Sir Rob Behrens CBE
Former Parliamentary and Health Service Ombudsman

Witness Statement

I believe that the facts stated in this witness statement, consisting of 34 pages, 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.

PRELIMINARIES:

1. My name is Sir Rob Behrens CBE. I was the Parliamentary and Health Service Ombudsman (Ombudsman) from 6 April 2017 to 27 March 2024. I was also the Chair of the unitary Board which is in place to improve the governance of the organisation. I was also the Accounting Officer and was accountable to Parliament for the stewardship of our resources.

2. The information provided within this witness statement relates to the period during which I was the Health Ombudsman.

THE ROLE OF THE PHSO:

3. The role of PHSO (the organisation) was set up by Parliament. It combines the two statutory roles of Parliamentary Commissioner for Administration (the Parliamentary Ombudsman) and Health Service Commissioner for England (Health Service Ombudsman). The PHSO's powers are set out in the **Parliamentary Commissioner Act 1967** (RB/01) and the **Health Service Commissioners Act 1993.** (RB/02)

4. The PHSO is not part of the Government or the NHS in England. It is independent and impartial. However, the PHSO is accountable to Parliament and its work is scrutinised by the Public Administration and Constitutional Affairs Committee of the House of Commons.

5. The PHSO service is free for everyone, and it investigates complaints where someone (or a group) believes there has been injustice or hardship because an organisation in jurisdiction, being one of the organisations set out at Schedule 2 to the Parliamentary Commissioner Act 1967 (RB/01), and sections 2, 2A and 2B of the Health Service Commissioners Act 1993 (RB/02), has not acted properly or fairly, or has given a poor service, and has failed to put things right.

6. Under the law, a person has to try to resolve their case by other available means before their complaint can be investigated by the PHSO's office. The PHSO is the point of last resort for complainants that have not been resolved by the NHS in England, UK government departments, and/or other UK public organisations.

7. As Health Ombudsman, the PHSO can look at administrative issues of maladministration and has the power to make judgements about clinical advice and acts of the clinicians who are complained about.

8. There is, however, a limit to the PHSO's powers. The PHSO is not allowed to look at issues that have not been complained about.

9. Whilst I had a statutory responsibility for individual cases, in order to ensure that the extensive casework was managed within a defined system of appropriate oversight, I put in place a detailed scheme of casework delegated authority and appointed two Deputy Ombudsman officers: the Chief Executive and the Director of Operations, Clinical and Legal. I also gave authority for case activity to

officers in a written delegation scheme. However, I acted personally in complex cases and where we identified serious or repeated mistakes that may have had system-wide relevance.

10. The Policy, Strategy & Public Affairs Team looked at themes, trends and systemic issues in the case work that the PHSO handled. They would consider the best way to share the learning from those cases externally.

GOVERNANCE AND MANAGEMENT STRUCTURES:

11. The Board, chaired by the Ombudsman, is made up of executives and non-executives. Its core purpose is to make collective decisions on the organisation's strategic direction and performance. The Board scrutinises overall performance of casework, but not individual cases.

12. I delegated executive responsibility to the Chief Executive for effective financial control arrangements. I discharged my responsibility through assurance from the Accountable Officer and the Executive Team, and through assurance and challenge by the Board, the Audit and Risk Assurance Committee, the Quality Committee, the Remuneration and Nominations Committee and the Inclusion and Wellbeing Committee.

WHO THE PHSO WORKS WITH:

13. The PHSO is a member of the **Health and Social Care Regulators Forum.** The Chief Executives of the bodies considered to be health or social care regulators or ombudsman organisations sit around the table;

    a. Care Quality Commission (also a body within our jurisdiction)
    b. General Dental Council
    c. General Medical Council
    d. General Optical Council

e. General Osteopathic Council
f. General Pharmaceutical Council
g. Health and Care Practitioners Council
h. Local Government and Social Care Ombudsman
i. NHS England & NHS Improvement
j. Nursing and Midwifery Council
k. Professional Standards Authority
l. Social Work England

14. NHS England used to sit on it, but it does not do so anymore.

15. The Forum is designed to ensure that where there is a common set of concerns, there is a formal procedure for bodies to come together and agree a way forward. Together with my senior team, I used to be able to pick up the phone to the other bodies and ask them whether they had anything on a particular issue, on which we had a number of cases, and ask what they had been doing to support the system.

16. As part of this partnership, the PHSO also participates in the **Emerging Concerns Protocol**. This is a mechanism intended to allow any member regulator or oversight body to share concerns about a particular health or social care provider, sector, or service area and, if appropriate, consider whether joint action is justified to address the risks to people who use services.

17. The Emerging Concerns Protocol was developed under the governance of the Health and Social Care Regulators Forum in October 2016.

18. The protocol strengthened existing arrangements, providing a clear mechanism for raising concerns and ensuring a collaborative approach to proposed actions.

19. Due to PHSO's position as the complaint handler of last resort, in practice, most of the issues raised via this Protocol are likely to have been identified before they reach PHSO. PHSO is bound by strict statutory rules about sharing information before any investigation we conduct has concluded. Before attending any Regulatory Review Panel, PHSO needs to decide whether to attend based on the likelihood that the issue being raised may come to us as a future complaint.

