1 April 2025

IN THE LAMPARD INQUIRY

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

SUPPLEMENTAL WITNESS STATEMENT
OF
SIR ROB BEHRENS CBE

I, Sir Rob Behrens CBE, will say as follows:

1. I make this statement to supplement my earlier statement dated 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. Any questions left unanswered in this statement have been responded to within the covering letter.

2. **Did PHSO encounter difficulties in obtaining evidence from mental health providers in Essex?**

   We do not routinely flag in our casework management systems if there have been challenges in obtaining evidence from providers. In the case of our investigations into Matthew Leahy and the case of Mr R, which formed the basis of our 'Missed Opportunities', we do not recall particular difficulty in gathering evidence from the Trust. The Trust cooperated throughout the investigations and made staff available for interview when requested.

3. **Were PHSO's statutory powers sufficient to properly investigate Essex mental health care failures? If not, what limitations prevented more effective scrutiny?**

   Although PHSO's existing legislation provides us with similar powers to a statutory inquiry including the ability to compel evidence and witnesses, we do not have the powers of own initiative investigation. Any investigations we undertake must be based upon a complaint submitted to PHSO. We can only investigate aspects complained about and within the scope of the complaint which is agreed between PHSO and the complainant. As PHSO is the Ombudsman and therefore the last resort, even if an issue is in the public interest to investigate, we cannot investigate it until the relevant complaint is brought to us after it has completed the local complaint resolution process.

4. **The statement does not fully answer Rule 9 questions 14-15 regarding complaint data. Can you provide a more detailed breakdown of mental health complaints, including:**

a. How many were accepted and investigated (and to what stage)?

b. How many were upheld or led to formal findings?

2011 – 2012:

- 1769 complaints were identified as relating to Mental Health
- 742 were closed at primary investigation stage
- 30 were accepted for detailed investigation
- 33 detailed investigations were concluded
- We upheld 16 complaints
- We partly upheld 7 complaints

2012 – 2013

- 2054 complaints were identified as relating to Mental Health
- 817 were closed at primary investigation stage
- 33 were accepted for detailed investigation
- 26 detailed investigations were concluded
- We upheld 11 complaints
- We partly upheld 8 complaints

2013 – 2014

- 2026 complaints were identified as relating to Mental Health
- 482 were closed at primary investigation stage
- 383 were accepted for detailed investigation
- 194 detailed investigations were concluded
- We upheld 26 complaints
- We partly upheld 46 complaints

2014 – 2015

- 2290 complaints were identified as relating to Mental Health
- 347 were closed at primary investigation stage
- 421 were accepted for detailed investigation
- 394 detailed investigations were concluded
- We upheld 39 complaints
- We partly upheld 105 complaints

2015 – 2016

- 2250 complaints were identified as relating to Mental Health
- 471 were closed at primary investigation stage
- 463 were accepted for detailed investigation
- 385 detailed investigations were concluded
- We upheld 32 complaints
- We partly upheld 119 complaints

2016 – 2017

- 2123 complaints were identified as relating to Mental Health
- 419 were closed at primary investigation stage
- 409 were accepted for detailed investigation
- 462 detailed investigations were concluded
- We upheld 41 complaints
- We partly upheld 127 complaints

2017 – 2018

- 2011 complaints were identified as relating to Mental Health
- 408 were closed at primary investigation stage
- 259 were accepted for detailed investigation
- 308 detailed investigations were concluded
- We upheld 36 complaints
- We partly upheld 82 complaints

2018 – 2019

- 1976 complaints were identified as relating to Mental Health
- 616 were closed at primary investigation stage
- 146 were accepted for detailed investigation
- 166 detailed investigations were concluded
- We upheld 8 complaints
- We partly upheld 48 complaints

2019 – 2020

- 2401 complaints were identified as relating to Mental Health
- 642 were closed at primary investigation stage
- 95 were accepted for detailed investigation
- 134 detailed investigations were concluded
- We upheld 7 complaints
- We partly upheld 64 complaints

2020 – 2021

- 1942 complaints were identified as relating to Mental Health
- 377 were closed at primary investigation stage
- 46 were accepted for detailed investigation
- 61 detailed investigations were concluded
- We upheld 8 complaints
- We partly upheld 34 complaints

2021 – 2022

- 2234 complaints were identified as relating to Mental Health
- 761 were closed at primary investigation stage
- 18 were accepted for detailed investigation

- 57 detailed investigations were concluded
- We upheld 5 complaints
- We partly upheld 28 complaints

