THE MABOTA REPORT

REPORT OF THE INDEPENDENT INQUIRY TEAM INTO THE CARE AND TREATMENT OF KUMBI MABOTA TO REDBRIDGE AND WALTHAM FOREST HEALTH AUTHORITY

STRICTLY CONFIDENTIAL

SEPTEMBER 5 1996

To: **Peter Brokenshire, Chairman**
Redbridge and Waltham Forest Health Authority:

We have now completed our inquiry and submit our report, hoping that the recommendations will serve to enhance practice and in a small way improve the quality of care.

We would like to thank everyone who gave evidence to us, particularly those members of staff who no longer work in Waltham Forest.

Whilst the panel was receiving evidence at Claybury, the remaining staff on site were extremely courteous and attended to all our needs in a quiet and professional manner.

We were also able to see for ourselves the existing wards and facilities, and in this transitional period of changing services were impressed by the care given.

It was noticeable to us that this was the first time that some of the staff were made aware of the final outcome of Mr Mabota absconding from Claybury Hospital and the tragic events which followed. If nothing else, this inquiry will set the record straight and should be viewed in a positive light by all those people who work in mental health services.

DEREK HOLWILL

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TERMS OF REFERENCE

To investigate all the circumstances surrounding the treatment and care of Mr Kumbi Mabota by local Mental Health Services, and in particular:

1. The quality and scope of health and social care including risk assessment.

2. The appropriateness of treatment, care and supervision in respect of:

   (a) assessed health and social care needs

   (b) assessed risk of harm to himself or others

   (c) psychiatric history

   (d) relevance of court convictions (if any)

   (e) the assessment of risk of absconding from hospital

3. The professional and in service training of those involved in the care and treatment of Mr Mabota or in the provision of services to him.

4. The extent to which Mr Mabota's care and treatment corresponded to the relevant statutory obligations, Department of Health Guidelines and local policies and procedures.

5. The extent to which his care and treatment plans were effectively drawn up, communicated and delivered particularly in relation to his family.

6. The history of Mr Mabota's compliance with treatment plans of those responsible for his care.

7. To evaluate the adequacy of the co-ordination and communication between the agencies (Forest Healthcare Trust, the Police, and other agencies) who were or who might appropriately have been involved in his care and how effectively they worked jointly in that care.

8. To prepare a report and make recommendations to Redbridge & Waltham Forest Health Authority.

PANEL MEMBERSHIP

Mr Derek Holwill	Barrister (Chair of the inquiry)
Dr David Ndegwa	Consultant Forensic Psychiatrist City & Hackney Community Services
Ms Shirley Stanner	Nursing Consultant
Mr Nicholas Welch	Assistant Director Oxfordshire Social Services
Mrs Jane M Mackay	Independent Inquiry Co-ordinator

ACKNOWLEDGEMENTS

We were pleased to have the skills of **Jane Mackay** who because of her previous experience made the management of the inquiry so much easier and ensured that we completed the inquiry in the shortest time possible.

Given the complexity of the interpretation skills that were identified in this inquiry, the panel were pleased to be able to use the skills of **Irene Masters** when we interviewed Mr Mabota at HMP Wormwood Scrubbs.

We are also grateful to **Eileen Riches** for her co-ordination of, and the recording of, as well as the transcribing of the evidence for us which made our task so much easier.

We would also like to record our grateful thanks to all the staff at Claybury Hospital, particularly **Dorothy Hinrich** for her tireless efforts in ensuring the smooth running of the interview schedule and providing the panel with copious refreshments.

Introduction

Kumbi Mabota was born on the 9th November 1964 in Kinshasa, Zaire. His first language was Lingala; his second language Swahili; with Portuguese as his third language; French as his fourth language and English as his fifth language.

He started school at the age of 3, going on to the École Normale at the age of 13 or 14 where he was studying for the State Diploma, the equivalent of the French Baccalaureate. He left school, however, at 17, without qualifications, taking up football as a full-time occupation. He was a semi-professional footballer for 3 years in Zaire until 1985 when as a result of an injury he was unable to continue playing. Thereafter, he worked as the manager of a building firm in Zaire, whilst living with his parents.

He had five siblings. There is an elder brother born in 1956, who lives in Paris working in a restaurant. He had a sister who was born in 1958 but who died shortly before the events with which we are concerned, whilst still living in Kinshasa, Zaire. He has another brother living in Paris who works as a security man; another sister also living in Paris, where she works as a chambermaid in a hotel; and finally a younger sister also living in Paris. Those members of his family who live in France have apparently been there since the early 1980s. Mr. Mabota keeps in touch by telephone and letter.

In 1987, when Mr. Mabota was 22, one of his sisters sent him money so that he could join the family in France. According to Mr. Mabota he lived there for 2 or 3 years doing various casual jobs, but one day he was stopped in the street by the Police and in

the absence of proper documentation, he was deported back to Kinshasa in 1990 or 1991.

Prior to this time Mr. Mabota had had a series of brief relationships with a number of girlfriends. In 1988, however, he married Lasamba Bidi (also known as Henriette). Henriette had two daughters, aged 12 and 6, by a prior relationship. Henriette and her children travelled with Mr. Mabota to Paris. When he was deported, she returned with him to Zaire.

On his return to Kinshasa, Mr. Mabota worked for about 11 months as the manager of a lottery company until the lottery's money was annexed by the Government.

Mr. Mabota's parents were both killed by the military in Kinshasa on the 27th September 1991 - apparently on account of a failure to pay either some form of tax or protection money.

Psychiatric reports provided in anticipation of Mr. Mabota's trial for murder record that he recalled his father as a good parent and a religious man of calm temperament, who had encouraged Mr. Mabota with his career as a footballer. His mother he remembers as a very sociable and talkative woman who worked in a local market.

Following the deaths of his parents, Mr. Mabota travelled to Belgium and thence to the United Kingdom. He arrived on the 24th October 1991 with his wife, Henriette.

Whilst in the UK Mr. Mabota and Henriette had a son, Niglere Bidi, who born on the 11th June 1993. Unhappily, however, this son died at St. Mary's Hospital, Paddington on the 5th May 1994.

Mr. Mabota told us that he had known a lady by the name of Lidie Njoli Diema ("Lidie") in Zaire since about 1991. Mr. Mabota's relationship with Henriette began to break down in 1993 and at about this time he invited Lidie to come and live with him in

England. They commenced a relationship in or about December 1993 and Lidie then became pregnant.

However, in early 1994 Mr. Mabota had problems with the Police. On the 25th February 1994 he went to the DSS and when he was not given benefits to which he felt he was entitled, he refused to leave. The Police became involved, as a result of which Mr Mabota spent some 48 hours in Police custody.

On the 26th February 1994 Mr Mabota began begging for food. Whilst doing this he met with someone who said that he could have £20 if he would cash a cheque for £180. However, he was stopped by the Police as he tried to cash this cheque and was arrested for fraud. He was taken to Pentonville Prison on remand and was then released on bail, being due to appear at Forest Gate Magistrates Court on the 8th April 1994.

According to a psychiatric report prepared by a Dr. Kennedy in June 1995, following Mr. Mabota's release from prison on the 25th March 1994 he attempted a reconciliation with his wife, Henriette. However, Mr. Mabota also learned at this time that Lidie had had a termination of pregnancy whilst he was on remand in prison. Mr. Mabota was severely affected by this news and apparently wrote an 11 page letter to relatives in Zaire indicating that he was going to commit suicide.

It is right to record that throughout the Inquiry it was apparent that there had been confusion amongst medical and nursing staff about the state of Mr. Mabota's personal relationships - no doubt largely a result of Mr. Mabota's own reluctance to communicate during this period of time. It remains unclear as to precisely what roles were being played by Henriette and Lidie.

What is clear, however, is that after learning of Lidie's abortion, Mr. Mabota went to her flat on the 6th April 1994. Whilst there he apparently threatened her with a knife stating that he would kill her. There was a struggle which then led to neighbours calling the Police. Lidie was injured in the course of this struggle, suffering a broken

nose, but by the time the Police arrived, Mr. Mabota himself had swallowed a large quantity of bleach in an attempt to commit suicide.

It is relevant to note that Mr. Mabota's own account of events is that he did not injure Lidie deliberately, but that she was injured as she tried to prevent him from committing suicide.

The police took Mr. Mabota to Whipps Cross Hospital where he was admitted to the Observation Ward. After a psychiatric assessment he was transferred to Claybury Hospital where he was initially kept on an open ward, Oak 2. His behaviour was such, however, that he had to be transferred to a locked ward, Maple 1. On the 14th April 1994, after a period of 7 days, Mr. Mabota was transferred back from Maple 1 to Oak 2 ward. On the 15th April 1994, at about 17.30 hrs, Mr. Mabota absconded from the hospital. His absence was not, however, noted until around 20.00 hrs. The Police were not notified until 20.50 hrs.

Following his departure from Claybury Hospital, it appears that Mr. Mabota went to find Lidie. He first attended the flat of Mr Francois Kabuika Tsisekedi. He then went to the flat of Miss Clothilde Ndaya Kayaye where he met Lidie and apparently spent the evening with her. Lidie apparently left Clothilde Ndaya Kayaye's flat at about 05.00 hrs on Saturday 16th April 1994. She was found murdered shortly thereafter having been kicked and beaten to death. There were a large number of wounds on her back.

Mr Mabota was eventually arrested and bailed in Dublin. After being bailed, however, he went to Scandinavia where he was again arrested. This time he was extradited and returned to England where he was tried for the murder of Lidie. There were two trials. At the first trial the jury were unable to agree upon a verdict. At the second trial Mr. Mabota was convicted.

A psychiatric report was obtained from Dr. Kennedy dated the 8th June 1995. This concluded that Mr. Mabota was fit to plead and stand trial and that he was not and never had been suffering either from schizophrenia or manic depression, although he

described phenomena typical of pseudo hallucinations, a recognised psychiatric manifestation of stress in those with a vulnerable or immature personality. Dr. Kennedy concluded that it was likely that, at the time of his absconding from Claybury Hospital, Mr. Mabota was suffering from: *"at least a mild affective disorder or adjustment reaction, which was not sufficient substantially to impair his mental responsibility for his acts and omissions, if and insofar as he was a party to Lidie's killing."*

Dr. Kennedy reported that there was no family history of mental illness or other health problems; that Mr. Mabota reported that he had never used drugs, consumed alcohol or smoked cigarettes and had no history of any significant or relevant illnesses. Mr. Mabota had had no previous contact with the psychiatric services.

Mr. Mabota's account (which he still maintains) is that he had nothing to do with Lidie's murder. He says that he left Lidie on amicable terms on the morning of the 16th April 1994 and that, after leaving her, he decided to go to Dublin. There was never any attempt by him to suggest that he had committed the crime, nor had done so whilst his mental state was impaired, with a view to a plea of diminished responsibility.

When recounting the history of Mr Mabota's treatment and discussing the issues raised by the Inquiry's Terms of Reference, we consider it convenient to deal separately with the following periods of time:

The time at Whipps Cross Hospital.

The time on Oak 2 prior to the transfer to Maple 1.

The time on Maple 1.

The time following his transfer from Maple 1 back to Oak 2.

WHIPPS CROSS HOSPITAL

When the Police attended at Lidie's flat in response to a call from the neighbours, they found not only that Lidie had been injured, but also that Mr Mabota had swallowed a large quantity of bleach in an attempt to commit suicide. The attending Police Officers accordingly took Mr Mabota immediately to Whipps Cross Hospital under arrest.

