

Wednesday, 14 October 2026

(10.00 am)

(Proceedings delayed)

(10.02 am)

THE CHAIR: Mr Griffin, good morning.

MR GRIFFIN: Good morning, Chair. This morning, the Inquiry will hear evidence from Dr Kallur Suresh and Mr Zephan Trent of EPUT. Chair, as you can see, they're giving evidence together.

Dr Suresh, as we heard last week, is EPUT's Executive Chief Medical Officer, and Mr Trent is EPUT's Executive Chief Digital and Information Officer. We heard from Mr Trent last October.

We are grateful that both have returned to give further evidence this week to address observation and technology.

As with previous days, Chair, there may be aspects of today's evidence that are difficult to listen to. For some people, it may not be possible to sit through the sessions today. 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 those who require it. Present here today are representatives from Hestia, wearing orange scarves, and

1 they'll be pleased to meet and speak with you. If you
2 prefer, you can come up and talk to a member of the
3 Inquiry team, we're wearing purple lanyards, and we'll
4 point you in the direction of Hestia.

5 And if you're watching online, there are references
6 to relevant support on the Inquiry website at
7 lampardinquiry.org.uk.

8 Chair, we want anyone and everyone engaging with
9 this Inquiry to feel safe and supported.

10 **ZEPHAN TRENT (affirmed)**

11 **KALLUR SURESH (affirmed)**

12 **Questioned by MR GRIFFIN KC**

13 **MR GRIFFIN:** Would you both give your full names, starting
14 with you, Dr Suresh.

15 **DR SURESH:** Kallur Suresh.

16 **MR TRENT:** Zephan Marcus Andrew Trent.

17 **Q.** Dealing first with the witness statements you have
18 provided to the Inquiry and that are relevant for the
19 purposes of our hearing today, please, Mr Trent you
20 provide three witness statements previously that we
21 discussed when you gave evidence last time. Have you
22 both now jointly authored two statements that have been
23 provided to the Inquiry for the purposes of this
24 hearing?

25 **MR TRENT:** Yes.

1 **DR SURESH:** Yes.

2 **Q.** Is the first of those entitled Witness Statement in
3 Response to Rule 9(114), and is it dated 22 May of this
4 year?

5 **DR SURESH:** That's correct.

6 **Q.** It's 116 pages long; is that correct?

7 **DR SURESH:** Yes.

8 **Q.** I am, during the course of today, going to refer to that
9 as your main statement.

10 **DR SURESH:** Yes.

11 **Q.** Have you, in fact, recently provided what you have
12 termed as a "Correction witness statement following
13 response to Rule 9(114)", dated 25 September 2026, which
14 notified some corrections to the main statement.

15 **DR SURESH:** We have.

16 **Q.** We'll come on to that in a moment.

17 The supplementary statement you have provided, is
18 that dated 30 June 2026 and is it 16 pages long?

19 **DR SURESH:** That is correct.

20 **Q.** As I have said, I will refer to that as the
21 supplementary statement. And have you also in fact
22 recently provided an addendum to the supplementary
23 statement to Rule 9(114) notifying some corrections to
24 the supplementary statement?

25 **DR SURESH:** That is correct.

1 **Q.** We will come on to that shortly.

2 Finally, Dr Suresh, have you provided your witness
3 statement of Dr Kallur Suresh dated 14 May 2026 and
4 running to 46 pages?

5 **DR SURESH:** That is correct.

6 **Q.** And I'll refer to that as "your statement" or
7 "Dr Suresh's statement", just so that we're clear: the
8 three main statements, the main statement, the
9 supplementary statement and Dr Suresh, your statement.

10 **DR SURESH:** Thank you.

11 **Q.** Can we deal, then, with corrections now and corrections
12 to the main statement first arising from the correction
13 statement I have just referred to.

14 Do those corrections all relate to your previous
15 description of TIAA auditors?

16 **MR TRENT:** Yes.

