

Tuesday 14 October 2025

(10.02 am)

THE CHAIR: Mr Hayes?

MR HAYES: Chair, today we continue with evidence about

Oxevision, a non-contact, vision-based monitoring system that we started to hear about yesterday. Its use has proved to be controversial. We will hear a prerecorded evidence session with Hat Porter, who is a representative of the Stop Oxevision campaign. That will take the form of two videos. These will cover key concerns about the operation of Oxevision, such as the invasion of patients' privacy and the impact of the technology on patients' health and recovery. We will then hear from Zephant Trent, the Executive Director of Strategy, Transformation and Digital at EPUT. He will give evidence about the use of the technology from EPUT's perspective.

Whilst this is evidence about the operation of a vision-based patient monitoring system, it will inevitably touch on troubling matters, particularly where it deals with concerns that have been raised about the way it operates. For example, there will be references to inquests in which those who died or were in rooms where Oxevision was deployed. People attending today or watching remotely may find some of the matters we will hear about distressing. The Inquiry would like to make

1 clear that emotional support is available for all who
2 need it. We have two support staff from Hestia, an
3 experienced provider of emotional support, here today and
4 for each day of this hearing. They are wearing orange
5 lanyards and scarves.

6 There is a private room downstairs available to
7 talk to Hestia support staff if anybody requires
8 emotional support throughout this hearing. For those
9 watching online, information about available emotional
10 support can be found on the Lampard Inquiry website at
11 www.lampardinquiry.org.uk and under the "Support" tab
12 near the top right-hand corner. We want all those
13 engaging with the Inquiry to feel safe and supported.

14 We will now play the first video of Hat
15 Porter's evidence.

16 **THE CHAIR:** Thank you, Mr Hayes.

17 **(Video played - Please refer to transcript dated 14**
18 **May 2025)**

19 **MR HAYES:** Chair, that concludes the first video of Hat
20 Porter's evidence. Can I propose that we break for ten
21 minutes and resume at 11.20.

22 **THE CHAIR:** 11.20.

23 **(11.12 am)**

24 **(Break)**

25 **(11.22 am)**

1 **MR HAYES:** Chair, we will now resume with the prerecorded
2 evidence of Hat Porter. I understand there is, in fact,
3 a short period of the first video still to play, which we
4 will play before we proceed to the second video.

5 **THE CHAIR:** Thank you.

6 **(Video resumed)**

7 **(Second video played - Please refer to transcript**
8 **dated 14 May 2025)**

9 **MR HAYES:** Chair, that concludes the prerecorded evidence of
10 Hat Porter. May I propose a 15 minute break and we will
11 resume with the evidence of Zephan Trent at 12.30.

12 **CHAIRMAN:** Thank you.

13 **(12.13 pm)**

14 **(Break)**

15 **(12.29 pm)**

16 **THE CHAIR:** Mr Griffin?

17 **ZEPHAN TRENT (affirmed)**

18 **Examination by MR GRIFFIN**

19 **Q.** Please give your full name?

20 **A.** My name is Zephan Marcus Andrew Trent.

21 **Q.** You have provided the Inquiry with three statements.

22 Dealing with the first statement, is it dated 21 March
23 this year and is it 29 pages long?

24 **A.** Yes.

25 **Q.** And similarly with the second statement, is it dated 9

1 May this year and is it 16 pages long?

2 **A.** Yes.

3 **Q.** Finally, the third statement, can you confirm that that

4 is dated 2 September this year and is 11 pages long?

5 **A.** Yes.

6 **Q.** And can you confirm that they are accurate to the best of

7 your knowledge and belief?

8 **A.** Yes.

9 **Q.** In each case, have you made a statement of truth and

10 signed the statement?

11 **A.** Yes, I have.

12 **Q.** Thank you. Your statements stand as part of your

13 evidence, along with the exhibits you have provided. I

14 will not, therefore, be asking you about all of the

15 matters that you have covered in them. Are you the

16 Executive Director of Strategy, Transformation and

17 Digital within Essex Partnership University NHS

18 Foundation Trust, or EPUT?

19 **A.** Yes, I am.

20 **Q.** What does that role entail?

21 **A.** I am a member of the executive team and a non-voting

22 member of the board. I have a portfolio where I lead on

23 the strategy development for the organisation, including

24 our five-year plan, for example. I provide leadership

25 and coordination on transformation across the

1 organisation, things like the Time to Care programme, you
2 have heard about previously, and I have oversight of our
3 digital services within the organisation.

4 **Q.** When you say digital services, would that include
5 technologies such as Oxevision?

6 **A.** It will include, and I am sure we will come on to this,
7 it will include the digital technology and systems, but
8 is distinct from the oversight of those on the wards, et
9 cetera.

10 **Q.** Thank you. And have you held that position since you
11 joined EPUT in April 2022?

12 **A.** Yes, I have.

13 **Q.** And since 15 July 2022 have you also held the position of
14 Senior Information Risk Owner or SIRO?

15 **A.** Yes, I have.

16 **Q.** What does that role entail, please?

17 **A.** So the SIRO, or the Senior Information Risk Officer, is
18 the person who has the overall accountability for
19 information risk management within an NHS trust. That
20 role is importantly alongside the Caldicott Guardian,
21 which will be a senior clinical leader with
22 responsibility for patient information and it's
23 typically, and is also the case in EPUT, supported by an
24 information governance team and specifically a data
25 protection officer.

1 Q. You mentioned working alongside the Caldicott Guardian.
2 I am not sure if everyone heard your description of what
3 that position is. Could you just say that again, please?
4 A. Yes, so the Caldicott Guardian this was a role that was
5 established after the recommendations of Dame Caldicott
6 and it requires a senior clinician, often the trust
7 Medical Director or the trust Chief Nurse to have
8 oversight of how patient information is used.
9 Q. Thank you very much. You hold Bachelor of Arts with
10 honours and Master of Science degrees; is that correct?
11 A. That is correct.
12 Q. And you are also a Chartered Financial Analyst charter
13 holder, is that a professional designation that relates
14 to matters such as investment analysis?
15 A. Yes, it is.
16 Q. But is it right you are not clinically qualified?
17 A. That is correct.
18 Q. And do you, in your roles, report directly to EPUT's
19 chief executive officer Paul Scott?
20 A. Yes, I do.
21 Q. We have previously heard that EPUT was formed at the
22 beginning of April 2017 by the merger between South Essex
23 Partnership University NHS Foundation Trust and North
24 Essex Partnership University NHS Foundation Trust. But
25 we are unlikely to be referring to the predecessor trusts

1 because Oxevision, as we heard yesterday, and we will
2 discuss later today, was first rolled out at EPUT in
3 2020. Is that correct?

4 **A.** Yes, that is right.

5 **Q.** Before we move on, I understand there is something you
6 would like to say?

7 **A.** Yes, thank you. I would like to say how sorry I am to
8 all of those who lost loved ones under the care of mental
9 health services in Essex, for the poor care that they
10 received. I would also like to apologise, if I may,
11 Chair, to you and the other Core Participants and
12 especially the witnesses for the late submission of
13 evidence in the April hearings and in particular the
14 impact that had on the Inquiry and those other witnesses,
15 thank you.

16 **Q.** Today we will be discussing EPUT's use of the Oxevision
17 system, which is provided by a company that was formerly
18 called Oxehealth, but has recently rebranded to the name
19 LIO, Capital LIO. For the sake of simplicity, I suggest
20 that today we refer to Oxehealth.

21 **A.** Yes.

22 **Q.** We considered Oxevision and how it operates yesterday
23 with Laura Cozens, who is Head of Patient Safety and
24 Quality at Oxehealth. And she described the operation of
25 the system, its advantages, as Oxehealth perceives them,

1 and I asked her about concerns that had been raised about
2 the way Oxevision operates in practice, amongst other
3 matters. I understand you heard her evidence yesterday.
4 Is that right?

5 **A.** Yes, I did in full.

6 **Q.** We heard that Oxevision is a type of technology that is
7 sometimes referred to as a vision-based patient
8 monitoring system or VBPMs or sometimes just VBMS. Is
9 that correct?

10 **A.** Yes.

11 **Q.** Could you confirm that Oxevision is the only vision-based
12 patient monitoring system in use by EPUT in mental health
13 inpatient wards and units?

14 **A.** Yes, I can confirm that.

15 **Q.** You described Oxevision in your first statement as a
16 vision-based patient monitoring system to monitor vital
17 signs of patients within select single occupancy rooms
18 and secure environments. Correct?

19 **A.** Yes.

20 **Q.** You also referred to Vital Signs software, which we heard
21 about yesterday, and say that it operates with an
22 infrared sensitive camera linked to an interface in a
23 nurses' station and on portable tablets, and you add it
24 does not require the patient to wear or be connected to
25 any device. Now, we heard and saw an example of a camera

1 monitor and tablets yesterday, but I would like just to
2 remind us of that before we move on. So I am going to
3 ask that the slide from yesterday is put up, please,
4 OXHE009041 at page 4. We can see the camera unit there
5 on the left-hand side. Is that right?

6 **A.** Yes, it is.

7 **Q.** It is effectively split into two, and we can see two
8 squares on the left-hand side, do you see those?

9 **A.** Yes.

10 **Q.** From what I understood yesterday, are those the infrared
11 sensors or emitters?

12 **A.** Yes, as I understand it, although Oxevision are best to
13 advise on their specific hardware.

14 **Q.** And we heard that they glow, in fact, all the time?

15 **A.** Yes.

16 **Q.** And the camera would be to the right of that unit,
17 correct?

18 **A.** Yes.

19 **Q.** And then we can see a monitor in the middle there, that
20 would be found in the nurse's station, right?

21 **A.** Yes.

22 **Q.** And an example of a tablet that individual members of
23 staff might carry with them?

24 **A.** Yes.

25 **Q.** Thank you. Could that go down, please. You add that

1 Oxevision is used as an assistive tool for staff working
2 on EPUT wards with a view to improving and enhancing
3 patient safety, and you say it is intended for
4 non-invasive spot measurements of pulse rate and
5 estimated breathing rate, so that staff do not need to
6 disturb a patient's sleep to undertake these
7 measurements. You add this, and this is paragraph 9 of
8 your first statement:

9 "It is not a substitute for staff visually
10 confirming that a patient is safe", and we will come back
11 to that particular point.

12 Is it right, as we have heard, that Oxevision
13 was first rolled out at EPUT in April 2020?

14 **A.** Yes.

15 **Q.** Was that initially to two wards and then the rollout
16 continued from there?

17 **A.** Yes. There was a pilot and it is set out in paragraph 14
18 of my statement.

19 **Q.** In fact, it was the pilot. As we will hear, it was the
20 pilot in relation to four wards?

21 **A.** Yes.

22 **Q.** We are going to have a look at the list in a moment?

23 **A.** Yes.

24 **Q.** You say Oxevision has been introduced in EPUT across
25 selected in-patient wards, seclusion rooms and

1 health-based places of safety and we will come back to
2 this point as well.

3 **A.** Yes.

4 **Q.** We also heard yesterday about another aspect of the
5 Oxevision system that is called Oxevision observations,
6 or sometimes shortened to Oxe-Obs. This is what you tell
7 us about it in your first statement, these are paragraphs
8 27 and 28 but I will summarise.

9 Oxevision observations is a digital
10 observation module within the Oxevision system. It is a
11 digital version of the paper observations record and is
12 implemented only on Oxevision equipped in-patient wards,
13 seclusion rooms and health-based places of safety.

14 You describe how staff carry out on time
15 observations using the handheld tablets, we have just
16 seen, and that this allows for the recording of comments,
17 individual risk factors and assists in the identification
18 of trends, and you say that it provides a clear record of
19 observations in a digital format for integration to
20 EPUT's electronic patient record, and you mention that it
21 is necessary at the moment manually to upload the
22 observations to the EPR (the electronic patient record)
23 but you at EPUT are hoping that after some delays, this
24 process will be automated. Is that all correct?

25 **A.** Yes.

1 Q. At this stage I would like to look at a recent document
2 from EPUT that covers both Oxevision Vital Signs and
3 Oxevision Observations. This is the clinical safety case
4 report for Oxevision and Oxevision observation from 30
5 April this year. Could we put up, please, EPUT008999 at
6 page 5. Thank you. Can we see here modules of the
7 Oxevision system. Would it be possible, Amanda, to
8 expand from that down, or if it is not, maybe just
9 highlight. Thank you that's perfect. Just reading part
10 of this first, can we see there "Modules of the Oxevision
11 System" and first of all we see, "Oxevision Vital Signs".
12 Just reading the third and fourth bullet points what they
13 say is this:

14 "The Oxevision Vital Signs provides pulse rate
15 and breathing rate measurements to a clinically validated
16 accuracy and is also not intended to be relied upon as
17 the sole basis for clinical decision-making".

18 And this adds:

19 "The Oxehealth Vital Signs device is for
20 spot-check observations; it does not provide alerts for
21 vital signs, for example high/low pulse and/or breathing
22 rate."

23 May I just ask a question arising from that.
24 Why is Vital Signs not intended to be relied on as the
25 sole basis for clinical decision-making?

1 **A.** I mean, there's very few things that you would rely on as
2 a sole basis for clinical decision-making. As I said,
3 I'm not a clinician, but you know each patient will be
4 under the care of a responsible clinician and that
5 clinician will take into account many different factors
6 in determining their care plan, and the point here -- and
7 the multidisciplinary team that supports that responsible
8 clinician. And the point here is that, you know this may
9 be useful information, but it should not be the sole
10 piece of information for decision-making.

11 **Q.** It is part of a bigger picture?

12 **A.** That's absolutely right.

13 **Q.** Because a pulse and a breath rate will only get you so
14 far?

15 **A.** That's right, yes.

16 **Q.** So if there was a problem with a patient, there are other
17 things you would like to do, for example measure blood
18 pressure?

19 **A.** It may well be the case, yes.

20 **Q.** Thank you. Can I ask you this. What do staff actually
21 do with the information that Vital Signs provides, other
22 than have the system log it?

23 **A.** I mean, one of the things where this has been useful,
24 which I've been told about by staff, is, for example,
25 it's helped to identify sleep apnoea because the trend

1 has allowed staff to identify there is a physical health
2 trend here that is not what we would normally expect. So
3 staff have used this reporting as an input into the
4 multidisciplinary and team, you know, reviews of
5 patients, et cetera.

6 **Q.** I suppose the point that I am really making is this.
7 What Vital Signs is providing is pretty limited, isn't
8 it?

9 **A.** I mean, it -- as with all inputs to decision-making, it
10 has limitations to it, yes.

11 **Q.** Just looking a little bit further down the page, we can
12 see it says also:

13 "The Oxevision activity tracker is intended to
14 display a warning and/or set off a visual and audible
15 alert if it detects activity in a room occupied by a sole
16 occupant, having detected occupancy, and" -- and then it
17 goes on to say this -- "The activity suggests that an
18 occupant is in a specified region within the room (such
19 as a doorway) or remains in that region for a specified
20 length of time;

21 The activity suggests that the occupant has
22 entered a camera blind spot or an adjoining area out of
23 the field of view (such as a bathroom), or remains in
24 that area for a specified length of time;

25 The activity suggests that the occupant is

1 making movements associated with leaving the bed region
2 or has got out of bed, having already detected occupancy
3 within the bed region. The activity suggests that the
4 occupant has left the room;

5 The activity suggests that a second occupant
6 has entered the room."

7 Now, that is quite a wide range of alerts. Are
8 these alerts, as far as you are aware, applicable across
9 all EPUT in-patient rooms or will some depend on the type
10 of ward or unit?

11 **A.** In each setting there is a process with the relevant ward
12 staff to make sure that all of the alerts that are
13 applicable there are right, and I think in particular in
14 seclusion rooms there's a difference, but largely in the
15 acute adult wards, then there's a similar deployment
16 across them.

17 **Q.** Thank you. So this document refers to an alert if a
18 patient is in their en suite bathroom, and we have heard
19 separately that this is triggered if they are there for
20 more than three minutes; is that correct?

21 **A.** Yes.

22 **Q.** Isn't it common that somebody will be in the bathroom for
23 more than three minutes and won't that lead to a large
24 number of alarms?

25 **A.** So it's not uncommon. Bathrooms are a known risk area.

1 It doesn't mean that, you know, this is something that's
2 really important in our policy, staff members to follow
3 that policy must then attend. They may call out to the
4 patient within a room. It will be their professional
5 judgment to make sure that they have assured themselves
6 of the safety of that patient.

7 **Q.** Can we go to the next page, please, and please expand the
8 second bullet point. Thank you. This is just on
9 Oxevision observations, Mr Trent. We can see here:

10 "Oxevision observations is intended for
11 digitally recording the results of non-intrusive patient
12 observations in situations where regular checks of
13 patient location, presentation, and breathing status are
14 required (normally referred to as 'level 1' and 'level 2'
15 observations" -- and they are referred to also as
16 "general observations" or "intermittent observations" --
17 "The Observations product is for digitally recording
18 patient observations and does not have any medical
19 diagnosis or monitoring capability."

20 Now, first of all, are there different levels
21 of observation within EPUT?

22 **A.** Yes, four levels.

23 **Q.** And do they include level 1, general observations, which
24 is the minimum level, is that correct?

25 **A.** Yes. It's set out in detail in the observation and

1 engagement policy.

2 **Q.** Thank you. In terms of level 1, are you aware that that
3 involves knowing the patient's location but without the
4 need to keep them in sight?

5 **A.** Yes.

6 **Q.** Does that sound right? And as we have seen, there are
7 then the enhanced observation levels from 2 to 4, yes?

8 **A.** Correct.

9 **Q.** And is the minimum of the enhanced levels, level 2,
10 intermittent observations, where it's necessary to check
11 the patient a minimum of four times an hour?

12 **A.** Yes, and it's important to understand with that that it
13 may be more than four times per hour and it should be not
14 predictable. You know, the point is that if you were
15 doing that exactly every 15 minutes, you wouldn't be
16 following the policy. The policy that there should be
17 some variation in it, but a minimum of four. Of course
18 colleagues do use professional judgment where they might
19 have a reason for concern to do an additional
20 observation. That would be absolutely in line with the
21 policy.

22 **Q.** Now, these are observations that would previously, before
23 the deployment of the technology, have been conducted by
24 a member of staff visibly checking on the ward. Is that
25 correct?

1 **A.** Yes, but the deployment of the technology doesn't change
2 that. The expectation in our policies is that staff will
3 still make a direct observation and engagement, but they
4 may use the system to assist them in doing so.

5 **Q.** Can we unpick that. Are you saying that effectively all
6 that is happening is that in-person observations continue
7 in exactly the same way, and they are just being logged
8 on the tablets, or are you saying that the observations
9 are in part at least being conducted remotely, through
10 the monitor in the nurses' station or through a tablet?

11 **A.** Observations should not be conducted remotely. You know
12 that's not what our policies say. When a member of staff
13 is undertaking engagement, and the engagement part, as
14 other colleagues, other witnesses have said, is really
15 important in the policy. People should be doing that
16 where they are able to see the patient and be assured.
17 The Oxevision system, that's why we describe it as an
18 assistant, an assistive system, is to assist them in
19 taking those observations at times. But the primary
20 observations and engagement should be done in person.

21 **Q.** Let's just be absolutely clear about your evidence,
22 please. We have got a Vital Signs function that allows
23 members of staff remotely to take pulse and breathing
24 rates. But that facility, the Vital Signs facility,
25 should not be used to conduct observations for other

1 reasons?

2 **A.** No, that's absolutely right. The technology here is to
3 assist staff in carrying out engagement and observations
4 in line with the engagement and observation policy. It's
5 not for another purpose.

6 **THE CHAIR:** I'm not sure you have quite answered that.

7 **A.** Sorry, Chair.

8 **THE CHAIR:** If we distinguish between observations, which are
9 prescribed by a care plan, for instance?

