**Tuesday, 21 July 2026**

**(10.00 am)**

**(Proceedings delayed)**

**(10.06 am)**

**THE CHAIR:** Mr Griffin.

**MR GRIFFIN:** Good morning, Chair.

Today, the Inquiry will hear from Mrs Elspeth Devanney and Mr Andres Patino. They will provide evidence about the use of Oxevision in hospital Trusts, other than EPUT, for the purposes of comparison.

Ms Devanney is from Tees, Esk and Wear Valleys NHS Foundation Trust and Mr Patino is from Leicestershire Partnership NHS Trust.

There may be aspects of today's evidence that are difficult to listen to. For some people, it may not be possible to sit through the full sessions. Anyone in the Inquiry room should feel free to leave at any time, and may I take this opportunity to remind those engaging with the Inquiry that emotional support is available for all who require it. Present again here today are representatives from Hestia, an experienced provider of emotional support at these types of hearings. They're currently in the room and they can be identified by their orange scarves.

There is a private room downstairs where anyone who

needs emotional support can talk to Hestia, and if you prefer, you can speak to a member of the Inquiry Team first and we'll put you in touch with them. We're wearing purple lanyards.

For those following the hearing online, information about emotional support is available and can be found on the Lampard Inquiry website @lampardinquiry.org.uk. The "Support" tab is near the top right-hand corner.

Chair, we want everyone engaging with this Inquiry, in whatever way, to feel safe and supported.

I'm going to ask now that the witness be sworn, please.

**ELSPETH DEVANNEY (sworn)**

**Questioned by MR GRIFFIN KC**

**MR GRIFFIN:** Please provide your full name.

**A.** Elspeth Mary Devanney.

**Q.** Mrs Devanney, since March 2022, have you been Director of Nursing and Quality at Tees, Esk and Wear Valleys NHS Foundation Trust, or TEWV?

**A.** That's correct.

**Q.** Does TEWV provide mental health, autism, learning disability and related services throughout County Durham, and Darlington, Teesside, North Yorkshire, York and Selby?

**A.** Yes.

**Q.** Are you a Registered Mental Health Nurse, or RMN?

**A.** I am.

**Q.** And when did you qualify as an RMN?

**A.** 2002.

**Q.** When did you start working at TEWV?

**A.** In that year, as soon as I've been qualified.

**Q.** Have you basically been employed at TEWV since 2002?

**A.** Pretty much apart from a six-month secondment to another organisation approximately 18 months ago.

**Q.** Can you help us with the roles that you've had at TEWV prior to your current role?

**A.** So following my initial registration I worked as kind of that route up from Clinical Lead, Ward Manager, to a Matron. I then spent quite a period of time in senior operational leadership roles, so I've worked as a head of service in a number of specialities, mental health services for older people, adult mental health services, and also learning disabilities. I did a period of time as a Director of Operations in the organisation until I took up my recent substantive post, which is the Director of Nursing and Quality.

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

**A.** So my role is to work alongside as a member of the care group board alongside a clinical triumvirate, so a Director of Allied Health Professionals, a Medical

Director, our Managing Director, Operational Lead for the Services, and a Director of Patient Experience, and Operational Directors to oversee the quality of care delivery across the services that are delivered within the organisation.

**Q.** You're going to be helping us with information about the way in which the technology Oxevision is used at TEWV. What is your experience or are your responsibilities in connection with that, please?

**A.** So I don't directly use Oxevision myself but I have oversight for services where it has been implemented, and reviewed over the last few years since we first started to use Oxevision in services. So I've seen our full journey with the use of Oxevision.

**Q.** And have you held senior roles, both operational and clinical, during the implementation of Oxevision?

**A.** Yes.

**Q.** Thank you. Does your role mean that if there was an incident in some way connected with Oxevision or in which Oxevision can assist, you would hear about it?

**A.** Yes.

**Q.** And have you been involved in wider discussions about Oxevision's impact on patients and families following concerns being raised there?

**A.** Yes.

**Q.** Can we just talk about terminology, please. We're going to be talking about a technology we've been referring to as Oxevision, provided by a company that we have been referring to as Oxehealth.

**A.** Yes.

**Q.** There has recently been a rebranding, so, for example, the company is now called LIO.

**A.** *(The witness nodded)*.

**Q.** For the sake of simplicity what I'd like to do is this, please: can we continue to refer to the technology as Oxevision and the company as Oxehealth?

**A.** Yes.

**Q.** Now, I know that in some of the documentation that you've provided from TEWV, the technology is actually referred to as Oxehealth?

**A.** That's correct.

**Q.** So that could become a little bit confusing. Between the two of us we'll be clear about what you're referring to; yes?

**A.** Yes. Thank you.

**Q.** Thank you. Now, as you're aware, the Inquiry received a witness statement from Beverley Murphy, TEWV's Chief Nurse, and number of exhibits that were provided with it.

**A.** *(The witness nodded)*.

**Q.** Is it right that Mrs Murphy is unable to give evidence at this hearing?

**A.** Yes.

**Q.** And have you therefore agreed to step in and give that evidence?

**A.** That's correct.

**Q.** Have you also provided a brief witness statement to that effect?

**A.** I have.

**Q.** Do you have Beverley Murphy's statement in front of you?

**A.** I do, yes.

**Q.** Now, it's dated 10 June this year. Does it run to 16 pages?

**A.** Yes.

**Q.** This statement says it was prepared on the basis of the information collated by the Trust's leads on Oxevision, namely a Senior Project Manager and the Associate Director of Nursing and Quality for Secure Inpatient Services. That's at paragraph 3.

Is that your understanding as well?

**A.** Yes.

**Q.** In addition, did Mrs Murphy bring her experience as the Trust's Chief Nurse to bear in drafting that statement?

**A.** Yes.

**Q.** Do you know how long she has been Chief Nurse?

**A.** So she's been Chief Nurse at TEWV for, I would say, approximately three years, but she's held a number of Chief Nurse roles across the country prior to coming to work in TEWV.

**Q.** If we turn to the last page of her statement, please. Over the bottom of page 15 and the top of page 16. Can we see there a statement of truth, and that Mrs Murphy has signed it?

**A.** Yes.

**Q.** Given your own role and experience, do you feel confident in formally adopting this statement as your evidence to the Inquiry --

**A.** *(The witness nodded)*.

**Q.** -- together with the further statement that you've provided?

**A.** I do.

**Q.** Can you confirm that you're authorised to give evidence on behalf of TEWV in relation to the matters addressed in Mrs Murphy's statement?

**A.** I am, that's correct.

**Q.** Can you confirm that both statements are true and accurate to the best of your knowledge and belief?

**A.** Yes.

**Q.** So these statements stand as part of your evidence along with the exhibits provided. I'm not therefore going to

be covering everything that's set out in them but you're welcome to refer to them as you need to.

The Lampard Inquiry is investigating the circumstances surrounding the deaths of mental health inpatients under the care of NHS Trusts in Essex between the start of 2000 and the end of 2023. Its Terms of Reference require the Chair to make recommendations and permit her to make national recommendations, as she considers appropriate.

**A.** *(The witness nodded)*.

**Q.** The Chair heard last year from representatives of Oxehealth and also Essex Partnership University NHS Foundation Trust, or EPUT, and we'll be hearing further evidence from both organisations.

The Chair was told last year that Oxevision is currently used by approximately 50 per cent of the National Health Service Mental Health Trusts and the Inquiry has now obtained evidence from a number of further NHS Trusts which use or have used Oxevision in order to assist its assessment of how the system has been implemented, governed, and used in practice across different settings. In particular, this comparator evidence is intended to assist the Inquiry in assessing whether issues arising from the evidence concerning EPUT are Trust-specific or are reflected more widely in the

implementation and use of Oxevision elsewhere.

So thank you for coming today to assist us for that purpose.

So for reasons I've just explained, Mrs Devanney, the Inquiry is aware of Oxevision --

**A.** *(The witness nodded)*.

**Q.** -- and in general terms its intended use and its actual use at EPUT --

**A.** *(The witness nodded)*.

**Q.** -- although, as I said, we'll be hearing more about that.

What I'd like to do now is to start by looking at a couple of TEWV documents by way of introduction, please.

**A.** Yeah.

**Q.** Could you put up, please, TEWV021317 at page 1.

Now, this is a TEWV leaflet detailing Oxevision use, provided to TEWV -- to patients at TEWV. And this is from the initial deployment of Oxevision at the Trust?

**A.** Yes.

**Q.** Can we just see parts of it now.

First of all, on the left-hand side:

"What Oxevision does.

"It is a medical device that uses an infrared-sensitive camera to measure your pulse and

breathing rate.

"It lets staff know where you are in your room.

"It provides notifications to staff as explained on the next page."

Can we see at the bottom a picture of the unit; yes?

**A.** Yeah.

**Q.** And on the left of the unit the camera sensor and then on the right, infrared lights.

Now, the fact that it's able to measure pulse and breathing rates, is that referred to as the vital signs function?

**A.** That's correct.

**Q.** And we'll come back to that in just a moment. Looking at the right-hand side:

"Where Oxevision is located: in every bedroom on the ward."

Can we see the unit there is fixed to the corner between the ceiling and the wall above the patient's bed --

**A.** Yeah.

**Q.** -- in this case.

Elsewhere the Trust has referred to Oxevision in connection with vision-based patient monitoring systems, or VBPMS.

**A.** *(The witness nodded).*

**Q.** Is Oxevision considered to be a VBPMS?

**A.** Yes.

**Q.** We've heard elsewhere that Oxevision is considered to be contact free. Is that correct? And what does contact free mean?

**A.** I suppose the device is situated in a room so there's no contact with the patient. It's there, it's in a permanent situation, and it doesn't have any direct contact with the patient.

**Q.** Thank you. Could you take that down, please.

So just picking up on vital signs. I'd like to look at TEWV's Oxehealth procedure which is a document from August 2024, please, where it deals with how to take a vital signs observation. This is still by way of introduction.

**A.** Yeah.

**Q.** Could you put up TEWV -- thank you very much -- just for the record, TEWV021313 and page 50, please.

Can we -- what I'm going to ask is that we take each box in turn, starting with the step 1 at the top. Thank you.

So is the Oxevision system operated either through a monitor, possibly in a nurses' station, or through handheld tablets that staff can carry with them on the ward?

**A.** So both those things are true. So there's a system box that is in the ward office but then the staff use handheld tablets. To take vital signs, they would be using the handheld tablet and standing directly outside the room of the patient that they wanted to take that vital signs from.

**Q.** Thank you. Can we go through the process that they would go through now, please. Do we see here a screenshot from that system, in other words what staff would see when they're looking at the tablet?

**A.** Yeah, that's correct.

**Q.** What can we see here at step 1?

**A.** So that's what they would see on the actual tablet as they were outside the room.

**Q.** So do each of these squares, some of which are green, represent bedrooms?

**A.** Yes.

**Q.** And if they're green does that mean that the bedroom is occupied?

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

**Q.** And if one wanted to take a vital signs measurement would one start by clicking on the box for the room in which the relevant patient was?

**A.** Yes.

**Q.** Is that what we see here?

**A.** Yes.

**Q.** Can we move to the next step, please.

Would you highlight or expand step 2. Thank you very much.

Now, does this show how a staff member selects the option to take an observation?

**A.** Yes.

**Q.** Moving then, please, to the step 3, thank you.

First of all, can we now see what's termed a clear view of the patient in their room?

**A.** Yes.

**Q.** We'll come on to what that is in a moment. So this is the view from the camera in the unit we were just looking at, is it?

**A.** Yeah.

**THE CHAIR:** Can that view be accessed from both the tablet and from the monitor in the nurses' station?

**A.** Yes. Yes, from both.

**THE CHAIR:** Thank you.

**MR GRIFFIN:** We can see there at the top it says:

"Step 3: Check if the patient is still and click Ready for Observation. If not, click Cancel."

Can you explain why it's necessary for the patient to be still?

**A.** So it's to get an accurate reading that would be

medically valid.

**Q.** So it wouldn't work if they were moving around?

**A.** Possibly not, yeah.

**Q.** Thank you.

Would you go to the next page, please, and expand the top, step 4. We can see here it says:

"Check if there are blobs that are not touching the body. If all blobs appear on the body, click the blue ' 'No' button. If any of the blobs are not touching the body, click the grey 'Yes' button."

We may need a little bit of help with that. What is happening there, please?

**A.** So my understanding is that actually it needs to be clearly directly on the body to get that valid reading. So it's about the infrared in the system but I don't understand the technology fully.

**Q.** In short, do the blobs -- can we actually see a blue blob in there?

**A.** Yeah.

**Q.** They need to be on the patient --

**A.** That's correct.

**Q.** -- if the -- if a correct reading is to be taken?

**A.** Yes.

**Q.** Thank you. Would you expand the next and final stage, please.

So can we see here "Record observation(s) and click Done".

**A.** *(The witness nodded)*.

**Q.** And do we see below the picture of the person in their bedroom, two boxes, one says "HR: 72bpm" and one says "BR: 21br/per min"?

**A.** Yes.

**Q.** Now, are those measurements for that patient's heart and breathing rate?

**A.** Yes, pulse and resps.

**Q.** So have the vital signs, or at least these two measurements, now been captured by the system?

**A.** Yes.

**Q.** By clicking "Done", does that record them into the system?

**A.** Yes.

**Q.** Is it right that the vital signs function is only able to take heart and breathing rate readings within certain parameters?

**A.** Yes.

**Q.** Now, as I understand it, for the pulse rate, that's between 50 and 130 beats per minute?

**A.** *(The witness nodded)*.

**Q.** And for the breathing rate it's between 8 and 39 breaths per minute. Do you know whether that's right?

**A.** I don't. I'm sorry.

**Q.** Can you also confirm that the system does not send an automatic alert or notification for fluctuations in vital signs?

**A.** No.

**Q.** You can confirm that?

**A.** Yeah. It doesn't.

**Q.** To what extent would the vital signs function actually alert staff to a deterioration in a patient's physical health?

**A.** It wouldn't unless we were taking the actual reading. It does, the system allows us to monitor themes, so it -- the system is assessing that at all points so it would allow us to see trends in somebody's heart and resp rate but that wouldn't be medically accurate unless it is being taken in this way outside the door of the room.

**Q.** So the themes that you might be able to see is to trace, for example, a breathing rate --

**A.** Yeah.

**Q.** -- during the time the person is in the bedroom?

**A.** Yeah.

**Q.** So long as it is within those parameters that I was just talking about?

**A.** Yes.

**Q.** Thank you. Could you take that down, please.

I want to move now --

**THE CHAIR:** Sorry, can I ask about that. It can trace how -- does it have a special function to trace it, or is that just a case of you having to go back and look at all the readings to assess what has happened?

**A.** Yeah, it's actually part of the system, but the part of the system that we would use is that function where we would take one reading for a specific reason. Yeah. I don't know whether -- do you want me to explain that now?

So the only reason we would use vital signs is overnight where somebody is on general observation, so it isn't a level of risk but it would be to do with -- we do care rounds on an hourly basis which can be quite disruptive to patients' sleep. So we would use this, if the patient is able to consent and if the patient is in agreement, we could care plan that we would use the vital signs overnight. Or we may use it if somebody perhaps is in seclusion or had rapid tranq, and we are unable to physically take observations, that we would use this as an additional way to monitor to understand if the patient was safe.

**MR GRIFFIN:** We'll come on to that in a little bit more detail, particularly in relation tonight time use.

What I'd like to do first, though, is to come on to the implementation and rollout of Oxevision at TEWV, please. The statement, so when I -- I'm going to refer to Mrs Murphy's statement as "the statement" just so we're clear.

**A.** Yes.

**Q.** So the statement says this, this is page 3, paragraph 4:

"Implementation of Oxehealth at the Trust commenced in 2019 with a pilot running across five wards. The system went live on three wards at the end of 2020."

**A.** *(The witness nodded)*.

**Q.** So as we understand it TEWV was fairly early --

**A.** Yeah.

**Q.** -- in the context of Mental Health Trusts in piloting and implementing Oxevision.

Could we look at part of the business case put forward for Oxevision, please.

Now before we do, are you able to confirm that this was co-authored with the company Oxehealth?

**A.** So I'm not able to confirm that because some of the people who were involved at that time in the organisation have moved on, so I don't understand the detail of how that business case was prepared.

**Q.** So this is what paragraphs 66 and 67 of the Murphy statement says. That's page 15:

"The Trust is unable to confirm the extent to which Oxehealth was involved in the design or drafting of the Trust's business case due to the passage of time and due to persons involved in preparing the initial business case no longer working within the organisation."

That's the point you've just made, isn't it?

**A.** Yes.

**Q.** It goes on to say this:

"The business case is dated 14 August 2019 and the document indicates it was co-authored by Oxehealth and Elizabeth Moody, Director of Nursing and Governance, Deputy CEO at the time."

So that would indicate that there was Oxehealth involvement in the production of the business case; would you agree?

**A.** Yes.

**Q.** Put up, please, TEWV021330, page 1, and would you expand the executive summary, please. So as I've just said, this is the business case. It's in fact entitled "Oxehealth Digital Care Assistant Trial to Scale"?

**A.** Yeah.

**Q.** And dated 14 August 2019, as I mentioned.

It says at the start this:

"TEWV would like to explore Oxehealth's Digital Care Assistant (DCA) to: [first of all] improve safety,

quality and patient experience in inpatient facilities [and to] release pressure on our inpatient patient workforce by saving clinical time on wards."

So can we see there a variety of purposes being considered for Oxevision from improving safety to saving clinical time?

**A.** Yes.

**Q.** If we drop down a bit we can see this:

"The Trust would like to trial-to-scale the DCA across a representative set of inpatient services, building on learning from other NHS Trusts. Should it deliver benefits to patients, staff and the Trust, TEWV has intent to scale it across its services.

"Each locality has nominated services to take part in the trial-to-scale."

Is another word for trial-to-scale "pilot"?

**A.** Yes.

**Q.** "... based on highest unmet clinical need, geographic spread, and minimal operational disruption."

And can we see then five pilot wards?

**A.** Yes.

**Q.** Do they cover MHSOP: Mental Health Services for Older People?

**A.** Yes.

**Q.** PICU: Psychiatric Intensive Care Unit?

**A.** Yes.

**Q.** CAMHS: Child and Adolescent Mental Health Services?

**A.** Now, that area did not go ahead because those wards were closed prior to it being installed, I understand.

**Q.** Thank you for clarifying that.

**A.** Yes.

**Q.** But also an adult acute ward and a seclusion ward?

**A.** Yes.

**Q.** So the pilot covered a range of wards and services --

**A.** Yes.

**Q.** -- deliberately.

Just going back to what's on our screen towards the bottom:

"Oxehealth had created a long-term investment option that would make both trial-to-scale and widespread uptake feasible for the Trust."

