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 Zephan 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

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

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

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

THE CHAIR: Thank you, Mr Hayes.

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

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

THE CHAIR: 11.20.

(11.12 am)

(Break)

(11.22 am)

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

THE CHAIR: Thank you.

(Video resumed)

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

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

CHAIRMAN: Thank you.

(12.13 pm)

(Break)

(12.29 pm)

THE CHAIR: Mr Griffin?

ZEPHAN TRENT (affirmed)

Examination by MR GRIFFIN

Q. Please give your full name?

A. My name is Zephan Marcus Andrew Trent.

Q. You have provided the Inquiry with three statements. Dealing with the first statement, is it dated 21 March this year and is it 29 pages long?

A. Yes.

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

May this year and is it 16 pages long?

A. Yes.

Q. Finally, the third statement, can you confirm that that is dated 2 September this year and is 11 pages long?

A. Yes.

Q. And can you confirm that they are accurate to the best of your knowledge and belief?

A. Yes.

Q. In each case, have you made a statement of truth and signed the statement?

A. Yes, I have.

Q. Thank you. Your statements stand as part of your evidence, along with the exhibits you have provided. I will not, therefore, be asking you about all of the matters that you have covered in them. Are you the Executive Director of Strategy, Transformation and Digital within Essex Partnership University NHS Foundation Trust, or EPUT?

A. Yes, I am.

Q. What does that role entail?

A. I am a member of the executive team and a non-voting member of the board. I have a portfolio where I lead on the strategy development for the organisation, including our five-year plan, for example. I provide leadership and coordination on transformation across the

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

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

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

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

A. Yes, I have.

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

A. Yes, I have.

Q. What does that role entail, please?

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

Q. You mentioned working alongside the Caldicott Guardian. I am not sure if everyone heard your description of what that position is. Could you just say that again, please?

A. Yes, so the Caldicott Guardian this was a role that was established after the recommendations of Dame Caldicott and it requires a senior clinician, often the trust Medical Director or the trust Chief Nurse to have oversight of how patient information is used.

Q. Thank you very much. You hold Bachelor of Arts with honours and Master of Science degrees; is that correct?

A. That is correct.

Q. And you are also a Chartered Financial Analyst charter holder, is that a professional designation that relates to matters such as investment analysis?

A. Yes, it is.

Q. But is it right you are not clinically qualified?

A. That is correct.

Q. And do you, in your roles, report directly to EPUT's chief executive officer Paul Scott?

A. Yes, I do.

Q. We have previously heard that EPUT was formed at the beginning of April 2017 by the merger between South Essex Partnership University NHS Foundation Trust and North Essex Partnership University NHS Foundation Trust. But we are unlikely to be referring to the predecessor trusts

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

A. Yes, that is right.

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

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

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

A. Yes.

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

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

A. Yes, I did in full.

Q. We heard that Oxevision is a type of technology that is sometimes referred to as a vision-based patient monitoring system or VBPMS or sometimes just VBMS. Is that correct?

A. Yes.

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

A. Yes, I can confirm that.

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

A. Yes.

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

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

A. Yes, it is.

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

A. Yes.

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

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

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

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

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

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

A. Yes.

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

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

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

A. Yes.

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

A. Yes.

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

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

A. Yes.

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

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

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

A. Yes.

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

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

And this adds:

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

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

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

Q. It is part of a bigger picture?

A. That's absolutely right.

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

A. That's right, yes.

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

A. It may well be the case, yes.

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

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

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

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

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

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

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

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

The activity suggests that the occupant is

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

A. Yes, four levels.

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

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

engagement policy.

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

A. Yes.

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

A. Correct.

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

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

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

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

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

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

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

reasons?

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

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

A. Sorry, Chair.

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

A. Yes.

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

A. Yes.

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

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

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

THE CHAIR: Thank you.

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

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

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

A. Yes.

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

A. Yes.

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

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

audit as quickly or easily.

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

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

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

A. Absolutely so. That provides better ward level oversight

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

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

A. Yes.

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

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

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

Then a little further down it says:

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

be reset."

