IN THE LAMPARD INQUIRY

FURTHER TO A REQUEST UNDER RULE 9 OF THE INQUIRY RULES 2006

WITNESS STATEMENT OF
REBECCA HILSENRATH KC (HON)

I, Rebecca Hilsenrath KC (Hon), will say as follows:

1. I am the interim Parliamentary and Health Service Ombudsman ("**PHSO/Ombudsman**") and Accounting Officer to Parliament for the PHSO, appointed on 18 April 2024. Prior to taking up the role of Ombudsman, I was the Chief Executive Officer of the PHSO from June 2023.

2. I make this statement in response to the Inquiry's Rule 9 Request.

3. The Inquiry's terms of reference establish the relevant period for this Inquiry to be between 1 January 2000 and 31 December 2023 and so my tenure as Ombudsman falls outside this period. Accordingly, my level of knowledge of certain matters occurring during the relevant period is limited and my predecessor Sir Rob Behrens CBE is better placed to assist the Inquiry given his contemporary access. Much of the evidence provided by Sir Rob in his witness statement to the Inquiry will provide the answers to the Inquiry's questions in their Rule 9 Request to me. I have had sight of Sir Rob's witness statement and understand its contents to be true to the best of my knowledge. Accordingly, save as set out below, I refer the Inquiry to Sir Rob's statement on the basis that the governance, procedures, and contemporary findings and conclusions during the relevant period, have not changed since my appointment.

4. I take the opportunity here to supplement the evidence given by Sir Rob.

5. <u>Emerging Concerns Protocol</u>

5.1. Sir Rob refers in his witness statement [RB Statement/Paragraph 16 - 19] to organisations that the Ombudsman works with, including the work undertaken by the participants of the Emerging Concerns Protocol.

5.2. In late 2024, following consultation on the terms of reference with members of that forum, it was agreed to merge the Emerging Concerns Protocol Group with the Health and Social Care Regulators Forum Thematic Group. The first combined meeting took place on 21 January 2025.

6. <u>Mental Health Case Summaries – Essex</u>

6.1. As can be seen in Sir Rob's statement [RB Statement/Paragraph 26], we have identified roughly 28,000[1] mental health complaints made to us since 2011, which is as far back as our records are available within the relevant period. Of those 28,000 we closed 1,233 cases relating to an Essex based NHS organisation. As is set out in those sections of Sir Rob's statement dealing with procedure [RB Statement/Paragraphs 37 - 59], cases can be closed on a number of different bases, spanning from marking the complaint as premature or not properly made, to the conclusion of a detailed investigation upholding the complaint.

6.2. I have presented in an Annex to this statement (RH/01) further information from Essex for which we have sufficient data over the relevant period. (this is to follow).

6.3. The final investigation reports will be of primary interest to the inquiry secretariat. However, we have included associated decision letters for investigations where we have them for transparency. The exhibits relate to all available detailed mental health investigations carried out by PHSO in relation to Essex NHS Trusts over the relevant period.

7. Post Covid Jurisdictional Development

7.1. As can be seen from the data, there has been a rough upward trend in the volume of mental health related complaints from year 2011/12 to year 2023/24, opening at 1,769 cases per year and closing at 2,558 cases per year. Within this period, the sharpest spike in cases year to year came between 2018/2019, with 1,976 cases and 2019/2020 with 2,401 cases, and we have attributed this to the impact of the Covid pandemic on the CQC's capacity to undertake mental health related investigations and to our own internal development of procedures to accommodate the increased demand for investigations in mental health related care. Specifically, on 11 May 2020, the CQC amended its intake of Mental Health Act cases to prioritise complaints received from or about people detained on an inpatient ward at the point of contact[2].

7.2. However, it is important to note that this spike appears to have levelled off in subsequent years and should be read within the context of an increase already prevalent, not only in mental health cases but across the gamut of complaints about the health service and government departments and agencies, which is clearly not attributable to the pandemic.

8. Health and Care Act 2024

8.1. Sir Rob referred in his statement to the concern initially felt with the establishment of the Health Service Safety Body as part of the then Health and Care Bill. The 'safe space' provisions within the Act, it was feared, might hamper our ability to access relevant information. However, in practice we have found to date that this has not had

[1] 27,891
[2] CQC has made changes to Mental Health Act complaints process | Care Quality Commission

a noticeable impact on our ability to investigate, as we retain our powers to compel production of evidence from the relevant health organisations directly.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

I/S

Rebecca Hilsenrath KC (Hon)

Date: 21 March 2025