The evidence given to the Inquiry by D.C. Pallas, who was at that time stationed at Leyton Police Station - he has since been transferred to Stanley Police Station, Thornayholme Terrace, Stanley, County Durham - was that Mr Mabota was arrested in connection with possible charges of assault occasioning grievous bodily harm to Lidie. However, Mr Mabota was not at this time formally charged with this or any other offence arising out of the incident with Lidie because, according to D.C. Pallas, a decision to charge him would be made only after he had been interviewed. Any interview was clearly impossible in the light of the fact that Mr Mabota had swallowed bleach and was seriously ill.

Because Mr Mabota had been arrested, however, two Police Officers went with him to Whipps Cross Hospital. Police officers then stayed with him throughout his time there. On his arrival at Whipps Cross Hospital Mr Mabota was seen by the Accident & Emergency Consultant, Dr Sadana. Dr Sadana gave evidence to the Inquiry. His clinical notes recorded that Mr Mabota had drunk about 250-350 mls of bleach, about 2 hours prior to his attendance. It was recorded that Mr Mabota had vomited. Physical examination revealed that his larynx was red, and there was tenderness in the upper abdomen. Advice was taken about the drinking of bleach from the Guys Poison Unit and in the light of the advice received it was decided that Mr Mabota should be put on the Observation Ward for continuous observation and that oral fluids should be encouraged.

It was established that Mr Mabota could not speak English very well but that he could speak French. The proposed treatment plan was explained to Mr Mabota by Dr Palazzo in French. Mr Mabota's response at this stage was simply that he wanted to die. He refused to allow blood to be taken from him.

Dr Sadana told the Inquiry that his concern was for the physical condition of Mr Mabota and that he did not make any attempt to become involved in a psychiatric evaluation.

Mr Mabota was duly transferred to the Observation Ward on 6th April 1994 where at 18.00 hrs it was noted by the nurses that he remained uncooperative, and was refusing to allow clinical observations to be done. Dr Gavalas recorded in the clinical notes that Mr Mabota was refusing treatment. After discussion with Mr Sadana, a decision was made that Mr Mabota should be sectioned under the Mental Health Act 1983.

Dr Al-Shalchi, a psychiatrist, examined Mr Mabota on the 6th April 1994. He noted that it was difficult to get a history from him because of the language difficulty, although he ascertained that Mr Mabota did admit that he had taken bleach. Dr Al-Shalchi noted that it was difficult to assess Mr Mabota's mental state but that he was clearly a suicide risk and should be sectioned under Section 5(2) of the Mental Health Act 1983.

On the following day Mr Mabota remained uncooperative. He was assessed as physically fit for psychiatric assessment and at 10.00 hrs Mr Mabota was seen by Dr Singh.

The nursing notes record that Dr Singh was accompanied by Dr Sadana.

Dr Singh gave evidence to the Inquiry. His interview with Mr Mabota is reported in a full 4 page note contained within the clinical notes from Whipps Cross. He recorded, amongst other things, that after about 10 minutes Mr Mabota stated that he did not want

to have any further conversation with Dr Singh, and that he turned his face away and asked Dr Singh to leave him alone. The history of suicide attempts was, however, noted and Dr Singh did manage to ascertain a number of important details. He learned of Lidie's abortion and of the argument with Lidie on the 6th April 1994. Mr Mabota also gave his account of this argument, stating that Lidie had been injured as she tried to stop Mr Mabota from doing harm to himself. Mr Mabota stated that he had got a lot of problems and that he was not prepared to discuss these with Dr Singh.

Dr Singh noted that Mr Mabota was miserable and depressed, expressing suicidal thoughts and being very determined to kill himself. He was, however, free from psychosis. Dr Singh concluded that Mr Mabota was suffering from *"major depression with serious suicidal risk"* and that he needed to be hospitalised for treatment for his own health and safety.

The assessment interview appears to have been conducted sensitively and with appropriate regard to the need to maintain confidentiality. It seems Mr Mabota's recent medical history of a serious suicide attempt dominated perceptions in an understandable way. Communication problems which were aggravated by his varying co-operation were appreciated and attempts made to resolve them in the limited time available.

Dr Singh's evidence to the Inquiry supplemented his clinical notes in at least one important respect. He recalled that he had been informed by the Police Officers who were with Mr Mabota that they were afraid that Mr Mabota was going to murder Lidie. Dr Singh did not record the police's concerns in this regard in the clinical notes or indeed anywhere else. He told the Inquiry that Mr Mabota had never mentioned to him that he was going to kill Lidie and had indeed denied any intention of killing anyone. Dr Singh indicated that because he was unable to confirm that there was indeed a danger to the girlfriend, he did not consider it appropriate to incorporate reference to the Police Officers' fears in the medical records.

The Police did take seriously the possibility that Mr Mabota might seek to do harm to Lidie. The Inquiry was informed by D.C. Pallas that, after the assault upon Lidie, he had gone to the trouble of *"tagging"* Lidie's home telephone number so that any emergency call received from that number was given immediate priority. Further, the Approved Social Worker who was involved later in the sectioning of Mr Mabota, a Mr Robert Bloomfield, recalled that when he saw Mr Mabota at Whipps Cross Hospital (and when he was later taken to Claybury Hospital) Mr Mabota was not merely hand-cuffed but had restraints put around his ankle.

After the decision had been made to section Mr Mabota, contact was made with the Social Services. An Approved Social Worker was unable to attend until about 15.00 hours.

At 11.40 hrs on the 7th April 1994, Mr Mabota went to the toilet and attempted to hang himself using the "Nurse Call" cord. The consequence of using this cord was, of course, that the nurses were immediately alerted to his suicide attempt and Mr Mabota was rescued by one of the Police Officers who was present.

The assessment proceeded that afternoon. Mr Robert Bloomfield, the Approved Social Worker, gave evidence to the Inquiry, including a very clear and well prepared written account of his involvement with Mr Mabota.

Mr Bloomfield stated that on 7th April 1994 he was notified that a Mental Health Assessment had been arranged for 14.00 hrs on the Observation Ward at Whipps Cross Hospital.

Mr Bloomfield duly attended and assessed Mr Mabota together with a Dr Staunton and Dr Singh. Mr Bloomfield was informed of the previous history of suicide attempts including the attempted hanging earlier that day. He was also made aware of the attack upon Lidie. He remembers enquiring whether she was now a patient in Whipps Cross

Hospital, fearing that if she was and Mr Mabota discovered this, he might perhaps resume or continue his aggressive behaviour towards her.

Mr Bloomfield recalled the two Police Officers standing by Mr Mabota's bed. He asked for the two Police Officers to wait outside Mr Mabota's room during the assessment. Apparently the Police Officers refused this request but eventually a compromise was agreed whereby the door was left wide open whilst they remained just around the corner but out of sight.

A French speaking nurse attended and Mr Bloomfield remembers Mr Mabota saying via the nurse, that he was already dead and that he had written to his parents to tell them of this. Mr Bloomfield recalled that Mr Mabota did not deny attacking Lidie although he did not admit it either.

Mr Bloomfield's recollection was that the assessment lasted from 1 hour to 1½ hours. Dr Singh, Dr Staunton and Mr Bloomfield were in agreement that Mr Mabota should be sectioned under Section 2 of the Mental Health Act 1983 following which Mr Bloomfield informed Mr Mabota of the decision and his right of appeal. So far as Mr Bloomfield can recall, Mr Mabota said nothing in response to this.

Mr Bloomfield was in no doubt that Mr Mabota presented a danger both to himself and to other people. In his Assessment Report he wrote:

> *"Mr Mabota presented as softly spoken, very subdued man. He made no attempt to deny the alleged attack on his girlfriend or his attempts at suicide. He denied he was ill although he told us he had written to his parents telling them that he was already dead. He admitted his determination to kill himself and told us we couldn't stop him. He wants to communicate with his girlfriend but apparently she doesn't want anything more to do with him. There is a concern that Mr Mabota may yet again attempt to take his own life or injure someone else. He*

obviously needs very close observation, care and support as his safety is at serious risk. Section 2 papers are therefore completed".

In contrast, however, the papers actually signed by Dr Staunton and Dr Singh did not make any reference to the perception that Mr Mabota might injure other people - and indeed that part of the standard form indicating that one of the reasons for sectioning was *"with a view to the protection of other persons"* was specifically deleted. When informed of this at the Inquiry, Mr Bloomfield was clearly surprised - he had considered Mr Mabota to be a danger to others as well as to himself.

After the sectioning procedure had been completed, Mr Mabota was taken to Claybury Hospital. Mr Bloomfield's recollection was that Mr Mabota went with the Police Officers and an Observation Ward Nurse whilst he, Mr Bloomfield, followed in his car. Mr Bloomfield then had a conversation with a nurse on Oak 2 ward at Claybury Hospital informing him/her of the events leading up to Mr Mabota's admission and of Mr Mabota's need for a French speaking interpreter.

The notes actually made at Whipps Cross Hospital were not transported to Claybury Hospital with Mr Mabota at the time of his transfer, or at least they were not available on the Oak 2 at the time of the initial assessment.

Mr Bloomfield had no further involvement at all with Mr Mabota until being contacted in 1995 concerning Mr Mabota's forthcoming trial. However, he was working as part of a well structured ASW service. Part of the procedure was for him to feed back to a senior social worker the work that he had undertaken during his period on duty. One outstanding issue from the assessment he undertook was the contact with the nearest relative. This, Mr Bloomfield told the Inquiry, did not take place firstly because he was unsure who was, in fact, the nearest relative, and secondly because if Mr Mabota's injured girlfriend was that individual, the position was that she was being treated for her injuries in another hospital and was not therefore available to be interviewed or seen. Mr Bloomfield was sure that he would have mentioned this in his handover to

the senior social worker, but has no recollection of doing so. We do not know therefore whether any attempts were made to contact the girlfriend after the ASW assessment, but in the absence of any further records we must assume that this was not done.

The documentation from Whipps Cross Hospital does include a telephone number for Lidie, described as "girlfriend". It is, of course, unlikely that Lidie would have been available at that telephone number at the material times since she was presumably being treated herself in respect of her injuries. A note has also been made in the records, however, of another contact number said to be that of a "Clontinde". It seems likely that this was the telephone number of Clothilde Ndaya Kayaye at whose flat Lidie and Mr Mabota spent the evening/night of the 15th/16th April 1994.

WHIPPS CROSS HOSPITAL - DISCUSSION

The Assessment Report prepared by Mr Bloomfield is the only document within the medical and nursing notes which the Inquiry has seen which includes any reference at all to the concern that Mr Mabota might injure someone else. This is, to say the least, surprising.

It is particularly odd that, notwithstanding the history of an assault upon Lidie and notwithstanding the fears expressed by the police officers to Dr Singh that Mr Mabota might murder his girlfriend, Lidie, the section papers which were completed and signed by Dr Singh and Dr Staunton actually deleted that part stating that one of the reason for the committal was the possibility that Mr Mabota might do harm to others. The matter must therefore have been considered, at least to some extent.

From the time of the assessment onwards, no concerns about Lidie's safety were, so far as we can tell, registered by any of the medical staff involved in Mr Mabota's care. A common thread in the evidence to the Inquiry was that, when asked about their concerns about Lidie, the Claybury Hospital staff all stated that they were most anxious to contact her in order to ascertain background information about Mr Mabota and his problems. However, no-one who gave evidence to the Inquiry suggested that, after the admission to Claybury Hospital, consideration was given to a possible threat to Lidie's well-being. The impression which the Inquiry received from the staff at Claybury Hospital was that Mr Mabota was perceived only as a suicide risk and that any other possible problems did not really feature.

