Witness Name: SIR ROB BEHRENS CBE

Statement No: WITN0228001

Dated: 12 November 2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF SIR ROB BEHRENS CBE

I, SIR ROBERT BEHRENS CBE, will say as follows

INTRODUCTION

1. I am the former Parliamentary and Health Service Ombudsman, holding the post from April 2017 until March 2024.

2. This witness statement is made to assist the Nottingham Inquiry (the **"Inquiry"**) with the matters set out in the Rule 9 Request dated 17 June 2025 (the **"Request"**)

BACKGROUND

3. I have been asked to set out
    a. an overview of my career to date
    b. my former role as Parliamentary and Health Service Ombudsman and the functions of the office
    c. the Parliamentary and Health Service Ombudsman (PHSO) policy report, 'Discharge from mental health care: making it safe and patient-centred', published in February 2024
    d. reflections on broader recommendations the Chair of the Inquiry should make to ensure lessons are learned for future.

CAREER AND ROLE

4. My name is Sir Rob Behrens CBE. I have had a career in higher education and public service. I was Secretary to the Committee on Standards in Public Life (2003-6), Complaints Commissioner to the Bar in England and Wales (2006-8) and Higher Education Ombudsman (2008-16). I was the Parliamentary and Health Service Ombudsman (Ombudsman) from 6 April 2017 to 27 March 2024, responsible for all investigations and recommendations. I was the Chair of the unitary Board which is in place to improve the governance of the organisation. I was also the Accounting Officer, accountable to Parliament for the stewardship of our resources.

THE PHSO ROLE AND FUNCTION IN PROVIDING AN INDEPNDENT COMPLAINTS HANDLING SERVICE

5. 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 (**PHSO0000001**) and the Health Service Commissioners Act 1993 (**PHSO0000002**).

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

7. 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 or sections 2, 2A and 2B of the Health Service Commissioners Act 1993,) has not acted properly or fairly, or has given a poor service, and has failed to put things right.

8. Under the law, a person has to try to resolve their case by a front-line body 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. The decisions of the Ombudsman are, however, subject to Judicial Review.

9. As Health Ombudsman, the PHSO can look at administrative issues of maladministration (including serious service failure), and has the power to make judgements about clinical decisions, on the basis of advice from independent clinicians in the context of national guidelines.

10. 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, as well as giving authority for case activity to officers. However, I chaired a review team to oversee sensitive cases, and acted personally in complex cases and where we identified serious or repeated mistakes that may have had system-wide relevance.

11. Alongside PHSO's casework functions within the Operations Directorate, PHSO's Strategy Directorate includes Communications, Strategy Development, Stakeholder Engagement and Policy and Public Affairs teams. The PHSO Policy and Public Affairs team look at themes, trends and systemic issues in the case work that the PHSO has handled. Working with the PHSO External Communications team, they would consider the best way to share the learning from those cases externally including through policy publications such as 'Discharge from mental health care: making it safe and patient-centred' (**PHSO0000003**), published in February 2024.

'DISCHARGE FROM MENTAL HEALTH CARE: MAKING IT SAFE AND PATIENT-CENTRED' – RATIONALE AND METHODOLOGY

12. The PHSO Policy and Public Affairs team regularly conduct casework research and analysis, to identify and examine systemic trends across our completed investigations.

13. In summer 2023, the then Director of Strategy commissioned the Policy and Public Affairs team to conduct analysis of PHSO's casework related to mental health services and care for people with a diagnosis of severe mental illness. This was with the view of developing and publishing a public-facing policy product, most likely a report with systemic recommendations.

14. The Policy and Public Affairs team programmes of work and outputs are informed by emerging trends in our casework. They also consider topics of interest in public and political debate. In addition to the complaints received, the rationale for considering a mental health publication was based on a combination of the following factors:
    a. The quality and delivery of mental health services had been a longstanding issue of concern for the PHSO and had been reflected in a number of prior publications and engagement activities including a survey of experiences of NHS mental health care in England (February 2020) (**PHSO0000004**), PHSO's 'Missed opportunities: what lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust' report (June 2019) (**PHSO0000005**) and 'Maintaining momentum: driving improvements in mental health care'(March 2018) (**PHSO0000006**).
    b. Challenges of delivering effective and safe mental health care continued to be raised in the public domain and in the media.
    c. In spite of commitments from the Government, new mental health legislation (amendments to the Mental Health Act 1983) had not been forthcoming and a policy publication provided an opportunity for PHSO to make a well-informed intervention on the need for legislative reform.

