Monday 13 October 2025

(10.05 am)

HEARING MANAGER: Good morning everybody. My name is Chloe, and I am part of the Inquiry team and am the hearing manager for today. Before the Chair enters and opens the hearings today, I have some announcements to make regarding the venue and today's proceedings. We are not expecting any fire alarm test today so if the fire alarm does sound, please move to one of the four exit doors in this room, taking the stairs down to the ground floor of the building. The muster point is in Temple Gardens which is directly opposite the doors through which you entered this morning.

You have passed through security to enter the venue this morning, all attendees will need to pass back through security checks each time they leave and re-enter the venue, so we do ask that you keep in mind any additional time that you might need when returning to the hearing following lunch or breaks.

For security reasons we ask that you wear your lanyards or badges at all times whilst in the Hearing Centre today and please do remember to hand these back to a member of the Inquiry team when you exit the building at the end of today.

If you need any assistance throughout today, members of the Inquiry team are wearing purple-coloured lanyards and can be found throughout the venue over the course of the day.

These hearings are being recorded and are also live-streamed with a 10 minute delay via YouTube. The Chair has made a Restriction Order under section 19 of the Inquiries Act restricting the publication or disclosure of any evidence unless and until it has been broadcast on the delayed live stream. In practice, this means that for those attending the hearings in person, you will need to wait 10 minutes before sharing or publishing anything you have heard with individuals outside of the hearing venue. Please can we ask that phones are now turned off or set to silent and just a reminder that filming or photo taking whilst in the hearing centre is not permitted.

We are now ready to begin proceedings so the live stream will now be turned on. Please can I ask that the room stands for the Chair.

CHAIR: Good morning everyone. For everyone joining us in the hearing room today, welcome back to Arundel House and a warm welcome also to everyone following these proceedings virtually.

This hearing, which begins today and ends on Tuesday 28 October, further builds on the evidence heard by this Inquiry earlier in the year during our July and April hearings.

We will shortly be hearing a statement from Counsel to the Inquiry, Nicholas Griffin KC. This will be followed later today and tomorrow by evidence about the use of technology in mental health inpatient settings, specifically about vision-based monitoring systems and how and why they are used and the issues and potential concerns arising from their use. From Wednesday of this week until the end of the hearing we shall hear from bereaved families about their experiences and the experiences of their family member or of mental health inpatient care and treatment within Essex.

It is a pertinent time to hear this evidence given that Friday was World Mental Health Day, a day in the global calendar dedicated to raising awareness of mental health.

It remains crucial that we keep in our minds the people who experienced, either directly or indirectly, the mental health inpatient services with which this Inquiry is concerned. My Inquiry team continues to engage with bereaved families to

assist them in understanding the work of the Inquiry and to support them where appropriate to participate in our work.

Mr Griffin will shortly provide further details about how the Inquiry has been engaging with core participants and witnesses.

One example of this engagement is the question and answer event which my Inquiry team hosted in Essex on 15 September. This provided an opportunity for bereaved family Core Participants to ask questions directly of my Inquiry team. My team found this to be a valuable way to gauge what more we can do within the Inquiry to explain and demystify the sometimes technical and complex Inquiry processes and how better to assist and engage with Core Participants. We plan to run this event again in the next few months. It will be a virtual event, allowing those participating to join remotely.

Shortly before this hearing I received a joint written application from the legal representatives acting for bereaved families, seeking permission to address me directly in relation to a number of matters. I am grateful for this offer and I am happy to provide an opportunity for legal

representatives to address me. In his opening remarks today, Mr Griffin will outline when and how this will occur.

Moving on, I now wish to talk briefly about confidentiality undertakings and their crucial importance to the Inquiry's work. In order to investigate matters properly in accordance with this Inquiry's terms of reference, we may need to disclose certain information to others. This may include personal data and information about those who are now deceased. This Inquiry takes very seriously its responsibilities and obligations in relation to the proper handling of all information, particularly personal and sensitive material. We take great care to ensure that such information is managed securely, lawfully and respectfully at each stage.

Anyone who is granted access to Inquiry documents is required to sign a confidentiality undertaking. This does not prevent the sharing of Inquiry material where it is necessary and authorised. It ensures that each individual who views or becomes aware of Inquiry material, whether a member of a legal team, a family representative, an expert or anyone else, personally undertakes to

treat that material in accordance with the Inquiry's requirements.

The confidentiality undertaking is deliberately broad. This is standard practice for public inquiries, reflecting both the sensitivity of the information we hold and our obligations under the law.

Recently the Inquiry has experienced issues with a small number of organisations who have not yet signed the confidentiality undertaking. Although the Inquiry understands that careful consideration may be required, continued delay restricts the Inquiry's ability to engage openly and to progress certain areas of its work.

For this Inquiry to carry out its work effectively, thoroughly and lawfully, everyone involved must handle Inquiry material in the manner we have set out. The confidentiality undertaking is a vital safeguard. It must be signed and it must be adhered to. I wish to record my appreciation to the large majority of individuals and organisations who have signed and complied with these undertakings. Your co-operation helps to protect the dignity of those whose information we hold and supports the Inquiry's ability to deliver its work with integrity

and trust that the public expects.

Before I pass over to counsel to the Inquiry, I wish to thank all those who will be providing evidence at this hearing. I appreciate that being a witness to a public Inquiry may be a challenging experience for many people and I am grateful to all the witnesses for their time, their participation and their candour.

I am now going to hand over to counsel to the Inquiry, Nicholas Griffin KC.

MR GRIFFIN: Thank you very much, Chair. This is the Lampard Inquiry's fifth public hearing and the second hearing during which the Inquiry will hear directly from those who are at the heart of its work. As you have said, Chair, today and tomorrow morning, we will be hearing evidence relating to the use of Oxevision in mental health in-patient units. From tomorrow afternoon onwards this hearing will focus on hearing oral evidence from more bereaved family members concerning the deaths of those under the care of Trusts in Essex.

Once again, can I join you, Chair, in saying how very grateful we are to all of the family members and to others who provided witness statements to the Inquiry. We do not take for

granted how difficult it is for those involved to share again the details of their family members' deaths.

We thank them for their courage.

Before I go any further, I must stress again that during this Opening Statement, and throughout the next two and a half weeks, the Inquiry will be referring to and hearing about matters that will be very distressing and difficult. We will be hearing disturbing evidence about further individual deaths and experiences. These details may be deeply painful and traumatic for many of those who are here today or watching online. As we have done at previous hearings, at the start of each day we will briefly summarise the evidence to be heard. This will give those attending, watching and listening the opportunity to decide whether they wish to engage with that evidence. The timetable for this hearing is also available on the Inquiry website.

I would like to reiterate to all those engaging with the Inquiry that emotional support is available for anyone who requires it. The wellbeing of those participating is extremely important to the Inquiry. Anyone in this hearing room is welcome to leave at any point. We have two support staff here from

Hestia, an experienced provider of emotional support, and they will be here today and for every day of this hearing. There is a private room where you can talk to the Hestia support staff if you require emotional support at all throughout this hearing.

The Hestia support staff are wearing orange-coloured lanyards and scarves and there is one in the room, I might just ask her to hold up her hand so people can see where she is. Just there, thank you very much. Alternatively, please do speak to a member of the Inquiry team and we can put you in touch with them. We are wearing, as you have heard, purple-coloured lanyards.

If you are watching online, information about available emotional support can be found on the Lampard Inquiry website at lampardinquiry.org.uk, and under the support tab near the top right-hand corner. You can also contact the Inquiry team's mailbox on contact@lampardinquiry.org.uk for this information. We want all of those engaging with the Inquiry to feel safe and supported.

The role and the remit of the Inquiry is to investigate mental health in-patient deaths. It is not the role of the Inquiry to intervene in clinical

decisions for current patients or to act as a regulator or in the role of the police. However, the Inquiry has a safeguarding policy and we have team members who are specifically responsible for overseeing safeguarding matters. We take safeguarding very seriously. Where we receive any information which meets our safeguarding threshold, we will continue to pass it on to the appropriate organisation.

I will be supported at this hearing by members of the counsel to the Inquiry team, including Rebecca Harris KC, Rachel Troup, Priya Malhotra, Tom Coke-Smyth, Natasha Lloyd-Owen and Thomas Hayes. They have been working closely and directly with bereaved families, and where applicable their legal representatives, particularly in advance of this hearing. The counsel team also works closely with The Lampard Inquiry solicitor team, under Catherine Turtle, and together we work with the secretariat team and the Inquiry's engagement team with whom many of those engaging with the Inquiry have been in contact.

Chair, the Inquiry team works for you and as instructed by you. We are independent from all other organisations and individuals involved in this

Inquiry and we must be very careful to ensure that we remain so.

I would also like, once again, to introduce the lawyers who are representing Core Participants. Representing bereaved families and those with lived experience, Bates Wells with counsel Sophie Lucas; Bhatt Murphy with Fiona Murphy KC and Sophy Miles; Bindmans with Brenda Campbell KC and Tom Stoate; Hodge Jones & Allen with Stephen Snowden KC, Eleena Misra KC, Dr Achas Burin, Rebecca Henshaw-Keene and Jake Loomes.

Irwin Mitchell, and separately Leigh Day, and separately Deighton Pierce Glynn who have all instructed Maya Sikand KC and Laura Profumo. And representing Core Participant organisations, Bhatt Murphy for INQUEST with Anna Morris KC and Lily Lewis; Browne Jacobson for Essex Partnership University NHS Foundation Trust, or EPUT, with Eleanor Grey KC and Adam Fullwood; Kennedys for the North East London NHS Foundation Trust or NELFT, with Valerie Charbit; and in-house representation and DAC Beachcroft for NHS England with Jason Beer KC and Amy Clarke; and the Government Legal Department for the Department of Health and Social Care; Mills & Reeve for the Integrated Care Boards

with Kate Brunner KC; Jenny Richards KC and Rachel Sullivan for the Care Quality Commission and Bevan Brittan for Oxehealth with Fiona Scolding KC; Essex County Council Legal Services for Essex County Council; Essex Police Legal Department for Essex Police; Cygnet Health Care Limited legal team for Cygnet Health care; Weightmans for British Transport Police and Womble Bond Dickinson for St Andrew's Healthcare.

Whilst the Inquiry must remain careful to preserve its independence, it continues to engage directly wherever it can with all Core Participants and their legal representatives. Specifically assigned members of the Inquiry team meet regularly both with the legal teams representing bereaved families and those representing healthcare providers and other stakeholders.

The Inquiry has sought views on important evidential and procedural matters, both via the submissions provided by Core Participants after the April hearing, and the meetings that followed. It will seek to engage Core Participants further in the course of its investigative work.

We will continue to hold meetings with those representing Core Participants. We consider that

these meetings provide a valuable additional opportunity to listen and discuss individual concerns.

Whilst as an independent Inquiry, it is not possible to accept every proposal or submission, the discussions have resulted in positive developments in relation to key themes, including clear focus on systemic issues and accountability as part of the investigative strategy in respect of illustrative cases; the establishment of an expert instruction protocol; the decision to obtain background expert evidence in respect of neuro-developmental conditions, in particular autism and ADHS; a recognition that there is a need for expert evidence in order to benchmark the relevant standards in inpatient care, and improvements in how disclosure is managed through Relativity and the creation of the Core Participant workspace.

Significantly, and as you have mentioned, Chair, earlier in September the Inquiry held an in person question and answer session in the Chelmsford Civic Centre to which bereaved family core participants were invited to attend. Senior members of the Inquiry team were present including Rachel Troup from the counsel team, Kieran Coleman from the

solicitor team and Tricia Rich from our secretariat, all of whom lead on family engagement in their respective areas and who were there to answer any questions posed.

We understand this session to have been received very positively by those who attended, to whom a note of the session will be circulated for their reference. As a result, and as you indicated, Chair, the Inquiry intends to run another similar session before the end of the year and this next session will be run virtually. Our aim is that this will allow greater access to the Inquiry team for those who wish to ask any questions and attend.

Although only a relatively short time has passed since our last public hearing in July, the Inquiry has made very substantial progress. It is important, Chair, that the wider public are aware of the large amount of work that takes place away from public hearings. This Opening Statement will therefore provide an update on some of that progress before turning to introduce the important evidence that we will be hearing over the course of the next two and a half weeks.

The Inquiry continues to engage with the families and friends of those who died whilst under

the care of Trusts in Essex and to obtain evidence from all those who wish to provide it. The Inquiry will hear oral evidence from many of those families during this hearing and will hear from more in February next year. Others have provided witness statements which will form part of the Inquiry's body of evidence and will underpin our ongoing investigations, which I will turn to in just a moment.

The Inquiry is also obtaining evidence and witness statements from bereaved families who are not Core Participants. As you have always made clear, Chair, it is possible to engage with the Inquiry and to provide evidence as a witness without being a Core Participant. Over 20 such families have confirmed that they wish to provide written statements. These families who were previously spoken to by the Essex Mental Health Independent Inquiry included.

Furthermore, the Inquiry is making considerable progress towards obtaining evidence from those who have lived experience of mental health services provided by trusts in Essex. The Inquiry has taken very great care with the input of its Chief Psychologist to put into place an appropriate

framework to enable Core Participants with lived experience to engage with the Inquiry and provide evidence about their experiences should they choose to.

Having sought the views of those representing the Core Participants affected, the framework was finalised and published shortly after the last hearing. Those who wish to provide evidence have been given an extended period of time in which to complete the first step, which is a questionnaire. I should stress, however, that for any Core Participant who prefers not to give evidence, there will be other ways by which they can engage with the Inquiry, including, for example, via the Inquiry's Recommendations and Implementation Forum. I will return to that shortly.

Separately, the Inquiry has also sought evidence from healthcare providers about the initiatives they have in place to seek, recognise and act upon information provided by those with lived experience of their services. Some of the most significant progress made by the Inquiry in the past few months relates to the investigation of its illustrative cases. On your direction, Chair, the Inquiry has set up a dedicated investigations team,

which leads on this crucial work.

As I set out in July, the Inquiry's approach to its illustrative cases has always been to begin by receiving the first-hand accounts and witness statements from the families and friends of those who died. Those accounts then inform the Inquiry as to further investigative steps that need to be undertaken. By putting the evidence of families and friends front and centre of its investigative work, the Inquiry ensures that families' concerns remain a key factor in determining what further evidence should be obtained. Development of the Inquiry's investigative strategy has been an iterative process. That process included the Inquiry reaching an agreement with His Majesty's Coroner for Essex to obtain permission for any materials provided to families and or other Interested Persons in coronial proceedings, to be forwarded to the Inquiry. In many cases, this will now allow the Inquiry to obtain relevant materials directly from families and trusts.

The Inquiry's investigative strategy is now finalised and will be published in November. The strategy clearly sets out, amongst other features, how illustrative cases will be assessed and then put

together in groups by issue and/or theme; how the Inquiry will rely on previous findings of fact from reliable sources, where appropriate -- for example, criminal prosecutions, coronial findings of neglect or regulatory proceedings; how the Inquiry will seek to assess compliance on the part of healthcare providers and other organisations with any previous reviews or recommendations, including Prevention of Future Death reports; the basis upon which the Inquiry will look to instruct expert evidence, when required, to consider common issues and themes that have arisen, focusing also on whether identifiable failings have been addressed since; how the Inquiry will look to its illustrative cases to explore the extent to which stated systems, policies and procedures have been or are effective as opposed to aspirational.

Importantly, the strategy sets out clearly how the Inquiry intends to engage with the families and friends of those who died, together with their legal representatives. The Inquiry will also seek input from healthcare providers and other corporate core participants and organisations.

Whilst much of the Inquiry's work is now being driven by the investigation of our illustrative

cases, the Inquiry is also working hard to seek the further evidence and information it needs from healthcare providers, enforcement agencies, regulators and other corporate stakeholders, all of whom the Inquiry considers may have material relevant to our terms of reference. By way of example, the Inquiry has sent multiple requests for evidence to EPUT, to NELFT, to Mid and South Essex NHS Foundation Trust, to private providers, to Essex Police, to British Transport Police, to healthcare regulators including the HSC and the CQC, the Health and Safety Executive, and the Care Quality Commission, to the local government and social care Ombudsman, to the Disclosure and Barring Service, and to the National Medical Examiner, this list is not exhaustive. The Inquiry is rigorously exploring and obtaining data on core issues, such as physical and sexual safety in inpatient units, safeguarding and discrimination in mental health services. The Inquiry has also reached out to key individuals including historians and authors whose individual research may assist the Inquiry in its work.

In short, the Inquiry continues to think laterally and expansively and will leave no stone unturned in order to meet its Terms of Reference.

As I already touched on when referring to the Inquiry's investigative strategy, the Inquiry will scrutinise candour and accountability and the overall governance structures of those who provided and continue to provide mental health inpatient care in Essex. The governance work is looking ward to board about how services should be run and will measure what we are learning about how they are run against those standards.

Chair, in April of this year you provided further clarification about how the Inquiry would approach two separate particulars of its definition of "inpatient". As I explained at that time, as a consequence the Inquiry invited the main healthcare providers to revisit and resubmit their lists of those who died whilst under their care in the relevant period.

Obtaining updated and, as far as possible, definitive lists of deceased remains an absolute priority for this Inquiry. Firstly, it is of the utmost importance for the Inquiry to understand as best we can the number of people who died during the relevant period whilst under the care of trusts in Essex. We consider it is our duty and responsibility to pursue this information. It is

extremely disturbing that we are still unable to say with any certainty how many people died. Whilst progress has been made, we are still not in a position to confirm numbers of deaths which fall within scope. We are acutely aware of the sensitivities surrounding this information and for that reason the Inquiry considers it would be irresponsible to publish any numbers until we are confident that these are as accurate as possible.

Secondly, information relating to deaths in scope is required to enable reliable and robust findings to be made about themes and patterns that are revealed. As I said at the July hearing, until the Inquiry receives full information in relation to the deaths which fall within scope, we are simply not able to say how many of those involved serious failings or issues of concern, or whether they were deaths that could have been avoided. Unhappily, progress in providing those updated lists of deceased has been slow. The Inquiry has only very recently received this information, some of which is still in draft form. We remain determined to get the most accurate figures available, using all of the information and expertise available to us, and we ask providers do all within their power to ensure

that this data is provided in as full a form as possible.

The Inquiry's expert health statistician, Professor Donnelly, remains engaged and ready to assist the Inquiry to understand the list of deceased. Although her final analysis will be determined by the updated information, Professor Donnelly has continued to advise the Inquiry on what further data ought to be obtained in order to place the lists of deceased into their proper context. That will be done using denominator data about populations of patients who were admitted to the same wards during the same period. Obtaining denominator data and other data necessary to corroborate information in the list of deceased has proved challenging. It has also highlighted some significant limitations in the available data.

For example, efforts have been made to identify a readily available source of Records of Inquest so that these can be used to supplement and corroborate the lists of deceased from providers. Somewhat surprisingly, the Inquiry has been informed that there is no central electronic repository for such records, meaning that any reconciliation must be done against archived paper records.

Despite these challenges, progress is being made. The Mental Health Services Data Set, the MHSDS held by NHS England, provides the best source of denominator data, although it only begins in 2016. Its two predecessors, the Mental Health and Learning Disability Data Set and Mental Health Minimum Data Set are sparser in the information they hold. The Inquiry has taken steps to obtain the MHSDS in the first instance, once this has been reviewed the earlier and sparser data sets can be considered.

Progress has also been made in reaching agreement with the National Confidential Inquiry into Suicide and Safety in Mental Health, to share anonymous, aggregate data. This will assist Professor Donnelly and her team in corroborating the accuracy of the List of Deceased.

Core participants have now been provided with an update from Professor Donnelly, setting out in outline her approach and her work to date. We hope that this update will assist in informing our planned data discussion, which is intended to facilitate constructive suggestions as to further avenues the Inquiry may wish to explore given the apparent limitations of the data available.

Arrangements for the date of discussion will be circulated after this hearing.

The Inquiry is also looking to Professor Donnelly and to her team to assist with the analysis and potential significance of other forms of information and sources of data. For example, staff and/or patient surveys; audits; evidence of evaluation and so on.

