. A Community Mental Health Nurse was allocated as Thomas's care co-ordinator on 2 March 2007 and a social worker wrote to him on 20 March 2007 encouraging Thomas to meet with him and his care co-ordinator.

148. On 17 April 2007, Magda called the Community Mental Health Team to report that Thomas was in Denmark. One 23 April 2007 she reported that he would be there till June 2007.

149. On 21 April 2007, Magda contacted police after returning to her address and disturbed three unknown males in the process of committing burglary.

150. On 17 July 2007, Thomas's care co-ordinator noted that a proactive approach was felt to antagonize Thomas. The care co-ordinator spoke to Magda who said she would contact the Community Mental Health Team if Thomas were psychotic.

151. Thomas's care coordinator made a home visit on 3 September 2007.

152. On 5 September 2007, Thomas was arrested for smashing several panes of glass with a hammer at Horse Guards Parade. He was noted to be drunk. It has not been possible to determine whether an assessment under the Mental Health Act took place on this occasion as the police records containing this information have been destroyed following expiry of their required retention period. Central and North West London NHS Foundation Trust, who provide mental health services for the area of London where Thomas was arrested, have no record of having any contact with Thomas, which strongly suggests that no mental health assessment was conducted. Thomas was subsequently charged with criminal damage and was found guilty of the offence at Horseferry Road Magistrates Court in January 2008.

153. Thomas was discharged from care co-ordination by the community mental health team on 10 September 2007 after he stated that he wanted no further contact. It does not appear that the Community Mental Health Team was aware of his recent arrest at Horse Guards Parade, which was in the Westminster area, and where the police did not request a mental health assessment. His case was still open to outpatient care and he was expected to see a psychiatrist twice a year.

154. On 4 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 that she did not know anything about the nature of a plant-based drug Magda was taking. Magda became aggressive and raised her

voice. The GP asked her to calm down and called a senior doctor to help. Magda was referred to a gynaecologist at the Royal Free Hospital and attended three appointments there during October and November before having a laparoscopy in December 2007. She also attended a cardiology appointment at the Royal Free in this period.

155. Thomas appeared at Horseferry Road Magistrates on 4 January 2008 in connection with the criminal damage at Horse Guards Parade the previous September. He was found guilty and compensation of £750 was awarded against him. He failed to surrender and was fined £100, which he did not pay, and as a result he served one-day imprisonment.

156. In January 2008, Magda presented to the community mental health team at the Peckwater Centre. She was concerned that Thomas was becoming unwell. He had been arrested for criminal damage and was becoming 'increasingly hostile' towards Magda. *(Author's note: this is believed to be his arrest at Horse Guards Parade in September 2007 which had recently come to court. It appears that Magda had paid his fine.)* She said that they had argued the previous day and she feared Thomas would attack her. Thomas had then left but in a later phone call they had argued again and Thomas had threatened to kill her. This was after Magda had told him to 'take responsibility', stop drinking, and not to contact her if he ended up in a police station again.

157. Thomas met with a social worker (social worker 1) from the community mental health team on 30 January 2008. He said his hostility to Magda was intended to reduce the frequency of contact between them as he found her 'overbearing' and 'intrusive'. Thomas declined further support from the team. Magda was sent a letter, encouraging her to get in touch if she felt Thomas's mental health was deteriorating in the future.

158. A letter of March 2008 from the Community Mental Health Team to Thomas's consultant mentions that Magda agreed with Thomas's discharge from CPA and that Thomas was in Denmark where he had been 'for some time'.

159. During 2008, Magda and Thomas went on holiday to South Africa. On 18 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.'

160. On 13 May and 19 May 2008, Magda attended the GP, concerned that she may have colon cancer. Tests proved normal. On 15 July 2008, she attended the GP concerned about a lump in her armpit. She had previously visited the GP with concerns about lumps in her armpit in June 2001, November 2007. In July 2008, she was referred to a vascular surgeon who found nothing wrong.

161. A different social worker was allocated as Thomas's care co-ordinator (care co-ordinator 1) on 6 August 2008 and remained in this role until Magda's death.

162. Thomas's psychiatrist (psychiatrist 2) emailed social worker 1 on 10 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 rather than discharge. Social worker 1 and Care Co-ordinator 1 planned a joint

home visit on 27 March 2009. There was no answer when they attended his address.

163. 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.

164. On 6 May 2009, Magda attended her GP again with a lump in her armpit. She was concerned regarding her breast although the result of a recent mammogram was normal.

165. Thomas did not attend an outpatient appointment with psychiatrist 2 on 7 May 2009 and did not respond to a letter from social worker 1, on 20 May 2009, inviting him to meet up to discuss whether he needed a service from the community mental health team.

166. On 13 July 2009, Magda attended the GP with severe back pain, which she had been treating with Arneca. She complained that GPs only give 'pain killers and antibiotics.' On 28 September 2009, Magda attended her GP, still worried that she was losing weight but the GP recorded there was no evidence to support this.

167. On 30 July 2009 and again on 2 August 2009, Magda attended the emergency department at the Royal Free Hospital as she thought she had a fish bone stuck in her throat. On the second occasion staff attempted to check her throat and Magda then insisted on washing her hands for ten minutes before putting her own finger into her mouth. She was referred to an Ear, Nose and Throat specialist. The hospital also wrote to her GP regarding her washing her hands for so long.

168. In October 2009, the community mental health team held a Care Programme Approach review for Thomas. Thomas had not attended any appointments or been seen for more than 18 months, though his mother and neighbour were in contact with the service. A plan was agreed to contact Magda and the neighbour for an update, to consider a home visit and then to come to an agreement over the appropriate course of action.

169. On 18 November 2009, Magda attended the GP with a lump in her throat, which she thought was due to her thyroid. Her blood tests proved normal. She said she was considering plastic surgery for bags under her eyes but was worried she would die under the anaesthetic.

170. In January 2010, the Community Mental Health Team discussed Thomas in the clinical slot at their team meeting. Thomas had continued not to engage with services. The team considered Thomas's risk history 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. The care plan was to include contact with Magda.

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

171. 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 that was not resolved with prescribed medication. She resorted to self-medicated homeopathic medication. The Rheumatology team recorded that Magda was rude and would shout them down. One put in a formal complaint for an "abusive" phonecall. Magda would complain about the "inefficient service" and demand to be seen on the same day.

172. On 27 March 2011, Magda was examined following symptoms relating to bilateral carpal tunnel syndrome. A left shoulder injury was identified, based on an ultrasound in 2009. She did not offer any explanation of how this was caused. An orthopaedic referral was offered but she did not attend the appointment.

173. Magda contacted the Community Mental Health Team on several occasions during April 2010 (6, 9, 20 April). Thomas had stopped communicating with her and she was also concerned about his financial situation, isolation and ability to manage his flat. The Mental Health Team attempted to visit Thomas at home on 8 April 2010 but he was not in. Care Co-ordinator 1 spoke with Thomas on 20 April 2010 who described his mother as over-bearing and said that he had no privacy. He agreed to meet Care Co-ordinator 1 once a week. Magda later came to visit Care Co-ordinator 1 and said that she was reluctant for Thomas to take medication but that the team needed to be more proactive.

174. On 15 April 2010, Magda attended her GP, worried that lumps in her armpit and neck could be cancer. She was referred to a thyroid specialist and the musculoskeletal service.

175. On 10 May 2010, Magda called the Community Mental Health Team Manager. She was concerned that Care Coordinator 1 did not come to a planned home visit that morning. Magda raised concerns 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. She said he was sleeping with a hammer and screwdriver under his bed. The manager agreed to follow up with Care Coordinator 1. Magda phoned the Manager again the following day. He explained that no meeting was planned but Magda disputed this. There is no record of how Thomas's reported "dead and buried" comment was addressed and the clinicians interviewed during the Serious Incident Investigation did not recall how it was followed up. *(Author's note – Camden & Islington NHS Foundation Trust said that a similar report would now lead to a risk assessment, safety planning with the (potential) victim and referral to a domestic violence service.)*

176. Thomas met with Care Co-ordinator 1 on several occasions during May 2010 and was accompanied to a meeting with a Welfare Rights Adviser that Magda also attended. On 25 May 2010, Thomas and Care Co-ordinator 1 agreed to reduce the frequency of meetings to fortnightly. Thomas felt his relationship with his mother had improved as his debts were being looked into and so she was "less intrusive."

177. They met again on 8 June 2010 but there is no record of a further meeting until 29 July 2010 which was described as a "brief meeting as Thomas did not want to engage." The next recorded meeting between Thomas and Care Co-ordinator 1 was 5 August 2010, which was the last recorded meeting in 2010.

178. Thomas met with a welfare rights adviser during July and August (13 and 27 July 2010, accompanied by Magda; 12 and 27 August 2010). As a result, a debt relief order was completed and submitted.

179. On 20 September 2010, a CPA Review was conducted for Thomas. He did not attend and no reason was given for his non-attendance. The team noted that he had engaged well over the past eight months, where the focus had been in addressing problems with debt.

180. On 30 September 2010, the GP visited Magda at home due to a presumed viral infection. Her condition deteriorated and she was admitted to hospital on 4 October 2010 as an emergency. 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 queried the diagnosis on occasion and requested further tests. She explored alternative therapies to treat her symptoms and initially rejected conventional approaches.

181. On 23 December 2010, Magda was noted to be abusive to the reception team at the GP surgery as her prescription was not ready. She was advised she would be removed from the list if she were rude again.

182. On 7 January 2011, Care Coordinator 1 made a home visit. Thomas's mental health was stable and he described his relationship with Magda as improving.

183. On 7 February 2011, Care Coordinator 1 visited Thomas at home as Magda was concerned by a recent incident whereby Thomas locked her out of her flat. Thomas was noted to be slightly agitated and spoke of his belief that a family member may have been a Nazi collaborator. This was a concern for the Community Mental Health Team. *(Author's note: Given Thomas's background, Nazi collaboration was not out of the question. Denmark, where Thomas and his father were born, was occupied during World War II. Magda was born two years after the end of the siege of Leningrad by the Nazis, one of the longest sieges in history.)*

184. Care Co-ordinator 1 met with Thomas again on 14 February 2011. He appeared more stable but his personal hygiene was poor. He agreed to a home visit by a doctor.

185. Magda saw her GP on 4 March 2011. She said she was fed up with everything. She was referred to gynaecology ten days later after a further appointment.

186. Care Co-ordinator 1 visited Thomas at home again on 4 March 2011. He seemed more stable but his relationship with Magda was noted to be difficult. The next recorded contact was on 10 May 2011. Thomas's mental health was stable and his relationship with Magda had improved.

187. On 17 June 2011, Magda called Care Co-ordinator 1 to say that Thomas was unwell and self-medicating. She felt that services had let him down. She said that he had not been visited for six months, though clinical records show five face-to-face

contacts (at home and in the community) between January and June. *(Author's note: Magda was not present at these contacts and may not have been aware of them.)* 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. Thomas was calmer when Care Co-ordinator 1 saw him on 20 June 2011 but he stated that he did not want Magda coming to his flat without notice. He declined the offer of family therapy. At a home visit on 28 June 2011, Thomas said that he did not want Magda to attend his CPA review meeting.

188. On 26 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. She said that Thomas wished to speak to Care Co-ordinator 1, who was on leave. Thomas declined an offer to see somebody else. The care co-ordinator attempted a home visit on 9 August 2011 and saw him on 25 August 2011. Thomas said 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 in September 2011 (8 and 25 September 2011).

189. On 6 September 2011, Magda attended her GP with a cough, demanding referral to the TB clinic. She complained that no one in the NHS listened or gave the right treatment.

190. On 14 September 2011, Magda reported having an 'angry blow out' in the TB clinic at hospital. On 16 September, she requested an unconventional antibiotic treatment for a cough and was recorded to be "clearly upset and desperate". A week later, Magda attended with irritable bowel syndrome. She wanted a referral and vitamin supplements as well as several unconventional blood tests. An urgent referral to gastroenterology was made on 27 September 2011 as her bowel symptoms were worse and she was losing weight.

191. Thomas received a home visit on 27 October 2011. Care Co-ordinator 1 recorded that Thomas "remains stable, as he has done for the past year. Thomas is having less contact with Magda and feels this is partly why he feels better". Care Co-ordinator 1 visited again on 17 November 2011. On 20 December 2011, Thomas's mental health appeared stable but he was concerned that Magda was over-involved in his care.

192. On 7 November 2011, Magda went to A and E due to pain.

193. Magda attended her GP 19 December 2011, unhappy with her treatment by the gastroenterologists at hospital. On 4 January 2012, she requested a second opinion about her thyroid. On 3 February 2012 she had a thyroidectomy at a private hospital. On 10 February 2012, Magda asked for an urgent referral to the hand clinic as she had a painful wrist. On 29 March 2012, Magda attended the GP with a rash and was diagnosed with shingles.

194. On 27 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. He was not at home when they called on six separate occasions (14, 23, 31 May 2012; 22 June 2012; 6 and 17 July 2012) and he did not return messages. A CPA review

was held on 22 June 2012 in his absence and the Community Mental Health Team decided to continue trying to engage/monitor from a distance.

195. On 23 April 2012, Magda requested an unlicensed drug from her GP to treat her rheumatoid arthritis, which was agreed. On 13 June 2012, the GP made a home visit to Magda. She was feeling dizzy, worried about her blood pressure and afraid to leave the house. On 2 August 2012, Magda attended the GP with a rash. She reported that she was no longer attending the hospital rheumatology clinic, as she did not agree with their treatment.

196. 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. He kept the same care coordinator. Patients were categorized under a Red, Amber, Green system (see Appendix 4). 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.

197. After a gap of five months, Care Co-ordinator 1 met Thomas on 30 August 2012. He was reported as managing well and spending a lot of time at Magda's house.

198. Care Co-ordinator 1 spoke on the phone with Magda on 11 October 2012. She was concerned that Thomas was unwell and said that he had complained of weakness. On the same day, Care Coordinator 1 advised Thomas to sign on with a GP to have his health assessed. Care Co-ordinator 1 noted that Thomas's mental health was stable and that he spent most of the time at his mother's house.

199. Magda saw her GP on 25 October 2012 with menopausal symptoms. She said that she might move to Spain as her joints were better there. On 3 December 2012, Magda's GP made a home visit and diagnosed a chest infection.

200. Care Co-ordinator 1 made a home visit to Thomas on 6 December 2012. He was spending a lot of time with his mother and had no interest in a structured daytime visit. Neither Thomas nor Magda wanted to participate in family therapy.

January 2013 – 6 May 2014
Thomas reported to be largely stable; divergent accounts of Thomas's drinking; Thomas staying with Magda at the end of 2013; Thomas has no recorded contacts with mental health services between January 2014 and 6 May 2014

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

202. Care Co-ordinator 1 met with Thomas on 12 February 2013. Thomas felt quite agitated but appeared to be coping well. Care Coordinator 1 noted that Thomas's mental health could deteriorate following Magda visiting him. A risk assessment, conducted by the South Camden Recovery and Rehabilitation Team on 3 April 2013, stated that, "there is little need for Magda to express the level of concern she does about Thomas."

203. Magda had a routine blood test at her GP surgery on 11 April 2013 to monitor rheumatoid arthritis. She had a rheumatology review on 5 June 2013 and said she had no faith in NHS treatment and preferred to pursue her own treatment.

204. A CPA Review Meeting was held on 9 May 2013, attended by Thomas, Magda, psychiatrist 3 and Care Co-ordinator 1. At the meeting, Magda said that Thomas often drank excessively, though Thomas said he drank small amounts occasionally. Thomas described anxiety about things going on around him. Magda was sceptical about medical treatment and diagnosis for psychiatric disorders. Her view was that Thomas had autism. Both Magda and Thomas agreed that individual psychology sessions could be helpful. The outcome of the review was to refer Thomas for a psychological therapy assessment and to continue monitoring Thomas's mental state. There is no record of the referral being made until December 2013.

205. 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.

206. Thomas and Magda were in Spain during June and July 2013. On their return, Magda attended her GP on 17 August 2013 requesting tests to check lead, mercury and aluminium levels in her blood. The results were normal.

207. On 20 August 2013, Magda contacted Care Co-ordinator 1. She felt that Thomas was deteriorating. He agreed to see Thomas soon. When the care coordinator visited Thomas on 9 September 2013, he found him to be slightly anxious but stable. The next recorded contact was on 26 November 2013 and noted that Thomas remained stable and was willing to engage with psychology.

208. Magda attended her GP on 5 November 2013 with joint pain and was referred back to the NHS rheumatologist.

209. Care co-ordinator 1 made an entry into Thomas's care plan on 10 December 2013 stating that Thomas had been referred for a psychology assessment with the aim of providing coping mechanisms for Thomas. This was seven months after Thomas's CPA review agreed to the referral.

210. Magda was seen by the outpatients 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 undergoing Vitamin C infusions which had helped her rheumatoid arthritis. She missed follow up appointments in April 2014.

211. Care co-ordinator 1 made another entry on 30 December 2013 stating that Thomas's mental state remained consistent. Thomas reported that the area around his own flat was crowded and he felt safer staying with his mother. Care Co-ordinator 1 noted that Thomas often misinterpreted things going on in the street; in particular he believed that he was at risk when he heard a group of males in the flat below.