20. The Care Quality Commission provides the secretariat to the **Health and Social Care Regulators Forum** and chairs the **Emerging Concerns Protocol.**

21. The PHSO also engages regularly with other oversight bodies such as NHS Resolution, the National Audit Office, and the Equality and Human Rights Commission. Whilst Ombudsman, I was able to communicate with Forum members and other relevant parties (see below, paragraph 22) where I had concerns and ask whether or not those concerns resonated with them. This was useful because these bodies do a lot of work around accreditation and standard setting.

22. In addition to engaging with membership of the HSCRF, PHSO also engaged regularly with other key stakeholders including:

- NHS England
- NHS Resolution
- Health Services Safety Investigations Body (HSSIB) (formerly Healthcare Safety Investigation Branch)
- National Audit Office
- Ombuds schemes in the devolved nations and internationally (including through membership of the Ombudsman Association)
- Parliamentary Select Committees
- Government departments (as bodies within our jurisdiction)

- Third sector organisations (through our Research, Outreach and Insight work)
- Advocacy organisations

23. In March 2024, our Clinical Advice and Policy team also had an introductory meeting with the secretariat for the Ministerial Council on Deaths in Custody (MCDC). The council comprises a number of tiers including a Ministerial Board, Independent Advisory Panel on Deaths in Custody (IAPDC) and a Practitioner Group.

24. The secretariat advised us that the IAPDC were intending to step-up work on the investigation of deaths and serious incidents for those detained under sections of the Mental Health Act. The secretariat was interested in how other bodies in the patient safety landscape can learn from PHSO best practice and any recent mental health policy work conducted by PHSO. We shared our PHSO-led NHS Complaint Standards and our February 2024 'Discharge from mental health care' policy publication.

25. Being independent enhances our role in supporting improvement, by working in partnership and (where necessary) being extremely robust.

NUMBER AND TYPES OF COMPLAINTS RECEIVED

26. In a non-Covid year, the PHSO's office would expect to receive in excess of 100,000 enquiries from the public, mainly relating to health service issues. However, there are a growing number of enquiries about parliamentary issues year on year.

PHSO received the following number of complaints from financial year commencing 2011 up to the end of financial year 2024:

2011 – 2012:

23846 complaints received in total of which **14615** were complaints falling into our health jurisdiction. **1769** complaints were identified as relating to Mental Health.

- **29** complaints were received related to North East London NHS Foundation Trust.
- **20** complaints were received related to North Essex Partnership University NHS Foundation Trust.
- **28** complaints were received related to South Essex Partnership University NHS Foundation Trust.

2012 – 2013:

26961 complaints received in total of which **16341** were complaints falling into our health jurisdiction. **2054** complaints were identified as relating to Mental Health.

- **34** complaints were received related to North East London NHS Foundation Trust.
- **15** complaints were received related to North Essex Partnership University NHS Foundation Trust.
- **55** complaints were received related to South Essex Partnership University NHS Foundation Trust.

2013 – 2014:

27566 complaints received in total of which **17964** were complaints falling into our health jurisdiction. **2026** complaints were identified as relating to Mental Health.

- **47** complaints were received related to North East London NHS Foundation Trust.
- **26** complaints were received related to North Essex Partnership University NHS Foundation Trust.
- **53** complaints were received related to South Essex Partnership University NHS Foundation Trust.

2014 – 2015:

28189 complaints received in total of which **19535** were complaints falling into our health jurisdiction. **2290** complaints were identified as relating to Mental Health.

- **52** complaints were received related to North East London NHS Foundation Trust.
- **19** complaints were received related to North Essex Partnership University NHS Foundation Trust.

- **52** complaints were received related to South Essex Partnership University NHS Foundation Trust.

2015 – 2016:

28936 complaints received in total of which **21306** were complaints falling into our health jurisdiction. **2250** complaints were identified as relating to Mental Health.

- **58** complaints were received related to North East London NHS Foundation Trust.
- **27** complaints were received related to North Essex Partnership University NHS Foundation Trust.
- **36** complaints were received related to South Essex Partnership University NHS Foundation Trust.

2016 – 2017:

31444 complaints received in total of which **23130** were complaints falling into our health jurisdiction. **2123** complaints were identified as relating to Mental Health.

- **39** complaints were received related to North East London NHS Foundation Trust.
- **66** complaints were received related to Essex Partnership University NHS Foundation Trust.

2017 – 2018:

32305 complaints received in total of which **24616** were complaints falling into our health jurisdiction. **2011** complaints were identified as relating to Mental Health.

- **36** complaints were received related to North East London NHS Foundation Trust.
- **40** complaints were received related to Essex Partnership University NHS Foundation Trust.

2018 – 2019:

29264 complaints received in total of which **22539** were complaints falling into our health jurisdiction. **1976** complaints were identified as relating to Mental Health.

- **47** complaints were received related to North East London NHS Foundation Trust.
- **42** complaints were received related to Essex Partnership University NHS Foundation Trust.

2019 – 2020:

31365 complaints received in total of which **24560** were complaints falling into our health jurisdiction. **2401** complaints were identified as relating to Mental Health.

- **42** complaints were received related to North East London NHS Foundation Trust.
- **53** complaints were received related to Essex Partnership University NHS Foundation Trust.

2020 – 2021:

24842 complaints received in total of which **18727** were complaints falling into our health jurisdiction. **1942** complaints were identified as relating to Mental Health.

