

Tuesday, 13 October 2026

(9.30 am)

(Proceedings delayed)

(9.34 am)

THE CHAIR: Mr Griffin, good morning.

CHRIS: Good morning, Chair.

This morning the Inquiry will hear evidence from Laura Cozens, Head of Patient Safety and Quality, at Oxehealth Ltd. We heard from Ms Cozens this time last year. Today she will address a number of points arising from the Oxevision system, including in light of two witness statements and evidence provided since last year.

This afternoon, we will hear from Derrick Trimble, the Oxevision project manager at EPUT. His evidence sets out how EPUT viewed the Oxevision platform and the organisation's experiences of the system during the rollout and since.

Chair, as with previous days, there may be aspects of today's evidence that are difficult to listen to. For some people, it may not be possible to sit through these sessions. Anyone in the Inquiry room should feel free to leave at any time.

May I take this opportunity to remind those engaging with the Inquiry that emotional support is available for

1 all those who require it. Present here again today are
2 Hestia emotional support staff. They are wearing
3 orange-coloured scarves and you can find them if you'd
4 like to talk to them. There is a private room
5 downstairs, to remind those engaging that they can go
6 talk to Hestia in a private place.

7 If you prefer, you could speak to a member of the
8 Inquiry team. We're wearing purple lanyards, and we can
9 point you in the direction of Hestia.

10 For those following the hearing online, information
11 about the emotional support that is available can be
12 found on the Lampard Inquiry website at
13 lampardinquiry.org.uk, the "support" tab is near the top
14 right-hand corner.

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

17 Could I ask, please, that Ms Cozens takes the
18 affirmation.

19 **LAURA COZENS (affirmed)**

20 **Questioned by MR GRIFFIN KC**

21 **MR GRIFFIN:** Would you give your full name, please.

22 **A.** Yes, Laura Jane Cozens.

23 **Q.** Ms Cozens, dealing first with the witness statements
24 you've provided to the Inquiry, please. You've provided
25 two witness statements that we discussed during your

1 evidence last year; is that correct?

2 **A.** That's correct.

3 **Q.** And you've since provided two further statements to the

4 Inquiry; is that right?

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

6 **Q.** Did you provide your third witness statement, dated

7 19 March this year, and does it run to eight pages?

8 **A.** That's correct.

9 **Q.** Does this statement respond to Inquiry requests for

10 further information and documentation?

11 **A.** That's correct.

12 **Q.** For example, did you provide a table of all of the

13 studies and research relating to the performance of the

14 Oxevision platform that the Inquiry's expert health

15 statisticians were able to consider for the purposes of

16 their report?

17 **A.** I did, yes.

18 **Q.** And did you recently provide a fourth witness statement,

19 dated 23 September this year, and is it 17 pages long?

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

21 **Q.** And is that statement provided in response to the

22 evidence the Inquiry heard at the July hearings,

23 especially focusing on the evidence given by

24 Jill Archibald, the nursing expert, and the Inquiry's

25 expert health statisticians, Professor Christl Donnelly

1 and Dr Maria Christodoulou?

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

3 **Q.** Can you confirm that both of your 2026 statements

4 contain a statement of truth at the end?

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

6 **Q.** And have they both been signed by you?

7 **A.** They have, yes.

8 **Q.** Can you confirm again today that they're both accurate

9 to the best of your knowledge and belief?

10 **A.** I can, yes.

11 **Q.** Ms Cozens, your statement and exhibits stand as part of

12 your evidence so today I don't intend to ask you about

13 every aspect of your recent witness statements.

14 The subject of the hearing this week is observation

15 and technology, and we will be discussing technology

16 that we've been referring to as Oxevision. I suggest

17 that today we continue to refer to it as "Oxevision"

18 just for the sake of simplicity although I understand

19 that, as we discussed last year, there's been a

20 rebranding and the name may have changed more recently.

21 **A.** That's correct.

22 **Q.** We have referred to the company providing the technology

23 as "Oxehealth".

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

25 **Q.** What is the current name now?

1 **A.** So the current name is LIO, but the trading name is
2 Oxehealth Ltd still.

3 **Q.** So what I suggest, again for the sake of simplicity, is
4 that we talk about either "Oxehealth" or "LIO" as we
5 think appropriate.

6 **A.** Okay.

7 **Q.** Last year we covered your own background. Can I just
8 remind -- could we just remind people of the essential
9 points again. Are you Head of Patient Safety and
10 Quality at Oxehealth Ltd?

11 **A.** I am, yes.

12 **Q.** Have you been employed by Oxehealth in this role since
13 May 2022?

14 **A.** I have, yes.

15 **Q.** Is that actually when you joined Oxehealth?

16 **A.** Yes.

17 **Q.** Are you a Registered Mental Health Nurse and have you
18 been an RMN since 2011?

19 **A.** I have, yes.

20 **Q.** Prior to working with Oxehealth, did you spend nearly
21 20 years working in the National Health Service in
22 various positions, including lastly as a senior clinical
23 manager within High Secure Forensic Services?

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

25 **Q.** And do you hold a Bachelor of Science degree in Mental

1 Health Nursing?

2 **A.** I do.

3 **Q.** And a post-graduate diploma in Clinical Forensic
4 Psychiatry?

5 **A.** I do.

6 **Q.** You gave evidence on this day last year?

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

8 **Q.** We covered a range of matters. We discussed how
9 Oxevision works, including its use at nighttime, and
10 Oxevision observations. We talked about the claimed
11 benefits and advantages, for example providing access to
12 up-to-date clinical information, time and cost savings,
13 improvements in patient and staff evidence, reductions
14 in rates of patient safety events, and provision of
15 video and other data following an incident and more
16 generally.

17 We also discussed some of the concerns that had been
18 raised about the technology, including the replacement
19 of in-person therapeutic engagement by staff with
20 patients; privacy concerns, for example arising from the
21 presence of a camera in a patient's bedroom which, when
22 activated, is recording 24 hours a day, seven days
23 a week; alarm fatigue; and staff misuse.

24 We also touched on certain data protection matters
25 and the issue of consent. That means there are a lot of

1 matters we have already addressed. My intention is to
2 go back to areas we have already covered only where
3 there's been a development since you last gave your
4 evidence.

5 In July, this year, and I think you attended the
6 hearing in July; is that right?

7 **A.** That's correct.

8 **Q.** We heard from the two expert witnesses I've just
9 mentioned, Ms Archibald, a Registered Mental Health
10 Nurse, on observation and engagement practices, and the
11 use of vision-based monitoring and technology, and the
12 Inquiry's health statisticians who conducted a review of
13 the available evidence relating to Oxevision and related
14 vision-based patient monitoring systems, or VBPMs, with
15 particular attention to their use in mental health
16 inpatient settings.

17 You were here I think yesterday, is that correct,
18 Ms Cozens, to hear Dr Denman give her evidence, as well?

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

20 **Q.** Whilst we've previously discussed the Oxevision system
21 in some detail, you summarise its capabilities in this
22 way in your fourth statement, and this is at
23 paragraph 8. It's probably helpful just to remind us
24 what you say there. I don't need it put up but this is
25 what you say:

1 "The Oxevision system provides a number of distinct
2 capabilities designed to support patient care:

3 "Remote vital signs observation: a registered
4 medical device enabling staff to obtain pulse and
5 breathing rate information without entering the
6 patient's room, which can be particularly valuable at
7 night, or where direct interaction may be difficult or
8 distressing."

9 Now, it's termed there "remote vital signs
10 observation". Why is the word "observation" included
11 there?

12 **A.** Because it's taking a remote vital sign measurement.

13 **Q.** But the observation element, is that because staff are
14 able to access the clear view function to see the
15 patient before they take the spot check?

16 **A.** They are able to access that 15-second clear video feed.
17 But it should be "vital sign measurements".

18 **Q.** Thank you.

19 "Alert to manage risks: providing location and
20 activity-based warnings, and alerts configured by each
21 partner organisation, according to the needs of its
22 wards and patient population.

23 "Retrospective incident review where enabled,
24 providing objective information that can assist
25 organisations in understanding serious incidents, and

1 strengthening clinical governance and accountability.

2 "Sleep monitoring: a registered medical device,
3 providing information about patient's sleep without
4 requiring repeated physical disturbance."

5 And:

6 "Digital observations: supporting the recording and
7 management of routine patient observations."

8 Now, is the last point there, digital observations,
9 is that the equivalent to what we have heard is called
10 Oxevision observations at EPUT?

11 **A.** That's correct.

12 **Q.** So are the points you're getting across there, first of
13 all, the vital signs, the two measurements that that
14 take; secondly the various alerts and notifications that
15 the system is able to provide and that we've discussed
16 before; thirdly the information and data that can be
17 provided following an incident to aid a review; sleep
18 monitoring, as you've just seen, and then, finally, this
19 observation OxeObs as we've been calling it, at EPUT.

20 Are those essentially the functions of this
21 technology?

22 **A.** That's correct.

23 **Q.** Thank you.

24 The first thing I want to ask you about arises in
25 your fourth statement, the most recent statement. And

1 it's really to ask you this: in essence, how do you say
2 the Inquiry should approach and consider VBPMs
3 technology, and Oxevision in particular? This is
4 a point that you raise at various stages in your most
5 recent statement. For example, at paragraph 14.

6 **A.** So I think it's important to consider the benefits that
7 this technology can offer to mental health patients and
8 I think we've seen that in the evidence that we heard
9 from EPUT last year around the incidents in which the
10 technology has assisted staff in intervening in critical
11 safety incidents, so I think that was over 1,400
12 incidents over a five-year period. So I think it's
13 important to consider that. And it's important to
14 consider how practice is at the moment and I think we've
15 heard that from some of the experts around those routine
16 observations, specifically at night. And that they
17 themselves may involve intrusion into privacy and
18 including staff entering bedrooms in the middle of the
19 night turning lights on, using torches, et cetera.

20 **Q.** So one of the points that comes across, I think at
21 various stages in the most recent statement, is the need
22 for balance when considering this technology. If I've
23 understood it correctly, but please correct me if I've
24 got this wrong, what you're urging on the Inquiry is
25 that when considering this kind of technology, one needs

1 to consider on the one hand privacy, but also on the
2 other, the safety of the patient. Have I understood
3 that correctly?

4 **A.** Yes, that's correct.

5 **Q.** And that's the kind of balance that needs to be struck
6 as we continue to consider this technology?

7 **A.** Yes, that's correct.

8 **Q.** What safety benefits do you say exist from the
9 technology and have to be balanced against privacy and
10 autonomy?

11 **A.** I think there are many safety benefits and, again, I go
12 back to the evidence we heard from EPUT around their
13 incident data as well as some of the incident data
14 that I provided in my third statement, I believe, from
15 other organisations. And I think it's not forgetting
16 that we're talking about incident numbers here, but
17 remembering that there is a patient behind each one of
18 those numbers where this technology has assisted with
19 the possibility of preserving life or serious harm.

20 **Q.** How do you say the privacy implications of the
21 technology should be weighed against the safety
22 benefits?

23 **A.** So all patients need to be aware of what the system does
24 and what the system does not do. And that's
25 a conversation clinicians should have with patients and

1 carers and families. And that's a consistent
2 conversation, as well. So it's not just one
3 conversation and done. It should be discussed within
4 MDT meetings, nursing one-to-ones, as a larger sort of
5 community meeting situation, as well.

6 **Q.** We heard from Dr Denman yesterday about the types of
7 things she would expect staff to explain to patients
8 before the technology is deployed. Do you broadly agree
9 with what she was suggesting yesterday?

10 **A.** Yes.

11 **Q.** Thank you.

12 **THE CHAIR:** She mentioned the need also to talk to patients
13 about the potential for misuse of the system. Do you
14 agree that that's something that patients should be made
15 aware of?

16 **A.** Potential misuse in what way, sorry?

17 **THE CHAIR:** Well, that there is a possibility that the
18 15-second clear view, for instance, might be accessed as
19 a means of looking at the patient primarily rather than
20 necessarily taking the vital signs reading.

21 **A.** So again, I think it's important that patients are aware
22 of what the system does and does not do, and when the
23 system is likely to be used, as well, and that agreement
24 with patients. So if we take the example of nighttime
25 observations, for instance, that that's a conversation

1 that's had with patients so they know when staff will be
2 using the system and when they won't be using the
3 system. And that that is documented within care plans,
4 et cetera.

5 **THE CHAIR:** Right, okay.

6 **MR GRIFFIN:** The Chair was asking a specific point, I think,
7 which was that one of the areas that Dr Denman suggested
8 should be covered with the patient is the potential for
9 misuse of the system. For example, using the spot-check
10 function but not to take a spot check, but to view
11 a patient remotely.

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

13 **Q.** Is that the kind of thing you would expect a staff
14 member to tell a patient before the technology was
15 deployed?

16 **A.** So again, it's about that conversation with patients
17 around what safeguards are in place to stop things like
18 that from happening. So an organisation's clinical
19 governance procedure in the reports that they receive
20 about how the system is being used in practice, and what
21 is done with those reports from an audit governance
22 level, to flag any concerns like that example that
23 you've given.

24 **Q.** May I just check I've understood. So are you agreeing
25 that it's appropriate, possibly depending on the

1 particular patient, to explain the potential for misuse
2 in the way I've just set out, but that the conversation
3 should be a balanced one, that you both identify the
4 potential for misuse, and what steps are taken to try to
5 minimise that risk?

6 **A.** That's correct.

7 **Q.** Thank you.

8 You say this in your fourth statement at
9 paragraph 79:

10 "The challenge for mental health services is not to
11 choose between technology, patient rights and patient
12 safety. Rather, it is to establish the conditions,
13 safeguards and governance arrangements under which
14 technology can be used responsibly so that it supports
15 and strengthens both patient rights and patient safety."

16 Would you explain what you meant by that.

17 **A.** Yes. So ultimately, I believe that patient safety,
18 privacy and dignity shouldn't be competing priorities.
19 We should be working towards a model of care in which
20 all three are supported and where technology can play an
21 appropriate role alongside clinicians delivering good
22 quality care.

23 **Q.** Thank you.

24 The Oxehealth Board wrote an open letter to the
25 Inquiry Chair on 24 September this year and I understand

1 they attempted to provide it to the lawyers of core
2 participants but perhaps not entirely successfully but
3 they have now received it via the Inquiry and I would
4 like to look at part of it with you now, please.

5 Could you put up OXHE028532 -- thank you.

6 This is from the fifth paragraph down, just starting
7 with what we see on the screen but I just want to remind
8 people what we're looking at is an open letter from
9 Oxehealth Ltd, this is not your own evidence, is it,
10 Ms Cozens?

11 **A.** That's correct.

12 **Q.** Thank you. Can we see here:

13 "Healthcare technology cannot be expected to emerge
14 with perfect foresight. As with any pioneering medical
15 device adopted across the NHS, platform capabilities,
16 training protocols, and ward workflows mature through
17 practical application. Crucially, digital systems
18 introduce for the first time unalterable operational
19 insights and objective auditing into ward environments.
20 Previously, the sector had to rely on retrospective
21 memory and unreliable paper records."

22 Do you think that should be taken to mean that we
23 must all keep an open mind about the development of new
24 technologies such as Oxevision?

25 **A.** I do, yes.

1 **Q.** Has Oxehealth itself always kept an open mind about the
2 development of this technology?

3 **A.** I believe so, yes.

4 **Q.** Has it always been open to learning from concerns that
5 have been raised with it by regulators and others?

6 **A.** I believe so.

7 **Q.** Can we just read on:

8 "Against this backdrop, the Board views the Lampard
9 Inquiry's focus on digital technology as an
10 unprecedented and welcome opportunity. The Inquiry
11 provides a platform for a thorough, sector-wide review
12 of how health tech is evaluated, governed, and
13 integrated across the entire stakeholder community,
14 a comprehensive review that no single technology
15 provider could orchestrate independently."

16 So this is the Oxehealth Board. Do you, Ms Cozens,
17 and LIO, as well as the Board, view this Inquiry's focus
18 on digital technology as an unprecedented and welcome
19 opportunity?

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

21 **Q.** Just reading on:

22 "However, there must also be pragmatic realism
23 regarding the limits of a public inquiry to reach
24 definitive, permanent conclusions about a technology
25 class and deployment model that continues to evolve.

1 Lessons learned from early implementations have already
2 driven substantial advances in system architecture, user
3 authentication and trust governance. An inquiry must
4 assess not just past implementation, but the continuing
5 trajectory of clinical learning."

6 The Board there refers to the limits of this Inquiry
7 to reach definitive conclusion on technology such as
8 Oxevision that continues to evolve.

9 Do you, Ms Cozens, on behalf of LIO, maintain that
10 there are limits on what Baroness Lampard in her role as
11 chair of a statutory inquiry can reasonably conclude and
12 the recommendations she should make accordingly?

13 **A.** I think, referring back to some evidence we heard
14 yesterday from Dr Denman around technology and that
15 technology is advancing and that we should be ready, and
16 that if there is a way where we can assist mental health
17 inpatient care with the use of technology, then we
18 should be ready for that and we should be looking at
19 that in any way that we can to improve the quality of
20 care.

21 And I refer back to some of my earlier evidence from
22 last year where, when you look at physical health care
23 and how technology is used within physical health care
24 and that mental health care has severely lacked behind
25 those technological advances.

1 **Q.** Thank you. Assuming that the Chair is aware that this
2 is evolving technology, do you today, on behalf of LIO,
3 suggest there are limits on what she can reasonably
4 conclude and any recommendations she should make?

5 **A.** Sorry, can you repeat that question?

6 **Q.** Yes. This is from the Board, so it's not from you, but
7 I want to see to what extent what the Board is
8 suggesting there is also the view of LIO, and we can see
9 that last paragraph on the screen:

10 "There must be pragmatic realism regarding the
11 limits of a public inquiry to reach definitive permanent
12 conclusion about" -- effectively, about a technology
13 that continues to evolve.

14 My question is basically this: assuming that the
15 Chair is aware that this is an evolving technology, do
16 you today suggest that there are limits to the
17 reasonable conclusions the Chair can make and any
18 resulting recommendations?

19 **A.** I think there's probably always limits in, especially
20 with technology and how that is evolving and ever
21 changing. So something that might be right today may
22 not be correct or right in six months as things advance.
23 So I think they need to be open to allow for those
24 advances to happen and for those advances to happen as
25 a broad group.

1 So I suppose what I'm trying to say is in involving
2 all the stakeholders within mental health inpatient care
3 so not solely technology providers or not solely
4 clinicians, but how that joint working happens.

5 **Q.** Is what you're saying effectively that conclusions and
6 any recommendations need to be taken in context?

7 **A.** Yes.

8 **Q.** Thank you.

9 Would you take that down, please.

10 As we've already established your fourth statement
11 refers to the evidence of the Inquiry's expert health
12 statisticians. You summarise their overall conclusion
13 at paragraph 50 of your most recent statement in this
14 way, that:

15 "... the evidence so far published in clinical
16 academic journals and conference proceedings provides
17 only limited and cautious support for the use of
18 Oxevision and related VBPMS in mental health inpatient
19 settings."

20 The expert health statisticians' conclusion says
21 this, so the most succinct aspect of their
22 conclusions -- it's slightly longer. Can I just read it
23 out?

24 So first of all the bit that you've quoted:

25 "In conclusion the current evidence provides only

1 limited and cautious support for the use of Oxevision
2 and related VBPMS in mental health inpatient settings."

3 And it says this:

4 "It suggests that the technology is technically
5 feasible and may have potential operational
6 applications, but it does not provide strong independent
7 evidence of clinical effectiveness, improved patient
8 safety, acceptability or cost effectiveness in mental
9 health inpatient settings. Further independent,
10 randomised, adequately controlled research would be
11 needed before stronger conclusions could be drawn."

12 Now, do you remember that aspect of their evidence?

13 **A.** I do, yes.

14 **Q.** Does LIO accept all of that conclusion from the health
15 statisticians?

16 **A.** I think it's a -- it represents a fair and balanced
17 view. And I think, again, going back on some of the
18 evidence we heard yesterday from Dr Denman that -- and
19 Professor Donnelly, actually -- around sort of
20 randomised control trials within psychiatry and how
21 difficult and I think Dr Denman hinted yesterday at
22 almost virtually impossible to do.

23 **Q.** Well, we can maybe deal with randomised control trials
24 separately, but, and we'll definitely come on to
25 a recommendation that you make for further research, but

1 my question was really whether LIO accepts the
2 conclusion reached by the health statisticians as
3 they've just summarised. You've said it represents
4 a fair and balanced view. May I just be clear, do you
5 accept, then, what they're saying?

6 **A.** Yeah, I believe it's a fair and balanced view.

7 **Q.** Is there any difference between that and saying you
8 accept that what they say is correct?

9 **A.** I think one thing that wasn't looked at is the, if I can
10 put it sort of, real-world examples of data. So again,
11 going back to EPUT's own evidence around their incident
12 data and the other organisations that I provided in my
13 second statement, I believe. So, looking at that
14 real-world data --

15 **Q.** I'm going to come on to ask you about that. Is that
16 information that Oxehealth or LIO receive from
17 providers, from patients and others?

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

19 **Q.** So I'll definitely come on and ask you about that --

20 **A.** Okay.

