NHS
Leicestershire Partnership
NHS Trust

WITNESS STATEMENT OF ANDRES FREIRE-PATINO DATED 27 MARCH 2026

1. I, Andres Freire-Patino, am a Deputy Director for the Directorate of Mental Health Services, for Leicestershire Partnership NHS Trust. I am signing this statement on behalf of the Trust. I have been a Registered Mental Health Nurse since 1998 and have worked in and managed mental health inpatient services for most of this time. I have worked in my current role since 23rd January 2023. I have written this statement in response to the Rule 9 Request dated 17 February 2026 to assist the Coroner in the Lampard Inquiry with ascertaining how mental health trusts across England use Oxevision.

Historic and Current Use of Oxevision System

2. In July 2022, the Trust procured Oxevision with a view to piloting the technology across seven wards, encompassing the full spectrum of inpatient environments within the Trust. These comprised of mental health, child and adolescent mental health (CAMHS), physical health, mental health services for older people, and a specialist ward for patients with Huntington's Disease. The overarching objective was to evaluate the suitability and efficacy of Oxevision across the breadth of the Trust's clinical settings.

3. Following procurement, it was determined that the initial installation would be limited to two wards, Ashby Ward and Aston Ward, prior to any wider deployment across the remaining five wards. At the time of the installation, Ashby Ward was a female acute mental health ward for adults over 18 years of age comprising of 14 beds with a seclusion room. Aston ward was a Male Functional Mental Health Services for Older People (MHSOP) ward with 17 beds with no seclusion room. It was intended that the pilot would commence on the aforementioned wards whilst preparatory work for the broader installation of Oxevision continued in parallel.

4. The first pilot was initiated across Ashby and Aston Wards between December 2022 and February 2023. Following approximately three months of operation, however, a decision was taken to pause the pilot. This decision was informed by a number of significant factors.

5. First, both wards were experiencing a high and frequent turnover of temporary staff during the pilot period, which presented substantial operational challenges in ensuring that adequate numbers of staff received the training necessary to use the technology proficiently. Second, technical difficulties arose in relation to internet connectivity, with certain areas of both wards failing to maintain the reliable connection upon which the effective operation of the system depended. Third, staff on both wards were already required to carry a separate mobile device, the Brigid system, for the purposes of recording patient observations. Concerns were raised that the requirement to carry two electronic devices concurrently was proving distracting to staff at the point at which they were conducting observations, with potential implications for the quality and attentiveness of that process. Fourth, and of particular significance, feedback received from staff gave rise to concerns that the technology could be susceptible to misuse. Specifically, it was identified that a member of staff could, in principle, use Oxevision to monitor a patient within their bedroom without any corresponding alert being generated or any notification being escalated to other members of staff on duty at the time.

6. The pausing of the pilot afforded the Trust the opportunity to address each of these matters in a considered and structured manner. It was determined that any subsequent pilot should serve a dual purpose: to refine the operational use of the technology on the initial wards and, more broadly, to assess its suitability for deployment across the other clinical environments originally identified as part of the procurement plan.

7. Concurrently, the Trust engaged directly with Oxehealth, the developer of the technology, and formally requested the development of an alert function capable of identifying instances in which a member of staff was accessing the system with a frequency beyond that which would ordinarily be anticipated. It was agreed that this alert would be disseminated to all tablets on the ward, thereby enabling staff, including the ward manager, to identify the relevant individual by reference to the system's log-out functionality and cross-referencing with the ward's observation rotas. This development represented a direct and substantive response to the staff

concerns raised during the course of the first pilot and constituted an important governance safeguard against the potential for misuse of the technology.

8. Following the completion of an extensive governance review of the system and having satisfied itself that the issues which had necessitated the suspension of the first pilot had been adequately and appropriately resolved, the Trust relaunched the pilot on Ashby Ward, the female acute ward on 14 November 2024 till 10 January 2025.

Information provided to patients and/or their families

9. In respect of the information provided to patients and their families regarding the use of Oxevision within the ward environment, and the manner in which consent was sought and recorded, I set out the position of the Trust as follows:

10. At the point of admission, all current inpatients and all new admissions during the pilot period were provided with information about the Oxevision system. This was achieved through a combination of means: each patient was shown directly how the technology operated, including a practical demonstration of the tablet used as part of the system, and was provided with written information in the form of a leaflet, **Exhibit NP01**. This process was conducted both at the point of admission and during one-to-one sessions with staff. In addition to the standard Oxevision information leaflet, staff also made use of an easy-read leaflet specifically describing how the system was being used on Ashby Ward as part of the pilot, thereby ensuring that information was accessible to patients with varying communication or cognitive needs. The same approach applied at any subsequent stage of the patient's admission, and no distinct process was applied upon discharge beyond that already described.