2022 – 2023

- 2257 complaints were identified as relating to Mental Health
- 741 were closed at primary investigation stage
- 63 were accepted for detailed investigation
- 67 detailed investigations were concluded
- We upheld 9 complaints
- We partly upheld 38 complaints

2023 – 2024

- 2558 complaints were identified as relating to Mental Health
- 806 were closed at primary investigation stage
- 65 were accepted for detailed investigation
- 64 detailed investigations were concluded
- We upheld 13 complaints
- We partly upheld 34 complaints

5. **Can you provide specific examples of when PHSO shared findings with regulators (CQC, NHSE, etc.) regarding Essex mental health services?**

5.1. We note two specific examples from our upheld and partly upheld cases of where we had shared our investigation report directly with CQC or NHS Monitor (predecessor to NHS England). These are cases 177402 and 237691. Case 237691 (partly upheld, 2017) relating to failings in care at the Linden Centre specifically and missed opportunities to mitigate the risk of an individual committing suicide. We asked for the report to be shared with CQC because there had been CQC reports of a similar incident in 2012 which suggest some of the same problems persisted at the Trust.

5.2. Following our publication of 'Missed Opportunities' we shared the individual investigation reports (Mr Leahy and Mr R) with NHS England and NHS Improvement. This was intended to inform their review of mental health care in Essex which was a recommendation of our policy report. Our investigation report into Mr Leahy's death was also shared with the General Medical Council and Nursing and Midwifery Council for information only.

a. In those cases, did regulators act on PHSO recommendations, or were any ignored, delayed or resisted?

5.3. As demonstrated in evidence RB10, following the publication of our 'Missed Opportunities' report, NHS England and NHS Improvement highlighted the findings to all mental health trusts. NHS England and NHS Improvement again committed to

undertaking a review of trust leadership and culture following the conclusion of the Health and Safety Executive investigation.

b. How did any lack of action by regulators impact patient safety or systemic oversight?

5.4. As detailed in paragraphs 5.1 – 5.2 above, we have noted examples of where we had identified similar failings to those previously reported by CQC in earlier investigations.

5.5. In broader terms beyond the Essex cases, there is a well-recognised 'implementation gap' – the difference between what we know improves patient safety and what is done in practice. The NHS is an incredibly complex and sometimes fragmented system, making it challenging to embed changes to working practices and cultures.[1]

5.6. More than a dozen different health and care regulators all play important roles in patient safety but there are significant overlaps in functions, which create uncertainty about who is responsible for what. This means patient safety voice and leadership are fractured. This is not due to a lack of dedication and professionalism from those tasked with championing patient safety. The problem is structural.[2]

6. Specify whether mental health providers acted on PHSO recommendations, particularly in Essex.

I have provided details of compliance levels in my earlier statement; I have no other details that I am able to add to this.

7. Were there instances of non-compliance, and if so, what were the consequences?

In the case of non-compliance, PHSO has the powers to lay an investigation report before Parliament and, by doing so, ask Parliament to intervene in holding Government or the relevant body to account for action on our recommendations. As an example of our response to non-compliance, in January 2022 we laid a report before Parliament of our investigation into the Department for Work and Pensions' (DWP) handling of migration to Employment and Support Allowance. We found that the DWP's decision to not offer compensation to those affected was inconsistent with its own Principles for Remedy guidance.

8. Specifically regarding the Mr. R and M. Leahy cases, were PHSO's recommendations implemented in full? If not, what actions were taken?

8.1. The usual process was for the caseworker to check if compliance had been completed and if satisfied, the case would be closed.

8.2. As explained previously, we do not hold all of the records. However, we understand that in the case of Mr M the standard monitoring and reminder letters we sent to the Trust in advance of the deadlines for compliance to be completed, the Trust responded to notify

[1] Broken trust: making patient safety more than just a promise, p. 12
[2] Broken trust: making patient safety more than just a promise, p. 39

us that this was in hand. As part of the compliance the Trust sent the apology letter to the complainant with the financial remedy around 6 March 2017. We received a letter around 10 May setting out the actions to be taken for service improvements. Around 22 May, the caseworker then emailed the Trust confirming we had reviewed this and were satisfied with what it. We are not able to find all the notes around this as the case management system where further details would have been recorded has been replaced and we were not able to retain all the information it held.

