

CLOSING STATEMENT OF COUNSEL TO THE INQUIRY

Civic Centre Chelmsford, 15 October 2026

1. Chair, the evidence we heard from Mr Reid this morning brings us to the end of the “in-person” part of this Interim Recommendations Hearing. Over the past two weeks, the Inquiry has made significant further progress in relation to these topics that earlier in the year you directed your team to explore as a matter of priority.
2. The oral evidence we have heard from witnesses and experts who came here to assist you in Chelmsford has been supported by extensive written evidence, and other relevant documentation, that was disclosed to all Core Participants ahead of this hearing.
3. As previously outlined, the Inquiry will reconvene virtually next Tuesday 20 October to hear oral submissions on behalf of the Core Participants who wish to make them. That hearing will be live streamed to the public via the Inquiry’s YouTube channel in the usual way. The Inquiry looks forward to receiving constructive submissions on the topics of Emergency Response and Resuscitation; and Observations and the Use of Technology. Equally, the Inquiry will consider with very great care the written submissions from Core Participants that will follow.
4. We have firmly in mind Chair, that we have not yet received those submissions, and that you have a great deal to think about before making any decisions as to whether to make any Interim Recommendations.

5. May we take this opportunity please, to pause and reflect on what we have learned during the course of this hearing? Whilst you have heard evidence in relation to two different topics, the evidence has purposely dovetailed in parts, evidencing clear correlation between themes. For example - the very rapid speed with which a patient can deteriorate in a mental health inpatient setting underlining the need for a robust and reliable system of observations to be in place.

Emergency Response and Resuscitation

6. In relation to Emergency Response and Resuscitation we learned again, that an increasing proportion of cardiac arrests are what are known as “secondary cardiac arrests”. This is very much the position in mental health inpatient settings. Secondary cardiac arrests are cardiac arrests that take place at the end of the physiological process following a trigger event. Those trigger events, often known as “*special circumstances*”, incorporate many of the sorts of incidents that take place on a mental health inpatient ward including, but not limited to, ligature by suspension or self-strangulation, choking and overdose. Deterioration leading to secondary cardiac arrest can also follow prolonged restraint situations and rapid tranquilisation.
7. The Inquiry heard from Professor Jasmeet Soar, an international expert in resuscitation. Professor Soar told us that the best chance of saving a patient in a medical emergency involving a secondary cardiac arrest is to prevent that cardiac arrest taking place at all.
8. It is his expert view that the person who arrives first on scene has the best chance of saving a life and that they should be trained and

equipped so they are in the best possible position to do so. Time is of the essence – every second counts.

9. Dr Suresh, the Executive Chief Medical Officer at EPUT, accepted Professor Soar's view that *"immediate response is required within seconds, or certainly within at least a minute"*. Interventions are time sensitive. With every minute that passes an intervention becomes less effective.
10. Over the course of its work, this Inquiry has received evidence from bereaved families, from staff, and through its investigation of its illustrative cases. It has learned that there have been occasions at EPUT when the first person arriving at the scene of a serious emergency ('the first responder') was a Healthcare Assistant ['HCA'].
11. Dr Suresh conceded that it does happen and agreed that non-registered staff were often the first at the scene. Professor Soar told this Inquiry that in his view, if it is possible that HCAs will be first on the scene of emergency, then HCAs must be put in the best possible position to respond to that emergency.
12. EPUT witnesses told the Inquiry that the Trust currently provides all registered staff, nurses in particular, with Immediate Life Support Training ['ILS']. EPUT seeks to ensure that there is at least one ILS-trained registered professional available on each ward for each shift. This does not quite meet the Trust's safer staffing model of a 50/50 split between registered staff and non-registered staff. Dr Suresh did not have an answer for what would happen if that ILS-trained member of staff was on a break or detained elsewhere in the middle of the night.

