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

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

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

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

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

JILL ARCHIBALD (affirmed)

Questioned by MR GRIFFIN KC

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

A. Yes. Jill Veronica Archibald.

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

A. Yes.

Q. Do you have it in front of you?

A. I do.

Q. Is it dated 1 July 2026?

A. It is.

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

A. It is.

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

A. There is.

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

A. Yeah, it should.

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

A. Yes.

Q. Should that actually be "not"?

A. Yes, that's correct.

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

A. Yeah.

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

A. Yes, that's correct.

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

A. Yes, that's correct.

Q. Thank you.

If we look at the bottom of page 101, does the report include your confirmation that you've made clear where facts and matters referred to are or are not within your own knowledge, at that where they are within your own knowledge, you confirm them to be true, and finally, that the opinions you've expressed represent your true and complete professional opinions on the matters to which they refer?

A. *(The witness nodded)*.

Q. Is that correct?

A. That's correct.

Q. And do you again confirm that today?

A. I do.

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

"In preparing this report, I have sought to provide objective, balanced and impartial evidence to assist the Inquiry on the matters within my area of expertise."

Again, is that correct?

A. That's correct.

Q. Have you signed the report?

A. I have.

Q. And subject to the corrections that you've just notified, is it true and accurate to the best of your knowledge and belief?

A. It is.

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

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

A. Yes.

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

Are you a Registered Mental Health Nurse or RMN?

A. I am.

Q. When did you qualify as an RMN?

A. 2006.

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

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

Q. And what does that entail?

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

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

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

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

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

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

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

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

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

A. Yes, 2019.

Q. And what is a Consultant Nurse?

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

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

A. *(The witness nodded)*.

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

A. Mm-hm.

Q. Is that sometimes abbreviated to RC/AC?

A. It is, yeah.

Q. Can we use that if we need to?

A. Yeah.

Q. What does an RC/AC do?

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

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

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

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

A. Yes.

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

A. Yeah, that's correct.

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

A. Yes.

Q. And mental health law in 2022?

A. Yes.

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

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

Q. So human rights principles --

A. Yes.

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

A. It was, yes.

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

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

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

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

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

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

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

Q. What's the non-medical element?

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

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

A. I'm able to prescribe.

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

A. Yes.

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

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

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

A. That's correct.

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

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

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

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

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

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

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

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

A. Yeah.

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

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

Q. Thank you very much.

Would you take that down, please.

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

A. I have, yes.

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

A. I did, yes.

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

A. I have been, yes.

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

Now, we have been using the acronym VBPMS, which is

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

A. It is.

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

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

Q. And how are you familiar with VBPMS? And this is paragraph 1.10.

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

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

A. I am, yes.

Q. Thank you.

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

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

And does the report cover those matters?

A. Yes.

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

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

A. It has.

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

A. *(The witness nodded)*.

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

A. It has.

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

A. *(The witness nodded)*.

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

A. Mm-hm.

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

A. Yeah, yeah.

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

A. I have.

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

A. I have.

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

A. *(The witness nodded)*.

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

A. *(The witness nodded)*.

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

A. I have, yes.

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

A. *(The witness nodded)*.

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

A. *(The witness nodded)*.

Q. Do you refer to all of them in your report?
A. I do.
Q. What information did you consider in relation to those deaths, please?
A. I considered the case summaries supplied by the Inquiry, the family statements, and the investigation from EPUT, and the coroner's information.
Q. So one of the questions I have is just for absolute clarity, is this: did you read the family statements prepared by the bereaved families or have you relied solely on the case summaries?
A. I read the family statements.
Q. Could we move, then, to our first topic. This is observations and engagement, and it's Section 3 of your report. Can I start by asking you what observations are in this context, please?
A. Yes. Observations is a formal approach to how often somebody should be observed. So there's lots of observations in a patient's daily life on a ward but this is a more formal approach and identified level of what's required, based on risk and need.
Q. And is -- is it an intervention of varying intensity?
A. The observation is an observation. That's -- the observation level will determine the frequency of when somebody should be observed, and then it's the

engagement that details more intervention.

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

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

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

A. That is correct, yeah.

Q. Thank you.

Why are observations and engagement considered together?

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

Q. So they're both essential elements?

A. They're both essential, yeah.

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

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

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

THE CHAIR: Thank you.

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

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

A. *(The witness nodded)*.

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

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

A. Yes, yeah.

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

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

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

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

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

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

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

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

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

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

A. Yes.

Q. Could we just see the next sentence says:

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

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

A. Yes.

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

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

And then at the bottom:

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

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

A. Yes, I would agree with the statement.

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

time?

A. Yes, in clinical practice it has evolved quite a bit. I think it was initially more about the observation, keeping an eye on somebody, checking where they are. But as we've learnt more, such as about trauma-informed care and managing risk, and what is helpful to a patient, it's become much more of an engagement tool. Just to point out, every patient on a ward should be engaged regardless, there should be an engagement plan, but for some patients they do need a more prescribed, more frequent engagement plan because their need at that time requires that.

So over the 23, 24 years, we've become much more patient centred and more mindful of the impact that those observations have, and that's why they are -- they should be time limited because they also come with, you know, it can be intrusive in somebody's -- in somebody's care. So that's why it should be really focused, it should be time-framed, it should be reviewed and it should be meaningful.

Q. And so just to pick up on what you've said, towards the start of the period that we're considering, the approach would have been quite different, potentially, with much more of a focus on the observation side and, as I've understood your evidence, as we go on through the period

of time, the engagement element becomes more important?

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

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

A. Yeah.

Q. Could you take that down, please.

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

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

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

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

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

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

What is constant observation?

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

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

A. It does.

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

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

A. It does, yeah.

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

A. Yes, it would.

Q. Can you take that down, please.

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

A. *(The witness nodded)*.

Q. Is that right?

A. That's right, yeah.

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

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

staff unfamiliar with the ward environment or patient group."

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

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

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

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

Do we see here:

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

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

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

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

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

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

A. Yes, yeah.

Q. Can you take that down, please.

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

of it, please.

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

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

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

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

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

considered as restrictive later on.

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

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

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

A. It does.

Q. You say this at paragraph 4.4:

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

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

A. It is.

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

Would you put up online source 2, please.

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

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

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

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

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

Can we see in the next paragraph:

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

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

inpatient setting?

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

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

Q. Thank you.

Would you take that down, please.

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

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

person centred, family/carer led.

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

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

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

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

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

A. Yeah.

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

A. Yes.

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

A. It did, yeah.

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

A. It's Enhanced Therapeutic Observation and Care.

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

A. Yes. That's my understanding.

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

paragraphs 4.10 onwards?

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

MR GRIFFIN: Thank you very much.

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

THE CHAIR: 11.10.

MR GRIFFIN: Thank you.

(10.57 am)

(A short break)

(11.12 am)

THE CHAIR: Mr Griffin.

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

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

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

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

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

A. Yes, that's my understanding.

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

A. Yes.

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

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

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

You say in the report that:

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

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

A. Yes.

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

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

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

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

A. My understanding is that the observation levels remain

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

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

A. Yes.

Q. Thank you.

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

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

Is that correct?

A. That is correct, yeah.

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

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

Q. Do we then see:

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

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

A. It is, yeah.

Q. Then do we move on to continuous observation. Now, we've already seen reference to this:

"... usually used when a service user presents an immediate threat and needs to be kept within eyesight or at arm's length of a designated one-to-one staff member, with immediate access to other members of staff if needed."

Is that what is sometimes referred to as level 3?

A. It is.

Q. And then level 4:

"Multi-professional" -- sorry, I said level 4, I will come back to ask you whether that is correct.

A. Yes.

Q. The fourth bullet point:

"multi-professional continuous observation: usually used when a service user is at the highest risk of harming themselves or others and needs to be kept within eyesight of 2 or 3 staff members and at arm's length of at least 1 staff member."

Now, does that equate to what is sometimes referred to as level 4?

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

Q. Thank you.

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

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

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

Is that correct?

A. That, is, yes.

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

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

Q. What, so the same time every hour?

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

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

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

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

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

Q. You were talking about predictability or unpredictability.

A. Yeah.

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

A. Yes.

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

A. Yes.

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

A. Yes.

Q. What's the purpose of that?

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

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

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

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

A. It does.

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

under observation in 2015?

A. They did.

Q. Could you put up online source 4, please, at page 3. And expand the left-hand column from "Key findings".

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

"There were an average of 18 suicides by inpatients under observation per year in the UK over a 7-year study period. 91 per cent of deaths under observation occurred under level 2 (intermittent) observation."

Is that a surprising statistic?

A. No, it's not surprising. You've got to take into consideration, as well, the amount of people -- patients who would have been on level 2 who didn't go on to complete the suicides. So, no, that does not surprise me.

Q. Dropping down, we can see:

"Deaths under observation tended to occur when policies or procedures, including times between observations were not followed. For example, when staff are distracted by other events on the ward; at busy periods, for example 7-9 am; when there are staff shortages; when ward design impedes observation".

Would you agree with that?

A. I would agree.

Q. Then it says:

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

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

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

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

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

A. It does.

Q. And do we see:

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

resources."

Is that something that you've been aware of?

A. Sorry, could you repeat the question?

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

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

Q. Thank you.

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

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

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

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

Q. Thank you.

Would you take that down, please.

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

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

So you say:

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

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

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

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

A. That's correct, yes.

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

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

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

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

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

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

How would one have tried to address that?

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

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

THE CHAIR: Earlier in your evidence you made reference to

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

A. Yes.

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

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

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

A. That's what you should see.

Q. That's what you should see?

A. Yes.

Q. Thank you.

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

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

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

Q. You say in the report:

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

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

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

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

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

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

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

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

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

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

A. Level 4.

Q. Thank you.

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

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

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

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

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

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

A. *(The witness nodded)*.

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

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

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

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

Q. Thank you.

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

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

A. Yes, they are.

Q. Why is that?

A. Why is that?

Q. Yes, why is that, please?

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

Q. Thank you very much.

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

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

Is that correct?

A. Yes.

Q. You add that:

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

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

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

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

A. Yes.

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

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

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

A. It's part, yeah.

Q. -- the complete picture?

A. Yeah, thank you.

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

A. No.

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

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

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

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

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

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

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

Q. Thank you.

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

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

influence when -- how the observations should be applied.

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

A. Oh sorry, yes. Sorry.

Q. What's a dynamic observation?

A. Dynamic?

Q. 8.1 for those --

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

Q. You say in the report:

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

Is that right?

A. Yeah.

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

You note that -- and this is paragraph 8.3:

"When Elise was alone or experiencing periods of

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

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

A. It is, yeah.

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

A. I have, yes.

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

Thank you.

So this is what this says:

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

You say in the report that:

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

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

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

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

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

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

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

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

A. Yes, correct, yeah.

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

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

Q. You say --

A. -- (overspeaking) -- confusion.

Q. -- this at paragraph 8.7:

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

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

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

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

A. No, no.

Q. Can you take that down, please.

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

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

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

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

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

A. Yeah.

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

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

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

Is this one of the reports you were involved in?

A. Yes.

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

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

and the availability of cutlery."

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

A. Yes.

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

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

Would you agree with that?

A. Yes.

Q. Thank you.

Could you take that down.

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

A. Yes.

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

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

And we see 14.11. Could that be expanded, please. Thank you.

I just want to read this, please:

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

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

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

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

A. Yeah.

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

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

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

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

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

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

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

A. Yes.

Q. -- in the old environment?

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

Q. You say in the report that:

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

This is paragraph 10.5.