21 **Q.** -- in a moment. You certainly, in your fourth
22 statement, you refer, for example, at paragraph 51 to
23 the limitations of the available published evidence
24 base. You talk about it, and then something similar in
25 the next paragraph:

1 "The limitations identified within the published
2 literature ..."

3 You say at paragraph 55 -- all of this in your most
4 recent statement -- that:

5 "Oxehealth ... accepts the recommendation of the
6 statisticians that additional research should be
7 undertaken."

8 At paragraph 61, you say:

9 "The evidence heard in July raised legitimate and
10 important questions ..."

11 And of course the fact that we'll come on to discuss
12 in a moment that one of your recommendations to this
13 Inquiry is that there should be further research.

14 **A.** That's correct.

15 **Q.** Can I take all of that together, subject to the point
16 you've just made, as being a general acceptance of the
17 essential conclusion reached by the health
18 statisticians?

19 **A.** That's correct.

20 **THE CHAIR:** Hang on, just to spell that out, there is a lack
21 of research into this technology?

22 **A.** I think we stand by the research that has been done, but
23 there is always, in any environment, there is always
24 a scope for further research to be done in order to
25 enhance that.

1 **THE CHAIR:** And so you are accepting the limitations of the
2 current evidence base?

3 **A.** That's correct.

4 **THE CHAIR:** Thank you.

5 **MR GRIFFIN:** Do you stand by research papers where the
6 expert health statisticians have concluded that only
7 moderate or low or very low weight should be attached to
8 them?

9 **A.** Again, I think it's a fair and balanced view. I think
10 that throughout some of those research papers, without
11 identifying the specifics, the researchers retained full
12 and independent publication rights and clinical
13 authority over those papers.

14 **Q.** So I visited the LIO website last week and I could see
15 that there is still reliance on five or six of the
16 papers that were reviewed by the health statisticians
17 and found to be of moderate, low, or very low weight.
18 Do you think it's appropriate to continue to rely on
19 that type of research as part of LIO's publicity?

20 **A.** I think it's a -- it's a piece of research that we do
21 still stand by, and I think you said about coming on to
22 sort of the real-life or the real-world sort of incident
23 data, but yeah, we still stand by those research papers,
24 but, again, agree that there does need to be more
25 research -- as with most things.

1 Q. You've suggested in the fourth statement, this is
2 paragraph 51, that the health statistician conclusion
3 concerning the state of the evidence base for Oxevision
4 and related VBPMs:

5 "... should be understood within the context of the
6 limitation of the available published evidence base and
7 should not be interpreted as establishing that Oxevision
8 is ineffective, unsafe, or of no benefit."

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

10 Q. Would you expand on that, please?

11 A. So, yes, I guess what I'm saying is that the evidence
12 that we've heard shouldn't be interpreted that the
13 Oxevision system is ineffective or unsafe, or of no
14 benefit. I think we've heard through, again, some of my
15 earlier evidence, the benefits of the system. We've
16 heard from patients who have personally experienced the
17 system, the benefits that they've seen, their families,
18 carers. And I think we've heard from the expert
19 witnesses so far that -- none of them have said that
20 this is unsafe and should not be used. Yeah, that's
21 what I'm trying to say.

22 Q. Would you urge the Chair to bear in mind, as she
23 considers conclusions and possible recommendations, that
24 particular point: that the current state of play is not
25 that Oxevision is ineffective or unsafe?

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

2 **Q.** Your point is that actually that more research is
3 needed?

4 **A.** Yes.

5 **Q.** Thank you.

6 Again, staying with your most recent statement, and
7 in fact, Ms Cozens, a number of my questions will
8 revolve around that most recent statement. In it at
9 paragraph 54, you suggest and explain why, in your view,
10 randomised control trials in inpatient mental health
11 settings present significant, practical and
12 methodological challenges.

13 Have you seen the recent addendum to the expert
14 health statisticians' report that addresses this point?

15 **A.** I believe I have.

16 **Q.** So what they've said is -- what they've done is to give
17 six examples of randomised control trials conducted in
18 mental health settings including large, multi-centre
19 studies, involving over 1,000 service users. Do you
20 have a response to that evidence in the context of what
21 you've previously said and what we can see in your
22 fourth witness statement about the utility or the
23 difficulty in achieving randomised control trials?

24 **A.** Yes. I think practically, it's -- it's not impossible,
25 but it is difficult. It would involve a substantial

1 period of time, and I think if we look at the population
2 sizes within mental health inpatient, they tend to be
3 relatively small in terms of being able to do
4 a randomised control trial. And again, I think from --
5 Dr Denman yesterday also agreed that that would be very
6 difficult.

7 I think it also, in relation to technology, it would
8 be difficult to isolate that from staff on the ward. So
9 staff would know who had the technology switched on or
10 didn't. I think things like patient mix, local
11 protocols. So I'm not saying it's impossible; I'm --
12 what I'm saying is that it would be difficult and it
13 would need a long period of time to be able to do that.

14 **Q.** Thank you very much.

15 The health statisticians have also, in their
16 addendum report, revisited the Buckley 2024 research
17 paper. That is Buckley, Malcolm, Hanlon "Economic
18 Impact of a vision-based patient monitoring system
19 across five NHS Mental Health Trusts" published in PLOS
20 Digital Health, and previously relied on by Oxehealth,
21 and that has been formally retracted by PLOS. The
22 health statisticians have concluded that the evidence
23 should now be afforded only low evidential weight and
24 have described a situation in which none of the authors
25 had underlying access to the data as highly unorthodox.

1 Do you accept that the retraction materially weakens
2 the evidence base previously relied upon by Oxehealth in
3 support of economic benefit claims?

4 **A.** Is that the Buckley 2024 paper?

5 **Q.** Yes.

6 **A.** Yes. So that was the published version of the three
7 YHEC papers, is my understanding. I think there may be
8 a slight misunderstanding around the reduction of
9 one-to-ones, so -- one-to-one observations within that
10 paper.

11 **Q.** Just to understand what you've said, my recollection is
12 that paper was put forward or the thrust of it is, at
13 least in part, to do with the economic benefit arising.
14 The suggestion is that because that has been retracted
15 by its publisher and revisited by the health
16 statistician and afforded lower weight, whether that has
17 led to a rethink at LIO about the extent to which it is
18 appropriate to continue to rely on it.

19 Do you accept that the retraction and the
20 revisitation by the health statistician materially
21 weakens the evidence base previously relied upon by
22 Oxehealth in support of economic benefit claims?

23 **A.** I think, with it being retracted, then possibly, yes.
24 And I think things have changed over the years in
25 relation to the benefits of the system. And I think

1 that goes far beyond money and financial claims.

2 **Q.** That's a point you make in your most recent statement.

3 I'm going to come on to ask you about that specifically.

4 You refer -- this is coming now back to a point you've

5 made couple of times already, I said I wanted to ask you

6 about it. You refer in your fourth statement -- this is

7 paragraph 52 -- to the evidential value of the extensive

8 experience of clinicians, patients and healthcare

9 providers who have used the technology in practice, in

10 multiple NHS Trusts as a relevant source of evidence

11 which also has to be considered.

12 Am I right, is that the point you were making

13 earlier?

14 **A.** Yes.

15 **Q.** Now, is this information that you've got directly from,

16 for example, providers, or is this is the information

17 that has been reviewed as part of a formal research

18 process?

19 **A.** No, this is information that we've received from partner

20 organisations.

21 **Q.** Now, can I just split that up. Can I ask you about

22 people with lived experience first. As far as that --

23 they are concerned, one of the conclusions reached by

24 the health statistician is that the available lived

25 experience evidence is limited and patient outcomes and

1 rights-based considerations have received less attention
2 than operational and safety claims.

3 If I've understood where we've got to in your
4 evidence, you're accepting limitations in the more
5 formal research process, but you're setting to one side
6 this other body of evidence which comes directly from
7 patients, carers, providers; is that right?

8 **A.** That's correct.

9 **Q.** But do you accept the point that the statisticians have
10 raised, at least on the basis of the papers and
11 research -- the research papers that they've reviewed,
12 that lived experience evidence is limited?

13 **A.** In the papers that they've reviewed --

14 **Q.** In the papers that they've reviewed.

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

16 **Q.** You're nodding. Is that a "Yes"?

17 **A.** Yes, sorry, yeah.

18 **Q.** Can we move on to providers, please. As far as
19 providers are concerned, would you agree that there's
20 been a difference of approach amongst Trusts concerning
21 this technology?

22 **A.** Yes.

23 **Q.** Some decided not to procure it, and those that have,
24 have procured it and used it for different purposes, in
25 short?

1 **A.** Yes.

2 **Q.** In your fourth statement at paragraph 71, you refer to
3 examples shared by providers where the use of Oxevision
4 has improved the quality of care for patients, and you
5 give examples.

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

7 **Q.** Is this, again, the kind of thing you were referring to
8 earlier?

9 **A.** That's correct. That real world.

10 **Q.** Yes, for example, you refer to an organisation you refer
11 to as "A" and that there were 1,774 incidents for which
12 Oxevision supported staff to respond to a situation
13 where a service user could otherwise come to serious
14 harm. Correct?

15 **A.** Correct.

16 **Q.** How firm is data such as that?

17 **A.** So that is data that we've received from organisations,
18 from their own analysis of their own incident data.

19 **Q.** We've heard from EPUT and we'll be hearing from
20 witnesses tomorrow, but in the joint -- a joint
21 statement from Dr Suresh and Mr Trent, they've said
22 this:

23 "The Trust considers the presence of a downward
24 trend in ligature incidents on a number of wards
25 following the installation of Oxevision to be an

1 important and encouraging finding. But the Trust
2 acknowledges that a range of other factors will also
3 have contributed to changes in incident numbers on
4 individual wards, including, for example, the Trust's
5 focus on suicide prevention and reducing restrictive
6 practice as quality priorities." [As read]

7 And:

8 "The Trust does not have quantitative evidence or
9 systematic analysis of the vital signs function being
10 used to identify incidents of self-harm." [As read]

11 Now, I'm just using that as an example from one
12 provider. Do you think there may be similar issues at
13 other providers calling into question the extent to
14 which reliance should be based on the kind of
15 information you're talking about, absent a more formal
16 kind of review?

17 **A.** I think that's fair. I think, when you're looking at
18 incident data, it's multifaceted. There are -- there's
19 lots of context that may play into that, and the example
20 that you've given of a downward trend. There could be
21 many factors that play into that, as well.

22 **Q.** Dr Denman suggests that new technology should only be
23 rolled out once the relevant research has been
24 undertaken or alongside clinical research taking place
25 at the same time. What is your view of the feasibility

1 of that?

2 **A.** Sorry, can you repeat that question?

3 **Q.** Yes, of course. Dr Denman suggests that new technology
4 should only be rolled out once the relevant research has
5 been undertaken, or alongside clinical research taking
6 place at the same time. What is your view of the
7 feasibility of that?

8 **A.** I think that these two things could be done at the same
9 time, rather than -- if you're waiting for research to
10 happen, and I think we've touched upon that, briefly,
11 around how long that research may take and I suppose
12 you're delaying the possibility of introducing something
13 that may be of assistance.

14 **Q.** So if I've understood you correctly, perhaps not waiting
15 for the research to take place first, but running the
16 research alongside the deployment of the technology?

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

18 **Q.** Is that where you've come down to?

19 **A.** Yes.

20 **Q.** Thank you. I'd like to look at the first of the
21 recommendations that you've suggested we should
22 consider.

23 Could you put up the fourth statement, please, at
24 page 11, and expand paragraph 55:

25 "Oxehealth ... accepts the recommendation of the

1 Inquiry's expert statisticians that additional research
2 should be undertaken. Oxehealth is willing to provide
3 an independent research bursary (£100,000) to an
4 appropriate qualified university, Health Innovation
5 Network, or accredited research body to support an
6 independent multisite study into de-identified incident
7 data and the safety impact of Oxevision in inpatient
8 mental health settings."

9 Would you explain a little bit more about what is
10 proposed there, please?

11 **A.** So I think, as I've said, we accept the recommendation
12 that additional research needs to happen. I think we've
13 covered, from other experts that -- especially Dr Denman
14 yesterday -- around funding for research is very
15 limited, that the funding just isn't there. And
16 therefore, we're willing to help assist with that in
17 order for that research and that recommendation from the
18 expert statisticians to begin.

19 **Q.** I'm going to ask that a little bit more of your
20 statement is put up from paragraph 56 on page 11 down to
21 paragraph 60, because you tease out some more points
22 there that we haven't quite captured yet.

23 We can see at paragraph 56:

24 "Any study having access to this bursary would be
25 conducted independently of Oxehealth, subject to

1 appropriate governance and ethical oversight."

2 And dropping down to paragraph 57:

3 "The researchers would retain full and independent
4 publication rights ..."

5 And paragraph 58:

6 "The purpose of the bursary would be solely to
7 facilitate independent research ..."

8 Then at paragraph 60:

9 "Oxehealth would see any research outcomes as an
10 opportunity to develop best practice in the use of VBPMS
11 in mental health settings ..."

12 So are those additional points you would wish the
13 Chair to consider?

14 **A.** Yes, that's correct.

15 **Q.** Can I just pick up on the independence point which is
16 repeatedly made in those paragraphs. If I've understood
17 correctly, are you at pains there to stress the
18 independence of this research notwithstanding the
19 £100,000 funding that Oxehealth is offering?

20 **A.** Yes, that's correct and I think from the evidence from
21 the expert health statisticians where some employees of
22 Oxehealth were involved in some of that research I think
23 that's why we've highlighted the independence of that
24 research.

25 **Q.** Can I just deal with that point, what the health

1 statisticians said. They've referred to independence
2 being a concern in the papers that they've considered.
3 A number of key publications were funded by Oxehealth,
4 authored by Oxehealth employees, involved Oxehealth in
5 data collection or analysis, or relied on data supplied
6 by Oxehealth. One relevant article was subsequently
7 retracted because conflicts of interest were not closed
8 in the required statement. These issues do not make the
9 evidence irrelevant but they materially reduce the
10 weight that can be placed on strong claims about
11 effectiveness, safety, or cost effectiveness.

12 Now, does LIO accept the conclusions reached there
13 by the health statisticians and is that one of the
14 reasons you're at pains to demonstrate that this
15 recommendation is meant to be wrapped up in
16 independence?

17 **A.** Yes.

18 **Q.** You just a couple of times told us that research could
19 take a long time. How long do you think this, what
20 you're suggesting, would take?

21 **A.** It depends how -- yeah, it depends how big, or the
22 context, or how many sites were involved. Yeah, how
23 long is a piece of string, I suppose.

24 **Q.** I think you're saying it's an impossible question?

25 **A.** Yeah.

1 **Q.** May I ask it in a different way: could it be
2 a substantial period of time?

3 **A.** Yes.

4 **Q.** I'm going to move on to a different topic. Before I do,
5 is there anything further you'd like to say about this
6 recommendation for further research?

7 **A.** No, I don't think so.

8 **Q.** Thank you. Would you take that down, please.

9 Do you agree that Oxehealth's stance about the state
10 of the evidence base and the need for further research
11 has changed markedly since last year?

12 Can I remind you what you said in your first
13 statement. This is paragraph 41:

14 "There is an extensive evidence base demonstrating
15 the clinical and operational value of Oxehealth's
16 contactless patient monitoring system in inpatient
17 mental health settings. Evaluations consistently show
18 that the technology supports staff to deliver
19 improvements in safety, quality and efficiency on mental
20 health wards. Most of this research is based on
21 provider-led service evaluations, a number of which have
22 culminated in peer-reviewed publications."

23 I referred you to that last year. You -- and
24 I suggested it presented a very positive picture, and
25 you said you thought it was an honest picture.

1 Is it the conclusions reached by the health
2 statisticians that has led Oxehealth/LIO to change their
3 mind about the quality of the evidence base?

4 **A.** I think, referring back to that statement that you've
5 just read out from last year, I think there are two
6 things here. So, we're talking about the published
7 research that the expert health statisticians reviewed,
8 but on the other hand, again, I'm going back to that
9 real-world examples of service evaluations that Trusts
10 undertake their own insights and benefits, realisation
11 reports, which contain patient and staff surveys. So
12 I think there's two sections to that.

13 **Q.** Thank you. So essentially the point you've previously
14 made: we need to bear in mind both that the more formal
15 research and the kind of information you're receiving
16 directly from providers, those with lived experience,
17 et cetera?

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

19 **Q.** Does Oxehealth continue to stand by the outcome figures
20 stated in its earlier product literature concerning the
21 use of Oxevision, for example, of reductions of 44% in
22 self-harm, 48% in falls, 37% in assaults and 24% in
23 restraints?

24 **A.** Are you referring back there to the Buckley paper again?

25 **Q.** No, I'm referring back to early, very positive figures

1 that were advanced in relation to what could be achieved
2 by the use of Oxevision at hospital Trusts.

3 **A.** I think my understanding is that there may have been --
4 yeah, I can't answer that question. Sorry.

5 **Q.** All right. Thank you. I want to come now to start
6 considering with you again some of the benefits of the
7 system, please. And one of the benefits that, if I've
8 understood correctly, you've stressed is its use at
9 night.

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

11 **Q.** We talked about this this time last year.

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

13 **Q.** You explained last year, when you were giving evidence
14 that, and I'm quoting from the transcript:

15 "So there's two ways that you can access the take
16 vital sign workflow, that is as standard, via the home
17 screen, selecting the room, and going in via that way.
18 The other way is through the Oxevision observations
19 module, so you're required to enter the location of the
20 patient and if the patient is in their room you've got
21 the ability then to be able to take vital signs again."

22 So I'm setting the scene for some questions about
23 nighttime use.

24 But what I wanted to come back to is what you say
25 there about two ways to access the take vital signs

1 workflow, the one that we'd understood previously via
2 the home screen and picking the room, but also via the
3 Oxevision observations module. Could you just explain
4 more about how you can access a clear view using OxeObs
5 module?

6 **A.** So using the OxeObs module, this is the digitalised
7 recording system of those general observations that
8 we've heard a lot about. Now, there are certain stages
9 to it where you would enter the patient's location, you
10 would enter their presentation. You've then got the
11 ability to be able to take those vital signs -- if you
12 want to, you don't have to. That's an optional step
13 within the module.

14 **Q.** I must admit, this is not something that I particularly
15 picked up on when you gave your evidence last year, but
16 as I'd understood the Oxevision observations module was
17 essentially an electronic version of the paper medical
18 records, but with additional functions, for example of
19 the possibility of auditing the notes, catching people
20 out if they were trying to fabricate observations that
21 didn't happen and so on. But if I've understood what
22 you said last year and what you're saying now, there's
23 actually another function and you can go in and access
24 vital signs and clear view through OxeObs?

25 **A.** You have got the ability to be able to take somebody's

1 vital signs through the OxeObs module, yes. I think
2 it's important to highlight that the OxeObs module is
3 requiring staff to sign in, because, as with the
4 old-fashioned way of pen and paper, staff were required
5 to sign or -- and print their name against those
6 observations. So staff are required to sign in, in
7 order to be able to log those observations.

8 **Q.** Do you think it might be confusing for staff, though, in
9 a module called Oxevision Observations, that they have
10 this facility to remote observe a patient? And they
11 might just use it to do that rather than actually do
12 a spot check?

13 **A.** I don't think so. I think through our product training
14 it's -- the steps of that module are clear. It is
15 optional, it's not mandated. And then I think that
16 product training, alongside the organisation's Standard
17 Operating Procedures about how they expect staff to use
18 the system and when to use the system, I think that
19 makes it -- that would make it clear for staff.

20 **THE CHAIR:** You've just told us that the OxeObs module
21 requires user authentication.

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

23 **THE CHAIR:** You have to sign in.

24 **A.** Yeah.

25 **THE CHAIR:** Would that also identify who had accessed the 15

1 seconds clear view image when doing a vital signs check?

2 **A.** As part of the Oxevision observation modules, yes,

3 that's correct.

4 **THE CHAIR:** But not if they were in the -- it's not yet got

5 an authenticator in the control room -- or in the

6 Nursing Station where the main monitor is?

7 **A.** So the ability for user authentication is there should

8 organisations want it, and they could put the "Take

9 vitals" function that is accessed via the home screen,

10 they could put that behind user authentication if they

11 wished so and therefore you would have a clear record of

12 who had accessed it and when they had accessed it.

13 **THE CHAIR:** But it's not inevitable as it is with the

14 OxeObs?

15 **A.** No. People are required to sign in, yeah, so you can

16 clearly identify who has taken those observations.

17 **MR GRIFFIN:** Just on user authentication, you're saying that

18 that's actually now available for providers. How long

19 has that been the case?

20 **A.** I would have to double check that for a specific date.

21 **Q.** Don't worry about a specific date; is it something

22 that's relatively recent?

23 **A.** I think it was something that we were working on prior

24 to this Inquiry starting, I believe, and I think we've

25 touched upon it. Technology is always advancing, the

1 platform capabilities and abilities of the platform is
2 always advancing, and user authentication is one part of
3 many other things, actually, that have advanced.

4 Q. But do you think, given the sensitivity of the
5 information and the data that user authentication should
6 have been built in from a much earlier stage for all
7 functions on vital signs, on Oxevision? I suppose my
8 point is: this is coming quite late in the day,
9 isn't it?