10 **A.** Yes.

11 **THE CHAIR:** For engagement with the patient, you are expecting
12 that to be done face-to-face?

13 **A.** Yes.

14 **THE CHAIR:** And the observation under the Vital Signs is only
15 to be used for the vital signs observation?

16 **A.** So the, you know, the vital sign can be taken as part of
17 the observation engagement with the patient. So if there
18 was a level 2 observation and the staff were going to see
19 that patient four more times, then they might use the
20 system to take a vital sign at the same time. I think
21 the particular value of the Vital Signs is, you know,
22 even at nighttime, if somebody was sleeping, staff, under
23 the policy, should go to the room. They may be able to
24 be professionally assured by visibly seeing the patient
25 and taking the observation with the system. It would not

1 be acceptable for them to have done that in the nurse's
2 office and say that was a complete observation.

3 **THE CHAIR:** Thank you.

4 **MR GRIFFIN:** Can we deal with nighttime just so that we are
5 really clear about your evidence. We heard yesterday
6 that one of the great advantages of Oxevision is that it
7 allows observations to be taken, for example, during the
8 night without disturbing the patient. Now if I have
9 understood your evidence correctly, even during the night
10 Oxevision should not be used to conduct remote
11 observations other than when there is a need to take
12 vital signs.

13 **A.** That's correct, so to conduct an observation in line with
14 the policy at nighttime a member of staff should go -- if
15 the patient was asleep in the bedroom, should go to that
16 bedroom door. They may use professional judgment on
17 whether they have looked through the door or they have
18 gone in, but they should be professionally assured that
19 that patient is safe and well. They can use the system
20 to take a vital sign to assist them. I was talking to
21 our trust wide quality matron for Oxevision about this
22 matter the other day and she said, "You know, I would be
23 looking to see the rise and fall of the patient's chest
24 to be professionally assured and the vital sign could
25 assist me in having that assurance."

1 **Q.** Thank you. When Oxevision is used for observation
2 purposes, well, when we are using the Vital Signs
3 function of Oxevision, we heard yesterday that staff are
4 accessing up to 15 seconds of clear view data using that
5 function. Do you agree with that?

6 **A.** Yes.

7 **Q.** And we heard reasons from Laura Cozens yesterday for
8 that?

9 **A.** Yes.

10 **Q.** Just one other thing and we touched on this yesterday,
11 but what was EPUT's role in the development of Oxevision
12 observations?

13 **A.** So we worked with Oxehealth to pilot that. One of the
14 reasons for that was, as you know, we had an inadequate
15 CQC rating on our CAMHS services and one of the things
16 the CQC were very concerned about was that there were
17 gaps in the observation records. One of the benefits of
18 the Oxe Observations digital system is the ward managers
19 can audit that in near realtime. So I've had
20 conversations with the senior manager for CAMHS who since
21 this has been implemented has said to me that, "I have
22 spotted where a member of staff was not carrying out
23 their observations and I have done it in near realtime
24 and they have taken corrective action." With the paper
25 records we wouldn't have been able to do that kind of

1 audit as quickly or easily.

2 **Q.** That's when you are using the tablet, for example, to
3 input information of an observation?

4 **A.** That's right and if I may say a little more on that, you
5 know, the tablet is assistive to the staff member. So if
6 we take that four times plus an hour, if it's gone over
7 15 minutes since the last observation it will nudge the
8 staff member and say, "You haven't completed another
9 observation." So that does assist our staff in making
10 sure they are taking timely observations. The further
11 point, and I know this has come up in inquests and
12 previous learnings, there has been concern about
13 falsification of records. You cannot falsify the record,
14 the observation record, using the tablet. You can record
15 a retrospective observation, so a staff member can go in
16 and say, for whatever reason, and there may be legitimate
17 reasons for that, they might have responded to an
18 incident or there may have been a problem with the
19 tablet, or whatever, "I didn't record these observations
20 at the time but I have now", but those would then be
21 noted as retrospective.

22 **Q.** So the tablet will inform anyone interrogating the
23 system, or the system would inform someone that these
24 entries have come after the event?

25 **A.** Absolutely so. That provides better ward level oversight

1 of observation practice and that was why we wanted to
2 work with Oxehealth to develop it.

3 **Q.** Thank you. We heard yesterday from Laura Cozens that a
4 live blurred view of the patient is available through the
5 system when an alert has been triggered by the system and
6 available for up to 15 seconds. Is that correct at EPUT?

7 **A.** Yes.

8 **Q.** And the Oxehealth Vital Signs process allows, as we have
9 seen, a clinician to access a 15 second live clear video
10 feed of the patient in their room before taking the vital
11 signs measurement. Can we look at a recent EPUT document
12 that covers this. Could you put up, please, EPUT009884
13 at page 11 and expand the second half of the page from,
14 "There are just two conditions." Mr Trent, this is from
15 the most recent Standard Operating Procedure at EPUT in
16 relation to Oxevision. Can we see here:

17 "There are just two conditions where visual
18 displays are available" -- and then the first bullet
19 point says this:

20 "During an alert ... A live 15 second
21 anonymized/blurred view is available ..."

22 Then a little further down it says:

23 "Remote viewing by camera does not negate the
24 requirement for an in-person clinical assessment. Only
25 when the in-person assessment is completed can an alert

1 be reset."

2 Is that what you were talking about a little
3 earlier on?

4 **A.** Yes, absolutely. So you know, one of the concerns that I
5 understand that people have around this system is that an
6 alert, a warning or an alert may go off and staff have
7 reset that without being professionally assured that the
8 person concerned is safe and well. So our policy is
9 clear that you should not be resetting an alert without
10 actually going to see the patient and being
11 professionally assured that they are safe and well.

12 **Q.** Has that always been part of the policy since the first
13 deployment of Oxevision or is that a recent development?

14 **A.** I believe that has been part of policy for some time. I
15 would have to review the historical versions to be able
16 to confirm that over the full period.

17 **Q.** So we may come back to you about that after you have
18 concluded your evidence. There may be further matters as
19 well.

20 **A.** Certainly, I am very happy to provide further evidence to
21 the Inquiry.

22 **Q.** I can say this, having looked at the earliest SOP that I
23 have been able to find from 2021, that that contains a
24 similar instruction.

25 **A.** Thank you.

1 **Q.** Is there a requirement within Oxevision or elsewhere for
2 staff to confirm that they have conducted an in person
3 assessment?

4 **A.** Within the system, within the Oxevision system?

5 **Q.** Or anywhere.

6 **A.** I don't think there's a specific tick box. The system
7 does have free text -- well, it has a couple of things.
8 So when they are doing an observation it will ask where
9 the patient was and so that will be preconfigured for a
10 ward. So the person undertaking the observation might
11 tap on they were in the communal living space or in the
12 bedroom or wherever they were at that time. There will
13 also be an opportunity to talk about the patient's mental
14 state and wellness and again options there. And there's
15 a free text to describe anything else, but not a
16 specific, "Did you go and do this in person?" However,
17 what I would say with this is, is that, you know, that's
18 covered in the policy and the training and, you know,
19 when we are talking about -- and I think this is a really
20 important matter when understanding technology in a
21 healthcare context -- there are multiple systems of
22 control here. You know, we expect staff to behave
23 professionally according to their training, to their
24 qualification and registration where applicable, and
25 according to the Trust policies, and we expect them to do

1 that using any system to whatever level of further
2 control there is built into the system.

3 **Q.** We are going to come on to talk about auditing, for
4 example, a little later on and that might be an aspect of
5 what you are talking about. I want to now move to the
6 advantages, as EPUT perceives them, to Oxevision. I
7 think you have touched on a couple already. You say in
8 paragraph 10 of your first statement that:

9 "Oxevision has been introduced in EPUT" -- as
10 we have heard -- "across selected in-patient wards,
11 seclusion rooms and Health Based Places of Safety to
12 enhance and improve patient care and safety in order
13 to" -- and then you list a number of items -- "Reduce the
14 risk of self-harm, including ligatures. Identify periods
15 when patients may spend prolonged times in bathrooms and
16 blind spots. Reduce the risk of multiple people in a
17 room at one time. Provide patient-centric reporting to
18 support patient care planning. Enhance a preventative
19 awareness for patient risk associated to falls."

20 Elsewhere you cover the availability of data
21 from Oxevision including following an incident, and we
22 may come on to aspects of that. Are there any other key
23 benefits to Oxevision that you would like to explain to
24 us now?

25 **A.** I think those have covered the key points.

1 Q. So moving to the use of data from Oxevision, the data it
2 produces, the system produces, can that be used for a
3 variety of reasons?

4 A. Which data do you mean specifically?

5 Q. Any of the data that Oxevision produces. Can that be
6 harnessed for a variety of different reasons?

7 A. I mean, any use of data must be for a purpose that's
8 consistent with the way it was collected. So, you know,
9 I think that's, forgive me, that's why I asked about
10 which specific elements --

11 Q. Shall we come on, rather than ask you a general question,
12 shall we come on and I will ask you about specific
13 aspects?

14 A. Yes, thank you.

15 Q. Can we start with usage reports?

16 A. Yes.

17 Q. We heard yesterday from Laura Cozens about these and I
18 would like to ask you some questions about them too,
19 please. Is it right that these provide details of the
20 use of Oxevision at EPUT?

21 A. Yes, it is.

22 Q. And are they sent by Oxehealth to EPUT at regular
23 intervals?

24 A. Yes.

25 Q. You refer to them in your first statement, this is

1 paragraph 60, where you explain that they are:

2 "Provided to ward managers and matrons on a
3 weekly and monthly basis for local monitoring and
4 discussion with staff."

5 What do you mean by "local monitoring and
6 discussion with staff"?

7 **A.** So I gave an example earlier of the scrutiny of
8 observations and being able to identify any gaps and so
9 on, but equally if there were any. If, for example, we
10 saw a particularly higher number of observations, and I
11 appreciate having heard others' witness evidence as an
12 area of concern, that might be a matter that was then
13 considered by the local ward management to understand,
14 you know, was there a legitimate reason for that. Of
15 course, level of acuity on wards will change, so if you
16 had a ward with higher acuity you would expect to see
17 more observations and more recordings. And of course,
18 you know, we have talked about, sorry, the Inquiry has
19 heard evidence about, the circumstances in which an
20 observation will complete or not with people moving
21 around. So, you know, a patient who is moving around a
22 lot you may have more failed attempts, et cetera. So
23 those reports are shared in order that there can be local
24 oversight of the system, is a more concise answer.

25 **Q.** That is helpful, thank you, just to pick up on something

1 you said in case people didn't hear everything that you
2 said, did you say that, for example, you refer to a
3 particularly higher number of observations, and then I
4 think what you said was that that might be a matter that
5 would be escalated to the local -- by the local ward
6 management, is that right?

7 **A.** Yes. So because the project board on a monthly basis
8 oversees these reports, if the project board had on a
9 Trust wide basis, if the project board had concerns then
10 the Trust wide quality matron will pick that up with
11 local wards as well, and she does regular visits to the
12 wards to discuss Oxevision and how it is used.

13 **Q.** Thank you very much. Let's look at an example of a usage
14 report that you have provided to us from July 2024. The
15 report addresses all ward usage over the last month.
16 Could you put up please EPUT009021 at page 30 and expand
17 the top third of the page. We looked at this yesterday
18 with Laura Cozens and can we see on the left the ward
19 name and then we see a column for "Vital Signs Attempts"
20 and we established with Laura Cozens yesterday that that
21 means the number of times a member of staff has used the
22 system to access up to 15 seconds of clear view video
23 prior to making a vital signs check?

24 **A.** Yes.

25 **Q.** Would you agree with that?

1 **A.** Yes, I would agree with that, yes.

2 **Q.** And next to that "Vitals Displayed". Does that mean --
3 well Laura Cozens told us yesterday that that means the
4 number of successful attempts to take vital signs, would
5 you agree with that?

6 **A.** Yes, so giving a specific example of Cherrydown Ward;
7 it's 10,000 attempts and 4,200 displayed, so 42 per cent
8 of those attempts resulted in a displayed or a completed
9 process and I was at Cherrydown last week visiting.

10 **Q.** Thank you. We looked at this yesterday and you may have
11 been there when we did, but the discrepancy that you have
12 just identified between the number of attempts and the
13 number of times that vitals are successfully displayed
14 carries on through all of the wards, as we saw when we
15 scrolled down. Can we look at a different part of this
16 please? Could you go to the bottom of the page where we
17 see The Lakes in the left-hand column and read the
18 Ardleigh Ward statistics? So here we see that there have
19 been 35,665 "Vital Signs Attempts", and only 9,413 times
20 were vitals successfully displayed. That reflects, I
21 think you referred to a rate of about 40 per cent before,
22 this reflects a rate of about a quarter, where the
23 attempt is successful. So that might be the largest
24 discrepancy on the page, but would you agree that what
25 this page shows, and that example in particular, is that

1 it takes a lot of attempts successfully to get a proper
2 vital signs reading?

3 **A.** That's likely to be a key part of the variance. I know
4 other witnesses have highlighted a concern about, you
5 know, whether this is being used inappropriately as well.
6 I understand that. You can't tell from this data, you
7 know, just in this report alone, what has driven that
8 discrepancy. So I can't be determinative and say it was
9 because the patients were moving -- you know, were moving
10 in a way that the system couldn't accommodate or there
11 were multiple people in rooms. I can't tell that from
12 this report but the discrepancy I accept.

13 **Q.** So let's unpick that. There is the possibility of
14 inappropriate use, we will come back to that if we may.
15 But first of all, do you accept that in principle, as
16 this data shows, it takes a lot of attempts before vitals
17 are successfully taken?

18 **A.** I mean, it can do. I think as we have heard in evidence
19 from Oxehealth, you know, if you are taking a vital and a
20 patient is lying in bed and their skin is visible, then
21 it should work first time. If you were trying to take a
22 vital sign and the patient was moving around or restless,
23 for example, in their sleep, it may not work. So you
24 know, I can't say definitively it takes many attempts or
25 it takes a few because it depends on each case.

1 Q. Could we see the whole of this page again, please? What
2 this shows us, at least from July 2024, is that this
3 discrepancy exists in all of the wards?

4 A. Yes it does, I agree that.

5 Q. So it is not ward, it is not specific to a particular
6 kind of unit. But if I have understood your evidence
7 correctly but please tell me if I have got this wrong,
8 there is a theme that is identified here that it takes
9 lots of attempts successfully to record vital signs?

10 A. Correct.

11 Q. Is that a wider issue? So, for example, not confined to
12 July 2024?

13 A. Yes, I believe so, yes.

14 Q. Thank you. You also mentioned the possibility of
15 inappropriate use. Might the statistics suggest that
16 staff are using the Vital Signs function effectively as a
17 CCTV system by repeatedly accessing the 15 second clear
18 view video function?

19 A. If I can differentiate for a moment between the
20 definition of CCTV and whether staff are taking
21 additional -- taking, you know, additional views, as it
22 were. It is possible that staff have taken additional
23 views over and above what is prescribed in the policy and
24 it is precisely because of that risk that the latest
25 policy and indeed the staff communications were

1 absolutely explicit that any additional observation taken
2 in that way must be documented in the record. So as a
3 Trust we are clear and we have sought to reassert this
4 with staff that you should not be using the system to
5 take additional observations in that way.

6 **Q.** So just putting CCTV, the term, to one side. We heard
7 yesterday from Laura Cozens that it is possible using
8 this system repeatedly to press the button on the tablet
9 to get a continued 15 second clear view feed.

10 **A.** I mean, you would have to repeat the workflow each time
11 so there might be a short pause in between each feed
12 because you would have to click through some buttons.
13 That is clearly an inappropriate use of the system. That
14 is not what we would expect our staff to be doing, that's
15 not what our policies say and that would not be
16 appropriate in terms of, you know, professional standards
17 either. So when I referred earlier to systems of control
18 and this applies, as I say, to all technologies that we
19 use, while the system itself doesn't have a control to
20 prevent that, we have other controls in terms of our
21 policy and training and professional standards for staff
22 which would mean that we would not expect staff to be
23 misusing the system to that effect.

24 **Q.** This is the second time that you have said you wouldn't
25 expect staff to act contrary to EPUT policy, but don't

1 these figures, the ones on the screen here, raise the
2 real possibility that the system is being misused?

3 **A.** I agree there is the possibility of that and it's why we
4 have taken actions to strengthen that, it's why there's
5 oversight at the project board and why these reports are
6 then shared with wards. You know as Paul Scott said in
7 his position statement, the Trust is still working
8 continuously to improve compliance with policies and
9 procedures and you know, I know we will talk later about,
10 you know, how the implementation of the SOP is going and
11 I will say more there about that.

12 **THE CHAIR:** When did you change the policy in relation to this
13 specific issue of misuse of observations?

14 **A.** So that was in version 12, the one that was released on 7
15 May, where we specifically -- I mean it would have been
16 contrary to our policies prior to that, but we made it
17 explicit that that was not an appropriate use and we
18 further highlighted that in all staff communications.
19 Prior to that it would still have been inconsistent with
20 our policies but we hadn't called it out explicitly in
21 the document.

22 **THE CHAIR:** And have you done any work to try and ascertain
23 what this discrepancy is actually down to on any
24 particular ward?

25 **A.** I know that the quality matron has visited those wards

1 and the project board has been looking at it. I don't
2 know whether there has been a further detailed analysis
3 but it's something certainly, Chair, that we could come
4 back to you on.

5 **MR GRIFFIN:** Can we stay with the Ardleigh Ward and look at
6 another aspect of this usage report, please. Could you
7 put up EPUT009021 at page 24 and expand part 1 at the
8 top? Perfect. Now this shows the number of "Vital Signs
9 Attempts" made on the ward on each day of the month, so
10 we can see the days of the month from 1 to 31 along the
11 bottom. We can see that the figures fluctuate, but can
12 we see that, for example, on 28 June, there were 2,219
13 attempts and 1,676 of those were made during the day and
14 the others overnight. We can tell that from the
15 different colours on the bar chart. Is that correct?

16 **A.** Yes.

17 **Q.** Now, Ardleigh Ward is a female acute ward; is that
18 correct?

19 **A.** Yes.

20 **Q.** And it has 18 beds; correct?

21 **A.** Yes.

22 **Q.** And the document, this document, tells us elsewhere that
23 daytime is defined as from 8 am to 8 pm, would you agree
24 with that?

25 **A.** Yes.

1 Q. So what do you think is going on there? The number of
2 attempts, 2,219, with 1,676 of those being made during
3 the day. Do you agree that it seems high?

4 A. It's certainly the modal point in that month, being the
5 highest number in that month. I don't know from this
6 report what's happened on that particular day in that
7 particular ward. And I mean that's exactly why these
8 reports are reviewed and shared so that, you know, so
9 that changes in the trend can be reviewed but I couldn't
10 speculate here on the precise reasons for that.

11 Q. Could you expand part 2 in the middle of this page,
12 please? This section covers how many alerts have you had
13 and how quickly are they reset over the last month, and
14 we can see that there are different categories. So at
15 the shortest between 0 and 15 seconds, then between 16
16 seconds and 2 minutes, and then over 2 minutes. We can
17 see again analysis over each separate day during the
18 month. In fact, the number of alerts on the ward
19 fluctuate, as one might expect, but they range from 159,
20 that's day 26, to 269 on day 9. We can see that on all
21 days the clear majority of alerts were reset in 15
22 seconds or less. Again, the figures vary day by day,
23 ranging from 59 per cent on day 6 to 86 per cent on day
24 16. So those are cases where the reset was in 15 seconds
25 or less. Would that suggest that staff members are often

1 not conducting in person checks of patients following an
2 alert?

