Witness: Stuart Wallace

IN THE MATTER OF THE INQUIRIES ACT 2005

Statement No: 2

AND IN THE MATTER OF THE LAMPARD INQUIRY

Exhibits: 2

Date of Statement: 25/03/2025

Second Statement of Stuart Wallace

Report by:	Stuart Wallace
Position:	Data Protection Officer / Senior Lawyer
Qualifications:	LLB (hons) LLM PGDip

I, Stuart Wallace, Data Protection Officer/Senior Lawyer at St Andrew's Healthcare, Billing Road, Northampton, NN1 5DG will say as follows:

1. I have been qualified as a solicitor for 13 years and have been employed at St Andrew's Healthcare ("St Andrew's") since August 2015. I am currently employed as the Charity's Data Protection Officer and Senior Lawyer. In the course of my employment at St Andrew's, I have had oversight of all inquests.

2. I make this statement in response to the Inquiry's request of 21 January 2025 for evidence pursuant to Rule 9 of the Inquiry Rules 2006 for Information concerning Findings of Neglect and/or Prevention of Future Death (PFD) Reports, Responses and Related Records of Inquest in respect of Deaths falling within the Inquiry's Scope.

3. I have set out below the Inquiry's questions (set out in Roman numeral numbering and in bold text) and the responses on behalf of St Andrew's to each question:

I. How many PFD Reports were received by St Andrew's Healthcare in relation to mental health inpatient deaths (as per the Inquiry's definition of inpatient) during the Relevant Period?

4. I have personal knowledge that St Andrew's Healthcare has received no PFD reports in relation to deaths relating to its Essex hospital since 2015. I can find no documentary evidence of St Andrew's receiving a PFD report before this date. This is not because of an absence of records, but because the majority of the deaths have been expected and have concluded with the coroner returning a conclusion or verdict of natural causes. In relation to deaths relating to pre-2015, I reviewed the available patient files, the legal shared folders and shared inbox which holds information dating back to around 2010. I could not find any evidence that a PFD had been received in relation to any death at the Essex hospital prior to 2015.

5. St Andrew's electronic records are made up of a number of structured and unstructured data stores. The electronic records relating to patients are made up of a series of structured databases, principally Rio (the primary EPR system), EMIS (a physical healthcare system),

EPMA (electronic prescribing system) and Datix (a patient safety system). Most patient information is now electronic with any hard copy documents being scanned and saved in Rio or kept in on premises files. Prior to patient records being electronic a project was undertaken to digitise hardcopy files and destroy paper copies. The Charity therefore holds very few paper copy files, but some do remain in a physical archive in Northampton awaiting destruction. Due to the short deadline provided by the Inquiry it has not been possible to undertake any physical searches for hardcopy documents.

6. There are also other systems that store patient information, such as patient finance and food ordering. There are then a number of other systems for different functions, such as HR and payroll, estates and facilities and procurement. Each department also has space on a shared drive where documents can be saved and each individual has their own space where information can be saved. Most of this data is unstructured.

7. For the avoidance of doubt, I can confirm that St Andrew's Healthcare has received PFD reports in relation to its other hospitals and non-Essex patients and therefore subsequent questions posed by the inquiry have been answered on the basis of the processes followed with these deaths.

II. Please provide a breakdown of PFD Reports received per year during the Relevant Period, and a copy of each Report. Please provide a copy of every PFD Report received and any related Record of Inquest ["ROI"]. If copies are not available, please explain why.

III. Please provide copies of all responses and any accompanying documentation that St Andrew's Healthcare provided with these responses. If copies of responses and/or any accompanying documentation are not available, please explain why. Where it is unclear whether a response was sent, please state this.

IV. The Inquiry would also be assisted by the provision of documentation referred to within the above responses, where it did not accompany the response but might help the Inquiry's understanding of any action taken. This is not an exhaustive request, but the Inquiry would be assisted by the following types of documents: amended action logs, induction packs, aide- memoires, internal protocols, investigation reports, and learning briefings. For the avoidance of doubt, the Inquiry is not – at this stage – seeking disclosure of any material that is publicly available or email chains relating to the actioning or implementation of such changes.

V. If St Andrew's Healthcare is in possession of the responses from others to whom a PFD Report was sent, please provide copies of those responses.