And then figures are given on a monthly basis for the trial, reducing to another figure at scale, and further reducing per ward per year. We can see at the end here:

"Whilst the trial will focus on quality improvement, anticipated financial benefits include a reduction in enhanced observations (reducing agency/bank spend), time and cost savings associated with fewer incidents and associated reviews) and the time savings associated with

faster, more effective observation and interventions on wards."

Can you see that?

**A.** Yes.

**Q.** So the reference there is both to a reduction in enhanced observations and to faster and more effective observation; correct?

**A.** Yes.

**Q.** Can you explain why it was felt use of the technology might lead to a reduction in enhanced observations and to faster observations?

**A.** I can't because that is not what the system allows us to do and it's not my understanding of how we've ever used it as an organisation. We've always been very clear that actually it does not replace the need for engagement with patients, and it's an assistive technology and does not therefore mitigate the use of additional staff and resource. All I can think is that people felt that it might contribute that at the time when the business case was developed.

**Q.** So your explanation is that this might have been one of the early reasons for trialling?

**A.** Yeah.

**Q.** But your understanding is that it hasn't been the purpose for which it was procured and used?

**A.** No.

**Q.** Do you know whether Oxevision was introduced at least in part because there was a concern about the rising need for enhanced observations?

**A.** No, it was about patient safety and improving patient safety on our wards, and at that time we had a number of patient safety incidents that drove us to look at a number of ways, I suppose, to improve the safety of environments. So Oxehealth was considered alongside the use of specific doors on inpatient areas so door alarms, and also key environmental changes around reducing ligatures in our inpatient environments.

**Q.** Thank you. But there does appear to be something of a mismatch between this early --

**A.** *(The witness nodded)*.

**Q.** -- intention --

**A.** Yeah.

**Q.** -- and what transpired, in your evidence?

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

**Q.** Thank you.

Just dealing with financial benefits, please. So at this early stage, there were anticipated to be financial benefits associated with the operation of Oxevision within the TEWV wards, yes?

**A.** Yes.

**Q.** The business case -- and just to remind us, this is from 2019 -- refers to a potential saving to the Trust of over £1 million a year arising from a 20 per cent reduction in enhanced observations which are mainly carried out by bank and agency staff, and we saw a reference to them, didn't we, just now?

**A.** Yes.

**Q.** Did TEWV actually see those financial benefits?

**A.** No.

**Q.** As far as you're aware, has it continued to be the case that there's been no saving in staff costs arising from the use of Oxevision?

**A.** That's correct.

**Q.** The statement -- this is paragraph 4 at page 2 -- goes on to say that:

"In 2021 permission to extend its use was obtained from the Trust Board and the use has been extended further since. The system is currently operating on over 50 wards across the Trust's sites."

In what types of wards is Oxevision now operating?

**A.** I think it's that full range of that small pilot group that was used initially. It's used in Adult Mental Health wards, rehab, including rehab assessment and treatment, and Psychiatric Intensive Care units. It's used across our secure inpatient estate. It's used on

our mental health services for older people.

**Q.** Across the board?

**A.** Yes.

**Q.** Does that include CAMHS?

**A.** We don't deliver any CAMHS inpatient services.

**Q.** You've helpfully, or TEWV have helpfully provided a list of the wards --

**A.** Mm-hm.

**Q.** -- to us. We don't need to put it up on the screen. But can you confirm this: that there's been a steady rollout of Oxevision across the TEWV wards ever since 2020?

**A.** That's correct.

**Q.** And there were further wards that were to go live this year; is that correct?

**A.** Yes.

**Q.** And further wards to go live in the future?

**A.** Yes.

**Q.** What proportion of inpatient wards now have it installed?

**A.** A large proportion. I wouldn't like to give an exact percentage but the majority of our wards now have that facility.

**Q.** Are there any wards that don't?

**A.** So we don't have it on our learning disabilities wards.

Yeah, and apart from that it's pretty much all areas. They're not all in use currently, that's what I would say, since we've reviewed our policy and updated our consent model. So there's a lot more out of use but the actual provision is available in those areas.

**Q.** Thank you. The Murphy statement talks about wards where there have been high opt-out rates?

**A.** Yes.

**Q.** And also wards where -- potentially with a higher risk --

**A.** Yeah.

**Q.** -- where it's used more. Do you mind if we come back to address that a little bit later?

**A.** Yeah, of course.

**Q.** The statement explains that at the time of the initial deployment there were no risks identified in the initial proposals. That's paragraph 34 at page 8. So we'll be hearing this afternoon from a witness from another Trust. It's right to note that they were trialling Oxevision later than you were at TEWV --

**A.** *(The witness nodded)*.

**Q.** -- and they identified I think seven risks.

**A.** Yeah.

**Q.** Do you find it surprising that no risks were identified by TEWV, even if it was 2019?

**A.** Yes.

**Q.** The statement -- this is paragraph 34 at page 8, and the next page -- it then lists anticipated benefits. We don't need to put this up but do you have it in front of you?

**A.** Yes.

**Q.** Are they as follows -- so these are the benefits that were anticipated at the start of the process.

**A.** Sorry, what paragraph are we at?

**Q.** So this is paragraph 34 under the title "Benefits and Risks of Oxevision", do you have that?

**A.** Yes, thank you.

**Q.** Are the anticipated benefits as follows: to reduce falls?

**A.** *(The witness nodded)*.

**Q.** To reduce self-harm --

**A.** *(The witness nodded)*.

**Q.** -- including ligatures. Why was it felt, do you know, that there might be a reduction in self-harm?

**A.** So I'm not sure whether people thought that the system could offer us more than actually we understood once the system was installed. So there is an option in terms of activity that actually it can tell us where people are in a room. So actually, it does add some benefits in terms of it can tell us, for example, if somebody is

standing for a longer period in the bathroom, three minutes in a bathroom, or standing near a door. So that may help us indicate that a patient was going to engage in a self-harm activity.

**Q.** So this is the alert function which we'll come on to?

**A.** Yes.

**Q.** Do you think that's what this reduction of self-harm might be referring to?

**A.** Potentially, yes.

**Q.** The anticipated benefits include reducing assaults. Do you know how it was anticipated that Oxevision could operate to reduce assaults?

**A.** No, I don't.

**Q.** The next is to reduce restrictive interventions. How would that benefit, do you know, be realised, using Oxevision?

**A.** I suppose, there may be some benefit in people not having disturbed sleep overnight to use that vital signs check overnight. But that's the only one I can think of.

**Q.** Because disturbing a patient might lead --

**A.** To distress or --

**Q.** -- to distress?

**A.** Yeah.

**Q.** Thank you. The next we can see is "Improve physical

health monitoring".

Is that a reference, do you think, to the vital signs function?

**A.** Potentially, but our physical health monitoring would take place, you know, kind of regularly on our wards in terms of that monitoring on a daily basis. The system only provides resps and pulse so actually, the circumstances where it can help with that might be around those circumstances I mentioned earlier, if somebody has been in receipt of rapid tranquilisation or is in seclusion, where you're unable to get their physical obs in any other way.

**Q.** So we have received evidence about NEWS2.

**A.** Yes.

**Q.** Can you just explain briefly what that is?

**A.** So we use NEWS2 as a regular daily monitoring and what it is, it almost takes a range of physical observations. It produces a score, and if that score caused us concern then it would indicate that we needed to seek, you know, either a review from a medic or perhaps emergency response if the score was high enough to indicate that.

**Q.** So you used that, as do many Trusts --

**A.** Yes.

**Q.** -- across the mental health wards?

**A.** That's correct.

**Q.** Does that involve taking, actually, six measurements?

**A.** Yes.

**Q.** Two of which are the vital signs measurements we talked about?

**A.** Yes.

**Q.** But then four others including, for example, blood pressure?

**A.** Yes, yeah.

**Q.** So the vital signs function is able to assist with two out of the six --

**A.** Yes.

**Q.** -- NEWS measurements?

**A.** Yeah.

**Q.** But not the others?

**A.** Not the others, no.

**Q.** Thank you.

We can see here also "Improve patient experience at night."

Is that for the reason you started to explain to us?

**A.** Yes.

**Q.** Thank you. I will come to discuss that a little bit more in a moment.

Then we see "Improve staff experience."

Do -- are you able to say why staff experience might be improved?

**A.** So I think there's something about for the workforce in mental health, I think they worry about patients. They worry about kind of patient self-harming, et cetera. So I think it may have been thought, back in when we first looked at introducing the system, that that would somehow help build staff confidence around, you know, clinical decision making that they were making, that it was an additional tool to support that clinical decision making.

**Q.** So an assistive technology?

**A.** Yes.

**Q.** Now, the statement includes a column for the types of ward where each of these benefits might be felt most keenly.

**A.** Yeah.

**Q.** So is it right that not all of the benefits we've just been addressing would necessarily apply across the range of wards?

**A.** Yes.

**Q.** Some would be more important in certain contexts?

**A.** Yes.

**Q.** Thank you.

So having dealt with potential risks and benefits can we move on to talk about the purpose of Oxevision at TEWV. We started to talk about that already.

The Trust's Oxehealth policy, which is from 2024 --

**A.** Yeah.

**Q.** -- refers to the primary purpose of Oxevision as being to assist staff in enhancing and supporting patient safety in realtime. That chimes with what you've just been saying, doesn't it?

**A.** Yeah.

**Q.** Would you just develop that for us, please?

**A.** I think it was absolutely a part of a suite of things that we've done to try and improve safety on inpatient areas. I mentioned the other environmental changes that we made. So I think the organisation were keen to explore anything that might give that opportunity to reduce incidents and, you know, improve the care of the patients that are inpatients on our wards.

**Q.** Is a significant element of that that the intention was that Oxevision should not be used to replace --

**A.** Absolutely.

**Q.** -- staff-to-patient contact?

**A.** Yeah. Engagement with patients is absolutely key in mental health and, you know, the narrative has always been very clear that this is an assistive technology and it is not there to replace the engagement or the importance of staff engagement with patients.

**Q.** Now, one of the points that's been made to the Inquiry,

and we'll hear more about later, is that there is a potential disconnect between policy and expectations on the one hand and what actually happens on the ground at wards. Do you know the point that I'm making?

**A.** Yes, I think we've experienced that in TEWV.

**Q.** Well, I was going to ask. The expectation at TEWV might have been that this should be an assistive or add-on tool?

**A.** *(The witness nodded)*.

**Q.** Has it actually happened or potentially happened that at TEWV it's been used sometimes to replace that kind of therapeutic face-to-face connection that one would want to see?

**A.** So, no. But I think that that message has always been very clear, but I think what we did see is, actually, you know, we'd set a number of alerts on the system that potentially led to some alert fatigue for staff because we initially set up the system to do more than it does now. So for example, it would alert if somebody had left their bedroom after 9 pm at night. So the amount of alerts that were happening across our inpatient areas was excessive and described as "unmanageable" by staff.

**Q.** Let's just deal with alerts now. Did TEWV have potential alerts -- this is paragraph 21 at page 6 -- for a patient at the door of the bedroom, in their

bathroom, leaving their bed?

**A.** Yeah.

**Q.** Out of their bed, and room entry?

**A.** Yeah.

**Q.** Now they didn't apply, again, to all wards, did they? They might apply to more particular kinds of wards; is that right?

**A.** Yes, so the leaving the bed and out of the bed only applies to our Mental Health Services for Older People and, indeed, I think that's where we've seen the benefit of the use of the system.

**Q.** Was there previously a further out-of-room alert?

**A.** There was.

**Q.** Is this what you were talking about?

**A.** Yes.

**Q.** That was de-activated; is that correct?

**A.** It was, yes.

**Q.** The statement says -- this is paragraph 22 -- that that was to allow staff to concentrate on critical alerts?

**A.** Yes.

**Q.** You mentioned fatigue, I think?

**A.** Yes.

**Q.** Alarm fatigue. Was that an issue?

**A.** Yes, it was an issue.

**Q.** There are still a lot of alerts and alarms, aren't

there, not limited to Oxevision?

**A.** Yes, there are. There are still quite a high proportion but it has reduced significantly since we've done that work to reduce the -- to take off the out-of-room alert. And we've also done a lot of work around the changes in the policy since 2004 to educate people beyond the use of the system and understanding the implications, I suppose, of the delivery of the system.

**Q.** But is there still an issue or possible issue of the multiplicity of alerts and alarms overwhelming staff and leading to fatigue?

**A.** Yes, and they have reduced significantly and what I would say is that we now have a monthly Matron report. So we explore -- we survey three patients on -- three patients or staff on every ward each month and there's a Matron report that gives us assurance around the function and the use of the system. So we are able to then validate that the alerts are being addressed appropriately as part of that monthly assurance audit.

**Q.** Thank you. We'll come back to the governance around the use of Oxevision a little later.

You've mentioned using the system for nighttime observations.

**A.** Yes.

**Q.** Can we just deal with the observations part of that

first, please. What -- can we just be clear by what you mean by observations, because we know that there is the vital signs function?

**A.** Yeah.

**Q.** But there is also a facility to view a patient in advance of taking --

**A.** Yeah.

**Q.** -- the vital signs function through the tablet or screen?

**A.** Yeah.

**Q.** When you say observations, what do you actually mean?

**A.** So on mental health wards we use observations as intervention in terms of managing risk, so when I refer to "observations" in relation to Oxehealth, we don't use -- Oxevision, sorry -- we don't use Oxevision to manage risk. What we also carry out on all of our wards is what we call as part of our policy "general observations". So that applies to all of our patients, just a wellbeing check, if you like, on the hour of every hour to checks that somebody's okay, that if there is anything they need, have a conversation with them during the day, and so we do that on the hour every hour on a ward.

**Q.** Is that also during night?

**A.** Yes, yes.

**Q.** So in addition to using Oxevision, would a member of staff be going into a patient's room every hour?

**A.** Yes, or checking their whereabouts. So they wouldn't necessarily go into their room but there's a care round that happens all the time for all patients just to say: Are they okay? Is there anything that you need? Et cetera.

**Q.** But might that involve going into the patient's room during the nighttime?

**A.** It could. And that's where we're using Oxevision, if appropriate, if somebody has the capacity to consent, and if we're not using that as a level of risk. So we would use the vital signs check instead of the going into the room to, you know, which potentially could disturb somebody.

**Q.** I'm not understanding, and it's me, not you. I'm trying to work out how you're using Oxevision at night. So there is the facility to take vital signs measurements in a contact-free way --

**A.** Yeah.

**Q.** -- so you don't disturb the patient?

**A.** Yeah.

**Q.** But that's not observations, is it? That's a health check of sort.

**A.** It's a care round. It's a care round.

**Q.** So to what extent at night is Oxevision the system being used for the purposes of observations?

**A.** So for formal observations around risk, it's not used at all. If anybody has a level of risk, so they have a risk of self-harm behaviour, that would absolutely be carried out by a person and it would be face-to-face monitoring. Where Oxehealth is used at night is to replace those care rounds. So if I describe what happens, that might be helpful?

**Q.** Yes.

**A.** So the member of staff would go to the patient's room. If we didn't have Oxehealth, they might look through the visor. They might not be able to see somebody's breathing or resp rates or might see something that, you know, kind of would concern them. So they would still go and check in that room. If the patient is settled, if the patient has consented and agreed, they would take a vital signs reading outside of that room so it prevents them having to go, actually, into the room and, you know, disturb the patient. So it's purely around that care rounds check, not around observation around risk.

**THE CHAIR:** And if the patient is a risk --

**A.** Yes.

**THE CHAIR:** -- or is in any way a risk, what happens?

**A.** They would have one-to-one observations or as prescribed by our engagement and observation policy.

**THE CHAIR:** And what does that amount to?

**A.** So for --

**THE CHAIR:** At night.

**A.** So for some people that could be one-to-one, so they may have a member of staff with them at all times. That could be -- some patients have two-to-one. Some people, you know, kind of, may have what's known as intermittent observations, so we might go and check on them regularly, you know, two times an hour, or, you know, have an increased number of engagements throughout the day. That can change during night and day. Some of our patients experience distress at different times during the day so that would be care planned with their MDT to understand what would be therapeutic and beneficial to their safety.

**THE CHAIR:** Can I just ask one more?

**MR GRIFFIN:** Please, please.

**THE CHAIR:** Prior to Oxevision being installed, what sort of check would have happened at night?

**A.** It would have been the care rounds as I described. They would go to the room, but if they couldn't establish that the patient was breathing, that everything was okay in the room, they would go in. So the patient may be

disturbed every hour, just for the sake of somebody checking on them.

**MR GRIFFIN:** So the process that's adopted at TEWV doesn't actually save staff time.

**A.** No.

**Q.** It allows for, in certain circumstances, less disturbance of the patient?

**A.** Yes, and improved patient experience.

**Q.** But in the context of the potential need to go into the room in any event during the night?

**A.** Yeah.

**Q.** There are different levels of observation that we are hearing about and we'll hear more about tomorrow. What level of observations is it permitted to use Oxevision for at TEWV?

**A.** So if there's any element of risk it's not allowed. It's not used at all. It's only around general observation that applies to all patients who come on to our wards, and that's purely a wellbeing check.

**Q.** So anything -- any form of enhanced observations --

**A.** *(The witness nodded).*

**Q.** -- which we've heard at TEWV are referred to as level 2 to level 4, that would not be appropriate --

**A.** No.

**Q.** -- to use Oxevision. You would need to revert to --

**A.** Yes.

**Q.** -- the non-Oxevision --

**A.** A person.

**Q.** -- way?

**A.** Yes.

**Q.** Thank you.

The business plan that we looked at referred -- so this is at the start of the process -- referred to one of the anticipated benefits being a reduction in enhanced observations.

**A.** Yeah.

**Q.** Your evidence is clear that it should not be used for enhanced observations.

**A.** No.

**Q.** So is that an example, again, of an element of the business case, what it was hoped might assist --

**A.** *(The witness nodded)*.

**Q.** -- not actually being the case in terms of how it was actually deployed on the ground at TEWV?

**A.** That's correct.

**Q.** Or intended to be deployed?

**A.** *(The witness nodded)*.

**Q.** Thank you.

So you've referred to using it at night only and not during the day.

**A.** *(The witness nodded)*.
**Q.** How would you define "night"? Between what hours?
**A.** I suppose it's difficult because some of our patients, you know, kind of go to bed at different times. It's when the patient is in their room and asleep. That's when that would be used, because the person would take their vital signs outside the room. I suppose the only other occasion is when I've mentioned if somebody was perhaps in seclusion or had had rapid tranq and if we felt that we couldn't, we would always try and take physical observations for the point you made earlier, manually, but actually, if we couldn't, then to get resps and pulse would be -- if that would be beneficial we would use it in that way.
**Q.** Why is it useful to have that facility for that type of scenario, seclusion, for example?
**A.** Yeah, because you're working with a highly distressed patient at a very difficult time and actually, you know, it's important that we do that physical monitoring after physical intervention or medical intervention to make sure that we're constantly monitoring the patient's wellbeing.
**Q.** So might vital signs and Oxevision be used during the day for that kind of patient?
**A.** Potentially, yes.