13. We heard that it is for those who organise the rosters to ensure the right numbers and skill mix when organising staff for each shift, and we were told that those in charge of the rosters now have access to the training records of those who may be allocated to the shift. We also learned however, that lack of compliance with initial training, or refresher training, is no bar to engaging in patient-facing roles. Clinical judgment and practical considerations will determine whether a person should be allowed to work. Those will include whether there are sufficient numbers of staff on any given shift.
14. On the first day of this hearing, we heard evidence from Ruth Bradley and Rebecca Lingard from East London NHS Foundation Trust. Ms Lingard's evidence, in which she outlined her own personal experience of a resuscitation incident on an inpatient mental health ward, brought to life for all of us quite how stressful such an event is for those involved, including the staff attending, even when that emergency response is successful. This is because, as almost all of the witnesses from whom we heard impressed upon us, these sorts of emergencies are relatively uncommon. That is not to say however, that preparation is any less important. Professor Soar explained that because staff are not training for an event that takes place weekly, but for incidents that do not occur very often, it is important not only for staff to be properly trained, but also for staff to receive regular refresher training and to undertake regular simulations and drills. Moreover, staff confidence about engaging in an emergency is absolutely key. Particularly if there is to be any chance of a successful response.

15. This Inquiry will need to consider very carefully therefore, the question of how all potential first responders to an emergency on a mental health inpatient ward can be given that essential confidence, along with the important knowledge and skills required. During this hearing, we heard a range of views as to whether or not ILS training is suitable for non-registered staff such as HCAs. Nicholas Archer who is Head of Deteriorating Patient Pathways at EPUT and Dr Suresh maintained EPUT's position that it is not appropriate to provide ILS training to HCAs. This position is based predominantly on the assertion that some sort of additional anatomical knowledge is required before a non-registered member of staff can undertake ILS training. This is despite evidence that until 2022, HCAs at EPUT were provided with training – firstly in the form of Enhanced Emergency Skills training and latterly in the form of “Grab Bag” training, which taught the very elements of ILS that EPUT now maintains are unsuitable. It is right to acknowledge however, that Dr Suresh stated EPUT would be prepared to consider the provision of an additional module to address anatomical knowledge so that HCAs could attend an ILS course, should such a course be proposed by Mr Archer.
16. Professor Soar's experience was that non-clinical staff do very well with ILS training in fact, and the pass rate is high. By way of illustration as to the contents of that training, Professor Soar explained that he had provided much of the information from the course, including detail of the ABCDE approach and the all-important airway management, to those of us in this room during the hearing. He described EPUT's practice of providing tools based on ABCDE, such as EPUT's Aide Memoire relating to assessing a critically unwell patient, and its non-contact observation tool, to non-registered staff without

giving them the requisite training as something of a “spray and pray” approach. Asked to comment on Dr Adamson’s position on behalf of NHS England that providing ILS training to HCAs (thereby putting them in a position to respond immediately in an emergency) would “*do more harm than good*”, Professor Soar simply pointed out the inevitable consequence and ultimate harm that would result from no response at all.

17. It is right to say that NHS England’s proposed changes to mandatory training still appear to be a “*work in progress*” despite Mr Simons’ initial evidence indicating that he expected ministerial approval before the end of December. It would appear from NHS England’s very recent increased engagement with the Inquiry, that the Inquiry’s examination of this topic has focussed minds. Professor Soar expressed concerns that based on what he has seen so far, the basic level of training proposed by NHS England for most staff, including in mental health settings, is probably set lower than at present in the new proposal. Whilst he wished, quite properly, to reserve any final opinion for when he sees something more tangible down “on paper”, Professor Soar did observe that the current proposals from NHSE seem to be directed at equipping staff to deal with primary cardiac arrests, as opposed to secondary cardiac arrests. In light of all the evidence we have heard Chair, any such proposals may misunderstand the risks inherent in mental health inpatient settings.

18. In terms of the emergency response and resuscitation provision at EPUT, the actual service structure at EPUT, as contemplated by RCUK Quality Standards for Mental Health Inpatient Care, remains unclear. Whilst seeking to explore the system for governance at EPUT, the

Inquiry heard of the apparent involvement of 4 Board members, with engagement including a large number of EPUT's governance groups and committees (into double figures) and lines of reporting that Dr Suresh himself agreed could be reviewed to determine whether they might be made clearer and more straightforward. Dr Suresh told us that he is the member of the Board assigned to the resuscitation service, but he was not able to give us a direct answer as to whether there are defined resources ringfenced for the resuscitation service itself, as required by the RCUK Standards.