It is, in retrospect, unfortunate that Dr Singh did not incorporate any reference in his notes to the Police Officers' fears that Mr Mabota might murder Lidie. None of the doctors who subsequently came to treat Mr Mabota or to carry out a risk assessment

upon him were, therefore, aware that the Police at any rate perceived Mr Mabota to be a serious risk to Lidie's well-being. Dr Singh appears to have decided not to record this because it was no more than a statement of opinion from the police and because Mr Mabota himself denied any intention to harm Lidie giving, instead, an account whereby she was injured as she tried to save him from committing suicide.

We consider that in a case where background information about Mr Mabota was so lacking - not least because of the language difficulties and Mr Mabota's lack of co-operation - the information that the Police themselves perceived Mr Mabota as a serious risk to his girlfriend should at least have been recorded. It could well have had a significant effect upon the decisions that were made at Claybury Hospital. Dr Travers and Dr Lewis both thought that had they been aware that the Police had expressed concerns about the possibility that Mr Mabota might murder his girlfriend, that would have had a material effect upon the decisions which they made.

Dr Singh was no doubt reluctant to record uncorroborated and highly subjective opinions from the police, particularly when of such a serious nature. He was not, however, really in a position to assess the likely accuracy of those opinions and by deciding not to record them in the notes (even, perhaps, qualified by a statement that he, Dr Singh, did not accept that the opinions were likely to be accurate) Dr Singh deprived doctors subsequently of what seems, at least in retrospect, to have been valuable information.

A further point for concern is the apparent lack of communication between Whipps Cross Hospital and Claybury Hospital. According to the evidence put before the Inquiry, the notes actually made at Whipps Cross were not transported to Claybury with Mr Mabota at the time of his transfer and it is unclear whether the notes ever actually arrived at Claybury Hospital. It follows that even if Dr Singh had recorded in his notes the opinions of the Police Officers, it still unlikely that that information would have been received at Claybury Hospital in time for it to make any difference to the assessment of Mr Mabota.

There is no good reason why the Whipps Cross Hospital notes should not have been transferred with Mr Mabota to Claybury Hospital so that the staff at Claybury Hospital had as much information as was then available about Mr Mabota's medical and psychiatric background.

We therefore recommend that in the event of patients being transferred from hospital to hospital, the patient's notes ought to be transferred with that patient. It may be, of course, that the transferring hospital wishes to maintain its own records and it may be, therefore, that photocopies will have to be taken of medical notes before a transfer. Be that as it may, it seems to us that the additional administration that would be involved in the photocopying exercise is more than outweighed by the advantages that would be derived for the medical staff at the new hospital having, from the outset, the benefit of the transferring hospital's notes and assessment.

The Inquiry heard evidence from Dr Sadana, the Accident & Emergency Consultant at Whipps Cross Hospital that his department does not have access to a Psychiatrist on call for 24 hours a day. Plainly cost considerations arise here but the absence of the services of a Psychiatrist for an Accident & Emergency Department seems to the Panel to be a serious omission and one which, if at all possible, should be rectified.

CLAYBURY HOSPITAL - OAK 2 Ward

When Mr Mabota was admitted to Claybury Hospital he was initially admitted on to Oak 2 ward. According to the nursing records completed by Staff Nurse Sharma, (now known as Senapati), he was accompanied by 2 police officers, 1 general nurse, 1 ambulance man and a social worker. In her evidence to the Inquiry, Staff Nurse Senapati (who is no longer working in the nursing profession) reported that Mr Mabota was hand-cuffed and wearing leg restraints.

Information available to the nursing staff at the time centred upon his attempts to self harm. They were aware that he had swallowed bleach and stabbed himself prior to admission to Whipps Cross and also that whilst at Whipps Cross he made an effort to hang himself. The nursing staff were also made aware that a charge of assault occasioning grievous bodily harm on his wife/girlfriend was pending and that D.C. Pallas wished to be informed if Mr Mabota left the hospital. Mr Mabota was, at this time, refusing food and drink.

Claybury Hospital allocates patients using a catchment area system and pursuant to this system Mr Mabota was allocated to the care of Dr W.J. Travers, Consultant Psychiatrist. Dr Travers was, however, away from the hospital at the time of Mr Mabota's admission and Mr Mabota was, accordingly, initially seen by Dr Travers' Senior House Officer, Dr Lewis.

Dr Lewis took a full history from Mr Mabota using a Staff Nurse from Oak 1 ward as a translator. Dr Lewis recorded in the clinical notes that there was a possibility of Mr Mabota being charged with grievous bodily harm to his girlfriend/wife. He also noted that 4 attempts of suicide had been made in the last 24 hours. His differential diagnosis

was of depressive illness, a drug induced state, a stress induced reaction or a personality disorder. Dr Lewis wrote in the clinical notes:

"(1)	*Police to be informed. D.C. Pallas 081-556-8855 - ext 22338 before he leaves hospital. Wife Lidie/Julie 081-539-9239.*
(2)	*Contact family and girlfriend for collateral information. No GP.*
(3)	*FBC, ESR, SMR, TFTS. Drug Screen.*
(4)	*Fluid/food chart. Push fluids.*
(5)	*For continuous observation night and day - patient is serious suicidal risk.*
(6)	*If not containable or trying to leave - will need to transfer to M1."*

Although a Named Nurse system was being operated on Oak 2, it appears that no nurse was allocated to Mr Mabota during his short stay on Oak 2.

Following his admission to Oak 2, Mr Mabota proved to be an extremely difficult patient to manage on an open ward. The door to the ward was locked and two nurses were used to provide continuous observation but Mr Mabota still attempted to abscond each time the door was opened. Staff Nurse Senapati recalled that she found Mr Mabota a very worrying, indeed threatening, patient who appeared to be greatly irritated by the fact that two nurses remained in close attendance upon him during his time on Oak 2.

A statement given to the Police by Staff Nurse Darin Maicoo stated that he was on duty when Mr Mabota was admitted to the ward and that he considered Mr Mabota to be very unpredictable and potentially violent. Staff Nurse Maicoo recorded an incident when Mr Mabota tried to lock himself in a toilet and remembers Mr Mabota as having been abusive and threatening.

As a result of the concerns of the nursing staff, the Duty Doctor, Dr Borrell, was called. Dr Borrell, who gave evidence to the Inquiry, said that she was aware when she was called that Mr Mabota had attempted suicide and that he was continuing to say

that he wanted to harm himself. Dr Borrell was also aware from the clinical notes that there was a possibility of Mr Mabota being charged with assault occasioning grievous bodily harm.

Dr Borrell was unable to get Mr Mabota to speak to her and she accordingly attempted to contact Mr Mabota's wife (presumably this was a reference to Lidie) by telephone in order to try and find out some background information. Unfortunately, these attempts were without any success.

Because of Mr Mabota's lack of co-operation, Dr Borrell's assessment was, of necessity, based on Mr Mabota's actions and his threats to kill himself. Accordingly, she took the decision that Mr Mabota should be transferred to the locked ward, Maple 1. Dr Borrell perceived herself as dealing with a crisis situation arising from a newly admitted patient whose only wish appeared to be abscond and/or to commit suicide.

An Operational Policy document for Maple 1 was produced for the Inquiry. This covers, amongst other things, the procedures to be followed upon the transfer of a patient to Maple 1. It states:

> *"(6) <u>BEFORE SENDING THE PATIENT TO MAPLE 1</u>*
>
> *The referring ward must include a handover note in the medical notes, briefly describing the treatment programme and the reason for the referral.*
>
> *Nursing Care Plans should be evaluated by the Named Nurse or the Nurse acting on their behalf and a summary should be made on the progress report.*

(7) <u>WHILE THE PATIENT IS IN TEMPORARY CARE</u>

(a) The referring ward should leave the care of the patient entirely to the medical and nursing staff at Maple 1.

(b) The Named Nurse from the referring ward should visit the patient so that a relationship can be built up/maintained in preparation for the patient's return. ..."

Dr Borrell was not certain whether or not she was familiar with that document and the procedures it laid down.

As noted above, no Named Nurse was allocated to Mr Mabota on his admission to Oak 2. However, Staff Nurse Senapati told the Inquiry that before Mr Mabota was transferred to Maple 1, a Nursing Care Plan was prepared by a Student Nurse, which was then approved by her, Staff Nurse Senapati.

The Care Plan, which is dated 7th April 1994, stated as follows:

"1. Form therapeutic relationship with Mabota based on trust.

2. Place Mabota on continuous observation 24 hours per day.

3. Remove all objects from Mabota with which he could harm himself.

4. Medicate as per chart and observe for side effects and effectiveness of medication.

5. Observe for signs that Mabota is about to attempt self harm.

1. Encourage to take food and drink.

2. Push fluids (encourage build up).

3. Keep fluid balance charge.

4. If refuses to drink inform doctor."

The emphasis was therefore on the need to provide Mr Mabota with a safe environment and to ensure that his physical needs, necessitated by his consumption of bleach, were met.

CLAYBURY HOSPITAL - OAK 2 - DISCUSSION

It is self evident that if Operational Policy documents exist, setting down procedures to be followed, medical staff should be familiar with their contents.

The fact that a Named Nurse was not apparently allocated to Mr Mabota was unfortunate. Part of the Operational Policy document relating to Maple 1 provides that during a patient's stay on Maple 1, the Named Nurse from the transferring ward should visit the patient and try to build up a relationship with him in anticipation of his eventual return to an open ward. Clearly this did not happen in this case. It may be that the creation of such a relationship could have helped to prevent Mr Mabota's eventual absconding - or at the very least resulted in his disappearance being noticed sooner than was in fact the case.

The de facto policy that the Care Plan for patients being transferred to Maple 1 would be prepared by the transferring ward strikes the Inquiry as odd. At the very least there ought to be some re-evaluation of that Care Plan after transfer. As will appear later in this Report, we have concerns about the way in which Care Plans and variation to those Care Plans were documented.

CLAYBURY HOSPITAL - MAPLE 1

In accordance with Dr Borrell's decision, Mr Mabota was transferred to the locked ward, Maple 1, on the evening of the 7th April 1994.

The nursing plan formulated on Oak 2 before Mr Mabota's transfer was not evaluated on admission to Maple 1; neither was it agreed and signed by the admitting nurse. According to Mr Buckman, the ward manager of Maple 1 who gave evidence to the Inquiry, this was not routine practice. He told the Inquiry that changes to the plan would have been made only as necessary.

Mr Mabota was allocated a Named Nurse, Staff Nurse Wong. Although he was not on duty at the time of the transfer, he was chosen because, as a Mauritian, he was fluent in French.

Shortly after Mr Mabota's transfer, he was seen again by Dr Borrell who noted that he had settled in. She also recorded in the clinical notes that he should remain on continuous observation, with a review on the following day. As recorded above, the Operational Policy for Maple 1 at this time provided as follows:

> *"(7) <u>WHILE THE PATIENT IS IN TEMPORARY CARE</u>*
>
> *(a) The referring ward should leave the care of the patient entirely to the medical and nursing staff at Maple 1."*

The Consultant in charge of Maple 1 at the material times was a Dr Duignan. It follows that upon Mr Mabota's transfer to Maple 1, responsibility for his entire care (not only his day to day management) passed to Dr Duignan.

At the time of the transfer, however, Dr Duignan was on leave with the result that her responsibilities were being covered by a locum Consultant, Dr Balasegaram.

