(i) Tess, Esk and Wear Valley NHS FT
(ii) Beverley Elizabeth Murphy
(iii) Second statement
(iv) May 2026

IN THE LAMPARD INQUIRY

WITNESS STATEMENT OF
BEVERLEY ELIZABETH MURPHY, CHIEF NURSE

I, **BEVERLEY ELIZABETH MURPHY**, Chief Nurse at the Tees, Esk and Wear Valleys NHS Foundation Trust, West Park Hospital, Edward Pease Way, Darlington, DL2 2TS ("the Trust") will say as follows:

1. I make this statement as the Chief Nurse at the Trust, in response to the request for evidence by the Lampard Inquiry, made pursuant to Rule 9 of the Inquiry Rules 2006 dated 17 February 2026 (the Request). The purpose of this statement is to detail the Trust's implementation and use of Oxehealth system on the wards.

Background information

2. The Request was received by the Trust's Solicitor, on 17 February 2026. The legal services liaised with Maxine Lawson, Senior Project Manager and Alison McIntyre, Associate Director of Nursing and Quality - Secure Inpatient Services, who are the Trust's leads on Oxehealth (Oxevision).

3. This statement was prepared on the basis of the information collated by Ms Lawson and Ms McIntyre and is accurate and complete whenever relating to events and documents dated August 2024 onwards, which is when Ms Lawson and Ms McIntyre were appointed to their posts. The parts of this statement relating to events prior to August 2024 are accurate to the best of my knowledge, based on information available.

Implementation of Oxevision

4. Implementation of Oxehealth at the Trust commenced in 2019, with a pilot running across 5 wards. The system went live on three wards at the end of 2020. In 2021, permission to extend its use was obtained from the Trust Board and the use has been extended further since. The system is currently operating on over 50 wards across the Trust's sites. Enclosed is a spreadsheet listing the wards where Oxehealth is utilised, detailing the level of deployment, the category of the ward, the relevant specialities, the description of the ward and the system's implementation / go live dates [**Exhibit BM1 - Spreadsheet**]. I understand it takes approximately two weeks from implementation of the system on a ward for it to become effective. The "go live" date in the Exhibit BM1 refers to the date when the system actually went live and became operational on the ward in question.

5. The Inquiry should note that due to lack of information available, whilst we are confident that the implementation dates are accurate, we are unable to ascertain whether the dates preceding August 2024 refer also to the "go live" dates. Due to the small and likely inconsequential difference between the same, the dates available on the Trust's internal system were adopted as the go live dates for the purpose of the spreadsheet.

Information provided to Patients and Families

6. At the start of the system deployment, between 2020 and 2022, signs informing of the use of the equipment were displayed in public areas within the wards where Oxehealth was in place. Enclosed is an example of such a patient poster [**Exhibit BM2 – RP Poster UK**] from the initial deployment, as well as a leaflet from the same time [**Exhibit BM3 – RP Leaflet Acute**] .

7. There was an expectation that the local crisis team would have discussed the use of this technology with the patient, prior to their admission to hospital. Further information was provided to the patients on admission, which formed part of the ward information pack [**Exhibit BM4 – L1164**]. This detailed what, when and how patient activity and vital signs were measured and/or recorded in the bedroom area. The staff

were required to answer any queries from the patient and/or family members in full, and a record of the discussion would have been documented in the patients' health record.

8. Enclosed is the Standard Operating Procedure from 2021 [**Exhibit BM5 - Standard Operating Procedure for the use of Oxehealth from 2021**]. This was replaced by the Oxehealth Policy [**Exhibit BM6- Oxehealth Policy**] and the Oxehealth Procedure [**Exhibit BM 7 – Oxehealth Procedure**], which were ratified in August 2024. The Policy addresses patient, carer and family communication in Section 6. All patients and/or carers are provided with a leaflet detailing Oxevision use at the point of admission [**Exhibit BM8 – L1220, v2 and v3**]. There are no agreed future intervals when these would be provided again, but information can be requested at any point during the admission. In addition, each ward has a poster displayed in communal areas [**Exhibit BM9 – Oxehealth Poster 2024**]. The poster and the Patient, Carer Information leaflet were co-created with lived experienced members.