212. Magda attended her GP on 3 January 2014. She wanted the NHS to pay for her Vitamin C infusions. She was noted to be very angry that the NHS always gave the wrong treatment. She requested further unconventional blood tests, which were normal. She requested further blood tests and x-rays on 22 April 2014.

213. On 24 February 2014, a Housing Officer from LB Camden wrote to Thomas regarding noise, following complaints from his neighbours. The noise related to 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 and a home visit arranged to establish whether he was keeping to his tenancy conditions.

214. There are no contacts recorded on the RiO system between Thomas and any community mental health service between January 2014 and 6 May 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. *(Author's note: 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. Care Co-ordinator 1 told the Serious Incident Investigation that he had been seeing Thomas approximately every four weeks but not documenting it in the clinical record. He also said that Magda had not contacted him during the previous four weeks.)*

7 – 9 May 2014

Magda and Thomas request admission on 7 May 2014 – agreed in principle but no beds available within Trust; Thomas sent home after assessment; Crisis Team visits Thomas on 8 May 2014; Magda and Thomas ask about admission but told it is not indicated; home treatment plan put in place on 8 May 2014; Thomas kills Magda on 9 May 2014 and sets flat on fire

215. At 10:10 on 7 May 2014, Magda called the South Camden Rehabilitation & Recovery Team (formerly Community Mental Health Team). She was concerned that Thomas would harm her, as he was not well. Care Co-ordinator 1 was on leave and she spoke to a different social worker (social worker 3). She was advised to contact the police immediately if she was concerned for her safety. Magda requested mental health services go to her flat. Social worker 3 said she would call back with a plan after getting some background information.

216. Ten minutes later, Magda called again and told another member of the team that Thomas needed to be admitted immediately. She was noted to be very emotional.

217. Social worker 3 returned Magda's call at 10:30 and spoke to both Thomas and Magda on the phone. Thomas 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 sounded lucid and articulate and said he did not want to go to his own flat. He was not able to identify any triggers to the symptoms he was describing nor was he receptive to suggestions for how he might manage any symptoms. He sounded impatient and insistent about wanting to go to hospital. He agreed to come to the Rehabilitation and Recovery Team offices at 13:00. Social worker 3 advised Thomas to leave the house if he was concerned about the situation escalating.

218. At 12:22, Magda called the Rehabilitation and Recovery Team offices again. She spoke to another social worker (social worker 4). Magda was angry and shouting. She said that Thomas had put his hands around her throat in the past, though she did not say when this had happened. It emerged that she thought that she was speaking with the Crisis Team and was angry that the team did not go to see Thomas, and instead suggested he go to them. Thomas had left Magda's flat at this time. Magda agreed to see whether Thomas attended his appointment at 13:00 and, if not, for the Rehabilitation and Recovery Team to liaise with Magda to find out if Thomas had come home and to arrange a home visit.

219. At 14:19, a trainee mental health worker from the Rehabilitation and Recovery Team (R&R nurse) met with Thomas and Magda at the Peckwater Centre where the Team is based. Initially Thomas stated that he was not sure if he had been hearing voices but went on to describe external voices and colours that he was seeing. Thomas appeared unwashed and nervous, his hands were shaking and nervous head jerks were noted. He reported not having eaten for four days and having disturbed sleep. Magda said that Thomas had been sleeping on the floor and breaking CDs. He repeated that he did not want to go to his own flat or to his mother's and seemed to think that hospital was the only option. The trainee mental health worker recorded in Thomas's RiO notes that the Crisis Team had completed gatekeeping but that no beds were currently available within the Trust.

220. The case was handed over to the Clinical Team Manager in the Recovery and Rehabilitation Team, who was taking over management cover of the Red Team for that afternoon *(Author's note: the Red Team deals with outpatient and urgent cases where the care co-ordinator is not available).* A Mental Health Nurse at the Crisis Team reported receiving a phonecall from Magda at about 14:30 and a call at about 15:00 from the Clinical Team Manager at the Recovery and Rehabilitation Team. The Clinical Team Manager spoke of Thomas seeming scared and self-medicating by drinking alcohol excessively. The Crisis Team agreed to authorise an informal admission on the basis of Thomas's chaotic behaviour, his request for admission, which was unusual for him, (*Author's note: he had not made such a request for more than 11 years).* The Crisis Team did not plan to meet with Thomas for a face-to-face assessment prior to agreeing the admission,[23] which is permitted under the Trust's bed management policy.

[23] The Trust's Bed Management Policy allows for gatekeeping to be completed without face-to-face assessment by the Crisis Team in exceptional circumstances where admission is

221. The plan was for the Clinical Team Manager to prescribe olanzapine, an anti-psychotic medication that Thomas had been prescribed previously and for a bed to be organised for admission now that the gatekeeping process had been completed. The Clinical Team Manager from the Rehabilitation and Recovery Team contacted the bed manager to arrange for Thomas to be admitted but there were no beds available in the Trust at that time. 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[24]. The Clinical Team Manager was aware of the process to follow if he considered a bed was urgently needed. *(Author's note: beds were sourced for four other patients on 7 May 2014, three formal detentions and one informal.)*

222. The Clinical Team Manager met with Thomas and Magda at Peckwater Centre (this was recorded on the RiO system at 15:03). Magda reported that the Care Co-ordinator had not responded to her messages for five days. In interview for the Serious Incident Investigation, Care Co-ordinator 1 denied receiving any messages and no records were found of any messages having been left. The Clinical Team Manager carried out a detailed assessment of Thomas and concluded that an informal admission would be most appropriate. 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 seeing different colours. Thomas also reported anxiety, not sleeping and not eating.

223. The Clinical Team Manager is a non-medical prescriber[25] and, with Thomas and Magda's agreement, he prescribed 5mg olanzapine[26] (an anti-psychotic medication which Thomas had been prescribed previously) once daily for five days. He also referred Thomas to the Crisis Team for them to visit and further assess. During interviews for the Serious Incident Investigation, the Clinical Team Manager stated that it remained his view at this time that Thomas required admission and that the referral to the Crisis Team was made for additional support because no bed was available within the Trust and not as an alternative to admission.

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indicated and further Crisis Team assessment is not needed and would not be in the best interest of the patient.

[24] If an AMHP assesses that a bed is urgently needed but one is not available, they should seek high level authorisation to source a bed outside the trust, usually in the private sector. 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."

[25] Non medical prescribers are health professionals other than doctors (such as nurses and pharmacists) who are able to prescribe drugs

[26] Olanzapine is an anti-psychotic medication. The rapidity of its effect is uncertain, varying from individual to individual. Alcohol use has an unpredictable negative impact on olanzapine's effectiveness. Both alcohol and olanzapine are sedating and it can be risky to take both.

224. At 15:04 the Clinical Team Manager telephoned the Crisis Team and spoke to a Graduate Mental Health Worker. He advised the Graduate Mental Health Worker that the bed manager had said there were no beds available within the Trust and so he felt the Crisis Team would be beneficial for extra support.

225. The Clinical Team Manager documented that Thomas was safe to go home with Crisis Team support. He identified the following protective factors for Thomas: agreeing to take medication, referral to the Crisis Team for an assessment and the fact that he was seeking help. The Clinical Team Manager informed the Graduate Mental Health Worker in the Crisis Team that he had issued a prescription for olanzapine and requested Crisis Team input to monitor compliance, efficacy and side effects of this medication. The Clinical Team Manager documented that the Crisis Team had agreed to contact Magda the same day to arrange a Crisis Team assessment.

226. Both Magda and Thomas left the Rehabilitation and Recovery Team offices and returned home. They were unhappy that a bed was not available straightaway.

227. The Graduate Mental Health Worker attempted to make contact with Magda on her mobile phone to confirm a time for the Crisis Team to see her but there was no answer and the Graduate Mental Health Worker left a message. At 16:00, the Graduate Mental Health Worker spoke to Magda by phone. Magda was upset that there were no beds to facilitate an admission. She said that Thomas was staying at her address because he was too scared to stay in his own flat. Magda reported that during the assessment at the Recovery and Rehabilitation Team offices, Thomas had said he was having thoughts about wanting to hurt her although he said he had no plan or intent to act on these thoughts. The Crisis Team advised her that if she was feeling unsafe then Thomas should attend A&E and/or she should call 999 and he could be reviewed by the Mental Health Liaison Team. However Magda was concerned about the envisaged waiting times at A&E. Magda expressed her frustration that she had made several attempts to make contact with the Recovery & Rehabilitation Team within the previous week to advise that Thomas was breaking down but had received no call back. (*Author's note: the Serious Incident Investigation Team could find no evidence that Magda had been calling via the switchboard. Such calls are logged and there are no entries indicating calls from Magda over this period. Calls direct to the mobile phones of Team members are not logged and the possibility that Magda had tried contacting members of the Team directly cannot be ruled out.)* Magda reported that she had already collected the prescription for olanzapine and had given Thomas one of the tablets. The Crisis Team offered a home assessment at Address 1 the following day, which Magda accepted.

228. Following the call, the Graduate Mental Health Worker phoned the Clinical Team Manager at the Recovery and Rehabilitation Team to inform him that contact had been made with Magda and to ask if someone from the Recovery & Rehabilitation Team could attend the home assessment. The Clinical Team Manager e-mailed this request to Care Co-ordinator 1.

229. At 16:34, a trainee mental health worker[27] from the Rehabilitation and Recovery Team 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 was recorded as saying he would call the Red team back the next day.

230. 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. As a result, the bed manager did not escalate the need for a bed for Thomas to the Matron who would have been able to instigate the agreed approval process for a private bed to be sought. There was nothing written in the notes advising that an admission to a bed was still required despite the fact that the Clinical Team Manager believed that a bed was still needed and had only put the additional support from the Crisis Team in place whilst a bed was being sought. There was no contact between the bed manager and Clinical Team Manager or with the Matron to confirm whether or not a bed was still needed. At that point any action to identify a bed and progress an admission effectively stopped.

231. At 17:20, Thomas's Consultant Psychiatrist (psychiatrist 3) returned to the Recovery and Rehabilitation Team's offices and discussed Thomas's non-medical prescription with the Clinical Team Manager. Psychiatrist 3 agreed that the non-medical prescription had been appropriate. During an interview for the Serious Incident Investigation, psychiatrist 3 confirmed that the Clinical Team Manager's view had been that Thomas required admission.

232. At 18:18, the Clinical Team Manager telephoned Magda and advised her that he had spoken to the Crisis Team. She confirmed that the Crisis Team had made contact with her. The Clinical Team Manager advised Magda to call emergency services if needed before the appointment with the Crisis Team the next day. Magda was more settled and she reported that Thomas had taken olanzapine and was in bed.

233. At 10:00 on Thursday 8 May 2014, a Clinical Nurse Specialist from the Crisis Team visited Thomas at Address 1, accompanied by Thomas's Care Co-ordinator, who had known Thomas for more than five years. Prior to the visit, Magda informed the Crisis Team that Thomas had left the flat. The staff members decided to go anyway, which was good practice.

234. Thomas was present when the Clinical Nurse Specialist and Thomas's Care Co-ordinator (referred to below as the assessors) arrived. He reported that he had moved in with his mother about a month previously because he was not feeling well in his own accommodation. Thomas said he found the area around Address 2 too stressful and wanted to move. He said, "There are too many people there." Magda later added that too many drinking bars in the area fuelled his alcohol intake and caused him to relapse. Thomas said he found his mother interfered in his affairs too much but did not want to go back to his own accommodation either.

[27] These are graduates who undertake a post graduate diploma in mental health whilst also working in the Trust for a year

235. Thomas was unable to give any clear picture of what had been happening prior to moving to his mother's flat; his responses were "nothing" and “not really". *(Author’s note: in interview for this review, Thomas said he had being having problems with his neighbours.)*

236. Thomas told the assessors that he drank four or five cans of beer (5% strength) daily and chain-smoked. He said that he had been hearing voices but could not say what the voices were saying. His responses were quite ambivalent. Thomas said he was also seeing colours.

237. Thomas asked several times if the assessors were going to take him to hospital. They explained to him that he did not need to go to hospital. *(Author’s note: from interviews as part of the Serious Incident Investigation, it appears that Care Co-ordinator 1 believed that the search for a bed for Thomas was ongoing and that home treatment was a short-term measure until an admission was possible; in contrast, the Crisis Team member thought that the plan was to provide home treatment without looking for a bed).* According to neighbours and friends, Magda told them that she had also requested again that Thomas be admitted to a psychiatric ward although this is not recorded in the RiO notes.

238. Magda said that Thomas had refused to take his medication that day although he did take olanzapine in the presence of the assessors. Magda said Thomas only took it because the assessors were present.

239. Thomas attributed his symptoms to his alcohol intake and was ambivalent when asked if he had any mental illness. However there was a query about a learning difficulty as 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?" Each time, Thomas was told he did not need to be in hospital. Magda suggested Thomas might have autism spectrum disorder.

240. Magda suggested that Thomas had a low tolerance for alcohol and was easily influenced by it. Thomas said he did drink alcohol but denied using any illicit drugs. Magda said that Thomas threatened her when he had been drinking. The assessors advised Magda not to let Thomas into the apartment 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.

241. During the Serious Incident Investigation, the Clinical Nurse Specialist reported that he thought alcohol use might have been an important factor in Thomas’s deterioration as the background notes showed that he had had multiple admissions followed by a long period of no admissions. This caused the Clinical Nurse Specialist to think that perhaps Thomas’s presentation was not a straightforward psychotic breakdown.

242. Magda said that Thomas had not bathed for days. The assessors felt that although Thomas’s fingernails seemed dirty, there was no evidence of being malodorous and he looked reasonably kempt. They encouraged Thomas to return to his own flat but Magda said that this could not happen. Both Magda and Thomas were encouraged

to consider Thomas returning to his own flat but Magda refused. *(Author's note: it appears that Thomas also indicated that he did not want to return to his flat. He had already said that he found the area too stressful. As part of the interview for this review, Thomas indicated that he had not wanted to return to his flat on 8 May 2014. He wanted to be admitted to hospital. He said he was not able to "drink in hospital. That's the whole bloody point." He was aware that drinking made his mental health worse and in hospital he would not be able to have access to alcohol. He said that alcohol fuels his illness like "putting fire out with gasoline." He said he wasn't able to stop drinking himself, which is why he wanted to be admitted).*

243. 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 and Rehabilitation Team offices later that day. The panel was unable to establish whether this was a formal appointment or a more informal arrangement. Thomas did not attend. There was no follow-up of his non-attendance. *(Author's note - Given what had occurred over the preceding 24 hours, it seems reasonable to expect the Care Co-ordinator to have attempted to contact Thomas and Magda regarding Thomas's non-attendance.)*

244. The exact events following the home assessment on 8 May 2014 are not clear. Thomas was not well enough to be interviewed by the police from the point of his arrest on 9 May 2014 until the trial on 3 November 2014. Neither was he well enough to be interviewed by the investigation team carrying out the Serious Incident Investigation. The Chair of this review wrote to Thomas in December 2014 via his psychiatrist seeking his involvement in the review. His psychiatrist judged that Thomas was now well enough to be interviewed and Thomas consented to being involved.

245. During the interview, which took place in January 2015, Thomas said that he was feeling horrendous in the days leading up to his mother's death. He had had a flashback that he thought was linked to his earlier history of acid use. He said he was experiencing a "dual reality" and thought he needed to kill his mother and destroy the flat to prevent spirits taking over. He felt he was going to hell. He said, "I just cracked."

246. Thomas left Address 1 around 04:40 on the morning of 9 May 2014. He walked to a shop about 500 yards away where he bought two packets of firelighters (12 in each box) and a bottle of olive oil. Then he returned to Address 1.

247. At about 05:00, one of the neighbours heard a scream. This was a really loud intense wailing noise that seemed to last about 30 seconds. At about 05:12, the same neighbour heard footsteps coming from next door. A second neighbour was woken by the slam of the front door as Thomas left the flat around this time. A short time later, the second neighbour smelt smoke and discovered a fire downstairs blocking their exit from the building. The occupants of the two flats above Magda's had to seek refuge from the fire and smoke by exiting a window at the rear of the second floor flat onto a flat roof area. At approximately 05:20, the London Fire Brigade responded to the fire at Address 1. They rescued the occupants of the top two flats. The fire brigade entered the ground floor flat and pulled Magda's body

from the lounge area of Address 1 and into the street. They immediately noticed that she had stab wounds. London Ambulance Service had also responded to the call and commenced CPR but life was pronounced extinct at 05:39. The LFB extinguished the fire.

248. Police were called to the scene and, shortly after, a murder investigation was launched. The victim was identified as Magda. She had sustained knife defence wounds to both hands. Thomas was quickly established as the suspect. He was not present at the time of police attendance and efforts quickly centred on tracing him.

249. On examination of the crime scene, four separate seats of fire were discovered. These were located in a corner area of two separate bedrooms; by a table within the living room area nearby to where Magda's body was found and which was also near to a coffee table on which a large knife was discovered; and a fourth seat of fire, which was the largest one, at the head of the stairs that led down to the basement area. The knife recovered was consistent with the injuries to Magda.

250. After he killed Magda, Thomas left the flat and went to Highgate Woods. He tried to burn down trees in the woods and had thoughts in Danish about burning down churches.