Dr Balasegaram gave evidence to the Inquiry. He saw Mr Mabota on the 8th April 1994, on the day following his transfer. His recollection was that he conducted the interview with Mr Mabota in English, and that he was accompanied by a locum, Dr Abbas, and a Nurse, probably Staff Nurse Wong. Dr Balasegaram's recollection was that the interview was conducted in English but it seems likely that he was mistaken in his recollection on this point. Firstly, the recollection of Dr Abbas - who made notes of the interview in the clinical notes - was that the interview was conducted in French with Staff Nurse Wong providing translation. Secondly, all the evidence suggests that Mr Mabota's English was very limited so it seems unlikely that Dr Balasegaram would have achieved the degree of communication which he did without the use of an interpreter. Finally, it was Mr Mabota's own recollection that, throughout his time in Claybury, he always communicated through an interpreter.

Dr Abbas's notes of the interview by Dr Balasegaram are not written in fluent English. Whether this reflects the quality of translation or the quality of Dr Abbas's own written English is uncertain, although Dr Abbas, who gave evidence to the Inquiry, clearly has good command of spoken English.

The notes made of this interview are, however, in some respects unsatisfactory insofar as, despite the fact that this was the first occasion on which Mr Mabota was reviewed by a consultant after his arrival at Claybury Hospital, all that is recorded apart from the exchanges between Dr Balasegaram and Mr Mabota is the final conclusion that Dr Balasegaram formed the view that Mr Mabota was suffering from acute stress adjustment. The notes do not include any details of Dr Balasegaram's plan for managing or treating Mr Mabota and Dr Balasegaram himself seemed surprised, when

he had an opportunity to consider the notes at the Inquiry, by the inadequacy of the clinical notes in this regard.

Entries in the documentation on 8th April 1994 show that Mr Mabota's vital signs were being recorded and fluid intake maintained on a regular basis.

On the evening of 8th April 1994, Dr Lewis was contacted by the staff on Maple 1. Dr Lewis's evidence to the Inquiry was that he was sure that this must have been because no medical staff were available on Maple 1 at the relevant time. He was sure that he would not have been asked to attend otherwise, because his view was that formal responsibility for Mr Mabota had shifted to the medical staff on Maple 1 and he would only have been contacted, therefore, in the event that no medical staff were available on Maple 1.

Dr Lewis thereafter discussed Mr Mabota's case with Dr Fagin, the other Consultant with responsibility for Oak 2. Following that discussion, Dr Lewis formulated a 4-point plan which read as follows:

"(1) *Encourage fluid/food.*

(2) *Still high risk of self harm/suicide.*

(3) *If patient were to continue to refuse fluids/food he may need transfer for rehydration if he cannot be persuaded to drink here.*

(4) *If he were to refuse fluids he should have regular i.e. 4 hourly p.b.p. and if there is any deterioration in his vital signs i.e. p. greater than 100 systolic less than 100 Duty Doctor should be informed."*

Dr Lewis inferred from this that he must have been called because of a reported problem with Mr Mabota not accepting fluids/food.

Over the following days Mr Mabota's condition was noted to be improving. Mr Mabota was described, on 9th April 1994, as having settled well. It was said that his mood was brightening and his fluid intake was satisfactory. He was watching the

television and taking a particular interest in African football. He had not attempted to self harm.

On the 9th April 1994 there is a note in the clinical notes made by Dr Abbas who recorded that Mr Mabota's condition appeared to have improved. In consequence Dr Abbas directed that continuous observation could be stopped and replaced with regular observation. When he gave evidence to the Inquiry, Dr Abbas stated that this attendance probably arose because the nursing staff had called him and suggested that it might be appropriate, in the light of the improvement in Mr Mabota's condition, for continuous observation to be discontinued.

A new Care Plan for Mr Mabota was prepared on the 10th April 1994. Somewhat surprisingly, this did not include any reference to the fact that Dr Abbas had directed that there should still be regular observation of Mr Mabota. No doubt, as a matter of practicality, the staff on Maple 1 relied upon word of mouth to communicate between themselves the fact that Mr Mabota was no longer on continuous observation but should be kept under regular observation.

The general perception on Maple 1 was that Mr Mabota thereafter continued to improve. It is, however, relevant in this context to note that Mr Mabota remained essentially uncommunicative. Evidence was heard from Staff Nurse Brew to the effect that Mr Mabota showed considerable interest in a football tournament which was being televised during his time on Maple 1 and that he did, on occasion, talk in broken English to Staff Nurse Brew about the football. However, apart from these discussions, it appears that there were no attempts made by Mr Mabota to enter into voluntary communications with any staff. It is particularly relevant in this context to note that his Named Nurse, Staff Nurse Wong, who speaks French (and with whom Mr Mabota himself said he was able to communicate tolerably well) told the Inquiry that he did not have <u>any</u> spontaneous conversations with Mr Mabota throughout the entirety of the time that Mr Mabota was on Maple 1.

Mr Buckman, the ward manager, described his perception that there was still something wrong about Mr Mabota albeit that it was something which he could not put his finger on. No reference to these doubts appears, however, in the nursing notes.

The next event of significance was on the 11th April 1994 when a telephone call was made by D.C. Pallas to Maple 1 in response to an earlier call which had been made by the staff. D.C. Pallas spoke to Staff Nurse Brew. Staff Nurse Brew made the following note in the nursing notes:

> *"He [D.C. Pallas] informed staff that Mr Mabota had not been charged with any offence yet. He however informed staff that Mr Mabota had attacked his wife kicked and punched her and also attempted to stab her but wife managed to run away from him to call the Police. When the Police arrived Mr Mabota had collapsed having drunk a bottle of Domestos hence was rushed to Whipps Cross. D.C. Pallas said that 3 knives were found in Mr Mabota's possession. When asked about the Court Hearing which Mr Mabota was supposed to have attended on Friday 8/4/94, D.C. Pallas stated that they are aware. It's a case regarding a Royal Mail deception but his office is not dealing with it. Can contact Walthamstow Magistrates' Court for further information. D.C. Pallas indicated that the staff must inform his office or him personally if any decision is being made on Mr Mabota's discharge."*

In the light of subsequent events, this telephone conversation seems to have been of considerable significance. When asked about it, D.C. Pallas indicated that he was unable to recall precisely what he would have said during this telephone conversation but he confirmed that his view throughout had been that Mr Mabota did present a potential danger to Lidie and that he was seeking to convey this to the staff at Claybury.

Staff Nurse Brew did not, however, get from this telephone conversation any sense that Mr Mabota represented a threat to third parties. There also appears to have been

something of an unfortunate misunderstanding. D.C. Pallas stated that all he would have told Staff Nurse Brew about possible criminal charges arising out of the assault on Lidie was that Mr Mabota had not yet been charged with any offence. D.C. Pallas's intention was that, as and when Mr Mabota was discharged, he would be arrested and interviewed with a view to charges of assault occasioning grievous bodily harm against Lidie. What appears, unfortunately, to have happened is that D.C. Pallas's information to Staff Nurse Brew to the effect that Mr Mabota had not yet been charged (which was accurately recorded in the nursing notes) later became interpreted as an indication that Mr Mabota was not being charged at all. This misunderstanding reinforced the general perception that Mr Mabota did not pose a risk to others and that he was, in effect, simply a suicide risk.

The information about the nature and extent of Mr Mabota's attack on Lidie, and in particular the fact that he was reported to have attempted to stab her, is, certainly in retrospect, information which could and should have been available to the medical staff at Claybury Hospital. It might perhaps have influenced their decision so far as Mr Mabota's treatment was concerned. Whilst Staff Nurse Brew's note was there to be read by the medical staff if they wished to do so, it is far from clear whether or not it was in fact ever read and/or appreciated by the medical staff responsible for decisions relating to Mr Mabota - specifically the decision to transfer him from Maple 1 back to the open ward, Oak 2.

On 12th April 1994, Mr Mabota was again interviewed by Dr Abbas. The clinical notes record what is, in effect, a question and answer session, albeit a very brief one. Dr Abbas confirmed that these notes represented a verbatim record of what was discussed between himself and Mr Mabota. Dr Abbas again indicated that his attendance on Mr Mabota on this day was as a consequence of being called by the nursing staff further to assess Mr Mabota's condition. Dr Abbas concluded, after this short interview, that regular observations could be discontinued. Once again, this was not reflected in any formal change in the Nursing Care Plan although a note was made in the nursing notes to the effect that regular observation was discontinued.

On 13th April 1994, Mr Mabota received his rights under Section 2 of the Mental Health Act 1983 and was given the relevant information leaflet. He was also reviewed by Dr Travers following his return from leave. Dr Travers saw Mr Mabota with Dr Lewis and an interpreter from Oak 1 ward. Prior to Dr Travers' interview with Mr Mabota, he was given a certain amount of information which is recorded at the beginning of the entry in the clinical notes for the 13th April 1994. Significantly this included the statement *"The Police are not charging him with any offence"*. As indicated above, this was a misapprehension of the true position. What the hospital staff had been informed by D.C. Pallas (and what indeed was recorded in the nursing notes) was that Mr Mabota had not yet been charged with any offence. It was also recorded that Mr Mabota had spoken to his wife on the phone.

In the interview itself, Mr Mabota denied his recent self harming behaviour and claimed he was now on good terms (following phone conversations) with his girlfriend.

Following the interview, Dr Travers reached the following conclusions, which are recorded in the clinical notes:

> *"(1) Need to meet with wife.*
> *(2) Maintain Section 2 at present.*
> *(3) Agrees to stay in hospital on open ward transfer to open ward O2".*

The nursing notes record that Mr Mabota was to be transferred to Oak 2 ward as soon as a bed was available. A note was also made to the effect that Dr Lewis was to see Mr Mabota's wife on Friday 15th April 1994 at 12.30 pm for any available information the wife might have on the incident. Dr Lewis told the Inquiry that he had himself managed to contact the girlfriend, Lidie (we assume it was Lidie, even though the notes referred to Mr Mabota's wife) and arranged this interview.

On 14th April 1994 staff on Maple 1 received a message from Oak 2 staff to the effect that a bed was available and a decision was made to refer Mr Mabota back to Oak 2 on the afternoon of 14th April 1994. A referral note appears in the Progress Report which reads as follows:

> *"Mabota was admitted to M1. The reason that he allegedly attacked girlfriend then made repeated attempts at suicide. On admission he was refusing to eat or co-operate with staff. He improved steadily and started eating and co-operating with the staff and he gained some weight. He is no longer threatening to harm himself or displaying any suicidal symptoms."*

This note is accordance with the Operational Policy referred to above. However, the aspect of the Operational Policy which required that the Named Nurse from the referring ward should visit the patient on Maple 1 so that a relationship can be built up/maintained in preparation for the patient's return was clearly not adhered to in any sense.

The evidence to the Inquiry disclosed confusion on the question of where formal responsibility for Mr Mabota's treatment lay during his time on Maple 1. Dr Balasegaram, the locum Consultant in charge of the ward at the time, was firmly of the view that his role, standing in for Dr Duignan, was merely to handle the day to day management of the patients on Maple 1. It was not his perception of his role that he would be responsible for taking longer term decisions. He did not, in particular, perceive it as his role to initiate steps to ascertain more about Mr Mabota's background and/or relationship with Lidie. He considered that overall responsibility for Mr Mabota's care remained with the responsible medical officer allocated to Mr Mabota prior to the transfer to Maple 1.

It seems clear that Dr Balasegaram was unaware of the Operational Policy relating to Maple 1 at that time which placed the <u>entirety</u> of the responsibility for the care of patients on Maple 1 upon the medical staff on Maple 1. Whatever procedures were in

place for ensuring that locum Consultants were appraised of the nature and extent of their duties, were inadequate in this particular instance.