**Q.** So there are scenarios in which it is permitted to use it during the day in certain types --

**A.** Yes.

**Q.** -- of ward or service?

**A.** Yes, it would be infrequent but yes, that is possible, in those scenarios.

**Q.** So seclusion, what would the other or others be?

**A.** Seclusion or if somebody has had rapid tranquilisation and perhaps then they've gone back to their bedroom.

**Q.** The statement is clear that otherwise, Oxevision is not to be used during the day; is that your understanding, as well?

**A.** Yes.

**Q.** So we have seen and you've helpfully provided monthly usage reports provided -- this is one of the benefits of the Oxevision system, as we understand it, is the type of data and reports it can provide to Trusts?

**A.** Yeah.

**Q.** Monthly usage reports, are they amongst the information that a Trust such as TEWV can receive from --

**A.** Yeah.

**Q.** -- Oxevision?

Do these provide a ward-by-ward summary of certain aspects of the use of Oxevision?

**A.** Yes.

**Q.** And do they also provide, I think towards the end, usually, an all-ward summary on a single page?

**A.** Yeah.

**Q.** Do the ward summaries cover things like the number of vital signs attempts each day?

**A.** Yes.

**Q.** And the number of successful times vital signs have actually been taken?

**A.** Yes.

**Q.** And other key data like that?

**A.** Yes.

**Q.** Could we look at a part of one of those now, please.

Would you put up TEWV021321 at page 3 and expand section 1. Would you expand the top box. That's very helpful, thank you.

Can we see "Esk" at the top there? Is that a reference to the Esk Ward at Cross Lane Hospital in Scarborough?

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

**Q.** Is that a female acute ward with 13 beds?

**A.** It is, yes.

**Q.** So we can see here that this shows attempts to take vital signs in Esk in June 2024?

**A.** Yeah.

**Q.** Do the numbers running along the bottom there from 1 to

30 denote days of the month?

**A.** Yes.

**Q.** And can we see above each day, a bar showing the cumulative total of vital signs attempts?

**A.** Yes.

**Q.** Can we see, for example, that on the 26th it was up to 340?

**A.** Yeah.

**Q.** Do you see that the bars are split into two --

**A.** *(The witness nodded)*.

**Q.** -- showing attempts during the day and during the night? So the night is the darker -- I don't really dare say what colour that is -- blue of some sort, and then the lighter blue is during the day?

**A.** Yes.

**Q.** We know from the monthly report that daytime results are from 8.00 am to 8.00 pm.

**A.** *(The witness nodded)*.

**Q.** With nighttime results for 8.00 pm to 8.00 am?

**A.** *(The witness nodded)*.

**Q.** So can we see actually here from the light blue part of each of these bars, that there are vital signs attempts during the day as well as at night?

**A.** Yes.

**Q.** Are you able to explain that, if the purpose of

Oxevision at TEWV is for nighttime use?

**A.** So I think this was around the period that we discovered that people were using vital signs attempts from the system that was available in the office, and on their handheld device. And actually, because what was happening was that as alerts were happening, so that might be that we've been alerted that somebody had been in their bathroom for a period of time or against the door for a period of time, staff were using this system to check whether the patient was okay. Obviously that didn't fit with our policy and procedure at that time, so that was the time that we had to do a lot of work on reducing this -- how people were using vital signs.

**Q.** So if we were to ask for the equivalent monthly usage report for June 2026 it would look quite different?

**A.** Yes, yes.

**THE CHAIR:** You said earlier that you didn't think that there had been instances of using Oxevision as a substitute for engagement.

**A.** Yes.

**THE CHAIR:** Do you think these figures also identify that that might also have been going on?

**A.** No, because I think this is a different concern for staff, so I think staff have been well intentioned when they're using this vital signs attempts because they're

worried that something has happened to the patient in the room, because this could be a patient who's an informal patient on no level of prescribed observations, but they can press the system, and then an image appears of -- that we saw earlier. So actually, they can check if the patient's safe. So it's --

**THE CHAIR:** So this, you think, is attributable only to misguided response to alerts.

**A.** Yes, I do, yes.

**THE CHAIR:** Have you had any instances of anybody reporting people using this also to undertake routine observations --

**A.** No.

**THE CHAIR:** -- and engagement? You've had none?

**A.** Not that I can recall, no.

**THE CHAIR:** Okay, thank you.

**MR GRIFFIN:** Is it a possibility that this represents some form of misuse?

**A.** This does represent misuse, yes.

**Q.** But illicit use outside policy potentially, for example, to watch someone in the privacy of their bedroom?

**A.** At that time, so we had a procedure in place, not a policy, and this was around the time that we reviewed that situation and developed the policy. But yes, this isn't appropriate use of the system.

**Q.** Putting this point to one side, please, the fact that it's clearly -- oh, by the way, if you scroll through the other wards in the months you've provided us in 2024, we do see a similar --

**A.** Yes.

**Q.** -- pattern. So it's not -- I haven't just picked this one at random.

**A.** Yeah.

**Q.** But putting that point to one side, I just want to ask you this question possibly before we have a break. On one view, would you agree with this, Oxevision, the observations and the vital signs function, is intended to be used -- and also the alerts -- but it's intended to be used for quite a narrow purpose, actually?

**A.** Yes.

**Q.** You'd agree with that?

**A.** Yes.

**Q.** Did you -- we'll obviously discuss more but do you consider, given the narrowness of the purposes of Oxevision at TEWV, do you consider it's proportionate to pay for that system and to have it in the wards?

**A.** So I think our knowledge of the system has grown since first implementation in 2019. I think that people's intention to install the system was absolutely with that purpose: to improve patient safety. I think that the

knowledge that we've gained over the years has caused us to question that, and we're currently undertaking a review --

**Q.** Well, I'm going to ask you about that review a little later on.

**A.** Yeah.

**Q.** So this is a review that's under way at the moment?

**A.** Yes.

**Q.** Is it possible that the repercussions of that review will be that the manner in which Oxevision is deployed at TEWV, or whether it's used at all, will be reconsidered?

**A.** Yes, potentially, alongside an evaluation that we're also -- is currently -- the scope is being developed. So we've got the review that is currently looking at how we align to our current policy. Whether we've got the consent model right, and querying, you know, kind of our longer-term commitment to the system --

**Q.** So it's all up for grabs, basically?

**A.** Yeah, potentially when we do the evaluation because we want to understand the benefits. I think it's important to say that any decision to remove the system needs to be well considered, to ensure that, actually, there are some potentials that if we remove this system suddenly, that our patients' understanding of what it delivers and

our staff's understanding could potentially introduce some risk.

**MR GRIFFIN:** Thank you very much.

Chair, we've been going for an hour and ten minutes. May I suggest a break until 11.25, please.

**THE CHAIR:** Yes, 11.25.

**MR GRIFFIN:** Thank you.

**(11.12 am)**

(A short break)

**(11.28 am)**

**THE CHAIR:** Mr Griffin.

**MR GRIFFIN:** Mrs Devanney, we were looking at purposes of the Oxevision system. I just want to ask you about one more of those, please, now.

**A.** Okay.

**Q.** When we were looking at the screen shots earlier on in your evidence about how to take a vital signs measurement, we saw a clear view of a patient in their room, didn't we?

**A.** Yes.

**Q.** Is another purpose of Oxevision the retention of what's referred to as Clear Video Data, or footage, that can subsequently be accessed if there's been an incident or something similar?

**A.** So, I suppose that's not an intended purpose of the

system but it can be and has been used in that way.

So you can request a clear view image from Oxevision within 24 hours of an incident.

**Q.** Just to pause there, is it deleted after that 24-hour period, the data?

**A.** No, because you can still receive what's -- it's almost a blurred vision. So a blurred video of the same picture for -- you can request that up to three months after an incident.

**Q.** So can we just pause for a second. So if there's been a patient safety incident, one option is that you can have Clear --

**A.** Yes.

**Q.** -- Video Data?

**A.** *(The witness nodded)*.

**Q.** But that needs to be obtained within 24 hours?

**A.** Yes.

**Q.** Another option is that you can have what is sometimes referred to as blurred or pixelated --

**A.** Yes.

**Q.** -- or anonymised footage that is available for considerably longer.

**A.** Yeah.

**Q.** Did you say three months?

**A.** Three months, but I understand that that might be about

to change, that that may be changing to it needs to be requested within 28 days. But currently you can request up to three months.

**Q.** So we've heard the vital signs function allows someone, a member of staff, a clear view of a patient prior --

**A.** Yes.

**Q.** -- to taking the vital signs?

**A.** Yeah.

**Q.** Is that for 15 seconds?

**A.** Yes.

**Q.** And that's what's explained to the patient, is it?

**A.** Yes.

**Q.** Now, in fact, we have learnt at the Inquiry that the Oxevision system, if it's switched on, is actually recording a patient in their bedroom 24 hours a day, seven days a week; is that your understanding?

**A.** Yes.

**Q.** Is that ever explained to patients at TEWV?

**A.** Yes.

**Q.** I haven't seen any explanation in any of the documentation you've provided, procedures, policies, leaflets or posters. It's not explained there as far as I'm aware. Do you understand it to be explained there?

**A.** So part of the work we did in 2024 was about the understanding of the capabilities of the system. So

absolutely, people I speak to on our wards, the work that we've done with the Associate Directors of Nursing, that is explained that it's always there and available. We would only request to see that if there was criminal or coronial process that meant that that information was requested. And that is signed off by only our Chief Nurse or our Deputy Chief Nurse.

**Q.** Two points there, both obviously valid. The second point is the use to which the footage can be put if it's obtained within the 24-hour period?

**A.** Yes.

**Q.** And your point there, as I understand it, is that's quite confined --

**A.** It is.

**Q.** -- and subject to an authoritative sign-off?

**A.** Yes, yes, so a Ward Manager, for example, they could come through the request process, they could request, but that may be declined because it wasn't felt an appropriate use of the footage. So that is signed off at Chief Nurse or Deputy Chief Nurse level.

**Q.** So that's a safeguard that's built in?

**A.** Yes.

**Q.** So that point is clearly made but I want to go back to the point I was asking you about before and that is what is explained to patients.

**A.** Yeah.

**Q.** Would you accept that if a patient were to know that an activated Oxevision system in their room is actually recording them 24/7 it would be quite a significant piece of information?

**A.** Yes.

**Q.** The point I was making is that I have not seen that explicitly explained in the policy, procedure, poster, leaflet that you've provided to us.

**A.** *(The witness nodded)*.

**Q.** Have I got that wrong or is that your understanding, as well?

**A.** So I wouldn't be able to comment on all of those in detail. If that's the case, I think that's something as an organisation that we do need to address --

**Q.** But it's your point that -- your understanding is that it would be explained to a patient in some way?

**A.** Yes, absolutely.

**Q.** Do you know how that would happen? Because presumably members of staff and -- are working from policy?

**A.** Yeah.

**Q.** And if the policy doesn't make that clear, how will they know to explain it to a patient?

**A.** Yeah. So our explanation around the system starts from the point that it's considered that somebody may come in

to one of our hospital beds, so that first conversation I would expect occurs with members of our Crisis Team that explain that we have the system. And that conversation is then picked up with the ward team at the point of admission. The system stays on in our ward for 72 hours and --

**Q.** We'll come on to all of that in some detail in a moment.

**A.** Yeah.

**Q.** But is the point there that the discussion with the patient starts before they even reach the ward?

**A.** Yes, yeah.

**THE CHAIR:** How do you know that the conversation takes place?

**A.** So part of that is about our -- the audit. I suppose prior to 2024, I wouldn't have been confident that we were doing that, but part of the conversation -- the audit that we do now is carried out by our Matrons and does explore people's understanding of the system, its function. We speak to patients. We have a Patient Experience Board that actually are part of our whole implementation of Oxevision.

**MR GRIFFIN:** So if a patient was to have this explained to them it would have to be at the face-to-face stage if it's not mentioned in any of the documentation?

**A.** Yes, yeah.

**Q.** And you believe it would be mentioned in the face-to-face?

**A.** I do, yes.

**Q.** I'm going to look at a document with you now please.

Would you please put up TEWV021314.

This is one of the leaflets.

Would you go to page 7, please, and expand the bottom. "What can staff see?" Would you expand that, please.

So this a leaflet from July 2025, so quite recent.

**A.** Yeah.

**Q.** Entitled "Oxehealth Information for patients". This is what we see in part of the leaflet. "What can staff see?":

"Ward staff will use Oxehealth to check your pulse and breathing rates.

"When these checks take place, staff will only have access to a clear image of your room for up to 15 seconds. These checks are used very infrequently, and only when there is a clinical need.

"This will not replace care rounds or staff coming straight to your room if you need help or support.

"Staff will also have access to a blurred image of your room for up to 15 seconds, only when they receive a notification of a safety alert from the system. Staff

will come straight to your room if they see you need help during their checks."

Just picking up on that first sentence, please "Ward staff will use Oxehealth to check pulse and breathing rates."

We spoke before about the six measurements that need to be taken as part of the NEWS2 approach. What's the point of just taking two of the six?

**A.** So I suppose it's understanding that somebody is safe, that, you know, kind of -- it tells you something about somebody's physical presentation even with those two readings. As I say, we would only use that in terms of if it was to replace those overnight care rounds, or in circumstances where somebody was in seclusion or had had rapid tranquilisation.

**Q.** But if it's taking quite a narrow view of --

**A.** Yeah.

**Q.** -- of much fuller measurement requirements, is its use potentially quite narrow?

**A.** Absolutely, yes.

**Q.** We looked at the screenshots of how you go through the system and you confirmed that once the vital signs measurements are taken --

**A.** Yes.

**Q.** -- they're then loaded on to the system?

**A.** Yes.

**Q.** What then happens to that data?

**A.** You're asking me a technological question --

**Q.** It's not a technological question; it's a question about information, medical information, being gathered by a Trust and the purposes to which that's put.

**A.** Yeah.

**Q.** Do you have an answer to that?

**A.** So I suppose in terms of what the vital signs are used, what the member of staff see, they use that to inform anything, actions that they might need to take at that point. The overarching report in terms of the themes and trends for the alerts are what are considered at kind of our Operational, Clinical Operational Delivery Group. What I would say is that we know that those themes and trends around somebody's resps and pulse are not medically valid so that information in itself is not key information in terms of the information that the system gives us.

**Q.** Thank you very much.

We can see here also in the second paragraph:

"These checks are used very infrequently."

That's the intention, as I understand.

**A.** Yeah.

**Q.** Would you accept that, at least historically, the checks

were actually frequent?

**A.** Absolutely. You know, before 2024, these were used quite regularly and they weren't used for the purpose of taking somebody's pulse and breathing rates. They were used for the purpose of being able to see that the patient was okay. So they weren't used for the purpose it was intended.

**Q.** Thank you.

Can we move to the next page, please, and expand from the bottom "Requesting data from Oxehealth". Would you expand that, please. That's very helpful.

So can we see here, Mrs Devanney:

"There may be times when we request information or data from Oxehealth to help us with internal reviews, for example if there's been a safety or safeguarding incident.

"You are also able to request information if you have been involved in an incident. Any request must be made within 24 hours because the data is not available after this time."

**A.** Yeah.

**Q.** And do we see, if we look at the bullet points, "Clear video images are automatically deleted after 24 hours"?

**A.** Yeah.

**Q.** And so on. Does this pick up on the points that you

were just explaining to us?

**A.** Yes.

**Q.** The leaflet we're looking at, do you know if Oxehealth were involved in co-producing it?

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

**Q.** Is it a possibility?

**A.** Yes, it's possible.

**Q.** Would you take that down, please.

You've mentioned consent --

**A.** Mm.

**Q.** -- a few times, and I want to move on to that topic now, please.

The statement, this is paragraph 7 on page 2, says this:

"There was an expectation that the local Crisis Team would have discussed the use of this technology with the patient."

Now, that is exactly the point that you were just discussing --

**A.** Yes.

**Q.** -- just making, is it?

**A.** *(The witness nodded)*.

**Q.** The reference is to an expectation that it would be discussed --

**A.** Yeah.

**Q.** -- not a requirement.

**A.** Yeah.

**Q.** Are you able to expand on that? How clear it is that -- (overspeaking) --

**A.** So in my view there is a requirement. There are a number of things that we should explore with patients when they're coming in to a hospital environment. So I don't know, for example, things like that we are a no-smoking environment, you know, what that might mean around visiting. You know, so there are a number of things that we would expect. Coming into an inpatient area, is very daunting for people, so we want to make sure that people -- that conversation starts at that point so people are not surprised, for want of a better phrase, when they arrive on our inpatient areas.

**Q.** So it would be part of a conversation before they reach the ward covering various other matters too?

**A.** Yes.

**Q.** How meaningful a conversation would it be before someone is able to hits the ward and is able, actually, see the unit and so on?

**A.** I suppose for different people it's back to that point that all of our patients are individuals, and actually for some people that might be incredibly important. For example, if somebody is experiencing some paranoia, the

fact that they may go into an environment where this system was available might -- it's a better way to prepare them for that conversation than just to land it on somebody. Some people might be so unwell that they don't take some of that information on board at that point, but it's important that we try.

**Q.** And as you say, it might be specific to a patient, the approach that you adopt?

**A.** That's correct, yes.

**Q.** Thank you.

I'd like to go back to the leaflet that we were looking at. Could you put up TEWV021314 at page 8, please. "Can I opt out?"

Would you expand that, please.

So this asks, "Can I opt out?"

"You can ask for Oxehealth to be switched off in your bedroom. This is called opting out.

"Our priority is to keep you safe. If you ask to opt-out this will need to be considered by your Responsible Clinician and the multidisciplinary team caring for you.

"Your care team will assess the risk to your safety and your current mental capacity. They will also consider any potential harm the system may present to you at this time, together with the views from your

carer, family or advocate. This will be regularly reviewed with you during your stay on the ward."

So in brief, does TEWV allow patients to opt out using Oxevision rather than the system being off and only switched on --

**A.** *(The witness nodded)*.

**Q.** -- if they consent?

**A.** Yes, and that will be part of the consideration of the review we mentioned earlier.

**Q.** Can we deal with that now?

**A.** Yeah.

**Q.** So when a patient first arrives on the ward, is there a period, you've mentioned 72 hours before --

**A.** Yeah.

**Q.** -- whilst they're assessed during which the question whether or not Oxevision should be activated in their case will be considered?

**A.** Yes. So previous to 2024, we operated what we called an assumed consent model, and actually then, as our understanding of the system grew, we recognised that actually we needed to think about that more carefully. So we now have this opt-out approach. So it is considered at the point of admission. For all patients that come into our inpatient areas, we hold what is known as a 72-hour formulation meeting. So the time

period that before -- so if somebody decided to opt out, we would -- it would still -- the system would still remain on for that 72-hour period.