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

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

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

Q. Thank you.

Could you take that down, please.

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

A. They should.

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

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

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

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

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

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

A. Informed?

Q. Informed?

A. Informal?

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

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

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

A. Yes.

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

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

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

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

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

A. Yeah.

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

A. *(The witness nodded)*.

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

the case of a voluntary patient who refused observations?

A. *(The witness nodded)*.

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

A. Yes.

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

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

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

A. Yes.

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

A. *(The witness nodded)*.

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

A. A person, yes.

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

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

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

A. That is true, yeah.

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

A. Yes.

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

A. Yes, if a patient lacks capacity.

Q. If a patient lacks capacity.

A. Yeah.

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

A. *(The witness nodded)*.

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

A. Yeah.

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

A. Yes, yes.

Q. Thank you.

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

You say at 12.1 at page 34:

"Initial observation levels should be determined at the point of admission ..."

A. They should.

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

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

A. *(The witness nodded).*

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

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

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

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

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

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

A. No.

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

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

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

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

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

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

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

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

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

A. *(The witness nodded)*.

Q. Is that correct?

A. Yeah.

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

A. (The witness nodded).

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

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

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

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

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

A. *(The witness nodded)*.

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

A. Mm, mm.

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

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

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

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

MR GRIFFIN: Thank you very much.

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

THE CHAIR: Yes.

MR GRIFFIN: Thank you very much.

(12.13 pm)

(A short break)

(12.26 pm)

THE CHAIR: Mr Griffin.

MR GRIFFIN: Ms Archibald, just picking up on a point arising from what we were discussing before the break, you've spoken about the process when a patient is admitted to the ward. What I wanted to ask you about arising from that was how is the information that the admitting nurse receives then disseminated to others on the ward, for example, HCAs, who will, actually, be performing the observations?

A. You should bring together a huddle. So you would ask everybody available who is available to come into the office, you'd give a handover of, the name of the patient, why they're coming in, or -- or -- well, we should be notified before they're coming in, why they're coming in, and the observations that are looking likely, based on the information. The shift planner would already identify an admitting nurse and a healthcare assistant, so the healthcare assistant's job is to, when the patient comes on to the ward, to show them their bedroom, to check their belongings, so they'll already be assigned for about the first hour to do all those administrative duties and you'd let the on-call doctor know if it's out of hours.

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

A. Yeah.

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

A. Yes.

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

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

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

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

A. *(The witness nodded)*.

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

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

therapeutically.

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

And:

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

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

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

Is that correct?

A. That's correct.

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

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

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

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

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

A. Mm.

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

A. *(The witness nodded)*.

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

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

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

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

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

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

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

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

to what extent would care planning involve this collaborative element?

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

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

A. Yes.

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

A. Yes.

Q. Are there any general reasons for that?

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

meet the Trust's expectations.

Q. Thank you very much.

Would you take that down, please.

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

Should staff assigned observations have specific training?

A. They should.

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

A. Not to my knowledge.

Q. Did that change with ETOC?

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

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

A. Yes.

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

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

Q. What might training look like prior to 2024? You address this at 13.2. For example you say:

"It was common for staff to be inducted locally to the ward."

A. That's correct.

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

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

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

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

A. It would be, yes.

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

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

Do you see here":

"... training, competencies and support:

"Why is this policy important?

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

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

A. It does, yes.

Q. Can you take that down, please.

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

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

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

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

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

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

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

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

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

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

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

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

THE CHAIR: Thank you.

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

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

comprehensive set of national training standards for staff conducting observations?

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

Q. Thank you.

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

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

Thank you.

So do we see here:

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

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

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

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

So we see here:

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

And can we see at the bottom:

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

circumstances?"

You cover this from paragraph 14.17 at page 49 of the report and you tell us that Sophie was at level 1 at the time of her death; correct?

A. Sorry, which page --

Q. 14.17 at page 49.

A. Yeah.

Q. And I just asked you whether, as far as you were aware, Sophie was at level 1 observations at the time of her death?

A. Yes.

Q. You cover this in the same paragraph. How many members of staff were on duty on the ward and the make-up of those staff?

A. There was ten members of staff on duty, three were regular or permanent members of staff to the ward.

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

A. That's correct.

Q. And you also cover the observation levels of the other patients. Can you just deal with that, please?

A. Yeah, so there was three patients required level 3 or level 4, one of whom required two-to-one observations. This would have required a minimum of four staff members to maintain those observations. And then the investigation also identified that five patients were

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

Q. You refer in the report to:

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

That's paragraph 14.24.

Does Sophie's case potentially demonstrate that issue?

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

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

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

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

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

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

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

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

working really hard."

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

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

Q. You say also in the report that:

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

Is that right?

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

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

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

Q. Thank you.

Would you take that down, please.

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

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

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

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

A. It is, yes.

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

A. That's correct, yes.

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

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

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

A. Yes.

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

"Guide Objectives:

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

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

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

other relevant factors."

And:

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

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

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

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

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

A. Yes.

Q. And you made the point that they're quite different. And I just want to look at something now that covers that point with you.

Could you go to page 4 and expand the text there. "Differences between Mental Health and other care settings":

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

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

"Mental health services require a higher proportion of interventions.

"Interventions are often reactive and unplanned.

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

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

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

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

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

and the non-mental health context?

A. Yes, I would agree.

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

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

A. Yes.

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

A. No, I agree with it all.

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

A. No.

Q. Would you take that down, please.

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

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

Would you just expand on that, please.

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

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

MR GRIFFIN: Thank you very much for that.

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

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

THE CHAIR: Can I just ask one question?

MR GRIFFIN: Yes, of course.

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

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

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

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

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

THE CHAIR: Thank you.

MR GRIFFIN: Thank you, Chair.

(1.02 pm)

(The Short Adjournment)

(1.45 pm)

(Proceedings delayed)

(1.45 pm)

THE CHAIR: Thank you, Mr Griffin.

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

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

Thank you.

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

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

Can we deal firstly with some definitions, please.

A. Yes.

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

A. Yes.

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

A. Yes, that's my understanding.

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

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

Is that correct?

A. That's correct.

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

A. No.

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

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

A. It does.

Q. You say in the report that:

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

Is that correct?

A. That's correct.

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

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

learning from it.

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

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

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

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

Is that right?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

Q. And you address this at 19.6.

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

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

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

A. Yes, that's my understanding.

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

A. Yes.

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

A. It does.

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

A. It does.

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

A. It did.

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

A. Yes.

Q. I'd like to look at the eight principles with you, please.

Could you put up the report at page 67, and expand paragraph 19.7.

Do you set out here the eight principles arising from that 2025 guidance? Yes?

A. Yes.

Q. Just working through some of those, please. Do we see, first of all:

"Human rights approach -- digital technology must support a human rights-based approach to care".

And also a reference there to:

"Consent and capacity -- use of digital technology and collection/storage of patient data, must be based on patient consent or a lawful best-interests decision."

And just dealing with that second bullet point on consent and capacity, can you confirm that that second principle includes that any decision to use digital technologies and to collect and store patient data from the use of such technologies must be based on consent from the patient or a person lawfully acting on their behalf, or be taken following a best interests decision-making process? Can you confirm that's part of that second bullet point?

A. That, is, yes.

Q. And does it or do the principles add that:

"Due to the need for personalised decision making, including seeking patient consent, digital technology must never be used as a blanket approach."

A. Yes.

Q. Do we see, just dropping down a little bit, other principles covering co-production:

"Co-production -- procurement, testing, implementation and evaluation should involve co-production with people with lived experience."

And then do we see:

"Therapeutic and personalised care -- digital technologies must support therapeutic personalised care and must not undermine staff-patient relationships."

THE CHAIR: Does that mean person-centred care?

A. No, personalised care. So that care is personalised to that patient's needs. Person-centred is another term to --

THE CHAIR: So it's individualised.

A. Yes, individualised.

MR GRIFFIN: This morning we discussed the need for therapeutic care in observations and engagement. Does that therefore also apply when using technology of this type?

A. Yes.

Q. Can we see also in the principles on the screen:

"Evidence base -- providers must assess and document the evidence base before procuring and implementing digital technology."

Chair, we'll be hearing from a separate expert witness tomorrow addressing matters relevant to the question of an evidence base so I won't take that further now.

But may I just ask you this, please, Ms Archibald, about the principles cumulatively: how significant are they in the context of vision-based patient monitoring systems, VBPMS, in the mental health inpatient context?

A. What, the evidence base? Sorry.

Q. No, all eight principles. How significant are they?

A. Oh, they're essential, they're essential, that we must consider all of those elements in delivering care.

Q. Thank you.

Would you take that down, please.

Can I ask you a question about the regulatory oversight of VBPMS, please. Do you have a view whether any particular regulatory body is well placed to consider and decide on the benchmark for the quality of vision-based monitoring systems?

A. I don't think I do. I'm not sure if I do know of a specific regulatory body that could comment on the

technology. I think each regulatory body might comment on its impact in that field, but I couldn't say an overall arch.

Q. Thank you. I'd like to ask you about the last sentence of paragraph 19.8 of the report. It's page 67 and in fact -- it's at the top of page 68. You say there that: "The central ethical tension is between privacy/autonomy, versus patient and staff safety" when you're talking about this form of technology.

Would you just expand on that point, please?

A. Yes, you've got to balance a patient's privacy and autonomy, whether they consent to such intervention, based with the patient safety. With it being a relatively new technology, I-- my interpretation of this is that it's assisting us with what we're already doing so it shouldn't be -- with vision-based technology it can be there to guide us and assist us but it shouldn't replace what's already there. So if somebody is not consenting or there's serious privacy and dignity concerns, I think you would revert back to the human factors, such as observations and engagement.

Q. Thank you.

A. You would rely in that for safety. I don't think it's an essential piece of equipment to keep somebody safe.

Q. Just dealing then, moving on to Section 21 of your

report where you describe Oxevision, a form of VBPMS. We've heard a fair amount of evidence about this technology from witnesses from Oxehealth, now LIO, EPUT, and yesterday two witnesses from other Trusts. I'd like to look at part of your report with you.

Would you put up the report, please, at page 72 and expand paragraphs 21.1 and 21.2.

Do we see here, Ms Archibald, that you say:

"In 2012 Oxevision was developed by Oxehealth, but its use in NHS mental health inpatient practice appears to have expanded mainly from around 2019 to 2021 [and] by December 2021 Oxevision was reported to be in use in 50 per cent of Mental Health Trusts ..."

Indeed, that accords, I think, with other evidence that we've heard.

Do you then list at paragraph 21.2 what Oxevision can do?

A. Yes.

Q. And can we see:

"Perform remote visual checks of a patient in their bedroom;

"Measure pulse and breathing rate without physical contact, where the patient is still and sufficiently visible to the camera, with suitable focal points such as hand or foot available for the system to calculate

the reading;

"Help staff check whether a patient is in bed, in the room, out of the room, or in the bathroom; and:

"Provide alerts or notifications for certain configured situations."

And also:

"[to] produce activity information ..."

Do you list all of those as what Oxevision can offer?

A. I did yes.

Q. Thank you.

Can you take that down, please.

I'd like to look with you at an Oxevision patient poster used at EPUT. This is from the Standard Operating Procedure version 12 from the 30 April 2025.

Could you put up, please, EPUT009884 at page 19 and could you expand down to and including both those points. Thank you very much.