11. In respect of consent, the Trust adopted a structured and carefully documented approach throughout the pilot. Upon admission, each patient was informed about the Oxevision system by the member of staff responsible for welcoming them to the ward. That staff member provided a practical demonstration of the devices installed within the patient's room and included the Oxevision information leaflet, **Exhibit NP02**, as part of the standard welcome pack given to all patients on arrival. Following this introduction, staff sought the patient's consent and completed an Oxevision-specific consent form, which clearly recorded whether the patient had opted in to or opted out of the use of the system. It was a firm requirement of the Trust's approach

that a fully completed consent form be in place before the system could be activated in respect of any individual patient.

12. Where a patient provided their consent, this was not treated as sufficient in itself to permit activation of the system. Rather, the matter was referred to the multidisciplinary team, which was required to review and formally approve the use of Oxevision at the daily review meeting. The system was not activated in respect of any patient without that explicit consent having first been obtained and subsequently ratified by the multidisciplinary team. The team's decision was clearly documented within the patient's care plan, and the completed consent form was additionally scanned onto SystmOne as part of the Trust's routine documentation processes, with the patient's consent status recorded in their care plan accordingly.

13. The consent status of each patient was not treated as a one-off determination. Rather, it was reviewed on a weekly basis as part of the patient's care plan, including during one-to-one sessions with staff, and the outcome of each review was clearly documented. Where a patient chose not to consent to the use of Oxevision, that decision was documented within their care plan and communicated to the wider clinical team during the daily multidisciplinary huddle as part of the handover process.

14. It should also be noted that the Trust's approach to consent evolved meaningfully between the first and second pilots. During the first pilot, which ran between December 2022 and February 2023, the consent model adopted was one of opt-out. Following careful reflection on the appropriateness of that approach, it was decided and agreed that the second pilot, commencing in November 2024, would operate on the basis of an opt-in consent model, under which the system was used solely where a patient had provided explicit and affirmative consent to its use.

15. For the avoidance of doubt, consent was sought in all cases throughout the pilot period. There were no instances in which the system was activated in respect of a patient who had not provided their consent, and the Trust did not at any point place reliance upon best interest’s decision-making or any alternative lawful basis under data protection legislation as a substitute for that consent.

Purposes for which Oxevision was/is used

16. Oxevision was introduced and used at the Trust for a number of defined and authorised purposes during the pilot period, each of which I address in turn.

17. The primary purpose of introducing Oxevision as part of the Ashby Ward pilot was to reduce the level of nighttime disturbance experienced by patients. Sleep and the maintenance of a stable daily routine are widely recognised as among the most crucial factors in supporting mental health recovery. Poor-quality or disrupted sleep is frequently one of the earliest indicators of mental health deterioration, and conversely, improvements in sleep quality and the re-establishment of a consistent daily routine are commonly associated with a patient's progress towards recovery. It was with this clinical rationale firmly in mind that the Trust identified Oxevision as a potentially valuable tool in the inpatient setting.

18. Traditional nighttime observations require staff to physically enter a patient's bedroom in order to conduct a breathing check. Whilst this practice is an established and essential element of patient safety, it carries with it the inherent risk of disturbing a patient's sleep. There had been occasions prior to the pilot on which clinicians, following a risk assessment conducted during a ward round, had taken the decision to suspend nighttime observations precisely because the disturbance caused by those checks was considered to be prolonging a patient's recovery. The Oxehealth technology offered a means of addressing this tension, enabling staff to obtain key vital signs (including pulse rate and breathing rate) without the need to enter the patient's room. This created a significant opportunity to conduct mental health observations remotely, with the expectation of reducing nighttime disturbance whilst continuing to maintain patient safety. No quantifiable assessment was undertaken prior to the pilot to determine additional workload arising from dual observation processes. The view from the clinicians at the start of the pilot was that this would be minimal due to the fact that the handheld device used for oxevision would simply replace looking through an observation window within the door with a torch or entering the room to complete the observation. It was felt by the clinicians that this was likely to save time when the technology worked effectively. It was not an area of concern that was raised as part of the evaluation.

19. In terms of how observations were documented during the pilot, all observations continued to be recorded on the existing documentation systems throughout,

ensuring consistency of record-keeping and maintaining the standards of safe documentation that the Trust requires as a matter of routine.