251. Thomas's details were circulated as being wanted for the offence of murder. On 9 May 2014 at about 19:50, Thomas presented himself at the Royal Free Hospital. He informed the receptionist at A&E that he had had a fight with his mother that morning and that he wanted to see a mental health doctor. His details were logged by the receptionist and he waited to be seen. Thomas was then dealt with by the triage/assessment nurse who noted he had an unkempt appearance. She asked him what had happened and he told her that he had had a fight with his mum that morning and that he hurt her. He told her he felt bad and felt suicidal. He appeared to her to be very agitated, he maintained poor eye contact with her, was continually twitching in his seat and moving from side to side. The Police were called and Thomas was arrested by PC Brooks at 21:17 for murder. He was then taken to Kentish 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 admitted to a secure hospital via Highbury Magistrates Court.

252. Thomas pleaded guilty to manslaughter on the grounds of diminished responsibility when the case came before the Central Criminal Court on 3 November 2014. He also pleaded guilty to arson. The prosecutor accepted the doctors' assessment that his ability to form any rational judgment was severely impaired at the time through mental illness. The judge imposed hospital orders in respect of the two counts Thomas had admitted and he was sent to a secure hospital for an indeterminate time.

Section Five: ANALYSIS OF INDIVIDUAL AGENCY RESPONSES

253. A comprehensive chronology of agency contacts was prepared and considered by the Review Panel. In the accounts that follow, agency involvement has been summarised to focus on those contacts of most significance to the DHR.

Camden & Islington NHS Foundation Trust

Summary of involvement

254. Camden & Islington NHS Foundation Trust (and its predecessor organisations) provided mental health services to Thomas for twenty years from February 1994 until Magda's death on 9 May 2014. This history included multiple inpatient admissions in the first eight years and a long period of being supported in the community by the team now known as South Camden Rehabilitation and Recovery Team. Mental health services also had contact with Thomas's mother, Magda, in her role as a carer. In the two days before Thomas killed Magda, he was under the care of South Camden Rehabilitation and Recovery Team and the Crisis Team and had requested admission to hospital a number of times.

255. Thomas had eleven admissions to psychiatric care between February 1994 and November 2002. Six of his first seven admissions were formal admissions under the Mental Health Act. Three of his last four admissions were voluntary.

256. Thomas requested voluntary admission on four occasions between 1997 and 2002. These requests were always agreed. He did not make another request for voluntary admission until 7 May 2014. His request for admission was initially agreed in principle but there was 'no bed available' within the Trust. He was assessed and a decision was made not to source a bed in the private sector as he was considered safe to go home on anti-psychotic medication while waiting for an NHS bed to become available. On 8 May 2014 Thomas again asked if he was going to be admitted but a home treatment plan was put in place instead as the Crisis Team felt they could work with him in the community. Had he been admitted on 7/8 May 2014, Thomas would not have been in a position to kill his mother on 9 May 2014.

257. There appeared to be confusion amongst staff about the meaning of 'no bed available' and the appropriate response if a bed was needed. In theory, staff should have been able to escalate the need for a bed to matron for one to be sourced outside the Trust but this did not happen. There was poor communication across different teams in relation to whether a bed was still needed. The bed manager halted the search for a bed on 7 May 2014 on the basis that the Recovery and Rehabilitation Team had documented a home treatment plan on Thomas's electronic record. However, the Recovery and Rehabilitation Team had put in place the home treatment plan as a temporary measure while they waited for a bed to be available for Thomas. This was not clear on the electronic record and the bed manager did not check with the

Recovery and Rehabilitation Team before ending the search. Camden & Islington NHS Foundation Trust have put in place actions to address this gap.

258. On a number of occasions, Thomas's admissions were linked to violence or threats of violence including threatening to stab his father (April 1995); smashing Magda's windows (August 1996); and threatening a psychiatrist with a combat knife (April 2000). In December 2001, Thomas was informally admitted at his own request because he was concerned he would stab a neighbour. This parallels the circumstances leading up to his requested admission in May 2014. It appears that staff who assessed him were aware of this and his previous use of informal admission when he was concerned he might harm someone but this did not lead to a decision to secure a private bed for him when a Trust bed was not available.

259. During the period of his multiple admissions, Thomas would tend to stop taking his medication whilst being supported in the community. A depot injection, which would have allowed for a slow release of medication over two to four weeks, was recommended on two separate occasions (August 1996 and April 2000) but not followed up.

260. For the majority of the period 2002 and 2014, Thomas was not taking medication but no longer needed to be admitted on a regular basis. The reasons for this improvement do not appear to have been explored.

261. When Thomas was sectioned in 2000, he was assessed by a Specialist Registrar in Forensic Psychiatry, who noted that Thomas tended to disengage with services, become non-compliant with medication and lose insight rapidly. Thomas's tendency to disengage continued over the following fourteen years. Attempts by Community Mental Health Services to increase his engagement were sporadic. Thomas did not attend any outpatient appointments with a psychiatrist after August 2005. He was supposed to see a psychiatrist twice a year but did not attend appointments and his next recorded contact with a psychiatrist was not until May 2013. Thomas's psychiatrist (psychiatrist 2) emailed a social worker 1 in the Community Mental Health Team on 10 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 rather than discharge. A home visit was attempted and a letter was sent to Thomas but there is no record that he was seen again until April 2010.

262. Thomas had the same care co-ordinator (Care Co-ordinator 1) for more than five years, from August 2008 until the time of his arrest. In interview for this review, Thomas reported that he found contact with Care Co-ordinator 1 helpful, although it was also the case that Thomas would often miss scheduled appointments.

263. Care Co-ordinator 1 was of the view that Magda made Thomas's mental health worse. Magda's reports that Thomas had been violent to her were not referred to other services and did not result is a safeguarding alert. A social worker discussed Magda's allegations with Thomas who said that his mother was intrusive. Care Co-ordinator 1 recorded Magda's reports as "unsubstantiated" and that they followed verbal attacks by Magda on Thomas. There was an underlying narrative that saw Thomas as a victim of Magda, which may have prevented the Rehabilitation and

Recovery Team from seeing Magda as a victim of Thomas and potentially at risk from him. In 2013, Care Co-ordinator 1 noted that Magda was "overly concerned about Thomas." On 7 May 2014 when Thomas and Magda requested that Thomas be informally admitted, staff recorded that Magda was being "overly dramatic".

264. Despite the fact that Magda had previously been seen as having a negative impact on Thomas's mental health, the home treatment plan put in place on 7 May 2014 resulted in Thomas returning to Address 1 with his mother. This was at a time when Thomas was saying he was worried he would hurt her.

265. Record keeping was at times inadequate. For example, there are no recorded contacts between Thomas and South Camden Rehabilitation and Recovery Team between January and May 2014 although it appears that Care Co-ordinator 1 saw him on 24 April 2014 as a contact on that date is recorded in his diary. He was supposed to be seen at least monthly at this time. Care Co-ordinator 1 maintains that he was having contact with Thomas prior to the crisis of 7-9 May 2014 but that he had not made a record of the contacts.

266. As part of Thomas's care plan, he was supposed to have annual check ups with a GP, but Thomas was not registered with a GP from 2007 when he was deregistered by Fitzrovia Medical Centre until September 2013 when he was re-registered. The Community Mental Heath Team does not appear to have ensured that Thomas's annual health check was conducted. However, Care Co-ordinator 1 did encourage Thomas to register with a GP in October 2012 after Magda reported that Thomas was feeling weak.

267. Aspects of Thomas's care were positive. He had regular contact with a psychiatrist from 2003-2005 and his mental health was reported as improving and becoming stable.

268. Thomas found contact with Care Co-ordinator 1 helpful. In May 2010, Care Co-ordinator 1 arranged for Thomas to access a welfare rights adviser. Thomas was accompanied to the first meeting by Care Co-ordinator 1. Thomas attended a number of subsequent appointments with the Welfare Rights Adviser between May and August 2010, resulting in a debt relief order being completed and submitted. Thomas was happy with this outcome.

269. Care Co-ordinator 1 made frequent home visits during 2011 when Thomas was experiencing some difficulties and his relationship with his mother was volatile. He attempted to visit Thomas frequently in 2012 but Thomas was rarely at home and later reported that he was spending most of his time at Magda's.

<u>Key events</u>

Admissions to hospital

270. Thomas was admitted to inpatient care on three occasions during the period of the review:

- On 18 April 2000, via the police after threatening a Consultant Psychiatrist with a combat knife (formal admission);
- On 24 December 2001, via A&E after feeling persecuted by his neighbours. He was concerned that he would lose his temper with a neighbour and stab

him and wanted admission to prevent this happening (informal admission initially, then formally detained);

- On 26 November 2002, via A&E as he was hearing voices and experiencing some 'command hallucinations'[28] (informal admission).

Care in the community

271. The established pattern of relapses leading to admission came to an end in November 2002 and it became possible to support Thomas in the community through the Community Mental Health Team (now known as South Camden Rehabilitation and Recovery Team). Thomas had already had contact with community mental health services in the periods between admissions. 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.

Regular contact with psychiatrist 2003 – Aug 2005

272. Thomas saw a psychiatrist regularly in the period 2003 to August 2005. He was reported to be making improvements at this time and his mental health was viewed as stable. On 9 August 2005, Thomas and Magda attended an appointment with psychiatrist 2. Thomas had experienced no psychotic symptoms in the previous six months. On 15 August 2005, Thomas's case was closed by the Community Mental Health Team and he was discharged from the Care Programme Approach (CPA), as he was thought to need outpatient appointments only.

Disengagement from services Dec 2005 – April 2010

273. There is no record of Thomas attending outpatient appointments with a psychiatrist in the years 2006-2012. Thomas was expected to see his consultant psychiatrist twice a year but there are no recorded attendances after August 2005 except for a CPA meeting on 9 May 2013, (also attended by Magda), a year before Magda's death.

274. Thomas was referred back to the Community Mental Health Team on 23 January 2007 and again on 10 July 2007 as a result of non-attendance at his psychiatric outpatient appointments. He had not attended an outpatient appointment since August 2005. He was discharged from the Community Mental Health Team on 10 September 2007 (although his case remained open to the outpatient clinic) as he reported that he did not want a service from them. A few days earlier, he had been arrested after smashing numerous panes of glass with a hammer at Horse Guards Parade but the Community Mental Health Team do not appear to have been aware of this.

275. Magda attempted to raise concerns about Thomas with his psychiatrist and/or the Community Mental Health Team on several occasions including:

[28] Command hallucinations are hallucinations in which a person perceives they are being given orders, either as auditory commands or inside the person's mind and/or consciousness.

- January 2008 with the Community Mental Health Team;
- 6 April 2010 with a Staff Grade Psychiatrist;
- April 2010 with the Community Mental Health Team;
- 17 June 2011 – she contacted the Community Mental Health Team and also requested the address of Thomas's psychiatrist, as she wanted to write to them;
- 26 July 2011 with the Community Mental Health Team;
- 20 August 2013 with the Community Mental Health Team;
- 7/8 May 2014.

276. In January 2008, Magda attended the Peckwater Centre, where the Community Mental Health Team was based, and reported that Thomas was becoming unwell and was hostile to her. Thomas met with social worker 1 on 30 January 2008 and said his hostility to Magda was aimed at reducing the frequency of her contact with him. He again declined a service from the Community Mental Health Team. The team requested that Thomas's psychiatrist offer him an appointment. There was no further recorded contact with Thomas for the rest of 2008 and throughout 2009.

277. As set out above, Thomas's psychiatrist emailed social worker 1 in the Community Mental Health Team on 10 March 2009 highlighting non-engagement as a risk factor for Thomas and suggesting that the Team put in place an assertive outreach approach. At Thomas's CPA review on 12 October 2009, it was noted that he had not been seen by either the psychiatrist or any member of the Community Mental Health Team for 18 months.

278. Thomas was not seen for a further six months, with Care Co-ordinator 1 finally making contact on 20 April 2010 and meeting with Thomas face-to-face on 26 April 2010. This was prompted by Magda contacting the Community Mental Health Team on several occasions in April 2010, including meeting Care Co-ordinator 1 on 20 April 2010. She was concerned about Thomas's financial situation, isolation and ability to manage his flat. She wanted the team to be more proactive but was opposed to Thomas taking medication.

Limited follow up of potential safeguarding issues

279. On 10 May 2010, Magda told the Community Mental Health Team Manager that Thomas had said to her that she was "dead and buried." There is no record of how this comment was addressed by the Community Mental Health Team. Over the course of their contact with Magda, the Community Mental Health Team noted that Magda reported threats and/or violence from Thomas on several occasions including concerns that he would assault her and threats to kill in 2008, an assault in 2008 and the "dead and buried" comment of 2010. Although Thomas was asked about these allegations there is no record that a referral to Adult Safeguarding was considered or that Magda was offered a referral to an appropriate domestic abuse support service. She was, however, offered a carer's assessment, which she refused.

Support regarding financial issues

280. Thomas met with Care Co-ordinator 1 on 26 April 2010, on several occasions in May 2010, and once in each of June (8th), July (29th) and August (5th) 2010. On 20 September 2010, a CPA Review was conducted for Thomas, which he did not attend. The team noted that he had engaged well over the past eight months, where the focus had been in addressing problems with debt. *(Author's note: Thomas had two recorded contacts with psychiatric services in January 2008. His next contact was with his care co-ordinator in March 2009 but there was no further contact until late April 2010, five months before the CPA review. Six of his eight recorded contacts with Care Co-ordinator 1 were in the period 26 April 2010 to 8 June 2010, with only two contacts in the next 15 weeks up until the review, and one of those, on 29 July 2010, was brief as Thomas did not want to engage. At this stage, Thomas was supposed to be seeing Care Co-ordinator 1 on a fortnightly basis. This suggests that Thomas may already have been disengaging rather than engaging well. He was noted at times to be out of the country which made contact more difficult to maintain.)*

Regular contact between Thomas and Community Mental Health Services 2011

281. Thomas was not seen again in 2010 but contact in 2011 was relatively frequent. Care Co-ordinator 1 made a home visit on 7 January 2011, where Thomas was reported to be stable. He made another home visit on 7 February 2011 after Magda reported that Thomas had locked her out of her flat and again on 14 February, 5 March, 10 May, 17 June, 28 June, 25 August, 8 September, 25 September, 27 October, 17 November and 20 December 2011. Thomas's relationship with Magda was noted to be unstable during this period.

282. The visit of 17 June 2011 was prompted by a call from Magda to Care Co-ordinator 1 as she was concerned that Thomas was unwell and self-medicating. Care co-ordinator 1 saw Thomas the same day. He wanted Magda to stop visiting him.

283. Magda called the Community Mental Health Team again on 26 July 2011. She said Thomas had raised his arm as if to hit her, though he did not hit her. There is no evidence that this was explored as a potential safeguarding issue.

284. Thomas received a home visit on 27 October 2011. Care Co-ordinator 1 recorded that Thomas "remains stable, as he has done for the past year. Thomas is having less contact with Magda and feels this is partly why he feels better".

285. It is unclear whether a CPA review meeting was held for Thomas in 2011.

Intermittent contact between Thomas and Community Mental Health Services 2012-13

286. Contact between Care Co-ordinator 1 and Thomas was much less frequent in 2012 than in 2011. Care Co-ordinator 1 made a home visit on 27 March 2012. Thomas said that he had not seen his mother for some time. His mental health appeared stable.

287. Thomas was not at home on the next six occasions when Care Co-ordinator 1 attempted to visit (14, 23, 31 May 2012; 22 June 2012; 6 and 17 July 2012) and he did not return messages. After a gap of five months, Care Co-ordinator 1 met Thomas on 30 August 2012. He was reported as managing well and spending a lot of time at Magda's flat. Care Co-ordinator 1 spoke on the phone with Magda on 11

October 2012. Thomas's mental health was stable and he was spending most of the time at his mother's house. Care Co-ordinator 1 made a home visit to Thomas on 6 December 2012. He was spending a lot of time with his mother and had no interest in a structured daytime visit. *(Author's note: Thomas's contact with Magda was viewed as potentially damaging to his mental health during 2011 and 2013 but in 2012 he was noted to be stable when he was spending most of his time with her. This apparent contradiction does not appear to have been explored.)*

288. Following a service reorganisation in July 2012, Thomas was categorised as the lowest level of risk patient under a Red, Amber, Green system (see Appendix 4). His situation and behaviour reflected elements of all three levels, red, amber and green, but overall he was identified as a green despite his disengagement from services, previous violence and threats of violence and his difficult relationship with his main carer, Magda. He had not had a psychiatric assessment since 2005 and was not seen by a psychiatrist until May 2013.

289. During 2013, Care Co-ordinator 1 conducted home visits with Thomas on 12 February and 9 September 2013. He also saw Thomas at the CPA meeting on 9 May 2013, on 26 November 2013, possibly at home, and at the Peckwater Centre on 30 December 2013. At the February visit, Care Co-ordinator 1 noted that Thomas's mental health could deteriorate following Magda visiting him. The September visit was prompted by a call from Magda on 20 August 2013 who thought Thomas was deteriorating but Care Co-ordinator 1 found him to be stable. On 30 December 2013, Thomas was noted to be stable. He was staying with his mother again as he felt safer there than in the area around his own flat.

