

Witness Name: (REBECCA HILSENATH KC (Hon))

Statement No: WITN0137001

Dated: 6 November 2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF REBECCA HILSENATH KC (Hon)

I, REBECCA HILSENATH KC (Hon), will say as follows

INTRODUCTION – MY ROLE, CAREER AND QUALIFICATIONS

1. I am the Chief Executive Officer of the Parliamentary and Health Service Ombudsman. I was appointed Chief Executive Officer in July 2023. Prior to this I held the post of Director of Strategy from April 2021. I also served as the interim Parliamentary and Health Service Ombudsman and Accounting Officer to Parliament for the PHSO from 18 April 2024 to 31 March 2025.
2. Before joining PHSO in 2021, I was Chief Legal Officer and then Chief Executive Officer of the Equality and Human Rights Commission. Prior to that, after holding a number of roles in the then Government Legal Service, I was for five years CEO of LawWorks (the Solicitors Pro Bono Group), a national charity facilitating free legal advice to community groups and individuals in need.
3. I trained as a lawyer and began my career at Linklaters. I set up the National Pro Bono Centre in Chancery Lane and have sat on the boards of a number of charities and advice agencies, including the Bar Pro Bono Unit and the Mary Ward Legal Centre. I hold two honorary doctorates awarded in recognition of services to law. I was also made an Honorary King's Counsel earlier this year.

This witness statement is made to assist the Nottingham Inquiry (the "Inquiry") with the matters set out in the Rule 9 Request dated 25 June 2025 (the "Request").

'DISCHARGE FROM MENTAL HEALTH CARE: MAKING IT SAFE AND PATIENT-CENTRED' – STAKEHOLDER ENGAGEMENT ACTIVITY ON THE 2024 REPORT RECOMMENDATIONS FROM APRIL 2024 TO PRESENT

3. In February 2024, during my time as Chief Executive, PHSO published the report, 'Discharge from mental health care: making it safe and patient-centred' (referred to as "**the 2024 report**") (**PHSO0000003**). The immediate engagement following the launch of the report is set out in the statement to this Inquiry of the then Ombudsman, Sir Rob Behrens CBE. The following statement summarises engagement on recommendations and ongoing activity following Sir Rob's departure and during my tenure as interim Ombudsman and as Chief Executive Officer respectively. It details PHSO's engagement with:
 - the Department of Health and Social Care (DHSC)
 - the Mental Health Bill Committee
 - Voluntary and Community Sector organisations (VCSE)
 - Conferences and professional networks
 - CQC and Independent Review into Nottingham Mental Health Care
4. Following publication, the PHSO Policy and Public Affairs team engaged closely with Government to seek action on recommendations and to use insight to shape the Government's mental health ongoing policy commitments.
5. Firstly, informed by the themes of our report, from summer 2024 to April 2025 the DHSC Secondary Care and Integration team led a series of system deep dives exploring the factors influencing discharge from mental health settings and the barriers to implementing best practice initiatives (**PHSO0000023**). This focused on engagement with eight Integrated Care Systems across the country. The PHSO Policy and Public Affairs team has worked closely with DHSC colleagues on this piece of work ensuring that the report insight has informed the Department's thinking on enablers in discharge planning. Findings from this work are intended to inform potential implementation of mental health care transfer hubs or similar

models, a commitment made in the Urgent and Emergency Care recovery plan and discharge change delivery plan. Dialogue between DHSC and PHSO continues on implementation, opportunities for sharing best practice nationally and in reconsidering the previous Government's roundtable proposal on discharge and housing.