There was subsequently a change in the Operational Policy on Maple 1 with effect from October 1994. The revised Operational Policy provided so far as is material as follows:

"WHILST THE PATIENT IS IN TEMPORARY CARE

(a) The patient's responsible Medical Officer will plan care in the management of the patient with medical and nursing staff of Maple 1.

(b) The patient's responsible Medical officer must agree review dates with the Nurse in charge of Maple 1.

(c) The Named Nurse from the referring ward should visit the patient so that the relationship can be maintained/build up in preparation for the patient's return.

(d) Temporary care is for the shortest possible period which meets the patients needs and does not normally exceed 12 weeks.

RETURNING PATIENTS TO THEIR WARDS

(a) The patient's RMO in discussion with the Maple 1 team, will decide when the patient is ready to be referred back.

(b) A handover note is to be made in the patient's medical notes.

(c) The Care Plan is evaluated.

(d) A summary is made in the progress report.

(e) The Named Nurse or the Nurse in charge of Maple 1 will contact the referring ward and arrange a convenient time for the patient's return."

It is evident, therefore, that shortly after the events with which we are concerned here, there was a fundamental change in the policy relating to the responsibility for patients on Maple 1 with responsibility shifting from the medical staff on Maple 1 back to the referring responsible medical officer.

The Inquiry heard that the reason for this change in policy was a loss of medical staff on Maple 1 which imposed upon Dr Duignan an excessive burden such that she was no longer able to cope with the full responsibility for care of the patients on Maple 1. In consequence, the decision was taken to shift responsibility to the referring Consultant.

It seems likely from the evidence given to the Inquiry by, in particular, Mr Buckman, the ward manager of Maple 1, that the formal change in Operational Policy of October 1994 was preceded by a period during which, due to the demands being made on Dr Duignan's time, some confusion existed as to where actual responsibility for the patient's care lay during the time that that patient was on Maple 1. It is relevant in this context to note that the evidence of Dr Travers (the Consultant into whose care Mr Mabota was initially placed - albeit that he did not actually see Mr Mabota prior to his transfer to Maple 1) was that responsibility for Mr Mabota's care lay with him as the referring Consultant. However, this is a view which was at odds with the formal Operational Policy in existence at that time. It was also at odds with the views of Dr Travers' SHO, Dr Lewis (who carried out the assessment on Oak 2 of the 7th April 1994). Dr Lewis was firmly of the view that, on transfer, responsibility shifted to the medical staff on Maple 1.

The Maple 1 staff who gave evidence to the Inquiry gave the impression that they saw Maple 1 as providing "temporary care". This is reflected in the documentation from Maple 1 which reveals a focus upon day to day management rather than a longer term planned approach to care.

CLAYBURY HOSPITAL MAPLE 1 - DISCUSSION

The decision to transfer Mr Mabota from the locked ward to the open ward can be seen, in retrospect, to have been unfortunate. The question is whether there were, at the relevant time, any indications which ought to have caused the medical staff to adopt a more cautious attitude.

The impression the Inquiry received was that Mr Mabota was essentially perceived as a straightforward crisis case where, following a specific incident, he had become suicidal but that with the passage of time, those suicidal feelings had dissipated and he was, accordingly, once again "alright". All the action which was taken vis à vis Mr Mabota seems to the Panel to be consistent with this, perhaps overly simplistic, analysis of Mr Mabota's condition.

The Inquiry heard evidence first of all to the effect that Mr Mabota remained largely uncommunicative during his time on Maple 1. Apart from the occasional exchange with Staff Nurse Brew about football, in broken English, it appears that he did not establish any sort of relationship with anyone on Maple 1 but kept himself to himself. It is significant, in particular, that he did not apparently form any sort relationship with his Named Nurse, Staff Nurse Wong, notwithstanding the presence of a common language.

Furthermore, there was, as was readily conceded by all witnesses, an absence of background information or context for Mr Mabota's behaviour. Dr Travers told the Inquiry that he had known that Police Officers had been with Mr Mabota throughout his time on the Whipps Cross Observation Ward but that his assumption had been that they had been there to help manage Mr Mabota's suicide risk and not because of the

risk that Mr Mabota posed to third parties. That assumption was, unfortunately, wrong and it seems to the Panel to have been reached without any real justification - save only that it fitted into the general picture which the hospital staff had formed of Mr Mabota as an acute suicide risk who had been through a crisis but who, once he had passed through that crisis, could quickly be given his freedom on an open ward and thereafter discharged.

No doubt, with this perception of the causes of Mr Mabota's behaviour, the absence of background/context seemed less important. Nevertheless, there was a gap in the hospital staff's knowledge about Mr Mabota and certainly in retrospect, it seems to the Panel that it would obviously have been sensible to try and fill those gaps by telephoning the Police and/or the girlfriend and seeking as much information as could be obtained.

It seems to the Panel, therefore, that the decision to transfer Mr Mabota back to an open ward (without even a transitional phase) may have been premature at least in the sense that an opportunity to gather further information about Mr Mabota was missed. We will never know, however, whether the additional information might have made any difference to the decision.

CLAYBURY HOSPITAL - THE RETURN TO OAK 2

Mr Mabota returned to Oak 2 at about 14.45 hrs. A note in the nursing records indicates that he appeared "very settled". It is recorded that he rang his "relatives" and then slept well throughout the night.

The nursing referral notes to Oak 2 recorded that one of the reasons for Mr Mabota's original transfer to Maple 1 was that he had allegedly attacked his girlfriend. In spite of this 'reminder', seven days on a locked ward, and periods of continuous and regular observations it was not considered necessary to introduce him gradually to the less restricted environment of an open ward and no other nursing intervention was planned to monitor his whereabouts.

On the 15th April 1994, a Friday, Mr Mabota was seen again by Dr Lewis. Staff Nurse Ahgun, a French speaking Mauritian Nurse from Oak 1 ward and an experienced interpreter, was used to translate. Dr Lewis has recorded that he was told by Mr Mabota that his "wife" - presumably Lidie - could not attend for her meeting with Dr Lewis that day as she did not have any money for transport. Dr Lewis explained that another appointment would have to be made to see her.

Dr Lewis noted that there were no psychotic features seen and no suicide intent apparent. His clinical notes are mirrored by similar notes in the nursing records.

Staff Nurse Senapati was working on Oak 2 on 15th April 1994. Whilst it was the belief of Mr Mahadeo that Staff Nurse Senapati had been the Named Nurse on Oak 2 for Mr Mabota, Nurse Senapati told us that this was not correct. She was unable to recall who the Named Nurse was. There is no indication on any of the

contemporaneous documentation who the Named Nurse for Mr Mabota was, if indeed there was one. The absence of any record, in the nursing notes or indeed anywhere else, of the identity of the Named Nurse is unfortunate.

Evidence was given to the Inquiry concerning staffing levels on Oak 2 on the evening of 15th April 1994. Mr Mahadeo, the ward manager, was on duty covering the entire hospital from 14.00 hrs to 18.00 hrs. He thereafter remained on duty until 21.15 hrs. Unfortunately two Staff Nurses, Staff Nurse Doyle and Agency Staff Nurse Ramtohul were off sick that day. As a result Staff Nurse Senapati agreed to stay on assisted by two Student Nurses and by two Nursing Assistants. A report completed by Mr Mahadeo shortly after Mr Mabota left the hospital recorded that Nursing Assistant Yeboah and Nursing Assistant Richards (who were on duty with Staff Nurse Senapati) were both unfamiliar with the patients on Oak 2. There was, therefore, a serious lack of trained and experienced staff on Oak 2 at the time when Mr Mabota absconded.

Staff Nurse Senapati was able to recall Mr Mabota on Oak 2, following his return from Maple 1. She said that she had been surprised by the apparent positive change in his general behaviour and mental state on his return to Oak 2. She did not perceive him to represent a risk.

It is recorded that on 15th April 1994, the nursing staff contacted Leyton Police Station to inform D.C. Pallas that Mr Mabota had been transferred to an open ward. As D.C. Pallas was unavailable a message was left at the Station.

Staff Nurse Senapati recalled that around 17.00 hrs Mr Mabota asked permission to go and make a telephone call. There were, at that time, no telephones available for use by patients on Oak 2 itself and it was, accordingly, necessary for Mr Mabota to leave the ward and go to the reception area to make a call from the public phones located close to the reception area. Mr Mabota apparently failed to get through on the first occasion when he went to make a telephone call and he returned to the ward. A few minutes later he indicated to staff that he wished to try again and he left the ward at about 17.30 hrs to go and make a further telephone call.

According to Mr Mabota himself he had 50p in his possession in order to make that telephone call. He said that as he walked down to the telephone boxes in the reception area, in his pyjamas, he saw a bus draw up outside the reception area. Seeing an opportunity to leave the hospital, Mr Mabota, on the spur of the moment, boarded the bus, in his pyjamas, and, using the money which he had for the telephone call to pay his fare, left the hospital in the bus.

The driver of the London Transport bus concerned, a No.276, did not apparently comment upon the fact of a person in pyjamas boarding his bus.

Mr Mabota's absence from Oak 2 was not noticed until 20.00 hrs that evening, a gap of some 2½ hours. A document made available to the Inquiry entitled "Ward Administrative Procedures - Search Procedure (Absent Patients)" stated, amongst other things the following:

> *"Patients should be accounted for at the following times:*
>
> *Meal times.*
>
> *Whenever they leave the ward.*
>
> *Whenever they return to the ward.*
>
> *At handover between shifts.*
>
> *If a patient, whether detained or informal is missing, at one of these checks or at other time, and his and her absence is in any way unusual or a cause for concern, the following action should be taken ..."*

Evidence given to the Inquiry by Mr Mahadeo, the ward manager on Oak 2 and by Staff Nurse Senapati, was to the effect that there would have been a mealtime check between 17.30 hrs and 20.00 hrs on the evening of the 15th April 1994. It is quite clear, however, that no check was made, at that time, to see whether all the patients, including Mr Mabota, were present on Oak 2 at that time.

Mr Mahadeo stated that it was not policy to carry out checks of patients on Oak 2 in accordance with the procedures outlined in the document referred to above.

The members of the Panel had the opportunity to visit Oak 2 ward. It is clear that the process of checking upon the presence or otherwise of patients on that ward would be a difficult procedure. The layout of the ward is such that even a head count could present practical difficulties. Furthermore, Oak 2 is, of course, an open ward and as such patients are not expected to remain on it at all times. The procedure of regular checks on patients is difficult to operate in such an environment.

Nevertheless, Mr Mabota was a patient who had only recently been discharged from a locked ward. We heard evidence from, amongst others, Dr Travers, to the effect that one procedure which was often followed was that patients who were being moved from Maple 1 to Oak 2 would have a transitional period whilst an evaluation was made of the risk of their absconding. Thus, patients on Maple 1 might be allowed a few hours each day outside of the locked ward, with the degree of freedom being increased over a period of time before the eventual transfer to Oak 2. This procedure was not undertaken in the case of Mr Mabota.

When Mr Mabota's departure was noted at 20.00 hrs, Nursing Assistant Yeboah was asked to look around the reception area, the Campbell Centre and various corridors for Mr Mabota. He was not, however, to be found. The grounds were not searched as required in Claybury's policy on absent or missing persons - with a fit and physically healthy patient such as Mr Mabota, this was felt, almost certainly correctly, superfluous.