Can we see here:

"Oxevision technology is installed in all bedrooms.

"Oxevision is a medical device that uses an infrared-sensitive camera to measure your pulse and breathing rate without disturbing you."

And can we actually see the unit there with the camera on the left and the infrared lights on the right?

A. Yes.

Q. And do we see in the last bullet point in the top half of the screen:

"Alert staff when you have entered the bathroom and are out of range of the sensor."

So does that pick up on one of the points that we've mentioned in your report?

A. Yes.

Q. And then at the bottom:

"Use of Video: what staff can see you in your room?

"A clear image can be seen for up to 15 seconds only when checking your pulse and breathing rate."

And:

"A blurred image can be seen for up to 15 seconds only when a notification has been received."

And these are points we've covered with other witnesses too. But may I ask you about that last bullet point, please, the blurred image. You say in your report, and this is 21.4, that:

"When a red or amber Oxevision alert is triggered, staff may be able to access a pixelated image of the room to help them understand the possible cause of the alert. The purpose of the pixelated view is to provide limited visual information while reducing the level of intrusion compared with a clear image."

So is the pixelation intended to provide some level of privacy whilst allowing a staff member to gain an idea of what is taking place in the room, in your understanding?

A. That's my understanding, yes.

Q. Can I ask you this: to what extent do you think that pixelating the image of the person actually reduces privacy and dignity concerns? You refer to this at 21.4?

A. When you're looking at the pixelated image you don't know what you're about to see, so you don't know if a patient is engaging in private time or getting changed. And even though you might not be able to solely identify the patient from the image, you still get an insight into what they're doing in their private space. But equally, you aren't assured that that's the patient that's meant to be in that room.

Q. Ah.

A. So if you've got a ward which is all-male patients, there's an opportunity that other patients go into each others' rooms. It doesn't give you -- it might give you a snapshot of what you might -- what the alert is, or it could be -- it doesn't give you enough assurances so you would need to go round anyway.

Q. Just picking up on aspects --

THE CHAIR: And it could have two people in the room too?

A. It could have two people in the room --

THE CHAIR: So compromising two people's --

A. Yeah, yeah.

THE CHAIR: -- (overspeaking) --

A. And the two people could be another member of staff in the room helping with personal care again. So when you look at the pixelated image you don't know what you're about to see so you can't -- where if you knock on a bedroom door, the patient might say, "Can you give me a minute?" So you're given a warning but with a pixelated image there is no warning of the image.

MR GRIFFIN: You add this in the report:

"A pixelated image is still visual access into a patient's private bedroom and should not be treated as non-intrusive."

A. Yes.

Q. And you say:

"The fact that the image is pixelated reduces but does not remove the privacy and dignity concerns."

And is that picking up on what you've just been explaining?

A. Yes, and also the patient has no idea that you've just looked into their bedroom.

Q. Unlike the knock at the door?

A. The knock at the door would give them a warning, yeah.

Q. What are the relevant considerations about whether to view a pixelated or blurred -- a pixelated image or not? What would be -- what should be in the forefront of a staff member's mind when deciding whether to access that pixelated view?

A. When an alert goes off, the ideal practice is that you would go and check on the area physically. You would walk round, check on the patient, and then you would reset the alarm because you're assured about the patient's safety.

In other situations where an example could be there's maintenance been taken place in the room, so there might be a painter and decorator in the room constantly triggering off the alarm. So you might be aware that there's some work going on in the room, so when the alarm goes off you might check to see if it's still the painter and decorator in the room. But it's only in those circumstances when you know there's a certain activity going on in the room or you know that there's a member of staff in the room, helping somebody, that you might just double check the pixelated image and not go round. But really, the practice would be: there's an alert going off, go and see what's happening. That's what --

Q. You add in the report, this is paragraph 21.6 for those following, that:

"The key question remains whether viewing the image is necessary, proportionate, individually justified and the least intrusive means of responding to the identified risk."

Is that correct?

A. Yes.

Q. And should the use of pixelated image be governed by clear policy, staff training, audit and documentation, including when a face-to-face check is required following an alert?

A. Yes.

Q. So doing -- dealing with the other bullet point we can see at the bottom of our screens about accessing a clear image for up to 15 seconds, please. The explanation there is that:

"A clear image is available when checking pulse and breathing rates."

Is that the vital signs function of the technology?

A. Yes.

Q. Why would it be important to have a clear view of a patient before taking vital signs using Oxevision?

A. I'm only assuming that the technology can only take the vital signs if it has a clear view. I'm not sure if

it's necessary for the nurse to have a clear view to get the vital signs.

Q. So this might be a requirement of the technology rather than of staff?

A. Yes.

Q. Just asking you about a very general point, please. What concerns may arise from the presence of a camera in an inpatient's bedroom? And we've seen photographs or stills previously of the unit in the bedroom. It's quite a big unit?

A. It is, yeah.

Q. Can you just in general terms explain what kind of concerns may just the existence of the camera have in an inpatient's bedroom? What kind of concerns might that give rise to?

A. Some patients can be particularly sensitive to being observed or feeling that they're being watched. The device itself doesn't obviously look like a camera, it's a device that I've never seen anything that looks like it before. So I can -- I think there'd be concerns of: what is it? What does it do? But equally, it can instil -- some of our patients already have -- are paranoid and struggle to trust professionals, and struggle to trust anybody, so that can reinforce that we're not to be trusted and equally increase their

paranoia. I've witnessed some patients scream at the device thinking ... and it's -- yeah, it can be confusing for some.

Q. We heard --

A. -- (overspeaking) --

Q. -- yesterday, we saw in a report an instance where a woman actually refused to go into the bedroom where there was an Oxevision unit, and had to be -- a different place had to be found for her to stay in. Have you had that kind of response to the Oxevision unit in your experience?

A. Yes, I have had patients that have brought the -- smashed the device or covered it up. And sleep on the sofas in the main areas, because they feel uncomfortable with the device in the room.

Q. Would you take that down, please.

I want to come back to consider with you this clear image view and what is termed clear-video data, please.

Would you put up EPUT009884 at page 12. This is the Standard Operating Procedure from EPUT version 12, published on 30 April 2025. So EPUT009884. Thank you very much.

So do we see here that EPUT SOP, or Standard Operating Procedure, governing Clear Video Data. I just want to look at aspects of this with you, please.

Clear Video Data, or CVD, is non-pixelated video footage that can be clipped and saved upon request if there is a situation that needs to be further investigated.

So you were referring before in relation to CCTV and body-worn cameras, that one of the advantages could be that -- the recorded footage there might be able to assist with an incident or something of that nature. Does this suggest that something similar can happen with footage captured by Oxevision within a patient's bedroom?

A. It does.

Q. Just dropping down a little bit:

"The request must be made directly to Oxehealth within 24 hours of the situation or incident ..."

And we've heard that the data is automatically deleted after a 24-hour period. Is that your understanding too?

A. Yes, that's my understanding.

Q. And:

"Upon receipt of a request, Oxehealth will clip and save CVD. Once authorisation has been granted, Oxehealth attend site to transfer the clipped CVD to a secure USP for delivery."

Do we see at the bottom:

"Clear Video Data is automatically deleted after 24 hours."

The point that we've just been discussing.

So if there's been an incident and you want to access the footage you have to do it pretty quickly, within 24 hours?

A. Yes.

Q. Now we've heard from a number of witnesses now that in fact, when the system is present in a patient's bedroom and activated, it's actually recording 24 hours a day, seven days a week, all the time. Is that your understanding, as well?

A. Yes, it is.

Q. And that is clear view footage, so not pixelated, clear footage, a clear view of the patient in their bedroom; correct?

A. Yes, yeah.

Q. What are your views about that facility, the fact that it's on and recording all the time?

A. I struggle to understand why it needs to be on. And I do -- it is concerning, and also it's not made explicit to patients that that is the case.

Q. Does that go to the question of informed consent?

A. Yes.

Q. We were talking about that before. In your view, is

that something that should be explained to a patient when they're deciding whether they want to consent to the use of the system?

A. Yes.

Q. You say this more generally in the report, this is 29.4:

"In my view, the ability to obtain a clear view, use pixelated images and retain clear view data for up to 24 hours creates a significant intrusion into a private space."

So that's paragraph 29.4 at page 97. Would you just expand on that, please?

A. I think it goes beyond being absolutely necessary. So if we consider that if patients are detained under the Mental Health Act or the Capacity Act, you still have to justify that it's absolutely necessary to do things against their wishes. I don't think 24-hour filming of them in their private space is absolutely necessary or justified. I can understand how it might give some reassurance to families, or even patients. Some patients do consent to -- some patients do seek reassurance. Applying the principles, if I was a patient or a family member, it's not something that I would be comfortable having. And I think, before you do anything or suggest anything to your patients you need to ask: is it good enough for me and is it good enough

for my family?

Q. Thank you very much.

Your report recognises that VBPMS may not be experienced as neutral by patients, and in fact you've just given us some fairly compelling examples of that, but rather as an intrusion or a loss of privacy, regardless of the intent.

Do you agree this is likely to be the case regardless of whether patients that have experienced trauma or psychosis?

A. It can be very trauma -- most people have not been filmed in their private area in any aspects of their life but for patients who have suffered significant trauma, that might have been the case. So it can be very traumatic. It's very intrusive.

Q. But the point here is actually, patients who haven't, for example, a patient who is not paranoid or doesn't have a specific trauma, do you agree that that feeling of loss of privacy can be equally keenly felt by them?

A. Yes.

Q. Can we take that down, please.

Can we stay with the vital signs function just for the moment. As we've seen, it covers pulse and breathing rates. Now, we looked this morning at the NEWS2 measurements, the six different measurements that

need to be taken. Is it right that vital signs actually covers only two of them?

A. That's right, yes.

Q. So for example, blood pressure would be something that wouldn't be covered --

A. No.

Q. -- by vital signs but would be required by NEWS?

A. Yes.

Q. You say in the report that:

"A reading -- a vital signs reading does not replace a full set of physical observations."

And that:

"The vital signs function cannot and does not replace physical health monitoring."

Is that correct?

A. That's correct.

Q. So Oxevision could not be misunderstood or should not be misunderstood to be a substitute for NEWS monitoring?

A. No, my understanding is that vital signs is not -- although it offers a 15-minute window it would not be used to replace NEWS or inform clinical assessment.

Q. Is there a purpose for a technology that covers only part of the NEWS2-required measurements and does not replace physical health monitoring?

A. It might just offer some assurances that the patient is

alive. The risk of that is the professional or the person using it might interpret it as a full set of observations when in fact it's not.

Q. Now, we've heard evidence, including yesterday, that the vital signs function, actually, only works within particular parameters?

A. Yes.

Q. Is that your understanding too?

A. Yes.

Q. So to what extent could it safely be used to demonstrate whether someone, a patient in their bedroom, was alive or not?

A. If it was able to have two body parts available, and that it could get a reading from those body parts.

Q. But where it is able to make a reading, within the defined or the recognised parameters, that could provide a sign of life, basically?

A. It could show a sign of life, yeah. The only time -- if a patient is stood up in their bedroom, that in itself is a sign of life so there would be no requirement to access vital signs, in my opinion.

THE CHAIR: Is there a danger, though, that because it can't recognise vital signs beyond certain parameters, that people will occasionally think: well, it's not actually showing me that someone's alive. But that may just be

because it's outside the parameters of what this can show?

A. Yes, if somebody is lying in their bed during the night and it can't pick up vital signs, there is a risk that there's an assumption it's just because they've got no two body parts available.