3 **A.** I mean, there could be multiple reasons for that. So you
4 know, for example, staff members are not confined to the
5 ward office, they will be out and about on the ward, and
6 so if an alert goes off at a point where they are close
7 to a patient they may reset it quickly. Equally, if they
8 have just done a check on a patient, for example, then
9 they might be professionally assured that the alert, you
10 know, that they have dealt with the risk the alert was
11 alerting to. So there are multiple reasons that a staff
12 member may appropriately reset an alarm quickly.
13 However, it's also possible that staff have reset that
14 prior to undertaking the professional observation and
15 assurance, which is the wrong way around, according to
16 our policy. And you know, again this is exactly why this
17 data is valuable, why it is overseen at the project board
18 and shared with the wards.

19 **Q.** But another reading of the data is that they are not
20 conducting in person checks, would you agree with that?

21 **A.** It's possible that that is part of the data but you know,
22 this is -- you know, this data is one point of evidence
23 and it's why we undertake audits and visits and other
24 practice as well. So it, as you say, it can point you in
25 a certain direction for further investigation.

1 **Q.** Finally, on this we can see a number of instances where
2 it has taken over 2 minutes before an alert is reset.
3 For example, we can see that on day 1 it happened 236
4 times. What would be the possible reasons for such
5 delays?

6 **A.** I mean there's plenty of legitimate reasons for that. I
7 mean, you know, if somebody was in crisis, the first
8 priority is to support that person in that moment of
9 crisis, not to reset the alarm. So you know, if somebody
10 went to engage and observe a patient and needed
11 clinically to support that patient in some way, that may
12 well take longer than 2 minutes.

13 **Q.** Another way of looking at it though, would you agree, is
14 that it is taking staff too long to conduct a check?

15 **A.** Well, again, I think that depends on the circumstances.
16 So you know, yes, if staff were taking too long, you
17 know, in the sense that they didn't actually attend to
18 the patient for over two minutes, that would be taking
19 too long. If they didn't reset the alarm because we have
20 said you must attend to the patient first, then that
21 would be appropriate behaviour. And you know this is the
22 kind of thing again that the nurse in charge and the ward
23 manager and matrons, you know, will be concerned with
24 about conduct on their wards.

25 **Q.** Thank you, would you take that down, please. We heard

1 yesterday from Laura Cozens about Vital Signs trends
2 data. In short, we learned that in addition to the
3 manual vital signs checked conducted by staff using the
4 system, Oxevision also attempts automatically to collect
5 vital signs in the background. Is that a facility also
6 at EPUT?

7 **A.** Yes, I believe so.

8 **Q.** This is then used as part of a report showing a summary
9 of average vital signs data, correct?

10 **A.** Yes.

11 **Q.** I am going to move on to the use of data in serious
12 incidents. Shall I -- I will keep going for another five
13 minutes or so. So the use of Oxevision data in serious
14 incidents, please. I think we have established that the
15 system is able to assist, or at least provide some data
16 in those circumstances. Is that right?

17 **A.** Yes.

18 **Q.** And we heard yesterday from Laura Cozens that this data
19 includes both video data and other incident data, such as
20 reports; correct?

21 **A.** Yes, yes.

22 **Q.** Could we deal with one aspect of that please. You
23 explain in your first statement that it's possible, after
24 an incident, for Oxehealth remotely to extract clear
25 video data from the Oxevision server and provide it to a

1 designated recipient at EPUT; yes?

2 **A.** Yes.

3 **Q.** You add that clear video data must be requested by a
4 member of staff within 24 hours of an incident, otherwise
5 data is automatically overwritten and you add, "The
6 Oxevision system runs on a" -- and these are the words
7 you use -- "24 hour rolling buffer, meaning that the
8 footage overwrites, i.e. automatically deletes, itself
9 every 24 hours and the clear video data becomes
10 irrecoverable."

11 You say that information, once it has been
12 extracted within that 24-hour period, is retained until
13 its purpose is exhausted, for example once a coroner's
14 process has concluded. Is that all correct?

15 **A.** Yes, but of course we have the moratorium, from the?
16 Inquiry on the deletion of evidence, so we are not
17 deleting any of those records in the way that's just
18 described.

19 **Q.** So absent a statutory public inquiry, would that have
20 been correct?

21 **A.** That's absolutely right, yes.

22 **Q.** Is there a mechanism or protocol in place for
23 automatically requesting clear video data within 24 hours
24 following an incident?

25 **A.** Yes, in the incident management policy it sets out that

1 you should request, that's one of the actions that you
2 know responsible colleagues should undertake during the
3 immediate circumstances after a serious incident.

4 **Q.** Thank you. That does take us to just before half-past.
5 Chair, may I ask that we rise now and return at 2.15, so
6 45 minutes rather than one hour? Thank you.

7 **THE CHAIR:** Yes.

8 **(1.27 pm)**

9 **(Break for lunch)**

10 **(2.17 pm)**

11 **THE CHAIR:** Mr Griffin?

12 **MR GRIFFIN:** Can we move on now, Mr Trent, to discuss some of
13 the concerns that have been raised about the operation of
14 Oxevision. One of those concerns relates to its
15 operation, in the way it creates multiple alerts, and we
16 have spoken about that already, which it may be hard for
17 staff to monitor and could lead to alarm fatigue. Is
18 that a risk or a concern that you are aware of?

19 **A.** I'm aware of that concern.

20 **Q.** You say in your first statement, and this is paragraph
21 29, that:

22 "In May 2021, EPUT's Oxehealth project board
23 explored the potential to lock down the audible alert
24 volume to 75% on the fixed monitors. This was explored
25 to remove the potential for staff to be able to

1 physically change the volume setting. The outcome was
2 that there wasn't a practical method to eliminate the
3 possibility on the fixed monitors. However, all tablets
4 are preset at 75% volume and are not adjustable by
5 staff."

6 That was before you joined EPUT, but is it in
7 fact the case that the catalyst for making this enquiry
8 with Oxehealth was the death of a 16-year-old patient,
9 Elise Sebastian, the previous month?

10 **A.** Yes, that is correct.

11 **Q.** Elise's death was on 19 April 2021. Oxevision had been
12 introduced in the ward two months beforehand. Did
13 Elise's death reveal that staff were muting or reducing
14 the volume of Oxevision alerts on wards?

15 **A.** Yes, it did.

16 **Q.** Was this considered a clear risk to patient safety?

17 **A.** Yes, it was.

18 **Q.** Why would staff mute or reduce the volume of Oxevision
19 alerts?

20 **A.** I do not know why staff in that case behaved in that way.

21 **Q.** Could it be the result of alarm fatigue?

22 **A.** That's one possible analysis.

23 **Q.** Laura Cozens referred in her evidence to a number of
24 inquests, this was yesterday, following deaths at EPUT
25 where Oxevision had been used. Three of those inquests

1 involved the muting or resetting of alarms by staff.
2 Now, we have just spoken about the situation with Elise
3 Sebastian on 19 April 2021, but there was also Michael
4 Nolan, who died on 10 July 2022. That would have been
5 shortly after you joined, I think, EPUT, correct? And
6 then the death of Morgan-Rose Hart, who died two days
7 later on 12 July 2022. As we heard yesterday, those
8 deaths are 15 months apart. You would accept, would you,
9 that clearly there was an ongoing problem at EPUT with
10 staff muting Oxevision alarms?

11 **A.** I think it's important to distinguish two different
12 issues here that both relate to alerts and alarms. The
13 first issue, which I address in that first bullet point
14 at paragraph 29, was that the monitor had been turned --
15 the volume had been turned down and what that means in
16 effect was when an alarm was raised on the system, nobody
17 heard it because the volume was off. That's different
18 from an alarm being raised, a member of staff seeing and
19 hearing that alarm and inappropriately resetting it
20 without following the standard procedure to attend in
21 person. I think in these cases, there's a difference
22 between the way in which staff behaved and what the
23 coroners have found.

24 **Q.** I think what you are saying that there are different
25 categories of problem here, they both relate to system

1 alerts?

2 **A.** Yes. One of those was essentially a problem, you know,
3 in turning down the system so that people couldn't hear
4 any alarm at all, and the other was in how staff
5 responded to alerts, which you know, they responded in a
6 way that was not in line with the policy.

7 **Q.** Two issues relating to Oxevision alerts; correct?

8 **A.** Yes.

9 **Q.** And they don't appear to have been properly addressed, at
10 least for a period of years or at least very many months;
11 correct?

12 **A.** Well, as I say, they are different issues and I think,
13 you know, you have highlighted to me earlier that the
14 earlier version of the SOP had the point in it which
15 staff should attend to patients when there is an alarm
16 before resetting it. That point of policy was already in
17 place. Staff did not follow that, with tragic
18 consequences.

19 **Q.** You say in your second witness statement, paragraph 8,
20 there should have been greater oversight at the outset of
21 the practical use of Oxevision on the wards, in
22 particular to address alarm fatigue, and to ensure that
23 each alarm was always actioned by a face-to-face visit
24 with the patient and that alarm volume settings were not
25 adjusted by staff. Would you agree that it was entirely

1 foreseeable that staff might seek to mute Oxevision
2 alerts?

3 **A.** It's difficult for me to say whether that was foreseeable
4 or not. You know, what I'm saying in the second
5 statement is, you know, the Trust accepts that it should
6 have done better in relation to these matters in terms of
7 the oversight and management of staff and making sure
8 that staff were fully compliant with the policies and
9 procedures that were there.

10 **Q.** So my question was would you agree that it was entirely
11 foreseeable that staff might seek to mute Oxevision
12 alerts. Is your answer to that that you can't really
13 answer?

14 **A.** Well, my answer is that the policy was clear, and we
15 expect staff to follow policies and procedures, that they
16 should attend alerts and not reset them without
17 attending. However, as you say, there was a risk that
18 they didn't do that and I accept that that was a risk
19 and, as I say, you know, the Trust accepts that it should
20 have done more to manage those risks historically.

21 **Q.** Who was responsible for providing the necessary oversight
22 for matters such as this at EPUT?

23 **A.** So we touched on this very briefly earlier. The
24 oversight of staff on the wards sits with the nurse in
25 charge, the ward manager, matron and we have an

1 accountability framework system and a senior leadership
2 team accountable for a care group, such as in-patient
3 services that then reports into committees and the board.
4 So there's a system of accountability there. The
5 compliance and adherence to policies and procedures on a
6 day-to-day basis is something that the nurse in charge
7 and ward manager, and so on, should be overseeing.

8 **Q.** Was it not recognised by EPUT leaders that a newly
9 introduced technology required robust oversight to ensure
10 that it was functioning properly and safely from the
11 start?

12 **A.** So the Trust had in place a project board from the outset
13 of this programme of implementation, chaired by the Chief
14 Operating Officer, with clinical and operational leaders,
15 so there was a trust-wide oversight of the implementation
16 and there was also ward-specific and care group-specific
17 oversight as well. So you know, those mechanisms were
18 there, but they clearly did not prevent these tragic
19 events.

20 **Q.** Isn't that a theme, that there are policies and
21 expectations in relation to policies, but it doesn't
22 necessarily follow that if something is in a policy,
23 members of staff will follow it; correct?

24 **A.** I mean this is an issue that Paul Scott addressed in his
25 position statement, that matters of compliance with

1 policies has been an issue at the Trust and continues to
2 remain an area of focus as we go forward.

3 **Q.** And there may be systems in place and people with
4 designated responsibilities, but the fact that they exist
5 doesn't mean that they are actually working to reduce
6 risk or to address risk?

7 **A.** I mean, I think colleagues at the Trust are, you know,
8 really for the most part working hard and doing their
9 best to address those things. But it's evident and, you
10 know, we acknowledge in this statement that, you know,
11 that has not been done to the highest standard that it
12 should have been in the past.

13 **Q.** May I ask you some questions about tablets, please.

14 **A.** Yes.

15 **Q.** And we saw a photograph of a tablet. How many members of
16 staff on a ward should be carrying Oxevision tablets?

17 **A.** So I think that varies ward to ward and wards can request
18 additional tablets. I couldn't give you a specific
19 number.

20 **Q.** So Laura Cozens suggested that typically there would be
21 two or three a ward, but possibly more where Oxevision
22 Observations was being used. Does that sound like an
23 average or is it impossible to say?

24 **A.** No, it would normally be more than that because you would
25 have multiple staff members doing observations at any

1 given time. So I would say from my visits I have seen
2 four to six would not be unusual, but we can give you a
3 more definitive answer on the number of tablets if that
4 is useful to you, Chair.

5 **Q.** How is it decided who should carry a tablet? Is one
6 given to every member of staff, for example?

7 **A.** So you know the nurse in charge in a ward will assign
8 observations to different members of staff, like the
9 practice of conducting engagement and observation with
10 patients, and will be clear about which members of staff
11 are supporting which patients, and will ensure that those
12 members of staff have the tablet they need to do that.
13 The key here is that Oxevision is not a stand-alone
14 system, it is a tool that the staff are using to carry
15 out that. So the normal oversight of who is doing
16 observations will take that into account and ensure they
17 have got the right tools.

18 **Q.** So it is not on the basis of a particular category of
19 staff, it could anyone, for example, a healthcare
20 assistant or it could be someone much more senior?

21 **A.** Yes, often it will be a healthcare assistant, but you
22 know, nurses will also undertake observations. We have a
23 multidisciplinary team on the wards, so it's not limited
24 to one single profession, no.

25 **Q.** Are there backup tablets on a ward if one isn't working?

1 **A.** Yes, there's usually enough that you've got a couple
2 spare that could be used if is there a problem.

3 **Q.** Is malfunction an issue with either the hardware or the
4 software?

5 **A.** Not that's extensively reported. I think one of the
6 issues earlier on in the use or the deployment of the
7 tablets as an observation tool was making sure that the
8 trust had good enough wi-fi everywhere that the tablets
9 could upload to that. The software does have an ability
10 to hold data until they get back into wi-fi, though. A
11 staff member can still conduct their observation even if
12 they are outside wi-fi. I am pleased to say that the
13 wi-fi has improved significantly at the Trust, so that is
14 not a widely reported issue now.

15 **Q.** But it was, wasn't it, in Elise Sebastian's case, where
16 handheld monitoring tablets were not working because of
17 poor wi-fi?

18 **A.** That's correct. There was an issue with the software, I
19 believe as well, in that case.

20 **Q.** Stop Oxevision raises the possibility that non-medical
21 staff, other patients or visitors could also view
22 patients in their bedrooms from the Oxevision tablets or
23 possibly even a monitor. Would you accept that this
24 remains a risk in respect of the current use and
25 operation of Oxevision?

1 **A.** So I mean, in the nurses' station with the monitor,
2 you -- and I think this was shown on screen yesterday,
3 you have the tiles that don't show images, so you know,
4 that risk is minimised by those images not being
5 available unless gone into. Clearly, at any point that
6 somebody goes through the work flow, just as at any point
7 you are, you know, doing anything, somebody can look over
8 your shoulder. That is always an information risk. You
9 know, staff are aware of the importance of protecting
10 privacy and dignity for patients and just as they would
11 be cautious in, you know, knocking on a door where before
12 entering in normal circumstances, making sure that other
13 patients are not following them into the room, they
14 should be carrying out the same good practice in relation
15 to the use of the tablet.

16 **Q.** So that's the expectation. Do you know whether in
17 practice there is an issue with inappropriate use, for
18 example, of the clear view function, to access clear
19 views of people in intimate moments in their bedrooms?

20 **A.** I know that there's a concern about that and it's why we
21 changed the Standard Operating Procedure and made that
22 point -- the point I made earlier about making it
23 explicit about the use of how that should be used. It
24 remains a risk.

25 **Q.** What about access to the information on a tablet? Would

1 it be possible to access the Vital Signs function, for
2 example, the work stream, without having to log in or to
3 go through any security function?

4 **A.** I understand you have to log into the tablet to be able
5 to do that and you know, I also understand and we have
6 had conversations with Oxehealth about this, that they
7 are bringing in a new authentication capability which
8 will improve that, provide a better control in the
9 technology in the future.

10 **THE CHAIR:** Does the Standard Operating Procedure say anything
11 about those with tablets, staff members with tablets,
12 using them in a discreet way, not in open areas?

13 **A.** Chair, I would have to recheck that to be sure. The
14 engagement and observation policy, which is
15 cross-referred to in the Standard Operating Procedure for
16 Oxehealth, is clear about privacy and dignity and those
17 themes I think are borne across, whether it specifically
18 says in relation to the tablets, I'm not sure, I would
19 have to check that.

20 **MR GRIFFIN:** We are just checking that, Chair. My
21 recollection is that it doesn't?

22 **THE CHAIR:** Because it does pose a risk, doesn't it? You
23 talked about looking at the monitors in the nurses'
24 station, that is a closed environment, but the nurses
25 themselves are holding these tablets in their hand

1 because it's while they are out and about, while they are
2 engaging people, that is the idea. Clearly, that is
3 going to raise a risk that somebody can see what is on
4 their tablet?

5 **A.** Yes, I agree it is a risk. Engagements and observations
6 are more likely to take place in somebody's, you know,
7 room if you are using the Oxevision system because the
8 system is only for the private bedroom. So being near to
9 the room and such like.

10 **MR GRIFFIN:** Can I just ask you to clarify a part of your
11 evidence a moment ago. You said you thought people would
12 need to log in to use a tablet, but if the tablet was
13 left somewhere, would it be possible for a patient or
14 someone visiting the ward to pick it up and access, for
15 example, the clear view function?

16 **A.** I think the tablets lock after a period of inactivity. I
17 couldn't immediately tell you how long that period is,
18 but we could confirm that.

19 **Q.** Thank you.

20 **A.** Again, staff are clear that they must not put down the
21 tablets except in the nurse's office.

22 **Q.** Is there any policy that actually says that?

23 **A.** So there's training for staff with the Oxehealth Academy
24 and there's two courses there. There's an OLM training
25 course and then there's also a staff competency

1 checklist, which is where a more senior member of staff
2 on the ward will assess an individual as to whether they
3 understand how the system should be used and how to
4 ensure that it's used appropriately and to minimise the
5 risks around it.

6 **Q.** I am not sure that has answered my question, though. Is
7 there any policy that expressly says that staff shouldn't
8 put down tablets and leave them unattended?

9 **A.** I would have to re-review those documents to be sure, but
10 I mean, I think any policy or procedure, you know, we try
11 and make explicit as many aspects of risks as possible,
12 but there is an important point about reading those
13 policies and procedures in their principles, and they
14 will set out principles, often, of how staff should
15 behave and conduct themselves and I think these
16 particular examples would be inconsistent with the
17 overall principles and objectives of the policy whether
18 or not they are called out as specific points, but
19 certainly if they are not, those are areas we can improve
20 our policies and we would seek to undertake that.

21 **Q.** I would like to ask you next about a concern that the
22 presence of a camera in a patient's room may exacerbate
23 underlying conditions. As we have seen, the camera unit
24 in the bedroom is large and would be obvious to the
25 patient. Do you agree?

1 **A.** Yes.

2 **Q.** The Inquiry will be hearing in evidence this session from
3 Tammy Smith, and as we heard yesterday, her daughter,
4 Sophie Alderman, tragically died on 19 August 2022 while
5 an EPUT patient and the Inquiry will hear that the
6 presence of what was presumed to have been an Oxevision
7 camera in her room may have caused or exacerbated severe
8 paranoia. Should it not have been anticipated from the
9 start that for certain patients the presence of a camera
10 in their rooms might be troubling and could exacerbate
11 underlying conditions?

12 **A.** Yes, this should have been anticipated sooner and it's
13 one of the things that I have said in my statement. I
14 have heard Tammy Smith's impact statement to the Inquiry
15 and take extremely seriously the concerns there. I have
16 said in my statements, we have raised with Oxehealth
17 whether the equipment can be adjusted or a shutter or
18 some other mechanism put in place to reduce that risk and
19 I know, as we have heard yesterday, they are redesigning
20 it but we don't have a firm timeline, yet on when that
21 would be released.

22 **Q.** Is that in their hands because I think the evidence was
23 it wouldn't be until next year some time.