- **36** complaints were received related to North East London NHS Foundation Trust.
- **39** complaints were received related to Essex Partnership University NHS Foundation Trust.

2021 – 2022:

36248 complaints received in total of which **26907** were complaints falling into our health jurisdiction. **2234** complaints were identified as relating to Mental Health.

- **40** complaints were received related to North East London NHS Foundation Trust.
- **54** complaints were received related to Essex Partnership University NHS Foundation Trust.

2022 – 2023:

35103 complaints received in total of which **26565** were complaints falling into our health jurisdiction. **2257** complaints were identified as relating to Mental Health.

- **48** complaints were received related to North East London NHS Foundation Trust.
- **39** complaints were received related to Essex Partnership University NHS Foundation Trust.

2023 – 2024:

36886 complaints received in total of which **27479** were complaints falling into our health jurisdiction. **2558** complaints were identified as relating to Mental Health.

- **56** complaints were received related to North East London NHS Foundation Trust.
- **64** complaints were received related to Essex Partnership University NHS Foundation Trust.

27. In terms of the split between mental and physical health providers, the PHSO receives disproportionately fewer complaints about mental health providers.

28. In terms of jurisdiction, complaints related to mental health care and treatment fall under the remit of four organisations including PHSO:

    a. CQC considers complaints about how powers or duties have been carried out under the Mental Health Act
    b. Local Government and Social Care Ombudsman (LGSCO) considers complaints about the actions of individuals employed by local authorities such as approved mental health professionals
    c. Mental Health Act Tribunal gives individuals the right to apply to ask if they can be discharged from a section
    d. PHSO considers complaints about care and treatment commissioned or delivered by the NHS in England.

29. Our view is that if you have a mental health condition that requires inpatient care, then you are likely to be quite unwell. Therefore, a complaint is unlikely to be a priority for you or your family and, once you leave, you had much to sort out. This view is supported by the 2019 YouGov poll looking specifically at mental health (RB/03) .[1] The PHSO also published an insight report, Maintaining Momentum: driving improvements in mental health care. (RB/04)

[1] Survey of experiences of NHS mental health care in England | Parliamentary and Health Service Ombudsman (PHSO)

30. In 2018, we completed a detailed qualitative analysis of a sample of 200 complaints about mental health care and treatment. These complaints related to periods of care in the preceding years. We published our findings in **Maintaining Momentum** (RB/04) We found that five key themes were common to many of the failings we found in our investigations of these complaints:

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

31. A number of the issues we identified in this analysis are consistent with those seen in the complaints we received about the former North Essex Partnership Trust, such as the failure to adequately manage environmental risks and risks relating to patients' suicidal feelings, which compromised the inpatients' safety. For example, no adequate risk assessment was conducted before Mr Leahy was granted ward leave.

32. However, the former North Essex Partnership Trust was distinctive in that it demonstrated a failure to learn from extremely serious past errors. One of the key reasons PHSO decided to publish **Missed Opportunities** (Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust) (RB/05) was the tragic similarities in the failings in the care of Mr R and Mr Leahy, four years apart. It is, sadly, not uncommon to see evidence of failings being repeated in the complaints we see about the NHS (not only in mental health settings, but elsewhere, as we highlighted in a recent PHSO report about patient safety failings in

relation to NHS imaging). It was, however, unusual to see such grave errors being repeated, as the Trust seemingly failed to act on the learning from Mr R's death in terms of risk assessment and safety.

33. Our investigations also highlighted concerns about the quality of investigations carried out by the former North Essex Partnership Trust. This was of particular concern for the same reason that the Trust failed to learn from its mistakes. We have found poor quality investigations in a number of other cases.[2] (RB/06)

34. Given our concerns, we were pleased to see the new national **Patient Safety Strategy** (RB/07) and accompanying **Patient Safety Incident Response Framework** (RB/08) focus on improving the quality of local investigations. While the former North Essex Mental Health Trust was particularly notable for its failure to act on the learning from Mr R's tragic death, complaints about mental health care or other healthcare in Essex do not appear to indicate a disproportionate number of failings across the country as a whole. I must emphasise, however, that the nature of PHSO's role means we will only ever see a limited and partial picture of the quality and safety of care in any sector, service, or geographical region. We see only those issues that people bring to us as complaints, and the pattern of issues raised in these complaints do not necessarily mirror those which are known to be significant or recurrent issues more generally. This means that PHSO's casework evidence can help provide insights into the quality and safety of care, but on its own it cannot provide a comprehensive picture.

35. To put it another way, although we can provide data about the number or type of complaints we've received about care in Essex, this data is likely to be much more meaningful when considered in the context of more comprehensive information held by others, such as NHS Digital,

[2] Ignoring the alarms: How NHS eating disorder services are failing patients

the Care Quality Commission, providers, commissioners, patients, and families.

36. To provide an illustrative example, we have received very few complaints relating to concerns about mistreatment or inappropriate segregation or seclusion of people with a learning disability, autism, or mental health condition in long-term inpatient settings. This is despite a series of significant concerns raised by programmes such as the BBC's Panorama and a thematic review by the Care Quality Commission. Over the next period PHSO plans to carry out some further research to better understand why some people may face barriers to PHSO's service due to their circumstances or background, so we can help improve access to justice for marginalised individuals and communities.