15. The process for developing the report was as follows:

a. The assembly of all 'Upheld' and 'Partly Upheld' cases that PHSO had investigated which had related to mental health care or severe mental illness. Over 100 cases, concluded between April 2020 and September 2023, were analysed.

   A manual thematic analysis conducted on these cases, identifying themes from final investigation reports. Complaints related to discharge and transitions in care emerged as a particularly common theme.

b. Desk-based research of wider Voluntary and Community Sector (VCSE) and regulatory sector publications on mental health care and an analysis of NHS England frameworks for mental health care (including the 'Care Programme Approach' and 'Community Mental Health Framework')

c. Stakeholder engagement throughout the research and drafting of the report with VCSE policy and service delivery organisations, the NHS England Quality Transformation Team for Mental Health Care, the Department of Health and Social Care (DHSC) Mental Health Policy Delivery Team, the Care Quality Commission (CQC), the Health Services Safety Investigations Body (HSSIB) and PHSO's own internal Mental Health Nurse Clinical Advisor.

d. Selection of key anonymised case summaries to spotlight within the report to reflect the different themes identified. Permission for inclusion in the report was sought from complainants.

e. Recommendations development workshops with internal colleagues and then external stakeholders including working level representatives from VCSE, NHS Resolution and individuals with lived experience of mental health discharge.

f. Internal sign-off and approval of the draft report by the Assistant Director of Policy, Strategy and Public Affairs, the Assistant Director of Communications, the Director of Strategy, Chief Executive and Ombudsman.

g. Publication of final report with press release accompanied by letters from the Ombudsman to NHS England National Mental Health Director, Minister for Mental Health and Patient Safety, Chair of the Health and Social Care Parliamentary Select Committee and Chair of the Public Administration and Constitutional Affairs Select Committee. Emails with the final report were

also shared with a broader range of health and social care stakeholders (including Shadow Health Ministerial Advisors) and the report was uploaded to the PHSO website and social media.

h. Internal evaluation after launch to assess impact and improvements to policy publication process (**PHSO0000008**).

'DISCHARGE FROM MENTAL HEALTH CARE: MAKING IT SAFE AND PATIENT-CENTRED' – FINDINGS AND RECOMMENDATIONS

16. The report spotlighted six case summaries which fell under three key themes of failings in mental health discharge planning and service delivery:
    a. Failings in patient, family and carer involvement in discharge planning:
        i. Case study 1: Failure to involve patient's family in discharge risk assessment and clinicians providing incorrect information on self-help support
        ii. Case study 2: Close family not updated on day of patient's discharge from hospital
        iii. Case study 3: Failings in how a Trust assessed a patient when they requested to be discharged
    b. Poor record-keeping
        i. Case study 4: Poor record-keeping around discharge planning and an absence of multi-disciplinary team (MDT) involvement in discharge
    c. Poor communication between clinical professionals and teams in planning transfers of care
        i. Case study 5: Failure to carry out a Mental Capacity Act assessment before discharge
        ii. Case study 6: Poor joint working leading to multiple transfers of care and emergency hospital admissions

17. The report made five primary recommendations with several sub-recommendations. These are as follows:

a. As the DHSC's new national statutory guidance on discharge from mental health settings is implemented, DHSC and NHS England must engage with people and services to assess the impact the guidance has had on them. In particular, they must make sure that Integrated Care Systems account for the different professionals that should be involved in the discharge MDT or state the reasons for excluding particular professionals from planning.
b. NHS England should extend the requirement for a follow-up check within 72 hours of discharge for people from inpatient mental health settings to include people discharged from emergency departments.
c. NHS England and Integrated Care Boards should make sure that people who are being discharged from mental health settings can choose a nominated person to be involved in discussions and decision-making around transitions of care.
d. NHS England should make sure that patients and their support network are active and valued partners in planning transitions of care and are empowered to give feedback, including through complaints. Noting NHS England's new 'Culture of Care Standards for Mental Health Inpatient Services' (**PHSO0000009**), Integrated Care Boards and mental health services must be held to account for making sure that:
    i. views and experiences of patients, families, carers and nominated person are held in balance with clinical perspective in making decisions about transitions of care
    ii. staff support and encourage people to use this right
    iii. people are empowered to give feedback and staff proactively seek this out
    iv. people are supported to make a complaint and know this will be responded to in an honest and compassionate way
e. Government must show its commitment to transforming and improving mental health care by introducing the Mental Health Bill to Parliament as a priority. Future draft versions of the Bill should:
    i. remove barriers to accessing justice for mental health patients by including mandatory signposting to the PHSO, Local Government and Social Care Ombudsman, CQC and Mental Health Tribunal as appropriate,