MR GRIFFIN: So you've mentioned two body parts a couple of times. We actually went through this yesterday. In order for a vital signs measurement to be successfully taken, we've seen blobs, actually, need to be on exposed body parts for the reading to be taken.

A. Yes.

Q. And so a reading may not be taken where that hasn't happen, just to explain what you've just

-- (overspeaking) --

A. Yes, yes.

Q. Thank you.

I'd like to look at another part of your report please. Would you put up the report at page 74 and expand paragraph 21.9.

So seclusion, HBPOS, is that health-based place of safety?

A. Place of safety, yes.

Q. LTS -- is that long-term segregation or seclusion?

A. Long-term segregation.

Q. And we see a reference to EPUT's policy. That's in fact a reference to the Standard Operating Procedure version 12 we've just been looking at.

Can we just read on, please:

"EPUT's policy distinguishes between the use of Oxevision in ordinary patient bedrooms and its use in higher-risk areas such as seclusion, LTS and HPBOS. In patient bedrooms, the vital signs function provides spot-check readings of pulse and respiratory rate when staff actively request them, but it does not alert staff to abnormal pulse, abnormal respiratory rate, cessation of breathing or clinical deterioration. However, EPUT's policy indicates that in seclusion, LTS and HBPOS settings, the system can alert to breathing and pulse concerns."

So vital signs outside the seclusion context does not alert staff to those matters such as clinical deterioration. To what extent, in your view, does that limit the assistance that vital signs can provide?

A. It would -- to request vital signs, there must be a professional curiosity in the first place to request it. It wouldn't -- the system, to my knowledge, doesn't alert us when there's a physical deterioration that might request -- lead us to request the vital signs. It would just be from our own instinct to request it. But

if I recall, remembering the way the policy was written is that there might be some assumptions, misunderstanding from patients and families that the system alerts us to deterioration.

Q. When it doesn't?

A. To my knowledge it doesn't.

Q. You say that -- sorry, this paragraph in the report says that:

"In the seclusion, LTS and HBPoS context, vital signs, breath and respiratory measurements can be used to alert to breathing and pulse concerns."

Why can they be used in that environment?

A. I don't know.

Q. Is it or might it be because those are potentially higher risk environments, and may -- there may be a patient who would react badly to, for example, a NEWS2 type of measurement?

A. Possibly. The -- seclusion and long-term segregation patients tend to possibly be on higher doses of medication, more acutely disturbed, where the hospital-based place of safety patients are unknown.

Q. You say, just finishing this paragraph:

"This distinction is important because patients, families and staff may assume that Oxevision provides the same level of physiological monitoring in all areas.

In ordinary bedrooms it should not be understood as a deterioration-alert system or a substitute for physical health monitoring, NEWS2, face-to-face assessment or professional judgement."

Is that all correct?

A. Yes.

Q. You add later in the report -- for those following it's 24.10 at page 85 -- that:

"Vital signs may be unable to obtain a reading if the patient is moving, has tremors, is covered, is not clearly visible, or where visible body parts are affected by factors such as scarring or tattoos. In effect, the vital signs function may provide an indication of pulse and breathing but it should not be understood as continuous physical health monitoring or as a system that will detect all forms of clinical deterioration."

Now, does that sort of summarise all of the points we've just been discussing?

A. Yes.

Q. Will you take that down, please.

What are the scenarios in which the vital signs function is most likely to be of use, in your view?

A. During the nighttime, in seclusions. It's important to note that people who are in seclusion or long-term

segregation are in the hospital place of safety and during the -- sorry, those three areas, they have an assigned member of staff with them at all times who will be reviewing the screen. The screen will be in front of them at all times. In comparison to the general wards, they more than likely won't have a member of staff assigned or watching a screen at all times.

But in regards to vital signs being used possibly through the night, could be beneficial if the patient agrees, so you're not entering the room and we're not disrupting the sleep.

Q. Are there particular patient groups where VBPMS is more likely to cause harm, increase distress, or undermine therapeutic relationships? You've given an example of someone who might be paranoid but are there other categories where there is more likely -- it's more likely that the system will cause harm?

A. Yeah, it could be any patient group, even with patients with an organic illness such as dementia, it could cause confusion, distress. For patients who have got a history of trauma. There's lots of factors that might negatively impact them. And also, the patients who distrust what we're doing with that information, and how we're accessing it and what we see.

Q. Thank you. You explain in the report that -- and this

is paragraph 21.10 at page 75:

"EPUT and some other Trusts have implemented an additional digital observations module within the Oxevision platform, sometimes referred to as Oxeobs or Oxevision observations. This appears to support the carrying out and recording of ward observations through digital devices."

So we covered this morning paper-based records and electronic records. Is your understanding that Oxevision observations is an electronic record system?

A. Yes.

Q. Can we just look at EPUT's Standard Operating Procedure. This is the same one we looked at before. Would you put up EPUT009884 at page 14 and expand the top half of the page. Thank you.

So this is the description there of Oxevision observations:

"Oxevision Observations is a digital observation module within the Oxevision system. The Oxevision Observations module is a digital version of the paper observations record ...

"Oxevision Observations is implemented only on Oxevision-equipped inpatient wards, seclusion rooms, and [health-based places of safety] to enhance and improve patient care and safety in order to ... "

And then do we see three bullet points with the reasons for it:

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

"Assist in the identification of trends.

"Report on quality of Therapeutic Engagement and Supportive Observation activity."

And then do we see at the bottom:

"The Nurse in Charge will check the completion of observations periodically during their shift and provide the assurance in the Clinical Guideline."

Do we see all of that there from the SOP?

A. Yes.

Q. So we see that it's meant to be a digital version of the paper observations record, and as I've said, we've discussed this morning records, both paper based and digital. You've suggested this, this is paragraph 21.10, so:

"This appears to support the carrying out and recording of ward observations through digital devices. However, the terminology risks further conflating 'observation'. Therefore, any use of an Oxevision Observations module should be clearly distinguished from the clinical and therapeutic purpose of close observations."

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

A. I think that the term "observation" is -- because it's called Oxevision Observations, there could be a risk that you use Oxevision to do your observations.

Q. Oh, I see, rather than just as a replacement for paper records?

A. Yeah. So the fact it's called Oxevision Observations, it could, for somebody who's not well experienced or not familiar with the -- it could imply that you use Oxevision.

Q. Thank you.

Would you take that down, please.

Before we move on to another topic, I'd like to look at one of the illustrative examples you've given in the report, and you've touched on the nighttime use of Oxevision, so this is going back to that point, please.

At 24.5 you refer to Adam Steel. His father Paul Steel has given a witness statement to the Inquiry and came to give evidence to us in October last year, and in fact also previously has given commemorative evidence.

Adam was a patient on the Peter Bruff Ward at the Colchester hospital. He was admitted to the ward on the afternoon of 13 October 2021 and he died the following morning at the age of 36.

THE CHAIR: I'm just going to interrupt you, it's 24.15.

MR GRIFFIN: 24.15. Thank you for that correction.

THE CHAIR: Forgive me.

MR GRIFFIN: Not at all. Thank you.

Do you have that in front of you if you --

A. Yes, I've found it, yeah.

Q. I'd like to put part of the transcript of Paul's evidence to us on the screens, please. Would you put up the transcript of Paul Steel, Day 34. That's 23 October 2025. The reference is INQY016285, page 15.

Could you expand up to and including line 21? Perfect.

I just want to look at part of this with you, please. Do you see a question there:

"And ... were his observations undertaken via Oxevision only, is that what your understanding is?"

And the answer is:

"That's my understanding, yes."

Then dropping down to the next answer:

"... there was an observation window in his room and his bed was in such a position that it couldn't be seen through the observation window due to its location and I was concerned that there was even more reason why he should have been physically visited face-to-face, if they couldn't see his bed through the observation

window."

And then looking at the last question and answer:

"And as far as you can ascertain, there was camera observations and no physical observations?"

Answer: "That's correct."

So is it your understanding here that Oxevision data showed that Adam's bedroom door had not opened at any point during the night?

A. Yes.

Q. As we can see from here, his bed wasn't visible from the door window?

A. *(The witness nodded)*.

Q. Was he on level 2 observations, meaning in this case four checks an hour?

A. I've documented that he was on level 2 observations.

Q. Yes. And so Adam wasn't observed face-to-face.

Just in your view, what does this illustrate, Adam's case, the conduct of observations remotely and not actually going into the bedroom overnight?

A. I've wrote in my report and it might just be from how I've read the information provided, that I couldn't determine whether the -- he was observed by either vision based, as well. I didn't see data to see how many times they'd checked on him, whether they did the check every 15 minutes as his prescribed observation

levels, but this shows -- highlights the risk of relying on a technology instead of human observation.

Q. You say this:

"The importance of face-to-face checks in determining a patient's safety and wellbeing is an important factor arising."

Yes?

A. Yes.

Q. And:

"Remote viewing or reliance on Oxevision is insufficient to determine whether a patient is physically well, emotionally distressed, deteriorating, or in need of urgent observation."

Yes?

A. Yes, the human assessment would pick up on a deteriorating patient.

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

So the suggestion has been that remote observations are less restrictive, particularly at night. Do you agree that reducing disturbance is not always necessarily less restrictive if it involves increasing remote surveillance?

A. You've got to balance up what's more, and take into consideration what the patient's views are, whether -- can we disrupt sleep in a more meaningful way? There's

lots of things in the environment that we can do rather than solely relying on technology, but the technology can assist, but it doesn't -- it still doesn't replace the human factors.

Q. Is it right to say that for some patients, nighttime is when they are most likely to need support and engagement because if they're awake, patients are likely to have experienced or may have been experienced night terrors, insomnia, or anxiety?

A. Yeah, nighttimes can be incredibly difficult for a lot of patients, for lots of various reasons. There's a lot of quiet time, a lot of time for reflection. People tend to miss their families more. And equally, it can be a trauma response. So nighttimes tend to be quite risky as well.

Q. Would you agree that there might actually need to be some form of human contact during the night in those kinds of circumstances?

A. Yes, and some patients are also frightened from other patients. So having staff available can offer them some reassurance.

Q. I just want to pick up on something you've said in the report. This is paragraph 25.13 at page 91.

You note that:

"Oxevision may provide information about room

activity, vital signs attempts, alerts, or whether someone is present in a room."

But you go on to say this:

"It cannot reliably identify who the patient is, understand the meaning of behaviour, assess emotional distress, recognise elation, agitation or hopelessness, or determine whether a patient is experiencing urges to self-harm."

Does that all underscore the need for the human element in addition to any virtual viewing of a patient or relying on technology such as vital signs?

A. Yes, it's -- they just highlight how the human interaction would pick up on those elements.

MR GRIFFIN: Thank you.

Chair, I've just finished a topic. This might be a good time for our afternoon break. May I -- it's now quarter to three, may I suggest we come back at 3.00 pm, please.

THE CHAIR: 3 pm.

(2.43 pm)

(A short break).

(3.00 pm)

THE CHAIR: Mr Griffin.

MR GRIFFIN: Ms Archibald, you've considered in your report two of EPUT's Standard Operating Procedures on

Oxevision. This is in Section 22 of your report and I'd like to move to that now, please.

And we'll bear in mind the NHS England principles that we've already discussed, including on the topic of consent.

Was the first SOP you considered Version 10, from 31 May 2024?