24 **A.** We are not able to, ourselves, make an adjustment to
25 those devices. If we did so, it could compromise their

1 capability in other ways. As an organisation,
2 strategically and in our policies, and you will see this
3 in the annex to the engagement and observation policy, we
4 have committed to becoming more trauma informed. This is
5 an area we have got more work to do. Responsible
6 clinicians, however, will have a responsibility and the
7 multidisciplinary team to ensure each patient is treated
8 according to their own need, presentations, et cetera and
9 has a care plan appropriate to them. So while we don't
10 currently have the facility to physically remove or block
11 the camera, those considerations should be taken into
12 account, any potential traumatic impact should be taken
13 into account by the care team in planning the care for
14 that individual.

15 **Q.** Thank you. We heard yesterday, and we have touched on
16 this today, that the illuminators I think you called
17 them, the infrared aspect of camera is glowing red all
18 the time. Isn't that a problem for patients for whom
19 the presence of a camera is already troubling?

20 **A.** Yes, I agree and I have acknowledged that in my third
21 statement. I mean, this is why it is so important that
22 we get right and acknowledge again that we have not
23 always gotten this right, the engagement with patients at
24 the point of admission and the material and information
25 that's given not just in paper, but verbally and through

1 ongoing discussions, you know, those are the mechanisms
2 that are so important for patients to understand the
3 system and how it's used.

4 **Q.** Another concern that has been raised is that in practice
5 the availability and use of the Oxevision system at EPUT
6 has undermined therapeutic engagement between staff and
7 patients, rather than supported it. I would like to ask
8 you about that now, please. You have referred to
9 Oxevision as an assistive tool for staff and you have
10 said that observations, other than for taking vital
11 signs, should be in person, yes?

12 **A.** Yes.

13 **Q.** In your statement you have add that:

14 "EPUT ward staffing levels are determined by
15 the Trust's safer staffing model, not the use of
16 Oxevision. There is not a separate staffing model for
17 the use of the technology on in-patient wards."

18 You add:

19 "Oxevision is operated by ward staff as part of
20 their normal duties therefore the use of the technology
21 does not affect the level of ward staffing in practice."

22 That's paragraph 55 of your first statement.
23 Do you think that is right, in fact? Do you think that
24 what you say there might actually represent the theory
25 rather than the practice?

1 **A.** No, I do think that's right. As Paul Scott said in his
2 position statement, over this period EPUT has increased
3 its substantive staffing since the point at which we
4 started implementing Oxehealth and the Time to Care
5 programme has added over 300 multiprofessional staff to
6 our wards. We've been under -- that Time to Care
7 programme really does also focus in on practise and, you
8 know, ties back to the guidance around fundamentals of
9 care and so on. So over the same period that we have
10 introduced and rolled out Oxevision, we have also
11 invested in staffing on our wards and we have also
12 changed -- we have improved that multidisciplinary mix
13 with peer support workers, that's people with lived
14 experience on our in-patient wards and activity
15 co-ordinators as two new roles, for example.

16 **Q.** But over the period we are talking about it has been an
17 issue, hasn't it?

18 **A.** Sorry, would you repeat that question. What has been an
19 issue?

20 **Q.** The issue of understaffing potentially and the issue of
21 EPUT staff relying too heavily on remote observations
22 rather than in person observations?

23 **A.** There certainly has been, you know, we have heard about
24 that in terms of the evidence from inquests and
25 elsewhere. Staff have over relied on Oxevision at times,

1 that's absolutely correct. We have significantly, as I
2 said, increased our nursing establishment and ran a
3 successful international recruitment programme as well,
4 you know, in the ways I have just described over that
5 period. However, as with all mental health trusts there
6 are days when staffing is pressured where, you know, on a
7 particular ward or a particular unit, for whatever
8 reason, we find ourselves pressured on staffing and there
9 are escalation processes and procedures to do that,
10 including getting additional bank staff or if necessary
11 agency staff to support on the wards.

12 **Q.** Do you agree that observations by staff in person are an
13 opportunity for establishing a therapeutic relationship
14 with a patient?

15 **A.** Absolutely and wholeheartedly.

16 **Q.** And does it follow if those observations are conducted
17 through a screen via Oxevision that opportunity for
18 therapeutic contact will be lost.

19 **A.** Yes, I agree.

20 **THE CHAIR:** Has Oxevision in fact made work for staff? You
21 talked about how the alert system requires somebody to
22 stop the -- to go and respond to those alerts and we saw
23 the numbers of alerts there have been. Would you think
24 that that has actually added to the burden of staff work?

25 **A.** It's a question I ask staff when I go and visit,

1 actually. I say to them, "You know, is this better than
2 when you were doing it on paper?" And they generally say
3 yes. They like the fact that it's easy to use, they like
4 the fact that it prompts them on observations being
5 timely. You know, the more senior staff members like the
6 ability to oversee that more rigorously. And staff have
7 on multiple occasions told me that it's assisted them in
8 saving lives and responding to incidents more quickly and
9 that matters tremendously to our staff, that they are
10 able to respond quickly when a person is in crisis to
11 support them in the best way they are able. So generally
12 the views I have heard from staff when I talked to them
13 about Oxevision is that it has been useful and assistive.

14 **MR GRIFFIN:** The failure properly to train staff that
15 Oxevision was not an alternative to face-to-face
16 observations and engagements has been a feature of
17 inquests in relation to patients who dies in EPUT mental
18 health units. I think you have just averted to that?

19 **A.** Yes.

20 **Q.** For example, Michael Nolan who, as we have heard, died on
21 10 July 2022. The narrative conclusion at his inquest
22 included that the Oxevision training was inadequate
23 because the clear and concise message that it was not an
24 alternative to face-to-face observations and engagements
25 was not effectively conveyed to staff. In Morgan-Rose

1 Hart's case, who as we have also just heard died days
2 after Michael Nolan, the report to prevent future deaths
3 following her inquest refers to observations mainly being
4 completed via the Oxevision system and that there were
5 limited therapeutic engagements or attempts to engage
6 with Morgan-Rose. Do you agree that those inquests
7 raised matters of grave concern about the operation of
8 Oxevision?

9 **A.** Yes, I do and it is why we have made significant changes
10 to the training process and now consider that to be much
11 more robust than it was at those times. I referred to it
12 earlier. There's three key elements of the training
13 process that's now in place that was not at that time,
14 which is the use of the OxeAcademy material which is
15 provided by Oxehealth, they are experts in their own
16 system and how it operates. Our own OLM training which
17 is an online training that's developed by the Trust and
18 particularly pulls out elements of the Standard Operating
19 Procedure, and then staff led assessment against the
20 competency checklist, to make sure that staff understand
21 the number of different points about how the system
22 should be used in practice.

23 **Q.** So these are recent changes to training, are they?

24 **A.** Those changes to training have been introduced over the
25 last year to 18 months, I would say. I mean, certainly,

1 you know, after those sad deaths, EPUT has undertaken
2 improvements between that time and now. I would need to
3 go back to colleagues to be more precise on exactly when
4 specific training materials were updated.

5 **Q.** How much of that training is online?

6 **A.** So the first two elements, the OxeAcademy is online, as I
7 say provided by Oxehealth, and the OLM is online. The
8 third bit, the competency checklist, that is done by a
9 senior member of staff in person through discussion with
10 a member of staff.

11 **Q.** Given the significance of training in this area and in
12 other areas, do you think having such a substantial
13 proportion of it online is appropriate?

14 **A.** In preparing to give evidence, I have completed all three
15 of those pieces of training myself, even though I am not
16 a clinical member of staff. And I found the online
17 material to be informative and to cover the key features
18 of the system in a way that was accessible. The third
19 element is the in person piece and the competency
20 checklist however, which gives assurance then that
21 somebody in practice knows how to use the system and that
22 can be supervised by somebody who has more experience of
23 using it.

24 **Q.** Thank you. You explain in your first statement that EPUT
25 has also been using a system called iWantGreatCare to

1 collect and process feedback since the start of 2022.

2 You provide details of the feedback located in relation
3 to Oxevision between July 2023 and July 2024. Can we
4 just look at an aspect of that, please?

5 **A.** Certainly.

6 **Q.** Would you put up EPUT009020 please, and show the full
7 document. This is feedback that EPUT has located. Would
8 you expand the top two rows. Is it possible to do that?
9 Let's just look at the top two rows. For example, the
10 second row we can see a date there, I think that's 22
11 November 2023, and we can see that this relates to the
12 Chelmer Ward at the Princess Alexandra Hospital, and here
13 we see some feedback, so from 2023 towards the end of
14 2023:

15 "I feel that staff looking at oxyhealth all day
16 is not nursing how it used to be. It's less personal.
17 We are always being told we are short staffed."

18 Then the next free text box says:

19 "We need more staff during the day."

20 So that would appear to be a comment from a
21 member of staff, would you agree?

22 **A.** No, I would think that that was a comment from a patient.
23 IWantGreatCare is a patient feedback system.

24 **Q.** So the patient is saying that from their perspective,
25 that staff are looking at Oxehealth all day, it's less

1 personal and the patient is raising, at the end of 2023,
2 the issue of short staffing. Is that your assessment of
3 that comment?

4 **A.** Yes.

5 **Q.** And, "We need more staff during the day", do you have any
6 observation about this comment about overreliance on
7 Oxevision and short staffing coming, as it does, at the
8 end of 2023 or towards the end of 2023?

9 **A.** So you know feedback around needing more staff during the
10 day, that's something that is fed into the Time to Care
11 programme, it's why we have now got the activity
12 co-ordinators on the wards and the peer support workers,
13 and the Time to Care programme also invested in other
14 professional staff as well. So I would say that. You
15 know, the concern here, clearly that's that person's
16 experience and it is of concern to me as well.

17 **Q.** Thank you. Would you take that down, please. Now in
18 terms of concerns about Oxevision that have been raised,
19 I would like to move on to ask you about an aspect of the
20 video function of the system and where video data is
21 held. We have already heard that it is possible after an
22 incident for Oxehealth remotely to extract clear video
23 data from the Oxevision server, but that it must be
24 requested by a member of staff within 24 hours of an
25 incident. Otherwise, as we have heard, the data is

1 automatically overwritten. Is that all correct?

2 **A.** Yes.

3 **Q.** This is covered in EPUT's most recent Standard Operating
4 Procedure for the use of Oxevision, and can we just look
5 at that part of it, please?

6 **A.** Yes.

7 **Q.** Could you put up EPUT009884, at page 12 please. This is
8 paragraph 1.5.6 and it says this:

9 "Clear Video Data (CVD) is non-pixelated video
10 footage that can be clipped and saved upon request if
11 there is a situation that needs to be further
12 investigated. The ward manager, Nurse in Charge (or
13 their nominated deputies), site manager and if out of
14 hours, the On Call manager, can request the clipping of
15 the clear video data. The request must be made directly
16 to Oxehealth within 24-hours ...

17 Upon receipt of a request, Oxehealth will clip
18 and save clear video data. Oxehealth will then seek
19 authorisation from the named CVD approvers. Once
20 authorisation has been granted, Oxehealth attend site to
21 transfer the clipped CVD to a secure USB for delivery to
22 The Lodge."

23 It says at the bottom:

24 "Clear video data is automatically deleted from
25 the local Oxevision server (on EPUT sites) after 24 hours

1 ..."

2 So it is reiterating that important point.

3 We learned yesterday from Laura Cozens that in
4 fact when Oxevision is activated in a person's bedroom
5 the camera is always on and always recording. Is that
6 also your understanding?

7 **A.** May I say something about what you have put on screen?

8 **Q.** Yes, by all means.

9 **A.** I believe that is from an older version of the Standard
10 Operating Procedure in terms of the USB because that's
11 not the current practice.

12 **Q.** In fact, it is from -- we will just double check but it's
13 from the current version, so the current version may be
14 out of date.

15 **A.** So I think we have addressed this in the Data Protection
16 Impact Assessment and the data flows. So on the point
17 about where the data is held, there's a server on site at
18 EPUT and the process is there must be a phone call to the
19 Oxehealth 24 hour line to request it's clipped. Then
20 staff within EPUT can't conduct that themselves. The
21 Oxehealth team will do the clipping and then there's a
22 secure transfer which Laura Cozens spoke about yesterday
23 via the Rgress system.

24 **Q.** Can we take this in stages?

25 **A.** Yes, of course.

1 Q. This is from the current most recent version of EPUT's
2 Standard Operating Procedure. So the first point is
3 this, it is incorrect, isn't it?

4 A. Please let me just read it for a moment. Yes, so the bit
5 that is incorrect which described past practice rather
6 than current practice, is the following that:

7 "Oxehealth attend site to transfer the clipped
8 CVD to a secure USB for delivery to The Lodge."

9 And so on. That process of transferring data
10 via a secure USB was the practice previously. That's now
11 been replaced by the Egress system that Laura Cozens
12 spoke about. The rest of the process is correct about
13 how a staff member would request something is clipped.

14 Q. Why is it necessary for Oxehealth to be involved at all
15 in the retrieval of clear video data?

16 A. Because they have the ability to do that and extract that
17 for us. Our staff are not able to do that directly
18 themselves. It's part of the process that's been in
19 place since we first started using Oxevision and
20 effectively it acts as an additional control because it
21 means that, you know, that's highly sensitive data,
22 clearly, and you have to go through a document, you know
23 this process, in order to be able to access that.

24 Q. Do Oxehealth ever hold clear video data themselves, for
25 example, on an Oxehealth server, cloud solution, et

1 cetera?

2 **A.** No, not to my knowledge.

3 **Q.** Is that something you can check and come back to us
4 about?

5 **A.** Well, you know, I have reviewed their Data Protection
6 Impact Assessment and our own and that's not my
7 understanding. I will ask our data protection officer to
8 further confirm that but no, I don't think that they do
9 have that.

10 **Q.** Do Oxehealth ever have access to unencrypted clear video
11 data from EPUT?

12 **A.** No, the process is they transfer that to us and I think
13 the Data Protection Impact Assessment statement and
14 latest data controlled guidance that is exhibited to
15 Laura Cozens's statement sets out, you know, some of the
16 detail about that and about how they ensure that their
17 staff do not have access to that.

18 **Q.** Are there any other circumstances, other than to assist
19 EPUT following an incident, in which EPUT clear video
20 data might be accessed and held by Oxehealth, for
21 example, for research purposes or to develop its
22 products?

23 **A.** No. If there were -- so if, for example, a member of
24 staff made a request for the footage to be clipped and it
25 was outside of that core purpose of a patient safety

1 review of an incident, then the data protection officer
2 would escalate that to the Caldicott Guardian and the
3 SIRO to consider on an exceptional case by case basis.
4 So, for example, perhaps there was an incident that was
5 not patient safety but may have been concerning for
6 another reason, you know, those kind of things would be
7 escalated, you know, to myself and to the executive
8 medical director, who is the Caldicott Guardian.

9 **Q.** Thank you. Just going back to the question I was asking
10 you a moment back, and that is what you are able to
11 access, when you are asking for Oxehealth's assistance
12 following an incident, what is available to EPUT? How
13 much data and what kind of data is available to EPUT,
14 video data?

15 **A.** Up to 24 hours of clear video data at the time that
16 request is made.

17 **Q.** So as I was saying, as we heard from Laura Cozens
18 yesterday, and do you accept this, that when Oxevision is
19 activated in a person's bedroom, the camera is always on
20 and always recording?

21 **A.** I do accept that that footage is continually recorded and
22 it is available. I think there's something that's really
23 important in this and it goes to the discussion about
24 CCTV and how you consider this. Which is that, you know,
25 the purpose of how the system is used and circumstances

1 in which someone is able to access that footage is very
2 controlled and limited. So no one, no member of staff is
3 able to view on a CCTV monitor that footage in a live
4 state. You know, that's not -- and notwithstanding your
5 points and questions earlier about the vital signs check,
6 we do not have a CCTV TV anywhere that watches the 24
7 hour streaming. There are only very limited
8 circumstances in which these requests should be made.
9 When they are made, they are reviewed by the data
10 protection officer and would be rejected if they were
11 inappropriate. So when we are talking about how many
12 times in a year, you know, this kind of footage is
13 viewed, this is tens of times in a year not hundreds.

14 **THE CHAIR:** But fundamentally it is a surveillance system,
15 however limited it might be called upon. Do you accept
16 that?

17 **A.** No. I mean, you know, it's a registered medical device.
18 The system uses video camera as part of that device.
19 There are limited circumstances in which you can access
20 the footage. By analogy, a mobile phone is capable of
21 recording video but we wouldn't consider that a
22 surveillance device per se. It really matters what the
23 purpose and the procedure for using the device is. So
24 you know, we absolutely do not in the Trust use Oxevision
25 as a surveillance device. It's, you know, the purpose

1 that's set out in the Standard Operating Procedure is not
2 that. It's to assist in patient care.

3 **MR GRIFFIN:** But the camera in the room is always on and
4 always recording, whether or not access to the footage is
5 controlled. That's a pretty significant fact, isn't it?

6 **A.** That is a fact and that is also on the Trust privacy
7 notice and has been since September 2020 -- sorry, was it
8 2020 or 2021? I would have to check that. Since the
9 early stages of implementation, I will confirm the date,
10 but the Trust privacy notice has been clear about that.

11 **Q.** Do you know what it actually says?

12 **A.** Yes, it says to the effect of, you know, video data is
13 retained for a period of 24 hours and I can provide you
14 with a statement that that privacy notice has been -- you
15 know, it's only one part of the privacy notice, there's a
16 much longer privacy notice, but that has been in place
17 substantially throughout the implementation of this
18 technology, it has been updated twice over that period,
19 once in 2022 where the language was made more transparent
20 than the first one, which referred to "salient video",
21 and then it becomes clearer. Because obviously I accept
22 that language is not accessible, and then it was again
23 updated in November 2024 after your moratorium, Chair, to
24 be clear that that video would be held indefinitely while
25 the moratorium was there.

1 Q. The Inquiry would be very interested in how express the
2 privacy notice is in explaining that a camera is on and
3 recording 24 hours a day. We will come on to look at
4 examples of what has been explained in a moment, but I
5 have to say, as far as I'm aware in the documents that I
6 have seen, it is never expressly explained that what is
7 available is up to 24 hours of clear video feed. So what
8 is explained is this; that there is a 24 hour rolling
9 buffer but not what is accessible during that 24 hour
10 period?

11 A. So at paragraph 24 of my statement.

12 Q. Which one?

13 A. I am sorry, let me make sure I have got the right one.
14 Sorry, at paragraph 24 of my second witness statement,
15 the penultimate bullet point provides a hyperlink to the
16 Trust privacy notice where that is set out. I would say
17 having re-read that last night, and I can't quote
18 verbatim, it is clear that clear video is retained for 24
19 hours.

20 Q. But not whether it's literally up to 24 hours of clear
21 video?

22 A. And it says words to the effect of, you know, "This may
23 be used in serious incidents and to support learning and
24 so on."

25 Q. I think there is some similar wording that we will come

1 on to have a look at in another document. So perhaps we
2 can have this conversation actually looking at possibly
3 equivalent language?

4 **A.** Certainly.

5 **Q.** But the SOP, as far as I'm aware, does not explain that
6 there is a camera that is recording 24/7 and that it's
7 literally 24 hours of clear video feed that is
8 accessible, does it?

9 **A.** Not in those terms.

10 **Q.** I don't believe it is covered in your witness statements,
11 other than possibly, and we will verify this through a
12 link to a privacy statement?

13 **A.** I mean, I think that I have addressed the point about
14 video being available for up to 24 hours and I think, you
15 know, that's -- clearly implicit in that is that it is
16 recording in order to be able to provide that video. But
17 I accept my statements could have been clearer on that.