Actually, we would do the conversations as you described there in that leaflet. We would do those conversations, and as part of our formulation, the MDT would then consider somebody's capacity, family views, mental health advocate, if that was appropriate, in terms of that system remaining on --

**Q.** So I'm going to ask -- in a moment, I'm going to take you to a part of the policy, I think, and ask you to help us trace through a flowchart explaining all of that.

**A.** Okay.

**Q.** So we'll deal with that in stages in a moment.

Then just dealing with the 72 hours, the assessment period.

**A.** Yeah.

**Q.** The statement refers to the system itself, its use being blanket --

**A.** Yeah.

**Q.** -- during this assessment period?

**A.** Yes.

**Q.** So there's no question of consent being an issue during this assessment period?

**A.** Yeah.

**Q.** Even if a patient does not want the system activated **--**

**A.** *(The witness nodded)*.

**Q.** -- it will be activated?

**A.** Yes, that's correct. But what we are doing as part of the review, considering whether that approach remains applicable.

**Q.** Thank you. Now, during this 72-hour period, what factors might be considered when deciding about the use of Oxevision? This is covered paragraph 30, page 7; do you ever that in front of you?

**A.** Yes, I can get that. Yes?

**Q.** Can we see here, "Reassessment of the mental health capacity status" is one.

**A.** Yes.

**Q.** The "Current risk of patient harm to self and others" is one; is that right?

**A.** Yeah.

**Q.** "Any particular risk of re-traumatisation"?

**A.** Yeah.

**Q.** "The availability and use of alternative care interventions"?

**A.** Mm.

**Q.** And whether the patient is admitted formally or informally?

**A.** Yes.
**Q.** Just dealing with that last point, why might it make a difference if a patient is a formal patient or information patient?
**A.** I suppose it's more part of the overall assessment, because, actually, I suppose it's more likely that somebody who's detained under the Mental Health Act, there may be some issues around capacity, but equally you could have somebody who was admitted informally, that that discussion may need to happen.
**Q.** One of the things we don't see here is patient choice?
**A.** Yeah.
**Q.** Is that a significant omission, in your view?
**A.** I think it is, yes. Because absolutely patient choice is key because we're exploring with them, you know, their views on the use of the system, as part of their stay on an inpatient area.
**Q.** So we've spoken already about an opt-out model of consent. And as I've said, what I want to do is just to work through that with you so we can understand it.
**A.** Yeah.
**Q.** You explain that this is a change in policy. Is that since August 2024?
**A.** Yes.
**Q.** Could you put up TEWV021316, please. Page 12. So this

is the TEWV policy document from 2024.

**A.** Yeah.

**Q.** Could you show the top of the twelfth page, please. Thank you.

What I want to do with you, Mrs Devanney, is to trace through what happens if you have to a patient who has capacity but does not consent to the use of Oxevision, please.

**A.** Yeah.

**Q.** So can we do that by reference to this flowchart. So do we see at the top "Oxehealth status initially switched on upon patient admission to support patient safety and safeguarding"?

**A.** Yeah.

**Q.** So is this is the 72-hour assessment period?

**A.** This is the 72-hour assessment period, yes.

**Q.** Then do we see at 1:

"Fully inform patients/family/carers/advocate about Oxehealth's purpose and functionality as part of the admissions procedure. Document discussion and decision and any queries in patient record."

Again, does that reflect what you've been explaining to us?

**A.** Yes.

**Q.** Thank you. Do we see then a diamond underneath with the

text "Does the patient have capacity to understand implications of Oxehealth"?

**A.** Yes.

**Q.** And if we say, as I've said, can we just take the example where they do.

**A.** Yeah.

**Q.** We follow the "Yes," to the right and then do we see underneath "Does the patient object"?

**A.** Yes.

**Q.** Can we follow that through, assuming that they do.

**A.** Yeah.

**Q.** Do we then go down to the box with 2b?

**A.** That's correct.

**Q.** So just reading that:

"Document discussion and objection in patient record and inform Responsible Clinician within 24 hours."

**A.** Yeah.

**Q.** So this is all, is it, within this 72-hour assessment period?

**A.** Yeah.

**Q.** And the system is remaining on at this stage?

**A.** At that point, yes.

**Q.** Do we then see at box 3 "Full MDT" -- that's multidisciplinary team, is it?

**A.** It is.

**Q.** "... Meeting within 72 hours. Patient capacity reassessed."

**A.** Yes.

**Q.** "Objection discussed and documented as part of individual risk assessment."

**A.** Yes.

**Q.** "Must consider potential harms of Oxehealth ..."

Now, Oxehealth there is a reference to the Oxevision system, isn't it?

**A.** Yes.

**Q.** "... to patient and alternative interventions"; yes?

**A.** Yes.

**Q.** And:

"Clinical recommendations made on use of Oxehealth."

So is the next step after a patient has objected that the issue is raised at the MDT?

**A.** Yes.

**Q.** So the patient's objection is not viewed as the final word in terms of consent and the consent model used at TEWV?

**A.** No.

**Q.** As the system continues to remain on?

**A.** Yes.

**Q.** What input do patients and carers have into the MDT?

**A.** So they would be involved. It's what's known, we call

our 72-hour formulation meeting. And that happens for all patients. It is -- so the purpose of that 72 hours, I suppose this chart describes the information we're gathering in terms of people's views towards the use of Oxevision. But actually, the 72-hour formulation meeting is gathering all of our clinical historical information about -- and current information about the patient. And then the MDT come together alongside the patient and the family to formulate care. So that's where the formulation plan is developed.

Obviously there's an initial plan at the point of admission, but this is about information gathering and it's part of our -- what's known as our purposeful inpatient admissions process.

**Q.** Can I ask you a question I asked you previously in a different connection. And it's about this disconnect between expectations and what actually happens --

**A.** Yeah.

**Q.** -- on the ward. So for example, we've heard from EPUT about a recent review of their consent process --

**A.** Yeah.

**Q.** -- which discovered, amongst other things, that the proper consent practice was not often being used. Are you confident or how confident can you be that all of this actually happens at TEWV?

**A.** So I think we've got a good level of assurance about that now. Previously, before 2024, I don't think we were in a strong position, but we now explore those Matron audits on a monthly basis in the clinical steering group.

We also know -- and I think there's certainly information within the packs submitted -- that our opt-out numbers have increased, so where we have what we would call rooms turned off, if you like. So we know that, actually, we see that practice happening. So we're checking it from, you know, a clinical perspective, in terms of that monthly basis from Matrons, but then we're also reviewing the data to say, actually, you know, is -- do we see that change, or, you know, is there, for example, if we saw a particular ward where nobody opted out, that would cause concern and identify a need to go and explore that further.

**Q.** Can I just pick up, since you've mentioned it, on the governance arrangements.

**A.** Yeah.

**Q.** You've mentioned, well, there's a monthly governance structure we understand from the statement --

**A.** Yes.

**Q.** -- from paragraph 43 since January 2025?

**A.** Yes.

**Q.** So it's a relatively recent development?
**A.** Yes.
**Q.** And we've heard -- you've mentioned the Matron, I think, and the statement at paragraph 44 picks up on the monthly Manager and Matron audit.
**A.** Yes.
**Q.** Is that what you were referring to?
**A.** Yes.
**Q.** And it explains that the purpose there is to ensure system functionality, adherence to policy, and to provide regular patient, carer and staff feedback; correct?
**A.** Yes.
**THE CHAIR:** You said earlier in answer to Mr Griffin that you agreed that patients' objections are not the final word, because we've seen what else the MDT --
**A.** Yes.
**THE CHAIR:** -- will be considering. What weight, though, do you think is given to the patients' objections?
**A.** So that's a difficult question to answer. But what I would say is that, actually, our options, if we thought somebody had capacity, if they are not consenting, our only option after that would be to consider a best-interests decision. And I can't recall when we've had to do that. So, actually, what that

tells me is that, you know, majority of the time, if a patient has capacity and is not consenting, then we would adhere to that and we would switch the system off at 72 hours.

**THE CHAIR:** Thank you.

**MR GRIFFIN:** Do you have data about that?

**A.** So we -- I think we would have that available. We could certainly -- I could certainly explore if that could be made available to the Inquiry if that's helpful.

**Q.** Thank you.

Just sticking with this flowchart, please. Can we see at 4b:

"MDT meeting with patient/family/care/advocate, decision documented in patient record?"

**A.** Yeah.

**Q.** And if we look at decision 5a:

"Oxevision status to be switched on."

And then following it through to 6:

"Use of Oxehealth further discussed as part of the MDT reviews with patient/family/carers/advocate to consider".

And then do we see a number of factors there?

**A.** Yeah.

**Q.** Only one of which is patient choice?

**A.** Yeah.

**Q.** So could one outcome be where you've got a patient with capacity who objects to Oxevision, be that they are effectively overruled by the MDT and it's kept on?

**A.** So it could be, but as I said, I can't recall a situation where that's -- because our only option after that would be a best-interests discussion and decision and I can't recall that ever happening.

**Q.** But, in theory, at least, the decision ultimately isn't the patient's, it's the MDT's; correct?

**A.** Yes, it's a joint decision, yes.

**Q.** With that in mind, can this system or this model actually be described as consent at all?

**A.** So in my view, yes. Because we're respecting the patient's decision once we've considered all the other information available. I think, you know, we recognise that we want to review that consent model further, which is why we've undertaken the review. So I think there are opportunities to strengthen that. But are patient views ultimately upheld? I believe yes, they are.

**Q.** Do you know whether Oxehealth had any involvement in the decision to use this opt-out model?

**A.** I'm sorry, I can't comment on that.

**Q.** In other words you don't know?

**A.** Yes, yeah.

**Q.** Thank you. Can you take that down, please.

You've spoken now or mentioned a number of times this ongoing review.

**A.** Yeah.

**Q.** So my questions, the questions I'm about to ask you, are subject, obviously, to that. I just want to look at the basis of the Trust's current policy from 2024.

The policy makes reference to the National Mental Health and Learning Disability Nurse Directors Forum.

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

**Q.** Did that forum have as its primary aim to review how vision-based patient monitoring systems are used across the country and to make recommendations that will support safe use of patients, staff and organisations?

**A.** I understand that's what it was. I wasn't involved in that review.

**Q.** But in fact are you able to confirm that members of the relevant working group included TEWV's then Chief Nurse?

**A.** Yes, it was Elizabeth Moody at the time.

**Q.** Elizabeth Moody?

**A.** Yeah.

**Q.** And several others, including Oxehealth's then UK Managing Director?

**A.** Yeah.

**Q.** Did the forum go on to provide a report which covered the issue of consent, as far as you're aware?

**A.** Yes.

**Q.** In fact, I think, and we've discussed this with other witnesses, but my recollection is that it provides two options for consent.

**A.** *(The witness nodded)*.

**Q.** One is implicit consent --

**A.** Yeah.

**Q.** -- and the other is a more explicit opt-in?

**A.** Yes.

**Q.** Is that your recollection?

**A.** Yes.

**Q.** The TEWV policy, the '24 policy, states that the forum guidance and recommendations from this work and further co-creation provides an evidence base which underpins this policy.

**A.** Yeah.

**Q.** So clearly important --

**A.** Yeah.

**Q.** -- to the 2024 policy?

**A.** Yeah.

**Q.** The Inquiry is aware of subsequent guidance of potential significance --

**A.** *(The witness nodded)*.

**Q.** -- that doesn't appear to have been considered for the purposes of the policy and procedure.

**A.** Yeah.

**Q.** So, for example, the NHS England principles for using digital technologies in mental health inpatient treatment, now that's from 2025, February 2025?

**A.** Yeah.

**Q.** Are you aware of that policy?

**A.** So I am, and the group has reviewed our current guidance alongside that. It's -- I think there's a number of publications that have been made available kind of since we reviewed the policy, and that will be part of the ongoing review and evaluation to make sure that we've considered all of those.

**Q.** Part of the principles, one of them relates to consent and capacity.

**A.** Yeah.

**Q.** And it includes that: "Where a patient has capacity to consent to the use of digital technology, consent should always be sought from the patient"?

**A.** Yes.

**Q.** And it refers to this: "A digital technology must never be used as a blanket approach."

**A.** Yeah.

**Q.** You say that this is going to be reviewed, but with that in mind, do you think there's need for an urgent review of current policy?

**A.** Yes. I think -- I think, when it's been reviewed I think the steering group did consider that policy and felt that we were compliant.

**Q.** That you were or weren't, sorry?

**A.** That we were compliant with that. But I think, from what you've said, I think it's fair to say that we would get to the point that we were compliant but it's taken us 72 hours to get to that point. So it is something that we should consider as a matter of urgency.

**Q.** Including, potentially also, that the decision for a patient with capacity is down to the MDT rather than to the patient? Is that something that you think might be reviewed?

**A.** So I think that that decision, that is the MDT, considering the person's position on capacity -- their consent -- sorry, not capacity -- I think the MDT is almost rubber-stamping that and I think that that would be good clinical practice to make sure that we've considered the views of the family, the patients, any advocates, before that final decision is made. I do think we hear the patient's voice in that decision.

**Q.** If it's just a rubber stamp, effectively, doesn't that beg the question about giving the final word to the MDT?

**A.** Yeah, I can hear what you're saying but I do think that actually, you know, the principle of that approach is

about best practice and making sure we've considered all information that is available to us before that device is switched off.

**Q.** Thank you very much.

What I'd like to do now, please, Mrs Devanney, is to move to the risks as they're currently understood at the Trust.

**A.** Yeah.

**Q.** This is covered in the statement at paragraph 38, and that's page 9.

Can we put that up, please. Page 9, paragraph 38, please.

Thank you very much.

So we can see risks from (a) to (k) there and we'll look at a few of them in a moment. The statement suggests that these issues were not anticipated and have emerged over time. I think, from an answer you gave earlier, that would surprise you; is that right?

**A.** *(The witness nodded)*.

**Q.** So I asked you previously when no risks were identified --

**A.** Yeah.

**Q.** -- at the start of (inaudible). The fact that they've only emerged over time, do you find that surprising?

**A.** So some of them, I think we should have understood at

the beginning.

**Q.** How did they emerge? Were they revealed for deaths or near misses, complaints, audits, patient feedback and the like?

**A.** I think it's a mixture of all of those things.

**Q.** What about information coming out of this Inquiry?

**A.** So yes, I think people have, you know, kind of taken note of what, not only what is being said in this Inquiry, but also is said more broadly, nationally. I think, you know, we are -- we're fortunate in TEWV that we have a co-production board and we have a Director for Patient Experience and we have a number of stakeholders who were involved in that group who have made their views very clearly known to us over the last few years.

**Q.** Thank you. Can we have a look at just a few of these points --

**A.** Of course.

**Q.** -- at paragraph 38 we can see at (a):

"Relational unintended consequences of the system as patient behaviours change and use of the system to seek relational support."

**A.** Yeah.

**Q.** What does that mean?

**A.** So for a number of our patients that may experience

relational challenges, they can become incredibly distressed. They might have experienced historic harm and trauma, and actually, therefore, how they communicate or how they're able to communicate may be very different from how you and I would understand how people communicate. So what is meant by that is that, actually, for some people, whereas historically before something like Oxevision kind of existed, if, when, you know, we had things like 15-minute checks or whatever, then a patient might choose to involve themselves in an episode of self-harm because they know that a staff member may then respond, that we'll come and check on them in 15 minutes. So actually, they might be trying to communicate something via that self-harm.

There's a risk, with Oxevision, that actually our patients understand that if they, for example, remain in their bathroom for three minutes, an alert will sound and a member of staff will respond. So that in itself is a risk, because actually, if somebody was delayed in their response in the same way if somebody didn't undertake a 15-minute check, then actually, you know, that could be dangerous and result in significant harm.

**Q.** May I just see if I've understood. Is part of the point that you're making that the system, the existence of the system in a patient's bedroom may actually alter their

behaviour?

**A.** It could do, for some patients. Not all patients.

**Q.** It depends on the individual person?

**A.** Their diagnosis, their individual presentation.

**Q.** We can see next "An impact on privacy and dignity".

Is there anything more you'd like to say about that? We've talked about the presence of the camera in the room, and so on.

**A.** Yeah, I think it's touched on a little further down, but for me, the concern around that one would be about people's psychological safety and feeling safe. Very often, when somebody is admitted to hospital, they've felt, whether they're suffering from, you know, kind of an effective or a psychosis presentation, actually, their world doesn't feel very safe and if somebody comes into an environment when then a camera is observing them, that can contribute to that feeling of not being safe.

**Q.** Is that the point at (h) that we see here, "latrogenic (sic) harm of use of the system, i.e. increasing paranoia and perception of surveillance, impact on historical trauma"?

**A.** Yeah, that's actually an "i", so it's "iatrogenic harm". Sorry.

**Q.** Sorry. Is that what you were talking about?

**A.** Yeah, so it's "iatrogenic harm of use of the system".

**Q.** Oh, that's an "i"?

**A.** Yes.

**Q.** That's my fault. Thank you for correcting me.

There are a number of the bullet points there, (c) and (d), for example, where we see points relating to alerts and alarm fatigue.

**A.** Yeah.

**Q.** I don't intend to ask you anything more about that unless there's something more you'd like to explain?

**A.** No.

**Q.** Can we see at (k) the risk, "Staff using the system as not initially intended and outside policy"?

**A.** Yeah.

**Q.** "... i.e. using the system to conduct observations during the day or as a replacement of direct observations."

**A.** Yeah.

**Q.** Could you go over the page, please, and expand paragraph 39.

So do we see there reference to the concern that the use of Oxevision technology for observations could decrease opportunities for therapeutic engagement?

**A.** Yes.

**Q.** And over-reliance on remote monitoring?

**A.** Yeah.

**Q.** Which I understand to be a similar point.

**A.** Yes.

**Q.** What's being addressed here, in your view?

**A.** So I think this is about the point that I mentioned earlier where we had staff who are pressing -- silencing the alert or resetting the alert, I should say, in the ward office, because, actually, they're anxious about what the patient is doing. So the system presented an opportunity that wasn't for its purpose, that actually you could then press for vital signs, you would then see the image of the patient and you would be able to say, you know, identify quickly if that patient was coming to harm or causing themselves harm in that room. And I think that's what it's been referring to.

**Q.** Thank you very much.

Would you take that down, please.

So we've heard of the 50 wards at TEWV that have or will have Oxevision installed.

**A.** Yeah.

**Q.** How is the expansion of the system in this way reconciled with what we've been talking about and the risks that we can see -- we've just been seeing on the screen?

**A.** I think that's our ever-evolving process, to review our

policy, and our approach to consent. I think we have seen that actually, since we've improved that, for a lot of areas, particularly our long-stay areas -- because of course all our wards aren't assessment and treatment -- so in secure inpatient services and our rehab wards people could be with us for months or even years and in those areas we're hardly using the system at all.

I think we do see benefits in the system in MHSOP because we are able to potentially respond to falls quickly, if somebody is on the side of the bed or out of bed, and also, that makes it, that risk of fall is identifiable earlier so therefore we can care plan more appropriately around that.