10 A. I think, as we've said, the technology is constantly
11 evolving.

12 Q. Thank you.

13 So we've discussed in a little detail last year
14 nighttime observations and the use of Oxevision so as
15 not to disturb a patient at night, and we've discussed
16 not just with you, but we've heard other evidence of the
17 need for the restorative benefits of sleep for those
18 with mental ill health.

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

20 Q. And you've explained how Oxevision can assist with that?
21 Is that a fair summary of how you've put forward the
22 role that Oxevision can play at night?

23 A. Yes, I believe so.

24 Q. Would you -- so one -- if I've understood it correctly,
25 one of the functions is to use the clear view function

1 as an observation tool so you're not going in and
2 disturbing the patient; is that right?

3 **A.** Again, I think it's -- so if we step back slightly,
4 a member of staff is walking around the ward at night in
5 order to complete those observations. So I think what
6 we're saying is, instead of having to turn lights on,
7 open doors, go in and disturb that patient, staff can
8 still walk around the ward but they've got the ability
9 to be able to utilise the system to assure themselves
10 that that patient is in their room, they're sleeping,
11 and they're alive.

12 **Q.** May I just be clear, because there are two aspects that
13 we might be dealing with at the moment. There's the
14 possibility of using Oxevision to conduct a remote
15 observation, and there's the possibility of using the
16 vital signs function to conduct a spot check. What I'm
17 trying to ascertain is what you're advancing as the
18 use -- utility of Oxevision at night. Is it, first of
19 all, the ability to conduct remote observations? Is it,
20 secondly, the ability to take vital signs, or is it,
21 third, both?

22 **A.** I think the ability is there for both, but again, it
23 is -- it's down to an organisation about how they use
24 that in clinical practice.

25 **Q.** But would you advocate the use of Oxevision at nighttime

1 for the taking of remote observations?

2 **A.** I think that can be of benefit to some patients, and

3 I think there are -- if I can refer to the Sleep Well

4 Project, which is an improvement package which is backed

5 by the Royal College of Psychiatry.

6 **Q.** I think in fact Jill Archibald referred to it in her

7 report.

8 **A.** She did. She did, yes. And that's around being able to

9 protect sleep for suitably risk-assessed patients, and

10 there has been some pilots of that back from I think it

11 was 2018 across seven wards at a London Trust where they

12 were able to roll this programme out and recognised the

13 positive impact that that had on patients.

14 **Q.** But did Sleep Well involve the use of technology or was

15 it just in fact deciding not to disturb patients between

16 particular hours during the night?

17 **A.** That is correct, and typically it was around 50% of

18 a ward's population, and I suppose what I'm trying to

19 say is, with the added benefit now of technology, the

20 50% that weren't included in that programme now, because

21 we have the added benefit of technology, in order to be

22 able to assist, there may be many more patients that

23 might be able to participate in that programme.

24 **THE CHAIR:** So you've identified that you can use the

25 technology to undertake observations at night and you're

1 suggesting the benefits of that, the patients who want
2 to sleep may agree with you about that. How does that
3 square though, with the very clear assertions that
4 Oxevision is assistive, it's an adjunct, to care and to
5 therapeutic observation; it is not meant to be
6 a substitute for them?

7 **A.** So I still think that is the case. I think it's those
8 conversations with patients around how the technology
9 sits with their care. It is assisting staff and
10 patients.

11 **THE CHAIR:** It may be assisting them, but it is also
12 replacing that ordinary -- I mean you have to accept,
13 don't you, that that would be a replacement of
14 a one-to-one in-person observation?

15 **A.** When you say one-to-one, do you mean a one-to-one
16 observation as in --

17 **THE CHAIR:** Real-time, person-to-person observation, going
18 into the room and actually observing somebody.

19 **A.** So again, it's that conversation with the patient
20 whether that's how they want those observations at night
21 to be conducted, and respecting their choices and wishes
22 and I think we heard from Dr Denman yesterday about
23 patients who actually would want that interaction in
24 those early hours of the morning, for instance. And
25 again, it's through that conversation with patients

1 about how this can be used for them in their best
2 interests around their care.

3 And I think, if you're -- again, this is an example,
4 but if you're using the technology at night and you're
5 able to conduct your observations quicker and you notice
6 that actually, Patient A in room 3 is awake, that
7 enables you then to be able to spend more time with that
8 patient who is awake at that point, that may want that
9 therapeutic engagement.

10 **MR GRIFFIN:** But the way that you get to the therapeutic
11 engagement is by using the remote observation function?

12 **A.** If appropriate for that patient.

13 **MR GRIFFIN:** Chair, we've reached a convenient moment for
14 the mid-morning break. May I suggest that we return at
15 11 o'clock.

16 **(10.45 am)**

17 **(A short break)**

18 **(11.02 am)**

19 **THE CHAIR:** Mr Griffin.

20 **MR GRIFFIN:** Ms Cozens. Dealing with the feature of the
21 technology which allows 15 seconds of viewing, whether
22 or not a spot measurement is taken, why has the product
23 been designed in that way?

24 **A.** So I think there are two aspects to that. So the first
25 is that you're taking a pulse and respiration rate of

1 somebody, and therefore you need to ensure that that is
2 the person that you're expecting to take those
3 measurements from. And also, to assure yourself that
4 that person is safe and well before taking those.

5 **Q.** Ensuring the person is safe and well before taking the
6 vital signs measurements, is that tied up with the two
7 measurements the staff member is about to take, or is
8 that a form of remote observation and therefore
9 potentially separate?

10 **A.** So you're checking, as part of taking those vital signs,
11 the system asks you two questions in order to be able to
12 take those vital signs, and one of those questions is:
13 is the person still? So you're checking that that
14 person is still when you're going to take those vital
15 sign measurements.

16 **Q.** I think you explained to us that the system has
17 difficulties in capturing vital signs or may not be able
18 to capture vital signs if a patient is moving around in
19 their bedroom?

20 **A.** Correct, yes.

21 **Q.** Do you recognise the possibility for abuse inherent in
22 that aspect of the design, for example viewing when not
23 warranted medically or otherwise? That aspect of the
24 design is the ability to look at the patient for
25 15 seconds with a clear view?

1 **A.** So I accept that that is a possibility. I would also
2 like to think that staff that we have working within
3 inpatient services would not -- aren't bad actors. So
4 they wouldn't be doing that for any other purpose.
5 I think, with the reports that we can provide to
6 organisations, it will allow them to look for trends in
7 how the system is being used in order to ask the most
8 appropriate questions around governance of the use of
9 the systems within organisations, and I think, with the
10 safeguards that are in place, and I know we've touched
11 upon one of those around user authentication, and
12 whether an organisation sees fit to put this part of the
13 system behind user authentication.

14 And I think we also heard, when we heard evidence
15 from the Senior Nurse at Leicestershire Partnership NHS
16 Trust around a safeguard that we'd developed alongside
17 Leicester and that was the vital sign attempt
18 notification as well.

19 **Q.** Which we'll come on to discuss because I think you
20 address that or you set that out in your fourth
21 statement; correct?

22 **A.** Yes, correct.

23 **Q.** Sorry, just as a side question to this, I noticed that
24 some of the more recent vital signs monthly usage
25 reports no longer display or give data for both the

1 number of vital signs attempts, and the number of
2 successful vital signs taken. So it's no longer
3 possible to make a comparison between the two to see if
4 there's a discrepancy of concern.

5 Now, is that a decision that has been taken
6 Oxehealth, and if so, why?

7 **A.** I'm not aware of that change. I would have to go and
8 have a look at a more recent usage report.

9 **Q.** Thank you. We may get back to you separately about
10 that.

11 **A.** Yeah.

12 **Q.** Have you been involved in or attended any meetings with
13 regulators such as NHS England or MHRA in which concerns
14 about this design aspect have been ventilated?

15 **A.** I don't believe so. I think I may have been involved in
16 a meeting many years ago with the Care Quality
17 Commission, but off the top of my head I can't think of
18 any other meeting involving NHS England or MHRA.

19 **Q.** Are you speaking from your personal point of view rather
20 than from that of LIO?

21 **A.** Yes, that's correct.

22 **Q.** So are you unable to address the question from the
23 possibility that someone else at LIO may have had such
24 meetings?

25 **A.** They may well have done, yes.

1 **Q.** Thank you. Just coming back to nighttime use of this
2 technology, please. You said this in your fourth
3 statement at paragraph 45. You say:
4 "Oxevision supports protected sleep by providing
5 non-disturbing nighttime checks for all patients across
6 a ward."
7 And the word there is "checks". Just going back to
8 a point we were addressing before the break, what does
9 "checks" mean, in this context?
10 **A.** I think what I mean by that is those non-disturbing
11 nighttime observations. And again, I suppose there's
12 a slight correction for "all patients across the ward
13 where appropriate."
14 **Q.** That could be either remote observations or spot checks,
15 or both?
16 **A.** That's correct.
17 **Q.** Thank you.
18 I'd like to also return to you about the question of
19 the financial benefits that might follow from the use of
20 the system. Now, I accept what you said earlier that
21 the benefits from this technology are not just
22 financial, and as I've said, we'll come on to talk about
23 that. But last year we touched on the Early Insights
24 and Implementation Lesson Learned Report for two of the
25 Oxevision pilot wards. And you mentioned in your first

1 statement, it's paragraph 89, that:

2 "In August 2020, together with EPUT, Oxehealth
3 produced an 'Early Insights and Implementation Lesson
4 Learned' report for Peter Bruff and Ardleigh [wards].
5 The Oxehealth system was installed in all rooms on both
6 wards and went live in April 2020. To identify early
7 insights and implementation learning, data was collected
8 in the form of patient questionnaires ... focus groups
9 (staff and patients), and 1:1 staff interviews."

10 Do you think it's appropriate for Oxehealth to have
11 been so involved in producing key documents such as this
12 for its customers, given its own commercial interest in
13 demonstrating successful implementation?

14 **A.** So I think Oxehealth provided samples, templates of
15 patient surveys, questionnaires. And this was to help
16 assist organisations, and they were free to amend,
17 change or use where they saw appropriate.

18 **Q.** So your recollection is that the Oxehealth assistance
19 only went so far, for example the provision of
20 templates, but didn't go beyond that?

21 **A.** That is correct, I think. I think the head of our --
22 and again, this is from -- I wasn't involved in this,
23 this is from sort of information that I've been able to
24 collect -- I believe our Head of Insights and Benefits
25 Realisation at the time may have been involved in some

1 of those meetings when discussing the outcomes of those
2 reports.

3 **Q.** Would you agree that it wouldn't be appropriate for the
4 involvement of Oxehealth to have gone beyond the
5 provision of some template documents?

6 **A.** I agree, yes.

7 **Q.** The co-produced report that resulted included this
8 finding:

9 "There are early signs the system is delivering
10 operational value. Early evidence suggests that the
11 Oxehealth system is delivering operational efficiencies
12 through fewer avoidable close observations, positive
13 risk taking in stepping down observation levels, and
14 faster observation rounds." [As read]

15 We've also seen early documents from EPUT envisaging
16 a reduction in bank and agency staff and spend with the
17 implementation of Oxevision.

18 Do you accept that Oxehealth represented to EPUT and
19 to other Trusts that Oxehealth could enable staff
20 observations to be reduced or produce staffing or
21 financial efficiencies?

22 **A.** I think when we're talking in relation to the reduction
23 of observations, I think that's in the reduction of
24 observations that have had to be put in place due to
25 an incident that has happened. So, again, let me try

1 and give you an example. So, if the use of Oxevision is
2 able to assist staff in intervening in preventing an
3 older person from falling, then we're preventing
4 a possible one-to-one that may have happened, had that
5 fall happened and that person needed to go to hospital,
6 et cetera.

7 **Q.** May I see if I've understood that. Are you saying that
8 the reduction in rates of patient safety events would
9 mean that there is not the need for staff that there
10 would otherwise have been?

11 **A.** Yeah, so there's avoidable -- if you can stop incidents
12 happening and avoiding those one-to-ones that may have
13 to occur due to incidents happening.

14 **Q.** Can we move, then, on to reductions in rates of patient
15 safety events. You've previously pointed to these
16 reductions resulting from providers' use of Oxevision.
17 My understanding was that in addition to the benefit
18 this would confer in terms of patient safety, there
19 would be not just staff saving but financial saving as
20 well; is that correct?

21 **A.** I think this goes back to the point that I was just
22 making around those avoidable one-to-ones. So a ward
23 will have a staffing establishment, and normally, if you
24 have a -- one patient on a one-to-one observation, you
25 will incorporate that within that staffing

1 establishment. However, if you've got two, three, four
2 patients on one-to-ones, you're now having to find extra
3 staff in order to be able to carry out those extra
4 one-to-ones.

5 So therefore, if you're avoiding an incident that's
6 occurring, you're avoiding that one-to-one, and you're
7 avoiding having to find extra staff over and above that
8 establishment for that ward group.

9 **Q.** Thank you.

10 **THE CHAIR:** That's quite a specific incident -- sorry, quite
11 a specific use of the system, so it's about falls,
12 probably, in older people. Can you think of any other
13 examples where that -- any other part of the functions
14 that might also end up with having to do less
15 observations?

16 **A.** So I think, as you've said, that's one example of the
17 benefits of the system within older adults, the
18 prevention of falls. Again, I think we heard from Chess
19 Denman yesterday around the benefits for seclusion,
20 within PICU wards, so Psychiatric Intensive Care Wards,
21 where there tends to be a higher rate of seclusion. So
22 avoiding harm to others. That may be other patients, or
23 staff being injured because again, if staff have been
24 injured, they would need to go off-duty and you're going
25 to need to replace those members of staff.

1 I think within eating disorders, again, from the
2 point of view of being able to use the activity monitor
3 from -- and again, these are just examples, from someone
4 that's overexercising, health-based place of safety,
5 then again, quite often these patients or these people
6 are unknown, and trying to work out whether -- and
7 again, I think Chess Denman said it yesterday -- around
8 people within health-based places of safety, is there
9 something physical going on that you need to be aware
10 of? Or they may be under the influence of alcohol or
11 illicit substances.

12 **THE CHAIR:** In the case of seclusion and places of safety,
13 what is the specific capability of the system that
14 you're relying on?

15 **A.** So it could be the alert function of the system. So, if
16 there's an en suite bathroom, if somebody's gone in
17 there for a prolonged period, that may be of assistance.
18 The taking of the contact-free vital signs, so
19 somebody's pulse and respiration rate. Again,
20 reiterating what Dr Denman said yesterday around NEWS2.
21 Where possible you would always want to take a full
22 NEWS2 score if that was clinically necessary. But if
23 you weren't able to enter that room for risk to staff,
24 or from -- or it's just not suitable for that patient,
25 if that patient started to calm down but by staff

1 entering that room, that's going to escalate that
2 patient again.

3 **THE CHAIR:** But that's not going to end up saving
4 observation time, is it? It's not going to replace
5 somebody having to observe somebody full time?

6 **A.** No, not in that case, because those patients within
7 seclusion and health-based places of safety should be on
8 one-to-one observations and there are guidelines for
9 that. But again, that possible prevention of harm.

10 **MR GRIFFIN:** Can we just stay, since we're now talking about
11 specific settings, I said I was going to ask you
12 a little bit more. Can we do that now. I think you've
13 largely covered it, but one of the areas I was going to
14 ask you about is whether there may be a particularly
15 strong argument for the use of Oxevision in certain
16 specific settings.

17 We've just been talking about seclusion and rapid
18 tranquilisation. I don't have much more to ask you
19 about that, because you've just been discussing it with
20 the Chair. I think one of the points that Dr Denman
21 made yesterday is that in this kind of setting, there
22 could be a role for Oxevision, but you'd want it to be
23 for as short a period as possible because you'd want to
24 get in to be with the patient as quickly as possible.
25 Would you agree with that?

1 **A.** Of course. Seclusion should be for the shortest amount
2 of time possible.

3 **Q.** And the use of vital signs as opposed to a staff member
4 actually being with the patient? That should be for as
5 short a time as possible as well?

6 **A.** Yes. Yes, I agree.

7 **Q.** Another area I asked Dr Denman about in case the similar
8 principles apply, was Psychiatric Intensive Care Units.
9 What would you say about those?

10 **A.** Again, I would agree with what Dr Denman said yesterday
11 in relation to what you quite often see within PICU
12 wards, Psychiatric Intensive Care wards, is a higher
13 rate of seclusion compared to general acute settings.

14 **Q.** So similar principles apply to those we've just been
15 discussing?

16 **A.** Yes.

17 **Q.** Thank you.

18 Health-based places of safety which you've touched
19 on already and, as you've said, Dr Denman noted that
20 sometimes you wouldn't know -- have the physical health
21 background for a patient. Would you say that similar
22 principles apply there as well?

23 **A.** Yes, that's correct.

24 **Q.** And falls and older people's mental health. I just want
25 to make sure I've given you the opportunity to develop

1 as you would wish the point about the benefit that
2 Oxevision could afford in that kind of context.

3 Before you do, Dr Denman, I think, said that there
4 was a role in relation to older adults but probably less
5 so to those that are younger. Would you address that in
6 your response?

7 **A.** Yes, so I think my understanding of the evidence that we
8 heard yesterday was also within CAMHS units from
9 a safeguarding point of view, and again, the system
10 being able to -- so the alert function of the system,
11 especially where we still have mixed-sex wards, and
12 sexual safety of patients.

13 So the system having the ability to be able to alert
14 staff that there are multiple people within a room, and
15 I think I've highlighted CAMHS wards there, but I think
16 that goes across any setting within inpatient services
17 where you've got those possible safeguarding concerns.

18 **Q.** Are there any other specific settings where you might --
19 that you might put forward as particularly appropriate
20 for the use of this kind of technology?

21 **A.** I think we've highlighted an example of those settings,
22 and I think it would be interesting to look at, again
23 referring back to EPUT's evidence around their incident
24 data, it would be interesting to look at those incidents
25 in more detail around was there any particular settings

1 that stood out from their data, but also, other Trusts'
2 incident data as well.

3 **Q.** Well, I will tomorrow be asking some questions about
4 that with the EPUT witnesses although, as I understand
5 it, there may be an absence of hard data about it, but
6 that's something I can ask about tomorrow.

7 We were talking about reductions in patient safety
8 events. Can we come back to that now.

9 **A.** Mm-hm.

10 **Q.** Overall, as we've seen, the health statisticians
11 concluded that there's no strong independent evidence of
12 cost effectiveness arising from the use of VBPMs, such
13 as Oxevision in mental health settings. I'd like to
14 look at part of what they've said, please.

15 Could you put up the EHS report and page 4, and
16 expand the second bullet point. Can we see, therefore,
17 that they've said this:

18 "Some studies and economic models report favourable
19 findings following implementation of Oxevision,
20 including suggested reductions in adverse incidents,
21 observation requirements or staffing costs. However,
22 these findings should be interpreted cautiously. They
23 do not provide robust evidence that Oxevision caused
24 reductions in self-harm, ligatures, assaults, falls, or
25 other safety outcomes. Nor do they establish that

1 reported cost savings would be realised consistently
2 across NHS mental health services. Several economic
3 conclusions depend on uncertain assumptions,
4 particularly around reductions in enhanced observation
5 hours and the transferability of local data to wider NHS
6 settings."

7 Can I ask you to confirm whether LIO accept the
8 current limitations in the evidence base as addressed
9 there?

10 **A.** I think that's fair, and again, I think that reiterates
11 the point around further research and as we've discussed
12 earlier this morning, that's one thing that we do
13 support.

14 **Q.** So this might be one of the areas that has spurred LIO
15 on to make this recommendation about the need for
16 further research?

17 **A.** I think that's one of the areas.

18 **Q.** One of the areas, thank you.

19 **A.** Yeah, I think it's important, again, to talk about those
20 real-world examples, and again, I'm not claiming that
21 the real-world examples constitute independent
22 scientific research, or evidence, but I don't think we
23 should dismiss them.

24 **Q.** But you're saying that's a pool of information to which
25 it's appropriate to have regard?

1 **A.** Yes.

2 **Q.** Thank you.

3 Would you take that down, please.

4 You've said a moment ago that where possible, you'd

5 always want to take the full NEWS2 measurements. Can we

6 come on to vital signs and NEWS2 now, please.

7 I'd like to raise with you one aspect of, as the

8 health statisticians put it, reductions in adverse

9 incidents. That is the extent to which the vital signs

10 measurements or other features of Oxevision are

11 meaningful in the context of either physical or mental

12 health. We've heard from Dr Denman and Ms Archibald of

13 the importance of the full six NEWS2 measurements and

14 I think you accept that.

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

16 **Q.** We touched on this last year when you said that two

17 vital signs, I think the way you put it, were relevant,

18 but as part of a bigger picture. Do you remember that?

19 **A.** I do.

20 **Q.** Dr Denman has suggested that any measure that is not the

21 NEWS2, for example just pulse and respiration, must be

22 treated with great caution, and the NEWS2 should be

23 preferred if at all possible. Would you agree with

24 that?

25 **A.** I do agree, but I think Dr Denman also said yesterday

1 that, actually, if it was a choice between no
2 measurements compared to having the two measurements of
3 pulse and respiration rate, then she would take those.