18 **Q.** Well, I think all of the statements perhaps could have
19 been clearer because what people are aware of is the fact
20 that prior to a clear -- prior to a vital signs check, a
21 member of staff will have access to up to 15 seconds of
22 clear video feed of the patient. So that they can see
23 whether it's appropriate to make -- to go on to make the
24 vital signs check; correct?

25 **A.** (No verbal response)

1 **Q.** So the information that we have as members of the public
2 and others is that those are the circumstances in which
3 clear video is being accessed by staff. So wouldn't most
4 people assume that if there is video data that is
5 available after the event, it would be limited to that,
6 for example?

7 **A.** Limited to what specifically?

8 **Q.** Just to the occasions where staff have actually accessed
9 15 seconds of clear video feed in advance of taking vital
10 signs.

11 **A.** No, and I mean there's good reason for that. If there
12 were, you know, a serious incident, it may not have
13 coincided with the point at which the staff member
14 clicked to take an observation and see 15 seconds. The
15 point is that in having that continuous video accessible
16 in very, very limited circumstances, it supports a much
17 fuller analysis and learning from what happened. So, you
18 know, appropriate clinical staff are able to review that
19 and ascertain, for example, were there -- if there were
20 an incident involving physical health, were there clear
21 signs that physical health conditions were overlooked by
22 staff prior to that. I mean, certainly these are
23 examples where, you know, by being able to view that
24 footage in very limited circumstances, as I say, being
25 able to identify where staff didn't carry out the correct

1 physical health procedures that has enabled learning in
2 the investigation. So you wouldn't have been able to do
3 that if you were limited just to 15 second snippets.

4 **THE CHAIR:** But Mr Griffin's point was that the statements
5 about what is being recorded and offering people an
6 opportunity to understand suggest that it is only the 15
7 second clear images that might be being recorded and
8 saved. It is not that there isn't a distinction between,
9 and we understand why they are different things. Do you
10 accept that the impression given is that it is only 15
11 seconds that might be being saved?

12 **A.** No, I wouldn't accept that fully. You know, the posters
13 and, you know, I recognise there can be made improvements
14 to these, but the posters do refer you to the website and
15 the ability to contact the DPO and the website and the
16 privacy notice. So there are ways in which those points
17 have been made known.

18 **Q.** Shall we look at the poster?

19 **A.** I can accept that, you know, criticism to say that that
20 should have been made clearer and put in more places, but
21 you know, that has been, as I say, it has been on the
22 privacy notice for some time.

23 **Q.** Can we look at the poster, just by way of example, this
24 is the most recent one it accompanies the most recent
25 Standard Operating Procedure. The SOP explains that it

1 must be displayed clearly in public areas within the
2 building? Could you put up EPUT009884, at page 19
3 please. So this is the poster that would be up on the
4 wall so that patients could see it?

5 **A.** Yes, and the point I am referring to is the bottom of
6 that if I read it out, it says:

7 "Have concerns or want to know more? Please
8 speak to the Ward Manager or Nurse in Charge" -- and then
9 it says:

10 "Privacy Notice in the use of person
11 identifiable salient video data (SVD) - further
12 information on your data rights and how the Trust uses
13 your data can be found at (the website). Alternatively,
14 you can contact the Trust's Data Protection Officer."

15 And this poster is also included in the welcome
16 pack.

17 **Q.** Thank you very much. What we can see here is use of
18 video:

19 "When can staff see in your room? A clear
20 image can be seen only for up to 15 seconds only when
21 checking your pulse and breathing rate. A blurred image
22 can be seen for up to 15 seconds only when a notification
23 has been received."

24 Nowhere does this poster expressly state that
25 the camera will be on and recording all the time,

1 correct?

2 **A.** Correct.

3 **Q.** I think what you are saying is that that information is
4 available if you go through the functions or the website
5 that we see at the bottom of the poster?

6 **A.** Yes.

7 **Q.** Do you think that that is really a way to be providing
8 important information to patients in a mental health
9 in-patient unit who may be troubled or vulnerable?

10 **A.** As I said earlier, it's important and we are clear about
11 this, that information is explained and provided to
12 patients in a variety of ways and not as a one-off event.
13 So that includes both at admission, staff should be
14 having conversations. There's videos available. One of
15 those is at the QR code on the patient leaflet, which I
16 am sure you will take us to later; and through ward
17 community meetings and other places, so I absolutely
18 recognise that people, full stop, whether they are
19 patients, have different preferences and abilities to
20 engage with different types of information. That applies
21 to everyone and particularly applies in a mental health
22 setting. That is why we would have multiple mechanisms.
23 On the specific point, could this have been more
24 prominent? Yes, I absolutely accept that and I think
25 that is something, as a Trust, we will review further.

1 We have a deep dive on Oxevision planned with our quality
2 committee in November, so it's certainly a matter I will
3 be escalating there.

4 **THE CHAIR:** Use of terms like, "Privacy notice in the use of
5 person identifiable salient video data", that's quite
6 obscure, isn't it, for the layman? I am finding that
7 quite obscure.

8 **A.** I mean privacy notice is commonly used by organisations,
9 but I mean the salient video data, I agree with you,
10 Chair, that's confusing to most people.

11 **MR GRIFFIN:** Can we just look at the leaflet because that
12 provides more information. Again, this is referred to in
13 the latest Standard Operating Procedure. Could you up
14 EPUT010164 and go to page 3, please. Can we see just the
15 bottom there:

16 "Can staff use the system to see into your
17 room? The system doesn't show a continuous live feed.
18 Ward staff can only see a clear view of your room when
19 measuring your heart and breathing rate for up to 15
20 seconds. You can also see a blurred view of your room
21 for up to 15 seconds when they receive a notification."

22 Could you go over the page and expand the text
23 at the top:

24 "How is your privacy protected? As well as
25 this 15 second time limit on viewing your room, there are

1 safeguards in place to protect your privacy. There's no
2 sound, they also can't see inside your bathroom."

3 Then we get this:

4 "Here are some of the other measures in place.
5 Recorded clear video can only be viewed by authorised
6 staff if there has been a safety incident and it must be
7 requested within 24 hours. You have the right to be
8 informed if this happens. All clear video is only kept
9 for 24 hours then it is automatically deleted."

10 Is that kind of wording that you were referring
11 to earlier?

12 **A.** It's slightly different on the website.

13 **Q.** But again, there is nothing here to expressly tell
14 someone that a camera is on 24/7 and recording.

15 **A.** I mean, I suppose this comes to the clarity of language
16 but I mean, recorded clear video and clear video is kept
17 for 24 hours that would to me imply that there is
18 recording. Now, I accept that, you know, these documents
19 can be made clearer on the point that you are making.

20 **Q.** Okay, thank you very much. Could you take that down,
21 please.

22 **A.** And the QR code had the IS on it, but that takes you to a
23 four and a half minute patient-friendly video. I have
24 viewed it. That our quality matron has been using with
25 patients on our wards where they have asked about

1 Oxevision, or where she has asked them about Oxevision,
2 two-way conversation is important there clearly, to show
3 them that. It is a video that has been produced by
4 Oxehealth, but we have found it to be useful in helping
5 patients understand that system.

6 **Q.** I viewed it as well, Mr Trent, and it is the same point
7 there. It doesn't expressly state that the camera is on
8 and recording 24 hours a day. I am going to come on to a
9 new topic in a moment. I am just wondering where now
10 might be an appropriate time for a break because we've
11 been going for about an hour. Do you want to say
12 something first?

13 **A.** May I say one more point.

14 **Q.** Yes, of course.

15 **A.** I think it goes again to this recording point. For the
16 vast majority of patients that 24-hour recorded video
17 will never be seen by anybody, for the vast majority. As
18 I say, it is in a limited number of cases under specific
19 circumstances, and I think we have probably already
20 discussed that sufficiently, but I wanted to say that
21 because for the vast majority of patients that will never
22 be viewed by anybody.

23 **Q.** I do understand that, but isn't the point that it would
24 nevertheless be significant to a patient to know that
25 there was a camera in their room that was recording them

1 at all times?

2 **A.** I accept that.

3 **MR GRIFFIN:** Thank you. Chair, could we come back at
4 half-past so a short ten minute break.

5 **THE CHAIR:** A long ten minute break, shorter than 15.

6 **MR GRIFFIN:** Sorry, shorter than 15 minutes.

7 **(3.19 pm)**

8 **(Break)**

9 **(3.31 pm)**

10 **MR GRIFFIN:** Mr Trent, I would like to now move on to ask you
11 about the rollout of Oxevision at EPUT, please. This is
12 what you say at paragraph 10 of your second statement:

13 "The Oxevision system was first implemented at
14 EPUT in 2020 following demonstrations to clinicians at
15 EPUT lab in 2019."

16 Could you just briefly tell us what EPUT lab
17 is?

18 **A.** Yes, it's a monthly meeting which is really well attended
19 by senior clinical staff, particularly psychiatrists and
20 psychologists at the Trust, as well as others, and
21 nurses, and it's been running for some time as a forum to
22 explore new innovations and new technologies and to see
23 them demonstrated. Some of those things are then
24 effectively fed back as not worth pursuing and others are
25 fed back by that clinical in the main group, other

1 managers as well, as worth pursuing.

2 **Q.** So in this case did EPUT lab forward it on for further
3 consideration?

4 **A.** Yes.

5 **Q.** And it goes on to say:

6 "An 'Early Insights and Implementation Lessons
7 Learned' report including patient and staff feedback was
8 presented to the Executive Operational Committee in
9 August 2020. In September 2020 a paper was submitted to
10 the Trust Board of Directors recommending the further
11 rollout, purchase and installation of Oxevision to
12 support quality and safety across a number of the Trust's
13 in-patient mental health wards. The Trust has continued
14 the rollout of Oxevision across in-patient and specialist
15 in-patient wards in a number of phases since then. This
16 includes the Time to Care business case presented to
17 Board in June 2023 which detailed the further rollout of
18 Oxevision on to EPUT wards."

19 Are you happy that that's an accurate summary
20 of the rollout?

21 **A.** Yes.

22 **Q.** And you provide more detail about it in your first
23 statement?

24 **A.** Yes.

25 **Q.** Could we put up, please, EPUT009030. Thank you. This is

1 a document that you have provided to us, Mr Trent, and
2 does this show the wards where Oxevision was deployed,
3 the number of rooms in each ward and when Oxevision went
4 live on each ward?

5 **A.** Yes.

6 **Q.** This shows, and I have counted them, a total of 43 wards
7 with go live dates from February 2020 to November 2024.
8 It shows that four wards went live in 2020. In fact,
9 were those the four pilot wards for testing Oxevision?
10 We can see them at the top, Ardleigh, Chelmer, Hadleigh
11 Unit and Peter Bruff?

12 **A.** Yes, those are and they correspond to the same in my
13 first statement I believe.

14 **Q.** What this shows is that 26 wards went live in 2021 and
15 then it starts to diminish, 6 in 2022, none in 2023 and
16 seven in 2024. But can we see that there was a
17 particular expansion of Oxevision in 2021 at EPUT?

18 **A.** Yes, following that business case, and I would just note
19 that there is some slight double counting in there. For
20 example, you have Larkwood and then you also have
21 Larkwood LTS underneath it. Those are effectively the
22 same ward, but the long-term segregation part within it.
23 So depending on how you count a ward, then that's
24 important to note.

25 **Q.** Thank you, that's very helpful. Could you take that

1 down, please. We learn from a report that you provided
2 us with from April this year that Oxevision is currently
3 on, at least as at April, 30 in-patient wards, four
4 health-based places of safety, eight seclusion or
5 long-term segregation and two intensive care rooms.
6 That's from the clinical safety case report of 30 April
7 2025, does that sound about right?

8 **A.** Yes.

9 **Q.** Do you regard that as an extensive roll out of the
10 technology at EPUT?

11 **A.** Yes, I would say that is a fair description.

12 **Q.** In what proportion of mental health in-patient units at
13 EPUT is Oxevision now installed and used?

14 **A.** So there's a further five wards where it is planned to be
15 rolled out that's covered in the business case, and then
16 there's 11 wards where there are currently no plans to
17 roll it out, but that may be reviewed in future.

18 **Q.** Ultimately, on current plans the substantial majority of
19 the relevant units will be using Oxevision?

20 **A.** I would say some 80 per cent, around that.

21 **Q.** 80 per cent, thank you.

22 **A.** Around that. So some of those other wards, for example,
23 they are different settings. So as, you know, we provide
24 some social care services and things like that, so not
25 necessarily applicable in this rollout.

1 Q. I see that is interesting and helpful to note, but across
2 a range of different types of in-patient unit?

3 A. Yes.

4 Q. Thank you. The Inquiry's expert health statistician team
5 will be considering some of the research and feedback, to
6 which reference is made in your statements, including as
7 they relate to evidential base for rolling out, we have
8 seen there were four pilot wards and so on. So I won't
9 ask you questions about that today. After the expert
10 health statistician has conducted the review, a report
11 will be written and issued and we can follow up on that
12 basis. Could we move on then, please, to the topic of
13 research. You refer in your first statement to other
14 evaluations of Oxevision and again, the expert health
15 statistician will be reviewing this. But one of the
16 studies you referred to and this is at paragraph 76 of
17 your first statement, is research that was jointly
18 conducted by EPUT and Anglia Ruskin University, or ARU
19 and you say this:

20 "ARU and EPUT commissioned an independent study
21 of a multisite evaluation of the use of vision-based
22 patient monitoring systems and body worn cameras in
23 mental health in-patient wards in England."

24 And you say this at paragraph 78:

25 "The interim results show that staff reported

1 positive feedbacks from VBPMs in relation to
2 communication (68%); therapeutic relationships (68%);
3 feeling safe (76%) and quality of sleep (68%). 62% of
4 patients reported positive impacts in relation to feeling
5 safe and 61% reported negative impacts in relation to
6 privacy. 65% of patients and 81% of staff said that
7 vision-based monitoring systems are useful."

8 Those are interim results. Do you know if
9 there are final results or if there are not, when they
10 might be available?

11 **A.** I met with the principal investigator in, I want to say
12 May, I would have to check my records, and at that time I
13 asked her whether this would be complete ahead of these
14 hearings. She did not think it would. The work was
15 going to take longer than that. I would have to follow
16 up with her directly to have a confirmation, but of
17 course, with any independent study it is the discretion
18 of the principal investigator to determine that not the
19 trust.

20 **Q.** You have referred it a couple of times now as an
21 independent study, and you have provided some underlying
22 documentation for it, but as we heard it was part
23 commissioned by EPUT, wasn't it?

24 **A.** Yes.

25 **Q.** And EPUT had actually been involved in the development of

1 Oxevision observations which is a significant element of
2 the technology, isn't it?

3 **A.** Yes, although the technology is, you know, clearly owned
4 by Oxehealth. We have no financial interest in that. I
5 mean, I would say it's common, and I'm not talking about
6 Oxehealth here I'm talking about health technology
7 companies in general, it's common for providers to work
8 with them to develop new bits of technology. Often,
9 whether it's a patient record or any other system, our
10 staff will be the people who know where the greatest
11 benefits are for a new development. So that's a common
12 occurrence in healthcare in my experience.

13 **Q.** Just following on, at this time, by the time this
14 research was being conducted, EPUT had already committed
15 substantial funding to the purchase and ongoing rollout
16 of Oxevision. So in those circumstances, isn't that, the
17 combination of those factors, a substantial conflict of
18 interest?

19 **A.** I mean, as a Trust, we, you know, the reason that we are
20 interested in this study was to, you know, have further
21 independent evidence that would inform our use of it
22 going forward, so the purpose of that was related to the
23 improvement of healthcare. We have no permanent
24 relationship with Oxehealth. We have heard about other
25 providers and other technologies and the Trust will, as

1 with all technology and practice, will continually review
2 what we are doing. So you know, I understand the
3 concern, but that certainly wasn't how the Trust saw it
4 at the time, nor how we see it now. You know, that study
5 is about understanding more fully the technology and in
6 getting further insights and we have heard how important
7 that is.

8 **Q.** In circumstances where the plan is to roll out to 80 per
9 cent or so of in-patient units?

10 **A.** Yeah, it's quite true that in the meantime, since that
11 was commissioned, we have further expanded our rollout,
12 yes.

13 **Q.** Thank you very much. What I would like to do now is to
14 move on to look at consent with you, please. The CQC
15 conducted an inspection of EPUT in November 2022 and
16 January 2023, this culminated in its inspection report of
17 12 July 2023 and I would just like to look at a couple of
18 aspects of that report with you now, please. Could you
19 put up STOX009062, please, at page 8. So could you
20 expand from, "Acute wards for adults of working age and
21 psychiatric intensive care units", please, down. We can
22 see a bullet point in the middle there.

23 "The Trust must ensure patients understand the
24 use of the contact-free patient monitoring and management
25 system" -- that would have been Oxevision -- "including

1 why it is used and how information will be stored and
2 accessed."

3 So this is a page that sets out some of the
4 report's findings and it shows, therefore, I think you
5 will agree, CQC concern about information being provided
6 to patients about Oxevision, but what I would like to do
7 with you is just to follow that through in the report,
8 please.

9 Could we go to page 102, and expand up to,
10 "Best practice in treatment and care". We can see here a
11 paragraph that starts:

12 "At the October 2022 CQC inspection at Willow
13 Ward and Galleywood Ward, the Trust were asked to make
14 improvements around the contact-free patient monitoring
15 and management system. This system helped clinicians to
16 plan care and intervene proactively by providing them
17 with location, activity based alerts, warnings and
18 reports on risk factor. Not all patients had provided
19 consent upon admission or were aware of the systems in
20 their bedrooms. The Trust told us that they assume
21 implied consent for this system to be used and they
22 required staff to record if a patient declines. On the
23 November 2022 CQC visit, we looked for evidence of
24 patients' consent to contact-free patient monitoring and
25 management system on Willow, Galleywood and Peter Bruff

1 wards; we were unable to locate consent within patients'
2 records sampled.

3 On Christopher's Psychiatric Intensive Care
4 Unit one patient had refused consent. Staff took a long
5 time to locate the refused consent in the patient's care
6 records. There was no record of ongoing consent being
7 sought.

8 Staff said the Trust were developing a record
9 to be added to the existing patients' care records,
10 specifically for ongoing consent to the contact-free
11 patient monitoring and management system. We sampled
12 ward welcome packs for Kelvedon and Ardleigh wards and
13 did not see any information around contact-free patient
14 monitoring and management systems. However, wards
15 displayed posters with brief information about technology
16 to monitor patients' vital signs."

17 So can we see, just arising from that, concerns
18 about consent and the fact that not all patients were
19 aware of the Oxevision system in their bedroom, and in
20 this report ongoing concerns about consent, concerns
21 about consenting patient records, the absence of
22 information about Oxevision in welcome packs and also
23 potentially limited information in posters?

24 **A.** Yes we can see this, yes.

25 **Q.** A further point raised in the report was that on one ward

1 managers told the CQC that it was possible while using
2 Oxevision to see a patient unclothed in their bedroom
3 following a shower. Were you aware of that concern being
4 raised?

5 **A.** So the CQC report and our response to that were overseen
6 by a working group to address the specific concerns, and
7 we have had CQC action plans put in place in relation to
8 each of the CQC reports that we have received.

9 **Q.** Thank you, and in wards where Oxevision is used, do you
10 know whether consent for Oxevision is now recorded in all
11 patients' records?