17 **Q.** In essence, is the main statement incorrect where it
18 characterises TIAA as external auditors, or to the
19 external TIAA follow-up re-audits for the purposes of
20 their work in 2025 and 2026, which we'll come on to
21 consider?

22 **MR TRENT:** Yes, they are our internal auditors. They are an
23 external company, they're independent of EPUT and
24 I think that's where the confusion lay, and we wanted to
25 be absolutely transparent, it's a different firm that

1 does external audit for EPUT. This company does
2 internal audit.

3 **Q.** For present purposes, in terms of corrections we need to
4 make to the main statement, is it right that there is
5 essentially a correction that we should be making to
6 paragraph 248 at page 55?

7 **MR TRENT:** Yes.

8 **Q.** And we should simply delete the word "external", the
9 second word in that paragraph?

10 **MR TRENT:** Yes.

11 **Q.** And in fact coming forward to paragraph 231, do we just
12 need to delete from the top line of that paragraph
13 reference there to "the Trust's external auditors"?

14 **MR TRENT:** Yes.

15 **Q.** So those two corrections deal with the various points
16 we've just addressed; is that right?

17 **MR TRENT:** Yes, I think so.

18 **Q.** Thank you.

19 Now, as I've said, you also wish to notify
20 corrections to the supplementary statement. And these,
21 as I understand it, are corrections to pages 5 and 6 of
22 the supplementary statement; is that correct?

23 **MR TRENT:** Yes.

24 **Q.** Now, you have set out in the further statement that you
25 provided very recently a number of corrections that

1 relate to exhibit numbers and a particular date; is that
2 correct?

3 **MR TRENT:** Yes.

4 **Q.** Now, I'm not going to go through all of those now but
5 should we read the supplementary statement as corrected
6 in accordance with the recent statement you've provided?

7 **MR TRENT:** Yes, please.

8 **Q.** Can you both confirm that all of the statements we've
9 referred to contain a statement of truth?

10 **MR TRENT:** There's one further correction, to just make on
11 the main statement.

12 **Q.** Oh yes, of course.

13 **MR TRENT:** At paragraph 544, we discussed the user
14 authentication, that paragraph reads as though that's
15 been rolled out across the Trust. Actually, it's just
16 describing the pilot and so that should be made clear,
17 it's in pilot on a limited number of wards, not across
18 the whole Trust.

19 **Q.** We'll come on to that actually, so that might be the
20 time to provide additional information --

21 **MR TRENT:** Of course.

22 **Q.** -- but thank you for that correction.

23 So I was asking if you could both confirm that all
24 of the statements that we've referred to contain at the
25 end statements of truth?

1 **DR SURESH:** We can.

2 **Q.** And that the main and supplementary statements and,
3 indeed, the correction statements you have provided are
4 signed by both of you?

5 **DR SURESH:** That's correct.

6 **MR TRENT:** Yes.

7 **Q.** And Dr Suresh, can you confirm that you've signed your
8 statement too?

9 **DR SURESH:** I have.

10 **Q.** Mr Trent and Dr Suresh, subject to the corrections we've
11 just dealt with, are the two jointly-authored statements
12 true to the best of your knowledge and belief?

13 **DR SURESH:** They are.

14 **MR TRENT:** Yes.

15 **Q.** Dr Suresh, is the further statement you've provided also
16 true to the best of your knowledge and belief?

17 **DR SURESH:** It is.

18 **Q.** Do the two jointly-authored statements broadly provide
19 updates in relation to the use of Oxevision at EPUT
20 since Mr Trent gave evidence last year?

21 **DR SURESH:** It does.

22 **Q.** Both of them?

23 **DR SURESH:** Yeah.

24 **Q.** Dr Suresh, does the statement you have provided cover
25 the management of physical health conditions on mental

1 health inpatient wards?

2 **DR SURESH:** It does.

3 **Q.** And my questions today, Dr Suresh, on the basis of that
4 statement, will be confined to aspects that relate to
5 the NEWS2 measurements and to Oxevision.

6 **DR SURESH:** Okay.