4 **Q.** Would you agree with that particular point?

5 **A.** I do, yes.

6 **Q.** Thank you.

7 As we heard yesterday, Dr Denman also cast doubt on
8 the utility of intermittent irregular four-hourly
9 checks. Now, this is in the context of observations
10 generally, rather than specifically the use of
11 technology. And that was on the basis that they are too
12 infrequently -- they are too infrequent to interrupt an
13 act of serious self-harm in time.

14 Do you have a view on that?

15 **A.** I do, from a nursing point of view.

16 **Q.** Yes.

17 **A.** And I think, again, it's important to highlight that
18 Dr Denman said yesterday that her view was
19 controversial --

20 **Q.** Yes.

21 **A.** -- and may not be shared by others. I think observation
22 practice within mental health inpatient services isn't
23 just a practice that happens in the UK; this is
24 a practice that happens worldwide. And it's well
25 established, it's widely recognised, and I think

1 yesterday we saw extracts from the Code of Practice as
2 well as CQC. So the regulators refer to it.

3 I think I would welcome a review of observation
4 practice, particularly if it considers how observations
5 can be more meaningful, reliable and therapeutic. And
6 I think it's also important to highlight that quite
7 often, when we look at Prevention of Future Deaths
8 reports, so PFD reports, observation failure is often
9 mentioned within those. And I think it's important to
10 look at, as a profession, what can we do to enhance that
11 practice? Yeah.

12 But I also think it's important to consider what
13 Professor Soar said last week in relation to the
14 possible risk of overnight and unobserved periods of
15 time, and that that carries a risk of deterioration and
16 cardiac arrest and death going unnoticed.

17 **Q.** Thank you. I mean, that last point we need to balance
18 against the point you made previously about
19 inappropriate circumstances, not disturbing patients at
20 night?

21 **A.** Yes.

22 **Q.** Thank you.

23 Dr Denman also suggests that the vital signs
24 function may not help with detecting the first signs of
25 self-strangulation or self-harm. Is that something you

1 accept?

2 **A.** I do accept, and I think it's important that Oxevision
3 does not claim to be -- that it's a full NEWS2 reporting
4 system, or that it's a self-harm/ligature detector.

5 **Q.** We've sort of skirted this question but can I ask it now
6 expressly. Dr Denman, as you heard yesterday, believes
7 that nighttime checks of pulse and respiration alone add
8 nothing to the clinical management of a sleeping
9 patient. Do you agree with that?

10 **A.** As a nurse, no, I don't. And I think it's important to
11 possibly highlight, and I think Dr Denman did do this
12 yesterday, that it's nurses and healthcare assistants
13 that conduct those observations and are responsible and
14 have that duty of care for patients on wards and
15 consultant psychiatrists only spend very brief periods
16 of time on wards.

17 **Q.** So from a different -- from a nurse's perspective, you
18 see utility in these checks at night?

19 **A.** I do, yes.

20 **Q.** Thank you.

21 I'd like to look now at a recent Instructions for
22 Use or IFU document, please. It's the Oxehealth
23 Instructions for Use for Oxevision Activity Tracker
24 dated 30 April 2025.

25 First of all, would you just clarify what the

1 Activity Tracker is?

2 **A.** So the Activity Tracker part of the Oxevision system is,
3 it's basically the alerts and warnings and room states
4 feature of the system, and it provides various reports
5 of a person's activity within of the room.

6 **Q.** So a big part of it is the alerts and notifications
7 function of Oxevision?

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

9 **Q.** Is there a separate vital signs IFU?

10 **A.** Yes, there is.

11 **Q.** So there's two IFUs: one Activity Tracker and one vital
12 signs; is that correct?

13 **A.** Yes, and there is a draft version of an IFU for the
14 OxeObs as well.

15 **Q.** Thank you very much.

16 Are IFUs produced by Oxehealth for providers?

17 **A.** Yes, that's correct.

18 **Q.** Right. I said I want to look at something.

19 Could you put up EPUT020916, page 4. This is from
20 the, as I said, the -- a recent Oxevision Activity
21 Tracker IFU. Can we just read parts of it, and I want
22 to ask you about them?

23 "The Oxevision Activity Tracker product is not
24 a patient monitor or a vital signs monitor."

25 Now, that shouldn't be too controversial, because as

1 you've said, there's a separate IFU for vital signs?

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

3 **Q.** "Its outputs do not indicate whether an individual is

4 alive nor does it give any indication of the health or

5 safety of an individual. The product cannot be used to

6 determine whether an individual is dead."

7 So that's the Activity Tracker. Can the vital signs

8 function, as opposed to the Activity Tracker, actually

9 determine if an individual is alive or really give an

10 indication of an individual's health or safety?

11 **A.** So the vital signs function allows you to take that

12 contact-free pulse and respiration rate within certain

13 parameters. So it will only give a measurement where it

14 is assured. So it doesn't -- it doesn't give you any

15 notification or alert to somebody's physical health

16 deteriorating, currently.

17 **Q.** So at the moment, at least, neither the Activity Tracker

18 nor the vital signs function are of particular utility

19 in determining if an individual is alive or really give

20 an indication of an individual's health or safety; would

21 you agree?

22 **A.** So I think the vital signs function, so those spot-check

23 measurements and the vital signs trend function, can

24 give you an idea around the pulse and respiration rate

25 of somebody. So if that is trending upwards or

1 downwards or off of somebody's baseline, it will give
2 you an idea that you may want to complete further
3 investigations.

4 **Q.** So the parameters, if I've got this right, "Vital signs
5 will only record pulse rates between 50-130 beats per
6 minute."

7 Oh, I'm not trying to put you on the spot.

8 **A.** Okay.

9 **Q.** I'm going to make suggestions to you. If, later, you
10 want to correct them, please do. I think I've got this
11 right, though.

12 It will only record pulse rates between 50-130 beats
13 per minute and breathing rates from 8 to 39 breaths
14 a minute; does that sound about right?

15 **A.** It does, yes.

16 **Q.** So it won't measure outside those parameters?

17 **A.** That's correct.

18 **Q.** Now, we talked about vital signs trends last year. Is
19 it "trends" or "trend"?

20 **A.** Trends.

21 **Q.** My recollection is this, please tell me if I've got this
22 wrong: the vital signs spot checks take measurements to
23 a medical grade; is that correct?

24 **A.** That's correct.

25 **Q.** The same cannot be said for vital signs trends; is that

1 correct?

2 **A.** That's correct, it's an average.

3 **Q.** It's taking measurements in the background, if it's able
4 to get sufficient measurements, and producing an
5 average?

6 **A.** That's correct, over a five-minute period.

7 **Q.** Over a five-minute period. So that's a form of data but
8 of less medical significance than the spot checks?

9 **A.** Yes, however, as a clinician, if you were looking at
10 that, that may give you a -- it may give you an
11 indication, as a clinician. And I think, if I can take
12 an example from Dr Denman's evidence yesterday around
13 rapid tranquilisation and the effect that certain
14 antipsychotic medications can have on somebody's
15 respiratory system. So if you were looking at the vital
16 signs trend, and again, that was trending downwards or
17 upwards, again, it would give you an indication as
18 a clinician that you may want to do an actual spot-check
19 measurement for that medically accurate measurement.

20 Or, doing a full NEWS2 score, for instance.

21 **Q.** But taken on its own, the vital signs trend data
22 shouldn't be relied on for clinical decision making?

23 **A.** No.

24 **Q.** Can we just read on, please:

25 "The Oxevision Activity Tracker product is

1 a Clinical Decision Support System intended to provide
2 additional information to support risk management and
3 care planning and must not be used as the sole basis for
4 making any decisions or recommendations relating to
5 clinical diagnosis, subject care or treatment."

6 Is there an equivalent paragraph in the vital signs
7 IFU too? Just the bit that I've read?

8 **A.** Without it in front of me, but I would expect there
9 to be.

10 **Q.** So with that caveat. I understand, thank you.

11 Just reading on:

12 "Relying on viewing a room using Oxevision Activity
13 Tracker only without completing a full assessment of
14 a situation could result in your subjects coming to
15 harm. Decisions or recommendations must be made by
16 a clinician based on broader evidence and knowledge than
17 the Oxevision Activity Tracker alone provides."

18 Now, that refers to using the Activity Tracker to
19 view a room. Do you know what was being referred to
20 there?

21 **A.** I believe that may be referring to when an alert is
22 triggered, staff have got the ability to be able to view
23 room, which gives staff access to a 15-second blurred --
24 and when I say "blurred", I mean pixelated -- view of
25 the room, or to reset that alert. That's what I believe

1 that's --

2 **Q.** So that's access to the blurred --

3 **A.** -- (overspeaking) --

4 **Q.** -- view that a staff member can access if an alert or

5 a notification has gone off?

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

7 **Q.** Not referring to the conduct of remote observations, as

8 far as you're aware?

9 **A.** Not as far as I'm aware.

10 **Q.** Just reading on:

11 "Oxevision Activity Tracker is only intended to

12 alert you to patient activity, posture, presence and

13 location and does not alert you to potential hazards to

14 the patient. Reliance on the Oxevision Activity Tracker

15 to provide alerts to risks of harm to individuals could

16 result in them coming to serious harm. Please observe

17 your organisation's existing safety checking protocols

18 and do not rely on the absence of Oxevision Activity

19 Tracker alerts as a means of establishing the health or

20 safety of individuals."

21 One point arising there is that the Activity Tracker

22 is not meant to alert to potential hazards? Is that

23 accurate?

24 **A.** Yes. It alerts you to, as it says in first sentence, so

25 patient activity, posture, presence, and/or location.

1 **Q.** Does all of what we've just read and the discussions
2 we've just been having suggest that the role of the
3 Activity Tracker is quite limited?

4 **A.** No, I disagree with that on the basis of the alerts and
5 warnings aspect of the Activity Tracker and also, from
6 the point of view of the activity report that it
7 provides, and personal experience that I've had in the
8 past of using those reports with patients as part of
9 care planning and interventions, et cetera.

10 **Q.** Thank you. Would you take that down, please.

11 I've been focusing more on physical health than
12 mental health. What would you say Oxevision's role is
13 in addressing mental ill-health specifically?

14 **A.** So again, referring to the Activity Tracker, part of the
15 system and the alerts and warnings in relation to
16 possible high-risk situations. I think using the
17 activity reports as part of patients' care if patients
18 are self-isolating within their rooms, again, being able
19 to have those conversations with patients. I think, for
20 some patients, again from the Activity Tracker point of
21 view, there may be elements of patients' behaviour in
22 relation to relapse signatures, triggers, et cetera,
23 that the Activity Tracker may be beneficial for.

24 **Q.** So for example, the alert that goes off if a patient
25 spends more than three minutes in their bathroom?

1 **A.** Yes.

2 **Q.** Is that the kind of thing you're talking about?

3 **A.** Yes, or again, an alert for somebody that has spent

4 a prolonged period of time around a doorway, or that

5 multiple people alert to -- alerts that there are

6 multiple people within a room from a safeguarding point

7 of view.

8 **Q.** For the reasons you've already explained?

9 **A.** Yes.

10 **Q.** Can you point to anything that the vital signs function

11 does that's specific to mental health as opposed to

12 physical health?

13 **A.** So I think there's a slight overlap, and again, I think

14 going back to what Dr Denman said yesterday around some

15 of the medications that are used within psychiatry and

16 the effect that that can have on somebody's physical

17 health. So the overlap is you're treating someone for

18 their mental health but that has an impact on their

19 physical health, certain types of medication. And also,

20 around the physical health of some of our mental health

21 patients, and their comorbidities that go alongside

22 that.

23 **Q.** Thank you.

24 Ms Archibald has suggested with regard to treatment

25 outcomes that she's not seen evidence that VBPMs

1 directly influenced individual patient care in
2 a systematic or clearly documented way.

3 She adds that:

4 "The data it produces does not in itself demonstrate
5 that VBPMs improved treatment outcomes or informed
6 clinical decision making for individual patients." [As
7 read]

8 Do you accept that?

9 **A.** I think that the use of the system, it's an added piece
10 of a bigger puzzle, I guess. So it can help provide
11 information that clinicians didn't have access to, and
12 I think any added information or data on a patient's
13 health and wellbeing that could provide clinicians'
14 assistance when thinking about things like discharge
15 planning. So again, an example of this might be the
16 sleep monitoring aspect of our system. As a clinician,
17 utilising the sleep monitoring in ensuring that
18 somebody's sleep pattern is back to what is normal for
19 them prior to discharge.

20 **Q.** Thank you.

21 Ms Cozens, is the reality that Oxevision's real
22 utility is as a remote observation system, saving staff
23 time and cost by allowing staff to observe patients
24 through a screen or tablet without having to go to their
25 rooms?

1 **A.** No, I disagree with that. When you're talking about
2 saving staff time, again, an example, if we look at the
3 OxeObs module of the system, and we look at what happens
4 where staff are still utilising pen and paper, there is
5 an admin burden to that. So all of those observation
6 records that are completed on paper have to be scanned,
7 uploaded, relevant uploads into a patient's electronic
8 health records, and the aspect of utilising the OxeObs
9 module takes that away. Staff no longer have to do
10 that.

11 So it's freeing up time from that point of view.

12 **Q.** Thank you.

13 **A.** That's one example.

14 **Q.** Now we've heard a lot in recent evidence about -- and
15 indeed in past evidence -- about Oxevision being
16 assistive technology. And you refer again, in your
17 fourth statement to the fact that "It's assistive
18 technology" -- sorry, this is paragraph 10:

19 "... designed to augment clinical awareness and
20 clinical judgement."

21 And you say in paragraph 11 that it's:

22 "... not intended to replace staff presence or
23 therapeutic engagement nor to reduce staffing."

24 First of all, do you maintain that now?

25 **A.** Yes.

1 **Q.** Thank you. Both Dr Denman and Ms Archibald have raised
2 the same point, essentially, and it comes down to this:
3 in essence, it's that there is a clear tension between
4 any suggestion on the one hand that the technology would
5 save staff time and cost, and on the other that it was
6 only to be used as an assistive technology. Do you
7 accept that there is or there would be a tension in
8 claiming simultaneously that the technology was both
9 assistive and would save providers money?

10 **A.** Again, I think referring back to my last example around
11 the admin burden of uploading observation records --

12 **Q.** Can you think of -- that's noted, the efficiency
13 afforded by Oxevision observations. Can you think of
14 any other areas where we see that?

15 **A.** Again, I think I spoke about this earlier around the
16 alerts and warnings part of the system. If you can
17 prevent patient safety incidents occurring, that is not
18 only of benefit to the patient, but also to an
19 organisation from -- and again, an example of that would
20 be a patient not having to attend a general hospital for
21 treatment due to a self-harm incident.

22 **Q.** So by avoiding an incident you're avoiding all of the
23 extra staff, time and indeed financial cost that would
24 be associated with it? Isn't that the point in
25 a nutshell?

1 **A.** Yes.

2 **Q.** Thank you.

3 In her report, Ms Archibald says this:

4 "If staff were to complete observations and

5 engagement properly, and if a designated staff member is

6 also required to monitor Oxevision alerts or alarms,

7 respond to them, review pixelated images where

8 appropriate, and undertake face-to-face checks, this may

9 increase rather than reduce the workload." [As read]

10 Do you agree with that?

11 **A.** I think that's Ms Archibald's view. It is not a view

12 that I have heard, or from anybody else.

13 **Q.** But is it one with which you would agree?

14 **A.** Not necessarily.

15 **Q.** "Not necessarily" leads to further questions, doesn't

16 it? Perhaps the fairest way of dealing with it is just

17 to ask you what you mean by "not necessarily"?

18 **A.** Could you repeat for me the first bit?

19 **Q.** Yes, of course.

20 **A.** Thank you.

21 **Q.** So she says in her report this:

22 "If staff were to complete observations and

23 engagement properly, and if a designated staff member is

24 also required to monitor Oxevision alerts, alarms,

25 respond to them, review pixelated images where

1 appropriate, and undertake face-to-face checks, this may
2 increase rather than reduce the workload." [As read]

3 **A.** So I think it's ... it would depend on an organisation's
4 Standard Operating Procedure about how the system is
5 used in practice, but quite often, what I've heard from
6 providers is the person that is designated to do those
7 general obs, so those maybe once-an-hour obs, is the
8 designated person that would carry the Oxevision tablet
9 with them, so their role in completing those general obs
10 would also be to respond to those alerts and warnings
11 where necessary.

12 **Q.** But my question -- I understand what you said and thank
13 you for it. My question was really for your view.
14 Maybe I could put it in this way: do you see that
15 correct usage of the technology could actually add to
16 staff time rather than reduce it?

17 **A.** I think correct usage of the system can assist staff in
18 what they're doing. I don't think that necessarily adds
19 time to what they're already doing.

20 **Q.** But it may not save time?

21 **A.** I suppose there's a possibility of that. Yeah, there's
22 a possibility of that with anything, depending on that
23 ward environment.

24 **Q.** Thank you.

25 I just want to come back to a point that you touched

1 on earlier and I said I'd come back to. You've said in
2 your fourth statement, this is paragraph 14, that:

3 "... the value of implementing Oxevision is not
4 limited to potential cost savings, and a range of other
5 anticipated benefits were also identified. These
6 broader considerations have informed decisions by
7 organisations to purchase Oxevision and in some cases to
8 renew existing contracts."

9 We've spoken already about the use in certain
10 settings. Is there anything else that you suggest the
11 Inquiry should consider in terms of benefits beyond cost
12 saving?

13 **A.** Yes, I think, again, reiterating around the patient
14 safety aspects, the earlier awareness of risk, the
15 additional clinical information that it provides staff,
16 the reliable taking OxeObs, for instance, the reliable,
17 auditable log of observations, and again, I think
18 I highlighted that we quite often see observation
19 failure within Prevention of Future Deaths reports;
20 supporting staff to prioritise attention where needed.
21 I think that's all that I would add.

22 **Q.** The Inquiry has considered several illustrative cases
23 where the intended benefits of the VBPMs have not arisen
24 as anticipated.

25 Do you think this shows it cannot work, or rather

1 that better understanding is required?

2 **A.** Sorry, can you repeat that?

3 **Q.** The Inquiry has considered several illustrative cases

4 where the intended benefits of the vision-based

5 monitoring system have not arisen as anticipated. So I

6 suppose an example might be where the vital signs clear

7 view function was used not to take spot checks but to

8 remotely observe a patient, for example.

9 Do you think this shows it cannot work or rather

10 that better understanding is required?

11 **A.** I don't believe that it shows that it cannot work.

12 I think there needs to be better understanding, better

13 guidance, from organisations about how they expect their

14 staff to utilise the system in practice.

15 **Q.** Overall, do you think the responsibility for correct use

16 of the system lies with the Trusts or does LIO have

17 a role?

18 **A.** I think -- Oxehealth are the manufacturer, I think we

19 have a responsibility in relation to ensuring that staff

20 know how to use the product and what it does and does

21 not do. But I think it is the organisation's

22 responsibility about how the system is used in clinical

23 practice. They are best placed to make that decision

24 with a wide range of internal stakeholders.

25 **Q.** I'll come back shortly just to ask you a little bit more

1 about that particular point.

2 I think we may have covered this already, I just
3 want to give you the opportunity to address it further
4 if you want to, the vital sign attempt notification,
5 which was developed following a request from
6 Leicestershire Partnership Trust, and we heard about
7 that from the LPT witness in July.

8 Is there anything more you'd like to tell us about
9 that?

10 **A.** So I think here is a clear example of an organisation,
11 a provider who has thought about potential concerns that
12 they may have around how the system is used, and how
13 working collaboratively with them in the development of
14 an added feature of the system, which will help them in
15 relation to that concern. So the development of the
16 vital sign attempts notification basically was there to
17 deter over-use of the vital signs feature, and it would
18 provide live management escalation, should this happen
19 in practice.

20 **Q.** But it did require a Trust to come to LIO rather than
21 LIO building it in as a safety feature from the start?

22 **A.** I think it's an example of Oxehealth working with
23 clinicians and taking that feedback from clinicians.
24 And, I have to say, that was the only -- if I remember
25 rightly, it was the only organisation that had raised

1 this, and this was due to an ongoing issue that had been
2 raised within that Trust. There was another issue that
3 had happened where --

4 **Q.** Well, I think in that Trust, there was concern that
5 a person might be able to be observed undressing, and
6 that led LPT to liaise with LIO to come up with the
7 solution.

8 **A.** That's correct. I also believe that there were other
9 things going on within that Trust --

10 **Q.** -- (overspeaking) --

11 **A.** -- as well.

12 **Q.** Is it -- but are you suggesting that LIO were not aware
13 of concerns arising from the misuse of the vital signs
14 function until LPT asked for assistance?

15 **A.** No, that's not what I'm suggesting. I think we, as
16 a responsible technology company, try and look at every
17 eventuality. However, building products or modules or
18 safeguards within technology isn't something that can
19 just be done overnight. These things take time to
20 develop, and we always like to ensure that we're having
21 a range of conversations with our partners, that we're
22 not just -- trying to get to the bottom of what it is
23 that that provider wants, and seeing whether that view
24 is shared amongst other organisations.

25 **Q.** Thank you.