Attempts were then made to contact Mr Mabota's wife/girlfriend by telephone but no response was obtained. Contact was made with Mr Mabota's sister but Mr Mabota was not there. Barkingside Police Station was contacted at 20.50 hrs to inform them that Mr Mabota had left hospital without medical permission.

D.C. Pallas's evidence to the Inquiry was to the effect that he had made arrangements for his weekend cover and that information about Mr Mabota (and in particular about D.C. Pallas's perception that he might wish to harm his girlfriend, Lidie) would have been available in a file at the Police Station. We have not, however, enquired into the events at Leyton Police Station after the staff at Claybury Hospital notified the Police of Mr Mabota's disappearance.

Over the following days, numerous telephone calls were made by the nursing staff to and received from all local police stations. These calls sought the same information: news of Mr Mabota's whereabouts. Every effort was made to contact members of Mr Mabota's family to inform them that he had left the hospital. It was reported that on one occasion his 'sister' answered the phone but said she had no information - otherwise the staff had no success.

D.C. Pallas eventually made contact on the 18th April to confirm that he had been informed of Mr Mabota's absence. The report from the police that his girlfriend had been murdered was not recorded in the nursing notes.

De-briefing sessions and counselling services were not provided for staff members stressed by the traumatic events.

CLAYBURY HOSPITAL - THE RETURN TO OAK 2 - DISCUSSION

According to the written procedure, patients were to be checked at certain specific times. However, Mr Mahadeo told us that patients on Oak 2 were not checked at each of these specific times. This was not a failure which resulted from the staffing difficulties - it was simply a ward procedure that was not being followed. It is obviously pointless to have ward procedures laid down which are not followed. If the procedures are not appropriate to a particular ward (as may well have been the case on Oak 2), the procedure should be adapted accordingly.

So far as the actual failure, on 15th April 1994, to notice that Mr Mabota had disappeared at any time before 20.00 hrs is concerned, the Panel has considerable sympathy with the staff on Oak 2 at the relevant time. There was clearly a shortage of trained staff familiar with the patients. Staffing levels on Oak 2 were a matter of concern expressed by the ward manager. The problem was not, however, just of numbers but of quality. According to the evidence given to the Panel there was an over reliance on untrained staff, many of whom were employed through an agency. It is doubtful whether on the night of the incident the team possessed sufficient observational and assessment skills to provide a safe level of care. The layout of Oak 2 makes the task of verifying the presence or otherwise of patients difficult. The policy of an open ward in any event makes the accurate determination of the presence or otherwise of patients at any particular time very difficult.

In this particular case, it appears that staff were indeed made aware by Mr Mabota of his reasons for wanting to leave the ward. However, the fact that he did not return for 2½ hours after saying that he was going off to make a telephone call should have raised concerns. The failure to do so should be perceived as unacceptable.

Linked to this was the failure to notify the Police before 20.50 hrs. The hospital staff knew that the Police were concerned about Mr Mabota, and that they wanted to be notified immediately there was a decision to discharge Mr Mabota. They should also have been aware that the Police were still considering charges against Mr Mabota in respect of the assault upon his girlfriend. Given that Mr Mabota had been absent for 2½ hours it was overwhelmingly probable that he had disappeared and left the hospital. A 50 minute delay before notifying the Police in a case where a potentially dangerous patient had absconded was too long.

The driver of the London Transport bus upon which Mr Mabota left Claybury Hospital should have realised that a person wearing pyjamas and slippers was almost certainly a patient in the hospital. Nevertheless, it appears that the bus driver paid no attention to Mr Mabota's attire and Mr Mabota was allowed to leave accordingly.

We recommend that bus companies with services visiting psychiatric hospitals are advised of the potential risk of patients absconding and are asked to ensure that their drivers are alert to the possibility of patients seeking to abscond by boarding one of their buses.

Post incident stress was reported to the Panel by at least one member of the staff. No provision was made for de-briefing or individual support although it is widely accepted that such services should be available as part of good practice. A failure to do so may have longer term detrimental effects both to the individual and the organisation.

We recommend that, in the event of a serious incident, psychological support, de-briefing sessions or post traumatic stress counselling are co-ordinated and made available to the staff.

SERVICE PLANNING AND DEVELOPMENT

It was clear from a number of witnesses, from both the Health Authority and from the NHS Trust that the closure of Claybury Hospital was a long standing objective in strategic plans. By 1994 it appears that the target date for closure was September 1995. It was recognised at the time that this was a very tight timetable, especially in the light of the complexity of developing the alternative Community Mental Health Services with Waltham Forest Social Services Department. It was recognised that the impending closure had a deleterious affect on the staffing and staff at Claybury Hospital. Attempts had been made to encourage the staff to stay in post at Claybury Hospital but nonetheless the clear impression gained by the Panel was of difficulties in attracting and maintaining a stable group of staff.

On the level of service planning and development, it was clear that the Health Authority and the Social Services Department were developing a strategy in 1994 and its implementation plan, which is currently being pursued. It is also clear that the provider, Forest Healthcare, was involved in the planning processes.

However, the strong impression that the Panel has is that the inpatient services at Claybury Hospital have had insufficient investment for a considerable period of time. The concerns are in two areas: the physical condition of the ward and the staff resources available to care for the patients.

It was accepted that the conditions the Panel saw in 1996 would be different, and in all probability, worse than those that were evident in 1994. However, the conditions in 1994 would have to have been very significantly better for the ward to be able to provide an environment for the practice of psychiatry in a manner and up to standards acceptable in the 1990s.

Staffing was clearly a problem in 1994. Whilst the minimum levels of staffing on the wards were reached, this was often through very heavy use of agency staff. It was commented to the Inquiry that this was often staff from the hospital working, in effect, overtime through an agency.

It is the overall impression of the Panel that Claybury Hospital has for some time been suffering from planning and development blight. Whilst the service development plans currently being implemented appear to be well founded, the maintenance of the old services at Claybury had not been sufficiently considered or resourced.

Lessons For The New Community Services

The recommendations and lessons that stem from this report will need to be applied to the inpatient services at Claybury Hospital and to the new services that are being provided as replacements.

GENERAL DISCUSSION

Interpretation Services

One interview with Mr Mabota, recorded verbatim in the clinical notes, was conducted by a locum Consultant, Dr Balasegaram, through a Mauritian nurse (of Chinese ethnicity) speaking to a Zairean national in his fourth language, French, and being recorded by an Iraqi locum, whose first language was not English. The possibility of misunderstanding in these circumstances seems very high - an accurate psychiatric assessment must have been very difficult.

Claybury Hospital is situated within a area where there a multiplicity of ethnic groupings with many local residents either not speaking English or not speaking English as their first language. The managers at Claybury Hospital are alert to the need for interpreters in certain circumstances, and evidence was given to the Inquiry that a list was drawn up of staff within the hospital who spoke a second language who might, therefore, be able to assist as interpreters. It seems clear from the evidence given to the Inquiry with regard to Mr Mabota, that the use of in-house interpreters of this sort is widespread and it seems to be the option of first resort. It appears that there is also access to formal interpreting services but these were certainly not called upon in the case of Mr Mabota and it seems clear that if and insofar as staff do exist who speak the language necessary to communicate with a patient, then the preference, as a matter of practicality, is for that member of staff to be used as an interpreter rather than to rely upon the services of an external interpreting service.

The system is not ideal but bearing in mind the range of languages with which staff might be faced and bearing in mind also cost restraints, it seems to the Panel that the use of psychiatric staff as in-house interpreters is an acceptable and sensible use of

resources. It was indeed suggested by some witnesses to the Inquiry that there were benefits in using staff who had psychiatric training when interpreting for patients because that training enabled the staff to respond sensitively and appropriately and to pick up nuances which might escape a professional interpreter. Whether that is right or wrong, however, it does not seem to the Panel that the establishment of a permanent in-house interpreting service capable of covering the wide range of the languages with which staff might be faced during the course of a working day, is a practical or cost effective option.

However the Panel were struck by the apparent difference in quality between the various interpreters who were involved in this particular case. Whether that difference is attributable to the experience and quality of the staff concerned or whether it is attributable to limitations upon the individual's own command of English remains an open question. We recommend that, whilst the system of using in-house interpreters can and should continue, some steps have to be taken (i) to ensure the minimum competence of such interpreters both in English and the relevant foreign language and (ii) to ensure that the best interpreter (both in terms of language skills and in terms of experience/nursing skills) should be available and should be used if at all possible.

The staff employed at Claybury Hospital come from a variety of different ethnic backgrounds. The quality of English spoken by the staff, both medical and nursing, varies considerably. In any psychiatric evaluation, the accurate understanding of what precisely the patient is saying is clearly of paramount importance.

We recommend that steps be taken to establish standards of minimum competence for interpreting staff ensuring not only competence in the relevant foreign language but also a high degree of familiarity with the English language. There is a need for the clear identification of the competencies necessary for someone to be an effective interpreter in a psychiatric or mental health context.

The Allocation of Responsibility for Mr Mabota's Care

The uncertainties which apparently existed in April 1994 concerning the question of where responsibility for patients on Maple 1 lay had the result, in the case of Mr Mabota, that no "strategic" decisions were made during his time on Maple 1. It seems likely that the uncertainty about the allocation of responsibility at this time was the result of difficulties arising from the loss of medical staff combined with the increasing workload upon Dr Duignan.

What in fact occurred was that day to day management was provided by medical staff (apparently largely in response to suggestions from the nursing staff) but there was no real continuity in the care of Mr Mabota and nobody took responsibility for taking the necessary steps to find out about Mr Mabota's background so as to put his behaviour into its proper context. In particular, whilst Dr Lewis sensibly recommended at an early stage that attempts be made to contact Mr Mabota's family and girlfriend for "collateral information", no formal or systematic attempts appear to have been made by any nursing or medical staff to follow this through during Mr Mabota's time on Maple 1, whether by telephone contact through either the Named Nurse or ward manager, or by, perhaps, a domiciliary visit by a member of the relevant community team.

Nobody appears to have been accountable for this, nor for other aspects of gathering or collating information.

When the Panel interviewed Mr Mabota in Wormwood Scrubs Prison where he is presently held, he stated that he had been told by one of the nurses on Maple 1 - he thought Staff Nurse Wong - that Henriette had called to see him whilst he was on Maple 1 but that it had been decided that she should not see him at that time. Mr Mabota was not, in the Panel's view, a reliable witness. However, the interpreter who had assisted Mr Mabota at his trial for murder, and who also interpreted for the Panel at Wormwood Scrubs when we spoke to Mr Mabota, confirmed that she recalled Henriette herself stating that she had indeed attempted to visit whilst Mr Mabota was at

Claybury Hospital. No such visit was, however, recalled by Staff Nurse Wong or indeed Mr Buckman, and it certainly seems to the Panel most unlikely that such a visit had occurred without, at the very least, some note having been made about it.

In any event, it was only when Dr Lewis himself, at some time on the 13th/14th April 1994, telephoned Lidie and arranged an appointment for her to come into the hospital, that steps were taken to obtain the requisite background information. It appears that that meeting with Dr Lewis did not take place because Lidie said she had insufficient money to attend the hospital. It may be that she was reluctant to attend and that even if earlier attempts to arrange such an interview had been made, they would have been unsuccessful. Furthermore, we do not know what information Lidie might have been able to provide to the hospital staff concerning Mr Mabota's background and we do not know whether that information would have made any difference at all to the way in which Mr Mabota was treated. However, information derived from an interview with Lidie could have had a material effect upon Mr Mabota's treatment and, just possibly, have avoided the subsequent course of events.