9. In cases of patients with cognitive difficulties and/or issues impacting upon capacity and consent, their carers were asked for input and/or we used the best interest decision making process when deciding on the appropriate use of the system for that patient and for obtaining consent (Oxehealth Procedure, section 7).

Consent for the use of Oxevision

10. Prior to August 2024, once the Oxehealth system was implemented and it went live on a ward, this was turned on as standard, with an implied consent model. A patient only had the opportunity to 'opt out' of the system in exceptional circumstances. If a patient wished to opt out, this was discussed on an individual basis and agreed with the MDT (multi-disciplinary team), patient and their families. Unfortunately, it is not clear from our records what circumstances were considered sufficiently 'exceptional' to permit a patient to opt out of Oxevision use prior to August 2024.

11. When the Oxehealth Policy and Procedure were ratified in August 2024, it was agreed that a consent based opt-out model would be utilised Trust-wide. This meant that any patient could request to opt-out of using Oxehealth after a 72-hour assessment of risk

and mental state had taken place, or sooner if the MDT considered it to be harmful to the patient. This would be agreed with the patient and/or their carer and the MDT.

The Policy also foresees that patient consent is reviewed within each subsequent MDT meeting. Consent would be recorded in the patient records, specifically within the observation and engagement section of the Electronic Patient Record (EPR).

12. In cases where it is assessed that an informal patient lacks capacity to consent, the decision whether to use Oxehealth to assist with their monitoring takes place in accordance with the MHA (Mental Health Act) and the best interest process, set out in the Mental Capacity Act 2005 (MCA). This is detailed in section 7 of the Procedure. The decisions are taken by the MDT, as is the case for any other care/treatment decision making process for a patient without capacity. This facilitates personalised consideration of individual preferences, safety/risk, and other alternatives. This decision-making process is documented within the patient's notes on the EPR, alongside an updated safety summary. Patient advocacy is also taken into consideration for any decisions i.e. views from the patient's carer / family or an independent mental health advocate, and this is documented within the EPR.

The purposes for which Oxevision was/is used

13. The Oxehealth Policy and Procedure allow staff to use Oxehealth to conduct nighttime observations only, to reduce impact on the patient's sleep disturbance. This is only for patients on general observations and only when their consent for this use has been obtained in advance. The system cannot be used for those patients who are on an enhanced level of observation or for conducting observations during the day.

14. When observations are due, the staff come to the doors of the rooms in order to record the observations, but rather than entering the room, the system's vital sign function can be used instead. The in-person attendance to the room is to ensure that if entry is required i.e. due to risk or being unable to obtain vital signs through the system, there is no delay in entering and responding to the patient's needs. The Oxehealth system can only be used for nighttime observations and it cannot be used during the day.

15. The observations are recorded in the hourly general observation document (care rounds document), which is signed by the member of staff on each review period. Vital signs measurements can only be taken if the patient has consented to its use. The National Early Warning Scale (NEWS) is always attempted first, if trying to obtain physical health metrics.

16. With regards to whether the use of Oxevision alternated the manner, frequency, or delivery of in-person observations in practice, the Trust does not have the observation module of Oxehealth, so this had no impact. Patients can request to have nighttime observations completed (once asleep) via the Oxehealth handheld device. Staff are still expected to attend in person to the patient in their room but can use the vital sign function to check on them. The staff still attend so, if required to enter the room, there is no delay in offering support to the patients.

17. To support the investigation of a patient safety incident, and only when it is not possible to do so via other available data services, information from the Oxevision system can be requested as part of the investigation. This can only be approved for release and use within an investigation by myself as the Chief Nurse and the Deputy Chief Nurse (CN/DCN). Oxehealth "Clear Video Data" is available for 24 hours after the event. This shows clear video images from the patient's room. This information is deleted automatically after 24 hours from the system, unless captured and stored as part of an investigation.