THE PROCEDURE – See Annex D (RB/21) for further summary as well as Service Model Policy Guidance (RB/22):

37. Whilst I was the Health Ombudsman the procedure was as follows:

(a) Receiving the Complaint:

38. First a person would contact the PHSO's **'Intake Team'** with an enquiry. The enquiry could initially be made in writing (by post, webform, or email) or via the helpline. We researched and compiled a report, Making Complaints Count, (RB/09) in 2020 which looked at the state of local complaint handling across the NHS and UK Government departments including people's experience in complaining. This contextualised the Intake Team's work.

39. The Intake Team would then consider whether or not the enquiry amounts to a complaint. If it is a complaint, we would **make sure it**

was in writing because, by law [Section 9 (2) of the Health Service Commissioner Act 1993] (RB/02), for something to be considered a complaint, it has to be in writing.

40. The Intake Team would then **make some checks to see if it was within PHSO's jurisdiction**. Broadly speaking, if it is a complaint about a mental health trust then it is probably within the PHSO's jurisdiction. However, if it is a complaint about a retailer (a private sector body), it is probably not in PHSO's jurisdiction. Often enquiries need to be directed elsewhere.

(b) Primary Investigation:

41. If, at first glance, it appeared to be within the PHSO's jurisdiction, then the PHSO's office would carry out a **primary investigation**. The PHSO's office accepts around a quarter of the enquiries made in any given year and initiates a primary investigation. During this stage, we decide if we can resolve the complaint quickly without further investigation.

42. The primary investigation could take a number of different routes:

    a. The **first step** was to consider whether or not the complaint was definitely something the PHSO could and should look at. For example, we could look at an issue with care inside a mental health trust, but we could not look at an issue that's to do with a member of staff's employment at that mental health trust.

        i. During this step, we would consider whether the complaint was in time. The complaint usually has to have come to the PHSO's office within a year of the complainant becoming aware of it, but the PHSO can use their discretion when considering that.

ii. The PHSO's office had to consider whether it was a suitable complainant. The person or group making the complaint had to be directly affected by it. If they were simply member of the public who thought that it was an issue of concern but was not directly affected by it, then, generally, that member of the public was not an appropriate complainant in law.

iii. The PHSO's office had to consider whether there was an alternative legal remedy (an alternative route to achieve the desired outcome) that was reasonable to pursue. If there was, then that complainant needed to be directed elsewhere.

b. We then considered whether there was a way the service user could satisfactorily resolve the complaint quickly. The process of making the complaint and reliving it is very stressful. The sooner one could give a complainant an outcome the better.

i. There was a dedicated team that looked at mediation. Mediation is an alternative process to investigation to help complainants and organisations reach a mutual resolution. The Ombudsman does not reach a decision or offer outcomes as part of mediation. Our role is to facilitate a meeting ensuring both sides can both listen and be heard. Mediation is especially useful when there is an ongoing relationship to rebuild. Specially trained caseworkers work with complainants and organisations to prepare attendees and provide an understanding of the mediation process before attending the mediation

meeting. We have seen the positive impact of mediation skills within standard casework investigations, ensuring the most important complaint issues are identified with appropriate desired outcomes. This has resulted in better targeted investigations and mutually acceptable resolutions providing more timely outcomes at the appropriate stage of investigation. This allows more complex cases to be identified and reach allocation sooner.

43. This primary investigation stage could involve a lot of detailed work. We could request expert advice from independent clinicians to determine the appropriateness of clinical decisions which were the subject of a complaint. Also, we could request legal advice on a range of issues, for example on questions around whether a person is suitable to bring a complaint, whether the complaint is in time and the scope of the complaint. Potential alternative legal remedies were also reviewed which would preclude PHSO from considering a complaint further.

44. In some cases, we might close a complaint without moving onto the next stage. This would be the case where having looked at the evidence, we find something did not go wrong. In some cases we were able to work with the complainant and the organisation complained about to reach a mutually agreeable outcome.

(c) Detailed Investigation Stage:

45. If, for any reason, the PHSO was unable to resolve the complaint at the preliminary investigation stage, it moved onto the **detailed investigation stage** if it met all the criteria for further investigation which includes if it is clear at the Primary Investigation (PI) stage that

there are indications of maladministration and there are indications of an unremedied injustice that have not been resolved at the PI stage.

46. . A much smaller number of complaints reached this stage. In financial year 2023 to 2024, PHSO accepted 840 complaints for detailed investigation related to NHS organisations. PHSO accepted 53 complaints for detailed investigation related to UK Government departments and agencies.

47. PHSO's aim is for a caseworker to stay with the case throughout the whole process, for the purpose of continuity, and (should it reach that point) that same caseworker would check for compliance.

48. The caseworker would agree the scope of the investigation (what it will cover) with all parties. We would also make reasonable adjustments throughout the process. For example, if somebody wanted to meet face to face, or if they wanted transcripts of meetings, or if they wanted to talk to us and for us to write it down, we would make all those adjustments to try to be as accessible as possible.

49. The entire investigation stage is private, as a matter of law [Section 11 (2) Health Service Commissioner Act 1993] (RB/02). Therefore, whilst a case is open, we cannot talk about potential findings t even if we want to. There are some very small exceptions to that, namely in the interests of the health and safety of a patient (s15(1)(e) HSCA 1993) (RB/02). This might include where PHSO may need to take steps to alert another body, such as a regulatory body. but generally we cannot talk about the open cases.