As I have already outlined, having considered careful observations made by Core Participants, the Inquiry has prepared and published the protocol on the role and instruction of experts which regulates the process of obtaining future expert evidence. The purpose of that protocol is to allow greater and earlier engagement from Core Participants in respect of proposed experts and other areas of expertise. In accordance with this protocol, the Inquiry recently distributed to Core Participants its proposal for instructing experts to provide evidence about neuro divergence, including autism and ADHD. The Inquiry proposes that this evidence covers, amongst other matters, key developments in the understanding and treatment of neurodevelopmental conditions across the relevant period. It is very important for the Inquiry to understand how neuro

divergence should be considered and reflected in the provision of mental health care. The Inquiry has also identified the need for expert evidence to address the suggestion made by some that suicide may in certain circumstances not be preventable in the context of mental health inpatient care. We recognise that this is a very difficult and sensitive topic. It is an issue which arises in many of the Inquiry's illustrative cases and is central to the concerns of many of the families and friends of those who died.

The Inquiry is acutely aware, in addition, that this is an area where there is a range of expert opinion and emphasis. Some practitioners advocate for a risk management approach, whilst others argue for greater focus on a patient's underlying care and treatment.

Chair, you have made clear that you wish to hear from both sides of that debate. To that end, we will shortly be sharing with CPs a proposal for the presentation of varied expert evidence on this topic. The Inquiry is also actively looking at other evidence which may assist you to understand the tension between these concepts.

I have already touched upon the Inquiry's

intention to instruct experts to consider its illustrative cases where appropriate. That process is set out in the investigative strategy, the Inquiry's protocol on the instruction of experts will apply.

I would like to say something now about staff evidence. This is because, given the background of poor staff engagement with the Essex Mental Health Independent Inquiry, we are aware that there remains, understandably, considerable interest and concern about how the Inquiry intends to secure relevant evidence from those who have seen or have heard first hand exactly what happens on mental health inpatient units. The Inquiry is working hard to secure the co-operation of present and former staff and to facilitate the flow of full and frank information. More individuals are now coming forward and we are grateful to them for their assistance and their candour.

The Inquiry will continue to do all that it can to identify and obtain evidence from relevant staff, particularly those whose identities we are aware of. As I have already stated, the evidence from the families and friends of those who died and the Inquiry's investigative strategy will inform the

Inquiry which staff may be able to provide relevant evidence. In addition, and importantly, the Inquiry has secured assistance from appropriate third parties to help track down staff members who have moved on from their original Essex employers. The Inquiry is also aware, however, that there may be many staff we do not currently know about, and who have not come forward, not only because they fear workplace repercussions, should they give evidence about colleagues and employers, but also because they fear professional repercussions should they now provide evidence which they could have provided before.

Chair, that is why you instructed us to seek limited undertakings from healthcare providers and regulators, to reassure those individuals and safeguard their position. You are aware, Chair, that following our hearing in July, the Inquiry circulated proposed undertakings to all Core Participants and invited those who wished to provide views on whether we should pursue undertakings at all. Once again, we are extremely grateful to those engaged in this exercise. There was a variety of views expressed. The Inquiry is in the process of reviewing all of the comments made

and considering next steps.

Chair, the Lampard Inquiry's Terms of Reference require you to make recommendations to improve the provision of mental health inpatient care. You have repeatedly stated your commitment to ensuring the recommendations you make bring about real and lasting change. The content and substance of any recommendation made is a matter for you, of course.

But as with any Inquiry, a recommendation is only as effective as the extent to which it is later implemented. As a consequence, not only is this Inquiry determined to make robust recommendations, it is also determined to do whatever it can to ensure their proper implementation. Chair, under your direction the Inquiry has established its recommendations and implementation forum. This forum will seek the views of others as to how the recommendations you make may be implemented to ensure meaningful change.

As far as we are aware, the Lampard Inquiry is the first public Inquiry ever to have undertaken such an important, innovative and collaborative step. With this forum in mind, the Inquiry commissioned a briefing paper on recommendations and implementation from Dr Emma Ireton, Associate

Professor at Nottingham Law School. This paper was circulated just over two weeks ago to Core Participants and was accompanied by a paper from Counsel to the Inquiry, which sets out proposed arrangements for the Lampard Inquiry's Recommendations and Implementations Forum. The Inquiry has invited views from Core Participants on how the forum might operate. We look forward to receiving those views next year. Dr Ireton's paper will be published on the Inquiry's website this week.

In August this year, as promised, the Inquiry extended the use of the Relativity platform to all Core Participants, material providers and their legal representatives, also creating a Core Participant work space. Training and technical support was provided. Relativity is a disclosure platform that facilitates the efficient review and analysis of documents. Disclosure for this hearing was made via Relativity and the same method will be used for future hearings in 2026, so we will continue to put in place suitable and workable arrangements for unrepresented Core Participants.

Disclosures outside the Inquiry's structure will also be made via Relativity. That disclosure

will be determined to a large extent by the Inquiry's investigative strategy and the material flowing from it. However it will also include relevant disclosure from all of the other areas of evidence that I summarised this morning. The Inquiry aims to begin its disclosure of material outside of the hearing structure with notice in the early part of next year if not before.

I would like now to say a few words about this hearing, which runs from today until Tuesday 28 October.

During the next two and a half weeks, the Inquiry will first return to the postponed evidence regarding the use of Oxevision, which was due to be heard in April, before hearing live evidence from further bereaved family members of those who died. As in July, the Inquiry has invited the family members to give evidence of their first-hand accounts, observations, recollections and concerns. We have also invited them to give their current views on what recommendations should be made for change.

As I stated earlier, hearing this evidence from families now is crucial. This evidence is the driving force behind the Inquiry's investigations.

As in July, the Inquiry will be inviting the families to give their own direct evidence. The Inquiry will not be seeking comments or analysis from the witnesses on other documents that relate to their relatives' care and treatment, nor will we be hearing other evidence relating to that care and treatment or any related issue at this particular hearing. Other evidence will form part of the Inquiry's investigations, however, and may form part of later hearings.

Immediately following this opening statement, we will hear evidence in relation to the use of vision-based digital technology. This will focus on Oxevision. Oxevision is a non-contact, vision-based monitoring system that uses an infrared camera to monitor the vital signs of mental health inpatients and for other purposes. The use of Oxevision has proved to be controversial, attracting very strong opinion across a range of individuals, including patients and clinicians. Its use has featured in a number of recent inquests and is of grave concern to a number of the family Core Participants in this Inquiry. It is currently drawing considerable national interest.

You have indicated, Chair, that you wish to

explore carefully the use of this type of technology. We will start this morning, therefore, by hearing from Laura Cozens, the Head of Patient Safety and Quality at Oxehealth Limited, which recently brand to become LIO, that is LIO. Oxehealth supplied the technology itself to inpatient settings. Ms Cozens will give evidence about how the technology works in practice and its various functionalities. The Inquiry understands that Oxevision is now deployed across half of all NHS Trusts. The technology has been rolled out within EPUT from April 2020. This afternoon we will play a prerecorded evidence session with Hat Porter, who is a representative speaking on behalf of the campaign "Stop Oxevision". Stop Oxevision is a network of former and current NHS inpatients who, in Spring 2023, founded a national campaign to raise awareness of serious harms they say are caused by this technology. "Stop Oxevision" has analysed research and collated an evidence base of individuals' first-hand experiences. Key concerns raised include significant invasion of the privacy of patients, the impact of the technology on the patients' health and recovery and staffing issues. They describe it as a superficial quick fix for wider systemic issues.

In their evidence, Hat Porter describes many patients' experience of the technology as being intrusive, undignified, dehumanising and traumatising, and suggests there is a lack of transparency about the technology's use.

Tomorrow, we will hear from Zephan Trent, Chief Strategy and Transformation Officer at EPUT. He will give evidence about the use of this technology from EPUT's perspective. Mr Trent gives evidence about the basis upon which Oxevision was introduced, its rollout and implementation at EPUT.

Mr Trent has also provided EPUT's latest Standard Operating Procedure, or SOP, for Oxevision. The Trust's position on the use of Oxevision changed potentially significantly in April this year, particularly in relation to the consent process and particularly, it appears, in response to matters raised in NHS England's Principles for Using Digital Technologies in Mental Health Inpatient Treatment and Care report, published in February this year.

It was this change in EPUT's position and the late service of a further statement giving notice of this change in position, Chair, that resulted in your decision to postpone hearing the evidence during our April hearing. This has allowed the

Inquiry and the other Core Participants to reflect on the new material and for additional enquiries to be made. Chair, you are aware that on 22 September this year Hat Porter provided a second witness statement to the Inquiry on behalf of Stop Oxevision. This second statement addresses issues that have arisen since they first provided evidence, including developments outlined in the further statements provided by Mr Trent and raises concerns about Oxevision and the use of that technology by EPUT. Stop Oxevision remain concerned, in particular about the consent procedures around Oxevision.

As I have already outlined, for the majority of this hearing, Chair, the Inquiry will hear oral evidence from 18 further bereaved families. May I say again, the Inquiry is very grateful indeed to those witnesses for their courage in sharing their accounts. The Inquiry will hear about the following people who have died:

Bethany Lilley, who died on 16 January 2019, aged 28. We will hear evidence from her brothers, Alexander and Peter Guille.

Dorothy Redditt, who died some time between 15 and 16 March 2021, aged 84. We will hear evidence from her daughter, Jane Stanford.

Doris Joyce Smith, who died on 14 October 2020, aged 74. We will hear evidence from her son, Paul Rucklidge-Smith and his partner Anna Rucklidge-Smith.

Keith Stubbings who died on 24 April 2019, aged 61. We will hear from his niece, Samantha Reains.

Valerie Dimoglou, also known as Val, who died on 19 October 2015, aged 76. We will hear evidence from her daughter Sofia Dimoglou.

Iris Scott who died on 14 March 2017, aged 74. We will hear evidence from her daughter, Dawn Johnson, and son, Craig Scott.

Richard Wade who died on 21 May 2015, aged 30. We will hear evidence from his father, Robert Wade.

Lee Spencer, who died on 27 August 2019, aged 20. We will hear evidence from Lee's mother, Carole Stokes.

Joshua Leader who died on 24 November 2020, aged 35. We will hear evidence from his brother, Daniel Leader.

Colin Flatt, who died on 7 September 2021, aged 81. We will hear from Colin's partner, Melanie Leahy.

Adam Steel, who died on 14 October 2021, aged 36. We will hear evidence from Adam's father, Paul

Steel.

Sophie Alderman, who died on 19 August 2022, aged 27. We will hear evidence from Sophie's mother, Tammy Smith.

Norman Noah Dunkley, who died on 15 March 2022, aged 90. We will hear evidence from his daughter, Joanne Woolley.

Mark Tyler, who died on 3 September 2012, aged 37. We will hear evidence from his ex-wife, Sally Mizon.

Margaret Annequin, who died on 3 July 2015, aged 68. We will hear evidence from her husband, Timothy Whitfield.

Carol Taylor, who died on 21 November 2023, aged 75. We will hear evidence from her husband Ralph Taylor.

Peter Ridley Joyce, who died on 17 March 2013, aged 83. We will hear evidence from Peter's children, Deborah Ridley Joyce and Nigel Ridley Joyce.

Terrence White, who died on 14 April 2016, aged 36. We will hear evidence from his sister, Emma Harley.

Chair, the Inquiry will also hear evidence in a private session from a witness to whom you have

granted a Restriction Order.

From these witnesses, all of whom have set out their recollections, observations and their views on the need for change with courage and clarity, the Inquiry will once again hear about a number of key themes it will be examining during the course of its work. The issues about which we will be hearing during this hearing often repeat and/or mirror those we heard about in July. Those include, but are by no means limited to, inadequate diagnosis and treatment, including a lack of therapeutic and personalised care, such that care and treatment was limited to crisis management. Failures in assessment, ranging from falls risk assessment to the adequacy of mental health assessments. Failures adequately to assess and admit or in some cases assess or admit at all. Inadequate handover upon transfer from one unit to another. Inappropriate medication including overmedication. Failures to engage with families at all stages of care planning and implementation, including a lack of a family voice in care plans and discharge planning. Inappropriate and inadequate communication with families. Inadequate and/or inappropriate discharge decisions and planning. Failure to respond to

physical health needs on a ward. Failures and inadequacies in relation to post-death investigations. Failures in relation to recordkeeping and access, including no trust-wide access to records. Lack of compassion shown on the ward by staff. Concerns in relation to the ward environment, including lack of activities and failures to differentiate between different cohorts of patients. Concerns in relation to access to high risk items on the ward. Inadequate communication between service providers, including health services, social services and the police. Inadequate care plans and risk assessments. Failures in observations, including inappropriate use of and overreliance on Oxevision. Failure to observe trust protocols, failures in safeguarding, staff shortages. Adverse coronial findings including neglect riders, Prevention of Future Death reports and findings of fact in relation to failures within internal trust post-death investigations.

As I previously said in my July opening statement, many families have sadly become experts in some of these areas and, therefore, are uniquely placed to speak to these important issues. I should

also reiterate, as I did in July, that the witness statements provided for this hearing by those witnesses will stand in full as their evidence. I say this as the statements will not be read out in full during the course of the hearing. Rather, the witnesses will be asked careful and focused questions about what they have written and the issues they have raised. Those witness statements will be published on the Inquiry's website once each witness has given their evidence. May I say once again, for the avoidance of doubt and for clarity, that copies of the statements that are published will be redacted in line with the Inquiry's published approach. There are two main categories where redactions may be applied. Staff names, including those of junior staff, will generally be disclosed in the course of the Inquiry. Individuals can apply for their names to be withheld, however, in line with relevant law and the Inquiry's protocol on Restriction Orders. Each application for a Restriction Order will be considered individually by the Chair.

Some staff may need time to decide whether to apply for anonymity and to seek legal advice. While they are given this time, their names will be

redacted temporarily. This ensures fairness. To be clear, in many cases those redactions are likely to be temporary only.

Second, methods of self-inflicted death or self-harm. These details as well as other highly distressing content, may be redacted to protect the public from potential harm. The Inquiry may also apply redactions where it considers the information is unusual and could instruct others.

There is also other information, which may fall under the Inquiry's privacy information protocol. This will be information which is personal in nature and which you, Chair, do not consider relevant and necessary to be made public. This would include details such as someone's address or other personal sensitive information.

Finally, in this section of the opening, can I also remind those following and engaging with the Inquiry that it has in place further various protocols. This is with the aim of assisting those who wish to engage with the Inquiry in providing the best possible evidence, in a way that also ensures they are supported through the process. All documents are accessible on the Inquiry's website and kept under review. Chair, you have a wide

discretion to put in place measures to support witnesses giving evidence. The Inquiry will continue to work with witnesses and their legal representatives to take an individualised approach as far as is reasonably possible.

I move now to the timetable. The Inquiry will sit on Monday to Thursday during this week and next week, in the third week we will sit on Monday and Tuesday.

For this hearing we will generally start at 10 am and finish by 4 p.m. There will be a short break in the morning and in the afternoon, in which teas and coffees will be provided for those who are attending. There will be a one-hour break for lunch each day. This is all subject to the need for the Inquiry to proceed flexibly and take more breaks or make other arrangements as required to support witnesses. It is not necessary to attend the hearing in person to follow the Inquiry's proceedings. Core Participants and their lawyers who are not attending in person can watch the hearing live on a secure weblink. The hearing will also be live streamed on the Lampard Inquiry YouTube channel, for anyone who wishes to follow us remotely, but please note this will be streamed with

a time delay of 10 minutes.

I have previously referred to the changing mental health landscape against which the work of the Inquiry is taking place. During my opening in July, I made references to the NHS 10 Year Health Plan for England, which includes proposed measures of relevance to the work of this Inquiry and which the Inquiry is considering carefully alongside its work. The Inquiry is also closely following the progress of the Mental Health Bill, this bill which will result in the most significant changes to mental health care since the Mental Health Act over 40 years ago, is now in its report stage and is due back in the House of Commons tomorrow, in fact, so that MPs can debate the amendments that have been made to it. In order to ensure we work towards meaningful and relevant recommendations the Inquiry is monitoring not only the significant changes proposed by the bill but also what the bill does not yet appear to propose.

Furthermore, in a significant and important development for all public inquiries, last month saw the introduction of the Public Office (Accountability) Bill and the specific proposals for duties of candour and assistance, including when

engaging with public inquiries. Whilst it is right to say that there has long been a statutory duty of candour for organisations who provide healthcare, we note that the position is underlined as NHS bodies and those who work for NHS bodies are specifically listed amongst those to whom the new proposed duties of candour and assistance apply. This Inquiry welcomes any measures intended to improve the prospects of full and frank disclosure at all stages of an investigation, whether related to healthcare or otherwise.

The Inquiry also notes with interest the proposed amendments to the Inquiries Act 2005, including the proposed power to be afforded to a chair to report a public authority, if they have concerns about its conduct and engagement with public Inquiry.

Last Wednesday, 8 October, the Independent Advisory Panel on Deaths in Custody report on Mental Health Act deaths was published. The chair of the IAPDC, Lynn Emslie states in the foreword:

"The IAPDC's latest statistical analysis of deaths in custody found that patients detained under the MHA have the highest rate of death in all detention settings, including three times higher

than that of prisons. However, unlike deaths in prisons, immigration detention, and police custody - which are independently investigated by the Prisons and Probation Ombudsman and the Independent Office for Police Conduct respectively - the deaths of patients detained under the MHA are not investigated by an independent body prior to an inquest."

The report recommends that the Department of Health and Social Care establishes an independent investigation mechanism to look at all deaths under the MHA. The IAPDC believes this should include clinical leadership and collaboration with expert organisations such as the Parliamentary and Health Service Ombudsman and the Health Services Safety Investigations body or HSSIB, and regulators like the CQC to meet common aims of improving patient safety.

Chair, shortly before this hearing you received a joint written application from the legal representatives acting for bereaved families seeking permission to address you directly in relation to a number of matters. As you have already indicated, you have considered that application carefully and whilst you have determined that for difficult and

delicate scheduling reasons, for scheduling family evidence, you could not accommodate those submissions at the outset of this hearing. Nevertheless, you consider it very important that legal representatives are provided with an opportunity to address you directly. As a result, you have directed that a specific hearing day be held in early December to provide this opportunity. This will also allow the circulation of the Inquiry's investigative strategy. Further details of that hearing will be announced shortly after this one.

As I have already outlined in this opening statement, Chair, the Inquiry is working hard towards the disclosure and presentation of evidence in 2026, both within and outside of its hearings structure. The next public hearing at which substantive evidence will be presented will be in February 2026 when the Inquiry will hear from the remainder of those who tragically lost family members and who wish to give live evidence to the Inquiry. Thereafter, at future public hearings the Inquiry will explore its illustrative cases and will hear evidence relating to the themes and issues of concern that arise in order to meet its Terms of

Reference.

Whilst it is important to underline the sheer volume of work that is taking place separately alongside our hearings, disclosure of which will be made starting in the early part of next year, the Inquiry recognises the paramount importance and significance of exploring issues in public. In order to ensure that sufficient hearing time is available, Chair, you have directed that a further substantive hearing be arranged for October next year, beginning on 5 October 2026 for a period of three weeks. That hearing will once again take place in Essex. It will be followed by a short break before the Inquiry resumes at the end of November 2026 for the purpose solely of hearing closing submissions. Not only will this provide additional hearing time, it will also provide space and opportunity for the preparation of those important closing submissions.

Chair, that further announcement in relation to the Inquiry's future hearings brings me towards the end of my opening remarks. Your aim and the aim of this Inquiry, Chair, is to bring about long-awaited improvements in mental health care. May I say again, Chair, to you, to all of the Core

Participants in this Inquiry and to the wider public, that your team remains committed absolutely to doing whatever it takes to help you scrutinise the provision of mental health inpatient services in Essex and make meaningful recommendations for long-term change. It is clear that this change is still needed against the backdrop of last Friday's World Mental Health Day. This Inquiry was particularly saddened to see in the media, just last week, reports that a patient in mental health crisis at Colchester Hospital had waited over 100 hours for an inpatient bed. Chair, a written version of this opening statement will shortly be available on the website.

Before I finish, I would like to make clear that this opening statement has been written with the considerable assistance of my colleagues, particularly Ms Harris. I am very grateful.

Chair, that is the end of the opening statement. May I ask that we rise for ten minutes for the first witness. That will take us to half-past 11, 11.30.