A. Yes.

Q. Does that therefore precede the NHS England principles?

A. It did, yes.

Q. Was the second one that you considered, Version 12, published on 7 May 2025 and therefore after the publication of the principles?

A. Yes.

Q. I'd like just to discuss with you Version 10 and the approach there with you now and to focus on the issue of consent and how that actually then goes on to change between Version 10 and Version 12. So that's just setting the scene; is that all right?

A. Yes.

Q. Now, we've heard evidence from EPUT about this and in fact we heard evidence yesterday from a witness from another Trust that has substantially the same approach currently to Version 10 of the EPUT SOP, and what we learnt there, and what we can see in the Version 10

SOP, is a process that I want to look at with you now.

Could you please put up EPUT SOP Version 10 at EPUT004791 at page 14. Thank you.

So this is the Oxevision consent flowchart from the earlier of the two SOPs that you've looked at.

What I want to do for present purposes is to trace with you through the scenario where you have a patient with capacity who does not want the Oxevision system to be switched on and used in their bedroom; all right?

A. Yes.

Q. Can we see therefore, at the top of the page:

"Fully inform patient/family/carers about the Oxevision system purpose and functionality as part of admission procedure."

So the SOP, so it requires that the patient and others are provided with information. Is that -- does that go to this point we've been discussing a couple of times now of needing to obtain informed consent?

A. Yes.

Q. We'll come on in a moment to look at some other information to see to what extent EPUT have actually been successful about -- in their consent processes. But that's a separate point that we'll come on to.

Can we see at the top of the page:

"In this SOP, Oxevision is switched on from

admission."

Is that what has been termed a blanket approach for the first -- up to 72 hours while an assessment takes place?

A. Yeah, that's my understanding.

Q. And so that will be turned on regardless of what background the patient has, and regardless of, initially at least, whether they consent or not?

A. Yes.

Q. Moving down, do we see:

"Does the patient/family/carer object?"

Can you see that?

A. Yes.

Q. If we move to the right "Yes," and following that through -- can I just say how helpful it is to have this highlighting, thank you very much -- just following down, can we see this, 2b:

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

So the system is on at this stage, correct?

A. Yes.

Q. "MDT meeting within 72 hours:

"Objection discussed as part of individual risk assessment."

This is number 3.

"Patient capacity established. Clinical recommendation on use of Oxevision."

So during the initial period of 72 hours or up to 72 hours, the system is on, as we've established, regardless of whether the patient has consented or not?

A. Yes.

Q. Do we next see on the flow chart to the left "Does the patient have capacity?"

A. Yes.

Q. And as I've said, let's assume for present purposes that they do. Do we then go to 4b, "Meeting with patient and decision documented in patient record"? Yes?

A. Yes.

Q. And under that the two options of "MDT decision to keep on implemented" or "MDT decision to switch off implemented".

Can we just take stock. In summary, does this flowchart mean that a patient arriving on the ward will have the system switched on by default for up to the first 72 hours?

A. Yes.

Q. And that where the patient objects and has capacity, the ultimate decision as to whether the system remains on is not the patient's; it's that taken in the MDT?

A. That's my understanding of how it's written and worded,

yeah.

Q. You set out at 22.6, at page 76, some of your views about this approach to consent. Could I just ask you to deal with those and explain a little bit more what your views are about this approach?

A. If a patient has capacity and they refuse, I struggle to identify how the MDT can overrule that, even if they were a patient under the mental -- sorry, under -- a patient detained under the Mental Health Act. And regardless of whether they have capacity or not, the patient can still have a view on something, and I think it ... yeah, I struggle to grasp that it still falls down to the MDT to make a decision when the patient either has capacity and refuses, or lacks capacity but still doesn't wish to use it.

Q. You say this at paragraph 22.6:

"In my view, SOP 10 risked placing organisational approval above the patient's expressed refusal."

So is that picking up on the point you've just made?

A. Yes.

Q. And you add:

"This is difficult to reconcile with a genuine consent-based patient-centred and rights-based approach, particularly where the patient was informal or where the legal basis for continued monitoring was not clearly

identified."

Can I just ask you about that point about the informal patient. Why would that make a difference here?

A. There would be no legal framework for that patient to object, and they would run the risk of the patient might take their own discharge even though they're in need of help, because of an intervention that they do not agree with.

Q. Thank you.

Could you take that down, please.

May I just ask you a few more questions about this. Do you -- is it your view that decisions should be taken on a case-by-case basis?

A. It should, yes.

Q. How likely do you think it is that decisions will, in reality, be taken on a case-by-case basis if Oxevision has been installed in every bedroom on many wards within a Trust?

A. I think it places clinicians in a difficult position: that they've got to justify why they're not using the technology. So it might place you in a position where you're in favour of a technology and you would hope that all patients would have it. So that might influence, sort of, your speaking to your patients about it. It's

like you're trying to sell them something. I can't think of another word, but it feels like you're trying to sell them something rather --

Q. Because it's there?

A. Because it's there --

Q. Thank you.

A. -- and you've got to -- there's a process that you've got to follow if somebody doesn't want it. It should be a harder process if somebody does want it, rather than if they didn't want it.

Q. Thank you.

That was Version 10, the second version you looked at, Version 12, 2025 and after the NHS England principles came out. And I think we can, in terms of consent, we can deal quite shortly with the change of approach. You deal with this at paragraph 22.7. You say:

"The main change to practice was reducing from 72 to 6 hours for MDT consideration."

And you describe that as a positive development.

As I understand it, the Version 12 still -- so there would still be a period, albeit much shorter, six hours -- where the system would be on by default, up to six hours, correct?

A. Yes.

Q. And did Version 12 maintain the other element we were looking at, namely that the final decision would not be that of the patient, but would be taken by the MDT?

A. It did not change that approach. It still -- final decision was made by the MDT.

Q. So to what extent do you see Version 12 as in reality an improvement on the points that you've made in relation to Version 10?

A. My opinion was that it showed recognition for the patient's views, but it still didn't go far enough.

Q. We covered yesterday the situation where a patient lacks capacity, the decision being a best-interests decision and we covered that best-interests concept briefly this morning, yes?

A. Yes.

Q. I'm not going to ask you more about that now.

Now, have EPUT signalled a change of approach in relation to their approach to consent?

A. I believe that they've changed or plan to change the procedure in that it's -- you have to consent for it to be switched on at the point of admission.

Q. So you say this at 22.10:

"A memo was issued with immediate effect stating that Oxevision should only be switched on where the patient consents. Where the patient lacks capacity to

consent, the decision to switch Oxevision on must be considered by the MDT with consultation with the patient's family and carers where appropriate. The decision to switch Oxevision on must be clinically justified."

Now, do you understand that potentially to be a move to an opt-in model of consent for the use of Oxevision at EPUT?

A. That's my understanding. The updated operational policy wasn't at hand when I wrote this. This was the memo to say that this was the planned way of working.

Q. And this is a change that was signalled at least in May this year, correct?

A. Yes.

Q. But that would signal a potentially major change of approach?

A. It would, yeah.

Q. I'd like to look now at the effectiveness of the consent processes at EPUT, please. And I'm going to ask that a document is put up for this, please.

Would you put up EPUT TIAA assurance review of consent for Oxevision, that's EPUT020913, on the second page, please.

Thank you, would you expand the left part of the page as you had it there, please.

So this is the executive summary. Can we see at the bottom:

"The overall objective was to provide assurance on the effectiveness of the consent processes in place within the Trust. This review focused on the arrangements for consent for Oxevision."

So this is October 2025, and just to remind us all, it's looking at consent processes at EPUT, yes?

A. Yes.

Q. And it's difficult to read, but the top, the circle there, can we see going round the top, "Adequate and effective governance risk and control processes" with the conclusion there "Limited Assurance"?

A. Yes.

Q. Would you expand the top right-hand box "Key strategic findings". So do we see here:

"The Trust has in place an Oxevision Standard Operating Procedure ... which clearly outlines the processes in place for obtaining consent for the use of Oxevision, training requirements, and roles and responsibilities clearly identified as part of the process."

So that's the first point, isn't it?

A. Yes.

Q. Do we then see:

"Audit testing identified that for four of 10 staff, the competency checklist was not evidenced as no response was received from the relevant Ward Manager within the timeframe of the audit."

And next:

"Testing of a sample of 17 patients across five wards, in June and July, where Oxevision is in use, identified significant exceptions, such as lack of evidence of completed admissions checklist within six hours of patient's admission for 21 patients."

And then:

"It was confirmed that at the time of audit fieldwork, there was no oversight arrangements for senior management/committee to regularly review data in relation to consent for Oxevision. The implementation plan for Oxevision did include steps to 'agree audit and assurance plan', and to align Tendable audit to new SOP."

So you address this at paragraph 22.9. What does this, and the further information in it, indicate to you in terms of consent processes at EPUT?

A. It highlighted that although the -- well, the policy might have changed, practice hadn't, or it wasn't compliant with the policy about gaining consent from patients.

Q. So does this potentially go in part to that question of informed consent that we were talking about before?

A. Yes.

Q. You say that -- this is 22.9:

"It also supports the concern that patients may have had regarding Oxevision being active in their bedrooms without timely evidence that they'd been properly informed, had capacity to consent, and had given meaningful consent."

Yes, correct?

A. Yes.

Q. Thank you.

Would you take that down, please.

You say in the report, this is paragraph 22.16 at page 78:

"I have not seen evidence that VBPMS directly influenced individual patient care in a sytemic -- systematic or clearly documented way."

Referring to the data, you say:

"It does not in itself demonstrate that VBPMS improved patient outcomes or informed clinical decision making for individual patients."

Now, would you explain what you meant by that?

A. I didn't see -- from the evidence that I was provided with, I didn't see where the Oxevision data influenced

patient care directly. So if you refer back to the 2025 guidance, it says it must impact treatment outcomes, and I couldn't see the link from the technology actually informing patient care, where the changes to care and treatment were made based on the data from Oxevision.

Q. Thank you.

I want to move on to another topic, please, and this is at Section 24 of your report, Oxevision data reports.

Now, you were provided with a number of Oxehealth monthly usage reports for EPUT wards, correct?

A. Correct.

Q. And in fact we've looked at these monthly usage reports with previous witnesses, including the equivalent yesterday for another Trust. So we're familiar with the layout and how they work in general terms. But were you provided with usage reports for June 2024, June 2025, and April 2026?

A. I was, yes.

Q. I want you -- what you then helpfully do in Section 24 of the report is, first of all, using that data, consider some high-usage wards and then later look at some low-usage wards. So can we work through that --

A. Yes.

Q. -- together, please.

Starting with the high-usage wards and I'm talking

about usage of the vital signs function.

Would you put up the report, please, at page 83 and expand the table at the top.

So we can see a table here, refer to it if you need to, we can see here a table of a number of different wards but do we actually see three older adult -- one adult acute -- two adult acutes and two older adult wards there, yes?

A. Yes.

Q. You suggest in the report that the '24 and '25 data raises significant privacy and dignity concerns. That's 24.4. Would you mind explaining what you meant by that?

A. The readings, the attempts, that's a lot of attempts in a day per ward per bed, but the actual reading was less than 50 per cent. So it would appear that a 15-second clear view of that bedroom occurred but an actual reading was taken in less than 50 per cent. So it would bring into question what was the purpose of the view, if it wasn't for a reading. And also, the high usage. I couldn't understand why you would need to do an attempt of vital signs that frequently per day.