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

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

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

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

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

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

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

A. Thank you.

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

A. Within the system, within the Oxevision system?

Q. Or anywhere.

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

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

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

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

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

A. I think those have covered the key points.

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

A. Which data do you mean specifically?

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

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

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

A. Yes, thank you.

Q. Can we start with usage reports?

A. Yes.

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

A. Yes, it is.

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

A. Yes.

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

paragraph 60, where you explain that they are:

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

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

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

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

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

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

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

A. Yes.

Q. Would you agree with that?

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

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

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

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

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

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

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

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

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

A. Yes it does, I agree that.

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

A. Correct.

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

A. Yes, I believe so, yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

A. Yes.

Q. And it has 18 beds; correct?

A. Yes.

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

A. Yes.

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

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

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

not conducting in person checks of patients following an alert?

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

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

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

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

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

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

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

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

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

A. Yes, I believe so.

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

A. Yes.

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

A. Yes.

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

A. Yes, yes.

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

designated recipient at EPUT; yes?

A. Yes.

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

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

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

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

A. That's absolutely right, yes.

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

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

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

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

THE CHAIR: Yes.

(1.27 pm)

(Break for lunch)

(2.17 pm)

THE CHAIR: Mr Griffin?

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

A. I'm aware of that concern.

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

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

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

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

A. Yes, that is correct.

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

A. Yes, it did.

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

A. Yes, it was.

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

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

Q. Could it be the result of alarm fatigue?

A. That's one possible analysis.

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

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

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

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

alerts?

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

Q. Two issues relating to Oxevision alerts; correct?

A. Yes.

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

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

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

foreseeable that staff might seek to mute Oxevision alerts?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Thank you.

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

Q. Is there any policy that actually says that?

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

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

A. Yes.

Q. In your statement you have add that:

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

You add:

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

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

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

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

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

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

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

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

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

A. Absolutely and wholeheartedly.

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

A. Yes, I agree.

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

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

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

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

A. Yes.

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

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

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

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

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

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

Q. How much of that training is online?

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

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

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

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

collect and process feedback since the start of 2022. You provide details of the feedback located in relation to Oxevision between July 2023 and July 2024. Can we just look at an aspect of that, please?

A. Certainly.

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

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

Then the next free text box says:

"We need more staff during the day."

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

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

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

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

A. Yes.

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

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

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

automatically overwritten. Is that all correct?

A. Yes.

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

A. Yes.

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

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

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

It says at the bottom:

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

..."

So it is reiterating that important point.

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

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

Q. Yes, by all means.

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

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

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

Q. Can we take this in stages?

A. Yes, of course.

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

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

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

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

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

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

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

cetera?

A. No, not to my knowledge.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Do you know what it actually says?

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

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

A. So at paragraph 24 of my statement.

Q. Which one?

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

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

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

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

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

A. Certainly.

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

A. Not in those terms.

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

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

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

A. (No verbal response)

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

A. Limited to what specifically?

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

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

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

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

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

Q. Shall we look at the poster?

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

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

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

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

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

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

And this poster is also included in the welcome pack.

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

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

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

correct?

A. Correct.

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

Then we get this:

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

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

A. It's slightly different on the website.

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

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

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

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

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

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

A. May I say one more point.

Q. Yes, of course.

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

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

at all times?

A. I accept that.

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

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

MR GRIFFIN: Sorry, shorter than 15 minutes.

(3.19 pm)

(Break)

(3.31 pm)

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

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

Could you just briefly tell us what EPUT lab is?

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

managers as well, as worth pursuing.

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

A. Yes.

Q. And it goes on to say:

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

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

A. Yes.

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

A. Yes.

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

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

A. Yes.

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

Q. 80 per cent, thank you.

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

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

A. Yes.

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

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

And you say this at paragraph 78:

"The interim results show that staff reported

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

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

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

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

A. Yes.

Q. And EPUT had actually been involved if the development of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes we can see this, yes.

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

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

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

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

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

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

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

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

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

A. Yes.

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

A. Yes.

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

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

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

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

A. I agree with that interpretation of the letter.

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

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

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

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

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

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

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

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

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

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

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

A. Yes, it certainly would have been helpful.

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

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

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

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

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

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

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

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

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

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

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

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

And it adds:

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

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

A. Yes.

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

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

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

A. Fine, yes, of course.

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

A. Okay.

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

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

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

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

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

You say:

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

Is that all correct?