7 **Q.** The subject of the hearing this week is observation and
8 technology. And we will be discussing technology that
9 we have been referring to as "Oxevision". I suggest
10 today we continue to refer to it as "Oxevision",
11 although, as we've heard, there's been a rebranding last
12 year, I think.

13 **DR SURESH:** That's correct.

14 **Q.** But for the sake of simplicity, can we just refer to it
15 as "Oxevision" today?

16 **DR SURESH:** We can.

17 **Q.** The company, called Oxehealth -- and I am now at slight
18 risk of over-simplification -- has also become known as
19 LIO. May I suggest that today we refer to either
20 "Oxevision" or "LIO" as we feel appropriate.

21 **DR SURESH:** That's fine, yeah.

22 **MR TRENT:** **(The witness nodded).**

23 **Q.** Now, Mr Trent, is it right, as we covered last year when
24 you gave evidence that Oxevision was first rolled out at
25 EPUT in 2020?

1 **MR TRENT:** Yes.

2 **Q.** Dr Suresh, you gave evidence last week and when you did
3 that, you provided details of your role and background.
4 In fact, I am going to ask you a little bit about them
5 today again because there may be people watching today
6 that didn't see that evidence last week.

7 Have you been Essex Partnership University NHS
8 Foundation Trust's or EPUT's Executive Chief Medical
9 Officer since 15 March this year?

10 **DR SURESH:** In a substantive role, yes.

11 **Q.** Before that, were you the interim?

12 **DR SURESH:** That's correct, for a period of three months.

13 **Q.** From 15 December 2025?

14 **DR SURESH:** That's correct.

15 **Q.** Please describe your role as Executive Chief Medical
16 Officer.

17 **DR SURESH:** I have responsibility for all medical staff,
18 day-to-day management of operational staff, research
19 within the organisation. I'm also the Caldicott
20 Guardian for the Trust, and I am also Responsible
21 Officer, which is a legally appointed role in relation
22 to the GMC, the General Medical Council, which regulates
23 doctors.

24 **Q.** Now, we heard evidence from Dr Chess Denman on Monday,
25 who had held the role of Medical Director at her Trust,

1 and she described what that role entails. Would you
2 agree with her that's equivalent to the Medical Officer
3 role at EPUT?

4 **DR SURESH:** It is.

5 **Q.** And do you agree, in broad terms, with her description
6 of the role?

7 **DR SURESH:** I do.

8 **Q.** I should have first established, you were here, I
9 understand, on Monday --

10 **DR SURESH:** I was.

11 **Q.** -- and were able to watch her evidence?

12 **DR SURESH:** That's correct.

13 **Q.** Thank you.

14 Prior to holding the role of Chief Medical Officer
15 or the interim role, were you EPUT's Deputy Medical
16 Director for the West Essex Care Unit?

17 **DR SURESH:** That is correct, one of the Deputy Medical
18 Directors.

19 **Q.** One of the Deputy Medical Directors. And was that from
20 April 2017?

21 **DR SURESH:** That's correct, following the merger of North
22 and South Essex Trusts.

23 **Q.** Thank you.

24 Now, I'm not going to ask you about roles before
25 that because we're talking about technology that was

1 rolled out in 2020, but what I would like to ascertain
2 with you now, please, Dr Suresh, is what your role would
3 have been, and responsibilities were, in connection with
4 Oxevision.

5 **DR SURESH:** In my Deputy Medical Director role?

6 **Q.** In any role, because we have this situation in which the
7 technology is being rolled out from 2020 at EPUT. Would
8 you just describe what your roles were in the period up
9 to now in connection with Oxevision?

10 **DR SURESH:** In March 2020, when I think Oxevision was rolled
11 out first, in EPUT, I was a Consultant Psychiatrist on
12 an inpatient older adult ward in West Essex looking
13 after patients with dementia and functional mental
14 health problems, as well as the Deputy Medical Director
15 for that area.