6. Secondly, under the new Government, a Mental Health Bill has been brought before Parliament. PHSO engaged with the DHSC Bill Team to share insight from the 2024 report and seek assurance about commitments to introduce a Nominated Person category in legislation. The Nominated Person replaces the 'nearest relative' role and could be a close relative, carer or another trusted person. The Nominated Person should be able to support the individual in advocating for their wishes and concerns in the transition of care. Healthcare professionals should listen to the Nominated Person's views and record them alongside the views of the person who is having their care transferred. The current draft Bill makes provisions for this. PHSO also made a submission to the Public Bill Committee on the Mental Health Bill in June 2025, highlighting the learning from the 2024 report and the need to improve access to justice for people seeking to make complaints about mental health care. This included more effective signposting to the appropriate regulator or Ombudsman for individuals with complaints about mental health care and allowing individuals to make a complaint in the way which is most suitable for them.
7. In relation to recommendation two of the report on 72-hour follow-up post-emergency department discharge, PHSO has engaged with Voluntary and Community Sector (VCSE) partners and the Royal College of Emergency Medicine and is meeting with policy officials in DHSC responsible for future Mental Health A&Es. This builds on a policy research sprint conducted by DHSC over the course of 2024 to look at mental health admissions in emergency departments.
8. The PHSO Policy and Public Affairs team has shared findings from the 2024 report with numerous VCSE policy and service delivery partners, clinical professionals

and NHS Mental Health Trust Clinical Leads and Commissioners through a series of conferences and seminars. These include:

- NHS Confederation Mental Health Network
- Association of Mental Health Providers
- Children and Young People's Mental Health Coalition
- 'Implementing the Patient Safety Incident Response Framework in Mental Health Settings' conference
- National Suicide and Crisis Prevention Conference
- 'No More Revolving Doors: Improving quality and safety in acute mental health care' conference, delivered in partnership with Cygnet Health Care

9. As a result of stakeholder engagement, the PHSO Policy and Public Affairs team has been able to use the report findings to inform a programme of work to be delivered by the Royal College of Psychiatrists on the role of supported housing in facilitating safe mental health discharge. PHSO has been able to broker relationships with stakeholders for this work including DHSC, a housing provider and the Housing Ombudsman who have all already shown interest in draft proposals. The policy briefing with system recommendations is expected to be launched later in 2025.

10. Specifically of relevance to this inquiry, the 2024 report was noted as a key piece of evidence on discharge best practice in CQC's 'Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust' (March 2024) (**PHSO0000024**) and the 'Independent investigation into the care and treatment provided to VC' (January 2025) (**NHSE0000298**). The latter highlighted that the findings around poor involvement of families in discharge planning and risk assessment resonated with the discharge decision-making failings evidenced in Valdo Calocane's case.

11. In August 2024 I was interviewed by BBC Radio 4's 'Today Programme', Sky News and LBC News about our mental health discharge report in connection to the Valdo Calocane case.

RECOMMENDATIONS FOR EFFECTIVE AND SAFE DISCHARGE PLANNING IN MENTAL HEALTH AND IMPROVEMENTS TO MULTI AGENCY WORKING

12. The 2024 report highlights the challenge of ensuring a balance between the continued push towards a 'community first' approach to mental health care, community and inpatient mental health services under strain, and the risk that services focus only on speed of discharge with metrics centred on the number of days from admission to discharge. While shorter inpatient stays should be the ambition for people who are well enough to leave hospital, this cannot come at the cost of patient safety, supported recovery and what is right for the individual, their carers and loved ones.

13. The evidence in the report demonstrates that unsafe discharge can lead to:

- poorer outcomes for patients,
- the risk of repeated cycles of readmission and
- a higher risk of suicide.

It is key that policymakers, commissioners and staff working in mental health services see discharge as part of recovery for a patient and not simply a process or system pathway.

14. Discharge from mental health services and transfers of care usually involve multiple teams and professionals. This means decision-making can be immensely complex and challenging. The report highlights the pivotal importance of the multi-disciplinary approach to discharge-planning, engaging early with professionals from across health, social care and housing whilst, at its core, championing the wishes of patients, families and carers.

15. Discharge discussions and plans must be transparent, people-centred and work towards achieving the overall objective of creating a safety net for an individual when they are leaving or moving between different mental health services or care settings. A jointly agreed care plan is therefore crucial in supporting people using mental health services. A comprehensive review of a patient's care should include a care planning meeting with all teams involved with input from an individual, family and carers to ensure a joined-up approach.