20. With regard to the measurement of vital signs, the use of Oxevision for this purpose was limited to the night-time period, in direct support of the objective of reducing sleep disturbance. Where staff were unable to obtain a clear reading for pulse or breathing rate after two attempts using the system, the observation was completed physically by the staff member entering the patient's bedroom in the conventional manner, thereby ensuring that patient safety was not compromised at any point.

21. The system also held the capability to support incident reviews in certain circumstances. Where an incident resulting in moderate or high harm had occurred, and where the patient concerned had consented to the use of Oxevision, clear video footage could be requested for the purposes of review. The Oxevision system retains what is known as Clear Video Data, and in exceptional circumstances this data may be accessed to support investigations and to contribute to organisational learning. The valid grounds for requesting such data were defined as patient safety incidents resulting in moderate or high harm, and safeguarding incidents or allegations. The Clear Video Data itself is encrypted and stored securely on local servers at the Trust and is subject to automatic deletion as part of a twenty-four hour rolling buffer unless an authorised request for retrieval is made within that period. It should be noted that no incidents arose during the pilot period that required this functionality to be utilised.

22. Finally, whilst the reduction of nighttime disturbance remained the primary purpose of the system throughout the pilot, Oxevision also provided a number of additional benefits through its alert functionality. Alerts were sent directly to the tablet held by the nurse conducting level one and level two observations, notifying staff of a number of specific situations: when a patient was at their bedroom door, when another person had entered the room, and when a patient had been in the ensuite for a period in excess of three minutes. These alerts served as a meaningful additional safeguard, supplementing the core observational function of the system and providing staff with timely information to support their clinical decision-making and patient safety responsibilities.

Approach to the use of Oxevision

23. In respect of the extent to which the Trust's approach to the use of Oxevision differed depending on the circumstances of individual patients, Oxevision was explained to a patient and staff formed the view that the patient did not have the capacity to make a decision regarding consent to its use, a clear and consistent approach was applied. If the patient expressed that they did not wish to consent, this was treated by the Trust as an opt-out decision, regardless of the patient's capacity status. In such circumstances, Oxevision was not used, and the system remained switched off within the patient's bedroom. The consent form was completed in all cases to accurately reflect the outcome of that process, whether the patient had opted out or had lacked capacity and declined its use.

24. Where there was a suspicion that a patient may lack capacity, but this had not been formally established, the same principled approach was followed. The system and its operation were explained to the patient in the same manner as for all other admissions. If the patient indicated that they did not consent, this was again treated as an opt-out decision, and the system was not activated. Where, however, a patient in those circumstances indicated that they were willing to consent to the use of Oxevision, the matter was referred to the multidisciplinary team, which was required to consider all relevant factors and reach a decision as to whether the use of the system was in the best interests of that patient before any activation could take place.

25. Our acute wards in Leicestershire Partnership NHS Trust all have daily MDT huddles every weekday morning at 0900hrs that are attended by the nurse in charge of the ward, the responsible clinician, resident doctor, ward occupational therapist and ward manager. The huddle operates as a morning handover where those in attendance are updated regarding newly admitted patients, any incidents from the previous 24 hours on the ward and any tasks that may be required for that day. During the pilot we did have 2 patients who were unable to engage fully in the admission process due to their mental state and staff were unable to complete any of the patient’s physical observations on admission. These patients were discussed in the MDT huddle as per the standard operating procedure and the decision made to use oxevision in their best interests to retrieve their pulse and respiration rate alongside their other care plans at the time being implemented through best interest.

26. In terms of who held the authority to activate or deactivate the system, this responsibility was limited to a defined group of senior clinical staff. Only the charge nurse, ward sister, their deputies, and Clinical Duty Managers were permitted to turn the Oxevision system on or off, and this could only be done following the completion of the consent form and a discussion at the multidisciplinary team level. This ensured that decisions regarding the use of the system were always taken at an appropriate level of seniority and with proper clinical oversight.

27. Finally, it should be noted that no distinction was drawn between voluntary and involuntary admissions in respect of the consent process. The same structured approach to information-giving, consent and documentation was applied consistently to all patients, regardless of the basis upon which they had been admitted to the ward.

Individual Patient decision making

28. The Trust's approach to individual patient decision-making in respect of Oxevision was, given the pilot status of the project, grounded in the established opt-in consent framework. The decision as to whether Oxevision was used in respect of any individual patient was determined by that patient's own informed consent, arrived at following a full explanation of the system. The pilot approach did not supersede, modify, or bypass any existing consent arrangements. Where consent was given, the multidisciplinary team was required to review and approve the use of the system before it could be activated, ensuring that individual patient factors were carefully considered in every case.