16 In terms of my own interface or interaction with
17 Oxevision at that time, I know that it was first rolled
18 out as a pilot on the adult wards, and it was probably
19 two or three years later that it came to older adult
20 wards. At that point I was curious to know what it was,
21 and what its functions were. It was mainly a nursing
22 observation tool and engagement tool at that time. So
23 the -- the times when Oxevision issues came to my
24 attention as a Consultant Psychiatrist on that ward was
25 when patients perhaps raised some concerns about being

1 monitored, and also, when nursing staff escalated
2 concerns around patients who may not have capacity and
3 therefore they were unsure of how to proceed.

4 **Q.** Thank you.

5 Can we just take stock of what you've just told us.
6 Now, you were working as a Consultant Psychiatrist?

7 And indeed, do you still work as a consultant
8 psychiatrist at the same time as being Chief Medical
9 Officer?

10 **DR SURESH:** I don't work on an inpatient ward anymore
11 because it's too large a time commitment to enable me to
12 perform the other role, but I do have a clinic that I'm
13 running at present but my clinical practice has reduced
14 quite significantly since taking on the role of Chief
15 Medical Officer.

16 **Q.** And you mentioned older adults, is that an area of
17 particular expertise for you as a Consultant
18 Psychiatrist?

19 **DR SURESH:** That is correct, I hold a certificate of
20 completion of specialist training in old age psychiatry
21 which is an accreditation given by the Royal College
22 of Psychiatrists.

23 **Q.** And as you were saying, you did work on an inpatient
24 ward?

25 **DR SURESH:** I did.

1 Q. Was that a ward that had Oxevision installed in it?

2 DR SURESH: Yes, but not from the beginning, as I mentioned

3 before.

4 Q. Not from the beginning, yes.

5 DR SURESH: But maybe a couple of years later. I don't

6 remember the exact time when it came on to the ward.

7 Q. So, in short, though, you have experience of being

8 a Consultant Psychiatrist on a ward where Oxevision was

9 installed?

10 DR SURESH: That is correct.

11 Q. You referred to it as an observation and engagement

12 tool. What did you mean by that?

13 DR SURESH: Well, it enables nursing staff to observe

14 patients remotely, given that when it was first

15 deployed, it came in during the Covid-19 pandemic where

16 social distancing was the norm and we had to make sure,

17 particularly on older adult wards, make sure patients

18 were not exposed to infections, Covid-19. So it was

19 during that time that the rollout happened in the

20 beginning, and I have had experience of it since it was

21 rolled out to the ward that I was working as

22 a consultant on, and that was an older adult ward.

23 Sorry, does that answer your question?

24 Q. That does answer my question. This is perhaps an aspect

25 of the rollout we haven't discussed in detail before at

1 hearings, the context of the Covid pandemic during the
2 time of the rollout. But if I've understood you
3 correctly, Dr Suresh, you've said that the pandemic made
4 the remote observation facility of Oxevision important
5 at that time?

6 **DR SURESH:** Yes, at that time.

7 **Q.** One of the issues that we have been grappling with, and
8 we'll come on to discuss more, is the extent to which
9 it's appropriate to use Oxevision remotely to view
10 patients, but we should, do you suggest, bear in mind
11 that towards the beginning of the process, it was being
12 used because of Covid?

13 **DR SURESH:** It was rolled out during Covid, but I'm not a
14 hundred per cent certain whether that was the entire
15 reason.

16 **Q.** All right, well, we'll come on to discuss remote
17 observation and Oxevision as we go along, thank you.

18 Mr Trent, we discussed your role at EPUT and
19 relevant experience when you last gave evidence to the
20 Inquiry. You told us then that you joined EPUT in April
21 2022; is that correct?

22 **MR TRENT:** Yes.

23 **Q.** So should we bear in mind that that is some way through
24 the rollout of Oxevision at EPUT?

25 **MR TRENT:** Yes.