**Q.** Can we come back to that point now?

**A.** Yeah.

**Q.** This point about where Oxevision may be of greatest assistance --

**A.** Yeah.

**Q.** -- and then also where it may be of least assistance.

**A.** Yeah.

**Q.** So I think you've mentioned at least two times now the older adult scenario, and falls.

**A.** Yeah.

**Q.** Is that where you see this kind of technology being of greatest application?

**A.** Yes. At this point, for what we know as an organisation, my view would be that's where we see the greatest benefit.

**Q.** We've received evidence that there are alternative forms of technology that address falls, for example --

**A.** There are, yes.

**Q.** -- like bed pads --

**A.** There are, yes.

**Q.** -- that might be cheaper and less invasive?

**A.** Yeah.

**Q.** When you take those into account, how significant is this function of Oxevision within the older adult context?

**A.** So I think some of those systems may do similar things. We're obviously working with the system at the moment and it's a system that we use in the organisation. So it makes sense that we continue to use this, to help us in that area.

**Q.** Are there other types of ward where, in your view, there is a real purpose for Oxevision?

**A.** So I think it has offered something as an assistive technology. I think, you know, kind of, that some of the areas that mentioned around the use in seclusion, the use after rapid tranq, the prevented -- preventing of disturbing people on a night, and the benefits for

our MHSOP wards have added something. I think we've also identified a number of risks along the way, and I'll come back to the review, I know you're going to ask me about that, but I think that's why we're clear as an organisation we need to change as new information becomes available and we need to make sure that the more we understand, we're clear that this is a system that's fit for purpose in our environments.

**Q.** You've referred to older adults and seclusion and that type of --

**A.** Yeah.

**Q.** -- ward. Would you agree that the evidence you're giving today suggests quite a narrow context in which Oxevision can usefully be deployed?

**A.** Yes, I think that's accurate.

**Q.** You -- the statement mentions, and this is paragraph 64 at page 15, that there are some wards across the Trust where all patients have opted out --

**A.** Yeah.

**Q.** -- of using Oxevision completely?

**A.** Yes.

**Q.** These are often wards with longer length of stay?

**A.** Yes.

**Q.** What's the correlation between a patient with a longer length of stay and opting out of Oxevision?

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

**Q.** My fault, with my question. So what's the correlation between wards with patients who have a longer stay and opting out? Why would it be more likely that a patient who has a longer stay would opt out of the use of Oxevision?

**A.** I suppose, they probably maybe have had opportunity to consider it and think about it more. Some people who were admitted to assessment and treatment wards, they may be new to that environment completely. Some people may have not had any experience of mental health services previously and for some of our environments people are detained for excessive periods of time so actually, they may be more familiar with the environment but certainly what our experience is that it's those environments where the patients choose to not have the system turned on.

**Q.** I want to look at a paragraph in the statement, please.

Would you put up the statement at page 8 and expand paragraph 32, please. Page 8, please. Paragraph 32 at the top, please.

Thank you.

This says:

"The use of the system is reviewed on a monthly basis."

**A.** Yeah.

**Q.** That's what you've been explaining.

**A.** Yes.

**Q.** "The recent reviews showed high rates of opt-out throughout the Trust, most notably in secure patient services, eating disorder wards and rehab wards."

Now, would secure patient services include seclusion?

**A.** Yes, but you would also see seclusion on our Psychiatric Intensive Care Units. So -- and so somebody could be transferred from an Adult Assessment and Treatment Ward, for example, to our Intensive Care Unit, if that need was identified, and then therefore could use -- be secluded in that environment.

**Q.** One of the areas in which you thought Oxevision has real benefit was seclusion?

**A.** Yeah.

**Q.** Have I -- am I over-simplifying things if I suggest that this paragraph at least suggests that's also one of the areas where there are higher opt-out rates?

**A.** So, yes, I think you are. Because actually our seclusion probably is used -- so we have a number of seclusion rooms in our Secure Inpatient Services. We also have those in our two Psychiatric Intensive Care environments, and for some people who are perhaps unwell

in our Secure Inpatient Services, they may not be the people who've chosen not to consent, and may end up in seclusion. So yes, I think, yeah. I don't know whether I've answered that.

**MR GRIFFIN:** Well, I think you've pointed out to me very politely that I may have misunderstood. So I take that point.

Chair, do you have any questions for Mrs Devanney?

**THE CHAIR:** No.

**MR GRIFFIN:** May I ask that we take a 15-minute break until 12.35.

This is the process now. I've finished with my questions for you. There's a pause while I find out whether there are one or two more questions I need to put to you. So we may come back in 15 minutes.

**THE WITNESS:** Okay.

**MR GRIFFIN:** But we may not. If we don't, may I say thank you to you for your evidence.

**THE WITNESS:** Thank you.

**THE CHAIR:** And may I thank you very much indeed. It's been incredibly helpful to hear from you.

**THE WITNESS:** Thank you, Chair.

**(12.20 pm)**

**(A short break)**

**(12.44 pm)**

**THE CHAIR:** Mr Griffin.

**MR GRIFFIN:** Chair, just a few more questions for Mrs Devanney.

You mentioned that Oxevision allows you to monitor themes and to see trends in, for example, someone's heart rate.

**A.** Yeah.

**Q.** But that those readings wouldn't be medically accurate?

**A.** Yeah.

**Q.** May I just ask you about that, please. Should we understand from that evidence that you mean that the system capability allows vital signs to be constantly monitored and therefore themes or patterns in a patient's heart rate or breathing rate are capable of being plotted and monitored?

**A.** Yes.

**Q.** Is that a tool that TEWV uses?

**A.** We don't use it in that way.

**Q.** When you were referring earlier to the use to which the data can be used and so on, my understanding is that you were referring to this kind of thing, or were you referring to something different?

**A.** So the data that we would look at would be information about -- from the Matron reports. We would look at information around rooms that were out of use. We would

look at information around where alerts have been reset. For particular wards we would also look at ... I can't think of what else we would look at but there's a variety of data that we would look at in relation to -- that the system provides as well as what we understand more broadly about how it functions and is delivered across our services.

**Q.** So we heard evidence last year from a witness from EPUT that they would use the vital signs function, as you've described, but that separately in the background, the system was functioning I think all of the time --

**A.** Mm-hm.

**Q.** -- and producing vital signs readings that were not medically accurate?

**A.** Yes.

**Q.** So is that the function that you do not use?

**A.** Yes. So it's there. It's available, but we don't use that data for anything because it's not medically accurate.

**Q.** You said in your evidence that the only wards where Oxevision is not installed is on learning disability wards. You've, as I mentioned before, we have been provided by TEWV with a list of the 50 or so wards --

**A.** Mm-hm.

**Q.** -- where Oxevision has been installed, is being

installed, or will be installed.

**A.** Yeah.

**Q.** That includes a number of learning disability wards. May I give you an example? Langley male forensic rehabilitation learning disabilities --

**A.** Yeah.

**Q.** -- going live 5 August last year.

Kite, male low secure learning disability going live 7 February last year.

**A.** *(The witness nodded)*.

**Q.** Clover, female medium secure learning disability going live on -- last year.

And similarly, Swift: female medium secure learning disability going live last year.

So that would suggest that in fact Oxevision is being deployed in learning disability wards. Can you comment on that?

**A.** Yeah, apologies. That's probably my description of it. All of those wards that you mentioned are part of our Secure Inpatient Services where we absolutely do use the system. What I was referring to was our adult learning disability services where we have a ward, a unit called Bankfields that has a number of smaller units on it. We don't -- we haven't installed it within that provision.

**Q.** Thank you.

Given the narrow purpose of Oxevision as in fact adopted by TEWV, your explanation that it should not be used at all for anyone at risk of self-harm or anyone requiring observations at level 2 or above, what basis is there for making it mandatory, that blanket approach, in the first 72 hours?

**A.** I think that's to gather all the relevant information to understand, you know, kind of because we do know, as we say, some patients may need rapid tranquilisation. They don't need to be on a PICU, for example, to receive rapid tranq, so somebody may receive rapid tranq in our assessment treatment wards or they may be transferred to a Psychiatric Intensive Care Unit. It is just about that 72-hour period is about making sure we've got all the relevant information available to us to make that decision.

**Q.** Thank you.

When addressing the topic of consent, you indicated that "After 2024, as our understanding of the system grew, we realised we need to consider consent more carefully."

**A.** Yes.

**Q.** In what respect did your understanding of the system and related consent issues change in or around 2024? So you've described to us the opt-out model. What was that

a change from? You -- the statement addresses it from paragraph 10.

**A.** Yeah, and I think what -- the system that we had in place prior to that was almost implied consent, and prior to that, I don't think we were using following the procedure that was set out at that point, not a policy, in terms of people's consent. And I don't think we had any assurance that that was being undertaken appropriately and as it should be.

So the review moved to that opt-out model that gave kind of that greater consideration to somebody's views, their kind of capacity to be able to consent at that point. And I think that the way that we're able to demonstrate that we're using that in an effective way is that prior to 2024, you would see very few of those what we called those rooms that are not in use, whereas now, we are able to monitor that that changes regularly as patients move in and out of our assessment and treatment wards -- more static in those longer-stay areas but it certainly changes more frequently and actually we do see that that consent approach does result quite frequently in people having rooms turned off.

**Q.** So just for the record, paragraph 10 of the statement, which refers to the approach prior to the opt-out approach in August 2024, says this:

"Prior to August 2024, once the Oxehealth system was implemented and it went live on a ward, this was turned on as standard, with an implied consent model.

A patient only had the opportunity to 'opt out' of the system in exceptional circumstances."

**A.** That's correct.

**Q.** Is that your understanding?

**A.** Yes.

**Q.** Why -- given that the system had first been piloted in 2019 and then was increasingly rolled out, why had it taken so long for TEWV to come on to the opt-out model only in October -- in August 2024? Why did it take so long to address consent issues to the extent that you have?

**A.** So I suppose I could offer a view on that as to whether it's factual, because, you know, the people who were involved in that time and no longer work for the organisation, but I think it was people believing that they were doing the right thing, and I think not considering fully the implications around consent, and I think it was, as those reviews were undertaken and the risks, as we talked about earlier, there was no risks identified initially, and actually, as those risks began to become further understood, it was readily accepted that we needed to look at the way that we were managing

the system, and the governance that we had around the system.

**Q.** Thank you.

Just sticking with the change of approach in August 2024, to what extent was that informed by additional information from Oxehealth?

**A.** I wouldn't be able to answer that, sorry. I don't know.

**Q.** Do you know, or can you estimate, whether there are any incidents or types of incidents that Oxevision has helped to prevent?

**A.** So I think that's difficult to answer. I would refer back to the answer that I gave earlier. So has there been circumstances where people have responded to a room and been able to intervene in a situation where people have been self-harming, been alerted to certain activity that would cause us concern? Yes.

**Q.** But is there data that underpins what you've just said?

**A.** Yes, we would be able to identify that data. However, I suppose what we wouldn't be able to clearly articulate or be confident of is the reason for, you know, was that somebody trying to communicate something? Did they understand that actually, if they stood in the bathroom for three minutes, then a member of staff would appear because actually an alert would be triggered?

**Q.** So is that going back to the point that you made that

I tried to summarise as being that in certain circumstances, the existence of the technology itself --

**A.** Yes.

**Q.** -- might change a patient's --

**A.** Yeah.

**Q.** -- approach?

**A.** Yes.

**Q.** How has the system been used to deal with concerns about safeguarding, and has it proven useful in that respect?

**A.** So I would say where we would have concerns about safeguarding, maybe where we've had an incident on the ward where, you know, perhaps an assault of a patient, et cetera, et cetera, where actually, it's deemed to be a criminal activity, that actually we would investigate and safeguard appropriately as an organisation.

So I think there has been a number of incidents where we've used footage in that way.

**Q.** Thank you.

You identified a number of risks in the witness statement, this is paragraph 38 at page 9. Do you recall we went through them?

**A.** Yes.

**Q.** The first one was relational unintended consequences of the system.

**A.** Yeah.

**Q.** Have they been mitigated by the new policy implemented from 2024 onwards?

**A.** No.

**Q.** You've given evidence about the now restricted use of Oxevision. But can you help with this: one type of service or ward that you haven't talked about yet is Section 136 suites or health-based places of safety?

**A.** Yes.

**Q.** Is Oxevision used there at TEWV?

**A.** No.

**MR GRIFFIN:** Chair, those are the question, the additional questions that I have. Do you have any further questions?

**THE CHAIR:** I don't have any further questions.

**MR GRIFFIN:** The further and ongoing evaluation that you referred to, the Inquiry legal team will be in contact with the TEWV legal team to seek disclosure of the report and any further relevant documents.

**THE WITNESS:** Of course, yes.

**MR GRIFFIN:** Thank you very much.

**THE CHAIR:** Can I thank you again for coming.

**THE WITNESS:** Thank you.

**THE CHAIR:** What time do you want us back?

**MR GRIFFIN:** 2.00. Apologies for forgetting to say that. 2.00.

**(12.57 pm)**

**(The Short Adjournment)**

**(2.00 pm)**

**(Proceedings delayed)**

**(2.03 pm)**

**THE CHAIR:** Mr Griffin.

**MR GRIFFIN:** Could the witness be sworn, please.

**ANDRES FREIRE-PATINO (affirmed)**

**Questioned by MR GRIFFIN KC**

**MR GRIFFIN:** Would you give your full name, please.

**A.** It's Andres Freire-Patino.

**Q.** Are you a Registered Mental Health Nurse or RMN?

**A.** I am.

**Q.** For how long?

**A.** Since 1998.

**Q.** Have you principally worked in and managed mental health inpatient services for most of the time since becoming an RMN?

**A.** Yes, I have, yeah.

**Q.** And are you Deputy Director for the Directorate of Mental Health Services for Leicestershire Partnership NHS Trust?

**A.** I was until 6 July this year.

**Q.** What role do you now have?

**A.** I now undertake the role of Head of Business and

Transformation for the Directorate of Mental Health within Leicestershire Partnership Trust.

**Q.** We'll probably refer to the Trust as "the Trust" or "LPT" just so we're clear.

**A.** LPT.

**Q.** Did your role -- let's just stick with your role in the Directorate of Mental Health. Can you just explain what that was, please?

**A.** So I was the Deputy Director of Mental Health and that meant that was -- I had strategic and operational management, responsibility for all the services in the Directorate of Mental Health. I reported to the Executive Director of Mental health and worked as part of a triumvirate leadership team so worked very closely with the Head of Nursing for the Directorate and also the Associate Medical Director.

**Q.** That's very helpful.

I'm going to ask you to slow down just a little bit. One of the reasons for that is that a note is being taken of what you say.

**A.** Okay.

**Q.** So if I ask you to pause it's not out of rudeness; it's just to slow you down -- if that's okay.

**A.** Okay.

**Q.** Prior to your role at LPT, did you work at a different

Trust?

**A.** I did, yes.

**Q.** Which Trust was that?

**A.** I worked for Northamptonshire Healthcare Foundation Trust.

**Q.** When did you join that Trust?

**A.** I returned back to the Trust in 2009. I previously worked there after qualifying as a nurse from Northampton University.

**Q.** Thank you. Can you give us an idea of the roles you conducted at that Trust?

**A.** Yes, I -- when I went back to the Trust in 2009, I actually went back as the -- in the role of Crisis Team Manager which was a community role and then in 2011, I became the Modern Matron for the inpatient mental health service at Berrywood Hospital and then from there undertook other management roles, so essentially got promotion to the Head of Hospitals post and then became the Head of Mental Health for Core Mental Health Services.

**Q.** Thank you very much.

So you joined LPT in January 2023. Does that mean that some of the matters we'll be discussing, for example decisions in discussions in advance of, and during, part of the first Oxevision pilot, which we'll

talk about in a moment at LPT, were before your time there?

**A.** Yes.

**Q.** You've provided a witness statement to the Inquiry. Have you provided it on behalf of LPT in response to a request from this Inquiry?

**A.** I have.

**Q.** And can you confirm that you're here today giving evidence on behalf of LPT?

**A.** I am.

**Q.** Do you have the statement in front of you?

**A.** Yes.

**Q.** Is it 16 pages long?

**A.** Unfortunately the copy I have doesn't have page-numbers.

**Q.** Will you take it from me that it's 16 pages long?

**A.** Okay.

**Q.** Does it have the Statement of Truth at the end?

**A.** Yes.

**Q.** And have you signed it?

**A.** Yes.

**Q.** Have you had the opportunity to read through that statement recently?

**A.** Yes.

**Q.** I think there are a couple corrections that you want to notify to the Inquiry; is that correct?

**A.** That's correct.

**Q.** Can we see, first of all, on page 1, paragraph 1, three lines up, we can see a reference to assisting "the coroner". Should that be corrected to "the Inquiry"?

**A.** It should.

**Q.** Thank you.

If we go to paragraph 23 on page 7, the third line down, should there be an "if" in front of "staff", so that whole sentence should read "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 if staff formed the view ..."; is that correct?

**A.** That is correct.

**Q.** And finally, paragraph 68 on page 16, the last page, should part of that paragraph be deleted? Do you see there towards the end of the first line "The minutes of which are annexed as exhibit MP 08"?

**A.** Yes.

**Q.** Should that be deleted --

**A.** Yes.

**Q.** -- from this paragraph? And is that because MP 08, that exhibit is actually a different document, a report to the Board for the purposes of a meeting in August 2025?

**A.** That is correct.

**Q.** Thank you very much.

Subject to those corrections, can you confirm that the statement is true and accurate to the best of your knowledge and belief?

**A.** Yes, it is.

**Q.** Mr Patino, your statement stands as part of your evidence and I won't therefore be asking you about every aspect of it today but you're welcome to refer to it as you need to.

The Lampard Inquiry is investigating the circumstances surrounding the deaths of mental health inpatients under the care of NHS Trusts in Essex between the start of 2000 and the end of 2023. Its Terms of Reference require the Chair to make recommendations and permit her to make national recommendations as she considers appropriate.

The Chair heard last year from representatives of LIO, formerly known as Oxehealth, and also from EPUT, Essex Partnership University NHS Foundation Trust, and we'll be hearing more evidence from those organisations in the future.

The Chair was told last year that Oxevision is currently used by approximately 50 per cent of the National Health Service Mental Health Trusts.

**A.** *(The witness nodded)*.

**Q.** And the Inquiry has now obtained evidence from a number of further NHS Trusts which have used, or are using, Oxevision in order to assist its assessment of how the system has been implemented, governed, and used in practice across different settings.

This comparator evidence is intended to provide relevant context and assist the Chair in whether issues arising from the evidence concerning EPUT appear to be specific to EPUT or whether they reflect wider issues relating to the introduction, governance and the use of Oxevision elsewhere.

Thank you for coming today to assist the Inquiry for that purpose.

So for reasons I've just explained, the Inquiry is aware of Oxevision and in general terms, its intended use and its actual abuse at EPUT, although, as I say, we'll be hearing more about that in the future.