19. What also emerged from the evidence we heard, is the fact that EPUT do not appear to have been monitoring or auditing their resuscitation service and resuscitation incidents appropriately. This is despite the very clear indication in the RCUK Quality Standards that they should do so. The Quality Standards' requirements to monitor and to audit are reflected to a certain extent in the current EPUT Policy: CLP14. This document is a consolidation of what were, previously, separate Policy and Procedure documents.
20. We identified during the course of this hearing, that there is a requirement for 3 yearly audits within the policy. Dr Suresh told us that this did not mean audits per se, but a more general review of the service provision. In any event, no 3 yearly review document is available from EPUT, despite the requirement being included in each iteration of the policy since the merger in 2017.
21. We also learned that there have been no yearly reports, despite that also being a requirement set out in EPUT's CPR policy. That too, has been a requirement since the merger in 2017.

22. Instead, Dr Suresh and Nicholas Archer told us that EPUT produce “Quarterly Reports” which provide the relevant information to EPUT’s “*Quality Committee*”, having been given to that Committee from the “*Quality of Care Meeting*”. Those quarterly reports had not been provided to the Inquiry prior to last week, so we asked EPUT for them. The Quarterly Reports have since been supplied and have been disclosed to Core Participants today. Core Participants will be able to see for themselves what is and is not included in those documents and will be able to refer to them in submissions should they wish to.
23. We did hear however, that EPUT are now beginning to audit if, and when, simulation training and drills are taking place and to keep local records of which staff did not attend. The Inquiry learned from all relevant witnesses, without exception, that scenario training is extremely important for teaching staff core skills in relation to emergency response and resuscitation, for keeping those skills up to date, for identifying deficiencies and points for learning, and, significantly, for providing the vital confidence that members of staff need if faced with an emergency situation. Dr Adamson from NHS England referred to such training as “*paramount*”. EPUT do not appear, for some time, to have had a clear understanding of whether, or the extent to which, scenario training was taking place within the Trust. This led to a period of possibly 17 months on Willow Ward without simulations or drills taking place at all. We heard a summary from a second statement provided to you from Louise Borton, a Matron at EPUT, that following various issues emerging from drills she took part in during June and August this year, a decision was made to increase their frequency at Basildon Mental Health Ward to weekly.

24. Closer oversight should now be achieved EPUT tell us, by the addition to their audits of a specific question relating to emergency simulations. This evidence gave rise to questions of why that action – which was identified following a Swarm Huddle in June 2025 - had only been completed in August 2026, some 14 months after the issue had first been identified. The delay was apparently created by the failure to convene a meeting that was quorate or because, as Ms Sheridan stated, she was looking for an alternative solution. We note that resolution was achieved shortly after the Inquiry focused its attention on this topic.

25. Chair, the more evidence we heard about the provision of emergency response and resuscitation at EPUT, the longer the list of Mr Archer's responsibilities became. It was also apparent, that owing to possible deficiencies within EPUT's reporting systems and Datix, EPUT rely heavily on Mr Archer's institutional knowledge. It remains to be determined the extent to which this impacts EPUT's ability to properly identify incidents, to reflect upon them and to draw learning which can be disseminated to others promptly. We heard for example, that the investigation and subsequent recommendations following the death of Jason Standing, who died in January 2022, took nearly two years to complete. In the meantime, other patients died in circumstances which appear to indicate the same systemic issues. Indeed, in a joint witness statement submitted by Ms Sheridan with Dr Suresh on behalf of EPUT for this hearing, and in her oral evidence, Ms Sheridan appeared reluctant to accept that the circumstances relating to emergency response and resuscitation in some of the Inquiry's illustrative cases should be grouped. This is despite what are

evidently similar issues. Again, it remains to be determined whether this approach reflects a continued reluctance on EPUT's part to see the bigger picture and whether this in itself creates a barrier to learning.