50. PHSO has relatively extensive powers to call for evidence. It would gather and evaluate all information needed to decide on the matter agreed in the scope. This included evidence from the complainant and

organisation, and any specialist legal or clinical advice. However, PHSO is constrained by the so-called principle of 'safe space' for clinicians. The Health and Care Act 2022 made provisions for the establishment of the Health Service Safety Investigation Body (HSSIB) with its own 'safe space' for evidence gathered for its investigation. This 'safe space' excludes PHSO unless by agreement with the High Court. Disclosure of information held by HSSIB in this area is prohibited to most public bodies including PHSO.

(d) Provisional Views:

51. PHSO shares emerging thinking with parties before we share our written Provisional Views when the end of the detailed investigation stage has been reached. The Provisional View is a way of gathering together the relevant information and our provisional analysis of it in a form that enables the parties to input into it, mainly by offering views on the proposed analysis or providing further information.

52. Parties comment on the report, and can even submit new evidence. Sometimes the comments or evidence provided off the back of the Provisional View can result in the continuation of the investigation if the caseworker establishes there is further evidence required.

(e) Formal Finding:

53. At the end of this stage, PHSO makes a **formal finding**; It either formally upholds or does not uphold the complaint. Formally upholding means all of the following three things must have been found:

    a. There was maladministration (i.e. something went wrong/ there was a service failure),

b. There was an injustice or hardship (i.e. the service failure negatively affected the person), and
c. That injustice or hardship has not been put right.

54. It was common for someone to complain about something that has a number of different components. The PHSO could uphold some of those components and not others.

55. PHSO writes to the complainant and the organisation complained about to let them know.

(f) Recommendations:

56. If the PHSO upheld a complaint, it would then consider what the body in jurisdiction should do to put it right and make a **recommendation** towards that end. The recommendation could include explanations, apologies, financial redress, and recommendations for learning and improvement. PHSO would give a timescale for implementing that recommendation and explain how it would assess whether or not it has been complied with.

57. If the complaint was about an NHS provider organisation, PHSO would ask for the report to be shared with the Care Quality Commission (CQC). If the complaint was about Clinical Commissioning Groups (CCGs), then PHSO would ask for the report to be shared with NHS England. The purpose is so that those oversight bodies can take the information into account in their regulation and oversight.

58. PHSO also shares findings from its casework with Parliament (and more widely), to help Parliament scrutinise public service providers and to help drive improvements in public services and complaint handling.

59. It is important to note that **the PHSO does not have binding powers.** The PHSO has no power to enforce its recommendations. However, in approximately 99 percent of the cases (2021-22) that it made recommendations about compliance, these were agreed to and carried out by the body in jurisdiction. In this area PHSO had a high press profile and published summaries of cases (protecting the anonymity of the complainants but making it clear what the body in jurisdiction was).

THE CASES OF Mr R AND Mr LEAHY

60. We had procedures in place for handing cases if we considered them to be particularly complex cases or if they were indicative of systemic issues. Such cases were personally overseen by the ombudsman or one of our deputy ombudsman officers.

Mr R's Case

61. The complaint about Mr R's care was brought to the PHSO in October 2015. The investigation began in November 2015 and was closed in February 2017., before I became Ombudsman. Due to the age of this case, by the time I looked into it, we only held limited information about this investigation. We had two changes of digital systems after the investigation closed and, in line with PHSO's records retention policy, only the final decision report was retained after two years had elapsed.

62. In terms of managing our data and getting the balance right between retaining records but not holding onto people's personal data longer than we should, our policy was - once a case was closed, we held on to the records for two years only. After two years had elapsed, only the final

decision report was retained unless, for example, there was a separate inquiry and then we retained it.

Mr Leahy's Case

63. Ms Leahy brought her complaint about Mr Leahy's care to the PHSO in March 2015. PHSO commenced the investigation in June 2015. The scope of the investigation was extended substantially at a later date. Further issues were added again later in the investigation as Ms Leahy presented new information. The changes in scope extended the length of the investigation as the PHSO considered new evidence and new lines of inquiry. The case was closed in June 2019.

64. Ms Leahy's complaint was overseen by me once I became Ombudsman.

65. PHSO did not have serious difficulties with the Trust in terms of being denied evidence. It made staff available for interview and it responded readily to our enquiries during the investigation. This may have been because there had been a merger and a change of status with the Trust – the name had changed, and people had moved on – which meant that people felt less of a sense of ownership over what had happened. However, the Trust's retention policy meant that they no longer had a record of some evidence that we asked for and that was compounded by the Trust's poor record-keeping.

66. What shocked me was the failure to care for Mr Leahy appropriately. We found 19 different instances of maladministration, which is unusual. The Trust got significant amounts of their care wrong:

    a. They broke their own rules about care planning.
    b. They failed to properly risk assess and manage on the issues of the suicide possibility. The physical availability of ligatures

had been pointed out by a number of bodies on a number of occasions.

c. They failed to properly look after Mr Leahy's physical care.
d. They used a rapid tranquiliser routinely rather than as a last resort.
e. They were supposed to allocate a key worker to Mr Leahy, but the key worker only found out some days after she had been allocated and shortly before she was due to go on leave.
f. They did not observe Mr Leahy or engage with him in the way that they were supposed to have done.
g. They did not follow up his allegation of rape.
h. They lost and falsified paperwork.
i. When they wrote up the investigation about what happened, that was done by the person who later falsified the care plan.
j. The Trust had not been open and honest with Ms Leahy about the progress they had made in acting on the learning from previous investigations and inquiries.
k. There was, in summary a near-complete failure of the leadership of this trust, certainly before it was merged. This was an indictment of the health service