THE CHAIR: Half-past 11.

MR GRIFFIN: Thank you very much.

(11.17 am)

(Break)

(11.35 am)

LAURA COZENS (sworn)

Examined by MR GRIFFIN KC

Q. Thank you. Please provide your full name.

A. My full name is Laura Cozens.

Q. You have provided the Inquiry with two statements. Do you have the statements in front of you?

A. I do.

Q. Dealing with your first statement, please, is it dated 19 February 2025 and is it 25 pages long?

A. That's correct.

Q. And if you go to the last page, can we see that you have made a statement of truth at the bottom and you have signed it?

A. That's correct.

Q. And in fact you signed it on 19 March 2025; correct?

A. That's correct.

Q. Can we go to your second witness statement, please is it dated 28 August 2025?

A. That's correct.

Q. Is it 21 pages long?

A. That's correct.

Q. And similarly if we go to the last page, can we see the statement of truth and your signature?

A. You can, yes.
Q. And in fact you signed it on 29 August 2025; correct?
A. That's correct.
Q. Have you had the opportunity to read through the statements recently?
A. I have, yes.
Q. And can you confirm that they are accurate to the best of your knowledge and belief?
A. I can.
Q. Thank you. You are welcome to refer to them as you wish.
A. Thank you.
Q. Your statements will stand as part of your evidence along with the exhibits you have provided. I am not, therefore, going to be asking you about everything that appears in your statements, but I do now want to move on to cover our first topic and that is your role, please. You work at a company that is now called LIO but was formerly called Oxehealth Limited; is that correct?
A. That's correct.
Q. We will come on to the rebranding in a moment. For the purposes of today, I am going to refer with you to Oxehealth just for the sake of simplicity?

A. Yes.
Q. When did you join Oxehealth?
A. I joined Oxehealth in May 2022.
Q. And you are Head of Patient Safety and Quality; is that right?
A. That's correct.
Q. What does that role entail?
A. So that role entails -- I am the clinical safety officer, so I work closely with our regulatory and compliance team. I also manage our training and support team, so have overall responsibility of ensuring that the product training that we offer customers, and managing the two members of staff within that team, and I also liaise with other teams within the company.
Q. Thank you. Do you hold a Bachelor of Science degree in mental health nursing?
A. I do, yes.
Q. And a Postgraduate Diploma in clinical forensic psychiatry?
A. I do, yes.
Q. Have you been a registered mental health nurse since 2011?
A. I have, yes.
Q. Before joining Oxehealth, did you work in the NHS in

various positions, including, lastly, as a senior clinical manager within high secure forensic services?

A. That's correct.

Q. Could we move then to Oxehealth the company. In your first statement, you describe Oxehealth as a health technology company; is that correct?

A. That's correct.

Q. Is it based in Oxfordshire and was it founded in 2012?

A. It was.

Q. When did the company first start selling its technology for use within mental health inpatient units on wards?

A. So Oxehealth was founded in 2012. Then over in 2014, 15 and 16, there were a couple of studies that were carried out and then the first commercial deployment, I believe, was around 2017.

Q. Thank you. Did the company originally develop its technology for settings other than mental health?

A. So in 2012 there were studies within premature babies and dialysis patients at Oxford University Hospital. These were in early stages looking at a prototype technique to be able to measure vital signs in a contact free way.

Q. Has the technology been used in police custody suites?
A. It has.
Q. And was that in the early stages of its deployment?
A. It still currently is.
Q. So moving then to the current position, other than mental health settings and police custody suites, where is this technology deployed?
A. So it's within police custody suites, mental health settings and that includes section 136 suites and health based places of safety.
Q. So the section 136 suites, the health based places of safety, mental health settings more generally, and police custody suites, is that the entirety of the environments in which the technology has been deployed?
A. I believe there was a deployment within the Prison Service but I would need to double check that.
Q. Is that a past deployment, not present?
A. Past.
Q. Thank you. Can we deal now with the rebrand to LIO. I am going to ask that part of your second statement is put up on our screens. This is the second statement, Amanda, at page 21. So OXHE009987. Could you expand 98 to 100, please. There we go,

thank you. So you say here that:

"On the 13th August 2025 Oxehealth announced that Oxehealth is evolving into LIO - a new identity.

We have listened to what matters most and made LIO more adaptable to the diverse and evolving need for patients and staff.

Building on the foundations of Oxevision, a new platform will be introduced in 2026 which will bring together ambient patient monitoring, digital observations and management insights in one purpose-built solution."

We will come on to talk about Oxevision in a moment but can you first tell me what you mean by paragraph 99 and what the reason for the rebrand actually is?

A. So it's not unusual for companies to rebrand and the rebrand was a long-standing project that was well underway prior to us being contacted or involved with the Inquiry. That is, we have listened to comments from customers, from experts by experience that we work with, and taken all of those on board and are in the process of developing a new platform, which would cover a number of different areas of the platform.

Q. Would you accept that this rebrand is taking place during a time where the technology we will be discussing, Oxevision, is being criticised and the system is garnering press attention?
A. I think as I said, the rebrand was a long-standing project that was well underway prior to any involvement with the Inquiry.
Q. So is your evidence that the rebrand has nothing to do with the recent press attention concerning Oxevision?
A. That's correct.
Q. Could you take that down, please. In your first statement you describe Oxevision as a contactless patient monitoring system for mental health hospitals and other settings. Can you, in general terms, tell us what its purpose is, please?
A. So there are many elements to the platform. So you've got the ability to be able to take contact free vital signs. So that's pulse rate and respiration rate. The system also provides safety alerts and warnings, which can be configured depending on the patient population, and that is down to the customer's choice. There is a module around mental health observations, so I think we have heard from other witnesses that within mental

health inpatient services all patients are subject to periodic checks. These could be every 15 minutes, every hour, those general observations. I think what we see within mental health services is staff still walk around with a clipboard and pen, writing down these observations, which can be quite timely and from an audit process not very effective and from a compliance point of view. So part of the platform is digitalising that practice so there's a module to do that.

Q. So is it installed in bedrooms only?

A. That's correct.

Q. Not in bathrooms or communal areas?

A. That's correct.

Q. And as we have heard, does that include rooms -- seclusion rooms and health-based places of safety?

A. That's correct.

Q. Thank you. We are going to come back to look at what you have just said in more detail, but can we start with the physical components of the technology, please. Can you first of all describe the camera that is part of this system?

A. So the platform uses a combination of software and hardware. So the hardware is made up of a camera and two infrared illuminators which are housed

within a secure housing unit within the patient's bedroom. This is normally located between the wall and the ceiling. It is probably about that size in length.

Q. You are indicating maybe a little over a metre. What we will do a little later on is we will look at a picture of all of these pieces of hardware. So there is the camera with the infrared illuminators, and there are also monitors and tablets, could you describe those please?

A. So the system provides information to staff on portable tablet devices so they have got access to all the information when they are on the ward, but there is also a fixed monitor in the nurses' office which is hardwired.

Q. So the tablet devices, are they a little like iPads?

A. Yes, they are not iPads, but yes.

Q. And how many, typically, tablets would there be on each ward?

A. So two to three, but if a ward had the Oxevision observation module, then there would be more.

Q. You have referred to the Oxevision system being contact free. Can you explain what you mean by that, please?

A. So what I mean is that there is nothing that the

patient has to wear. So there's no wearables. It's able to remotely monitor with nothing attached to the patient.

Q. And you have said "remotely". Is it right that staff don't actually need to be with the patient to use the system?

A. That's correct.

Q. I would like to come on to one aspect of the technology referred to as Oxehealth Vital Signs, please. You say this is in your first statement and can we put this up, please? It is the first statement at paragraph 14. That's OXHE009031. Thank you very much. So we can see here that Oxevision, and I am quoting from 14:

"Oxevision includes two regulated medical devices:

Oxehealth Vital Signs" -- so that's the one we will focus on -- "It can be used to measure a patient's vital signs (pulse rate 50-130 beats per minute and breathing rate 8 to 39 breaths per minute) and will not give measurements outside these ranges. It provides a 15-second live, clear video feed into a room at the point at which a pulse and breathing rate observation is being taken to allow the clinician to confirm suitability."

Can we see in the first of the two bullet points:

"Spot-check vital signs measurements are taken manually when a staff member clicks into the 'Take Vital Signs' workflow for the selected room."

We will come on to look at aspects of that in a moment. Can I ask you a more basic question at this stage. Why is it necessary to monitor these in mental health settings?

A. So I think there are many reasons. So within mental health settings people still have physical health issues that need to be addressed and people have pre-existing physical health concerns. Quite often within mental health, the medication that patients are prescribed can have a sedative effect, so being able to monitor those vital signs from that point of view. There was an example that during COVID we know that from a physical health point of view the effect of COVID on respiratory rate, so breathing rate, so being able to monitor that. And also from the point of view of, I was talking earlier about those general mental health observations that need to take place.

Q. We will come on to those, thank you very much. But just in terms of taking vital signs measurements,

those would be the primary reasons for the need in the context of a mental health setting?

A. Yes. And you have got the example of if somebody's in seclusion as well, being able to closely monitor.

Q. You say that Vital Signs, and we can see at the top of the screen, is a "regulated medical device". What do you mean by that, please?

A. So there are two regulated medical devices to the platform. One of those is the "Take Vital Signs" and the other is our sleep module. So what that means is it's subject to regulations and monitoring by a notified body, so subject to increased regulation. Technical documentation reviews and they happen unannounced and announced, both with audits as well. So every year there's a planned audit by the British Standards Institute and every five years, approximately, there's an unannounced audit. And the purpose of those are to go through our quality management system and the, all the records that we keep on those devices so our technical files, and they are regularly submitted for review, approximately every three years.

Q. Is it cleared by the Medicines and Healthcare products Regulatory Authority, the MHRA?

A. That's correct.

Q. Can you tell us what, you have just described part of the process, is that -- you talked about the British Standards Institute, do you know what the MHRA does in respect of this technology?
A. So I believe, I will double check but the British Standards Institute communicate with MHRA.
Q. Do either the BSI or the MHRA consider the ethical implications of the use of Vital Signs in mental health inpatient care?
A. So the BSI review any claims that we make around safety and effectiveness.
Q. Do you know to what extent either consider whether it's appropriate in the first place to put this kind of technology in the bedroom of a mental health inpatient?
A. I don't.
Q. You have provided the Inquiry with a document that explains how the infrared camera works within the Oxevision system. It says this:

"When your heart beats your skin flushes red. The human eye cannot see those micro-blushes but Oxevision's infrared sensitive camera can. The system counts these micro-blushes to calculate a pulse rate. The system collects breathing rates by counting the rise and fall of the individual's

chest."

Now, does that correctly summarise how this is working?

A. Yes.

Q. Thank you. So the system will need access to a person's skin and will need to be able to see the rise and fall of their chest if it's to operate for vital signs purposes?

A. Yes, so access to the skin in order to be able to measure pulse rate and the rise and fall of the chest for breathing rate.

Q. Thank you very much. Is Oxevision a type of technology that is sometimes referred to as a vision-based patient monitoring system?

A. It has been, yes.

Q. And sometimes that's referred to as a VBPMS or just VBMS?

A. That's correct.

Q. Thank you. Do you know whether there are companies, other than Oxehealth, that provide this technology to the NHS within England?

A. I believe there may be one other company. It is my understanding that they do not have a registered medical device yet, I believe.

Q. Thank you. Just discussing using the vital signs

function, is the process that a clinician first accesses 15 second live clear video feed of the patient in their room?

A. So the first step of that process is the system provides an up to 15 seconds --

Q. Up to?

A. Yes.

Q. And when we say "clear video feed", could you just be clear about what that means?

A. It is a clear live picture of the room.

Q. So it's what most people would consider a video feed to be?

A. Yes.

Q. Why is it necessary that a clinician accesses up to 15 seconds of clear view prior to taking -- making a vital signs check?

A. So there are two points to this. So the first point being that you are taking somebody's pulse and respiration rate and, therefore, that would form part of their medical record. So you want to assure yourself that that is the person that you expect to be in that room and that another patient isn't in there. And the other purpose is to be able to answer the first question within the work flow; and that question is, is the subject still?

Q. We will come on to see that. Thank you. We can see reference in that first bullet point to spot check vital signs measurements being taken by clicking into the system and we will also come on to that in a moment.

A. Okay.

Q. Can we just look at the bottom bullet point on the screen, please. It says this:

"The vital signs trends chart shows a summary of average vital signs data that is automatically generated in the background to assist trend identification. It cannot be used in isolation to measure or monitor pulse rate or breathing rate."

Amanda, would you go over to the top of the next page, please. Then we can see here:

"The vital sign trend data is represented by grey trends diamonds on the report which show a summary of average collected by Oxevision for at least 75 seconds of a five minute period, vital signs data."

There is quite a lot to unpick there. Can you explain what is being described there?

A. So one of the reports of the system is what we call the vital signs trends report. Now, this is a report which has two graphs, so there's a graph at

the top and a graph at the bottom. I believe the graph at the top is pulse rate and the bottom graph is breathing rate. What this shows is it's got the scale of the measurements on the left-hand side and then across the bottom there's a 24 hour period. Now on each of these graphs it will show you when a staff member has gone through the vital sign work flow and obtain spot check measurements so there's medical device measurements. These will be represented by a red or a blue dot depending on which graph. Now, as a clinician you've got the ability to be able to select these red and blue dots so you can see what that measurement was and at what date and time that was taken. What the report also shows is grey diamonds, and these grey diamonds represent an average of what's going on -- an average measurement for what's going on for that patient. So they are not actual spot check measurements because you have not gone through the work flow on the vital signs, but it provides an average over a 5 minute window of what's going on for a patient.

Q. Can I ask you this. Does that mean that Oxevision cameras attempt to take continuous vital sign measurements without manual prompts from staff?

A. So the system is constantly monitoring the room.
Q. So the system is constantly monitoring the room, so the system, absent any staff request or operation, is engaging with the patient and trying to take vital signs measurements itself?
A. Not necessarily taking vital signs measurements, but it's working out that average over a five minute window. They are not actual measurements those grey diamonds.
Q. But is it doing so in the same way you described before by looking at micro-blushes in the skin and the rise and fall of the chest?
A. That's correct.
THE CHAIR: Hang on, let's be clear about this, you referred to two graphs, red dots and blue dots, and that demonstrates that there is constant monitoring by the system?
A. No. So those red and blue dots are the actual measurements that have been taken by a clinician going through the take vitals work flow. So they are the actual spot check measurements.
Q. Right.
A. Then the grey diamonds are a trend of what's happening in the background, so it's not an actual measurement because it's an average over a

five-minute period.

MR GRIFFIN: Let's be completely clear about this. So it appears that there are two ways for this system to make measurements of vital signs. One involves staff input; correct?

A. That's correct.

Q. And that is by clicking through to get the clear view first, and then clicking, as we will see, on a screen and taking a manual spot check?

A. That's correct.

Q. But quite separate from that, the system itself is continuously monitoring the person in the room and trying itself to take the same measurements?

A. To be able to provide that average, yes.

Q. To provide an average, so it's less accurate, is it?

A. It's not medical grade because it's an average over a five-minute period, so it's not done at a point in time.

THE CHAIR: And how does it overcome what you said was the need for the observation at the same time, the clear view 15 second observation? You said then that there was an issue with trying to identify that somebody was alone in the room and that they were resting. How does that five minute average overcome, as it were, those particular restrictions

on how accurate it is?

A. So as I said before, the grey diamonds aren't an actual medical grade reading. It is an average. The system knows when, if it knows that the room is occupied and that a second person has entered, it recognises that. And it's -- it's over that five-minute window, but what it needs is 75 seconds of confidence within that five minute window in order to be able to produce a grey diamond.

MR GRIFFIN: So if there are two people in the room, the system won't necessarily be taking the vital signs of the patients, it may be someone else?

A. That wouldn't appear on the graph.

Q. How would the system know?

A. The system knows when there's multiple occupants within the room.

Q. And does not take signs during that time?

A. As far as I'm aware, yes.

Q. Can you take that down, please. To follow up on vital signs I would like to go to a slide deck that you have provided the Inquiry with, which you tell us in your statement was provided by Oxehealth to EPUT for a meeting on 4 March 2020. Could you put up please OXHE009041, at page 15. Right. We will just look at aspects of this slide deck and sorry

that it is in black and white.

A. I can't read it sorry, it's completely blurred.

MR GRIFFIN: Can other people read it on their screens? No, that doesn't help. I think there is a colour version of this. I think we need to load that on to the system, so that we can go through slides that you can actually read. For that to happen I am going to ask that we rise for ten minutes and hopefully by then we will have put on to the system a clear version of this, if that's all right, Chair?

THE CHAIR: That is all right.

MR GRIFFIN: You are absolutely right it is very difficult to engage with this. Can we come back at quarter past 12, please.

(12.05 pm)

(Break)

(12.25 pm)

MR GRIFFIN: Thank you very much Chair, we have now loaded the relevant documents on to the system. We will go to them in a second. Before we do, just picking up on the vital signs trends data we were talking about, I had asked you about what happens if there are two people in a room and you responded to that. But if there's only one person in a room, the vital signs trends function won't know whether

that's actually the patient or not; is that correct?
A. That's correct.
Q. So if there's only one person in the room and it's not the patient, it could be picking up the vitals of somebody completely different?
A. So the system, yes, the data is based by room rather than by a patient in relation to that. The Oxevision observations module is slightly different.
Q. We will come on to that in a moment, thank you very much. So can we put up the document that I tried to go to before, Amanda, please. Just to remind people, this is -- actually that's showing just part of the -- there we go, thank you. Thank goodness. This is from 2020, this slide deck and can you just explain to us here, what we can see is a slide with a series of green tiles with room numbers on them and a window in the middle for room 4 and it says on it, "Either pause for 15 minutes" or under "Vital Signs", circled, "Take observation". Can you tell us from your experience what the text underneath that says?
A. So this is a screenshot from 2018, I believe. Yes, so this is how the system used to look, so the system doesn't look like this any more. However what that shows is that room 4 has been selected

from the room tiles. You have then got that pop-out tile and it then it has got "Vital Signs" and "Take Observations". So that would take you into the vital signs work flow.

Q. When it says "Pause for 15 minutes" what would that be for?

A. That's pausing the system. An example of this would be in older adult settings, for instance. If clinicians needed to go in to deliver personal care, you've got the ability to be able to pause the system so therefore basically it switches the system off for that period of time.

Q. Is that a facility, as far as you are aware, that is available at EPUT?

A. Yes.

Q. Thank you. What does it say under "Take Observations"? It's difficult to read?

A. I think it says "Observation History".

Q. Yes?

A. Yes, observation history, thank you. So that will show you the vital signs that have been taken for that room. I am unsure as to whether the vital sign trend function had been introduced at this point.

Q. Understood.

A. I think that's outlined in my statement.

Q. Amanda, could you show the full screen again, please. This is the screen from the monitor or tablet. Is that correct?
A. That's correct.
Q. Is this the start of the vital signs spot-check process?
A. As I say, this is old so this is no longer the process now. However, in 2018 that would have been the process.
Q. One selects a room and then taps "Take Vital Signs"?
A. Yes, so each room is donated by a tile, which you can see underneath there, and then you've got the ability to select that room and select "Take Observations".
Q. In what way has this changed after 2018?
A. It looks very different. Each room is still donated by a room tile, however now when you select on a room, you've got access to all information for that room. So you've got access to the activity report the vital sign trend report, the observation history so the mental health observation history.
Q. So it gives you access more quickly to more information?
A. It gives you all the information for that room in one place. Also the wording, it says "Take Vital

Signs".

Q. So that has changed?

A. That changed, yes.

Q. When did that change?

A. That changed, there's been various changes since this one in 2018. So there's been a number of different changes to how the home screen looks and how it's set out in relation to when you select a room.

Q. So you say in your statement that this slide deck was provided to -- by Oxehealth to EPUT for a meeting in March 2020. So changes would have been at some stage after that; correct?

A. There's been many changes since then.

Q. But the essential point we are looking at here is that you bring up, you select a room via the monitor and then click on a part of the monitor to take vital signs remains the same?

A. Yes.

Q. Thank you. Can we go to the next slide, please, and can we see the full slide. This says:

"Step 2: Check if the patient is still and click Ready For Observation."