26. As you are aware Chair, EPUT have been asked repeatedly about the methods by which resuscitation events are reported and reviewed by the Trust. We learned that all incidents involving CPR should be recorded on Datix including a completed Resuscitation Event Form. This does not appear to be failsafe for a number of reasons. Mr Archer explained that the Datix entry system is not straightforward. Its reliability is largely dependent on the method by which a user inputs relevant information, including which "dropdowns" they use. With regards resuscitation events, Mr Archer explained that incidents were often mis-categorised when incorrect dropdowns were selected. Mr Archer told us that he "*hoped*" that he was aware of all resuscitation events if not by Datix, by other means, such as being copied into emails reaching out to staff.

27. There is on any view, an issue with the way Datix is being used and the data it generates is used by EPUT, which the Inquiry intends to look at in more detail. Whilst we heard evidence from a number of EPUT witnesses who insisted that EPUT can retrieve various information with the support of its Datix management team, EPUT's complete and abject failure to respond to what Dr Suresh *agreed* should have been a very straightforward request for information relating to all resuscitation events from 2017 post-merger, demonstrates clearly that the system is not doing what is intended for whatever reason. The information provided to the Inquiry by way of spreadsheet was, for

reasons Dr Suresh accepted, but is still not able to explain, completely unreliable.

28. Similar issues may have been revealed by evidence the Inquiry heard yesterday about the reliability of Datix reporting in the context of observations and the use of technology. In a witness statement provided to the Inquiry, EPUT stated there had been over 1,400 incidents recorded by Datix in which Oxevision was said to have played a role in bringing the incident to the attention of staff. That was recorded on 1,453 occasions via a relevant tick box, but the number was seen to reduce by over half when the question was whether Oxevision was described in the written narrative of the Datix report. Zephan Trent's evidence was that such data tells us *something* about the use of Oxevision, but that he was unable to say on basis of those Datix reports whether the system was of value or not.

Observations and the Use of Technology

29. I turn then Chair, to what we have learned this week as the Inquiry continued its examination of issues relating to Observations and the Use of Technology.

30. We heard evidence from Gareth Harry of NHS England on Monday 5 October, the first day of this hearing. Mr Harry is NHS England's National Delivery Director for Mental Health, Learning Disability and Autism, and his evidence covered NHS England's role in regulating the use of technology in Mental Health services.

31. Mr Harry told the Inquiry that the responsibility for the safe use of digital health technology products rest with the individual Trusts, and that NHS England supports the safe use of technology through its framework standards and policies. Mr Harry did acknowledge that NHS England has wider responsibility for the overall delivery of services, and that it may, where systemic patient safety issues have been reported, take action at a national level. However, Mr Harry told us that NHS England does not proactively monitor these issues, emphasising this responsibility rested with the individual Trusts and the CQC.
32. Mr Harry provided evidence in relation to NHS England's awareness of concerns relating to the use of the Oxevision system in May 2021 and June 2022. This gave rise to NHS England's formal letter to Trusts in September 2023. Mr Harry told this Inquiry that he was not aware whether Trusts reviewed their practices relating to Vision Based Patient Monitoring Systems (VBPMS) following receipt of that letter. Mr Harry also told us of existing concerns in relation to Trusts' use of Oxevision, including current concerns that ten Trusts using Oxevision appear not to be using the system in line with NHS England's published guidance: "Principles for using digital technologies in mental health inpatient treatment and care."
33. We heard this morning from Dr Robert Reid, Deputy Director for Innovative Devices at the Medicines and Healthcare Products Regulatory Agency (MHRA), who described the MHRA's jurisdiction in respect of medical devices, and spoke about its oversight of new technologies and its assessment of Oxevision.