VI. In the event that there was no response to a PFD Report by St Andrew's Healthcare, please explain why.

VII. Please identify whether a particular topic of concern raised within a PFD Report had been raised in a previous PFD Report received by St Andrew's Healthcare.

8. St Andrew's has no relevant information to share with the Inquiry in relation to enquiries II to VII for the reasons provided at paragraphs 4 and 5 above.

VIII. Please set out the process(es) by which St Andrew's Healthcare has dealt with and will continue to deal with PFD Reports and any related ROIs – both historically and presently. Please explain who was in the past, and who is now responsible for ensuring PFD Reports and any related ROIs are properly processed, shared if necessary, and responded to, and what internal processes were, and are currently, in place for their review and

implementation. In particular, explain how St Andrew's Healthcare has monitored the implementation of actions taken in response to PFD Reports to ensure their effectiveness and sustainability. How have PFD Reports and any related ROIs been fed upwards, for example, to the Charity's Directors? Please explain how organisational systems and processes for responding to PFD Reports – recording any related ROIs –have evolved over time, including any improvements in governance, communication or accountability, and indicate where these have worked well.

9. There are a number of processes in place at St Andrew's to ensure the outcome and learnings from inquests and PFDs reach the wards as well as the Board.

10. Usually St Andrew's has on average around fifteen live inquests at any one time. The majority of inquests relate to older adult patients cared for in St Andrew's Healthcare's neuropsychiatric services who have illnesses such as frailty, dementia, Alzheimer's or Huntingdon's disease, complex physical health conditions, and are on End of Life Care Pathways. The vast majority of deaths only require an inquest to be held because the patient is detained under the Mental Health Act 1983 and therefore the patient is in custody or otherwise in state detention for the purposes of the Coroners and Justice Act 2009.

11. All of the inquests are managed by a central legal team who liaise with clinical colleagues across the organisation. Following an inquest, a memo outlining the conclusion, PFD decision and issues that were evident during the inquest are shared with the ward team and executive team.

12. Once the memo is circulated we hold debrief meetings with ward teams and divisional senior management to run through learning points from the inquest. At these meetings the clinical management teams will consider if any actions need to be included on the ward and divisional quality improvement plans. Any issue that affects services across the organisation will then be added to the charity-wide quality improvement plan. Responsibility and oversight for these plans is overseen by the Chief Quality Officer and the Quality team that sits under him.

13. A quarterly Legal performance report is provided to the Executive team, which amongst other updates includes information on all of the upcoming inquests and concluded matters. This report has been instigated in the last year to ensure that the Executive team have oversight of a number of legal matters, including all inquest matter from an operational reporting line.

14. In terms of the committee structure, the Mortality Surveillance Group has oversight of patient deaths within St Andrew's Healthcare. This committee considers the mortality reviews undertaken for each patient death, which includes an update from the Legal team on inquest matters. The Mortality Surveillance Group then reports into the Quality and Safety Committee, which is a board committee that presents an update at board meetings.

15. Additionally, the Legal team also prepare an update for the Chief Executive on inquest matters that is included in her board paper that is considered in the closed session of the board meetings.

16. One of the Charity's Deputy Medical Directors has responsibility for inquests and the Legal Team has a monthly catch up with him to discuss any issues that have arisen at inquests. He then has accountability for considering these issues across the organisation.

17. Should there be learning from a clinical incident, St Andrew's will usually have identified these lessons before an inquest takes place. St Andrew's has a learning lessons group and a number of communication channels with frontline staff, such as a weekly must read newsletter, must watch video, red top alerts, messages on computer locked screens, a staff Facebook group, an intranet site, and posters. The communication mode used will depend on the severity of the risk and the group of staff to whom the message is aimed. Should a risk of an issue be deemed to be high, communication of this risk will be through a number of communication channels in order to reach as wide an audience as possible, but in an organisation with around 4,000 employees it is not possible to ensure centrally that every message has been properly received by every colleague.

18. The Charity has a Quality Management System that will include monitoring recommendations from SI reports and learnings from inquests. As part of this system each clinical division (the Essex hospital is one division) has a Quality Matron whose role it is to improve and monitor the quality of the clinical services in the particular division. One of the aims of these changes is to embed learning across the organisation.

19. The above process will also apply to any inquest conclusion received where St Andrew's actions have been criticised, where an adverse narrative verdict has been returned or where a neglect rider has been included in the inquest conclusion

IX. In relation to each of the PFD Reports received, please set out in broad terms what, if any, action has been taken by St Andrew's Healthcare to address the concerns raised within a Report further, after a response had been submitted. Please set out any examples of where measures have proved to be effective.