290. South Camden Recovery and Rehabilitation Team conducted a risk assessment on 3 April 2013. It stated that, "there is little need for Magda to express the level of concern she does about Thomas." This suggests a somewhat dismissive attitude to her views.

First contact with psychiatrist in eight years – May 2013

291. A CPA Review Meeting was held on 9 May 2013, attended by Thomas, Magda, psychiatrist 3 and Care Co-ordinator 1. This was the first CPA meeting that Thomas had attended for many years and the only time he met psychiatrist 3. He had not seen a psychiatrist in almost eight years. The psychiatrist assessed Thomas as somebody with continuous psychotic symptoms that were not always very apparent and noted that his social isolation may have been related to paranoid delusions that he was not always talking about. Thomas and Magda's accounts of Thomas's drinking were at odds. Thomas was referred for a psychological therapy assessment but there is no record of the referral being made for seven months.

No recorded contact between Thomas and Community Mental Health Services Jan – May 2014

292. There is no recorded contact on RiO between Care Co-ordinator 1 (or any other community mental health staff) and Thomas between January 2014 and 6 May 2014 although it appears that Care Co-ordinator 1 may have seen him on 24 April 2014 as a contact on that date is recorded in his diary. 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. During the Serious Incident Investigation, Care Co-ordinator 1 said that he had been seeing Thomas approximately every four weeks but not documenting it in the clinical record. This is poor practice. Care Co-ordinator 1 reported that Magda had not contacted him during the four weeks prior to her death, when Thomas was staying at her flat, as she usually would have done if she had been concerned for him.

Response to Crisis 7-9 May 2014

293. Magda contacted South Camden Rehabilitation and Recovery Team on the morning of Wednesday 7 May 2014, concerned that Thomas would harm her. She wanted him to be admitted. When a social worker returned Magda's call Thomas 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 at 13:00. Magda was unhappy that services were not coming to Thomas and reported that Thomas had put his hands around her throat in the past, though she did not say when this had happened. This information was documented but does not appear to have influenced the risk assessment conducted later that day. *(Author's Note: The appropriateness of providing crisis treatment to a mental health service user at the address of someone who they have been alleged to have threatened or abused will be considered in the next section.)*

294. Thomas attended his appointment at the Rehabilitation and Recovery Team offices at the Peckwater Centre that afternoon and requested a hospital admission. The Trainee Mental Health Worker who saw him contacted the Crisis Team who agreed that Thomas should be informally admitted on the basis of his chaotic behaviour, his request for admission (which was unusual for him) and his poor self-care. Following completion of the gatekeeping process by the Crisis Team, the Clinical Team Manager from the Rehabilitation and Recovery Team contacted the bed manager to arrange for Thomas to be admitted but there were no beds available in the Trust at that time. In such a situation the options available to staff are:

    - to wait and see if a bed becomes available (if someone else is discharged or self-discharges). However there are no facilities for someone to wait at the service outside office hours;
    - to direct the patient to A&E, where there are facilities to wait as it is a 24-hour service and where the government's waiting time targets can help facilitate an admission or other treatment plan. However, the busy environment of an A&E department can be difficult to manage for someone in mental health crisis[29];
    - to reassess the patient and identify a home treatment plan, either as an alternative to waiting for a bed, or while still waiting for a bed;

[29] Camden & Islington NHS Foundation Trust provide psychiatric liaison services to the three A&E departments in the catchment area and there are facilities for those attending A&E with a need for psychiatric services to wait.

- to request a bed outside the Camden & Islington NHS Foundation Trust. The Trust has contracts with other Trusts and will use private provision if necessary. This requires authorisation at a senior level in the Trust due to the cost involved.

295. In Thomas's case, the main approach was the third of these options. No attempt was made to source a bed from either another Foundation Trust or a private hospital. Staff suggested that Thomas and Magda could go and wait in A&E but Magda was noted to be reluctant to do this due to the anticipated waiting time. Even if a private bed had been authorised, Thomas and Magda may have needed to wait in A&E while it was sourced as there would have been nowhere to wait at the Recovery & Rehabilitation offices outside of office hours. *(Author's note: Her concerns about the possible wait at A&E are not documented but it might have been difficult to get Thomas to agree to remain in that environment at a time when he was experiencing hallucinations and feelings of paranoia and was noted to seem scared. Camden & Islington NHS Foundation Trust has access to five waiting rooms for mental health patients across A&E hospitals in its area but it is not known whether one of these would have been available and whether Magda and Thomas were aware of this.)*

296. The case was handed over by the Graduate Mental Health Worker who initially saw Thomas and Magda to the Clinical Team Manager. He met with Thomas and Magda. Magda reported that Care Co-ordinator 1 had not responded to her messages for five days. *(Author's Note - In interview for the Serious Incident Investigation, Care Co-ordinator 1 denied receiving any messages. There was no record of calls coming through the switchboard but the possibility that Magda contacted Care Co-ordinator 1 directly cannot be ruled out entirely.)*

297. The Clinical Team Manager concluded that an informal admission would be most appropriate. 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 seeing different colours. Thomas also reported anxiety, not sleeping and not eating.

298. The Clinical Team Manager contacted the bed manager but there were still no beds available within the Trust. The Clinical Team Manager assessed Thomas and at 15:03, the Clinical Team Manager documented that Thomas was safe to go home with Crisis Team support. The Clinical Team Manager would have had access to Magda's report earlier that day that Thomas had put his hands around her throat in the past. Thomas had said during the assessment that he was worried he might hurt his mother and that he was hearing voices telling him to kill. It is not clear whether the Clinical Team Manager had access to information about Magda's previous allegations of violence and threats that Thomas had directed towards her. However the Clinical Team Manager did have access to information about previous admissions and noted that Thomas had requested and been granted informal admission in 2001 when he was concerned he would hurt a neighbour. His requested admission in May 2014 paralleled these circumstances but this time he was not admitted as no Trust bed was available and staff did not request authorisation for a private bed. No DASH assessment was conducted with Magda to inform the risk assessment and subsequent planning.

299. The Clinical Team Manager prescribed olanzapine and referred Thomas to the Crisis Team for them to visit and further assess. During interviews for the Serious Incident Investigation, the Clinical Team Manager stated that the referral to the Crisis Team was made for additional support because no bed was available within the Trust and not as an alternative to admission. The Clinical Team Manager was aware of the process to follow when advised by the bed manager that no beds were available and of how to obtain a bed outside the Trust in that situation.

300. Both Magda and Thomas were unhappy that a Trust bed was not available for him to be admitted straightaway. The Crisis Team got in touch with Magda later that afternoon and arranged for a home visit the following morning. Magda said that Thomas was staying at her address because he was too scared to stay in his own flat. She reported that during the assessment at the Recovery and Rehabilitation Team offices, 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 or Magda should phone 999. Magda was concerned about the envisaged waiting times at A&E. Magda again reported that she had made several attempts to make contact with the Recovery & Rehabilitation Team within the previous week to advise that Thomas was breaking down but had received no call back.

301. The Crisis Team informed the Clinical Team Manager that they had succeeded in making contact with Magda and requested input from the Recovery and Rehabilitation Team at the home visit the following day. This was an example of good communication between the teams. The Clinical Team Manager telephoned Magda later that afternoon to check how Thomas was. This was good practice. He advised Magda to call emergency services if needed before the appointment with the Crisis Team the next day.

302. While the Crisis Team were putting in place arrangements for the home visit, the Recovery and Rehabilitation Team continued to try to get a bed for Thomas. At 16:34 a mental health graduate worker from the Rehabilitation and Recovery Team recorded on the electronic system that they had contacted the bed manager again, who had reported there were still no beds available but that he was aware that a referral had been made for an admission for Thomas and he would contact the Red Team the following day to update on the situation.

303. The bed manager checked Thomas's electronic records soon after (recorded at 16:35) and noted that the Clinical Team Manager had assessed Thomas and decided that he was appropriate for home treatment. As a result, the bed manager did not escalate the need for a bed for Thomas to the Matron. There was nothing written in the notes advising that an admission to a bed was still required despite the fact that the Clinical Team Manager believed that a bed was still needed. There was no contact between the bed manager and Clinical Team Manager or with the Matron to confirm whether or not a bed was still needed. At that point any action to identify a bed and progress an admission was stopped. The bed manager had told the mental health graduate that he would update the Red Team the following day regarding the search for the bed but this did not happen. The Rehabilitation and Recovery Team were not aware that the bed search had been stopped. This was an example of poor communication between the bed manager and the

Rehabilitation and Recovery Team that needs to be addressed in future practice. *(Author's Note – Camden & Islington NHS Foundation Trust has now put in place a process whereby the search for a bed will continue until the bed manager has had a conversation with the referrer.)*

304. A Clinical Nurse Specialist from the Crisis Team and Care Co-ordinator 1 (henceforth referred to as 'the assessors') visited Thomas at Address 1 at 10:00 on 8 May 2014. Magda was present. The joint team approach was good practice but their understanding of the situation was at odds. Care Co-ordinator 1 believed that the bed search was ongoing and that home treatment was a temporary measure until Thomas could be admitted. The Crisis Team member, in contrast, believed that home treatment was the option and that a bed was not needed. *(Author's note: in joint team approaches, staff members need to exchange information and reach a shared understanding of the circumstances. Had this happened, Care Co-ordinator 1 might have realised that the bed search had been stood down and been in a position to re-initiate it. There were both pros and cons to the involvement of Care Co-ordinator 1 as his previous knowledge of Thomas and Magda and the fact that he had never felt threatened by Thomas may have overly influenced his perception of the potential risk that Thomas posed at this time.)*

305. Thomas reported that he had moved to his mother's flat a month previously after finding the area around his own flat too stressful. Thomas was unable to give the assessors any clear picture of what had been happening prior to moving to his mother's flat. *(Author's note: in interview for this review, Thomas said he had being having problems with his neighbours. This had also been the case in 2001, when he had requested admission because he was worried he would stab a neighbour.)* He said his mother interfered in his affairs too much but he did not want to go back to his own accommodation either. He said he wanted to be admitted to hospital. He asked several times if the assessors were going to take him to hospital but staff explained to him that he did not need to go to hospital. *(Author's note: In interview for this review, Thomas said that the staff "didn't understand I needed to go to hospital." He said he should have been admitted when he needed it. "Just because I hadn't been in hospital for ten years didn't mean I didn't need it." He felt that "they didn't see that I was a danger to myself and to others… If I'd thrown a punch at one of them, then they'd have sectioned me and called the police." During the assessment, he remembers sitting thinking that he "would have to do something so they'll section me.")*

306. Thomas said that he had been hearing voices but could not say what the voices were saying and he was also seeing colours. There was no evidence during the assessment that Thomas was distracted by voices or any hallucinatory phenomenon. *(Author's note: Thomas's last assessment by a psychiatrist on 9 May 2013, noted that he had "continuous psychotic symptoms that were not always very apparent" and that he may have had "paranoid delusions that he was not always talking about.")* The assessors noted that he appeared not to understand or fully take in everything and would intermittently ask, "so am I going into hospital?" Each time, Thomas was told he did not need to be in hospital. *(Author's note: this appears to prejudge the outcome of the assessment that day and contradicts the assessment of the previous day, when hospital admission was considered*

appropriate but did not take place because no bed was available within the Trust. Given Thomas's tendency to disengage from services rather than seek them out and the fact that he had not requested an admission for 11 1/2 years, more weight should have been given to his repeated request for admission.)

307. Magda said that Thomas threatened her when he had been drinking. The Clinical Nurse Specialist noted that alcohol use might have been an important factor in Thomas's deterioration but no intervention was put in place to address his drinking other than to tell Magda not to let him in if he was drunk.

308. Thomas denied thoughts or intent to harm his mother. He said that he would walk out if she nagged him. This was viewed as a protective factor by the assessors.

309. Both Magda and Thomas were encouraged to consider Thomas returning to his own flat but Magda was noted to have refused. *(Author's note: Thomas also indicated that he did not want to return to his flat. He said that he found the area too stressful but eventually agreed to visit the flat the following week with Care Co-ordinator 1.)*

310. 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 also agreed to see Care Co-ordinator 1 at the Recovery and Rehabilitation Team offices later that day. As set out previously, the panel has been unable to determine whether this was a formal appointment or a more informal arrangement.

311. The view of the assessors was that the situation with Thomas was ongoing and that there was a co-dependency between Thomas and Magda as she needed Thomas to be around and also to let Thomas know he was still/always her child. *(Author's note: whilst this view may have had some justification, it pathologises Magda's understandable concerns about Thomas. The relationship between Magda and Thomas was undoubtedly difficult but there were also periods when Thomas was having a lot of contact with his mother and his mental health was stable. The assessment does not appear to have considered Magda's previous reports of Thomas's violence to her nor his reports of the previous day that he was worried he would harm her. It does not address why Thomas was suddenly requesting psychiatric admission after such a long period without admission.)*

312. Both assessors felt that the best solution was for Thomas to go home. Magda did not agree with this and Thomas remained reluctant to return home. Thomas asked on several occasions whether he was going to be admitted to a psychiatric ward. Although not recorded by the assessors, Magda told friends and neighbours that she still wanted Thomas to be admitted. This did not happen.

313. The Serious Incident Investigation Team concluded that there was nothing within the assessment of 8 May 2014 that suggested that Thomas could not continue to be supported within the community in the short term, particularly with the additional input from the crisis team and Thomas re-commencing on medication. The Investigation Team noted that it appeared that the 'crisis' of the previous day had abated and that Thomas (and Magda) had reverted to their usual and chronic situation, which was well known to the community team. The assessment did not

suggest anything out of the ordinary from previous contact. The Investigation Team was not critical of the assessment or of the decisions reached. *(Author's note: as with the original assessment, the Serious Incident Investigation Team's analysis does not address the fact that Thomas was requesting admission for the first time in more than eleven years and that he had said the previous day that he was worried he might hurt Magda. This* was not *"their usual and chronic situation". It* was *"out of the ordinary". As the events of the following day proved, the crisis had not abated. Assessments need to give greater weight to requests for admission from patients with a history of serious mental health issues who are worried that they might hurt themselves or somebody else. This is particularly the case when the request for admission is out of the ordinary, when there are allegations that the individual has been violent or made threats of violence and when the alternative to admission is for the patient to stay with the person that he/she has allegedly threatened or been violent towards).*

314. Care Co-ordinator 1 reported during the Serious Incident Investigation that part of the reason he wanted to see Thomas at the community offices that day was to speak with Thomas without Magda present to discuss going back to his own home. Thomas failed to attend the team offices that day. There is no record of any follow up of this non-attendance by Care Co-ordinator 1 or any other member of staff. *(Author's note: given what had occurred over the preceding 24 hours, it seems reasonable to have expected Care Co-ordinator to attempt to contact Thomas and Magda regarding Thomas's non-attendance.)*

Metropolitan Police Service

Summary of involvement

315. The Metropolitan Police Service had a number of contacts with Magda as a victim of crime during the period of the review including:

- 31 October 2000 - allegation of a common assault following a civil dispute with a workman;
- 15 December 2001 - victim of a distraction theft at an ATM machine;
- 29 July 2003 - allegation of Criminal Damage to her front window by local youths;
- 09 February 2004 - allegation of Common Assault after Magda was verbally abused and assaulted by a passenger on a bus;
- 21 April 2007 - allegation of Burglary after Magda disturbed three unknown males in the process of committing burglary at her address.

316. None of these incidents was linked to Thomas.

317. The Metropolitan Police Service had contact with Thomas as both a victim and suspect during the period of the review including:

- 18 April 2000 – Thomas was arrested for Possession of a Bladed Article;
- 20 October 2002 – Thomas was the victim in an allegation of burglary;
- 5 September 2007 – Thomas was arrested for Criminal Damage after smashing nine panes of glass with a hammer at Horse Guards Parade.

318. The 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. 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.

319. There were no police reports of domestic abuse within the period covered by the review. However, the police identified that Magda had made two allegations against Thomas during the 1990s:

- In 1996, Magda alleged that Thomas had thrown a rubbish bin against her window causing damage. She did not wish to pursue the allegation but wanted her son found to ensure that he underwent a mental health assessment;
- In 1998 Magda reported that she believed that he had broken a window at Address 1 and stole her Social Security book. Thomas admitted breaking the window but Magda declined to substantiate the allegation as Thomas was being detained at St Luke's Hospital having been 'sectioned' under the Mental Health Act.

Key events

320. On 18 April 2000, Thomas was arrested for Possession of a Bladed Article. Whilst undergoing an assessment at Tottenham Mews Hospital, Thomas threatened a psychiatrist with a knife and then absconded. He was reported as a missing person but he voluntarily attended Hammersmith Police station in the early hours of the following morning and was arrested. He was still in possession of the knife. He was charged but the case was eventually withdrawn under the Mental Health Act at Horseferry Road Magistrates Court (now Westminster Magistrates Court).

321. On 5 September 2007, Thomas was arrested after smashing nine panes of glass with a hammer at Horse Guards Parade. He was noted to be drunk. He was subsequently charged with criminal damage and found guilty of the offence at Horseferry Road Magistrates Court in January 2008.