1 I want to move on to a new topic, please, and that's
2 data protection. We covered the data generated by
3 Oxevision last year and before we go any further, can
4 I just ascertain from you the extent of your knowledge
5 of data protection matters.

6 Now, your first statement deals with a little detail
7 about the data that the system produces, and we spoke
8 about data protection matters this time last year. But
9 how would you describe your knowledge of the data the
10 system produces and data protection matters more
11 generally?

12 **A.** So I think it's really important, I'm not the Data
13 Protection Officer. We have a designated person within
14 the organisation, where that is their area of expertise.
15 I'm a Mental Health Nurse by background. I understand
16 some of its principles, but as I've said, I'm probably
17 not the best person, as it's not my area of expertise.

18 I think, just to add, as a technology company, we
19 take our data protection responsibilities seriously and
20 cooperate with the regulatory standards, and all of the
21 customers are provided with a DPIA, Data Protection
22 Impact Assessment, which is regularly reviewed and
23 updated.

24 **Q.** The point you've just made, provided with a Data
25 Protection Impact Assessment, or DPIA, are you referring

1 there to a template that Oxehealth provides to providers
2 for them to then adapt?

3 **A.** So we complete a DPIA that is then given to providers to
4 complete their own DPIA.

5 **Q.** So it may be there's two things we're talking about.
6 Oxehealth's own DPIA?

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

8 **Q.** And then the assistance that Oxehealth affords to
9 providers by providing a template DPIA that they can
10 then complete?

11 **A.** They would -- organisations would -- yeah, have to
12 provide -- have to complete their own DPIA but we
13 identify within our Data Protection Impact Assessment
14 and then it's up to providers to complete their own.

15 **Q.** Perhaps this will become clearer as I ask you my
16 questions. So as we proceed through some questions --
17 I don't have too many -- on data matters, we'll see
18 where we go, but if we get beyond your area of knowledge
19 or expertise, would you let me know, please.

20 **A.** Mm-hm.

21 **Q.** By way of introduction, when we consider data produced
22 by the Oxevision system, are there essentially two
23 categories of data or information that are of particular
24 significance, namely personal data and special category
25 data?

1 **A.** Yes, that's correct.

2 **Q.** In short, is personal data any information relating to
3 an identified or identifiable living person?

4 **A.** That's my understanding.

5 **Q.** And are there rules that apply to the way in which
6 personal data must be treated, for example it must be
7 kept secure, it must be kept accurate, and retained only
8 as long as needed?

9 **A.** That's my understanding.

10 **Q.** And is special category data a subset of personal data
11 that is particularly sensitive, and therefore requires
12 extra protection? For example, does it include
13 personal-data-revealing health data?

14 **A.** That's my understanding.

15 **Q.** I'd like to ask you about the Oxevision blurred view and
16 blurred video data, please. The Inquiry has heard on
17 various occasions about two forms of view that Oxevision
18 affords to staff. We've spoken about them: the clear
19 view and the blurred view; correct?

20 **A.** Correct.

21 **Q.** Does the clear view -- does the Oxevision system produce
22 or create clear view data?

23 **A.** It does.

24 **Q.** And is that the raw video or still footage captured by
25 the automatic operation of Oxevision?

1 **A.** That is correct. So, organisations have the choice of
2 whether to have a Clear Video Data buffer. So the Clear
3 Video Data is on a 24-hour rolling buffer, so it's auto
4 deleted.

5 **Q.** So we discussed that last year. That's -- if a provider
6 signs up for the facility, that's the facility that
7 records and keeps the 24/7 footage created by the camera
8 in a patient's bedroom but only for 24 hours?

9 **A.** Yes, it's auto deleted.

10 **Q.** Unless, within that 24-hour period, for example
11 following an incident, a request is made to keep some
12 of it?

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

14 **Q.** Yes ... sorry to interrupt.

15 **A.** That's okay.

16 **Q.** Can we move then to blurred view. So we've referred to
17 this but that's for up to 15 seconds. As you've said
18 already, when staff receive a notification from the
19 system, they can have up to 15 seconds of blurred view
20 of a patient?

21 **A.** That's correct.

22 **Q.** And does the system create what Oxehealth referred to as
23 anonymised video data?

24 **A.** That is that blurred video.

25 **Q.** That is, again, what I was going to ask you. And again,

1 is that created during the automatic running of
2 Oxevision?

3 **A.** Yes.

4 **Q.** What I'd like you to do, please, is you've provided
5 a 10-second example of blurred video generated in a
6 demonstration environment using an Oxehealth employee.
7 What I'd like to do is look at that clip with you,
8 please.

9 Could we look at -- thank you very much. Just for
10 reference, this is OXHE020945. We may play this more
11 than once if it would be of assistance to people
12 watching it.

13 So could you play the clip, please. Thank you.

14 [Video played]

15 Now, that's footage that's been filmed using the
16 Oxevision camera in the bedroom; correct?

17 **A.** That's correct, that's within our --

18 **Q.** Do we see an individual entering from the left of the
19 screen, moving over and then lying down on the bed?

20 **A.** That's correct.

21 **Q.** I think I am going to ask that that be played once more
22 just because I was talking over it.

23 [Video played].

24 Now, is that clip representative of the blurred
25 video created by the system at EPUT and other providers?

1 **A.** That's my understanding, yes.

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

3 Last year, you explained that Oxehealth does not

4 consider blurred or anonymised video data to be personal

5 data because the patient is pixelated and Oxehealth does

6 not have access to the underlying Clear Video Data; do

7 you remember saying that?

8 **A.** I do.

9 **Q.** Does that remain the position?

10 **A.** Yes.

11 **Q.** Does Oxehealth maintain that it's not possible for it to

12 work out who is in the footage, including matters such

13 as their gender, race or mental health difficulties,

14 from a blurred video?

15 **A.** I don't think that would be possible, yeah.

16 **Q.** In response to concerns raised by the MHRA and

17 NHS England in 2022, an Oxehealth staff member, in an

18 email on 4 January 2022, describes video footage being

19 blurred using a process of Gaussian filter and said:

20 "When the users access this video, these images are

21 of course not necessarily anonymised, from the user's

22 perspective, if they are aware of the identity of the

23 room occupants. The blurring is provided to preserve

24 and maintain privacy and dignity as far as possible."

25 [As read]

1 Would you agree, therefore, that at least from early
2 2022, Oxehealth recognised that the patients in blurred
3 video footage remained identifiable at least to
4 providers?

5 **A.** Yes, I agree with that, because they have various other
6 bits of information that they can put together.

7 **Q.** We've learnt that blurred video data is now considered
8 by EPUT to be special category personal data and I'll
9 ask EPUT witnesses about that tomorrow.

10 Might that cause LIO to change its view about
11 whether or not blurred video data is personal or
12 special-category data?

13 **A.** That would be a question for our Data Protection
14 Officer.

15 **Q.** Have we gone beyond your area of --

16 **A.** I think we have, yes. Sorry.

17 **Q.** Thank you.

18 So can I come back to the point about DPIAs, please.
19 Did Oxehealth provide customers such as Trusts with
20 templates for Data Protection Impact Assessments?

21 **A.** We provided, so going back to my -- I think this is my
22 first statement -- we provided EPUT with a DPIA for the
23 Oxevision service that was reviewed by EPUT's Caldicott
24 Guardian and Data Protection Officer back in 2019, and
25 regularly update and review.

1 **Q.** So what I have in mind is, for example, a 2021 EPUT
2 DPIA, just take that as an example of what I have in
3 mind. It looks as if this has been created using
4 a template provided by Oxehealth, and it says this on
5 its title page:
6
7 "Note to partner: as part of its commitment to good
8 data protection governance, Oxehealth provides this DPIA
9 template to assist its partners with their obligations
10 under the GDPR. However, it remains the partner's sole
11 responsibility to conduct a DPIA that meets the
12 requirements of applicable law. Nothing in this DPIA
13 template constitutes legal advice." [As read]
14
15 Now, does that suggest that as part of its support
16 to providers, Oxehealth was, and may still be, providing
17 DPIA templates to providers, subject to the caveat I've
18 just read out?
19
20 **A.** Yes.
21
22 **Q.** Now, this DPIA suggests that for EPUT, the blurred video
23 data was non-personal data. Now, does Oxehealth
24 maintain that that was the correct position?
25
26 **A.** Again, I've had no input in writing or developing that
27 document. That would be a question that I -- I can go
28 and ask our Data Protection Officer and come back to you
29 with ...
30
31 **Q.** But that's another area where you can't assist at the

1 moment?

2 **A.** Sorry, unfortunately.

3 **Q.** But can I just stick to this point that's not data
4 protection specific, but it's about templates that
5 Oxehealth or LIO provide to providers to support them.
6 We've also seen examples of templates, special SOPs for
7 the use of Oxevision, for example, provided to EPUT.
8 Would you agree that that's another type of document
9 that is being provided by you to providers?

10 **A.** I would agree, yeah, to assist them in being able to
11 develop their own documents.

12 **Q.** Would you agree that -- where we get a situation where
13 Oxehealth/LIO are providing significant documents to
14 providers, even if it's subject to the kind of proviso
15 I've just read out to you, that Oxehealth was at least
16 partly responsible, not just for the technical aspects
17 of the system, but also how it operated in practice?

18 **A.** No, I don't agree with that. I think we provided
19 templates in good faith to assist providers in some of
20 the areas that they should be thinking about. And may
21 want to consider. But again, it is for providers. So
22 each provider will have their own Data Protection
23 Officer where that is their area of expertise, so they
24 will know what is -- or they should know what is
25 expected in order to be able to complete their own.

1 **Q.** Thank you.

2 In your third statement, this is paragraph 20, you
3 said this:

4 "Blurred video data is retained primarily to support
5 system performance [it's gone up on the screen, thank
6 you], monitoring technical support and investigation of
7 reported issues. Where a customer raises performance
8 concern, relevant data may be retained for the duration
9 of the investigation to enable verification and
10 resolution. The contract permits retention for up to
11 a maximum of two years, which operates as a ceiling
12 rather than a standard retention period; in practice
13 retention is significantly shorter. Retention periods
14 are governed contractually, and data will also be
15 deleted at the customer's request, although early
16 deletion may impact the ability to investigate and
17 resolve issues."

18 So that makes clear that blurred video data is used
19 to improve the Oxevision system; do you agree?

20 **A.** It states system performance, monitoring, technical
21 support, yeah.

22 **Q.** Yes. In what ways might it be used for this purpose?
23 Are you able to answer this question?

24 **A.** So I can give you an example of if a provider informed
25 us that they had used the take vital signs function and

1 they were given a measurement and they don't agree that
2 that is the correct measurement, we would be able to, or
3 we would have a duty to investigate that.

4 **Q.** Is that without individual consent being obtained from
5 the patients involved?

6 **A.** I would expect an organisation to communicate with the
7 patient the same as if an organisation has the clear
8 video buffer for investigation, and they've requested
9 that. I would expect an organisation to have informed
10 and spoken to the patient that they have requested that
11 clear video, or, in the example I've just given you,
12 informed the patient that that's what they wanted to do.

13 **Q.** In short, that would be an issue for the provider rather
14 than Oxehealth?

15 **A.** Yes.

16 **Q.** Does LIO appreciate that such a practice, providing
17 that -- that using video data for system performance
18 matters may have had human rights implications if
19 patients were never expressly told about the use of
20 their data in this way?

21 **A.** Again, I think I would have to refer to our Data
22 Protection Officer for an answer for that.

23 **Q.** We could see on the screen that retention is for up to
24 two years. What purpose is served by the retention of
25 blurred video data for up to two years?

1 **A.** Again, that's out of my area of expertise.

2 **Q.** Thank you.

3 Would you take that down?

4 I want to turn now just to ask you about a point on
5 clear video, please. Again, the same rules apply. Will
6 you let me know if we're straying beyond questions you
7 can reasonably answer.

8 Lawyers for one Core Participant have provided the
9 Inquiry with a spreadsheet describing how Oxehealth
10 processes EPUT patient data. The spreadsheet refers to
11 a data protection impact assessment from August 2022,
12 updated following external legal advice on processing of
13 Clear Video Data. On reviewing the DPIA, Oxehealth's
14 then privacy manager, and then Data Protection Officer,
15 flagged a concern that some activities, specifically use
16 of CVD, Clear Video Data, for improving functionality
17 and for regression testing of the software may be
18 controller activities and would therefore require
19 Oxehealth to establish a lawful basis for processing.

20 Following the advice provided and the options
21 presented, Oxehealth agreed that CVD should not be
22 collected or processed for these purposes and updated
23 the Template Service Agreement and DPIA accordingly.

24 So that's the background.

25 Question. Prior to the changes made in August 2022,

1 did Oxehealth use Clear Video Data obtained from
2 patients' bedrooms for regression testing and/or
3 improving the functionality of Oxevision?

4 **A.** Again, I can't answer that question. I would have to go
5 away and find -- if you want to provide me with that
6 spreadsheet, I can go away and come back with an answer.

7 **Q.** Thank you.

8 What I want to do now, please, is to end my
9 questions for you by going back to recommendations that
10 you've suggested on behalf of LIO.

11 Now, we've already addressed Oxehealth
12 recommendation for further research. Could we move,
13 then, to another recommendation you make in your fourth
14 statement. This is for a national framework in relation
15 to digital technologies such as VBPMS. We'll look at
16 how you've articulated the recommendation in a moment.

17 Before we do, would you explain the background to it
18 and what has brought Oxevision to make it?

19 **A.** So I think listening to Jill Archibald's evidence
20 earlier this year, I think she stated that she felt that
21 the NHSE digital principles and the CQC guidance are
22 adequate and a sufficient set of standards to govern the
23 use. However, I think she highlighted a number of other
24 recommendations, and I think Oxehealth welcomed the
25 publication of the NHSE principles and the CQC guidance.

1 And I think what's -- what's been apparent is -- and
2 I think it's been discussed in evidence -- is the
3 implementation of the system has varied over time, and
4 by -- varied by organisation.

5 And I think that NHS Trusts are navigating between
6 multiple sets of principles or guidelines, and I've
7 highlighted the NHSE, CQC, and then there were, a couple
8 of years ago, the Nurse Directors Forum guidance, as
9 well. So there's three sets of principles or guidance.

10 And I think while all three of those frameworks are
11 largely similar, there is (*sic*) differences between
12 them, which could create ambiguity or inconsistency from
13 organisation to organisation. And I think, by having
14 a single set of clear -- or a single set of clear and
15 consistent guidance or a national framework that brings
16 all three of those pieces together and aligns with the
17 existing principles and guidance into one set, ensuring
18 that they're clear, measurable and actionable
19 recommendations across four sort of key areas --

20 **Q.** Well, shall we put up -- that's a very helpful
21 background. Shall we put up the recommendation on the
22 screen, and we can look at it there.

23 Fourth statement page 4, paragraph 22 down. There
24 we go.

25 So this is what you say:

1 "Oxehealth would advocate the development of
2 a single, clear and consistent national framework that
3 brings together and aligns the existing principles and
4 guidance into one coherent set of guidelines, ensuring
5 there are clear, measurable and actionable
6 recommendations across four key operational areas:

7 "Patient involvement, consent and objection;
8 "Staff training;
9 "Role of technology;
10 "Governance, assurance and auditability.

11 "23. To achieve a coherent set of guidelines,
12 Oxehealth would suggest that a nationally representative
13 and independently led working group should be
14 established to integrate the existing guidance from CQC,
15 NHS England and the Nurse Directors Forum. The working
16 group should include a broad range of expertise and
17 lived experience, including:

18 "NHSE/CQC;
19 "Senior clinical leadership (including those who
20 have experience of implementing the technology within
21 their organisations);
22 "A range of people with lived experience and their
23 families (including those who have experience of
24 inpatient services and the technology);
25 "Frontline staff (with direct patient contact and

1 the end users);

2 "Relevant legal/ethical expertise;

3 "Technology providers."

4 Additionally, you've suggested the national
5 framework should have robust protocols, and you go into
6 further detail about them elsewhere, but one of them,
7 for example, relates to informed patient consent.

8 Now, is there anything more you'd like to say about
9 the recommendation now, given the background you've also
10 given to us?

11 **A.** No, I don't think so just, I suppose, to reiterate that
12 the aim of this recommendation is alignment. It's not
13 that Oxehealth is suggesting that existing guidance is
14 fundamentally deficient. It's just about that alignment
15 of those three documents.

16 **Q.** May I ask you this: if the existing principles and
17 guidance are broadly similar, with only minor
18 inconsistencies, would it not be rather more efficient
19 just to address those in subsequent iterations of the
20 existing guidance?

21 **A.** I think that's a possibility, but I think you then still
22 have three separate principles or guidance, and I think
23 what is vitally important is ensuring that all voices
24 have been heard in the development -- and I'm not
25 suggesting that the NHSE principles or CQC guidance

1 didn't take into consideration all views, but I think
2 it's ensuring that everybody has a seat round the table.

3 **Q.** Would another approach be just to get the three
4 organisations behind the existing guidance to get
5 together to produce a single document?

6 **A.** Possibility, but ensuring that, I think as I've
7 highlighted in my statement, that a range of people with
8 lived experience and their families are included within
9 that as well, and those frontline staff with direct
10 patient contact, and those that have utilised the system
11 are involved in that, as well.

12 **Q.** Thank you.

13 Do you consider that you should have gone to
14 NHS England and the CQC to develop the principles before
15 the technology was rolled out? Now, this is rather
16 a riff on a question I asked you earlier, but
17 specifically in the context of this recommendation.

18 Do you want me to ask it again?

19 **A.** Please.

20 **Q.** Do you consider that you should have gone to NHS England
21 and the CQC to develop these principles before the
22 technology was rolled out?

23 **A.** I only started working for the company in 2022. But
24 it's my understanding that conversations were or had
25 happened. The content of those conversations, I don't

1 know.

2 **Q.** I'm almost at the end of my questions but I think
3 there's one further point that you're at pains to put
4 across in your fourth statement. We've now heard both
5 of the recommendations that you are asking the Chair to
6 consider; is there a further point that you make,
7 I think more than once, that it's your suggestion that
8 whilst -- if these recommendations are accepted, that
9 whilst that's all happening, the use of Oxevision
10 shouldn't be paused or stopped? Have I over-simplified
11 a point that comes across from your fourth statement?

12 **A.** No, that is correct, on the whole. And I think that is
13 also supported by the expert witness evidence that we've
14 heard. I don't believe that any of the expert witnesses
15 or the comparator Trusts have said that the use of the
16 system should be paused or halted or stopped. I think,
17 if these recommendations are accepted, they should be
18 done alongside the use of the system.

19 **MR GRIFFIN:** Chair, those are the questions I have at the
20 moment. Do you have any questions?

21 **THE CHAIR:** No.

22 **MR GRIFFIN:** Ms Cozens, what will happen now is we're going
23 to take a pause for around 15 minutes, possibly a little
24 longer. I'm going to see if there's any further
25 questions I need to ask you and we'll then reconvene,

1 but let's aim to come back at 12.45, please.

2 **THE CHAIR:** Thank you. 12.45.

3 **(12.29 pm)**

4 **(A short break)**

5 **(12.54 pm)**

6 **THE CHAIR:** Mr Griffin.

7 **MR GRIFFIN:** Ms Cozens, I have a few extra questions for
8 you, please. You said in your evidence earlier:

9 "... we've seen that in the evidence that we heard
10 from EPUT last year around the incidents in which the
11 technology has assisted staff intervening in critical
12 safety incidents, so I think that was over 1,400
13 incidents over a five-year period."

14 Do you remember saying that this morning?

15 **A.** I do.

16 **Q.** So that comes from, or relates to, paragraph 531 from
17 the joint statement of Dr Suresh and Mr Trent of EPUT,
18 where they state:

19 "... Oxevision has been directly linked to over
20 1,400 recorded incidents in which staff indicated, via
21 Datix, that 'Oxevision played a role in alerting us to
22 this incident.'"

23 However, at paragraph 357 of the same statement,
24 Mr Trent and Dr Suresh concede that approximately half
25 of these reports contain no narrative description, and

1 at paragraph 360 they confirm no comparative analysis
2 was done against non-Oxevision wards.

3 You've already accepted that these real-world
4 examples don't constitute scientific research or
5 evidence, but do you accept that the limits of the
6 evidence further diminish the weight which can be
7 attached to the claim that Oxevision contributed to the
8 intervention in 1,400 incidents?

9 **A.** I think that statement around EPUT's evidence is one
10 snapshot of that incident data, and I refer also to the
11 examples that I gave in my second statement from
12 organisation A and B, and I think to come to a more
13 concrete conclusion around that incident data, there
14 should be some sort of further analysis around the
15 incident data on a wider scale.

16 **Q.** I think the question here, though, is specifically in
17 relation to an example you gave. I understand the point
18 that you're making that there are other pools of
19 information that you might suggest are similar, but just
20 going back to the point that's being raised here,
21 because you specifically used it as an example, the
22 1,400 incidents. The essence of the question, I think,
23 is whether you accept, given that further context,
24 perhaps less weight can be attached to it as being
25 significant?

1 **A.** I think the context behind it is important, and the
2 comment around no narrative within some of those
3 incident documents, I think that could lead you to the
4 conclusion that there is less possible weight, but
5 I don't think it's -- I don't think it should be written
6 off because of that. I think, again, there probably
7 needs to be further investigation into that.