And we can see guidelines for considering the patient to be still can be found in the instructions

for use. We see underneath:

"The patient must be still to get a reliable reading. If you are unsure, do not proceed."

Can you explain a little bit more what is going on in this slide?

A. So that's the first question of the work flow where the system is asking if the subject is still. You would use the view of that room to check if the patient is still. You would then select, I believe that says "Ready for Observation", the blue button.

Q. So this is all part of the process of checking whether it is appropriate to take the vital signs?

A. That's correct.

Q. And as we can see there, the patient has to be still. It won't work if the patient is moving around?

A. They have got to be relatively still, yes.

Q. Next slide, please. So this is stage 3 or step 3 and we have got some interesting language here:

"Step 3: Check if there are blobs that do not touch the body & click No."

And we can see on the right-hand side:

"Blobs on skin = pulse rate.

Blobs on body = breathing rate.

Examples can be found in Instructions For Use."

At the bottom we can see:

"The blobs must be on the body to get a reliable reading. If the patient is completely covered, proceed with caution."

Would you just explain what's going on there, please?

A. So this is the second stage of the workflow. I just want to highlight here that this image is now a paused image. This is no longer a live image of that room. So the system basically takes a screen grab, a screenshot so to speak, from the first question and then what the system is asking, it overlays that paused screenshot with blue blobs, and that's indicating to the user where the system is intending to take those measurements from. So an example, I can give would be it's, if there is an air flow mattress, for instance, being used in a room, the system may interpret the rise and fall of an air flow mattress as the rise and fall of somebody's chest. But what it would do is it would put one of those blue blobs on to that mattress area rather than the person. So as long as you are satisfied that those blobs are on the person, you would then select "No".

Q. Can we actually see a blue blob on the person in the

screen here? Thank you. It says here:

"If the patient is completely covered, proceed with caution."

What does "completely covered" mean in this context? Does it mean the head is covered as well?

A. So if somebody was completely covered with a blanket, for example, proceed with caution. Again you would be going through those two stages of the work flow to ensure you are satisfied.

Q. Can we go to the next slide, please, so:

"Step 4: Record Observation."

We can see here under the still, heart rate is given of 93 beats per minute and the breathing rate is given at 30 breaths per minute and the information provided says exactly when that reading was taken. Is that correct?

A. That's correct, it's date and time stamped.

Q. As we have seen already, there is a bracket both in relation to pulse rate and breathing rate within which this technology can work. In other words it can't take measurements outside those ranges; is that correct?

A. That's correct it will not give you a measurement outside of those range.

Q. We can see the bottom text:

"Work in progress to extend pulse rate range. Updated ranges to be released and as when within Instructions For Use."

This isn't for privacy or any other reasons, it is just a limitation of the technology, is that correct?

A. As in those ranges?

Q. Those ranges, yes.

A. Yes.

Q. You have told us that this is actually from 2018, have those ranges increased since then as far as you are aware?

A. No.

Q. Thank you very much. Can we go to the next slide, please. We have got here "Observation History" and we can see screenshots of two screens. We see on one that 'Observation History' is circled and then on the other we see a graph and we see text that says:

"Check: the occupancy of a room may have changed within the 24-hour default period."

Can we start, please, first, with the screenshot on the left and what that is showing us?

A. So that is a picture of the home screen within the background. Then you will see there that the smaller square within that says "Room 4" and it has

got "Observation History" with a red circle around it. So somebody has selected "Room 4" and they are then given that menu.

Q. And at this stage the vital signs checks have been made and recorded?

A. That's correct.

Q. So let's see if we can expand the graph, please, on the right-hand. Here we see what I think you have described previously. Is that right?

A. No, it's not strictly right. This is the observation history. So these two graphs we are looking at now shows you those actual measurements they have been taken. So this was prior to the vital signs trend because there are no grey diamonds within the background of that.

Q. This demonstrates where successful vital signs have been taken, both in relation to heart rate, with red at the top, and breathing rate with blue at the bottom.

A. That's correct.

Q. And with vital signs trends we might also see grey diamonds?

A. That's correct.

Q. And that would, as you said, indicate where the system itself has been able to take averages in the

background.

A. That's correct.

Q. Thank you, could you take that down, please. I would like to come on now to alerts and warnings, please. You explain in your first statement, this is paragraph 15, that Oxevision provides location and activity based warnings and alerts, which are configured by each organisation based on what they consider is appropriate for their individual ward settings. Can I ask you, first of all, what is the difference between a warning and an alert?

A. So the difference between a warning and alert is the colour of the room tile. So if an alert -- if the room is in a warning state, the room tile -- so if we think back to that home screen where we had green tiles, the colour of the tile would be amber. Now, if an alert has been triggered, the colour of that room tile would be red, but also you would have a audible alert to go alongside the red room tile. Warnings are only visual.

Q. Thank you. So let's just unpick that if we may. The audible alert, is it something like "Oxevision alert" literally?

A. Now it just says "Alert, alert". It was "Oxehealth alert, Oxehealth alert".

Q. So you would hear a person's voice?
A. Yes.
Q. Thank you. You have told us the difference of effect between a warning and alert in that one leads to an amber tile and one leads to a red tile, but we still don't know the difference between a warning and an alert?
A. I think it's important to highlight as well before, that an alert has to be interacted with by staff. So staff have got the ability when the alert is raised, they need to action something. When I say "something" that would all be dependent on what an organisation's standard operating procedure states in relation to the use of the system and how staff should respond to alerts.
Q. But in terms of interacting with an audible alert we are dealing with now, can that alert either be paused or switched off or are there other options too?
A. So there are two options. One is to view a room, so you are able to view the room, and if I just provide an example to this. So if it's the middle of the night, you are dealing with a patient in room 2, an alert has been raised for a patient in room 6. If the organisation's protocol states staff have got

the ability to be able to view that room. Now, what that provides is a anonymized video for that room of up to 15 second. What I mean by anonymized is it's pixelated and blurred, so you couldn't tell --

Q. We will come on to the difference between clear view and blurred view at the moment. What I am trying to ascertain at the moment is the difference between an alert and a warning. Could you give us an example of when an alert might be triggered?

A. So if I give you an example of "at door" for instance, so predominantly used within working age adult wards. So an organisation may have a warning configured that if somebody loiters within a door area for a set period of time, this raises a warning, so the room tile would change to amber, and then after another configurable set time period, it would change to an alert.

Q. So the alert system is in relation to more serious potential situations than the other scenario.

A. Potentially.

THE CHAIR: Can the warnings be differentiated between individual rooms, individual patients?

A. Not at the moment but that's something we are looking at in relation to the new generation of the platform.

THE CHAIR: Sorry, thank you.
MR GRIFFIN: Not at all, thank you very much. You referred to anonymised view of a room and I would like to turn to that with you now, please. This is also referred to as a blurred view or blurred video; is that correct?
A. That's correct.
Q. You explain in your statements that Oxevision video data is made available to staff during an alert and you have just been telling us about that. So when there is that kind of alert and the system has triggered it, and we will hear an audible person speaking alert, what happens? What does a member of staff have access to at that time?
A. So when that alert is triggered, a member of staff has got access to be able to view that room. So that example that I gave that if you were busy, helping another patient but an alert has been raised -- again, it depends on an organisation's protocol for use, but you've got the ability to be able to view that room, that is a blurred video of up to 15 seconds, in order for you to be able to make that clinical judgment, that actually do you immediately leave what you are doing right that second and attend to the other patient. Do you need

to summon help for the other patient immediately, or can you finish what you are doing and then attend to the other patient. But, again, it depends on an organisation's protocol on how staff respond to alerts.

Q. So what is blurred precisely, is the whole picture blurred or just the bits of the individual, just their face, for example?

A. So it's not personally identifiable data so the person is pixelated.

Q. The whole of the body?

A. Yes, the whole of the person.

Q. We will come back to that a little bit later. Can you confirm that access to blurred view in this way is for up to 15 seconds at EPUT?

A. I can.

Q. Thank you. There is one question that presents itself, why does a member of staff have access to clear view of a patient for the purposes of taking vital signs, but only a blurred view for a potentially more serious event when an alert has been triggered?

A. So for the purpose of taking the vital signs, again you need to identify that that is the patient that you are expecting to be in that room and you

wouldn't be able to do that if that was a blurred, pixelated image. However, the other point is a very good point and we have had that raised by a number of customers, that actually a clear view would be better when looking from an alert point of view. However, it was done with privacy in mind.

Q. We will come back to the question of privacy in a moment. You have also mentioned already another aspect of the system, Oxevision observations. I would like to move on to that now with you, please. Is that sometimes abbreviated to Oxe-Obs?

A. Yes, that's correct.

Q. What I am going to do is put up part of Zephan Trent's witness statement. His first statement at paragraph 27. This is EPUT009024, at 7, page 7. Can we see here that Mr Trent says that EPUT has also deployed Oxevision observations, an additional module to Oxevision:

"Oxevision observations helps mental health providers, and their staff improve safety with observation compliance; prompting staff to carry out on time observations using a handheld tablet device and giving access to accurate and up to date patient observations for all staff. It supports therapeutic and personalised care as it allows for the recording

of comments and individual risk factors."

And he says a little bit further down:

"Oxevision Observations is a digital observation module within the Oxevision system. The Oxevision Observations module is a digital version of the paper observations record" -- and he goes on to say:

"Oxevision Observations is implemented only on Oxevision equipped inpatient wards, seclusion rooms and Health Based Places of Safety to enhance and improve patient care and safety in order to:

Provide a clear record of observations in a digital format for integration to the electronic patient record.

Assist in the identification of trends.

Report on quality of engagement and observation activity."

Now does that provide an accurate summary of what Oxevision observations is and which how it works?

A. It does.

Q. Was Oxevision observations actually developed by Oxehealth in conjunction with EPUT?

A. That's correct.

Q. I understand from your evidence that that started

from, that development started from late 2021. Does that sound about right?

A. Yes, October 2021, I believe.

Q. Now, it's not clear to me from this description and from what we have seen so far, how a member of staff conducts observations using Oxe-Obs. Can I ask you this, do they do this? Do they perform an in person check, so the member of staff goes to the bedroom, and then logs it electronically through the tablet, for example. Or are they actually using the Oxevision camera to conduct remote observations?

A. So again this would depend on an organisation's protocol and how they want their staff to interact with the Oxevision observations module.

Q. Do you know what the situation is at EPUT?

A. I believe it is that they walk around with the tablet and use that as they are walking around the ward and log those observations as they walk around.

Q. We can ask, I will ask Mr Trent about that tomorrow, but does this give the facility to actually conduct a remote observation through the camera, so that a member of staff does not actually need to go and see the patient in person?

A. That's correct, yes, and it enables staff to be able to carry out that general observation at night, so

less intrusive at night, so staff are able to not have to wake patients up. So at night those general observations that I spoke about earlier continue and as a member of staff you need to assure yourself that that patient is safe and well. So this could result in you having to go into a patient's room. That could be every 15 minutes, every 30 minutes, every 60 minutes. Now you may have to turn a light on to be able to see that rise and fall of somebody's chest, you may use a torch. So from an intrusive point of view, you can see how intrusive these observations can be. We know how important sleep is for recovery. Now if somebody is woken up four times an hour during the night, that is not therapeutic. That's not helping that person. So where suitable and in agreement with the patient and the multidisciplinary team and the organisation, you could use the system in that way at night for certain patients.

THE CHAIR: Sorry, but I think Mr Griffin's point is whether if you are walking around with the hand held one, you can actually use it for the same functions as the monitors in the nursing station. In other words, for actually undertaking the 15 minute clear view and then prompting the vitals --

A. 15 seconds.
THE CHAIR: Sorry, 15 second clear view and then prompting the vital signs check?
A. Yes, in order to assure yourself that that person is safe and well.
MR GRIFFIN: Thank you. So there are two ways of conducting of observations using Oxe-Obs. One is to use the tablet, effectively, just to input information from an in-person view. The other is not to visit the patient at all but to conduct the observation remotely through the screen or tablet; is that correct?
A. You could do that and again it depends on the organisation.
Q. You said you didn't know really what happened at EPUT; is that correct?
A. I believe, and again this would be a question for EPUT but I believe EPUT walk around with their tablet and record those observations.
Q. Are you aware of concerns that had been raised in relation to the use of Oxevision at EPUT, that staff have become over-reliant on observations that are conducted remotely through the tablet or through the screen?
A. I was aware of that information through some of the

inquests that I have attended --

Q. So it would appear, wouldn't it, that at EPUT they are conducting observations, at least some remotely, not just at night but at all times?

A. It would appear that way from that information.

Q. Can I ask you this; when conducting a remote observation, what is a member of staff able to access. Is it clear view or blurred view?

A. Are you talking about the take vital signs?

Q. Well, I am just trying to understand how you are able to make an observation remotely using the system and a monitor or a tablet. Can you just take us through that process?

A. So there's two ways that you can access the take vital sign work flow that is as standard, via the home screen, selecting the room, and going in via that way. The other way is through the Oxevision observations module. So you are required to enter the location of the patient and if that patient is in their room you've got the ability then to be able to take vital signs again, for that example that I gave at nighttime for instance.

Q. Forgive me if I haven't understood, but are you effectively using the vital signs function also to conduct observations? So do you have access to the

15 seconds of clear view?
A. If you access the take vital signs work flow, you've got access to the 15 second clear view. If you are accessing it via the Oxevision observations, that's giving you the assurance that somebody is breathing, rather than having to go in -- this is an example by the way -- rather than having to go in and disturb that patient at night.
Q. But, sorry, what I don't understand at present is when you are using Oxe-Obs as opposed to vital signs, what is the member of staff actually able to see if they are not conducting an in person check?
A. So if they access the take vitals via Oxevision observations it's exactly the same as if you access it via the room tile.
Q. Okay, so a remote observation is conducted as part of the vital signs work flow?
A. You've got access to a 15 second clear video.
Q. Thank you. So a member of staff might be asking the system to give up to 15 seconds of clear view, either to take vital signs or to conduct observations, or both?
A. Yes. Again, dependent on the organisation's protocol for use.
Q. In terms of EPUT, would that be the case as far as

you are aware?
A. That would be a question for EPUT to answer.
Q. Thank you. Just moving on, or back to the hardware. We have not seen what it looks like yet. So I am going to ask that a slide is put up from a staff information presentation. This is OXHE009041, at page 4. This is from a training deck provided by Oxehealth to EPUT for a meeting on 4 March 2020, according to your statement. So page 4, please. It should be OXHE009041, page 4. Here we go. Amanda, could you first of all expand the left hand square there the "Bedroom/seclusion room". Thank you. So just explain what we see there, please?
A. So that, at the top left of that image is the housing unit. So what you can see there is you've got the two infrared illuminators which allows the system to work during all, at varying light levels within the room. Then you've got the camera as well, which is behind that black piece of Perspex.
Q. And does the unit look substantially similar so that now?
A. Currently.
Q. It's quite big, isn't it?
A. It is.
Q. It would be very clear to the patient in the room

that there was that unit right close to their bed?
A. Yes.
Q. We have heard evidence that there is a light that is illuminated within the unit when it's plugged in. Is that correct?
A. That's correct. If I could explain a little bit? So the illuminators may display a subtle glow from them and that happens even when the system is switched off. So even when the camera is off the housing unit is still powered and those illuminators stay on. Now we use a visible part of the infrared spectrum in relation to the illuminators but we are looking at this for future development.
Q. And I will ask you a little bit more about that later. So we can see the two illuminators on the left-hand side of the unit in this photograph, correct, as you have said?
A. Correct.
Q. So those would glow, is that what you are describing?
A. There is a possibility that there may be a subtle red glow, yes.
Q. We have also heard in the evidence that has been provided to us that there is a light that is displayed that shows that the unit is plugged in.

Are you aware of that, no?

A. No. I think it's sort of also important to note that this glow may be more obvious at night when the light levels within the room are lower and could possibly be not seen during daylight hours.

Q. Thank you very much. Amanda, would you expand the next "Staff interface", so the right-hand side of the screen, please? So can we see here the monitor in the nurse's station and an example of a tablet?

A. Yes.

Q. We can see the graph, the observation history graph there. We can see a variety of tiles showing on the tablet, including from green, amber to red; correct?

A. Yes, and there's also an empty room state on there.

Q. And that's the white square?

A. Yes.

MR GRIFFIN: Thank you very much. Chair, we have reached 1 o'clock so it might be appropriate to rise now until 2.

THE CHAIR: Yes.

(12.59 pm)

(Break for lunch)

(2.05 pm)

MR GRIFFIN: Ms Cozens, what I would like to do now please, is to come on to ask you some questions

about what Oxevision is not designed to do, or can't do. I think we have touched on some of this already this morning. We have heard that it's installed only in bedrooms, deliberately, and it shouldn't film inside ensuite bathrooms and we will come back to that. As you said, it's not able to identify a patient. It's doing it by room, I think you said. It doesn't pick up audio, is that deliberate?

A. It does not need to pick up audio.

Q. So is that for privacy reasons and just because it's not necessary generally?

A. Both.

Q. It doesn't work if there's more than one person in the room; is that correct?

A. It identifies if there's more than one person in the room.

Q. But it doesn't do more than that?

A. Mm hmm.

Q. When you say "mm hmm", you are agreeing with me?

A. Sorry, yes.

Q. And it is unlikely to work if the patient is moving?

A. The vital signs element of it.

Q. The vital signs element?

A. Yes, there are other modules to it that would work but the vital signs element of it.

Q. So the observations module might -- you might be able to use it for observations purposes even if someone is moving?

A. You could still record, yes, the mental health observations and then you have got the activity tracker as well.

Q. Thank you. The most recent EPUT Standard Operating Procedure document says that:

"Oxehealth must be notified should the room configuration be altered, including repositioning of the bed space. A failure to notify Oxehealth of configuration changes will have an adverse impact on Oxevision performance and accuracy. Note, movement of furniture, a distance as small as 50 cm, can impact the system's accurate evaluation of a room configuration."

What are your expectations in relation to the requirement for providers to notify Oxehealth in these circumstances and how do such changes affect the technology's efficacy?

A. So we would communicate with all providers -- sorry, excuse me.

Q. Do you want to take a sip of water?

A. Thank you -- around movement of furniture. However, within the majority of mental health in-patient

units, furniture is fixed, from a risk point of view. So if I provide you an example of an older age adult ward, where there may be the need for a hospital bed, so where the bed is movable. What we say is that if the bed is moved within a certain amount, that providers should notify us because that may have an effect on, again, as an example, the leaving bed or out of bed alert that may be configured for that room.

Q. So if I could put it in short, and tell me if I have got this wrong, there could be an issue if room furniture isn't where the system expects it to be?

A. Yes.

Q. Thank you. We have seen that it takes vital signs only within particular parameters, 50-130 pulse rate a minute, and forgive me I have forgotten what the other --

A. 8-39 breaths per minute.

Q. Say that again?

A. 8 to 39 breaths per minute.

Q. Thank you very much, per minute. If someone, if their pulse or breath rate is outside those parameters, the system is probably not going to be able to pick it up; is that correct?

A. That's correct, the system does not measure outside

of those.

Q. But from a health perspective, isn't it just that kind of reading outside those parameters that a member of staff would want to be aware of?

A. Not necessarily. I think there may be other reasons where, again, depending on what a patient's baseline pulse or breathing rate, yeah, the staff may want to be able to keep an eye for other reasons, say physical health concerns.

Q. But in terms of worrying pulse or breath rates, they will generally fall outside the range covered by the vital signs technology?

A. Generally, but again it depends on --

Q. That person?

A. On the patient, yes.

Q. Thank you. We have heard that there are problems using it, or there may be, when the patient is completely covered. Is that because the system won't be able to see the micro-blushes in the skin or the rise and fall of the chest?

A. That's correct. So to measure pulse rate the system needs to be able to see skin.

Q. And clearly for observations purposes, it won't be ideal if the person is completely covered?

A. That's correct.

Q. It's been suggested that the system may not be able to provide an accurate or possibly any reading if a person has scarring or tattoos; is that correct?
A. That's what's documented within our instructions for use as a caution/warning.
Q. You say in your first statement, this is paragraph 17:

"The Oxehealth Vital Signs device is indicated for use on humans 12 years of age or older with all skin types."