A. Yes.

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

A. Yes, right from the beginning, yes.

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

A. Yes.

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

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

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

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

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

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

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

A. Sorry, version 11.

Q. The penultimate one.

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

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

A. Yes, I accept that.

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

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

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

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

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

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

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

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

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

A. Yes, that's correct.

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

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

Q. Let's come on to version 12.

A. Yes.

Q. And you talk about this in your second statement from paragraph 22. That is what you say in paragraph 22:

"The principal changes to the SOP in the latest version (version 12) relate to consent."

This is paragraph 22.

A. Sorry, which of my statements is that?

Q. In your second statement.

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

Q. Yes, thank you:

"The principal changes to the SOP in the latest version (version 12) relate to consent. In line with the NHS England guidance" --

That is a reference to the NHS England principles we have just been talking about?

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So could we deal first, please, with the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

of what is on the screen, the second paragraph:

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

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

A. Yes.

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

So this is referring to the MDT decision meeting:

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

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

Q. In respect to this particular issue?

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

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

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

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

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

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

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

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

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

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

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

MR GRIFFIN: Thank you.

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

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

A. The policy is clear about that.

THE CHAIR: Therapeutic and personalised care.

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

THE CHAIR: Thank you.

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

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

Is that what is being looked at at the moment? Is that what the report will be covering?

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

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

Q. Sorry just pause there.

A. And patients are still reporting --

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

A. That's correct.

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

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

MR GRIFFIN: Yes.

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

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

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

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

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

A. Yes.

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

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

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

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

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

A. Certainly.

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

A. Yes.

Q. Do you know what the actual figure is?

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

Q. What was that?

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

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

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

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

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

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

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

THE CHAIR: Yes.

(4.43 pm)

(Break)

(5.06 pm)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. That is helpful, but of course that 1.8 was foreseen at a time when the rollout hadn't extended to the 40 plus --

A. I mean, that's precisely why I give you the 1.2 million of 24/25 because it's recent and reliable.

Q. Thank you very much. Ms Cozens told us yesterday that Oxevision was used in police cells. Was that something you were aware of?

A. I note that, you know, Hat Porter's latest statement referred to, you know, a point in my statement about Oxevision being designed for mental health. That was not intended to express that it had only ever been designed for mental health. It was intended to say that at the time we engaged with Oxevision, we understood it to be a system that had been designed, you know, had been further designed or for use in that setting, and we were not the first to work with that we knew about Oxford Health and we knew about Coventry and Warwickshire at the time.

Q. But just dealing with the question; were you aware from an early stage that Oxevision had been used in police cells?

A. I mean I wasn't at the trust at that early stage, so I don't know whether people were aware or not.

Q. Were you aware from your early stages at the trust?

A. Not immediately, no, I wasn't aware of that.

Q. Do you know whether EPUT was ever given data relating to

its use or effectiveness in police cells or prison cells?
A. I am not aware that we have ever received that. I can undertake further searches but I don't believe we have.
Q. In fact, I have just said prison cells, I can't recollect now frankly whether there was a suggestion it was used there, so let's just stick with police cells for now. So you are not aware of any concerns may have arisen from its use in that kind of environment?
A. Not that I'm aware of that were specific to that that were shared with the Trust, no.
Q. Was EPUT one of the first trusts to trial Oxevision?
A. As I said, you know, the papers from the time clearly refer to Oxford Health and Coventry and Warwickshire having already been using Oxehealth. I think you know when you look at the, you know, circa half of mental health trusts using Oxevision now, we were probably one of the earlier ones to adopt it, but I don't have an analysis of when other trusts took it on, but I know we were aware of at least two that had already done that before us.
Q. Do you know if EPUT has been used by Oxevision to recommend its product to other trusts?
A. We wouldn't make a recommendation of a product.
Q. Sorry, no the question is whether Oxevision has used the EPUT experience to recommend its product to other trusts?

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

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

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

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

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

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

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

A. Of course.

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

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

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

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

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

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

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

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

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

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

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

that as quickly as practically possible.

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

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

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

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

Q. It's a very precise question.

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

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

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

A. Yes, either --

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

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

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

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

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

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

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

A. Yes.

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

A. Certainly, of course.

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

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

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

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

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

Q. Non-intrusive?

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

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

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

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

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

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

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

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

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

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

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

globally?

A. Certainly.

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

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

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

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

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

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

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

(5.34 pm)

(Adjourned till 10 o'clock tomorrow morning)

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