8 **Q.** You've emphasised the importance of real-world data.
9 But do you agree that anecdotal data from staff carries
10 a risk of bias following institutional buy-in?

11 **A.** I do agree. However, I think that needs to be taken
12 into consideration when looking at anecdotal evidence
13 from staff, and anyone that was looking at that would
14 take that into consideration. Yeah, I think it's also
15 important to highlight that the current independent work
16 that is ongoing into the evidence of staff and patients
17 that's being completed by Professor Fiona Nolan, I think
18 it's important to highlight that.

19 **Q.** Is this is the research that you cover in one of your
20 earlier statements?

21 **A.** Yes.

22 **Q.** That's still ongoing, is it?

23 **A.** That is still ongoing and that's due -- it was presented
24 at a workshop this year at Design in Mental Health, and
25 there was also a presentation at NAPICU Conference.

1 Q. Is this Anglia Ruskin?

2 A. Yes.

3 Q. You've just suggested that's independent?

4 A. Yes.

5 Q. Okay, thank you. Do you agree that EPUT's Datix data

6 does not differentiate between interventions which would

7 have happened without Oxevision and those where

8 Oxevision was directly responsible for the intervention?

9 A. Yes, possibly without having all of the information that

10 is contained within the Datix or the incident reporting

11 system, that could possibly be the case. But I think

12 it's difficult to come to that conclusion without that.

13 Q. Can I just move on to something else now. This morning

14 I was asking you about an open letter that was provided

15 by Oxehealth Ltd's Board to the Chair. And we were

16 differentiating the Board from you as an individual, and

17 from LIO, the company; correct?

18 A. Correct.

19 Q. Can I just ask you, just further to that, are you

20 a Board member yourself?

21 A. No, I'm not.

22 Q. Do you have a financial interest in the company?

23 A. In no other respect than working for them.

24 Q. Are you a shareholder, for example?

25 A. I do. I do have shares.

1 **Q.** Thank you.

2 **MR GRIFFIN:** Chair, those are the questions that I wanted to
3 ask.

4 Do you have any further questions?

5 **THE CHAIR:** No, I don't. So can I thank you very much
6 indeed for your evidence.

7 **MR GRIFFIN:** Chair, can we reconvene for this afternoon's
8 witness at 1.45 pm, please.

9 **THE CHAIR:** 1.45.

10 **MR GRIFFIN:** Thank you.

11 **(1.01 pm)**

12 **(The Short Adjournment)**

13 **(1.45 pm)**

14 **(Proceedings delayed)**

15 **(1.48 pm)**

16 **THE CHAIR:** Ms Onabanjo.

17 **MS ONABANJO:** Good afternoon, Chair.

18 Good afternoon, Mr Trimble.

19 **THE WITNESS:** Good afternoon.

20 **MS ONABANJO:** Could I ask that Mr Trimble be sworn, please.

21 **THE WITNESS:** What was that? Oh. Do you want me to read it
22 now?

23 **DERRICK TRIMBLE (sworn)**

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Questioned by MS ONABANJO

MS ONABANJO: Please state your full name for the record.

A. My name's Derrick Sterling Trimble.

Q. You have provided one witness statement to the Inquiry dated 21 August 2026 and you have a copy of that statement in front of you?

A. That is correct.

Q. Could you turn to the last page on page 11.

A. Yes.

Q. And that page bears your signature?

A. Well, this is a digital version of it, but yes.

Q. And a statement of truth?

A. That is correct.

Q. Have you had the opportunity to read that statement recently?

A. Yes, I have.

Q. Do you have any corrections you wish to make?

A. None at this time.

Q. Can you confirm that the contents of the statement are true and accurate to the best of your knowledge and belief?

A. That is correct.

Q. Your statement will stand as your evidence to this Inquiry.

In the course of evidence today, we will be

1 referring to technology Oxevision that has been
2 rebranded LIO. For convenience, I will continue to
3 refer to "Oxevision", and in respect of the
4 manufacturer, I will -- I will refer interchangeably to
5 "Oxehealth" or "LIO".

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

7 **Q.** The Inquiry has heard evidence already and will hear
8 further evidence this week that pertains to the use of
9 Oxevision on EPUT wards, including in particular from
10 EPUT corporate witnesses. Much of your evidence
11 overlaps with that. I therefore do not intend to go
12 over all of the detail of your statement; instead,
13 I will focus on discrete points on which the Chair will
14 be assisted by clarification or expansion of what you've
15 said in your statement.

16 **A.** Thank you.

17 **Q.** First, I'll ask you about your qualifications and your
18 experience. You have a Bachelor of Science in Business
19 Administration and a Master's also; is that right?

20 **A.** That is correct.

21 **Q.** And you also have an Associate of Arts in Instructional
22 Technology; is that correct?

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

24 **Q.** And you said in your statement that, before joining
25 EPUT, you were employed in the United States, and your

1 roles included business development, project management
2 and contract management; is that right?

3 **A.** Correct.

4 **Q.** And so it is correct to say that you don't have any
5 clinical qualifications, training or experience.

6 **A.** That's correct, Ma'am.

7 **Q.** If I then turn to your experience at EPUT, you say that
8 you began in 2016 as a Clinical Management Systems
9 Trainer. And then you were promoted to the Senior
10 Clinical Management Systems Trainer in March 2017; is
11 that right?

12 **A.** Correct.

13 **Q.** Could you explain what you did as part of those roles?

14 **A.** Initially, it was in a support role for records
15 management, Head of Records Management, and then I was
16 seconded over to the North Essex Partnership Fellowship
17 Trust as a trainer to train in the electronic patient
18 record system known as PARIS, created by Civica, and
19 I did that until the end of my term.

20 **Q.** Thank you. You took a career break in 2019?

21 **A.** Correct.

22 **Q.** And you say you returned to EPUT as a bank worker in
23 January 2021 to support the then Oxevision project
24 manager?

25 **A.** Correct.

1 **Q.** Is it correct to say that when you returned to join EPUT
2 you had no prior knowledge of Oxevision or how it's
3 used --

4 **A.** That's correct.

5 **Q.** -- in clinical settings?

6 You then became the Project Support Officer in
7 April 2021 and subsequently the project manager.

8 **A.** That is correct.

9 **Q.** And is that within EPUT's IT Directorate?

10 **A.** That is correct.

11 **Q.** And could you assist the Chair with where you fit in to
12 the structure, so, for example, who you report to, who
13 reports to you, who they report to?

14 **A.** Certainly. Inside the Directorate there is a digital
15 Portfolio Management Office and in that Digital
16 Portfolio Management Office, at the time we were
17 developing the Portfolio Management Office and therefore
18 that was a new structure within the organisational
19 orientation. And that's -- when I became the project
20 manager was about that same time. So, there was a lot
21 of developmental elements in terms of how the PMO,
22 Portfolio Management Office would work, and I was
23 a project manager within that structure. I reported to
24 a lead, I can't give names, can I? So the -- I reported
25 to a lead, and then there was just a hierarchical

1 movement forward in that developmental -- in that
2 organisational structure.

3 **Q.** Thank you. If I may take you to paragraph 5 of your
4 statement on page 1, and if I could have that shown on
5 the screen, please.

6 You say that your role included liaising with ward
7 staff -- this is your role as part of the project
8 manager team --

9 **A.** Correct.

10 **Q.** -- and subsequently as project manager:

11 "... liaising with ward staff, clinical leads and
12 Oxehealth; support for implementation and training;
13 management of the Oxevision Observations proof of
14 concept and deployment; support for EPR integration;
15 response to operational issues; and later subject-matter
16 and business-as-usual support within the IT
17 Directorate."

18 If I may just ask you about aspects of that. When
19 you say that you were providing support for
20 implementation and training, is that in relation to the
21 rollout of Oxevision?

22 **A.** For the implementation, that's correct, to the different
23 wards.

24 **Q.** And what was the nature of the support that you were
25 providing?

1 **A.** Communications with the wards, helping them to find
2 information, being there for them when they had
3 questions about operational issues, ensuring that the
4 correct people are included in the communications,
5 escalating when issues arose, liaison -- liaising with
6 LIO, or Oxehealth at the time, if issues came up or
7 questions about how to do things. There was -- I was
8 their go-to person for anything related to the technical
9 elements of the LIO system.

10 **Q.** And when you say you escalated issues that arose, who
11 would you escalate issues to?

12 **A.** In a project management environment, keeping this in
13 context, it is within a project management environment,
14 so it's based upon a PRINCE2 project management
15 orientation. Therefore, there is an established
16 structure for how you escalate elements to it.

17 Within -- all of the projects that I have that were
18 Oxehealth and/or LIO, had been under the direction or
19 the supervision, I suppose, of a project group and there
20 was a Senior Reporting Officer on there and a Deputy, or
21 a Chair and a Deputy Chair in that environment who, in
22 terms of escalation, I would start in terms of
23 implementation, start with the Ward Manager, work up to
24 the Matron, Service Lead, and then that probably was
25 where I tapped out for escalating it and then I would go

1 to the Project Board members being either the Senior
2 Reporting Officer or the Deputy Chair.

3 **Q.** Thank you.

4 Mr Trimble, could I ask that you please slow down
5 when you're giving your answers just to assist the
6 transcriber who's taking the notes?

7 **A.** Absolutely, and thank you for calling me out on that.

8 **Q.** Returning to paragraph 5 of your statement and the
9 nature of your role, one of the things you list there is
10 the management of Oxevision Observations proof of
11 concept and deployment. Could you explain what that
12 means and what that entailed?

13 **A.** The Oxevision Observations proof of concept was
14 originally called electronic observations or digital
15 observations. We didn't actually have the name
16 Oxevision Observations until quite lengthy into the
17 programme, but overall we call it the Oxevision
18 Observations proof of concept, and in that we had
19 dialogue with LIO, and when I say "we", it wasn't me, it
20 was Senior Leadership having conversations with LIO
21 about the potential of creating a mirror, if you would,
22 of our paper observation forms for levels 1, 2 and 3 and
23 level 4 on to a digital format.

24 Dialogue had been going on for some time prior to me
25 getting it. As a point of entry, as a project manager,

1 I receive the project once it's gone through the vetting
2 process. So my engagement in this is not -- does not
3 pre-date a project; it is when it's initiated under
4 a project initiation document, that's when I get it, and
5 that's when I start working with it.

6 So, in that initial scope, the scope was to create
7 a digital, if you would, a digital replica of the paper
8 documentation to eliminate the paper documentation and
9 put it into a digital format.

10 **Q.** Thank you. If I understand you correctly, in terms of
11 the substantive discussions as to what EPUT wanted,
12 those discussions with LIO would have been undertaken by
13 Senior Management and then you deal with the practical
14 aspects of managing the deployment; is that right?

15 **A.** It was much more complex than that because it was
16 a proof of concept. It took quite a while for us to
17 develop a product that was to be deployed, and the
18 reason for that is multiple -- multiplied. There was
19 a software design. They had -- "they" being LIO -- had
20 to design everything from scratch to create this
21 dashboard for observations to go into. The observations
22 on the dashboard needed to duplicate, or replicate,
23 exactly what was on our paper documents which is
24 governed by a clinical governance, a national clinical
25 governance.

1 So, that proof of concept was finding ways to
2 integrate the existing form into the digital
3 environment, as well as enhancing it with elements that
4 would make it more user-friendly, and more accessible
5 for the staff to use in the day-to-day environment.

6 So proof of concept literally was the conception of
7 this digital formatted observation dashboard that has
8 ... that went through -- I can't tell you how long it
9 took, but it took about a year and a half to go through,
10 with a lot of clinical support in that design process.

11 Does that answer your question okay?

12 **THE CHAIR:** I don't think it does. I think you were being
13 asked what part you played in all of that.

14 **A.** Ah, thank you, madam. What part I played was, in large
15 part, was communication and -- the engagement with
16 getting the clinical staff that were participating in
17 that to contribute to the process. So as a project
18 manager, these were project team groups, so we had a
19 clinical project team group, we had a technical project
20 team group, we had the LIO project team group, there
21 were various groups within a project team that
22 contributed to the process, and as a project manager
23 mine was to ensure that all of these groups talked with
24 one another and we got the results that we needed.

25 Does that answer your question more?

1 **MS ONABANJO:** It does answer my question, thank you. So you
2 were coordinating the -- (overspeaking) --

3 **A.** Coordinating was part of my role as a project manager,
4 yes, Ma'am.

5 **Q.** Thank you. If could ask you to please speak up?

6 **A.** Absolutely.

7 **Q.** Or move the mic closer. That might assist.

8 **A.** I can speak up.

9 **Q.** Thank you. If I may then turn to paragraph 6 of your
10 witness statement, you explain there that:

11 "In relation to LIO, my work has included
12 coordinating projects and system changes; supporting
13 technical aspects of the Trust Standard Operating
14 Procedure; monitoring platform use and report flows;
15 escalating technical or operational issues; supporting
16 authorised requests for clear video data; reporting to
17 project and governance groups; and providing
18 business-as-usual support."

19 Turning first to your role in relation to the
20 Standard Operating Procedures, what do you mean when you
21 say "supporting technical aspects of the Standard
22 Operating Procedure"?

23 **A.** The specificity of that answer is related to what was in
24 the Information for Use that are produced by LIO and
25 what elements of it that the Clinical Lead that was part

1 of the development of the SOPs would need to include in
2 the -- as Standard Operating Procedure.

3 My goal would be to review the Standard Operating
4 Procedure to ensure that the data that was being
5 presented in the SOP is accurate, in accordance with the
6 respective Information for Use guidance from Oxehealth
7 or LIO.

8 **Q.** And noting that you don't have any clinical experience
9 or training, in relation to -- insofar as the SOPs cover
10 clinical questions of -- questions of clinical judgement
11 or clinical content, who was responsible for that?

12 **A.** Well, it would depend on which version of the Standard
13 Operating Procedure that we were discussing with. My
14 more hands-on aspects of working with somebody directly
15 was with the Trust's Quality Matron, with whom I worked
16 a number of different times on supporting her with the
17 technical aspects of it, some grammatical editing, and
18 just flow of the document but no clinical oversight
19 whatsoever on my part.

20 **Q.** For example, in relation to version 8 where you are
21 listed as the co-author with the Trust Quality Matron,
22 that is the extent of your input. So in terms of the
23 drafting of the SOP, who undertakes that exercise?

24 **A.** That is correct, yes. I was supporting the Quality
25 Matron in her development of it from a technical aspect.

1 I believe there's only one Standard Operating Procedure
2 that has my name on it, and that's because I was
3 supporting her in that endeavour.

4 Q. Thank you.

5 Turning to the project and governance groups that
6 you report to, which groups are those?

7 A. I'm sorry, could you repeat that, please?

8 Q. The project and governance groups that you report to?

9 A. Correct. The project group.

10 Q. Yes.

11 A. What's your question about that?

12 Q. What groups do you report to?

13 A. That has changed a couple of times in the terms of
14 reference. It was through -- the Transformation
15 Strategy Group was one of them and it has changed again.
16 I'm not sure what the TOR, the terms of reference say
17 now, but that was who it was reporting to, and I know
18 the Executive Team is another -- I believe the Executive
19 Team is another reporting group to that, as well, and
20 that has occurred in the last couple of years.

21 Q. Thank you.

22 I will now turn to ask you questions about the
23 Oxevision platform and some of the modules and functions
24 that you highlight in your statement.

25 You describe the Activity Tracker module in your

1 statement and the warnings and alerts that may be
2 generated by the statement. The Inquiry has heard much
3 about the Activity Tracker this morning so I wouldn't
4 take you through the general descriptions, but at
5 paragraph 22 in the last sentence of paragraph 22 of
6 your witness statement, you say that:
7 "The timing of alerts are locally configured ..."
8 And you then refer to a three-minute threshold.
9 Can you explain about the threshold and who
10 determined the configuration?
11 **A.** The -- is this going to come up here?
12 **Q.** Yes.
13 **A.** I could look at it from here. So you're asking me for
14 the last sentence in paragraph 22:
15 "The timing is locally configured: where I refer to
16 a three-minute threshold, I mean the EPUT configuration
17 relevant to the wards concerned and not a universal
18 product threshold."
19 **Q.** Yes.
20 **A.** Yes, apologies for the ambiguity of that statement. The
21 ambiguity is related to the bathroom alerts,
22 specifically, the three-minute threshold. That
23 three-minute threshold is -- it doesn't mean that all
24 Trusts that use that the LIO platform have that set at
25 three minutes. It's our set for three minutes.

1 **Q.** So it's an EPUT-configured three minutes?

2 **A.** Correct.

3 **Q.** And who makes that determination as to the

4 configuration?

5 **A.** This is to the best of my knowledge, right? So the

6 three-minute threshold is based upon a national

7 understanding on -- forgive me for not knowing the

8 specific details of the language, and the clinical

9 terms, but the, if you would, the -- do not -- if you go

10 past this time in a ligature attempt, you're going to

11 have brain damage and possibly death.

12 So the three minutes is your maximum or your

13 threshold, as I have referred to here, that you need to

14 be able to attend to the person in that amount of time

15 before there is irreversible damage to the patient's

16 brain.

17 **Q.** I understand that. What I'm trying to understand is the

18 determination of that three minutes, was that

19 a determination that your team would have made or was

20 that a clinical judgement that is made by, for example,

21 the Trust Quality Matron --

22 **A.** Yeah.

23 **Q.** -- in putting together the SOP?

24 **A.** I don't know who made that initially because there was

25 a pilot of four wards before I came on board and that

1 would have already been established in an initial phase,
2 so I can't tell you from documentation or my personal
3 experience who set that three minutes. But it has
4 stayed in that time frame based upon the information
5 I just previously provided.

6 **Q.** Thank you. At paragraph 26 of your statement, staying
7 on the Activity Tracker, you say that:

8 "The Activity Tracker may misinterpret the movement
9 of a second person as the movement of the person
10 occupying the room. In particular, if one person is in
11 a bathroom or blind spot and a second person enters and
12 leaves, the displayed room state may be inaccurate."

13 You then go on to state at paragraph 37, which is on
14 page 5, that:

15 "A Room Refresh is a user-initiated restart of the
16 relevant room process where the Activity Tracker has
17 incorrectly determined the location of the occupant or
18 another person."

19 How does the user know or become aware that the
20 tracker has incorrectly determined the location of the
21 occupant or another person?

22 **A.** I'm just getting the paragraph up now. So it's a little
23 difficult to track what you've just said and what I've
24 got here. So would you mind asking me the question
25 again?

1 **Q.** So turning -- so at paragraph 37 of your statement on
2 page 5, you say that:

3 "A Room Refresh is a user-initiated restart of the
4 relevant room process where the Activity Tracker has
5 incorrectly determined the location of the occupant or
6 another person."

7 So how does the user know that the Activity Tracker
8 has incorrectly determined?

9 **A.** This is based upon my experience and engagement with
10 ward staff. There have been times when they say --
11 there's many wards where the ward office faces corridors
12 where they can see patients coming in and out of their
13 rooms or in the corridors. And they would see, on --
14 "they" being the staff -- would see, they're on the
15 dashboard of a tablet or dashboard on the monitor that
16 it shows that they're in room. But in fact they're not
17 in room, they're out of room. Because they're looking
18 at them in the hallway or the corridor, right?

19 And knowing that there is a misalignment, if you
20 would, in the perception that a person is in the room
21 and that the system is saying they're in the room, the
22 recommendation that I would give is to refresh the room
23 and it recycles it with the server, so that it -- the
24 algorithm that's driving the system, the platform, is
25 aligned again with what's actually concurring.

1 On a ward, a person can move in and out of a room
2 quite frequently, and get to different parts of the ward
3 very rapidly, just because of the space in that area.
4 So room -- so at times, it's possible that a room
5 configuration or a room tab, if you would, a button, is
6 going to show that they're in room or out of room when
7 they're not, simply because of the speed of egress or
8 entry.

9 **Q.** Thank you.

10 Turning now to the vital signs function at
11 paragraph 15, on page 3 of your statement, you explain
12 that:

13 "When a user initiates a vital signs measurement,
14 a clear live view is displayed for a limited period to
15 enable the user to confirm that the patient is still and
16 that the measurement markers are on the person."

17 Is there anything that prevents the live view
18 function, the clear live view function, from being used
19 repeatedly?

20 **A.** From it being used?

21 **Q.** Repeatedly?

22 **A.** No.

23 **Q.** And --

24 **A.** Oh, there is a 15 -- pardon me -- there is a 15-second
25 needs to finish, I believe. Now, it doesn't mean that

1 you can't do a subsequent, but I believe the 15-second
2 clip needs to play out for -- so, in terms of -- does
3 that answer your question?

4 **Q.** It does answer my question. What I'm saying is, after
5 the 15-second clip, a staff member could press it again.
6 There is nothing --

7 **A.** Correct.

8 **Q.** -- to stop the repeated use?

9 **A.** There is nothing configured in the system that stops
10 them from doing that, no.

11 **Q.** When you say at paragraph 19 that the platform is not
12 a CCTV and should not be used as a surveillance system,
13 is there any practical difference, are you saying
14 there's a practical difference between a CCTV and, for
15 example, continuous repeated use of that clear view
16 function?