Q. You say this:

"If each attempt involved a clear visual view into the patient's bedroom then the level of visual access may be considerably greater than patients understand

when the function is described as vital signs monitoring."

Yes? Is that right?

A. Yes.

Q. And you add:

"The question is whether repeated unsuccessful attempts are compatible with privacy, dignity, meaningful consent and least restrictive practice. "

Yes?

A. Yes.

Q. You, at 24.6, you raise concerns particularly about the Cherrydown Ward. We can see at the top of the list. Would you just explain what your concerns were there?

A. Their usage of vital signs doubled in a year.

Q. Could you find any obvious clinical rationale for the high amount of times that they were checking for vital signs? 24.7 you cover this.

A. I've put in the report that they were checking on average it was every 29 minutes per bedroom.

Q. Across a 24-hour period?

A. Across a 24-hour period per bedroom. I cannot identify what clinical rationale there would be to do this level of vital sign check.

Q. And you list, or you cover at 24.8, possible explanations for this. But is one of them, for example,

that the vital signs function might be being used as a substitute for observations and engagement?

A. Yes, that's a possibility.

Q. And is there also, as you say there, a theoretical risk of inappropriate use?

A. Yes.

Q. Can we just talk about the 2026 data. You cover this from 24.9, and you make the point that the high use of the Oxevision vital signs function continued on three of the wards although attempts were reduced slightly. But is there any significant change in those wards between the June '24 and the April '26 data that you've considered?

A. There's not a significant change, apart from Gloucester Ward. No, sorry, there's still -- there's no change. It's reduced from 2024 but it hasn't significantly reduced in the --

Q. Thank you.

Can you take that down, please.

Can we then to move low-usage wards. This is from 24.20. Do you identify three wards with significantly lower usage of the vital signs function over the same time periods?

A. I did, yes.

Q. And in these cases, does the April 2026 data, so the

last period of data that you have, show a significant reduction in a vital signs test, equating to fewer than two attempts per bed per day across all three wards?

A. Yes, that's is a significant -- you could argue that that's more unexpected usage.

Q. So those wards were -- one was a forensic secure ward, one was a young persons' ward and one was a low-secure ward, correct?

A. Yes.

Q. You've given us one side of the data, the high-usage wards, and we've talked very briefly about what might be going on there. We're now looking at these low-usage wards. Are you able to provide an explanation or possible explanation for why the usage is so much lower here?

A. Potentially it could be the patient population. The low-secure forensic wards by nature of it are high-risk patients. It could be that they're on high observation levels so it's not required to do remote checking at all, because there's somebody there. And particularly with the young persons it might be, have more staff availability and higher observation levels than older adult only -- adult acute ward. They're just potential reasons why.

Q. Understood.

You say this at 24.22, "The contrast" -- and I think this is the contrast between the high- and the low-usage wards:

"... therefore raises an important governance question: why are some adult and older adult wards using the vital signs function at substantially higher rates than secure or young person services?"

And you add at 24.23:

"The variation between wards suggest that high usage is unlikely to be an unavoidable feature of this technology itself. It may instead reflect differences in ward culture, training, clinical expectations, staffing practice, or governance."

Is there anything more you'd like to say about that point?

A. Yeah. On some wards it could just be the culture that it's expected -- that it's not uncommon to frequently access a patient's bedroom where on other wards the governance might be more clear and training might be -- staff would be more trained and familiar on its purpose. So there could just be a difference of --

Q. Culture?

A. -- culture.

Q. Thank you. Just moving now towards the end of the report, where you reflect on potential benefits and

harms and you provide your reflections and conclusion.

Now, during the course of the evidence we've heard and received so far from Oxehealth, or LIO, and EPUT, we've been informed of a number of important claimed benefits that Oxevision afford, and they include but are not limited to: a suggestion of enhanced physical health monitoring; also of time savings, allowing for staff time to be freed up for patient engagement; and linked with that, improvements in patient and staff experience, in the context of allowing for a more therapeutic approach; financial incentives; that the technology can be less intrusive than a staff member coming into the room and disturbing a patient, particularly at night; that the system delivers reductions in the rates of patient safety events; and the provision of video and other data following an incident; and the provision of reports of the type that we've just been discussing.

Now, we've discovered those points but the suggestion in terms is that they add up to an important tool to assist in looking after mental health inpatients, keeping them safe, and maximising the potential for properly therapeutic engagement.

Now, having considered all of this and having gone through your evidence today, what do you say about that?

A. I welcome assistive technology. My experience of

Oxevision in practice is that for it to be effective, you almost have to put Oxevision on observations. So somebody is assigned to have that portable device that would alert. So that member of staff has to respond to those alerts. So my experience, it's not saved time. It's added an extra layer of work on, but what it has done is give us an insight into what is going on inside patients' bedrooms when we're not there. That is what it has given, but you've got to balance of is that absolutely necessary?

Q. You say this at paragraph 31.2, it's page 99:

"However, I remain concerned that the introduction of such technology into inpatient mental health settings carries significant clinical, ethical and human rights implications. A camera sensor or alert cannot understand distress, hopelessness, shame, agitation, elation, paranoia, trauma, responses or the meaning of the patient's behaviour. It cannot determine whether a patient is becoming more withdrawn, more frightened, more suicidal, more suspicious, or more in need of a human connection."

Now, the reference there to the technology carrying significant clinical, ethical and human rights implications, have we touched on those points during the course of your evidence?

A. I believe so, yes.

Q. Is there anything more that you'd like to say about that?

A. No.

Q. Could that then bring us on to Section 31 of the report and your recommendations and we can see these set out from page 100.

Before we go to them, these proceed on the assumption that Oxevision remains in an inpatient unit, don't they?

A. It does, yes.

Q. So before we get to that, do we need to bear in mind all the points you've made, including the ones you've just made, about your views on Oxevision, and all the points you've just raised? Do we need to take those into account on the question of whether Oxevision should be there in the first place?

A. Yeah, and I still remain on the fence whether I think Oxevision should remain on inpatients. I can see the benefit of assisted technology, but not for all patients. Like any intervention, it's not one thing fits all. So I'm still on the fence that it's an 'all' model but I can certainly see that it might benefit some.

Q. Thank you. So just moving on to dealing with your

recommendations in turn. The first recommendation is: use of Oxevision should be clinically justified, appropriate, and consent based.

Would you explain what you mean, by that, please?

A. I think if there's a clinical rationale for it needing to be used and the patient consents to it, then it can be used, but it should be used with time limited, like observations, because a patient's risk, clinical need should change and it should change in line with that patient travelling through their recovery. So it should not be on from the point of admission to the point of discharge. It might be just necessary for a period of 48 hours when somebody is in the most distress, and we balance observation levels with the use of assisted technology.

Q. Thank you. The second recommend is that:

"Staff access should be individually logged and auditable."

Could you just cover that, please.

A. Yes, I believe it has moved to that staff log-in does require to access a room. So that is absolutely, when you're accessing patient's clinical record, there's a data log of that and I think the same should apply for accessing a patient's bedroom and it should be communicated that it is only when absolutely necessary

would you view a bedroom. And when it is viewed it's followed up by a discussion. Was it necessary? Was it informative? And also, let the patient know that they've just had their room viewed and what that tells us.

Q. Thank you. The third recommendation:

"There should be clear national standards on the minimum response to VBT and VBPMS alerts."

Would you just address that?

A. Yeah, having talked to colleagues and different professionals in the field, there seems to be a difference of what is good practice in response to alert times. So some people assume the quicker the response time, that was good practice, where the delay -- so I think I touched on it in the report. So a reset of three seconds would say, oh yes, you've been alerted to that incident immediately, but it doesn't actually evidence whether you've checked on the patient; it could just be that you've just reset the button.

Or a check that went beyond the 15 seconds, that could imply that somebody actually has gone physically round and spoke -- reviewed the patient.

So depending on who you talk to, a better understanding of what is the expected standard of alerts set. And actually, do they mean anything?

Q. Thank you.

Your fourth recommendation is:

"Audits should include patient and family experience."

Would you expand on that?

A. Yes, so when we audit observations and engagement and the use of Oxevision, it should be capturing the patient's and family's views. How was it for them? Did they feel as though their observations were compliant? Did the staff member come the number -- patients do tell me "I'm on level 2 obs and nobody's been to check on me". So that would be another source of: are those engagements happening, not just from a professional's point of view, but gathering from families and carers.

Q. Now, we may have covered most of the final recommendation:

"Observations Engagement and VBPMS training should be face-to-face and competency based."

We can read what you've set out there. Is there anything more you'd like to say about that now?

A. No, I've got nothing more to add. I think I've just stated because there's a lot of emphasis on the Nurse in Charge ensuring that somebody's competent, and they're juggling competing demands and it's a really, really busy and challenging environment and I do believe that

the competency of those staff should lie with the higher management.

MR GRIFFIN: Thank you.

Chair, do you have any questions for Ms Archibald at this stage?

THE CHAIR: I don't, no.

MR GRIFFIN: So we're going to take a pause in a moment for 15 minutes.

When we come back, there will be some questions from other lawyers representing some of the Inquiry's Core Participants.

Chair, we'll hear from a maximum of four lawyers, as I understand it. They've provided the Inquiry with notice of the areas they wish to cover, and the Inquiry has responded about those areas about which they are permitted to cover. We require a short period of time just to arrange things.

The lawyers will have a maximum of 15 minutes from the moment they sit down at the table and Chair, your instructions are that that must be enforced. There is one lawyer who will -- who is dealing with the shorter matters who will have five minutes in which to raise those matters. And if necessary, there may be some more questions from me, as well.

I will call advocates forward and they'll come to

the table here, but as I've said, we'll have a pause before that happens.

Could we be back and starting again, please, at 3.55?

THE CHAIR: 3.55.

(3.38 pm)

(A short break)

(3.55 pm)

THE CHAIR: Mr Griffin.

MR GRIFFIN: Chair, we're now at the stage where we will be hearing questions from recognised legal representatives of Core Participants. I'm going to ask in each case that when an advocate comes forward, before they ask their questions, would they kindly introduce themselves first.

Questioned by MS SCOLDING KC

MS SCOLDING: Good afternoon, Ms Archibald. My name is Fiona Scolding King's Counsel, I'm asking questions on behalf of LIO Limited, who, for today's purposes, I shall refer to as Oxehealth.

I've been permitted to ask a few questions arising from your report.

The first question I wanted to ask you, is about the CQC and NHS England guidelines. I think I can see extensive reference to them in your report. In your

professional opinion, do they set out an adequate set of standards and balances for Trusts to consider and reflect upon before deciding whether or not to use vision-based monitoring systems?

A. I do, yes.

Q. And do you consider that that guidance is sufficient for Trusts in order to start them down the road of determining whether it would be appropriate to introduce or not introduce the technology?

A. I do, yes.

Q. Thank you very much.

In respect of using technology to support observations, and just to indicate, the position of Oxehealth is not that it is a substitute for observations, but it should only be used to support physical observations by staff, do you agree that in respect of pulse and respiration, the vital signs observations, they are necessary for the vast majority of patients who are in inpatient care, in particular because of the drugs that most of them will be taking?

A. Sorry, can you rephrase the question? Sorry.

Q. Yes. The vast majority of patients in inpatient care will be taking some form of drug or very often will be taking some form of drug to try and help them with their mental health condition. As a result of that, those

drugs may well have a sedative effect or other physical side effects. Is it therefore necessary to take somebody's pulse and respiration rate in order to ensure that they are physically well whilst taking those sorts of drugs?