20. St Andrew's has no relevant information to share with the Inquiry in relation to enquiry IX for the reasons provided at paragraphs 4 to 7 above.

X. In each case where a PFD Report was issued and a response provided, please confirm whether any follow-up correspondence was sent by St Andrew's Healthcare to HM Coroner. Please provide copies of any such correspondence where it related to changes (whether made or not) to the care and/or treatment of mental health inpatients.

21. I am not aware of any follow up correspondence being sent to a coroner by St Andrew's where a PFD has been made. I am not aware that any request has been made by a coroner for follow-up correspondence. It would, in my experience, be unusual to update a coroner on changes made following a PFD being made given that a coroner is functous officio at the conclusion of an inquest and there is neither a power nor a duty under the Coroners and Justice Act 2009 and/or the Coroners (Investigations) Regulations to allow a coroner to follow up on a PFD response. This is reflected in Revised Chief Coroner's Guidance No.5 Reports to Prevent Future Deaths, which does not mention any requirement to keep a coroner updated on progress of actions in response to a PFD.

XI. How many findings of neglect and/or other adverse findings were made in respect of St Andrew's Healthcare or members of its staff, in relation to mental health inpatient deaths (as per the Inquiry's definition of inpatient) during the Relevant Period.

22. As far as I am aware there has been one conclusion with the neglect rider in relation to St Andrew's Essex Hospital.

23. I have personal knowledge of the inquests that have taken place since 2015, but in relation to the pre-2015 deaths I have obtained copies of the death certificates for each death from the General Register Office. I also made enquiries with the Essex Coroners Service to request copies of the records of inquest, but this request was declined by the Senior Coroner.

XII. Please provide a breakdown of the findings at paragraph 11 per year during the Relevant Period. Please provide a brief summary and circumstances of each finding along with any related ROI. If copies are not available, please explain why.

24. This conclusion relates to an inquest held in 2023 that relates to the death of an inpatient in 2020. I produce as Exhibit '**SW1**' a copy of the record of inquest for this death.

XIII. Please identify whether any particular finding of neglect reflected a repeat or similar incident to that giving rise to a previous finding. Where patterns or recurrences are identified, please provide an analysis of contributing factors.

25. There has been no previous findings in relation to a repeat or similar incident in relation to St Andrew's Essex Hospital. In providing this response I have taken instructions from clinical colleagues and reconsidered the external investigation commissioned by St Andrew's and serious case review report.

XIV. In relation to each finding of neglect and/or other adverse finding made in respect of St Andrew's Healthcare, or members of staff, please set out in broad terms what, if any, action was taken by St Andrew's Healthcare to address the concerns that gave rise to the finding. Please set out any examples of where measures have proved to be effective.

26. In the case of the 2020 death there was a delay of approximately three years from the patient's death to the conclusion. The consequence of this is that recommendations of the serious incident investigation were almost all implemented by the time the inquest was heard.

27. Following receipt of the jury's conclusion, it was reviewed by the leadership triumvirate and it was felt that there were no additional actions that could be implemented to address these concerns. I produce as Exhibit '**SW2**' to this statement a copy of the statement provided to the Coroner that sets out the steps St Andrew's took following the patient's death. Attached to this exhibit is an action plan that was formulated in response to the learning identified by the serious incident investigation.

28. In terms of the action taken by St Andrew's in response to the patient's death, the one action that appears to have made a particular difference in another case is improving staff's awareness of emergency procedures and responses. I am aware that in the Essex Hospital the prompt emergency response to a patient medical emergency saved his life. Other than anecdotal accounts such as this it is not always possible to determine that an action has removed a risk as considering if something could have happened can be difficult.

XV. Please provide details of the processes in place during the Relevant Period to disseminate information obtained and/or lessons learned and/or action taken arising from:

a. Findings of neglect and/or other adverse findings; and

b. Receipt of PFD Reports.

29. The processes outlined at paragraphs 9 to 19 above provide information in relation to this question.

I believe that the facts stated in this statement are true. I understand that proceedings for contempt of court 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 in its truth.

Signed: [I/S]

Stuart Wallace
Data Protection Officer/Senior Solicitor

Date: 25 March 2025