16. Our 2024 report and wider mental health discharge casework includes examples of where Trusts have not kept or adequately updated records of multi-disciplinary care planning and the communications between different teams. Poor record-keeping presents a patient safety issue both in terms of support for patients (if care or discharge plans are inaccurate) and in relation to the investigation of complaints. A lack of records can hinder our own investigations or leave a family not knowing if a different outcome for their loved-one could be possible.
17. The need for clear care plans is also a key learning point from our 2022 joint guidance issued with the Local Government and Social Care Ombudsman on 'Section 117 Aftercare' (**PHSO0000026**). Failings in delivery of aftercare once people are discharged from mental health settings is symptomatic of poor working across NHS and Local Authority boundaries.
18. Effective communication between professionals who understand the aims and potential risks of discharge is vital to make assessments and planning as comprehensive as possible. Findings of poor communication with patients, families, carers and between different clinical and care professionals is sadly common in PHSO's wider casework. It is a basic requirement of safe care.
19. The 2024 report also considered how individuals in mental health crisis who present to emergency departments can be safely discharged to home and community services. Although these are very different environments to inpatient settings, the basic principles of good discharge must remain.
20. How services are able to respond in partnership when people are in crisis must be a key focus for this inquiry. Changes in how police forces respond to calls related to mental health announced in 2023 under the 'Right Care, Right Person' National Partnership Agreement (**PHSO0000028**) demonstrate the need for clear understanding of each service's role in responding effectively at pace and in a way that can still be conducive to supporting an individual's longer-term recovery.
21. PHSO welcomes Government's statutory guidance on discharge from mental health inpatient settings, issued in January 2024 (**PHSO0000010**). However,

adequate resourcing is critical to ensure that systems can meaningfully adopt and engage with the principles of MDT working that it sets out. In line with the report recommendations, DHSC should look to evaluate implementation of the guidance and its real world impact on staff, patients, families, carers and wider community partners.

22. More broadly, the failings we see in mental health discharge and wider mental health casework are the result 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.

ENSURING LESSONS ARE LEARNED TO PREVENT SIMILAR ATTACKS IN FUTURE

23. As PHSO's jurisdiction only relates to complaints received about NHS funded care in England, government departments and other public bodies, we are unable to comment on the actions of wider police and public services (where this does not relate to NHS commissioned services) which may have played a role in Valdo Calocane's care and wider system response.

24. Nevertheless, our casework provides strong evidence of the risk of future harm when NHS organisations fail to learn from mistakes when things go wrong. Mistakes are inevitable in complex health systems which rely on human judgement.

25. In 'Broken trust: making patient safety more than just a promise' (June 2023) (PHSO0000018) we set out findings from our casework relating to avoidable harm and deaths. The report highlights the real threat of compounded harm when families and carers who have already experienced the devastating consequences of losing a loved one try to understand what has happened but are met with a poor response from NHS organisations. This includes a failure to be honest, poor quality investigations and a failure to respond to complaints in a timely and compassionate way.

26. Any health or social care environment can develop a 'closed culture' which affects a service's ability to respond when things go wrong and prevent learning from complaints. Settings such as inpatient mental health wards are at even greater risk, since they care for people who may be less able to advocate for themselves and whose circumstances may lead to greater fear of repercussions when complaints are made.

27. PHSO welcomes NHS England's 'Culture of Care Standards for Inpatient Services' (**PHSO0000009**) including the core commitments to the right of patients and their support network to be engaged in all parts of care and to transparency through open and honest conversations with all people involved in an individual's care. PHSO understands that delivery of the Standards and associated quality improvement initiatives continues at a regional level. The behavioural and system change underpinning the Standards must be meaningfully embedded at all levels of mental health services and accompanied by national leadership committed to building and maintaining an open culture.

I believe the content of this statement to be 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:

GRO-B

Date:

6 November 2025

Annex A

Index to Witness Statement of Rebecca Hilsenrath KC (Hon)

Inquiry URN	Document Description
PHSO0000003	Discharge from mental health care: making it safe and patient-centred
PHSO0000023	DHSC MH Themes Findings Pack
PHSO0000024	Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust
NHSE0000298	Independent investigation into the care and treatment provided to VC
PHSO0000026	LGSCO-PHSO Section 117 Aftercare Guidance
PHSO0000028	Right Care Right Person: National Partnership Agreement
PHSO0000010	DHSC statutory guidance on discharge from mental health inpatient settings (January 2024)
PHSO0000018	Broken trust: making patient safety more than just a promise
PHSO0000009	Culture of Care Standards for Mental Health Inpatient Services