34. Dr Reid expanded upon the remit of the MHRA in regulating medical devices and ensuring their safety, quality and effectiveness, as well as how its role sits alongside that of Notified and Approved Bodies. He explained that the MHRA's role in this respect depends on the risk classification of a product, and that its principal functions include post-market vigilance, whereby patient safety issues relating to devices on the market are monitored and responded to.
35. Dr Reid provided evidence that the MHRA's awareness of patient safety issues regarding Oxevision began in Spring 2021. This was when NHS England shared with the organisation analysis of patient safety incidents involving the technology. This led the MHRA to undertake regulatory engagement with Oxehealth, specifically focusing on the accuracy of claims being made by the company about the clinical benefits of the device in reducing self-harm. There was further engagement relating to marketing and other matters.
36. Dr Reid spoke of the benefits of introducing a whole system approach to patient safety and medical device regulation, which would incorporate multiple government agencies, as well as patients, family members and others as key stakeholders.
37. The evidence of Mr Harry, Dr Reid and the summary of the evidence provided by the National Institute for Health and Care excellence, the Department of Health and Social Care, the CQC, and the British Standards Institution, which has been read this afternoon, highlight the complex regulatory oversight relating to the deployment, implementation and use of technology in mental health services.

38. We heard on Monday from Dr Francesca Denman, a Consultant Psychiatrist, with significant experience of governance within NHS trusts. Dr Denman provided expert evidence to the Inquiry relating to the role, function and efficacy of observations, and the role of VBPMS in inpatient mental health settings. Dr Denman also considered, from a Chief Medical Officer's perspective, EPUT's adoption and implementation of Oxevision.

39. Dr Denman provided her view on the development of risk assessments within the period of the Inquiry's investigation, in what she described as a "a move from risk assessment to safety planning". She noted that the attempts to stratify and formulate risk through assessment were misleading and failed to accurately predict acts of self-harm or suicide. She praised the "unimpeachably" sensible shift towards the holistic and dynamic assessment of risk, which has formally been in place since 2022. Chair, this contextual understanding of the different approaches to risk management will assist you in your assessment of issues across the full scope of the relevant period.

40. Dr Denman identified an urgent need for further research and academic analysis in relation to the role of observations practice in general, in order to consider what best practice looks like. Further, she identified the enduring shortage of guidance specifically for psychiatrists on observations, and proposed this may be an area where further guidance would assist clinicians.

41. Dr Denman's evidence emphasised the evidence provided by Professor Soar as to the value and importance of NEWS2 observations in monitoring a patient's physical health. Dr Denman told you that

“any measure that is not the NEWS2 (for example just pulse and respiration) must be treated with great caution and the NEWS2 should be preferred if at all possible”. Dr Denman also underlined the important distinction between different measurements to monitor a patient’s physical health, and mental health observations.

42. With regard to the use of VBPMS, Dr Denman accepted that the technology may provide useful information but warned of “alarm fatigue” and the risk of reduced therapeutic engagement if such systems were to replace in-person observations. Dr Denman concluded that *“sole reliance on VBPMS would therefore be inconsistent with responsible practice in almost all circumstances.”* However, Dr Denman recognised there may be instances where VBPMS provide benefits to patients but emphasised the need to recognise the use of Oxevision as a clinical intervention for the individual patient, with its appropriateness considered through an individualised, patient-centred approach.

43. Dr Denman identified the potential utility of VBPMS in specific circumstances, including seclusion and Health Based Places of Safety, where there may be risks in entering a patient’s bedroom. However, these circumstances were identified as relatively uncommon, and Dr Denman stressed that reliance on remote monitoring should not continue indefinitely, stating *“we should be working to repair that situation as fast as possible.”*

44. Dr Denman also provided her expert opinion regarding the findings this year of the Parliamentary and Health Service Ombudsman (the ‘PHSO’) relating to deficiencies in EPUT’s consent practice in respect of Oxevision. Dr Denman’s clear view is that

observations, including those performed using technology, constitute a part of a patient's care to which the patient is required to provide consent where they are able to do so.

45. Chair, you once again invited Laura Cozens to come and give evidence to the Inquiry on behalf of LIO.

46. During the course of her evidence Ms Cozens accepted the limits of the evidence base underpinning the clinical utility of Oxevision, noting that there is a need for further research. Ms Cozens' view was that this should run concurrently with the deployment of Oxevision within mental health inpatient units so as not to miss out on the potential benefits to patients. Ms Cozens accepted that this represented a change in LIO's position, particularly when contrasted to this time last year, and which reflected the evidence and opinions provided by the Inquiry's Expert Health Statisticians in July.