1 **Q.** You've explained that you've been since April 2022
2 Executive Director of Strategy, Transformation and
3 Digital at EPUT and explained you led on the strategy
4 development for the organisation, you provided
5 leadership and coordination on transformation across the
6 organisation and you had oversight of digital services;
7 is that all correct?

8 **MR TRENT:** Correct.

9 **Q.** We can see from the recent correction statements that
10 you've provided that your job title has changed. What
11 is it now?

12 **MR TRENT:** Executive Chief Digital and Information Officer,
13 and that's effective from 2 September. It's a temporary
14 change and the reason for the change is that, as the
15 Inquiry is aware, and we've said in previous evidence,
16 the Trust is implementing a new electronic patient
17 record system, and we're at a crucial phase of that
18 work, it's a major transformation programme. So the
19 Board of Directors agreed I should prioritise more of my
20 time on that, and so other colleagues are temporarily
21 holding the responsibility for strategy and
22 transformation until we complete that transformation
23 programme.

24 **Q.** So that role is from 2 September 2026?

25 **MR TRENT:** Yes, that's when the Board made its

1 determination.

2 Q. Thank you.

3 You were last year, and are you still, Senior
4 Information Risk Owner at EPUT?

5 MR TRENT: Yes, I am.

6 Q. And when you gave evidence last year you explained your
7 qualifications, including as a Chartered Financial
8 Analyst charterholder, but you also made clear that you
9 don't have clinical qualifications; is that all correct
10 too?

11 MR TRENT: Yes.

12 Q. Now, the EPR, may I ask you very briefly about that
13 because we have heard about it before. What is it
14 called at EPUT?

15 MR TRENT: So the product is branded the Nova EPR.

16 Q. N-O-V-A?

17 MR TRENT: N-O-V-A, yes.

18 Q. Thank you.

19 MR TRENT: But it's provided by Oracle Health, common with
20 a number of other NHS Trusts, we use a local brand.
21 Other examples, Guys and Tommies use Apollo, Manchester
22 uses HIVE as a brand to engage staff, and that was
23 determined some years ago, and the programme essentially
24 replaces a number of existing electronic patient record
25 systems with a single system, and it does so across both

1 EPUT and our acute partners in Mid and South Essex NHS
2 Foundation Trust, which has real benefits in terms of
3 physical and mental health care integration.

4 **Q.** Understood.

5 When is it scheduled to go live at EPUT?

6 **MR TRENT:** In the next financial year, '27/'28.

7 **Q.** May I ask you this: to what extent will the new
8 electronic patient record afford the possibility, for
9 example, of conducting observations using that rather
10 than, as we've previously heard, Oxevision Observations
11 as part of the Oxehealth product?

12 **MR TRENT:** The new EPR will have significantly greater
13 capabilities than our current systems. Things like
14 conducting -- and it has more capability for handheld
15 and remote devices. The configuration of that system
16 will determine how it's used. So I couldn't say it
17 would exactly replicate or be able to exactly replicate
18 what e-obs does but the substance of it is something
19 that it could be configured to do, yes.

20 **Q.** So I suppose for present purposes, there is a possible
21 overlap between Nova and certain aspects of Oxevision?

22 **MR TRENT:** Well, with any electronic patient record system
23 and with any NHS Trust, whether mental health or acute,
24 there will be a multitude of clinical systems in use at
25 any time and sometimes capabilities will be part of the

1 core electronic patient record system and sometimes
2 they'll be add-on or integrated systems. So it's not
3 uncommon at all to have a number of systems that
4 integrate with your EPR, and Oxevision and e-obs could
5 be one of those, nor is it uncommon to replace some of
6 those ancillary or additional systems with your core
7 EPR. It depends on the scope you procured.

8 **Q.** That's fine, thank you. So there is a possibility but
9 it's all to be seen?

10 **MR TRENT:** Well, we're still in the process of the
11 implementation, the configuration, you know, and of
12 course we have the independent review on Oxevision so
13 we'll pay attention to the outcome of that, which will
14 complete ahead of the EPR.

15 **Q.** Understood, and we'll come on and I'll ask you about the
16 independent review as we go along.