Just reminding ourselves that in terms of one aspect of the vital signs it is looking for micro-blushes in the skin. Is it correct that the system still works for all skin types?
A. That's correct.
Q. Has Oxevision actually been tested on all skin types?
A. I believe it has, yes, using --
THE CHAIR: Can I -- forgive me, finish what you were going to say.
A. Using what I believe is the Fitzpatrick scale.
THE CHAIR: Going back to the need to have exposed skin, you say if somebody is covered up, but can it take a reading from their face?
A. If that skin is exposed, yes.

THE CHAIR: Thank you.

MR GRIFFIN: Might the accuracy of the system also be affected by people with tremors, alcohol withdrawal or motion disorders?

A. Again, that is listen within our instructions for use under caution/warnings.

Q. Would you accept that the system has quite a few limitations, whether by design or because of the current stage of the technology?

A. There are some limitations with the system, yes.

Q. We have referred to the fact that Vital Signs is a regulated medical device. Given the limitations we have just discussed, to what extent would you say it reliably confirms whether a patient is physically well or not?

A. I think that there's a lot of other things from a context point of view that would have to be considered from that point of view, but it gives you two measurements of vital signs that can be used to help gauge physical health, not completely, but it gives you two pieces of that.

Q. So it would need to be part of a bigger picture?

A. Yes.

Q. Thank you. We saw at the beginning that Oxevision is rebranding to LIO, and also that a new platform

is being introduced next year; correct?

A. That's correct, yes, a new generation of the platform.

Q. This is what you said, this is paragraph 100 of your second statement, you have seen it but I will just remind you:

"Building on the foundations of Oxevision, a new platform will be introduced in 2026 which will bring together ambient patient monitoring, digital observations and management insights in one purpose built solution."

What is new about the LIO platform compared to Oxevision?

A. So if I break this down into four sections, so looking at -- and I think we briefly touched upon it earlier, so configurable modes per patient rather than per ward. So looking at those configurable modes, and providing that flexibility. Enhanced access and user controls to ensure appropriate usage, so user authentication, so providers have got the ability to be able to lock any part of the system behind user authentication. So again, an example would be if they want to monitor who is resetting alerts or who is accessing the take vital sign work flow, they have got the ability to put

that behind user authentication. Enhanced digital observations, so the Oxevision observations and enhancing how that work flow works and looking at more enhanced compliance reporting alongside the digital observations. And then looking at a new ambient monitoring unit. So looking at the housing unit and looking at changing that. So for ease of installation and designed to be smaller and more reassuring for patients.

Q. You said, I think the second of your four descriptions of how it is different, was enhanced access with controls to monitor appropriate usage. Is that in recognition of previous issues with inappropriate use of the system?

A. No. So it was -- that facility has been there since early 2025, yeah.

Q. You said if someone is resetting alerts, so presumably, added functionality to be able to monitor that is because that has previously been an issue?

A. That was an example of being able to -- so at the moment to use any part of the system apart from Oxevision observations, it doesn't require a staff to log in. However, with user authentication, providers will have the choice to be able to have

any part of the system behind user authentication if they so wish to.

Q. Thank you. But does that mean, for example, on the tablets that someone doesn't need to log in before they are able to access the functionality of Oxevision?

A. The functionality apart from Oxevision observations. So those digitised mental health observations require staff to log in from an accountability point of view.

Q. But someone would be able to have a tablet and access vital signs, would they, without logging in?

A. Yes.

Q. So they would access to a clear view of the patient for up to 15 seconds?

A. Yes, there are various other safeguards that are in place and again that's split into two sections. So what the system offers from a safeguard and that is you've got the ability to switch a room off should that not be -- should it not be appropriate to use the system for certain patients.

Q. Thank you. I am going to come on to ask you about safeguards specifically. Thank you though for explaining the difference of the new platform. One of the concerns that has been raised is that

Oxehealth uses language that is deliberately obscure. Would you accept that it would be difficult for most people to understand what is meant by "ambient patient monitoring", for example?

A. So that language is on our website. Our website is not designed to act as information directly for patients and their carers. So there are nationally co-produced leaflets and posters that have been designed with the National Mental Health and Learning Disability Nurse Directors' Forum across England and Wales, which looks at things like accessibility, language.

Q. Thank you. Just generally in relation to the new platform, does the fact that it is being introduced reflect any concerns with the operation of the current Oxevision platform?

A. No. This was something that had been on the cards for some time.

Q. So again, it's not in response to concerns that have been raised in the press and elsewhere, including this Inquiry, about the way in which Oxevision currently operates?

A. We are constantly looking at how to develop the platform and that's in conjunction with providers and a large group of experts by experience that we

work with.

Q. Thank you and we may come on to experts by experience. What I would like to turn to now, please, is to look at the advantages of Oxevision, the system, as Oxehealth perceives them. You deal with this from paragraphs 41-42 of your first statement but I am going to ask that that is put up on our screen, please. That's OXHE009031. This is dealing with research and research we may come back to later, but I just wanted to read this out because I think it summarises advantages as you see them:

"There is an extensive evidence base demonstrating the clinical and operational value of Oxehealth's contactless patient monitoring system in in-patient mental health settings. The evaluations consistently show that the technology supports staff to deliver improvements in safety, quality and efficiency on mental health wards. Most of this research is based on provider-led service evaluations, a number of which have culminated in peer-reviewed journal publications.

Key findings include: reductions in rates of patient safety events (self-harm, falls, assaults and restraints); enhanced physical health monitoring; time and cost savings; and improvements

in both patient and staff experience. Notably, recent interim findings from independent research on patient experience showed that the vast majority of patients with direct experience of the Oxehealth system feel as safe or safer when the technology is in use."

We may return to the research aspect later on but looking at these points, you refer to reductions in rates of patient safety events, I will come back to that in a moment. "Enhanced physical health monitoring", we can see in paragraph 42. Is that a reference to the vital signs technology and the trends that we have just been talking about?

A. That's correct.

Q. Is the intention that Oxevision provides access to accurate and up-to-date clinical information?

A. That's correct.

Q. You say that the monitoring is enhanced. In what way is it enhanced?

A. So enhanced physical healthcare monitoring, from the point of view of being able to access that pulse and respiration rate should that be needed, and the vital signs trend chart. So if you had a unit that didn't have Oxevision in, as a clinician, you are not going to know what a patient's trend is from a

pulse and a breathing rate point of view.
Q. So the enhanced element is really the trend data that the system provides, is it?
A. And the ability to be able to do that contact-free, pulse and respiration rate.
Q. You also refer here to time and cost savings, what do you mean by that?
A. From a point of view, and I think this is a really important point, so financial benefit from the point of view of this is not about reducing safe staffing. So mental health units and providers have what they call a safe staffing number per ward. So the minimum amount of staff that you need per ward per shift. So by introducing our technology, it is not about reducing the safe staffing number, and each unit will have a substantive staff establishment so how many staff they should have per ward. So it's not about reducing that either. But if I give you an example, again an older adult setting. So if staff are using the platform and are alerted to a potential fall in which they can intervene with earlier, then the financial and time benefit is around the possibility of not having to have extra staff if that patient needs to go and visit a general hospital and then having to back fill staff

on the ward with extra staff. So it's about having access to that up-to-date information and how that can help with the planning of care.

Q. Does part of Oxehealth's marketing to trusts emphasise the economic efficiencies that come with using the system?

A. Again, we do talk about time saving from a nurse's point of view of being able to provide them with that up to date information to prevent incidents. So again, time if an incident is prevented, you haven't got a member of staff having to complete incident forms and the various paperwork then that follows.

Q. Thank you, you talk about improvements in both patient and staff experience. Can you explain what you meant by that?

A. So from a patient point of view, again, I spoke about it earlier, about that the general observations at night and being able to use the platform to be able to allow people to sleep and rest and recover without waking them up. So less intrusive and the positive impact that this has if someone has had a good sleep in relation to their recovery or their engagement within therapy the next morning, again patient safety incidents. If you can

prevent incidents from happening, that only has a positive experience for both staff and patients.

THE CHAIR: Can I ask you about time, time saved. Have you done studies, audits, on how much time is saved? You talked, for instance, about preventing incidents. I can see how you might look at that, but have you actually been able to establish that time is saved.

A. We have got some papers in relation to time, yes. And that frees up time, then, for staff to have that direct patient contact if they are not having to complete paperwork.

THE CHAIR: Thank you.

MR GRIFFIN: Thank you. Can we come back to consider the first of the key findings, that you include, reductions in rates of patient safety events. You have touched upon that a little bit already but you referred specifically to self-harm, falls, assaults and restraints. Can you explain a little bit more what you mean by that?

A. Yes. So again, if I provide examples, so last week I received an e-mail from one of the providers that we work with to say that Oxevision had alerted or warned staff to three ligature attempts within a doorway, which may have otherwise have been missed

and that was only over a two-week period. Again, Oxevision played a critical role in a ligature event which resulted in an individual not coming to significant harm. And I believe that there are some stats and percentages within my second statement. Can I refer to those?

Q. We will come back to the research and evaluation separately if that is all right. If there is something particular you would like to refer to now, by all means?

A. Again, a comment from a Chair from an organisation that in their own trust they are well aware of the significant number of falls that have been prevented on the dementia units. And again, organisation A in 26 months there were 1,774 incidents where Oxevision supported staff to respond to a situation where a service user, users, could have otherwise come to some serious harm. And there are others in there as well.

Q. Thank you, in fact, that specific type of category of data is something I may raise tomorrow with Mr Trent and the basis for it. May I say this, Chair. That the Inquiry's expert health statistician team will be considering some of the research evaluations and feedback to which reference

is made in Ms Cozens' statements and also Mr Trent's statements and the exhibits that have been provided that are relevant to that. A report will be produced and provided to Core Participants. After that has happened, the Inquiry will review the position and we may ask that Oxehealth provide further information.In the meantime, I may have some questions and we will come on to that if we may But thank you for that. Could you take down, please the two paragraphs from the screen. What I would like to move on now to is to ask you about provision of video and other data following an incident. Would another aspect of reducing the rates of patient safety events be that the Oxevision system can provide video and other data following an incident?

A. That's correct. I think it is important to add that the provision of video, again, is a decision for a provider. So they don't have to have that.

Q. We will come on to that if we may. How does the provision of incident data assist when there has been a patient safety event? You talk about this from paragraph 70 in your second statement.

A. So the provision of data enables providers if they have got -- if they have made a decision to have that 24-hour clear video data buffer, they have got

the ability to have access to that. Again it's under very strict governance.

Q. We will come on to that in a moment, but there is access to video data and we can come on to exactly what is available shortly. Is there also access to other incident data such as reports?

A. So all of the reports that the Oxevision system provides, so the activity report the observation report the vital sign trend report and the sleep report can all be exported, so providers will have access to that. There is also data that we are able to provide in relation to anonymised system data. So what I mean by that is able to provide a snapshot of what the system was doing for a set period of time.

Q. For example, members of staff interacting with it?

A. So yes, any interactions either with the fixed monitor or the tablet device. Any alerts that may have been triggered, when those alerts were reset and what device reset those alerts. Whether the vital sign work flow was accessed and room state information.

Q. And when you say room state information, do you mean whether a room is occupied or not?

A. Whether a room is occupied or not, but also -- so if

someone had been in the room and then in the bathroom and then left the room, it will provide that list of those states.

Q. Thank you very much. Just dealing with the video data that is available, we have heard that the system allows access to clear view for the purposes of vital signs and observations and blurred view in response to a warning?

A. Alert.

Q. Or an alert, thank you. Does clear video data remain available after there has been an incident?

A. So there's a clear video data buffer. Now, this is only for 24 hours and it auto deletes. Again, this is a choice for providers, they don't have to have this. But if they do choose it, then they have the ability to request if there has been a serious incident, the ability to be able to save parts of that video data should they want that. Again, like I say, they have got to have requested that within the 24-hour time period because it does auto delete.

Q. Thank you, we will come on to talk about that feature shortly. Where is the clear video data stored? I have read in your statements that encrypted clear video data is stored on EPUT servers; is that correct?

A. That's correct.
Q. If the trust or provider is EPUT?
A. Yes, it is stored at the provider's site.
Q. Is Oxehealth able to assist to provide clear video data to a trust an after an incident, as you have just discussed I think?
A. Yes, if that I have the CVD buffer, so the clear video data buffer and that they request it within the time frame.
Q. Thank you. So we will come back, as I say, to that. Has Oxehealth, in fact, provided a number of clear video data clips to trusts, such as EPUT, at their request?
A. That is correct.
Q. Does Oxehealth also provide blurred video data to a trust after an incident, if requested?
A. Yes, so if there has been a serious incident and that buffer, 24-hour buffer period, has been missed, then there is the opportunity to be able to provide blurred video data. I think it's important to note that the provider organisation is the data controller, so therefore it's their data.
Q. Thank you, we will come back to all of that. Just at the moment looking at the kinds of information that Oxehealth is able to provide following an

incident. Is Oxehealth also able to provide system data logs after an incident?

A. That's correct.

Q. What are they?

A. So that is the room states, the device usage, the user interaction with the system as I explained earlier.

Q. As you explained before, thank you very much. You refer in your first statement also to provision of data reports following an incident. This is at paragraph 136, and you say that, or we have heard that 19 were sent to EPUT between 2021 and 2023. What I would like to do is look at part of a data report with you, please. Could you put up OXHE009035 at page 1, please. So this is, you refer to it in your statement as a data report I think. We can see here that it calls itself "Oxehealth anonymised data review". So that's the same thing, is it?

A. Yes.

Q. So what we see here is for EPUT for 3 August 2024, and this is for a particular ward although that has been redacted out, and can we see under "Introduction":

"On the 3rd September 2024, Oxehealth received

a request from" -- a particular person -- "to provide the data logs for" -- a particular room, in a particular ward.

And can we then see a timeframe on a particular date, so between 6 and 7.30 pm on 3rd August last year. These notes have been made by a member of Oxehealth staff who is not medically trained, and is a representation of anonymised system data with the intention to provide information on activity within the room. So is all of this an aspect of what you have just been describing to us?

A. That's correct.

Q. Can we look to table 1, the upper table, please, first. We can see there are, in fact, two different tables under table 1, but the upper table. Does it show under time stamp, a date and time? Is that correct?

A. Yes.

Q. Then does it show the nature of the alert or the location of the alert?

A. It is the nature of the alert.

Q. So we can see here on the first line the "In bathroom".

A. That's correct.

Q. So we may talk about this later, but is there a

feature whereby if someone is in a bathroom for more than 3 minutes, an alert is triggered on the system.

A. Again it is configurable, that time period, for what the provider wants.

Q. We will hear that it is three minutes in EPUT. So is three minutes a pretty standard time for that particular alert?

A. It varies, so what we see is when providers are looking at what alerts to consider for the system, quite often they will do a review of their own incident date in order to inform --

Q. So it will depend upon the particular provider?

A. Yes.

Q. And then we can see a status and we can see in each case "Resolved" and then a time in seconds. Can you tell me first what does "Resolved" mean?

A. That that alert has been reset.

Q. So by the member of staff?

A. Yes.

Q. Does it mean that a member of staff has actually conducted an in-person check of a patient or does it mean they have simply reset the alert?

A. It simply means they have reset the alert. This is the system data rather than --

Q. So "Resolved" doesn't mean that an in-person check

has been conducted just that the alarm has been switched off?

A. That's correct.

Q. Thank you very much. And the time in seconds, is that the time between the alert first sounding and it being switched off?

A. That's correct, reset, yes.

Q. Or reset, that's the best word, thank you. The lower table, please. We can see a time stamp, an event and a device. Can you just explain what's happening there, please?

A. So this is in relation to the alerts that are in the above table. So this tells you that what alert, that it was reset and by what device and again it's date and time stamped.

Q. So display 1 --

A. Would be the fixed monitor within the nurse's office, and then each of the tablets then have got their own number.

Q. Thank you. Can you take that down, please. You deal in your statement with usage reports. Do these provide details of the use of Oxevision at a trust?

A. Yes. So we provide usage reports to providers. This is to enable providers -- I suppose they form part of providers' governance and audit and use of

the system. So it provides them with, again an example, of how many times the vital sign work flow has been accessed and that is split between day and night.

Q. We'll have a look at one in a moment. We know, and perhaps you could confirm that Oxehealth has sent usage reports to EPUT at regular intervals?

A. That's correct.

Q. Could you put up, please, the usage report for July 2024. That's EPUT009021 on page 1. Can we see here a monthly usage report from Oxehealth sent to EPUT, is that correct?

A. That's correct.

Q. And could you go to the top of the second page, please, and expand up to -- that's perfect, thank you. So can we see here what the usage report covers. Individual ward usage summary, a page for each ward; the number of vital sign attempts each day over the last month, split between day and night -- that is what you just referred to, is it?

A. That's correct.

Q. -- with trend lines; speed of alert resets each day over the last month; the usage of each device that has been used over the last month; list of all devices assigned to the ward, if they are being used

or not, and when they were last used, correct?
A. Correct.
Q. Could you go, please, to page 30 of this document and enlarge the top. Could you just enlarge "Basildon MHU" at the top, please, up to the bottom of that Thank you. Can we see here the ward names down the left-hand side here at Basildon. Vital sign attempts we can see in the next column; correct?
A. Correct.
Q. Vitals displayed in the next column and activity report views in the final column?
A. Correct.
Q. Vital signs attempts, does that mean the number of times a staff member has used the system to access up to 15 seconds of clear video prior to making a vital signs check.
A. Correct, it's when they have accessed that work flow. So when they've selected that work flow
Q. And "Vitals Displayed" does that mean the number of successful attempts to take vital signs?
A. That's when one or, so either pulse and/or breathing rate have been displayed to the user.
Q. Thank you. What are activity report views?
A. So the activity report is, again, a report that the system provides and it provides this over a 24-hour

period, over a seven day, and we quite often see these used in practice to form part of handovers, care planning with patients. So what this indicates is how many times the activity reports have been viewed for that ward.

Q. Thank you very much. If we compare the "Vital Signs Attempts" column, and the figures there, with the "Vitals Displayed" columns, we see a discrepancy in the figures provided, don't we?

A. Yes, that is correct, they are different.

Q. The number of attempts is much higher in each case. For example, we can see on Grangewater ward there were 17,550 attempts, but only 7,884 times that vitals were displayed.

A. That's correct.

Q. Does it demonstrate this it regularly takes many attempts before vital signs are successfully taken?

A. No, I don't think it does. I think it's difficult to try and work out why that is without context of that ward and the patient population within that ward. So again, an example may be that patient -- there may have been patients that were on more routine physical healthcare monitoring than others. It's difficult to know without the context.

Q. Could we look at, could you show the full page, please,

Amanda. Let's just have a look and we will scroll down in second. Generally speaking, that trend seems to continue in Brockfield House. Could you show Rochford Hospital and down please. The trend appears to continue there, it appears to continue at the St Aubyn Centre and indeed at all of the units that are listed there. So do you maintain that it's ward-specific or is this an issue, do you think, across different wards?

A. I think that's probably a question for EPUT around how they use that. This, I think, is the whole reason about why we provide these usage reports, so it gives providers information about how the system is being used, so they can use that as part of governance and audit against their standard operating procedure, to ensure that there is consistent and appropriate use.

Q. So this situation here, where we have many more attempts than successful vital signs checks, are you saying this these figures here are EPUT specific, or is it likely that if we are were to look at equivalent statistics from other trust or providers, that we would see the same trend?

A. So the system will only output if it's completely confident. If it's not confident within a reading,

it won't output a reading at all.
Q. My question was whether we would see the same trend at other providers?
A. I would have to look at that.
Q. To what extent does Oxehealth record and address instances of improper or unsafe use of Oxevision of which it becomes aware?
A. I don't think it's for Oxevision or Oxehealth, sorry, to determine what is inappropriate or unsafe. We are a technology provider. We don't have context of wards or the patients within those wards. That is a question for the providers and ensuring that they are working alongside what their Standard Operating Procedure would say is appropriate and safe use.
Q. You are a registered mental health nurse, are you really saying that Oxehealth can divorce itself from that kind of consideration?
A. I suppose what I'm saying is if you consider other types of technology that are used within mental health wards, so again, a blood pressure machine. You don't have the manufacturer of the blood pressure machine auditing wards about the appropriate use of it.
Q. But this is technology that's used in mental health

in-patient units in connection with people who are or may be incredibly vulnerable?