Decisions not to use Oxevision

29. Where decisions were taken not to use Oxevision as part of a particular patient's care, those decisions were made within the framework of the consent process that had been established for the pilot. As this was a pilot, it was agreed from the outset that staff would follow the existing consent guidance, operating on the basis of both opt-in and opt-out processes depending on the circumstances of the individual patient.

30. Beyond the consent process itself, the system would also be disabled where the multidisciplinary team collectively agreed that it was in the patient's best interests for

it to be switched off. This would arise in circumstances where the team did not consider that the patient had the capacity to consent to its use. In such cases, the decision rested with the multidisciplinary team as a whole and was made on the basis of clinical judgement rather than by reference to formally defined thresholds relating to, for example, the level of risk presented by the patient or the frequency of observations required. Clinical discretion therefore played a vital role in the decision-making process throughout the pilot period.

31. To support staff in navigating these decisions and in using the system effectively more broadly, a Standard Operating Procedure was developed. That document is produced at **Exhibit NP03**.

Policies and Procedures

32. In respect of the policies, procedures, and guidance relevant to the use of Oxevision that were in place from the date of its implementation, and insofar as these have not already been addressed in the responses above, the position of the Trust is as follows.

33. All staff who participated in the use of Oxevision were required to complete an online training module as a mandatory precondition to using the system. The module covered both how the system worked and how it was to be used in practice, and staff were required to pass the module before they could proceed further. Upon successfully completing the online element of their training, staff then attended an in-person training session, during which the expectations set out in the Standard Operating Procedure were discussed in detail and staff were given the opportunity to raise any questions they had about the system or its use. That Standard Operating Procedure is produced at **Exhibit NP04**.

Benefits and Risks of Oxevision

34. At the time of deployment, the Trust identified seven risks associated with the use of Oxevision, each accompanied by a corresponding mitigation.

35. The first concerned the scope of the system's use. The Clinical Safety Case Report confirmed that Oxevision was not intended to replace physical in-person checks or to monitor vital signs, but rather to provide supplementary information to support patient

wellbeing. Clarification was sought from Oxehealth, which confirmed that daily physical observations remained a mandatory requirement and that Oxevision was deployed solely for supportive mental health observations at night to limit disturbance to patients.

36. The second risk was that the vital signs data provided might lack sufficient accuracy. This was addressed by reference to Oxehealth's status as an ISO 13485 certified medical device manufacturer, with the Vital Signs module registered as a Class IIa medical device whose accuracy had been assessed and agreed with the relevant notified body. The Standard Operating Procedure required staff to enter the room manually if a reading could not be obtained after two attempts.

37. The third risk was that staff might use the system to inappropriately monitor patients. This was mitigated by alerts notifying ward leads of excessive access, restrictions limiting ward office access to staff with a legitimate clinical relationship with the patient, and compliance monitoring arrangements set out in the Standard Operating Procedure.

38. The fourth and fifth risks related to staff recording footage on personal devices and the possibility of a data breach. Both were addressed through the same alert system, access restrictions, a prohibition on personal mobile devices for work purposes, CCTV across ward areas, and restricted access to clear video data footage.

39. The sixth risk was that patients might not fully understand what they had consented to. This was mitigated through explicit consent on admission, recorded on the Electronic Patient Record and reviewed weekly, together with ward posters and an updated Privacy Notice.

40. The seventh risk concerned the absence of multi-factor authentication. This was addressed through device whitelisting, kiosk mode configuration, PIN protection, and automatic device locking.

41. In terms of benefits, the principal advantage identified was a reduction in nighttime disturbance. Some patients on Ashby ward reported improved sleep as a result of fewer disturbances, though no broader formal evidence of improved patient care outcomes was gathered during the pilot.

42. The Trust's current assessment of the risks and benefits is not applicable, as the system is no longer deployed.

Understanding of the use of technology for observations

43. Turning to whether the Trust anticipated or came to understand that the use of Oxevision could give rise to the concerns identified, the position is set out as follows:

44. In respect of the potential for the technology to decrease opportunities for therapeutic engagement, this was not considered to be a significant concern in practice. Given that the system was used primarily to conduct nighttime observations, therapeutic engagement with patients continued as normal during the day and was not affected by the deployment of Oxevision.