We have noted above the fact that Dr Balasegaram, the locum Consultant with care of Mr Mabota, did not perceive himself as having any responsibility over and above day to day management. This was itself, no doubt, linked to the difficulties arising from the loss of medical staff combined with the increasing workload upon Dr Duignan. It is unlikely that this specific problem will continue following the reorganisation of mental health care in Waltham Forest.

However it is plainly of paramount importance, in whatever context, that medical staff are properly aware of the nature and extent of their responsibilities vis à vis patients. This is particularly so where locums are being used to cover for existing staff. It is quite clear that Dr Balasegaram was wholly unaware of the Operational Policy relating to Maple 1 which indicated that he, as the locum Consultant covering for Dr Duignan, had full responsibility for Mr Mabota's care, not just his day to day management.

We therefore recommend that steps are taken to implement procedures to ensure that all medical staff, including - indeed particularly - locums being used to cover for existing medical staff are fully aware of their responsibilities and of any relevant Operational Policies.

Liaison with the Police

Another area of concern is the failure of the medical staff at Claybury to contact and obtain background information about Mr Mabota from D.C. Pallas and/or a Police Officer involved with Mr Mabota. Given the absence of background information on Mr Mabota, it is surprising that the medical staff did not, at any stage, contact D.C. Pallas direct (notwithstanding that he had left his telephone number and extension with the hospital staff and indeed apparently got in touch with the hospital himself to pass on information on 11th April 1994 to Staff Nurse Brew).

It may well be that there is some reluctance on the part of medical staff to contact the Police with regard to their patients. Often it may be the case that the Police will be in a "hostile" position vis à vis the patient in that, as here, they may wish to interview and/or prosecute him for criminal offences. They may be perceived as having a less sympathetic attitude generally. Patients may be greatly concerned to know that information provided by the police was influencing their treatment. Nevertheless, it seems to the Panel that the Police can, and in this case would, have been a valuable source of additional information about Mr Mabota. After Mr Mabota was sectioned, the medical staff focused almost entirely upon the risk that Mr Mabota might do himself harm. They did not really consider the possibility that Mr Mabota might, if he left the hospital, do harm to others, specifically Lidie, whom he had previously assaulted. If the Police had been contacted, this danger would have been brought back into focus and would at least have been a consideration in the mind of the medical staff before they made the decision to transfer Mr Mabota off the locked ward onto an open ward.

There is, so far as the Panel can tell, no particularly good reason why an attempt was not made by medical staff, at any stage, to contact D.C. Pallas to seek his input. Without exception, when staff at Claybury Hospital were asked about their thoughts so far as the girlfriend was concerned, the answer given was that they were concerned about her because they wished to interview her to obtain information about Mr Mabota and his background. At no stage did any witness suggest that they had had concerns about the possibility of Mr Mabota doing harm to Lidie.

We recommend that attempts be made to improve liaison with the Police wherever possible and that staff be encouraged to consider contacts with the Police, if and insofar as information may be needed for a proper assessment of a patient. Dr Travers, in an internal memorandum, has focused on this area and has emphasised the need for written information from the police and ongoing liaison between the police and medical staff. Certainly written information from the police would be ideal, but there is no reason why information should not be sought in a less formal context, always provided, of course, that an accurate record is kept of information supplied.

Liaison with the Social Services

The Inquiry heard from Mr Spelman, who was in 1994 the Principal Manager for people with mental health problems, that there was social work and social services support for the wards in Claybury Hospital in 1994. He understood that there was regular attendance at ward rounds by Social Workers and that each ward would have had a designated social work cover. This is, however, not consistent with what we had understood from other witnesses from medical and nursing professions. Their impression was that there was no social work cover directly available and that specific referral would have had to have been made. It was not felt that there were any needs in relation to this case that would warrant such a referral. Consideration was not given by the ward staff to asking Social Services, through a Social Worker, to contact Mr Mabota's girlfriend or wife to give more information on the background circumstances.

If social work involvement on the wards had been present, as indicated by Mr Spelman, then it is clear it had not made an impact on those involved directly with Mr Mabota in how they considered the management of his care and in how they would obtain the necessary background information on his circumstances.

The system which Mr Spelman believed was operating back in 1994, of regular attendance at ward rounds by Social Workers, with each ward having designated social work cover is one to be commended and if and insofar as it does not presently operate we recommend that steps be take to revive this system.

Record Keeping

The quality of the internal documentation left a lot to be desired. Generally speaking, the records lacked evidence of the process by which decisions, particularly multi professional decisions, had been reached. There was no system for "flagging up" key information relevant for the assessment of possible risk to self or others. The information, for example, about Mr Mabota's previous violent behaviour, whilst recorded, seems to have become diluted and overlooked. It is recognised that discussions would have taken place at hand overs and ward rounds but it is important to have proof of that debate.

We recommend that there should be some system adopted for "flagging up" key information relevant for the assessment of possible risk to self or others.

Care Plans were not routinely re-assessed following transfers from one ward to another nor were changes properly documented - omissions which could contribute to a failure to assimilate vital information. Signatures in nursing documentation were unclear and only one nurse printed his name as well as signing. Student nurse entries were frequently only initialled by trained staff.

There ought, for example, to have been contemporaneous records made of the changes in the Care Plan applicable from time to time so that, in the event of some breakdown in communication, the current Care Plan for Mr Mabota was readily ascertainable from a single document.

There are a number of examples of failures in this regard. The plan set out by Dr Lewis, following his original assessment on the 7th April 1994 (including the plan to contact the family and girlfriend for collateral information) and the more specific plan noted by Dr Lewis following his discussions with Dr Fagin on the 8th April 1994 do not feature in the Nursing Care Plan at all. Only if a Nurse had taken the trouble (and had had the time) to read through the entirety of the clinical notes, would the existence of these recommendations have been identified.

The Nursing Care Plan was not revised immediately following Dr Abbas's recommendation on the 9th April 1994 that continuous observation should be replaced by regular observation. When it was revised on 10th April 1994, there was no reference in the Care Plan to the decision to maintain regular observation. It was not revised at all following Dr Abbas's recommendation that regular observation could be discontinued altogether as of the 12th April 1994. There was no formal review of the Care Plan before the transfer back to Oak 2.

It may well be that all of the relevant information could have been obtained by reading through the nursing notes and the clinical notes. However, it is clearly unrealistic to expect nursing staff (which may include temporary or agency staff) to undertake this exercise. It is likely that much reliance was/is placed upon oral communications between nurses on Maple 1 but this can obviously be unreliable.

There ought to be available, in respect of every patient, a single document setting out, in a clear and unambiguous way, the current Nursing Care Plan for each patient so that on handover at the end of shifts or upon the involvement of new or agency staff, all relevant information about Mr Mabota is immediately accessible. No such document existed in the case of Mr Mabota.

We recommend, therefore, that steps be taken to ensure that Nursing Care Plans are drawn up and re-evaluated on a regular basis, and in particular, to ensure that they incorporate recommendations made by medical staff, recorded in the clinical notes.

A further point which arises in this context is that at Claybury, as in many other hospitals, the clinical notes and the nursing notes are separate documents maintained in separate files. On our visit to Maple 1, we were shown that whilst both sets of notes are (usually) kept within the same room, they are not kept in the same place. We were told by nursing staff that they sometimes read through the clinical notes. Likewise we were told by medical staff that they sometimes read through the nursing notes.

However, particularly in a case such as that of Mr Mabota, when background or collateral information was so sparse, it is of vital importance for all staff to be as aware as possible of all information derived from Mr Mabota. We consider that the practice of maintaining the nursing notes and medical notes in different physical locations can lead to important information being overlooked. By way of example, the information set out in Staff Nurse Brew's note of his telephone conversation with D.C. Pallas was clearly to the effect that Mr Mabota had not <u>yet</u> been charged with any offence in connection with the assault upon his girlfriend. This was information of which the medical staff were not aware. No doubt in the course of the information being passed on by way of mouth, the information became misinterpreted/distorted to a dangerously misleading degree. It came to be understood by the medical staff, in particular, by Dr Travers, that the Police were not in fact charging Mr Mabota with any offence <u>at all</u>, thereby causing Dr Travers to be misled about the Police's perception of the threat which Mr Mabota posed to his girlfriend.

We recommend that the practice of maintaining medical and nursing notes in different physical locations be discontinued. We consider it of paramount importance that the medical and nursing notes are kept in one place.

Our principal recommendation in this regard is that all disciplines should record observations, chronologically, in a single continuous record so that a full history can be discerned from a single document. At the very least, multi professional records should be contained in one folder and a system established which requires each discipline to regularly refer to the documentation of the others. Training needs must be addressed. It is imperative that all staff understand the importance of documentation in the delivery of good patient treatment and care and the legal implications if documentation is not of the required standard.

The Named Nurse System

There was evidence of a poor understanding and implementation of the 'Named Nurse' concept. Nursing staff on both wards clearly demonstrated a caring attitude in their work. There were at this time a number of difficult circumstances, mainly staffing difficulties, which impacted upon their capacity to care. It was, however, impossible to identify a system on Maple 1 (or indeed on Oak 2) which ensured planned, individual care at times when the 'Named Nurse' was not available. Much of the care appeared to be delivered on an ad hoc basis. This had implications as to how patients who were not on either continuous or regular observation were monitored and their whereabouts known.

Furthermore, the clear impression which emerged from all of the evidence submitted to the Inquiry by nursing staff was that the Named Nurse system was a system which existed in name more than in substance. It was not possible to discern from the records who was, in fact, the Named Nurse on either Oak 2 or Maple 1. It does not appear that a Named Nurse was allocated on Oak 2 prior to transfer, notwithstanding that part of the role of such a nurse would have been to visit Mr Mabota on Maple 1 to build up a relationship in anticipation of the transfer back to Oak 2.

Furthermore, the Named Nurse on Maple 1, Staff Nurse Wong, did not make any entries in the nursing notes throughout the 7 days that Mr Mabota was on Maple 1 ward. Mr Mabota himself was unaware that Staff Nurse Wong was his Named Nurse. Either this indicates that Staff Nurse Wong, as the Named Nurse, did not take any or any adequate steps to fulfil that role and seek to obtain information about Mr Mabota which might be of assistance to the medical staff from time to time, or his note taking was completely inadequate. In either case, there is a serious failing which should have been picked up by an effective system of clinical and managerial supervision.

Mr Buckman, the ward manager on Maple 1, told the Inquiry that there had been previous occasions when a Named Nurse had failed to make entries in the nursing notes over a period of days and that he had had to inquire into this. He also said that he had had occasion to speak to Staff Nurse Wong about *"bringing his records up to date"*. He did not, however, pick up the failure of the Named Nurse in this particular case, over a period of 7 days, to make any entry at all in the nursing notes.

We still do not know who was the Named Nurse allocated on Mr Mabota's return to Oak 2. The ward manager, Mr Mahadeo, believed it was Staff Nurse Senapati, but, in her evidence to the Inquiry, she said that this was not the case. At the time of the incident the old "Nursing Process" format was being used on both wards (although a different nursing model was then in operation). No space was provided on the form for the name of the "Named Nurse" and consequently it was not possible to identify the Named Nurse from the documentation.

We recommend that there should be a review of the working of the Named Nurse system and that steps should be taken to ensure that the purposes underlying the system are fully understood, so that the system operates otherwise than just in name.

Clinical Supervision

Clinical supervision provides support to the individual nurse - it facilitates reflective practice and ensures a patient-centred focus to care. It should not be confused with every day managerial oversight. A nursing model such as the "Named Nurse" is, of course, dependent upon the skills of the identified nurse for the planning and delivery of care.