17 Do you both report directly to EPUT's Joint CEOs,
18 Trevor Smith and Alex Green?

19 **DR SURESH:** We do.

20 **MR TRENT:** Yes.

21 **Q.** I'm just going to ask you both to slow down a tiny bit
22 whilst you're giving your evidence. That's so everyone
23 can hear what you have to say and understand what you
24 have to say, and also because a note is being taken of
25 what you say.

1 **MR TRENT:** Sure.

2 **Q.** If I ask you to pause or slow down from time to time,
3 please don't take it the wrong way; it's just so that
4 everyone can capture what you're saying.

5 Before I go any further, Dr Suresh, I understand
6 there's something you would like to say.

7 **DR SURESH:** Yes, on behalf of Mr Trent and myself, I wanted
8 to offer my sincere condolences and apologies to the
9 families affected by the issues being investigated by
10 this Inquiry.

11 **Q.** Thank you.

12 Thank you for both agreeing to give your evidence
13 together. I will direct questions to one or other of
14 you, taking into account your different backgrounds.
15 But if one of you feels you've something significant to
16 add to an answer given by the other, would you let me
17 know?

18 **MR TRENT:** Yes.

19 **DR SURESH:** We will.

20 **Q.** You explain in the main statement that Dr Suresh retains
21 overall responsibility for the evidence provided.
22 Dr Suresh; is that correct?

23 **DR SURESH:** That is correct.

24 **Q.** The Inquiry has received evidence relevant to the issue
25 of observation and technology at previous hearings, and

1 in October last year, Mr Trent, you and I covered a wide
2 range of matters about Oxevision, including the vital
3 signs alerts and OxeObs functions, the perceived
4 advantages of the technology at EPUT, concerns that had
5 been raised about its operation, the rollout at EPUT,
6 the issue of consent, including in light of the
7 publication of the NHS England Principles of 2025, the
8 Standard Operating Procedure, or SOP, auditing and
9 technology, and we touched on its cost. So we covered
10 quite a lot of ground before.

11 There have been developments since you last gave
12 evidence, and we'll catch up on those during the course
13 of your evidence today.

14 Dr Suresh and Mr Trent, in July this year, we heard
15 from two expert witnesses, Jill Archibald, Mental Health
16 Nurse Consultant, and our expert health statisticians,
17 Professor Donnelly and Dr Christodoulou. Now, am
18 I right in thinking that either one or both of you were
19 present for that evidence or have subsequently
20 reviewed it?

21 **MR TRENT:** I've reviewed both of their reports. I wasn't
22 present. I have been present all of this week, and
23 I reviewed online Mr Harry's evidence from Monday last
24 week.

25 **Q.** Thank you.

1 And Dr Suresh?

2 **DR SURESH:** I wasn't present at the July hearings, but
3 I have reviewed their evidence.

4 **Q.** And, of course, we heard on Monday from Dr Francesca
5 Denman, another expert for the Inquiry. Again, am
6 I right in understanding that you're both aware of what
7 she said?

8 **DR SURESH:** Yes, we were present as well for the live
9 hearings.

10 **MR TRENT:** Yes, and we've read her report.

11 **Q.** As you will know, we also heard in July from the former
12 EPUT CEO, Paul Scott, and the then Acting Chair, Loy
13 Lobo, and Mr Lobo told us of a plan to appoint an
14 Interim Trust Chair. Has that now happened?

15 **MR TRENT:** Yes, and indeed she is here today, Chair.

16 **Q.** Is that Jackie Craissati?

17 **MR TRENT:** Yes, that's right.

18 **Q.** And was that from 1 September 2026?

19 **MR TRENT:** Yes, that's right.

20 **Q.** We've covered in this hearing, a number of times, what
21 Oxevision is, including in fact this week, but I'm aware
22 that there may be some people who are listening to this
23 evidence who don't have that background so I'd like to
24 just quickly refresh us as to what its essential
25 functions are. Can we do that by reference to a poster

1 relating to Oxevision that was part of the most recent
2 EPUT SOP.