17 **A.** Well, as I understand CCTV, close circuit television,
18 that is a continuous feed. So that's the primary
19 difference between that and what you're seeing here.
20 This is a 15-second clip, if you would, with a specific
21 purpose orientated for it whereas a close circuit
22 television tracks the activity and is visual on
23 a screen, a monitor somewhere, where people can monitor
24 that.

25 **Q.** Thank you.

1 **A.** That's my understanding of the differentiation in a very
2 simple way.

3 **Q.** Thank you. At paragraph 57 of your statement on page 8,
4 in the first sentence you say:

5 "Reporting showed patterns of vital signs attempts
6 that, in my view, warranted review of how the function
7 was being used."

8 What reporting are you referring to there?

9 **A.** We receive a monthly usage report from LIO that goes to
10 the Project Board on a monthly basis and that shows
11 the -- I believe the Inquiry has reviewed this document
12 before, so hopefully I'm not going over previously-known
13 information, but there is a summary page at the end of
14 the usage report that shows how many vital sign attempts
15 have been made.

16 **THE CHAIR:** We heard this morning about an authenticator
17 capability on the OxeObservations and that there is now
18 an authenticator function available for the home
19 monitor, as it were.

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

21 **THE CHAIR:** Is that installed at EPUT?

22 **A.** Madam Chair, that's a project that is in process. We
23 have rolled it out to The Lakes for a pilot under the
24 project governance that says it needs to be clinically
25 approved before it moves to a fuller rollout. User

1 authentication has been live at The Lakes, which is
2 Gosfield and Ardleigh wards, has been there since May,
3 we, "we" being the project team and the service lead of
4 The Lakes there, believe that that has completed, and
5 now we're trying to get sign-off for it to move to
6 a larger rollout to the various sites.

7 When that occurs, then we will have user
8 authentication which is a soft -- it's permissions
9 within the system that enables us to be able to report
10 on activities a bit more granularly.

11 **THE CHAIR:** And will it require the individual user to
12 authenticate who it is who is using it?

13 **A.** That is correct, with their NHS email.

14 **THE CHAIR:** Thank you.

15 **MS ONABANJO:** Are you able to tell the Inquiry why user
16 authentication was not implemented at the outset?
17 Because you note in your evidence that it's important to
18 have user authentication for audit trail.

19 **A.** User authentication has been something on the product
20 development side for LIO for a time that I can't
21 determine when they first started the product
22 development phase for that, but the reason why it wasn't
23 available nearly six years ago is because it wasn't
24 developed, it's only been developed for rollout within
25 the last year, I estimate about a year. Probably

1 a little bit more, maybe it was 18 months.

2 Q. Thank you.

3 Returning to the issue of the usage reports that you
4 referred to, the Inquiry has the evidence of Laura
5 Cozens of LIO, and she says that in October 2024 it was
6 agreed with EPUT that the usage reports would be sent to
7 you; is that correct?

8 A. Yes.

9 Q. So you receive the usage reports?

10 A. I receive them and distribute them.

11 Q. Do you carry out any review of the reports?

12 A. I look at them to see what kind of activities there are,
13 and I raise that to the Project Board. I present it to
14 the Project Board, I don't make an estimation or
15 assessment of them, I present them to the Project Board
16 when we meet. I don't make any recommendations, I just
17 give them the data.

18 Q. So would it then be for the other members of the Project
19 Board who have clinical experience to consider the
20 content of those usage reports?

21 A. That is correct.

22 Q. Thank you.

23 At paragraph 59 of your statement, you note that,
24 and that's on page 8, you note that:

25 "... specialist-services staff were required to

1 submit a Datix report where vital signs function was
2 used for a purpose other than taking vital signs."

3 Who imposed that requirement?

4 **A.** The Deputy Director of Quality and Safety for Specialist
5 Services.

6 **Q.** And why was that requirement imposed?

7 **A.** Why did the Deputy Director of Quality and Safety
8 Specialist Services do that? That was -- I can't tell
9 you. I don't know what ... because the Deputy Director
10 of Quality and Safety for Inpatient Services did not
11 initiate the same thing at the same time. I think this
12 was a bit forward thinking.

13 **Q.** If we return to paragraph 57 of your statement, you say
14 that the reporting showed patterns of vital signs
15 attempts that warranted a review. And EPUT would hear
16 from -- the Inquiry is going to hear from EPUT corporate
17 witnesses tomorrow but they say in their statement that
18 there was a significant and persistent trend identified
19 from usage reports of a material discrepancy between the
20 number of vital signs attempts recorded and the number
21 of vital signs readings obtained. Is that the pattern
22 that you're also referring to in your statement?

23 **A.** Yes, and I believe my impetus behind this was due to the
24 testimony that was given some time ago by our Executive
25 Director for IT services in relationship specifically to

1 the quantity of attempted vital signs that were in
2 a report that were previously reviewed by the Inquiry.

3 **THE CHAIR:** Slow down, please.

4 **MS ONABANJO:** If I may then turn to the issue of data that
5 is generated on the Oxevision platform. You describe
6 Clear Video Data at paragraph 16 of your statement, and
7 at paragraph 6 -- we've previously looked at paragraph 6
8 of your statement you say that as part of your role you
9 support requests for Clear Video Data.

10 If I may then take you to paragraph 49 of your
11 witness statement on page 7, you say there that:

12 "Where an incident or authorised external process
13 requires preservation of video, EPUT may request the
14 relevant material from LIO before it becomes unavailable
15 through the normal refresh process."

16 What is the relevant material that you refer to
17 here?

18 **A.** We have 176 Clear Video Data logged for almost six years
19 that we've done -- that we've been working with
20 Oxevision/LIO. Relevant material has quite a range. It
21 could be -- well, it's evidenced by patient deaths, is
22 what is probably of greatest relevancy for here, but
23 also assaults on staff that have to be referred to the
24 police. There are incidents of staff accusations of
25 sleeping. Those are the kind of things that maybe that

1 I have requests for, and Clear Video Data files for.
2 It's quite a range.

3 **Q.** Yes, I understand. So you told me -- so the reasons for
4 the requests are what you've told me, but in relation to
5 the material that is requested from LIO, it is -- you're
6 simply referring to the Clear Video Data?

7 **A.** The Clear Video Data, yes.

8 **Q.** Thank you.

9 **A.** It's the recorded video data, not the live clear video.

10 **Q.** EPUT's corporate witness has told the Inquiry that Clear
11 Video Data must be requested by a member of staff within
12 24 hours of an incident, and that the data is
13 overwritten every 24 hours. So the request must be made
14 to LIO within 24 hours --

15 **A.** Correct.

16 **Q.** -- is that correct? And what is your role in the
17 process of requesting that information?

18 **A.** When a request is made to the LIO support desk, either
19 by -- we tell them -- we tell staff always to call it
20 because it's more of an urgent thing, so there's
21 a number that they can call that's a direct to the
22 support desk. The support desk initiates an
23 authorisation form to me through DocuSign, I sign it,
24 I sign them all and approve it, but prior to that, LIO
25 has already clipped the data for -- just to ensure that

1 it's secured, right? So my role is to authorise it and
2 then that process formalises the clipping of the data to
3 be recovered and sent to us.

4 Shall I continue?

5 Once that data is clipped, I receive an email with a
6 DocuSign link, where I go to -- I click on the link and
7 I download that from an encrypted cloud, I download it
8 on to my local system and then I upload it to
9 a restricted area in a SharePoint and then delete it
10 from my local drive.

11 **Q.** So you will view the Clear Video Data as part of that
12 process?

13 **A.** I view it for quality control --

14 **Q.** -- (overspeaking) --

15 **A.** -- oh, and I log it, as well. I register everything.
16 It's a pretty robust process for ensuring that, first of
17 all, the data that has been requested is the data that's
18 been received, and then how it's managed or handled
19 after the fact.

20 **Q.** Thank you. One of the cases that the Inquiry is
21 investigating is that of Sophie Alderman and you gave
22 evidence to the inquest in that case. And your evidence
23 was that the Clear Video Data was not requested in her
24 case. In your experience, how familiar are EPUT's staff
25 with this requirement that the Clear Video Data must be

1 requested within 24 hours?

2 **A.** I'm not quite sure how to be very specific on that
3 because we're talking about a lot of people and a lot of
4 use of the system. Clearly, because there are times
5 when people don't do it correctly, there have been
6 failures in that. They don't do it within the 24 hours
7 and they come back and they ask for it three or four
8 days later. So there are situations where -- or, I
9 don't know, because I don't know what's going on in
10 a person's mind when they ask these questions, why they
11 didn't do it at the time. So I'd be speculating to put
12 it -- to put into words why people do what they do.

13 To the best of my knowledge, we saturate the staff.
14 It's an SOP, it's on the intranet page. It's on all the
15 wards. They have a poster that tells what to do when
16 you have a CVD. When I'm out of office I have
17 instructions on my out-of-office that tells them how to
18 do it. There's plenty of ways that we communicate to
19 saturate the wards with the knowledge that you need to
20 do this within 24 hours.

21 **Q.** Thank you. If I may turn to paragraph 52 of your
22 witness statement, still on page 7. You say that:

23 "I understand that LIO personnel may process
24 platform data for authorised support, performance or
25 requested-data purposes, subject to the relevant

1 contracts and information-governance controls."

2 Do you know what authorised support performance and
3 requested data purposes you are referring to in --

4 **A.** Of the -- in our service level agreements they -- it
5 defines very clearly who are owners of different types
6 of data that we receive. I believe that may have been
7 covered in the Inquiry at a different time, as well.
8 But in this situation, the requested data would be
9 things like algorithms, logs for a room. They would be
10 technical data that they need to ensure that the
11 accuracy of the system working correctly.

12 **Q.** Thank you. I will now ask you a couple of questions
13 about the issues relating to connectivity of the
14 Oxevision platform that you refer to in your statement.

15 You explain at paragraph 35 on page 5 of your
16 statement that the tablet devices depend on the Trust's
17 wireless network to communicate with the local platform.
18 Can a loss of connectivity give rise to a data loss?

19 **A.** Can the loss of connectivity --

20 **Q.** Of the connectivity, yeah, give rise to data loss?

21 **A.** Give rise to what?

22 **Q.** The loss of data on the --

23 **A.** No.

24 **Q.** No.

25 **A.** No, not from my experience, or the knowledge that I have

1 of how the platform works. There is a -- oftentimes
2 there's a confusion which we work very hard to try to
3 correct amongst the staff when the connection loss shows
4 up on a screen. Right? A connection loss, the typical
5 person who is holding a device that says wi-fi, that's
6 driven by wi-fi, they look at the device and it says
7 connection loss, they automatically think it's
8 a connection loss of wi-fi. It doesn't mean that.
9 There are a number of different factors that are
10 available in the Information for Use that define what
11 a connection loss means.

12 Where there is a genuine loss of connectivity from
13 the wi-fi, there's also instructions in the training
14 material that the staff receive, it's one of the last
15 things in the training material for the LIO Academy,
16 that talks about what to do when you have low or no
17 wi-fi. In terms of Oxevision Observations, or
18 observation history, that data is saved in a pool, if
19 you would, a pending observations area. When wi-fi
20 connectivity is established again, either because the
21 ward may be down from wi-fi, or it may just because, if
22 it's being located in an isolated environment, like
23 they've walked out into the garden or something like
24 that or to some other area where wi-fi coverage isn't
25 available, and when they move back towards the main

1 wi-fi in the ward office, that pending observations will
2 upload again.

3 So in terms of observation -- in terms of Oxevision
4 Observations, loss of data is -- we worked very hard to
5 ensure that that doesn't happen during the proof of
6 concept.

7 **Q.** Thank you.

8 At paragraph 44 of your witness statement on page 6
9 you explain that:

10 "Ward staff are encouraged to report suspected
11 platform or connectivity issues through the LIO support
12 route so that they can be triaged to the appropriate
13 supplier or EPUT technical team."

14 Then you say EPUT's formal IT route is the IT
15 service desk and Hornbill system.

16 Do you have a role to play in this process of
17 reporting issues?

18 **A.** Yes, to a degree. Just to go back to the beginning of
19 my statement, I'm a project manager by my role. That is
20 my role. But as a person who has been working with
21 Oxevision for such a long time, and working with the
22 staff, I do help frequently where -- when asked. So in
23 terms of that, I do assist.

24 The -- in terms of whether or not there is an issue
25 and they report it, I do on occasion help out when they

1 ask, you know -- LIO may come back and say, "Can we
2 check this out?" And I'll check it out with our IT
3 network team or infrastructure team. "Is there an issue
4 going on with the wi-fi right there?" They'll do
5 a check on it to see if there's been anything reported
6 or if there's been any drops in the service.

7 So I help facilitate it, is probably the best way of
8 saying it, facilitating the assistance, simply because
9 I work with the wards and when I work with -- I liaise
10 with a number of teams on -- in IT to help things along.

11 I hope that makes sense.

12 **Q.** It does, and it's come to a question that I had for you,
13 which is broader than connectivity issues. Given the
14 role, your project manager role -- and we'll come to,
15 shortly, the role that you play in training staff, as
16 well -- are you a point of contact for staff when they
17 have issues with LIO?

18 **A.** The first point of contact is the service desk, the LIO
19 support desk. And I make that abundantly clear. So
20 it's documented everywhere. And if they do come to me
21 first, I tell them very clearly: you need to contact the
22 support desk first, always, because I'm not there
23 24/7/365. The first point of contact is always the LIO
24 support desk.

25 **Q.** But do you have any awareness as part of your role of

1 the types of issues that staff are raising in relation
2 to the use of Oxevision or OxeObs?

3 **A.** Well, I used to receive a log some time ago from LIO
4 that showed me all the different types of tickets that
5 are coming in. And that would be things like broken
6 tablet, missing a cable, and we just stopped doing those
7 reporting for me.

8 If there's an issue that needs to be escalated, my
9 LIO account manager will usually reach out to me, and
10 I am always -- I help. And staff, I have to say that
11 staff probably -- especially those who I've been working
12 with for a significant amount of time, and quite a --
13 and I help a lot -- and they're my point of contacts on
14 the ward, we have a working relationship that's quite
15 fluid in terms of Oxehealth.

16 So if they referred to me as the point of contact
17 person, then yes, I would wear that hat with gladness
18 because I like being able to support them.

19 **Q.** Thank you. At paragraph 18 of your witness statement
20 you refer in particular to privacy concerns relating to
21 the use of Oxevision, which came to your attention.
22 Were these issues raised with you directly?

23 **A.** Um

24 **Q.** It's on page 3.

25 **A.** The privacy issue here, I believe, that behind this has

1 to do with the privacy masks, if I'm not mistaken. And
2 quite frankly, I don't remember where it was brought up.
3 I think I -- it seems to me as I recall, to my
4 recollection, anyway, that I asked the question if
5 privacy masks were in place, and then just began to
6 investigate it and made sure they were there.

7 If that's what the initial question was related to.

8 **Q.** In your statement you say that:

9 "The privacy concerns to which I referred arose
10 thorough my professional involvement in implementation,
11 governance, discussion, staff engagement, and
12 patient-facing information rather than a formal research
13 study."

14 So my question simply was: was that concerns that
15 were raised directly with you, either by staff or
16 anybody else?

17 **A.** I think sometimes it comes up in conversation when we've
18 gone out to the wards and had a conversation with them,
19 or during reviews. I have checkpoints with ward staff
20 at times, for instance Brockfield House. We have
21 a regular quarterly meeting where they're able to raise
22 questions. I've met with the clinicians and the Matrons
23 and the Ward Managers at Brockfield House as a for
24 instance, and they've raised these kind of questions at
25 that, in those dialogues.

1 I can't pinpoint them to specific persons, specific
2 times, specific emails, but it's -- usually they come up
3 in general conversations, and I communicate those --
4 I try to communicate those to somebody who might be able
5 to influence it in a clinical way.

6 **Q.** I'll now turn to your training in relation to Oxevision
7 and your role in that. If I may turn to paragraph 68 of
8 your statement on page 9. This is on the second
9 sentence. You explain that:

10 "The method of delivering and evidencing training
11 has changed over time. During earlier phases, Oxehealth
12 delivered Microsoft Teams sessions for wards approaching
13 go-live."

14 That was before your time, before --

15 **A.** No, it was also when I first started.

16 **Q.** Okay.

17 "Recordings were made available to support local
18 cascade and staff who could not attend a live session".

19 And then at paragraph 69, you explain that:

20 "OxeAcademy became a primary training source from
21 December 2021."

22 Then you say:

23 "The knowledge element later moved into Electronic
24 Staff Record and the Online Learning Module ..."

25 Could you explain what OxeAcademy is and how

1 training is delivered via OxeAcademy.

2 **A.** OxeAcademy has evolved, but the basis of it, or the
3 foundation of it, remains similar. It's a similar type
4 of format. Initially, when OxeAcademy was out there,
5 there was a slide deck with a narration of the various
6 slides that were, that had relevant data whatever was
7 going to be communicated. There would be some clips,
8 video clips in there that would show various aspects of
9 the use of the system. That was early phases of it.

10 **THE CHAIR:** That's online?

11 **A.** Pardon me?

12 **THE CHAIR:** That was online?

13 **A.** That was online, yes, Ma'am, and that was available
14 through OxeAcademy, which was a Oxehealth-curated site.
15 We did not download data from there for this purpose
16 because they curate this OxeAcademy.

17 If there are changes to the system, then that would
18 be updated within the OxeAcademy to reflect the changes
19 that were in the system. Therefore, we did not --
20 OxeAcademy is a LIO-curated data. So the evolution of
21 that, now it's on our OLM, our Online Learning
22 Management system, which is in our ESR, which is
23 employment, employee --

24 **MS ONABANJO:** Electronic Staff Record?

25 **A.** That's the one. Acronyms; they get us all the time.

1 So the -- it's still being curated by LIO, but it's
2 in a module, I think -- I can't remember what the
3 technical term is, a kern or kernel on our OLM that is
4 updated through a remote process.

5 **Q.** And so the training, there is no involvement of somebody
6 with clinical knowledge and experience in the training?

7 **A.** This is a knowledge-base element of the training. This
8 is just showing how the system works. The furtherance
9 of that is through the competency checklist that the
10 clinicians need to do with anybody who's new to the
11 ward. They have to have completed the OxeAcademy, or
12 the LIO Academy now. They have to complete that, get a
13 100% pass rate on that, and then once they have that,
14 then they attend a ward and go through a competency
15 checklist having also been required to review the
16 Standard Operating Procedures.

17 Though there is an engagement with new staff on the
18 wards with a nurse in charge or a designatee (sic) who
19 is on the ward to go over the competency checklist with
20 that new person. The training would be part of that,
21 demonstration and actions that, quite frankly, I haven't
22 witnessed it myself so I can't attest to the depth of
23 that training, but I do know that the competency
24 checklists are something that must be completed before
25 the person can use the system.

1 **Q.** Thank you. And how does EPUT or does EPUT keep a record
2 of those who have completed the training?

3 **A.** In terms of the OxeAcademy or the LIO Academy, yes.
4 Prior to it being on an OLM, we received regular updates
5 from LIO on who has or has not passed those and that
6 information was filtered out to the wards. When it was
7 made a mandatory requirement, then mandatory training
8 became part of the process, and since I've turned that
9 all over to Mandatory Training to manage, and they were
10 very specific on the requirements that they had people
11 to attain in -- you had to show evidence of training,
12 either a certificate or proving it in -- on
13 a spreadsheet that you'd actually completed the
14 training.

15 The competency checklist is something that Mandatory
16 Training does not involve with. That's at ward level.

17 **Q.** You and the Quality Trust Matron delivered refresher
18 training sessions in January and February 2024 and these
19 were -- were these in-person training sessions?

20 **A.** That's correct.

21 **Q.** And what prompted the delivery of these refreshers?

22 **A.** That's a very good question and I don't know how to
23 answer it, to be perfectly honest. We had -- the
24 Quality Matron and myself, we had been wanting to do
25 onsite discussions. I don't recall what the impetus was

1 behind it. I'm sure there must have been something from
2 a senior level that was suggesting it, but I can't tell
3 you specifically what it was. I don't recall that.
4 I apologise for that. All I know is that whenever
5 I have the opportunity to go out and talk with staff
6 about the system or to be engaging with the staff on the
7 wards, I take any opportunity I can.

8 **Q.** And what was covered in these refresher sessions?

9 **A.** I wish I had the agenda. We had an agenda of all the
10 things that were covered in them. Essentially, we were
11 looking at the things that were in the SOP that were
12 requirements, and asking -- and also getting feedback.
13 So any time we engage with the staff on the use of the
14 system, there's always an element of feedback. What can
15 we do to improve? What can we take back? What are the
16 areas that you're having difficulties or challenges
17 with?

18 But we also had a specific agenda of things that the
19 Clinical Lead, our Trust Quality Matron who I work with,
20 that she needed to cover, and I was there to provide the
21 how-to, technical support. Okay, if this happens, how
22 do we do this?

23 One of the things was the room refresh. We brought
24 up -- we discussed how the room refresh worked, using
25 that aspect of the system. I recall that was one of

1 them. I can't think of all the other items on that
2 checklist, sorry.