The Panel feel, however, that clinical supervision was not systematically provided and that this contributed to the poor understanding and implementation of the Named Nurse concept in this case. If Staff Nurse Wong had had effective clinical supervision, it would have facilitated his interpretation of the Named Nurse role.

Information Supplied to Locums

We have already commented upon Dr Balasegaram's lack of proper understanding of the nature and extent of his responsibilities as the locum covering for Dr Duignan. It is relevant also to record that he was unaware of the interpreting facilities which were available at Claybury. We have already recorded above that it is the Panel's view that Dr Balasegaram was probably mistaken in his recollection that his interview with Mr Mabota was conducted in English, rather than through an interpreter, but the fact remains that Dr Balasegaram was unaware of the translation facilities which were available at Claybury. Clearly, there was some communication breakdown here. In addition to making locums properly aware of the nature and extent of their responsibilities, it seems to the Panel entirely sensible and obvious that locums should also be made aware of the availability of interpreting services throughout the hospital.

Audit

The Panel are also concerned by the absence of auditing procedures to check whether ward procedures were complied with. At the time of the incident there were no formal

mechanisms for ensuring that the documentation of care provided had reached and was maintained at a satisfactory quality standard or that policies and guidelines were adhered to.

Mr Malcolm Scott, who was formerly the Care Group Director, Mental Health Services, gave evidence to the Inquiry and informed us that "auditing" at this time was, in effect, no more than a response to problems on an ad hoc basis and that there was no systematic review of procedures. He explained that following managerial changes, the senior nurse structure had been "flattened" and he had no available person to regularly audit quality standards.

The consequence of this approach was that written procedures were not followed. To take one specific and relevant example, Mr Mahadeo informed the Inquiry that the procedure in relation to absent or missing patients was simply not followed. Checks were not carried out at each of the times specified in the written procedure. The absence of compliance with such procedures would have been readily identified had any form of systematic auditing been in place.

However, Geoff Smith, the Operational Director Mental Health Services, Forest Healthcare NHS Trust told us that he had recently created a post in Nursing Research and Development which will include the review and up-dating of ward procedures. The Panel regard this as an excellent initiative although we have doubts as to whether the task of auditing the procedures even in relation to only the mental health services provided by the NHS Trust can adequately be carried out by a single person.

We recommend that, in addition to auditing policies and procedures, the post-holder has an opportunity to audit current documentation and make improvements.

SUMMARY OF RECOMMENDATIONS

We recommend that:

1. (a) The practice of maintaining medical and nursing notes in different physical locations be discontinued - we consider it of paramount importance that the medical and nursing notes are unitary notes.

(b) There should be some system adopted for "flagging up" key information relevant to the assessment of possible risk to self or others.

2. In the event of a patient being transferred from hospital to hospital, the patient's notes ought to be transferred with that patient.

3. (a) Steps be taken to ensure that Nursing Care Plans are drawn up and re-evaluated on a regular basis, and in particular, to ensure that they incorporate recommendations made by medical staff; and

(b) That there should be a review of the working of the Named Nurse system and that steps should be taken to ensure that the purposes underlying the system are fully understood, so that the system operates otherwise than just in name.

4. In addition to auditing policies and procedures, the post-holder of the newly created post in Nursing Research and Development has an opportunity to audit current documentation and make improvements.

5. Steps be taken to establish standards of minimum competence for interpreting staff ensuring not only competence in the relevant foreign language but also a high degree of familiarity with the English language. There is a need for the clear identification of the competencies necessary for someone to be an effective interpreter in a psychiatric or mental health context.

6. Attempts be made to improve liaison and information exchange with the Police wherever possible and that staff be encouraged to make contact in appropriate cases.

7. Steps are taken to implement procedures to ensure that all medical staff, particularly locums being used to cover for existing medical staff, are fully aware of all relevant Operational Policies.

8. If and insofar as the system of regular attendance at ward rounds by Social Workers, with each ward having designated social work cover, does not presently operate, steps should be taken to revive this system.

9. Bus companies with services visiting psychiatric hospitals are advised of the potential risk of patients absconding and are asked to ensure that drivers are alert to the possibility of patients seeking to abscond by boarding one of their buses.

10. In the event of a serious incident, psychological support, de-briefing sessions or post traumatic stress counselling are co-ordinated and made available to the staff.

DRAMATIS PERSONAE

Dr Abbas	Locum Registrar Maple 1 Ward
Dr Al-Shalchi	The doctor who decided that Mr Mabota should be detained under Section 5(2) Mental Health Act 1983
Dr Balasegaram	Locum Consultant Maple 1 Ward (whilst Dr Duignan was on holiday)
Mr Bloomfield	Approved Social Worker Waltham Forest Local Authority Social Services
Dr Borrell	Registrar in Psychiatry and the duty doctor in the evening when Mr Mabota was admitted to Oak 2 Ward, and made the arrangements for the transfer to Maple 1 Ward.
Mr Brew	Staff Nurse on Maple 1 Ward who appeared to have a reasonable relationship with Mr Mabota
Mr Buckman	Ward Manager Maple 1 Ward
Dr Duignan	Consultant Psychiatrist Claybury Hospital With a geographical catchment area as well as the medical responsibility for all patients on Maple 1 at the time of the incident.
Dr Fagin	Consultant Psychiatrist With a geographical catchment area, who also had beds on Oak 2. He was also consulted by Dr Lewis when Dr Travers was on holiday
Dr Gavalas	A doctor who saw Mr Mabota in the accident and emergency department at Whipps Cross Hospital, and then discussed the case with Dr Sadana
Dr Lewis	Senior House Officer to Dr Travers
Mr Maicoo	Staff Nurse on duty at the time when Mr Mabota was admitted to Oak 1 Ward

Mr Mahadeo	Ward Manager Oak 2 Ward when Mr Mabota went missing and who was also the Senior Nurse on duty for the hospital
Detective Constable Pallas	Police Officer at Leyton Police Station who had requested that the police be informed when Mr Mabota was discharged
Dr Palazzo	A doctor at Whipps Cross Hospital who interpreted during the interview between Mr Mabota and Dr Sadana
Dr Sadana	Consultant Accident & Emergency Departrment Whipps Cross Hospital, who was responsible for Mr Mabota's care on admission when he had ingested the bleach
Ms Senapati-Sharma	The Staff Nurse in charge of Oak 2 at the time of Mr Mabota's admission (now known as Ms Senapati and is no longer working as a nurse)
Dr Singh	Clinical Assistant Liaison Psychiatry Whipps Cross Hospital, who carried out an assessment to detain Mr Mabota under Section 2 Mental Health Act 1983
Dr Staunton	Section 12 doctor who signed the Section 2 Mental Health Act 1983 papers
Dr W Travers	Consultant Psychiatrist Claybury Hospital Responsible for the geographical catchment area where Mr Mabota lived and therefore became the Responsible Medical Officer whilst Mr Mabota was an inpatient
Mr Wong	Staff Nurse and the Named Nurse for Mr Mabota whilst he was a patient on Maple 1 Ward

LIST OF WITNESSES INTERVIEWED

Mr Mabota	Subject of the Inquiry
Dr Abbas	Locum Registrar Maple 1 Ward - Claybury Hospital
Dr Balasegaram	Locum Consultant Maple 1 Ward - Claybury Hospital
Dr Borrell	Registrar in Psychiatry Claybury Hospital 1994
Dr Travers	Consultant Psychiatrist Claybury Hospital
Mr Brew	Staff Nurse Maple 1 Ward - Claybury Hospital
Mr Wong	Staff Nurse Maple 1 Ward - Claybury Hospital
Mr Ahgun	Staff Nurse Oak 1 Ward - Claybury Hospital
Ms Senapati - Sharma	Staff Nurse Oak 2 Ward - Claybury Hospital
Mr Buckman	Ward Manager Maple 1 Ward - Claybury Hospital
Mr Mahadeo	Ward Manager Oak 2 Ward - Claybury Hospital 1994
Mr Bloomfield	Social Worker London Borough of Waltham Forest
Ms Hawkes	Commissioning Director Mental Health & Learning Disabilities Redbridge & Waltham Forest Health Authority

Mr Mullins	Associate Director Mental Health & Learning Disabilities Redbridge & Waltham Forest Health Authority
Dr Sadana	Consultant Accident & Emergency Department Whipps Cross Hospital
Mr Scott	Care Group Director Mental Health Services Forest Healthcare NHS Trust (until April 1996)
Mr Smith	Operational Director Mental Health Services Forest Healthcare NHS Trust
Mr Spelman	Principal Manager Mental Health Services London Borough of Waltham Forest

LIST OF INQUIRY DATES

12 April 1996

15 May 1996

12 June 1996

13 June 1996

18 June 1996

19 June 1996

20 June 1996

21 June 1996

9 July 1996

16 July 1996

22 July 1996

24 July 1996

BACKGROUND READING

Hospital case note files for Mr Mabota whilst he was a patient in Whipps Cross Hospital and Claybury Hospital	Forest Healthcare Trust
Mental Health Policies and Procedures	Forest Healthcare NHS Trust
Operation Policy Maple 1 Ward - Amended October 1993 and May 1994	Forest Healthcare NHS Trust
Mental Health Act Commissioner's Reports and Responses 1993/4/5 Claybury Hospital	Forest Healthcare NHS Trust
Internal Memorandum Mr Mabota Inquiry from Dr Travers to the Operational Director dated 21/02/96	Forest Healthcare NHS Trust
Mental Health Strategy: January 1994	Redbridge & Waltham Forest Health Authority
Mental Health Contract: 1994/95 1996/97	Redbridge & Waltham Forest Health Authority
Purchasing Framework for Forensic/Secure Mental Health Services 1995/96	Redbridge & Waltham Forest Health Authority
Community Care Plan 1992 - 1995	London Borough of Waltham Forest
Report on Mental Health Strategy 1994	London Borough of Waltham Forest
Mental Health Task Force Plan 1994/5	Redbridge & Waltham Forest Health Authority London Borough of Waltham Forest
Your Guide to New Mental Health Services 1995	Redbridge & Waltham Forest Health Authority London Borough of Waltham Forest

Healthcare Case Note Files of Mr Mabota	HMP Prisons Pentonville Belmarsh Wormwood Scrubs
Medical Reports prepared for Mr Mabota's Trial Proceedings	Central Criminal Court 1995
The Code of Pursuant To The Mental Health Act of 1983 - 1993	
Guidance on the Discharge of Mentally Disordered People and Their Continuing Care in The Community	NHS Executive HSG (1994)27
The Care Programme Approach for People with a Mental Health Illness referred to the Specialist Psychiatric Services	Health and Local Authorities Circular 1990
Building Bridges - a guide to arrangements for inter-agency working for the care and protection of severely mentally ill people	Department of Health 1995
Finding a Place - A Review of Mental Health Services for Adults	Audit Commission 1994
Risk Taking in Mental Disorder - Analysis, Policies and Practical Strategies	Edited by David Carson SLE Publications 1990
The Report of the Inquiry into the Care and Treatment of Christopher Clunis	North East and South East Thames Regional Health Authorities 1994
Learning the Lessons Mental Health Inquiry Reports published in England and Wales between 1969 and 1994 and their recommendations	The Zito Trust 1995

Report of the Confidential inquiry into Homicides and Suicides by Mentally Ill People	The Royal College of Psychiatrists 1996
The Grey Report	East London and the City Health Authority 1995
The Hampshire Report	Redbridge & Waltham Forest Health Authority 1996
Clinical Supervision and Mentorship in Nursing	Butterworth, C.A., Faugier J. 1992