67. The case demonstrated repeated and serious service failure to a young man who was in a very vulnerable position.

68. We found that there were different accounts of what had happened in the last couple of hours before Mr Leahy was found in his room. There was one witness who gave an account during interview that Mr Leahy was agitated in the period before he was found. The witness claimed that they had told a nurse that they had heard Mr Leahy saying that he was going to kill himself and that the nurse had dismissed this. The witness claimed to have told a manager after Mr Leahy was found dead

and claimed he was told to "keep schtum" and not tell anyone. We sent a transcript of the interview to the witnesses, but it took a very long time for the witness to come back to us. However, ultimately the witness did confirm the notes of the interview.

69. There were other members of staff who offered different accounts, saying that Mr Leahy was not acting in an unusual way and that he did not appear agitated. The nurse, who the witness referred to above had allegedly spoken with the witness about Mr Leahy on 15 November, and the ward manager, were interviewed separately and confidentially. The nurse was interviewed at the Trust premises with the Trust's solicitor present. The ward manager was interviewed at PHSO's Millbank office with their union representative. They also gave different accounts about what had happened. In fact, none of the parties had a shared view of Mr Leahy's behaviour and who had said what to whom. Therefore, even on the balance of probabilities, we were unable to make a decision about what really happened, which we know was very difficult for Mr Leahy's family.

70. We made a series of recommendations in our report. We recommended that EPUT should, within two months:

    a. Write to Ms Leahy to provide a full and final acknowledgement of the failings identified in this report (see paragraph 307) and the distress this caused her.
    b. Apologise for the distress caused by the information NEP sent in February 2015 about the extent of the safety changes made.
    c. Make a payment of £500 to Ms Leahy in recognition of the distress caused by the receipt of the inaccurate information.
    d. Write to Ms Leahy to provide a detailed summary of the action that has or will be taken to help prevent a recurrence of the failings we have identified, together with any further

action planned to address the ongoing concerns noted in the most recent CQC inspection in respect of its acute psychiatric wards. EPUT should also explain how it will measure and report on the effectiveness of these changes.

e. Send a copy of the above information to us.
f. Send a copy of our investigation report and the information sent to Ms Leahy to NHS Improvement and CQC.

71. When it came to our recommendations, the fact that so many other things were going on at the same time – a police investigation and a Health and Safety Executive (HSE) investigation – instilled a degree of circumspection about whether or not to call for a public inquiry at that time.

72. There was demonstrable and very serious service failure across a range of issues. However, the parallel police and HSE investigations were still on-going. Further, because of the restricted mandate of PHSO we had only seen part of what had happened at NEP through our own investigations. These had looked at incidents that took place at single points in a much longer timeline. As a result, PHSO was not (at the time) best placed to look at the much broader issues of overall culture and leadership at the Trust over the ten-year timeline which stretched to several years before the death of Mr R.

73. In summary, PHSO had to be careful that it was not making recommendations without knowing the wider and emerging picture. PHSO also gradually became aware that there was a wider picture of death and wider systematic failures - such as the fact that the Trust had failed to learn from countless, previous investigations, inspections, etc – which were out of scope of our complaint We could only investigate the issues brought to us within complaints received which were not

necessarily the same as issues that had been highlighted in previous reports on failings such as those undertaken by CQC.

74. From what we could see, this was not a Trust that had lacked help and support. It. It was not just about how the oversight system operated. It was also the leadership in the Trust. The 2016 CQC inspection report (eight years on from Mr R's death and four years on from Mr Leahy's) had identified serious failings persisting around the assessment and management of risks for fixed ligature points, as well as the training and awareness of NEP staff about past mistakes. The merger of NEP with South Essex Partnership University NHS Foundation Trust (SEP) in April 2017, which saw the formation of the Essex Partnership University NHS Foundation Trust (EPUT), led to an improved grip on the systemic failings and avoidable deaths spanning decades.

75. One of the things that was eventually uncovered was that there had been a number of Freedom of Information requests to the hospital to disclose the numbers and circumstances of the suicides that had taken place over a particular period and the Trust said it did not have the information and it would be too expensive to pull it together. As we knew that the HSE was still investigating and because we had talked to NHS England Improvement about the issues, we felt that the best option, albeit not the preferred option, was to recommend that there be a wider inquiry. This recommendation was formally made in our 'Missed Opportunities' report publication. In September 2019, NHS England and NHS Improvement committed to undertaking this review as soon as the HSE concluded their investigation.[3] (RB/10) The review would be led by the regional NHSE and NHSI team in line with PHSO's recommendations.

[3] See 'NHS England and NHS Improvement letter to Chief Executives, Medical Directors and Directors of Nursing - Mental Health Trusts, 3 September 2019', provided as evidence

MISSED OPPORTUNITIES AND THE AFTERMATH:

76. At the point we decided to proceed with the report that became known as **Missed Opportunities**, (RB/05) we had been looking further at the complaint about Mr Leahy's death for some time and our investigation into Mr R's death had concluded.