3 Thank you. It's up on our screens. The reference,
4 for those who need it, is EPUT026149.

5 So, can we see here, this is a poster that would go
6 up on a ward; is that correct?

7 **MR TRENT:** Yes.

8 **Q.** Can we see here:

9 "Our contactless monitoring system:
10 "How do staff use the system to support your care?"
11 And it says this:
12 "The system gives staff information about your heart
13 rate, breathing rate, and your location and movement."
14 Dr Suresh, is Oxevision installed exclusively in
15 patient bedrooms?

16 **DR SURESH:** It is.

17 **Q.** And is it right that it has the two main functions that
18 we can see here: non-contact monitoring of pulse and
19 respiratory rates, but also, a system of alerts relating
20 to patient movement in their bedrooms?

21 **DR SURESH:** That's correct.

22 **Q.** Can we just see a little bit further down, is that
23 a picture of the Oxevision unit that we would find in
24 a patient's bedroom?

25 **DR SURESH:** It is.

1 Q. Do we see on the left the camera?

2 DR SURESH: Yeah.

3 Q. And on the right, two infrared lights, sometimes

4 referred to as illuminators?

5 DR SURESH: (The witness nodded).

6 Q. Is that correct?

7 DR SURESH: That is correct, yeah.

8 Q. And then if we drop down to the second half of the

9 poster, do we see this:

10 "Ward staff can only see a clear view of your room

11 when measuring your heart and breathing rate for up to

12 15 seconds.

13 "They can see a blurred view of your room for up to

14 15 seconds when they receive a notification."

15 So the two types of view that the system affords are

16 either a clear view of a patient in their room or

17 a blurred or pixelated view of a patient in their room;

18 is that correct?

19 DR SURESH: That is correct.

20 THE CHAIR: What do those photographs show, the top one and

21 the bottom one?

22 MR TRENT: These are examples, I think, provided by

23 Oxevision, I believe.

24 THE CHAIR: And are they meant to be clear images or are

25 they meant to be the blurred image, or are they meant to

1 be both?

2 **MR TRENT:** They're meant to be both.

3 **THE CHAIR:** So the top one, is that the clear view?

4 **MR TRENT:** Yes.

5 **THE CHAIR:** And the bottom one is the blurred?

6 **MR TRENT:** Yes, I believe so.

7 **THE CHAIR:** Thank you.

8 **MR GRIFFIN:** Can we drop to the bottom of the poster,

9 please.

10 Now, I understand, Mr Trent, there is something you

11 want to inform us about in relation to the bottom of the

12 poster?

13 **MR TRENT:** Yes. This poster has since been corrected since

14 our statement, so you'll see at the bottom there's a QR

15 code. That plays a video. That was added in response

16 to patient feedback wanting videos to explain the

17 system. Beneath that, there is now a section which

18 refers to the Trust's Privacy Notice and refers to Clear

19 Video Data and how to raise concerns and find out more

20 information about that. So that's not visible on this

21 one but it since has been corrected.

22 **Q.** We looked at something along those lines last year when

23 we looked at an earlier version of the poster, I

24 believe. Is that the kind of wording that we would see

25 again at the bottom of the corrected poster today?

1 **MR TRENT:** Yes, similar to that. I mean, last year I think
2 the Chair rightly challenged the question of whether
3 "salient" was a meaningful word and it's since been
4 changed to "clear" but I think the substance of it is
5 the same.

6 **Q.** Does the poster, for example, or the leaflet, there's
7 a slightly longer leaflet, isn't there, that can be
8 provided to patients, do either of those expressly state
9 that if the system is activated in a patient's bedroom,
10 it's recording them 24 hours a day, seven days a week?

11 **MR TRENT:** Yeah, the leaflet does do that, and also the
12 Privacy Notice, as well.

13 **Q.** Has the Privacy Notice changed since we talked about it
14 last year?