I'd like to look with you at a leaflet you've provided by way of introduction, please.

Could you put up LPT022563 at page 1.

Now, was this leaflet provided to patients as part of the explanation of the Oxevision system during the pilot at LPT?

**A.** Yes, it was.

**Q.** Can we see here, on the left-hand side what Oxevision does: it's a medical device that uses an infrared-sensitive camera to measure your pulse and breathing rate; it lets staff know where you are in your room; it provides notifications to staff. And we can see that the system is able to measure pulse and breathing rates. We've heard that that is known as the vital signs function. Is that how you knew it during the pilot stage at LPT?

**A.** Yes.

**Q.** In fact, when patients were admitted to an Oxevision-enabled ward during the pilot at LPT, in addition to being given written information about Oxevision, were they also shown how the technology operated, including a practical demonstration of the tablet?

**A.** Yes.

**Q.** Can I just deal with one other point. Were staff required to undergo training at LPT prior to using Oxevision on a ward?

**A.** Yes, they were.

**Q.** Can we just see on the right-hand side "Where Oxevision is located: in every bedroom on the ward".

So that would be, in LPT's case, the pilot wards?

**A.** Yes.

**Q.** Could you take that down, please.

I'd like to deal first with you, please, Mr Patino, with the overall chronology at LPT, of Oxevision.

Can you confirm whether the following is correct: was Oxevision -- this is from paragraph 2 of the statement -- was Oxevision procured by LPT in July 2022?

**A.** Yes.

**Q.** Was there a first pilot conducted at LPT between December '22 and February 2023?

**A.** Yes, there was.

**Q.** Was there then a pause of about 20 months and was the pilot relaunched as a second pilot from 14 November 2024 to 10 January 2025?

**A.** Yes, that's right.

**Q.** Thank you.

Just coming back to a point we've already made, having joined the Trust in January 2023, to what extent were you involved in the first pilot?

**A.** I had absolute minimal involvement. Other than being part of the decision making to cease the pilot in February. But I'd been in the organisation by that time for just over a fortnight. So, you know, I was -- I played a minimal role, really, in that decision.

**Q.** So you joined during the currency of the first pilot?

**A.** Yeah.

**Q.** Minimal involvement but involvement, you say, in the decision to pause?

**A.** Yes.

**Q.** But this was early days for you at the Trust?

**A.** Yeah.

**Q.** Correct?

Did you subsequently then become more involved in the process during the pause?

**A.** Yes.

**Q.** What was the nature of your involvement then?

**A.** We needed to -- we'd procured Oxevision on a three-year contract so it was always the intention, before making the decision about Oxevision in the longer term that we needed to repeat a pilot, and so that was the -- that was my involvement. So I led the project around the second pilot.

**Q.** Thank you. And I think you were involved in the development of the Standard Operating Procedure for that second pilot; is that correct?

**A.** That's correct, yeah.

**Q.** You explain in paragraph 2 what the purpose of the first pilot was, which started in July 2022. Could you just explain a little bit more about that now here, please. How many wards, for example, was it originally intended that the pilot would extend to?

**A.** Originally the pilot -- the pilot was intended to extend to seven wards and I think for context, what's important, because this was a pilot, this wasn't a decision to implement from the outset, those seven wards are amongst a total of 36 wards that we have within the Trust.

**Q.** Paragraph 2 says that overarching objective was to evaluate the suitability and efficacy of Oxevision across the breadth of the Trust's clinical settings. I think that picks up on what you've just been saying.

**A.** Yeah.

**Q.** So was the intention deliberately, initially at least, to trial it across different kinds of ward?

**A.** Yeah, the seven environments that we were looking to pilot, pilot the devices, were essentially good -- a true representation of the 36 wards in total.

**Q.** How many wards were actually involved in the first pilot?

**A.** Two.

**Q.** Was that a female acute ward, Ashby?

**A.** Yes.

**Q.** Fourteen beds with a seclusion room?

**A.** *(The witness nodded)*.

**Q.** And was it a male functional ward, Mental Health Services for Older People, with 17 beds, Aston Ward?

**A.** That's correct.

**Q.** Why, ultimately, were only two wards involved in the first pilot?

**A.** I don't know the reason why two were chosen at the outset, as I wasn't in the organisation at the time.

**Q.** The -- you say, at the end of paragraph 3, bottom of page 1:

"It was intended that the pilot model commence on the aforementioned ward [so those two wards] whilst preparatory work for the broader installation of Oxevision continued in parallel."

**A.** Yes.

**Q.** Does that sound right?

**A.** Yes.

**Q.** Why were Ashby and Aston Wards specifically the two that were initially picked for piloting?

**A.** Again, I wasn't part of the decision --

**Q.** That's not a question you can answer?

**A.** No, it's not, I'm afraid.

**Q.** Do you know whether, before the pilot, LPT had sought information from other Trusts who'd already trialled Oxevision to learn from others' experiences?

**A.** I don't.

**Q.** Did Oxehealth introduce LPT to any other Trusts using Oxevision?

**A.** At any point?

**Q.** Yes.

**A.** We were invited to take part in a forum that consisted of other Oxehealth users, and that was in between, as we were preparing for the second pilot.

**Q.** So that would have been during a pause?

**A.** Yeah.

**Q.** And was that facilitated by Oxehealth?

**A.** Yes, it was, yeah.

**Q.** Can we look at LPT's business case for Oxevision, please. It's dated April 2022. I don't think you were involved in the creation of that document; is that right?

**A.** No.

**Q.** But I'd like to ask you a couple of questions and we'll see where we go.

Could you put up LPT022545, please, at page 6.

Thank you. Could you expand -- that's perfect, thank you.

So can we see here at the top "Objectives/benefits/outcomes":

"This business case aims to improve safety and quality of care for patients and staff on inpatient services and deliver operational value in releasing time and generating cashable savings.

"If this case is successful, it will strengthen the safety and quality of the Trust's inpatient services, improve staff confidence, peace of mind and productivity, and position LPT at the forefront of the digitisation of inpatients services and translating research into practice.

"It is expected to deliver safety & quality improvements that lead to operational efficiencies, including releasing clinical time to care through fewer incidents, faster night observations and more effective data sharing as well as reducing avoidable 1-2-1 observations."

So that suggests that LPT had high expectations about the benefits that Oxevision could deliver. Is it your understanding that that was the case at the time?

**A.** I had nothing to do with the -- (overspeaking) --

**Q.** So that's a question you can't answer?

**A.** Yeah, exactly, sorry. Yeah.

**Q.** Could we deal with the point of reducing avoidable one-to-ones, can you see that at the end of the third paragraph on the screen? Does that suggest that Oxevision was intended to replace at least some observations?

**A.** Again, I can't --

**Q.** You don't know?

**A.** I can't answer that.

**Q.** Just reading on:

"The following six core outcomes have been identified as the projected outcomes to rolling out the digital monitoring across identified inpatient wards across the Trust."

There can we see from 1 to 6 the outcomes are listed. So at number 1, improved patient safety; number 2, improved physical health monitoring; number 3, improved patient care; number 4, improved patient carer experience; number 5, improved staff experience; and number 6, increased time to deliver direct care.

**THE CHAIR:** I suspect you may not be able to answer this, but do you know who wrote this? Who would have written this?

**A.** Part of the difficulty is that when I came into post in -- into February, a number of the senior staff in the Directorate were all relatively new. I do know who wrote the original business case. And actually the case, it -- I think the initial first draft of the business case actually started in 2020.

**THE CHAIR:** And that was an employee of --

**A.** Of LPT, yeah.

**THE CHAIR:** Thank you.

**MR GRIFFIN:** Do you know whether, or the extent to which,

Oxehealth were involved in the creation of the business case?

**A.** No.

**Q.** You just don't know?

**A.** I don't know.

**Q.** Thank you. Can we look at one more part of this, and I understand that you may be in difficulties in answering some of these questions. Let's see where we go, if that's okay.

**A.** Okay.

**Q.** Could you put up page 11 of this document, please, and expand. Can you expand from 7, "Economic Case", down, please.

So we see at the start here the economic case:

"Oxehealth recently commissioned an independent evaluation via York Health Economics Consortium which evaluated the impact of Oxevision from a return-on-investment perspective across adult acute inpatients, psychiatric intensive care unit, and older adult inpatient wards. The findings of the evaluation are detailed below in figure 1 and highlight both cash and non-cash releasing benefits."

Were you aware, at this initial stage, of the financial case for introducing Oxevision? Were you aware that was originally part of the interest of LPT?

**A.** No.

**Q.** Just reading on, this is the executive summary:

"Oxevision was evaluated to have a positive return on investment, including a cash releasing in-year saving across multiple services. Overall, the cash releasing benefits are predominantly delivered through reducing 1:1 observations, a proportion of which is cash releasing from reducing agency/bank spend. Non-cash releasing time efficiencies are delivered through a reduction in 1:1 observations within safe staffing levels, reduction in incidents, and faster nighttime observations."

So this business case, and the potential spendings, is this another area that you won't be able to assist us with?

**A.** I can't assist on that point, I'm afraid.

**Q.** We can see at the top reference to information provided by Oxehealth. Again, are you unable to assist as to the extent to which Oxehealth might have been involved insisting LPT with its business case for the technology?

**A.** Yeah, I can't answer it, I'm afraid.

**Q.** Can you take that down, please.

We learn from the LPT data protection impact assessment that prior to the decision to undertake a pilot, LPT had gone thorough a consultation process.

So that's, again, before you became Deputy Director.

It shows the various people and organisations that were consulted from the Trust's Executive Management Board to lived experience patient groups and another Trust that was using Oxevision. Is that what you were referring to before, in terms of speaking to others about the introduction of Oxevision at any stage?

**A.** No.

**Q.** No, okay.

We understand that the Trust that was involved in this consultation was EPUT. Are you able to say at all what kind of information EPUT was able to provide to LPT?

**A.** No.

**Q.** So can we come on, then, to pausing the pilot, please. So the first pilot, as we've said, ran from the end of 2022 to February 2023. And then the decision was taken to pause it. And as you said, that's when you started to become involved. Why was the first pilot paused?

**A.** At the time, as it says in my statement, at the time the requirement to train staff in the use of Oxevision against the fact that we were using a proportion of temporary staff on the ward meant that actually it was very difficult to implement Oxevision consistently on a shift-by-shift basis. Because what we were getting

was staff that were not familiar with the ward and who were therefore not familiar with Oxevision, and that essentially meant that it was difficult to continue with the pilot. So that was one of the reasons, really: it was our use of temporary staff at the time.

**Q.** So you felt that if temporary staff were to be used at Oxevision-enabled wards they should have undergone appropriate training first?

**A.** Yeah.

**Q.** And putting them through that training was proving difficult, given the high numbers that were needing to be used at that time?

**A.** Yeah, I mean the numbers weren't particularly high, necessarily. But actually, what was typical is that, you know, often you would get temporary members of staff that would come to the ward that hadn't worked there before and therefore hadn't done the Oxevision training.

**Q.** Thank you.

Were there further reasons for the pause? You deal with this at paragraph 5 at page 2 of the statement. Did they include, for example, Internet connectivity difficulties?

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

**Q.** That staff already carried a mobile device called Brigid, and we'll come back to that?

**A.** Yeah.

**Q.** Did they find it distracting to carry two?

**A.** Yes.

**Q.** Was there one further important point leading to the pause?

**A.** What I've said at the bottom of point 5, I've already mentioned that there were a number of us in the Leadership Team that were relatively new to the Directorate of Mental Health and, actually, what we realised was that the use of Oxevision, we weren't able to understand. So a member of staff could continue to request a vital signs check, therefore given access to live video -- a live video feed in the room, and they could continue to ask that without anybody else becoming aware of it. And so that was a concern. And even though we would get data each week as to the number of alerts that we might have -- that would have been requested, actually, that number, it would be very difficult from the number provided to determine whether the use of the vital signs technology was being misused or not.

**Q.** So there was a concern at the Trust that the function that allows a member of staff to view a patient in their room through the system, through the tablet --

**A.** Yeah.

**Q.** -- that that might be susceptible to misuse?
**A.** Yes.
**Q.** And it was sufficiently significant concern, that that was one of the reasons for pausing -- to rethink; is that right?
**A.** Yes, that's right.
**Q.** What did you want to achieve during the pause at the Trust?
**A.** We wanted to -- at that point in time, the technology wasn't working for us. So what we wanted to do essentially was re-look at it, and we also, on the point that I've just discussed a moment ago around access, we also raised that with Oxevision and wanted a solution for that before we considered doing another pilot.
**Q.** You address this at paragraph 7, at page 3 of the system. So was it your idea to go to Oxevision to ask them if anything could be done about this concern?
**A.** Yes.
**Q.** And did you engage with Oxevision on that point?
**A.** Yes.
**Q.** And did they come up with a potential solution?
**A.** Yes.
**Q.** What was that solution?
**A.** The way that Oxevision is implemented on a ward is that what you have is a screen in the office which you can

use to undertake the observations. You also have a tablet that can be carried around by a member of staff. And there is a third tablet that sits within the -- belongs to the Ward Manager. And so the solution that Oxevision devised for us was that if a vital signs check was requested three times concurrently, an alert would go to all of the monitors that would need to be then closed by a member of staff.

And that alert then would identify the Ward Manager that -- to the Ward Manager that somebody had accessed it and that would lead then to an inquiry from the Ward Manager to the members of staff that were on duty to understand the reasons why.

**Q.** I'm just going to pause to make sure everyone can hear what you're saying.

Yes? Thank you.

Was that solution implemented on the pilot ward at LPT?

**A.** When we --

**Q.** When you restarted the pilot.

**A.** When we re-commenced the pilot, yes, it was.

**Q.** Do you know to what extent it had to be used?

**A.** No.

**Q.** So are you able to say to what extent it was successful in addressing potential instances of misuse?

**A.** It was successful. So in terms of the alerts, yeah, we didn't get a case where we were alerted to the fact that somebody was repeatedly trying to use the technology to access the vital signs check.

**Q.** Thank you. I've referred already to the Standard Operating Procedure that was created at LPT and indeed your role doing so. Do you know whether Oxehealth were involved in drafting the SOP or assisting?

**A.** They assisted.

**Q.** Was -- what was the purpose of the Standard Operating Procedure?

**A.** Well, all practice that we use in hospitals should be supported by Standard Operating Procedure, and it's really to provide clarity to the staff that had undertaken any kind of procedure as to the way it needs to be, the way it needs to be carried out.

**Q.** Thank you. Can we look at a part of the Standard Operating Procedure now, please.

Would you put up LPT022562 at page 15, please. Could you expand from 5.7. That's perfect, thank you very much.

So do we see here the alert function that you've just been discussing but described in a little bit further detail within the Standard Operating Procedure?

**A.** Yes.

**Q.** So can we see "Notifications for multiple attempts to take vital signs":

"If multiple attempts are taken to review a patient's bedroom a vital sign attempt notification will generate an alert. This will happen if the Oxevision system is accessed 3 times or more within a 5-minute period."

So that's what we've just been discussing, isn't it?

**A.** Yeah.

**Q.** We know that Oxevision involves both the monitors in the Nursing Station and the tablets that you've described. Can you make an observation from the Nursing Station through the monitor there?

**A.** Yes.

**Q.** So would that trigger an alert or would it just be the tablets?

**A.** That would trigger alert as well.

**Q.** Carrying on, do we see here:

"A notification will appear on every device and will need to be dismissed on all active devices (usually the tablet in use and the nurse base screen), if this scenario happens the staff member who triggers the alert must explain the incident to the nurse in charge and the nurse in charge should record as an incident on Ulysses."

What's Ulysses?

**A.** That's our incident recording system.

**Q.** The reference there is to a notification appearing on devices. Was it that, a written notification, or would there actually be an alert, an audible alarm of some sort?

**A.** It was an alert. There was no alarm. From memory.

**Q.** So the incident then would need to be explained and also recorded?

**A.** Yeah.

**Q.** I think you've said, but could you correct me if I'm wrong, that you were able, at LPT at the second pilot, to see that in action.

**A.** Yeah.

**Q.** But that, if I've understood what you've said, that having gone through this process, you didn't actually uncover misuse?

**A.** No.

**Q.** Thank you.

Could you move over to the top paragraph of the next page, please. Oh there it is, thank you. Sorry. I can't see that.

Do we see here:

"A report will be sent by Oxevision to the ward sister, deputies and Matron on a weekly basis. Any

incidences where an incident hasn't been raised should be investigated and an IRF completed."

Would you just explain what an IRF is, please.

**A.** That is just the incident recording form within Ulysses.

**Q.** So that's Ulysses again?

**A.** Yeah.

**Q.** So do we see here weekly reports in addition to the initial alert?

**A.** Yes.

**Q.** Did that happen during the second pilot, as far as you're aware? That there was this weekly system --

**A.** Yes.

**Q.** -- of reporting as necessary? Thank you.

Would you take that down, please.

What I'd like to do, please, is to move on to the re-launch or the second pilot now.

So that resumed as we've heard, in November 2024, 14 November, and lasted until 10 January 2025; yes?

You explain in your statement that the resumed pilot had a dual purpose. This is at paragraph 6 on page 2. Can you just explain what the dual purpose of the second pilot was, please?

So you say one of them was to refine the operational use of the technology on the initial wards.

**A.** *(The witness nodded).*

**Q.** Can you just explain what that meant?

**A.** That is in relation to the alert that we were just talking about.

**Q.** Does it also mean that the focus of the second pilot would be narrower than the focus that you described of the first pilot?

**A.** Yeah.

**Q.** Are you able to describe how the focus narrowed for the second pilot?

**A.** For the second pilot we made the decision to pilot the device at nighttime only. So we would only use Oxevision for completing observations from 11 pm until 7.30 in the morning. What we wanted to do was test that hypothesis about whether Oxevision could support patients in getting a better night's sleep in hospital.

**Q.** And was the relaunched pilot, actually, on a single ward?

**A.** It was.

**Q.** Was that the female acute ward, Ashby?

**A.** Yes.

**Q.** What led you, for the second pilot, in reducing the number of wards and choosing that particular ward to continue the pilot on?

**A.** There's a very simple reason in that Oxevision, when we initially implemented it, we had it installed, as we

discussed, on Ashby and Aston Ward. Aston Ward, when we started pilot 1, was a ward for older persons. So -- and they were on -- they were occupying Aston Ward because their original ward was being refurbished so the whole of that area of the hospital was being refurbished. We had a refurbishment programme and it was affecting the three older person -- sorry, the two older persons' ward and another ward in that area. And Aston, the patients on Aston were returning back to their original ward, which was Langley Ward, at some point in 2024.

As it happened, they returned in December 2024, but that was due to some last-minute delays in that building work being completed -- (overspeaking) --

**Q.** And the ward that they were returning to did not have Oxevision --

**A.** It did not have Oxevision --

**Q.** -- installed in it?

**A.** Yeah.

**Q.** And that is the reason why it went from two down to one?

**A.** Yes.

**Q.** So the more focused reason for the second pilot, can we deal with that now, please. You address this from paragraph 17 at page 5 of your statement where you described the primary purpose for the second pilot being

to reduce the level of nighttime disturbance experienced by patients. That's what you were saying, as well, isn't it?

