

Wednesday, 22 July 2026

(10.00 am)

(Proceedings delayed)

(10.07 am)

THE CHAIR: Mr Griffin.

MR GRIFFIN: Good morning, Chair.

Today, the Inquiry will hear from Jill Archibald, an expert witness, and she will deal with observation and engagement and the use of vision-based monitoring.

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 session, and we'll be hearing from Ms Archibald both in the morning and in the afternoon.

Anyone in the Inquiry room should feel free to leave at any time.

May I take the opportunity to remind those engaging with the Inquiry that emotional support is available for all who require it. Present today, as on every day, are representatives of Hestia, and they are able to provide emotional support. They are currently in this room and can be identified by their orange-coloured scarves.

There's a private room downstairs where anyone who needs emotional support can talk to Hestia. If you prefer, you can speak to a member of the Inquiry Team. We're

1 identifiable by our purple lanyards. And we can put you
2 in touch with Hestia.

3 For those following the hearing online, information
4 about emotional support that's available can be found on
5 the Inquiry's website @lampardinquiry.org.uk. The
6 "Support" tab is near the top right-hand corner.

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

9 Chair, with your permission, I'll now ask for
10 Ms Archibald to be sworn.

11 **JILL ARCHIBALD (affirmed)**

12 **Questioned by MR GRIFFIN KC**

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

14 **A.** Yes. Jill Veronica Archibald.

15 **Q.** Ms Archibald, have you provided the Inquiry with an
16 expert report called "Report for the Lampard Inquiry:
17 Observation and Engagement and the Use of Vision-Based
18 Monitoring"?

19 **A.** Yes.

20 **Q.** Do you have it in front of you?

21 **A.** I do.

22 **Q.** Is it dated 1 July 2026?

23 **A.** It is.

24 **Q.** And in total, is it 104 pages long?

25 **A.** It is.

1 Q. Are there a couple of corrections that you'd like to
2 bring to the Chair's attention?

3 A. There is.

4 Q. Can we start with page 92, please, and paragraph 25.16.
5 Should that paragraph simply be deleted because it
6 repeats most of the paragraph above it?

7 A. Yeah, it should.

8 Q. Could we go to page 101, please, and the last paragraph
9 there. Can we see at the end of the first sentence the
10 word "note"?

11 A. Yes.

12 Q. Should that actually be "not"?

13 A. Yes, that's correct.

14 Q. Thank you. And then can we look at your appendix at
15 page 102.

16 A. Yeah.

17 Q. Do we see the penultimate paragraph there starting with
18 number 3, "Date: September 2021 to November 2023".
19 Should that simply be deleted as it repeats the
20 paragraph above it?

21 A. Yes, that's correct.

22 Q. And finally, in the same appendix at the top of the next
23 page where we see "5/Date", can we see there a reference
24 to July 2026, and should that in fact be July 2016?

25 A. Yes, that's correct.

1 Q. Thank you.

2 If we look at the bottom of page 101, does the

3 report include your confirmation that you've made clear

4 where facts and matters referred to are or are not

5 within your own knowledge, at that where they are within

6 your own knowledge, you confirm them to be true, and

7 finally, that the opinions you've expressed represent

8 your true and complete professional opinions on the

9 matters to which they refer?

10 A. *(The witness nodded)*.

11 Q. Is that correct?

12 A. That's correct.

13 Q. And do you again confirm that today?

14 A. I do.

15 Q. You say at paragraph 1.11, so that's at page 5, that:

16 "In preparing this report, I have sought to provide

17 objective, balanced and impartial evidence to assist the

18 Inquiry on the matters within my area of expertise."

19 Again, is that correct?

20 A. That's correct.

21 Q. Have you signed the report?

22 A. I have.

23 Q. And subject to the corrections that you've just

24 notified, is it true and accurate to the best of your

25 knowledge and belief?

1 **A.** It is.

2 **Q.** Ms Archibald, the report stands as part of your
3 evidence, the Chair, the Inquiry, and others have read
4 it with care and that means I don't intend today to ask
5 you about every aspect of it.

6 What I'd like to do now, please, is to ask you
7 a little bit about your own background and experience;
8 is that okay?

9 **A.** Yes.

10 **Q.** You provided a summary at Section 1 of the report so
11 that's on page 3 and we've seen the appendix and there's
12 more information there, as well, isn't there?

13 Are you a Registered Mental Health Nurse or RMN?

14 **A.** I am.

15 **Q.** When did you qualify as an RMN?

16 **A.** 2006.

17 **Q.** Can you help with this, what is an RMN?

18 **A.** An RMN is the terminology for a Registered Mental Health
19 Nurse.

20 **Q.** And what does that entail?

21 **A.** A mental health nurse specialises in supporting people
22 with mental illness which involves assessing, treating,
23 enabling recovery, and it's a highly skilled role that
24 helps develop a therapeutic relationship and providing
25 holistic care.

1 **Q.** Thank you. And does the registered element of it
2 demonstrate that the nurse has completed an approved
3 programme of education in mental health nursing and is
4 registered with the Nursing and Midwifery Council?

5 **A.** Yes, the registration allows you to practise as a mental
6 health nurse.

7 **Q.** Since November 2023, have you been employed as
8 a Consultant Nurse and Responsible Clinician/Approved
9 Clinician on a male acute ward in Cumbria within the
10 Cumbria, Northumberland, Tyne and Wear NHS Foundation
11 Trust, or CNTW?

12 **A.** Yes, I've been a consultant nurse since 2019 and became
13 a Responsible Clinician in 2023 but since November 2023
14 I've been a consultant nurse with Responsive Clinician
15 duties on a male acute ward in Cumbria.

16 **Q.** Just staying with the male acute ward, what would your
17 role be there, please?

18 **A.** I am the Responsible Clinician for ten patients, it's an
19 18-bedded ward, and I'm consultant nurse for the 18
20 patients, or I am responsible for the care and treatment
21 of the patients assigned to my care, and that is also,
22 I have statutory obligations due to the Mental Health
23 Act for those patients.

24 **Q.** If you pause there, I'm going to break that down and
25 come back and ask you about individual parts of it.

1 First of all, you -- how long have you been a Consultant
2 Nurse? Did you say from 2019?

3 **A.** Yes, 2019.

4 **Q.** And what is a Consultant Nurse?

5 **A.** A Consultant Nurse is a high-level nurse. The role came
6 about about 26 years ago and it was developed to
7 encourage nurses, highly experienced nurses, to remain
8 in clinical practice and not just go into operational
9 roles. So it was encouraged to keep skilled and
10 experienced nurses in face-to-face practice. The role
11 incorporates four elements, such as clinical practice,
12 research and development, leadership, and education and
13 training. Some Consultant Nurses have a balance of more
14 clinical work than research, and some are more
15 researchers than clinical, but ultimately, we work
16 within those four pillars of those nursing.

17 **Q.** So we've also heard that you are a Responsible
18 Clinician/Approved Clinician?

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

20 **Q.** And you've touched on that already but I just want to
21 come back to that, please?

22 **A.** Mm-hm.

23 **Q.** Is that sometimes abbreviated to RC/AC?

24 **A.** It is, yeah.

25 **Q.** Can we use that if we need to?

1 **A.** Yeah.

2 **Q.** What does an RC/AC do?

3 **A.** An AC is approved by the Secretary of State to act in
4 accordance with the Mental Health Act. The RC is the
5 role by your employer to act in such a manner. So the
6 AC is the training and the approval to do it and the RC
7 is the role in which you're in.

8 **Q.** So the Approved Clinician, as you've said, approved by
9 the Secretary of State, and is that to make certain
10 decisions, as you say, under the Mental Health Act?

11 **A.** Yeah, within the Mental Health Act, yeah.

12 **Q.** Can we deal with certain other qualifications, please.

13 **A.** Yes.

14 **Q.** Did you obtain a diploma in mental health nursing in
15 2006, and are there the following amongst the
16 qualifications you received subsequent to that: so a BSc
17 in practice development in nursing in 2014?

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

19 **Q.** And post-graduate certificates in clinical leadership in
20 2020?

21 **A.** Yes.

22 **Q.** And mental health law in 2022?

23 **A.** Yes.

24 **Q.** What did you study or cover for the mental health law
25 post-graduate certificate?

1 **A.** I completed the post-graduate in mental health law in
2 preparation for becoming an Approved Clinician. So the
3 course covered the Human Rights Act, Mental Capacity Act
4 and the Mental Health Act.

5 **Q.** So human rights principles --

6 **A.** Yes.

7 **Q.** -- and the Human Rights Act 1998 specifically were
8 amongst the areas that you studied?

9 **A.** It was, yes.

10 **Q.** What further experience do you have of the application
11 of human rights concepts in the context of mental health
12 and mental health inpatients?

13 **A.** It's incorporated into my daily practice, maintaining
14 the rights of individuals, it's working in accordance
15 with the law. The majority of my patients are detained
16 under the Mental Health Act, but that doesn't mean that
17 we don't take into consideration their rights. And so
18 it's a very -- it's a responsible role that takes great
19 consideration that you're always doing the right thing
20 at the right time.

21 **Q.** What experience do you have in relation to Mental Health
22 Tribunals, specifically?

23 **A.** Quite frequent. It's part of my weekly work. Patients
24 that are in my care have the right to appeal the
25 decision to be detained under the Mental Health Act and

1 in preparation for that, I have to write reports and
2 attend tribunals. Usually on a weekly basis.

3 **Q.** Thank you. Do you also have a Level 7 qualification in
4 non-medical prescribing?

5 **A.** I do, yes. I'm a non-medical prescriber.

6 **Q.** What's the non-medical element?

7 **A.** I'm just not a doctor, medical doctor.

8 **Q.** So to laypeople, you're able to prescribe --

9 **A.** I'm able to prescribe.

10 **Q.** -- it's just that you are not a doctor?

11 **A.** Yes.

12 **Q.** Thank you. Could we look briefly at some of the
13 previous roles that you have performed. I'm going to
14 ask that part of your report is put up, please.

15 I'm going to give the reference of your report once,
16 it's INQY025967. But I'll just refer to it as "the
17 report". Would you put up, please, page 102 and expand
18 from "Employment history" to the bottom of the page.
19 Thank you.

20 Just starting with the top of the list there. This
21 is the role I think that you have told us about from
22 November 2023 to current, within the Trust that we've
23 just discussed. And the RC/AC Consultant Nurse role.
24 And I think you've already explained it's an adult acute
25 18-bed inpatient ward; yes?

1 **A.** That's correct.

2 **Q.** Can we see there underneath it the role that you
3 performed before, from September 2021 to November 2023
4 in the same Trust as a Consultant Nurse.

5 So that was Crisis Resolution Home Treatment Team,
6 and then if we drop down to number 4, between 2019 and
7 2021 in the same Trust as Consultant Nurse.

8 Would you go over to the top of the next page,
9 please.

10 And we can see that was on a mixed-sex 22-bed adult
11 acute inpatient psychiatric intensive care ward.

12 And then we see work as a Service Manager between
13 2016 and 2019, work as a Ward Manager, Team Lead,
14 Clinical Lead, and Staff Nurse before that.

15 Those are all at the Cumbria Partnership NHS
16 Foundation Trust. What is the relationship, if any,
17 between that Trust and the Trust that you currently work
18 for?

19 **A.** In October 2019 the North Cumbria Mental Health and
20 Learning Disability Services merged with Newcastle Tyne
21 and Wear Mental Health and Learning Disability Services
22 and South Cumbria merged with Lancashire Care Trust.

23 **Q.** So it's a development into that --

24 **A.** Yeah.

25 **Q.** -- into the -- (overspeaking) --

1 **A.** Cumbrian Partnership Trust was not solely a mental
2 health and learning disability Trust, it also
3 incorporated district nursing, community hospitals, so
4 it allowed Cumbria to be part of a bigger mental health
5 and learning disability focused Trust.

6 **Q.** Thank you very much.

7 Would you take that down, please.

8 Now, amongst the other facets to your career that
9 are set out in the report, have you on two occasions
10 acted as an expert advisor to the Health Services Safety
11 Investigations Body, or HSSIB?

12 **A.** I have, yes.

13 **Q.** And did that include, in 2024, working on the
14 investigation examining the use of enhanced observation
15 levels for patients who self-harm on inpatient wards?

16 **A.** I did, yes.

17 **Q.** And since 2014 have you been a Lead Peer Reviewer for
18 the Royal College of Psychiatrists Accreditation for
19 Inpatient Mental Health Services, or AIMS, programme?

20 **A.** I have been, yes.

21 **Q.** You're here today to provide expert evidence to the
22 Inquiry on observation and engagement practices, the use
23 of vision-based technology such as CCTV and body-worn
24 cameras, and vision-based patient monitoring systems.

25 Now, we have been using the acronym VBPMs, which is

1 a bit of a mouthful but we do understand what that means
2 thanks to the evidence we've heard recently. Is this
3 all in the context of mental health inpatient care?

4 **A.** It is.

5 **Q.** First, can I ask you how you are familiar with the use
6 of CCTV and body-worn cameras? And for those following,
7 this is at paragraph 1.9 at page 4.

8 **A.** Um, yeah, so in my previous role as Service Manager CCTV
9 was beginning to be implemented into the wards that I
10 worked. So CCTV was implemented first, if I recall, and
11 then followed by body-worn cameras, but around about
12 that time I wasn't, I wasn't directly involved in the
13 governance of the implementation. So I was part of the
14 early talks about introducing it on to acute wards.

15 **Q.** And how are you familiar with VBPMs? And this is
16 paragraph 1.10.

17 **A.** From a professional -- I had a professional interest in
18 that I was aware of the technology from my time on a
19 PICU, which is the Psychiatric Intensive Care ward, so
20 that was around about 2019/20, that I was aware of the
21 technology, but I didn't actively -- well, I didn't work
22 on a ward until 2023 when it was implemented. It had
23 just been implemented around about the time that I
24 started working on the ward and that was when -- my
25 first experience of working with the technology.

1 **Q.** So are you familiar with the system in practice?

2 **A.** I am, yes.

3 **Q.** Thank you.

4 You provide a summary of your instructions at
5 Section 2 of your report. Can we deal briefly with them
6 now, please, before we move on to address your first
7 topic. You say this at paragraph 2.2, and that's
8 page 6, that:

9 "This report will discuss observation and engagement
10 practices and the use of VBPMs/VBT [vision-based
11 technology] within mental health inpatient settings. It
12 will benchmark practice against relevant national
13 standards, legislation and guidance, and will identify
14 what good practice looks like during the relevant
15 period. It will also consider the challenges faced in
16 mental health inpatient care in England during the
17 relevant period as well as current practice."

18 And does the report cover those matters?

19 **A.** Yes.

20 **Q.** And you've provided, as I've said, a detailed summary of
21 your instructions in Section 2 and I don't intend to
22 take you through that now.

23 Has the Inquiry provided you with a large amount of
24 evidence and information to review for the purposes of
25 providing your report?

1 **A.** It has.

2 **Q.** Does that include witness statements, exhibits and
3 transcripts of evidence from sources such as LIO or
4 Oxehealth --

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

6 **Q.** -- and Essex Partnership University NHS Foundation Trust
7 or EPUT?

8 **A.** It has.

9 **Q.** Could we just deal with what we should call Oxehealth.
10 We understand that the company Oxehealth has rebranded
11 and is currently known as LIO?

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

13 **Q.** But we have, during the course of this Inquiry, been
14 referring to Oxehealth as the name of the company. What
15 I suggest, just for the sake of simplicity, is that we
16 continue to do so if we need to refer to the company
17 today.

18 **A.** Mm-hm.

19 **Q.** And we have been referring to the technology as
20 "Oxevision". Could we continue to do that, again for
21 the sake of simplicity today so that we all know what
22 we're talking about. Yes?

23 **A.** Yeah, yeah.

24 **Q.** Have you also been provided with a statement and
25 material provided by the organisation Stop Oxevision?

1 **A.** I have.

2 **Q.** And have you been provided with case summaries and
3 further material, including witness statements from
4 bereaved family members, concerning the 14 tragic deaths
5 that you've considered for the purposes of the report?

6 **A.** I have.

7 **Q.** So you refer in the report to 14 deceased individuals,
8 and you do so in the context specifically of your
9 instructions?

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

11 **Q.** So that's observations, engagement, technology?

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

13 **Q.** And do you take aspects of their experience to then
14 discuss points that you're able to make falling within
15 your instructions?

16 **A.** I have, yes.

17 **Q.** And within the report, do you refer to the following
18 people: Adam Steel?

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

20 **Q.** Bethany Lilley, Diana Hammond, Edwige Nsilu, Elise
21 Sebastian, Gareth Clarke, Jason Standing, Johnson
22 Omotoyinbo, Kelly Campbell, Madison Naylor, Michael
23 Nolan, Morgan-Rose Hart, Sophie Alderman, and Stephen
24 Neville?

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

1 Q. Do you refer to all of them in your report?

2 A. I do.

3 Q. What information did you consider in relation to those

4 deaths, please?

5 A. I considered the case summaries supplied by the Inquiry,

6 the family statements, and the investigation from EPUT,

7 and the coroner's information.

8 Q. So one of the questions I have is just for absolute

9 clarity, is this: did you read the family statements

10 prepared by the bereaved families or have you relied

11 solely on the case summaries?

12 A. I read the family statements.

13 Q. Could we move, then, to our first topic. This is

14 observations and engagement, and it's Section 3 of your

15 report. Can I start by asking you what observations are

16 in this context, please?

17 A. Yes. Observations is a formal approach to how often

18 somebody should be observed. So there's lots of

19 observations in a patient's daily life on a ward but

20 this is a more formal approach and identified level of

21 what's required, based on risk and need.

22 Q. And is -- is it an intervention of varying intensity?

23 A. The observation is an observation. That's -- the

24 observation level will determine the frequency of when

25 somebody should be observed, and then it's the

1 engagement that details more intervention.

2 **Q.** Thank you. That then does bring us on to the question
3 of what engagement is.

4 **A.** Engagement is the prescribed need of engagement to help
5 that patient. There's an identified risk that -- sorry,
6 a patient that is identified as a risk, that requires
7 increased observation levels. So the engagement is what
8 interventions are going to be done on the frequency of
9 those observations.

10 **Q.** You say at paragraph 3.2, at page 12, that "Engagement
11 refers to the therapeutic interaction that supports
12 assessment and care"; would that be correct?

13 **A.** That is correct, yeah.

14 **Q.** Thank you.

15 Why are observations and engagement considered
16 together?

17 **A.** Because the observation just tells us where somebody was
18 at what time. The engagement tells us how somebody is,
19 which then informs treatment and recovery.

20 **Q.** So they're both essential elements?

21 **A.** They're both essential, yeah.

22 **THE CHAIR:** Is it the case that an engagement very much
23 depends on the nature of risk and the presentation? So
24 just to suggest that turning up and talking to somebody
25 or observing that they are breathing, fit and well is

1 too simple, and you have to moderate engagement to the
2 circumstances of the patient?

3 **A.** Yes, so example, if somebody is not eating or drinking,
4 the engagement is to support with the eating and
5 drinking. If somebody's highly distressed, the
6 engagement is to offer comfort and support. So it
7 should be tailored specifically to each patient.

8 **THE CHAIR:** Thank you.

9 **MR GRIFFIN:** You say this towards -- at paragraph 18.1, this
10 is page 62 of your report:

11 "Observation and engagement practice exists for an
12 important purpose: to preserve life".

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

14 **Q.** "Reduce harm, provide reassurance, and support
15 therapeutic recovery during periods of significant
16 distress and vulnerability. When delivered well,
17 observations can save lives."

18 Is that something that you've seen in your own
19 practice and experience?

20 **A.** Yes, yeah.

21 **Q.** Could you put up EPUT020729 at page 4, please. And
22 expand the top of the page to include 1.1.

23 So this is from the 2023 Therapeutic Engagement and
24 Supportive Observation policy of EPUT and, as you know,
25 EPUT has been the focus of the Inquiry's work.

1 I just want to ask you about a couple of things
2 here, please.

3 First of all, can we see at 1.1 the first sentence
4 or two:

5 "Therapeutic Engagement and Supportive Observation
6 is an intervention by which staff engage with a patient
7 to develop a therapeutic relationship, offer therapeutic
8 intervention and to reduce risk to the patient and
9 others on the ward."

10 So the reference there is to therapeutic engagement.
11 How is that different from simple engagement?

12 **A.** It should have purpose and meaning and it should be
13 meaningful to the patient.

14 **Q.** There is also reference there to "supportive
15 observation". How is that different from simple
16 observation?

17 **A.** Supportive observation, again, should be meaningful to
18 that patient and be -- it should be viewed by the
19 patient as supportive, helpful.

20 **Q.** Do you agree in general terms with the description here
21 of the Therapeutic Engagement and Supportive
22 Observation -- do you agree with what is set there as an
23 intention?

24 **A.** Yes.

25 **Q.** Could we just see the next sentence says:

1 "It is imperative that this policy has patients and
2 their loved ones' experiences at the heart of it."

3 That would follow, I think, from what you've just
4 been saying, yes?

5 **A.** Yes.

6 **Q.** Just dropping down a little bit just over halfway:

7 "Therapeutic Engagement and Supportive Observation
8 should be used to support care and treatment and not
9 purely to avoid risk. It is an opportunity to build
10 therapeutic relationships and maximise the opportunity
11 for therapeutic support. It should be goal directed and
12 seen as an integral part of the inpatient care plan."

13 And then at the bottom:

14 "Individualised care plans, mindful of patient and
15 carer preferences, are central to providing considerate
16 care at a time of increased need and vulnerability; and
17 in order to promote dignity."

18 Just breaking that down, it suggests that the
19 engagement and observation should be used to support
20 care and treatment and not purely to avoid risk. What's
21 your view about that?

22 **A.** Yes, I would agree with the statement.

23 **Q.** Has the approach to observations changed over the time
24 being considered by this Inquiry from the beginning of
25 2000 to the end of 2023 and indeed beyond, up to present

1 time?

2 **A.** Yes, in clinical practice it has evolved quite a bit.

3 I think it was initially more about the observation,

4 keeping an eye on somebody, checking where they are.

5 But as we've learnt more, such as about trauma-informed

6 care and managing risk, and what is helpful to a

7 patient, it's become much more of an engagement tool.

8 Just to point out, every patient on a ward should be

9 engaged regardless, there should be an engagement plan,

10 but for some patients they do need a more prescribed,

11 more frequent engagement plan because their need at that

12 time requires that.

13 So over the 23, 24 years, we've become much more

14 patient centred and more mindful of the impact that

15 those observations have, and that's why they are -- they

16 should be time limited because they also come with, you

17 know, it can be intrusive in somebody's -- in somebody's

18 care. So that's why it should be really focused, it

19 should be time-framed, it should be reviewed and it

20 should be meaningful.

21 **Q.** And so just to pick up on what you've said, towards the

22 start of the period that we're considering, the approach

23 would have been quite different, potentially, with much

24 more of a focus on the observation side and, as I've

25 understood your evidence, as we go on through the period

1 of time, the engagement element becomes more important?

2 **A.** Yeah, there used to be a general feeling amongst nurses
3 that intermittent level 2 observations didn't save lives
4 because it gave opportunity -- a window of opportunity,
5 but what -- as we've learnt more and evolved in our
6 practice we do recognise that actually it does, it can
7 save lives. And you learn from that patient being able
8 to maintain their own safety for those 15 minutes is
9 really telling. That's a big deal for somebody who
10 struggles to maintain their safety. So if they're able
11 to maintain safety for 15 minutes, you build on it so
12 then they can maintain their safety for 30 minutes and
13 then you build and build. There's a saying: take every
14 step, take every day. We say take every 15 minutes.
15 You know, so we've now realised that the level 2 can be
16 really helpful.

17 **Q.** We'll come on to level 2 in just a moment.

18 **A.** Yeah.

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

20 You refer in the report, this is paragraph 3.3 at
21 page 12, to work by Len Bowers and others into Suicide
22 and self-harm in inpatient psychiatric units: a national
23 survey of observation policies, from 2000.

24 So that's right at the start of the period that
25 we're interested in in this Inquiry.

1 I'd like to look at part of that, please.

2 Could you put up online source 1 at page 7, please.

3 Could you expand the paragraph on the left-hand
4 column above "Conclusions". Perfect. This is what that
5 says:

6 "Lastly, it should not be forgotten that good
7 relationships with, and knowledge of patients, are the
8 foundations of patient safety. The establishment of
9 such relationships is the heart of psychiatric nursing
10 acute inpatient work, for which psychiatric nurses are
11 specifically trained. Such relationships promote
12 a strong therapeutic alliance to which the patient can
13 become committed, and facilitate the sharing of suicidal
14 thoughts and impulses. Linked to a competent,
15 systematic, research-based risk assessment, they enable
16 the proper identification of those patients who require
17 CO" -- I think that's a reference to constant
18 observation -- "in the first place".

19 What is constant observation?

20 **A.** That is where you've got somebody with you at all times.

21 **Q.** Does it equate to what we'll talk about in a moment:
22 levels 3 and 4?

23 **A.** It does.