A. They are two elements that are essential alongside other physical health observations, yes.

Q. Thank you.

Do you consider that pulse and respiration taken remotely can be of assistance in maintaining or keeping some record of physical health or physical deterioration over time?

A. I haven't seen evidence that the record of the vital signs taken remotely, have actually been used directly into the other set of physical observations that you might want to take.

Q. But it could be, you just haven't seen evidence that it has been?

A. In my understanding you would need to take it over a longer period of time rather than the 15 seconds to get an accurate reading. It could alert you to, or not -- it could encourage you to go and do a full set of physical observations.

Q. Okay.

And also, do you agree or accept that the technology

can be useful at night to take remote observations as alongside a physical check, if necessary, for risk assessment purposes?

A. It could be helpful during the nighttime.

Q. Right. Okay.

You say in your report at paragraph 12.17 that staffing levels in available clinical time have not increased in line with the need for additional governance and accountability over observations. Are you therefore saying that if this sort of technology is to be implemented, there does need to be additional time, as you suggested towards the end of your evidence, that there would need to be a person who was responsible for looking at the visual-based monitoring systems?

A. I think there needs to be a robust -- so within a shift plan in the day -- who is checking that alert system, and that it's not just solely reliant on somebody in a room that might not be in the room.

So there needs to be some structure around --

Q. Somebody on the ward --

A. Yes -- (overspeaking) -- so that will be an additional task assigned to a member of staff.

Some places will assign the person who is doing level 1 observations to the portable device, for example.

Q. Right.

Do you consider that Oxehealth/Oxevision can be particularly useful in places such as seclusion, in long-term segregation, or in health based places of safety?

A. I can see their use in those areas, yeah, if it's not safe to enter.

Q. Yes, and can you explain why they would be of particular use in those areas?

A. It can offer some assurances that a patient is breathing. If you are not able to get a full view of the -- those areas, although they are designed for full view, there are areas that might not give a full view for the practitioner reviewing them.

Q. Yes. And in respect of seclusion, particularly patients who may be in seclusion or long-term segregation there may well be health -- or particular safety risks to staff, less so with health-based places of safety, I would envisage.

A. Yes, particularly in seclusion, the risk profile tends to be risk to others.

Q. Yes, okay. You set out some very useful guidance within your reports, within your report at paragraph 23.2 to 23.3 about who should be consulted in respect of consent to Oxehealth. Do you agree that those individuals

should be consulted about all other aspects of a patient's care? You talk about family members, loved ones, other groups. And that it shouldn't just be -- it shouldn't just be for vision-based monitoring systems but there should be kind of a good process of engaging with family members and wider kinship groups?

A. Yes.

Q. On all aspects of inpatient --

A. All aspects of care, it should be -- wherever possible, you should be getting the views and the consent of everybody involved.

Q. And so this is a more widespread issue throughout mental health generally in terms of levels of consent or ways in which family members are engaged; it's not just an issue with vision-based monitoring; it's an issue with the system as a whole. Is that right?

A. Yes, I would agree that it could be improved on.

Q. Okay. At sort of a Section 31 of your report you summarise various conclusions which says -- in which you say that technology can have a legitimate role in supporting patient safety but it should only ever be a supplementary tool to assist staff about movement, room presence, deterioration, nighttime activity, and potential risk, and it cannot replace human interaction nor understand the meaning of and signs of different

emotional responses.

Is that your concluded view as to the usefulness of the vision-based monitoring system, therefore: that it's in addition to, not a replacement for?

A. Yes. I see it as an addition. I think, from having gone through writing this report, preparing the report, I think when it was implemented it's gone as a blanket for everybody and I think that's where the error -- it can be used but it has to be meaningful and specific to individuals.

Q. Can you also identify that you -- you looked at a number of case summaries, some of which involved the use of Oxevision. Can you identify with any of those in any way in which, whether there was any way in which it was the technology that was problematic or it was the use of the -- or was it rather the use of that technology, or the misuse of that technology that was problematic?

A. I think it was the use and the misuse of the technology.

MS SCOLDING: Thank you very much, I have no further questions.

MR GRIFFIN: Chair, we'll be hearing next from Ms Campbell. May I ask that she comes forward.

Questioned by MS CAMPBELL KC

MS CAMPBELL: Thank you, and good afternoon, Ms Archibald. My name is Brenda Campbell and the questions that I ask

are on behalf of the families of Christopher Nota, of Edwige Nsilu, and Sophie Alderman, in fact the latter two, you have considered their case summaries and their families' evidence.

And I also represent Stop Oxevision, whose work you have considered in the preparation of your report.

Many of my questions are premised on your first recommendation and we looked at it just a little while ago. It's at page 100 of your report, and I don't need it on screen unless it would be helpful to you but it says that:

"The use of Oxevision should be clinically justified, appropriate, and consent-based. Oxevision should only be used where there is a clearly documented individualised clinical rationale, and where its use is proportionate to the identified risks."

I might just focus in initially on the issue of consent-based, if I may. As to obtaining that informed consent, have you, in your research or preparation, seen any data or research demonstrating what proportion of patients would actually consent to being monitored by Oxevision if they were fully informed as to how the technology works?

A. The only information that I've reviewed was the audit on the consent base, which didn't highlight that it was

routinely been -- so the standard was that consent would be sought at the beginning of an admission within a timeframe. The audit data that I've seen didn't show compliance with that.

Q. With that protocol --

A. Yes.

Q. -- or with that process? The Inquiry heard evidence, in fact yesterday, that where an informed opt-in consent model was adopted by Leicestershire Partnership Trust, fewer than half of the patients were willing to consent to the use of Oxevision in their bedrooms and some of those who did consent later withdrew that consent when they became aware that the system included cameras that were recording. Does that surprise you?

A. No, that doesn't surprise me.

Q. We also -- well, perhaps I can ask you, why not?

A. I think, when patients realise that it can record them over 24 hours, that that might raise concerns for them. So initially they would say, "I don't want it on."

As they progress through their care, that might -- they might reconsider that. But it does not surprise me. I think when they're fully informed, that they might be a bit sceptical of what it can offer so they would rather not go with it rather than go with it.

Q. We looked at, yesterday also, a further Leicestershire

Partnership Trust report which contained an account of an incident in which a pregnant patient -- I think, in fact, you've discussed this briefly this afternoon -- a pregnant patient had initially consented to Oxevision but subsequently withdrew that consent, sleeping in an interview room rather than in the bedroom with the Oxevision system installed.

And this afternoon you've told us that one significant consequence of having Oxevision installed on a blanket basis in wards is that it can cause that element of distress to patients who refuse consent to having it in their room. And you have experience of that; isn't that right?

A. That's right, yes.

Q. Now, another consequence of that, however, is also related difficulties for staff trying to resolve that distress, or make practical changes to keep that patient safe in an alternative environment. How significant is that consequence, the other side of that?

A. It can be quite significant consequence in that when -- it can lead to patients not trusting us, but equally, some patients report that they feel that we don't trust them either. So it's -- and that's why we're using this remote monitoring to monitor their behaviour. So it works on both parts.

Q. Does it, conversely, also materialise that having Oxevision enabled in some rooms but not others is liable to cause inefficiencies for staff running perhaps two parallel approaches in relation to different patients in different bedrooms?

A. It might make, if not all patients have Oxevision switched on, the patients who do that have it on, it might actually make the staff who are monitoring that system more alert because of the -- where when it was a blanket ban, it became possibly less meaningful to the staff who were monitoring the system. So if -- and if it's switched on for patients who agree and then there's a specific purpose to it and a known risk, it might make the professional more alerted to the alert as such.

Q. That may be an optimistic or a hopeful outcome, but does it also give rise to a risk, again on the flipside of that coin, of perhaps failures in handover or failures in communication, or recordkeeping, resulting in misunderstandings because checks have been missed on Oxevision where it's believed they have been done?

A. Yes, I suppose it does, and there's also a risk that if patients' bedrooms move that the device doesn't get switched off in line with the patient moving so there would have to be robust systems in place to make sure that Oxevision is meaningful to that patient that is

switched on. Because patients do move bedrooms quite frequently on inpatient wards so it's just being mindful of that.

Q. Now, you've been asked a number of questions about clinical justifications over benefits, and you've observed, in relation to nighttime checks, I think your evidence this afternoon was possibly there could be benefits through the night, so that you're not interrupting sleep by way of example. I want to ask you a few questions about that.

An August 2020 Early Insights Report, which we understand was prepared jointly by EPUT and Oxehealth, repeatedly characterises remote observations as less restrictive than in-person observations, particularly at night.

Now, do you accept that a measure that might be thought less physically intrusive can simultaneously constitute a much greater infringement on a patient's privacy?

A. Yes, I do.

Q. And you've observed, in fact, in answer to a question from Mr Griffin this afternoon that for some patients, nighttime is a particularly difficult time, when they might need an additional degree of support for the reasons that you've outlined. Does it follow that

withdrawing regular nighttime physical checks that provide a level of in-person reassurance and replacing them with remote observation or surveillance, far from being clinically justified to promote sleep, might in fact be clinically detrimental for some patients?

A. It could be. That's why it would have to be individually tailored, whether it would be appropriate for each patient to do remote checks.

Q. And it comes back to your evidence about it very much a patient-centred case -- (overspeaking) --

A. -- (overspeaking) --

Q. -- basis. You mentioned in your evidence this morning about nighttime ward environment and about other noises and you talked about heavy doors or other patients or alarms going off. To what extent has this source of sleep disturbance on wards been measured? So, in other words, are observations more likely to keep a patient awake at night than other environmental noise such as staff talking or heavy doors or alarms going off?

A. To my knowledge, I don't know, I know there's been research done on sleep on mental health inpatient wards, and I think there's a number of factors that keep patients awake and it's not just on -- it's not just observations but it is other noise factors. And environmental factors as well.

Q. Yes, because wards can be busy and noisy places even during the night?

A. They can, and the mattresses aren't particularly comfortable. The bedding is not particularly comfortable. So there's -- lighting isn't particularly comfortable so there's lots of factors that can affect a patient's sleep.

Q. I want to move on to ask you about another recollection given by EPUT staff in the Early Insights Report and it's under the heading "Improving privacy for vulnerable persons" and a member of staff is quoted as saying:

"Many of our patients have histories of sexual abuse. When we have male staff on observations they need to enter the ladies' bedrooms at night to check on them. For these ladies it can be very triggering waking up confused and seeing a man in their bedroom. For a moment they forget where they are and it's very disturbing for them but now we use Oxehealth to observe them overnight discreetly and remotely, which we really like and which we know benefits the patients."

In thinking about that as an example, do you agree that a female patient being monitored remotely and observed in her bedroom at night by a male member of staff is hardly better than a staff member going into her bedroom to check on her?

A. I would see it more distressing to be observed remotely because you're not aware of when and how frequent it's happening, where in the room you're aware.

Q. Well, that in fact deals with, to some extent, my next question. At least with a physical check a female patient would be aware --

A. And you can raise -- (overspeaking) -- and it empowers the patient to raise an objection.

Q. I want to ask a few questions about the potential benefits of collecting of vital signs using the technology during the night.

We heard yesterday from Mr Patino from LPT about their experience of piloting Oxevision on their wards. Are you aware that one of the reasons LPT ultimately terminated the contract with Oxevision following the conclusion of their pilots last year was that the staff reported that the system frequently failed to collect vital signs during the night, rendering in-person nighttime checks necessary in any event?