**A.** Yeah.

**Q.** Why is that important?

**A.** Because sleep is incredibly important in terms of people's recovery from poor mental health.

**Q.** And how would Oxevision operate to lessen or avoid nighttime disturbance, in your understanding?

**A.** Because the process that, in LPT, that we had for checking patients at night was we'd got what we called different levels of observations from level 1 to level 4, level 1 meaning that people need to be checked hourly, their safety needs to be checked hourly. Level 2s are what we call intermittent observations where people are checked more frequently, and in order to do those checks, what we have to establish is that the patient is alive on each of those checks and that often means or usually means entering a patient's room to establish that they're breathing.

**Q.** So --

**A.** Oxevision gives us the opportunity to not have to enter the patient's room therefore not causing as much disturbance, if that --

**Q.** I want to ask you just about a couple of points you've

just raised. So at LPT during the second pilot it was felt appropriate to use the vital signs Oxevision function at night for level 1, but also level 2 patients. So level 2 being the lowest level of enhanced observations, if I've understood correctly?

**A.** Level 2 is intermittent checks.

**Q.** Intermittent checks.

**A.** So that will usually be every 10 or 15 minutes.

**Q.** The other point is this: the evidence we've received and will be receiving more of tomorrow explains to us that there are a suite of measurements that need to be taken as part of a health check, part of the NEWS2 measurements and that there are in fact six of them and that vital signs only covers two of those six.

**A.** *(The witness nodded)*.

**Q.** So for example, blood pressure would be a further one, wouldn't it?

**A.** Yes.

**Q.** Just explain why it was felt that the two aspects of the six measurements that vital signs addresses would be sufficient for patients during the night?

**A.** Well, to try and explain that clearly, when you're actually not using something like Oxevision in order to undertake a safety check what you're doing is establishing breathing, which is only one of the six.

So Oxevision actually provides you with two.

**Q.** So the nighttime checks wouldn't be looking to address all of the six of the NEWS2 measurements in any event?

**A.** Not at all.

**Q.** Thank you. Prior to this second pilot commencing, what consideration, including patient input, was given to the actual need to reduce disruption from nighttime observations? Was there actually an issue that needed to be addressed?

**A.** It's always been an issue, and in every environment that I've worked in, you know, in my long career, patients have always complained that nighttimes are noisy, and in acute environments, what you'll often have, as well as having to enter bedrooms to establish safety checks, there will be other noise going on on the wards, as well. So the nighttime checks are a consistent theme for inpatient services.

**Q.** Was the Oxevision observations or vital signs facility also used during the day at LPT?

**A.** Sorry, just repeat the question.

**Q.** So you've talked about, in the second pilot, focusing on nighttime use --

**A.** Yeah.

**Q.** -- for Oxevision, correct?

**A.** That's correct.

**Q.** Was there any use of Oxevision in the day? So outside the nighttime hours that you've provided to us?

**A.** There was some use, and that tended to -- that always -- you know, it tended to happen in the morning. So there are occasions in acute environments where -- you've just talked about the requirement to complete a NEWS2, there are occasions where patients refuse to have their physical observations taken, and so we didn't use NEWS in order to be -- sorry, we did use Oxevision in order to get a baseline of somebody's pulse and respiration because that was the only physical check and we would only do that for people that consented to Oxevision. We wouldn't be able to, if you didn't consent, then we would not be able to undertake those vital signs checks to get a baseline.

**Q.** Yes, we'll come on to consent in just a moment. So primarily, if I've understood your evidence correctly, the system was used for nighttime observations?

**A.** Yeah.

**Q.** But on occasion it might be used in the circumstances that you've just described, but only if there'd been prior consent from the individual patient?

**A.** That is correct.

**Q.** How would observations and vital signs measurements taken be recorded at LPT during the second pilot?

**A.** They would be recorded on the normal observation paperwork that's within our policy. So actually, the recording is the same whether the checks are done in the traditional way of entering the room or whether it's done using the Oxevision technology.

**Q.** Is the medical record in that respect at LPT a paper record?

**A.** For recording observations --

**Q.** For recording observations?

**A.** Well, there's a question in there of itself. So --

**Q.** Shall we stick with the period covered by the --

**A.** At the period covering the second pilot it was recorded on paper.

**Q.** Thank you.

You've mentioned an electronic device, Brigid. Was that used for recording observations?

**A.** Yes.

**Q.** Or was that for something else?

**A.** So that is what we are currently using for recording observations and at the time throughout the first pilot, that was being used to record the NEWS.

**Q.** But during the second pilot it wasn't?

**A.** Yes, it was also being -- yeah, in the second pilot it was, as well.

**Q.** Sorry, I'm confused but it's almost certainly me.

So we've got observations that are conducted using vital signs, and then we've got to the stage of recording those observations --

**A.** *(The witness nodded)*.

**Q.** -- and there seems -- there are two possibilities. One is to record them on paper?

**A.** *(The witness nodded)*.

**Q.** And the other is to record them electronically using the Brigid device?

**A.** No.

**Q.** No? That's my misunderstanding.

**A.** So physical observations, the full suite of six physical tests that are done outside of Oxevision, they are undertaken on a daily basis with all the patients on the ward who agree to it, and they are recorded using Brigid.

**Q.** Thank you.

**A.** Vital signs done through Oxevision, or the traditional way of doing what we call mental health observations, so that is a safety check, are recorded on paper.

**Q.** That's very clear. Thank you very much.

We've heard that at EPUT they had a module from Oxehealth called Oxevision Observations --

**A.** *(The witness nodded)*.

**Q.** -- that allowed observations to be recorded

electronically.

**A.** *(The witness nodded)*.

**Q.** Now, am I right, therefore, that LPT did not obtain or trial that module for the purposes of the second pilot?

**A.** We didn't.

**Q.** Thank you.

Moving on, then, please. I want to talk about alerts. We've touched on this but I want to look at another aspect of it, please, and another perceived advantage of the Oxevision system. You've helpfully told us about the solution that was agreed with the assistance of Oxevision to address potential misuse. But I want to look at other potential alerts that were used during the second pilot, please.

You cover this at paragraph 22 at page 6 of your statement. Can we see there that alerts used -- were available through the Oxevision system where a patient was at their bedroom door, another person had entered their room, or a patient had been in the en suite bathroom for a period in excess of three minutes. Were those the three other areas of alerts that were available to be used at LPT during the pilot?

**A.** Yes.

**Q.** Would you just explain how those alerts worked. So, say someone had been in the bathroom for over three minutes,

what would then happen? What would be triggered?
**A.** The tablet, whether it be in the office or whether it be -- whether it be the tablet that's being carried by the member of staff allocated to do the observation, the room tile would signify -- sorry, would signify the alert through turning it -- I think it went -- it goes orange. So it's a visual, yeah, a visual prompt.
**Q.** So this morning with our witness we saw the view a member of staff would have on their tablet with a number of squares --
**A.** Yeah.
**Q.** -- on the tablet each representing an individual room. And in fact when -- what we looked at this morning, the tiles, the individual boxes were green to indicate that a room was occupied.
**A.** Yeah.
**Q.** And is what you're explaining that where this is triggered, for example, by someone being in a bathroom for over three minutes, that that box representing a room turns a different colour, orange?
**A.** Yes, it does go a different colour.
**Q.** Thank you. Is there any associated sound with that alarm or alert?
**A.** I can't answer that.
**Q.** Thank you.

How helpful did LPT find this alert function during the second pilot?

**A.** It's the reason I can't answer the previous question, is because we don't have -- the ward where we piloted Oxevision, only two out of the 14 bedrooms have en suite toilets and therefore the en suite alerts didn't provide any benefit to us as part of the pilot.

**Q.** What about --

**A.** With us only having two bedrooms we couldn't even guarantee that those people -- well, we couldn't guarantee that those people that opted in to using Oxevision would land in a room with an en suite toilet. So, so that -- the en suite alerts, we didn't use.

Secondly, the doors that we have within the ward have got anti-ligature technology on them so they've got alarms that go off if somebody tampers with the door. So therefore the alerts that are offered by somebody standing by the door for three minutes, again, that's a helpful alert but actually it doesn't provide any additional benefit because we've got different technology for that.

**Q.** Is this what's referred to in the statement as the Safehinge door?

**A.** Yes.

**Q.** How does that operate?

**A.** What it does is it sounds an alarm, if any weight is applied to any of the outside edges of the door. So a very common method for self-harm/suicide is for people to try and trap things within the frame of the door by closing the door against it and so the Safehinge technology alerts when something is applying weight to any of the three corners of the door -- three sides of the door.

**Q.** Thank you. So if I've understood you correctly, we were discussing the three potential alerts that were available at LPT. The alert for the bathroom wasn't of huge assistance in the context of the ward at LPT because there were only a couple of en suites?

**A.** Yeah.

**Q.** Did that affect the position across other wards at Leicester or just the one the trial remained in?

**A.** Largely the one that the trial remained in, so we do have some wards outside of the seven wards that were originally thought to be -- you know, we wanted to include as part of the pilot at the beginning, outside of that seven, there are -- we do have wards which are fully en suited.

**Q.** Thank you. And then there's the second of the three alerts, person at the bedroom door; again, not that attractive at LPT because of the alternative technology

that you had with Safehinge?

**A.** Yeah.

However, the alert around someone else entering the room, we found that helpful.

**Q.** You found that helpful?

**A.** Yeah.

**Q.** Thank you.

I'd like to turn with you now, please, to look at the issue of consent to the use of Oxevision in the first pilot and then in the second pilot.

As far as the first pilot was concerned, at the end of 2022 and the first couple of months of 2023, what model of consent was adopted during that time? This is paragraph 14 of your statement.

**A.** So in the first pilot it was an opt-out consent model. And so what that meant is that a patient had to specifically request for Oxevision not to be turned on in their room.

**Q.** Thank you. Do you know why LPT decided to use the opt-out model for the purposes of the first pilot?

**A.** No, not specifically. No.

**Q.** Do you know whether the opt-out process during the first pilot was overly onerous to operate?

**A.** No.

**Q.** Could we move then to the second pilot, where you'll

probably have more information. What model of consent was used during that second pilot? And you cover this at paragraph 14.

**A.** Yes, so that was opt-in.

**Q.** So you say there:

"Following careful reflection, it was decided and agreed that the second pilot 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."

Are you able to remember discussions around that and why it was felt that that was the more appropriate model for the second pilot?

**A.** I think later on in the statement I do state, or it is certainly in one of the documents that I've included, that there was also guidance provided to us by NHS England in September 2023 which was before the second pilot commenced, that their recommendation is actually that there should be collaboration, joint decision making, with patients around the use of -- they call it vision-based monitoring systems.

**Q.** Thank you. Let's look at that.

Would you put up, please, LPT022555 at page 3. At the bottom and expand the bottom two lines, and in fact over the page, the first two bullet points, as well.

Perfect, thank you.

So do we see here -- this is Oxehealth: Learning from Contract, a document that you've provided to us from August 2025. And it includes this:

"Around the time of the visit of Oxehealth there was a lot of media attention around Oxehealth on the news and social media with patients expressing their concerns with the system."

Now do you recall the visit, the Oxehealth visit that's being referred to there?

**A.** Yeah.

**Q.** Were you part of that visit?

**A.** Yeah.

**Q.** What was that visit in connection with, please?

**A.** The alert we discussed earlier on.

**Q.** Do you recall what the media attention was that you're referring to, that was -- is being referred to here at this particular time?

**A.** In terms of the media attention, I can recall that there was concerns around, and non-specifically around the Internet, around surveillance of people in their bedrooms that was being referred to in relation to Oxehealth. It was a few years ago.

**Q.** Issues connected to invasion of privacy?

**A.** Invasion of privacy, yeah.

**Q.** This document goes on to say this:

"A letter was provided to trusts with vision-based monitoring systems by NHS England in September 2023 ..."

Now, is that what you've just been referring to?

**A.** Yes.

**Q.** "... stating the following ..."

So as I understand it this is effectively taking text from that letter:

"It is our view that Vision-based monitoring systems should never be implemented in a blanket way and that any decisions to use VBMS [vision-based monitoring systems] in patient bedrooms should be made in a person-centred way with the patient themselves where they have capacity to make a decision or through a Best Interest process compliant with the Mental Capacity Act 2005 where they lack capacity to consent to the monitoring system."

Can we see this in next bullet point:

"The use of such systems should be carefully considered on a case by case, patient by patient basis to ensure that any decision to use such systems has a legitimate aim and is both lawful and fair."

Now, is that what -- part of what gave Leicester pause for thought?

**A.** Yeah.

**Q.** And was it that which you at the Trust wanted to consider before relaunching into the second pilot?

**A.** Yes.

**Q.** To what extent, ultimately, did this letter from 2023 influence LPT in the different consent model that you adopted for the second pilot?

**A.** It was a significant influential factor --

**Q.** Thank you.

**A.** -- in our decision.

**Q.** Would you take that down, please.

Could we therefore look at the LPT approach during the second pilot to consent under the opt-in model, please, and starting with a patient who has capacity.

You address this from paragraph 11 of your statement. But could you walk us through the process in that scenario. So this is a patient with capacity under the new opt-in consent model.

**A.** Would you like me to read the statement?

**Q.** Not to read it. Are you able just to -- from what I understand from the statement, there was an introduction to the patient. What would be discussed with the patient at that time, in terms of consent?

**A.** So on arrival on the -- you know, following the, you know, on arrival to the ward, the staff would spend some time with the person being admitted, the leaflet would

come out that we referred to earlier on. The equipment would be shown to the patient. It would be explained that they could opt in or opt out, you know, of it. If they opted in, this would be what we believed would be the benefits of it in terms of delivering a good night's sleep, less disturbance, et cetera, et cetera.

And if they opted out or said, "No, I don't consent to that", then that was it. If they opted in, it would be then discussed. The opt-in would then be discussed by the multidisciplinary team the next day, and once a decision is made by the -- a supportive decision made by the multidisciplinary team the technology would then be switched on that evening.

**Q.** Thank you. Let's just unpick that a lilt bit.

**A.** Yeah.

**Q.** So patient with consent, opt in, following the conversation that you've just described --

**A.** Yeah.

**Q.** -- ultimately, would the decision whether actually to use Oxevision be the MDT's?

**A.** If the patient consented, yeah.

**Q.** So if a patient has consented to the use of Oxevision, is there a scenario in which, under the second pilot, the MDT might convene and consider that in fact it wasn't in the patient's interests for Oxevision to be

used?

**A.** Yes.

**Q.** So that's for the first scenario. The second scenario that I want to ask you about is this: where a patient objects, so doesn't opt in, to the use of Oxevision, I think you said, "That's it"?

**A.** Yeah, there's no -- (overspeaking) --

**Q.** There's no subsequent MDT stage --

**A.** No.

**Q.** -- or there wasn't, at Leicester. The patient's word would be final?

**A.** Yeah, that's correct.

**Q.** The patient with capacity?

**A.** Yeah.

**Q.** Thank you. Was that -- were decisions about the use of Oxevision then reviewed on a regular basis?

**A.** Yes. So each week, that consent was revisited.

**Q.** And would the approach to consent in the use of Oxevision depend on whether a patient was a voluntary patient or an involuntary patient or would that make any difference?

**A.** It wouldn't make any difference.

**Q.** Can we then move to the scenario where a patient lacked capacity. How would the issue of consent be addressed there?

**A.** It would be similar. So if a patient without capacity said they consented, the MD -- that would be discussed within the MDT. It would be acknowledged, actually, that the person lacks capacity and then the MDT would make a decision based on best interest principles. If the patient without capacity said that they wanted to opt out, then it wouldn't go any further.

**Q.** So at Leicester, even where a patient lacked capacity, if they indicated they did not want Oxevision to be used, their word would be final?

**A.** Yeah.

**Q.** There wouldn't be a subsequent MDT stage --

**A.** No.

**Q.** -- or anything like that?

**A.** *(The witness shook head)*.

**Q.** Do you know what the reasoning was behind that particular scenario, using the patient without capacity having a clear ability to refuse the use of Oxevision without anyone reviewing that? Do you know what the rationale for that was? Do you remember the reasoning behind that?

**A.** I don't specifically remember the rationale behind it. This was about providing patients with the best circumstances at night in order for them to get rest. And that was it, really. But yeah, I don't specifically

remember any more than that.

**MR GRIFFIN:** Thank you.

Chair, I've finished one topic. We've been going for an hour -- a little over an hour. I -- may I suggest that we pause for 15 minutes now and then come back. So that would be 3.25, please.

**THE CHAIR:** 3.25.

**MR GRIFFIN:** Thank you.

**(3.11 pm)**

**(A short break)**

**(3.27 pm)**

**MR GRIFFIN:** Mr Patino, we've -- just in terms of where we've got to, so we've come now to the end of the second pilot. Was there then a process of evaluation at LPT about whether to continue with Oxevision, and if so, how?

**A.** There was, yeah. Yeah, so we completed a full evaluation and I believe you've got the outcome of that or a copy of that evaluation as part of the pack.

**Q.** So there are various documents that you provided to us, and we're very grateful for them. I want to look at one of them with you, please. It's the August 2025 review of the Oxevision Learning from Contract which we've mentioned before. I'm going to ask that it's put up on our screen, please.

LPT022555 at the bottom of page 4. That's perfect.

So what we see here is the bottom of page 4 and part of page 5. Can we just look at part of this together now, please. So the review document from August 2025. Can we see at the top, near -- towards the bottom of the top paragraph:

"Following the pilot end an evaluation took place measuring feedback from staff, case studies, patient sleep survey, consent uptake and any change in incidents."

Were you part of the overall evaluation process at LPT?

**A.** Yeah.

**Q.** Do we then see a summary of findings that are listed? I'd like to look at some of the bullet points that we can see there, please. Can we see:

"The number of patients who consented during the pilot was less than half, with 16 patients consenting and 22 patients not consenting (42% of patients)."

And:

"Out of the 14 bedrooms with the Oxevision devices installed the average number of rooms switched on at any one time was 5, the lowest was 1 and the most was 8 at one time."

And can we see also that:

"Patients withdrew consent when they understood that there were cameras."

And actually, if we just drop down a bullet point:

"One patient slept in [the] interview room as refused to stay in a bedroom with Oxevision (even with it switched off). This patient did originally consent however their mental health declined and withdrew consent. This patient was pregnant and did not have a bed to sleep in until a bed was located on another ward."

So uptake remained below half of the ward population. What was the principal consequence of that on the ward, in terms of the work that members of staff had to do? You cover this at paragraph 61.

You say there that:

"Staff actually had to maintain two parallel processes."

Does that make sense?