24 **Q.** So does this bring up, right at the start of the period
25 we're looking at, a point that you've already made more

1 than once: the importance of good relationships and
2 therapeutic care?

3 **A.** It does, yeah.

4 **Q.** So this is referring to constant observation but what
5 I was wondering was whether the same points here would
6 apply to lower levels of observation too?

7 **A.** Yes, it would.

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

9 What I want to do, even at this very early stage, is
10 just to ask you something that I may ask you again as we
11 go along, and it's a point that is made at different
12 stages in your report and it's this: is one of your
13 observations that there can sometimes be a gap between,
14 on the one hand, policy and expectations, for example,
15 we've just been looking at an EPUT policy, and on the
16 other, what is actually happening on the ward.

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

18 **Q.** Is that right?

19 **A.** That's right, yeah.

20 **Q.** For example you say this at paragraph 18.11, that's
21 page 64, for people who are following:

22 "The ability to consistently deliver observations to
23 the desired standard is increasingly challenged by
24 growing clinical demand, staffing pressures, workforce
25 shortages, high patient acuity and reliance on temporary

1 staff unfamiliar with the ward environment or patient
2 group."

3 And we'll come back and I'll ask you about aspects
4 of that.

5 What I'd like to do now though, please, is to move
6 on to legislation, national policies, standards and
7 guidance. And this is Section 4 of your report.

8 What I want to do is to say with the Len Bowers
9 paper from 2000 that we were just looking at.

10 Could you put up online source one please, at page 1
11 and expand just under the title, please.

12 Do we see here:

13 "There is little empirical literature on observation
14 as a psychiatric nursing procedure to prevent patients
15 from harming themselves or others. National guidelines
16 for this practice do not exist, with a consequence that
17 local policies might be variable in content and
18 quality."

19 Now, that makes a point that you make in your report
20 at paragraph 4.1 where you say that prior to 2000 there
21 was little guidance for observations practices in mental
22 health inpatient settings. What happened locally
23 instead?

24 **A.** There was policies back in 2000s, the Trust had
25 policies, and it was implemented on to the ward but you

1 might see variations on different wards, even within the
2 same Trust. So it would be very much led by the Ward
3 Manager and what the practice would be. So you might
4 see wards who have more high observation levels compared
5 to others. It would also vary on some wards, because
6 we're talking back in 2000, the environments probably
7 weren't as safe as what they are now as well. So
8 depending on the environment, that might also inform if
9 someone is on higher observations.

10 And back in 2000 we had an open door. I didn't work
11 on a locked door until about 2014. It was traditionally
12 acute wards were open doors. So the practice was
13 completely different but it was very much before then
14 you were very much led by your Senior Leaders on the
15 actual practice.

16 **Q.** So you've talked about the possibility of a variation
17 even between wards in the same Trust. Would there also
18 be variations between different Trusts and providers?

19 **A.** Yes, yeah.

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

21 In the report you chart the relevant legislation
22 policies, national policies, standards and guidance, as
23 they came into existence. You do that in some detail.
24 I'm not going to ask you about everything in that
25 section of your report, but I will ask you about aspects

1 of it, please.

2 So do the relevant legislation, policies, et cetera,
3 include the 2005 National Institute for Health and
4 Clinical Excellence or NICE guidance on restrictive
5 practices, observations, de-escalation, and management
6 of violence in mental health settings -- so you address
7 this, just for those following, at paragraph 4.2. You
8 also explain that that 2005 guidance was updated in
9 2015. You refer to this as "The major influence in
10 driving policy and practice and remains relevant to this
11 day."

12 Would you just explain what you meant by that,
13 please?

14 **A.** I think the NICE guidance was the closest thing that we
15 had to guide us in our practice. We had work, there was
16 research, there was papers written, but this was -- we
17 hold NICE to the pinnacle of our guidance for care and
18 treatment of patients so when it was developed in 2005,
19 that was our starting point, really, for guiding us, and
20 then later updated in 2015.

21 But it was influenced by recognising observations
22 and engagement as a restrictive practice and seeing it
23 more in that concept, which I don't think we'd
24 considered it before.

25 **Q.** We'll pick up on that point of observations being

1 considered as restrictive later on.

2 Was another of the important developments the Mental
3 Health Code of Practice from 2015?

4 **A.** The Code of Practice 2015 also highlighted about
5 restrictive practices in line with the Mental Health Act
6 but we took it for all patients on all wards. So again,
7 it just made us more informed and more aware of how we
8 practise and the impact it has.

9 **Q.** Does the Code of Practice provide statutory guidance to
10 registered medical practitioners, approved clinicians,
11 and others, on how they should carry out functions under
12 the Mental Health Act in practice?

13 **A.** It does.

14 **Q.** You say this at paragraph 4.4:

15 "... through the principles of: least restrictive
16 measures, maintaining dignity and respect, being person
17 centred, carer involvement, and being trauma-informed
18 and necessary."

19 That's how it influenced inpatient observations; is
20 that correct?

21 **A.** It is.

22 **Q.** Could we look at a part of it, please.

23 Would you put up online source 2, please.

24 This is the Code of Practice dealing with enhanced
25 observation which we'll come on to.

1 So would you put up, yes, online source 2 at
2 page 287.

3 So do we see here -- thank you for that:

4 "Provider policies should cover the use of enhanced
5 observation and include," and we see some bullet points
6 including the last one there:

7 "How observation can be carried out in a way that
8 respects the individual's privacy as far as practicable
9 and minimises any distress. In particular, provider
10 policies should outline how an individual's dignity can
11 be maximised without compromising safety when
12 individuals are in a state of undress, such as when
13 using the toilet, bathing, showering, dressing, etc."

14 Can we see in the next paragraph:

15 "Staff should balance the potentially distressing
16 effect on the individual of increased levels of
17 observation, particularly if these are proposed for many
18 hours or days, against the identified risk of
19 self-injury or behavioural disturbance. Levels of
20 observation and risk should be regularly reviewed and
21 a record made of decisions agreed in relation to
22 increasing or decreasing the observation."

23 First of all, dealing with the points about
24 respecting privacy, minimising distress, and maintaining
25 dignity. Why is that important in the context of an

1 inpatient setting?

2 **A.** All those aspects could be re-triggering a trauma and
3 delay somebody's recovery. And so it is a balance and
4 we do have techniques and skills that we can balance,
5 maintaining privacy and dignity, but also maintaining
6 the patient's welfare and safety at the same time. But
7 it's crucially important that those factors are taken
8 into consideration and also, we do know, just from my
9 own practice, that when patients are on high observation
10 levels, they tend to neglect personal care because of
11 the privacy and dignity element. And that is not the --
12 that's not what we're aiming to achieve. So it's
13 getting a fine balance.

14 But it's really -- we work with patients at the
15 worst time of their lives so we certainly don't want to
16 cause any more harm.

17 **Q.** Thank you.

18 Would you take that down, please.

19 You refer also to the Culture of Care Programme from
20 2024. Were the Culture of Care Standards produced by
21 NHS England?

22 **A.** Yes, it was in partnership with other, I believe, the
23 Royal College of Psychiatry It was a very collaborative
24 approach and it was identifying not just standards but
25 the culture on inpatient wards and it was very much

1 person centred, family/carer led.

2 **Q.** You address at paragraph 4.9, which is page 15, more
3 about the Standards themselves. But could you give us
4 the key points arising from them, for the purposes of
5 the areas that we've asked you to cover.

6 **A.** The Culture of Care Programme was a really good
7 programme in letting us see it from the other side,
8 letting us see it from the family and patient
9 experiences, and getting us -- reinforcing. We knew it,
10 but it didn't always translate into practice. So it
11 helps -- the Culture of Care Programme offered coaching
12 for inpatient wards, to improve their practices and
13 improve the way they interact with patients and
14 families, and also looking at the environment to make it
15 more therapeutic and caring because the environments
16 themselves, you've got lots of standards to achieve but
17 they don't always -- so I think if you think of fire
18 regulation, so you've got to have heavy doors, you've
19 got to -- and infection control, everything has got to
20 be clinical. You can't have soft furnishings. But then
21 you've got, equally, the voice of the patients and the
22 carers and even the staff, that the environment is not
23 therapeutic.

24 So you're balancing a lot of expectations on a ward
25 and the Culture of Care sort of helped bring together

1 those conflicting demands that we might have. That
2 environment must be safe but equally it must be
3 therapeutic at the same time.

4 **Q.** And you say in the report that it also highlights the
5 importance of understanding the reasons behind a
6 patient's distress and behaviour --

7 **A.** Yeah.

8 **Q.** -- and the importance of involving patients and family
9 in care planning; is that right?

10 **A.** Yes.

11 **Q.** Does the guidance also recognise that ward culture,
12 staffing pressures, leadership, training and workforce
13 wellbeing all influence the quality and effectiveness of
14 observation and engagement practice?

15 **A.** It did, yeah.

16 **Q.** Then the last of the developments that I want to ask you
17 about is another NHS England document, I think --
18 ETOC -- from 2024. Can you explain what ETOC stands for
19 and what it is, please?

20 **A.** It's Enhanced Therapeutic Observation and Care.

21 **Q.** What does "enhanced" mean here? Is that levels 2 and
22 above?

23 **A.** Yes. That's my understanding.

24 **Q.** And what was the importance or significance of ETOC,
25 which you cover, for those following, from

1 paragraphs 4.10 onwards?

2 **A.** I think the importance of it was it was the first major
3 dedicated guidance or programme on observations and
4 engagement practice. Although it had been touched on
5 from restrictive practices, this was the first time that
6 observations and engagement was defined in its own
7 meaning. It gave clear expected guidance and support to
8 what individual Trusts should work on and how it can
9 achieve better outcomes.

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

11 Chair, I'm about to move on to a new area. May
12 I suggest, we've been going for just a little under an
13 hour. May I suggest that we break now until 11.10.

14 **THE CHAIR:** 11.10.

15 **MR GRIFFIN:** Thank you.

16 **(10.57 am)**

17 **(A short break)**

18 **(11.12 am)**

19 **THE CHAIR:** Mr Griffin.

20 **MR GRIFFIN:** Chair, may I pick up on something I said by way
21 of introduction this morning and indeed, we say every
22 morning. We understand that the evidence that's been
23 given at these hearings can be very difficult to listen
24 to, and of course people should feel free to leave the
25 hearing room if they feel they need to. We will just

1 ask that they do not come back in until there is a pause
2 so as not to disturb others, including the witness. So
3 I just wanted to reiterate that point.

4 I said, Ms Archibald, that I was going to move on to
5 a new topic, and this is Section 5 of your report on
6 defined levels of observation and engagement.

7 And we have already started to talk about different
8 levels and enhanced levels but can we now deal with that
9 topic itself.

10 Is it right that there is no single nationally
11 mandated system defining the different levels of
12 observation?

13 **A.** Yes, that's my understanding.

14 **Q.** So is this another scenario where the approach is on
15 a local level?

16 **A.** Yes.

17 **Q.** So typically defined within local Trust policies, for
18 example?

19 **A.** It is, but to my knowledge most Trusts follow a similar
20 principle, but, like, the definition of what level 4 is
21 might vary.

22 **Q.** So I'm going to ask you about that in a moment. I'm
23 going to ask you first just to take us through the
24 different levels, and then we will look in terms of
25 level 4 at EPUT's policy.

1 You say in the report that:

2 "Although terminology and exact frameworks may vary
3 between Trusts, they have the same clear principles as
4 per NICE (2015) and ETOC (2024) guidance."

5 Does that pick up on what you've just been saying?

6 **A.** Yes.

7 **Q.** And do you set out the different levels of observations
8 and engagement in some detail in the report? What
9 I want to do, please, is to look at the NICE guidelines
10 but in fact I'm going to take them as they're set out in
11 the ETOC report, just for the sake of simplicity.

12 I'm going to ask now that online source 3 is put up,
13 this is the ETOC guidance at page 7. Can you expand
14 from the top of the page to the bottom of the bullet
15 points.

16 So I'm just going to read this, please. We can see
17 four levels of observation that should be used in
18 inpatient psychiatric wards, including general adult
19 wards, older adult wards, Psychiatric Intensive Care
20 units, and forensic wards.

21 So I suppose the first question that arises from
22 that is: are there particular types of ward or service
23 where different approaches to observation are
24 appropriate?

25 **A.** My understanding is that the observation levels remain

1 the same on each of the wards. The -- it's just some
2 wards might use them more frequently than others.

3 **Q.** So the general approach in terms of the levels that
4 we're about to go through should be of wide application?

5 **A.** Yes.

6 **Q.** Thank you.

7 Can we start, then, in the first bullet point:

8 "Low-level intermittent observation: the baseline
9 level of observation in a specified psychiatric setting.
10 The frequency of observation is once every 30 to 60
11 minutes."

12 Is that correct?

13 **A.** That is correct, yeah.

14 **Q.** So that's, in layman's terms, is that the entry level of
15 observation and the only level that's not an enhanced
16 level?

17 **A.** Yeah, that's a minimum level that most, if not all,
18 patients would be placed on.

19 **Q.** Do we then see:

20 "high-level intermittent observation: usually used
21 if a service user is at risk of becoming violent or
22 aggressive but does not represent an immediate risk.
23 The frequency of observation is once every 15 to
24 30 minutes."

25 Again, is that what some people refer to as level 2.

1 **A.** It is, yeah.

2 **Q.** Then do we move on to continuous observation. Now,

3 we've already seen reference to this:

4 "... usually used when a service user presents an

5 immediate threat and needs to be kept within eyesight or

6 at arm's length of a designated one-to-one staff member,

7 with immediate access to other members of staff if

8 needed."

9 Is that what is sometimes referred to as level 3?

10 **A.** It is.

11 **Q.** And then level 4:

12 "Multi-professional" -- sorry, I said level 4,

13 I will come back to ask you whether that is correct.

14 **A.** Yes.

15 **Q.** The fourth bullet point:

16 "multi-professional continuous observation: usually

17 used when a service user is at the highest risk of

18 harming themselves or others and needs to be kept within

19 eyesight of 2 or 3 staff members and at arm's length of

20 at least 1 staff member."

21 Now, does that equate to what is sometimes referred

22 to as level 4?

23 **A.** In my practice that is level 4, yeah.

24 **Q.** Thank you.

25 Can we deal then first with level 1 to the extent we

1 haven't covered it already. You say this at
2 paragraph 5.3:

3 "The purpose is primarily to maintain awareness of
4 each patient's location and general presentation
5 including for environmental safety purposes."

6 Is that correct?

7 **A.** That, is, yes.

8 **Q.** Now, you've mentioned level 2 before the break and now
9 we can come back to look at it again. You say in the
10 report that this approach is intended to reduce
11 predictability and thereby minimise opportunities for
12 self-harm, suicide attempts, absconding or other adverse
13 incidents. Would you expand on that, please?

14 **A.** Yes. So I would say in about the last maybe
15 eight years -- so previously practice would be: 10
16 minutes, 15 minutes, or 30 minutes, intervals, and you
17 would do it specifically on the 10 minutes, 15 minutes,
18 30 minutes.

19 **Q.** What, so the same time every hour?

20 **A.** Every time, yes. And then some evidence and some review
21 of practice has been undertaken and it was felt that the
22 observations were becoming predictable in nature, and
23 that if a patient was intending to cause themselves harm
24 or cause other harm or abscond, they had a window of
25 opportunity that they could act on. So we moved away

1 from specific 10-, 15-, 20- or 30-minute checks to
2 number of checks within the hour. So such as you'll be
3 checked on four times the hour. And those four times
4 could technically be checked on within the first 30
5 minutes, so there might be 30 minutes of not being
6 checked on.

7 I can see the advantage and disadvantage of both and
8 I believe there's place for both regular checks and ones
9 where they're sporadic within the hour. So some
10 patients will need that frequency of every ten minutes,
11 whether it's for eating or drinking or falls or physical
12 health where -- people where their risk profile might
13 be -- predictable timings might place them at greater
14 risk then I could see that being more used in practice.

15 **Q.** Just asking you about that last point, so in the later
16 approach, more recent approach, is there a deliberate
17 unpredictability to the times at which an observation
18 will be made?

19 **A.** Sorry, could you just reword that, sorry.

20 **Q.** You were talking about predictability or
21 unpredictability.

22 **A.** Yeah.

23 **Q.** Is the approach more recently to deliberately be
24 unpredictable --

25 **A.** Yes.

1 Q. -- so a patient won't know?

2 A. Yes.

3 Q. It won't be at ten past the hour that someone will be
4 turning up; they could turn up at any time to conduct an
5 observation?

6 A. Yes.

7 Q. What's the purpose of that?

8 A. It's to -- I suppose it's to observe the patient in the
9 most natural state, and also reduce the opportunity for
10 them to come to some harm or be -- or cause harm. So
11 it's sporadic in nature and that's meant to -- I suppose
12 it's a risk management of it, the element of it.

13 Q. You mention in the report that there's limited evidence
14 that intermittent level 2 observation alone prevents
15 serious self-harm or suicide, but that used as part of
16 a wider therapeutic risk management plan that there may
17 be more effect; is that correct?

18 A. Yeah, observation and engagement as a standalone are
19 only useful in the context of other treatment available.

20 Q. Sticking with that point I'd like to look at an NCISH
21 publication with you, please. Does NCISH stand for the
22 National Confidential Inquiry into Suicide and Homicide
23 by People with Mental Illness?

24 A. It does.

25 Q. NCISH. Did they produce a report on inpatient suicide

1 under observation in 2015?

2 **A.** They did.

3 **Q.** Could you put up online source 4, please, at page 3.

4 And expand the left-hand column from "Key findings".

5 So this says, I'm not going to read all of it, but:

6 "There were an average of 18 suicides by inpatients

7 under observation per year in the UK over a 7-year study

8 period. 91 per cent of deaths under observation

9 occurred under level 2 (intermittent) observation."

10 Is that a surprising statistic?

11 **A.** No, it's not surprising. You've got to take into

12 consideration, as well, the amount of people -- patients

13 who would have been on level 2 who didn't go on to

14 complete the suicides. So, no, that does not surprise

15 me.

16 **Q.** Dropping down, we can see:

17 "Deaths under observation tended to occur when

18 policies or procedures, including times between

19 observations were not followed. For example, when staff

20 are distracted by other events on the ward; at busy

21 periods, for example 7-9 am; when there are staff

22 shortages; when ward design impedes observation".

23 Would you agree with that?

24 **A.** I would agree.

25 **Q.** Then it says:

1 "Half of deaths occurred when observation was
2 carried out by less experienced staff or staff who were
3 likely to be unfamiliar with the patient (for example,
4 healthcare assistants or agency staff)."

5 Now, we'll come on a little bit -- in a little
6 while, to talk about temporary staff.

7 Would you go, please, to the top of the first
8 column, just the first three bullet points we see there,
9 please.

10 Can we see in fact the second bullet point there
11 "Patients have mixed views about observation, some
12 describing the process as intrusive, and some as
13 protective."

14 Does that pick up on a point that you've made about
15 a balance that needs to be struck, on the one hand about
16 keeping people safe but on the other, in not -- in
17 understanding this is a restrictive intervention and the
18 privacy and other rights of the patient need to be
19 considered, as well?

20 **A.** It does.

21 **Q.** And do we see:

22 "Staff often do not see the purpose of observing the
23 patient or how it links to the overall plan of risk
24 management. They view the decision to start or stop
25 observation as influenced by staffing levels and

1 resources."

2 Is that something that you've been aware of?

3 **A.** Sorry, could you repeat the question?

4 **Q.** Yes, that last bullet point that we can see on the page,
5 I was just asking whether that's something that you had
6 also been aware of, staff often not seeing the purpose
7 of observing the patient?

8 **A.** Yes, and I think that that is a concern, and I think
9 it's because they don't understand why that patient or
10 understand the care plan or read the care plan or
11 familiar with the patient's care, but the second part of
12 the statement, in my experience, observations are not
13 reduced based on staffing levels.

14 **Q.** Thank you.

15 **A.** Or shouldn't be reduced based on staffing levels.

16 **Q.** Have you seen evidence to indicate that level 2
17 observations are overused, and do you consider that this
18 may have an impact on patient safety and outcomes if
19 you do?

20 **A.** My experience is some patients are unnecessarily placed
21 on level 2 observations, particularly at the point of
22 admission. It generally tends to be that, if it's the
23 patient's first admission to hospital, the Nurse in
24 Charge might just put in an extra intervention just
25 for -- to get to know the patient. And also, just from

1 supervising nurses throughout my career, there's
2 a practice some nurses might be more inclined to
3 implement level 2 observations and some might not. So
4 it does vary, but yes, I have seen observation levels
5 used unnecessarily.

6 **Q.** Thank you.

7 Would you take that down, please.

8 Moving on to level 3, you refer to the purpose of
9 this level as being to allow the staff member to provide
10 an immediate intervention should risk behaviours arise.
11 And we've seen what was said in the ETOC document.

12 But could you expand on that point, please. This is
13 paragraph 5.10 at page 18, for people who are following.

14 So you say:

15 "The purpose of level 3: to allow the staff member
16 to provide an immediate intervention should risk
17 behaviours arise."

18 **A.** Yeah. So this is where you need to be with the patient
19 at all times because they've got the highest level of
20 need and the risks associated with that need can be life
21 threatening. So it's absolutely paramount that you
22 remain with them.

23 **Q.** Can I ask you about the beginning of the period that
24 we're interested in and the approach to this level of
25 observation back then. You address it in your report at

1 5.11, where you talk about it not being uncommon to
2 observe staff sitting outside bedroom doors or
3 maintaining continuous visual supervision with limited
4 therapeutic interaction; is that correct?

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

6 **Q.** You actually describe it as custodial in nature. Can
7 you just explain what you meant by that?

8 **A.** It was very common in the early 2000s that you would
9 just watch a patient. You would just follow them from
10 room to room. You would just -- and it gives, naively,
11 some level of assurance to the treating team that that
12 patient can't harm themselves because they're under
13 constant watch. It wasn't therapeutic for the patient.
14 Some cases, there'd be times when it possibly was, but
15 the practice would be: you would be sat at the bedroom
16 door, the patient would be in their bedroom, and more
17 often than not the person doing the observations would
18 be distracted by reading something or engaging with
19 another staff member. So it wasn't -- I wouldn't say it
20 was practice based on evidence at that time.

21 **Q.** Thank you. Do we see over the period we're interested
22 in, and indeed up until recent times, the same trend to
23 a more therapeutic approach even at level 3?

24 **A.** Yeah, it's -- so it's around the same time that we
25 started to become more aware of the engagement element

1 of it, and the purpose, and the meaning behind it.

2 **Q.** You suggest in the report that level 3 observations can
3 have a negative impact on the patient -- this is
4 paragraph 5.12 -- particularly where privacy and dignity
5 are affected.

6 How would one have tried to address that?

7 **A.** It can be part of a patient's care plan that they could
8 go in the toilet by themselves even though they're on
9 level 3 observations within eyesight. It might be
10 identifying that they feel more comfortable going to the
11 toilet with certain members of staff if it's felt that
12 you would need to be in the room. We also have gadgets
13 or technology where they can put headsets on to make
14 noise whilst they're in the toilet to maintain their
15 dignity. We can play music, or we can stand on the
16 other side of the door. And this is what should form
17 part of the care plan that in the event that somebody
18 needs to use the toilet or on a morning, you would, if
19 it was a male patient, you would prioritise that they
20 have a male member of staff with them whilst they're
21 getting dressed. So this is what the care plan should
22 be. Some male patients would prefer female staff. That
23 should be identified in the care plan, and --

24 **Q.** Okay, we'll come on possibly to touch on that.

25 **THE CHAIR:** Earlier in your evidence you made reference to

1 you having techniques to balance the need to undertake
2 quite demanding observations, and the distress that that
3 might cause to a patient, and you suggested that you
4 could fine tune the way you did things. Is that what
5 you are referring -- is that an example --

6 **A.** Yes.

7 **THE CHAIR:** -- of what you're referring to?

8 **A.** Yes. Another example would even be if a patient is not
9 eating because they're intensely paranoid that their
10 food has been poisoned, that intervention would be that
11 that nurse eats the same food as that patient to
12 demonstrate that it's safe to eat. So it would be at
13 certain parts of the day that a member of staff would be
14 assigned to have breakfast with them, have lunch, and
15 that's -- it's so specific to that patient that it's
16 that individualised care planning and understanding that
17 patient, and they're the skills that you would apply.

18 **MR GRIFFIN:** Could I just ask you this, and it's back to the
19 recurrent theme. Is what you're describing what one
20 would want to see, rather than what one will actually
21 necessarily see on any ward at any given time?

22 **A.** That's what you should see.

23 **Q.** That's what you should see?

24 **A.** Yes.

25 **Q.** Thank you.

1 Can we come on to level 4, please. The highest
2 level of observation and engagement, which you describe
3 as involving two members of staff allocated to a patient
4 continuously. This level typically implemented in
5 response to the highest levels of assessed risk.

6 So the NICE guidelines that we saw up on our screen
7 said that two or three staff members and at arm's length
8 at least one staff member. So can it involve more than
9 two members?

10 **A.** It could. I've not experienced more than two.