322. It has not been possible to determine whether an assessment under the Mental Health Act took place on this occasion as the police records containing this information have been destroyed following expiry of their required retention period. However it appears unlikely that an assessment did take place - Central and North West London NHS Foundation Trust, who provide mental health services for the area of London where Thomas was arrested, have no record of having any contact with Thomas, which strongly suggests that no mental health assessment was conducted. Camden & Islington NHS Foundation Trust were not made aware of the offence until Magda contacted them with concerns about Thomas in January 2008 which also suggests that a mental health assessment was not carried out.

323. The police should have been aware of Thomas's mental health history following his arrest in 2000. The 2007 offence was committed at a high profile location and Thomas was in possession of a hammer. Although a hammer is not an offensive weapon per se, it could have been used to cause injury. The offence involved smashing numerous windows, suggesting recklessness and/or an

intent to cause a lot of damage. Given Thomas's history and the nature of the offence, a mental health assessment should have been carried out and Camden & Islington NHS Foundation Trust should have been informed of the arrest.

London Borough of Camden Housing

Summary of involvement

324. Thomas took up tenancy at Address 2, a one-bedroom council flat in a busy area of central London, on 30 November 1998. He remained a tenant at this address throughout the period covered by the review. He also had periods of staying with Magda.

325. Thomas requested an informal admission to psychiatric care on 24 December 2001 as he was feeling persecuted by his neighbours. He was concerned that he would lose his temper with a neighbour and stab him and wanted admission to prevent this happening. There is no record that LB Camden were aware of any conflicts between Thomas and his neighbours at this time.

326. On 12 January 2007, a Housing Officer wrote to all residents in Thomas's block of flats regarding noise in the communal areas. The source of noise was unknown and all residents were asked to be considerate towards their neighbours.

327. On 24 February 2014, a Housing Officer wrote to Thomas regarding noise following complaints from his neighbours. The complaints were linked to Thomas playing very loud music at night and at unsocial hours. He was advised to ensure that all floors were covered with carpet rather than wooden or laminate flooring. He was also advised that if the Housing Department received further complaints, the matter would be investigated and a home visit arranged to establish whether he had laid wooden or laminate flooring, which would have been in breach of his tenancy conditions. There is no record of any further complaints. *(Author's note: During the period of Thomas's multiple admissions, his relapses were noted to follow a pattern of him spending large amounts of time listening to loud music, increasing his use of alcohol and illicit substances and becoming aggressive, hostile and irritable. With hindsight, this might have been a warning signal that Thomas's mental health was beginning to deteriorate. The conflict with his neighbours around this time appears to have been the trigger for him going to stay with Magda. On 8 May 2014, he told the assessors from Camden & Islington NHS Trust that he'd been staying with his mother for about a month but it is possible that he had been there longer than that.)*

328. Thomas's housing record had a flag on it, indicating that he might be violent but it is not clear why this flag was put in place.

Fitzrovia Medical Centre (Thomas's GP)

329. Thomas was registered with the Fitzrovia Medical Centre until February 2007 when he was deregistered. He was reregistered in September 2013 but deregistered again in January 2014. He rarely attended the GP and his last recorded visit was on 17 September 2004.

330. As part of Thomas's care plan, his GP was supposed to conduct an annual medical check. There is no record of a single annual check being carried out. Thomas's Care Co-ordinator encouraged Thomas to register with a doctor in 2012 so that he could have his health assessed.

331. At the time of Magda's death, Thomas was no longer registered with Fitzrovia Medical Centre or any other GP. One of the actions agreed during the home visit on 8 May 2014 was to encourage Thomas to register with a GP.

Caversham Group Practice (Magda's GP)

332. Magda registered with Caversham Group Practice in 1986 and remained with that practice throughout the period of the review. Although she saw a variety of different doctors, she had the same registered doctor, GP1, throughout this period and was well known to her.

333. Magda never discussed Thomas in any consultation throughout the review period. She was not on a carers' register and it appears that the GP had no knowledge of Magda's ongoing caring role . GP1 described Magda as preoccupied with her various medical complaints during appointments. She had a great mistrust of the NHS and preferred to pursue alternative health treatments.

334. Magda's contact with the GP was relatively infrequent in the years 2000-09:

- 2000 – three appointments; 2001 – one; 2002 – one; 2003 – four; 2004 – three; 2005 – two; 2006 – two; 2007 – five; 2008 – three; 2009 – four.

335. Magda's attendance at the practice became more frequent from 2010 - 2012, with 17, 18 and 9 appointments respectively. This was linked in part to Magda developing rheumatoid arthritis. In 2013 she had only four appointments and had two appointments in 2014.

336. On a number of occasions the GP noted that Magda preferred to treat herself or that she did not want conventional treatment.

337. Magda often requested referrals to specialists and/or a variety of tests. She raised concerns that she had cancer on a number of occasions, linked to lumps in her armpit and neck and changes in her bowel habits and weight loss.

338. On two occasions, her behaviour at the surgery caused concern:

- On 4 October 2007, Magda became aggressive and raised her voice when the GP could not interpret an ultrasound scan undertaken in Russia and that the GP did not know anything about the plant-based drug she was taking. The GP had to ask her to calm down and called a senior doctor to help;
- On 23 December 2012, Magda was abusive to the reception team as her prescription was not ready. She was advised that she would be removed from the GP's list if she was rude again.

339. Given the GP's lack of knowledge of either Magda's caring responsibilities or the seriousness of Thomas's mental health issues, there are no clear missed opportunities for the GP to have prevented Magda's death.

Royal Free Hospital

340. The Royal Free Hospital had contact with Magda in the period covered by the review. Thomas presented to the hospital on the evening following the homicide where he was arrested.

341. Magda attended outpatient appointments in the gynaecology clinic on 16 October 2007, 24 October 2007 and 14 November 2007. On 7 December 2007 she was admitted as a daycase for a clinical procedure. She was subsequently discharged. Magda attended a cardiology outpatient appointment on 14 November 2007. None of these appointments gave rise to any concerns of relevance to this review.

342. On 30 July 2009, Magda attended the emergency department as she was having difficulty swallowing. She had eaten sardines and thought she had a fish bone stuck in her throat. No fishbone was seen on an X-Ray and she was advised to take anti-inflammatory drugs and return if the situation did not settle. Magda returned to the emergency department on 2 August 2009 as she was still having difficulty swallowing. Staff attempted to check her throat, with a decompressor on her tongue. Magda insisted on washing her hands for ten minutes before she then put her own finger into her mouth. She was referred to the Ear, Nose and Throat specialist for the next day and given a letter to take to them. The hospital also wrote to Magda's GP regarding her washing her hands for so long. This was appropriate.

343. Thomas did not have contact with the Royal Free Hospital prior to Magda's death. In the evening following the homicide he presented to the emergency department. He said that he had, 'had a fight with his Mum that morning and beat her up'. He had blood on his hands and clothes. He did not know where or how she was as he had left her house and had been drinking all day. He said he had been feeling bad all week, suicidal and scared, and that he had a history of paranoid schizophrenia. Staff recognized him from details circulated by Camden & Islington NHS Foundation Trust and the police were called and arrested him. This reflects good information sharing in the hours following the homicide.

University College London Hospital

Summary of involvement

344. Both Magda and Thomas had contact with University College London Hospital in the period covered by the review.

345. Magda had extensive contact with a range of departments at UCLH dating back to at least 1984. The medical team identified that she had a fraught relationship with them and there are mentions throughout the years of contact of "difficult" consultations with her. She was described as "difficult", "extremely angry & anxious", demanding", "aggressive" and "confrontational". She was able to make decisions about her medical treatment and often declined the care that was offered. There was good communication and joint working with Magda's GP regarding her plan of care.

346. The majority of Magda's contact with UCLH was in the final five years of her life:

- 2014 – 3 entries with 2 specialities
- 2013 - 12 entries with various medical specialities
- 2012 – 42 communications with 6 specialities
- 2011 – 82 entries with 9 specialities
- 2010 – 21 entries with 6 specialities
- 2009 – 10 entries with 4 specialities

347. From around 2009, Magda was being investigated for various ailments including rheumatoid arthritis and bilateral carpal tunnel syndrome. In 2010 and 2011, she was reported to be in considerable pain that was not resolved with prescribed medication. She resorted to self-medicated homeopathic treatment. Communication with the Rheumatology team was difficult in 2011 and staff reported that she was rude and shouted them down. Some staff felt harassed by her and one put in a formal complaint for an "abusive" phonecall.

348. UCLH recorded that Magda had a son who lived with her. There are no records of additional information about him and no mention of her son's mental health condition. There is no evidence to suggest that she ever discussed him with staff. Magda had regular physical examinations but no suspicious injuries were identified and staff did not identify any concerns about domestic violence concerns. Magda was perceived to be a strong character who understood and verbalised her needs and wishes.

349. Thomas had contact with UCLH on a number of occasions dating back to 1995. In 1998, he had a minor surgical procedure. There were 12 records of visits to the emergency department between 1995 and 2009, with five of these in the period covered by the review. In two of these five attendances (in December 2001 and November 2002) he was referred to mental health services for further assessment and treatment and subsequently informally admitted to psychiatric care. His last recorded admission was in 2009 for a medical treatment. There were no further records of any admissions or communication with UCLH.

<u>Key events - Magda</u>

350. On 27 March 2011, Magda was examined following symptoms relating to bilateral carpal tunnel syndrome. A left shoulder injury was identified, which was based on an ultrasound in 2009. She did not offer any explanation of how this was caused. An orthopaedic referral was offered. She did not attend the outpatient appointment.

351. Magda missed numerous OPD appointments throughout 2013 but was seen by the OPD clinic on 24 December 2013. She had stopped all her prescribed medication. She reported having her amalgam fillings removed and undergoing Vitamin C infusions which she said had helped her rheumatoid arthritis. An ultrasound was arranged for her hands and wrists to review disease intensity. She missed follow up appointments for the Rheumatology Clinic on 1 and 21 April 2014.

352. On 10 January 2014, Magda was discharged from the Osteoporosis Clinic.

353. On 6 May 2014 an entry was made regarding a referral from her GP for a gynaecological screening. This was the final entry.

Key events - Thomas

354. On 3 October 2001, Thomas attended the emergency department of UCLH with a wasp sting to his right arm. He was noted to have schizophrenia. He was very rude and verbally abusive to a doctor. Thomas was accompanied by Magda who was noted not to accept waiting too long to be seen. She said that NHS care was terrible. She told staff to leave Thomas alone as he didn't want to listen to them warning him not to swear. He was given medical treatment and discharged.

355. On 24 December 2001, Thomas presented to the emergency department asking to see a doctor. He reported hearing voices and banging noises and thought people wanted to kill him. His known history of schizophrenia and numerous previous admissions was noted. He said he had not been feeling well for a few months. He felt persecuted by his neighbours and reported the man downstairs banging on his floor and the woman upstairs banging on his ceiling. He was concerned that if he complained too much he would lose his temper and stab his neighbour "and then I'd end up in Broadmoor." It was noted that he should not be allowed to leave the emergency department without a Mental Health Act Assessment unless it was for an informal admission to psychiatric care. This was due to his psychosis and risk of violence. He was given medication and discharged to a psychiatric ward managed by Camden & Islington NHS Foundation Trust on the same day where he was informally admitted.

356. On 13 November 2002, Thomas presented to the emergency department experiencing auditory hallucinations. He said he was hearing multiple voices calling him the devil. He felt he would "explode soon" and was worried that he would harm someone in the street out of anger. He had not been coping since the ceiling of his flat fell through. *(Author's note: the damage to his flat followed a flood in the flat upstairs).* He denied any suicidal intentions. It appears that Magda was with him as it was noted that she reported that he had become increasingly withdrawn and was not answering the phone. He was given medication and seen by the mental health Crisis Team the same day which resulted in an informal admission to psychiatric care.

357. On 16 March 2009, Thomas presented to the emergency department at 05:20 with a rash. He was given medication and discharged but represented that evening at 22:12. He said he felt "sick" with "something in my stomach". His skin was red and he had a rash. He complained of pain. He said that he was seeing poisonous vapours but denied mental illness and substance/alcohol misuse. He was assessed as not suicidal or homicidal. He was given medical treatment before being discharged and advised to see his GP for follow up. *(Author's note: he was not registered with a GP at this time).*

Section Six: ANALYSIS – KEY ISSUES

358. This section sets out the key issues identified by the panel in the course of the review, including consideration of the Terms of Reference. Key events for each agency are set out in the previous section.

Quality of risk assessment

359. Decision making by Camden & Islington NHS Trust on 7 and 8 May 2014 gave insufficient weight to Magda's concerns about her safety, especially given her report about a previous attempted strangulation and to Thomas's concerns that he might hurt her, especially given his previous use of informal admission when he was worried he might hurt someone.

360. Thomas had eleven admissions, both formal and informal, between 1994 and 2002. On three of his final four admissions he had presented to health services requesting informal admission. All of his previous requests for informal admission had been agreed. Thomas had not been admitted to inpatient care since 2002. Neither had he requested admission in the period between November 2002 and 7 May 2014.

361. Thomas's last two admissions were in December 2001 and November 2002. On the former he had asked for admission as he was worried about stabbing a neighbour. He was initially admitted informally but was subsequently formally detained. In November 2002, he was worried that he would "explode" and that he might harm someone in the street because he was angry. He was admitted informally. Information about these admissions was available to the Clinical Team Manager and should have been known by his Care Co-ordinator who was part of the assessment team the following day.

362. No DASH risk assessment was conducted with Magda to inform the risk assessment. Nevertheless, on 7 May 2014, the Clinical Team Manager was aware that:

- Thomas had previously requested and been granted informal admission because he was worried he might hurt someone;
- 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.

363. Insufficient weight was given to these factors when a decision was made that Thomas should be treated at Magda's home rather than requesting authorisation of a private bed when a Trust bed was not available.

364. 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.

365. 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

366. On 7 May 2014, both Thomas and Magda reported that they were frightened that he might harm her. Thomas also said that he was hearing voices telling him to kill someone. Magda said that he had previously put his hands around her throat. Thomas was assessed as requiring an informal admission but when no bed was available he was reassessed and considered safe to go home with Magda with crisis support. Risk factors included psychosis, anxiety, reported not sleeping and eating, and protective factors included agreeing to take medication, referral to Crisis Team, seeking help.

367. 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.

368. Thomas was assessed again on 8 May 2014, this time by a member of the Crisis Team and Care Co-ordinator 1. Although Thomas 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.

369. 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. Thomas eventually agreed to visit the flat the following week with Care Co-ordinator 1 but in the meantime the plan was for him to continue to stay at Magda's and receive support from the Crisis Team.

370. Camden & Islington NHS Trust should review their 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.

Weight given to admission request

371. As mentioned above, Thomas had not requested an admission for more than eleven years. Whilst there are service users who frequently seek admission, Thomas's tendency was to avoid contact with services. His request for admission should have been given greater weight. In interview for this review, Thomas said that he thought that doctors should listen when people request admission and that their approach should be "safety first."

372. Camden & Islington NHS Trust should give greater weight to requests for admission from patients with a history of serious mental health issues who are worried that they might hurt themselves or somebody else. This is particularly the case when the request for admission is out of the ordinary, when there are allegations that the individual has been violent or made threats of violence and when the alternative to admission is for the patient to stay with the person that he/she has allegedly threatened or been violent towards.

No beds available

373. There was confusion over the meaning of no beds being available. Trust policy is that if admission is required and no bed is available immediately within the Trust, authorisation will be sought and given for a bed outside of the Trust to be located by the bed manager.

374. 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 as required to authorise the admission. At this point, the responsibility was placed back on the Rehabilitation & Recovery Team to contact the bed manager who advised that no bed was available.

375. The Trust policy is clear that when a bed is not available within the Trust and a bed is needed, the bed manager is responsible for escalating this and seeking authorisation for a private bed to be used. Therefore, Trust policy would expect that in this situation, the bed manager would have escalated the situation with his line manager, to seek authorisation for a non-Trust bed. The Trust's bed management 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". The policy does not set out criteria for judging what constitutes an extreme emergency or who makes that judgement. Nor does it identify what should happen when a bed is not available in situations that are not considered an "extreme emergency". *(Author's note - This has been addressed in the Trust's new bed management policy.)*

376. 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. A further assessment was to be made

by the Crisis Team the following day. The Recovery & Rehabilitation Team saw this as a temporary solution while waiting for a bed to become available for Thomas to be admitted but this was not clearly documented on RiO. The bed manager understood the RiO note at 16:34 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 on 8 May 2014.

377. Failure to locate a bed for Thomas had catastrophic consequences for both Magda and him. It should not be possible to stand down a bed search on the basis of an (incorrect) interpretation of an electronic record without speaking to the staff involved about whether a bed is needed or not. *(Author's note - This has been addressed in the Trust's new bed management policy.)*

378. The majority of requests for admission are via Crisis Team assessments at A&E but community teams like the Rehabilitation & Recovery Team may also request an admission. However 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. In such cases, service users may be advised to attend A&E but they may not wish to do so, finding the environment of a busy A&E department an additional stress at a time when they are unwell. *(Author's note – other options are currently being discussed within the Trust.)*

379. In Thomas's case, on the afternoon of 7 May 2014 staff at the Rehabilitation & Recovery Team advised that Thomas should be escorted to A&E. However, Thomas and Magda did not want to go and wait in A&E. They left the Peckwater Centre, unhappy that no beds were available straightaway. There are no documented discussions with Thomas and Magda of other options, such as calling a taxi or ambulance to take them to A&E immediately.