8.3. In the case of Mr Leahy, this was closed on 11 June 2019 and we allowed 2 months for compliance. The Trust sent an apology and the evidence of the financial remedy to us on 25 June 2019 and an action plan on 9 August 2019. The caseworker requested clinical advice to assess compliance and asked the Trust for all the policy docs referenced in its action plan on 21 August 2019. The Trust sent the policies on 29 August 2019 and the documents allayed some concerns our clinical adviser had about the action plan. There were still a couple of points the caseworker wanted the Trust to clarify, and I asked it to provide more information on 25 September 2019. The Trust responded on 4 October 2019 and we closed compliance on 7 October 2019.

9. Are there statistics or research on how often PHSO recommendations are accepted and implemented by NHS providers?

9.1. We monitor compliance on an individual recommendation made basis. For clarity, compliance on recommendations may crossover multiple financial years. The reportable period for compliance data is limited due to a change in casework management system in 2019/20.

In financial year, 2020-21:

- We made 615 recommendations on health investigations.
- We closed 422 recommendations as complied with.
- We closed 2 recommendations as not complied with.

In financial year, 2021-22:

- We made 836 recommendations on health investigations.
- We closed 733 recommendations as complied with.
- We closed 1 recommendation as not complied with.

In financial year, 2022-23:

- We made 866 recommendations on health investigations.
- We closed 805 recommendations as complied with.
- We closed 1 recommendation as not complied with.

In financial year, 2023-24:

- We made 984 recommendations on health investigations.
- We closed 736 recommendations as complied with.
- We closed 6 recommendations as not complied with.

In financial year, 2024-25 (up to Period 11) – Cleansed figures only available after financial year end:

- We made 1038 recommendations on health investigations.
- We closed 992 recommendations as complied with.
- We closed 2 recommendations as not complied with.

10. Can you confirm whether Essex exhibited uniquely severe failings compared to other regions? Or were similar systemic issues present nationally, indicating a broader regulatory failure?

10.1. From the figures provided in paragraph 25 of my first statement, the inquiry can see that cases related to Essex were on average 5% of our cases related to mental health received by PHSO between 2011 and 2023.

10.2. In our complaints received about Essex trusts discharge is a relatively common theme and we know that complaints around poor discharge planning and process are seen in our broader mental health casework. We highlighted this in our February 2024 publication, 'Discharge from mental health care: making it safe and patient-centred' which I have shared with the inquiry for its consideration.

10.3. Poor communication between patients, families and carers during treatment and also through the complaints process itself is also a common theme in our Essex complaints. We know issues with communication are often at the core of many of our complaints across our NHS and government jurisdiction. Communication is key for effective and safe care. Arguably clear and transparent communication is even more pivotal in scenarios where someone may be under the care of the state through sections of the Mental Health Act or when being cared for in more longer term residential settings such as inpatient mental health units.

10.3. Linked to communication issues, poor record keeping is also often seen in our mental health casework more broadly. We again highlighted this as a key aspect of delivering safe and patient centred care in our 2024 publication, 'Discharge from mental health care'.

11. Based on PHSO's investigations, do you believe a statutory inquiry is necessary to fully examine the systemic failures in Essex mental health care?

Without the powers of own initiative investigations and because PHSO was only able to investigate the issues that had been brought to us in complaints, a public inquiry is well placed to undertake a broader strategic view of all the issues that had emerged in various investigations. The power to compel witnesses and evidence is important to ensure that the inquiry can fully ascertain what had happened.

12. Given PHSO's investigatory limitations, do you believe only a statutory process can fully address the systemic failures in Essex?

12.1 As I state in paragraph 9 above, PHSO sees overwhelming compliance with our recommendations even though the recommendations are not legally binding. I believe that this also ensures we are able to adopt a less adversarial approach to investigation which does not seek to place blame on individuals for failings but instead place emphasis on accountability for systems to learn from mistakes.

12.2. It is key that the statutory inquiry is able to make recommendations which are pertinent, practical and relevant to the way mental health services operate in Essex and nationally today. The inquiry must hold relevant bodies to account for implementing and acting in the spirit of any recommendations made and reflect upon mechanisms for ensuring that learning is embedded beyond the life-course of the inquiry.

13. Did PHSO receive any complaints related to Oxevision technology in Essex mental health inpatient settings?

13.1 From a rapid analysis of upheld and partly upheld investigations, we do not have evidence of complaints relating to Oxevision technology.

13.2 From a rapid analysis of summaries of complaints received (including those where we did not conduct a detailed investigation), Oxevision is not named as a component of complaints.

14. Did PHSO investigate Oxevision's impact on patient monitoring or safety?

Please see my response in paragraph 13 above.

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]

Sir Rob Behrens CBE
Date: 1 April 2025