11 **Q.** You say in the report:

12 "There has been increasing recognition of the
13 significant staffing governance and therapeutic
14 challenges associated with prolonged two-to-one
15 observation. It was recognised that this level of
16 observation is the most intrusive, restrictive, and is
17 likely to be traumatic for the patient."

18 So what kind of governance around this would you
19 need? What kind of review within a ward would this
20 level of observation require?

21 **A.** It would tend to have more senior oversight. So the
22 Associate Director of Nursing or the Director of Nursing
23 would have oversight. There would be independent panel
24 reviews on a weekly basis, or more frequent if
25 identified. And there would be a 24-hour review on

1 measuring where we're at in trying to reduce those
2 observations and make it less restrictive. So it has
3 much more -- it's a big deal. It's a big deal to do
4 that. So it has -- it gets everybody's attention and
5 that you have to look at alternative strategies,
6 possibly a change of environment, which could be
7 a change of ward, maybe.

8 You have to look at all eventualities and when it's
9 level 2 it's mainly, for an example, if a patient is
10 frequently trying to leave the ward and it requires
11 a nurse to place hands on to try and prevent them,
12 that's where two might be more safe.

13 Or if somebody is actively trying to harm themselves
14 in the most serious of ways. Again, it might require
15 hands-on from the nurse, and that's where -- and also --
16 it's rare, but a member of the nursing team might be at
17 risk from the other patient either through allegations
18 or assault. So the two persons are necessary. But
19 they're rare.

20 **Q.** So in terms of oversight, and governance, it should be
21 at all levels, as I understand it, but it becomes
22 increasingly important, the higher the level of
23 observation there is?

24 **A.** Yeah, it is -- it has more of an -- we do get even on
25 level 3s where there's eyesight, there's an independent

1 review but when it's level 2 that is really restrictive
2 practice, so that's when you might start to see the
3 HOPE(S) model being implemented and that's where an
4 independent panel would come --

5 **Q.** You're talking about level 2 or level 4?

6 **A.** Level 4.

7 **Q.** Thank you.

8 So I said I wanted to look at the EPUT policy on
9 level 4 with you and I'm just going to tell you what it
10 says. This is Therapeutic Engagement and Supportive
11 Observation Policy of 2023 and it says this:

12 "Level 4, continuous within arm's length. This
13 means a nominated staff member will be allocated to
14 observe the patient in close proximity within
15 arm's length. For patients who pose the highest level
16 of risk or harm towards themselves or others, more than
17 one nurse may be required to implement this level of
18 observation safely."

19 But it could be just one, a nominated staff member,
20 in relation to level 4. You've referred to two, and
21 I think the policy that we looked at before said that,
22 you know, up to three, even. Can I just ask you this in
23 relation to the EPUT policy: a single person in relation
24 to level 4. Can that be safe?

25 **A.** Within arm's length, yes, depending on what the patient

1 is on the -- requiring the level 4 for. So it could be
2 digesting, placing stuff in the mouth. One member of
3 staff might be able to safely manage that. If it isn't
4 safely managed then you might need two. And also
5 somebody at risk of falls, maybe one member of staff,
6 and that's why you're in arm's length so you're close
7 by.

8 Q. You mentioned the fact that we still have a scenario
9 where the approach to levels of observation is on
10 a local basis rather than a national basis --

11 A. *(The witness nodded)*.

12 Q. -- would this be an example of a local policy doing
13 something slightly different from, for example, your
14 Trust?

15 A. Yeah, I think the principle is the same. The
16 categorising it is sometimes different.

17 Q. Do you know of other Trusts that would allow a single
18 staff member to be appointed to a level 4 observation?

19 A. My level 4 understanding is two people, but within
20 arm's length, yes, I've practised with one person within
21 arm's length.

22 Q. Thank you.

23 Your report also covers policies and procedures with
24 regard to specific scenarios, including seclusion and
25 long-term segregation or LTS. During periods of

1 exclusion or LTS, are patients generally maintained on
2 higher levels of observation?

3 **A.** Yes, they are.

4 **Q.** Why is that?

5 **A.** Why is that?

6 **Q.** Yes, why is that, please?

7 **A.** It's because they're considered the most in serious need
8 and at risk.

9 **Q.** Thank you very much.

10 I want to move now to physical health. This is
11 Section 6. So this is physical health monitoring in the
12 context of patients admitted to mental health wards.
13 And you say this at paragraph 6.1:

14 "People with severe mental illness experience
15 significantly poorer physical health outcomes than the
16 general population and are at greater risk of premature
17 mortality, with a report that people with severe mental
18 illness die on average 15 to 20 years earlier than the
19 general population."

20 Is that correct?

21 **A.** Yes.

22 **Q.** You add that:

23 "Observation practice must include active assessment
24 of physical wellbeing, not simply confirmation of
25 presence or location."

1 I want to ask you about NEWS2, please. What is the
2 National Early Warning Score, NEWS? This is
3 paragraph 6.2, for people following.

4 **A.** It is a tool that is used within the health service that
5 you monitor all six, which I've stated in 6.2, such as
6 blood pressure, oxygen saturation, temperature, and then
7 you input the scores -- well, the findings, then it
8 gives an overall score then it gives guidance of when
9 you would escalate it or monitor it, depending on the
10 frequency.

11 **Q.** So there's six. You've mentioned three of them. Are
12 the other three: respiration rate, pulse rate and level
13 of consciousness, or new confusion?

14 **A.** Yes.

15 **Q.** Are any one of those more important than the others?

16 **A.** I don't think so but them alone, you can have patients
17 who might score really low on the NEWS, but their
18 presentation just doesn't look right. So for the
19 professional eye, you would maybe repeat the NEWS. So
20 yes, the NEWS is there as a guide, but it shouldn't take
21 away your professional judgement.

22 **Q.** So it's part of the picture but not --

23 **A.** It's part, yeah.

24 **Q.** -- the complete picture?

25 **A.** Yeah, thank you.

1 **Q.** You address in Section 17 of your report, nighttime and
2 sleep. Is there any part of the day when it's more
3 important that these NEWS2 or some of those measurements
4 should be taken? For example, is it necessary to take
5 them all at night?

6 **A.** No.

7 **Q.** We've heard already of the benefits of sleep for
8 patients with mental ill health. Is there a generally
9 agreed approach to nighttime observations and the nature
10 or quality of the checks that need to be made?

11 **A.** You try and -- I think that's where we would accept that
12 engagement reduces, depending on if the patient is awake
13 or asleep, or trying to get to sleep, and where it
14 becomes observations, and we're just checking on their
15 welfare, making sure that they're safe and they're well,
16 but you try to do it in the least -- sorry, I'm
17 struggling to find my words -- disruptive way.

18 **Q.** How do you strike the right balance between allowing
19 a patient undisturbed sleep with all of the benefit that
20 that brings with it, and keeping a patient appropriately
21 monitored and safe?

22 **A.** It's really challenging. The room should be designed
23 that you should have a clear view from the window of the
24 door of the bedroom. For patients where -- they're
25 all -- to my -- I work in single bedrooms with

1 en suites. So there might be some bedrooms that offer
2 better observations, and I think if those patients are
3 higher risk, I would be moving that patient's bedroom
4 into a more visible compared to a patient who is
5 considered a lower risk.

6 So you have to be dynamic, and you have to -- you
7 maybe have the conversation with the patient, because
8 you do get patients who say, "I haven't slept all night"
9 but the records will document "Slept since 10 o'clock".

10 So you might say to a patient: "If you hear us come
11 in or you hearing us through the visor, raise your hand
12 so we know you're awake" and that might give us an
13 incentive then to go into the room and see what's caused
14 that patient to remain awake. But it is challenging and
15 also you've got the noise of other patients that might
16 be noisy on the ward. That may also disrupt sleep. And
17 the doors are heavy, so you can't get in and out of the
18 doors there. It's really challenging and I don't think
19 it's one that we've managed to tackle.

20 **Q.** Thank you.

21 You address dynamic and fluctuating observations at
22 Section 8 of the report. What is a dynamic observation?

23 **A.** In that it fluctuates within the day. It's recognising
24 that somebody might be more at risk at mealtimes, less
25 of a risk at other times of the day so that should

1 influence when -- how the observations should be
2 applied.

3 Q. Let's be clear. That is a fluctuating observation, is
4 it?

5 A. Oh sorry, yes. Sorry.

6 Q. What's a dynamic observation?

7 A. Dynamic?

8 Q. 8.1 for those --

9 A. Yeah, it's just responding to when something happens.
10 It's being prepared that something might not go to plan
11 at any given time and you have to be prepared to
12 increase observation levels at any given time and you
13 must have the resources to be able to do that.

14 Q. You say in the report:

15 "Dynamic observation plans enable care to be
16 tailored to the individual's needs, promote least
17 restrictive practice, and support recovery while
18 maintaining safety."

19 Is that right?

20 A. Yeah.

21 Q. I want to ask you about Elise Sebastian. She was on the
22 Longview Ward at the St Aubyn Centre and tragically died
23 on 19 April 2021 at the age of 16.

24 You note that -- and this is paragraph 8.3:

25 "When Elise was alone or experiencing periods of

1 isolation she was required to be placed on level 3
2 observations but she could be managed on level 2
3 observations when participating in activities or group
4 settings."

5 Now, is that an example of a fluctuating observation
6 plan?

7 **A.** It is, yeah.

8 **Q.** The Inquiry heard evidence from Elise's mother last
9 week, Victoria Sebastian. I'd like to look now at part
10 of the statement that she provided to the Inquiry. Is
11 this one of the statements that you've considered?

12 **A.** I have, yes.

13 **Q.** Could you put up HJA019679 at page 23, and expand
14 paragraph 94, and the top -- yeah, thank you very much.

15 Thank you.

16 So this is what this says:

17 "Despite being on level 3 observations during
18 isolation periods (which all staff were informed about
19 during the shift handover) Elise was allowed to enter
20 her bedroom alone. To date, none of the staff members
21 present on the day Elise died, has admitted to letting
22 her through the ... door."

23 You say in the report that:

24 "The failure to provide Elise with a level 3
25 observations when she returned to her room resulted in

1 her being able to cause herself harm resulting in her
2 death."

3 Now, you make observations about Elise's case from
4 paragraph 8.5 in your report, starting with asking why
5 Elise was not placed on level 3 observations when she
6 returned to her room, and suggesting it's difficult to
7 determine.

8 But you then set out several factors which may have
9 contributed to the failure. Would you just take us
10 through those, please.

11 **A.** Yeah. When somebody is on fluctuating observations,
12 it's absolutely paramount that everybody knows that
13 patient's risks because there's the -- the fluctuating
14 observations helps patients have some independence and
15 some relief from being on constant observation. So it's
16 done with the right intention. But that -- having said
17 that, there must be systems in place for when the
18 situation changes, such as Elise going back to her
19 bedroom.

20 When she was on level 2 observations, so when I've
21 said it's not -- there's not one single cause,
22 misidentifying where she was when she was on level 2
23 observation is a root cause -- one of the triggers of
24 it, and then the person letting her in her room is also
25 a trigger. It's everybody's responsibility to make sure

1 she's safe on that ward and if there was -- if
2 I remember from the case, you weren't able to move
3 around the ward without staff enabling you to let you
4 in. So it sounded like the environment was able to
5 monitor the movement of patients. So how she was able
6 to go from a communal area to her own bedroom and even
7 let in without anybody thinking the observations need to
8 be increased is a concern.

9 Q. So just to be clear, this was a scenario where what
10 should have happened under the fluctuating observation
11 plan is that when she went from one area to her bedroom,
12 where she would be alone, there should have been an
13 increase in the level of observation; is that correct?

14 A. Yes, correct, yeah.

15 Q. But that didn't happen. There was no observation once
16 she was in her room?

17 A. And that must have been really confusing for her, if she
18 was aware of her care plan and what should have
19 happened, to be left alone in her bedroom.

20 Q. You say --

21 A. -- (overspeaking) -- confusion.

22 Q. -- this at paragraph 8.7:

23 "The fact that the observation requirements were not
24 implemented when Elise returned to her bedroom indicate
25 deficiencies in communication during the shift,

1 inadequate handover of risk information, competing
2 clinical demands, staffing pressures, or a lack of
3 familiarity with Elise's care requirements."

4 Whilst it's not possible to identify a single
5 causative factor from the evidence that you've seen, the
6 information suggests that a combination of individual
7 team and organisational factors contributed to the
8 failure to provide the observation arrangements intended
9 to keep Elise safe.

10 Now, is there anything you'd like to add to that?

11 **A.** No, no.

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

13 Could we address observations levels when
14 transferred to another ward or hospital. And this is
15 Section 10 of your report. What might the effect be on
16 a patient's risk profile if they're moved from a mental
17 health inpatient unit to an acute ward or hospital?

18 **A.** Completely different environment, that isn't designed to
19 meet their needs. So you have to take into
20 consideration when a patient does get transferred from
21 a mental health ward to an acute medical ward, what is
22 that patient's individual risk? And what would the
23 impact on them in a different environment be? For some
24 it might have minimal impact for them. Others, it might
25 be quite significant.

1 Q. You say that it might significantly alter the patient's
2 risk profile; is that right?

3 A. Yes, yeah. You've got to reassess because it's
4 a different environment.

5 Q. And you say that acute general hospital environments are
6 not typically designed or risk assessed in the same way
7 that mental health inpatient wards are?

8 A. Yeah.

9 Q. Could we look at something that develops that point,
10 please.

11 Would you put up the HSSIB Investigation Report,
12 this is online source 6:

13 "Patients at risk of self-harm: continuous
14 observation," page 19.

15 Is this one of the reports you were involved in?

16 A. Yes.

17 Q. We see there two paragraphs. I just want to look at
18 aspects of those. We see in the first:

19 "Acute hospital environments, particularly intensive
20 care and high dependency units ... create additional
21 risks for patients at risk of self-harm. The staff from
22 both the acute hospital and MHH [which we understand is
23 mental health hospital] told the investigation that
24 risks arose from, for example, medical equipment, the
25 ability to open windows, potential ligature points ...

1 and the availability of cutlery."

2 Now, is that something that would all be familiar
3 with you as risks when you move to a different
4 environment?

5 **A.** Yes.

6 **Q.** Do we then see, towards the bottom of the second
7 paragraph:

8 "In a new environment the risks were likely to be
9 different potentially leading to different unpredictable
10 behaviours."

11 Would you agree with that?

12 **A.** Yes.

13 **Q.** Thank you.

14 Could you take that down.

15 So would that mean that for someone moving from
16 a mental health inpatient environment to an acute
17 environment, that then there may need to be
18 a reconsideration of their observation level?

19 **A.** Yes.

20 **Q.** Can we look at the case of Bethany Lilley, please.

21 Bethany's brothers, Alexander and Paul Guille, have
22 provided a statement to the Inquiry. Could you put up
23 BHAT010167 at page 56, and expand paragraph 14.11.

24 And we see 14.11. Could that be expanded, please.

25 Thank you.

1 I just want to read this, please:

2 "We have been asked to comment on the level of
3 observations in place when Beth was transferred from the
4 Peter Bruff Unit to the Thorpe Ward in Basildon Hospital
5 on 15 January, the day before her death. In essence,
6 Beth was transferred without any handover,
7 consultant-to-consultant discussions, or any member of
8 staff accompanying her, so that receiving staff had no
9 clinical history of Beth when she was transferred. The
10 lack of proper handover meant that Beth went from being
11 on level 3 1:1 observations being in line of sight at
12 all times at Peter Bruff Ward to level 2 observations, 4
13 observations per hour. Then, purely on the basis there
14 had been no adverse incidents in 24 hours she was
15 further downgraded to level 1 observations on
16 16 January, without any further risk assessment carried
17 out by a Consultant Psychiatrist. Given the near misses
18 and consistent attempts at self-harm in the weeks
19 leading up to 16 January, with the last instance of
20 self-harm being on 14 January, to have this done without
21 input from a psychiatrist and preferably input from
22 a team of people involved in her care, this was clearly
23 inappropriate."

24 So was Bethany a mental health inpatient transferred
25 to an adult acute ward?

1 **A.** My memory from the case was that Bethany was a mental
2 health inpatient and was transferred to Accident
3 and Emergency for treatment, and whilst she was at
4 accident and emergency she was reallocated a different
5 bed on a different mental health ward. So when she was
6 medically fit, she returned to a different ward, is what
7 I can recall -- (overspeaking) --

8 **Q.** But what we see here on arrival, her observation level
9 was then reduced and then reduced again.

10 **A.** Yeah.

11 **Q.** Would it be common, when someone is transferred to a new
12 environment, for observation levels to actually be
13 reduced?

14 **A.** It would be surprising. The only time that you might
15 see that is if a patient is transferred to your care
16 who's more -- you're more familiar with that patient
17 than the previous ward. So if you -- a patient might be
18 transferred back to you because you know that patient
19 particularly well, you've worked with them, you know
20 them. You might feel, after reviewing the patient, that
21 you might be able to take more of a dynamic risk --
22 positive risk take.

23 However, you would be heavily influenced on the
24 previous decision to be put on higher -- high
25 observation levels. And you would be more inclined to

1 wait for a period of time to make your own judgement
2 rather than just basing your judgement on past
3 experience of the patient, because there might be new
4 changes. You might know the patient of old but you
5 won't be familiar with recent events.

6 **Q.** So just taking an example, if someone on level 3
7 observations moved to a different environment, would the
8 normal approach be to keep them on at least that level
9 whilst some form of risk assessment in the new
10 environment is taken?

11 **A.** That would make more sense, and good practice would be
12 to review a period of time and allow for more follow-up
13 conversations with the previous care team.

14 **Q.** And is that for the reasons that we were just talking
15 about: that the new environment may have new types of
16 risk that didn't exist --

17 **A.** Yes.

18 **Q.** -- in the old environment?

19 **A.** There's so many factors that can influence a decision.
20 Sometimes you need time to be able to explore all those
21 factors.

22 **Q.** You say in the report that:

23 "This case highlights the importance of robust
24 handover arrangements ..."

25 This is paragraph 10.5.

1 "... comprehensive risk assessment during ward
2 transfers, and ensuring that any changes to observation
3 levels are based on clinical need rather than
4 assumptions, environmental factors or changes in care
5 setting alone."

6 Is there, in your experience, a standard or optimum
7 practice for how long a patient should be maintained on
8 an observation level before they are reviewed,
9 especially when transferring from another ward?

10 **A.** There's no specific length of time, but it has to be
11 enough time so you get a longitudinal assessment, but
12 not too long where it's having -- it's unnecessary. So
13 there's a balance of being satisfied with your new
14 assessment where, combined with trying to be the least
15 restrictive at the same time.

16 **Q.** Thank you.

17 Could you take that down, please.

18 In Section 11 of your report you address legal
19 framework and capacity to consent. For consent to be
20 valid, must it be both voluntary and informed? And must
21 the person consenting have the capacity to make the
22 decision?

23 **A.** They should.

24 **Q.** What does "voluntary" mean in this context?

25 **A.** Voluntary is that they agree to be there, they volunteer

1 to be there. They're agreeing to their care and
2 treatment.

3 Q. Is there a further element to it: that they shouldn't be
4 influenced by pressure from medical staff, for example,
5 or friends or family, or indeed anyone?

6 A. Yeah. No, they shouldn't be coerced into it.

7 Q. What does "informed" mean in this context, please?

8 A. Informed?

9 Q. Informed?

10 A. Informal?

11 Q. Sorry, informed. So you've said that consent must be
12 voluntary and informed. We've dealt with "voluntary".
13 I just wanted to ask you about "informed" and what that
14 mean in this context?

15 A. They must understand what they're agreeing to and they
16 must be given all relevant information for them to make
17 an informed choice.

18 Q. When you say "all relevant information", would that
19 included both benefits and risks?

20 A. Yes.

21 Q. What are the options where a voluntary patient refuses
22 observations? You deal with this at paragraph 11.1, for
23 those following, that's page 32.

24 A. If the presenting need and risk from a professional
25 point of view indicates that a patient needs enhanced

1 observation levels, you would have that conversation
2 with them, you would give them the reasons why you think
3 it was necessary. If they didn't agree just for that
4 element of their care, but say they agree to remain as
5 an informal patient on the ward, they are agreeing to
6 other aspects of the care plan but they're not agreeing
7 to the observations, then you would respect their views
8 and you would try and work with them in an alternative,
9 but maybe with the agreement that if things don't go to
10 plan, that we could increase or ... it's -- they would
11 have to agree.

12 We couldn't overrule it unless we use the Mental
13 Capacity Act which is then assuming that they lack the
14 capacity, or we would have to use the Mental Health Act
15 if we think it's absolutely necessary to prevent them.
16 But really, they would be the last resorts.

17 **Q.** So if I've understood you correctly, the general
18 approach would be you need consent even just for
19 observations --

20 **A.** Yeah.

21 **Q.** -- and you would work with the patient on that; but
22 there may be scenarios, particularly serious ones,
23 potentially --

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

25 **Q.** -- where you'd have to consider your statutory powers in

1 the case of a voluntary patient who refused
2 observations?

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

4 **Q.** Is that, in summary, what you're saying?

5 **A.** Yes.

6 **Q.** Can we deal with capacity. I think you've touched on it
7 because we just talked about the Mental Capacity Act.
8 But what is capacity, as a concept in the context?

9 **A.** It's the ability to understand, weigh up information,
10 retain information, and communicate a decision. On any
11 element of anything. But we start from a standing point
12 that we assume everybody's got capacity first.

13 **Q.** So this is the Mental Capacity Act, Section 1, is it?
14 Must a person be assumed to have capacity unless proven
15 otherwise?

16 **A.** Yes.

17 **Q.** And are there further important principles that are set
18 out in the Mental Capacity Act that must influence the
19 approach in relation to patients?

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

21 **Q.** Do they include: "A person is not to be treated as
22 unable to make a decision unless all practicable steps
23 to help him" -- they always use "him" in these Acts but
24 we take that to mean a patient --

25 **A.** A person, yes.

1 **Q.** "A person is not to be treated as unable to make a
2 decision unless all practicable steps to help him to do
3 so have been taken without success."

4 **A.** Yes. You must -- if a patient is struggling to
5 communicate verbally, that doesn't mean that they can't
6 communicate. So you would look at alternative ways that
7 they might be able to communicate their wishes. And
8 it's important to point out that people can have
9 capacity but still be detained under the Mental Health
10 Act. There's an assumption that everybody detained
11 lacks capacity and that's not my experience at all.

12 **Q.** Is another of the principles that the Mental Capacity
13 Act sets outs that a person is not to be treated as
14 unable to make a decision just because they make an
15 unwise decision?

16 **A.** That is true, yeah.

17 **Q.** And does it also stipulate that a decision made under
18 this Act for or on behalf of a person who lacks
19 capacity, must be made or done in his best interests?

20 **A.** Yes.

21 **Q.** Now, we've heard actually quite a bit yesterday and
22 during the course of the evidence about best interests
23 decisions. So is that what this is referring to:
24 a requirement that at the heart of any decision is the
25 best interests of the patient?

1 **A.** Yes, if a patient lacks capacity.

2 **Q.** If a patient lacks capacity.

3 **A.** Yeah.

4 **Q.** And finally, in terms of the principles I want to ask
5 you about, before a decision is made -- does the Mental
6 Capacity Act also say this: that before a decision is
7 made, regard must be had to whether the purpose can be
8 as effectively achieved in a way that is less
9 restrictive of the person's rights and freedom of
10 action?

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

12 **Q.** And again, we have heard over the course of the evidence
13 reference to the least restrictive approach.

14 **A.** Yeah.

15 **Q.** So do these requirements apply in the context of
16 observation and engagement as in other areas?

17 **A.** Yes, yes.

18 **Q.** Thank you.

19 Moving, then, to Section 12 of your report, please:
20 initiating care planning and reviewing observation
21 levels.

22 You say at 12.1 at page 34:
23 "Initial observation levels should be determined at
24 the point of admission ..."

25 **A.** They should.

1 Q. "... but may fluctuate throughout the duration of the
2 admission."

3 And I think we've already talked a little bit about
4 that.

5 A. *(The witness nodded)*.

6 Q. Can we deal with what happens at the point of admission
7 first, please. What should happen then, what is the
8 thought process or the requirement when someone enters
9 the ward in terms of observation and engagement?

10 A. The admitting nurse, so the nurse -- it tends to be the
11 shift lead on the ward -- will receive notification of
12 a new admission coming in. There should be a verbal
13 handover and we should be able to access the most
14 up-to-date risk assessment electronically, and what
15 happens is a patient comes on to the ward, predominantly
16 it's out of hours but if it's in hours it might be the
17 wider MDT, will meet with the patient individually, we
18 don't meet as a big group. We ask that everybody meets
19 them individually. We already get a handover of what
20 the risks are going to be before somebody comes in. It
21 might be that it would be looking -- there's often
22 conversations might be: we think this patient is going
23 to need level 3 within eyesight, based on the
24 information that we've got. We prepare for that, the
25 patient comes in, and actually -- the way they're

1 interacting with us, we think: oh, maybe we can do least
2 restrictive and maybe go level 2, intermittent, to begin
3 with, and that's ultimately how it is determined. But
4 it can change at any point, escalate up. However, on
5 reduction, what we advise is that it always goes back to
6 the MDT.