A. I understand that. I do understand that.

Q. Your second statement says that the right to autonomy and respect for privacy is something which is central to considerations of treatment of care of all patients in hospital. That's paragraph 45 for your reference, and you go on to talk about the importance of balancing privacy and security.

A. Safety.

Q. Could you put up paragraph 46 please, Amanda, of the second statement. This is what you say:

"Oxevision is designed to be used in a way which enables autonomy and respect for privacy alongside the need to keep patients as safe as is feasible. The following features are deployed as standard:

a) The ability to switch off Oxevision for individual rooms" -- you have told us about that, haven't you -- "(b) The ability to pause Oxevision for individual rooms" -- and I think we saw that in connection to one of the screenshots that we were looking at?

A. I don't remember, sorry.

Q. Or you told us about it anyway?

A. Yes, I think I said and give the example of personal care within older adults?

Q. Thank you:

"(c) A homescreen that displays rooms as 'tiles'" -- which we have seen -- "with video only available in two specific circumstances, i.e. when taking vital signs spot-check measurements (clear images) and when an alert has been triggered by the system (blurred images).

(d) Privacy masks to blur areas of the video feed, particularly when bathroom doorways are visible, applied by default."

So just dealing with that last point, privacy masks, in relation to ensuite bathrooms and other areas, what is a privacy mask?

A. So the easiest way to describe this is basically a box, a black box over the bathroom doorway, if the bathroom doesn't have a door on it, which we do see in some mental health units for safety reasons. So when staff would be accessing the take vital signs work flow, if the bathroom door or the bathroom doorway was visible and there was no door or curtain, there would be a black box over three quarters of that doorway.

Q. The bottom three quarters or the top three quarters?

A. I believe it's the --
Q. Or the middle?
A. I believe it's the top three quarters but I would have to check, sorry.
Q. So when a member of staff was accessing a vital signs clear view, they would not be able to see that portion of the bathroom entrance?
A. No, that's correct.
Q. Would that apply even if a bathroom door was in place?
A. I believe that we have put it over all bathroom, it's over all bathroom doorways, but I can double check that.
Q. Thank you, could you take that down, please. Now safeguards which is something you were mentioning before and I said we would come back to. You say at paragraph 50 of your second statement that there are safeguards about monitoring the use of Oxevision and can you -- so this is paragraph 50 -- can you identify what those are and how they work, please?
A. Yes. So I think for ease of understanding, I think there's -- I will split this into two sections. So there are safeguards in place directly from the system, and I think we have spoken about a few of those. So the ability to switch a room off, to

pause a room, the design of the home screen, the privacy masks, the user authentication, which also I spoke about, the option not to have that clear video buffer. We also have what we call a vital sign attempt notification. So if, and again this is an example, if an organisation had written in their standard operating procedure that during nighttime checks staff were able to use the take vital signs work flow in order to assure themselves that somebody was safe rather than disturbing them, but they only wanted them to be able to use that twice in a period of five minutes, we could configure this that a notification, if people attempted to access it more than that a notification would be sent to every Oxevision device on that ward, so the tablets and the fixed monitor. And we can also configure that an e-mail could be sent to a nominated recipient as well. So they are the safeguards that are in place directly from the system, but I think there are safeguards also from outside of the system in relation to governance and audit. I think we have touched upon some of these; so the Nurse Directors Forum guidance that was published in 2022, that's got some clear guidance and recommendations within it. The SOP guidance document also, that's

available from the Nurse Directors website. The ward audit tool/template. So again an audit tool that providers can use. This is split into four sections, so there's a section on consent, patient feedback, staff feedback.

Q. We will be looking at examples of those, or an example of that, with Mr Trent tomorrow. So we will certainly be looking at that in more detail. But the two categories you have been talking about are those that are built in to the system and those that are external to the system; is that correct?

A. That's correct.

Q. Thank you. Were there any other safeguards that you wanted to mention before I turn to a new topic?

A. No. I suppose I just want to mention that, recognise that the platform may not be suitable for everybody and we do recognise that. I think an example would be if you had five people that were suffering with severe depression, you wouldn't necessarily treat all of those five people with the same medication. However, there are patients that do benefit from the use of this system and I think that also needs to be recognised as well.

Q. What that would suggest, though, is that clinicians would have to conduct a case by case assessment of

whether the technology should be deployed; correct?
A. But I think that's what clinicians do in general. You're assessing everybody as individuals --
Q. Well that's not actually what was happening at EPUT as we will come on to hear tomorrow. The system was on by default. But your evidence to us today, so we are absolutely clear, is that this is generally a tool that can assist but that you need to analyse in the case of each patient whether it will?
A. It's about that assessment and that conversation with the patient and ensuring the patient knows exactly what the system does, what it doesn't do, how it would be used as part of their care and not just having that conversation once either. That's an ongoing conversation.
Q. Thank you very much. Can we move on, then, to talk about some concerns that have been raised about the operation of Oxevision. You mentioned before that Oxevision is meant to operate along with normal staffing levels. I may be summarising it or overgeneralising but is that in essence correct?
A. Yes.
Q. One of the concerns that has been raised, has been raised in this way by Stop Oxevision, the campaign group which we heard this morning seeks to highlight

the use of Oxevision and which is calling for a halt to its rollout pending an independent review. Could you put up, please, this is part of Hat Porter's first statement at paragraph 3.26. That's STOX009054, at page 13. Can we see here that SO, that's Stop Oxevision, is concerned that Oxevision and other VBMS, and we established before that that's Vision Based Monitoring Systems; correct?

A. Sorry, yes, that's correct.

Q. Do you have water in your glass, would you like to pour some?

A. Thank you.

Q. I will start again:

"SO (Stop Oxevision) is concerned that Oxevision and other VBMS are being used as a superficial quick fix for wider systemic issues in mental health care, including inadequate levels of staffing and high levels of poor practice on mental health wards. In that context, the introduction of such systems risks widening pre-existing and underlying cracks in the system, which continue to go unaddressed."

Now as a registered mental health nurse yourself, is that a concern you understand?

A. I can understand, yes, but I don't think from my

point of view this is an assistive tool for staff, it is not about replacing staff and I think I spoke about that earlier. I think it's -- mental health care over the years hasn't, in my opinion, necessarily had the same level of innovation as physical health monitoring, physical healthcare. So you go into a general hospital and there's technology everywhere which helps support those clinicians and like I said earlier, within mental health care you still have staff walking round with a pen and a piece of paper documenting observations. So yes, I think there needs to be that equalness between mental health care and physical.

Q. Thank you. The technology that Oxevision affords, particularly in relation to vital signs, would make sense in a physical health context, wouldn't it?

A. That's correct.

Q. But as far as I'm aware it's not deployed there?

A. Not currently, no.

Q. Wouldn't it actually make more sense in a physical health context than a mental health context?

A. Not necessarily. I think, again, my own experience when you look back at mental health nursing, there was always -- and I think this has been recognised as well over the years, that physical healthcare

didn't tend to get the attention that it should do within mental health services. So people don't just have -- yeah, so people with mental health concerns also have physical healthcare concerns as well. So, therefore, as mental health nurses, you need to be able to look after those physical healthcare concerns too.

Q. Do you think the reason it hasn't been rolled out in the physical healthcare sector is because people would consider it too intrusive, there would be privacy concerns?

A. No.

Q. Just dealing with the quick fix point and staffing, does Oxehealth recognise that mental health trusts frequently face financial strains and staffing shortages?

A. Yes.

Q. Do you accept that in circumstances like that, the risk of your systems used to make observations remotely and therefore save staff time and costs, is a very real possibility?

A. So again it's about why organisations purchase the system and it's around the implementation of the system and the engagement with staff about how the system should be used, why it should be used, when

it should be used, and having that robust standard operating procedure in place, but also those governance and audit processes to ensure that that doesn't happen.

Q. Do you see the last sentence here from Hat Porter, if we are dealing with a mental health inpatient unit in circumstances of staff shortages, do you agree that in that kind of context the introduction of such systems as Oxevision risks widening preexisting and underlying cracks in the system which then continue to go unaddressed?

A. Possibly, but I also think the benefits of the system as well in relation to patient safety need to be considered.

Q. Thank you very much. Would you agree with this -- that can be taken down, thank you very much. Would you agree with this: that the safe and successful operation of Oxevision requires that other systems, for example, safe staffing and comprehensive training are in place and operating successfully?

A. Sorry, could you repeat that?

Q. Yes, of course. I asked you whether you agreed with this statement: that the safe and successful operation of Oxevision requires that other systems, for example safe staffing and comprehensive

training, are in place and operating successfully?
A. Yes.
Q. So if Oxevision is deployed somewhere where we don't have safe staffing or comprehensive training, it may not operate in the way Oxehealth intends?
A. Correct.
THE CHAIR: Can I ask another question? Do you accept that, it's a very basic question, but if there is remote observation going on, that staff may miss the chance for important therapeutic observation and engagement?
A. So that's a really interesting point and I think, I was having a conversation around the purpose of what these mental health observations are with a senior clinician last week. And they described the distinction that they made between therapeutic engagement with patients and routine general observations and splitting that. So there is a necessity, and they emphasised that routine periodic observations should never be interrupted from a safety point of view, and posed a question around how interactions with patients can be truly meaningful and therapeutic if staff are rushing to the next person, in order to meet and stay on schedule for those timed observations. However,

what they said was that by using the platform that staff can effectively complete those safety observations while freeing up time for others for those therapeutic interventions to take place.

CHAIR: Do you accept though that a therapeutic intervention can also be a safety intervention?

A. It could be, it could be.

MR GRIFFIN: Can we pick up on aspects of what you have just explained because obviously another major concern raised the use of vision based patient monitoring systems, including Oxehealth, is that they actually undermine therapeutic engagement by staff with a patient. To illustrate this point I would like to go in a moment to a recent investigation report which you have provided by the Health Services Safety Investigations Body or HSSIB. It's called "Mental health in-patient settings: overarching report of investigations directed by the Secretary of State for Health and Social Care", and it is from May this year. Before we go to it, is it right that HSSIB investigates patient safety concerns across the NHS in England, and in independent healthcare settings where safety learning could also help to improve NHS care; is that correct?

A. That's correct.

Q. Could we please put up OXHE009978 at page 36, and could you highlight paragraph 2.6.18. That's perfect, thank you. So this is part of that report. Just reading one part of it first:

"The investigations heard variable views on the benefits and value of these technologies in mental health inpatient settings. Some staff felt they provided a 'safeguard' because of the challenges they faced when trying to observe all patients on a ward, particularly when short staffed."

Now that seems to support the point I was putting to you before, where Oxevision is used to prop up staff at a ward that's understaffed, would you agree?

A. Yes.

Q. Just moving on:

"However, others were concerned that the use of the technologies may discourage some staff from actively engaging with patients, which is essential for therapeutic care."

I think that is the point that the Chair was just raising with you. Hat Porter has suggested that the use of vision based monitoring systems, such as Oxevision, on wards to allow the conduct of

remote observations and checks on patients at best reduces and at worst removes the opportunity for therapeutic engagement between staff and patients. Looking at the HSSIB report and hearing from Hat Porter, do you accept that this is a risk?

A. I accept that they have said that some staff that they spoke to, yes. There was also some positive stories as well that was raised by HSSIB.

Q. Has Oxehealth seen any examples of overreliance on Oxevision as a replacement for therapeutic engagement?

A. Speaking from my experience, I believe that that was raised at one of the inquests that I attended.

Q. So it is an issue that you are aware of and Oxehealth would be aware of?

A. (No verbal response).

Q. What could be done to prevent this overreliance on Oxevision?

A. Again, as I said earlier, this is an assistive tool providing staff with information that they didn't have access to and it's around the providers' Standard Operating Procedure and their governance processes. I think there are things that we have done, as in those safeguards that I spoke about that are inbuilt into the system.

Q. Thank you. You refer in your statement to EPUT and Oxehealth producing an Early Insights and Implementation Lessons Learned report. Sorry, I will say that again. Early Insights and Implementation Lessons Learned report in August 2020. You say this at paragraph 89 of your first statement. It includes that early evidence suggests that the Oxehealth system is delivering operational efficiencies through fewer avoidable close observations, positive risk taking in stepping down observation levels and faster observation rounds.

Now is that an example of how the use of Oxevision may lead to greater risk and lower therapeutic engagement?

A. I wasn't involved in writing that report and that was pre my employment with Oxehealth. However, that report was written in conjunction with EPUT, so Mr Trent may be in a better position to answer that.

Q. Just picking up on something the Chair asked you a moment ago, would you agree that face-to-face observations, rather than conducted through a screen, provide a way to spend time and be with a person and so build a therapeutic relationship?

A. Yes, I do agree with that, however, not if a patient is sleeping at night and asleep.

Q. Thank you very much. Where do you think Oxehealth's responsibility lies in ensuring that the technology is put to appropriate use?

A. I think we provide training to organisations in relation to product training, so how the system works, i.e. what do you select when and what the system looks like. I think there is a lot of national guidance out there now in relation to remote patient monitoring systems. So we had the guidance from the Nurse Directors Forum across England and Wales from 2022. There is now the NHSE principles and more recently the Care Quality Commission.

Q. We will come on to touch those specifically in relation to consent in a moment. Thank you very much for that. Could you take that down, please. Chair, we have reached quarter past 3, so it may be a good time for a break for 15 minutes, please, until half-past.

THE CHAIR: Yes, till half-past.

(3.13 pm)

(Break)

(3.33 pm)

MR GRIFFIN: Ms Cozens, we've been talking about concerns that have been raised about the operation of Oxevision and I would like to come on to one more

now, please. You have told us about the audible alerts that are part of the functioning of the system. Would those have been part of multiple alarms of different types on a typical mental health in-patient unit?

A. So in my experience the other type of alarms or noises that you have going on could be, for instance, and again this is my own experience, a doorbell for the ward, so anyone entering that environment they may be required to press a doorbell, or a telephone ringing, or fire alarms, but they are few and far between. Possibly incident alarms, although I know some mental health units these are, rather than being across the whole ward, they are on individual devices that are carried by staff, as well as like a call bell, like nurse call bell systems for rooms.

Q. So the Oxevision audible alert would be one of a number of alarms or other noises that would be in the background in any mental health unit?

A. Yes, the alert could be.

Q. Now we have already seen in the usage report logging alerts and how they have been resolved, reset. What I would like to do now is look at another part of Hat Porter's evidence to this Inquiry, please.

Please put up STOX009054 at paragraph 16 and expand paragraph 3.33. So this statement says that:

"We are also aware that alarm fatigue is recognised as a significant patient safety issue for most types of patient monitoring technology - and the same is true for Oxevision and other VBMS. Evidence at inquests has exposed delays in staff responding to alarms on mental health wards, even resetting them without making necessary checks on patient safety. This is not a new phenomenon" -- and they go on to talk about hospital environments in the US.

Do you accept that there is a problem of staff failure to attend Oxevision alarms in a timely manner?

A. So I think if we take the subject of alert fatigue first, so it is a provider's choice what alerts that they have depending on the patient population. And I think I spoke about it briefly earlier, where we have seen providers do some analysis of their own incident data first around actually what alert would be suitable and doing this off the back of that analysis of incident data. We quite often see that there are certain alerts that are configured for time periods only, so not constant. So again, if I

provide an example it might be helpful. It could be that on an older person's ward that actually the leaving bed and the out of bed alerts are configured for a nighttime period only, because that's when people are in bed. During the day the majority of people are up.

Q. Those are things, if I may say, that may be used to address alarm fatigue. My question was, do you accept that there is a problem of staff failure to attend Oxevision alarms in a timely manner?

A. I think, again, based on the experience of the inquests that I have attended, alerts have been attended to by staff and again without going into the specific inquests. However, that in person check, according to EPUT Standard Operating Procedure, may not have taken place.

Q. Can we just deal with the inquests. You refer in your second statement to four inquests, following deaths at EPUT, where Oxevision had been used. Now, three of those inquests involved the muting or resetting of alarms by staff. Elise Sebastian, who died on 19 April 2021; Michael Nolan, who died on 10 July 2022 and Morgan-Rose Hart, who died on 12 July 2022, so just two days after Mr Nolan. So those deaths are 15 months apart. When did Oxehealth

first consider and address the risks of muting of alerts, or resetting?

A. So it's the resetting of that alert, so that alert has triggered when it should have triggered and staff have interacted with the system. What staff have then done afterwards is a matter of EPUT Standard Operating Procedure. But I think what we have done is consideration around what we spoke about earlier, so user auth. So again, it's down to a provider about certain parts of the system where staff could be required to log in, so therefore you would know who has reset that alert, if that's what was decided by a provider.

Q. Zephan Trent says in his first statement to this Inquiry, that in May 2021, so that would be the month following Elise Sebastian's death, he puts:

"Oxehealth project board explored the potential to lockdown 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."

Now, that is before your time at Oxehealth, but do you accept that Oxehealth was aware at this time of concerns that staff were resetting the volume, or reducing the volume of Oxevision alerts?

A. I do and there was those conversations that happened with EPUT. I also think it's important that we do have some organisation where they allow for this to happen and that's written within their Standard Operating Procedure. So if I give you an example, particularly at night, for instance, where they don't want the noise of the alert disturbing people, so we have had organisations request whether the tablet could vibrate instead of making a noise, for instance.

Q. When you said they allow for this to happen, did you mean that there could be scenarios, the one you just explained, at night where it is appropriate to mute the volume of a monitor or a tablet?

A. To turn it down or to not necessarily have the tablet in an area where it may disturb patients who are sleeping.

Q. But my question was directed more at Oxehealth's knowledge of these serious issues that were arising in inquests in relation to patients who had died at EPUT, and I think you have answered that Oxehealth

were aware of that and were engaging with the provider?

A. That's correct, yes.

Q. Is this a concern, this muting or resetting, that has arisen in other trusts that you are aware of?

A. I may be aware of one other incident.

Q. Thank you. Does Oxehealth accept that this may be linked to alarm fatigue?

A. I think the config of alarms is regularly reviewed by organisations, and I think this comes down to staff engagement and staff communication, again around standard operating procedures. So an example would be another piece of technology on the ward, say for instance, a defib machine. You wouldn't expect staff to go and unplug that if that's being charged within a clinical room. So therefore, it's around that communication with staff that the volume is the volume and you don't touch it.

Q. Zephan Trent refers to tablet volumes being preset to 75 per cent as we just heard. Are there any other ways the system is designed so that staff can't simply ignore alerts?

A. So we have spoken about the volume preset. I suppose if staff didn't have access to the tablets, if they made a conscious decision to not engage with

the tablets, there could be a possibility. But again, this is an assistive piece of technology.

Q. Thank you. Just moving on now to video, continuing with concerns that have been raised about the operation of Oxevision. I would like to begin just by ensuring I understand the different ways in which video can be accessed by those operating Oxevision and the circumstances in which video data can be captured. So we have heard about the 15 second clear view, also that could be used, not just for vital signs checks, but for the purposes of conducting remote observations, correct?

A. It's the vital signs check within the observation, so it's exactly the same as how you would access it via the room tile. That's just built into being able to access as part of those mental health observations as well.

Q. And up to 15 second of blurred video following a notification, correct?

A. That's correct.

Q. Just dealing with blurred video, please, you tell us in your first witness statement that blurred video data is typically kept for three months, that is paragraph 131. What is the purpose of keeping blurred video data at all?

A. Sorry what paragraph?
Q. Paragraph 131.
A. So if I, again, provide an example. So if a customer notified us of a serious incident and said, "We expected an alert to be triggered", we would be able to take a look via the anonymised video data. Again, it's anonymised, and I think it's also important to note that you can roughly tell where a human is within the room and it's one frame per second. So it's more like a series of images, rather than a complete video. So yes, so we would be able to check if that alert has triggered or hasn't triggered or what was going on, but again, following a customer query that would be.
Q. Why for three months? Why keep it for three months?
A. I'm not sure why three months. I wasn't involved in that decision.
Q. Thank you. Oxehealth's current clinical project meeting slide deck says that in addition to viewing up to 15 seconds of live blurred video during safety notifications, you can replay 10 minutes of blurred video after safety notifications. Is that correct?
A. Again, it's configurable. So you would be able to -- it would provide you with five minutes of blurred video before an alert was raised and then

five minutes after. So again, an example would be if somebody has had a fall within a room, you would be able to check what happened in the lead-up to that fall, how that fall occurred, has that person hit their head, is it simply down to the layout of a room, so do pieces of furniture need to be moved to prevent that from happening again? So from a learning lessons point of view.