3 **THE CHAIR:** What do you mean by room refresh in this --

4 **A.** We spoke about it earlier, Madam Chair, about the room
5 refresh, that if the room doesn't appear to be aligned
6 with what a staff member is seeing, they can do a room
7 refresh, and it'll restart the room back to a clear
8 point.

9 **MS ONABANJO:** And in your -- in the interactions that you
10 had with staff, whether at the refresher event or any
11 other interactions, your opportunity to interact with
12 staff in relation to Oxevision, are you able to say the
13 extent to which they understand the SOPs that govern the
14 operation of Oxevision in EPUT?

15 **A.** Yeah, most of the attendees at these refreshers were
16 Ward Managers, Deputy Ward Managers, and Matrons. There
17 were a number of -- in some cases there were HCAs and
18 nurses as well. It was pleasantly engaging to see the
19 level of participation at these meetings. They were
20 quite engaged. I hope that answers your question. I
21 don't know if it does or not, but the refreshers were
22 a really good opportunity for them to have their say and
23 to discuss the things that the Quality Matron was
24 proposing.

25 **Q.** Thank you.

1 From what you describe, the refresher, it appears
2 that the refresher was an *ad hoc* session. Is there
3 a programme, is there a programme of refreshers or was
4 that just a one-off?

5 **A.** It was a one-off. It was a one-off time.

6 **Q.** And are there plans to run refresher sessions in
7 relation to the use of Oxevision?

8 **A.** Well, yes, this is part of the -- is there a documented
9 version of it? No, there isn't. Not to my awareness.
10 But my role, as a project manager, has limitations to
11 it, in that it's the proverbial "could have, should
12 have, would have", there's a lot of things I would like
13 to do but in my role as a project manager, there are
14 limitations to that role specific to relating to
15 projects.

16 My BAU, my business-as-usual responsibilities, are
17 primarily that of being reactive to some degree, whereas
18 I probably would like -- you saw my background is in
19 training and technology, and I would love to be more
20 proactive in that environment, if that makes sense.

21 **Q.** Yes, thank you.

22 Finally on this topic, you say you were unable to
23 locate complete attendance records for the refresher
24 course. Why is that? The attendance records, you say
25 you were --

1 **A.** For those --

2 **Q.** -- (overspeaking) -- for the refresher course?

3 **A.** We did take attendance, the Quality Matron kept those.

4 I don't have the records, apologies. I don't have

5 those. They were sent out to all the wards, and there

6 was attendance and there was an attendance sheet, but I

7 don't have that attendance sheet --

8 **Q.** Thank you.

9 **A.** -- or sheets, I should say, because we went to multiple

10 sites.

11 **Q.** Thank you.

12 I'll now turn to your recommendations -- your

13 proposed recommendations.

14 Earlier in your evidence we went over the

15 configuration of the bathroom alert in particular, and

16 one of your recommendations is that there should be

17 a clinical review of service configurations, including

18 the EPUT threshold used for in-bathroom alerts so that

19 configurations remained proportionate to the risks and

20 patient population.

21 What do you say, is there an issue with current

22 thresholds, and why do you think there needs to be

23 a review?

24 **A.** One of the questions you asked me earlier is the

25 feedback I received from wards. Where a ward has a low

1 patient population of -- that have suicide ideation, the
2 idea of having a bathroom alert going off every three
3 minutes if you're going to have the bathroom alerts
4 active has been told to me as being a bit excessive, and
5 they don't want them on, because they don't have
6 problems with suicide ideation within their patient
7 population.

8 And then there are other ones like that, as well,
9 where they don't necessarily need the three minutes on,
10 for instance, older adult wards. In an older adult
11 ward, it goes off at three minutes if it's an en-suite
12 bathroom, and older adults in the conditions that
13 they're in, are inevitably going to be in the bathroom
14 longer than three minutes. So the recommendation that
15 I'm making here for clinical is to review what fits for
16 each environment as to how those bathroom alerts should
17 be configured. Is three minutes the -- is it truly a
18 universal for all of these patients or is it something
19 that would be beneficially changed in different
20 environments?

21 I do believe that LIO is working on enhancements to
22 the system that will enable us to have bespoke, more
23 bespoke type of alerts, and therefore right now, if you
24 turn on bathroom alerts, for instance, on a ward that
25 has en suites, all of the bathrooms have them on unless

1 the room is off.

2 So any room that is on, on a ward that has the
3 bathroom alerts on, all of the rooms on that ward will
4 have them on, if the room is on.

5 **Q.** I understand. You make a further recommendation in
6 relation to a sleep function and you say at paragraph 87
7 that that needs to be clinically elevated, including
8 patient engagement and be used only as an adjunct to
9 clinical assessment.

10 What is the sleep function?

11 **A.** That is something that LIO has recently developed and I
12 believe they have rolled it out, I don't know if it's
13 available for -- if it's not, it will be soon. It
14 will -- I have a watch. I use this watch every night to
15 track how I sleep. Wearables are not allowed in our
16 mental health wards like this. So having a sleep
17 function in a room that enables clinicians to be able to
18 see the type of sleep activity that they have in a night
19 might be able to help them diagnosis better or to
20 support the patient's wellbeing, as well as for staff to
21 be able to be aware of how that is -- how their sleep
22 may affect their behaviours during the day. So that's
23 why I recommended that.

24 **Q.** You make a further recommendation in relation to the
25 functions of the system, and in this case, it's the

1 pause function. And you explain the purpose of that
2 function at paragraph 67, and you say:

3 "The current Activity Tracker Instructions for Use
4 describes it as temporarily turning off the camera for
5 a configured period during which room states and safety
6 notifications are unavailable before the room
7 automatically resumes."

8 You recommend that there also be a clinical and
9 governance review of the pause function before
10 implementation.

11 Can you explain why you have made that
12 recommendation?

13 **A.** The -- there are other Trusts that use the pause
14 function that we've learned through the LIO Community of
15 Practices groups and they use the pause function for
16 patient dignity in relationship to older adult wards
17 when they're being cared for in a hygienic way and
18 I just think that it might be something that we should
19 consider as a possibility for our own Trust.

20 **Q.** Thank you.

21 And finally, you recommend that there should be
22 clearer national guidance on consent for contactless
23 patient monitoring. Why have you made this
24 recommendation? And secondly, in what way do you
25 consider that inadequate guidance has impacted the

1 deployment of Oxevision?

2 **A.** I think that's a multiple-layered question, I don't know
3 how to unpack it to ensure I do each one justice.

4 **Q.** Why have you made the recommendation? If we start with
5 that.

6 **A.** The reason for that is that because of listening to --
7 again, going back to the Community of Practices, they've
8 been an invaluable way for myself and the Quality Matron
9 to interact with other Trusts that use the LIO system,
10 or have considered using the LIO system. A lot of good
11 questions come up in there, and we also learn that
12 different wards, different -- excuse me, different
13 Trusts do things differently. There is no continuity to
14 how -- I say no continuity, that sounds very absolute.
15 There is sometimes a lack of continuity in the way that
16 wards -- Trusts implement the LIO system on theirs.

17 Consent is probably one that is the biggest or the
18 most evident different -- differentiator in this
19 category. So having a governmental oversight or at
20 least -- perhaps not governmental oversight, but at
21 least some form of structure that provides a guidance
22 for Trusts to develop that continuity, would certainly
23 be helpful for all of us as a Trust, because then we're
24 working from the same page. I hope that --

25 **MS ONABANJO:** That answers my question. Thank you.

1 Chair, those are my questions. Do you have
2 additional questions for Mr Trimble?

3 **THE CHAIR:** I don't, thank you very much.

4 **MS ONABANJO:** We will now take a break for ten minutes while
5 we consider whether I need to put additional questions
6 to you.

7 **THE CHAIR:** Thank you. Ten minutes.

8 (2.57 pm)

9 (A short break)

10 (3.16 pm)

11 **THE CHAIR:** Ms Onabanjo.

12 **MS ONABANJO:** Mr Trimble, I asked you earlier about whether
13 there was a plan to run further refresher courses in
14 relation to the training for the use of Oxevision. And
15 in your answer, you explained that there are limitations
16 in your role and that you would prefer to be more
17 proactive as opposed to reactive.

18 A. (The witness nodded) .

19 Q. Could you just explain a little bit more what you mean
20 by that, by the limitations of your role and how you
21 would want to be more proactive?

22 **A.** The role of a project manager, a project is something
23 that has a beginning and an ending, right? So in terms
24 of that, inevitably, there will be no more new LIO
25 projects, or conceivably no more LIO projects, and yet

1 the system needs to still be managed somehow, and it
2 needs to be cared for and the staff need to be supported
3 in that and there needs to be liaison between the
4 organisations that are enabling this platform to
5 operate, as well as to innovate, as well as ensuring all
6 of the elements that we're looking for, patient safety,
7 staff safety, all of the bits and pieces that work
8 together.

9 As a project manager, all the things that I do
10 outside of a project are outside of my formal job role.
11 And I suppose in terms of pounds and pence, there has to
12 be a justification for me doing things that are outside
13 of the remit of my formal employment.

14 **Q.** So if I understand you correctly, you are saying that
15 the question as to whether there should be a series of
16 refresher and -- the decision on that is for somebody
17 else?

18 **A.** The decision on it, in part, I mean Ms Onabanjo, if
19 I said, look, I want to do a monthly training, that they
20 would -- my -- the director that I speak with, who is
21 the CIO, she would be more than happy to let me do
22 whatever I want to do, but there is an absolute
23 necessity of it being a clinical and technical
24 collaboration. So therefore, it requires a much broader
25 level of coordination and implementation in order for

1 that to occur.

2 I hope that --

3 **Q.** Yes.

4 **A.** -- that suits, without being too specific.

5 **Q.** Thank you.

6 In relation to the Oxevision system and the Activity
7 Tracker in particular, you explain that the system can
8 provide inaccurate information to the extent that it
9 might say a person is in their room when they are not,
10 and that those -- and that in those circumstances, it
11 needs to be refreshed. Is that a relatively common
12 issue?

13 **A.** If I asked for one log for one month from one ward, the
14 amount of data that is in there is absolutely incredible
15 amount of data. To be able to hone down and say is that
16 a common occurrence would be like pulling a needle from
17 a haystack. There is so much data to consume.

18 The information that we get in that regard is often
19 anecdotal, and anecdotal data or anecdotal information
20 really isn't the basis for setting a scientific
21 measurement for the quantity of these events happening.
22 Again, in a BAU environment where you have somebody who
23 is dedicated to seek out these kind of things then you
24 might be able to get a more accurate assessment based
25 upon a metric -- based upon metrics and measurements

1 that are established by a clinical oversight group, for
2 instance.

3 But I couldn't pin down whether that's common or
4 not.

5 **THE CHAIR:** But you did tell us, didn't you, that there had
6 been a refresher training, and one of the issues that
7 needed to be covered was the business of refreshing
8 rooms after --

9 **A.** Correct.

10 **THE CHAIR:** -- activity, the tracker had given an
11 inaccurate --

12 **A.** Correct.

13 **THE CHAIR:** -- alert. So that's clearly something that had
14 been on your mind, or, and the --

15 **A.** Yes, Madam Chair. It's been on our -- it was on my mind
16 at the time because it would have been raised as an --
17 not an incident; it's been raised as a recurrence of
18 some staff having experienced that, and we say, okay,
19 well, let's get ahead of this, and this is how you
20 fix it.

21 **THE CHAIR:** Okay, so it happens, it's not uncommon, you're
22 not prepared or not able to give us more specific
23 -- (overspeaking) --

24 **A.** No, in terms of quantity no, but I was early in -- in my
25 view, it was early intervention to try to enable the use

1 of the system rather than it being something that was
2 a fix, if you would.

3 **THE CHAIR:** Thank you.

4 **MS ONABANJO:** In her evidence this morning, Laura Cozens
5 relied on the information gathered by EPUT from Datixes
6 to support her claim that they are real-life examples of
7 Oxevision assisting staff in intervening in critical
8 incidents. Similar statistics were relied upon by
9 Mr Trent in his evidence last October.

10 Is it correct that you were involved in EPUT's
11 decision to alter the Datix form to include a check box
12 dealing with Oxevision?

13 **A.** Yes, I initiated it with the Datix manager -- I'm not
14 sure of his title, but the person who manages Datix.
15 But he had -- that question was supported by the Trust's
16 Quality Matron. She's the one who helped to devise the
17 words for it. And then that had to go through
18 a clinical review panel before the change could be made
19 to the Datix form. All of that is far outside of my
20 influence. Mine was to initiate the contact with the
21 Datix Manager -- can we do this and how do we do it?
22 That's the --

23 **Q.** But in terms of determining the content of the
24 information to be obtained from the Datix form, that
25 was -- that was -- (overspeaking) --

1 **A.** On the Datix? On the tick box?

2 **Q.** Yes.

3 **A.** That was working by the Trust Quality Matron. I may

4 have said, "Maybe this wording might work better" or

5 something, but it was a collaboration and eventually

6 she's the one who submitted the change.

7 **Q.** There was a meeting, a Project Board meeting on

8 27 March 2025 and one of the notes in that meeting was

9 that:

10 "The Datix team are going out to train staff and

11 will include the use of Oxevision tick box in the

12 system, and to add text in the description. Headlines

13 are 'Ligature incidents have declined, numbers may

14 defer, unable to tell without text in the description

15 for each incident, to explain how Oxevision assisted.

16 AW: spellings do differ in the reports. Can the Datix

17 team assist at all?" [As read]

18 You then advise that all versions of spellings are

19 within the search along with a "Yes" or "No" field to

20 capture, whether Oxevision assisted. So that's the

21 record that was in the minutes of the meeting.

22 Do you remember the rationale for wanting to capture

23 that information -- (overspeaking) --

24 **A.** Oh yes, I do.

25 **Q.** And what was the rationale?

1 **A.** Yes, I do. I report to the Project Board every month,
2 and one element of that was Datix reporting. And the --
3 you can't control or -- I say can't, again it's an
4 absolute. It's difficult to control what people put
5 into a Datix report, and -- but to make that Datix part
6 of a qualitative understanding of what's happening on
7 the ward in relationship to how Oxevision is used, you
8 need certain amount of data. You can tick a box, but
9 that just says that Oxevision was used.

10 To put information in the narrative on how it was
11 used, gives you more specificity on how it was actually
12 employed by the staff in that incident. And therefore,
13 you have more accurate assessment of how Oxevision is
14 being used on the wards by the staff. And that's what
15 the key point of the Project Board, and I suppose the
16 Executive Team, also want to know is: how is the system
17 being used in serious incident reporting to enable us to
18 be able to have quality lessons learned on the lessons
19 from the LIO activities?

20 That Datix form creates or provides that foundation
21 for us to begin the investigation. If it's -- if a box
22 is ticked and there's nothing in the narrative that
23 describes it, either you have to do an investigation
24 with the reporter of the -- the author of the Datix, or
25 you have to do some other kind of investigative work.

1 This just speeds the process of enabling somebody, and
2 in this case it has been me, to find out how the system
3 has been used, and then I report that to the Project
4 Board.

5 **Q.** Thank you. Was it any part of the intention behind
6 gathering the data for it to support claims that the
7 implementation of Oxevision resulted in a reduction of
8 incidents on the ward and/or assisted staff in
9 intervening in incident of self-harm?

10 **A.** The reality of it is I provide data, and somebody else
11 reads that data and makes a determination as to what
12 that data would say. While I might have perceptions of
13 how the data is being -- presents itself, there is
14 somebody else who'd be clinical who understands the
15 Datix and what kind of activities happen on the ward,
16 they would be more suited to answer a question relative
17 to: did it make a difference?

18 **Q.** Thank you, but my question, actually, is: in the
19 discussions that you had at the Project Board meeting
20 about capturing the data, was part of the intention
21 expressed at those meetings that the data should be
22 captured in order to support the claims that the
23 implementation of Oxevision resulted in a reduction of
24 incidents?

25 **A.** I don't know that it was specific to that degree.

1 I can't recall a conversation that said -- in my
2 position, when we're looking at data, data should speak
3 for itself. If you're looking to create something to
4 prove a point, that's called confirmation bias, and
5 if -- I'm not going to be looking at data to try to make
6 my point, I want data to tell me the truth so I can
7 adjust according to the truth, or whatever is evidence
8 of it.

9 So I did not create anything in the Datix or suggest
10 anything in the Datix to prove a point other than what
11 does it do? Can you give me something? And the Datix,
12 it tells me what is happening, so that we can report it
13 accurately. And then let somebody else make a decision
14 on whether or not it's having the impact that they want
15 or they don't want, because, quite frankly, there's
16 people on both sides; there's ones that want it to be
17 a glowing recommendation and there's people who want it
18 to fail.

19 So, you know, it depends on the perspective of it.

20 **Q.** Did the data captured from the Datix reports
21 differentiate between interventions which would have
22 happen without Oxevision and those where Oxevision was
23 directly responsible for the intervention? So, for
24 example, if a staff member observes a patient
25 self-harming remotely when conducting hourly or

1 four-hourly checks, would that be one of the incidents
2 where Oxevision played a role in the response?

3 **A.** Yeah, there have been bathroom alerts where people's
4 lives have been saved. So yeah.

5 **Q.** I'm going to read you out a record of the minutes of
6 a Project Board meeting on 5 July 2025. It states that:
7 "Noted that we are seeing more Datix reports
8 including Oxevision description in the body of the text,
9 seen a good response here." [As read]

10 Then it says:
11 "DT" -- you -- "advised that reminders are sent out
12 but those that are included are very thorough and clear
13 that it is saving lives." [As read]

14 It then notes that:
15 "VC says: there needs to be a clear message to those
16 areas not including sufficient information." [As read]

17 And it further notes that you, DT:
18 "... attended Datix training this week and it was
19 very clear on how to use the tick box for Oxevision and
20 how and when to use it." [As read]

21 The question is whether -- is this an example within
22 the currency of this Inquiry of what Dr Denman says in
23 her report: that the issue of gathering effectiveness
24 data was mainly from the perspective of trying to gather
25 data for the -- gather support for the efficacy of the

1 system rather than in relation to a balanced evaluation?

2 So it goes back to the previous question as to
3 whether the purpose of gathering the data was to support
4 the efficacy of the system or was it to get objective,
5 independent evidence as to how staff were using the
6 system?

7 **A.** I did read Dr Denman's report so I'm familiar with what
8 you're talking about. I have to say, I don't recall any
9 conversations or any emails, I don't recall any that
10 specifically asked us to prove a point that it's saving
11 lives.

12 The evidence of it, in my opinion, shows that --
13 because I've read the Datixes, they're there, you cannot
14 deny the fact that the Datixes say, "Alert went off,
15 went in there, found patient ligature", okay? They're
16 there, they exist. We don't make them up. Those are
17 facts.

18 So you can -- whomever can make the conjecture or
19 they can make the assessment what they want. Does it
20 save lives? In my opinion, based upon the reading the
21 Datixes that I've seen, yes. Numerous times. Somebody
22 else might not agree with me on that, but in my opinion
23 from reading the Datixes that I read, based upon these
24 reports and the ones that I see on a daily basis, yes.
25 It has saved lives.

1 **MS ONABANJO:** Thank you.

2 Chair, those are my questions.

3 **Questioned by THE CHAIR**

4 **THE CHAIR:** Thank you. I've got one further question.

5 Both you and Ms Cozens referred to the fact that

6 there is no longer a report of the numbers of

7 attempts --

8 **A.** Correct.

9 **THE CHAIR:** -- of the vital signs, as opposed to the actual
10 successful capturing of vital signs. Do you know

11 anything about why that report is no longer generated?

12 How did that come about? What's the reason for that?

13 **A.** I think there's, from my perspective, there's several
14 layers on this one here, and I know that LIO gave us
15 a specific reason why they did not do that, but I can't
16 recall what that specific reason was.

17 I do know from experience that that vital sign
18 attempted -- or it's the last column on the sheet that
19 was removed, it caused a lot of confusion. Even though
20 in the legend at the beginning, or the instructions at
21 the beginning of the usage report would say what that
22 meant so that it was very clear what "vital signs
23 completed", "vital signs attempts" were. Inevitably,
24 we'd still get questions from staff as to "What is vital
25 signs attempted?"

1 So the -- in the numbers, obviously, there was
2 a disparity between them. In my view -- and it's
3 clearly my view, and I know that there is a reason why
4 LIO said it, and it's in writing some place in the
5 documentation -- but in my view, the reason why, it was
6 to help to reduce the confusion on the usage report, and
7 that's the reason why.

8 I don't believe for a minute it was to alter
9 a perception of a heightened number or a lower number.
10 It was simply because the report itself was generating
11 more difficulties of understanding how to read it, and
12 I think that's why that was removed.

13 **THE CHAIR:** Thank you.

14 **MS ONABANJO:** Thank you, Chair. That's the end of the
15 evidence session today.

16 **THE CHAIR:** Can I thank you very much indeed for coming to
17 give your evidence, it's been very helpful. And we will
18 sit again at --

19 **MS ONABANJO:** We will resume at 10.00 am tomorrow.

20 **THE CHAIR:** 10.00 tomorrow. Thank you.

21 **(3.36 pm)**

22 **(The hearing adjourned until 10.00 am the following day)**

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