7 **Q.** So in dealing with the time that a person enters the
8 ward, the initial decision is based to a large extent on
9 information that's being provided by the people --

10 **A.** Yeah, and what information's available. So there has
11 been times where you get information and it would imply
12 that the patient might be able to placed on level 1
13 observations. When the patient attends that -- what the
14 patient presents as and what has been handed over do not
15 match.

16 **Q.** So you wouldn't take as a given --

17 **A.** No.

18 **Q.** -- the information that you're provided with? That's
19 your starting point?

20 **A.** Yeah, and the admitting team tend to be the Crisis Team
21 or come from a Mental Health Act Assessment. They
22 aren't experts in observation levels. It's not an area
23 of their practice so they often will -- they can make
24 a recommendation, some do have inpatient experience, but
25 ultimately the decision lies with the Inpatient Team.

1 **Q.** You say at paragraph 12.6 of the report that:

2 "The level of the observation and its rationale must
3 be clearly documented in the clinical records and should
4 include current mental state, risk assessment, purpose,
5 goal and agreed interventions, timescale of review,
6 physical health concerns, patient, family and carer
7 perspectives."

8 Now, I just wanted to be clear about that. Is that
9 what you're considering as soon as someone comes on to
10 the ward, or is that part of the consideration once
11 they've been on the ward for a while?

12 **A.** That's as soon as they come on to the ward. Those are
13 what we're aiming to get a better understanding of.
14 We've received the handover, we've got the information
15 available, but we've then reviewed the risk. So there's
16 somebody who has done the risk assessment prior to
17 coming in, it's paramount wherever possible that we
18 speak to families and carers because it might be that
19 that family member has had to be with that patient 24/7
20 for days because of the level of risk. So we would
21 replicate that. That would inform that maybe that
22 patient needs level 3 observation.

23 So, or if they come from a supported, like,
24 community support placement, we need to speak to their
25 support workers.

1 So there's always information that gets missed in
2 a verbal and written handover. So we need to do our own
3 digging of information, really, to be informed.

4 **Q.** So you've explained in the report, and this is something
5 we've heard this elsewhere, that during the earliest
6 part of the period we are looking at, so I think you say
7 around 2000 to 2010, clinical records tended to be paper
8 based and not always immediately available, and then
9 over time you see more electronic records.

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

11 **Q.** Is that correct?

12 **A.** Yeah.

13 **Q.** You've spoken about a handover and what that might
14 entail, but would those involved include, for example
15 the Mental Health Act Assessment Team the Crisis Team,
16 or the Community Mental Health Team?

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

18 **Q.** You also mentioned a verbal handover. What's the
19 significance or importance of that, please?

20 **A.** That is crucial. You need to speak to the practitioner
21 who has been familiar with the case before, and it's an
22 opportunity to ask questions or clarify information
23 that's written, because sometimes it can be
24 misinformation. So you would want to know when was the
25 last time the patient took some medication? Have they

1 got medication on them? Yeah, that verbal handover,
2 which still often takes place via the telephone.

3 For a patient been admitted -- who has been detained
4 under the Mental Health Act, it's -- you still want
5 a practitioner, mental health practitioner from the
6 Crisis Team or the Community Mental Health Team wherever
7 possible, but equally, you then receive a handover from
8 the Approved Mental Health Practitioner, the AMPH, which
9 is often a social worker who is delivering the section
10 papers, so you would check those section papers and you
11 would check that the information you've received, and
12 the clinical records that you've got. So it's lots of
13 fact checking.

14 **Q.** You describe in the report the increased requirement
15 over the period we're looking at and beyond for relevant
16 information to be inputted into the record?

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

18 **Q.** And you suggest that that can at times be quite onerous
19 on any -- on a busy inpatient ward?

20 **A.** Mm, mm.

21 **Q.** Can I ask you this: to what extent, in reality, on the
22 ground, would a receiving team in an inpatient unit
23 necessarily have the time to work through the electronic
24 records before deciding on a level of observation?

25 **A.** It's very limited. They would prioritise, because often

1 admission follows a discharge with NHS bed pressures,
2 there's -- vacant beds don't sit for very long. So that
3 nurse might be processing a discharge and then get
4 Information that an admission is coming in. So they've
5 got multiple demands but they crucially prioritise
6 speaking to the community practitioner to get
7 a handover, and briefly reviewing the records.

8 If it's within hours, for example in my practice and
9 my colleagues', we would notify and then we would also
10 look. If there's limited information and we have not
11 received a verbal handover, which is sometimes the case,
12 a patient can turn up with ambulance crews, new
13 admission, very limited information, you would err on
14 the side of caution and place them on level 3 until
15 you're able to gather information.

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

17 Chair, may I suggest that we pause now and that we
18 take a break for ten minutes which will take us to 12.25
19 and that we come back and do a little bit more before we
20 break for lunch.

21 **THE CHAIR:** Yes.

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

23 **(12.13 pm)**

24 **(A short break)**

25 **(12.26 pm)**

1 **THE CHAIR:** Mr Griffin.

2 **MR GRIFFIN:** Ms Archibald, just picking up on a point

3 arising from what we were discussing before the break,

4 you've spoken about the process when a patient is

5 admitted to the ward. What I wanted to ask you about

6 arising from that was how is the information that the

7 admitting nurse receives then disseminated to others on

8 the ward, for example, HCAs, who will, actually, be

9 performing the observations?

10 **A.** You should bring together a huddle. So you would ask

11 everybody available who is available to come into the

12 office, you'd give a handover of, the name of the

13 patient, why they're coming in, or -- or -- well, we

14 should be notified before they're coming in, why they're

15 coming in, and the observations that are looking likely,

16 based on the information. The shift planner would

17 already identify an admitting nurse and a healthcare

18 assistant, so the healthcare assistant's job is to, when

19 the patient comes on to the ward, to show them their

20 bedroom, to check their belongings, so they'll already

21 be assigned for about the first hour to do all those

22 administrative duties and you'd let the on-call doctor

23 know if it's out of hours.

24 **Q.** That's the process that should happen --

25 **A.** Yeah.

1 Q. -- in terms of dissemination of information across the
2 ward, or at least to the relevant people who will be
3 conducting the observations?

4 A. Yes.

5 Q. I want to ask you about care planning. This is raised
6 in your report from page 42 at paragraph 12.30 for those
7 who are following. What I want to do is look at this
8 part of the report, please.

9 Could you look up the report, page 42, at
10 paragraph 12.30. So do we see here:

11 "Having a collaborated care plan in place can assist
12 with measuring the effectiveness of the engagement. It
13 can help avoid overly subjective decision making as to
14 when observation levels should be reduced. The plan
15 should clearly outline ..."

16 Then do you list a number of things it should
17 outline?

18 A. *(The witness nodded)*.

19 Q. "Rationale" -- sorry, you nodded there, I'm just going
20 to ask you when you nod to say, "Yes," so the transcript
21 can pick it up:

22 "Rationale; identified risks and positive factors;
23 purpose/goals agreed engagement,
24 strategies/interventions, and any specific approaches
25 required to support the patient safely and

1 therapeutically.

2 "How staff should respond to distress, escalation,
3 or changes in presentation;

4 And:

5 "Agreed review timescales and criteria for reducing
6 or increasing the observation level."

7 In fact you say, as we can see at the next
8 paragraph:

9 "It is important that the patient not only is safe
10 but feels safe. The observation can keep someone safe,
11 the engagement can help someone feel safe."

12 Is that correct?

13 **A.** That's correct.

14 **Q.** When should a care plan be formulated and put in place?

15 **A.** At the point of admission. So the first hour, the nurse
16 should sit with the patient and, based on the risk
17 assessment and the needs assessment, determine the level
18 of observation levels, and then agree, or on --
19 a collaborative approach with the service user on what
20 would be the purpose and what's the goal and that's when
21 you should formulate the care plan.

22 **Q.** So is that what makes a -- what we have been referring
23 to as a care plan, is that what makes it collaborative:
24 is that you're working with the patient or engaging with
25 the patient?

1 **A.** You're agreeing with it, yeah. Everybody gets confused
2 with what a care plan is, but if we say, "Somebody's
3 plan of care", everybody says, "All right, that's the
4 plan", but when we say care plan, we seem to think, oh,
5 it's a bit more confusing, but actually it's a plan of
6 care for the patient. The care plan is a physical
7 document that the patient has a copy of, the families
8 can have a copy of, that details the plan of care.

9 **Q.** You've talked about a collaborative care plan and we
10 have traced in other contexts a development over the
11 time we're looking at, so from 2000 up to end of
12 '23 and, indeed, beyond that --

13 **A.** Mm.

14 **Q.** -- whereby there was a narrower approach generally in
15 relation to observations --

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

17 **Q.** -- to one in which we see a more therapeutic and
18 collaborative approach, in principle, in any event.

19 Now, for how long have collaborative care plans been
20 the norm? Are they the norm?

21 **A.** They should be the norm. And care plans in general, so
22 observation levels should form -- be an aspect of their
23 overall care plan altogether. There should be one care
24 plan and the interventions might be that they're on
25 enhanced observation levels, and that's where it

1 shouldn't be lots of different care plans for different
2 things, it should be one, and specifically identifying
3 what that person's observation levels should be.

4 Over time, we are encouraging and supporting more
5 collaborative approach in that there should be evidence
6 that it has been collaborative by using the patient's
7 language, getting the views of people who know them
8 best, and when you're auditing a care plan, you should
9 be looking for those, like the language used. Can it --
10 does it feel like the patient was involved in this care
11 plan? Can you see the patient's voice in this care
12 plan? That's what we mean by collaborative. It
13 might -- you might not always agree on certain elements
14 of the care plan and that should be evidenced in the
15 care plan, as well.

16 So when a -- a patient might say, "I'm agreeing for
17 these observation levels for 24 hours only." So you
18 would put the -- intervention would be: the agreed
19 timescale is 24 hours because Patient A is not agreeing
20 beyond that.

21 So that's where you can see that it's
22 a collaborative approach.

23 **Q.** So how long has the collaborative approach been part of
24 the process? So, for example, if we go back to the
25 early years that we're interested in from 2000 onwards,

1 to what extent would care planning involve this
2 collaborative element?

3 **A.** I would say more recently in about 10 years -- the last
4 10 years, we've seen a more active -- there will be
5 services and there will be practitioners who have always
6 worked in a collaborative way, but I think, it's -- it's
7 more of a -- it's always been the expected standard, but
8 I don't think it's been given as much creed as it has
9 been in the recent ten years.

10 **Q.** Can I come back, then, to a question I've asked you
11 previously: so this is the expected standard?

12 **A.** Yes.

13 **Q.** But does that expected standard differ sometimes to
14 what, in reality, actually happens on a ward?

15 **A.** Yes.

16 **Q.** Are there any general reasons for that?

17 **A.** Just not enough time, too many demands, too much
18 expectations placed on the nurses to do the job. Nurses
19 will ultimately focus on spending time with the patient
20 and maybe paperwork second, but when things don't go to
21 plan, it's the paperwork that is checked. So that
22 really affects a nurse in the workplace and that's what
23 tends to lead to people leaving the inpatient
24 environment because sometimes it can feel like an
25 impossible task to meet the patient's needs but equally

1 meet the Trust's expectations.

2 **Q.** Thank you very much.

3 Would you take that down, please.

4 I'd like to move on to training. This is at
5 Section 13 of your report from page 43.

6 Should staff assigned observations have specific
7 training?

8 **A.** They should.

9 **Q.** Could you confirm whether prior to the introduction of
10 ETOC, so that's the Enhanced Observation and Therapeutic
11 Care programme we were talking about from 2024, there
12 was any nationally mandated training package for
13 observation and engagement?

14 **A.** Not to my knowledge.

15 **Q.** Did that change with ETOC?

16 **A.** Yes. My understanding that some organisations had
17 a training package prior to ETOC but ETOC made it
18 mandatory expectation that there would be one.

19 **Q.** You describe in the report how training requirements
20 were determined prior to ETOC. So, for example, at
21 paragraph 13.1, where you say they were largely
22 determined by individual Trusts and providers. Correct?

23 **A.** Yes.

24 **Q.** What did that mean, in terms of the consistency of
25 training across the country?

1 **A.** The quality of the training varied. The Trust,
2 individual Trusts might have different priorities based
3 on findings from investigations, so there might be more
4 focus on the paperwork of observations, where some might
5 focus on the interactions with patients. It really
6 varied depending on each individual organisational need.

7 **Q.** What might training look like prior to 2024? You
8 address this at 13.2. For example you say:
9 "It was common for staff to be inducted locally to
10 the ward."
11 **A.** That's correct.

12 **Q.** Could you just explain what that process might be?

13 **A.** Yes. So if a new member of staff started working on
14 a ward, it wouldn't be uncommon that they would be given
15 the observation and engagement policy, asked to read it,
16 sign a declaration that they'd read the policy, then
17 they would be classed as supernumerary, so not assigned
18 any task for a period of time whilst they shadowed
19 another, more experienced, member of staff.

20 And they would be guided through the process of what
21 you do with observations and then at a certain point
22 they would be considerate competent to do them
23 independently.

24 **Q.** Other than reading the policy, the training would really
25 be on the job?

1 **A.** It would be, yes.

2 **Q.** Coming back to ETOC, I'd like to look at one of the
3 components of that programme so from 2024.

4 Could you put up online source 3 at page 7. And
5 expand the section. That's it. Thank you very much.

6 Do you see here":

7 "... training, competencies and support:

8 "Why is this policy important?

9 "Enhanced observations are a clinical intervention.
10 Clearly defined training, competency requirements, and
11 staff wellbeing support ensure staff are equipped to
12 deliver therapeutic, person-centred care. Standardising
13 these expectations across the organisation promotes
14 consistency and quality in ETOC delivery, ensuring all
15 patients receive appropriate care."

16 So does that capture in essence why training is
17 important in the context of an inpatient ward?

18 **A.** It does, yes.

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

20 You say in the report, this is paragraph 13.4, that:

21 "ETOC guidance recommends Trusts should develop a
22 local training programme incorporating e-learning,
23 face-to-face teaching, simulation, reflective learning,
24 competency assessment, and supervised clinical
25 practice."

1 What is the significance, in your view, of the
2 face-to-face teaching part of that?

3 **A.** I think the face-to-face and the simulation is crucial
4 in ensuring that staff who are asked to do a task or an
5 activity or an intervention know what they're doing.
6 It's such a big part of inpatient care, observations and
7 engagement, it's the major intervention that we do, but
8 previously it's been given very little attention and it
9 can be really difficult to do good observations and
10 engagement. So I just think that face-to-face teaching
11 could offer people who aren't familiar with the process
12 that guidance, those opportunities for question and
13 answers, to practise, to really prepare them as much as
14 possible for stepping foot in an acute inpatient ward --
15 well, any mental health ward, and give them the best,
16 you know, the best skills that we can give them.

17 **Q.** We heard from you that prior to ETOC, a lot of the
18 training is just on the job.

19 When you say face-to-face training, do you have
20 a particular type of scenario in mind?

21 **A.** Yes. So there's some training -- so there's e-learning,
22 which -- it's -- you go on, and you're trusting the
23 people who are doing the e-learning that they're taking
24 notice and they're not just guessing the questions and
25 you get so many attempts, so you're not really measuring

1 somebody's active engagement in the process. It can be
2 informative but I think it's limited. And I think with
3 certain training, it has to be face-to-face. I think it
4 then shows how it's a really important intervention, and
5 I think it should be treated as such.

6 **Q.** When you say face-to-face training, might that just be
7 following someone around a ward? Or do you envisage
8 some other form of face-to-face training?

9 **A.** No, more formal training. So a training day. It's
10 where it's just designated. And I also -- when you just
11 train with another person you miss the opportunity from
12 other people's learning. So a group can contribute to
13 the discussions, people might have more experiences of
14 working in other services, and I just think it enriches
15 somebody's learning.

16 **THE CHAIR:** Would you want to see those who are already on
17 the wards doing observations as a result of having had
18 just on-the-job training, would you want to see them now
19 being trained?

20 **A.** I would like to see everybody on the inpatient wards
21 being retrained.

22 **THE CHAIR:** Thank you.

23 **A.** For any level, even for doctors. And I just think it
24 would be a valuable lesson for all of us.

25 **MR GRIFFIN:** Do you consider there is a need for a more

1 comprehensive set of national training standards for
2 staff conducting observations?

3 **A.** I think it should be mandated that it is face-to-face or
4 in-classroom learning. We do prevention management and
5 violence and aggression training as part of that, and
6 that would be mirrored across all mental health and
7 learning disability Trusts. That's in the classroom.
8 I would like to see that expanded to observations and
9 engagement. We do immediate life support training in
10 the classroom, with simulation. Again, I would like to
11 see that applied to observation and engagement.

12 **Q.** Thank you.

13 So we've started to talk about temporary staff.
14 I just want to pick up on that now, and ask you about an
15 aspect of the case of Sophie Alderman. She was the
16 daughter of Tammy Smith. Sophie was an inpatient at
17 Willow Ward at Rochford Hospital and she died on
18 19 August 2022 at the age of 27.

19 Can you put up part of Tammy Smith's statement,
20 BIND010161 at page 62. And would you expand "Staffing"
21 to the bottom of the page.

22 Thank you.

23 So do we see here:

24 "I know that EPUT's evidence to Sophie's inquest was
25 that the ward was fully staffed on the day of Sophie's

1 death, but I believe they attempted to obscure rather
2 than address the problem. Firstly the supposed full
3 staffing was only possible by recourse to a majority
4 complement of bank and agency staff and the ward manager
5 acting down and effectively working in two roles
6 simultaneously. Relying on bank and agency staff means
7 that there are fewer people on a ward who know patients
8 well, and who patients, in turn, know well. Who was
9 Sophie going to be able to build a strong and trusting
10 relationship with?"

11 So Tammy there refers to a majority of bank and
12 agency staff here, and the effects on Sophie.

13 Can we move over the page, please, and highlight
14 that -- thank you very much.

15 So we see here:

16 "Secondly and perhaps more importantly, even if the
17 staffing levels were technically up to standard, EPUT
18 were holding -- were up to a standard EPUT were holding
19 themselves to, that standard was obviously too low.
20 Staff member after staff member gave evidence at
21 Sophie's inquest that they did not have time to engage
22 therapeutically with patients."

23 And can we see at the bottom:

24 "How can it be considered by EPUT that there was
25 enough staff on Willow Ward in all of [those]

1 circumstances?"

2 You cover this from paragraph 14.17 at page 49 of

3 the report and you tell us that Sophie was at level 1 at

4 the time of her death; correct?

5 **A.** Sorry, which page --

6 **Q.** 14.17 at page 49.

7 **A.** Yeah.

8 **Q.** And I just asked you whether, as far as you were aware,

9 Sophie was at level 1 observations at the time of her

10 death?

11 **A.** Yes.

12 **Q.** You cover this in the same paragraph. How many members

13 of staff were on duty on the ward and the make-up of

14 those staff?

15 **A.** There was ten members of staff on duty, three were

16 regular or permanent members of staff to the ward.

17 **Q.** And seven -- that means seven temporary staff?

18 **A.** That's correct.

19 **Q.** And you also cover the observation levels of the other

20 patients. Can you just deal with that, please?

21 **A.** Yeah, so there was three patients required level 3 or

22 level 4, one of whom required two-to-one observations.

23 This would have required a minimum of four staff members

24 to maintain those observations. And then the

25 investigation also identified that five patients were

1 subject to level 2 observations but I have not been
2 provided with the information of how many staff were
3 allocated to those level 2 observations, and then I'm
4 assuming somebody was allocated to level 1 observations,
5 as well.

6 **Q.** You refer in the report to:

7 "... the conflicting demands staff can face within
8 inpatient ward environments, particularly where multiple
9 patients require high levels of support, observation, or
10 immediate response."

11 That's paragraph 14.24.

12 Does Sophie's case potentially demonstrate that
13 issue?

14 **A.** Yes. I'm always cautious because I don't always think
15 it's about staffing numbers; I think it's about the
16 competency of the staff that you have and the skill mix.
17 Yes, there's an essential number that you need, but if
18 those ten staff worked on that ward and knew those
19 patients well, the care shouldn't have been impacted.
20 The challenge is when you've got multiple patients on
21 high observation levels, they do become -- tend to
22 become the focus and the patients who aren't on enhanced
23 observation levels can, if -- not always, but may be, of
24 secondary, or not in the -- not as given as much
25 attention as what they should have.

1 **Q.** Just dealing with the point about the prevalence of
2 temporary staffing, please. You say this in the report,
3 15.1:

4 "Temporary staffing may impact continuity of
5 therapeutic relationships and patient experience ..."

6 That's potentially picking up a point that we saw in
7 the statement.

8 "... particularly within mental health inpatient
9 settings where familiarity, consistency and relational
10 security are important components of care."

11 Can you just explain why familiarity, consistency,
12 and that type of thing, are important in these kinds of
13 environments?

14 **A.** The key to mental health nursing is that interpersonal
15 relationships, that a bit -- patients report -- they are
16 always keen to know who is going to be on shift, who is
17 going to be their allocated worker because they have
18 a sense of security knowing who is caring for them that
19 day. When it's unfamiliar staff and the staff don't
20 know them, they don't know the staff, that can increase
21 somebody's anxiety and less likely for them to seek out
22 help or make us aware that they're distressed.

23 They might see the regular members of staff busy
24 doing something. You often hear patients going:
25 "There's not enough staff on the ward, everybody's

1 working really hard."

2 So they don't want to interrupt people because they
3 think: oh, that person's need looks greater than mine.

4 And that's not what we want to hear. We want to be
5 available to them at all times. So if they don't know
6 the staff, they're less likely to approach them in times
7 of distress.

8 **Q.** You say also in the report that:

9 "High use of temporary staff may introduce
10 additional safety risks where staff are unfamiliar with
11 local procedures, ward environments, electronic systems,
12 and patient needs."

13 Is that right?

14 **A.** That's right. Sometimes temporary staff don't have
15 access to electronic records, or if they did have
16 access, they haven't worked a shift so the time has
17 lapsed or they're logged out. They might not be
18 familiar with where to find things on the electronic
19 records, and they might not be familiar with local ward
20 procedures or if somebody wants to get something out of
21 a cupboard, is it fine to get it out of the cupboard?
22 So it just puts extra pressure on the regular staff
23 because they feel as though they're multi-tasking.

24 And it also feels like you're having to take care of
25 the unfamiliar staff to make sure they know where to go,

1 what to do, and that adds extra pressure to an already
2 pressured environment.

3 **Q.** Thank you.

4 Would you take that down, please.

5 Can we now consider some more questions about
6 staffing. This is covered in Section 15 of the report.

7 Has there been guidance over the period from 2000 to
8 the end of 2023 about how NHS Trusts and service
9 providers respond to the need for additional staffing?
10 So this is from paragraph 15.2 of the report on, for
11 those who are following.

12 **A.** Yeah. So there has been, involving guidance. It looks
13 at making sure that you've got the right staff, right
14 skills, right place. And it also recognised,
15 particularly in NHS England's Mental Health Staffing
16 Framework, that staffing in mental health wards is very
17 different from an acute medical, often, say, staffing
18 levels always were based on medical hospitals and it
19 didn't take into consideration mental health needs.

20 **Q.** I think what I'd like to do is actually look part of
21 that Mental Health Staffing Framework. Is that
22 a national -- is that an NHS England document from 2015?

23 **A.** It is, yes.

24 **Q.** Mental Health Staffing Framework: a Practical Guide to
25 Staffing Inpatient Mental Health Services; correct?

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

2 **Q.** Put up online source 7, please, and page 1. Expand the
3 text at the bottom there, please. Do we see:

4 "New framework for senior mental health
5 professionals, designed to ensure the right people with
6 the right skills are recruited into the right inpatient
7 mental health settings. This is not intended to be
8 rigid or prescriptive, but aims to provide support in
9 seeking organisational assurance, how to complete
10 a workforce analysis and how you can make it work in
11 your own environment."

12 So this isn't mandatory; it's a framework intending
13 to provide support, yes?

14 **A.** Yes.

15 **Q.** Could you go over the page, please and expand "guide
16 objectives" on the right there. Just looking at this:

17 "Guide Objectives:

18 "To equip leaders within Mental health with the
19 skills, knowledge and competencies to plan and deliver
20 safe staffing.

21 "Assure all stakeholders that the skill mix and
22 staffing numbers are appropriate for safe, compassionate
23 care.

24 "Assure stakeholders that staffing numbers and skill
25 mix are balanced with professional judgement and any

1 other relevant factors."

2 And:

3 "To provide a means of assessing Mental Health
4 services against agreed best practice."