ii. allow people to complain in the most suitable way for them, not only in writing.

18. It should be noted that recommendations made by PHSO, both in individual case reports and policy publications, are not legally binding. However, compliance with individual recommendations made by PHSO is on average 99%.

'DISCHARGE FROM MENTAL HEALTH CARE: MAKING IT SAFE AND PATIENT-CENTED' – IMPACT AND RESPONSE TO RECOMMENDATIONS UP TO MARCH 2024

19. During the drafting of the report, PHSO Policy and Public Affairs colleagues engaged closely with the DHSC Mental Health Policy Delivery Team who authored new statutory guidance on 'Discharge from mental health inpatient settings' (**PHSO0000010**). The guidance reflected some of the key areas of concern identified in the PHSO report, including the importance of multi-disciplinary working across health, care and housing services to ensure safe discharge planning. The guidance was published on 26 January 2024.

20. The report itself was published on 1 February 2024 and received press coverage and media attention including a broadcast interview with me and a radio interview with one of the complainant's whose case was featured in the report.

21. The report and findings were welcomed by NHS England's Quality Transformation Team for Mental Health in working level discussions preceding and following publication.

22. A Parliamentary Question (**PHSO0000011**) on the report was asked in the House of Lords by the then Shadow Minister for Mental Health and Patient Safety, Baroness Merron, on 5 March 2024. The Parliamentary Under-Secretary of State responded and committed to further roundtable discussions on the topic with the Mental Health Minister. Although discussions between PHSO and DHSC did take place on planning for the roundtable focused on mental health discharge pathways,

housing and the nominated person category, the Ministerial roundtable did not take place due to the general election.

23. My tenure as Ombudsman ended in March 2024. However, I understand the PHSO has continued to engage with key stakeholders on implementation of recommendations after my departure.

BROADER RECOMMENDATIONS FOR EFFECTIVE AND SAFE DISCHARGE PLANNING IN MENTAL HEALTH

24. First, the resourcing and prioritising of mental health services requires equal status with other public health care.

25. Second, the *sine qua non* of this issue is effective and continuous engagement with patients and their families and advocates. The evidence (see below) is that this does not happen. There is a continuing need for people-centred care and holistic approaches to the discharge pathway, particularly acknowledging Government's desired shift to move care from 'hospital to home' in the most recent 10 Year Plan.

26. Third, there is a need to simplify and make more accessible the way in which complaints about mental health issues are handled, as set out in the PHSO-led Complaints Standards Framework [*NHS Complaint Standards | Parliamentary and Health Service Ombudsman (PHSO)*] (**PHSO0000012**)

27. Fourth, there is a need to eliminate cultures of cover-up in the NHS which I encountered too frequently during my tenure as Ombudsman. Learning from mistakes should be part of daily practice not the sole duty of regulators, the Ombudsman or public inquiries.

28. Last, the Ombudsman service should have powers of 'own initiative', like almost all European counterparts to enable investigations where no complaint has been made. This is particularly important in the area of mental health. [*Art_of_the_Ombudsman_WEB.pdf*] (**PHSO0000013**).

RECOMMENDATION FOR THE INQUIRY CHAIR TO CONSIDER TO ENSURE LESSONS ARE LEARNED AND TO PREVENT SIMILAR ATTACKS IN FUTURE

29. Historically, there has been a tendency for the recommendations of both public and independent inquiries to fail to be implemented through a lack of effective scrutiny and monitoring. This unhappy situation was pointed out by Dr Bill Kirkup in his report on East Kent maternity issues and caused him to make general, thematic points only. [*Reading the signals: maternity and neonatal services in East Kent, the report of the independent investigation (print ready)*] (**PHSO0000014**)

30. I note that the Chair of the Infected Blood Public Inquiry used the terms of reference to reopen the Inquiry when he believed implementation was too slow.