12 **A.** Yes, so this is something that, you know, as I said in my
13 second statement, we have accepted as a Trust, we are
14 clear as a trust that, you know, we should have done
15 better. We have now put a specific field in the
16 electronic patient records to confirm that consent has
17 been sought. Obviously at this time we were on the
18 previous implied consent model which, I know, is one of
19 models in the Nurse Directors' Forum, and actually, as we
20 heard yesterday, was probably the predominant model in
21 use at the time across trusts, so it wasn't without
22 relevance to guidance at the time. However we recognise
23 that it is really not the right way to do this. So in
24 terms of changes to be made since, that addressed some of
25 these things, in the patient records systems Mobius and

1 Paris are our two in-patient record systems, there's an
2 admission checklist, so we now have a box there for staff
3 to confirm that they have actively sought consent. So
4 that's a key change. We have obviously changed the
5 Standard Operating Procedure, and the welcome packs, one
6 of those exhibited includes the poster, and we've been
7 giving patients leaflets. Like I said, over the last
8 couple of weeks I have done four focused visits with our
9 policy lead and our Deputy Director of Quality and Safety
10 on the wards. Patients have told me, "There's a poster
11 in my room telling me about Oxevision, I have seen it on
12 the ward", those sorts of things. So we've been taking
13 steps to address these findings of the CQC and of course,
14 as a trust, we fully accept the findings of each of the
15 CQC reports.

16 **Q.** Thank you. We have looked at the poster. I don't recall
17 anything in that poster about consent and likewise,
18 although I will be corrected if I am wrong, the leaflet
19 doesn't refer to consent either, the most recent leaflet.
20 We can check all of that and come back to it if we need
21 to?

22 **A.** It's very clear in the Standard Operating Procedure and
23 in the communications with staff, and so on, that this is
24 about actively seeking consent and if those materials are
25 not clear enough, then we need to improve them.

1 **Q.** Yes, thank you. Let's just follow this through, and we
2 will come on to some of the points you have made in the
3 context of the actual documents.

4 **A.** Yes.

5 **Q.** We have been informed about and provided with a letter
6 from NHS England on the use of vision-based monitoring
7 systems in mental health in-patient settings, dated 7
8 September 2023. So this is about two months after the
9 CQC report and this is a letter from three people at NHS
10 England, a professor, a Deputy Chief Nursing officer and
11 the National Clinical Director for Children's Mental
12 health, and it's addressed to mental health providers,
13 Chief Nursing Officers and Chief Medical Officers. In
14 those circumstances it should have gone to relevant
15 personnel at EPUT, would you agree?

16 **A.** Yes.

17 **Q.** Could you put up STOX009063. Can you expand the
18 paragraph under, "Our request for your support." This
19 says:

20 "It is our view that vision-based monitoring
21 systems should never be implemented in a blanket way and
22 that any decisions to use VBMS in patient bedrooms should
23 be made in a person-centred way with the patient
24 themselves, where they have capacity to make a decision,
25 or through a best interest process compliant with the

1 Mental Capacity Act 2005, where they lack capacity to
2 consent to the monitoring system. The use of such
3 systems should be carefully considered on a case-by-case,
4 patient-by-patient basis to ensure that any decision to
5 use such systems has a legitimate aim and is both lawful
6 and fair. Their use must also be proportionate to the
7 aim. We are, therefore, asking all services to please
8 review, clinically and ethically, current VBMS practice
9 within your organisation to ensure your use of these
10 technologies aligns with the principles of least
11 restrictive, compassionate, therapeutic and personalised
12 care."

13 Would you agree that this is urging that
14 consideration is given to the use of systems like
15 Oxevision with patients on a case-by-case basis, rather
16 than their use, as it says here, in a blanket way?

17 **A.** I agree with that interpretation of the letter.

18 **Q.** The letter was asking for a review to be conducted into
19 current practice. Can I ask you this, were you aware of
20 this letter yourself?

21 **A.** I was not directly aware of that letter. It was not
22 addressed to me, as you have said, but I would need to
23 consult with our Medical Director and our Chief Nurse has
24 since changed. The ... yeah.

25 **Q.** Thank you, but again, would you agree in 2023, concerns

1 were being flagged about the operation of VBMS
2 (vision-based monitoring systems) and consent being
3 authoritatively flagged?

4 **A.** Yes, I mean, I would also say that, and I think this is
5 one of the things which can always be a challenge with
6 new technologies, the government has been clear in their
7 ten-year plan for health, they want to see a shift from
8 analogue to digital, so there is an expectation of
9 healthcare providers adopting technologies to assist in
10 what they are doing from the Government more broadly.
11 But at this time there was not extensive guidance
12 available, NHS England's guidance comes later. The
13 guidance that was available at the time was the, you
14 know, provider-led produced Nurse Directors' guidance,
15 which as we discussed earlier, has the implied consent
16 model in it as one of the two options. I know that the
17 Oxevision project board, that meets monthly, has
18 continually reviewed the practice of how Oxevision is
19 used, but on this specific question of how was this
20 letter dealt with I would have to come back to you.

21 **Q.** Thank you. But you have raised an interesting point, a
22 separate point about where there is a new technology, how
23 that technology should be reviewed, who should be
24 responsible for it and so on. Is that the point that you
25 are making?

1 **A.** Yes, and you know, I think this is a really important
2 point more generally for the health service. You know,
3 we do need to adopt new technologies and very many of
4 these are in the best interests of patients. Some are
5 more controversial than others and there's an important
6 role here for, you know, regulators in supporting
7 provider organisations in this. NHS England's guidance,
8 when published this year, and you know, we have heard
9 in Hat Porter's evidence --

10 **Q.** We will come on to that in just one moment. But just
11 sticking with your point about how a provider such as
12 EPUT is meant to decide for itself how to deploy new
13 technology, what are the ethical issues that arise from
14 it, is that a point that you are seeking to flag here?

15 **A.** Yes, I mean, of course, you know, the board of an NHS
16 Trust is responsible for that Trust and I would not
17 suggest otherwise, and the decision-making there. But it
18 can be greatly assisted by regulators and I include both
19 the CQC and NHS England and other respected public
20 authorities, in providing guidance on these things, but
21 inevitably new technologies, it's probably not
22 proportionate to produce guidance on every single one of
23 them immediately, so there does tend to be a lag in those
24 regulators producing guidance.

25 **Q.** But are you suggesting, just so that we are absolutely

1 clear, that it would have been helpful, for example, with
2 technology such as Oxevision for there to have been a
3 more authoritative set of principles or guidance from a
4 body such as NHS England or the CQC at an earlier stage?

5 **A.** Yes, it certainly would have been helpful.

6 **Q.** And do you see those two organisations as the obviously
7 people to be providing that kind of guidance or are there
8 others that you can think of?

9 **A.** Obviously NICE, the National Institute For Health and
10 Care Excellence considers new technologies and appraises
11 those from an effectiveness and an economic perspective,
12 so I think their analysis is -- generally, you know, we
13 take their analysis as the principles to which we then
14 apply in trusts our standards of care. So NICE is
15 clearly a relevant authority here. NHS England, you
16 know, obviously we have regard for their guidance and
17 direction on a regular basis and they have a position
18 obviously to oversee trusts, but you know, they have
19 historically sought to promote best practice and other
20 activities. So we find their guidance helpful.

21 **Q.** Do you think the situation is that too much is left to
22 individual providers, certainly in the early days of a
23 technology?

24 **A.** I mean, I think this is such a difficult thing to say one
25 way or another. If you look at the many great

1 innovations that our health service has produced over
2 many years, they probably tend to come from innovative
3 clinicians on the front line, not from a national body,
4 if you were to look at those. And allowing and
5 facilitating that innovation is crucial for the benefit
6 of all. And that, I think, you know, what this
7 discussion and evidence and others have contributed to
8 importantly, is about getting that right with different
9 technologies to get that balance right so that there is
10 space for innovation and improvement and adoption of new
11 ways of doing things, but that we manage the risks
12 better. And I think that is, as I have said in my second
13 statement, something that should have been done better in
14 the past.

15 **Q.** And that is the experience of EPUT with Oxevision, that
16 provides the basis for what you are telling us now in
17 terms of what would have been helpful.

18 **A.** Yes, around having guidance a bit sooner on that, yes,
19 that is our experience.

20 **Q.** Can we come on then to the NHS England Principles for
21 Using Digital Technologies in Mental Health In-patient
22 Treatment. So these are dated 7 February this year and
23 updated on 25 of the same month. You refer to them in
24 your second statement explaining, and this is paragraph
25 13, that:

1 "NHS England issued guidance on use of digital
2 technologies in mental health inpatient treatment,
3 including 8 principles for digital technologies (such as
4 Oxevision), to help clinicians consider whether use of a
5 digital technology is the most appropriate, effective and
6 least restrictive method of caring for or treating a
7 patient in inpatient mental health settings."

8 You then refer in brief to each of the eight
9 principles, including principle 2, the requirement that
10 the use of digital technologies such as Oxevision must be
11 based on consent where a person has capacity.

12 We looked at the principle in the document
13 yesterday and it said this:

14 "Any decision to use digital technologies and
15 to collect and store patient data from the use of such
16 technologies must be based on consent from the patient or
17 a person lawfully acting on their behalf, or be taken
18 following a best interest decision-making process."

19 And it adds:

20 "Where a patient has the capacity to consent to
21 the use of digital technology in connection with their
22 care and treatment, consent should always be sought from
23 the patient and the use of the digital technology should
24 be regularly reviewed with them and if appropriate with
25 their families and carers."

1 We also saw yesterday that the principle
2 referred to the need for personalized decision-making and
3 that digital technology must never be used in a blanket
4 way. It then set out also a particular process where
5 patients are unable to consent. Does that all accord
6 with your understanding of principle 2?

7 **A.** Yes.

8 **Q.** Thank you. Would you agree that it should have been
9 clear to EPUT by now, after this principle and the NHS
10 England letter that we looked at, that Oxevision should
11 not be used in a blanket way, that is in all rooms with
12 the default being that it is turned on?

13 **A.** Yes, I mean, I just want to address that piece about the
14 default being that it is turned on. So in response to
15 this guidance, we changed our Standard Operating
16 Procedures as you know, and our assessment was that our
17 new Standard Operating Procedure was in line with this
18 guidance. On the specific point about, you know, blanket
19 restrictions, I can appreciate there will be a concern
20 that, you know, we say in our updated guidance that the
21 system would be switched on typically at the beginning,
22 and then it should, the consent should be obtained in up
23 to six hours.

24 **Q.** Can I come on because I would like to ask you
25 specifically about that when we come to the --

1 **A.** Fine, yes, of course.

2 **Q.** Rest assured I will ask you about that specifically.

3 **A.** Okay.

4 **Q.** I think there may have been another part of the NHS
5 England principles that you wanted to refer to; is that
6 correct?

7 **A.** Yes, so I wanted to note that, you know, on this point
8 that we discussed earlier about surveillance, NHS England
9 does not say in this guidance, and it would have been a
10 clear opportunity to do so, that they consider vision
11 based monitoring systems to be surveillance systems.
12 They do refer to a literature review on the surveillance
13 and they do warn against using systems as surveillance,
14 but, you know, in having regard to NHS England guidance,
15 had NHS England said, "We consider vision based
16 monitoring systems to be surveillance and to be
17 inappropriate", then of course as a Trust we would have
18 responded differently to that than we did with the
19 guidance that they published. You know, I am saying that
20 because this debate about whether this technology is
21 surveillance or not is not just restricted to this trust
22 it is of national importance given the number of trusts,
23 and I wanted to note that in terms of NHS England's
24 guidance.

25 **Q.** Thank you. Can we just come on to the last but one

1 Standard Operating Procedure, version 11. Now that was
2 issued on 28 February this year, so shortly after the NHS
3 England principles had been published. It was approved,
4 as I have just said, on 28 February. You refer to it in
5 your first statement, this is paragraph 42-43, explaining
6 that.

7 "The target audience for the SOP are inpatient
8 staff ..."

9 You say:

10 "The SOP sets out how Oxevision works, what it
11 is used for ... and how staff are trained in its use.
12 The SOP also sets out that every patient must be informed
13 about the use of Oxevision and that staff will have a
14 discussion with patients, carers and families at the
15 point of admission."

16 Is that all correct?

17 **A.** Yes.

18 **Q.** And has EPUT actually had an SOP, Standard Operating
19 Procedure, in place since 26 March 2020?

20 **A.** Yes, right from the beginning, yes.

21 **Q.** So there have been various iterations of it between then
22 and the most recent one.

23 **A.** Yes.

24 **Q.** You also explain, and you have touched on this a few
25 moments ago, that version 11 of the SOP operates on a

1 model of implicit consent. Let's just deal with that
2 quickly. Is it right that the SOP explains that where
3 Oxevision is installed, the system is continually
4 switched on and monitored, therefore all patients are
5 opted in upon admission as part of the standard ward
6 practice. And you summarise the position in your first
7 statement in this way:

8 "It is standard practice for EPUT to use
9 Oxevision unless a request is made by a patient not to
10 use it ... and this request will go to the
11 (Multidisciplinary Team) MDT for review."

12 That is paragraph 52. So would you agree that
13 this appears to be a blanket approach, this penultimate
14 SOP, whereby a patient is opted in by default to the
15 system on the basis of implicit consent to its use?

16 **A.** I mean, I would note what I said at paragraph 41 about
17 objections can be raised at any time during the admission
18 episode, and the points that you have quoted about
19 there's a clear expectation in version 11 and previous
20 versions that this is discussed with patients and carers
21 at the point of admission. So, you know, on the point
22 about blanket, the policy is clear here that there must
23 be a meaningful conversation. It has started from a
24 premise that the system is on and a meaningful
25 conversation would then take place and only if that

1 concluded it needs to be switched off, was it switched
2 off. But there is clearly in the policy the requirement
3 for the meaningful conversation which would be unique to
4 that patient and therefore not blanket in its approach.
5 However, we have also accepted in reviewing the NHS
6 England guidance that, you know, that starting point was
7 the wrong starting point and that we should flip it round
8 and it should be, you know, opt-in, as it were.

9 **Q.** But essentially, version 11 of the SOP operates an opt-in
10 implicit consent process?

11 **A.** Sorry, version 11.

12 **Q.** The penultimate one.

13 **A.** Yes, the version 11 you have to opt out of the process,
14 but you should be informed and have a meaningful
15 conversation with staff according to the process.

16 **Q.** Do you accept that version 11 does not follow the NHS
17 England principles in relation to consent?

18 **A.** Yes, I accept that.

19 **Q.** So this SOP coming after the publication of the NHS
20 England principles effectively ignores them?

21 **A.** Well, I have addressed this in paragraph 13 of my third
22 statement. You know, there's a timing lag here. The
23 update that went through in version 11 was part of the
24 normal 6 month review and, you know, I think it even says
25 "6 month review with rewording, no activity detection and

1 minor changes." So that was a routine update. At that
2 point the Trust hadn't completed its review of the new
3 guidance and I absolutely accept that version 11 wasn't
4 compliant with that and we didn't move to a compliant
5 position, from our assessment, until 7 May.

6 **Q.** Would you agree it was a pretty pointless update?

7 **A.** I mean, I'm not sure I would necessarily use those words.
8 I'm sure that, you know, the intention of the rewording
9 and other changes was to make it clearer, so I wouldn't
10 describe that as pointless. But was it a significant
11 update? No, it was a routine update.

12 **Q.** Is there an issue with EPUT issuing SOPs with minor
13 changes which serve no particular purpose?

14 **A.** You know, when you are making improvements to policies,
15 procedures and, you know, we have spoken a lot about
16 clarity of language and transparency earlier, even some
17 small changes that make something clearer can actually be
18 important. So I think the important thing here is that
19 the SOP is being regularly reviewed and when you go
20 through the 12 versions, yes, there are some, like 11,
21 which are incremental in their changes. There are others
22 that are more fundamental in their changes over that
23 period.

24 **Q.** So you have touched on the period between version 11
25 which comes out shortly after the NHS England principles,

1 and then bringing it up to version 12, the most recent
2 version. And, effectively, do we have a process where
3 there is review of the principles of a focus group that
4 had been conducted, and I think also some external legal
5 advice had been obtained, and were all of those three
6 sources used to decide ultimately to agree the SOP in its
7 form that we see in version 12?

8 **A.** Yes, that's correct.

9 **Q.** We have seen the history, haven't we, we have seen CQC
10 report in 2022 and 2023 raising issues of consent. We
11 have seen the letter from NHS England in September 2023
12 which said that VBMS should never be implemented in a
13 blanket way. Do you think this is a reasonable point to
14 make, that EPUT should have reviewed and amended its
15 approach to conflict significantly earlier than in the
16 version 12 SOP?

17 **A.** Yes, I think it's arguable to think about whether the
18 consent could have been changed earlier. I mean, yes, it
19 is possible it could have been changed earlier. Did we
20 have national guidance that really supported us in that
21 change earlier? No, we didn't, not in that way. That
22 was published by NHS England in February. And in my
23 second statement we have accepted that, you know, when we
24 look back at that, we probably should have changed it
25 earlier, you know.

1 Q. Let's come on to version 12.

2 A. Yes.

3 Q. And you talk about this in your second statement from
4 paragraph 22. That is what you say in paragraph 22:
5 "The principal changes to the SOP in the latest
6 version (version 12) relate to consent."
7 This is paragraph 22.

8 A. Sorry, which of my statements is that?

9 Q. In your second statement.

10 A. In my second statement. Thank you for bearing with me.

11 Q. Yes, thank you:
12 "The principal changes to the SOP in the latest
13 version (version 12) relate to consent. In line with the
14 NHS England guidance" --
15 That is a reference to the NHS England
16 principles we have just been talking about?

17 A. Yes.

18 Q. -- "the latest SOP takes a human rights approach with a
19 focus on individual informed consent at the point of
20 admission and throughout treatment and/or assessment on
21 mental health wards with consent to be recorded
22 explicitly in the patient record. This is a significant
23 change from the previous approach of informed implicit or
24 implied consent where patients were provided with
25 information about the system and consent was implied

1 unless an objection was made. The specified time limits
2 for responding to the withdrawal of consent by a patient
3 have been changed from a maximum of 72 hours to a maximum
4 of 6 hours and the updated SOP is clear that the system
5 should be switched off as quickly as practicable and
6 safe."

7 Now are you still happy with that description
8 there of the essential changes in SOP version 12?

9 **A.** Yes. We have spoken earlier about the additional
10 emphasis on making sure that the system is only used for
11 its proper purpose, you know, I noted that earlier in the
12 evidence I have given today. I think that's an important
13 one as we all as what is here.

14 **Q.** Thank you very much. Can we look at the relevant part of
15 the SOP? Could you put up EPUT009884, at page 9. That's
16 perfect, thank you. So can we see here at paragraph
17 1.5.2 "Oxevision Informed Consent Process", and can we
18 see:

19 "As part of the admission process all patients
20 must be provided with clear, accessible information about
21 the use of Oxevision and Oxevision Observations."

22 Then looking at the second paragraph:
23 "Patients are encouraged to ask questions, express any
24 concerns, and given the opportunity to fully understand
25 how and why the system is used. The patient will be

1 informed that the Oxevision system is currently in an
2 'on' state and they will be required to give informed
3 consent for this to remain on or the Oxevision system
4 will be switched off within 6 hours."

5 That is what you have just been describing in
6 your statement. Just dropping down:

7 "Consent for the use of the Oxevision system
8 must be obtained and clearly documented in the clinical
9 case notes ..."

10 And I think that is something you actually
11 referred to a little while back as well. Can you expand
12 the bottom half of the page, please, from "If there are
13 concerns", thank you. We can see in this paragraph text
14 that says:

15 "If there is reason to believe the person lacks
16 mental capacity to make the decision they should proceed
17 to make a best interests decision ..."

18 "They" being a reference to the nurse in charge
19 along with the responsible clinician or duty doctor. We
20 can see also in that same paragraph:

21 "Where there is reason to believe a patient
22 lacks mental capacity a Multi-Disciplinary Team (MDT)
23 meeting should then be arranged to specifically review
24 this decision as soon as is reasonably possible."

25 So could we deal first, please, with the

1 situation where a patient lacks capacity. Does the SOP
2 and what we have just looked at mean this; that if it's
3 believed that a patient lacks capacity, the decision
4 about whether to keep the system on is made in the first
5 instance by the nurse in charge and another clinician,
6 and then reviewed in an MDT.