5 To what extent has this guidance or guidance of this
6 sort been helpful or led to improvements, in your view?

7 **A.** In my view, the guidance, has given more structure to an
8 escalation process about staffing. What the challenge
9 has been since 2015, the recruitment into inpatient has
10 nosedived at the same time as this come out. So
11 recruitment has become increasingly difficult. So there
12 is an over-reliance on bank and agency. I think we're
13 moving more away from agency but we're still highly
14 using a flexible workforce, which aren't -- you know,
15 people who might have a contract, but they're not
16 specifically to work on one ward; they move around all
17 the wards. But the guidance was helpful and it did give
18 an escalation process and it gave a senior overview of
19 the staffing pressures on acute inpatient wards.

20 When I was in an operational role, most of my job
21 was staffing. Addressing staffing needs, addressing
22 staffing concerns. It really did -- it does dominate
23 inpatient services.

24 **Q.** You mentioned a moment ago the difference between
25 staffing in the mental health context and otherwise?

1 **A.** Yes.

2 **Q.** And you made the point that they're quite different.

3 And I just want to look at something now that covers
4 that point with you.

5 Could you go to page 4 and expand the text there.

6 "Differences between Mental Health and other care
7 settings":

8 "It is vital to recognise and take into
9 consideration these important differences between Mental
10 Health and other areas of care."

11 Do we see there a number of bullet points setting
12 out differences? So for example:

13 "Mental health services require a higher proportion
14 of interventions.

15 "Interventions are often reactive and unplanned.

16 "Higher proportion of service users are ambulatory
17 rather than bed-based.

18 "Length of stay in hospital tends to be longer for
19 mental health service users.

20 "Higher percentage of service users are detained
21 rather than there by choice.

22 "Around half service users require a higher degree
23 of security."

24 Would you agree that those are points which mark an
25 important difference between the mental health context

1 and the non-mental health context?

2 **A.** Yes, I would agree.

3 **Q.** And do we see at the end of the text:

4 "All of these factors demonstrate the need for
5 a purpose-designed framework for effective mental health
6 staffing"?

7 **A.** Yes.

8 **Q.** So is there anything there that we see on the screen
9 with which you would disagree?

10 **A.** No, I agree with it all.

11 **Q.** Is there anything there that's of particular
12 significance, in your view?

13 **A.** No.

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

15 You've provided at Section 18 of the report your
16 reflections on observations and engagement and you say
17 this at 18.12, which is page 65:

18 "Ultimately, observations are most effective when
19 they remain human, relational, and patient centred,
20 rather than becoming purely procedural or surveillance
21 based."

22 Would you just expand on that, please.

23 **A.** Observations can and do save lives, but they -- it
24 really does boil down to the quality of them and the
25 relationship that you have with the patient. That

1 patient is going to interact with lots of professionals
2 in a day when they're on enhanced observations and it
3 actually doesn't matter that there might not be some
4 staff that they don't like or get on particularly well
5 because you are not going to engage -- it's not normal
6 to have therapy for 18 hours a day. So as long as it is
7 meaningful and there's certain elements in the day where
8 they get to be with a professional that they do that
9 work with, then it really can change lives, and also, it
10 really enhances the quality of our work and it keeps
11 mental health nurses doing what they do. Because they
12 go into mental health nursing to be with people, and so
13 it can be really important and meaningful intervention.
14 I think it's become -- but when it's become procedural
15 or surveillance, that's when we've completely lost the
16 meaning of it.

17 **MR GRIFFIN:** Thank you very much for that.

18 We'll come back this afternoon and we'll move to
19 a different area of the report where you discuss
20 vision-based patient monitoring systems. So that's
21 where we will turn to next.

22 May I, Chair, ask that we have a 45-minute lunch
23 today which would mean starting again at 1.45.

24 **THE CHAIR:** Can I just ask one question?

25 **MR GRIFFIN:** Yes, of course.

1 **THE CHAIR:** I wanted to ask about staff undertaking
2 observations. And we've heard about people suggesting
3 that the quality of the observations, the engagement,
4 can be compromised by staff fatigue, staff burnout, and
5 long-day rotas. Do you have a view on that?

6 **A.** Yes. So it seems across the board that they've gone to
7 long-day working, and that -- that can be exhausting,
8 working 14 hours a day, and sometimes they're working
9 back-to-back shifts. And if you've got multiple
10 patients on observations, that's where the fatigue may
11 set in. But ultimately, I think if you are good at your
12 job and care about what you do, you make it work. You
13 engage that patient. And it can be a really meaningful
14 intervention.

15 I mean ... so -- sorry, I've lost the original
16 question.

17 **THE CHAIR:** It was whether you thought observations and
18 engagement can be compromised by staffing arrangements
19 beyond just numbers but rotas and time spent doing
20 observations?

21 **A.** Yes, I think it has a major influence on the quality of
22 the observations.

23 **THE CHAIR:** Thank you.

24 **MR GRIFFIN:** Thank you, Chair.

25 **(1.02 pm)**

1 **(The Short Adjournment)**

2 **(1.45 pm)**

3 **(Proceedings delayed)**

4 **(1.45 pm)**

5 **THE CHAIR:** Thank you, Mr Griffin.

6 **MR GRIFFIN:** Thank you, Chair. And may I thank everyone for
7 having a shorter lunch hour today. It's much
8 appreciated.

9 We're going to move on to vision-based technology in
10 just a moment. Before we do, can I just clarify one
11 matter with you from this morning's evidence. We spoke
12 about Bethany Lilley and we looked at part of the
13 statement provided by her brothers, Alexander and Paul
14 Guille. And can I just get the sequence of events right
15 with you. The statement says this: that Beth was
16 transferred from the Peter Bruff Unit to the Thorpe Ward
17 in Basildon. You mentioned A&E but my understanding of
18 the sequence is that in fact what happened was that she
19 went from the Peter Bruff Unit to A&E but back to the
20 Peter Bruff Unit, and then from there to the Thorpe Ward
21 in Basildon. I just want to correct that on the record.

22 Thank you.

23 So can we move now on to the second part of my
24 questions for you, from Section 19 of your report,
25 please.

1 So dealing with vision-based patient monitoring
2 systems, which we'll focus on, but touching on
3 vision-based technology, such as CCTV and body-worn
4 cameras.

5 Can we deal firstly with some definitions, please.

6 **A.** Yes.

7 **Q.** First of all, vision-based technology. Close circuit
8 television systems and body-worn cameras, are they
9 aspects of vision-based technology?

10 **A.** Yes.

11 **Q.** The surveillance camera Code of Practice defines CCTV as
12 a surveillance camera system used to record or view
13 visual images within a defined environment with images
14 transmitted to designated monitors or recording systems
15 rather than broadcast publicly. Would that accord with
16 your understanding of CCTV, as well?

17 **A.** Yes, that's my understanding.

18 **Q.** You add this in the report, this is paragraph 19.2:

19 "CCTV is usually fixed and environmental, providing
20 live or recorded footage of communal ward areas for
21 safety, security, and incident review."

22 Is that correct?

23 **A.** That's correct.

24 **Q.** So we wouldn't see CCTV within in a patient's bedroom,
25 for example?

1 **A.** No.

2 **Q.** The Information Commissioner's Office refers to
3 body-worn video, as involving the use of cameras that
4 are worn by a person and are often attached on to the
5 front of clothing or a uniform. These devices are
6 capable of recording both visual and audio information.

7 Again, does that accord with your understanding of
8 what body-worn cameras do?

9 **A.** It does.

10 **Q.** You say in the report that:

11 "BWC [body-worn cameras] are mobile and
12 staff-operated, usually activated in response to
13 incidents or escalating situations".

14 Is that correct?

15 **A.** That's correct.

16 **Q.** What are the key benefits in the context of mental
17 health inpatients or the inpatient environment of
18 vision-based technology such as CCTV and BWC, for those
19 following, it's still paragraph 19.2 at page 65.

20 **A.** The benefit of body-worn cameras and CCTV, it helps with
21 investigations if an incident occur, it can help us do
22 a more timely and thorough investigation. And it also
23 helps with learning. So particularly the body-worn
24 cameras. We can review footage where there's been an
25 incident of violence and aggression and identify any

1 learning from it.

2 **Q.** Are there, on the other hand, some concerns arising from
3 the use of this technology?

4 **A.** Yeah, particularly with body-worn cameras in a busy
5 environment sometimes they're not switched off. If they
6 are switched on, sometimes the professional wearing them
7 might forget to switch them off so inadvertently it can
8 record the full shift. You would be -- the light is on
9 but it doesn't -- it still doesn't take away that you
10 might have not switched it off. And equally, staff do
11 forget to switch them on.

12 **Q.** Do you also say this in the report that:

13 "Their use can also feel intrusive or coercive,
14 particularly for patients who are distressed, detained,
15 traumatised or mistrustful of services."

16 Is that right?

17 **A.** Yeah, some patients might feel intimidated, if you're
18 going to say, "I'm going to switch on the body-worn
19 camera", they can -- they have reported that they feel
20 that's intimidating. But equally, some patients have
21 asked for the body-worn camera to be switched on and
22 that happens with their request as well, even though the
23 clinical situation might not indicate you would need to
24 switch it on, if a patient asked for it to be switched
25 on, we switch it on.

1 **Q.** You provide further information about vision-based
2 technology in Section 20 of the report. I'm not going
3 to ask you further questions about that now.

4 Moving then to VBPMS, vision-based patient
5 monitoring system. You refer in the report to the CQC
6 definition of these, and this is 19.4, as:

7 "... digital contactless patient monitoring
8 technology using infrared cameras to monitor vital signs
9 and in some systems, short video clips, to assist staff
10 in reviewing movement and presentation."

11 In general terms, how are VBPMS different from
12 vision-based technology such as CCTV and BWC?

13 **A.** They're in patients' private areas, and they're more
14 specific to patient care, so it's not a general
15 oversight; it's more regarding the patient-only areas,
16 private areas.

17 **Q.** And you say in the report that they're designed
18 primarily as clinical monitoring tools to support
19 patient safety and wellbeing?

20 **A.** They are designed to assist us with the safety and
21 welfare of patients, where CCTV and body-worn -- yes,
22 they assist in the investigation, but they don't offer
23 a prevention.

24 **Q.** You stressed "assist", and this may be a point that we
25 come on to, but would you just explain why you stressed

1 "assist" in there when you answered my last question?

2 **A.** Yeah, it should assist the practice that's already
3 there, not replace the practice.

4 **Q.** You explain that national guidance governing the use of
5 techno -- digital technologies started to appear from
6 2022. This is 19.5 of your report. And you provide
7 details of relevant guidance in Section 19 of the
8 report.

9 For present purposes, did that guidance include the
10 19 -- sorry, the 2022 National Mental Health and
11 Learning Disability Nurse Directors Forum Guidance on
12 Standard Operating Procedures in the views of VBT in
13 mental health wards?

14 **A.** Sorry, are you asking me if the 2025 guidance referenced
15 the --

16 **Q.** No. So you refer in Section 19 of your report to
17 various guidance of relevance. I'm just asking you if
18 one of those was this Nurse Directors' Forum Guidance
19 from 2022?

20 **A.** Yes.

21 **Q.** And you address this at 19.6.

22 **A.** Yes, that was the guidance for mental health and
23 learning disabilities and the 2025 guidance was for NHS
24 services overall.

25 **Q.** Well, we'll come on to that in just a moment. In terms

1 of the Nurse Director's Forum guidance, we've looked at
2 that with individual witnesses previously and we
3 actually touched on it yesterday, as well, but do key
4 points include from the guidance that VBPMS should be
5 used in addition to, and not in place of, therapeutic
6 positive engagement?

7 **A.** Yes, that's my understanding.

8 **Q.** So picking up on the point you've just made?

9 **A.** Yes.

10 **Q.** Does the Forum guidance also include recommendations on
11 consent models that should be considered?

12 **A.** It does.

13 **Q.** And also what Trusts should consider during the rollout
14 of VBPMS such as Oxevision?

15 **A.** It does.

16 **Q.** Thank you. So this first guidance came out some years
17 after the technology first appeared, if I have
18 understood things correctly.

19 **A.** It did.

20 **Q.** You've mentioned the 2025 NHS England principles. Can
21 we come on to those now, please. Are these the
22 principles for using digital technologies in mental
23 health inpatient treatment and care and are they from
24 February last year?

25 **A.** Yes.

1 **Q.** I'd like to look at the eight principles with you,
2 please.

3 Could you put up the report at page 67, and expand
4 paragraph 19.7.

5 Do you set out here the eight principles arising
6 from that 2025 guidance? Yes?

7 **A.** Yes.

8 **Q.** Just working through some of those, please. Do we see,
9 first of all:

10 "Human rights approach -- digital technology must
11 support a human rights-based approach to care".

12 And also a reference there to:

13 "Consent and capacity -- use of digital technology
14 and collection/storage of patient data, must be based on
15 patient consent or a lawful best-interests decision."

16 And just dealing with that second bullet point on
17 consent and capacity, can you confirm that that second
18 principle includes that any decision to use digital
19 technologies and to collect and store patient data from
20 the use of such technologies must be based on consent
21 from the patient or a person lawfully acting on their
22 behalf, or be taken following a best interests
23 decision-making process? Can you confirm that's part of
24 that second bullet point?

25 **A.** That, is, yes.

1 **Q.** And does it or do the principles add that:
2 "Due to the need for personalised decision making,
3 including seeking patient consent, digital technology
4 must never be used as a blanket approach."
5 **A.** Yes.
6 **Q.** Do we see, just dropping down a little bit, other
7 principles covering co-production:
8 "Co-production -- procurement, testing,
9 implementation and evaluation should involve
10 co-production with people with lived experience."
11 And then do we see:
12 "Therapeutic and personalised care -- digital
13 technologies must support therapeutic personalised care
14 and must not undermine staff-patient relationships."
15 **THE CHAIR:** Does that mean person-centred care?
16 **A.** No, personalised care. So that care is personalised to
17 that patient's needs. Person-centred is another term
18 to --
19 **THE CHAIR:** So it's individualised.
20 **A.** Yes, individualised.
21 **MR GRIFFIN:** This morning we discussed the need for
22 therapeutic care in observations and engagement. Does
23 that therefore also apply when using technology of this
24 type?
25 **A.** Yes.

1 **Q.** Can we see also in the principles on the screen:

2 "Evidence base -- providers must assess and document
3 the evidence base before procuring and implementing
4 digital technology."

5 Chair, we'll be hearing from a separate expert
6 witness tomorrow addressing matters relevant to the
7 question of an evidence base so I won't take that
8 further now.

9 But may I just ask you this, please, Ms Archibald,
10 about the principles cumulatively: how significant are
11 they in the context of vision-based patient monitoring
12 systems, VBPMS, in the mental health inpatient context?

13 **A.** What, the evidence base? Sorry.

14 **Q.** No, all eight principles. How significant are they?

15 **A.** Oh, they're essential, they're essential, that we must
16 consider all of those elements in delivering care.

17 **Q.** Thank you.

18 Would you take that down, please.

19 Can I ask you a question about the regulatory
20 oversight of VBPMS, please. Do you have a view whether
21 any particular regulatory body is well placed to
22 consider and decide on the benchmark for the quality of
23 vision-based monitoring systems?

24 **A.** I don't think I do. I'm not sure if I do know of
25 a specific regulatory body that could comment on the

1 technology. I think each regulatory body might comment
2 on its impact in that field, but I couldn't say an
3 overall arch.

4 **Q.** Thank you. I'd like to ask you about the last sentence
5 of paragraph 19.8 of the report. It's page 67 and in
6 fact -- it's at the top of page 68. You say there that:
7 "The central ethical tension is between
8 privacy/autonomy, versus patient and staff safety" when
9 you're talking about this form of technology.

10 Would you just expand on that point, please?

11 **A.** Yes, you've got to balance a patient's privacy and
12 autonomy, whether they consent to such intervention,
13 based with the patient safety. With it being
14 a relatively new technology, I-- my interpretation of
15 this is that it's assisting us with what we're already
16 doing so it shouldn't be -- with vision-based technology
17 it can be there to guide us and assist us but it
18 shouldn't replace what's already there. So if somebody
19 is not consenting or there's serious privacy and dignity
20 concerns, I think you would revert back to the human
21 factors, such as observations and engagement.

22 **Q.** Thank you.

23 **A.** You would rely in that for safety. I don't think it's
24 an essential piece of equipment to keep somebody safe.

25 **Q.** Just dealing then, moving on to Section 21 of your

1 report where you describe Oxevision, a form of VBPMS.
2 We've heard a fair amount of evidence about this
3 technology from witnesses from Oxehealth, now LIO, EPUT,
4 and yesterday two witnesses from other Trusts. I'd like
5 to look at part of your report with you.

6 Would you put up the report, please, at page 72 and
7 expand paragraphs 21.1 and 21.2.

8 Do we see here, Ms Archibald, that you say:

9 "In 2012 Oxevision was developed by Oxehealth, but
10 its use in NHS mental health inpatient practice appears
11 to have expanded mainly from around 2019 to 2021 [and]
12 by December 2021 Oxevision was reported to be in use in
13 50 per cent of Mental Health Trusts ..."

14 Indeed, that accords, I think, with other evidence
15 that we've heard.

16 Do you then list at paragraph 21.2 what Oxevision
17 can do?

18 **A.** Yes.

19 **Q.** And can we see:

20 "Perform remote visual checks of a patient in their
21 bedroom;

22 "Measure pulse and breathing rate without physical
23 contact, where the patient is still and sufficiently
24 visible to the camera, with suitable focal points such
25 as hand or foot available for the system to calculate

1 the reading;

2 "Help staff check whether a patient is in bed, in

3 the room, out of the room, or in the bathroom; and:

4 "Provide alerts or notifications for certain

5 configured situations."

6 And also:

7 "[to] produce activity information ..."

8 Do you list all of those as what Oxevision can

9 offer?

10 **A.** I did yes.

11 **Q.** Thank you.

12 Can you take that down, please.

13 I'd like to look with you at an Oxevision patient

14 poster used at EPUT. This is from the Standard

15 Operating Procedure version 12 from the 30 April 2025.

16 Could you put up, please, EPUT009884 at page 19 and

17 could you expand down to and including both those

18 points. Thank you very much.

19 Can we see here:

20 "Oxevision technology is installed in all bedrooms.

21 "Oxevision is a medical device that uses an

22 infrared-sensitive camera to measure your pulse and

23 breathing rate without disturbing you."

24 And can we actually see the unit there with the

25 camera on the left and the infrared lights on the right?

1 **A.** Yes.

2 **Q.** And do we see in the last bullet point in the top half
3 of the screen:

4 "Alert staff when you have entered the bathroom and
5 are out of range of the sensor."

6 So does that pick up on one of the points that we've
7 mentioned in your report?

8 **A.** Yes.

9 **Q.** And then at the bottom:

10 "Use of Video: what staff can see you in your room?

11 "A clear image can be seen for up to 15 seconds only
12 when checking your pulse and breathing rate."

13 And:

14 "A blurred image can be seen for up to 15 seconds
15 only when a notification has been received."

16 And these are points we've covered with other
17 witnesses too. But may I ask you about that last bullet
18 point, please, the blurred image. You say in your
19 report, and this is 21.4, that:

20 "When a red or amber Oxevision alert is triggered,
21 staff may be able to access a pixelated image of the
22 room to help them understand the possible cause of the
23 alert. The purpose of the pixelated view is to provide
24 limited visual information while reducing the level of
25 intrusion compared with a clear image."

1 So is the pixelation intended to provide some level
2 of privacy whilst allowing a staff member to gain an
3 idea of what is taking place in the room, in your
4 understanding?

5 **A.** That's my understanding, yes.

6 **Q.** Can I ask you this: to what extent do you think that
7 pixelating the image of the person actually reduces
8 privacy and dignity concerns? You refer to this at
9 21.4?

10 **A.** When you're looking at the pixelated image you don't
11 know what you're about to see, so you don't know if a
12 patient is engaging in private time or getting changed.
13 And even though you might not be able to solely identify
14 the patient from the image, you still get an insight
15 into what they're doing in their private space. But
16 equally, you aren't assured that that's the patient
17 that's meant to be in that room.

18 **Q.** Ah.

19 **A.** So if you've got a ward which is all-male patients,
20 there's an opportunity that other patients go into each
21 others' rooms. It doesn't give you -- it might give you
22 a snapshot of what you might -- what the alert is, or it
23 could be -- it doesn't give you enough assurances so you
24 would need to go round anyway.

25 **Q.** Just picking up on aspects --

1 **THE CHAIR:** And it could have two people in the room too?

2 **A.** It could have two people in the room --

3 **THE CHAIR:** So compromising two people's --

4 **A.** Yeah, yeah.

5 **THE CHAIR:** -- (overspeaking) --

6 **A.** And the two people could be another member of staff in

7 the room helping with personal care again. So when you

8 look at the pixelated image you don't know what you're

9 about to see so you can't -- where if you knock on

10 a bedroom door, the patient might say, "Can you give me

11 a minute?" So you're given a warning but with

12 a pixelated image there is no warning of the image.

13 **MR GRIFFIN:** You add this in the report:

14 "A pixelated image is still visual access into

15 a patient's private bedroom and should not be treated as

16 non-intrusive."

17 **A.** Yes.

18 **Q.** And you say:

19 "The fact that the image is pixelated reduces but

20 does not remove the privacy and dignity concerns."

21 And is that picking up on what you've just been

22 explaining?

23 **A.** Yes, and also the patient has no idea that you've just

24 looked into their bedroom.

25 **Q.** Unlike the knock at the door?

1 **A.** The knock at the door would give them a warning, yeah.

2 **Q.** What are the relevant considerations about whether to
3 view a pixelated or blurred -- a pixelated image or not?
4 What would be -- what should be in the forefront of
5 a staff member's mind when deciding whether to access
6 that pixelated view?

7 **A.** When an alert goes off, the ideal practice is that you
8 would go and check on the area physically. You would
9 walk round, check on the patient, and then you would
10 reset the alarm because you're assured about the
11 patient's safety.

12 In other situations where an example could be
13 there's maintenance been taken place in the room, so
14 there might be a painter and decorator in the room
15 constantly triggering off the alarm. So you might be
16 aware that there's some work going on in the room, so
17 when the alarm goes off you might check to see if it's
18 still the painter and decorator in the room. But it's
19 only in those circumstances when you know there's
20 a certain activity going on in the room or you know that
21 there's a member of staff in the room, helping somebody,
22 that you might just double check the pixelated image and
23 not go round. But really, the practice would be:
24 there's an alert going off, go and see what's happening.
25 That's what --

1 **Q.** You add in the report, this is paragraph 21.6 for those
2 following, that:

3 "The key question remains whether viewing the image
4 is necessary, proportionate, individually justified and
5 the least intrusive means of responding to the
6 identified risk."

7 Is that correct?

8 **A.** Yes.

9 **Q.** And should the use of pixelated image be governed by
10 clear policy, staff training, audit and documentation,
11 including when a face-to-face check is required
12 following an alert?

13 **A.** Yes.

14 **Q.** So doing -- dealing with the other bullet point we can
15 see at the bottom of our screens about accessing a clear
16 image for up to 15 seconds, please. The explanation
17 there is that:

18 "A clear image is available when checking pulse and
19 breathing rates."

20 Is that the vital signs function of the technology?

21 **A.** Yes.

22 **Q.** Why would it be important to have a clear view of
23 a patient before taking vital signs using Oxevision?

24 **A.** I'm only assuming that the technology can only take the
25 vital signs if it has a clear view. I'm not sure if

1 it's necessary for the nurse to have a clear view to get
2 the vital signs.

3 **Q.** So this might be a requirement of the technology rather
4 than of staff?

5 **A.** Yes.

6 **Q.** Just asking you about a very general point, please.
7 What concerns may arise from the presence of a camera in
8 an inpatient's bedroom? And we've seen photographs or
9 stills previously of the unit in the bedroom. It's
10 quite a big unit?

11 **A.** It is, yeah.

12 **Q.** Can you just in general terms explain what kind of
13 concerns may just the existence of the camera have in an
14 inpatient's bedroom? What kind of concerns might that
15 give rise to?

16 **A.** Some patients can be particularly sensitive to being
17 observed or feeling that they're being watched. The
18 device itself doesn't obviously look like a camera, it's
19 a device that I've never seen anything that looks like
20 it before. So I can -- I think there'd be concerns of:
21 what is it? What does it do? But equally, it can
22 instil -- some of our patients already have -- are
23 paranoid and struggle to trust professionals, and
24 struggle to trust anybody, so that can reinforce that
25 we're not to be trusted and equally increase their

1 paranoia. I've witnessed some patients scream at the
2 device thinking ... and it's -- yeah, it can be
3 confusing for some.

4 **Q.** We heard --

5 **A.** -- (overspeaking) --

6 **Q.** -- yesterday, we saw in a report an instance where
7 a woman actually refused to go into the bedroom where
8 there was an Oxevision unit, and had to be --
9 a different place had to be found for her to stay in.
10 Have you had that kind of response to the Oxevision unit
11 in your experience?

12 **A.** Yes, I have had patients that have brought the --
13 smashed the device or covered it up. And sleep on the
14 sofas in the main areas, because they feel uncomfortable
15 with the device in the room.

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

17 I want to come back to consider with you this clear
18 image view and what is termed clear-video data, please.

19 Would you put up EPUT009884 at page 12. This is the
20 Standard Operating Procedure from EPUT version 12,
21 published on 30 April 2025. So EPUT009884. Thank you
22 very much.