RECOMMENDATIONS FOR IMPROVEMENT TO LOCAL AND NATIONAL MULTI AGENCY WORKING

31. Before we can be in a position to consider how different agencies in mental health and social care effectively work together, I think it is critical that we consider the poor culture that can appear entrenched in mental health care and that I saw time and time again as Ombudsman. This is the basic building block for services to be able deliver decent, safe and people-centred care and to work in partnership with others to do the same.

32. Calling out serious service failure in NHS mental health provision was an early and consistent theme of my tenure as Ombudsman from 2017-18, and was set out in my evidence to the Lampard Inquiry earlier this year. [*Lampard-Inquiry-6-May-2025.pdf*] (**PHSO0000015**)

33. In March 2018, we published 'Maintaining momentum: driving improvements in mental health care' (**PHSO0000006**). This publication highlighted serious human rights violations in the treatment and 'care' of mental health patients. [*Failings in mental healthcare are violating basic human rights | Rob Behrens | The Guardian*] (**PHSO0000016**)

34. In November 2018, I interviewed Claire Murdoch, National Director for Mental Health Care on our podcast Radio Ombudsman [*Radio Ombudsman: Claire Murdoch on driving improvements in NHS mental health care | Parliamentary and Health Service Ombudsman (PHSO)*] (**PHSO0000017**)

35. In February 2020, we published a survey commissioned from YouGov of 3480 adults, a third of whom had experienced a mental health condition. In this survey, one in five people did not feel safe while in the care of the NHS mental health service that treated them. And almost half (48%) said they would be unlikely to complain if they were unhappy with the service provided, mostly because they did not want 'to cause trouble' (**PHSO0000004**)

36. A broader study of avoidable deaths, 'Broken trust: making patient safety more than just a promise' (**PHSO0000018**) which included the care of mental health patients, made clear that there continues to be 'a gaping hole between best practice policy and consistent real-life practice.'

37. There remain serious issues of concern, including the defensive NHS culture which too often prioritises organisational reputation over patient safety, the failure of law relating to both duty of candour and whistle-blowing, an over-complicated ineffective regulatory framework, and the lack of accountability of boards and senior NHS managers for operational and strategic failures. [*NHS ombudsman Rob Behrens: 'There are serious issues of concern' | NHS | The Guardian*] (**PHSO0000019**), [*NHS ombudsman warns hospitals are cynically burying evidence of poor care | NHS | The Guardian*] (**PHSO0000020**)

Statement of Truth

I believe the content of this statement to be true. I understand that proceedings may be brough 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

Dated: 12 November 2025

Annex A – Index to First Witness Statement of Sir Rob Behrens

Inquiry URN	Document Description
PHSO0000001	Parliamentary Commissioner Act 1967
PHSO0000002	Health Service Commissioners Act 1993
PHSO0000003	Discharge from mental health care: making it safe and patient-centred
PHSO0000004	Survey of experiences of NHS mental health care in England – survey results
PHSO0000005	Missed opportunities: what lessons can be learned from failings at the North Essex Partnership University Foundation Trust
PHSO0000006	Maintaining momentum: driving improvements in mental health care
PHSO0000008	Mental health report evaluation 2024
PHSO0000009	Culture of Care Standards for Mental Health Inpatient Services
PHSO0000010	Discharge from mental health inpatient settings
PHSO0000011	Mental health patients – Discharge - Hansard
PHSO0000012	NHS Complaint Standards, PHSO
PHSO0000013	Art of the Ombudsman
PHSO0000014	Reading the signals: maternity and neonatal service in East Kent
PHSO0000015	Lampard Inquiry into Essex Mental Health Deaths
PHSO0000016	News Article: Failings in mental healthcare are violating basic human rights
PHSO0000017	Radio Ombudsman: Claire Murdoch on driving improvements in NHS mental health care
PHSO0000018	Broken trust: making patient safety more than just a promise
PHSO0000019	NHS Ombudsman Rob Behrens, 'There are serious issues of concern'

PHSO0000020	NHS ombudsman warns hospitals are cynically burying evidence of poor care