18. "Anonymised Video data" can be obtained instead of the Clear Video Data, if the request is made more than 24 hours but less than 3 months after the event. This shows blurred images only.

19. If needed, "Activity Reports", which provide an activity timeline of a patient's movement within the room, i.e. in bed, in bathroom, can also be obtained, as well as a "Vital Sign Report", which provides vital sign trends.

20. This information is stored securely within TEWV, and no one can access without prior permission by CN/DCN.

21. With regard to the alerts, the Trust currently utilises the following alerts:

Type of Alert	Specialty	Configuration
At Door	AMH SIS	Warning after 30 seconds. Escalate to an alert after 2 minutes
In Bathroom	ALL	Warning then escalate to an alert after 3 minutes
Leaving Bed	MHSOP	Alert immediately7.00pm – 9.00am (Organic) Alert immediately 9.00pm - 8.00am (Functional)
Out of bed	MHSOP	Alert immediately 7.00pm – 9.00am (Organic) Alert immediately 9.00pm - 8.00am
Room Entry	ALL	Warning only

- AMH – Adult mental health
- SIS – Secure Inpatient Services
- MHSOP – Mental Health Services for Older People

22. The "Out of Room" alerts were originally used on Adult Mental Health (AMH) and Secure Inpatient Services (SOIS) wards between 9.00pm and 9.00am, but were deactivated on the 4 August 2025, to allow staff to concentrate on critical alerts like those for 'in bathroom' or 'at door'.

23. The consent based "opt out" model applies to all of the above categorisations. In cases where a person is unable to consent due to lack of capacity, a best interest decision would be made using either an MCA advocate and/or family/carer, as detailed above.

24. If a patient lacks capacity and cannot make an informed decision but expresses a request for it to be switched off, their wishes would be respected.

Decision-making in relation to the use of Oxevision

25. Overall, some wards were identified as not being suitable for the use of Oxehealth, for example, for those patients who are in standalone rehabilitation wards, as they are moving towards discharge, as the level of overall risk is considered to be less on those wards. Also, within learning disability services as often these patients require additional level of supervision due to their learning disability need.

26. Beyond that, decisions are made in line with individual factors with the exception of the operation of the system itself, which, at this stage, is blanket. The patients however have an option to opt-out of the use, irrespective of their individual factors.

27. As noted in response to question 2, the Oxehealth Policy and the Oxehealth procedure have been in place since August 2024.

28. In line with the Policy, the level of risk a patient poses is assessed by the community team prior to admission. However, on admission, a further period of review is required to assess the level of presenting risk, as this may differ in the hospital environment. A period of 72 hours is therefore considered appropriate to achieve the fuller risk assessment and formulation by the MDT on the clinical decision, using clinical discretion on the use of Oxehealth.

29. For the purposes of safeguarding and maintaining patient safety and upon completion of a comprehensive risk assessment, generally Oxehealth will be turned on for the first 72 hours from admission. The patients are informed of this and their wishes and feelings obtained.

30. The factors which are taken into consideration are as follows:
    a. Reassessment of the mental capacity status of the patient in relation to their understanding of the use and implications for them of Oxehealth;
    b. The current risk of patient harm to self and others;
    c. Any particular risk of re-traumatisation based on patient history, or other potential harms to the patient over the use of Oxehealth;
    d. The availability and use of alternative care interventions and other least restrictive approaches;
    e. Whether the patient is admitted formally or informally.

31. The risks and rationale for the proposed decision would then be discussed with the patient, carer/family and patient advocate as appropriate, and the discussions fully documented in the records. As noted above, the choice of the patient and personalised care is paramount when making the decision, as Oxehealth is assistive and does not replace normal routine nursing practices.

32. The use of the system is reviewed on a monthly basis. The recent reviews showed high rates of opt-out throughout the trust, most notably in secure patient services, eating disorder wards and rehab wards.

Policies, procedures and guidelines

33. The documents in relation to the use of Oxevision are as outlined in the enclosed Exhibits list.

Benefits and Risks of Oxevision

34. The original pilot dates back to 2019. At the time of the initial deployment, there were no risks identified in the initial proposals. The benefits anticipated following the pilot, and to propose the extension of the implementation, were listed as follows:

Benefit	Desired Outcome	Services
Reduce falls	• Reduced falls in bedrooms • Reduced severity of harm • Reduced demand for A&E services	Older Adult
Reduce self-harm, including ligatures	• Reduced incidences & early warnings to self-harm	Acute
Reduce assaults	• Reduced incidences & early warnings to assaults	PICU
Reduce restrictive interventions	• Reduced incidences of rapid tranquillisation	PICU
Improve physical health monitoring	• Improve adherence to physical health monitoring • Earlier detection of physical health deterioration	All
Improve patient experience at night, including sense of safety, sleep and privacy	• Digitally assisted nursing observations that are as safe as traditional methods • Improved sense of sleep at night • Improved sense of privacy at night • Improved sense of safety at night	All
Improve staff experience	• Improved confidence in managing patient risk • Improved clinical decision making	All

	• Improved sense of safety • Improved peace of mind	

35. In terms of benefits, as understood *now* by the Trust, when a patient consents to the use, Oxehealth provides an ability to obtain vital signs. It also alerts the nursing staff to patients who may be in areas of increased risk i.e. at a door for over 2 minutes or in a bathroom for 3 minutes so that staff can attend and offer assistance if required.

36. The system also provides "edge of bed" and "out of bed" alerts, which have supported early identification of a patient fall. There is also the ability to use the vital sign function for nighttime observations, so as to promote sleep, by not disturbing patients frequently and thus impacting on their wellbeing.

37. A recent survey of the staff and patients on the use of Oxehealth revealed that some staff and patients report that they feel safer with the Oxehealth alerts.

38. In terms of risks, as understood *now* by the Trust, these are noted as follows:
    a. Relational unintended consequences of the system as patient behaviours change and use of the system to seek relational support;
    b. An impact on privacy and dignity;
    c. Patients report intrusive nature of critical alerts;
    d. Staff report alert fatigue and prioritisation of the system alerts;
    e. Technical reliability i.e. false alerts;
    f. Alerts can interrupt therapeutic engagement;
    g. Limited benefits in long stay environments;
    h. Iatrogenic harm of use of the system i.e. increasing paranoia and perception of surveillance, impact on historical trauma;
    i. Increased requests for CVD (clear video data);
    j. Blanket approach within ward setting on alert configuration and unable to customise to individual patient;
    k. Staff using the system as not initially intended and outside policy, i.e. using the system to conduct observations during the day or as a replacement of direct observations.

Use of Oxevision Technology for Observations

39. The Trust is now aware that the use of Oxevision technology for observations could decrease opportunities for therapeutic engagement, result in alarm fatigue amongst staff, pose a risk to patients (including through over-reliance on remote monitoring), give rise to a risk of harm to patients and give rise to a risk of the system being abused by staff.

40. These issues have emerged over time and were not anticipated, so far as is understood, at the time of the original implementation.

41. In order to mitigate those risks, following implementation and reflection of the ways in which the pilot and early implementation were analysed, a new policy was introduced in August 2024. This implemented improved provisions surrounding consent and sought to put in place measures to minimise the effect on patients' human rights when utilising the system, such as the need for explicit consent, nighttime use only and providing an opt-out option to all patients.

42. Each ward at the point of the ward 'going live', with the available staff on that day, has been trained by the Associate Director of Nursing and Project Lead for Oxehealth on the policy – specifically focusing on Human Rights, Privacy and Dignity, Ethical considerations, personalisation of the system, consent-based approach. This was to ensure that the Trust can be confident that all staff are clear on the policies and procedures to assist patients and ensure that they were being implemented consistently.

43. Since January 2025, The Trust have established a monthly governance structure co-created and attended by lived experience members and senior clinicians for the respective ward areas. This is to ensure that the monthly Oxehealth reports are scrutinised and that the system is being used as intended and in line with policy.

44. In March 2025, the Trust introduced monthly ward manager and matron audits. The purpose of these were to ensure system functionality, adherence to policy and provide regular patient/carer and staff feedback.

45. The number and nature of alerts are also regularly reviewed in a meeting held with the Chief Nurse and Deputy Chief Nurse, Director of Nursing and other senior nurse leaders. Following such a review, in August 2025, the out of room alerts were ceased due to reported high levels of alerts at concentrated times (i.e. early morning/late night).

46. The Trust have also made changes to the incident recording system, to easily capture and analyse those incidents that were supported by Oxehealth. Additionally, whenever a learning point has been identified, the Trust sends out a patient safety alert to all staff, to ensure that the lessons are learned and the system is used in line with the policy.

Staffing Costs

47. The initial Oxehealth business case of August 2019 [**Exhibit BM10 - Oxehealth business case**] indicated that there may be a direct cost benefit, as staffing costs were expected to reduce because of the system benefits. It stated that "whilst the trial will focus on quality improvement, anticipated financial benefits include a reduction in enhanced observations (reducing agency/bank spend), time and cost savings associated with fewer incidents (& associated reviews) and time savings associated with faster, more effective observation and interventions on wards".

48. There is reference within the business case to examples of other NHS organisations who had reduced enhanced observation spend, reduced serious incident costs and improved staff productivity.

49. However, I can confirm that initial valuations of the pilot (as outlined in the Oxevision Benefits Realisation Results dated March 2022) indicated that there was no direct impact on spending, and there was no evidence of any reduction in staffing or costs [**Exhibit BM11 - Oxevision Benefits Realisation Results, March 2022**]

50. As detailed above, the Oxehealth Procedure states that the use of the Oxevision system should not replace the usual care rounds, rather, that it should be used as an additional monitoring tool.

Assessments of Oxevision's Performance

51. An evaluation was undertaken to identify early insights after 6 months of use of the Oxehealth system. The Early Insights Report from 2021 [**Exhibit BM12 - Early Insights Report**] outlines that an evaluation was undertaken on a female acute ward, a mixed PICU (Psychiatric Intensive Care Unit) ward, and after 4 months of use on an older adult ward. The report was prepared from data collection and conducting surveys, interviews, and long-answer feedback forms with both ward staff and patients. The evaluation report concluded that the implementation of the Oxehealth system on the Trust wards had led to significant improvements in patient safety, risk management, patient experience, care quality and operational efficiency. The Early Insights Report noted that there was "improved safety on the wards because staff can respond in time to incidents and better manage risky behaviour".

52. It was acknowledged within the Early Insights Report that the system had potential limitations as, while the results were positive, findings were mostly determined from staff feedback and their perception of the impact of the Oxehealth system on patients. Therefore, to increase the amount of insight from patients on their perceptions of the Oxehealth system, it was acknowledged that more feedback needed to be gathered from both staff and patients.

53. A 'Quantitative impact of the Oxehealth system' was presented in February 2022 with the aim assessing the impact of Oxevision in the 3 'active' wards [**Exhibit BM13 - Quantitative impact of the Oxehealth system**]

54. A further service evaluation was undertaken in 2023 by Dr [I/S] (Chief Psychological Professions Officer) at the Trust [**Exhibit BM14 – 2023 Service Evaluation**]. The service evaluation was designed in discussion with key stakeholders,

i.e., nursing and governance teams, psychologists, and peer workers. Focus groups were also held with staff, patients and carers.

55. The conclusions indicated that there were both some clear benefits and clear harms of Oxehealth. The nature of the clear harms related to some patients raising concerns around a fear of being watched and how that impacted on their privacy and dignity, especially when tending to their daily personal care needs. Other concerns related to the noise of the alerts which were described as persistent, intrusive and could impact on the patient's clinical sessions. Some patients and staff also reported that the concept of being watched could lead to re-traumatisation of early life experiences and / or increased paranoia.