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

**Q.** So could you just explain what that means?

**A.** Well, the observations for those that had consented to Oxevision were done outside of the room using a tablet, the traditional method would be that they would have to enter the room. And so what I'm trying to describe there is the fact that for those that consented there

was a slightly different way of -- there was a different way of doing the observations to those that hadn't consented.

**Q.** So the two parallel processes, the Oxevision process --

**A.** Yes.

**Q.** -- and the non-Oxevision process --

**A.** Yes.

**Q.** -- both had to be used?

**A.** Yeah.

**Q.** Thank you.

Just looking at some further bullet points with you, please. Do we see on the second page there:

"Staff raised concerns with the devices often not taking vital signs resulting in the need to physically check the patient."

And a little bit further down:

"It was evidenced that patients who did consent to Oxevision that their sleep had improved due to less disturbances in the night."

And:

"There was one scenario where a nurse informed the project team that there was an avoidance of potential self-harming behaviours following an observation made using Oxevision."

So that indicates potential benefit or actual

benefits from the system in terms of improved sleep --

**A.** *(The witness nodded)*.

**Q.** -- and for the avoidance of self-harm. How significant did the Trust regard those benefits to be?

**A.** Well, they were significant but in the whole evaluation, given the number of people that did not consent, in terms of the 42 per cent and also the ongoing issues that we had around the ability to take the vital signs, that was why we decided in the end not to implement Oxevision any further.

**Q.** You explain elsewhere in the statement that "staff had 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."

Is that what you're referring to there?

**A.** Yeah.

**Q.** Then the last two bullet points, reference there to the Safehinge doors and the fact that there's only two en suite bathrooms. Are those the points that we've actually covered already?

**A.** They are, yeah.

**Q.** Was the question of financial benefit at Oxevision -- of Oxevision also considered as part of the evaluation process?

**A.** In respect of?

**Q.** To -- the extent to which Oxevision as a system conferred a financial benefit on LPT. Was that considered as part of the evaluation process? Whether it saved money?

**A.** We didn't consider Oxevision as, certainly as part of the pilot, the second pilot, about whether it would save us money. We obviously looked at the 42% that consented, the one room at a time. So we had to consider the finance involved as part of the ongoing cost, if we were to implement it, given the fact that what we were seeing was a relatively low number of patients opting in to using the technology, yes. But it wasn't a defining factor.

**Q.** Thank you very much.

You say this at paragraph 54:

"Whilst sleep hygiene improved for certain individuals ..."

We've just seen that, haven't we?

**A.** Yeah.

**Q.** "... 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."

Is that correct?

**A.** That's correct.

**Q.** Was a decision therefore ultimately taken to discontinue the use of Oxevision at LPT?

**A.** Yes.

**Q.** You say at paragraph 52 that:

"The evaluation concluded that there was no robust evidence to support the continued use of the system at the Trust."

And you make similar points elsewhere in the statement; is that correct?

**A.** That's correct.

**Q.** So does it mean that the pilot originally conceived for seven wards, initially piloted on two, and then on one, ultimately led to the decision not to progress with Oxevision at all?

**A.** Yes.

**Q.** You suggest at paragraph 64 that there was no single defining factor in the decision to discontinue the use of Oxevision, and you say:

"Rather, a number of considerations were taken into account collectively."

But you say:

"A primary factor was the relatively low numbers of patients who opted in to using Oxevision."

Now, does that pick up on what you've just been saying?

**A.** Yes.

**Q.** Was that, do you think, in part the consequence of moving to an opt-in consent model or might there be other reasons for it?

**A.** Sorry?

**Q.** So we heard that in the first pilot, the consent model was to opt out --

**A.** Yeah.

**Q.** -- whereas in the second pilot, you turned to an opt-in model, and we went through that before the break.

**A.** Yeah.

**Q.** I was just asking you whether the change to the opt-in model, in your view, might be a reason why fewer people were agreeing to the use of the system or whether you weren't able to say?

**A.** I'm not able to say.

**Q.** The Oxehealth learning from the contract document includes this: "After consideration by the DMT" -- what's the DMT?

**A.** The Directorate Management Team.

**Q.** "... it was agreed that termination of the contract was the most appropriate decision following the insignificant evidence from the pilot in comparison to

the financial burden.

"Oxehealth was sent formal notice to end the contract 18 February 2025 by the procurement team. Initial contract end date was expected to be 31 March 2025 in line with the four-week notice discussed between Procurement and Oxehealth in October 2024."

Does that all sound correct?

**A.** Yes.

**Q.** So was that the end of Oxevision at Leicester?

**A.** Yes.

**MR GRIFFIN:** Chair, do you have any questions for Mr Patino?

**THE CHAIR:** I don't.

**MR GRIFFIN:** Mr Patino, the process now is this: we will pause for 15 minutes or so just to see if there are any further questions. If there are no further questions, that's the end of your evidence and I thank you for it.

If there are a few more questions, we'll come back in, and I will ask you then at that time.

**THE WITNESS:** Okay.

**MR GRIFFIN:** Thank you very much.

**THE CHAIR:** Can I thank you too, if we don't come back, for giving us your evidence. We really appreciate it. Thank you.

**(3.39 pm)**

**(A short break)**

**(3.56 pm)**

**MR GRIFFIN:** Chair, just couple more questions for Mr Patino.

Mr Patino, we were talking about the evaluation process following the second pilot. And we looked at part of one of the evaluation documents. Was another of the relevant documents a cost-benefit analysis that was conducted?

**A.** *(No audible answer)*.

**Q.** And was that dated January 2025?

**A.** Yeah.

**Q.** I just wanted to ask you about something that includes, which I'll read to you. It says this:

"Overall cost analysis".

And then it has this sentence:

"Oxevision is a high-cost system and although there have been some benefits to patient sleep, due to the period of time of the pilot, there is insufficient evidence to demonstrate any impact on patient outcomes."

Now, does that make sense to you?

**A.** Sort of, yeah.

**Q.** I was going to ask you what your views were of it.

So shall we break it down? So the cost-benefit analysis at page 3 and the reference is to the high cost

of the system. Do you accept or do you agree with this analysis: that the system was high cost to LPT? Page 3 if you've got it in front of you, under "Overall cost analysis".

So the reference is to a high-cost system. So my first question is, did Leicester consider that Oxevision, for the purposes it wished to use it, was a high-cost system?

**A.** No. I think the way the paper has been written, it was in the context of we didn't -- we purchased Oxevision initially for three years and we used it out of that three-year period for a very limited period of time. That is my --

**Q.** That would be your reading?

**A.** Yeah.

**Q.** So the context is, instead of three years, it's two pilots, and that's it?

**A.** Yeah.

**Q.** Thank you.

Then the reference is to "Some benefits to patients' sleep but due to the period of time of the pilot, there's insufficient evidence to demonstrate any impact on patient outcomes."

Do you agree with that?

**A.** Yes.

**Q.** Do you understand that there are inpatients, possibly particularly adolescents and children, receiving treatment and care who feel safer when there is staff visibility at night, and that simple things like opening the door or a flick of a torchlight has the capability of comforting and reassuring patients alone in their bedrooms at night?

**A.** I can -- yeah, I can understand that.

**Q.** Would you just repeat that, please?

**A.** I can understand that.

**Q.** Do you agree with that?

**A.** It's not my -- if we're talking specifically about child and adolescent, it's not an area of -- that I've worked in, so it's not -- yeah, it's not something really I can comment on.

**Q.** So you can understand that this might be correct but it's not really within your area of experience or expertise?

**A.** Yeah, exactly.

**Q.** Thank you.

Chair, those are the questions I have for Mr Patino. Unless you have any further questions at this stage, could Mr Patino be discharged, please?

**THE CHAIR:** Yes.

Thank you very much, you may go.

**THE WITNESS:** Thank you.

**THE CHAIR:** Thank you for helping us.

**MR GRIFFIN:** Chair, at this stage my colleague Mr Hayes is going to read a short summary of comparator Trust evidence received by the Inquiry, other than the evidence from TEWV, who we heard from this morning, and Leicester, from whom we've just heard.

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

## Summary of Comparator Trust Evidence

**MR HAYES:** Chair, in February 2026, the Lampard Inquiry sent Rule 9 Requests to several NHS Trusts seeking information concerning their historic and current use of the Oxevision system in mental health inpatient wards. This exercise was undertaken by the Inquiry in order to aid its exploration of how the use of Oxevision by EPUT compares to that of other Mental Health Trusts across England.

We've just heard evidence from the representatives of two such Trusts regarding their use of Oxevision in inpatient wards, namely Leicester Partnership NHS Foundation Trust and Tees, Esk and wear Valleys NHS Foundation Trust. The Inquiry has additionally received evidence from four other NHS Trusts regarding their use of Oxevision. This evidence has been provided to Core Participants and will be available via the Inquiry's

website shortly following today's hearing.

Those Trusts are: North East London NHS Foundation Trust, or NELFT; East London NHS Foundation Trust, or ELFT; Oxford Health NHS Foundation Trust, or Oxford Health; and South London and Maudsley NHS Foundation Trust, or SLAM. These Trusts will not be giving live evidence at this hearing. This paper summarises the evidence they have provided to the Inquiry in response to its Rule 9 Requests.

Starting with NELFT. NELFT's evidence is set out in the witness statement of Paul Calaminus, Chief Executive Officer of NELFT, dated 20 May 2026. His statement is 15 pages long and accompanied by 30 exhibits.

Mr Calaminus explains that NELFT decided to implement Oxevision in its inpatient wards following a pilot that commenced in June 2021 in a seclusion suite within a male psychiatric Intensive Care Unit. A Clinical Safety Case Report was prepared following the pilot. This analysed the initial deployment of Oxevision in NELFT's Section 136 seclusion suite with a view to providing assurance its use would not impact the quality and safety of care for service users.

The 2021 safety case report identified several risks including of the software displaying the wrong data, a patient's location or activity posing a risk which the

user did not act on, and sensor tampering, all of which were considered to be an acceptable level of risk.

Overall, the 2021 Clinical Safety Case Report recommended proceeding with the deployment of Oxevision, concluding that there were no high-level risks identified with good clinical safety risk management.

Following the pilot, the purchase order was issued authorising the installation of Oxevision in all inpatient wards at Goodmayes Hospital, all seclusion rooms, and all Section 136 suites for an initial period of 36 months, subsequently extended by six months.

In March 2023, Oxevision was installed in a further three wards with full capability for use in all bedrooms. This was followed by full capability deployment for use in all bedrooms in a further two wards in October 2023, and full capability of appointment in all bedrooms in a further eight wards in the first half of 2024.

The initial deployment of Oxevision in designated seclusion rooms was accompanied by a Standard Operating Procedure, or SOP. The SOP provided guidance to staff working on wards where Oxevision was in place. It reminded staff to follow ordinary operational procedures as usual, including NELFT's Safe and Supportive Observations Policy and emphasised that Oxevision had

been installed to act as a safety net between mandated observations rather than to replace the observation and engagement policy.

As to consent, whilst the first version of the SOP stated that patients and their family or carers must be informed of its use, consent would not be required and individually recorded. Where a patient objected to its use, any request to turn it off would be discussed with the multidisciplinary team and the patients' wishes adhered to if clinically safe to do so.

This approach evolved over time with the latest version of the SOP requiring opt-in consent for Oxevision and the default setting for Oxevision being off. The SOP stated that Oxevision should only be turned on in response to an identified need and/or with consent, with decision making being comprehensively recorded in the patient's notes.

An exception was made in respect of seclusion rooms and health-based places of safety where Oxevision was to remain switched on at all times.

In 2025, NELFT was exploring the case for renewing its contract with Oxehealth for an additional four-year term. The Executive Management Team asked the relational care faculty to review the use of Oxevision.

The review report completed in July 2025 ultimately

recommended ending the use of Oxevision at NELFT in all patient bedrooms, with a phased end to its use in seclusion areas, Section 136 suites and health-based places of safety.

Overall, the review concluded that there was insufficient evidence to suggest that Oxevision usage met its intended outcomes, that there was little evidence to suggest that consent obtained for the use of Oxevision was fully informed, voluntary, and free from coercion, that it risked subjecting vulnerable people to further restriction and potential harm, that there were legitimate concerns regarding the negative impact of Oxevision on therapeutic and personalised care and that there were significant safety concerns raised relating to its use.

A subsequent paper dated 6 January 2026 considered options for monitoring of vital signs in seclusion and Section 136 settings, recommending that the use of Oxevision be retained in these areas subject to strengthening governance arrangements.

In sum, whilst NELFT has decommissioned its use in most wards, Oxevision remains in use and on by default in seclusion and Section 136 rooms.

Oxford Health. Oxford Health's evidence is set out in the witness statement of Britta Klinck, Chief Nursing

Officer, dated 28 May 2026. Her statement is 11 pages long and accompanied by 20 exhibits.

Ms Klinck's statement outlines that Oxevision was initially installed in six rooms on Vaughan Thomas Ward, an acute adult inpatient ward for men in Warneford Hospital in 2017.

An SOP was prepared in anticipation of the pilot of Oxevision. The SOP notes that supportive observations may disturb patients' sleep and have a negative impact on therapeutic relationship between patients and staff.

Oxevision was proposed as a potential solution to aid patients in sleep, improve privacy, and reduce the length of admissions, but it was emphasised that Oxevision would not replace clinical judgement or expertise.

Ms Klinck explains that at the end of the pilot, a lessons learned report was produced by Oxford Health to evaluate its deployment of Oxevision. The report noted that:

"From the start of the project there has been a need for greater transparency and openness from the supplier".

And cited two instances where testing had to be suspended. On one such occasion, Oxevision use was suspended entirely pending the receipt of assurances

from LIO, formerly Oxehealth, as to the governance and security concerns.

Notwithstanding those concerns, the initial pilot was widened in 2022 and Oxevision was installed in a further seven wards.

A second phase of the implementation took place from February 2024 to August 2025 during which time Oxevision was installed in Oxford Health's remaining forensic wards as well as a rehabilitation ward. Oxford Health carried out a benefits analysis as part of this deployment, reviewed and accepted by its project board in July 2024.

Ms Klinck's summary of the benefits analysis report sets out the feedback from its staff and patients on the use of Oxevision was general positive.

However, the report was limited in scope and the benefit analysis was hindered by the loss of Trust clinical systems limiting the ability to report outcomes effectively.

Following deployment, all wards operate an opt-in consent model whereby the camera is not switched on until consent has been provided by the patient. However, the clinical team may override the patient's wishes where the patient lacks capacity to make the decision and the use of the system is considered to be

clinically in the patient's best interest.

The opt-in consent model has been in place since the installation of Oxevision.

Oxevision is also used in seclusion units. Whilst consent is still sought in such units, this is subject to exceptions. Consent is not required where the person nursed in seclusion lacks capacity as assessed by medical staff, the person is refusing for physical observations to be completed, and/or there's a significant risk to others and the multidisciplinary team agrees to the use of Oxevision.

The Inquiry has been informed that Oxevision was also due to be installed in an eating disorder ward in June 2026, meaning that it is now in place on 25 of Oxford Health's 26 mental health wards.

ELFT. ELFT's evidence is set out in the witness statement of Evah Marufu, Director of Nursing, dated 21 May 2026. Her statement is 26 pages long and accompanied by 10 exhibits.

ELFT first deployed Oxevision in its facilities after signing a service agreement with LIO in November 2021. Usage began from September 2022 with the exception of Shoreditch Ward in John Howard Hospital where use began in 2023.

Currently, ELFT has deployed Oxevision in 13 wards

across seven medical centres. Oxevision is installed exclusively in seclusion areas rather than in general wards or Section 136 areas, primarily as a means of mitigating risks of harm.

It is used to support spot-check measurements of pulse and breathing rates and recordings may be requested where needed to support incident reviews or investigations.

Guidelines for the use of Oxevision first issued in June 2022 emphasise that staff must be trained and deemed competent with the system before use and that Oxevision does not replace ELFT's ordinary observation policies and practices.

Ms Marufu states that consent to use Oxevision in patients' rooms is not always sought. She explains that patients in seclusion areas are often acutely unwell, highly distressed and not in a position to engage meaningfully in a consent discussion. In those circumstances, ELFT considers that seeking consent in every case could result in issues such as delays in implementing safety monitoring, escalation of patient distress and a reduced ability to carry out observations in a timely manner. As such, there is no standard process for seeking a patient's consent.

Where a patient raises a concern about the use of

Oxevision, their concern is recorded and considered through a multidisciplinary team discussion, and the patient is provided with information about the use of Oxevision. First, a patient may not opt out of Oxevision without the agreement of clinicians.

ELFT reviewed its use of Oxevision in 2023 after NHS England issued correspondence to mental health providers regarding the use of vision-based monitoring systems in September 2023.

The review concluded that ELFT's deployment of Oxevision was in accordance with its seclusion governance framework.

Ms Marufu sets out that ELFT understands the benefits of Oxevision to include the provision of an additional safety net for seclusion wards, supporting least restrictive approaches to basic observations, and the ability to carry out and contemporaneously document vital signs checks.

This must be balanced against the need to mitigate risks such as technical failures, and the ongoing need to guard against substitution for inpatient observations.

Finally, SLAM. SLAM's evidence is set out in the witness statement of Philippa Galligan, Interim Chief Operating Officer, dated 3 June 2026. Her statement is

five pages long and accompanied by six exhibits.

Ms Galligan explains that Oxevision was originally installed as part of an improvement project in late 2019 in the Eileen Skillern PICU seclusion room. Oxevision remained in use in the room until the seclusion room itself was decommissioned in October 2022. The consent of patients to the use of Oxevision was not sought, although patients were informed through signage and engagement sessions of the use of Oxevision, and could raise objections. Oxevision was used in the unit to conduct remote physical health observations in addition to observations conducted by nursing staff.

Oxevision was also used in Peak Ward, a bespoke inpatient unit for one female patient, Patient A, whose complex needs and behaviour led to her being managed in isolation from other patients. Each area of the ward had an Oxevision system which was operational between July 2019 and August 2022. The decision to use Oxevision in Peak Ward was made under the best-interests decision-making framework within the Mental Capacity Act 2005 and Patient A's consent was not sought. Oxevision was used to monitor patient A's vital signs and physical health safely by reducing risk to staff.

Ms Galligan sets out that Oxevision has since ceased to be deployed by SLAM. This is because Patient A's

placement in Peak Ward came to an end, and the provision of seclusion in the Eileen Skillern Unit was moved to a different suite that was not equipped with Oxevision. SLAM did not identify any issues arising from its use of Oxevision in these settings over the deployment period.

Chair, that concludes the paper.

**THE CHAIR:** Thank you very much indeed.

**MR HAYES:** I understand that we will commence again tomorrow at 10.00 am, where we will hear from Jill Archibald, who is the nursing expert instructed, and who will give evidence on the use of observations and the use of technology.

**THE CHAIR:** Thank you very much indeed. 10.00 tomorrow.

**(4.14 pm)**

**(The hearing adjourned until 10.00 am the following day)**

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