45. As to whether the use of the system gave rise to alarm fatigue amongst staff, this was not raised as a concern by staff at any point during the pilot.

46. In respect of the risk of harm to patients through over-reliance on remote monitoring, the Standard Operating Procedure, produced at Exhibit NP, provided a clear safeguard by requiring staff to make two attempts to obtain a reading before entering the room to conduct a manual check. It is also relevant to note that Ashby ward already had safe hinge doors in place prior to the pilot, meaning that a system for managing door-related incidents was already operational and the door alerts offered by Oxevision were not considered essential. Similarly, the ward had only two en-suite facilities, and as a result the en-suite duration alerts did not have a material impact on practice.

47. In terms of whether the system gave rise to any risk of harm to patients more broadly, no increased risk was identified during the course of the pilot. On the contrary, one instance was reported by a nurse to the project team in which the use of Oxevision had assisted in identifying and avoiding a potential self-harming incident, demonstrating the system's capacity to contribute positively to patient safety.

48. Finally, in respect of the risk of the system being abused by staff, Oxehealth implemented an alert mechanism designed to identify instances where a member of

staff was accessing the system more frequently than would ordinarily be expected. The logging system meant that any such individual could be readily identified. On each occasion that this alert was triggered during the pilot, the project team conducted an investigation, and in all cases the access was found to be attributable to staff familiarising themselves with the new system rather than any improper use.

Risks and mitigation of risks

49. Each of the risks identified prior to the pilot had corresponding mitigations in place before it commenced, as set out in the response to question 11 above in paragraphs 42 - 47. No risk was identified during the pilot for which a mitigation had not already been considered and implemented.

Whether LPT anticipates decrease in spending on staff

50. As the pilot was principally directed towards improving sleep hygiene, Leicestershire Partnership NHS Trust did not anticipate that the deployment of Oxevision would give rise to any reduction in staff expenditure. Accordingly, no such financial benefit was sought, and none has been realised.

Assessment of Oxevision's performance

51. Following the conclusion of the Ashby pilot, Leicestershire Partnership NHS Trust undertook a full evaluation of the Oxevision system. The pilot had been scoped to support improvements in sleep hygiene across a 14-bedded female ward.

52. The evaluation concluded that there was no robust evidence to support the continued use of Oxevision within the Trust. Over the course of the three-year contract, a number of challenges and delays were encountered. These included a temporary suspension of the pilot owing to safeguarding concerns and issues relating to bank and agency staff usage, delays in obtaining Information Commissioner's Office approval of the requisite Data Protection Impact Assessment, and reduced patient uptake attributable to a shift in the consent model.

53. In accordance with NHS England guidance, the pilot operated on an explicit opt-in consent basis, which presented difficulties for effective implementation. With an average uptake of approximately 42%, staff were required to maintain two parallel

methods of observation, with the consequence that the system did not deliver improvements in staff efficiency. Staff also raised concerns that the system did not consistently capture vital signs data, specifically pulse and breathing rate, which meant that patients continued to be disturbed during the night in order to complete the required observations. Notwithstanding this, some patients did report improvements to their sleep during the course of the pilot.

54. Whilst sleep hygiene improved for certain individuals, the evaluation found no clear financial benefit arising from the use of Oxevision. There was no reduction in the use of one-to-one observations, no evidence of released staff time, and no measurable reduction in either incidents or length of stay.

Further documents

55. In respect of the documents and materials requested, and insofar as these have not already been provided, the Trust's position is as follows.

56. A full Data Protection Impact Assessment was completed in respect of the Oxevision system by the Trust's data privacy team and was supported by the Director of Finance in their capacity as Senior Information Risk Owner. That document is produced at **Exhibit NP05**.

57. In relation to the monthly usage reports produced by Oxehealth over the period June to December 2024, all reports received by the Trust during that period are produced at **Exhibit NP06**.

58. Finally, in respect of the consent materials used by the Trust throughout the pilot, including posters, leaflets, digital content and privacy notices, the Trust's consent form, which was used in respect of all patients, is produced at **Exhibit NP07.**

Rationale for current level of deployment across LPT wards

59. Oxevision is not currently deployed across any of the Trust's wards. Following the conclusion of the Ashby pilot, the evaluation undertaken by the Trust found no compelling evidence to support the continued use of the system within Leicestershire Partnership NHS Trust. As set out in the response to the preceding question, the pilot did not demonstrate clear clinical or financial benefit, and it is on that basis that the

Trust has not sought to deploy the system more widely, nor has it continued its use on Ashby Ward or any other ward. The decision to bring the pilot to a close was therefore driven by the findings of the evaluation rather than by operational or logistical considerations and reflects the Trust's commitment to ensuring that any technology deployed within its clinical settings is supported by a sufficient evidence base.