380. 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.

381. The policy and process of bed management should be reviewed with a view to providing 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.

382. The Trust's new bed management policy seeks to address these issues.

Availability of Beds

383. The difficulty of locating a bed for Thomas should be considered within the context of pressures on inpatient psychiatric care not only in Camden & Islington but across England and Wales. There have been widespread concerns across England and Wales in recent years including:

- the increase in patients travelling out of their local area to access a bed;
- a number of suicides and a homicide linked to a psychiatric bed not being available between 2012-2014;[30]
- psychiatric wards operating at above the Royal College of Psychiatrists recommended 85% occupancy level.

384. These pressures come at a time when there is an increase in the number of people subject to the Mental Health Act, the number detained in hospital and the number requiring more long-term detentions.[31] 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.[32] Its interim findings were published in July 2015.[33]

385. Community based services are often preferred by service users and can achieve better outcomes however inpatient admissions are also needed. There were pressures on beds in Camden & Islington NHS Foundation Trust at the time of Thomas's requested admission. During 2013/14 bed occupancy levels excluding leave in Camden & Islington NHS Foundation Trust averaged 97% and were only less than 95% on one occasion (94.8% in October 2013). 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%.[34]

386. Despite these pressures, beds were located for four other patients on 7 May 2014. Three were formal admissions under the Mental Health Act where there was no

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[30] *Deaths linked to mental health beds crisis as cuts leave little slack in system*, Community Care, 28 November 2014, http://www.communitycare.co.uk/2014/11/28/deaths-linked-mental-health-beds-crisis-cuts-leave-little-slack-system/

[31] *Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Annual report, England, 2013/14*, Health & Social Care Information Centre, 2014, http://www.hscic.gov.uk/catalogue/PUB15812/inp-det-m-h-a-1983-sup-com-eng-13-14-rep.pdf

[32] https://www.rcpsych.ac.uk/mediacentre/pressreleases2015/independentcommissionlaunch.aspx

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

[34] *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

option but to find a bed. The fourth was an informal admission. It is not known whether these were made before or after the time when Thomas had requested a bed.

387. When the bed was requested for Thomas by the Rehabilitation & Recovery Team, the bed manager advised that no bed was available in the Trust. The bed search at that stage was limited to Camden & Islington NHS Foundation Trust. When no bed is available and is needed, senior level authorisation is required to obtain a bed outside Camden & Islington Foundation Trust. This is generally sought within the private sector or from one of the Trusts with whom Camden & Islington NHS Foundation Trust have arrangements for an agreed number of beds. 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.

Reports of violence and abuse

388. The Serious Incident Investigation referred to "historical allegations of domestic violence [by Magda] which were never proven". These allegations included 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. On 7 May 2014 she reported that he had put his hands around her throat in the past.

389. There was limited information recorded by Camden & Islington NHS Foundation Trust 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.

390. No safeguarding alerts were made in relation to Magda. Even if an alert had been made, it may not have resulted in any action under safeguarding to protect Magda. The definition of an "adult at risk" (previously referred to as a "vulnerable adult") that was in operation at the time under "No Secrets" was someone:

"who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation" [35]

391. This definition underpinned the safeguarding adults policies and procedures[36] in use at Camden and Islington NHS Foundation Trust and across the borough of Camden at the time. Magda was not in receipt of community care services and there is no evidence that she was in need of them, and as a result, she is unlikely to have met this definition of "an adult at risk".

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[35] Department of Health (2000), *No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*. Page 8, paragraph 2.3

[36] SCIE (2011), *Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse*.

392. This has now changed with the Care Act 2014, which was enacted on 1 April 2015. Safeguarding duties now apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs); and
- is experiencing, or at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

393. Under the current definition it would be expected that a safeguarding alert would be raised for Magda. The Care Act statutory guidance says that "circumstances in which a carer could be involved in a situation that may require a safeguarding response include:

- a carer may witness or speak up about abuse or neglect;
- a carer may experience intentional or unintentional harm from the adult they are trying to support or from professionals and organisations they are in contact with; or
- a carer may unintentionally or intentionally harm or neglect the adult they support on their own or with others."[37]

394. 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.

395. Care Co-ordinator 1 recorded that Magda's reports were "unsubstantiated" and that they followed verbal attacks by Magda on Thomas. Magda had been noted to belittle Thomas in public, to shout at him and place her face very close to his in a threatening manner. No safeguarding alerts were made in relation to Thomas.

396. Magda and Thomas's relationship was often difficult. 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.

397. Care Co-ordinator 1 noted in 2013 that Magda was "overly concerned about Thomas." There was an underlying narrative that saw Thomas as a victim of Magda. This may have prevented the Rehabilitation and Recovery Team from seeing Magda as a victim of Thomas and potentially at risk from him.

Disengagement from services

398. Thomas frequently disengaged from services. He also had lengthy periods on holiday out of the country, which hampered efforts to engage with him. There is no record of him attending an outpatient psychiatric appointment from 2005 until 2013. He was expected to see his consultant psychiatrist twice a year during this period. He was referred back to the Community Mental Health Team who struggled to get him to engage. In 2009, Thomas's psychiatrist suggested that the Team put in place an assertive outreach approach and there is some evidence that this was put in

[37] Care and Support Act Statutory Guidance 14.35 Issued under the Care Act 2014 Department of Health

place during 2010 and 2011. Contact was more intermittent in 2012 and 2013 and there was no recorded contact in 2014 although Care Co-ordinator 1 has stated that he did see Thomas on 24 April 2014.

GP Role in Care Plan

399. Fitzrovia Medical Centre did not notify Camden & Islington NHS Foundation Trust when Thomas was deregistered from Fitzrovia Medical Centre 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.

400. Patients are deregistered by health commissioners to ensure that GP lists accurately reflect the number of patients being served. In 2007, deregistration decisions for Fitzrovia Medical Centre were made by either the practice itself or the Primary Care Trust. Such decisions would now be made by the practice or by Camden Clinical Commissioning Group. It is recommended that NHS England 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.

401. There was good communication and joint working between Magda's GP, Caversham Group Practice, and UCLH regarding her care.

Police assessment and referral of mental health issues

402. 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

403. 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

404. There were examples of good communication and information sharing. For example:

- Camden & Islington NHS Foundation Trust notified Thomas's GP practice that he had threatened a psychiatrist with a knife, resulting in the practice modifying its arrangements for appointments with him;

- Follow up contact with Magda on the afternoon of 7 May 2014 after she had left the Peckwater Centre
- Between Magda's GP and UCLH regarding referrals and the outcome of any assessments.

405. However there were also gaps as set out previously, particularly in relation to:
    - The search for a bed for Thomas on 7 May 2014;
    - Deregistration of Thomas from Fitzrovia Medical Centre;
    - Police contact with Thomas in 2007.

406. There was a lack of information about his mental health issues within his housing records. Although there was a flag on his records there was no information about why this was in place.

407. Following the inquest into Magda's death, the Coroner sent a Regulation 28 Prevention of Future Deaths Report to Camden & Islington NHS Trust. It raised gaps in communication as a matter of concern stating that, "It seemed to me from the evidence I heard that, when a need for good communication (for example between clinician and bed manager) has been identified, there has been a lack of precision in your trust about exactly what that means and how it needs to be actioned. Rather than simply talking about the need for better communication, it is necessary to identify that information A must be delivered on every occasion, by person B, at time C, and using method D. Without this level of detail, staff are left with a vague concept and the communication is unlikely to achieve the desired result."

408. Camden & Islington NHS Trust provided a response to the Coroner, outlining the steps that it was taking to improve communication including:
    - amending the action plan template for lead investigators writing recommendations and action plans. The revised format facilitates authors to make actions specific and concrete, and requires the inclusion of a named lead, a date for completion and detail of the evidence required to show that the action has been taken. The Trust has also revised guidance to lead investigators on writing recommendations and actions. This includes specific guidance on writing actions to improve communication;
    - implementing a Serious Incident Review Group from March 2015. This group is chaired by the Associate Director for Governance and Quality Assurance and is attended by Associate Directors for each clinical division and Risk and Patient Safety Managers. The role of this group is to a) have oversight and scrutiny of all serious incident investigations; b) to review recommendations arising from all serious incident investigations and to monitor, review and sign off all action plans developed from the recommendations; and c) to receive all Prevention of Future Death reports issued by the coroner. These actions have contributed to ongoing work to improve serious incident processes, with a particular focus on learning lessons. Improvements in learning lessons from serious incidents have been noted by the Care Quality Commission in recent inspections, reflecting the focused work that has taken place.

Delivery of services (including professional standards; domestic violence policy, procedures and protocols; safeguarding children/adults policy, procedures and protocols)

Professional standards

409. There were elements of the NICE guidelines not covered in Thomas's care plan:

- Thomas was not registered with a GP at the time of the incident and had only intermittent contact with GP services over the years. The Rehabilitation & Recovery Team should have ensured that Thomas's physical health needs were met as part of his CPA;
- Peer support for people with schizophrenia to help improve service user experience and quality of life is recommended. The Trust has introduced this model as part of a research study to test its effectiveness;
- A manualised self-management programme is recommended but it is unclear whether the Trust has developed these services;
- Consideration of other occupational or educational activities, including pre-vocational training, for people who are unable to work or unsuccessful in finding employment;
- Routinely record the daytime activities of people with schizophrenia in their care plans. There was some mention of how Thomas spent his time during the day, but this was not captured in a systematic or meaningful way, which would have aided care planning. During interviews with staff, it was evident that staff members had considered opportunities for Thomas to try out new activities, e.g. visiting local museums, but had found it difficult to encourage Thomas to do so.
- The Care Programme Approach, Operational Policy does not reflect current national guidance. It may be useful during the next review of this policy to consider including reference to "No Health Without Mental Health, A cross-Government mental health outcomes strategy for people of all ages (2011)" as part of the update which it is noted is due for review in October 2014.

Domestic Violence Policy, Procedures and Protocols (including MARAC)

410. 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. 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.

411. In interview for this review, Thomas said he witnessed domestic abuse as a child. The NICE guidelines on domestic violence suggest that "a large proportion of those inflicting [domestic] abuse will themselves have been physically or sexually abused

or have witnessed abuse."[38] There is no evidence that agencies were aware of this background.

Safeguarding Adults Policy, Procedures and Protocols

412. The difficult and complex relationship between Thomas and his mother had been a long-standing issue from the beginning of the first contact with services dating back some 21 years. Magda had made allegations of domestic violence. Thomas complained that his mother was intrusive and overbearing and Magda was witnessed to verbally abuse him and behave in a threatening manner.

413. A safeguarding alert was never raised in relation to either Thomas or Magda. Although Magda might not have met the threshold to be considered an "adult at risk", Thomas's mental health issues mean that he probably would have. 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.

414. The Care Act 2014 has extended safeguarding responsibilities as set out previously. Making Safeguarding Personal[39] is a central tenant within Camden & Islington NHS Foundation Trust's updated Safeguarding Adults Policy. The new Electronic Patient Record system to be introduced in September 2015 has very clear guidance around ensuring the views of the adult are gathered at every stage of the safeguarding process.

Referrals and Assessments

415. As set out above, Magda should have been referred by Camden & Islington NHS Foundation Trust to a domestic abuse service but was not. A carer's assessment might have led to better support for Magda in the challenging role of caring for her son but she refused the offer of an assessment.

416. A safeguarding alert should have been considered by Camden & Islington NHS Foundation Trust in relation to Thomas but was not.

417. Magda and Thomas were offered family therapy but both refused. Thomas was referred for cognitive behavioural therapy (CBT) and had attended a programme of ten sessions in 1999 and again in 2003. In May 2013, Thomas's CPA meeting agreed that he would be referred for individual psychology sessions but this referral was not made until December 2013 and had not resulted in him receiving this service at the time of Magda's death.

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[38] NICE, 2014, *Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively*, p31 http://www.nice.org.uk/guidance/ph50/resources/guidance-domestic-violence-and-abuse-how-health-services-social-care-and-the-organisations-they-work-with-can-respond-effectively-pdf

[39] http://www.local.gov.uk/documents/10180/6869714/Making+safeguarding+personal_a+toolkit+for+responses_4th+Edition+2015.pdf/1a5845c2-9dfc-4afd-abac-d0f8f32914bc

418. The risk assessments on 7 and 8 May 2014 did not explicitly address Magda and Thomas's expressed fears that he might harm his mother nor did they explicitly address the previous history of allegations that he had threatened her and been violent to her. Thomas's request to be admitted, which was very unusual for him, was not given sufficient weight. The Trust risk policy "Clinical Risk Assessment and Management Policy" comprises of a 27-page document last ratified in July 2011 and which was due for review in July 2013; it was not clear why this had not been completed.

Thresholds for intervention

419. When Thomas presented to the Peckwater Centre on 7 May 2014, he was assessed as requiring a bed. The threshold for admission to psychiatric care appears to have been appropriately set.

420. 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

421. As set out previously, all nine protected characteristics in the 2010 Equality Act were considered by both IMR authors and the DHR Panel and several were found to have potential relevance to this DHR, including age, sex, ethnicity and disability.

422. No specific recommendations for changes in practice were identified in relation to these issues.

Escalation to senior management or other organisations/professionals

423. As set out previously, there was confusion over the meaning of no beds being available. Trust policy is that if admission is required and no bed is available immediately within the Trust, authorisation will be sought and given for a bed outside of the Trust to be located by the bed manager. This did not happen. Instead the bed search was stood down as the bed manager thought that it was no longer needed.

424. As set out previously, referrals to domestic violence services and a safeguarding alert should have been considered but were not.

The impact of organisational change

425. 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

426. It took some time to obtain information from both Magda and Thomas's GPs and neither produced a full IMR. Although NHS Trusts are named within the statutory guidance on DHRs, the changing structures of the NHS mean that increasingly it is GP surgeries themselves who are responsible for producing the required report for the domestic homicide review. It can be difficult to get GPs to engage with the process.

427. 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; and
- information provided in the report was subsequently contradicted on further investigation during this review.

428. The report concluded that the homicide could not have been prevented. It did not acknowledge that if Thomas had been admitted on 7 May 2014, he would not have been in a position to attack Magda at her home on 9 May 2014.

429. There were gaps in Safer Camden's initial organization 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 has agreed to draw up a checklist for conducting domestic homicide reviews to address these issues.

Section Seven: CONCLUSIONS

430. 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 on 7 and 8 May 2014;
- the degree of risk that Thomas posed to Magda was not recognised and managed on 7 and 8 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.

431. 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.

432. These issues have been considered above and are addressed within the recommendations and action plan. The action plan will be monitored and reviewed by Camden Community Safety Partnership Board.

Section Eight: WAS THIS HOMICIDE PREVENTABLE?

433. 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." Thomas said he was not able to "drink in hospital. That's the whole bloody point." He was aware that drinking made his mental health worse and in hospital he would not be able to drink. Alcohol fuels his illness like "putting fire out with gasoline."

434. Thomas had tried to get admitted to inpatient psychiatric care in the days before his mother's death. He had been worried about hurting Magda. He had also been thinking of suicide and considering throwing himself in front of a train. He said that in the time before he attacked his mother, he felt he was going to hell and had to get rid of everything. He felt that he should have been sectioned when he needed it as had happened on previous occasions.

435. Both Thomas and Magda asked that he be admitted on 7 May 2014. He was assessed by the Rehabiliation & 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 on 9 May 2014.

436. 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 on 7 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.

437. 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.

438. A further opportunity to initiate a bed search was presented on 8 May 2014 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 7 May 2014 that he might hurt her were not explicitly addressed. Instead a home treatment plan was confirmed.

439. Thomas was asked to attend the Peckwater Centre on the afternoon of 8 May 2014. 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.

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

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

Section Nine: RECOMMENDATIONS

Camden & Islington NHS Trust

Risk assessment and risk management

442. Camden & Islington NHS Trust should review its approach to risk assessment and risk management, including the weight given to allegations of abuse and/or threats and the actions taken to address such allegations.

443. All assessments of service users in a crisis period should include consideration of the factors leading to that crisis. These factors should be explicitly incorporated into risk assessments and care plans.

444. 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.

445. Camden & Islington NHS Trust should give greater weight to requests for admission from patients with a history of serious mental health issues who are worried that they might hurt themselves or somebody else. This is particularly the case when the request for admission is out of the ordinary, when there are allegations that the individual has been violent or made threats of violence and when the alternative to admission is for the patient to stay with the person that he/she has allegedly threatened or been violent towards.

Bed Management

446. The Trust Bed Management Policy should be reviewed to ensure clarity over:

- the admissions process and key decision points;
- the gatekeeping process from all avenues of referral;
- time limits for securing a bed;
- the role of the bed manager; and
- the process for standing down the search for a bed.

447. The Trust should review the gatekeeping section of the Bed Management Policy to ensure that expectations and procedures are clear to all staff members. In particular, the definition of “exceptional circumstances” in which the Crisis Team may agree to admission without a Crisis Team assessment should be clarified.

448. The Trust should review the Crisis Team Operational Policy and the Bed Management Policy to ensure clarity over the expected response times to a referral.