23 So do we see here that EPUT SOP, or Standard
24 Operating Procedure, governing Clear Video Data. I just
25 want to look at aspects of this with you, please.

1 Clear Video Data, or CVD, is non-pixelated video
2 footage that can be clipped and saved upon request if
3 there is a situation that needs to be further
4 investigated.

5 So you were referring before in relation to CCTV and
6 body-worn cameras, that one of the advantages could be
7 that -- the recorded footage there might be able to
8 assist with an incident or something of that nature.
9 Does this suggest that something similar can happen with
10 footage captured by Oxevision within a patient's
11 bedroom?

12 **A.** It does.

13 **Q.** Just dropping down a little bit:

14 "The request must be made directly to Oxehealth
15 within 24 hours of the situation or incident ..."

16 And we've heard that the data is automatically
17 deleted after a 24-hour period. Is that your
18 understanding too?

19 **A.** Yes, that's my understanding.

20 **Q.** And:

21 "Upon receipt of a request, Oxehealth will clip and
22 save CVD. Once authorisation has been granted,
23 Oxehealth attend site to transfer the clipped CVD to
24 a secure USP for delivery."

25 Do we see at the bottom:

1 "Clear Video Data is automatically deleted after
2 24 hours."

3 The point that we've just been discussing.

4 So if there's been an incident and you want to
5 access the footage you have to do it pretty quickly,
6 within 24 hours?

7 **A.** Yes.

8 **Q.** Now we've heard from a number of witnesses now that in
9 fact, when the system is present in a patient's bedroom
10 and activated, it's actually recording 24 hours a day,
11 seven days a week, all the time. Is that your
12 understanding, as well?

13 **A.** Yes, it is.

14 **Q.** And that is clear view footage, so not pixelated, clear
15 footage, a clear view of the patient in their bedroom;
16 correct?

17 **A.** Yes, yeah.

18 **Q.** What are your views about that facility, the fact that
19 it's on and recording all the time?

20 **A.** I struggle to understand why it needs to be on. And
21 I do -- it is concerning, and also it's not made
22 explicit to patients that that is the case.

23 **Q.** Does that go to the question of informed consent?

24 **A.** Yes.

25 **Q.** We were talking about that before. In your view, is

1 that something that should be explained to a patient
2 when they're deciding whether they want to consent to
3 the use of the system?

4 **A.** Yes.

5 **Q.** You say this more generally in the report, this is 29.4:

6 "In my view, the ability to obtain a clear view, use
7 pixelated images and retain clear view data for up to
8 24 hours creates a significant intrusion into a private
9 space."

10 So that's paragraph 29.4 at page 97. Would you just
11 expand on that, please?

12 **A.** I think it goes beyond being absolutely necessary. So
13 if we consider that if patients are detained under the
14 Mental Health Act or the Capacity Act, you still have to
15 justify that it's absolutely necessary to do things
16 against their wishes. I don't think 24-hour filming of
17 them in their private space is absolutely necessary or
18 justified. I can understand how it might give some
19 reassurance to families, or even patients. Some
20 patients do consent to -- some patients do seek
21 reassurance. Applying the principles, if I was
22 a patient or a family member, it's not something that I
23 would be comfortable having. And I think, before you do
24 anything or suggest anything to your patients you need
25 to ask: is it good enough for me and is it good enough

1 for my family?

2 **Q.** Thank you very much.

3 Your report recognises that VBPMS may not be
4 experienced as neutral by patients, and in fact you've
5 just given us some fairly compelling examples of that,
6 but rather as an intrusion or a loss of privacy,
7 regardless of the intent.

8 Do you agree this is likely to be the case
9 regardless of whether patients that have experienced
10 trauma or psychosis?

11 **A.** It can be very trauma -- most people have not been
12 filmed in their private area in any aspects of their
13 life but for patients who have suffered significant
14 trauma, that might have been the case. So it can be
15 very traumatic. It's very intrusive.

16 **Q.** But the point here is actually, patients who haven't,
17 for example, a patient who is not paranoid or doesn't
18 have a specific trauma, do you agree that that feeling
19 of loss of privacy can be equally keenly felt by them?

20 **A.** Yes.

21 **Q.** Can we take that down, please.

22 Can we stay with the vital signs function just for
23 the moment. As we've seen, it covers pulse and
24 breathing rates. Now, we looked this morning at the
25 NEWS2 measurements, the six different measurements that

1 need to be taken. Is it right that vital signs actually
2 covers only two of them?

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

4 **Q.** So for example, blood pressure would be something that
5 wouldn't be covered --

6 **A.** No.

7 **Q.** -- by vital signs but would be required by NEWS?

8 **A.** Yes.

9 **Q.** You say in the report that:

10 "A reading -- a vital signs reading does not replace
11 a full set of physical observations."

12 And that:

13 "The vital signs function cannot and does not
14 replace physical health monitoring."

15 Is that correct?

16 **A.** That's correct.

17 **Q.** So Oxevision could not be misunderstood or should not be
18 misunderstood to be a substitute for NEWS monitoring?

19 **A.** No, my understanding is that vital signs is not --
20 although it offers a 15-minute window it would not be
21 used to replace NEWS or inform clinical assessment.

22 **Q.** Is there a purpose for a technology that covers only
23 part of the NEWS2-required measurements and does not
24 replace physical health monitoring?

25 **A.** It might just offer some assurances that the patient is

1 alive. The risk of that is the professional or the
2 person using it might interpret it as a full set of
3 observations when in fact it's not.

4 **Q.** Now, we've heard evidence, including yesterday, that the
5 vital signs function, actually, only works within
6 particular parameters?

7 **A.** Yes.

8 **Q.** Is that your understanding too?

9 **A.** Yes.

10 **Q.** So to what extent could it safely be used to demonstrate
11 whether someone, a patient in their bedroom, was alive
12 or not?

13 **A.** If it was able to have two body parts available, and
14 that it could get a reading from those body parts.

15 **Q.** But where it is able to make a reading, within the
16 defined or the recognised parameters, that could provide
17 a sign of life, basically?

18 **A.** It could show a sign of life, yeah. The only time -- if
19 a patient is stood up in their bedroom, that in itself
20 is a sign of life so there would be no requirement to
21 access vital signs, in my opinion.

22 **THE CHAIR:** Is there a danger, though, that because it can't
23 recognise vital signs beyond certain parameters, that
24 people will occasionally think: well, it's not actually
25 showing me that someone's alive. But that may just be

1 because it's outside the parameters of what this can
2 show?

3 **A.** Yes, if somebody is lying in their bed during the night
4 and it can't pick up vital signs, there is a risk that
5 there's an assumption it's just because they've got no
6 two body parts available.

7 **MR GRIFFIN:** So you've mentioned two body parts a couple of
8 times. We actually went through this yesterday. In
9 order for a vital signs measurement to be successfully
10 taken, we've seen blobs, actually, need to be on exposed
11 body parts for the reading to be taken.

12 **A.** Yes.

13 **Q.** And so a reading may not be taken where that hasn't
14 happen, just to explain what you've just
15 -- (overspeaking) --

16 **A.** Yes, yes.

17 **Q.** Thank you.

18 I'd like to look at another part of your report
19 please. Would you put up the report at page 74 and
20 expand paragraph 21.9.

21 So seclusion, HBPOS, is that health-based place of
22 safety?

23 **A.** Place of safety, yes.

24 **Q.** LTS -- is that long-term segregation or seclusion?

25 **A.** Long-term segregation.

1 **Q.** And we see a reference to EPUT's policy. That's in fact
2 a reference to the Standard Operating Procedure
3 version 12 we've just been looking at.

4 Can we just read on, please:

5 "EPUT's policy distinguishes between the use of
6 Oxevision in ordinary patient bedrooms and its use in
7 higher-risk areas such as seclusion, LTS and HPBOS. In
8 patient bedrooms, the vital signs function provides
9 spot-check readings of pulse and respiratory rate when
10 staff actively request them, but it does not alert staff
11 to abnormal pulse, abnormal respiratory rate, cessation
12 of breathing or clinical deterioration. However, EPUT's
13 policy indicates that in seclusion, LTS and HBPOS
14 settings, the system can alert to breathing and pulse
15 concerns."

16 So vital signs outside the seclusion context does
17 not alert staff to those matters such as clinical
18 deterioration. To what extent, in your view, does that
19 limit the assistance that vital signs can provide?

20 **A.** It would -- to request vital signs, there must be
21 a professional curiosity in the first place to request
22 it. It wouldn't -- the system, to my knowledge, doesn't
23 alert us when there's a physical deterioration that
24 might request -- lead us to request the vital signs. It
25 would just be from our own instinct to request it. But

1 if I recall, remembering the way the policy was written
2 is that there might be some assumptions,
3 misunderstanding from patients and families that the
4 system alerts us to deterioration.

5 **Q.** When it doesn't?

6 **A.** To my knowledge it doesn't.

7 **Q.** You say that -- sorry, this paragraph in the report says
8 that:

9 "In the seclusion, LTS and HBPoS context, vital
10 signs, breath and respiratory measurements can be used
11 to alert to breathing and pulse concerns."

12 Why can they be used in that environment?

13 **A.** I don't know.

14 **Q.** Is it or might it be because those are potentially
15 higher risk environments, and may -- there may be
16 a patient who would react badly to, for example, a NEWS2
17 type of measurement?

18 **A.** Possibly. The -- seclusion and long-term segregation
19 patients tend to possibly be on higher doses of
20 medication, more acutely disturbed, where the
21 hospital-based place of safety patients are unknown.

22 **Q.** You say, just finishing this paragraph:

23 "This distinction is important because patients,
24 families and staff may assume that Oxevision provides
25 the same level of physiological monitoring in all areas.

1 In ordinary bedrooms it should not be understood as
2 a deterioration-alert system or a substitute for
3 physical health monitoring, NEWS2, face-to-face
4 assessment or professional judgement."

5 Is that all correct?

6 **A.** Yes.

7 **Q.** You add later in the report -- for those following it's
8 24.10 at page 85 -- that:

9 "Vital signs may be unable to obtain a reading if
10 the patient is moving, has tremors, is covered, is not
11 clearly visible, or where visible body parts are
12 affected by factors such as scarring or tattoos. In
13 effect, the vital signs function may provide an
14 indication of pulse and breathing but it should not be
15 understood as continuous physical health monitoring or
16 as a system that will detect all forms of clinical
17 deterioration."

18 Now, does that sort of summarise all of the points
19 we've just been discussing?

20 **A.** Yes.

21 **Q.** Will you take that down, please.

22 What are the scenarios in which the vital signs
23 function is most likely to be of use, in your view?

24 **A.** During the nighttime, in seclusions. It's important to
25 note that people who are in seclusion or long-term

1 segregation are in the hospital place of safety and
2 during the -- sorry, those three areas, they have an
3 assigned member of staff with them at all times who will
4 be reviewing the screen. The screen will be in front of
5 them at all times. In comparison to the general wards,
6 they more than likely won't have a member of staff
7 assigned or watching a screen at all times.

8 But in regards to vital signs being used possibly
9 through the night, could be beneficial if the patient
10 agrees, so you're not entering the room and we're not
11 disrupting the sleep.

12 **Q.** Are there particular patient groups where VBPMS is more
13 likely to cause harm, increase distress, or undermine
14 therapeutic relationships? You've given an example of
15 someone who might be paranoid but are there other
16 categories where there is more likely -- it's more
17 likely that the system will cause harm?

18 **A.** Yeah, it could be any patient group, even with patients
19 with an organic illness such as dementia, it could cause
20 confusion, distress. For patients who have got
21 a history of trauma. There's lots of factors that might
22 negatively impact them. And also, the patients who
23 distrust what we're doing with that information, and how
24 we're accessing it and what we see.

25 **Q.** Thank you. You explain in the report that -- and this

1 is paragraph 21.10 at page 75:

2 "EPUT and some other Trusts have implemented an
3 additional digital observations module within the
4 Oxevision platform, sometimes referred to as Oxeobs or
5 Oxevision observations. This appears to support the
6 carrying out and recording of ward observations through
7 digital devices."

8 So we covered this morning paper-based records and
9 electronic records. Is your understanding that
10 Oxevision observations is an electronic record system?

11 **A.** Yes.

12 **Q.** Can we just look at EPUT's Standard Operating Procedure.
13 This is the same one we looked at before. Would you put
14 up EPUT009884 at page 14 and expand the top half of the
15 page. Thank you.

16 So this is the description there of Oxevision
17 observations:

18 "Oxevision Observations is a digital observation
19 module within the Oxevision system. The Oxevision
20 Observations module is a digital version of the paper
21 observations record ...

22 "Oxevision Observations is implemented only on
23 Oxevision-equipped inpatient wards, seclusion rooms, and
24 [health-based places of safety] to enhance and improve
25 patient care and safety in order to ... "

1 And then do we see three bullet points with the
2 reasons for it:

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

5 "Assist in the identification of trends.

6 "Report on quality of Therapeutic Engagement and
7 Supportive Observation activity."

8 And then do we see at the bottom:

9 "The Nurse in Charge will check the completion of
10 observations periodically during their shift and provide
11 the assurance in the Clinical Guideline."

12 Do we see all of that there from the SOP?

13 **A.** Yes.

14 **Q.** So we see that it's meant to be a digital version of the
15 paper observations record, and as I've said, we've
16 discussed this morning records, both paper based and
17 digital. You've suggested this, this is
18 paragraph 21.10, so:

19 "This appears to support the carrying out and
20 recording of ward observations through digital devices.
21 However, the terminology risks further conflating
22 'observation'. Therefore, any use of an Oxevision
23 Observations module should be clearly distinguished from
24 the clinical and therapeutic purpose of close
25 observations."

1 Would you just explain what you meant by that,
2 please?

3 **A.** I think that the term "observation" is -- because it's
4 called Oxevision Observations, there could be a risk
5 that you use Oxevision to do your observations.

6 **Q.** Oh, I see, rather than just as a replacement for paper
7 records?

8 **A.** Yeah. So the fact it's called Oxevision Observations,
9 it could, for somebody who's not well experienced or not
10 familiar with the -- it could imply that you use
11 Oxevision.

12 **Q.** Thank you.

13 Would you take that down, please.

14 Before we move on to another topic, I'd like to look
15 at one of the illustrative examples you've given in the
16 report, and you've touched on the nighttime use of
17 Oxevision, so this is going back to that point, please.

18 At 24.5 you refer to Adam Steel. His father Paul
19 Steel has given a witness statement to the Inquiry and
20 came to give evidence to us in October last year, and in
21 fact also previously has given commemorative evidence.

22 Adam was a patient on the Peter Bruff Ward at the
23 Colchester hospital. He was admitted to the ward on the
24 afternoon of 13 October 2021 and he died the following
25 morning at the age of 36.

1 **THE CHAIR:** I'm just going to interrupt you, it's 24.15.

2 **MR GRIFFIN:** 24.15. Thank you for that correction.

3 **THE CHAIR:** Forgive me.

4 **MR GRIFFIN:** Not at all. Thank you.

5 Do you have that in front of you if you --

6 **A.** Yes, I've found it, yeah.

7 **Q.** I'd like to put part of the transcript of Paul's

8 evidence to us on the screens, please. Would you put up

9 the transcript of Paul Steel, Day 34. That's

10 23 October 2025. The reference is INQY016285, page 15.

11 Could you expand up to and including line 21?

12 Perfect.

13 I just want to look at part of this with you,

14 please. Do you see a question there:

15 "And ... were his observations undertaken via

16 Oxevision only, is that what your understanding is?"

17 And the answer is:

18 "That's my understanding, yes."

19 Then dropping down to the next answer:

20 "... there was an observation window in his room and

21 his bed was in such a position that it couldn't be seen

22 through the observation window due to its location and

23 I was concerned that there was even more reason why he

24 should have been physically visited face-to-face, if

25 they couldn't see his bed through the observation

1 window."

2 And then looking at the last question and answer:

3 "And as far as you can ascertain, there was camera
4 observations and no physical observations?"

5 Answer: "That's correct."

6 So is it your understanding here that Oxevision data
7 showed that Adam's bedroom door had not opened at any
8 point during the night?

9 **A.** Yes.

10 **Q.** As we can see from here, his bed wasn't visible from the
11 door window?

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

13 **Q.** Was he on level 2 observations, meaning in this case
14 four checks an hour?

15 **A.** I've documented that he was on level 2 observations.

16 **Q.** Yes. And so Adam wasn't observed face-to-face.

17 Just in your view, what does this illustrate, Adam's
18 case, the conduct of observations remotely and not
19 actually going into the bedroom overnight?

20 **A.** I've wrote in my report and it might just be from how
21 I've read the information provided, that I couldn't
22 determine whether the -- he was observed by either
23 vision based, as well. I didn't see data to see how
24 many times they'd checked on him, whether they did the
25 check every 15 minutes as his prescribed observation

1 levels, but this shows -- highlights the risk of relying
2 on a technology instead of human observation.

3 **Q.** You say this:

4 "The importance of face-to-face checks in
5 determining a patient's safety and wellbeing is an
6 important factor arising."

7 Yes?

8 **A.** Yes.

9 **Q.** And:

10 "Remote viewing or reliance on Oxevision is
11 insufficient to determine whether a patient is
12 physically well, emotionally distressed, deteriorating,
13 or in need of urgent observation."

14 Yes?

15 **A.** Yes, the human assessment would pick up on a
16 deteriorating patient.

17 **Q.** Thank you, would you take that down, please.

18 So the suggestion has been that remote observations
19 are less restrictive, particularly at night. Do you
20 agree that reducing disturbance is not always
21 necessarily less restrictive if it involves increasing
22 remote surveillance?

23 **A.** You've got to balance up what's more, and take into
24 consideration what the patient's views are, whether --
25 can we disrupt sleep in a more meaningful way? There's

1 lots of things in the environment that we can do rather
2 than solely relying on technology, but the technology
3 can assist, but it doesn't -- it still doesn't replace
4 the human factors.

5 **Q.** Is it right to say that for some patients, nighttime is
6 when they are most likely to need support and engagement
7 because if they're awake, patients are likely to have
8 experienced or may have been experienced night terrors,
9 insomnia, or anxiety?

10 **A.** Yeah, nighttimes can be incredibly difficult for a lot
11 of patients, for lots of various reasons. There's a lot
12 of quiet time, a lot of time for reflection. People
13 tend to miss their families more. And equally, it can
14 be a trauma response. So nighttimes tend to be quite
15 risky as well.

16 **Q.** Would you agree that there might actually need to be
17 some form of human contact during the night in those
18 kinds of circumstances?

19 **A.** Yes, and some patients are also frightened from other
20 patients. So having staff available can offer them some
21 reassurance.

22 **Q.** I just want to pick up on something you've said in the
23 report. This is paragraph 25.13 at page 91.

24 You note that:

25 "Oxevision may provide information about room

1 activity, vital signs attempts, alerts, or whether
2 someone is present in a room."

3 But you go on to say this:

4 "It cannot reliably identify who the patient is,
5 understand the meaning of behaviour, assess emotional
6 distress, recognise elation, agitation or hopelessness,
7 or determine whether a patient is experiencing urges to
8 self-harm."

9 Does that all underscore the need for the human
10 element in addition to any virtual viewing of a patient
11 or relying on technology such as vital signs?

12 **A.** Yes, it's -- they just highlight how the human
13 interaction would pick up on those elements.

14 **MR GRIFFIN:** Thank you.

15 Chair, I've just finished a topic. This might be
16 a good time for our afternoon break. May I -- it's now
17 quarter to three, may I suggest we come back at 3.00 pm,
18 please.

19 **THE CHAIR:** 3 pm.

20 **(2.43 pm)**

21 **(A short break) .**

22 **(3.00 pm)**

23 **THE CHAIR:** Mr Griffin.

24 **MR GRIFFIN:** Ms Archibald, you've considered in your report
25 two of EPUT's Standard Operating Procedures on

1 Oxevision. This is in Section 22 of your report and I'd
2 like to move to that now, please.

3 And we'll bear in mind the NHS England principles
4 that we've already discussed, including on the topic of
5 consent.

6 Was the first SOP you considered Version 10, from
7 31 May 2024?

8 **A.** Yes.

9 **Q.** Does that therefore precede the NHS England principles?

10 **A.** It did, yes.

11 **Q.** Was the second one that you considered, Version 12,
12 published on 7 May 2025 and therefore after the
13 publication of the principles?

14 **A.** Yes.

15 **Q.** I'd like just to discuss with you Version 10 and the
16 approach there with you now and to focus on the issue of
17 consent and how that actually then goes on to change
18 between Version 10 and Version 12. So that's just
19 setting the scene; is that all right?

20 **A.** Yes.

21 **Q.** Now, we've heard evidence from EPUT about this and in
22 fact we heard evidence yesterday from a witness from
23 another Trust that has substantially the same approach
24 currently to Version 10 of the EPUT SOP, and what we
25 learnt there, and what we can see in the Version 10

1 SOP, is a process that I want to look at with you now.

2 Could you please put up EPUT SOP Version 10 at
3 EPUT004791 at page 14. Thank you.

4 So this is the Oxevision consent flowchart from the
5 earlier of the two SOPs that you've looked at.

6 What I want to do for present purposes is to trace
7 with you through the scenario where you have a patient
8 with capacity who does not want the Oxevision system to
9 be switched on and used in their bedroom; all right?

10 **A.** Yes.

11 **Q.** Can we see therefore, at the top of the page:

12 "Fully inform patient/family/carers about the
13 Oxevision system purpose and functionality as part of
14 admission procedure."

15 So the SOP, so it requires that the patient and
16 others are provided with information. Is that -- does
17 that go to this point we've been discussing a couple of
18 times now of needing to obtain informed consent?

19 **A.** Yes.

20 **Q.** We'll come on in a moment to look at some other
21 information to see to what extent EPUT have actually
22 been successful about -- in their consent processes.
23 But that's a separate point that we'll come on to.

24 Can we see at the top of the page:

25 "In this SOP, Oxevision is switched on from

1 admission."

2 Is that what has been termed a blanket approach for

3 the first -- up to 72 hours while an assessment takes

4 place?

5 **A.** Yeah, that's my understanding.

6 **Q.** And so that will be turned on regardless of what

7 background the patient has, and regardless of, initially

8 at least, whether they consent or not?

9 **A.** Yes.

10 **Q.** Moving down, do we see:

11 "Does the patient/family/carer object?"

12 Can you see that?

13 **A.** Yes.

14 **Q.** If we move to the right "Yes," and following that

15 through -- can I just say how helpful it is to have this

16 highlighting, thank you very much -- just following

17 down, can we see this, 2b:

18 "Document discussion and objection in patient record

19 and inform Responsible Clinician within 24 hours."

20 So the system is on at this stage, correct?

21 **A.** Yes.

22 **Q.** "MDT meeting within 72 hours:

23 "Objection discussed as part of individual risk

24 assessment."

25 This is number 3.

1 "Patient capacity established. Clinical
2 recommendation on use of Oxevision."

3 So during the initial period of 72 hours or up to
4 72 hours, the system is on, as we've established,
5 regardless of whether the patient has consented or not?

6 **A.** Yes.

7 **Q.** Do we next see on the flow chart to the left "Does the
8 patient have capacity?"

9 **A.** Yes.

10 **Q.** And as I've said, let's assume for present purposes that
11 they do. Do we then go to 4b, "Meeting with patient and
12 decision documented in patient record"? Yes?

13 **A.** Yes.

14 **Q.** And under that the two options of "MDT decision to keep
15 on implemented" or "MDT decision to switch off
16 implemented".

17 Can we just take stock. In summary, does this
18 flowchart mean that a patient arriving on the ward will
19 have the system switched on by default for up to the
20 first 72 hours?

21 **A.** Yes.

22 **Q.** And that where the patient objects and has capacity, the
23 ultimate decision as to whether the system remains on is
24 not the patient's; it's that taken in the MDT?

25 **A.** That's my understanding of how it's written and worded,

1 yeah.

2 **Q.** You set out at 22.6, at page 76, some of your views
3 about this approach to consent. Could I just ask you to
4 deal with those and explain a little bit more what your
5 views are about this approach?

6 **A.** If a patient has capacity and they refuse, I struggle to
7 identify how the MDT can overrule that, even if they
8 were a patient under the mental -- sorry, under --
9 a patient detained under the Mental Health Act. And
10 regardless of whether they have capacity or not, the
11 patient can still have a view on something, and I think
12 it ... yeah, I struggle to grasp that it still falls
13 down to the MDT to make a decision when the patient
14 either has capacity and refuses, or lacks capacity but
15 still doesn't wish to use it.

16 **Q.** You say this at paragraph 22.6:

17 "In my view, SOP 10 risked placing organisational
18 approval above the patient's expressed refusal."

19 So is that picking up on the point you've just made?

20 **A.** Yes.

21 **Q.** And you add:

22 "This is difficult to reconcile with a genuine
23 consent-based patient-centred and rights-based approach,
24 particularly where the patient was informal or where the
25 legal basis for continued monitoring was not clearly

1 identified."

