
**ROBERT WADE ADDENDUM STATEMENT PURSUANT TO RULE 9 REQUEST
FROM THE LAMPARD INQUIRY**

The Inquiry asks for recommendations, which I have set out below:

1. The Trust must never again manage a Serious Incident Investigation into either a death or near miss occurring within itself; instead being managed by a different Trust with independent legal oversight nominated by, and reporting to, the victims next of kin
2. The Trust redesign its entire care delivery service by using Safety Cases within a Patient Safety Doctrine (as outlined in the attached proposal)
3. The CQC and Coroner develop mechanisms to track and report a range of performance data relating to the Patient Safety Doctrine for mental health care