A. I wasn't aware of that.

Q. Well, does it surprise you?

A. No. When I've looked at the vital signs attempts but the actual readings, the reading is below 50 per cent but I wasn't able to interpret why it was less than 50 per cent. I made the assumption that the patient

just wasn't sitting still or the areas were covered. I didn't know what the rationale was for that.

Q. And in fact in your evidence today you've told us of an additional degree of danger that comes from perhaps assumptions like that being made by staff, that the system is failing to collect vital signs, and the danger could be that the failure to collect vital signs is in itself being misinterpreted and there's a much more significant risk in the room to that patient at that time?

A. I don't know enough about it to say why it couldn't get vital sign readings so I don't feel as though I'm fully able to comment.

Q. But do those failures to get readings in the data that you have considered raise further questions about the purported clinical justification of collecting vital signs during nighttime observations?

A. There's also an assumption that people are present for vital signs but the patient might not be in the room. So it might be inappropriate use from staff attempting to get vital signs.

Q. Okay.

MR GRIFFIN: Can I just indicate --

MS CAMPBELL: And my final question.

MR GRIFFIN: Oh, perfect, sorry to have interrupted.

MS CAMPBELL: My final question is this: in circumstances where we understand that Oxehealth charges a flat licensing fee per ward, regardless of whether the system is switched on or even installed in rooms, and of course that is ultimately paid from the public purse, would you agree that consideration, perhaps serious consideration, should be given as to whether the financial outlay for the system is justified?

A. Yes, well, I think individual Trusts would need to answer if it's financially justified in their service and if they're seeing the benefit from it.

MS CAMPBELL: Thank you. Those are all my questions.

MR GRIFFIN: Chair, we'll next hear questions from Ms Bartlam. May I ask that she comes forward.

Questioned by MS BARTLAM

MS BARTLAM: Good afternoon, Ms Archibald. My name is Chiara Bartlam and I ask questions on behalf of the charity INQUEST. I just have two short questions on Oxevision.

The first relates to the appropriate use of it. And a couple of weeks ago now, the Inquiry heard evidence from a person called Ian Arthur. Now, he was the Matron on the Peter Bruff Unit when Oxevision was piloted in 2020 and helped to produce the first Standard Operating Procedure.

Mr Arthur explained that Oxevision could be used as an observation tool, that could help staff to provide a less intrusive intervention to somebody who might otherwise need to be observed constantly. And the question is this: should Oxevision be used for this purpose, in your view?

A. No.

Q. And can I ask why?

A. I -- it does not take away the human factors that a professional or mental health nurse needs to be able to engage the patient to make an informed decision about their care and treatment and vice versa. So it should not replace.

Q. And my second question is on that informed decision, and the patient's informed consent. You've explained to the Inquiry that in your view, patients should be told that Oxevision is recording 24/7. In your view, should patients also be told about the risk of staff misuse and any limits on the available measures to prevent that from happening?

A. I think patients should be informed of what staff have access to and what they do with that information, and patients should be informed of how frequent that the camera is accessed.

MS BARTLAM: Thank you. I don't have any other questions.

Thank you, Chair.

MR GRIFFIN: And the last advocate we will hear questions from today is Ms Misra. May I ask that she comes forward.

Questioned by MS MISRA KC

MS MISRA: Good afternoon, Ms Archibald. My name is Eleena Misra and I'm leading counsel instructed by Hodge Jones & Allen which represents a number of bereaved families and lived experience clients.

So thank you very much for confirming earlier today that in preparing your report you reviewed the documents provided by the Inquiry, which included family statements, some of which related to our clients, and case summaries. I'm going to ask you some questions by way of clarification of your report, if I may, but I have very clearly in mind what your Terms of Reference were.

I hope with the benefit of having read the material provided by the Inquiry, you may be able to assist a little further, and no doubt you'll be pleased to know that I think I am the last to be questioning you at the end of what is a long day, no doubt.

So if I could start, first of all, with page 12, paragraph 4.1 of your report, where you say that:

"Prior to 2000 there was little guidance for

observations practices in mental health settings."

And you go on, very helpfully, through to about paragraph 4.10, to cite a chronology for policies and procedures as they then developed.

Ms Archibald, I wonder if I could ask you, in your opinion, how effective were any of these in providing sufficient guidance on observations?

A. I think they were effective. It definitely -- I witnessed changes on the ground of how we thought about observations and engagement and the governance became more robust. It definitely influenced -- we became more trauma-informed in our way of the practice. So I do think it significantly influenced practice.

Q. And going back to your evidence this afternoon, is that because of the emphasis on the therapeutic engagement side of it?

A. Yes, yeah.

Q. Thank you.

So remaining at page 12 of your report, I'm now at paragraph 3.3, where you say that:

"When supported observations are delivered effectively, they can improve safety of care."

Now, based on your review of the evidence which has been made available to you by the Inquiry and where necessary, contrasting with your professional experience

in Cumbria, are you able to say whether this was happening across the Essex Trusts in the index period 2000 to 2023?

A. I've only been given evidence of where things haven't gone to plan, or where sadly people have died. I am sure that there was people who -- patients who received care in Essex Trusts who observations did help them. So the information I have was based on people who had died, unfortunately.

I'm sorry, I don't know if that's answered --

Q. So from your perspective it's a snapshot --

A. Yeah, it's a snapshot. I'm assuming that they have lots of patients in their care who observations did benefit.

Q. Thank you.

So I'm now going to move on to page 16 of your report and it's paragraphs 5.1 to 5.24, in which you deal with the defined levels of observations and engagement. And in particular, at paragraph 5.1, you refer to the NICE guidelines and the ETOC guidance. And you say:

"The guidance emphasises that observation is a therapeutic intervention and should not be undertaken as a passive or purely observational task."

So again, based on your review of the case summaries and other underlying materials and documents you were

provided with, do you consider that that guidance was followed in the cases concerned, and if so, to what extent? Just as a general impression.

A. No, it does not appear that the guidance was followed in the majority of the cases. Sometimes the observation -- I couldn't see evidence of the engagement, but in some cases the observations didn't occur.

Q. Thank you very much.

Are you able to say, from what you've seen, which factors played or may have played a role in not following the guidance?

A. It seems staffing, training, experience, all played a factor. Culture.

Q. Thank you very much.

So, moving on now to page 22 of your report, and I'm going to paragraph 6, if I may, you say there that:

"Physical health monitoring is an essential part of holistic assessment for all patients admitted to mental health wards."

In the evidence which you've reviewed in preparing your report, did you see any evidence of holistic assessments being carried out?

A. Yes, I've seen there was cases where physical health monitoring had taken place, and there was some elements of holistic care, but not completely. And as I say,

I've seen cases where the outcome was deaths. I've not seen the other side of the care that was given.

Q. Thank you very much indeed.

So turning now to page 33, paragraph 11.3, of your report. You state there that:

"Capacity and consent should always be considered when determining and implementing observation levels."

And you go on in that same paragraph to explain that:

"Valid consent should be informed and voluntary with patients receiving a clear explanation regarding the purpose and nature of the observations."

Again, in your review of the illustrative cases in Essex with which you were provided, was there any evidence that this was considered and implemented?

A. There was cases where there was informal voluntary patients on enhanced observation levels, and I took it that the patients had consented to those observation levels. The evidence didn't suggest that they were objecting to them. I did see cases where patients were admitted informally and then later on in their treatment became detained and observation levels were increased. So I seen -- but the case summaries didn't specifically refer to whether the patient consented or not to the observation levels.

Q. Thank you very much.

For my next question, I'm going to refer to a couple of paragraphs that you've included in your report, and if it's helpful I can summarise them but I'll put them to you and then go to the question and please do let me know if it will be helpful for me to either take you to them or summarise.

So in particular it's paragraphs 8.1, 12.7 and 12.15 of your report. And my question is really this: is the efficacy of observations in terms of a safety net for patients who are under the care of the Trust inextricably connected with the accuracy, timeliness, and appropriateness of care plans and risk assessments? Do the two go hand in glove?

A. They should do, yes.

Q. Can I ask you in your own practice how often do you feel that observations have been adversely affected by the lack of appropriate care plans or risk investments or the documentation of them?

A. Yes, there's serious consequences if there's a lack of care planning or adherence to the care plan.

Q. Did you find any evidence of this in the materials you reviewed for the report to the extent that you can recall specific cases?

A. I didn't see any evidence to suggest that the care plans

were collaborative. There might have been care plans, I just didn't see them. But in the case of -- I think it was Elise, the care plan wasn't followed when she went back to her room. So I've seen non-compliance with the care plan, but I haven't seen the details of the individuals and their care plan.

Q. Thank you. Was that the case of Elise Sebastian you're referring to there?

A. Yes.

Q. Thank you.

Moving on to a different area and perhaps one of the knotty issues -- I know you said earlier that it's sometimes quite difficult to achieve the right balance, but how is the tension between using the least intrusive method possible and dealing with the increased risk of harm or death resolved, in your opinion, and is it really a proportionality question?

A. I don't know. That's a big question.

Q. It is a big question. I think you earlier expressed it was difficult.

If I can put it this way: what, in your professional expertise and opinion, what is the best way to balance those factors if it is simply a balancing of factors, to arrive at the right course of action, as it were?

A. You want to be the least restrictive in all cases, and

it might be when you do a restrictive practice that's where it's time limited. It is a balance of that interpersonal relationship with the person that you you're caring for. It could be the treatment plan that the patient, the effectiveness of the treatment plan, and alongside that it could be the observation levels to meet that patient's needs and it has to be done at the right time by the right people with the right skills to do that.

A combination of all those, a good understanding of the patient formulation, knowing who the patient is, what they're about, who they are, collaborating with families, developing a treatment plan, and adapting observation levels in accordance with need. Somebody might be having a difficult day followed by a good day, and that's when it should fluctuate. But you should be prepared for things not going to plan, as well, at all times. There's a reason why people are in hospital, so you have to be prepared for deterioration -- rapid deterioration in some cases.

Q. Does this go back to your point to the Inquiry earlier that really this is best achieved by a case-by-case basis?

A. It is, yeah.

Q. Thank you.

And finally, page 99 of your report from about paragraph 31.1 onwards in the reflections and conclusions section. You say, and this chimes with what you said in your evidence a little bit earlier:

"Technology can have a legitimate role in supporting patient safety ..."

But you have of course in your report identified concerns and you've also identified in the course of your extensive evidence today concerns that you hold, as well.

Can you say whether, in any of the illustrative case summaries with which you were provided with the Inquiry, the use of Oxevision technology led to improved care for any of the patients?

A. I can't -- I don't believe I can see the direct link from improving their care.

MS MISRA: Thank you very much for your time, Ms Archibald. Those are my questions and I believe that I'm within my time, as well. Thank you.

MR GRIFFIN: Thank you very much.

Chair, I have no further questions for Ms Archibald. Do you have any further questions at this stage?

THE CHAIR: I don't.

MR GRIFFIN: Ms Archibald, that is the end of all of our questions for you. May I personally thank you both for

your report and for your evidence today.

THE CHAIR: I would like to reiterate those thanks. We have worked you very hard but it has been extremely helpful, both your report and your evidence today. So thank you.

THE WITNESS: Thank you.

THE CHAIR: Tomorrow?

MR GRIFFIN: Thank you very much. Tomorrow we resume at 10.00 am where we will be hearing from a further expert witness, in fact two witnesses giving evidence simultaneously. Thank you, Chair.

(4.33 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X