2 Can I just ask you about that point about the
3 informal patient. Why would that make a difference
4 here?

5 **A.** There would be no legal framework for that patient to
6 object, and they would run the risk of the patient might
7 take their own discharge even though they're in need of
8 help, because of an intervention that they do not agree
9 with.

10 **Q.** Thank you.

11 Could you take that down, please.

12 May I just ask you a few more questions about this.
13 Do you -- is it your view that decisions should be taken
14 on a case-by-case basis?

15 **A.** It should, yes.

16 **Q.** How likely do you think it is that decisions will, in
17 reality, be taken on a case-by-case basis if Oxevision
18 has been installed in every bedroom on many wards within
19 a Trust?

20 **A.** I think it places clinicians in a difficult position:
21 that they've got to justify why they're not using the
22 technology. So it might place you in a position where
23 you're in favour of a technology and you would hope that
24 all patients would have it. So that might influence,
25 sort of, your speaking to your patients about it. It's

1 like you're trying to sell them something. I can't
2 think of another word, but it feels like you're trying
3 to sell them something rather --

4 **Q.** Because it's there?

5 **A.** Because it's there --

6 **Q.** Thank you.

7 **A.** -- and you've got to -- there's a process that you've
8 got to follow if somebody doesn't want it. It should be
9 a harder process if somebody does want it, rather than
10 if they didn't want it.

11 **Q.** Thank you.

12 That was Version 10, the second version you looked
13 at, Version 12, 2025 and after the NHS England
14 principles came out. And I think we can, in terms of
15 consent, we can deal quite shortly with the change of
16 approach. You deal with this at paragraph 22.7. You
17 say:

18 "The main change to practice was reducing from 72 to
19 6 hours for MDT consideration."

20 And you describe that as a positive development.

21 As I understand it, the Version 12 still -- so there
22 would still be a period, albeit much shorter,
23 six hours -- where the system would be on by default, up
24 to six hours, correct?

25 **A.** Yes.

1 Q. And did Version 12 maintain the other element we were
2 looking at, namely that the final decision would not be
3 that of the patient, but would be taken by the MDT?

4 A. It did not change that approach. It still -- final
5 decision was made by the MDT.

6 Q. So to what extent do you see Version 12 as in reality an
7 improvement on the points that you've made in relation
8 to Version 10?

9 A. My opinion was that it showed recognition for the
10 patient's views, but it still didn't go far enough.

11 Q. We covered yesterday the situation where a patient lacks
12 capacity, the decision being a best-interests decision
13 and we covered that best-interests concept briefly this
14 morning, yes?

15 A. Yes.

16 Q. I'm not going to ask you more about that now.

17 Now, have EPUT signalled a change of approach in
18 relation to their approach to consent?

19 A. I believe that they've changed or plan to change the
20 procedure in that it's -- you have to consent for it to
21 be switched on at the point of admission.

22 Q. So you say this at 22.10:

23 "A memo was issued with immediate effect stating
24 that Oxevision should only be switched on where the
25 patient consents. Where the patient lacks capacity to

1 consent, the decision to switch Oxevision on must be
2 considered by the MDT with consultation with the
3 patient's family and carers where appropriate. The
4 decision to switch Oxevision on must be clinically
5 justified."

6 Now, do you understand that potentially to be a move
7 to an opt-in model of consent for the use of Oxevision
8 at EPUT?

9 **A.** That's my understanding. The updated operational policy
10 wasn't at hand when I wrote this. This was the memo to
11 say that this was the planned way of working.

12 **Q.** And this is a change that was signalled at least in May
13 this year, correct?

14 **A.** Yes.

15 **Q.** But that would signal a potentially major change of
16 approach?

17 **A.** It would, yeah.

18 **Q.** I'd like to look now at the effectiveness of the consent
19 processes at EPUT, please. And I'm going to ask that
20 a document is put up for this, please.

21 Would you put up EPUT TIAA assurance review of
22 consent for Oxevision, that's EPUT020913, on the second
23 page, please.

24 Thank you, would you expand the left part of the
25 page as you had it there, please.

1 So this is the executive summary. Can we see at the
2 bottom:

3 "The overall objective was to provide assurance on
4 the effectiveness of the consent processes in place
5 within the Trust. This review focused on the
6 arrangements for consent for Oxevision."

7 So this is October 2025, and just to remind us all,
8 it's looking at consent processes at EPUT, yes?

9 **A.** Yes.

10 **Q.** And it's difficult to read, but the top, the circle
11 there, can we see going round the top, "Adequate and
12 effective governance risk and control processes" with
13 the conclusion there "Limited Assurance"?

14 **A.** Yes.

15 **Q.** Would you expand the top right-hand box "Key strategic
16 findings". So do we see here:

17 "The Trust has in place an Oxevision Standard
18 Operating Procedure ... which clearly outlines the
19 processes in place for obtaining consent for the use of
20 Oxevision, training requirements, and roles and
21 responsibilities clearly identified as part of the
22 process."

23 So that's the first point, isn't it?

24 **A.** Yes.

25 **Q.** Do we then see:

1 "Audit testing identified that for four of 10 staff,
2 the competency checklist was not evidenced as no
3 response was received from the relevant Ward Manager
4 within the timeframe of the audit."

5 And next:

6 "Testing of a sample of 17 patients across five
7 wards, in June and July, where Oxevision is in use,
8 identified significant exceptions, such as lack of
9 evidence of completed admissions checklist within
10 six hours of patient's admission for 21 patients."

11 And then:

12 "It was confirmed that at the time of audit
13 fieldwork, there was no oversight arrangements for
14 senior management/committee to regularly review data in
15 relation to consent for Oxevision. The implementation
16 plan for Oxevision did include steps to 'agree audit and
17 assurance plan', and to align Tendable audit to new
18 SOP."

19 So you address this at paragraph 22.9. What does
20 this, and the further information in it, indicate to you
21 in terms of consent processes at EPUT?

22 **A.** It highlighted that although the -- well, the policy
23 might have changed, practice hadn't, or it wasn't
24 compliant with the policy about gaining consent from
25 patients.

1 Q. So does this potentially go in part to that question of
2 informed consent that we were talking about before?

3 A. Yes.

4 Q. You say that -- this is 22.9:

5 "It also supports the concern that patients may have
6 had regarding Oxevision being active in their bedrooms
7 without timely evidence that they'd been properly
8 informed, had capacity to consent, and had given
9 meaningful consent."

10 Yes, correct?

11 A. Yes.

12 Q. Thank you.

13 Would you take that down, please.

14 You say in the report, this is paragraph 22.16
15 at page 78:

16 "I have not seen evidence that VBPMS directly
17 influenced individual patient care in a sytemic --
18 systematic or clearly documented way."

19 Referring to the data, you say:

20 "It does not in itself demonstrate that VBPMS
21 improved patient outcomes or informed clinical decision
22 making for individual patients."

23 Now, would you explain what you meant by that?

24 A. I didn't see -- from the evidence that I was provided
25 with, I didn't see where the Oxevision data influenced

1 patient care directly. So if you refer back to the 2025
2 guidance, it says it must impact treatment outcomes, and
3 I couldn't see the link from the technology actually
4 informing patient care, where the changes to care and
5 treatment were made based on the data from Oxevision.

6 Q. Thank you.

7 I want to move on to another topic, please, and this
8 is at Section 24 of your report, Oxevision data reports.

9 Now, you were provided with a number of Oxehealth
10 monthly usage reports for EPUT wards, correct?

11 A. Correct.

12 Q. And in fact we've looked at these monthly usage reports
13 with previous witnesses, including the equivalent
14 yesterday for another Trust. So we're familiar with the
15 layout and how they work in general terms. But were you
16 provided with usage reports for June 2024, June 2025,
17 and April 2026?

18 A. I was, yes.

19 Q. I want you -- what you then helpfully do in Section 24
20 of the report is, first of all, using that data,
21 consider some high-usage wards and then later look at
22 some low-usage wards. So can we work through that --

23 A. Yes.

24 Q. -- together, please.

25 Starting with the high-usage wards and I'm talking

1 about usage of the vital signs function.

2 Would you put up the report, please, at page 83 and
3 expand the table at the top.

4 So we can see a table here, refer to it if you need
5 to, we can see here a table of a number of different
6 wards but do we actually see three older adult -- one
7 adult acute -- two adult acutes and two older adult
8 wards there, yes?

9 **A.** Yes.

10 **Q.** You suggest in the report that the '24 and '25 data
11 raises significant privacy and dignity concerns. That's
12 24.4. Would you mind explaining what you meant by that?

13 **A.** The readings, the attempts, that's a lot of attempts in
14 a day per ward per bed, but the actual reading was less
15 than 50 per cent. So it would appear that a 15-second
16 clear view of that bedroom occurred but an actual
17 reading was taken in less than 50 per cent. So it would
18 bring into question what was the purpose of the view, if
19 it wasn't for a reading. And also, the high usage.
20 I couldn't understand why you would need to do an
21 attempt of vital signs that frequently per day.

22 **Q.** You say this:

23 "If each attempt involved a clear visual view into
24 the patient's bedroom then the level of visual access
25 may be considerably greater than patients understand

1 when the function is described as vital signs
2 monitoring."

3 Yes? Is that right?

4 **A.** Yes.

5 **Q.** And you add:

6 "The question is whether repeated unsuccessful
7 attempts are compatible with privacy, dignity,
8 meaningful consent and least restrictive practice. "

9 Yes?

10 **A.** Yes.

11 **Q.** You, at 24.6, you raise concerns particularly about the
12 Cherrydown Ward. We can see at the top of the list.
13 Would you just explain what your concerns were there?

14 **A.** Their usage of vital signs doubled in a year.

15 **Q.** Could you find any obvious clinical rationale for the
16 high amount of times that they were checking for vital
17 signs? 24.7 you cover this.

18 **A.** I've put in the report that they were checking on
19 average it was every 29 minutes per bedroom.

20 **Q.** Across a 24-hour period?

21 **A.** Across a 24-hour period per bedroom. I cannot identify
22 what clinical rationale there would be to do this level
23 of vital sign check.

24 **Q.** And you list, or you cover at 24.8, possible
25 explanations for this. But is one of them, for example,

1 that the vital signs function might be being used as
2 a substitute for observations and engagement?

3 **A.** Yes, that's a possibility.

4 **Q.** And is there also, as you say there, a theoretical risk
5 of inappropriate use?

6 **A.** Yes.

7 **Q.** Can we just talk about the 2026 data. You cover this
8 from 24.9, and you make the point that the high use of
9 the Oxevision vital signs function continued on three of
10 the wards although attempts were reduced slightly. But
11 is there any significant change in those wards between
12 the June '24 and the April '26 data that you've
13 considered?

14 **A.** There's not a significant change, apart from Gloucester
15 Ward. No, sorry, there's still -- there's no change.
16 It's reduced from 2024 but it hasn't significantly
17 reduced in the --

18 **Q.** Thank you.

19 Can you take that down, please.

20 Can we then to move low-usage wards. This is from
21 24.20. Do you identify three wards with significantly
22 lower usage of the vital signs function over the same
23 time periods?

24 **A.** I did, yes.

25 **Q.** And in these cases, does the April 2026 data, so the

1 last period of data that you have, show a significant
2 reduction in a vital signs test, equating to fewer than
3 two attempts per bed per day across all three wards?

4 **A.** Yes, that's is a significant -- you could argue that
5 that's more unexpected usage.

6 **Q.** So those wards were -- one was a forensic secure ward,
7 one was a young persons' ward and one was a low-secure
8 ward, correct?

9 **A.** Yes.

10 **Q.** You've given us one side of the data, the high-usage
11 wards, and we've talked very briefly about what might be
12 going on there. We're now looking at these low-usage
13 wards. Are you able to provide an explanation or
14 possible explanation for why the usage is so much lower
15 here?

16 **A.** Potentially it could be the patient population. The
17 low-secure forensic wards by nature of it are high-risk
18 patients. It could be that they're on high observation
19 levels so it's not required to do remote checking at
20 all, because there's somebody there. And particularly
21 with the young persons it might be, have more staff
22 availability and higher observation levels than older
23 adult only -- adult acute ward. They're just potential
24 reasons why.

25 **Q.** Understood.

1 You say this at 24.22, "The contrast" -- and I think
2 this is the contrast between the high- and the low-usage
3 wards:

4 "... therefore raises an important governance
5 question: why are some adult and older adult wards using
6 the vital signs function at substantially higher rates
7 than secure or young person services?"

8 And you add at 24.23:

9 "The variation between wards suggest that high usage
10 is unlikely to be an unavoidable feature of this
11 technology itself. It may instead reflect differences
12 in ward culture, training, clinical expectations,
13 staffing practice, or governance."

14 Is there anything more you'd like to say about that
15 point?

16 **A.** Yeah. On some wards it could just be the culture that
17 it's expected -- that it's not uncommon to frequently
18 access a patient's bedroom where on other wards the
19 governance might be more clear and training might be --
20 staff would be more trained and familiar on its purpose.
21 So there could just be a difference of --

22 **Q.** Culture?

23 **A.** -- culture.

24 **Q.** Thank you. Just moving now towards the end of the
25 report, where you reflect on potential benefits and

1 harms and you provide your reflections and conclusion.

2 Now, during the course of the evidence we've heard
3 and received so far from Oxehealth, or LIO, and EPUT,
4 we've been informed of a number of important claimed
5 benefits that Oxevision afford, and they include but are
6 not limited to: a suggestion of enhanced physical health
7 monitoring; also of time savings, allowing for staff
8 time to be freed up for patient engagement; and linked
9 with that, improvements in patient and staff experience,
10 in the context of allowing for a more therapeutic
11 approach; financial incentives; that the technology can
12 be less intrusive than a staff member coming into the
13 room and disturbing a patient, particularly at night;
14 that the system delivers reductions in the rates of
15 patient safety events; and the provision of video and
16 other data following an incident; and the provision of
17 reports of the type that we've just been discussing.

18 Now, we've discovered those points but the
19 suggestion in terms is that they add up to an important
20 tool to assist in looking after mental health
21 inpatients, keeping them safe, and maximising the
22 potential for properly therapeutic engagement.

23 Now, having considered all of this and having gone
24 through your evidence today, what do you say about that?

25 **A.** I welcome assistive technology. My experience of

1 Oxevision in practice is that for it to be effective,
2 you almost have to put Oxevision on observations. So
3 somebody is assigned to have that portable device that
4 would alert. So that member of staff has to respond to
5 those alerts. So my experience, it's not saved time.
6 It's added an extra layer of work on, but what it has
7 done is give us an insight into what is going on inside
8 patients' bedrooms when we're not there. That is what
9 it has given, but you've got to balance of is that
10 absolutely necessary?

11 **Q.** You say this at paragraph 31.2, it's page 99:

12 "However, I remain concerned that the introduction
13 of such technology into inpatient mental health settings
14 carries significant clinical, ethical and human rights
15 implications. A camera sensor or alert cannot
16 understand distress, hopelessness, shame, agitation,
17 elation, paranoia, trauma, responses or the meaning of
18 the patient's behaviour. It cannot determine whether
19 a patient is becoming more withdrawn, more frightened,
20 more suicidal, more suspicious, or more in need of
21 a human connection."

22 Now, the reference there to the technology carrying
23 significant clinical, ethical and human rights
24 implications, have we touched on those points during the
25 course of your evidence?

1 **A.** I believe so, yes.

2 **Q.** Is there anything more that you'd like to say about
3 that?

4 **A.** No.

5 **Q.** Could that then bring us on to Section 31 of the report
6 and your recommendations and we can see these set out
7 from page 100.

8 Before we go to them, these proceed on the
9 assumption that Oxevision remains in an inpatient unit,
10 don't they?

11 **A.** It does, yes.

12 **Q.** So before we get to that, do we need to bear in mind all
13 the points you've made, including the ones you've just
14 made, about your views on Oxevision, and all the points
15 you've just raised? Do we need to take those into
16 account on the question of whether Oxevision should be
17 there in the first place?

18 **A.** Yeah, and I still remain on the fence whether I think
19 Oxevision should remain on inpatients. I can see the
20 benefit of assisted technology, but not for all
21 patients. Like any intervention, it's not one thing
22 fits all. So I'm still on the fence that it's an 'all'
23 model but I can certainly see that it might benefit
24 some.

25 **Q.** Thank you. So just moving on to dealing with your

1 recommendations in turn. The first recommendation is:
2 use of Oxevision should be clinically justified,
3 appropriate, and consent based.

4 Would you explain what you mean, by that, please?

5 **A.** I think if there's a clinical rationale for it needing
6 to be used and the patient consents to it, then it can
7 be used, but it should be used with time limited, like
8 observations, because a patient's risk, clinical need
9 should change and it should change in line with that
10 patient travelling through their recovery. So it should
11 not be on from the point of admission to the point of
12 discharge. It might be just necessary for a period of
13 48 hours when somebody is in the most distress, and we
14 balance observation levels with the use of assisted
15 technology.

16 **Q.** Thank you. The second recommend is that:

17 "Staff access should be individually logged and
18 auditable."

19 Could you just cover that, please.

20 **A.** Yes, I believe it has moved to that staff log-in does
21 require to access a room. So that is absolutely, when
22 you're accessing patient's clinical record, there's
23 a data log of that and I think the same should apply for
24 accessing a patient's bedroom and it should be
25 communicated that it is only when absolutely necessary

1 would you view a bedroom. And when it is viewed it's
2 followed up by a discussion. Was it necessary? Was it
3 informative? And also, let the patient know that
4 they've just had their room viewed and what that
5 tells us.

6 **Q.** Thank you. The third recommendation:

7 "There should be clear national standards on the
8 minimum response to VBT and VBPMS alerts."

9 Would you just address that?

10 **A.** Yeah, having talked to colleagues and different
11 professionals in the field, there seems to be
12 a difference of what is good practice in response to
13 alert times. So some people assume the quicker the
14 response time, that was good practice, where the
15 delay -- so I think I touched on it in the report. So
16 a reset of three seconds would say, oh yes, you've been
17 alerted to that incident immediately, but it doesn't
18 actually evidence whether you've checked on the patient;
19 it could just be that you've just reset the button.

20 Or a check that went beyond the 15 seconds, that
21 could imply that somebody actually has gone physically
22 round and spoke -- reviewed the patient.

23 So depending on who you talk to, a better
24 understanding of what is the expected standard of alerts
25 set. And actually, do they mean anything?

1 **Q.** Thank you.

2 Your fourth recommendation is:

3 "Audits should include patient and family
4 experience."

5 Would you expand on that?

6 **A.** Yes, so when we audit observations and engagement and
7 the use of Oxevision, it should be capturing the
8 patient's and family's views. How was it for them? Did
9 they feel as though their observations were compliant?
10 Did the staff member come the number -- patients do tell
11 me "I'm on level 2 obs and nobody's been to check on
12 me". So that would be another source of: are those
13 engagements happening, not just from a professional's
14 point of view, but gathering from families and carers.

15 **Q.** Now, we may have covered most of the final
16 recommendation:

17 "Observations Engagement and VBPMS training should
18 be face-to-face and competency based."

19 We can read what you've set out there. Is there
20 anything more you'd like to say about that now?

21 **A.** No, I've got nothing more to add. I think I've just
22 stated because there's a lot of emphasis on the Nurse in
23 Charge ensuring that somebody's competent, and they're
24 juggling competing demands and it's a really, really
25 busy and challenging environment and I do believe that

1 the competency of those staff should lie with the higher
2 management.

3 **MR GRIFFIN:** Thank you.

4 Chair, do you have any questions for Ms Archibald at
5 this stage?

6 **THE CHAIR:** I don't, no.

7 **MR GRIFFIN:** So we're going to take a pause in a moment for
8 15 minutes.

9 When we come back, there will be some questions from
10 other lawyers representing some of the Inquiry's Core
11 Participants.

12 Chair, we'll hear from a maximum of four lawyers, as
13 I understand it. They've provided the Inquiry with
14 notice of the areas they wish to cover, and the Inquiry
15 has responded about those areas about which they are
16 permitted to cover. We require a short period of time
17 just to arrange things.

18 The lawyers will have a maximum of 15 minutes from
19 the moment they sit down at the table and Chair, your
20 instructions are that that must be enforced. There is
21 one lawyer who will -- who is dealing with the shorter
22 matters who will have five minutes in which to raise
23 those matters. And if necessary, there may be some more
24 questions from me, as well.

25 I will call advocates forward and they'll come to

1 the table here, but as I've said, we'll have a pause
2 before that happens.

3 Could we be back and starting again, please, at
4 3.55?

5 **THE CHAIR:** 3.55.

6 **(3.38 pm)**

7 **(A short break)**

8 **(3.55 pm)**

9 **THE CHAIR:** Mr Griffin.

10 **MR GRIFFIN:** Chair, we're now at the stage where we will be
11 hearing questions from recognised legal representatives
12 of Core Participants. I'm going to ask in each case
13 that when an advocate comes forward, before they ask
14 their questions, would they kindly introduce themselves
15 first.

16 **Questioned by MS SCOLDING KC**

17 **MS SCOLDING:** Good afternoon, Ms Archibald. My name is
18 Fiona Scolding King's Counsel, I'm asking questions on
19 behalf of LIO Limited, who, for today's purposes, I
20 shall refer to as Oxehealth.

21 I've been permitted to ask a few questions arising
22 from your report.

23 The first question I wanted to ask you, is about the
24 CQC and NHS England guidelines. I think I can see
25 extensive reference to them in your report. In your

1 professional opinion, do they set out an adequate set of
2 standards and balances for Trusts to consider and
3 reflect upon before deciding whether or not to use
4 vision-based monitoring systems?

5 **A.** I do, yes.

6 **Q.** And do you consider that that guidance is sufficient for
7 Trusts in order to start them down the road of
8 determining whether it would be appropriate to introduce
9 or not introduce the technology?

10 **A.** I do, yes.

11 **Q.** Thank you very much.

12 In respect of using technology to support
13 observations, and just to indicate, the position of
14 Oxehealth is not that it is a substitute for
15 observations, but it should only be used to support
16 physical observations by staff, do you agree that in
17 respect of pulse and respiration, the vital signs
18 observations, they are necessary for the vast majority
19 of patients who are in inpatient care, in particular
20 because of the drugs that most of them will be taking?

21 **A.** Sorry, can you rephrase the question? Sorry.

22 **Q.** Yes. The vast majority of patients in inpatient care
23 will be taking some form of drug or very often will be
24 taking some form of drug to try and help them with their
25 mental health condition. As a result of that, those

1 drugs may well have a sedative effect or other physical
2 side effects. Is it therefore necessary to take
3 somebody's pulse and respiration rate in order to ensure
4 that they are physically well whilst taking those sorts
5 of drugs?

6 **A.** They are two elements that are essential alongside other
7 physical health observations, yes.

8 **Q.** Thank you.

9 Do you consider that pulse and respiration taken
10 remotely can be of assistance in maintaining or keeping
11 some record of physical health or physical deterioration
12 over time?

13 **A.** I haven't seen evidence that the record of the vital
14 signs taken remotely, have actually been used directly
15 into the other set of physical observations that you
16 might want to take.

17 **Q.** But it could be, you just haven't seen evidence that it
18 has been?

19 **A.** In my understanding you would need to take it over
20 a longer period of time rather than the 15 seconds to
21 get an accurate reading. It could alert you to, or
22 not -- it could encourage you to go and do a full set of
23 physical observations.

24 **Q.** Okay.

25 And also, do you agree or accept that the technology

1 can be useful at night to take remote observations as
2 alongside a physical check, if necessary, for risk
3 assessment purposes?

4 **A.** It could be helpful during the nighttime.

5 **Q.** Right. Okay.

6 You say in your report at paragraph 12.17 that
7 staffing levels in available clinical time have not
8 increased in line with the need for additional
9 governance and accountability over observations. Are
10 you therefore saying that if this sort of technology is
11 to be implemented, there does need to be additional
12 time, as you suggested towards the end of your evidence,
13 that there would need to be a person who was responsible
14 for looking at the visual-based monitoring systems?

15 **A.** I think there needs to be a robust -- so within a shift
16 plan in the day -- who is checking that alert system,
17 and that it's not just solely reliant on somebody in
18 a room that might not be in the room.

19 So there needs to be some structure around --

20 **Q.** Somebody on the ward --

21 **A.** Yes -- (overspeaking) -- so that will be an additional
22 task assigned to a member of staff.

23 Some places will assign the person who is doing
24 level 1 observations to the portable device, for
25 example.

1 **Q.** Right.

2 Do you consider that Oxehealth/Oxevision can be
3 particularly useful in places such as seclusion, in
4 long-term segregation, or in health based places of
5 safety?

6 **A.** I can see their use in those areas, yeah, if it's not
7 safe to enter.

8 **Q.** Yes, and can you explain why they would be of particular
9 use in those areas?

10 **A.** It can offer some assurances that a patient is
11 breathing. If you are not able to get a full view of
12 the -- those areas, although they are designed for full
13 view, there are areas that might not give a full view
14 for the practitioner reviewing them.