Q. Are you aware if EPUT have the 10 minutes blurred video replay facility?

A. Again, you would have to ask EPUT or I could find out for you.

Q. How long has it been available that facility?

A. Again, I would have to find out to give you the accurate date.

Q. Thank you very much. You refer in your first statement to guidelines for using the Oxehealth system that were provided to EPUT in February 2020. Could we go to OXHE009047 at page 3, please. So these guidelines from, or at least that were provided in 2020, say:

"The use of the Oxehealth system for bedroom observations. Observing staff should ensure that, when a patient is in the Oxehealth room, they take and document the vital signs of that patient

every 15 minutes.

So at every 15 minutes, use the Oxehealth system to take the patient's pulse and/or breathing rate; document the vital signs on the observation sheet, including any visual causes for concern and actions to take. This will include any unusual signs or abnormalities notices from the results."

Does that remain Oxehealth advice?

A. No, so this was provided in the very early days, so 2020, and this was around providing a sample. So an example of possible guidelines. This isn't how, we are not directing how the system should be use.

Q. So the provider, in our case EPUT, will decide what level of observations is appropriate on a patient-by-patient basis; is that correct?

A. That's correct.

Q. And I think every 15 minutes is level 2 observations; is that correct?

A. It depends on where you work and what the environment is.

Q. But there are more enhanced versions of observations that require closer observation of a patient. Correct?

A. Yes, so there tends to be four levels of observation, so general, intermittent, eyesight and

then arm's length.
Q. So this would be intermittent, every 15 minutes or so?
A. I have worked somewhere where this was general observations every 15 minutes.
Q. I think I am not going to get very far with this. Generally speaking, is it right that a member of staff may legitimately be accessing clear video data of a patient multiple times an hour, particularly if they fail successfully to take vital signs and measurements on the first attempt?
A. Possibly, if that's care planned for that patient.
Q. And is it also correct that the patient will not know when those observations are being made within any given hour?
A. Yes, so they are sporadic.
Q. And all they will be aware of is the camera in their room, not when someone is watching them through it?
A. That's correct.
Q. Could you take that down, please. Is there also a concern about the misuse of the system by staff. For example, the possibility that staff accessing the clear video facility multiple times, that they access it multiple times in a row, effectively providing a much longer live feed of a patient?

A. That is possible. However, I think we have spoken about the safeguards that can be put in place to deter that from happening, as well as those safeguards outside of the system as well and the usage reports.

Q. Thank you. But in theory a member of staff would be able repeatedly to access up to 15 seconds of clear view data and video feed?

A. That's correct.

Q. Isn't that effectively CCTV?

A. It's not designed as CCTV or surveillance and it's not designed for that use.

Q. But it can be used in that way?

A. You would hope that people wouldn't use it in that way. I don't think anybody goes to work purposely to not carry out their job correctly. But yes, it's not designed to be used in that way.

Q. Hat Porter, on behalf of Stop Oxevision, has referred to this point about there being no way of knowing if someone is watching, particularly for example, if you are getting undressed. They say there is always the potential that someone is looking and they describe this as intrusive, undignified, dehumanising and traumatising. Do you understand such concerns?

A. I do understand.
Q. Are you aware of concerns about patients feeling distressed or experiencing a worsening of existing paranoia or psychosis by having a camera in their room?
A. I do understand that from certain individuals, yes.
Q. The Inquiry will be hearing troubling evidence from Tammy Smith about her daughter Sophie Alderman, that the presence of what is presumed to have been an Oxevision camera in her room caused or exacerbated severe paranoia. To what extent does Oxehealth consider that it has a responsibility to minimise or mitigate long-term trauma experienced by some patients as a result of the presence of a camera in their room?
A. I think, as I said earlier, we recognise the fact that this platform or the use of the platform may not be suitable for everyone. However, I would just like to highlight that again, from one of our providers, that there was a patient who had previous traumas and found it very distressing to have male staff conducting what he described as obtrusive nighttime observations, and the MDT had discussions with the patient and made a decision that actually to use the system at night, to stop that for him, to

stop that introducing trauma for him.
Q. But that goes back, if I understand it, to your point that there should be individual assessment of the use of the system on a patient-by-patient basis?
A. That's correct.
Q. Thank you. We have also talked about vital signs trends and the fact that the system is always trying to engage with the person in the room in order to get average vital signs information; correct?
A. That's correct.
Q. Can you see how knowledge that a system is trying to engage with an individual regularly or constantly, to take their vital signs, might of itself be of concern to them?
A. Again, yes, and that's where those conversations and assessments should take place and ensuring that patients know what the system is and what it does and what it doesn't do and how staff are going to use it.
Q. Would you accept that the operation of Oxevision, whether just by the presence of a camera in a bedroom or whether by way of allowing access to clear or blurred video or by constantly and automatically engaging with a patient in the background, marks a substantial invasion of their

privacy in their bedrooms?

A. Again, as I have said, the use of the technology may not be suitable for everyone. But there is a flipside to that as well and that's where those conversations with clinicians, patients and their carers needs to take place.

Q. Thank you very much. I would like now ask you about whether Oxevision can fairly be compared with CCTV or forms of surveillance, please. We have already touched on the possibility of multiple views of clear video. Can we look at what you said in your second statement about this, please. I am going to have it put up on the screen. It is OXHE009987. It is your paragraph 7 to 9:

"The use of the words CCTV and surveillance.

7. Oxehealth has noted in the concerns raised by Stop Oxevision and in other materials, the Oxevision system has been described as 'CCTV' and 'surveillance'. We consider these terms to be inaccurate and not reflective of the system's true nature or functionality. It differs from both of these systems in the following ways.

8. For CCTV and surveillance systems, video images are available continuously, with a live video feed visible on a screen. This is not the case with

Oxevision; Oxevision does not display continuous video images. A user can only see a clear video feed into a room for a maximum of 15 seconds when taking a patient's vital signs ...

9. There are no other circumstances where staff can clearly see into a room. Oxevision is designed to provide clinicians with valuable clinical insights and data which CCTV and surveillance systems do not."

Is that all correct?

A. That's correct.

Q. Could you please take that down. Can we look at the position with clear video data, please. We have covered this in part already, but I want to return to it. You have said that Oxevision has the ability to deliver secure video recording under strict controls to support the investigation of safety incidents. This is paragraph 22 and 132 of your first statement. You say that clear video data is encrypted and stored on servers on site at EPUT, and you add that it is automatically deleted from the server after 24 hours. You were talking earlier on about a 24-hour buffer, is that describing what this says?

A. That's correct.

Q. Thank you. Is the situation then that Oxehealth can retrieve clear video data from servers held at EPUT but that a request for this data must be made by EPUT within 24 hours?

A. So no one from Oxehealth can view that video data. However, yes, if a customer requests it, so EPUT, it is stored on their local server. We can prevent that from being auto deleted on that buffer, and then that is directed to a nominated person at EPUT, and that is clearly outlined within their Standard Operating Procedure and there are governance and controls over that.

Q. That could be a member of their legal team, for example?

A. I believe it is.

Q. So we have got 24 hours that we are talking about. What is actually available to access over that 24-hour period? So we have spoken about accessing up to 15 seconds of clear view data for the purposes of vital signs observations. Is what is accessible limited to those 15 second intervals when members of staff have interacted with the system, or is it actually possible to access more clear video than that?

A. For the purpose of a serious incident?

Q. Yes. So let's assume there has been a serious incident. A request is made by a provider for assistance from Oxehealth. You have spoken about a 24-hour period. What is actually available to access for that 24-hour period?
A. So again an example. So if a serious incident occurred between the hours and 6 and 7 in the evening, a provider could request for that hour of clear video data to be saved, so it's not auto deleted, in order to be able to review what has happened to a patient.
Q. Can we just take stock. Does that mean that the Oxevision camera is on and recording clear video all the time?
A. So it has that clear video buffer for a 24-hour period if the system is switched on, and again that is a choice for an organisation. That is not -- they don't have to have that.
Q. I understand that EPUT do have this facility, correct?
A. They do.
Q. So let's just recap. The camera in the patient's room, if it's switched on, is recording all the time, correct?
A. That's correct; but nobody has access to that unless

that's requested and under those strict governance.
Q. But it could be requested and it could subsequently feature in a criminal trial or an inquest; correct?
A. That is correct. Again, the Nurse Directors' Forum guidance has got a section in there about the use of video data and data in investigations, and again, that would be dependent on the provider of what they deem as appropriate use of that.
Q. Understood, but it's pretty significant, isn't it, if an Oxevision camera, when the system on, is filming all the time, isn't it something that patients should know about?
A. I agree they should know about, they should know about what the system does and doesn't do and how that may be used.
Q. Do you know whether trusts and providers, such as EPUT, actually explain that to their patients?
A. Again referring back to one piece of the national guidance, which is the Nurse Directors' Forum guidance, it's clear in there what should be communicated to patients, it should be completely open and transparent.
Q. Has Oxehealth ever advised that this specific aspect of the system should be communicated to patients?
A. I think we always say that patients should be

informed about what the system does and doesn't do and any data around the system.

Q. Would you agree that filming a patient 24 hours a day constitutes a very significant invasion of privacy?

A. Possibly, yes.

Q. A patient would want to know, for example, I put to you, because they may want to get changed in the bathroom rather than in their bedroom, would you agree?

A. Again, it's that communication with patients.

Q. So there are practical circumstances that arise from the fact that the camera is always filming. You have mentioned this, the CQC guide, and I would like to go and have a look at that, please. Your second statement mentions that in August 2025 the Care Quality Commission published a guide on digital contactless patient monitoring technologies in mental health in-patient services. The full title is:

"Brief guide: Digital contactless patient monitor technologies in mental health in-patient units."

Is it right that the guide sets out what CQC inspectors look at when inspecting services that use

digital contactless patient monitoring technologies?
A. That's correct.
Q. And that it applies in mental health settings?
A. That's correct.
Q. Amanda, could you put up OXHE010156 at page 5. This is from August 2025. Can we see here:

"Our position on the use of digital contactless patient monitoring technologies by mental health in-patient services."

Just the second bullet point:

"These technologies should not be used for covert surveillance purposes. Surveillance should not be carried out in a way that is designed to make people unaware that surveillance is (or may be) taking place. This guidance must not be interpreted as CQC tasking or authorising covert surveillance activity."

Do you accept that a camera in a patient's room, which records continuous footage and stores it without their knowledge, constitutes in most people's minds the use of a CCTV system for surveillance purposes?
A. I think the important thing there is about "with their knowledge". Again, it's about informing them about the system, what it does, what it doesn't do

and in what circumstances this type of data may be accessed or reviewed.

Q. Thank you. Could you take that down, please. Just moving to look where the video data we've been talking about is kept, could you put up EPUT009018 at page 20. This is part of the data protection -- the DPIA from EPUT from 2014, the data protection impact assessment. Can we go to the bottom at 14, we see there, "Are you transferring information?"

Then could you go over the page please and expand from the top, thank you, to just above "put an [x] next to all that apply" at the bottom. The question was, "Are you transferring information?" We can see that "yes" is ticked. "How will that information be transferred? We use a cloud-based strategy to provide clear video data." We will come back to that -- sorry, would you expand down, thank you. Then we see:

"How will you ensure that information is safe and secure? All data generated by the Oxevision system is stored on local secure servers at EPUT Oxevision deployed sites."

That's a point we have covered already, isn't it? Some data, we will come back to work out what these acronyms mean in a moment, AVD, APD, UIOD, SID

and PHRD is backed up to Oxehealth's secure cloud servers provided by Amazon Web Services, and you go on to say that those are based in UK data centres. So some data is actually held by Oxehealth; correct?

A. That's correct. That's not personally identifiable data.

Q. Thank you. So we just go back to using a cloud-based strategy to provide clear video data. Would this be data that's being provided from EPUT to Oxehealth following an incident. Is this tracking actually physically how that data would go to Oxehealth?

A. No, again, I believe this is an EPUT document.

Q. Yes, I know.

A. I believe what they are referring to here is the transfer of that clear video data, should they have requested it, and how that is transferred to them.

Q. So that is coming from Oxehealth and going to EPUT?

A. It's coming from the servers on EPUT that we are transferring, so that’s only because it's got the word "Egress" there. So Egress is -- it's used by the NHS anyway to transfer and send data. It's a secure delivery platform --

Q. Rather than getting you to try and interpret another organisation's document, I think I can simplify

this. When clear video data is need, for example, following an incident for an investigation, we have heard that the data is held on a server at the provider, in our case EPUT, but we have also heard that it requires access from Oxehealth to access the data; correct?

A. We don't access the data, no, because it's completely encrypted?

Q. Sorry, it requires Oxehealth involvement to provide the data from the server to, for example, a member of EPUT's legal team?

A. In the simplest terms, yes.

Q. Is there any stage at which that data is held by Oxehealth rather than by EPUT, as far as you are aware?

A. The clear video data, no.

Q. Are there any circumstances in which Oxehealth might obtain and retain a patient's clear video data, for example, for research purposes or to develop further functionality?

A. No.

Q. You say that with great certainty, you are sure about that?

A. Yes. I wonder whether it's important to say, so again this is from experience, so I have seen some

clear video data when I have been involved with inquests but that's not -- I haven't, I haven't accessed that from Oxehealth's point of view. That's been provided via the coroner, I think it is just important to highlight that.

Q. Yes. We have seen these acronyms. Can we come back to that. Could we go to page 23 of this document, please, could you expand the second, third and fourth paragraphs. So from anonymised data. That’s perfect. So this just describes what those acronyms are. So we saw AVD and that's "Anonymized (blurred) Video Data"; correct?

A. That's correct.

Q. Then we see "Algorithm Processed Data", do you know what that is?

A. So that is, my understanding is that it's in mathematical format, so it's number format of things like pulse and breathing rate, but it's not, when I say mathematical it's not just a number. There's --

Q. So it's data of some form?

A. Yes.

Q. And "User Interface Output Data", do you know what that is?

A. So that is what I referred to earlier in relation to room states, device usage, what alerts have been triggered.

Q. And so this says they:

"Do not constitute personal data in circumstances where Oxehealth does not have access to Clear Video Data."

I think that's a point you made earlier about blurred video. Can we just see this:

"Oxehealth only uses these data to provide Oxehealth Service to the EPUT and for monitoring and improving the Oxehealth system" -- and -- "Oxehealth has a retention policy of 2 years for these data, after which they will be deleted."

So, for example, blurred video data is accessed and retained by Oxehealth for up to two years; is that correct? As far as you are aware?

A. As far as I'm aware it's for three months. Again, this is an EPUT document.

Q. Okay, so that's something we can resolve, but for a period of time, whether it's months or years. And one of the reasons for keeping the data, as we can see there, is for improving the Oxehealth system. Is that correct?

A. Not necessarily, so all algorithm and product creation, so that's including the medical devices, is carried out on data owned by Oxehealth and collected with explicit consent of individuals. So

an example of this would be Oxehealth staff. So if we are -- we have got a demo room within our office, if we are looking at product development or algorithm creation, then we will use Oxehealth staff for that or individuals with explicit consent?

Q. Thank you. We are just dealing with blurred, anonymised or blurred video data, could that be retained and kept to improve the Oxehealth system?

A. As far as I'm aware, no.

Q. So we may come back to you about some of this data protection stuff and you could follow up, if necessary, in that way?

A. I could do that, yes.

Q. Would you be willing to do that?

A. Yeah, yeah, I'm not the data protection officer, that's not my area of expertise.

Q. I totally understand and that's the reason why I think we may follow up separately following this. Can you take that down please? May I ask one more question about clear video. Can a member of staff access a clear video on a tablet prior to making a vital signs check. I think the answer is yes, but I just wanted to double check.

A. Yes, the tablet devices and the fixed screen work in exactly the same way.

Q. Isn't there a danger that other patients or people near to the staff member using the tablet may be able to see the clear video data as well, the clear video view?
A. Again, that's something that I would expect staff who were using the system to be well aware of, the same as if you were having a conversation with a patient that may contain sensitive information, you wouldn't do it in a day area.
Q. We are going to come on to consent in a moment and the circumstances in which a camera may be switched off. Before we do, I would like to cover with you whether there is currently any way for patients to be certain that Oxevision has been turned off in their room. You spoke about the infrared element glowing red, for example, even, I think, if the system is off or not recording; correct?
A. That's correct.
Q. So patients would have no way of knowing whether the camera was on or switched off?
A. So I think those conversations with staff, and I have heard examples of organisations where staff may show the patient the home screen, so that's the room tiles, and it would specifically say on the room tile "camera off".

Q. That would involve some human interaction to put them on notice that the system had been switched off; correct?

A. Yes.

THE CHAIR: Can I ask a very basic question, forgive my ignorance. Why can't the infrared light be switched off?

A. That's one thing we are currently looking at. So currently when the system is switched off and not recording any data it's due to how the housing unit is powered. So, again it's powered -- so, for example, by one cable, again this is an example, so therefore you can turn the camera off but that power is still running through. But that is something we are looking at in relation to the redesign.

THE CHAIR: So you could have a system where the light went off?

A. Yes, it's possible, yes.

MR GRIFFIN: Zephan Trent has said in his third statement that EPUT understands from Oxehealth that nothing can be done about that design element, the light, which you have just said. However, Oxehealth have agreed to produce a new housing to try and alleviate concerns about privacy and subject to consultation and feasibility. This will be rolled out in 2026.

Do you know whether that is still on track for delivery in 2026?

A. As far as I'm aware, yes, so we are still developing that new monitoring unit. No decisions have been made to date but as far as I am aware that is still on track.

Q. Do you know why it is taking so long to provide that solution?

A. I think there's many things that play into that and that is the design of something that is suitable for mental health environments, so there are certain standards within some environments that need to be -- so tamper proof and things like that.

Q. Thank you. We have covered a number of concerns that have been raised about the operation of Oxevision. Do you accept that its operation has caused real concern to patients for a variety of reasons?

A. Sorry, can you repeat that.

Q. Do you accept that the operation of Oxevision has caused real concerns to patients for a variety of reasons?

A. So I accept that some people will have concerns about the system and again going back to what I said earlier that this may not be right for everybody,

but there are some patients that do benefit from it.

Q. Thank you very much. Moving now to the issue of consent, to the use of Oxevision. In your first statement, this is just for your reference, 77 and 78, you say that:

"Oxehealth has always stated that where the Oxehealth system is installed all service users and their careers are informed and that consent for its use whilst within in-patient services will be required."

So has always stated that. And you say in the next paragraph:

"It is Oxehealth's understanding that on admission to the ward all patients and family members will be informed about the Oxehealth system and will be provided with a leaflet to explain what, when and how they record activity and vital sign measurements."

Does that remain the position?

A. That's correct, and when we talk about leaflets, we talk about those national co-produced leaflets to ensure that there is consistency nationally with how the system is explained and what it does and doesn't do.

Q. And in fact we may look at a leaflet tomorrow with Mr Trent. Oxehealth guidance on consent and signage

for patient, staff and visitors from December 2019. You refer in your statement to this. That's paragraph 80 of your first statement and I would like to look at it, please. Could you put up OXHE009044, first page. Can we see that this says " "Signage consent, guidance for customers". This is an Oxehealth document and can we see actually the date there is December 2019? Can we go to page 3 of this document and expand the text in the top half:

"Signage and consent -- patients.

Customers should consider the potential impact of the Oxehealth technology on any people who may be recorded by it. These fall into 3 groups" -- and the first of the groups is "Patients", right:

"If the system is being used in the normal course of treatment, we do not believe there is a need to obtain consent and many customers do not seek consent. However, some customers do choose to consent patients who have capacity.

We recommend you place signage notifying patients of the use of the technology. For example:

Oxehealth monitoring system in use. Please ask [ward] staff if you wish to learn more'."