449. The Trust should review the role of the duty nurse / bed manager / site coordinator to ensure that the most efficient use is being made of their time.

Domestic abuse and safeguarding

450. The Trust should ensure that NICE Guidance on Domestic Violence and Abuse (February 2014) is implemented.

451. The Trust should ensure that all teams are aware of their responsibilities to identify and act on safeguarding concerns relating to carers, and that they do so consistently.

Patient care

452. The implementation of NICE guidance CG178 (Psychosis and schizophrenia in adults: treatment and management) within the Trust should be reviewed to ensure that guidance around employment, educational and occupational activities (Section 1.5.8), self-management (Section1.1.6) and physical health (Section 1.1.3) is followed, and reflected in all CPAs and care plans.

    An audit of care plans should be undertaken to establish the level of current implementation of this guidance, and to identify specific actions necessary to improve adherence.

Carers' needs

453. The Trust should ensure that carer's assessments are routinely offered and conducted, and that all teams are aware of their responsibilities in this process.

454. Camden & Islington NHS Trust should encourage all carers to have a carer's assessment and should routinely offer a carer's assessment before every CPA meeting to ensure a holistic assessment of needs and care plan are drawn up.

Updating policies and procedures

455. The Trust should ensure that all national guidance is incorporated in the update of its policies (e.g. NICE Guidance).

456. The out-dated Clinical Risk Assessment Policy should be reviewed and updated.

457. The out-dated Non-Medical Prescribing Policy should be reviewed and updated.

458. During the next review of the CPA Policy (due October 2014), the Trust should consider including reference to "No Health Without Mental Health, A Cross-Government Mental Health Outcomes Strategy for People of all Ages" (2011) as part of the update. In particular, the policy should be consistent with areas for action identified under objectives two and three, that "More people with mental health problems will recover," and that "More people with mental health problems will have good physical health."

459. The Divisional Director for the R&R Division should consider the implications of professional practice arising from this report.

460. Since an investigation into a serious incident in 2011, the Trust has been implementing an action plan to audit and develop supervision procedures within the Trust, which includes scrutiny of current samples of care delivery (e.g. electronic records) to monitor and improve clinical practice. An update to this action plan was published in November 2014 (C&I Trust Reference 2011/24831). The R&R Division should ensure that actions from this action plan are fully implemented within R&R Teams.

Transparency

461. To ensure that the findings of this report are communicated to Thomas and the family of Magda in line with the Foundation Trust's 'Being Open' policy.

462. To ensure that the findings of this report are communicated to the services directly involved in Thomas's care, in line with the Foundation Trust's 'Being Open' policy.

NHS England

463. Commissioners of GP services should ensure that GP practices are not able to deregister patients who have a care plan without contact with the relevant Adult Social Care department and/or NHS Foundation Trust.

464. Commissioners of GP services should ensure that GP practices are aware of their responsibility to contribute to statutory reviews, including domestic homicide reviews.

465. Strategic Clincial Network for Mental Health should work with London based mental health trusts to explore the potential for pan-London planning to increase the availability and affordability of in-patient care.

Safeguarding Adults Partnership Board

466. Gain assurance that, under the current safeguarding adults framework,

- the risks to Magda would have been identified;
- there is clarity amongst the workforce on pathways for raising and acting on safeguarding concerns for carers, and;
- a safeguarding concern would be raised.

Camden Community Safety Partnership Board

467. Camden Community Safety Partnership Board should develop a checklist for the process to follow when initiating a domestic homicide review.

468. The Chair of Camden Community Safety Partnership Board should write to the Secretary of State for Health requesting a review of waiting times for informal admissions to psychiatric care made outside the Accident & Emergency system.

469. Camden Community Safety Partnership will monitor and review the action plan set out at Appendix 2.

APPENDIX 1 Terms of Reference

Camden Community Safety Partnership Domestic Homicide Review

Terms of Reference for the case of MAGDA ERIKSEN

Contents

Overarching aim
The over-arching intention of this review is to increase safety for potential and actual victims by learning lessons from the homicide in order to change future practice. It will be conducted in an open and consultative fashion bearing in mind the need to retain confidentiality and not apportion blame. Agencies will seek to discover what they could do differently in the future and how they can work more effectively with other partners.

Principles of the Review

1. Objective, independent & evidence-based
2. Guided by humanity, compassion and empathy, with the victim's voice at the heart of the process
3. Asking questions to prevent future harm, learn lessons and not blame individuals or organisations
4. Respecting equality and diversity
5. Openness and transparency whilst safeguarding confidential information where possible

Legislation
The Domestic Violence, Crime and Victims Act 2004 Section 9 requires the commissioning of a Domestic Homicide Review by the Community Safety Partnership within the victim's area of residence.

A Domestic Homicide Review is defined as:

'A review of the circumstances in which the death of a person aged 16 years or over has, or appears to have resulted from violence, abuse or neglect by –

a) A person to whom (s)he was related or with whom (s)he was or had been in an intimate relationship or
b) a member of the same household as himself/herself

A review to be held with a view to identifying the lessons to be learned from the death; this may include considering whether appropriate support, procedures, resources and interventions were in place and responsive to the needs of the victim'.

Governance and Accountability
The Review will be conducted in accordance with the Home Office's guidance on Domestic Homicide Reviews.

As the Accountable Body responsible for its commissioning, the Camden Community Safety Partnership will receive updates on progress of the Review and the Chair of the Community Safety Partnership will receive regular briefings from the Review Panel Chair/Author on progress.

Administrative support will be provided by Jennifer Holly at AVA.

Family Details
Summary of details of victim and alleged perpetrator.

Party	Name and DOB	Age	Known and previous addresses
Victim	Magda ERIKSEN	67	Address 1
Suspect	Thomas ERIKSEN	44	Address 2 Address 1

Incident Summary

In May 2014 the London Fire Brigade responded to a fire at the ground floor premises of Address 1. Occupants of the building were believed to be trapped inside. Address 1 is a semi-detached house which is split into three separate flats. The LFB entered the ground floor flat and pulled a female occupant (Magda Eriksen) from the lounge area of the premises out of the address and into the street. They immediately noticed that she had stab wounds. London Ambulance Service also responded to the call and commenced CPR but life was pronounced extinct. The LFB extinguished the fire that had been started within the premises. Police were called to the scene and shortly after a murder investigation was launched.

The suspect was identified as Thomas Eriksen, the victim's son, who had been staying with her recently. He was arrested on suspicion of murder at the Royal Free Hospital that evening.

Specific areas of enquiry

The Review Panel (and by extension, IMR authors) will consider the following:

1. Each agency's involvement with the following family members from 1 January 2000 until the death of Magda Eriksen in May 2014:
   a. Magda Eriksen
   b. Thomas Eriksen

   Each agency should include a summary of any relevant contact prior to 1 January 2000.

   The review will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons.

2. Whether, in relation to the family members, an improvement in any of the following might have led to a different outcome for Magda Eriksen:
   a. Communication between services
   b. Information sharing between services

3. Whether the work undertaken by services in this case was consistent with each organisation's:

a. Professional standards

b. Domestic violence policy, procedures and protocols

c. Safeguarding adults policy, procedures and protocols

4. The response of the relevant agencies to any referrals relating to Magda Eriksen or Thomas Eriksen concerning violence or other significant harm from 01/01/00. In particular, the following areas will be explored:
   a. Identification of the key opportunities for assessment, decision-making and effective intervention from the point of any first contact onwards
   b. Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective
   c. Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made
   d. The quality of the risk assessments undertaken by each agency in respect of Magda Eriksen and Thomas Eriksen.

5. Whether thresholds for intervention were appropriately set and correctly applied in this case.

6. Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of the respective family members and whether any additional needs were explored, shared appropriately and recorded.

7. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.

8. Whether the impact of organisational change over the period covered by the review impacted in any way on agencies' ability to respond effectively.

Panel Membership

Name	**Organisation**
Hilary McCollum	Independent Chair and Report writer
Head of Community Safety	LB Camden
Safeguarding Manager	Camden and Islington NHS Foundation Trust
Detective Sergeant	Metropolitan Police
Detective Chief Inspector	Metropolitan Police
Director of Quality and Effectiveness	Camden CCG

Name	Organisation
Patient Safety Lead / Clinical Quality Manager	NHS England
Safeguarding Development Officer	LB Camden, representing Camden Safeguarding Adults Partnership Board
Assistant Director Adult Social Care and Joint Commissioning	LB Camden
Assistant Director Housing Management	LB Camden
Trust Lead Safeguarding Adults & the Mental Capacity Act	University College London Hospital Foundation Trust

Individual Management Reports (IMRs) and Chronologies

9. The first meeting of the DHR Panel agreed that IMRs would be requested from the following organisations:

   - Metropolitan Police
   - London Borough of Camden Housing
   - Camden and Islington NHS Foundation Trust

10. It is likely that IMRs will also be requested from the GP for Magda Eriksen and the GP for Thomas Eriksen. In the first instance, the Chair will write to both GPs requesting a brief summary of any relevant contact and, on the basis of the information provided, will decide whether an IMR is required.

11. Additional agencies may be asked to submit IMRs in the light of further information received and the progress of the Review.

12. The table below sets out what is expected from each agency:

Who	What	By when
Metropolitan Police	Chronology IMR	16 September 30 September
London Borough of Camden Housing	Chronology IMR	16 September 30 September
Camden and Islington NHS Foundation Trust	Chronology IMR	16 September 30 September
GPs for both family members	Initial response Chronology	19 August 23 September

Who	What	By when
	IMR	7 October

13. Additional agencies may be asked to submit IMRs in the light of further information received as the Review progresses.

Family involvement and Confidentiality

14. The review will seek to involve the family of both the victim and the alleged perpetrator in the review process, taking account of who the family wish to have involved as lead members and to identify other people they think relevant to the review process.
15. We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.
16. We will identify the timescale and process and ensure that the family is able to respond to this review endeavouring to avoid duplication of effort and without undue pressure.

Disclosure & Confidentiality

17. Confidentiality should be maintained by organisations whilst undertaking their IMR. However, the achievement of confidentiality and transparency must be balanced against the legal requirements surrounding disclosure.
18. The independent chair, on receipt of an IMR, may wish to review an organisation's case records and internal reports personally, or meet with review participants.
19. A criminal investigation is running in parallel to this DHR, therefore all material received by the Panel must be disclosed to the SIO and the police disclosure officer.
20. The criminal investigation is likely to result in a court hearing. Home Office guidance instructs the Overview Report will be held until the conclusion of this case. Records will continue to be reviewed and any lessons learned will be taken forward immediately.
21. Individuals will be granted anonymity within the Overview Report and Executive Summary and will be referred to by an alias or by initials.
22. Where consent to share information is not forthcoming, agencies should consider whether the information can be disclosed in the public interest.

Timescales

23. The period under review is January 2000 to May 2014. In addition, agencies should summarise any relevant contact in the period prior to 2000.
24. The review began on 29 July 2014. The aim is to conclude the review within six months. However this will be affected by the criminal trial and the review may be suspended pending any court case and resumed when any trial is concluded.
25. Everyone involved in the Domestic Homicide Review process should be mindful of not jeopardising any criminal proceedings.

Media strategy

26. Until the conclusion of any criminal proceedings, all media queries will be referred to the Metropolitan Police. Following the conclusion of any trial, all media queries will be referred to Camden Council.

Legal Advice

27. Legal advice will be sought as required from LB Camden Legal Department to ensure the review process and final Overview Report maintains a commitment to safeguard all parties.

Liaison with the Police

28. The Chair of the Review Panel will be responsible for ensuring appropriate liaison with the Crown Prosecution Service and the Police through the Disclosure Officer identified by the Metropolitan Police.

Review of Terms of Reference

29. In the light of information brought to her attention, these Terms of Reference will be subject to review and revision at the discretion of the Independent Chair/Author in consultation with the Review Panel.

APPENDIX 2 – ACTION PLAN

Camden & Islington NHS Trust

	RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
	Camden & Islington NHS Trust should review its approach to risk assessment and risk management, including the weight given to allegations of abuse and/or threats and the actions taken to address such allegations.	Caroline Harris-Birtles deputy Director of Nursing Acosia Nyanin Associate Director Governance & Quality Assurance	CARE ACADEMY	April 2015		**ACTION COMPLETE** The Trust has revised the Clinical Risk Training Strategy and a clinical risk training plan for 2015-16. This includes the Care Academy "Keeping patients safe" themed training days now available for all staff.
	Camden & Islington NHS Trust			April 2015		**ACTION**

	RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
	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.					**COMPLETE** The Trust has rolled out updated domestic violence training, including identification of risk to people living at the same address. This is also incorporated in all safeguarding training. The Trust is also a pilot site for the ARD-SA project which focuses on raising awareness of domestic abuse.

	RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
	Camden & Islington NHS Trust should give greater weight to requests for admission from patients with a history of serious mental health issues who are worried that they might hurt themselves or somebody else. This is particularly the case when the request for admission is out of the ordinary, when there are allegations that the individual has been violent or made threats of violence and when the alternative to admission is for the patient to stay with the person that he/she has allegedly threatened or been violent towards.			April 2015		**ACTION COMPLETE** The revised Clinical Risk strategy addresses this. In addition where there are concerns about a person's safety, who is eligible for services, staff have a statutory responsibility under the Care Act to raise a safeguarding concern and to protect service-users and their carers from harm. The

	RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
						safeguarding adult managers and the Designated Adult Safeguarding Manager (DASM), a new role under the Care Act is now also available for all staff to consult.
	Camden & Islington NHS Trust should encourage all carers to have a carers' assessment and should routinely offer a carer's assessment before every CPA meeting to ensure a holistic assessment of needs and care plan are drawn up.			April 2015		**ACTION COMPLETE** Support for carers is a key part of the Care Act. Provision of carers' assessments is monitored via

	RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
						monthly divisional performance meetings, by reports to the Care Act Boards of each local authority, and via the Section 75 Partnership Agreements in collaboration with colleagues in CCGs and local authorities.
	The Trust should review the gatekeeping section of the Bed Management Policy to ensure that expectations and procedures are clear to all staff members. In particular, the definition of "exceptional circumstances" in which the	Aisling Clifford Divisional Director Acute Acosia Nyanin Associate		February 2015	Revised policy	**ACTION COMPLETE** The Bed Management Policy review was led by the Associate Director of the

	RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
	Crisis Team may agree to admission without a Crisis Team assessment should be clarified	Director Governance & Quality Assurance				Acute Division, working in conjunction with key clinical leads and the Trust Policy Manager. The review was complete in Feb 15. Additionally, two cross-divisional workshops took place as planned to ensure there is a common understanding of the expectations around bed management and the procedures for admissions.

	RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
	The implementation of NICE guidance CG178 (Psychosis and schizophrenia in adults: treatment and management) within the Trust should be reviewed to ensure that: a) guidance around employment, educational and occupational activities (Section 1.5.8), b) self-management (Section1.1.6) and c) physical health (Section 1.1.3) is followed, and reflected in all CPAs and care plans. An audit of care plans should be undertaken to establish the level of current implementation of this guidance, and to identify specific actions necessary to improve adherence.	Ian Prenelle Clinical Director R&R Acosia Nyanin Associate Director Governance & Quality Assurance		March 2015	Nice Baseline assessment completed for guidance CG178 Care plan audit	**ACTION PARTIALLY COMPLETE** NICE guidance CG178 was issued to the Clinical Director for Recovery & Rehabilitation Services and a Baseline Assessment and action plan has been completed. The Clinical Audit and Service Improvement Facilitators are working with the Clinical Director to complete an audit of Trust

	RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
						compliance with Guidance. The audit has been added to the yearly audit plan for the Trust. This work is still in process.
	All assessments of service users in a crisis period should include consideration of the factors leading to that crisis. These factors should be explicitly incorporated into risk assessments and care plans.	Ian Prenelle Clinical Director R&R Andy Stopher Associate Divisional Director		February	Risk Assessment & Care Plan audits as part of the divisional audit plan CQUIN audit reports for crisis and contingency planning	**ACTION COMPLETE** Division wide audits of the existence and quality of crisis plans have been included in the Recovery and Rehabilitation divisional audit plan for 2015/16. The target for Q4 15/16 is 100% crisis

	RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
						plans in place. The Trust Readmissions group, chaired by the Recovery and Rehabilitation Clinical Director, is currently developing a quality measure. This will be based on a best practice example of a crisis plan, also being developed by this group. The exemplar crisis plan will contain a number of key

	RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
						elements, one being the consideration of the factors leading to that crisis. Crisis plans are now also assured through the Crisis Concordat workstream
	The Trust should ensure that carer's assessments are routinely offered and conducted, and that all teams are aware of their responsibilities in this process.	Ian Prenelle Clinical Director R&R Andy Stopher Divisional Director R&R		March 2015	Carer's assessments undertaken as reported in the LBC & LBI performance reports	**ACTION COMPLETE** Carer's assessments are currently monitored via the Local Authority monthly performance reports and also monthly via the

	RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
						Trust Divisional Performance Meetings. The Recovery and Rehabilitation division has identified a Carers' lead in every team who is responsible, along with service management, to ensure every carer's needs are reviewed on an annual basis, and where new carers are identified their needs are assessed as per

	RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
						the Care Act 2015. The responsibilities as highlighted by this recommendation have also been reinforced to staff through the leadership and clinical forums in the division.
	The Trust should ensure that all teams are aware of their responsibilities to identify and act on safeguarding concerns relating to carers, and that they do so consistently.	Ian Prenelle Clinical Director R&R Andy Stopher Divisional Director R&R Theresa Renwick		March 2015	Safeguarding Quality Assurance Audit of patient records	**COMPLETE** This responsibility is currently monitored via the Local Authority monthly performance

	RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
		Safeguarding Lead				reports. Within the Care Act 2015 there is a statutory responsibility to follow up concerns relating to safeguarding of carers. Training has been delivered to all staff in relation to the Care Act 2015. The responsibilities as highlighted by this recommendation have also been reinforced to staff through the leadership and

	RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
						clinical forums in the division.
	The Trust should review the role of the duty nurse / bed manager / site coordinator to ensure that the most efficient use is being made of their time.	Aisling Clifford Divisional Director Acute Ian Griffiths Clinical Director Acute		March 2015	Evidence of the role review and appropriate changes put in place if required	**COMPLETE** A new bed management / discharge coordinator has been appointed. . This is one of the first steps in the revision process for the whole of the site coordination / duty nurse system. This ensures there are clear role definitions / process maps / and the

	RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
						operational policy reflecting these changes has been written
	The Trust should ensure that all national guidance is incorporated in the update of its policies (e.g. NICE Guidance).	All Trust Divisional Directors Acosia Nyanin Associate Director Governance & Quality Assurance Simon Rowe Policy Lead		March 2015	Nice baseline assessments	**ACTION COMPLETE** The Clinical Audit and Service Improvement Facilitators identify all published NICE Best Practice guidance and produce a monthly report for the Divisional Performance meeting. At the Monthly

	RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
						Divisional Performance meeting, members are asked to review the contents of this report and in turn determine the relevance of each piece of guidance in relation to the Trust. Following this, a lead is allocated to undertake an initial Baseline Assessment of compliance with the guidance provided. Clinical Directors delegate the

	RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
						most appropriate person, service, team or Trust Committee to co-ordinate this. The Baseline Assessment includes a detailed review of the guidance and identification of any weaknesses in service provision or current practice. It also includes cross-referencing and reviewing of existing policy to ensure up to date national guidance is

	RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
						incorporated. There is a system in place to notify the Trust policy lead of all Baseline Assessments to be undertaken. Following the Baseline Assessment an action plan is developed to ensure compliance where appropriate.
	The out-dated Clinical Risk Assessment Policy should be reviewed and updated.	Simon Rowe Policy Lead		December 2014	Updated policy ratified by Quality Committee	**ACTION COMPLETE** The Clinical Risk Assessment and Management Policy review

	RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
						was completed and the revised policy published in Oct 2014.
	The out-dated Non-Medical Prescribing Policy should be reviewed and updated.	Jennifer Oates Deputy Director of Nursing Lucy Reeves Chief Pharmacist		March 2015	Updated policy ratified by Quality Committee	**ACTION COMPLETE** The Non-Medical Prescribing Policy was reviewed and the updated policy ratified in March 15.
	The Trust Bed Management Policy should be reviewed to ensure clarity over: • the admissions process and key decision points; • the gatekeeping process from all avenues of referral; • time limits for securing a bed;	Aisling Clifford Divisional Director Acute Ann Hunt CQC Compliance		December 2014	Updated policy ratified by Quality Committee	**ACTION COMPLETE** The Bed Management Policy review was led by the Associate Director of the Acute Division,

	RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
	• the role of the bed manager; and • the process for standing down the search for a bed.	Lead				working in conjunction with key clinical leads and the Trust Policy Manager. The review was complete in Feb 15.
	During the next review of the CPA Policy (due October 2014), the Trust should consider including reference to "No Health Without Mental Health, A Cross-Government Mental Health Outcomes Strategy for People of all Ages" (2011) as part of the update. In particular, the policy should be consistent with areas for action identified under objectives two and three, that "More people with mental health problems will recover," and that "More people with	Simon Rowe Policy Lead Acosia Nyanin Associate Director Governance & Quality Assurance		January 2105	Updated policy ratified by Quality Committee	**ACTION COMPLETE** The CPA policy was reviewed to include reference to "No Health Without Mental Health, A Cross-Government Mental Health Outcomes Strategy. The revised policy was published in

	RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
	mental health problems will have good physical health."					Dec 14
	The Trust should review the Crisis Team Operational Policy and the Bed Management Policy to ensure clarity over the expected response times to a referral.	Aisling Clifford Divisional Director Acute		November 2014	Updated policy ratified by Operational Management meeting	**ACTION COMPLETE** The CRT Operational Policy and Bed Management Policy were both reviewed and the new policies ratified in March 2015.
	The Divisional Director for the R&R Division should consider the implications of professional practice arising from this report.	Ian Prenelle Clinical Director R&R Andy Stopher Divisional Director R&R		January 2015	Written confirmation of review of practice issues	**ACTION COMPLETE** The implications of professional practice arising from this report have been considered and

	RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
						action taken via appropriate HR procedures.
	Since an investigation into a serious incident in 2011, the Trust has been implementing an action plan to audit and develop supervision procedures within the Trust, which includes scrutiny of current samples of care delivery (e.g. electronic records) to monitor and improve clinical practice. An update to this action plan was published in November 2014 (C&I Trust Reference 2011/24831). The R&R Division should ensure that actions from this action plan are fully implemented within R&R Teams.	Ian Prenelle Clinical Director R&R Andy Stopher Divisional Director R&R		February 2015	Evidence associated with the action plan into the serious incident in 2011	**ACTION COMPLETE** Senior leaders from the Recovery and Rehabilitation Division attended a multi team feedback sessions with the authors of "C&I Trust Reference 2011/24831" on 27 June 14. Learning and outcomes from this session were disseminated to

	RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
						team managers via the Recovery and Rehabilitation Division Quality Forum.
	The Trust should ensure that NICE Guidance on Domestic Violence and Abuse (February 2014) is implemented.	Theresa Renwick Safeguarding Lead & Shirley McNicholas Women's Lead for the Trust		February 2015	Domestic Violence & abuse address in the safeguarding policy. CQUIN audits associated with Domestic Violence & Abuse	**ACTION COMPLETE** Nice guidance is being implemented by embedding domestic and sexual abuse training in safeguarding level 2 and 3 as well as stand-alone training sessions. The Trust is meeting the CQUIN target attached

	RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
						to this measure.
	To ensure that the findings of this report are communicated to Thomas Eriksen and the family of Magda Eriksen in line with the Foundation Trust's 'Being Open' policy.	Acosia Nyanin Associate Director Governance & Quality Assurance		January 2015	Email confirmation	**ACTION COMPLETE** The report has been shared with Mr XX via his clinical team and with his consent a copy has been sent to family members of Mrs YY.
	To ensure that the findings of this report are communicated to the services directly involved in Thomas Eriksen's care, in line with the Foundation Trust's 'Being Open' policy.	Ian Prenelle Clinical Director R&R Andy Stopher Divisional Director R&R Aisling Clifford		January 2015	Minutes of team meetings	**ACTION COMPLETE** Learning the lessons workshop 25/09/14 and 08/01/15.

	RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
		Divisional Director Acute Ian Griffiths Clinical Director Acute				

NHS England

	Recommendation	Lead	Action	Timescale	Milestones	Target Date (including progress if applicable)
	Commissioners of GP services should ensure that GP practices are not able to deregister patients who have a care plan without contact with the relevant Adult Social Care department and/or NHS Foundation Trust.	Camden CCG and NHS England	Update practice registration policy Pan London communication to all GPs via	3 months Immediate	Updated policy Newsletter and	31st December 2015

	Recommendation	Lead	Action	Timescale	Milestones	Target Date (including progress if applicable)
			the NHS England Newsletter		distribution list	
	Commissioners of GP services should ensure that GP practices are aware of their responsibility to contribute to statutory reviews, including domestic homicide reviews.	NHSE Medical Directorate and CCGs	GP practice training on domestic violence, in particular, risk factors for it, how to identify it in both victims and perpetrators and referral and support. NHSE have secured funding to scope IMR training and toolkit for GPS	Dec 2015 6 months	Training developed and cascaded IMR training developed and delivery package	Dec 2015 April 2016
	Strategic Clinical Network for	Strategic	Strategic	Dec 15 and	Agenda/minutes	

	Recommendation	Lead	Action	Timescale	Milestones	Target Date (including progress if applicable)
	Mental Health should work with London based mental health trusts to explore the potential for pan-London planning to increase the availability and affordability of in-patient care.	Clinical Network for Mental Health Patient safety Lead for Mental Health NHSE (London region)	Mental Health clinical network to ensure current planning of MH inpatient considers service availability and affordability Deep dive to be commissioned into themes of MH incidents where in relation to incidents occurring where bed availability has been identified as a causative factor	ongoing March 2016 findings to be presented at NHSE MH clinical network to agree actions to be taken	discussion Thematic review	

Safeguarding Adults Partnership Board

RECOMMENDATION	LEAD	ACTION REQUIRED	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE
Gain assurance that, under the current safeguarding adults framework, • the risks to Magda would have been identified; • there is clarity amongst the workforce on pathways for raising and acting on safeguarding concerns for carers, and; • a safeguarding concern would be raised.	Camden Safeguarding Adults Partnership Board (SAPB) – task and finish group for localizing the new Pan-London policy and procedure	Distribute revised carers' safeguarding leaflet to raise awareness Include in the localization of the new Pan-London policy and procedure clear guidance on how to raise safeguarding concerns for carers in Camden and who leads on Section 42 safeguarding enquiries.	January 2016	August 2015 – setting up task and finish group October 2015 – progress report to SAPB January 2016 – final report to SAPB and adoption of new Pan-London policy and procedure Ongoing – monitor numbers of safeguarding concerns raised for carers.	

Camden Community Safety Partnership Board

RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
Camden Community Safety Partnership Board should develop a checklist for the process to follow when initiating a domestic homicide review.	Tom Preest, Head of Community Safety	LB Camden to adopt the template for information used by Leeds. Will contact all agencies represented at the following in the event of any further domestic homicides: • The Community Safety Partnership Board. • The Domestic Violence and Abuse working group from the monthly	July 2015	Template adopted	Completed

RECOMMENDATION	LEAD	ACTION	TIMESCALE	MILESTONES	TARGET DATE (INCLUDING PROGRESS IF APPLICABLE)
		partnership afternoons and any other appropriate specialist agencies. • The Safeguarding Adults Partnership Board. • The Camden Safeguarding Children Board.			
The Chair of Camden Community Safety Partnership Board should write to the Secretary of State for Health requesting a review of waiting times for informal admissions to psychiatric care made outside the Accident & Emergency system.	Tom Preest, Head of Community Safety	To write letter regarding waiting times issue raised in this review	January 2016	Letter written and sent by end of January 2016	29 January 2016

APPENDIX 3 – SUMMARY OF THE MENTAL HEALTH ACT[40]

The Mental Health Act 1983 (which was substantially amended in 2007) is the law in England and Wales that allows people with a 'mental disorder' to be admitted to hospital, detained and treated without their consent – either for their own health and safety, or for the protection of other people.

People can be admitted, detained and treated under different sections of the Mental Health Act, depending on the circumstances, which is why the term 'sectioned' is used to describe a compulsory admission to hospital. Section 2 is used to admit someone for assessment, Section 3 for treatment and Section 4 in an emergency. People who are compulsorily admitted to hospital are called 'formal' or 'involuntary' patients.

The decision to detain someone in hospital is taken by doctors and other mental health professionals who are approved to carry out certain duties under the Act and must follow specific procedures.

Sections 2 and 3

The sections most commonly used to admit someone to hospital are Sections 2 and 3.

Section 2 is an 'assessment' order. It allows for someone who is unwell to be admitted to hospital so health professionals can find out what is wrong, recommend how to help and start treatment.

Two doctors must agree that someone should be detained in hospital for assessment, and one of them must be a 'Section 12 approved' doctor. They then recommend admission using statutory forms. An approved mental health professional (AMHP) or someone's nearest relative can then apply to hospital managers for an individual to be admitted under Section 2 (though applications from nearest relatives are very rare).

An AMHP should inform the nearest relative if someone is to be detained under Section 2. People admitted under Section 2 can be kept in hospital for up to 28 days. Section 2 cannot be renewed: if health professionals want to detain a patient for a longer period, they must do so under Section 3 of the Act.

Section 3 allows people to be admitted and detained for treatment for up to six months. Two doctors have to agree someone should be detained for treatment in the interests of their health or safety, or for the protection of others. One of them must be a Section 12 approved doctor. An approved mental health professional (AMHP) or nearest relative can then apply to hospital managers for an individual to be admitted under Section 3. Applications from nearest relatives are very rare.

A nearest relative must be consulted by an AMHP before someone is detained under Section 3 unless it is not practicable to do so, or unless consultation would result in

[40] Thank you to the Mental Health Care website for this summary. http://www.mentalhealthcare.org.uk/mental_health_act#What_the_law_allows

'unreasonable delay.' If a nearest relative objects, detention under Section 3 cannot go ahead unless legal action is taken to remove the title of nearest relative (and the rights that accompany the title) from the person who is objecting.

A patient's responsible clinician may renew Section 3 to keep them in hospital for a period longer than six months. The responsible clinician may also decide to discharge a patient onto a Community Treatment Order. This means they will be treated in the community, rather than in the hospital.

In an emergency – Section 4

Section 4 applies when there is a crisis and someone needs urgent help but there is not enough time to arrange for an admission under Section 2 or Section 3.

Section 4 allows people to be admitted and detained for up to 72 hours after one doctor has said that urgent admission is needed. An application for a Section 4 admission is usually made by an approved mental health professional (AMHP). A nearest relative can also make an application, but this very rarely happens.

During the 72-hour period, a second doctor should review the patient. The outcome may be that the individual is detained under Section 2 or Section 3; that the individual agrees to stay in hospital as an informal or voluntary patient; or that he or she is allowed to leave the hospital. If this is the case, community-based mental health professionals will usually make sure an individual is getting appropriate treatment and support.

Use of Section 4 has been steadily decreasing over recent years. In 2013/14, Section 4 was used just over 300 times in England, compared with 851 times in 2007/8.

Detaining voluntary patients – Section 5

People who are admitted to hospital when they are unwell without the use of compulsory powers are called ‘informal’ or ‘voluntary’ patients.

If someone has been admitted to hospital as an informal or voluntary patient, they are not detained and are free to come and go.

However, the doctor in charge of their care (or someone delegated by this doctor) can complete a Section 5(2) to stop them leaving hospital. This would be done if mental health professionals believed there were risks to the patient or other people. Section 5(2) lasts for up to 72 hours, allowing time for a decision to be taken about whether a Section 2 or Section 3 should be applied.

In a small number of cases – if a doctor is not available – a registered nurse can use Section 5(4) to prevent someone leaving hospital. This power only lasts for up to six hours and ends when a doctor arrives on the ward.

APPENDIX 4 – CAMDEN & ISLINGTON NHS FOUNDATION TRUST – TRAFFIC LIGHT ASSESSMENT SYSTEM

Category 1 (Green light)

- Long periods of being well, relatively high level of functioning, a good level of support from family or carers
- Monthly or less contact
- Low level of assessed risk
- Well engaged with services
- Non-complex

Category 2 (Amber light)

- A higher degree of assessed risk and need. More frequent contact, possibly including other services.
- Likely to have more relapses that could become complex in nature:
- Contact is less frequently than fortnightly and up to monthly
- Medium level of risk. Risk management plan available
- A variety of needs, maybe complex but engaging in services
- Greater risk of relapse and breakdown in carer support

Category 3 (Red light)

- Multiple, complex needs, chaotic lifestyle and poor engagement
- Daily to weekly contact
- Acute phase of illness
- High level of assessed risk
- Detailed risk management is evident in care plan
- Crisis Plan in place
- Family/carer support is not present or is breaking down.

APPENDIX 5 – LETTER FROM HOME OFFICE QUALITY ASSURANCE PANEL

Home Office

Public Protection Unit
2 Marsham Street
London
SW1P 4DF

T: 020 7035 4848
www.gov.uk/homeoffice

Tom Preest
Head of Camden Community Safety Services

5 April 2016

Dear Mr Preest,

Thank you for submitting the Domestic Homicide Review report for Camden to the Home Office Quality Assurance Panel. The report was considered at the Quality Assurance (QA) Panel meeting on 24 February 2016.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel found this to be a clear, thorough and well structured report. In particular the Panel felt the pen portraits helped humanise the report, and the contextual information about the local area provided useful background.

There were some aspects of the report which the Panel felt could be revised or benefit from further clarification which you may wish to consider before you publish the final report:

- The Panel queried the relevance of recommendations in respect of DASH given the dominant feature of this particular case appeared to be mental health;
- The Panel took the view that the action set out in point 463 for NHS England was important good practice and that the recommendation, therefore, should be more definitive;
- The Panel felt it may be helpful if the report could clarify the reasons why no female doctors should see the perpetrator as recorded on his GP notes (point 123);
- Please proof read for errors. For example, page 82 contains the real name of the victim.

The Panel does not need to see another version of the report, but I would be grateful if you could include our letter as an appendix to the report.

I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel