

**Report for the Lampard Inquiry:
Observation and Engagement and the use of Vision Based Monitoring**

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Contents

Contents	2
1. Summary of Experience.....	3
2. Summary of Instruction	6
3. Observations and Engagement	12
4. Legislation, National policies, Standards and Guidance from 1 st January 2000 to 31 st December 2023, and at present day.	12
5. Defined levels of Observations and Engagement	16
6. Physical Health.....	22
7. Nighttime / Sleep	24
8. Dynamic and Fluctuating Observations	25
9. Staff Allocation	29
10. Observations levels when transferred to another ward or hospital.....	30
11. Legal Framework and Capacity to consent	32
12. Initiating, Care planning and Reviewing Observation Levels	34
13. Training.....	43
14. Observation and Engagement Rota	47
15. Staffing	54
16. Documentation	56
17. Monitoring and Compliance	59
18. Reflections on observations and engagement.....	62
19. Vision Based Patient Monitoring Systems (VBPMS) and Vision Based Technology in mental health inpatient wards	65
20. CCTV and BWC.....	69
21. VBPMS / Oxevision.....	72
22. Policy and Procedure comparisons with 2025 Guidance	74
23. Capacity to consent.....	79
24. Oxevision data reports	82
25. Alert Response Times	88
26. Falls	93
27. Finances	94
28. System Failure.....	95
29. Potential Benefits and Harms	96
30. Alternative Assistive Technology	98
31. Reflections and Conclusion	99
32. Recommendations	100
Appendix 1: Curriculum Vitae	102

1. **Summary of Experience**

- 1.1 I would first like to acknowledge the families and loved ones of those whose deaths led to this inquiry and express my condolences for their loss. In this report, I provide a number of case studies in which I refer to relevant circumstances surrounding the deaths of inpatients. I do so because it is important that what I say below is grounded in the cases being considered by the Inquiry. I do so with respect to the families of those to whom I refer and in the knowledge of the tragedies families, friends and carers have experienced. I hope the reflections and recommendations within this report contribute towards safer, more compassionate, and less restrictive care.
- 1.2 I, Jill Archibald, am a Registered Mental Health Nurse (RMN) with the Nursing and Midwifery Council (NMC). My qualifications include a Diploma in Mental Health Nursing and a BSc in Practice Development in Nursing. I also hold postgraduate certificates in Clinical Leadership and Mental Health Act Law, alongside a Level 7 qualification in Non-Medical Prescribing (NMP). I gained Approved Clinician status in June 2023. Further details of my training, qualifications, and experience are provided in Appendix 1.
- 1.3 I qualified as an RMN in March 2006, having begun my career in NHS mental health services in 2001 as a Nursing Assistant prior to undertaking nurse training in 2003. My early career was with Cumbria Partnership NHS Foundation Trust (CPFT).
- 1.4 I am currently employed as a Consultant Nurse and Responsible Clinician/Approved Clinician (RC/AC) on a male acute ward in Cumbria, a position I have held since November 2023. I have overall responsibility for the care and treatment of patients who have been admitted to the ward either on a voluntary basis or detained under the Mental Health Act (MHA) (1983, 2007, 2025)¹.
- 1.5 Since 2019, I have worked for Cumbria Northumberland Tyne and Wear NHS Foundation Trust (CNTW) as a consultant mental health nurse. I have worked clinically in Crisis Resolution Home Treatment (CRHT) and community mental health teams as well as single and mixed sex acute wards and a psychiatric intensive care unit (PICU). Prior to 2019 I worked for CPFT and held the position of service manager for acute, PICU and rehabilitation wards in Cumbria.

¹ *Mental Health Act 1983*, as amended by the *Mental Health Act 2007* and *2025*.

- 1.6 I was the clinical and training lead for self-harm, suicide assessment and risk management in Cumbria. I led and co-authored CPFT policies and practice on the assessment of self-harm and observation and engagement. I have also led on the production, training, and auditing for care planning within mental health and learning disability services.
- 1.7 In 2014, I became a Lead Peer Reviewer for the Royal College of Psychiatrists Accreditation for Inpatient Mental Health Services (AIMS) programme. AIMS is a standards-based accreditation model for mental health wards across the UK².
- 1.8 In 2024, I acted as an expert advisor on the investigation by the Health Services Safety Investigations Body (HSSIB), examining the use of enhanced observation levels for patients who self-harm on inpatient wards, and into the investigation of young people transitioning to adult in-patient services.³
- 1.9 I am familiar with the use of vision-based monitoring technology in clinical practice. From 2018 onwards, closed circuit television (CCTV), and Body Worn Cameras (BWC) were introduced to my area of practice. In my service manager role, I was not directly involved in the commissioning of CCTV, but I was involved in the governance discussions and implementation into adult in-patient wards. Body worn cameras were later introduced into my practice from 2019. I was not involved in either the commissioning, implementation or monitoring of this technology.
- 1.10 Oxevision is now referred to as LIO, following Oxehealth's rebrand in August 2025. However, many trusts and policy documents that I refer to in this report use the name Oxevision. Therefore, I will refer to this technology as Oxevision throughout this report. I first encountered Oxevision when I commenced my role as Responsible Clinician in 2023. The system had recently been implemented on the ward where I began working. I was not involved in its commissioning, implementation, training arrangements, or governance. I am familiar with the system in practice.
- 1.11 Whilst I am employed as a Nurse Consultant and Responsible Clinician within an NHS mental health trust, this report has been prepared independently and in

² Royal College of Psychiatrists (2024) *Quality Standards for Acute Inpatient Services for Working Age Adults: Ninth Edition*. London: Royal College of Psychiatrists, College Centre for Quality Improvement.

³ Health Services Safety Investigations Body (HSSIB) (2024) *Mental health inpatient settings: Supporting safe care during transition from inpatient children and young people's mental health services to adult mental health services*. London: HSSIB. Health Services Safety Investigations Body (2024) *Patients at risk of self-harm: continuous observation*. London: HSSIB.

accordance with my duties as an expert witness. The opinions expressed are my own professional opinions, based upon my knowledge, experience, review of the evidence provided, and consideration of the relevant literature, policy and guidance. They do not represent the views of my employer, any NHS organisation, or any other individual or body. 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.

2. **Summary of Instruction**

- 2.1 On 2nd May 2026, I was instructed to provide expert evidence as a mental health nurse on observation and engagement practices, and the use of vision-based monitoring and technology (VBPMS/VBT), in the context of mental health inpatient care. The relevant period is from 1st January 2000 to 31st December 2023.
- 2.2 This report will discuss observation and engagement practices and the use of VBPMs/VBT 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.
- 2.3 The report will address the themes highlighted by the Inquiry. I will reference the evidence provided to me by the Inquiry such as; case summaries, witness statements and relevant policies provided by the Inquiry, including material from Essex Partnership University NHS Foundation Trust (EPUT).
- 2.4 I have been asked to provide my expert opinion on the following areas set out below.
- 2.5 Background and benchmarking in relation to observations and the use of technology, including:
- 2.5.1 Relevant legislation, national policies, standards, and/or guidance, relating to observations and their development and deployment in the context of mental health inpatient care, including an account of any changes over the relevant period up to the present day.
- 2.5.2 Relevant legislation, national policies, standards and/or guidance, relating to the use of vision based patient monitoring systems, CCTV, and Body Worn Cameras, including an account of any changes over the relevant period up to the present day and when the relevant technology was introduced to mental health inpatient services, the impact of their use, the extent of adoption nationally, and any requirements or encouragement to adopt.
- 2.5.3 The extent to which I have, in my own practice, made use of technology in the observation of patients.

- 2.5.4 Relevant legislation, national policies, standards and/or guidance, pertaining to the implementation of new technologies in healthcare settings in/around 2020 and subsequently.
- 2.5.5 Best practice in respect of care and clinical practice to be expected during the relevant period, setting out how and when these changed in relation to:
- i. Observations (in respect of the assigned levels of observations);
 - ii. Therapeutic engagement;
 - iii. The use of vision based patient monitoring systems, CCTV and body worn cameras; and
 - iv. Any other technologies which should be available for the purpose of providing inpatient mental health care.
- 2.5.6 Challenges that arise in delivering best practices in respect of care, including, but not limited to:
- i. Staffing levels;
 - ii. Skills of workforce;
 - iii. Acuity levels on ward;
 - iv. Intensive observations;
 - v. Managing therapeutic engagement;
 - vi. Staff training; and
 - vii. Decision-making on ward, including Multi-Disciplinary Team decision making.
- 2.6 Thematic Issues in relation to observations, including:
- 2.6.1 Core principles, including why observations and therapeutic engagement are required, their intended benefits, and any recognised harms. This should include, but is not limited to, the following:
- i. The purpose of, and intended outcome, of observations;
 - ii. Patient safety considerations and the role of observations in keeping patients and others safe;
 - iii. The duration of intensive observations;
 - iv. Therapeutic interventions;
 - v. How practice in respect of observations and therapeutic engagement interacts with the principle of least restrictive practice;
 - vi. How observation and therapeutic engagement practices may need to account for a patients' specific circumstances;
 - vii. Standards and practice in relation to observation and therapeutic engagement following incidents of self-harm;
 - viii. Privacy and dignity considerations;

- ix. Agreement to frequency of review;
 - x. Role of care plans; and
 - xi. Record management, and responsibilities, in respect of decisions relating to observations.
- 2.6.2 The different levels and types of observations and therapeutic engagement, and why they are used. Including reference to national guidance in respect of levels of observations and how this is delivered at different Trusts. Including consideration of the adequacy of the Relevant Trusts' policies over the relevant period.
- 2.6.3 How a patient's level and/or type of observations and therapeutic engagement are decided and reviewed, including the assessment of risk in relation to the decision to change levels of observations, the process by which these decisions are made, and whether the patient or their family is involved in this decision.
- 2.6.4 Standards of documentation relating to the recording of observations and opportunities for therapeutic engagement.
- 2.6.5 How a patient's capacity, their ability to provide consent, the thoughts of their family, and the input of any best interests decision or Independent Mental Capacity Advocate are considered.
- 2.6.6 Staff training including the adequacy of the framework in place for staff training, competency checklists and initial supervision, any process that is or should be in place to monitor staff competence.
- 2.6.7 The enforcement of relevant standards, and processes for audit, monitoring and evaluation, including different mechanisms available to assess staff compliance with observations levels.
- 2.6.8 Observations use in the context of physical health conditions.
- 2.6.9 Appropriate strategies where a patient refuses consent for observations, including how the Mental Health Act 1983 or Mental Capacity Act 2005 apply.
- 2.6.10 Any other relevant considerations not covered by the above the above, such as the '*SleepWell*' initiative.

- 2.6.11 How the application of these principles varies as between voluntary and involuntary patients.
- 2.7 Thematic Issues in relation to vision-based patient monitoring systems (VBPMS), including:
- 2.7.1 Core principles relating to the use of vision-based patient monitoring systems including and practical consideration of its use to assist the administration of observations.
- 2.7.2 Potential benefits and harms from vision-based patient monitoring systems, both from the perspective of the Trust and individual patients, including:
- i. Utility of the Oxevision functionality, including the vital sign's function and its overall accuracy/reliability;
 - ii. 'Alarm fatigue';
 - iii. Impact on sleep;
 - iv. Prevention of self harm;
 - v. Protection of others;
 - vi. Efficiency of financial savings;
 - vii. How observation and therapeutic engagement practices may need to account for a patients' specific circumstances;
 - viii. Worsening of a patient's mental health;
 - ix. Over-reliance on vision-based monitoring systems versus physical observations and therapeutic intervention; and
 - x. Reduced opportunities for therapeutic engagement.
- 2.7.3 How the use of vision-based patient monitoring systems may interact with routine observations and therapeutic engagement practice.
- 2.7.4 The role, if any, of vision-based patient monitoring systems in managing concomitant physical health issues. This should include the consideration of whether safeguards are, or should be, in place to ensure physical monitoring is necessary, clinically indicated, and proportionate.
- 2.7.5 Standards of documentation which apply when using a vision-based patient monitoring system.
- 2.7.6 The potential for misuse or abuse, for example, access to vision-based monitoring by staff of the opposite sex to the patient.

- 2.7.7 Staff training, including the adequacy of the framework in place for staff training, competency checklists and initial supervision, any process that is or should be in place to monitor staff competence.
- 2.7.8 Any necessary contingency plans should the system fail or be unavailable.
- 2.7.9 The enforcement of relevant standards, and processes for audit, monitoring and evaluation.
- 2.7.10 How a patient's capacity, their ability to provide consent, their thoughts and those of their family, and the input of best interests decisions or an Independent Mental Capacity Advocate are considered.
- 2.7.11 The application of the relevant provisions of the Mental Capacity Act 2005, to include assessments of capacity; identification of best interests where a patient lacks capacity; the consideration of their wishes and feelings; and consultation with those concerned with the patient's welfare or engaged in caring for them.
- 2.7.12 Any impact from their use on the culture of care on wards and in the wider organisation, e.g. impacts on workload, task substitution, and clinical priorities.
- 2.7.13 The adequacy of relevant providers' policies over the relevant period.
- 2.7.14 The approach of healthcare providers to trialling, deploying, procuring and scaling new technologies in patient care, and any specific concerns relating to their use for mental health inpatients.
- 2.8 CCTV and Body Worn Cameras:
 - 2.8.1 A summary of the principles described above in respect of vision based patient monitoring systems, insofar as they relate to the use of CCTV and body worn cameras in inpatient mental health settings.
- 2.9 Other assistive technologies:
 - 2.9.1 A summary of any other assistive technologies which may be deployed on mental health wards (e.g. pressure sensor mats to monitor falls) and the principles relating to their use.

- 2.9.2 An account of the risks, benefits, and evidence base supporting the use of such technologies.
- 2.9.3 Consideration of other, less restrictive, technologies that can achieve the same outcome as Oxevision and benefits of those.
- 2.10 Where relevant, hypothetical examples have been used throughout the report to illustrate practical points discussed.

3. **Observations and Engagement**

- 3.1 Observations and engagement describes a clinical and risk intervention used in inpatient mental health settings. Together they provide for monitoring of the patient's mental state, behaviour and level of risk. They should maintain a patient's safety, privacy and dignity. The intervention can be considered intrusive and restrictive, therefore should only be used when clinically indicated to maintain safety and preserve an individual's dignity.
- 3.2 While observation and engagement can be described separately for conceptual clarity, in practice they should occur concurrently. Observing a patient can be considered a reactive response to a patient's mental state and runs the risk of providing for surveillance rather than therapeutic intervention. When an engagement element is added it provides for a more proactive response. Engagement refers to the therapeutic interaction that supports assessment and care. In practice, the two should be intrinsically linked. Effective care requires that both are undertaken simultaneously.⁴
- 3.3 When supportive observations are delivered effectively, they can improve safety of care and lead to better patient experience and improved clinical outcomes. Supportive observations are useful to prevent self-harm such as head-banging, cutting, burning, hair pulling, tampering with wound care, ligaturing and risk associated with choking, absconding, reduced nutrition and hydration, through self-neglect. They may also perform a role in maintaining a patient's privacy and dignity at times of disinhibited behaviour, reducing falls, reducing the risk of harm to and from others (e.g. violence and aggression) and managing clinical risks, such as those associated with declining physical health.⁵

4. **Legislation, National policies, Standards and Guidance from 1st January 2000 to 31st December 2023, and at present day.**

- 4.1 Prior to 2000 there was little guidance for observations practices in mental health inpatient settings. Instead, policies and procedures were developed locally. In 1999 the Standing Nursing and Midwifery Advisory Committee on

⁴ Walker, L., Reynolds, T., O'Shaughnessy, M., Pereira, S., (2005) 'Safe and supportive observation in practice: A clinical governance project', *Mental Health Practice*, 8(8), pp. 13-16.
<https://doi.org/10.7748/mhp2005.05.8.8.13.c1859>.

⁵ Bowers, L., Gournay, K. and Duffy, D. (2000) 'Suicide and self-harm in inpatient psychiatric units: a national survey of observation policies', *Journal of Advanced Nursing*, 32(2), pp. 437–444.

acute inpatient care (SNMAC) produced guidance on the practice.⁶ In 2003, the National Institute for Mental Health in England (NIMHE) published “*Preventing suicide: A toolkit for mental health services.*”⁷ This publication further influenced local policies on the prevention on self-harm and suicide.

- 4.2 In 2005 the National Institute for Health and Clinical Excellence (NICE)⁸ first published guidance on restrictive practices, observations, de-escalation, and management of violence in mental health settings. This was later updated in 2015.⁹ This guidance was the major influence in driving policy and practice and remains relevant to this day.
- 4.3 The Royal College of Psychiatrists introduced the Accreditation for Inpatient Mental Health Services (AIMS) programme in 2006. The programme was developed to improve the quality of inpatient mental health care through nationally agreed standards relating to safety, therapeutic care, patient experience, staffing, governance, and clinical practice. Although AIMS did not specifically create observation and engagement policies, it contributed to wider quality improvement initiatives that influenced how inpatient services approached risk management, therapeutic engagement, care planning, and least restrictive practice.¹⁰
- 4.4 The revised Mental Health Act Code of Practice 2015, chapter 26 influenced inpatient observations, through the principles of: least restrictive measures, maintaining dignity and respect, being person centred, carer involvement, and being trauma-informed and necessary.¹¹

⁶ Standing Nursing and Midwifery Advisory Committee (SNMAC) (1999) *Mental Health Nursing: Addressing Acute Concerns*. London: Department of Health. The original Department of Health publication could not be obtained despite reasonable searches. The description of the guidance is based on subsequent peer-reviewed publications that cite and discuss the original report. Cited in Walker, L., Reynolds, T., O’Shaughnessy, M., Pereira, S., (2005) ‘Safe and supportive observation in practice: A clinical governance project’, *Mental Health Practice*, 8(8), pp. 13-16, <https://doi.org/10.7748/mhp2005.05.8.8.13.c1859>.

⁷ National Institute for Mental Health in England (2003) *Preventing Suicide: A Toolkit for Mental Health Services*. Leeds: National Institute for Mental Health in England. Available at: <https://www.nescon.medicina.ufmg.br/biblioteca/imagem/1222.pdf>

⁸ National Institute for Health and Care Excellence (2005) *Violence: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments* (Clinical Guideline 25). London: NICE.

⁹ National Institute for Health and Care Excellence (2015) *Violence and aggression: short-term management in mental health, health and community settings* (NG10). London: NICE.

¹⁰ Lelliott, P., Bennett, H., McGeorge, M. and Turner, T. (2006) ‘Accreditation of acute in-patient mental health services’, *Psychiatric Bulletin*, 30(10), pp. 361–363.

¹¹ Department of Health (2015) *Mental Health Act 1983: Code of Practice*. Revised edition. London: The Stationery Office. Chapter 26, ‘Safe and therapeutic responses to disturbed behaviour.’

- 4.5 Around 2010, the Safewards Model started to complement national guidance. Safewards research was heavily influential in shaping how trusts understand observations, engagement, conflict, and containment. The research further strengthened the evidence for moving away from custodial observation and towards therapeutic engagement, relational security, and least restrictive practices. Safewards was/is closely aligned with trauma-informed approaches and although it was not a mandatory national framework, it became one of the most influential evidence-based practice models underpinning modern inpatient observation and engagement approaches.¹²
- 4.6 2018/2019 Mersey Care NHS Foundation Trust developed the HOPE(S) model.¹³ HOPE(S) stands for:
- **H** – Harness the system through key attachments and partnerships.
 - **O** – Opportunities for positive behaviours, meaningful and physical activities.
 - **P** – Protective and preventative risk and clinical management strategies.
 - **E** – Enhance the coping skills of both staff and patients.
 - **S** – System support and development throughout all stages of the approach.
- 4.7 The HOPE(S) model is a human rights-based, trauma-informed framework that aims to reduce long-term segregation and restrictive practices. It supports staff to understand the factors maintaining segregation, develop therapeutic relationships, enhance coping skills, increase meaningful activity, and create opportunities for safe progression towards less restrictive care. Although not an observation framework, its principles influence how staff engage with patients who require prolonged observation or segregation by promoting therapeutic engagement rather than solely surveillance and containment.¹⁴
- 4.8 The model is a structured multidisciplinary review framework, typically facilitated by staff trained in the model, and is primarily used for patients in long-term segregation or other highly restrictive care environments. It provides a framework through which staff, patients, families, and professionals can explore the factors maintaining the restrictive placement and develop a therapeutic plan aimed at reducing restrictions and supporting progression towards less

¹² Len Bowers (2014) *Safewards: a new model of conflict and containment on psychiatric wards*. Journal of Psychiatric and Mental Health Nursing, 21(6), pp. 499–508. King's College London (2024) *Safewards: A dynamic model for dealing with conflict and containment*. Available at: [King's College London Safewards Feature](#).

¹³ Mersey Care NHS Foundation Trust *HOPE(S) Model*. Available at: <https://www.merseycare.nhs.uk/hopes-model>.

¹⁴ Mersey Care NHS Foundation Trust *HOPE(S) Model*. Available at: <https://www.merseycare.nhs.uk/hopes-model>

restrictive care. Although the model was not specifically designed for observation practice, its principles of therapeutic engagement, collaborative care planning, understanding unmet needs, and reducing restrictive interventions may be applicable when considering patients who remain on enhanced observation levels for prolonged periods without a clear plan for progression.¹⁵

4.9 In 2024 the Cultures of Care programme (2024) further reinforced the importance of therapeutic, person-centred, and trauma-informed approaches within inpatient mental health services.¹⁶ Cultures of Care highlights the importance of understanding the reasons behind a patient's distress and behaviour, maintaining therapeutic relationships, involving patients and families in care planning, and ensuring restrictive interventions are regularly reviewed, necessary, proportionate, and reduced at the earliest safe opportunity. The guidance also recognises that ward culture, staffing pressures, leadership, training, and workforce wellbeing all influence the quality and effectiveness of observation and engagement practice.

4.10 In 2024, NHS England launched the Enhanced Observation and Care (ETOC) programme.¹⁷ The programme worked with trusts to improve care in relation to observations and engagement. The programme has four pillars, which are:

- 1) Effective leadership and oversight: governance, data, local assurance, clinical policy making;
- 2) Effective person-centred and safe therapeutic care: identifying the need for ETOC, monitoring and stepdown;
- 3) Effective education and training: staff are trained in reviewing, providing and overseeing ETO; and
- 4) Effective workforce planning and deployment: planning for levels of ETOC, ensuring ETOC is considered during safe staffing establishment setting processes.

¹⁵ Mersey Care NHS Foundation Trust *HOPE(S) Model*. Available at: <https://www.merseycare.nhs.uk/hopes-model>

¹⁶ NHS England (2024) *Culture of care standards for mental health inpatient services*. London: NHS England.

¹⁷ NHS England (2025) *Enhanced therapeutic observation and care: developing a local policy*. London: NHS England. Available at: <https://www.england.nhs.uk/long-read/enhanced-therapeutic-observation-and-care-developing-a-local-policy/>.

5. Defined levels of Observations and Engagement

- 5.1 There is no single nationally mandated system defining the levels of observation. They are typically defined within local trust policies, which are informed by national guidance as mentioned. Although terminology and exact frameworks may vary between trusts, they have the same clear principles as per NICE (2015)¹⁸ and ETOC (2024) guidance.¹⁹ The guidance emphasises that observation is a therapeutic intervention and should not be undertaken as a passive or purely observational task.
- 5.2 Observation levels are described in Levels 1 to 4 or by terminology such as general, intermittent, continuous, and constant observations. They can also be referred to as “specials”, “1-1”, “enhanced” and “close observations”.
- 5.3 **Level 1 (General Observations)** Level 1 refers to general observations, where patients are monitored at routine intervals while maintaining maximum independence. This usually involves checks at approximately hourly intervals. The purpose of Level 1 observations is primarily to maintain awareness of each patient’s location and general presentation, including for environmental safety purposes. Level 1 observations should still involve ongoing awareness of the patient’s presentation, wellbeing, mental state, and risk. Staff should use routine interactions throughout the shift to build therapeutic relationships, assess changes in presentation, and identify emerging risk. Some services adopt a less time restricted approach. They will do regular checks at the start, middle and end of a shift instead of hourly.
- 5.4 During the early 2000s, Level 1 observations were often viewed primarily as routine welfare checks, focused on monitoring patient location and basic safety at fixed intervals, with less emphasis placed on interaction/engagement. Over the years they have increasingly aimed to be more interactive. A significant development has been the move towards more flexible and dynamic observation systems. Some trusts have moved away from rigid hourly observation schedules towards approaches that emphasise continuous awareness, engagement, and clinical judgement.

¹⁸ National Institute for Health and Care Excellence (NICE) (2015) Violence and aggression: short-term management in mental health, health and community settings. NICE guideline NG10. London: NICE.

¹⁹ NHS England (2025) *Enhanced therapeutic observation and care: developing a local policy*. London: NHS England. Available at: <https://www.england.nhs.uk/long-read/enhanced-therapeutic-observation-and-care-developing-a-local-policy/>.

- 5.5 **Level 2 (Intermittent Observations)** involves observations being conducted at regular/frequent intervals within a defined period. This may include checks at 10, 15, or 30-minute intervals, or a specified number of checks per hour such as twice, four and six times within the hour. When a specified number of checks per hour is prescribed, the precise timing of each observation is often varied rather than conducted at fixed intervals. This approach is intended to reduce predictability and thereby minimise opportunities for self-harm, suicide attempts, absconding, or other adverse incidents. For patients assessed as being at risk of self-harm or suicide, predictable observation patterns may create opportunities to engage in harmful behaviour between checks. Conversely, where Level 2 observations are implemented primarily to monitor vulnerability or physical health needs, fixed intervals may provide a more consistent and clinically effective approach. For example, a patient placed on Level 2 observations due to poor fluid intake may benefit from observations occurring every 15 minutes, ensuring regular encouragement and monitoring of hydration. In contrast, four variable checks within an hour could result in observations being clustered together, potentially reducing the effectiveness of monitoring and intervention. The timing of observations should therefore be informed by the purpose of the observation and the specific risks being managed.
- 5.6 Since 2000, Level 2 observations have evolved significantly within inpatient mental health settings. During the early 2000s and up to approximately 2010, intermittent observations were often viewed by some nursing staff as relatively ineffective for managing high levels of risk. There was a perception that patients could still cause themselves significant harm during the periods when they were not being directly observed, resulting in observations becoming more reactive to incidents of harm rather than proactive in preventing them. At that time, observations were frequently more focused on monitoring and surveillance, with less emphasis placed on therapeutic engagement and relationship-building.
- 5.7 From around 2010 onwards, observation practice was influenced by the Safewards programme.²⁰ There was an increasing recognition that proactive engagement, and therapeutic relationships, could contribute to reducing conflict, distress, and self-harm. This shift influenced how Level 2 observations were understood and implemented. Compared with Level 3 observations, Level 2 allowed patients greater privacy, dignity, independence, and opportunity for normal ward activity while still providing increased support and monitoring. As therapeutic engagement became more central to observation practice, Level 2

²⁰ Len Bowers (2014) *Safewards: a new model of conflict and containment on psychiatric wards*. Journal of Psychiatric and Mental Health Nursing, 21(6), pp. 499–508.

observations became more widely accepted as a potentially effective and less restrictive intervention.

- 5.8 There is limited evidence that intermittent Level 2 observations alone prevent serious self-harm or suicide. The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) found that 91% of inpatient deaths under observation occurred while the patients were on Level 2 intermittent observations, highlighting concerns about relying on this approach as a standalone intervention.²¹ However, the NICE guidance from self-harm 2022 supports observation according to individual need where it is delivered by trained staff and includes therapeutic observation methods such as engagement and rapport-building.²² Level 2 observations may therefore be justified where proportionate to risk and used as part of a wider therapeutic risk management plan, rather than relied upon in isolation.
- 5.9 In my experience, where patients have died while allocated to Level 2 observations, findings have often related to observations not being completed to the required standard. This may include observations not being undertaken at all, visual checks being replaced by verbal checks, or staff relying on assumptions rather than directly confirming the patient's location, presentation, and safety. Risks may also arise where staff are unfamiliar with the patient group and incorrectly identify a patient, or where they rely on another colleague's statement that they have "just seen" or recently engaged with the patient. These examples highlight the importance of direct observation, accurate patient identification, familiarity with the patient group, and contemporaneous documentation. However, it is also recognised that some patients may fatally harm themselves despite observations being completed in accordance with policy and expected standards. This demonstrates that Level 2 observations can reduce risk but cannot eliminate it and should not be relied upon as a standalone safety intervention.
- 5.10 **Level 3 (Continuous Observations)**, also referred to as "1-1", "constant" and "specials", these require a designated staff member to always remain with the patient and to maintain uninterrupted visual contact. This level may be further specified as "within eyesight" or "at arm's length," indicating the required proximity between staff and patient. The purpose is to allow the staff member to provide an immediate intervention should risk behaviours arise.

²¹ University of Manchester (2015) *In-patient suicide under observation*. Manchester: National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, page 8.

²² National Institute for Health and Care Excellence (2022) *Self-harm: assessment, management and preventing recurrence*. NICE guideline NG225. London: NICE.

- 5.11 In the early 2000s, it was not uncommon to observe staff sitting outside bedroom doors or maintaining continuous visual supervision with limited therapeutic interaction. It was custodial in nature, with less emphasis placed on patient involvement, collaborative care planning, or understanding the patient's individual experience of being observed. Patients' views and preferences were often given less consideration, and trauma-informed practice was not yet widely recognised or embedded within inpatient mental health care.
- 5.12 Being on Level 3 observations can have a negative impact on the patient, particularly where privacy and dignity are affected. Some patients may avoid using the toilet, showering, or attending to personal care because they feel uncomfortable being observed. Although Level 3 observations usually require the patient to remain within eyesight, individualised care and safety planning should consider how this can be delivered in the least intrusive way.
- 5.13 This may include agreeing planned times for showering or changing, allocating staff members the patient feels comfortable with, and considering gender, trauma history, cultural needs, and patient preference. Where the patient needs to use the toilet, it may be appropriate for staff to temporarily adjust the approach, such as swapping the allocated staff member or using verbal checks for a brief period, provided this has been agreed through the MDT, is supported by the risk assessment, and remains safe and proportionate. During these times, the staff member should remain within the patient's proximity physically and be emotionally available, with clear expectations about how safety will be maintained.
- 5.14 Since the Safewards programme 2014²³ and the publication of the NICE guidance on self-harm (2015, updated 2022)²⁴ combined with the ETOC programme (2024/2025)²⁵ there is now a greater understanding of trauma and its impact on behaviour, resulting in approaches that are increasingly person-centred, trauma-informed, and therapeutically focused. These principles should be reflected within care plans, which should clearly identify the purpose of the observation level, intended outcomes, review criteria, and circumstances under which levels may be increased or reduced. Care plans should also identify

²³ Len Bowers (2014) *Safewards: a new model of conflict and containment on psychiatric wards*. Journal of Psychiatric and Mental Health Nursing, 21(6), pp. 499–508.

²⁴ National Institute for Health and Care Excellence (2022) *Self-harm: assessment, management and preventing recurrence*. NICE guideline NG225. London: NICE.

²⁵ NHS England (2025) *Enhanced therapeutic observation and care: developing a local policy*. London: NHS England. Available at: <https://www.england.nhs.uk/long-read/enhanced-therapeutic-observation-and-care-developing-a-local-policy/>.

personalised strategies that help the patient be safe and feel safe, along with promoting recovery.

- 5.15 HSSIB's 2024 investigation into continuous observation (level 3 and 4) found that it is a widely used but complex intervention, with limited evidence about its effectiveness and significant variation in how it is understood and delivered. The report emphasised that continuous observation should not be seen as a guaranteed way to prevent self-harm, particularly where it becomes passive, custodial, or task focused. HSSIB highlighted that the therapeutic element of observation is crucial, and that effectiveness depends on staff being appropriately trained, supported, and able to engage meaningfully with the patient.²⁶ The investigation recommended further national work to understand the efficacy and acceptability of continuous observation and to develop clearer guidance for staff, including expectations around training, competence, purpose, and delivery. This supports the view that observations should form part of a broader, individualised care plan rather than being relied upon as a standalone safety intervention.
- 5.16 **Level 4 (Constant Observations / 2:1 Observations)** represents the highest level of observation and engagement, whereby two staff members are allocated to a patient continuously. This level is typically implemented in response to the highest levels of assessed risk.
- 5.17 There has been increasing recognition of the significant staffing, governance, and therapeutic challenges associated with prolonged 2:1 observation. It was recognised that this level of observation is the most intrusive, restrictive and is likely to be traumatic for the patient. With Safewards and the later HOPE(S) model the practice was adapted to be a least restrictive approach. This level of observation now requires frequent MDT review, senior oversight, dynamic risk assessment, independent review and consideration of alternative strategies.
- 5.18 **Hospital Based Place of Safety (HBPOS):** local policies and procedures commonly state that patients detained under Section 135 or Section 136 of the MHA (1983) and brought to HBPOS should be placed on enhanced observations, typically level 3 or level 4. However, it is not, to my knowledge, mandated in national guidance that all such patients must automatically be placed on enhanced observations. This appears to be more commonly adopted as a default position by individual service providers. Patients brought to hospital

²⁶ Health Services Safety Investigations Body (2024) *Patients at risk of self-harm: continuous observation*. London: HSSIB, page 22.

under Section 135 or Section 136 may not previously be known to local mental health services or to the staff responsible for supporting them. As a result, local policies and procedures generally require, or strongly encourage, staff to actively engage with the patient, assess their mental state, identify current risks and vulnerabilities, and establish their immediate care needs.

- 5.19 Changes introduced through *Policing and Crime Act 2017* subsequently amended the MHA 1983 in 2017, which reduced the maximum duration of a Section 136 detention from 72 hours to 24 hours, except in exceptional circumstances where extension is authorised. This change reinforced expectations that assessments and clinical decision-making should occur more promptly and efficiently. Even within highly restrictive environments, observations should remain therapeutic and relational rather than purely custodial.
- 5.20 **Seclusion, Short and Long-Term Segregation:** When clinically necessary, some patients already admitted to a mental health inpatient ward may require seclusion or short/long term segregation, commonly referred to as S/LTS, from the main ward environment. This may be due to significant risks associated with violence, aggression, or behavioural disturbance. During periods of seclusion or LTS, patients are generally maintained on high levels of observation, commonly Level 3 or Level 4 observations. Within seclusion environments, observations are usually maintained through continuous visual monitoring via observation panels, supported in some services by additional VBPMs. Prolonged restriction can have a significant psychological impact, and staff should ensure that care remains therapeutic rather than custodial, with active attention to the person's wellbeing, communication needs and opportunities for meaningful engagement.
- 5.21 Patients are placed in seclusion because they are presenting a level of behaviour that poses an immediate and significant risk of harm to others that cannot be safely managed through less restrictive means. Seclusion is defined as the supervised confinement of a patient away from other patients to contain severely disturbed behaviour that is likely to cause harm to others.²⁷
- 5.22 Patients placed in seclusion require continuous observation because they are often experiencing a period of acute behavioural disturbance, emotional distress, or mental illness that places them at increased risk of both physical and

²⁷ Department of Health, *Mental Health Act 1983: Code of Practice* (The Stationery Office 2015), paragraph 26.103.

psychological deterioration. The circumstances leading to seclusion, such as aggression, violence, psychosis, severe agitation, or emotional dysregulation, may continue or worsen while the patient is secluded. In addition, the restrictive nature of seclusion can increase feelings of isolation, fear, frustration, hopelessness, or distress, particularly for patients with a history of trauma. Patients may also be at increased risk of self-harm, suicide, self-neglect, dehydration, poor nutrition, exhaustion, medication side effects, complications following restraint or rapid tranquillisation, and the deterioration of underlying physical health conditions. Continuous observation is therefore required not only to monitor ongoing risk to others, but also to assess mental state, physical wellbeing, response to treatment, and identify the earliest opportunity for the patient to safely return to a less restrictive environment.

5.23 **Zonal observations** can also be referred to as “visible nurse”. This approach involves dividing the ward into specific areas, with each staff member allocated responsibility for observing and engaging patients within a designated zone. However, in practice, where zonal observations are used, it is often the busiest or main communal area that is allocated a designated staff member. This reflects the reality that there are not always sufficient staff to allocate individuals to every area of the ward while still having enough time to deliver care and treatment and complete other ward tasks. Zonal observations can offer continuous awareness of patient activity in that location. Patients might feel reassured that there is a staff member present and promote engagement.

5.24 Zonal observations are not routine on all wards, and there is no national standard on their use. It is up to local trusts whether they support this practice. Zonal observations are more likely to be used on older adult in-patient wards. They should not be used as a replacement for more structured defined observations and engagements levels such as level 1 to level 4, as these are based on individual risk assessment.

6. **Physical Health**

6.1 Physical health monitoring is an essential part of holistic assessment for all patients admitted to mental health wards. 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 15–20 years earlier than the

general population.²⁸ Patients subject to restrictive interventions or enhanced observations may also be at increased risk of physical deterioration due to factors such as self-harm, violence, intoxication, medication effects, rapid tranquillisation, restraint, poor nutrition, dehydration, choking risk, reduced mobility, or underlying physical health conditions. Staff undertaking observations should therefore remain alert to changes in physical presentation and ensure concerns are escalated promptly for clinical review.

- 6.2 Monitoring may include physical observations such as respiration rate, pulse, blood pressure, oxygen saturation, temperature, and use a recognised and standardised assessment tool for acute illness severity such as National Early Warning Signs (NEWS 2).²⁹
- 6.3 **Illustrative Case Summary, Jason Standing:**³⁰ Jason was placed on Level 3 observations, meaning he should have remained within eyesight of staff.³¹ He had several significant physical health conditions, including Type 2 diabetes, sleep apnoea and hypotension. In addition, Jason was prescribed a high dose of clozapine and received additional sedating medication, including lorazepam and promethazine, on the night of his death.³² At approximately 6am, a healthcare assistant raised concerns with the Nurse in Charge that Jason did not appear to be breathing. Following a second check, the Nurse in Charge did not agree and presumed that Jason was safe. The healthcare assistant remained concerned and asked another nurse to review him. The second nurse confirmed that Jason was not breathing. Oxevision records report there had been no signs of life from approximately 3:32am.³³ Observations at night were not conducted in line with EPUT policy, which requires staff conducting observations to ensure the safety and wellbeing of a patient.³⁴
- 6.4 This situation demonstrates the importance of understanding physical health conditions in the context of mental illness. An understanding of the effects of sedated medication is also crucial in maintaining the safety and wellbeing of the patient. In Jason's case he was allocated to level 3 observations but

²⁸ Chesney E and others. 'Risks of all-cause and suicide mortality in mental disorders: a meta-review' World Psychiatry 2014: volume 13, issue 2, pages 153 to 160.

²⁹ Royal College of Physicians (2017) *National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS*. London: Royal College of Physicians.

³⁰ Illustrative Case Summary, Jason Standing.

³¹ Illustrative Case Summary, Jason Standing.

³² Illustrative Case summary Jason Standing.

³³ Illustrative Case summary Jason Standing.

³⁴ CLP8 – Therapeutic Engagement and Supportive Observation Policy (Inpatients) Version 4.1, 15/11/2023, [EPUT009028].

unfortunately, they were not carried as per policy.³⁵ This case highlights how observation practice must include active assessment of physical wellbeing, not simply confirmation of presence or location.

7. Nighttime / Sleep

- 7.1 There is no universally accepted approach to night-time observations. Current practice increasingly emphasises an individualised, risk-based approach that balances patient safety with the therapeutic benefits of sleep. The nature and frequency of observations should be informed by the purpose of the observation, the patient's current risks, physical health needs, and the least restrictive principle.
- 7.2 During nighttime hours, patients' safety and wellbeing is paramount albeit with reasonable emphasis not to disrupt their sleep. Visual checks are common practice during the night, with less emphasis on engagement. Checking on patients' wellbeing and safety during the night does require staff to enter the bedroom. The room layout can also provide greater challenges, for example, if the bed is not easily observed from the door. All bedroom doors have windows, with open and closed shutters. It can be common practice that staff will conduct visual checks through the door window. This type of observation is only satisfactory if staff are assured the patient is safe and well (breathing). If they cannot determine this from outside, they should enter the room.
- 7.3 Some trusts have adopted sleeping initiatives, referred to as "SleepWell".³⁶ The initiative promotes practices that help aid sleep, such as reducing noise and lighting, and not entering the patient's room during sleep. Instead of applying a standard observation level throughout the night, it is based on clinical judgement and individual risk assessment. The practice involves staff either completing discreet visual welfare checks or not doing checks between the hours of 12am and 6am. The overall aim is to balance patient safety with the therapeutic benefits of sleep, recognising that poor sleep can negatively affect both mental and physical health and may delay recovery.
- 7.4 Before a patient can be considered appropriate for the "SleepWell" initiative, a comprehensive assessment should be completed, including current mental state, risk of self-harm or deterioration overnight, physical health needs,

³⁵ Case summary Jason Standing.

³⁶ Novak, C., Packer, S., Paterson, A., Roshi, J., Locke, T., Keown, P., Watson, N. and Anderson, K.N. (2020) 'Feasibility and utility of enhanced sleep management on in-patient psychiatry wards', *BJPsych Open*, 6(S1).

medication and sedation levels, and risks associated with sleep-disordered breathing. This may include the use of screening tools such as the STOP-Bang Questionnaire³⁷ to assess the risk of obstructive sleep apnoea, alongside consideration of factors such as Body Mass Index (BMI), physical health history, and the patient's ability to maintain their own safety overnight.³⁸ The decision should be individualised, regularly reviewed, and balanced against the need to maintain patient safety.

- 7.5 **Illustrative Case Summary, Jason Standing:**³⁹ As stated in Section 5.3, in the context of the SleepWell programme, Jason would not have been considered suitable for remote monitoring alone. A STOP-Bang assessment would have highlighted several risk factors, including obesity, hypertension, tachycardia, diagnosed sleep apnoea and the use of highly sedating medication. These factors placed Jason at increased risk of physical deterioration during the night. In my view, these risks meant that face-to-face checks during the night were clinically necessary.

8. **Dynamic and Fluctuating Observations**

- 8.1 Observation levels should be dynamic and responsive to changes in a patient's presentation, risk, environment, and circumstances. Fluctuating observation plans may therefore be appropriate where risk is not constant throughout the day or is linked to specific situations, activities, or triggers. Dynamic observation plans enable care to be tailored to the individual's needs, promote least restrictive practice, and support recovery while maintaining safety. Any variation in observation levels should be clearly documented within the care plan and risk assessment, with staff understanding the rationale, triggers, and criteria for escalation or reduction.
- 8.2 **Hypothetical Example 1:** Patient A is considered vulnerable to harm from others and to be at risk of harm to others, due to their intrusive disruptive behaviour. However, they are considered a lower risk to themselves. When Patient A is in communal ward areas, they require Level 3 within arm's length. However, when they are in their bedroom or alone in an area, eyesight observations may be appropriate. When asleep, observations can be reduced to Level 2 and then

³⁷ Nagappa, M., Liao, P., Wong, J., Auckley, D., Ramachandran, S.K., Memtsoudis, S., Mokhlesi, B. and Chung, F. (2015) 'Validation of the STOP-Bang Questionnaire as a Screening Tool for Obstructive Sleep Apnea among Different Populations: A Systematic Review and Meta-Analysis.

³⁸ Chung, F., Subramanyam, R., Liao, P., Sasaki, E., Shapiro, C. and Sun, Y. (2012) 'High STOP-Bang score indicates a high probability of obstructive sleep apnoea', *British Journal of Anaesthesia*, 108(5), pp. 768–775.

³⁹ Illustrative Case Summary, Jason Standing.

increased back to Level 3 when awake. The circumstances in which observation levels can be increased or reduced should be clearly identified in the risk assessment, risk management plan, and care plan.

- 8.3 **Illustrative Case Summary, Elise Sebastian:**⁴⁰ When Elise was alone, or experiencing “periods of isolation,” she was required to be placed on Level 3 observations.⁴¹ The staff member who escorted Elise to her room stated that “maybe I forgot” that Elise should have been on Level 3 observations when in her room.⁴² Based on the information available, the risk assessment appeared appropriate in recognising that Elise required Level 3 observations when alone but could be managed on Level 2 observations when participating in activities or group settings. This demonstrated a patient centred approach to care planning and showed consideration of dynamic risk factors. However, the failure to provide Elise with level 3 observations when she returned to her room, resulted in Elise being able to cause herself harm resulting in her death.
- 8.4 I have not been issued with a copy of Elise’s risk assessment, but I am assuming that she was considered less of a risk to herself when in the company of others. The case summary reports that areas of the ward were locked off or required a staff member to open the doors to move around freely on the ward.⁴³ This further suggests that Elise was limited in her ability to move from a crowded area to her room alone, further reducing the risk of her being able to be alone.
- 8.5 Why Elise was not placed on Level 3 observations when she returned to her room is difficult to determine with certainty from the information available. However, it appears that several factors may have contributed to this failure. The investigation identified that the staff member assigned to undertake the Level 2 observations incorrectly reported that Elise remained in a communal area when she had in fact returned to her bedroom.⁴⁴ The same staff member was reportedly responsible for observing and engaging eleven patients during that period.⁴⁵ In my opinion, it would have been extremely difficult for a single member of staff to deliver meaningful observation and therapeutic engagement to this number of patients whilst maintaining awareness of each patient’s location, presentation, and risk.

⁴⁰ Illustrative Case summary. Elise Sebastian.

⁴¹ Illustrative Case summary. Elise Sebastian.

⁴² Illustrative Case summary. Elise Sebastian.

⁴³ Illustrative Case Summary. Elise Sebastian.

⁴⁴ Illustrative Case Summary. Elise Sebastian.

⁴⁵ Illustrative Case Summary. Elise Sebastian.

- 8.6 The staff member who allowed Elise access to her bedroom and left her unaccompanied was not the staff member assigned to the Level 2 observations.⁴⁶ This suggests that the failure was not solely attributable to one individual's actions, but may have involved a wider breakdown in communication, shared understanding, or situational awareness amongst the ward team. Given that Elise reportedly required Level 3 observations when alone, it would have been important that all staff involved in her care were aware of this requirement and understood the circumstances under which the observation level should change.
- 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 is not possible to identify a single causative factor from the evidence available, 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.
- 8.8 **Hypothetical Example 2:** Patient B has trouble swallowing with risk of choking. They eat rapidly and without chewing adequately. Following assessment by the Speech and Language Therapy (SALT) team, Patient B is placed on Level 3 observations (within arm's length) during mealtimes, and Level 1 observations at all other times.
- 8.9 Staff are required to remain with Patient B during designated mealtimes and for up to one hour following meals to monitor for signs of choking or deterioration. Staff should support Patient B to make suitable food choices in line with SALT recommendations, such as selecting easy-to-chew meals or modified diets where indicated. During meals, staff should sit with Patient B, provide encouragement around pacing of eating, and support safer eating behaviours. Although snacks remain available throughout the day, Patient B is advised to notify staff when wishing to eat so appropriate support and supervision can be provided.
- 8.10 Where Patient B is unable to meaningfully engage in the care planning and risk management process, or lacks the capacity to understand the associated risks, consideration should be given as to whether the current observation arrangements remain sufficient and proportionate. In such circumstances, it

⁴⁶ Illustrative Case Summary, Elise Sebastian.

may be necessary to consider whether Level 3 observations (within arm's length) during mealtimes and Level 3 observations (within eyesight) outside of mealtimes are required to safely manage the ongoing choking risk.

- 8.11 **Illustrative Case Summary, Johnson Omotoyinbo:**⁴⁷ Johnson was placed on Level 3 observations due to his risk of choking.⁴⁸ The evidence provided indicated that he was known to ingest non-digestible items. In these circumstances, it would be difficult to justify a fluctuating observation plan whilst Johnson remained acutely mentally unwell, as the risk was not confined to specific activities or periods of the day. Although choking risks are often associated with eating and drinking, in Johnson's case the risk extended beyond mealtimes because he was known to place non-food items such as a chess piece in his mouth, creating an ongoing risk of airway obstruction.⁴⁹ Consequently, the risk was present whenever Johnson had access to objects that could be swallowed or aspirated. This level of risk required a high degree of vigilance from the staff member allocated to his observations and may have justified maintaining Johnson within close proximity, potentially within arm's length, to enable prompt intervention should he attempt to place an object in his mouth. This case illustrates that observation levels should be determined by the nature, immediacy, and predictability of the risk, and that some risks may not be safely managed through dynamic or fluctuating observation arrangements. Johnson was not on fluctuating observations, but his risks did indicate that the staff member assigned to the observations would be required to be extremely vigilant.
- 8.12 Fluctuating observation levels allow care to be responsive to a patient's changing level of risk, ensuring they receive the right level of support at the right time. This approach can promote person-centred care by balancing safety with the least restrictive practice, helping to maintain dignity, privacy, and independence. It can improve therapeutic relationships, as patients often feel less controlled when observation levels are reduced appropriately. At the same time, it supports ongoing risk assessment by requiring staff to regularly review and respond to changes in presentation.
- 8.13 Fluctuating observation levels, while beneficial, also have weaknesses. There is a risk of inconsistency, as different staff members may interpret risk levels differently, leading to inappropriate increases or reductions in observations. This can potentially compromise patient safety, particularly if risk is underestimated or changes are not recognised quickly. It also relies heavily on clear

⁴⁷ Illustrative case summary Johnson Omotoyinbo.

⁴⁸ Illustrative case summary Johnson Omotoyinbo.

⁴⁹ Illustrative case summary Johnson Omotoyinbo.

communication and thorough documentation; without this, important information may be missed during handovers. Additionally, frequent changes in observation levels can be confusing or anxiety-provoking for patients, especially if they do not understand why adjustments are being made. Finally, it places greater responsibility on staff to continuously assess risk, which can be challenging in busy ward environments and may increase the likelihood of error if staffing levels are low or experience is limited.

9. Staff Allocation

9.1 The allocation of staff to undertake observations may change throughout the day in response to ward activities, staffing arrangements, breaks, or the needs of the patient. For example, a patient on enhanced observations may be allocated a designated staff member; however, while participating in structured activities such as arts and crafts, occupational therapy sessions, or group interventions, responsibility for observation and engagement may temporarily transfer to another member of staff who is facilitating the activity. In such circumstances, there should be a clear handover between staff to ensure continuity of care, awareness of current risks, and understanding of the observation requirements. The change in allocated staff should not result in a reduction in the observation level itself, but rather a transfer of responsibility for maintaining the prescribed level of observation and engagement. Effective communication between staff is essential to ensure that risks continue to be managed safely and that the therapeutic purpose of the observation is maintained.

9.2 **Illustrative Case Summary, Edwige Nsilu:**⁵⁰ in Edwige's case whilst she was on Level 2 observations, the staff member re-allocated the observations to a different staff member, as they were needed for other duties.⁵¹ The new staff member recalls seeing Edwige at 3:45pm, but did not document the observation at the time, due to being distracted.⁵² Edwige was found collapsed at 3:55pm.⁵³ It is possible that Edwige was not observed for 25 minutes.⁵⁴ This case shows that while it is common practice to re-allocate observations, it is essential that the handover of the observations is conducted, and that they adhered to local trust policy. In this case the new allocated staff member appears to acknowledge the new assumed responsibility of observing and engaging Edwige but failed to perform to the necessary standard of engaging and documentation.

⁵⁰ Illustrative Case summary, Edwige Dikoko Nsilu.

⁵¹ Illustrative Case summary, Edwige Dikoko Nsilu.

⁵² Illustrative Case summary, Edwige Dikoko Nsilu.

⁵³ Illustrative Case summary, Edwige Dikoko Nsilu.

⁵⁴ Illustrative Case summary, Edwige Dikoko Nsilu.

- 9.3 **Hypothetical Example 3:** Patient C is allocated Level 2 observations (e.g. 10-minute checks) and is participating in an arts and crafts activity. The activity may be facilitated by an activity coordinator (AC), with three other patients attending the group. If Patient C's risk assessment supports this approach, and the AC is deemed competent to do so, it may be appropriate for the AC to temporarily support the delivery of Level 2 observations and engagement during the session, while the originally allocated staff member retains overall responsibility of ensuring that observations and engagement are completed effectively. At the end of the activity, the AC should inform the originally allocated staff member that the session has concluded and provide a handover of Patient C's level of engagement, behaviour, and any relevant verbal disclosures. The allocated staff member would then resume responsibility for completing pro-active observations and engagement.
- 9.4 Alternatively, Patient C may attend the group while the designated staff member continues to complete visual checks without interrupting the session, with engagement primarily delivered by the AC. A further option is that the designated staff member completes both observations and engagement during the session; however, this may be disruptive to the therapeutic activity.
- 9.5 The most appropriate approach should be guided by Patient C's risk assessment, staff knowledge of the patient, and the need to balance therapeutic engagement with privacy, dignity, and respect.
10. **Observations levels when transferred to another ward or hospital**
- 10.1 Patients on a mental health ward sometimes require admission to a physical health hospital. Although Level 1 observations may have been considered appropriate within the mental health ward environment, transfer to a different clinical setting may significantly alter the patient's risk profile. Acute general hospital environments are not typically designed or risk assessed in the same way as mental health inpatient wards and may contain increased access to potential ligature points, sharps, medication, medical equipment, or opportunities for absconding. As a result, some patients may require increased observation levels, such as Level 3 observations (within eyesight), while attending or admitted to a general hospital setting. This can be for either detained or informal/voluntary patients, which would require a capacity assessment and consent.

- 10.2 Changes in observation levels within acute hospitals are not solely related to risks of self-harm or suicide. Some patients may be considered vulnerable due to cognitive impairment, confusion, exploitation risk, suggestibility, or reduced ability to maintain their own safety within unfamiliar environments. In these circumstances, observation levels should also be reviewed to ensure appropriate support, supervision, and safeguarding are maintained. Local policies commonly state that observation levels should be reviewed dynamically in response to changes in risk, presentation, environment, or clinical circumstances, with the least restrictive option maintained where safely possible.
- 10.3 When a patient is transferred to another mental health ward, either within the same trust or to another trust, there should be a robust handover of key clinical information. This should include the patient's risk assessment, care and treatment plan, medication, observation and engagement levels, legal status, known triggers, communication needs, and any relevant patient passports, particularly for patients who are neurodivergent or have a learning disability. The care and risk management plan should clearly identify the current observation level, the rationale for it, and any agreed review criteria.
- 10.4 **Illustrative Case Summary Bethany Lilley.**⁵⁵ Bethany was transferred to another adult acute ward whilst subject to Level 3 observations and following attendance at Accident and Emergency department for self-harming, by cutting her arm.⁵⁶ However, her prescribed Level 3 observation status was not communicated to the receiving ward during handover, nor was she accompanied by a member of staff.⁵⁷ Consequently, the receiving team assessed Bethany as requiring Level 2 observations (four checks per hour) on admission without knowledge of the previously prescribed observation level. The omission of this information deprived the receiving team of important clinical context when determining the appropriate observation level.
- 10.5 Observation levels should be determined by current risk, clinical presentation, and available information, and any reduction should be supported by a documented assessment and rationale. The reduction in Bethany's observation levels shortly after transfer may suggest that the significance of her recent self-harm and ongoing risk was not fully recognised or incorporated into decision-making. One day later, Bethany was found unresponsive with a ligature around

⁵⁵ Illustrative case summary, Bethany Julia Lilley.

⁵⁶ Illustrative case summary, Bethany Julia Lilley.

⁵⁷ Illustrative case summary, Bethany Julia Lilley.

her neck.⁵⁸ In my view this case highlights the importance of robust handover arrangements, 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.

- 10.6 It is recognised that transfer to a new ward or care team can increase anxiety and distress for patients. The receiving team may not be familiar with the patient's presentation, routines, risks, or preferred ways of engaging, and the patient may also feel unfamiliar or unsafe with new staff and surroundings. This can increase risk, particularly in the immediate period following transfer. For this reason, it is generally not considered safe practice to immediately reduce observation levels on transfer unless there is a clear clinical rationale, the receiving team has sufficient knowledge of the patient, and the decision is made collaboratively with the patient and, where appropriate, their family or carers.⁵⁹

11. Legal Framework and Capacity to consent

- 11.1 For informal/voluntary patients, care and interventions, including enhanced observations, should be delivered with the patient's consent. Where a patient refuses observations, the clinical team must consider whether the level of observation required remains compatible with informal/voluntary admission, or whether assessment under the MHA⁶⁰ and/or Mental Capacity Act (MCA) is necessary.⁶¹ For detained patients, observations may be implemented as part of care and risk management under the authority of the MHA, provided they are necessary, proportionate, justified, and represent the least restrictive option.
- 11.2 For patients subject to the Deprivation of Liberty Safeguards (DOLS) (MCA 2005),⁶² Observations must be delivered in the patient's best interests and remain necessary and proportionate to the identified risks. Where an informal/voluntary patient or a patient subject to DOLS refuses observations considered necessary to maintain safety, review of the legal framework is

⁵⁸ Illustrative case summary Bethany Julia Lilley.

⁵⁹ Health Services Safety Investigations Body (HSSIB) (2024) *Mental health inpatient settings: Supporting safe care during transition from inpatient children and young people's mental health services to adult mental health services*. London: HSSIB.

⁶⁰ Department of Health (2015) *Mental Health Act 1983: Code of Practice*. London: The Stationery Office. Available at: <https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>

⁶¹ *Mental Capacity Act 2005*.

⁶² Ministry of Justice (2008) *Mental Capacity Act 2005: Deprivation of Liberty Safeguards Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice*. London: The Stationery Office, page 12. Available at: <https://www.gov.uk/government/publications/deprivation-of-liberty-safeguards-code-of-practice>.

required to determine whether the current basis for admission remains appropriate.

- 11.3 Capacity and consent should always be considered when determining and implementing observation levels. Under the MCA 2005,⁶³ individuals are presumed to have capacity unless proven otherwise, and capacity must be assessed in relation to the specific decision being made, such as consenting to observations. A patient with capacity may make what others consider to be an unwise decision, including refusing observations, provided they are able to understand, retain, use or weigh the relevant information, and communicate their decision. Valid consent should be informed and voluntary, with patients receiving a clear explanation regarding the purpose and nature of the observations. Where a patient is assessed as lacking capacity, decisions regarding observations must be made in the patient's best interests, considering their wishes and the least restrictive available option. This may include gathering the views of families, and an Independent Mental Health Advocates (IMHA).⁶⁴ If a patient with capacity refuses observations that are considered necessary to manage significant risk, consideration should be given to whether the MHA provides a more appropriate lawful framework to support care, treatment, and safety.
- 11.4 **Hypothetical Example 4:** Patient D is detained under Section 3 of the MHA⁶⁵ for assessment and treatment and is assessed as having capacity regarding discussions about Level 3 observations. Patient D is repeatedly attempting to leave the ward and has been tying ligatures around their neck with suicidal intent. Due to the immediate and significant risk to life, Level 3 observations (within arm's length) are considered necessary, proportionate, and the least restrictive option available to maintain safety and reduce the risk of serious harm or death.
- 11.5 Under the MHA,⁶⁶ care and treatment may be provided without consent where necessary for the treatment of mental disorder and the protection of the patient or others. If Patient D were an informal patient attempting to leave the ward with the intention of ending their life, consideration could be given to the use of nursing or medical holding powers under Section 5(4) or Section 5(2)⁶⁷ while

⁶³ *Mental Capacity Act 2005*, s 1.

⁶⁴ *Mental Capacity Act 2005*, s.1.

⁶⁵ *Mental Health Act 1983*, s 3.

⁶⁶ *Mental Health Act 1983*, s 62.

⁶⁷ *Mental Health Act 1983*, s 5.

urgent assessment under the MHA is undertaken. In these situations, preservation of life and immediate patient safety remain paramount.

11.6 **Hypothetical Example 5:** Patient E was admitted to the ward on an informal basis following an overdose requiring treatment in intensive care. Prior to admission, Patient E recognised that they remained at significant risk of a further suicide attempt if they were to return home. They agreed to admission to a mental health ward for support and safety. Although Patient E continued to experience suicidal thoughts, they also expressed a desire to receive help in managing these thoughts and reducing the risk of acting upon them. Following assessment, the admitting nurse proposed Level 2 observations consisting of 30-minute intervals. At the time of assessment, Patient E identified overdose as their primary suicide method. As access to medication was significantly restricted within the ward environment, the immediate opportunity to repeat the overdose was reduced. However, as suicidal thoughts remained present, there was concern that alternative methods of self-harm or suicide could emerge.

11.7 Enhanced observations and therapeutic engagement were therefore considered appropriate to support ongoing risk management, emotional support, and monitoring of mental state. Patient E consented to the proposed observation level and engaged collaboratively with the associated care plan. However, the decision to implement enhanced observations was based on clinical assessment and risk, rather than patient consent. Whilst a patient's views should be sought and taken into account wherever possible, clinicians remain responsible for prescribing and maintaining the level of observation required to manage identified risks.

12. **Initiating, Care planning and Reviewing Observation Levels**

12.1 Initial observation levels should be determined at the point of admission but may fluctuate throughout the duration of the admission. The level of observation should be based on the clinical handover, available clinical information, and a comprehensive risk assessment.

12.2 In the early 2000s, most service providers relied on paper based clinical records, as electronic records were still in their infancy. Between 2000 and 2010, the admission process commonly involved a verbal handover from the admitting team, such as the MHA assessment team, crisis team, or community mental health team. This handover was usually provided either face-to-face or by telephone. As clinical records were not always immediately available, the quality

and accuracy of the verbal handover were particularly important in determining the initial observation level.

- 12.3 Over the last decade, most service providers have adopted electronic patient record systems, which has improved access to clinical information where records are available, although verbal handover remains essential.
- 12.4 Based on the content of the receiving handover the admitting nurse and medic would be the decision makers when it came to appropriate observations levels in the early 2000s. Over the years MDT working has significantly evolved and there is much more presence of other professional disciplines. There is now a greater opportunity to discuss observation levels as a wider MDT. However out of hours the professions available are that of a medic and nurse.
- 12.5 **Illustrative Case Summary, Stephen Neville:**⁶⁸ Stephen was placed on level 2 observations at the point of admission, with staff not completing an individualised risk assessment.⁶⁹ The usual process for admission had not been followed, staff focused only on Stephen's admission for ECT.⁷⁰ The lack of communication contributed to the ward not understanding Stephen's risk or clear rationale for purpose of admission, and the justification for level 2 observations. This case highlights the importance of the rationale for enhanced observation levels being individualised, which should influence meaningful care. If every new patient admitted to a ward was placed on enhanced observations, it runs the risk of becoming surveillance based and effectiveness not measurable.
- 12.6 The level of observation and its rationale must be clearly documented in the clinical records and should include:
- Current mental state
 - Risk assessment (including risk to self, others, and vulnerability)
 - Purpose, goal and agreed interventions
 - Timescale of review
 - Physical health concerns (such as sleep apnoea, sedation, diabetes etc)
 - Patient, family and carer perspectives (when available)
- 12.7 **Increasing observation levels:** Observations levels can change at any stage during a hospital admission and should be reviewed regularly and dynamically in response to changes in presentation and risk. From the early 2000s through to

⁶⁸ Illustrative case summary Stephen Neville.

⁶⁹ Illustrative case summary Stephen Neville.

⁷⁰ Illustrative case summary Stephen Neville.

the present day, it has commonly been the nurse on shift who initiates an increase in observation levels, usually following a deterioration in the patient's mental or physical health or an escalation in risk. In practice, increases in observation levels commonly occur following incidents or escalating concerns.

- 12.8 **Hypothetical Example 6:** Patient F is admitted to hospital under Section 2 of the MHA.⁷¹ Prior to admission, their clozapine dose had been reduced in the community, which had a detrimental effect on their mental state. As a result, Patient F had become non-compliant with both mental health and physical health treatment, including prescribed antihypertensive medication. Patient F is admitted at 10pm following assessment, the Nurse in Charge determines that Level 1 observations are appropriate, as Patient F has no history of self-harm and is not presenting an immediate risk of harm to themselves or others.
- 12.9 The following day, the RC reviews Patient F and raises concerns that they are not eating or drinking and are presenting with symptoms of catatonia. Catatonia is a serious neuropsychiatric syndrome characterised by disturbances in movement, behaviour, communication, and responsiveness. Symptoms may include mutism, immobility, staring, posturing, negativism, and refusal of food or fluids. Left untreated, catatonia can result in significant physical deterioration and may become life-threatening.⁷²
- 12.10 The RC requests that Patient F be placed on Level 2 observations (six checks per hour), a food and fluid chart be commenced, and lorazepam be prescribed, initially orally and intramuscularly if oral medication is refused. Given the seriousness of Patient F's presentation and poor oral intake, the increased observation level is intended to support food and fluid intake, monitor physical and mental state, provide reassurance, and mitigate risks associated with vulnerability and deterioration. The RC advises that there should be a low threshold for increasing observations to Level 3 should Patient F fail to improve or show signs of further deterioration.
- 12.11 At the time of assessment, Patient F is unable to consent to the intervention, as they are unable to demonstrate an understanding of the information provided or communicate a decision regarding their care. Patient F's family are contacted and updated on their presentation and treatment plan, including the rationale for enhanced observations. The family agree with the proposed plan and request regular updates regarding Patient F's progress.

⁷¹ *Mental Health Act 1983.*

⁷² Rogers, J.P., Zandi, M.S. and David, A.S. (2023) 'The diagnosis and treatment of catatonia', *Clinical Medicine*, 23(3), pp. 242–245.

- 12.12 **Illustrative Case Summary, Diana Hammond:**⁷³ Diana had a diagnosis of Recurrent depression and Bi-Polar.⁷⁴ There was a history of impulsive self-harming such as overdosing and standing Infront of a slow-moving train.⁷⁵ Diane received her first electroconvulsive therapy (ECT) session on the morning before she left the ward and placed herself in front of a train.⁷⁶ Diana was an informal/voluntary patient at the time and free to leave the ward.⁷⁷ I have made an assumption that the ward had an open door policy, enabling patients to leave freely able to leave the ward freely. The risk assessment, conducted three days before the incident, stated Diana denied thoughts of self-harm.⁷⁸ There is no mention from the evidence provided to me that references the possible impact ECT may have on Diana.
- 12.13 Following ECT treatment, a patient's mental state, physical health, cognition, and risk profile should be reviewed to determine whether the existing observation level remains appropriate. Whilst ECT does not automatically necessitate a change in observation levels, the treatment may result in temporary cognitive impairment, disorientation, drowsiness, altered mobility, or changes in mental state that require reassessment of risk and care needs.
- 12.14 Observation levels should be reviewed dynamically and may be increased whenever there is evidence of escalating risk, deterioration in mental or physical health, increased vulnerability, or a significant change in circumstances. Although the Nurse in Charge will often coordinate the implementation of increased observation levels, concerns may be raised by any member of the MDT, including doctors, nurses, healthcare support workers, psychologists, occupational therapists, SALT, pharmacists, social workers, or other professionals involved in the patient's care. Family members, carers, and patients themselves may also identify concerns that warrant further assessment. Any member of the MDT who identifies a significant increase in risk should communicate their concerns promptly so that an appropriate review can take place. In situations where there is an immediate concern for safety, observation levels may need to be increased without delay, pending a more comprehensive MDT review. This approach recognises that risk is dynamic and

⁷³ Illustrative Case Summary, Diana Hammond.

⁷⁴ Illustrative Case Summary, Diana Hammond.

⁷⁵ Illustrative Case Summary, Diana Hammond.

⁷⁶ Illustrative Case Summary, Diana Hammond.

⁷⁷ Illustrative Case Summary, Diana Hammond.

⁷⁸ Illustrative Case Summary, Diana Hammond.

that all members of the care team have an important role in identifying and responding to changes in a patient's presentation.

- 12.15 Since 2000 the governance, accountability, and documentation requirements associated with increasing observation levels have become significantly more robust. When a patient's observation level is increased, the care plan, risk assessment, and risk management plan would ordinarily be reviewed and updated to reflect the rationale for the change, identified risks, intended outcomes, and management strategies. In contemporary practice, observation levels are expected to form part of a wider MDT plan rather than operate as a standalone intervention.
- 12.16 Increases in observation levels frequently follow incidents such as self-harm, violence, absconding attempts, significant deterioration in mental state, or concerns regarding physical health. Additional documentation and governance processes may also be required following an unexpected incident. These can include completion of an incident report, review of restrictive interventions, debriefing of patients and staff, communication with family members or carers where appropriate, and referral to safeguarding services if concerns relating to abuse, neglect, or vulnerability are identified.
- 12.17 While these developments have strengthened governance, accountability, and oversight of observation practice, staffing levels and available clinical time have not always increased in line with these additional demands. As a result, documentation quality and timeliness may be compromised in busy ward environments where staff are managing multiple competing clinical priorities alongside direct patient care.
- 12.18 **Reducing observations levels:** The process for reducing observation levels has evolved considerably since the early 2000s. Historically, nurses were often required to seek approval from medical staff before observation levels could be reduced. This was debated by the nursing profession as observations were, and continue to be, predominantly a nursing intervention. Observation levels were commonly initiated, delivered, and reviewed by nursing staff; however, nurses were not always granted the authority to independently reduce them.
- 12.19 From around 2010 onwards, some local trust policies began to change, allowing senior nurses, commonly Band 6 and above, to reduce observation levels. This change was influenced by feedback from nursing staff in practice, highlighting that medical staff were not always as familiar with the patient's day to day presentation and frequently relied on nursing handovers and recommendations

when making decisions regarding observation levels. As MDT working evolved, observation reduction increasingly became viewed as a shared clinical decision-making process.

- 12.20 **Illustrative Case Summary, Bethany Lilley:**⁷⁹ As stated in paragraph 10.5 above, Bethany's observation levels were reduced on transfer to another ward. The original ward had sent an email handover to the receiving ward, detailing risks and observation levels; however, the email was not read.⁸⁰ Bethany had originally been placed on Level 3 observations due to cutting herself.⁸¹ On arriving at the new ward, she was promptly assessed by consultant psychiatrist and nurse and placed on level 2 observation (four checks within the hour).⁸² Within 24 hours observations levels were reduced to level 1, and within four hours of this decision Bethanny was found unresponsive.⁸³
- 12.21 The reduction of observations highlights poor transfer information as a contributory cause, but the ward also reduced the Level 2 observations to Level 1 within 24 hours. It would appear from the evidence that there were no further incidents of self-harm in the period of Level 2 to Level 1, but given she was initially on level 3 at the point of transfer and immediately placed on level 2. The receiving ward assessed Bethany as requiring level 2, without the knowledge that she was on level 3 on transfer. It was noted that Bethany was still experiencing suicidal thoughts and was refusing to disclose a plan, although she reported one had been made.⁸⁴ The following day Bethany had spent time outside (on leave), and there had been no incidents of self-harm.⁸⁵ A registered nurse reduced her observations to level 1. There was no clinical rationale documented nor was it discussed with the consultant psychiatrist.⁸⁶
- 12.22 In my opinion, the transfer process was inadequate because the receiving ward was unaware that Bethany had been subject to Level 3 observations immediately prior to transfer. Information relating to observation levels forms an important component of risk management and should ordinarily be communicated as part of the handover process. The absence of this information meant that the receiving team were unable to fully consider the rationale underpinning the previous observation arrangements when undertaking their own assessment.

⁷⁹ Illustrative case summary, Bethany Lilley.

⁸⁰ Illustrative case summary, Bethany Lilley.

⁸¹ Root Cause Analysis Investigation Report – Mrs B, 27/08/2019, [BHAT010883], page 8.

⁸² Root Cause Analysis Investigation Report – Mrs B, 27/08/2019, [BHAT010883], page 8.

⁸³ Root Cause Analysis Investigation Report – Mrs B, 27/08/2019, [BHAT010883], page 8.

⁸⁴ Root Cause Analysis Investigation Report – Mrs B, 27/08/2019, [BHAT010883], page 33.

⁸⁵ Root Cause Analysis Investigation Report – Mrs B, 27/08/2019, [BHAT010883], page 34.

⁸⁶ Root Cause Analysis Investigation Report – Mrs B, 27/08/2019, [BHAT010883], page 34.

- 12.23 However, the fact that Bethany was subject to Level 3 observations immediately prior to transfer is clinically significant. Whilst observation levels should always be reviewed and determined according to the patient's current presentation and assessed risks, knowledge that a patient has recently required a higher level of observation should ordinarily prompt caution before reducing those arrangements. Had I been aware that Bethany had been on Level 3 observations immediately prior to transfer, I would have expected a period of further assessment and observation before considering a reduction to Level 2. In my opinion, a period of approximately 12 to 24 hours would have been reasonable to allow the receiving team to assess Bethany's presentation, understand the rationale for the previous observation level, establish a therapeutic relationship, and evaluate whether the risks that necessitated Level 3 observations remained present. The failure to communicate this information deprived the receiving team of an important piece of clinical information that may have influenced their decision-making.
- 12.24 Similarly, the subsequent reduction from Level 2 to Level 1 observations may have reflected a positive risk management approach. Bethany was an informal patient and had reportedly remained free from self-harm for approximately 24 hours prior to the reduction.⁸⁷ Mental health services are expected to balance safety with recovery, autonomy, dignity and least restrictive practice.⁸⁸ It is therefore conceivable that the clinical team considered a reduction in observations appropriate despite the continued presence of some risk. However, the evidence available is significantly limited by deficient documentation. There was no documented clinical rationale for the reduction in observation level, and the failure to communicate Bethany's existing Level 3 observation status during transfer meant that the receiving team undertook their initial assessment without important clinical information. These deficiencies substantially limit the ability to understand and scrutinise the decision-making process retrospectively. Consequently, whilst I consider the handover arrangements and documentation to have fallen below the expected standard, I am unable, on the evidence available, to conclude that the decisions to implement Level 2 observations and subsequently reduce to Level 1 observations were, in themselves, clinically indefensible.

⁸⁷ Root Cause Analysis Investigation Report – Mrs B, 27/08/2019, [BHAT010883], page 34.

⁸⁸ National Institute for Health and Care Excellence (2022) *Self-harm: assessment, management and preventing recurrence* (NG225) page 69.

- 12.25 From approximately 2014 onwards, national guidance such as NICE 2015⁸⁹ and ETOC 2024,⁹⁰ and modern observation policies increasingly promoted reduction and escalation of observations as part of an MDT approach, incorporating collaborative decision making, least restrictive practice, and patient involvement wherever possible. Most wards conduct a daily or regular MDT handover involving the RC and wider MDT members. Observation and engagement levels should be discussed, and decisions clearly documented. The patient's and family/carers' views should also be considered. The rationale for any decision should be reflected within the clinical records, alongside updated care plans and risk assessments.
- 12.26 It may be the case that whilst an MDT discussion takes place in reality, there may be insufficient documentation to fully evidence the decision-making process. Contributing factors include time pressures, repetitive documentation requirements across multiple electronic and paper systems, and competing clinical demands. Discussions with the patient, family, and carers; updates to the risk assessment, risk management plan, and care plan; and documenting the rationale thoroughly can take a significant amount of time. In busy ward environments, where there may only be two (or one) on duty alongside multiple competing demands, the quality and completeness of record keeping may be affected. The documentation usually falls to the nurse to complete.
- 12.27 The extent of documentation required to reduce observation levels may also contribute to patients remaining on enhanced observations longer than clinically necessary. Conversely, reducing observation levels without thoroughly reviewing the patient's risks may increase the likelihood of the patient coming to harm. Safe review of observation levels requires an understanding of the patient's presentation over a meaningful period, such as the previous 24 to 72 hours. This should include reviewing engagement records, the nature and outcome of any incidents, patterns of behaviour, and whether alternative risk management strategies can safely replace enhanced observations. When a collaborative care plan is developed at the commencement of enhanced observations, it should identify the intended purpose, goal and a timescale of review.
- 12.28 **Hypothetical Example 7:** Patient G was placed on Level 2 observations consisting of 15-minute intervals due to risks of self-harm and suicide. Patient G

⁸⁹ National Institute for Health and Care Excellence (NICE) (2015) *Violence and aggression: short-term management in mental health, health and community settings*. NICE guideline NG10. London: NICE.

⁹⁰ NHS England (2025) *Enhanced therapeutic observation and care: developing a local policy*. London: NHS England. Available at: <https://www.england.nhs.uk/long-read/enhanced-therapeutic-observation-and-care-developing-a-local-policy/>.

had been reopening wounds and tying ligatures around their neck. The engagement aim was to help Patient G feel safe and reduce the need to self-harm. The frequency of observations was intended to ensure staff engaged with Patient G on a consistent basis and to enable a rapid response should Patient G self-harm/attempt suicide or experience deterioration in their mental or physical state.

- 12.29 The care plan incorporated a range of therapeutic interventions and activities, including supporting Patient G to maintain a mood diary, attend group and one to one activities, use the gym, spend time in the allotment, and participate in regular sessions with their RC, psychologist, and key worker. Patient G and their key worker jointly identified that if there were no incidents of ligaturing over a 24 hour period and Patient G was able to attend and engage in planned therapeutic activities, and their mood remained above 5 out of 10 (10 being the best it could be), the observation frequency could be reduced from 15-minute observations to 30-minute observations.
- 12.30 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:
- 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.
- 12.31 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.
- 12.32 The development of collaborative care plans for enhanced observations can vary significantly. Although policy and guidance promote collaborative, person-centred planning, enhanced observations are often initiated rapidly in response to immediate risk. In practice, care plans may sometimes focus more heavily on risk management and procedural requirements than therapeutic engagement. Patients may not always feel fully involved in the process. Ward staff may also have limited time to complete detailed collaborative planning while managing

competing demands. As a result, the quality of engagement can vary considerably.

- 12.33 There is inconsistency on how frequently collaborative care plans are read, understood and used by staff. Staff rely heavily on verbal handovers and previous knowledge of the patient. Factors such as high bank or agency usage and redeployment from other wards, high acuity, access to electronic records and overall time pressures reduce the likelihood of staff reading and participating in the care plan. As a result, important information regarding triggers, preferred engagement approaches, trauma history, or specific observation requirements may not always be consistently applied in practice.
- 12.34 Once an observation and engagement plan is agreed, at the start of each shift the Nurse in Charge is responsible for producing an observation rota. Only staff who have completed observation and engagement training, and who are deemed competent should be assigned observations. The Nurse in Charge is also responsible for ensuring the observations and engagement are completed safely, consistently, and documented in real time.

13. **Training**

- 13.1 Since the introduction of the ETOC programme in 2024,⁹¹ all mental health service providers must have their own training package on observations and engagement. Prior to the ETOC programme, there was no nationally mandated training package. Training requirements were largely determined by individual NHS trusts independent service providers, resulting in variation in the content, frequency, and assessment of competence. Whilst observation practice was commonly addressed through local induction programmes, risk management training, and restrictive intervention training, serious incident investigations, CQC inspections, and national reviews repeatedly identified inconsistencies in staff understanding and implementation of observation and engagement practice.⁹²
- 13.2 Before 2024 it was common for staff to be inducted locally to the ward, asked to read the policy and sign a declaration, and shadow a more experienced member of staff for a specific length of time before they were considered competent to

⁹¹ NHS England (2025) *Enhanced therapeutic observation and care: developing a local policy*. London: NHS England. Available at: <https://www.england.nhs.uk/long-read/enhanced-therapeutic-observation-and-care-developing-a-local-policy/>.

⁹² Health Services Safety Investigations Body (2024) *Patients at risk of self-harm: continuous observation*. London: HSSIB.

work independently. From 2020 onwards service providers started to introduce specific training packages on observations. Although training programmes vary in how they are delivered and how often you should complete the training, they are applicable to anyone working in a clinical in-patient role.

13.3 Most training packages cover the following areas:

- the purpose and principles of observations and engagement;
- observation levels (1 to 4) and local policy requirements;
- what is meant by therapeutic engagement and how to engage;
- risk assessment and dynamic risk formulation;
- recognising deterioration in mental and physical health;
- suicide and self-harm awareness;
- aggression, violence, and absconding risk;
- documentation standards and record keeping;
- legal and ethical frameworks, MHA, MCA HRA;
- trauma-informed practice;
- safeguarding;
- communication and de-escalation skills, escalation procedures;
- physical health monitoring;
- professional accountability; and
- learning from serious incidents and coroners' findings.

13.4 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. As a result, many trusts now use a combination of online learning, classroom teaching, scenario-based exercises, supervised ward practice, and competency sign-off to prepare staff to safely undertake observations and engagement in practice.

13.5 Once deemed competent to undertake observations and engagement, the allocated staff member may work independently. Training and competency assessment can provide a level of assurance that the staff member understands the expectations of the role, local policy requirements, and the associated documentation standards.

13.6 **Illustrative Case Summary, Elise Sebastian:**⁹³ The member of staff who accompanied Elise to her bedroom and subsequently left her unattended had reportedly not received training in observation and engagement practice.⁹⁴

⁹³ Illustrative Case summary Elise Sebastian.

⁹⁴ Illustrative Case summary Elise Sebastian.

Whilst it is not possible to determine whether the absence of training directly contributed to the events that followed, it may provide a possible explanation for why the requirement for Level 3 observations was not recognised or implemented. Staff who have not received appropriate training may be less familiar with dynamic/fluctuating levels, and the circumstances observation in which observation requirements should change in response to a patient's location, presentation, or risk profile.

- 13.7 Notwithstanding this, the responsibility does not rest solely with the individual staff member. The organisation has a duty to ensure that staff are appropriately trained, competent, and supported before undertaking duties that involve the observation and management of high-risk patients. Similarly, those responsible for staffing allocation and shift coordination should satisfy themselves that staff possess the knowledge and competence required for the roles assigned to them. In my opinion, this case raises questions not only about the actions of the individual staff member, but also about the systems, supervision, training, and governance arrangements that permitted an untrained temporary member of staff to undertake duties involving a patient with complex and fluctuating observation requirements.
- 13.8 Training can provide the basic concept of observations and engagement, and a general overview of why patients might be on enhanced observations levels, but it's limited in preparing any staff member for caring for individual patients with specific risks. A key competency is knowledge and understanding of the patient with whom you are caring for. This is often achieved through familiarity with the patient, understanding their risk, current presentation, triggers, communication style, and preferred ways of interacting. Patients often develop recognisable patterns of behaviour and routine, and noticeable changes in these patterns may indicate either escalating risk or clinical improvement. Therefore, meaningful engagement and understanding of the individual patient remain central to effective observation practice.
- 13.9 **Hypothetical Example 8:** Patient H is allocated Level 3 observations (within eyesight) and has a documented trauma history indicating that they find evenings more difficult and dislike water. The staff member allocated to undertake observations and engagement has not previously worked with Patient H. At approximately 19:15 hours, Patient H requests to use the bath. Throughout both the current and previous admissions, Patient H has consistently preferred showers. The allocated staff member initially considers this to be a reasonable request and seeks guidance from the Nurse in Charge regarding how to maintain Patient H privacy and dignity while continuing within eyesight observations. The

Nurse in Charge, who is familiar with Patient H history, presentation, and behavioural patterns, recognises this change from the patient's usual routine as a potential indicator of increased risk. Following further discussion, Patient H discloses experiencing distressing thoughts and thoughts of submerging themselves in water to cause harm.

- 13.10 It highlights how familiarity with a patient's usual behaviours, routines, triggers, and presentation can support the identification of subtle changes in risk that may otherwise appear benign to unfamiliar staff members. It also demonstrates the importance of effective handover, communication, and seeking support from colleagues with greater knowledge of the patient when uncertainty arises. With ever increasing reliance on bank and agency staff group for both registered and unregistered role, there is a higher chance that high number of staff rostered on shift have limited knowledge of each patient on the ward.
- 13.11 If a staff member does not know the patient, it is essential that relevant clinical and risk information is clearly communicated. Ideally, the staff member would have the opportunity to review the patient's care plan, provided it has been completed to an appropriate standard, and receive a comprehensive clinical handover. However, with many trusts adopting long day or double shift working patterns, clinical handovers are often limited to short periods of time, commonly around 30 minutes between night and day shifts. Depending on bed occupancy, patient acuity, and other ongoing incidents or ward pressures, delivering a comprehensive handover for all patients can be challenging.
- 13.12 **Hypothetical example 9:** For a patient with physical health concerns. Patient I is alcohol dependent, obese, and has high blood pressure. They are not eating or drinking adequately and have commenced a medication assisted alcohol detoxification regime. Due to fluctuating capacity and their current mental state, Patient I is not always able to reliably verbalise symptoms of withdrawal or symptoms associated with elevated blood pressure. Patient H is therefore placed on Level 2 observations at 15-minute intervals.
- 13.13 The focus of engagement is to encourage food and fluid intake, particularly fluids, and to monitor for signs of physical deterioration such as dizziness, tremors, sweating, agitation, confusion, seizures, or involuntary shaking. Staff should also observe for changes in presentation that may indicate worsening withdrawal, dehydration, or cardiovascular concerns. NEWS 2 observations should be completed four times daily, or more frequently if clinically indicated by the patient's score, presentation, or local policy. This example demonstrates

how enhanced observations may be used to monitor and respond to physical health risks as well as mental health risks within an inpatient setting

- 13.14 If the staff member assigned to Patient I's observations is not fully aware of the engagement plan or is not clinically competent in recognising signs of physical deterioration, the observation level may become ineffective or inadequate. It is also important that the staff member understands Patient I's usual presentation (if known), as this supports recognition of both deterioration and improvement. Any noticeable changes in presentation, physical health, engagement, or risk should be escalated promptly to the Nurse in Charge so that appropriate clinical review, escalation, or intervention can be initiated. The NICE 2015 guidance,⁹⁵ HSIBB 2024 investigation,⁹⁶ and ETOC⁹⁷ also raise that staff allocated to the observation levels must be trained, appropriately skilled and considered competent to undertake the role.

14. **Observation and Engagement Rota**

- 14.1 The practice of allocating staff to undertake observations has not fundamentally changed since 2000. Traditionally, at the beginning of each shift, the Nurse in Charge would complete an observation and engagement rota, identifying which staff members were responsible for undertaking enhanced observations. Whilst the basic process remains largely unchanged, there is now greater recognition of the importance of allocating staff according to their competence, experience, familiarity with the patient, and the purpose of the observation. Consideration may also be given to factors such as the patient's gender, communication needs, trauma history, cultural needs, and the staff member's ability to engage therapeutically.
- 14.2 Contemporary practice increasingly recognises that observations are not simply a surveillance task but require active assessment, engagement, and the ability to recognise changes in risk, mental state, or physical health. Consequently, the allocation of staff is expected to take account of both patient needs and staff competencies rather than simply staffing availability.
- 14.3 In practice, staffing pressures, sickness absence, vacancies, and the use of temporary staff may influence allocation decisions. As a result, the ideal

⁹⁵ National Institute for Health and Care Excellence (2015) *Violence and aggression: short-term management in mental health, health and community settings* (NG10). London: NICE.

⁹⁶ Health Services Safety Investigations Body (2024) *Patients at risk of self-harm: continuous observation*. London: HSSIB.

⁹⁷ NHS England (2024) *Enhanced Therapeutic Observation and Care (ETOC)*.

allocation may not always be achievable. Where possible, continuity of staff should be promoted, as familiarity with the patient's usual presentation can assist in recognising deterioration, identifying subtle changes in behaviour, and building therapeutic relationships. However, continuity must be balanced against the potential for staff fatigue, particularly where observations are required for prolonged periods or involve high levels of concentration.

- 14.4 When the Nurse in Charge completes an observation rota, they must also consider patient's views, preferences, and individual needs. This includes factors such as ethnicity, sexual orientation, age, sex, gender identity, and the need to be trauma informed. In practice, the staff mix may not always allow for an all-female or all-male staff allocation. Where personal care or intimate support is required, priority should be made to allocate staff in accordance with the patient's preferences and dignity needs. Additional staff may also be temporarily redeployed from other clinical areas to support safe and appropriate observation delivery when required. Re-deployment of staff from other clinical areas also increases the chances of them being unfamiliar with the patients.
- 14.5 When allocating staff members to observation and engagement duties, consideration must also be given to the wider operational demands of the ward. On average, a 16-bedded ward at full occupancy may have six staff members on duty, commonly consisting of two registered nurses and four nursing assistants. Within this staffing establishment, one patient may require Level 3 observations (within eyesight), while three additional patients require Level 2 observations at varying frequencies, such as twice, four, or six times per hour.
- 14.6 In practice, the allocated staff member may be responsible for more than one patient on Level 2 observations and engagement. Each service provider may provide guidance on what constitutes a reasonable number of patients per staff member; however, this can vary significantly depending on the ward environment, patient acuity, and staffing levels. For example, some service providers may indicate that one staff member can safely observe up to three patients on Level 2 observations. In contrast, ward staff may argue that focusing on a single patient allows for more meaningful, therapeutic engagement and ensures observations are completed to a higher standard. This highlights the tension between expectations from a policy perspective and the realities of delivering safe, person centred care in practice.

- 14.7 **Illustrative Case Summary, Elise Sebastian:**⁹⁸ The investigation highlighted that one member of staff was assigned responsibility for observing and engaging with eleven patients on Level 2 observations.⁹⁹ The investigation identified that this allocation was not suitable, as it was unrealistic for one staff member to meaningfully engage with each patient while also completing the required observation checks. This meant that the observations were likely to become surveillance based rather than therapeutic.
- 14.8 This case demonstrates the risks associated with allocating one staff member to an excessive number of patients on enhanced observations. High observation demand can reduce the quality of engagement, delay staff responses, and limit the ability to identify changes in presentation or escalating risk. As a result, patients may not receive the level of support, interaction, or timely intervention required to reduce the risk of serious harm.
- 14.9 In addition to considering how many patients are allocated to a designated staff member, consideration should also be given to the length of time each staff member is assigned to undertake observations with an individual patient. Local policies vary in their guidance, and national guidance does not prescribe a specific maximum duration. Within nursing practice, there can be differing views; some staff may argue that observation duties should rotate at least hourly to maintain alertness and reduce fatigue, while others may suggest that longer periods, such as two hours, may provide greater continuity for the patient and reduce disruption.
- 14.10 **Illustrative Case Summary, Gareth Clarke:**¹⁰⁰ In Gareth's case the investigation highlighted the same member of staff was assigned to his observation levels from 10:30am to at least 3:15pm.¹⁰¹ 5 hours or more on enhanced observations with the same patient would likely increase the staff member becoming fatigued, which would have a negative impact on the quality of the intervention delivered.
- 14.11 **Illustrative Case Summary, Morgan-Rose Hart:**¹⁰² The investigation found that staff fell asleep whilst on observations, which enabled Morgan-Rose to tie a ligature around her neck.¹⁰³ In addition, the investigation found that Morgan-Rose was allocated male staff on her Level 2 observations, when there were three

⁹⁸Illustrative Case summary, Elise Sebastian.

⁹⁹Illustrative Case Summary, Elise Sebastian.

¹⁰⁰Illustrative Case summary, Gareth Clarke.

¹⁰¹Illustrative Case summary, Gareth Clarke.

¹⁰² Illustrative Case Summary, Morgan- Rose Hart.

¹⁰³ Illustrative Case Summary, Morgan Rose Hart.

female staff on duty. Morgan-Rose's specific needs and risk profile highlighted trauma and ongoing safeguards in relation to sexual safety.¹⁰⁴ Morgan-Rose was accommodated on a mixed-sex ward and had a history of sexual trauma, together with a pattern of engaging in sexual activity with peers, all of which formed part of her identified risk profile, enhanced observations were clinically indicated.¹⁰⁵ Their purpose was not solely to monitor her whereabouts, but to provide timely therapeutic engagement, identify escalating vulnerability or emotional distress, and reduce opportunities for behaviours that could place her at risk of exploitation, re-traumatisation or further harm. Although achieving an appropriate gender balance on inpatient wards can be operationally challenging, where gender-specific risks have been identified, staffing arrangements should be planned so far as reasonably practicable to meet those needs. This includes considering the allocation of female staff where appropriate.

- 14.12 With many staff working long-day or double-shift patterns, often between 8 and 12 hours, sometimes over consecutive days, ward environments can be physically and emotionally demanding. It can be difficult for staff to remain alert throughout an entire shift, particularly during night shifts. Observing a patient who is asleep while on Level 3 observations can be especially challenging; however, it remains the responsibility of the allocated staff member to remain awake, alert, and able to respond immediately if risk changes.
- 14.13 During the day, maintaining alertness may be supported through therapeutic engagement and meaningful interaction with the patient. At night, this can be more difficult, and consideration should be given to shorter rotation periods, such as 30-minute intervals, where fatigue or reduced alertness becomes a concern. Staff should be expected to inform the Nurse in Charge if they feel unable to safely continue observation duties or require a temporary change in allocation. Falling asleep while undertaking observation duties represents a serious breach of professional conduct and may place the patient at significant risk.
- 14.14 **Hypothetical Example 10:** Observation and Engagement Rota. This rota shows six staff members. Two registered nurses, and four nursing assistants. Staff Member A is allocated to Level 1 observations, Staff Member B to Level 2 observations, and Staff Member C to Level 3 observations, leaving three remaining staff members available to complete all other ward duties.

¹⁰⁴ Illustrative Case Summary, Morgan-Rose Hart.

¹⁰⁵ Illustrative Case Summary, Morgan-Rose Hart.

Example of an observation rota:

Time	Level 1 General Observations	Level 2 Patient A (30 minute) Patient B (15 minute) Patient C (10 minute)	Level 3 Patient D (within eye sight)
8am	Staff E	Staff F	Staff A
9am	Staff F	Staff A	Staff B
10am	Staff A	Staff B	Staff C
11am	Staff B	Staff C	Staff D
12pm	Staff C	Staff D	Staff E
1pm	Staff D	Staff E	Staff F
2pm	Staff E	Staff F	Staff A
3pm	Staff f	Staff A	Staff B
4pm	Staff A	Staff B	Staff C
5pm	Staff B	Staff C	Staff D
6pm	Staff C	Staff D	Staff E
7pm	Staff D	Staff E	Staff F
8pm	Staff E	Staff F	Staff A

- 14.15 Other clinical responsibilities can significantly reduce the available workforce. For example, five patients on the ward may require escorted Section 17 leave. Section 17 leave refers to authorised leave from the ward for detained patients, either escorted or unescorted, with the conditions and staffing requirements specified within the authorisation. A patient may require 2:1 escorted leave within the community for one hour, despite only requiring Level 1 observations whilst on the ward. This results in two staff members accompanying the patient, leaving only one unallocated staff member remaining on the ward. That staff member may still be required to undertake a range of additional duties, including medication administration, pre- and post-leave risk assessments, ward rounds, family liaison, physical healthcare monitoring, psychology interventions, admissions, personal care, responding to incidents, and general ward coordination. As a result, staff are often required to balance intensive observation responsibilities alongside multiple competing clinical demands, which may impact the quality of therapeutic engagement, continuity of care, and completion of documentation.
- 14.16 Using the table/example above, at 6:00pm Staff E is scheduled to take over Level 3 observations. However, Staff E is delayed while assisting with meal service and does not take over the observations until 6:10pm. As a result, the handover of Level 3 observations is delayed, which subsequently impacts the timely allocation of Level 2 and Level 1 observations. Situations such as this are common within inpatient settings, particularly when wards are managing multiple patients on enhanced observation levels alongside other competing operational demands.

- 14.17 **Illustrative Case Summary, Sophie Alderman:**¹⁰⁶ Sophie was on Level 1 observations at the time of her death. The evidence provided indicates that there were ten members of staff on duty: two permanent registered nurses, one permanent non-registered member of staff, and seven temporary staff. Three patients required Level 3 or Level 4 observations, one of whom required 2:1 observation. This would have required a minimum of four staff members to maintain those observation levels. The investigation also identified that five patients were subject to Level 2 observations. I have not been provided with information regarding how many staff members were allocated to undertake these Level 2 observations. However, if one staff member was responsible for observing all five patients, it is difficult to envisage how meaningful therapeutic engagement could have been consistently delivered alongside the completion of the required observation checks.
- 14.18 **Emergency Allocation:** There may be occasions when observation levels need to be increased at short notice due to a sudden deterioration in a patient's mental or physical health, an episode of self-harm, escalating violence, absconding risk, or other significant changes in presentation. In these circumstances, staff may need to be reallocated immediately to maintain patient safety, even where the ward is already operating at or near capacity. This may result in non-essential activities being postponed, staff being redeployed from other duties, or additional staffing being requested through escalation processes. Whilst such situations can place considerable pressure on the ward environment, maintaining the prescribed observation level should remain a priority.
- 14.19 **Illustrative Case Summary, Madison Naylor:**¹⁰⁷ The investigation highlighted that she asked to speak "1:1" with a member of staff at approximately 10pm. However, the staff member was due to commence Level 3 observations with another patient at that time. Later, after Madison was found with a ligature, she was left alone while a staff member went to obtain equipment to check her vital signs. The staff member was then delayed by another patient requesting lip balm.¹⁰⁸ When the staff member returned to Madison's room, she had ligatured again, resulting in her death.
- 14.20 Madison was left unattended following an incident of self-harm. Good practice is to assess promptly by a registered nurse to identify any immediate physical

¹⁰⁶ Illustrative Case Summary, Sophie Alderman.

¹⁰⁷ Case summary Madison Naylor.

¹⁰⁸ Case Summary Madison Naylor.

health concerns, assess mental state, and review current risk. In Madison's case, delegating to another member of staff to get the physical health monitoring machine, or allocating a staff member to stay with her would have been the desired practice.

- 14.21 In Madison's case she should have received an assessment of whether the act was associated with suicidal intent, an attempt to manage overwhelming distress, or a combination of both before being left alone. NICE (2022) defines self-harm as intentional self-poisoning or self-injury. Self-harm may occur with varying degrees of suicidal intent, including no suicidal intent, uncertain intent or a clear wish to die. Consequently, the intent underlying any act of self-harm should not be assumed but determined through individual clinical assessment.¹⁰⁹
- 14.22 Consideration should be given to the patient's own account of the act, including whether it provided temporary relief from emotional pain or increased distress. There can be differing professional views regarding how self-harm should be managed. Some clinicians may support a harm minimisation approach where this is clinically appropriate, collaborative, and risk assessed, while others may feel that staff should intervene more actively to prevent harm. In practice, any response should be proportionate to the level of risk, prioritise preservation of life, and be delivered with compassion, curiosity, and therapeutic engagement. Where there is an immediate risk to life or serious injury, staff should intervene promptly and remain. This may look like a staff member remaining in the vicinity of the patient either visible nurse, or eyesight or arm's length depending on the risk, and be emotionally available if the patient wishes to talk.
- 14.23 The caveat to the above is that practice may differ within children and young people inpatient services. My experience and expertise relate to adult mental health services for people aged 18 and above. Therefore, approaches to assessing, supporting, and intervening in self-harm incidents involving children and young people may vary significantly, particularly in relation to safeguarding, consent, parental involvement, developmental needs, and legal frameworks.
- 14.24 The examples of the illustrative case summaries highlight the conflicting demands staff can face within inpatient ward environments, particularly where multiple patients require high levels of support, observation, or immediate response. It also demonstrates how even brief interruptions, competing

¹⁰⁹ National Institute for Health and Care Excellence (2022) *Self-harm: assessment, management and preventing recurrence* (NG225). London: NICE. Available at: <https://www.nice.org.uk/guidance/ng225>.

priorities, or gaps in supervision can have serious consequences when a patient is at acute risk.

- 14.25 If observations cannot be undertaken due to or other ward demands such as escorted Section 17 leave, or require other planned interventions to be delayed, the Nurse in Charge should be informed. Consideration should then be given to reviewing the circumstances surrounding this. In the event observations have not been completed or are delayed, a debrief should take place to identify contributory factors and discuss actions to reduce the likelihood of recurrence. In practice, however, staff are already struggling to complete multiple priorities and may not always have sufficient time to engage in a formal team debrief at the time of the incident, which can lead to a missed opportunity of learning.
- 14.26 **Incident Reporting:** An incident report should also be completed to document the delay, outline the impact on patient care, and identify any actions required to improve practice or reduce future risk. Between 2000 and 2023, incident reporting systems evolved significantly from predominantly paper-based processes to electronic reporting platforms. Paper-based systems were often quicker and simpler to complete locally; however, they were less accessible to senior leadership teams and limited wider organisational oversight and data analysis. In contrast, electronic reporting systems allow incidents to be reviewed by a broader and more targeted audience, support governance processes, and facilitate organisational learning and trend analysis. Despite these advantages, electronic systems are often viewed by frontline staff as time consuming, repetitive, and administratively burdensome, particularly within busy ward environments where clinical demands remain high. Incident reporting systems vary from between trusts. EPUT use the Datix system.¹¹⁰

15. **Staffing**

- 15.1 When wards experience high acuity and increased observation levels, ward managers may identify that staffing levels are insufficient to safely meet clinical demand. In these circumstances, additional staff may be sourced through bank, agency, or redeployment from other clinical areas. Over the last decade, the NHS has increasingly relied on temporary staffing to maintain safe service delivery, largely due to workforce shortages and unfilled vacancies. National reviews have identified that high use of temporary staff may introduce additional safety risks where staff are unfamiliar with local procedures, ward environments, electronic

¹¹⁰ Oxevision Datix Trend Report, 21/07/2024 [EPUT009019].

systems, and patient needs.¹¹¹ Temporary staffing may also impact continuity of therapeutic relationships and patient experience, particularly within mental health inpatient settings where familiarity, consistency, and relational security are important components of care.¹¹²

- 15.2 Between 2000 and 2023, there has been evolving national guidance regarding how NHS trusts and service providers respond to increased clinical acuity and the need for additional staffing. Key developments included the National Quality Board Guidance Right staff, right skills, right place, right time (2013),¹¹³ alongside NHS England’s Mental Health Staffing Framework: A Practical Guide to Staffing Inpatient Mental Health Services (2015).¹¹⁴ The 2015 framework was one of the first national documents to specifically recognise the unique staffing pressures associated with inpatient mental health care, including enhanced observations, therapeutic engagement, violence and aggression, escorted leave, and fluctuating levels of patient acuity. The guidance promoted the principle that “safe staffing” should be determined not simply by bed numbers, but by patient need, dependency, and clinical risk.
- 15.3 From approximately 2015 onwards, most trusts developed local safer staffing policies and escalation procedures to identify when staffing levels were insufficient and outline processes for securing additional staff through redeployment, bank, or agency usage. In my experience recruitment into inpatient mental health services had already been challenging prior to the COVID-19 pandemic; however, workforce pressures intensified significantly following the pandemic. Inpatient settings increasingly experience difficulties recruiting and retaining staff due to workload pressures, burnout, and competition from community and specialist services often perceived as more desirable working environments.
- 15.4 The 2024 ETOC programme, has further highlighted the importance of workforce planning. Pillar 4 of the ETOC framework specifically emphasises the need for trusts to develop workforce models capable of safely responding to enhanced

¹¹¹ Health Services Safety Investigations Body (2024) *Workforce and patient safety: temporary staff – integration into healthcare providers*. London: HSSIB, page 3.

¹¹² Care Quality Commission (2022) *Monitoring the Mental Health Act in 2021/22*, page 12

¹¹³ National Quality Board (2013) *How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability*. London: NHS England.

¹¹⁴ NHS England (2015) *Mental Health Staffing Framework: A practical guide to staffing inpatient mental health services*. London: NHS England. Available at: <https://www.england.nhs.uk/6cs/wp-content/uploads/sites/25/2015/06/mh-staffing-v4.pdf>.

observation demands, patient acuity, therapeutic engagement requirements, and restrictive practice reduction initiatives.

- 15.5 In the event of low staffing levels, maintaining observation levels should remain a priority. Observation levels should not be reduced solely in response to staffing pressures, as they should be determined by the patient's assessed risk, clinical need, and care plan. Where staffing levels are insufficient to safely meet all ward demands, other activities may need to be temporarily stepped down or postponed, such as Section 17 leave, group activities, therapeutic interventions, meetings, or non-urgent tasks. Any such decision should be risk assessed, escalated to senior staff, and documented clearly. Where appropriate, local incident reporting procedures should be followed, and patients and families should be informed of any significant impact on planned care or leave.

16. **Documentation**

- 16.1 When conducting observations and engagement, staff assigned to these duties are expected to complete contemporaneous clinical records, either in paper format or electronically. The format and recording requirements are determined by local trust policy. Observation records typically include the patient's name, prescribed observation level, scheduled observation times, the name of the staff member undertaking the observations, and a section to record clinical observations, engagement, risk assessment, and relevant events occurring during the observation period. Depending on local systems, records may also require staff signatures or electronic authentication to confirm completion.
- 16.2 Where paper observation records are used, these are ordinarily reviewed by the Nurse in Charge or delegated clinician to ensure observations have been completed and documented appropriately. The information recorded during observations contributes to the ongoing assessment of risk, mental state, physical health, and engagement, and may inform decisions regarding whether the current observation level remains appropriate or requires adjustment. Paper records should subsequently be incorporated into the patient's clinical record in accordance with local information governance procedures.
- 16.3 In practice, there can be delays in paper observation records being uploaded to electronic clinical systems, which may reduce their accessibility to members of the MDT and delay review of information relevant to clinical decision-making. The quality of observation documentation can also vary between staff members. Whilst some records provide detailed descriptions of presentation, engagement, risk factors, and interventions, others may contain limited information. Good-

quality documentation should clearly describe the patient's presentation, identify any increasing or decreasing risk factors, record the nature and effectiveness of engagement, and support clinical decision-making regarding the continuation, escalation, reduction, or cessation of enhanced observations. Where appropriate, the Nurse in Charge should provide an overall summary of the shift, highlighting significant events, changes in presentation, and recommendations for ongoing care and observation levels.

- 16.4 I have not personally worked within services that utilise electronic observation recording systems and therefore cannot comment on their day-to-day operation from direct experience. My observations regarding electronic recording are based upon a review of available literature, local policies and information provided by the inquiry.
- 16.5 Over the last decade, many mental health service providers have moved from paper-based observation records to electronic observation systems. The bundle of evidence provided for the purpose of this report indicates that EPUT has adopted e-observations through Oxehealth.¹¹⁵ Electronic recording can improve the timeliness, accessibility, and legibility of documentation. Many systems incorporate features such as automated timestamping, prompts for overdue observations, mandatory fields, and audit trails, which can support governance and compliance monitoring. Electronic systems may also reduce the risk of lost documentation and facilitate real-time review by the MDT.
- 16.6 However, electronic recording alone does not guarantee that observations have been completed to the required standard. Whilst an electronic record may confirm that an observation was documented at a particular time, it cannot necessarily verify the quality of the observation, the effectiveness of the engagement, or whether the patient's presentation was accurately assessed. As with paper records, the value of electronic observation systems remains dependent upon the competence, integrity, and clinical judgement of the staff undertaking and recording the observations. Furthermore, technical failures, delayed entries, and over-reliance on completing electronic tasks rather than engaging meaningfully with patients remain potential limitations of electronic observation systems. Ultimately, electronic recording should be viewed as a tool to support observation practice rather than a substitute for therapeutic engagement, clinical assessment, and professional judgement.¹¹⁶

¹¹⁵ CLP8 – Therapeutic Engagement and Supportive Observation Policy (Inpatients) Version 4.1, 15/11/2023, URN [EPUT009028].

¹¹⁶ Health Services Safety Investigations Body (2024) *Patients at risk of self-harm: continuous observation*. London: HSSIB.

- 16.7 Any delay in conducting observations should be accurately reflected within the clinical record. Documentation should record when the observation was completed rather than when it was scheduled to occur. Where observations have been delayed, this should be brought to the attention of the Nurse in Charge and the reason for the delay documented where appropriate.
- 16.8 Delayed observations may also increase the risk of retrospective or inaccurate record keeping, particularly if staff subsequently document observations as having been completed at the prescribed time rather than the actual time undertaken. Recording an observation as having occurred when it did not, or documenting an incorrect time, undermines the accuracy and integrity of the clinical record and may compromise patient safety, governance processes, and subsequent investigations. In some circumstances, knowingly recording inaccurate information may be considered a falsification of clinical records and could result in disciplinary, regulatory, or professional consequences.
- 16.9 It is recognised that, in some circumstances, staff may unintentionally miss or forget to complete observations due to competing demands, interruptions and workload pressures. In these situations, the omission is not usually intentional but instead reflects the complexity and pressures associated with working within busy inpatient environments. Conversely, intentionally failing to complete prescribed observations, or knowingly recording observations that did not occur, would be considered a serious breach of professional standards and neglectful of professional duty.
- 16.10 **Illustrative Case Summary, Kelly Marie Campbell:**¹¹⁷ Kelly was assigned Level 1 observations. The investigation into her death identified that at 00:00 hours there had been verbal interaction with Kelly while she was in the bathroom. It also identified an error in the recording of the 01:00 observation, which was marked as completed when, in fact, no observation had taken place at that time.¹¹⁸
- 16.11 The verbal interaction at 00:00 may have been considered appropriate to maintain Kelly's privacy and dignity while she was using the bathroom. Where verbal contact is used because a patient requires privacy, experienced staff or natural professional curiosity may recognise the need to return and complete a visual welfare check once it is appropriate to do so. This expectation may not

¹¹⁷ Illustrative Case Summary, Kelly Marie Campbell.

¹¹⁸ Illustrative Case Summary, Kelly Marie Campbell.

always be explicitly stated within local policy but can form part of professional judgement and good observation practice.

16.12 The incorrect recording of the 01:00 record could be due to a variety of reasons. It may be due to competing clinical demands, staff shortages, interruptions, emergencies elsewhere on the ward, or a workload that exceeds the capacity of the staff member assigned to the observations. Staff may believe they have maintained sufficient awareness of the patient despite not completing the observation in the manner prescribed, such as believing they have seen the patient in the vicinity or been assured from another colleague that they have seen them. In other situations, retrospective documentation may occur when staff attempt to reconstruct events from memory after the fact, increasing the risk of inaccuracies. There may also be occasions where observations are knowingly recorded as completed despite not having been undertaken, often due to perceived pressure to demonstrate compliance with policy, fear of criticism, concerns about disciplinary action, or a workplace culture in which missed observations are not openly acknowledged and addressed. Whilst the underlying reasons may vary, inaccurate recording undermines the integrity of the clinical record, compromises patient safety, and can significantly hinder subsequent investigations, reviews, and learning processes.

16.13 However, the existence of observation documentation alone does not automatically confirm that observations were completed to the required standard. It is only through audits that it may be identified that observations had either not occurred, or had not been undertaken in the manner recorded. Alternatively, the same may become apparent after a serious incident investigation.

17. **Monitoring and Compliance**

17.1 Each service provider will have their own processes for monitoring compliance with observation and engagement practice. This includes auditing the recording of observations, specifically looking at whether records are signed at the correct time and whether the narrative informs clinical decision processes. Such audits may be ongoing or may be undertaken on a randomised basis.

17.2 Over recent years, the governance surrounding this area of practice has become significantly more robust and structured. During the early 2000s, monitoring processes were largely focused on reviewing observation records to ensure observation forms had been completed and signed appropriately. More detailed

scrutiny of practice often occurred following a serious incident or near miss involving a patient on enhanced observations.

- 17.3 There is currently no nationally mandated audit tool for monitoring compliance with observation and engagement practice. However, national guidance including ETOC,¹¹⁹ HSSIB recommendations,¹²⁰ CQC Fundamental Standards,¹²¹ and wider clinical governance requirements, expects providers to have systems in place to monitor the quality, safety, effectiveness, and compliance of observation practice. This is typically achieved through local audit programmes, incident review processes, quality assurance mechanisms, and governance oversight.
- 17.4 Audit findings are commonly reviewed through local governance structures, such as ward governance meetings, patient safety forums, or clinical governance committees. Where non-compliance or areas of concern are identified, action plans should be developed, which may involve direct feedback or supervision with individual staff members, alongside wider team-based or service-level improvement initiatives where appropriate.
- 17.5 **Illustrative Case Summary, Stephen Neville:**¹²² The inquest into Stephen's death found that documentation relating to level 2 observations were not completed as standard.¹²³ Despite this, the ward audit for monitoring compliance with observation documentation reported 100% compliance. The evidence found in Stephen's investigation and inquest highlighted that compliance was not 100%.¹²⁴
- 17.6 The evidence also demonstrates the limitation of relying on documentation compliance as assurance of safe and effective practice. In Stephen's case, the reported 100% audit compliance was not supported by the evidence considered within the investigation and inquest. This highlights an important distinction between recorded compliance and actual clinical practice.
- 17.7 In my experience, where audit findings report full compliance, but other evidence demonstrates gaps, this raises concern about the reliability and quality of the

¹¹⁹ NHS England (2024) *Enhanced Therapeutic Observation and Care (ETOC)*.

¹²⁰ Health Services Safety Investigations Body (2024) *Patients at risk of self-harm: continuous observation*. London: HSSIB.

¹²¹ Care Quality Commission (2025) Regulation 17: Good governance. Available at: Regulation 17: Good governance.

¹²² Illustrative Case Summary, Stephen Neville.

¹²³ Illustrative Case Summary, Stephen Neville.

¹²⁴ Illustrative Case Summary, Stephen Neville.

audit process. Possible explanations include misunderstanding of the audit criteria, superficial review of documentation, a tick-box approach to assurance, inadequate scrutiny, or a ward culture in which staff feel pressure to report compliance. I cannot conclude from the evidence that the audit was deliberately falsified, but the discrepancy raises serious concerns about the robustness of local assurance processes and whether they accurately reflected the care being delivered.

- 17.8 In recent years, some trusts have also utilised CCTV and other forms of VMT to support compliance monitoring within observation and engagement practice. CCTV may be reviewed to determine whether the staff member allocated to observations completed them within the required timescales and whether engagement with the patient occurred as documented. Compared with routine audits, CCTV review is usually undertaken less frequently and may occur more sporadically throughout the year, often following incidents, concerns regarding practice, or as part of targeted governance reviews.
- 17.9 Some providers have utilised CCTV systems as part of wider governance and assurance processes. In addition to supporting patient and staff safety, CCTV footage may be reviewed following incidents, complaints, serious incident investigations, or as part of local quality assurance processes to determine whether observations were conducted in accordance with policy. Whilst CCTV may provide evidence that staff were present in designated locations at particular times, it cannot assess the quality of therapeutic engagement, the effectiveness of clinical assessment, or the appropriateness of the intervention delivered. Consequently, CCTV should be regarded as a supplementary governance tool rather than a substitute for direct observation, therapeutic engagement, supervision, and clinical audit.
- 17.10 Serious incident investigations, coroners' findings, and CQC inspections have repeatedly identified concerns relating to inpatient observation practice, staffing pressures, therapeutic engagement, and risk management within mental health services.¹²⁵ Observation practices have required many trusts to review and address areas of poor practice. These concerns have included issues relating to missed observations, inadequate therapeutic engagement, poor documentation, staffing pressures, and failures to recognise or respond to escalating risk. In response, national programmes such as ETOC were developed

¹²⁵ Care Quality Commission (2022) *Monitoring the Mental Health Act in 2021/22*. Newcastle upon Tyne: CQC. Available at: <https://www.cqc.org.uk/publications/monitoring-mental-health-act/2021-2022>.
University of Manchester (2023) *National Confidential Inquiry into Suicide and Safety in Mental Health: Annual Report 2023*. Manchester: University of Manchester.

to support trusts in strengthening observation and engagement practice, as a result, trusts have increasingly been expected to review local policies, governance arrangements.

- 17.11 Monitoring and auditing processes can provide assurance that observations and engagement are being delivered in accordance with local policy, national guidance, legal frameworks, and patient safety requirements. Modern governance processes increasingly aim to assess not only whether observations occurred, but also whether they were clinically appropriate, proportionate, therapeutic, and accurately documented. However, in my view they are less accurate in identifying if they were appropriate and therapeutic than simply whether they were performed.

18. **Reflections on observations and engagement**

- 18.1 Observation and engagement practice exists for an important purpose: to preserve life, reduce harm, provide reassurance, and support therapeutic recovery during periods of significant distress and vulnerability. When delivered well, observations can save lives. Effective observation practice relies not simply on completing prescribed checks, but on staff having the time, experience, compassion, curiosity, and professional confidence to meaningfully engage with patients, recognise subtle changes in presentation, and respond dynamically to risk. Staff who know the patient well, understand their triggers and behaviours, and maintain a caring and inquisitive approach are often best placed to identify when someone is deteriorating, becoming more withdrawn, or preparing to harm themselves.
- 18.2 **Hypothetical example 11:** Patient J an inpatient on an adult acute ward. They have a diagnosis of Complex Post-Traumatic Stress Disorder (C-PTSD) and a significant trauma history, including childhood neglect, witnessing domestic abuse, and being sexually assaulted at the age of 16. Patient J experiences persistent suicidal thoughts and engages in frequent ligaturing behaviours, often daily. They also restrict food and fluid intake and report chronic feelings of hopelessness, isolation, and emotional disconnection from others.
- 18.3 Initially, Patient J is managed through environmental restrictions. Their bedroom is locked at designated times, items that could be used for self-harm are removed, and they are issued with limited clothing each day. The MDT considers these environmental controls sufficient to manage immediate risks, and Patient J remains on Level 1 observations. Whilst this approach reduces opportunities for self-harm, Patient J continues to experience suicidal thoughts, poor sleep,

food and fluid restriction, and increasing withdrawal from staff and therapeutic activities. Their mental and physical health continue to deteriorate. Although the environmental restrictions may have reduced opportunities to act on suicidal impulses, they do not appear to improve Patient J's wellbeing, sense of safety, or engagement with treatment.

- 18.4 Following an MDT review, an alternative approach is implemented. Patient J is placed on Level 3 observations with a strong emphasis on therapeutic engagement and trauma-informed care. Personal belongings are returned, the bedroom is personalised with soft furnishings and sensor lighting, and efforts are made to create a more calming and less institutional environment. Through discussions with Patient J, it is identified that they feel most comfortable being supported by female staff, although they also report feeling safe with two specific male members of staff. Allocation is assigned with these preferences.
- 18.5 Review of incident data and discussions with Patient J identify that the highest-risk period is between 3pm and 3am, with distress, self-harm urges, and emotional dysregulation worsening during the evening and overnight. It is also recognised that Patient J typically does not fall asleep until 3am–4am and routinely sleeps until late morning. Rather than attempting to immediately impose a conventional routine, the care plan seeks to understand and work with Patient J's existing patterns whilst gradually encouraging change.
- 18.6 The engagement plan focuses on meaningful activity and relationship-building. Patient J is encouraged to participate in group activities and takes a leading role in art-based sessions. Together with staff, they identify nine daily goals, represented through artwork and colouring activities, with each goal being marked as completed when achieved. Food and snacks are made readily available within the bedroom. Staff are instructed not to repeatedly encourage eating or drinking, recognising that previous attempts to do so had become a source of conflict and distress. Instead, intake is documented, opportunities are provided, and discussions occur within planned therapeutic sessions rather than through repeated prompting.
- 18.7 Patient J receives two planned sessions each week with their Responsible Clinician, three sessions with their Key Worker, and two sessions with the Occupational Therapist. Initially, Patient J struggles to engage verbally and finds face-to-face discussion overwhelming. The team adapts their approach by encouraging Patient J to write down their thoughts before meetings. Early sessions consist largely of staff being present, engaging in informal conversation, and discussing the written material provided by Patient J. Over

time, trust develops, and Patient J begins to communicate more openly. A therapeutic alliance gradually forms.

- 18.8 As trust and engagement improve, observation levels are adjusted. Level 2 observations are initially introduced during the morning and when asleep. Staff remain present with Patient J until they fall asleep, often between 3am and 4am. Evening engagement incorporates relaxation strategies, calming music, and breathing exercises. A gradual sleep programme is introduced, with Patient J being supported to wake approximately 30 minutes earlier every few days by putting the radio on and making patient J a coffee. Eventually, their sleep routine improves, with waking occurring around 9am and sleep commencing between 1am and 2am.
- 18.9 Over a period of approximately three weeks, Level 2 observations are expanded to additional periods of the day before ultimately reducing to Level 1 observations. Throughout this period, Patient J continues to experience suicidal thoughts. However, they increasingly report feeling safe, understood, and cared for. Most importantly, they begin to seek support from staff when distressed rather than acting immediately on suicidal impulses or self-harm urges.
- 18.10 This example demonstrates that observation and engagement can be used not only as a means of preventing harm but also as a therapeutic intervention. Whilst environmental restrictions and risk management measures may reduce immediate opportunities for self-harm, sustainable improvements were achieved through the development of trust, therapeutic relationships, meaningful engagement, personalised care planning, and a trauma-informed understanding of Patient J's needs.
- 18.11 However, 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. Across the illustrative cases discussed within this report, observations were frequently present in policy and documentation but not always delivered effectively in practice. Themes included missed observations, assumptions being made, limited therapeutic engagement, communication failures, competing demands, and inadequate response to physical or mental deterioration. These failures contributed to patients not receiving the level of safety and support intended by the intervention.

18.12 Importantly these illustrative cases I have referred to should not lead to the conclusion that observations are ineffective. Rather their effectiveness depends heavily on the quality, consistency, and context in which they are delivered. Meaningful learning must therefore come from these incidents. Observation and engagement practice should continue to evolve through reflective practice, staff training, compassionate leadership, safer staffing approaches, therapeutic culture, and systems that support staff to care effectively rather than simply complete tasks. Ultimately, observations are most effective when they remain human, relational, and patient centred, rather than becoming purely procedural or surveillance based.

19. **Vision Based Patient Monitoring Systems (VBPMS) and Vision Based Technology in mental health inpatient wards**

19.1 VBPMS and VBT are different forms of technology used within mental health settings, although they may overlap in their role supporting safety and governance. VBPMS such as Oxevision are designed primarily as clinical monitoring tools to support patient safety and wellbeing. Oxevision is registered as a medical device with Medicines and Healthcare Regulatory Agency (MHRA).

19.2 CCTV and BWC are both forms of VBT, but they operate differently to VBPMS such as Oxevision. CCTV is usually fixed and environmental, providing live or recorded footage of communal ward areas for safety, security and incident review. BWC are mobile and staff-operated, usually activated in response to incidents or escalating situations. Both may provide useful safeguards, including evidence for investigations, complaints, safeguarding and learning. However, their use can also feel intrusive or coercive, particularly for patients who are distressed, detained, traumatised or mistrustful of services. For this reason, even where these technologies are used for legitimate safety purposes, they require clear governance, transparency, access controls, retention rules and safeguards to protect privacy, dignity and therapeutic relationships.

19.3 Over recent years, increasing attention has been given to how observation and engagement practice can be delivered more safely, consistently and therapeutically within inpatient mental health settings. NHS England's ETOC programme emphasises locally led, patient-centred approaches to improving observation and care provision, with staff effectively trained and deployed to provide therapeutic and safe care.¹²⁶ Alongside wider developments in inpatient

¹²⁶ NHS England. (2025). *Enhanced therapeutic observation and care: A guide to improving data collection and reporting*. London: NHS England.

governance, restrictive practice reduction and patient safety, digital technologies have increasingly been considered within mental health inpatient care.

- 19.4 Care Quality Commission (CQC) describes VBPMS 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. The reported aims and drivers for VBPMS include supporting patient safety, monitoring physical wellbeing, reducing disruption to sleep or rest, alleviating staff pressures, and generating data to support clinical oversight and governance. However, the current evidence base remains limited, with much of the published literature originating from stakeholders involved in the development or implementation of the technology. Independent reviews have concluded that there is no clear consensus regarding the effectiveness and wider impact of VBPMS and have called for further independent research.¹²⁷
- 19.5 VBT/VBPMS within mental health inpatient wards began to emerge in the UK during the mid-2010s, with wider adoption occurring from approximately 2018 onwards. Prior to 2022, I have not identified specific national guidance governing the use of digital technologies in mental health inpatient wards. Services instead relied on broader legal and professional frameworks, including data protection legislation, CCTV guidance, the MHA Code of Practice,¹²⁸ NICE 2015 guidance,¹²⁹ and local trust policies. Although the guidance wasn't specific to VBPMS/VBT it established the relevant principles for inpatient environments. These principles are directly relevant to the later introduction of VBPMS/VBT such as CCTV, BWC and Oxevision.
- 19.6 From 2022 onwards, the national position on VBPMS and VBT became more defined. In 2022 the National Mental Health and Learning Disability Nurse Director's Forum produced guidance on Standard Operating Procedures (SOP) in the use of VBT in mental health wards.¹³⁰ This was followed by NHS England guidance in 2025, Principles for using digital technologies in mental health

¹²⁷ Care Quality Commission (2025). *Exploring evidence regarding vision-based monitoring in inpatient mental health units*. CQC.

¹²⁸ Department of Health, *Mental Health Act 1983: Code of Practice* (The Stationery Office 2015).

¹²⁹ National Institute for Health and Care Excellence (NICE) (2015) *Violence and aggression: short-term management in mental health, health and community settings*. NICE guideline NG10. Published 28 May 2015. London: NICE.

¹³⁰ National Mental Health and Learning Disability Nurse Directors Forum (2022) *Vision-based patient monitoring systems (VBPMS) in mental health wards: National recommendations, guidance, and best practice on safe use of VBPMS*. Published 29 September 2022.

inpatient treatment and care,¹³¹ in collaboration with the Cultures of Care programme.¹³² CQC's 2025 brief guide on digital contactless patient monitoring technologies in mental health inpatient services is directly relevant to systems such as Oxevision. The guidance explains that inspectors and MHA reviewers will consider how providers use these technologies through the lens of safety, governance, safeguarding, learning and compliance with the MHA Code of Practice.¹³³

19.7 The 8 principles in NHS England's 2025 guidance are:

- Human rights approach — digital technology must support a human rights-based approach to care;
- 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;
- Equity of access — patients' opportunities to benefit from digital technologies must be equitable;
- Co-production — procurement, testing, implementation and evaluation should involve co-production with people with lived experience;
- Therapeutic and personalised care — digital technologies must support therapeutic, personalised care and must not undermine staff-patient relationships;
- Safety planning — safety planning must be personalised and co-produced; digital technology should only be used to manage safety risks where proportionate;
- Evidence base — providers must assess and document the evidence base before procuring and implementing digital technology; and
- Treatment outcomes — providers must regularly measure the impact and benefit of the technology on patient care, treatment outcomes and patient experience.

19.8 The UK appears to be leading internationally in the adoption of VBPMs in mental health inpatient bedrooms. However, this does not necessarily mean the UK is leading in ethical safeguards or evidence-based practice. My knowledge of international use is limited but I have been able to establish that camera-based surveillance in mental health in-patient settings exists abroad, but its use varies

¹³¹ NHS England (2025) *Principles for using digital technologies in mental health inpatient treatment and care*. Published 7 February 2025. London: NHS England.

¹³² NHS England (2024) *Culture of care standards for mental health inpatient services*. London: NHS England.

¹³³ Department of Health (2015) *Mental Health Act 1983: Code of Practice*. London: The Stationery Office. Available at: GOV.UK.

widely. A 2020 international review found that video surveillance is used in mental health inpatient services in many countries, but practice varies considerably because there is limited research, discussion and agreement on best practice. The central ethical tension is between privacy/autonomy versus patient and staff safety.¹³⁴

- 19.9 National Institute for Health and Care Research (NIHR) Policy Research Unit in Mental Health, involving King's College London and University College London,¹³⁵ undertook a systematic review of surveillance-based technologies in inpatient and acute mental health settings, including CCTV, VBPMS, BWC and Global Positioning System (GPS) monitoring and wearable sensors. The review found insufficient evidence to conclude that these technologies are achieving their intended outcomes, such as improving safety or reducing costs. The authors also noted that the evidence base was limited by methodological weaknesses, limited lived-experience involvement and declared conflicts of interest in a proportion of studies.¹³⁶ This supports the need for caution when relying on surveillance technology as evidence of improved safety or treatment outcomes.
- 19.10 The CQC guidance titled *Using surveillance in your care service*¹³⁷ sets out expectations for providers who use surveillance technologies such as CCTV, cameras and microphones. The guidance recognises that surveillance may help services keep people safe and monitor care but emphasises that it must be used in a way that protects people's privacy and human rights. CQC states that providers should be clear about the purpose of surveillance, consult people whose privacy may be affected, consider whether less intrusive alternatives are available, and ensure that the use of surveillance is lawful, fair and transparent. This provides an important governance framework for technologies such as CCTV, BWC and VBPMS.

¹³⁴ Appenzeller, Y.E., Appelbaum, P.S. and Trachsel, M. (2020) 'Ethical and practical issues in video surveillance of psychiatric units', *Psychiatric Services*, 71(5), pp. 480–486. doi:10.1176/appi.ps.201900397.

¹³⁵ Griffiths, J.L., Saunders, K.R.K., Foye, U., Greenburgh, A., Regan, C., Cooper, R.E., Powell, R., Thomas, E., Brennan, G., Rojas-García, A., Lloyd-Evans, B., Johnson, S. and Simpson, A. (2024) 'The use and impact of surveillance-based technology initiatives in inpatient and acute mental health settings: a systematic review', *BMC Medicine*, 22(1), p. 564, doi: 10.1186/s12916-024-03673.

¹³⁶ Griffiths, J.L., Saunders, K.R.K., Foye, U., Greenburgh, A., Regan, C., Cooper, R.E., Powell, R., Thomas, E., Brennan, G., Rojas-García, A., Lloyd-Evans, B., Johnson, S. and Simpson, A. (2024) 'The use and impact of surveillance-based technology initiatives in inpatient and acute mental health settings: a systematic review', *BMC Medicine*, 22(1), p. 564, doi: 10.1186/s12916-024-03673.

¹³⁷ Care Quality Commission (2025) *Using surveillance in your care service*. Available at: CQC website.

20. CCTV and BWC

- 20.1 National data protection guidance relevant to CCTV was available from 2000, when the Information Commissioner's Office issued its first CCTV Code of Practice under the Data Protection Act 1998.¹³⁸ This was not specific to mental health, but it established important principles for organisations using CCTV.
- 20.2 The first specific guidance for the use of BWC in mental health settings emerged from The Mental Health Units (Use of force) Act 2018.¹³⁹ The Act brought in the requirement for police officers attending mental health units to wear and operate BWC, with statutory guidance in 2021.¹⁴⁰
- 20.3 Up to 2023, I have not identified a specific national policy or statutory guidance governing the routine use of BWC by mental health ward staff. For mental health staff, use of BWC appears to have been governed mainly by local trust policies and emerging professional guidance, including the RCN's 2023 position statement:

*“body-worn cameras may be supported where a suitable and sufficient risk assessment has identified them as an appropriate control measure for violence and aggression, but only if legal, ethical, training, privacy and governance requirements are met. It emphasises that employers should first address underlying causes of violence and aggression, including staffing, resources, training, de-escalation, communication and workplace risk management”.*¹⁴¹

- 20.4 For NHS staff, guidance on the use of BWC remained less developed until the NHS and CQC both published guidance in 2025.¹⁴² The NHS guidance applies to digital technologies used in inpatient mental health settings and requires consideration of whether the technology is appropriate, effective and the least restrictive method of care or treatment. It also emphasises consent, human rights, privacy, dignity, data protection, staff training, governance, individualised

¹³⁸ Data Protection Act 1998.

¹³⁹ Mental Health Units (Use of Force) Act 2018.

¹⁴⁰ Department of Health and Social Care. (2021). *Mental Health Units (Use of Force) Act 2018: Statutory guidance for NHS organisations in England, and police forces in England and Wales*. London: DHSC.

¹⁴¹ Royal College of Nursing (2023) RCN position on the use of body worn cameras. London: Royal College of Nursing. Available at: RCN website.

¹⁴² NHS England (2025) *Principles for using digital technologies in mental health inpatient treatment and care*. Published 7 February 2025. London: NHS England. Care Quality Commission (2025) *Using surveillance in your care service*. Available at: CQC website.

care planning and review. Therefore, CCTV, BWC and Oxevision-type VBPMS should all be considered within this framework when used in mental health inpatient environments.

- 20.5 BWC may offer some benefits in mental health wards, particularly in relation to staff safety, incident review, safeguarding, accountability and evidence gathering after serious incidents. Some patients may also request that a camera is switched on, for example if they feel unsafe, want an interaction recorded, or believe that recording may protect them or provide accountability. In my experience, BWCs are not always used effectively or consistently. Staff may forget to switch them on when an incident begins or fail to switch them off once the incident has ended. This creates risks in relation to both the usefulness of the footage and the privacy and dignity of patients and staff.
- 20.6 EPUT guidance is that where an incident is occurring, such as violence or aggression, the patients involved should be informed that the camera is being switched on, and that the recording also captures sound. Patients should also be told when the camera is switched off.¹⁴³ Were used appropriately, the footage can support patient and staff debriefs, assist incident review, and help identify learning. However, this depends on staff using the cameras in line with policy, including clear communication, proportionate use, accurate recording, and timely switching off once recording is no longer necessary.
- 20.7 BWCs are registered/signed out to individual staff members, which provides an audit trail of who was using the device and when. This can support tighter governance, accountability and review of whether the camera was used appropriately.¹⁴⁴
- 20.8 EPUT guidance on CCTV operates differently to BWC. It is not allocated to an individual staff member, because the cameras are fixed in specific communal areas of the ward. CCTV is not located in personal bedrooms or bathrooms, and footage is recorded for a limited retention period. If footage is required for a safety, security, safeguarding, complaint or incident investigation, it can be secured and saved as evidence. If there is no request to retain footage and no identified incident or concern, the footage will usually be overwritten or deleted after the retention period.¹⁴⁵ EPUT guidance also states that CCTV guidance is

¹⁴³ CP28 – Surveillance Systems Policy xV1.0, 17/03/2025, [EPUT009001], page 21.

¹⁴⁴ CP28 – Surveillance Systems Policy xV1.0, 17/03/2025, [EPUT009001].

¹⁴⁵ CP28 – Surveillance Systems Policy xV1.0, 17/03/2025, [EPUT009001].

not to replace clinical care and it does not and cannot replace skilled employees.¹⁴⁶

- 20.9 Before CCTV was available, fact-finding investigations often relied primarily on witness statements, clinical records and staff accounts. CCTV can provide more objective evidence about whether observations and engagement occurred as expected, including whether staff were present, whether checks were completed, and whether there were gaps in practice. Although CCTV may be experienced by staff as a “big brother” approach and may not always be welcomed, it can provide safeguards by identifying non-compliance, supporting incident review, and highlighting learning for practice. However, CCTV is retrospective in nature and does not, by itself, prevent harm from occurring. Its value is therefore mainly in assurance, accountability and learning, rather than as a substitute for safe staffing, therapeutic engagement, clinical judgement or active risk management.
- 20.10 Accessing CCTV and BWC footage is determined by local policy. In many services, review of pre-recorded footage is restricted to authorised staff, often a senior member of staff such as a ward manager, matron or service manager. Individual logins and access controls strengthen governance by creating an audit trail of who accessed footage, when, and for what purpose. CCTV does offer live streaming from a ward monitor, which is different from accessing pre-recorded footage which has tighter controls.¹⁴⁷
- 20.11 For mental health wards that use CCTV, BWC and VBPMS, local policies and procedures should promote clear communication with patients, families, carers and staff about how these systems are used. This includes visible posters, patient information leaflets, information in admission packs, and opportunities for discussion. The evidence provided indicates that EPUT has these communication methods in place, including written information and visual explanations about CCTV, BWC and Oxevision.¹⁴⁸ However, it is difficult to determine from the evidence if they were used in care delivery and teams were compliant with using them.
- 20.12 Evidence from “iWantGreatCare” feedback shows mixed patient views about the use of VBPMS/VBT.¹⁴⁹ Some patients welcomed the technology and felt it contributed to their safety, while others experienced it as inappropriate

¹⁴⁶ CP28 – Surveillance Systems Policy xV1.0, 17/03/2025, [EPUT009001].

¹⁴⁷ CP28 – Surveillance Systems Policy xV1.0, 17/03/2025, [EPUT009001].

¹⁴⁸ Body Worn Camera Poster, undated, [EPUT009016]. CCTV Poster, 08/03/2022, [EPUT009015].

¹⁴⁹ iwantgreatcare feedback, undated [EPUT009020].

surveillance. EPUT's policy position appears to distinguish between different forms of technology. CCTV and BWC do not operate on an individual patient opt-in or opt-out basis. For BWC, patients should be informed when the device is switched on, including that sound is recorded, and should be told when recording stops. By contrast, with VBPMs such as Oxevision, patients may not be aware at the exact moment the device is being used, particularly where staff access the live-view or vital-signs function remotely. This difference is important because it affects the patient's ability to understand, challenge or respond to the monitoring at the time it occurs.

21. **VBPMs / Oxevision**

21.1 In 2012 Oxevision was developed by Oxehealth, a company from Oxford University research, but its use in NHS mental health inpatient practice appears to have expanded mainly from around 2019–2021. By December 2021, Oxevision was reported to be in use in 50 percent of Mental Health Trusts, suggesting that its adoption had become more widespread by that stage.¹⁵⁰

21.2 Oxevision can:

- 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 a 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;
- provide alerts or notifications for certain configured situations, such as prolonged time in the bathroom, another person entering the room, or other ward-defined risk events; and
- produce activity information that may help staff understand sleep, movement or room-use patterns.

21.3 Red and amber alerts are used to help staff prioritise responses to Oxevision notifications, but they should not be treated as evidence that harm is or is not occurring. A red alert would usually indicate a higher-priority situation requiring prompt review and, where necessary, a face-to-face check. An amber alert may indicate a lower-level or emerging concern that still requires staff attention and clinical interpretation. In both cases, the alert only shows that the system has detected a configured trigger; it does not confirm the patient's safety, explain the

¹⁵⁰ Witness Statement of Laura Cozens, 19/02/2025 [OXHE009031].

reason for the alert, or replace staff judgement. Staff should interpret red and amber alerts in the context of the individual patient's risks, care plan, presentation and location, and should document what action was taken. Resetting an alert alone does not evidence that the patient was checked or that the risk was resolved.

- 21.4 **Pixelated Image:** 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. However, a pixelated image is still visual access into a patient's private bedroom and should not be treated as non-intrusive.
- 21.5 A pixelated image is intended to reduce the level of visual detail available to staff when responding to an Oxevision alert. This may be less intrusive than a clear image, because staff are not able to see the patient or the bedroom environment in the same level of detail. However, it remains a form of visual access into a private bedroom and should not be regarded as non-intrusive simply because the image is blurred or pixelated.
- 21.6 In my view, the fact that the image is pixelated reduces but does not remove the privacy and dignity concerns. The key question remains whether viewing the image is necessary, proportionate, individually justified and the least intrusive means of responding to the identified risk. The use of a pixelated image should be governed by clear policy, staff training, audit and documentation, including when a face-to-face check is required following an alert.
- 21.7 Oxevision cameras and sensors may be fitted into individual patient bedrooms, seclusion and HBPOS and are secured behind a clear screen. When the device is switched off, red lights may remain visible, indicating that power is still going to the device, even though the system is not active. This can be confusing for patients who have requested that Oxevision be switched off, because the visible light may give the impression that the device remains in use. However local policies usually state that the switch off function is not available in seclusion and HBPOS, unless the environments are empty/not occupied.
- 21.8 The red light remaining on is significant as even where staff provide reassurance that the device is inactive, the continued presence of an illuminated camera or sensor in the bedroom may increase suspicion, mistrust or distress, particularly for patients experiencing paranoia, trauma-related symptoms, heightened anxiety, or concerns about surveillance. This can create difficulties for the

clinical team because it may undermine trust, affect engagement, and damage the therapeutic alliance. It is my understanding that individual trusts are unable to control this element, and that it is a manufacture design.

21.9 **Seclusion, HBPOS, LTS:** 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 HBPOS.¹⁵¹ 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.¹⁵² 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 as a substitute for physical health monitoring, NEWS2, face-to-face assessment or professional judgement.

21.10 EPUT and some other trusts have implemented an additional digital observations module within the Oxevision platform, sometimes referred to as OxeObs or Oxevision Observations.¹⁵³ 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.

22. **Policy and Procedure comparisons with 2025 Guidance**

22.1 I have been asked by the Inquiry to consider EPUT’s compliance with the 2025 NHS England guidance.¹⁵⁴ I have focused specifically on the human rights approach and treatment outcomes, as these are, in my view, the areas where compliance is most open to question.

¹⁵¹ Standard Operating Procedure for the use of the Oxehealth Oxevision and Oxevision Observations version 12, dated 30/04/2025, [EPUT009884]

¹⁵² Standard Operating Procedure for the use of the Oxehealth Oxevision and Oxevision Observations version 12, dated 30/04/2025, [EPUT009884].

¹⁵³ Second Witness Statement of Zephany Trent, 09/05/2025 [EPUT009026].

¹⁵⁴ NHS England (2025) *Principles for using digital technologies in mental health inpatient treatment and care*. Published 7 February 2025. London: NHS England.

- 22.2 I have reviewed SOP 10,¹⁵⁵ which was in place prior to the national guidance, and SOP 12,¹⁵⁶ which was produced after the guidance was published. I have also reviewed the current practice changes that came into immediate effect in May 2026, following findings from the Parliamentary and Health Service Ombudsman investigation (PHSO).¹⁵⁷
- 22.3 SOP 10 was developed in May 2024.¹⁵⁸ Its position was that Oxevision was continually switched, meaning all patients are opted in upon admission. If a patient refused or declined use of the system, they had to be considered to have capacity to do so. If they were not deemed to have capacity, an assessment was required, and decisions were to be made in their best interests. The SOP did not appear to differentiate between patients detained under the Mental Health Act and informal or voluntary patients. I have therefore assumed that the same principle was applied to all patients.
- 22.4 Under SOP 10, where a patient requested that Oxevision be switched off, the device remained active until an MDT meeting took place. Wards had up to 72 hours to convene this MDT meeting. The system therefore remained in use during this period, even where the patient had objected. SOP 10 stated: *“Switching rooms off for another purpose than MDT approved patient refusal is not permitted.”*¹⁵⁹
- 22.5 Although the 2025 national guidance had not yet been published, this practice raised significant concerns in relation to Article 8 of the European Convention on Human Rights (ECHR), incorporated into UK law through the Human Rights Act 1998.¹⁶⁰ Article 8 protects the right to respect for private life, including privacy, dignity, autonomy and psychological integrity. VBPMs in a patient’s bedroom clearly engages those rights. Where a patient was assessed as having capacity to refuse, but the system nevertheless remained active pending MDT approval, this raises concerns about whether the continued interference with the patient’s privacy was necessary, proportionate, individually justified and the least intrusive means of managing risk.

¹⁵⁵ Standard Operating Procedure for the Use of Oxehealth Oxevision and Oxevision Observations -Version 10, 31/05/2024, [EPUT004791].

¹⁵⁶ Standard Operating Procedure for the use of the Oxehealth Oxevision and Oxevision Observations Version 12, 30/04/2025, [EPUT009884].

¹⁵⁷ Parliamentary and Health Service Ombudsman, Complaint by Miss B, 27/03/2026, [EPUT023600].

¹⁵⁸ Standard Operating Procedure for the Use of Oxehealth Oxevision and Oxevision Observations -Version 10, 31/05/2024, [EPUT004791].

¹⁵⁹ Standard Operating Procedure for the Use of Oxehealth Oxevision and Oxevision Observations -Version 10, 31/05/2024, [EPUT004791], page 8.

¹⁶⁰ *Human Rights Act 1998*, Schedule 1, Part I, Article 8.

- 22.6 In my view, SOP 10 risked placing organisational approval above the patient's expressed refusal. 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.
- 22.7 Following publication of the 2025 NHS guidance,¹⁶¹ EPUT reviewed and updated the SOP to version 12.¹⁶² The main change to practice was reducing from 72 to 6 hours for MDT consideration. This was a positive development and demonstrated recognition that patient objections to VBPMS should be addressed more promptly, particularly where the patient experiences the system as distressing, intrusive or surveillant.
- 22.8 However, SOP 12 still retained an approval process before switch-off could occur. The request still required consideration by the RC and MDT, or by the on-call clinician out of hours to meet the 6-hour timeframe. Therefore, although the shorter timeframe was an improvement, it did not fully resolve the concern that Oxevision remained active while the patient awaited approval. SOP 12 was not fully compliant with the 2025 NHS England guidance because it permitted patients who objected to VBPMS to remain subject to monitoring for up to 6 hours whilst awaiting approval for switch-off. In my opinion, this was inconsistent with the guidance's emphasis on timely, individualised decision-making and respect for patient autonomy, privacy, dignity and Article 8 rights.¹⁶³
- 22.9 **Consent Audit Data** relating to patient consent for Oxevision was provided by the Inquiry. A sample of 17 patients who were admitted in the month of June and July 2025 showed in nine cases there was no admission checklist, and therefore no evidence of informed consent being obtained at admission. In four further cases, informed consent was captured after seven days, five days, one day and eight hours respectively.¹⁶⁴ The data findings showed that this was outside the six-hour standard. This suggests that although the SOP had improved on paper, compliance in practice was inconsistent. It also supports the concern that patients may have had regarding Oxevision being active in their bedrooms without timely evidence that they had been properly informed, had capacity to consent, and had given meaningful consent.

¹⁶¹ NHS England (2025) *Principles for using digital technologies in mental health inpatient treatment and care*. Published 7 February 2025. London: NHS England.

¹⁶² Standard Operating Procedure for the use of the Oxehealth Oxevision and Oxevision Observations Version 12, 30/04/2025, [EPUT009884].

¹⁶³ *Human Rights Act 1998*, Schedule 1, Part I, Article 8.

¹⁶⁴ Draft TIAA Assurance Review of follow up of consent (Oxevision) (EPUT023598)

- 22.10 I was provided with the minutes from the Executive Team Operational Committee meeting. The Committee discussed the findings from the PHSO¹⁶⁵ and agreed immediate changes to practice in relation to consent and the switch-on/switch-off function.¹⁶⁶ 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 also be clinically justified.¹⁶⁷
- 22.11 EPUT's stated position is that it will review its current SOP in line with these practice changes and seek legal advice on matters arising in relation to the HRA.¹⁶⁸ It is notable that EPUT had not sought such legal advice in relation to its previous SOPs.¹⁶⁹
- 22.12 I was also provided with audit data dated May 2026 relating to patient consent for the use of Oxevision. The data was collected between January and February 2026, and 25 patient cases were audited. In 44% of cases, there was no evidence of consent. This represented a reduction from 55% in the 2025 audit data, although the 2025 data set was smaller. The audit identified actions in relation to consent as a top priority for the Trust.¹⁷⁰
- 22.13 In my view, this audit data demonstrates some improvement when compared with the previous audit; however, it also shows that significant compliance concerns remained. Almost half of the audited cases remained to have no evidence of consent, despite the publication of national guidance and the amendments made through SOP 12. This supports the concern that the issue was not solely one of policy wording, but also of implementation, assurance and compliance in practice.
- 22.14 Gaining consent at the point of admission, and regularly reviewing that discussion, appears to have improved since VBPMS was first implemented within EPUT in 2020. However, although communication at admission had

¹⁶⁵ Parliamentary and Health Service Ombudsman, Complaint by Miss B, 27/03/2026, [EPUT023600].

¹⁶⁶ Minutes of Extraordinary Board Meeting on the use of Oxevision, 20/05/2026, [EPUT023601], page 2.

¹⁶⁷ EPUT Memo, Immediate actions required – Changes to use of Contactless Patient Monitoring, 22/05/2026, [EPUT023599], page 1.

¹⁶⁸ *Human Rights Act* 1998, Schedule 1, Part I, Article 8.

¹⁶⁹ Minutes of Extraordinary Board Meeting on the use of Oxevision, 20/05/2026, [EPUT023601], page 3-4.

¹⁷⁰ EPUT – TIAA Assurance Review of Follow Up of Consent (Oxevision), 01/01/2026, -[EPUT023598], page 3.

become more rigorous, the presence of a discussion or that information was provided does not demonstrate meaningful consent. Patients must be able to understand, retain, use and weigh the relevant information, and communicate their decision, before consent can be considered valid.

- 22.15 This is particularly important because admission to an acute mental health ward often occurs when a patient is distressed, overwhelmed, acutely unwell or in crisis. In that context, agreement to Oxevision may not always reflect genuinely informed consent, particularly where the technology is presented in terms of safety and wellbeing. Patients and families may understandably assume that something described in this way must be beneficial. For consent to be meaningful, information must be presented neutrally and clearly, including the purpose of Oxevision, what it can and cannot do, how images or data may be used, the circumstances in which staff may view the bedroom, the patient's right to decline or withdraw consent, and any alternative approaches available.
- 22.16 **Treatment Outcomes:** I have not seen evidence that VBPMS directly influenced individual patient care in a systematic or clearly documented way. The data I have reviewed appears to focus primarily on activity and usage, for example the number of vital-signs attempts, completed readings, alerts and alert resets. While this information may be useful for operational monitoring, it does not, in itself, demonstrate that VBPMS improved treatment outcomes or informed clinical decision-making for individual patients.
- 22.17 I have not seen evidence that the monthly VBPMS data routinely fed into MDT reviews, care planning, risk formulation, observation levels, safety planning, discharge planning, or therapeutic interventions. In my view, this creates a gap in demonstrating compliance with the treatment outcomes principle in the 2025 guidance. If VBPMS is being used as part of inpatient care, there should be a clear line of sight between the data collected, the clinical interpretation of that data, and any resulting changes to patient care. Without that, the data risks functioning mainly as usage or assurance data, rather than evidence that the technology is improving care, safety, patient experience or clinical outcomes.
- 22.18 In my experience VBPMS has not directly informed the care and treatment of patients in a meaningful or systematic way. In my own clinical practice, patient care and progression continue to be informed by direct observational assessment, face-to-face engagement, discussion with the patient, MDT formulation, risk assessment, sleep monitoring, food and fluid intake, physical health monitoring, medication response, incidents, leave outcomes and therapeutic engagement. These remain the key sources of information when

considering observation levels, care planning, risk management, discharge planning and overall clinical progress.

- 22.19 Overall, the changes to practice and the current SOP under review appears more closely aligned with national guidance than earlier practice. EPUT appears to have recognised that assumed consent was problematic and has introduced more robust processes. However, unless there is clear evidence that VBPMS data is being reviewed, interpreted and used within MDT decision-making, care planning and risk formulation, it is difficult to conclude that it is contributing directly to treatment outcomes.

23. **Capacity to consent**

- 23.1 Where a patient lacks capacity, any decision to continue using Oxevision should be made through a properly documented best-interests process. This should consider necessity, proportionality, less restrictive alternatives, privacy, dignity, distress, and the patient's known wishes and feelings. A finding that the patient lacks capacity should not automatically lead to a best-interests decision in favour of Oxevision use. A person may lack capacity to make the specific decision, but still express a clear view, preference, fear or objection about having VBPMS in their bedroom. Those views should be given proper weight in the decision-making process.
- 23.2 The best-interests decision should therefore not start from the assumption that Oxevision is beneficial because it is available or because it is described as a safety intervention. The MDT should consider whether it is necessary for that individual patient, whether the same risk could be managed through less intrusive alternatives, and whether continued use may increase distress, mistrust or feelings of surveillance. The patient's objection, even if they lack capacity, remains relevant to privacy, dignity, psychological safety and therapeutic engagement.
- 23.3 Where a patient lacks capacity, the decision-making process should also include gathering views from people who may have legal authority or a legitimate role in supporting the decision. This may include parents or those with parental responsibility for children and young people, an attorney appointed under a Lasting Power of Attorney LPA, a court-appointed deputy, family members, carers, or advocates.¹⁷¹ Their views may help establish the patient's past and present wishes, feelings, values, beliefs, fears and preferences. However,

¹⁷¹ *Mental Capacity Act 2005*, s.4.

involvement of others should not mean that Oxevision is automatically used. The decision-maker must still consider whether the technology is necessary, proportionate, in the person's best interests, and the least restrictive option. Where a person with legal authority exists, such as an LPA or deputy, the scope of their authority should be checked to ensure it covers the relevant health and welfare decision.

- 23.4 For patients under 16, consent should be assessed using Gillick competence rather than the MCA.¹⁷² A child under 16 may consent to treatment if they have sufficient intelligence, competence and understanding to fully appreciate what is involved in the decision.¹⁷³
- 23.5 **Illustrative Case Summary, Michael Nolan:**¹⁷⁴ Michael was admitted to hospital on Section 2 of the MHA, I am not aware of any clinical documentation to determine if admission was offered to him on voluntary basis.¹⁷⁵ He was placed on Level 3 observations on admission.¹⁷⁶ Michael was transferred to another ward, and it is documented that he consented to Oxevision, but there was no documentation as to whether he consented to Oxevision on the first ward.¹⁷⁷ The evidence provided to me does not clearly evidence if Michael was reliably informed about Oxevision or if he had the capacity to consent to its usage.
- 23.6 **Hypothetical example 12:** Patient I is admitted to the ward and is told about Oxevision as part of the admission process. They are provided with written and verbal information about how the system works, including that it is used for safety and welfare purposes. The patient states that they do not want VBPMS active in their bedroom.
- 23.7 If Patient I is detained under the MHA,¹⁷⁸ the fact that they are detained does not automatically determine whether Oxevision can be used. The original decision to detain may not have specifically considered Oxevision or whether VBPMS was necessary as part of the patient's care and treatment. The ward therefore still needs to make a separate, individualised decision about whether Oxevision is clinically justified, proportionate and lawful for that patient.

¹⁷² *Gillick v West Norfolk and Wisbech Area Health Authority and Department of Health and Social Security* [1986] AC 112.

¹⁷³ NHS (2022) Children and young people: consent to treatment. Available at: NHS website.

¹⁷⁴ Illustrative Case Summary, Michael Nolan.

¹⁷⁵ Illustrative Case Summary, Michael Nolan.

¹⁷⁶ Illustrative Case Summary, Michael Nolan.

¹⁷⁷ Illustrative Case Summary, Michael Nolan.

¹⁷⁸ *Mental Health Act 1983*, s 5.

- 23.8 If Patient I is an informal patient, the position is even more sensitive. If they have capacity and refuse Oxevision, continued use would be difficult to justify without a clear lawful basis. The MCA¹⁷⁹ cannot be used to override a capacious refusal, and the MHA would not apply unless the patient is detained, or the legal threshold for detention is met. If the clinical team considers that the patient's risks are so significant that Oxevision is necessary despite their refusal, this should prompt a review of whether the current legal framework is appropriate, rather than relying on default bedroom monitoring. However, I would struggle to understand how detention solely because a patient refuses Oxevision would meet the legal criteria for detention. In my view, Oxevision is not an essential intervention in itself; it is an assistive technology. Refusal of Oxevision should not be treated as evidence that detention is required. The focus should remain on the patient's overall mental disorder, risk, care needs, and whether any intervention is necessary, proportionate and least restrictive.
- 23.9 **In the PHSO response regarding Miss B's care**, it was found that there was no evidence that Miss B had been suitably informed about the use of Oxevision. There was also no evidence within her care plan explaining how Oxevision would be used, and the Trust failed to seek her consent for its use.¹⁸⁰
- 23.10 In my view, this is significant because the use of VBPMS in a patient's bedroom engages privacy, dignity and autonomy. Where a patient is not clearly informed, where consent is not sought, and where the purpose and use of the technology are not documented in the care plan, it is difficult to demonstrate that the intervention was lawful, necessary, proportionate or individually justified. It also means that the clinical team cannot show that Oxevision was being used as part of a personalised care plan, rather than as a default ward-level safety measure.
- 23.11 This finding is consistent with the wider concerns identified in the audit data and the subsequent changes made by EPUT. It suggests that the issue was not limited to the wording of the SOP, but extended to how the policy was understood, implemented and assured in practice.
- 23.12 EPUT's improved communication materials and consent processes support greater transparency such as welcome packs and posters,¹⁸¹ but equitable

¹⁷⁹ *Mental Capacity Act 2005*, s.4.

¹⁸⁰ Parliamentary and Health Service Ombudsman, Complaint by Miss B, 27/03/2026, [EPUT023600], page 1.

¹⁸¹ Oxevision poster, update, [EPUT009027]. Information for patients, carers and relatives Welcome Pack, undated, [EPUT009023].

practice depends on whether all patients can genuinely understand and exercise choice. Patients with learning disabilities, autism, psychosis, cognitive impairment, trauma histories, language barriers, sensory needs or low health literacy may require adapted information, advocacy, interpreters, family involvement or repeated discussions.

- 23.13 The evidence also suggests movement towards co-production, including patient, family and staff forums, questionnaires, one-to-one discussions and independent review. However, full co-production depends on whether patients and families influenced the design, implementation and governance of Oxevision practice, rather than only being informed or consulted after implementation.

24. **Oxevision data reports**

- 24.1 I have been provided with Oxehealth month usage reports for EPUT dated from June 2024 to September 2025, as well as more recently April 2026 data report. The reports provide monthly data for each ward with the following functions:

- Number of vital signs attempts, each day, split between day and night;
- Speed of alerts resets each day;
- Device usage; and
- List of devices assigned to each ward, and whether they are being used.

- 24.2 The vital signs function allows staff to observe a clear view of a patient's bedroom for up to 15 seconds. Vital signs attempted and vital sign displayed, mean two different things. Vital signs attempted means staff opened or activated the vital-signs function to try to obtain a reading. This may involve the system accessing a clear view of the patient's bedroom for up to 15 seconds, but it does not necessarily mean pulse and respiratory rate were successfully obtained. Vitals displayed means the system successfully calculated and showed vital signs, usually pulse rate and respiratory rate, to staff.

- 24.3 Comparing wards with high usage vital signs. June 2024 and June 2025¹⁸² and most recently April 2026.¹⁸³

¹⁸² Oxevision Implementation Dates, undated, [EPUT009030] & Oxevision Monthly Usage Report June 2025, 01/06/2025, [EPUT020852].

¹⁸³ Oxevision Monthly Usage report for EPUT April 2026, 01/04/2026, [EPUT023597].

	Bed Occupancy ¹⁸⁴	June 2024	June 2024	June 2025	June 2025	April 2026	April 2026
Ward		Attempt	Reading	Attempt	Reading	Attempt	Reading
Cherrydown Adult Acute	16	12,347	5,904	23,955	10,442	20,948	Not available
Henneage Older Adult	16	23,872	8,685	24,342	9,212	21,027	Not available
Ardleigh Adult acute	18	29,565	9,729	27,432	9,958	24,292	Not available
Gloucester Older Adult	22	17,733	8,461	24,393	11,778	10,737	Not available

24.4 The 2024 and 2025 data raises significant privacy and dignity concerns. Although the activity is recorded as “vital signs attempted,” fewer than half of attempts resulted in displayed readings, suggesting that the function was frequently accessed without producing physiological observations. 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. This is particularly important because a bedroom in an inpatient mental health unit remains a private space, even within a restrictive environment. Repeated visual access, especially where it does not result in clinical data, may be difficult to justify unless it is clearly necessary, proportionate, documented and understood by the patient. The issue is therefore not only whether Oxevision can obtain pulse and respiratory rate, but whether repeated unsuccessful attempts are compatible with privacy, dignity, meaningful consent and least-restrictive practice.

24.5 If staff are using the vital signs function to undertake observations, this raises concerns about transparency, consent, privacy and dignity. Patients may understand “vital-signs monitoring” as a physical health function but may not appreciate that repeated attempts could also involve clear visual access into their bedroom. The trust should therefore be able to evidence why the function was accessed so frequently, whether the purpose was physiological monitoring or visual observation, and how this was explained to patients as part of informed consent.

24.6 Cherrydown ward data appears to demonstrate a high use rate. In June 2025, there were 23,955 vital-signs attempts on a 16-bed ward, equating to approximately 799 attempts per day, or almost 50 attempts per bed per day. This is broadly equivalent to each patient having the vital-signs function attempted

¹⁸⁴ Ward Lists and Services, [EPUT009526].

on average once every 29 minutes across a 24-hour period. I have used Cherrydown ward as an example, but the other wards in the table have higher usage.

- 24.7 Checking or attempting to check vital signs once every 29 minutes per bedroom, on average, appears extremely high. I cannot identify an obvious clinical rationale for this level of use in routine practice. Even if Oxevision was being used overnight to reduce sleep disturbance, this would not explain such high usage across a 24-hour period. The data is particularly concerning because the number of vital-signs attempts on Cherrydown ward more than doubled between June 2024 and June 2025, while the proportion of successful readings remained below 50%. This suggests that the function was being accessed very frequently without consistently achieving the stated clinical purpose of obtaining vital-signs readings.
- 24.8 Possible explanations include the vital-signs function being used as a substitute for observations and engagement (minus the engagement), staff misunderstanding the intended purpose of the function, over-reliance on the technology, inadequate training, poor local governance, or a ward culture in which remote checking became normalised. There is also a theoretical risk of inappropriate use, although the pattern of high usage across the ward may indicate a broader team or system issue rather than the actions of a single staff member. In either case, the data would warrant audit and explanation, including why the function was accessed so frequently, whether each attempt was clinically justified, whether patients were informed that this may involve clear visual access to their bedroom, and whether face-to-face engagement was being displaced.
- 24.9 The April 2026 data shows that high use of the Oxevision vital-signs function continued on Cherrydown, Henneage and Ardsley, although attempts reduced slightly compared with June 2025. When adjusted for bed numbers, this equates to approximately 44–45 vital-signs attempts per bed per day across these three wards. This remains a very high level of use and suggests that the vital-signs function continued to be accessed frequently. Gloucester showed a more substantial reduction, from 24,393 attempts in June 2025 to 10,737 attempts in April 2026, equating to approximately 14 attempts per bed per day. The April 2026 data does not include the number of successful/displayed readings,¹⁸⁵ so it is not possible to determine whether the success rate improved or whether fewer attempts resulted in displayed vital signs.

¹⁸⁵Oxevision Monthly Usage Report for EPUT April 2026 [EPUT023597].

- 24.10 The Oxevision vital-signs function can read pulse and respiratory rate for a short period, usually up to approximately 15 seconds, where the patient is still and suitable focal points are visible, such as a hand or foot. It 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.
- 24.11 Importantly, Oxevision does not alert staff to all physical deterioration, nor does it identify that a self-harm or suicide attempt is occurring unless this triggers a configured alert, such as a prolonged bathroom alert. For example, if a patient remains in the bathroom for more than three minutes, an alert may occur, but the system does not replace staff assessment, professional curiosity or clinical judgement. Physical health monitoring remains crucial alongside mental health observation. An experienced and trained member of staff may recognise signs that a remote vital signs reading cannot, such as over-sedation, colour or complexion changes, confusion, disorientation, pain, intoxication, or changes in behaviour.
- 24.12 Although the vital-signs function is registered as a medical device, a short reading does not replace a full set of physical observations. A full physical health assessment may also include blood pressure, temperature, oxygen saturation, level of consciousness, blood glucose or other blood monitoring, depending on the clinical context. Therefore, even where pulse and respiratory rate appear within normal range, this does not rule out deterioration or clinical concern. Individual patients should have it identified how many times a day or week physical health checks should occur. In some instances, a patient may be checked four times a day, due to either physical health concerns or the monitoring of new medication. Whereas others might have weekly checks, or more if clinical indicated. The vital sign function on Oxevision cannot and does not replace physical health monitoring.
- 24.13 Where face-to-face monitoring or a full physical health assessment is clinically indicated, alternative methods should be used rather than relying on the Oxevision vital-signs function. This is particularly important where there are concerns about physical health stability, deterioration, intoxication, over-sedation, self-harm, confusion, disorientation, pain, infection, falls or other acute clinical concerns. In these circumstances, staff should undertake direct

assessment and complete appropriate physical observations, such as NEWS2 where indicated.¹⁸⁶

- 24.14 There may be situations where use of the vital-signs function is proportionate, for example where a patient is asleep and staff wish to avoid unnecessary disturbance, or where a patient is in seclusion and entering the room is assessed as unsafe at that moment. However, even in these circumstances, use of Oxevision should be clinically justified, documented, and kept under review. It should be understood as an additional tool, not a substitute for professional judgement, physical health monitoring, therapeutic engagement or face-to-face assessment where this is required.
- 24.15 **Illustrative Case Summary, Adam Steel:** Oxevision data showed that Adam's bedroom door had not opened at any point during the night, and that his bed was not visible from the door window.¹⁸⁷ Adam was on level 2 observations (four checks per hour). Adam was neither observed face-to-face or by VBPMs.¹⁸⁸ In my view, this case illustrates the importance of face-to-face checks in determining a patient's safety and wellbeing. Remote viewing or reliance on Oxevision, is insufficient to determine whether a patient is physically well, emotionally distressed, deteriorating, or in need of urgent intervention.
- 24.16 Adam's requirement to isolate due to COVID-19 may have contributed to a reliance on remote observation. I note that EPUT introduced Oxevision in 2020,¹⁸⁹ during the COVID-19 pandemic, when social distancing and reduced physical contact were being promoted across healthcare settings. In that context, it is possible to see how staff may have become unclear about the distinction between remote monitoring as an assistive tool and face-to-face observation as a required clinical intervention. However, I recognise that this is an inference, rather than a finding that can be confirmed from the evidence I have reviewed. The key issue remains that Oxevision should not have been used as a substitute for face-to-face observation unless there was a clear, documented and clinically justified rationale for doing so.
- 24.17 The use of vital signs function also raises questions about whether staff of the opposite sex may view patients in their bedrooms when using live view or the vital-signs function. Patients may be in bed, partially clothed, having private

¹⁸⁶ CG87 - Clinical Guidelines on the Use of Early Warning Scoring Systems Version 2, 08/06/2022, [EPUT020786].

¹⁸⁷ Illustrative Case Summary, Adam Steel.

¹⁸⁸ Illustrative Case Summary, Adam Steel.

¹⁸⁹ Second Witness Statement of Zephany Trent, 09/05/2025 [EPUT009026], page 4.

time, or unaware that the function is being accessed at that moment. For some patients, including those with trauma histories, experiences of sexual abuse, cultural or religious privacy needs, paranoia, or gender-related vulnerabilities, being viewed by staff of the opposite sex may be especially distressing or humiliating. This has implications for privacy, dignity, consent and psychological safety.

24.18 I believe EPUT are bringing in individual staff logins for accessing the vital-signs function which would provide stronger governance and accountability.¹⁹⁰ This would allow the trust to audit who accessed the function, when it was accessed, how frequently it was used, and whether use was consistent with policy and clinical need. This would also support identification of individual training or competency issues, patterns of overuse, inappropriate access, or poor compliance with privacy and dignity requirements.

24.19 Comparing wards with low usage vital signs. June 2024, June 2025 and April 2026.¹⁹¹

		June 2024	June 2024	June 2025	June 2025	April 2026	April 2026
Ward	Bed Occupancy ¹⁹²	Attempt	Reading	Attempt	Reading	Attempt	Reading
Aurora Forensic/secure	12	1,607	614	1,281	547	238	Not available
Poplar Young persons	13	5,959	1,003	9,407	1,695	800	Not available
Dune Low secure	15	4,609	1,981	5,449	2,895	590	Not available

24.20 The second group of wards shows significantly lower use of the Oxevision vital-signs function when compared with the adult acute and older adult wards. This remains the case even when bed numbers are taken into account. For example, Aurora recorded approximately 3.6 vital-signs attempts per bed per day in June 2025, and Dune approximately 12.1, compared with Cherrydown at almost 50 attempts per bed per day. Poplar showed higher use than Aurora and Dune but remained considerably below Cherrydown.

¹⁹⁰ Witness Statement of Dr Kallur Suresh, 14/05/2026, [EPUT022570], Paragraph 126.

¹⁹¹ Oxevision Implementation Dates, undated, [EPUT009030], Oxevision Monthly Usage Report June 2025, 01/06/2024, [EPUT020852], & Oxevision Monthly Usage report for EPUT April 2026, 01/04/2026, - [EPUT023597].

¹⁹² Ward Lists and Services, (EPUT009526)

- 24.21 The April 2026 data for Aurora, Poplar and Dune shows a significant reduction in Oxevision vital-signs attempts compared with June 2024 and June 2025. When adjusted for bed numbers, this equates to fewer than two attempts per bed per day across all three wards in June 2026. This is a marked change from the earlier data and may suggest a change in practice, training, governance, patient cohort, consent arrangements, or local interpretation of when the vital-signs function should be used.
- 24.22 Possible explanations for lower usage include differences in ward function, patient group, observation levels, staffing model, culture, training, or local understanding of how the technology should be used. Secure and CAMHS wards may have different staffing ratios, higher levels of direct engagement, or more patients on enhanced observations, reducing reliance on remote vital-signs checks. Alternatively, these wards may have clearer local practice around when Oxevision should and should not be used. The contrast 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?
- 24.23 The variation between wards suggests that high usage is unlikely to be an unavoidable feature of the technology itself; it may instead reflect differences in ward culture, training, clinical expectations, staffing practice or governance.

25. Alert Response Times

- 25.1 I have used the same period when reviewing alert response times.

Ward	Bed Numbers	June 2024 Alerts			June 2025 Alerts			April 2026 Alerts		
		0-15 sec	16-120 sec	2 min +	0-15 sec	16-120 sec	2 min +	0-15 sec	16-120 sec	2 min +
Forest Forensic	16	37%	58%	5%	45%	51%	4%	44%	53%	3%
Poplar CAMHS	13	84%	15%	1%	69%	30%	1%	45%	51%	4%
Ruby Older A	17	68%	30%	2%	75%	23%	3%	78%	21%	1%

- 25.2 The example wards show broadly similar patterns of alert-reset times, although Forest appears more evenly divided between alerts reset within 0–15 seconds and those reset within 16–120 seconds. The data also indicates that, on most

wards, the majority of alert resets were completed using the main display unit, which is usually located in the ward office. Poplar also appears to follow this pattern, with most resets completed from the main office. In contrast, Ruby's reset data appears to show greater use of a portable device.

- 25.3 This distinction is important. Where an alert is reset from a portable device, it may be more consistent with staff responding while mobile on the ward, and potentially after undertaking or moving towards a face-to-face check. By contrast, where alerts are reset from the main display unit in the ward office, it may be less clear whether any direct patient contact occurred before the reset. However, the data alone does not prove whether a face-to-face check did or did not take place.
- 25.4 Resetting an alert within 0–15 seconds appears to show only that staff were alerted and that the alert was acknowledged or reset very quickly. It does not, by itself, evidence that the alert resulted in a clinical action, face-to-face assessment, therapeutic engagement, or confirmation of patient safety. If the reset process allows staff to view a pixelated image or glance into the room, the data should clarify whether such a view was used and whether any further action followed.
- 25.5 Using the diagram from paragraph 24.1, Ruby averaged approximately 188 alerts per day, Poplar 112 alerts per day, and Forest 66 alerts per day, meaning staff may have been responding to multiple alerts every hour. Ruby recorded 5,277 alerts over 28 days; this equates to approximately 188 alerts per day. This means staff were receiving, on average, around 8 alerts per hour across a 24-hour period. Even where most alerts were reset quickly, this frequency may have a significant impact on staff workload, alarm fatigue, prioritisation and response quality.
- 25.6 **Alarm Fatigue:** Most mental health wards already have several forms of audible alert in operation. These include personal alarms worn by staff, which are used to summon assistance or an emergency response, and bedroom call bells, which indicate that a patient has requested support from their room. Personal alarms and call bells usually have a bleeping alert tone, and some personal alarms also include a vibrating function. The introduction of Oxevision adds a further audible alert to the ward environment. In my experience, the Oxevision alert is distinctive and may be heard as “Oxehealth alert”.
- 25.7 Oxevision appears to have a sensitive alert system, which can be triggered multiple times each day. When added to the existing alarm systems already

present on mental health wards, this can contribute to a noisy and overstimulating working environment. For staff, repeated exposure to multiple alarms may cause sensory overload and contribute to alarm fatigue. If alerts are heard frequently, staff may become desensitised to them over time, which can reduce the perceived urgency of the alert and affect the quality or timeliness of the response.

- 25.8 This may provide one possible explanation for the quick reset times evident in the data. In a ward office, staff may be managing important telephone calls, clinical discussions, documentation, handovers or competing patient requests. Repeated alerts may cause disruption, and, in some circumstances, alerts may be reset quickly to stop the noise rather than because a full clinical response has occurred. There was previously a function that allowed the sound to be turned down, meaning the alert may only have been visible through a flashing sequence on the computer screen or low-level sound. This created a potential risk, as staff may not have been aware of a possible patient risk unless they were directly looking at the screen at the time. My understanding is that the system now restricts the sound being switched off, which may reduce this risk.
- 25.9 An alert may also be reset with the intention of following up face-to-face, but staff may then become diverted by another urgent task or patient need. These possibilities do not necessarily prove poor practice, but they highlight the importance of auditing whether alerts result in appropriate action, rather than assuming that a reset means the patient was checked or the risk was resolved. I have not been provided with, nor have I seen, any EPUT audit data examining whether alerts that were reset resulted in a timely face-to-face review or other appropriate clinical response. Consequently, I am unable to comment on the extent to which this aspect of practice was monitored or assured within the organisation.
- 25.10 **Illustrative Case Summary, Sophie Alderman:** The oxevision bathroom alarm triggered at 17:29 indicating that Sophie had been in the bathroom for 3 minutes.¹⁹³ The alarm was reset 11 minutes and 20 seconds later.¹⁹⁴ Staff attended the room 17:36pm, 7 minutes after the alarm, 10 minutes after Sophie entered the bathroom.¹⁹⁵ The member of staff assigned to monitor oxevision

¹⁹³ Illustrative Case summary, Sophie Alderman.

¹⁹⁴ Illustrative Case summary, Sophie Alderman.

¹⁹⁵ Illustrative Case summary, Sophie Alderman.

alarms/alerts, admitted they had not been trained in its use, and the ward could not provide any training records for all staff working on the ward.¹⁹⁶

- 25.11 This case highlights the importance of ensuring that staff allocated responsibility for monitoring and responding to technological systems are appropriately trained and competent in their use. The effectiveness of any safety technology is dependent not only on the functionality of the system itself, but also on the ability of staff to understand the significance of alerts, recognise when a response is required, and integrate the information into wider clinical decision-making. Where staff have not received appropriate training, there is an increased risk that alerts may be misunderstood, incorrectly prioritised, overlooked, or not acted upon in the manner intended. Whilst it is not possible to conclude that the lack of training directly caused the delayed response in this case, it may provide a potential explanation for why the alarm did not result in a more immediate intervention. The absence of training records also raises wider governance concerns regarding staff competency, assurance processes, and organisational oversight. Collectively, these factors highlight that the safe implementation of technology-assisted observation systems depends not only on the technology itself, but also on the training, competence, and supervision of the staff expected to use it.
- 25.12 Alerts reset within 16–120 seconds, or after more than 2 minutes, are more difficult to interpret. A longer reset time could indicate that staff attended the room before resetting the alert, but it could also indicate delay, competing clinical demands, staff unavailability, or that the alert was not immediately acted upon. Therefore, reset-time data should not be treated as evidence of patient safety or staff response unless it is linked to audit data showing whether the alert was viewed, whether the patient was checked face-to-face, what action was taken, and how this was recorded.
- 25.13 VBPMS has important limitations. It may provide information about room activity, vital-signs attempts, alerts or whether someone is present in a room, but 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.
- 25.14 **Illustrative Case Summary, Michael Nolan:**¹⁹⁷ The investigation into Michael's death found that observations were replaced by Oxevision. The data shows that

¹⁹⁶ Illustrative Case summary, Sophie Alderman.

¹⁹⁷ Illustrative case summary, Michael Nolan.

the Oxevision alert went off at 07:11:41. The alarm was reset at 07:11:53, meaning there was a 12 second reset. CCTV shows that no face-to-face check was made and no member of staff attended the room. In this case it appears that Oxevision was switched on, but staff were not using its function correctly. If it had been used correctly, it would have alerted them to Michael being in the bathroom. His Inquest found that staff were not adequately trained in its use.¹⁹⁸

- 25.15 This case shows that alert data and observation documentation cannot be relied upon in isolation. A reset time may show that staff interacted with the system, but it does not confirm that staff entered the room, saw the patient, engaged with them, assessed their physical or mental state, or responded appropriately to risk. In my view, this demonstrates why Oxevision data must be triangulated with CCTV, clinical records, observation records, staff accounts and investigation findings. It also supports the wider concern that remote monitoring should not be used as a substitute for face-to-face therapeutic observation and engagement. Taken together, these cases show that alert data and observation documentation cannot be relied upon in isolation.
- 25.16 A reset time may show that staff interacted with the system, but it does not confirm if staff entered the room, saw the patient, engaged with them, assessed their physical or mental state, or responded appropriately to risk. In my view, this demonstrates why Oxevision data must be triangulated with CCTV, clinical records, observation records, staff accounts and investigation findings. It also supports the wider concern that remote monitoring should not be used as a substitute for face-to-face therapeutic observation and engagement.
- 25.17 The Oxevision data does not, by itself, prove abuse or misuse. However, it can identify patterns that may indicate possible inappropriate use, poor governance, training issues, or practice that is inconsistent with policy. For example, high numbers of vital-signs attempts with low numbers of displayed readings may suggest that the function is being accessed frequently without achieving its stated clinical purpose. Similarly, large numbers of alerts reset within 0–15 seconds, particularly from the main display unit, may show that alerts were acknowledged quickly but does not evidence that staff undertook a face-to-face check or therapeutic response. These patterns should therefore trigger audit and investigation, including whether the system was used in line with policy, whether patients were informed about the extent of visual access, whether staff actions were documented, and whether any use was necessary, proportionate and clinically justified.

¹⁹⁸ Illustrative Case summary, Michael Nolan.

25.18 The 2024 and 2025 data do not appear to show a significant change in practice. Although there are some variations between wards, the overall patterns appear relatively consistent, with each ward broadly maintaining its own pattern of usage. This suggests that there may not have been a substantial change in practice over the period reviewed, particularly in relation to the use of the vital-signs function and alert reset behaviours. If the data indicates potentially inappropriate or excessive use, the consistency over time raises a governance concern: either the trust has not identified the pattern as problematic, or it has not taken effective action to change practice.

26. Falls

26.1 Oxevision alerts may indicate when a patient is getting in and out of bed, which can be relevant where falls risk has been identified. For some patients, repeated movement from bed may increase the likelihood of a fall, particularly where there is frailty, sedation, confusion, poor mobility, postural hypotension or medication side effects. Traditionally, patients assessed as being at high risk of falls may be placed on enhanced observations, such as Level 2 or Level 3 observations. Level 2 observations may not prevent a fall but may support earlier detection if a fall occurs. Level 3 observations are more proactive and may reduce the likelihood of harm through closer staff presence but may also be intrusive and restrictive if not clinically proportionate.

26.2 Assistive technologies, such as mattress sensors, have already been used in some settings to support falls management. VBPMs can also assist by alerting staff to potential falls-related risk, such as a patient repeatedly getting out of bed. However, to my knowledge, Oxevision does not prevent falls and may not detect all falls. For example, if a patient falls from standing, this may not necessarily trigger an alert. It would also not detect a fall that occurs in a communal area of the ward, outside the bedroom monitoring area.

26.3 The effectiveness of the alert system also depends on staff response. EPUT's SOP 12 identifies the need for a designated staff member to monitor Oxevision devices.¹⁹⁹ This may support timely response, but it also creates practical challenges. If multiple alerts occur at the same time, the designated staff member must prioritise which alert to respond to first. This requires clinical judgement and knowledge of individual patient risks. Therefore, while Oxevision

¹⁹⁹ Standard Operating Procedure for the use of the Oxehealth Oxevision and Oxevision Observations Version 12, 30/04/2025, [EPUT009884].

may provide additional information to support falls risk management, it should not replace individualised falls assessment, face-to-face observation, staff engagement, environmental safety measures or professional judgement.

- 26.4 Where a patient has an unwitnessed fall in a communal area, CCTV can be reviewed to better understand the circumstances of the fall. For example, footage may help establish whether the patient tripped, collapsed, fainted, placed themselves on the floor, or whether there was an environmental hazard. In this context, CCTV can support investigation, learning and monitoring of compliance, although it may still be experienced as intrusive or surveillance based.
- 26.5 If an unwitnessed fall occurs in bedroom, my understanding is that Oxevision can retain clear-view data for up to 24 hours and that this data is automatically deleted if not requested for investigation or review within that period. While this may assist in understanding an unwitnessed fall or incident in a bedroom, it raises greater privacy and dignity concerns than CCTV in communal areas. In my view a patient's bedroom is a private space and should attract a significantly higher expectation of privacy than corridors or shared ward areas. The key question is therefore one of proportionality. Although bedroom recording may assist investigations, this benefit must be weighed against the impact on privacy, dignity, autonomy and therapeutic trust.

27. **Finances**

- 27.1 In 2024 there was an economic evaluation across five NHS mental health trusts estimated potential savings of £93,433 per ward in acute services and £413,651 per ward in older adult services, again identifying reduced one-to-one observation hours as a major driver of savings.²⁰⁰ It is important to state the evaluation was funded by Oxehealth and undertaken using data supplied by Oxehealth.
- 27.2 Financial saving claims about Oxevision mainly come from health economic evaluations, not from independent national guidance. The savings are generally claimed to arise from reduced staff time and reduced adverse events, particularly:
- reduced one-to-one observation hours;
 - reduced night-time observation workload;

²⁰⁰ Buckley, C., Malcolm, R. and Hanlon, J. (2024) 'Economic impact of a vision-based patient monitoring system across five NHS mental health trusts'.

- fewer self-harm incidents;
- fewer falls, A&E attendances or emergency call-outs; and
- improved operational efficiency

27.3 Financial savings claims are clinically and ethically significant because if savings are driven by reductions in enhanced or one-to-one observations, there is a risk that the technology is treated as a replacement for staff presence and therapeutic engagement. In mental health care, observations should not be understood solely as a surveillance or staffing-cost function; they also involve relational contact, assessment of distress, de-escalation, reassurance and helping the patient feel safe. Therefore, any financial benefit should be scrutinised against patient experience, privacy, dignity, consent, safety outcomes and whether reductions in observation are clinically justified on an individual basis.

27.4 If Oxevision is not intended to replace observation and engagement, as stated in national and local guidance, then the basis for financial savings requires careful examination. I can understand how clinical teams may have misunderstood its purpose and relied on the technology instead of undertaking normal observation and engagement. However, if the correct position is that Oxevision should only support and not replace observations, it is difficult to see how significant cost savings can safely be achieved through reduced staffing or reduced observation hours.

27.5 Oxevision may provide assistive technology that supports safety and helps reduce some incidents. However, if staff were to complete observations and engagement properly, and if a designated staff member is also required to monitor Oxevision alerts/alarms, respond to them, review pixelated images where appropriate, and undertake face-to-face checks, this may increase rather than reduce workload. In that scenario, the benefit of Oxevision would be improved safety and additional information for staff, rather than reduced staffing costs. The financial case should therefore be considered alongside the clinical reality of safe implementation, including staff workload, alert response, face-to-face engagement, patient experience.

28. **System Failure**

28.1 If Oxevision or another VBT system fails, my understanding is that practice should revert to business as usual, because the technology is not intended to replace observations, engagement, clinical judgement or face-to-face assessment. Staff should continue to follow the patient's care plan, observation

level and local clinical procedures as they would if the technology were not available. Any failure of the system should be escalated through local operational and clinical governance routes, including informing the Nurse in Charge, senior clinical staff and relevant technical support. Where the failure creates or contributes to a patient safety risk, it should also be reported through the organisation's incident reporting system. This is important because if the technology is truly an additional support, rather than a replacement for care, its failure should not leave a gap in observation, engagement or risk management.

29. Potential Benefits and Harms

- 29.1 Mental health care has arguably lagged behind acute physical healthcare in the use of technology, with inpatient treatment and care remaining largely based on professional interaction, therapeutic engagement and medication. Given the continuing importance of suicide prevention, particularly in inpatient mental health settings, technological developments that may help reduce suicide, self-harm or other serious incidents should be welcomed and carefully considered.
- 29.2 However, because these technologies are relatively new in mental health inpatient practice, it is unsurprising that their implementation may be associated with confusion, inconsistent use, misunderstanding, misuse, or assumptions that they replace existing practice. Observations are a routine part of mental health ward care, and most wards will have patients on enhanced observations at any given time. Observations themselves are challenging and are not risk-free. If technology can assist staff to reduce risk, improve response times, support physical health monitoring, or reduce unnecessary sleep disturbance, it is understandable why services may welcome it.
- 29.3 VBPMS has important limitations. Whilst it may provide information about room activity, vital-signs attempts, alerts, or whether someone is present within a room, it cannot reliably identify who the patient is, understand the meaning of behaviour, assess emotional distress, recognise elation, agitation, hopelessness, or determine whether a patient is experiencing urges to self-harm. As a result, VBPMS cannot replace the clinical judgement derived from direct observation and therapeutic engagement. If used as a substitute for these interventions, rather than as a supplementary tool, there is a foreseeable risk that important changes in mental state, risk, or physical wellbeing will go unrecognised, potentially resulting in serious patient harm.
- 29.4 Some patients, families and staff may experience VBPMS as a step too far. The key question is whether it is proportionate to place VBPMS in patient bedrooms.

Patients in mental health wards may have trauma histories, sensory difficulties, cultural or religious privacy needs, mistrust of services, paranoia, or may already feel powerless because of detention under MHA. The presence of a bedroom-based monitoring device may therefore increase distress, compromise privacy and dignity, and reduce the patient's sense of choice and control. 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. However, I also accept that for some patients and families the technology may provide additional reassurance about safety and wellbeing. This is why informed consent, individualised assessment and clear governance are crucial.

- 29.5 **Illustrative Case Summary, Sophie Alderman:** In Sophie's case it is reported that she suffered with paranoia and reported distress in relation to Oxevision being used in her room.²⁰¹ This is an important consideration, as patients experiencing paranoia, suspiciousness, persecutory beliefs, or heightened anxiety may perceive monitoring technologies differently from other patients. Whilst VBPMs may be intended to enhance safety, for some individuals it may inadvertently contribute to distress, mistrust, hypervigilance, or feelings of being watched.
- 29.6 For people with a learning disability, autism or other neurodivergence, VBPMs may have both potential benefits and specific harms. Some patients may find Oxevision less intrusive than repeated in-person night-time checks, particularly if it reduces sleep disturbance, unexpected staff entry into the bedroom, or repeated physical observations. For some families and carers, the technology may also provide reassurance that additional safety monitoring is available. However, other patients may experience bedroom-based monitoring as confusing, frightening, intrusive or sensory distressing. The presence of a camera or visible light in the bedroom may increase anxiety, mistrust or feelings of being watched.
- 29.7 Consent and information may not be equally meaningful for all patients. Some people may require easy-read information, visual explanations, social stories, repeated discussions, advocacy, family/carer involvement, interpreters or other reasonable adjustments to understand what Oxevision does, when staff can view images, what data is collected, how to object, and how to request switch-off. If these adjustments are not consistently provided, the technology may be experienced as something done to the person rather than with them. For neurodivergent patients, the impact on predictability, control, privacy and trust

²⁰¹ Illustrative Case summary, Sophie Alderman.

should be considered individually. Therefore, use of VBPMs should not be assumed to benefit all patients equally; it should be based on individualised assessment, communication needs, sensory profile, trauma history, consent or lawful authority, and what helps the person both be safe and feel safe.

30. **Alternative Assistive Technology**

- 30.1 Alternative technologies such as mattress sensors, bed-exit sensors, pressure mats, door sensors, nurse call systems, falls alarms, wearable devices and contact based physical health monitoring are generally less intrusive than VBPMs because they do not provide visual access to a patient's bedroom. They may still support specific safety needs, such as falls risk, seizure monitoring, requests for assistance, or physical health checks, without requiring camera-based monitoring. In many cases these technologies may also be cheaper to purchase and implement than a whole-ward VBPMs, although costs will vary depending on procurement, maintenance, integration, staff training and governance requirements.
- 30.2 Assistive technology can support care and safety when used thoughtfully and for a clearly identified purpose. However, it should be introduced with the patient's agreement wherever possible. If the patient lacks capacity to make that decision, the clinical team should be able to demonstrate why its use is in the person's best interests, how the decision was reached, and why less intrusive approaches would not meet the identified need.²⁰²
- 30.3 Assistive or digital monitoring technology may not be appropriate where it does not add meaningful clinical value to the patient's care or safety. NHS England's principles state that digital technologies in mental health inpatient settings should be used only where they are appropriate, effective and the least restrictive method of caring for or treating the patient. The CQC's review of vision-based monitoring also highlights the need to consider consent, best practice and potential threats to patients' human rights. Therefore, where a technology repeatedly alerts in response to behaviour that is expected, understandable or not clinically unsafe, its continued use may be disproportionate and potentially harmful.²⁰³

²⁰² *Mental Capacity Act 2005*, s 4.

²⁰³ NHS England. (2025). *Principles for using digital technologies in mental health inpatient treatment and care*. London: NHS England.

Care Quality Commission. (2025). *Exploring evidence regarding vision-based monitoring in inpatient mental health units*. London: Care Quality Commission.

- 30.4 If the identified risk is specific, for example falls, leaving the bed, seizure risk or a need to call for help, a non-vision technology may be a more proportionate and less intrusive option than VBPMs. However, these technologies also have limitations and should not replace observation, engagement, clinical assessment or staff response. The question should be whether the least intrusive technology can meet the individual patient's safety need, rather than assuming that VBPMs is necessary.

31. **Reflections and Conclusion**

- 31.1 I recognise that technology can have a legitimate role in supporting patient safety, particularly where it is used to supplement, rather than replace, skilled clinical judgement and therapeutic engagement. VBPMs/VBT may assist staff by providing additional information about movement, room presence, possible deterioration, night-time activity or potential risk. It may also support governance by creating data about alerts, response times and use of the system.
- 31.2 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 a patient's behaviour. It cannot determine whether a patient is becoming more withdrawn, more frightened, more suicidal, more suspicious, or more in need of human connection.
- 31.3 In my view, the greatest risk is that VBPMs/VBT may gradually shift observation practice away from therapeutic engagement and towards remote surveillance. This risk is particularly important in environments already affected by staffing pressures, high acuity, competing demands and reliance on temporary or less experienced staff.
- 31.4 I am also concerned that VBPMs/VBT may not be experienced as neutral by patients. For some patients, particularly those with trauma histories, paranoia, neurodivergence, past abuse, sexual trauma, or experiences of coercive care, the presence of a camera or monitoring device may increase distress, mistrust or a sense of being watched and controlled. Even where the intention is safety, the subjective experience for the patient may be one of intrusion, surveillance or loss of privacy.
- 31.5 I think the impact of VBPMs/VBT depends greatly on the culture of the ward and the quality of the staff team using them. Where there is a strong, experienced

and therapeutically minded team who know their patients well, understand individual risks, communicate effectively and use clinical judgement appropriately, assistive technology may provide an additional layer of support. In that context, VBPMs, CCTV and BWC may help staff identify risks earlier, respond to incidents more effectively, reduce avoidable harm, and support patient wellbeing without replacing face-to-face care.

32. Recommendations

- 32.1 **1. 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. It should not be used as a routine intervention or where less intrusive measures would adequately meet the patient's needs. Where a patient has capacity, informed consent should be sought and reviewed regularly throughout its use. Where a patient lacks capacity, any decision to use Oxevision should be made in accordance with the requirements of the MCA including a documented best interests' decision where appropriate. Patients should be provided with regular feedback regarding any data collected, presented in an accessible and meaningful format, and should be involved in ongoing discussions regarding the continued appropriateness of the intervention.
- 32.2 **2. Staff access should be individually logged and auditable:** Staff using Oxevision to gather vital signs should have individual logins. This would create a clear audit trail showing who accessed the system, when, and why. The clinical reason for taking vital signs should also be documented in the patient's clinical notes, with supervision and audit used to identify any inappropriate or unexplained use.
- 32.3 **3. There should be clear national standards on the minimum response to VBT/VBPMs alerts:** Alerts should not be reset without appropriate clinical consideration. Where an alert indicates potential risk, staff should be required to undertake a face-to-face response unless there is a clearly documented clinical reason not to do so. Systems should record who viewed the alert, who reset it, the time taken to respond, whether the room was entered, and the outcome of the response.
- 32.4 **4. Audit should include patient and family experience:** Monitoring should go beyond compliance and include qualitative feedback from patients and families or carers. Audits should explore whether patients felt safe, supported, informed,

and involved in their plan in respect of enhanced observations and the use of Oxevision.

32.5 **5. Observation and engagement and VBPMS training should be, face-to-face, and competency-based:** Observation and engagement training should be delivered face-to-face, with sufficient protected time allocated to ensure staff develop the necessary knowledge, skills, and confidence. The training should be aligned with trauma-informed care principles and given equivalent priority to mandatory training such as Management of Violence and Aggression. Real life simulation and scenario-based learning should form a core part of the programme.

- Newly recruited staff should not be deployed onto inpatient wards until this training has been completed. Following ward allocation, staff should undertake a structured induction period that includes supervised practice, shadowing, and competency assessment before they are considered competent to undertake these duties independently.
- Responsibility for ensuring staff have completed training and competency requirements before being rostered should sit with service managers and ward managers. While the Nurse in Charge should support induction, supervision, and the monitoring of standards, they should not hold responsibility for verifying training compliance due to the operational pressures and competing demands associated with the role.

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

Signed:

[I/S]

Date: 01/07/2026

Name: Jill Archibald

Appendix 1: Curriculum Vitae

Professional Registration:

NMC: PIN 06A2203E

RMN, NMP.

North-East Approvals Panel (NEAP) (Secretary of State)

Approved Clinician status Active.

Education & Professional Qualifications

Subject/Qualification	Place of study	Year
Eye Movement Desensitisation and Reprocessing (EMDR)	EMDR European academy	2025
Non-medical independent prescribing Level 7	University of Cumbria	2023
Approved clinician status	Approved by Secretary of State	2023
Mental Health Law Pgcert	Northumbria University	2022
Clinical Leadership Pgcert	Teesside University	2020
Practice development degree (MH Nursing)	Cumbria University	2014
Supporting Learning in practice Level 6 module. Sign off mentor certificate	Cumbria University	2009
Diploma Mental Health Nursing	St Martins College	2006

Employment History:

1/ Date: November 2023 – current

Current: Cumbria, Northumberland Tyne and Wear NHS Foundation Trust.

Role: Responsible Clinician/Approved Clinician. Consultant Nurse.

Area: Adult Acute 18 bed in-patient ward.

2/ Date: September 2021 to November 2023.

Current: Cumbria, Northumberland Tyne and Wear NHS Foundation Trust.

Role: Consultant Nurse

Area: Crisis Resolution Home Treatment Team.

3/ Date: October 2019 to September 2021.

Current: Cumbria, Northumberland Tyne and Wear NHS Foundation Trust.

Role: Consultant Nurse

Area: Mixed sex 22 bed adult acute in-patient / Psychiatric Intensive Care ward (PICU)

4/ Date: July 2016 to October 2019.

Current: Cumbria Partnership NHS foundation Trust.

Role: Service Manager.

Area: Adult Acute in-patient, rehab and PICU.

5/ Date: January 2012 to July 2016.

Current: Cumbria Partnership NHS foundation Trust.

Role: Ward Manager.

Area: Mixed sex 27 bed adult acute in-patient.

6/ Date: August 2011 to January 2012

Current: Cumbria Partnership NHS foundation Trust.

Role: Team Lead

Area: Crisis Resolution Home Treatment Team.

7/ Date: September 2009 to August 2011

Current: Cumbria Partnership NHS foundation Trust.

Role: Clinical Lead.

Area: Mixed sex 27 bed adult acute in-patient.

8/ Date: September 2006 to August 2009

Current: Cumbria Partnership NHS foundation Trust.

Role: Staff Nurse.

Area: Mixed sex 27 bed adult acute in-patient.

Training Courses Attended

Course	Facilitator/Area of Study	Year
HCR 20 Risk Assessment	Tully training Academy	2025
RSVP Sexual violence risk assessment.	Tully training Academy	2024
Approved Clinician Training (academic and work based professional development)	Cumbria, Northumberland Tyne and Wear NHS Trust	Completion 2022
Introductory Approved Clinician Course	SLAM	Sep 2021
AC preparation portfolio workshop	NEAP	August 2021
Pharmacology	CNTW	June 2021
AMHP Legal Update	Cumbria County Council webinar	January 2021
Supporting families bereaved by suicide	PABBS	Oct 2018

STORM Self-harm mitigation course Facilitator Training	STORM Manchester University	June 2016
Suicide Prevention Training	University of Salford	July 2015
Ward Mangers leadership development course	Hillary McCallion Consultancy Limited	2013
Aims reviewer training	Royal College of psychiatry	Oct 2013
Introduction to the psychoanalytic Understanding of MH	Cumbria Partnership NHS Foundation Trust.	July 2007
Personality Disorder: Understanding,, management & treatment	Cumbria Partnership NHS Foundation Trust.	Feb 2007