15 **Q.** Yes. And in respect of seclusion, particularly patients
16 who may be in seclusion or long-term segregation there
17 may well be health -- or particular safety risks to
18 staff, less so with health-based places of safety, I
19 would envisage.

20 **A.** Yes, particularly in seclusion, the risk profile tends
21 to be risk to others.

22 **Q.** Yes, okay. You set out some very useful guidance within
23 your reports, within your report at paragraph 23.2 to
24 23.3 about who should be consulted in respect of consent
25 to Oxehealth. Do you agree that those individuals

1 should be consulted about all other aspects of
2 a patient's care? You talk about family members, loved
3 ones, other groups. And that it shouldn't just be -- it
4 shouldn't just be for vision-based monitoring systems
5 but there should be kind of a good process of engaging
6 with family members and wider kinship groups?

7 **A.** Yes.

8 **Q.** On all aspects of inpatient --

9 **A.** All aspects of care, it should be -- wherever possible,
10 you should be getting the views and the consent of
11 everybody involved.

12 **Q.** And so this is a more widespread issue throughout mental
13 health generally in terms of levels of consent or ways
14 in which family members are engaged; it's not just an
15 issue with vision-based monitoring; it's an issue with
16 the system as a whole. Is that right?

17 **A.** Yes, I would agree that it could be improved on.

18 **Q.** Okay. At sort of a Section 31 of your report you
19 summarise various conclusions which says -- in which you
20 say that technology can have a legitimate role in
21 supporting patient safety but it should only ever be
22 a supplementary tool to assist staff about movement,
23 room presence, deterioration, nighttime activity, and
24 potential risk, and it cannot replace human interaction
25 nor understand the meaning of and signs of different

1 emotional responses.

2 Is that your concluded view as to the usefulness of
3 the vision-based monitoring system, therefore: that it's
4 in addition to, not a replacement for?

5 **A.** Yes. I see it as an addition. I think, from having
6 gone through writing this report, preparing the report,
7 I think when it was implemented it's gone as a blanket
8 for everybody and I think that's where the error -- it
9 can be used but it has to be meaningful and specific to
10 individuals.

11 **Q.** Can you also identify that you -- you looked at a number
12 of case summaries, some of which involved the use of
13 Oxevision. Can you identify with any of those in any
14 way in which, whether there was any way in which it was
15 the technology that was problematic or it was the use of
16 the -- or was it rather the use of that technology, or
17 the misuse of that technology that was problematic?

18 **A.** I think it was the use and the misuse of the technology.

19 **MS SCOLDING:** Thank you very much, I have no further
20 questions.

21 **MR GRIFFIN:** Chair, we'll be hearing next from Ms Campbell.

22 May I ask that she comes forward.

23 **Questioned by MS CAMPBELL KC**

24 **MS CAMPBELL:** Thank you, and good afternoon, Ms Archibald.

25 My name is Brenda Campbell and the questions that I ask

1 are on behalf of the families of Christopher Nota, of
2 Edwige Nsilu, and Sophie Alderman, in fact the latter
3 two, you have considered their case summaries and their
4 families' evidence.

5 And I also represent Stop Oxevision, whose work you
6 have considered in the preparation of your report.

7 Many of my questions are premised on your first
8 recommendation and we looked at it just a little while
9 ago. It's at page 100 of your report, and I don't need
10 it on screen unless it would be helpful to you but it
11 says that:

12 "The use of Oxevision should be clinically
13 justified, appropriate, and consent-based. Oxevision
14 should only be used where there is a clearly documented
15 individualised clinical rationale, and where its use is
16 proportionate to the identified risks."

17 I might just focus in initially on the issue of
18 consent-based, if I may. As to obtaining that informed
19 consent, have you, in your research or preparation, seen
20 any data or research demonstrating what proportion of
21 patients would actually consent to being monitored by
22 Oxevision if they were fully informed as to how the
23 technology works?

24 **A.** The only information that I've reviewed was the audit on
25 the consent base, which didn't highlight that it was

1 routinely been -- so the standard was that consent would
2 be sought at the beginning of an admission within
3 a timeframe. The audit data that I've seen didn't show
4 compliance with that.

5 **Q.** With that protocol --

6 **A.** Yes.

7 **Q.** -- or with that process? The Inquiry heard evidence, in
8 fact yesterday, that where an informed opt-in consent
9 model was adopted by Leicestershire Partnership Trust,
10 fewer than half of the patients were willing to consent
11 to the use of Oxevision in their bedrooms and some of
12 those who did consent later withdrew that consent when
13 they became aware that the system included cameras that
14 were recording. Does that surprise you?

15 **A.** No, that doesn't surprise me.

16 **Q.** We also -- well, perhaps I can ask you, why not?

17 **A.** I think, when patients realise that it can record them
18 over 24 hours, that that might raise concerns for them.
19 So initially they would say, "I don't want it on."

20 As they progress through their care, that might --
21 they might reconsider that. But it does not surprise
22 me. I think when they're fully informed, that they
23 might be a bit sceptical of what it can offer so they
24 would rather not go with it rather than go with it.

25 **Q.** We looked at, yesterday also, a further Leicestershire

1 Partnership Trust report which contained an account of
2 an incident in which a pregnant patient -- I think, in
3 fact, you've discussed this briefly this afternoon --
4 a pregnant patient had initially consented to Oxevision
5 but subsequently withdrew that consent, sleeping in an
6 interview room rather than in the bedroom with the
7 Oxevision system installed.

8 And this afternoon you've told us that one
9 significant consequence of having Oxevision installed on
10 a blanket basis in wards is that it can cause that
11 element of distress to patients who refuse consent to
12 having it in their room. And you have experience of
13 that; isn't that right?

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

15 **Q.** Now, another consequence of that, however, is also
16 related difficulties for staff trying to resolve that
17 distress, or make practical changes to keep that patient
18 safe in an alternative environment. How significant is
19 that consequence, the other side of that?

20 **A.** It can be quite significant consequence in that when --
21 it can lead to patients not trusting us, but equally,
22 some patients report that they feel that we don't trust
23 them either. So it's -- and that's why we're using this
24 remote monitoring to monitor their behaviour. So it
25 works on both parts.

1 **Q.** Does it, conversely, also materialise that having
2 Oxevision enabled in some rooms but not others is liable
3 to cause inefficiencies for staff running perhaps two
4 parallel approaches in relation to different patients in
5 different bedrooms?

6 **A.** It might make, if not all patients have Oxevision
7 switched on, the patients who do that have it on, it
8 might actually make the staff who are monitoring that
9 system more alert because of the -- where when it was
10 a blanket ban, it became possibly less meaningful to the
11 staff who were monitoring the system. So if -- and if
12 it's switched on for patients who agree and then there's
13 a specific purpose to it and a known risk, it might make
14 the professional more alerted to the alert as such.

15 **Q.** That may be an optimistic or a hopeful outcome, but
16 does it also give rise to a risk, again on the flipside
17 of that coin, of perhaps failures in handover or
18 failures in communication, or recordkeeping, resulting
19 in misunderstandings because checks have been missed on
20 Oxevision where it's believed they have been done?

21 **A.** Yes, I suppose it does, and there's also a risk that if
22 patients' bedrooms move that the device doesn't get
23 switched off in line with the patient moving so there
24 would have to be robust systems in place to make sure
25 that Oxevision is meaningful to that patient that is

1 switched on. Because patients do move bedrooms quite
2 frequently on inpatient wards so it's just being mindful
3 of that.

4 **Q.** Now, you've been asked a number of questions about
5 clinical justifications over benefits, and you've
6 observed, in relation to nighttime checks, I think your
7 evidence this afternoon was possibly there could be
8 benefits through the night, so that you're not
9 interrupting sleep by way of example. I want to ask you
10 a few questions about that.

11 An August 2020 Early Insights Report, which we
12 understand was prepared jointly by EPUT and Oxehealth,
13 repeatedly characterises remote observations as less
14 restrictive than in-person observations, particularly at
15 night.

16 Now, do you accept that a measure that might be
17 thought less physically intrusive can simultaneously
18 constitute a much greater infringement on a patient's
19 privacy?

20 **A.** Yes, I do.

21 **Q.** And you've observed, in fact, in answer to a question
22 from Mr Griffin this afternoon that for some patients,
23 nighttime is a particularly difficult time, when they
24 might need an additional degree of support for the
25 reasons that you've outlined. Does it follow that

1 withdrawing regular nighttime physical checks that
2 provide a level of in-person reassurance and replacing
3 them with remote observation or surveillance, far from
4 being clinically justified to promote sleep, might in
5 fact be clinically detrimental for some patients?

6 **A.** It could be. That's why it would have to be
7 individually tailored, whether it would be appropriate
8 for each patient to do remote checks.

9 **Q.** And it comes back to your evidence about it very much
10 a patient-centred case -- (overspeaking) --

11 **A.** -- (overspeaking) --

12 **Q.** -- basis. You mentioned in your evidence this morning
13 about nighttime ward environment and about other noises
14 and you talked about heavy doors or other patients or
15 alarms going off. To what extent has this source of
16 sleep disturbance on wards been measured? So, in other
17 words, are observations more likely to keep a patient
18 awake at night than other environmental noise such as
19 staff talking or heavy doors or alarms going off?

20 **A.** To my knowledge, I don't know, I know there's been
21 research done on sleep on mental health inpatient wards,
22 and I think there's a number of factors that keep
23 patients awake and it's not just on -- it's not just
24 observations but it is other noise factors. And
25 environmental factors as well.

1 **Q.** Yes, because wards can be busy and noisy places even
2 during the night?

3 **A.** They can, and the mattresses aren't particularly
4 comfortable. The bedding is not particularly
5 comfortable. So there's -- lighting isn't particularly
6 comfortable so there's lots of factors that can affect a
7 patient's sleep.

8 **Q.** I want to move on to ask you about another recollection
9 given by EPUT staff in the Early Insights Report and
10 it's under the heading "Improving privacy for vulnerable
11 persons" and a member of staff is quoted as saying:

12 "Many of our patients have histories of sexual
13 abuse. When we have male staff on observations they
14 need to enter the ladies' bedrooms at night to check on
15 them. For these ladies it can be very triggering waking
16 up confused and seeing a man in their bedroom. For a
17 moment they forget where they are and it's very
18 disturbing for them but now we use Oxehealth to observe
19 them overnight discreetly and remotely, which we really
20 like and which we know benefits the patients."

21 In thinking about that as an example, do you agree
22 that a female patient being monitored remotely and
23 observed in her bedroom at night by a male member of
24 staff is hardly better than a staff member going into
25 her bedroom to check on her?

1 **A.** I would see it more distressing to be observed remotely
2 because you're not aware of when and how frequent it's
3 happening, where in the room you're aware.

4 **Q.** Well, that in fact deals with, to some extent, my next
5 question. At least with a physical check a female
6 patient would be aware --

7 **A.** And you can raise -- (overspeaking) -- and it empowers
8 the patient to raise an objection.

9 **Q.** I want to ask a few questions about the potential
10 benefits of collecting of vital signs using the
11 technology during the night.

12 We heard yesterday from Mr Patino from LPT about
13 their experience of piloting Oxevision on their wards.
14 Are you aware that one of the reasons LPT ultimately
15 terminated the contract with Oxevision following the
16 conclusion of their pilots last year was that the staff
17 reported that the system frequently failed to collect
18 vital signs during the night, rendering in-person
19 nighttime checks necessary in any event?

20 **A.** I wasn't aware of that.

21 **Q.** Well, does it surprise you?

22 **A.** No. When I've looked at the vital signs attempts but
23 the actual readings, the reading is below 50 per cent
24 but I wasn't able to interpret why it was less than
25 50 per cent. I made the assumption that the patient

1 just wasn't sitting still or the areas were covered.
2 I didn't know what the rationale was for that.

3 **Q.** And in fact in your evidence today you've told us of an
4 additional degree of danger that comes from perhaps
5 assumptions like that being made by staff, that the
6 system is failing to collect vital signs, and the danger
7 could be that the failure to collect vital signs is in
8 itself being misinterpreted and there's a much more
9 significant risk in the room to that patient at that
10 time?

11 **A.** I don't know enough about it to say why it couldn't get
12 vital sign readings so I don't feel as though I'm fully
13 able to comment.

14 **Q.** But do those failures to get readings in the data that
15 you have considered raise further questions about the
16 purported clinical justification of collecting vital
17 signs during nighttime observations?

18 **A.** There's also an assumption that people are present for
19 vital signs but the patient might not be in the room.
20 So it might be inappropriate use from staff attempting
21 to get vital signs.

22 **Q.** Okay.

23 **MR GRIFFIN:** Can I just indicate --

24 **MS CAMPBELL:** And my final question.

25 **MR GRIFFIN:** Oh, perfect, sorry to have interrupted.

1 **MS CAMPBELL:** My final question is this: in circumstances
2 where we understand that Oxehealth charges a flat
3 licensing fee per ward, regardless of whether the system
4 is switched on or even installed in rooms, and of course
5 that is ultimately paid from the public purse, would you
6 agree that consideration, perhaps serious consideration,
7 should be given as to whether the financial outlay for
8 the system is justified?

9 **A.** Yes, well, I think individual Trusts would need to
10 answer if it's financially justified in their service
11 and if they're seeing the benefit from it.

12 **MS CAMPBELL:** Thank you. Those are all my questions.

13 **MR GRIFFIN:** Chair, we'll next hear questions from
14 Ms Bartlam. May I ask that she comes forward.

15 **Questioned by MS BARTLAM**

16 **MS BARTLAM:** Good afternoon, Ms Archibald. My name is
17 Chiara Bartlam and I ask questions on behalf of the
18 charity INQUEST. I just have two short questions on
19 Oxevision.

20 The first relates to the appropriate use of it. And
21 a couple of weeks ago now, the Inquiry heard evidence
22 from a person called Ian Arthur. Now, he was the Matron
23 on the Peter Bruff Unit when Oxevision was piloted in
24 2020 and helped to produce the first Standard Operating
25 Procedure.

1 Mr Arthur explained that Oxevision could be used as
2 an observation tool, that could help staff to provide
3 a less intrusive intervention to somebody who might
4 otherwise need to be observed constantly. And the
5 question is this: should Oxevision be used for this
6 purpose, in your view?

7 **A.** No.

8 **Q.** And can I ask why?

9 **A.** I -- it does not take away the human factors that
10 a professional or mental health nurse needs to be able
11 to engage the patient to make an informed decision about
12 their care and treatment and vice versa. So it should
13 not replace.

14 **Q.** And my second question is on that informed decision, and
15 the patient's informed consent. You've explained to the
16 Inquiry that in your view, patients should be told that
17 Oxevision is recording 24/7. In your view, should
18 patients also be told about the risk of staff misuse and
19 any limits on the available measures to prevent that
20 from happening?

21 **A.** I think patients should be informed of what staff have
22 access to and what they do with that information, and
23 patients should be informed of how frequent that the
24 camera is accessed.

25 **MS BARTLAM:** Thank you. I don't have any other questions.

1 Thank you, Chair.

2 **MR GRIFFIN:** And the last advocate we will hear questions
3 from today is Ms Misra. May I ask that she comes
4 forward.

5 **Questioned by MS MISRA KC**

6 **MS MISRA:** Good afternoon, Ms Archibald. My name is Eleena
7 Misra and I'm leading counsel instructed by Hodge Jones
8 & Allen which represents a number of bereaved families
9 and lived experience clients.

10 So thank you very much for confirming earlier today
11 that in preparing your report you reviewed the documents
12 provided by the Inquiry, which included family
13 statements, some of which related to our clients, and
14 case summaries. I'm going to ask you some questions by
15 way of clarification of your report, if I may, but
16 I have very clearly in mind what your Terms of Reference
17 were.

18 I hope with the benefit of having read the material
19 provided by the Inquiry, you may be able to assist
20 a little further, and no doubt you'll be pleased to know
21 that I think I am the last to be questioning you at the
22 end of what is a long day, no doubt.

23 So if I could start, first of all, with page 12,
24 paragraph 4.1 of your report, where you say that:

25 "Prior to 2000 there was little guidance for

1 observations practices in mental health settings."

2 And you go on, very helpfully, through to about
3 paragraph 4.10, to cite a chronology for policies and
4 procedures as they then developed.

5 Ms Archibald, I wonder if I could ask you, in your
6 opinion, how effective were any of these in providing
7 sufficient guidance on observations?

8 **A.** I think they were effective. It definitely --
9 I witnessed changes on the ground of how we thought
10 about observations and engagement and the governance
11 became more robust. It definitely influenced -- we
12 became more trauma-informed in our way of the practice.
13 So I do think it significantly influenced practice.

14 **Q.** And going back to your evidence this afternoon, is that
15 because of the emphasis on the therapeutic engagement
16 side of it?

17 **A.** Yes, yeah.

18 **Q.** Thank you.

19 So remaining at page 12 of your report, I'm now at
20 paragraph 3.3, where you say that:

21 "When supported observations are delivered
22 effectively, they can improve safety of care."

23 Now, based on your review of the evidence which has
24 been made available to you by the Inquiry and where
25 necessary, contrasting with your professional experience

1 in Cumbria, are you able to say whether this was
2 happening across the Essex Trusts in the index period
3 2000 to 2023?

4 **A.** I've only been given evidence of where things haven't
5 gone to plan, or where sadly people have died. I am
6 sure that there was people who -- patients who received
7 care in Essex Trusts who observations did help them. So
8 the information I have was based on people who had died,
9 unfortunately.

10 I'm sorry, I don't know if that's answered --

11 **Q.** So from your perspective it's a snapshot --

12 **A.** Yeah, it's a snapshot. I'm assuming that they have lots
13 of patients in their care who observations did benefit.

14 **Q.** Thank you.

15 So I'm now going to move on to page 16 of your
16 report and it's paragraphs 5.1 to 5.24, in which you
17 deal with the defined levels of observations and
18 engagement. And in particular, at paragraph 5.1, you
19 refer to the NICE guidelines and the ETOC guidance. And
20 you say:

21 "The guidance emphasises that observation is a
22 therapeutic intervention and should not be undertaken as
23 a passive or purely observational task."

24 So again, based on your review of the case summaries
25 and other underlying materials and documents you were

1 provided with, do you consider that that guidance was
2 followed in the cases concerned, and if so, to what
3 extent? Just as a general impression.

4 **A.** No, it does not appear that the guidance was followed in
5 the majority of the cases. Sometimes the observation --
6 I couldn't see evidence of the engagement, but in some
7 cases the observations didn't occur.

8 **Q.** Thank you very much.

9 Are you able to say, from what you've seen, which
10 factors played or may have played a role in not
11 following the guidance?

12 **A.** It seems staffing, training, experience, all played
13 a factor. Culture.

14 **Q.** Thank you very much.

15 So, moving on now to page 22 of your report, and I'm
16 going to paragraph 6, if I may, you say there that:

17 "Physical health monitoring is an essential part of
18 holistic assessment for all patients admitted to mental
19 health wards."

20 In the evidence which you've reviewed in preparing
21 your report, did you see any evidence of holistic
22 assessments being carried out?

23 **A.** Yes, I've seen there was cases where physical health
24 monitoring had taken place, and there was some elements
25 of holistic care, but not completely. And as I say,

1 I've seen cases where the outcome was deaths. I've not
2 seen the other side of the care that was given.

3 **Q.** Thank you very much indeed.

4 So turning now to page 33, paragraph 11.3, of your
5 report. You state there that:

6 "Capacity and consent should always be considered
7 when determining and implementing observation levels."

8 And you go on in that same paragraph to explain
9 that:

10 "Valid consent should be informed and voluntary with
11 patients receiving a clear explanation regarding the
12 purpose and nature of the observations."

13 Again, in your review of the illustrative cases in
14 Essex with which you were provided, was there any
15 evidence that this was considered and implemented?

16 **A.** There was cases where there was informal voluntary
17 patients on enhanced observation levels, and I took it
18 that the patients had consented to those observation
19 levels. The evidence didn't suggest that they were
20 objecting to them. I did see cases where patients were
21 admitted informally and then later on in their treatment
22 became detained and observation levels were increased.
23 So I seen -- but the case summaries didn't specifically
24 refer to whether the patient consented or not to the
25 observation levels.

1 **Q.** Thank you very much.

2 For my next question, I'm going to refer to a couple
3 of paragraphs that you've included in your report, and
4 if it's helpful I can summarise them but I'll put them
5 to you and then go to the question and please do let me
6 know if it will be helpful for me to either take you to
7 them or summarise.

8 So in particular it's paragraphs 8.1, 12.7 and 12.15
9 of your report. And my question is really this: is the
10 efficacy of observations in terms of a safety net for
11 patients who are under the care of the Trust
12 inextricably connected with the accuracy, timeliness,
13 and appropriateness of care plans and risk assessments?
14 Do the two go hand in glove?

15 **A.** They should do, yes.

16 **Q.** Can I ask you in your own practice how often do you feel
17 that observations have been adversely affected by the
18 lack of appropriate care plans or risk investments or
19 the documentation of them?

20 **A.** Yes, there's serious consequences if there's a lack of
21 care planning or adherence to the care plan.

22 **Q.** Did you find any evidence of this in the materials you
23 reviewed for the report to the extent that you can
24 recall specific cases?

25 **A.** I didn't see any evidence to suggest that the care plans

1 were collaborative. There might have been care plans,
2 I just didn't see them. But in the case of -- I think
3 it was Elise, the care plan wasn't followed when she
4 went back to her room. So I've seen non-compliance with
5 the care plan, but I haven't seen the details of the
6 individuals and their care plan.

7 **Q.** Thank you. Was that the case of Elise Sebastian you're
8 referring to there?

9 **A.** Yes.

10 **Q.** Thank you.

11 Moving on to a different area and perhaps one of the
12 knotty issues -- I know you said earlier that it's
13 sometimes quite difficult to achieve the right balance,
14 but how is the tension between using the least intrusive
15 method possible and dealing with the increased risk of
16 harm or death resolved, in your opinion, and is it
17 really a proportionality question?

18 **A.** I don't know. That's a big question.

19 **Q.** It is a big question. I think you earlier expressed it
20 was difficult.

21 If I can put it this way: what, in your professional
22 expertise and opinion, what is the best way to balance
23 those factors if it is simply a balancing of factors, to
24 arrive at the right course of action, as it were?

25 **A.** You want to be the least restrictive in all cases, and

1 it might be when you do a restrictive practice that's
2 where it's time limited. It is a balance of that
3 interpersonal relationship with the person that you
4 you're caring for. It could be the treatment plan that
5 the patient, the effectiveness of the treatment plan,
6 and alongside that it could be the observation levels to
7 meet that patient's needs and it has to be done at the
8 right time by the right people with the right skills to
9 do that.

10 A combination of all those, a good understanding of
11 the patient formulation, knowing who the patient is,
12 what they're about, who they are, collaborating with
13 families, developing a treatment plan, and adapting
14 observation levels in accordance with need. Somebody
15 might be having a difficult day followed by a good day,
16 and that's when it should fluctuate. But you should be
17 prepared for things not going to plan, as well, at all
18 times. There's a reason why people are in hospital, so
19 you have to be prepared for deterioration -- rapid
20 deterioration in some cases.

21 **Q.** Does this go back to your point to the Inquiry earlier
22 that really this is best achieved by a case-by-case
23 basis?

24 **A.** It is, yeah.

25 **Q.** Thank you.

1 And finally, page 99 of your report from about
2 paragraph 31.1 onwards in the reflections and
3 conclusions section. You say, and this chimes with what
4 you said in your evidence a little bit earlier:

5 "Technology can have a legitimate role in supporting
6 patient safety ..."

7 But you have of course in your report identified
8 concerns and you've also identified in the course of
9 your extensive evidence today concerns that you hold, as
10 well.

11 Can you say whether, in any of the illustrative case
12 summaries with which you were provided with the Inquiry,
13 the use of Oxevision technology led to improved care for
14 any of the patients?

15 **A.** I can't -- I don't believe I can see the direct link
16 from improving their care.

17 **MS MISRA:** Thank you very much for your time, Ms Archibald.

18 Those are my questions and I believe that I'm within my
19 time, as well. Thank you.

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

21 Chair, I have no further questions for Ms Archibald.

22 Do you have any further questions at this stage?

23 **THE CHAIR:** I don't.

24 **MR GRIFFIN:** Ms Archibald, that is the end of all of our
25 questions for you. May I personally thank you both for

1 your report and for your evidence today.

2 **THE CHAIR:** I would like to reiterate those thanks. We have
3 worked you very hard but it has been extremely helpful,
4 both your report and your evidence today. So thank you.

5 **THE WITNESS:** Thank you.

6 **THE CHAIR:** Tomorrow?

7 **MR GRIFFIN:** Thank you very much. Tomorrow we resume at
8 10.00 am where we will be hearing from a further expert
9 witness, in fact two witnesses giving evidence
10 simultaneously. Thank you, Chair.

11 **(4.33 pm)**

12 **(The hearing adjourned until 10.00 am the following day)**

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I N D E X

JILL ARCHIBALD (affirmed)2

 Questioned by MR GRIFFIN KC2

 Questioned by MS SCOLDING KC167

 Questioned by MS CAMPBELL KC173

 Questioned by MS BARTLAM183

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