56. Further development of the system, and the way it was implemented in practice, were required, in order to ensure that the Trust was realising the opportunities presented for increasing patient safety, whilst also minimising harms. It was acknowledged that different services and individual wards had differing requirements. Ensuring that these differences were recognised in future developments was essential for the ongoing benefits realisation.

57. In October 2023, the Executive Directors Group was asked to consider and review the Oxehealth position including process, governance and implementation. The report provided reasonable assurance that Oxevision roll-out was underway, incorporating awareness of risks, learning from initial roll-out including SOP and Policy development with service user involvement and consideration of wider system concerns. It is unclear if this initial evaluation was based on any qualitative data or audit findings undertaken by the Trust, or on information provided by Oxehealth in respect of findings from other NHS organisations. The Trust now triangulates information from incidents, Oxehealth performance data, patient/carer and staff feedback.

58. There is a further ongoing evaluation being conducted by the Trust evaluating how we have implemented and used Oxehealth which will be presented to the Trust's Executive team in April 2026.

59. In addition to the above evaluations, the Trust also now has in place a number of monthly meetings which have oversight of the use of Oxevision. These consist of the following:

    - Oxehealth Installation Sub Group
    - Oxehealth Clinical Sub Group
    - Oxehealth Steering Group
    - Oxehealth Contract meeting

    A copy of the Terms of Reference for the Trust's Oxehealth Governance Groups is attached [**Exhibit BM15 - Terms of Reference for the Trust's Oxehealth Governance Groups**].

    The information from these meetings are reported bi-monthly to the Environmental Risk Group and a quarterly report to the Quality Assurance Committee.

Data Protection and Contractual Requirements

60. A copy of the Data Protection Impact Assessment (DPIA) for Oxevision (Vision Based Patient Monitoring System provided by Oxehealth) dated November 2023 is attached [**Exhibit BM16 - Data Protection Impact Assessment (DPIA) for Oxevision**], along with the DPIA for the Oxehealth Sleep Module Pilot dated February 2025 at [**Exhibit BM17 - DPIA for the Oxehealth Sleep Module Pilot dated February 2025**]. A data and governance overview was carried out in December 2025 which provides information on the processing, storage, retention and security of data [**Exhibit BM18 - Data and governance overview 2025**]

61. A copy of the Service Level Agreement between Oxehealth and the Trust is attached [**Exhibit BM19 - Service Level Agreement**], as are monthly usage reports produced by Oxehealth over the period June to December 2024 for the Trust [**Exhibit BM20 - monthly usage reports June – Dec 2024**].

62. The consent materials used by the Trust, including posters and leaflets, are already referenced within the response to Question 2 above. We also enclose a copy of the Trust's Privacy Notice [**Exhibit BM21 - Trust's Privacy Notice**].

Current levels of Oxevision deployment

63. Following the Trust's full-service evaluations referenced above at Question 14, there are benefits for deployment of Oxehealth on wards which may have patients with more complex needs and risks associated, one of which is that the system is an earlier identifier of falls. The Trust constantly monitors the level of deployment of Oxehealth across all wards where it is in place via the Governance Groups. Oxehealth can be stopped whenever required and a copy of the Trust's latest 'Stopped Rooms Report' dated February 2026 is attached [**Exhibit BM22 - Stopped Rooms Report**].

64. Some wards across the Trust have wards where all patients have opted out of using Oxehealth completely. These are often wards with longer lengths of stay.

65. The use of Oxehealth across the Trust is monitored closely via the internal Governance Groups in place within the organisation and as referenced above, a further service evaluation is being presented to the Executive team in April 2026 on the use of Oxehealth within the Trust.

Trust's business case

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

67. The business case is dated 14 August 2019 and the document indicates it was co-authored by Oxehealth (Digital Care Assistant) and Elizabeth Moody (Director Nursing & Governance, Deputy CEO at the time). I can confirm that Ms Moody is no longer at the Trust and retired from the NHS in April 2023.

Statement of truth

I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a

false statement in a document verified by a statement of truth without an honest belief in its truth:

Signed [I/S]

Printed Beverley Elizabeth Murphy

Dated 10 June 2026