77. When the caseworker spoke to two senior managers of the Trust to explain that we were likely to publish **Missed Opportunities**, (RB/05) the Trust felt that the publication had come as a surprise to them. At this point the Trust was aware that we were considering publishing Ms Leahy's complaint, but had not expected PHSO to publish a report that considered Mr R's case as well, as that case had closed some time previously. I understand that this meeting was difficult. Ultimately the Trust was cooperative but it had a number of concerns (e.g. about media attention) and it took some time for them to understand why we were publishing.

78. When the report was published the Trust did not challenge it and they agreed to meet our recommendations

79. The Report indicated that the Trust had, at the time, attempted to distort what had happened. It was an attempt to routinise and normalise the deaths of young people in a way that led to falsehoods and denials in a flawed institutional setting.

80. PHSO raised the issues with the Cabinet Office. I did an interview for ITV as part of the dissemination of the Report. I also ensured I provided enough evidence for the Public Administration and Constitutional Affairs Committee (PACAC) to hold a one-off inquiry on the report in Parliament. This might enable the Committee to raise awareness of the serious issues in the policy system The Committee took our report very

seriously and called it 'excellent' report, which gave it further credibility. Alongside PHSO's '**Missed Opportunities'** (RB/05) report, evidence was submitted by NHS England, the Care Quality Commission, the Department of Health and Social Care and the Leahy family. The Minister for Mental Health was called to give oral evidence.

81. We argued that there had been a complete failure of leadership on this issue, that the culture was flawed and there had been little or no learning. One solution which was subsequently proposed as part of a programme of wider NHS improvement was to develop the PHSO-led **Complaint Standards Framework**[4] (RB/11) which sets out benchmarks, good practice and professional development for bodies in jurisdiction seeking to improve their own complaint handling processes.

82. I was also of the view that there now needed to be a public inquiry with the power to undertake a strategic view of all the issues which had emerged in multiple inquiries and with the power to compel witnesses to cooperate in ascertaining what had happened.

SETTING STANDARDS FOR COMPLAINT HANDLING

83. The process of making a complaint can itself be a source of further harm for families because of the response they receive from NHS organisations. The act of making a complaint requires a great deal of determination and energy because it is very challenging for patients and families to navigate the complex NHS landscape when they want to raise concerns and seek answers. This is, especially the case given that complainants are often in a vulnerable condition resulting from service failures or even bereavement. PHSO frequently saw examples of unacceptable and unreasonable delays in responding to complaints and failure to keep families informed and updated about the progress

[4] NHS Complaint Standards: Summary of expectations | Parliamentary and Health Service Ombudsman (PHSO)

of their case. Families we interviewed for our June 2023 policy report, **Broken Trust[5],** (RB/12) described the process of trying to resolve their complaint with Trusts as *'long and tortuous', 'a long, dragging sequence of events'* and *'very lengthy and distressing'*.

84. We worked with a wide range of Trusts and stakeholders to co-produce the **NHS Complaint Standards**, (RB/11) which was launched in 2021, to support organisations to provide a quicker, simpler and more streamlined complaint handling service. The Standards set out how NHS services should approach complaint handling. This included welcoming complaints in a positive way by clearly publicising how people could raise complaints in a range of ways that suit them and met their specific needs. It also included ensuring people knew how to get advice and support when they a make a complaint, for example, through sharing details of appropriate independent complaints advocacy and advice providers and any Patient Advice Liaison Service (PALS) and other support networks.

85. The Standards apply to NHS organisations in England and independent healthcare providers who deliver NHS-funded care. Building on good practice where it already exists, they provide a consistent approach to complaint handling across the NHS. The PHSO offered advice and training to support the roll out of the Standards.

86. In 2022, we published the **UK Central Government Complaint Standards[6]** (RB/13) developed in collaboration with central Government departments, other public bodies, and advice and advocacy groups.

[5] Broken trust: making patient safety more than just a promise, June 2023
[6] UK Central Government Complaint Standards - summary of expectations

87. NHS complaints processes are another opportunity for learning that can prevent future harm. PHSO's 2020 report, **Making Complaints Count**[7], (RB/09) examined the state of complaint handling across the NHS and UK Government. The report highlighted that public bodies still tend to view complaints negatively, rather than as a valuable source of intelligence that can be used to improve services. This can lead to responses that lack compassion and are characterised by defensiveness rather than a willingness to listen and learn.

ARE THE ISSUES/FAILINGS CONFINED TO ESSEX?

88. I do not believe that these issues are confined to Essex or even to a particular institution in Essex.

89. As Health Service Ombudsman, I visited hospitals, Trusts, and surgeries and talked to as many service users and stakeholders as I could at all levels in private and public meetings across the country. I know from visiting secured institutions that it is an additionally stressful environment for the staff as well as for the patients. The defensive disposition of NHS leaders, the sub-optimal culture in the NHS, the often negative experience of staff, the under resourcing of mental health care, and the use of bank and temporary staff, are all key issues.

90. PHSO's own evidence from reports we have researched and published from surveys we have commissioned including our 2019 Mental Health survey (RB/03) suggests that the issues are all generic to mental health care. A 'closed culture' of poor working culture and practices risk causing harm to patients and affect a service's ability to respond when things do go wrong. Settings that care for people who may be less able to advocate for themselves, such as inpatient mental health wards, are

[7] (HC 390) - Making Complaints Count- Supporting complaints handling in the NHS and UK Government Departments.pdf

at even greater risk of this. The failings we see in PHSO's mental health casework are symptomatic of services that have lacked the necessary political prioritisation and real will for radical change. The lack of traction in bringing about reform to the Mental Health Act is a testament to this. Here there is confirmatory evidence from the CQC, professional regulators, and from patient groups and family groups that supports this position.