7 **A.** Yes, and I think, you know, the reasoning here is to be
8 as timely as possible. So, you know, it refers to the
9 nurse in charge along with the responsible clinician or
10 duty doctor. And that is recognising that admissions
11 happen at all times of day and night. So if somebody,
12 you know, were to be admitted late in the evening it
13 might not be feasible for an MDT to happen until the next
14 day. And so what this procedure is being clear about is
15 that those responsible clinicians who are on duty at that
16 time must consider mental capacity for the individual.
17 And it's, you know, it's not saying that they should be
18 predisposed to one answer or another for that individual.
19 They should, you know, I am not a clinician, as I have
20 said, but they should follow their established practice
21 in undertaking that best interests assessment for that
22 individual.

23 **Q.** Let's unpick that. Let me ask a few things about that.
24 So the system may be kept on until the MDT which may take
25 place some time after the six hour period?

1 **A.** No, if the nurse in charge and the responsible doctor
2 said, "This should be switched off now", it would be
3 switched off now.

4 **Q.** I understand but in the other scenario, the nurse in
5 charge may decide that the system should remain on, in
6 which case it will remain on until the MDT convenes, is
7 that correct?

8 **A.** Yes, because essentially they would have then done a best
9 interests assessment, concluded that it should stay on
10 and then that would have been further reviewed at the
11 MDT, but they would have been acting in accordance with
12 their professional duties and, you know, assessments.

13 **Q.** I understand all of that, it is just the timeliness
14 element I wanted to ask you about because we have got
15 this six hour time period now. But if the nurse in
16 charge or the equivalent clinician decides that the
17 system should remain on, the ultimate decision will have
18 to wait until the MDT, and that could be some time after
19 the six hour period has elapsed.

20 **A.** No, I disagree with that because I think the phrase
21 "ultimate decision" is not quite right. The nurse in
22 charge and the duty doctor are undertaking a capacity
23 assessment with reference to the Mental Capacity Act. So
24 they aren't doing that at that time and then additionally
25 there is going to be a further review and assessment of

1 that later. So, you know, that is a clinical decision at
2 that point in time. It's, you know, so there may be a
3 further review and I think one of the things that the
4 SOP, you know, talks about is that capacity is not a
5 constant, so it may be that somebody's capacity changes
6 over time. This is a well-established point in mental
7 health care, that you have to regularly return to
8 questions of capacity --

9 **Q.** Well, I think the SOP talks about returning to it every
10 week or so or every six days; is that right?

11 **A.** Yes, but the responsible clinician and the nurse in
12 charge and the team should be responding to this in
13 whatever frequency was appropriate as well, they have to
14 have the ownership of the care under that individual.

15 **Q.** So you are saying that in fact the nurse in charge
16 decision is the decision and that will happen within the
17 six hour period?

18 **A.** Yes, and we're clear here it's the nurse in charge along
19 with responsible clinician or duty doctor.

20 **Q.** Thank you, yes, thank you for the correction. Do you
21 know whether in fact in most cases of patients lacking
22 capacity, the system is actually kept on?

23 **A.** I don't know the answer to that question.

24 **Q.** Thank you. Can we move to the situation for patients
25 with capacity and we need to read just a little bit more

1 of what is on the screen, the second paragraph:

2 "If the patient consent is not given on
3 admission, or is withdrawn during the admission process
4 or following the MDT clinical decision, the Oxevision
5 system can be individually isolated by the Nurse in
6 Charge (NIC) using the monitor to select 'Camera off' for
7 that patient's bedroom."

8 So here we see the procedure using Oxevision to
9 actually isolate the camera in a particular room.

10 **A.** Yes.

11 **Q.** "A decision to turn the camera off should only occur if
12 the Nurse in Charge or doctor, deems the action
13 clinically safe prior to a Multi-Disciplinary Team (MDT)
14 decision meeting."

15 So this is referring to the MDT decision
16 meeting:

17 "If the Nurse in Charge or doctor deems this to
18 not be clinically safe, then the Oxevision system will
19 remain on and the rationale to be explained to the
20 patient and clearly documented in the patient record."

21 Can we just deal with what that is saying. So
22 this relates to patients with capacity, have I got that
23 right first of all?

24 **A.** Yes.

25 **Q.** Do you understand it to mean this; that if such a patient

1 does not give consent, the system may be turned off?

2 **A.** No, what this is trying to say is that if the patient
3 does not give consent, then the system should be turned
4 off, but the turning off of the system, and there's
5 important considerations around that in terms of
6 maintaining good knowledge and working across the ward.
7 So if, for example, a nurse were to switch the system off
8 but not tell the rest of the team, that would be a cause
9 of concern because they might think, "Oh it's on" when
10 it's not. So this paragraph, and I can accept it
11 probably needs some redrafting to make it clearer. This
12 paragraph is trying to say that there may be reasons in a
13 clinical judgment of the nurse in charge that that needs
14 to be delayed. Perhaps there was an incident and they
15 are responding to it, and might mean they can't switch
16 the camera off immediately. Perhaps there are other
17 issues. I couldn't be exhaustive in what those scenarios
18 might be. But the nurse in charge must make sure they
19 have used their clinical judgment, risk assessment, of
20 what's happening on the ward to turn it off safely with
21 other colleagues properly informed.

22 **Q.** Right, let's deal with that in stages. First of all, you
23 are saying this paragraph lacks clarity?

24 **A.** I think to the question that you have said, I think its
25 clarity can be improved.

1 **Q.** Can we just follow through, what it appears to say is
2 that a patient with capacity can refuse consent, but that
3 the nurse in charge or equivalent clinician might decide
4 effectively to ignore that because that person doesn't
5 feel it's safe to turn off the system. The words that
6 are used:

7 "A decision to turn the camera off should only
8 occur if the nurse in charge or doctor deems the action
9 clinically safe prior to an MDT."

10 As this reads, the suggestion seem to be that
11 even where a patient with capacity refuses consent, there
12 is a scenario where the camera may remain on.

13 **A.** If the nurse has -- there was an immediate safety concern
14 or something going on, then the nurse has to make that
15 judgment. The reason it says that this needs to be
16 clearly documented in the patient record is because this
17 is allowing for, you know, a very limited set of possible
18 circumstances. The clear intention of the SOP is that if
19 the patient withdraws consent, you switch the system off,
20 you do that as quickly as practically possible. And this
21 "practically possible" point, admission processes are
22 quite long complex processes. Our steps for that --
23 there are 43 steps to go through on admission and wards
24 are complex environments with lots of different things
25 happening at any given time. So our nurses in charge are

1 constantly judging a number of different factors to keep
2 patients safe and engaged and supported on the wards.
3 Here we are trying to acknowledge that and recognise
4 there may be some limited circumstances, but if that's the
5 case, it's effectively a deviation from the core intent
6 of the SOP and it must be documented. That will allow
7 for subsequent audit and review and improvement.

8 **Q.** Can we just deal with that? So you talked about the 43
9 steps that need to be gone through. So this is a busy
10 ward, with a clinician who has a lot to get through, how
11 on earth are they going to properly explain consent in
12 the context of all the other matters they have to deal
13 with and relying on a Standard Operating Procedure, which
14 is drafted in a way that lacks clarity and understanding.

15 **A.** I don't accept that the whole procedure lacks clarity and
16 understanding.

17 **Q.** In respect to this particular issue?

18 **A.** I accept this paragraph could be improved. In terms of
19 that admission process, the team have to go through a
20 number of steps and do each of those conscientiously. A
21 discussion about consent on Oxevision is not a discussion
22 that is necessarily going to take an hour. It could be
23 quite a short discussion. It depends on the individual
24 patient. And I can't say it will take this long or that
25 long. Our clinicians, they are experienced in supporting

1 people in moments of crisis, supporting people with
2 different states of capacity and they make complex
3 judgments every day and work with patients with complex
4 and different needs in different circumstances. The
5 policy is there, it's really clear and that conversation
6 needs to be had at admission and we would expect staff to
7 do that.

8 **Q.** Thank you. I said I would come to the point you were
9 raising about opt-out or opt-in, but would you accept
10 this from me that, as we have seen the system is
11 initially switched on as a default for all patients and
12 across all wards, and this revised consent process still
13 actually remains an opt-out rather than an opt-in model?

14 **A.** I wouldn't accept that, and I will explain it a bit more.
15 When considering standard operating procedures, they are
16 operating procedures, they are about how things happen in
17 practice and the practical elements of this are really
18 important. The time it takes somebody to walk from one
19 place to another to have a conversation, to carry out a
20 task, matters. And we know in healthcare safety
21 literature, more broadly, that communication and time for
22 communication is incredibly important for safety. So the
23 point of saying "up to six hours" and it is "up to" and
24 the policy is clear it should be as quickly as
25 practically possible, it is to allow the time that in

1 whatever the practical circumstances are of the
2 admission, working through all of those steps, what's
3 going on on the ward, that the nurse in charge and the
4 team would be able to have that conversation as soon as
5 practically possible.

6 **Q.** Has the Trust considered having Oxevision turned off as
7 default and turned on only if the patient consents?

8 **A.** Yes, this is something that the quality matron for
9 Oxevision was heavily involved with and discussed with
10 staff on the wards. The reason for having it switched on
11 at the start is again a practical one about safety and
12 understanding on the wards. Often patients will move
13 between rooms as part of an admission. There may be a
14 patient that moves from A to B and things like that. The
15 view of staff was there was a risk if they had to try and
16 switch rooms off at the point of discharge, that patient
17 moves from a room, that might mean that there wasn't a
18 common understanding of the room states. So by having on
19 at the beginning, the staff across the ward would be
20 clearer about the current position and how to maintain
21 the safety and oversight of the ward. I am not sure if I
22 have explained that as clearly as I might have. It came
23 from on the ground discussions between the quality matron
24 and ward staff who were concerned that the room state
25 should be clear for all staff and patients at admission.

1 **Q.** Wouldn't turning it off as default, at the start, and
2 then opting-in effectively be more consistent with a
3 properly informed consent model?

4 **A.** The point here is we are trying to change this as quickly
5 as practically possible. As I say, that practicality is
6 important. There are other considerations around the
7 overall safety and communication around the ward, that
8 mean that the view of staff and the quality matron was
9 that the ward, safety and overall safety of patients
10 would be better supported by having it on at the point of
11 admission. I do think these are issues, which as I
12 referred to earlier, will be considered further in the
13 Quality Committee's deep dive in November. The Trust's
14 Quality Committee has already planned a focused session
15 on Oxevision, where it will be considering some of the
16 things I have set out in my statements, audits and so on,
17 to look at how this is working practice, following the
18 latest change to the operating procedure.

19 **Q.** That is something you can report back to us once the that
20 has been produced?

21 **A.** I would be very happy to and that will give us also an
22 opportunity to consider the important evidence that has
23 been heard in this Inquiry the over the last two days.

24 **MR GRIFFIN:** Thank you.

25 **THE CHAIR:** Given that one of the principles of the NHS

1 guidance is about therapeutic and personalised care,
2 would you not accept that it would be a more personalised
3 approach to have it off and to consider the needs of
4 individual patients and whether it should be switched on?

5 **A.** The policy is clear about that.

6 **THE CHAIR:** Therapeutic and personalised care.

7 **A.** Yes, the point of having the conversations at the
8 beginning and having the informed explicit consent is to
9 be line with that guidance. The practical points about
10 switching it off, it's clear it should be switched off as
11 quickly as possible. So the six hours, I would expect it
12 would be switched off more quickly than six hours in most
13 cases, and it may be switched off as soon as that
14 conversation is had. But the procedure has to allow for
15 a variety of situations so it's more permissive than
16 that. Chair, I think, you know, if there weren't the
17 other considerations raised by ward staff about
18 communication and consistency and understanding of the
19 environment, then we probably would have had it switched
20 off at the beginning in this SOP, and I think certainly
21 it's something that the Quality Committee will be
22 interested in considering further. But it was the
23 practical considerations in order to support a
24 therapeutic and personalised approach.

25 **THE CHAIR:** Thank you.

1 **MR GRIFFIN:** Could you take that down, please. Just moving on
2 to a different topic now, you say in your third
3 statement, where you cover impact of change from the
4 version 11 Standard Operating Procedure to the one we
5 have just been looking at, this is paragraph 45, you say
6 that:

7 "EPUT is not yet in a position to provide
8 comprehensive data or detailed analysis regarding the
9 full impact of the changes implemented between version 11
10 and version 12 because more time is needed to embed the
11 process across all wards."

12 Is that what is being looked at at the moment?

13 Is that what the report will be covering?

14 **A.** Yes, exactly. The Quality Committee will be looking at
15 exactly those matters and I have highlighted in my
16 statements several of them. The commission of an
17 internal audit focused on consent in Oxevision, and that
18 internal audit's method includes going to look at a
19 sample of patients to understand whether this policy was
20 followed in practice, and I think, you know, goes to your
21 question, Chair, about how quickly and how adequately was
22 that addressed for individual patients. So that internal
23 audit will help us understand it better. We have also,
24 and I attached some examples, we have been using a
25 Tendable (Tendable is our kind of audit system we have)

1 -- Tendable audits which is where staff self-assess
2 compliance with the Standard Operating Procedure. The
3 two examples that were attached show compliance, but
4 there are others that don't and that's an opportunity for
5 staff to review and revisit and make changes. Then the
6 other thing I referred to in my statement is, you know,
7 patient focus group meeting. In fact, rather than
8 holding a focus group, the patient experience team
9 determined to go out on to the wards, so we had feedback
10 from 46 patients to a number of questions about their
11 personal experience of Oxevision, which is being compiled
12 into a report which will be considered. Early findings
13 from that are clear that we do not have full compliance
14 with this at the moment.

15 **Q.** Sorry just pause there.

16 **A.** And patients are still reporting --

17 **Q.** So you don't at the moment, the information is that the
18 process set out in SOP version 12 isn't being fully
19 complied with?

20 **A.** That's correct.

21 **Q.** Thank you. I want just to finally ask you about cost.
22 Is it correct that --

23 **THE CHAIR:** Sorry can I ask a follow-up question about
24 consent?

25 **MR GRIFFIN:** Yes.

1 **THE CHAIR:** As I understand it, there is a weekly discussion
2 once somebody has opted out as to whether or not that
3 wish still stands, is that right?

4 **A.** Whether they have opted in or out, it would be regularly
5 reviewed. It is not specific to them having opted out.
6 There's also regular community meetings on the wards
7 where Oxevision is expected to be an agenda item, and I
8 have heard from patients that that has been their
9 experience, and that individual nursing teams should be
10 regularly revisiting these questions. They should be
11 revisiting that whether the patient said they wanted it
12 or whether they didn't. It's not specific to their
13 choice.

14 **THE CHAIR:** So this is a free discussion, once a week, is it,
15 with who, the MDT and the patient about --

16 **A.** As part of their discussions about their care they should
17 be revisiting these questions, yes.

18 **THE CHAIR:** Including inviting them to opt out, should they
19 wish to do so or rather drawing to their attention that
20 they could opt out?

21 **A.** Yes.

22 **MR GRIFFIN:** That's the theory, but at the moment the
23 information you have is that it is not necessarily being
24 implemented properly?

25 **A.** That's right. So for some patients they are reporting,

1 and I have heard this in my recent visits and this is
2 shown in the early indications I have had from the
3 patient experience team, some patients are getting that
4 experience and saying, "I did have a conversation on
5 admission. I have been told about this. This is in my
6 community meetings and I have heard about it from staff
7 regularly." Other patients are saying, "I don't know
8 enough about this system. I don't feel I have been
9 properly consulted on it or engaged on it or had my
10 consent taken or not." So we are, from our patients,
11 still hearing a variety of experiences. I anticipate
12 that the internal audit will also show areas where we
13 need further improvements to be fully compliant with the
14 SOP. I mean, I would note generally for healthcare
15 providers that compliance with standard operating
16 procedures requires continued work and focus and you
17 know, when you look at reported statistics, when people
18 are talking about standards, you know, they are often not
19 100 per cent standards that they are measuring against,
20 when they are looking at -- mandatory training compliance
21 is a good example. A trust won't have a 100 per cent
22 mandatory training compliance in general terms because
23 they recognise there will be reasons and constant
24 improvement activities.

25 **Q.** Thank you. The Inquiry will be liaising with EPUT

1 through its legal team to ensure we get all relevant
2 information.

3 **A.** Certainly.

4 **Q.** Chair, I was going to deal with one more topic briefly
5 and that is cost. Is it correct that the total cost to
6 date of the contract with Oxehealth runs into millions of
7 pounds?

8 **A.** Yes.

9 **Q.** Do you know what the actual figure is?

10 **A.** I know what the figure is for how much was spent in
11 2024/2025.

12 **Q.** What was that?

13 **A.** That was approximately £1.2 million. To put that in
14 context, we spent, our business case for Time to Care is
15 to spend £14 million on increased staffing on the wards.
16 As a trust we turn over some in the same financial year
17 £580 million of income related to patient activity. So
18 that 1.2 is about 0.2 per cent and it compares to around
19 £420 million spent on staffing as a whole. I say those
20 because I am not diminishing the sum, it is an important
21 sum, but it has to be seen in the context of the
22 organisation as a whole.

23 **Q.** I understand the point about millions of pounds possibly
24 being a small proportion of the overall budget, but it's
25 still millions of pounds. Do you think, after what we

1 have been discussing today, that Oxevision actually
2 represents a good use of public funds and value for
3 money?

4 **A.** So we went through business case processes to decide as a
5 board to invest in Oxevision and if I take the Time to
6 Care business case as an example, that follows the
7 Government guidelines on five business cases. So there
8 was a clear and robust assessment in that of the
9 strategic case, the financial case, the economic case,
10 the management case and the commercial case. So on the
11 basis of that the Trust board did agree that it was value
12 for money and an appropriate investment. That case sets
13 out the safety priorities and I do want to, I can't, I'm
14 not very good at turning the pages, do I want to note the
15 point I think in my third statement that our evidence on
16 our Datix instant reporting system is over the multiyear
17 period that I have cited there, over 1400 incidents staff
18 have ticked the Datix reporting note to say, "Oxevision
19 played a role in alerting us to this incident." In the
20 patient focus group that we held in March, a patient
21 there said, "Oxevision saved my life." That was their
22 experience. I know others have had other experiences and
23 some terrible and tragic experiences. Staff have often
24 told me when I have been visiting wards and asking about
25 Oxevision, "This has helped us in saving lives." So I

1 think we talked about innovation and technology earlier,
2 it's really important that these debates are had and that
3 you know we welcome the Inquiry's focus on these matters.
4 I think it will be of service to us and to the NHS mental
5 health providers more broadly, but we must look at all
6 sides of that because our experience has been that this
7 has supported improvements as well as having risks and
8 issues that we have talked about.

9 **MR GRIFFIN:** Thank you very much. Chair, those are all the
10 questions that I have for Mr Trent at the moment. Could
11 we break, subject to any questions you have at the
12 moment, so that I can liaise to see if there are any
13 further questions.

14 I am going to aim to come back at 5 o'clock.
15 It is possible, Chair, that I will ask for a little bit
16 more time than that, but we will make that request
17 through other channels.

18 **THE CHAIR:** Yes.

19 **(4.43 pm)**

20 **(Break)**

21 **(5.06 pm)**

22 **MR GRIFFIN:** Thank you, Chair. Mr Trent, a few more
23 questions. First of all, I would like to go back to the
24 iWantGreatCare feedback we looked at. I am going to ask
25 that EPUT009020 is put up on the screen again, please.

1 If you see there's the top right-hand corner, there are
2 four boxes there and we looked at the entries in the
3 second row. Can I just draw your attention to the text
4 that we see below that. So this is in relation to 1
5 February 2024, Chelmer Ward at Princess Alexandra
6 Hospital. So the same ward at the same hospital, but two
7 or three months later on. We can see the text there that
8 says:

9 "Yes, really safe with staff and with the
10 Oxehealth and staff personal cameras" -- and -- "Can a
11 mirror be put in the laundry room, please?"