We will come on to the rest in a moment. But the suggestion here at the end of 2019 is that

Oxehealth did not need believe that there was a need to obtain consent if the system was being used in the normal course of treatment. Do you know what the basis was for suggesting that no consent was necessary?

A. I don't. So this predated my employment with Oxehealth, however, from my perspective, I believe that we should haven't said that. However, I do believe it was with the best intention and it was caveated, I think that's the next page in the document, that states each organisation should seek their own independent legal advice on consent. We now don't advocate for any model of consent at all, apart from what I had said earlier, that patients have got to be informed, and carers. And I think what we would do is point providers and organisations to the national guidance out there so the Nurse Directors, NHSE.

Q. We are going to come on to that. Just looking a little bit more at what is on the screen:

"We recommend that patients with capacity, or their representatives, who enquire about the system should have the right to request that identifiable video data are deleted; we recommend that they also have the right to request that the system is turned

off" -- just for context there.

Could we take that down, please. So you have referred a couple of times to the Nurse Directors Forum national recommendations from 2022; correct?

A. That's correct.

Q. So these are from 29 September 2022 and you tell us in your first statement, I think this is paragraph 44, that:

"The National Mental Health and Learning Disability Nurse Directors Forum " -- shall we call it the NDF -- "co-produced national recommendations, guidance and best practice on safe use of Vision Based Patient Monitoring Systems."

Is it right that the working group that created the report included a representative from Oxehealth?

A. It did on the basis that this was a new technology. This technology didn't exist and, therefore, ensuring that there was full understanding and knowledge of what the system did, what it didn't do, et cetera.

Q. In fact, was that the UK managing director, so fairly high level?

A. That's correct. I think there is a list of all names that were involved in the guidance?

Q. Correct. Does the guidance suggest an approach to the issue of consent?
A. There is a section on consent within the guidance.
Q. Shall we look at it, could you put up OXHE009034 at page 6, please [16]. It says:

"We have provided two options for how to implement an informed consent regime."

Then just dropping to the third paragraph:

"Whilst we put two positions regarding informed consent here that providers may consider, we are in no way recommending either of the approaches."

So the two informed consent positions below each have advantages and disadvantages and need clarity and proper structure in their implementation to ensure the guidelines are followed. Can we see that the first of the two positions is implicit consent, on the screen? Number 1 "Implicit consent"?
A. Yes, sorry.
Q. "all service users are opted in upon admission as part of the standard practice on the ward. Service users can raise questions and concerns, and there should be regular opportunities for service users to be engaged by staff in conversation about their questions and concerns."

We can see:

"The responsible clinician will decide whether to withdraw the use of the technology if in the best interest of the patients, taking into account the balance with individual preference, safety/risk management and other alternatives."

Can we go to the top of the next page, please. Thank you. We can see at the top there dealing with the implicit consent model:

"This approach needs open and honest communication."

I think that picks up on what you have been talking about previously with the patient?

A. That's correct.

Q. And it says towards the bottom:

"It should be noted that most providers who have deployed VBPMS to date have made use of some form of this informed implicit consent model."

So this is recommendations from September 2022. So as at that time that model seems to have been the one that was being favoured according to this?

A. That's correct. I think it's important to add as well, so I'm aware of two providers that, one seeked or consulted with the British Institute of Human Rights and one consulted with the Information

Commissioner's Office. However, both came up with a different consent model.

Q. So not one of the two that we are looking at?

A. So, no, so I think it's all the national guidance including this document, NHSE principles, CQC guidance, highlight how complex the issue of consent can be and needs careful consideration.

Q. Can we look at the second model here "Explicit consent", and we see here:

"service users opt in upon admission, with due consideration given to an individual's capacity to to make this decision."

And it says:

"This approach requires significantly more staff confidence and competence to administer in practice."

So is this approach, putting forward two models but not saying to providers which they should actually be using, do you think that reflected Oxehealth's views at the time, given that there was a high level representation on the NDF from Oxehealth?

A. I believe so, and I think it does say there at that last paragraph that it is recommended that all healthcare providing organisations receive their own

legal and ethical advice on that position as well.

Q. And that picks up on a point you were making a little earlier as well?

A. Yes, that's correct.

Q. Could you take that down please. You have also mentioned the NHS England principles and they came out in February 2025, Principles for Using Digital Technologies in Mental Health In-Patient Treatment and Care. You have explained in your statement, this is your first statement from paragraph 52, that the principles detail eight principles to guide decision-making on procurement, implementation and the use of digital technologies in mental health in-patient settings. And that it says that the use of digital technologies can support in-patient care, giving patients a greater voice and choice in their care and it says the use of digital technologies should be accompanied by personalised clinical decision-making. You say, and I quote from your paragraph 55:

"Oxehealth agrees with this position and warmly welcomes the publication of these principles, all of which are consistent with the appropriate use of the Oxevision system."

Can we just look at the principle materials

with consent and capacity. Would you put up EPUT009000 at page 3. Here we see, "Principle 2: Consent and capacity":

"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 interests decision-making process."

We can see:

"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."

Can you confirm that Oxehealth considers this principle, in particular, to be consistent with the appropriate use of the Oxevision system?

A. Yes.

Q. Would you agree with this, and I think it may follow from what you said, that Oxevision should not be used in an undifferentiated way, that it's on in all rooms in an in-patient unit as a default?

A. Sorry, say that again? I missed that.
Q. Would you agree with this. That Oxevision should not be used in an undifferentiated way, that is in all rooms in an inpatient unit with the default being that it is turned on?
A. So on the whole, yes. I think there possibly may be a situation, so when you are looking at things around, and I think the CQC guidance highlights this, that that may differ slightly when considering detention under the Mental Health Act, yes.
Q. Thank you. But in principle, shouldn't it be used for specific patients in specific situations decided on a case-by-case basis?
A. Again, it's that individualised care that we have spoken about.
Q. With informed consent explicitly obtained from patients with capacity?
A. Yes.
Q. Hat Porter, on behalf of to be Stop Oxevision, suggests that the possibility of genuine consent is undermined in mental health in-patient units, where there is little awareness of rights and patients may be unable to advocate for themselves. In all of the circumstances they maintain that Oxevision technology is not compatible with the legal

treatment of mental health in-patients, and that it could never be appropriate for consent to be given. How do you respond to that suggestion?

A. I think consent is very complex, and I don't think anyone is denying that, and I think when you look at the guidance, I think that also indicates that actually it's a very complex subject, especially when you've got considerations around capacity, best interests decisions and then you've got the Mental Health Act possibly on top of that as well. So it is a very complex area. However, those conversations should be individualised and open and transparent.

Q. Thank you. Could you take that down, please. You tell us in your first statement that each organisation is responsible for developing their own standard operating procedures or SOPs for the use of Oxevision, it is 29, be that Oxehealth supports this by providing various documents and information. As you will know, EPUT produced an updated SOP for the use of Oxevision on 30 April this year, which was published on 7 May. A flowchart in the SOP says that the Oxevision system is currently in an on state at admission and the patient will be required to give informed consent for the Oxevision system to

remain on, or the Oxevision system will be switched off within six hours. I will be asking Mr Trent about the SOP in more detail tomorrow, but for present purposes I just want to ask you this. Do you think that it is appropriate that the system is on as default for all patients for up to six hours?

A. So EPUT know their patient population. With backgrounds, I think that -- yeah, I think there could be -- there could be a conversation either way or that. If that's what they deem to be appropriate, then that's their decision.

Q. You say the EPUT know their patient population, but isn't the whole point that that patient population will be extremely varied, each with their own personal characteristics. And I think this chimes with what you were saying earlier, that decisions need to be made on a case-by-case basis?

A. Yes, that is correct.

Q. Thank you. Can we move now to research being conducted into vision-based monitoring systems, such as Oxevision. As I mentioned, this is an area that the expert health statistician will be reviewing. I would like to go to your first statement, to part of it that we have actually looked at before, but just to remind ourselves. Could you please put up the

first statement at paragraphs 41 and 42. So you talk here about the extensive evidence base demonstrating the clinical and operational value of Oxehealth's contactless patient monitoring system, and you talk about what the evaluations show. We have read this before. And you say:

"Most of this research is based on provider-led service evaluations, a number of which have culminated in peer reviewed journal publication."

And then you go on to talk about the key findings that we had a look at earlier. That presents a very positive picture of what the research shows, doesn't it?

A. I think it's an honest picture.

Q. Do you know to what extent the research incorporates patient feedback?

A. Without looking at each of the individual publications, no.

Q. Fine, thank you. Could you take that down, please. You refer in your second statement, this is paragraphs 68 and 69, to a literature review commissioned by the CQC. Is it right that this was a rapid literature review, reporting in July this year, with analysis of 68 research documents?

A. I believe so.

Q. Is its full title, "Exploring evidence regarding vision-based monitoring in in-patient mental health units."
A. Is that the literature review or the guidance?
Q. Yes, the literature review is what I am talking about.
A. Okay.
Q. So just the full title, "Exploring evidence regarding vision-based monitoring in in-patient mental health units." That's the title?
A. I haven't got that, but yes.
Q. You can take it from me. In fact, that then informed the CQC guide that we talked about.
A. That's correct.
Q. You quote from the review and so it's something that I assume you have looked at yourself?
A. I have, yes, briefly.
Q. Don't worry I am not going to ask you about bits of it without taking you to them. Can we look at part of the report, please. Could you put up OXHE009976 at page 3, please. That's OXHE009976 on page 3, t thank you. Could you expand paragraph 4. That's fine, thank you. So this says: "The evidence was qualitatively reviewed against the Nesta standards of evidence framework. Based on this framework, the overall quality of the

evidence base is varied. It is important to highlight that a significant proportion of the evidence reviewed was developed (or contributed to) by individuals or organisations with a particular interest in VBMS. This meant that much of the literature presents evidence from a particular viewpoint or perspective of VBMS."

Do you agree that overall the evidence base is currently varied?

A. If that's what they found from their literature review.

Q. The review goes on to identify the need for further development of the evidence base, and suggests that the voices of people with lived experience are critically important. Do you agree that there is a need for further development of the evidence base?

A. I think there's always the need to increase evidence base, whether you are talking about a piece of technology or anything else.

Q. Is there, in fact, currently insufficient evidence to suggest that technologies such as Oxevision used in in-patient mental health settings are achieving the outcomes that they have been employed to achieve?

A. No, I don't agree with that.

Q. Thank you, could you take that down, please. Just dealing quickly with the rollout of Oxevision within the NHS and at EPUT, starting with the NHS, you explain in your first statement that Oxevision is currently used by approximately 50 per cent of the National Health Service mental health trusts and that it has supported 70 million of hours of in-patient care, that was up to the end January this year. In your view why do so many trusts use Oxevision?

A. I think so many trusts use it because they see the benefit of the technology, and I think I have highlighted a couple of those anecdotal quotes from organisations, and for how this has had a positive impact on patients' recovery and a patient's journey within services.

Q. Thank you. Moving then to EPUT, you helpfully set out in your first statement that signing of contracts and rollout, you talk about that, of Oxevision at EPUT, and you explain that Oxevision first went live there on the Peter Bruff and Ardleigh wards on 3 April 2020. There is paragraph 63 onwards?

A. Yes.

Q. A document provided by Mr Trent explains the

position at EPUT as at April this year, and that Oxevision is currently on 30 in-patient wards, four health based places of safety, eight seclusion and long-term segregation and two intensive care rooms. Is EPUT unusual in the extent of the rollout of Oxevision there?

A. In comparison to other organisations?

Q. Yes.

A. No.

Q. Thank you. Can we move, then, to a final topic and that is Oxehealth responsibility for the operation of Oxevision. In your witness statements and today you appear to draw a distinction between the system offered by Oxehealth on the one side and the way the system is actually deployed by a trust, such as EPUT, on the other. To what extent do you think that Oxehealth can distance itself from the way in which its product is actually used in mental health in-patient units?

A. I don't think it's about distancing ourselves. It's about having those open honest conversations with the organisations that we work with in relation to the product, as well as our experts by experience that we work with as well.

Q. Do you accept that as the developer, manufacturer,

retailer and ongoing provider of a product used on vulnerable inpatients, you have a responsibility towards those on whom the product will be used?

A. I think that's why we work with a very large group of experts by experience from diverse backgrounds, both those who have had in-patient experience as well as carers that have cared for someone within in-patient services and they work with us on a number of projects. I think between 2023 and 2024, I think there was 24 projects that our experts by experience worked with us on.

MR GRIFFIN: Thank you very much. Chair, that is the end of the questions I have at the moment. Could we break just to see if there are more questions that need to be put to the witness? I am aware that we are now at quarter to 5, so we will just take stock about that as well. Thank you very much.

THE CHAIR: Thank you.

(4.47 pm)

(Break)

(5.16 pm)

THE CHAIR: Mr Griffin?

MR GRIFFIN: Ms Cozens, just a few more questions. I would like to ask you first about the activity tracker. You cover this in your first statement at

paragraph 34 and you say there that:

"In November 2022 the activity tracker IFU" -- is that instructions for use?

A. Mm hmm.

Q. -- "was published and included intended use warnings and cautions for the use of Oxevision activity tracker, the part of the system that provides location and activity based warnings and alerts."

And you go on to say that there have been updates to the instructions and that it's available on the Oxevision fixed monitor, the instructions, and from April 24 via your online training system, OxeAcademy. Could you just perhaps explain a little bit more about the activity tracker and what you are talking about there in your statement, please?

A. So I spoke about earlier the various reports the system can provide. So the activity report is one of these reports. Now, that provides, again, it's almost like a bar chart, so down the left-hand side you've got the days of the week, so over a seven day period, and across the bottom you've got hours which cover the 24 hours. What this shows is the activity within that room during those periods of time. So there's a colour key as well at the top, a colour

coded key. So this could show staff how long somebody has spent in bed, how long somebody has spent in their room, how long they have spent out of the room. It just provides that information that can be used as part of staff handovers, care planning, MDTs, the weekly ward round discussions.

Q. So it is there as an element of the system to assist staff?

A. Staff and patients. So in my previous role I have use these reports with patients as part of their care planning.

Q. Thank you very much. Given the advertised primary functionality of Oxevision to monitor vital signs, would you accept that the fact that it has not been rolled out in any physical healthcare settings is indicative of the relevant providers having concerns about its use? So this would be concerns in physical settings about the use of Oxevision.

A. So I don't think the vital signs function is the primary use. I think that is an element of the system. I think the platform provides so much other information that can be useful for staff and patients, and I believe there may be a possibility in the future that it could be rolled out within physical healthcare settings.

Q. Thank you. Would you accept that, in a psychiatric in-patient context, conducting therapeutic as opposed to physical vital signs observations requires staff members to engage with the patient, where awake, to ensure there are no adverse changes to their mental welfare that require escalation?
A. Yes, I agree with that. When a patient is awake, the purpose of that therapeutic engagement, observation, however I do believe when somebody is sleeping, and I think we have spoken about --
Q. You have made that very clear, the advantages of not disturbing someone at night.
A. Yes.
Q. Is it your view that therapeutic observations should only be conducted remotely via Oxe-Obs in circumstances where a patient is asleep?
A. Yes, yes. So if somebody is asleep, and again I think it's -- it's dependent on the patient as well, so that the context of the patient and those conversations that have happened with the patient. I wouldn't advocate that this is done without any conversation with the patient.
Q. The question is, is it your view that therapeutic observations should only be conducted remotely, via Oxe-Obs, when the patient is asleep, so that is

suggesting it shouldn't be used during the day. Is your answer to that that it depends on the patient?

A. Again it depends on that individual. There may be circumstances that it is suitable to use during the day.

Q. If a patient is awake, would you accept that conducting therapeutic observations remotely may impair a staff member's ability to discern whether the patient is suffering from signs of mental distress or deterioration?

A. Yes. If somebody is awake, then those observations need to be therapeutic. Therapeutic involves conversations with patients.

Q. Thank you how much has Oxevision charged EPUT for its services since implementation?

A. I'm unaware of that. That's not, again, within my job role.

Q. Would you be aware whether it ran into millions of pounds, for example?

A. I don't know, I'm sorry.

Q. You were asked about savings to providers and responded by saying that the time was saved in terms of paperwork and time spent responding to an incident, such as a form. The Oxehealth LIO website currently states in its benefits to providers

section under the heading, "Lowering costs and realising Time to Care", lower need for one-to-one continuous observation. Do you accept that saving staff costs on time for observations is an explicit part of Oxehealth's promotional model?

A. Could you repeat that, please? Sorry.

Q. Yes, of course. So the website currently refers to one of the benefits of the system as being lowering costs and realising time to care, and it says, "A lower need for one-to-one continuous observation." So that's being used on the website as an example of a benefit. The question is, do you accept that saving staff costs on time for observations is an explicit part of Oxehealth's promotional model?

A. So I think if you have got an environment where staff are provided with up to date and accurate information, this may save time and costs of having additional staff over and above that safe staffing number, that substantive establishment that we spoke about.

Q. Okay, thank you. You stated that you recognise that the platform is not suitable for everyone. To what extent is that fact communicated to providers at the point of piloting the scheme?

A. I recognise that the platform may not be suitable

for everybody, and I would expect that providers are able to recognise that as well.

Q. But the expectation would be that the provider, the trust or whoever, should be aware of that fact themselves?

A. So I think it's also within, and again I would have to go back and double check this, but I think there is an element of that within the Nurse Directors' Forum as well.

Q. Thank you. How, if at all, did Oxehealth anticipate that alerts may be marked as resolved or alerts may be muted without a physical observation taking place?

A. Again, it's about providers providing clear guidance to their staff about how they expect alerts to be responded to.

Q. I understand that. The question, though, is actually about Oxehealth and whether, and if so how, Oxehealth anticipated that alerts might be marked as resolved and/or muted without a physical observation having been undertaken before the muting, for example? Is that something Oxehealth anticipated might happen on wards?

A. No, I don't believe so.

Q. Inquests have noted repeated issues with training on

Oxevision, noting the language used by Oxehealth to describe its own system, for example contact free, vital signs observations, ambient monitoring unit, vision-based monitoring technology and observation modules. Do you accept that Oxehealth's use of language may have contributed to confusion as to whether Oxevision should be used by staff in lieu of physical observations?

A. No. We try -- so the use of "ambient monitoring" I don't believe that's ever been discussed at an inquest that I have been part of or at. I think we try and be as clear as possible around our language, especially within our training materials to staff as well.

Q. Thank you. Are you always updated by individual trusts when they update their Oxevision protocols?

A. No. We don't hold copies of organisations' protocols.

Q. You were asked about the problem at EPUT with staff lowering the volume and/or resetting the alarm and you were asked whether to your knowledge this was a problem in other trusts. You said, "I may be aware of one other incident." Can you explain, do you mean one incident only, or one other trust where this is a problem?

A. So I'm aware of one incident at one trust, that I can think of off the top of my head.
Q. Which trust was that?
A. It was a Northern trust.
Q. Do you know the name of the trust?
A. No, without going away and looking at it but I know what the incident was.
Q. At paragraph 46 of your second statement, you mention blurred images. Stop Oxevision's first witness statement describes concerns about blurred images it raised with the NHS Health Research Authority last year. In light of the HRA's (The Health Research Authority's) decision, to suspend its favourable ethics opinion following a lack of clarity on whether Oxevision images being collected were in fact anonymous. Do you accept that blurred Oxevision footage is not de-identified by UK research ethics standards?
A. So that was anonymised footage that had gained ethics approval via the ethics committee. We understand that that may have made people feel uncomfortable but it was anonymised.
Q. Is it correct that in blurred footage identifying details or personal characteristics of patients may be visible or recognisable, such as body shape, skin

tone, hair, clothing or other unique features, and that it would also be possible to see a patient undressed?

A. So, no, so I think we spoke about this earlier. That blurred video is pixelated, so you can roughly work out where somebody is within a room but it's full pixelation. You couldn't tell what colour someone's hair was or what they were wearing.

Q. We might follow up after your evidence and ask for some examples of blurred footage and then we can look at those ourselves. Chair, those are the questions I have. Do you have any questions for the witness?

THE CHAIR: No, I don't, thank you very much and we will meet again tomorrow at 10?

MR GRIFFIN: Starting again tomorrow at 10 o'clock. Thank you.

(5.30 pm)

(Adjourned till 10 o'clock tomorrow morning)