1 April 2025

IN THE LAMPARD INQUIRY

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

SUPPLEMENTAL WITNESS STATEMENT
OF
REBECCA HILSENRATH KC (HON)

---

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

   I make this statement to supplement my earlier statement of 21 March 2025 in response to the Inquiry's further questions. For the sake of clarity, this statement takes the form of direct answers to those questions, which form the subheadings below.

2. Beyond the Inquiry's relevant period (2000-2023), has PHSO identified continuing systemic failures in Essex mental health inpatient care?

In the financial year 2024 to 2025, PHSO has received 75 complaints related to Essex Partnership University NHS Foundation Trust and 76 complaints related to North East London NHS Foundation Trust.

3. Are there trends in post-2023 complaints data that suggested ongoing risks?

At the time of submission of this statement, there are no additional completed investigations where we have found failings and upheld or partly upheld elements of a complaint. We are therefore not able to comment on evidence of continuing systemic failings in Essex mental health care beyond the relevant period of the inquiry.

4. What was the reasoning behind merging the Emerging Concerns Protocol with the Health and Social Care Regulators Forum Thematic Group?

4.1. On a practical level, it is hoped that bringing together the two groups will reduce the potential for duplication of discussion and encourage proactive discussion on thematic issues of interest across members. By incorporating the ECP discussions into the forum, it is hoped that there will be more organic consideration of where a thematic interest area could generate an early indicator of a need to trigger the Emerging Concerns Protocol based on insight from other members.

A. Has the merger improved or weakened information-sharing on systemic risks?

4.2. The first meeting of the merged group took place in January 2025 so it is too early to say whether or not there will be a radical change in information sharing on systemic risks.

B. Were any stakeholders opposed to the merger, and if so, on what basis?

4.3. CQC led on the consultation on Terms of Reference for the newly combined group. As participants, we are not aware of any opposition to the merging of the groups.

5. Of the 1,233 closed cases relating to Essex NHS organisations, what proportion were upheld or led to recommendations?

Of the 139 Detailed Investigations:

- 15 were upheld
- 50 were partly upheld

5.1. Do these cases indicate recurring systemic issues, and if so, what are the key themes?

From a rapid analysis of the upheld and partly upheld investigation reports, we have seen the following key themes:

- poor complaint handling at trusts when incidents have occurred, including an example of where the serious incident process had not been correctly followed
- poor record keeping, including in terms of discharge care plans, records which were found to be inaccurate or errors in correspondence to patients and carers
- poor referral and discharge planning
- some findings of poor medication management, including monitoring of side-effects
- some findings of misdiagnosis and poor assessments, including risk assessments.

6. Beyond the 2020-2021 spike in complaints did PHSO observe lasting effects on mental health inpatient care oversight?

6.1. We can only comment on the number of complaints we receive relating to mental health inpatient care and the issues being complained about. We set this out in detail below and in the annual complaint figures set out in paragraph 4 of Sir Rob Behren's supplementary statement.

A. Have pre-pandemic failures worsened, improved or remained unchanged?

6.2. As stated in my first witness statement, we see only those issues that people bring to us as complaints. I am not aware that there has been a significant change in the sort of issues that people complain to us about. The recurring failures identified in our investigations into mental health complaints over the years have not noticeably changed. For example, our (pre-pandemic) 2018 report 'Maintaining momentum: driving improvements in mental health care', included case studies of complaints about:

- Diagnosis and failure to treat (e.g. missed diagnoses),
- Risk assessment and safety,
- Dignity and human rights,
- Communication, and
- Inappropriate discharge and provision of aftercare.

6.3 In our (post-pandemic) 2024 policy report Discharge from mental health care: making it safe and patient-centred we looked at complaints where we found failures in the discharge and transitions in care from emergency and inpatient mental health settings. The failures we identified related to:

- Patient, family and carer involvement
- Record keeping, and
- Communication.

6.4. A recent in-depth analysis of our mental health related complaints from September 2023 onwards shows a similar trend in failures related to:

- Communication (with families, carers and patients)
- Record keeping
- Discharge and provision of aftercare.

7. While you state PHSO's ability to compel evidence remains intact, have any practical challenges emerged due to safe space provisions? Are there instances where access to key evidence was restricted?

Thus far, we have not encountered any practical challenges due to safe space provisions. We continue to monitor the situation.

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: 1 April 2025