60. Oxevision provided the trust with statistical information regarding its use which was supported by an impact case study, completed by Oxford University. This case study also cited other research articles which supported the statistical information provided by them. The business case was drafted and sent to all stakeholders (of which Oxehealth were one) for comments before submission. The business case was written by Leicestershire Partnership Trust staff.

Discontinuance of the use of Oxevision

61. The Trust's decision to discontinue its use of Oxevision was principally driven by the absence of robust evidence to support the system's continued deployment within Leicestershire Partnership NHS Trust. As the pilot operated on an explicit opt-in consent model, patient uptake remained below half of the ward population, with the consequence that staff were required to maintain two parallel processes for observations, one using Oxevision and one using traditional methods, or those patients who had not consented. This placed an additional operational burden on staff without delivering a corresponding clinical benefit.

62. The decision to discontinue was not taken unilaterally but was arrived at following a considered review of feedback gathered from both patients and staff. That feedback was drawn from patients who had consented to the use of the system as well as those who had not, and from staff who had used the system in practice throughout the course of the pilot. The conclusions drawn from that feedback, combined with the findings of the formal evaluation, informed a decision that touched upon each of the areas identified, namely governance, risk, clinical utility, and cost. There was no single determining factor; rather, the decision reflected a holistic assessment of the system's performance against the objectives that had been set for the pilot, and a collective judgement that those objectives had not been sufficiently met to justify continued use.

63. The decision to discontinue the use of Oxevision followed a clear and structured governance route. The project group responsible for overseeing the pilot completed a formal evaluation of its findings, which was subsequently reviewed at directorate level. Following that review, a paper was prepared and presented to the Executive Management Board, setting out the conclusions of the evaluation together with a recommendation to decommission the Oxevision system. The decision to discontinue was therefore taken at the highest level of the Trust's executive governance structure, reflecting the significance of the decision and the rigour with which it was approached.

64. There was no single defining factor in LPT's decision to discontinue the use of Oxevision, rather a number of considerations were taken into account collectively. , A primary factor was the relatively low numbers of patients who opted into using Oxevision. During the 8 week pilot period, fewer than half of the patients admitted to Ashby Ward chose to opt in to the use of Oxevision in their care, , a total of 16 out of 38. Whilst the majority of the patients who did opt in, did report less disturbance at night, two of the 16 participants reported that they had been disturbed by staff entering their rooms on occasion. , When this was investigated further, it was established that this was because the Oxevision device had been unable to detect the patient's pulse rate and therefore as per the agreed standard operating procedure, staff were required to enter the room to physically check the patient. This was reported as a theme in the evaluation where there were occasions where "two blobs" could not be seen, with the missing blob being the pulse rate.

65. A further consideration was that the Trust had previously used an electronic device and application called Brigid to record intermittent observations, and had plans to revert to using this system. Continuing to use Oxevision alongside Brigid would have required nursing staff to carry two separate electronic devices simultaneously, which was considered operationally impractical.

66. LPT had already implemented alternative solutions for some of the areas of functionality of Oxevision. One such implementation was the door-proximity alert, which is designed to detect patients standing by doors. This was a measure to reduce the risk of a trapping a ligature between a door and its frame, which is a well known method of self-harm and suicide. LPT had installed safehinge doors In the bedrooms on some of the wards originally intended for oxevision. Safehinge doors are specialist doors where an alarm is activated at any time when weight is applied

on any point of the door and therefore this functionality of the oxevision technology was not required by us.

67. Further, the acute mental health wards have very few bedrooms with ensuite facilities and therefore the bathroom alerts provided by Oxevision were not able to be universally applied and although there was some benefit in the bedrooms that did have ensuite as shown in the pilot, as a Trust we felt we did not need the full functionality of the system.

68. An Executive management board meeting took place on 5 August 2025, the minutes of which are annexed at **Exhibit NP08**, to discuss the Trust's decision to discontinue the use of Oxevision.

69. As annexed at **Exhibit NP09** a project evaluation of Oxevision was discussed at an Executive Management Board meeting on 3 February 2025 along with a Cost Benefit Analysis also annexed to this statement at **Exhibit NP10.**

Statement of Truth

I believe the contents of this statement to be true.

Signed **[I/S]** Dated: 20 May 2026