91. Roughly 90 NHS trusts piloted our Complaint Standards. There is now understanding that people have to be trained in order to get them to act professionally, and that leaders have a responsibility to change the culture and to take complaints handling into account.

92. I used to go around the country and talk to boards and Chief Executives, and many would tell me that they were a joined-up institution fully committed to resolving complaints. Then I would talk to complaints handlers, clinicians and people who were not on the leadership team. They would describe a situation far from joined-up and far from sensitive to service user opinion. This is a big cultural weakness in the NHS.

IMPROVEMENTS:

93. Improvements to mental health services:

    a. The complaint about Mr R's care was brought to PHSO in October 2015. The investigation began in November 2015 and was closed in February 2017. Due to the age of this case, we hold only limited information about this investigation, in line with PHSO's records retention policy
    b. In Mr Leahy's case, CQC had found: that the management of environmental risks had improved significantly, but safety risks including ligature points were still found on some

wards, not all patients had a detailed risk assessment, lessons from incidents were not always identified or shared and, while the vast majority of patient records contained an adequate care plan and physical health assessment, care plans did not always address patients' physical health needs. We recommended that the Trust should write to Ms Leahy to provide a detailed summary of the action that it had or would take to help prevent a recurrence of the failings we identified. This should be sent together with any further action planned to address the ongoing concerns noted in the most recent CQC inspection in respect of its acute psychiatric wards. EPUT should also explain how it will measure and report on the effectiveness of these changes.

c. Our **Missed Opportunities** (RB/05) report argued that the cases referenced should have prompted significant action from Trust leadership as to why learning had not taken place at the NEP for so many years and change had only started once the leadership of the newly merged Essex Partnership University NHS Foundation Trust (EPUT) started to drive improvement. The primary recommendation made was that NHS Improvement should conduct a review of what went wrong at the North Essex Partnership University NHS Foundation Trust, focusing on patient safety, culture and leadership and that this learning should be disseminated with the wider sector and relevant stakeholders.

94. In terms of the role and powers of the PHSO, I led a 2021 study of 57 Ombudsman schemes in 38 countries for the International Ombudsman Institute.[8] (RB/14) This enabled comparison between the powers available to national Ombudsman schemes internationally, and

[8] The Art of the Ombudsman: leadership through International Crisis | Parliamentary and Health Service Ombudsman (PHSO)

those available to the Ombudsman in the United Kingdom. The following changes, entirely compatible with **the Venice Principles**[9], (RB/15) the Venice Commission's landmark guiding document for national Ombudsman schemes, should be made to the jurisdiction of PHSO:

a. **The PHSO should have, like all major national European national Ombudsman schemes the power of 'own initiative' or 'own motion'. This would allow the PHSO to undertake strategic investigations without having had a complaint from an individual.** If PHSO had had this power during the investigation into the death of Matthew Leahy, it could have conducted a timely investigation into all the deaths in the Essex hospital he died in, not just those cases where families of the deceased complained. This would have saved the wasted public money on the failed independent public inquiry set up, and possibly this current public inquiry.

b. The PHSO is not allowed to look at issues that have not been complained about and that is a weakness in the governance arrangements of PHSO, particularly in terms of mental health or ageing and vulnerable communities generally because they are least likely to complain. When PHSO looked at two critical cases at London House, it was aware that there were a number of other deaths which people had not complained about.

c. **There should be a single, joined-up national public service Ombudsman in line with the Venice Principles, ,**

[9] Principles on the protection and promotion of the Ombudsman institution

international practice, and with the legislation concerning devolved Ombudsman schemes in Wales, Scotland and Northern Ireland. This would raise public awareness of the Ombudsman concept, and therefore do a good deal to enhance public access to administrative justice. It would also join together Ombudsman oversight of health (currently under the jurisdiction of PHSO) and social care (currently under the jurisdiction of the Local Government and Social Care Ombudsman.)

d. **Complaints concerning the Parliamentary context should not have to go through an MP filter in which complaints about central government matters must first go to the complainants local Member of Parliament.** The 'filter' prevents a direct relationship between the complainant and the Ombudsman. This is an 'iniquitous' provision which PHSO and select committees have campaigned to get rid of for at least 25 years without success.

e. **Complaints should not have to be in writing.** Legislation underpinning our service should allow people to complain to us in the most suitable way for them. This should not be in writing only as this discriminates against people who may find it difficult to communicate their experiences of care in this way, including:
    a. people living with severe mental health conditions
    b. people with specific accessibility needs
    c. people who do not have English as their first language.

f. **Complainants should not be barred from complaining to PHSO if they have brought legal action**.

95. The PHSO has no power to enforce recommendations, unlike a small number of counterparts in other countries. I do not think having a binding power necessarily helps because a binding power becomes justiciable, and – as we have seen in South Africa - ends up in expensive and contentious litigation, and leads to a judicialization of the process. When I was Ombudsman, in about 97 per cent of the cases that we made recommendations about compliance, they were agreed to and carried out by the body in jurisdiction.

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.

Signed I/S

Dated 21 March 2025