47. Ms Cozens emphasised that the real-world experience of clinicians who find Oxevision useful, while not the same as a Randomised Control Trial, was important, and it is appropriate to have regard to it.

48. Ms Cozens maintained that the ability to conduct remote observations at night was a benefit so as not to disturb sleeping patients. Ms Cozens also acknowledged that the ability to conduct remote observations was not a replacement for in-person engagement by staff and that technology should be used to assist staff in conducting observations. This should only occur after discussion with the patient.

49. With regards to the benefits of Oxevision, Ms Cozens developed her previous evidence to this Inquiry regarding the specific settings in which LIO consider the ability to take remote observations useful. These include seclusion units, older adult wards and following rapid tranquilisation. There are further savings possible, mainly through the prevention of serious incidents, saving staff time and cost in responding to serious incidents.

50. Ms Cozens stated that beyond this, it is not envisioned by LIO that Oxevision would be used to reduce the time actually spent by staff on observations. Further, that the system should not be used as a replacement for in-person observations.

51. With regards to NEWS2, the importance of which I have already referenced when outlining Dr Denman's evidence, Ms Cozens confirmed that Oxevision is able to take two vital signs readings from patients remotely. These are breath rate and pulse. It does not fulfil all the functionalities of a full NEWS2 reading. Ms Cozens' view was that information on breathing rates and pulse readings is capable of being of some assistance, as well as providing reassurance to staff.

52. Ms Cozens emphasised that she would expect Oxevision to be used only with the consent of patients and that this would be for the relevant organisation to communicate with the patient around its use. This would include being told how the system works.

53. As with our resuscitation topic, the Inquiry went on to consider how Oxevision was, and is, utilised at EPUT, alongside EPUT's observation practices more generally. The Inquiry heard evidence on Tuesday

afternoon from Derrick Trimble, a Project Manager at EPUT involved in the deployment and ongoing use of Oxevision at the Trust.

54. Mr Trimble gave evidence about his role in relation to the roll-out of Oxevision on EPUT wards. This included the part he had played in drafting the technical elements of Standard Operating Procedures. Mr Trimble said his role was limited to project management of the introduction of Oxevision. Mr Trimble is not a clinician and he told you that he was not a decision-maker in relation to the decision of the Trust to procure the technology.

55. As to how staff are trained and helped to gain an understanding of the system, Mr Trimble explained that staff members were required to complete the OxeAcademy training course with a 100% pass rate, and there were competency checklists for new staff which were used at ward level. Following the initial training, Mr Trimble and the Quality Matron undertook one further round of training through refresher sessions, based on staff feedback and the requirements of the Standard Operating Procedure.

56. Mr Trimble told us that he was aware of instances when Oxevision had generated inaccurate information. Mr Trimble explained that when this happens, it may be necessary to refresh the software. This was an issue that had been raised recurrently as a point of feedback from staff. Mr Trimble was firmly of the view however that the Oxevision system has saved lives. This view was based on his interpretation of Datix reports and staff feedback.

57. Mr Trimble further explained that user authentication had been introduced in the Lakes in May 2026 and will be rolled out across the Trust following clinical approval. This will provide an important safeguard and accountability mechanism. Mr Trimble also expanded on his view that clearer national guidance on consent to the use of VBPMS should be issued. Mr Trimble understands, through wider conversations in the sector, that there is significant variation between the approaches adopted by different trusts. Mr Trimble considered that having greater structure and guidance would be helpful.
58. Yesterday, Chair, the Inquiry heard evidence from Dr Kallur Suresh (again), and Mr Zephan Trent, who is Executive Chief Digital and Information Officer at EPUT.
59. Mr Trent and Dr Suresh's evidence touched upon broad aspects of observations practice at EPUT, in particular the role of the Oxevision system. Their evidence covered not only historic use of the system at EPUT, but recent changes in practice mandated by revisions to the Standard Operating Procedure, or 'SOP', in June of this year.
60. The Inquiry heard evidence regarding the need to obtain patients' consent for the use of Oxevision. EPUT now accepts that patients should have been required to provide explicit consent on an 'opt in' basis from the first time the system was deployed. Whilst that form of consent is required by EPUT's most recent SOP, it was accepted that there had been internal inconsistencies in previous versions of the SOP, and that informed consent had not always been obtained. That was a view echoed by the PHSO, whose findings have been accepted by EPUT.