12 I have just been asked to draw your attention
13 to those. Are those, well the first of the two comments,
14 is that the kind of comment that you have heard as well?

15 **A.** Yes, you know, this iWantGreatCare allows for positive
16 and negative feedback. It is something we implemented to
17 support us in better listening to patients and their
18 families, and it's all publicly available and we do
19 receive positive comments as well. And when I have
20 spoken to patients on the ward, and you see this in the
21 Professor Nolan review as well, some patients do
22 acknowledge the safety benefits of it and you know, I
23 spoke to patients recently who said, "Yeah, actually for
24 me I would like that on, that's helpful to my care."

25 **Q.** And that picks up on what you were saying at the end of

1 the last session we had about the positive aspects of the
2 system?

3 **A.** Yes, but I mean that is not a universal view and, you
4 know, obviously, we have heard evidence of the contrary,
5 but you know that is also what some people have said,
6 yes.

7 **Q.** That's very helpful. Would you take that down, please.
8 You been clear in your evidence that you expect all
9 therapeutic observations to be undertaken by staff in
10 person with Oxe-Obs there as a tool really to enter data.
11 Beyond revised training, and you spoke about that, with
12 the majority of it being online, what practical steps has
13 EPUT taken in order to ensure and monitor staff adherence
14 to this policy requirement?

15 **A.** So you know, you have heard before about the Time to Care
16 programme, and we keep mentioning it because it's one of
17 the big transformational programmes we are undertaking at
18 EPUT and that £40 million every year investment is a
19 significant one. As part of that programme we have been
20 going through an implementation checklist for each and
21 every ward and we have got a broader Time to Care
22 Standard Operating Procedure, which really engages staff
23 on these overall principles to focus on more
24 patient-centred personalised care, to be more trauma
25 informed, to use that multidisciplinary team better.

1 That steering board has been overseeing those changes,
2 that's important, in relation to that. I have already
3 referred to the regular ward visits undertaken by the
4 quality lead for Oxevision, but there's a number of other
5 senior clinical staff that regularly visit wards,
6 directors of nursing and the chief nurse go out to wards
7 usually on Fridays but every week to talk to staff and
8 engage with them and talk about the fundamentals of care.
9 So you know there's a number of different things going on
10 to support improved adherence to that and it is about the
11 core focus of improving care.

12 **Q.** Thank you. To what extent has EPUT considered
13 comparative trusts' patient information literature on the
14 use in Oxevision in formulating and revising its own
15 patient literature on this technology? The suggestion is
16 that other trusts provide much more information and much
17 more accessible information in their patient-facing
18 documentation. So is that something that EPUT has done
19 to have a look at what other trusts are doing?

20 **A.** Yes, absolutely. So EPUT has been actively involved in
21 the Nurse Directors Forum for some years, including in
22 the Standard Operating Procedure working group. It's
23 also been involved in the Communities of Practice. Our
24 quality matron for Oxevision and the service manager --
25 sorry, the kind of systems manager, both of them engage

1 with that and share practice and materials. So I know
2 they have discussed different practices around the
3 documents. I couldn't tell you here immediately what
4 documents have been shared between trusts but that is
5 something we could address in the further statement that
6 I have promised.

7 **Q.** That's fine, thank you very much. This Inquiry may
8 conduct further investigations which might include having
9 reference to the equivalent documentation produced by one
10 or more other providers to compare for purposes of
11 clarity and other reasons. Do you accept that the
12 evidence you have provided as to the circumstances in
13 which it would be clinically unsafe to deactivate a
14 camera, this is in relation to version 12 of the SOP,
15 where a patient with capacity has refused consent, don't
16 amount to a clinical rationale as to why the Oxevision
17 camera should remain on, it's more of a staffing
18 resources issue?

19 **A.** I mean, I say in my statements I'm not clinically
20 qualified and so you know, in answering that question
21 earlier, I have sought to, you know, describe
22 circumstances that may be applicable. By no means were
23 those exhaustive and, you know, you would want to take
24 clinical evidence or, you know, evidence from a clinician
25 and we can follow up with colleagues to give some

1 specific examples of that. So you know, I would suggest
2 that those were not exhaustive. I was not making a
3 clinical assessment and that we can provide some further
4 evidence from our clinical leads if that would assist the
5 Inquiry.

6 **Q.** Thank you. Ms Cozens couldn't answer yesterday but said
7 an EPUT witness could, how much EPUT has spent on
8 Oxevision in the last few years since it was deployed
9 there. You were here yesterday to hear her evidence, so
10 you might have been expected to have prepared to answer
11 the question. Can you help us, even with ballpark
12 figures what the total spend on Oxevision at EPUT has
13 been?

14 **A.** I don't want to give you an incorrect sum and while it
15 might seem as though that would be a simple exercise,
16 actually, I commissioned that piece of work a week or so
17 ago to find out the latest spend before hearing
18 Ms Cozens' evidence and it did take the finance team a
19 couple of days to work through invoices and other things.
20 So I wasn't able to immediately have that information. I
21 know that the initial business case presented at the
22 outset talked about a 1.8 million investment over four
23 years, but the information the Inquiry seeks can be
24 provided and we will provide that in terms of the total
25 spend since inception.

1 Q. That is helpful, but of course that 1.8 was foreseen at a
2 time when the rollout hadn't extended to the 40 plus --
3 A. I mean, that's precisely why I give you the 1.2 million
4 of 24/25 because it's recent and reliable.
5 Q. Thank you very much. Ms Cozens told us yesterday that
6 Oxevision was used in police cells. Was that something
7 you were aware of?
8 A. I note that, you know, Hat Porter's latest statement
9 referred to, you know, a point in my statement about
10 Oxevision being designed for mental health. That was not
11 intended to express that it had only ever been designed
12 for mental health. It was intended to say that at the
13 time we engaged with Oxevision, we understood it to be a
14 system that had been designed, you know, had been further
15 designed or for use in that setting, and we were not the
16 first to work with that we knew about Oxford Health and
17 we knew about Coventry and Warwickshire at the time.
18 Q. But just dealing with the question; were you aware from
19 an early stage that Oxevision had been used in police
20 cells?
21 A. I mean I wasn't at the trust at that early stage, so I
22 don't know whether people were aware or not.
23 Q. Were you aware from your early stages at the trust?
24 A. Not immediately, no, I wasn't aware of that.
25 Q. Do you know whether EPUT was ever given data relating to

1 its use or effectiveness in police cells or prison cells?

2 **A.** I am not aware that we have ever received that. I can
3 undertake further searches but I don't believe we have.

4 **Q.** In fact, I have just said prison cells, I can't recollect
5 now frankly whether there was a suggestion it was used
6 there, so let's just stick with police cells for now. So
7 you are not aware of any concerns may have arisen from
8 its use in that kind of environment?

9 **A.** Not that I'm aware of that were specific to that that
10 were shared with the Trust, no.

11 **Q.** Was EPUT one of the first trusts to trial Oxevision?

12 **A.** As I said, you know, the papers from the time clearly
13 refer to Oxford Health and Coventry and Warwickshire
14 having already been using Oxehealth. I think you know
15 when you look at the, you know, circa half of mental
16 health trusts using Oxevision now, we were probably one
17 of the earlier ones to adopt it, but I don't have an
18 analysis of when other trusts took it on, but I know we
19 were aware of at least two that had already done that
20 before us.

21 **Q.** Do you know if EPUT has been used by Oxevision to
22 recommend its product to other trusts?

23 **A.** We wouldn't make a recommendation of a product.

24 **Q.** Sorry, no the question is whether Oxevision has used the
25 EPUT experience to recommend its product to other trusts?

1 **A.** I don't know whether that's the case or not. I would
2 think that Oxehealth would be best to respond to that.

3 **Q.** Fine. Sorry, I said Oxevision, Oxehealth.

4 Issues relating to continual monitoring now,
5 please. When did you personally first know that
6 Oxevision does, in effect, record constantly through a 24
7 hour period?

8 **A.** When I reviewed the DPIA, that was a clear piece of
9 evidence that I reviewed at that time. As you can see
10 from the documentation, the first DPIAs for this were --
11 Data Protection Impact Assessment, sorry -- were approved
12 before I was at the Trust, but when one came to me for
13 review I reviewed all of that information.

14 **Q.** Would you agree that the 24/7 filming and recording of a
15 patient in their bedroom constitutes a very significant
16 invasion of privacy?

17 **A.** I mean, we have discussed extensively these issues
18 earlier. There clearly is an invasion of privacy and
19 that has to be put against the robustness of the consent
20 process because, you know, and we accept this elsewhere
21 in healthcare that people can consent to different forms
22 of treatment to support their care --

23 **Q.** Can I just cut to the quick with this question, please?

24 **A.** Of course.

25 **Q.** Even with the, what you have described to us in terms of

1 securing the data and only using it in confined
2 circumstances, even given that, would you accept that
3 filming a patient in their room 24 hours a day
4 constitutes a very significant invasion of privacy?

5 **A.** I, you know, the Trust would not make that overall
6 assessment, you know, the position that we have set out
7 is that you know, we recognise there's a balance here
8 between privacy and safety and the provision of care and
9 that that needs to be struck and supported by a robust
10 consent process.

11 **Q.** How many staff to your knowledge have been disciplined at
12 EPUT for the misuse of the Vital Signs system?

13 **A.** I don't know the answer to that question immediately. We
14 would have to review our HR and disciplinary files in
15 order to answer that. I would also caveat that to
16 undertake that research you would have to be mindful that
17 in reviewing that it may not be as precise as "the Vital
18 Signs system was inappropriately used", because as I have
19 spoken about earlier, the concern would be a staff member
20 has not followed proper conduct. So I would think that
21 would be quite an extensive exercise, it could be
22 undertaken.

23 **Q.** Right, so that be something the Inquiry should follow up
24 on with you and your legal representatives at a later
25 stage?

1 **A.** Certainly, we would be happy to engage with you about
2 that.

3 **Q.** Thank you very much. You talk in one of your statements
4 about quality walkarounds focused on Oxevision being
5 undertaken by the Deputy Director of Quality and Safety
6 and the quality matron on a monthly basis. How
7 frequently does the DOQ, the Deputy Director of Quality
8 and the trust wide Quality Matron, address high instances
9 of observations? Will the Director of Quality and the
10 Quality Matron disclose work to the Inquiry about the
11 wards of concern? Did you understand that question?

12 **A.** I think I get the central focus of the question. We
13 would be happy to provide the Inquiry with further
14 evidence about how our senior clinical staff, you know,
15 provide supervision and oversight of this on the wards
16 and the relationship between that and the project board
17 where those usage reports are reviewed, which we
18 discussed earlier.

19 **Q.** Thank you. Do you agree with Laura Cozens that because
20 your patient population is so varied, having Oxevision on
21 by default isn't appropriate?

22 **A.** I don't agree with the premise of that statement or
23 question. I have explained earlier that, you know, in
24 our latest Standard Operating Procedure, we have got an
25 explicit consent at the outset and we seek to implement

1 that as quickly as practically possible.

2 **Q.** So your answer goes back to the explanation that you have
3 given to us previously?

4 **A.** Yes, and further, the point about having a varied
5 population, which we do in Essex, of people with a wide
6 range of needs, care needs and support, is again coming
7 back to that individualised conversation about consent
8 which we have talked about.

9 **Q.** Thank you. Can we go back to the usage report that we
10 looked at elements, if you remember. You were asked
11 about one of the graphs with specific attention being
12 drawn to a graph that suggested there were a
13 significantly high number of vital sign attempts, do you
14 remember that? Is it correct that a vital sign attempt
15 would be reflected within these figures, these very high
16 figures that we were seeing, if a member of staff had
17 selected the tile of a bedroom as if to carry out a vital
18 signs check, but for whatever reason did not then
19 complete the workflow?

20 **A.** I mean that's a technical question for how the data is
21 calculated from the system so we would need to check --
22 because it's quite precise that question.

23 **Q.** It's a very precise question.

24 **A.** So, you know, is it on the first click or the second
25 click effectively. Usually, in clinical systems you will

1 be able to somewhere in the code audit the two different
2 clicks. I don't know which one Oxehealth have used. I
3 think they would probably be best to answer that
4 question.

5 **Q.** Or we might go back to EPUT in terms of the way it is
6 configured for the Trust --

7 **A.** Yes, either --

8 **Q.** -- because there are questions here about at what stage
9 one would access the clear video feed and so this is
10 another area where the Inquiry may follow up with EPUT
11 and/or Oxehealth, just to ensure we understand the
12 procedure and therefore can understand the figures that
13 we've been looking at. So you are willing to co-operate
14 with that?

15 **A.** Yes, and I mean certainly we would be happy to show you
16 in practice on the wards with an empty room or a
17 volunteer or something like that, if it would assist the
18 Inquiry, because my experience is that it's in the visits
19 and the conversations that you really get to understand
20 how this system is being used.

21 **Q.** Thank you very much. You said that to your knowledge
22 Oxehealth do not have access to clear video data. An
23 extract from an EPUT Data Protection Impact Assessment
24 from 2023 states that under certain circumstances clear
25 video data may be clipped, marked for attention on the

1 local secure server so that it is not recorded over, by
2 Oxehealth remotely and in some cases securely transferred
3 to Oxehealth's facilities. Now, that might suggest that
4 Oxehealth do or did in fact have access to clear video
5 data in some circumstances. Is that something that you
6 were aware of? Because that falls within your time at
7 EPUT?

8 **A.** So they shouldn't have access to the clear video data and
9 I think the exhibit to Laura Cozens's statement, which is
10 their latest DPIA and data management principles, has in
11 there the risk that Oxevision staff could access it and
12 talks about the controls to prevent that. So you know, I
13 maintain what I said earlier, which is my understanding
14 and our data protection officer's understanding is that
15 they cannot access that clear video data. One thing that
16 is important, we have spoken a lot about 24 hours, 24
17 hours is the maximum, so when clipping data and
18 certainly, you know, after clipping it there's that
19 further stage of the data protection officer determining
20 that it's appropriate use, the final stage where someone
21 views that they would only be given access to the bit
22 that was proportionate for that particular purpose. So
23 if someone was requesting to say, "Look there has been a
24 serious incident and we need to do that patient's safety
25 investigation", that might relate to, you know, a defined

1 period of an hour or some other time. They wouldn't be
2 given the whole 24 hours, they would only be given that
3 defined period that was proportionate to the purpose and
4 use that was being undertaken.

5 **Q.** I think you gave an example about a timeframe or at least
6 we certainly covered that with Laura Cozens?

7 **A.** Yes.

8 **Q.** But that's again an issue that we may follow up with you
9 and possibly Oxehealth in terms of more precise detail of
10 exactly where data is held and in what circumstances, and
11 again you are willing to co-operate with that?

12 **A.** Certainly, of course.

13 **Q.** Thank you very much. You were asked about the EPUT
14 clinical safety case report and under the heading
15 "Oxevision Observations", it's observed that Oxevision
16 can be used to conduct non-intrusive observations at
17 level 1 and 2 but not for levels 3 and 4. Does that
18 actually reflect EPUT's policy? For example -- does that
19 actually reflect EPUT's policy?

20 **A.** Yes, I mean, I think that's consistent with the policy.
21 You know, when you are getting into, you know, level 3
22 and 4, you are talking about people being very close to
23 the patient for most of the time.

24 **Q.** I think the question isn't directed on whether it can
25 also be used for levels 3 and 4, but that seems to

1 suggest that Oxevision observations can be used for
2 remote observations for levels 1 and 2, which would be
3 inconsistent with your evidence earlier today?

4 **A.** No, I don't think -- I don't think it does indicate that.
5 I think when it's saying non-invasive.

6 **Q.** Non-intrusive?

7 **A.** Non-intrusive, apologies, then I give the example of, you
8 know, somebody who's asleep. You know, the staff member
9 needs to still have, you know, line of sight, be
10 professionally assured that that person is safe and well
11 and can then take their breathing and heart rate without
12 having to physically touch them while they are sleeping,
13 for example. That would be what that is referring to in
14 terms of being non-intrusive. Non-intrusive should not
15 be taken there to mean remotely. They are different.

16 **Q.** But would that or might that be another example of
17 unclear language being used in EPUT documents?

18 **A.** I don't think that one is, no. Others I have accepted
19 but that one I don't think it is.

20 **Q.** You say, well, let me ask you this; is it possible or
21 even likely that on EPUT wards today there are patients
22 who have not been asked at all to give consent to the use
23 of Oxevision in their bedrooms, if even for an initial
24 period of six hours?

25 **A.** I mean that, as I have said, that is clearly contrary to

1 the Standard Operating Procedure and we expect staff to
2 follow that and that, you know, there's posters in the
3 wards and in the bedrooms and so on. I have already
4 referred to some early findings from the patient feedback
5 that says that some patients say that that hasn't been
6 their experience. So I can't stand here and say we have
7 got full compliance because I have already said to you I
8 don't believe we have full compliance.

9 **Q.** No, I understand, but does that mean that it's possible
10 that on EPUT wards today, there are people where
11 Oxevision is being used who have not been asked to
12 consent?

13 **A.** Well, that is what some of the patients have said.

14 **Q.** Thank you. Does it follow from that that it is possible
15 that there are people on wards today who have not been
16 told by staff that the equipment in their bedrooms
17 include a camera that is recording constantly?

18 **A.** So you know, I think as I have said earlier, you know,
19 the -- you know, it's possible that people haven't
20 followed the procedures and policies fully. As an
21 organisation we have sought to put in place controls and
22 oversight to improve compliance with that and we have
23 continued to focus and improve on that so --

24 **Q.** I understand your answers. I have got a series of points
25 I am going to put to you and maybe we can deal with them

1 globally?

2 **A.** Certainly.

3 **Q.** Because I suspect your answer will be the same, but I
4 want to put to you a number of potential scenarios on
5 EPUT wards today in relation to the issue of consent and
6 other matters. So also, do you think it is possible --
7 let me ask all of these scenarios and then answer in one
8 go. Do you think it's possible that people on the wards
9 haven't been told that the system is continuously
10 attempting in the background to take their vital signs;
11 have not been informed that continuous clear video
12 footage is being held for 24 hours; have not been
13 informed that blurred video footage is being held by a
14 private company, Oxehealth, for a period of time; have
15 indicated that they do not consent but are still subject
16 to the use of the system; are being watched for
17 continuous periods of 15 seconds by members of staff
18 accessing cameras remotely on tablets; or are
19 experiencing distress and/or paranoia because of the use
20 of cameras in their rooms?

21 Now I know that is a number of different
22 scenarios but taking them globally, do you accept that
23 it's possible that on the wards today, we might see
24 instances of each of those examples?

25 **A.** I accept that those things are possible. I would also

1 say that they are likely to be possible on every mental
2 health trust because when we are talking about compliance
3 here, it's very difficult to be able to guarantee 100 per
4 cent compliance on, you know, these matters in general
5 terms. You know, that point about compliance is
6 something that healthcare organisations in general focus
7 on continually and repeatedly because there are often
8 issues with compliance. So I think I can't obviously say
9 that these things aren't possible. They are possible.
10 But that is not exclusive to this organisation and needs
11 to be seen in a wider frame of assistance of reasonable
12 and appropriate controls and oversight.

13 **MR GRIFFIN:** Thank you very much. Mr Trent, those are the
14 questions I have for you. Chair, do you have any
15 questions for Mr Trent?

16 **THE CHAIR:** No, I have no further questions. Thank you very
17 much indeed for your evidence today.

18 **MR GRIFFIN:** Chair, that is it for today. We reconvene
19 tomorrow at 10 o'clock. Thank you very much.

20 **(5.34 pm)**

21 **(Adjourned till 10 o'clock tomorrow morning)**

22

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