61. In terms of potential changes in the future, Dr Suresh supported Dr Denman's view that there may be value in having an identified board member with responsibility for consent. Zephan Trent further told you that he found the Inquiry's consideration of technology and patients' consent to be timely, given the current focus of the healthcare system on the role of technology.
62. Another theme which arose from yesterday's evidence was the limited support and guidance available to a Trust seeking to deploy a new technology. We heard from Mr Trent of an expectation that NHS Trusts will look at the opportunities available with regards to technology, for example when implementing the NHS Ten-Year Plan. Notwithstanding that expectation, the evidence of both Dr Suresh and Mr Trent was that the practical support provided to Trusts when evaluating, piloting and deploying new technologies is, at present, limited. Dr Suresh gave his opinion that there should be evaluation of emerging technologies at a level above that of individual Trusts. Mr Trent told the Inquiry that once new technologies are rolled out, there were opportunities for the NHS to learn of issues and improve practice more systematically and draw on multiple providers' experience.
63. Turning to the functions of the Oxevision system, Dr Suresh's evidence was that the Oxevision Vital Signs function conferred limited benefits. When asked whether there was any reason for the frequent checks of heart rate and respiratory rate using that feature, which have been seen to have occurred at EPUT, he responded '*All other things being equal, probably not*'. His evidence was that, at its most basic, the Vital Signs device can inform a clinician whether a patient is alive, and may alert them to carry out a more rigorous assessment if either the pulse or respiratory rate are found to be elevated.

64. Mr Trent's evidence was similar. He accepted that it was difficult to conclude that the Oxevision system was having an impact on ligature incidents from EPUT's own analysis of its self-harm data. He further accepted that there were deficiencies in the Trust's approach to that data analysis, and explained the improvements made by EPUT with respect to its data interpretation since. Both witnesses provided evidence as to the benefits of the system, including its potential use in settings where the risk to both patients and staff is higher, such as Health Based Places of Safety and seclusion suites, as well as older adult wards where, for instance, there may be an elevated risk of falls. The system may also confer benefits at nighttime, by virtue of allowing for reduced disturbance of a sleeping patient. Their evidence as to the system's role and proper purpose echoed many of the features of Dr Denman's evidence.

65. Lastly, I want to say something about the evidence heard concerning the roll out of Oxevision at EPUT. Mr Trent's evidence was that the deployment of Oxevision was done with a clear strategic intent, to improve patient safety. However, Mr Trent accepted Dr Denman's expert opinion that the specific benefits by which that ambition would be realised had not been identified. Mr Trent went on to accept that a fuller analysis of the potential risks associated with the use of Oxevision should have been undertaken by the Trust at an earlier stage. Further that there was a lack of lived experience involvement in consideration and implementation of the system. Mr Trent gave evidence of his own experience of the value of constructive challenge from those with lived experience, and he conceded that it should have been sought sooner. The EPUT board recognises that the Trust should have done better in the past.

66. Chair as I stated at the outset of this Closing Statement, the Inquiry looks forward to receiving submissions from the Core Participants on these two important issues. Thereafter you will consider everything you have read and heard to determine whether there are **ongoing** risks to the safety of **current** patients and whether Interim Recommendations are required.

67. The Inquiry will then move on to examine further substantive themes in 2027. We will begin in January by considering issues relating to

- a. Assessments (pre-admission),
- b. Safeguarding; and
- c. Sexual Safety.

68. The Inquiry hopes to release its first tranche of disclosure in relation to those thematic areas in the near future.

69. That announcement having been made, may I once again take this opportunity to thank all of those who have engaged in this hearing.

Nicholas Griffin KC

Rebecca Harris KC

Claudia Hyde

Dr Thomas Hayes

Katie Sage

Fergus Spence

15 October 2026