15 **MR TRENT:** It has actually been updated to more -- so now,
16 when you go on the Privacy Notice, you could click on it
17 today, there's a discrete section which is just about
18 Oxevision to make it more accessible to the public and
19 patients.

20 **Q.** But your evidence today is that the leaflet and the
21 privacy notice expressly state that when the system is
22 activated, it's recording a patient in their bedroom
23 24 hours a day, seven days a week?

24 **MR TRENT:** Yeah, I'd have to go to the exhibit to confirm
25 the exact wording, but yes, that's the substance of it.

1 **Q.** Thank you. So we've talked about the vital signs
2 function of the capturing those two measurements, we've
3 talked about the system of alerts and notifications, and
4 we've actually already touched on another area where the
5 system is used at EPUT and that is Oxevision
6 Observations. Again, you and I discussed this last
7 year, Mr Trent.

8 But would it be right to describe Oxevision
9 Observations, or OxeObs for short, as essentially an
10 electronic version of the paper record, but with
11 additional functions to monitor and audit the nature and
12 timing of staff entries and so forth?

13 **MR TRENT:** Yes.

14 **Q.** Now, we heard evidence yesterday from Ms Cozens picking
15 up on something she'd said the year before that there is
16 the possibility, using Oxevision Observations, to access
17 the vital signs workflow and to take measurements and
18 remote view a patient in that way. So let's be clear
19 what I'm saying: that using the Oxevision Observations
20 module, you can access vital signs and a clear view of
21 this patient. Is that something that can happen at
22 EPUT?

23 **MR TRENT:** Yes, that's right. And I think when we're
24 talking about modules here, they just mean different
25 capabilities of the same product, really. So from

1 a user perspective, they're using the tablet to record
2 the observations and to take vital signs. So staff
3 would probably just refer to that to say, "I'm using the
4 Oxevision tablet".

5 Q. One of the points made by Jill Archibald in July was
6 that calling it "Oxevision Observations" might be
7 a little bit confusing for a staff member and my
8 question is really this: does that not really further
9 the confusion if an observation module actually allows
10 staff remotely to view patients?

11 MR TRENT: I haven't found, when I've spoken to staff, that
12 they've been confused by this. They've seen the
13 handheld device as a way to record their observation
14 electronically rather than on a piece of paper, and to
15 be able to take the vital signs reading as part of their
16 observation engagement practice. So I haven't found
17 staff, when I've spoken to them, to be confused by that.
18 I can see how when described in this setting that can be
19 confusing, but that hasn't been what staff have said to
20 me.

21 Q. Thank you.

22 I'd like to move on to a topic that has been of
23 significance at this Inquiry in relation to VBPMs and
24 Oxevision, and that's consent. Again, this is an area
25 we covered in part last year, Mr Trent.

1 Who should I direct my questions about consent to
2 today?

3 **MR TRENT:** I mean, I think both of us can respond on
4 different elements of this, and we both have experience.
5 Clearly, Dr Suresh has the medical expertise and
6 training that's highly relevant to this, but I'm also
7 able to comment on aspects of the process and the
8 changes in the documents, et cetera.

9 **Q.** So shall we see how we go, and either of you reply as
10 appropriate?

11 **DR SURESH:** Yes.

12 **MR TRENT:** If that's satisfactory, then of course.

13 **Q.** We covered in Mr Trent's evidence last year a CQC
14 inspection report from the 12 July 2023 following
15 inspections at EPUT in late 2022 and early 2023, and in
16 fact you address that evidence in your main statement at
17 paragraph 175. This is what you say, so this is from
18 your more recent statement but going back and
19 summarising your evidence from last year. This is what
20 you say:

21 "In the oral evidence of Zephah Trent, at the
22 hearing on 14 October 2025, the findings of the CQC
23 Report dated 12 July 2023 on consent were put to
24 Mr Trent in examination. The report recorded that EPUT
25 had 'assumed implied consent'; that the CQC was unable

1 to locate evidence of consent in sampled records; that
2 where one patient had refused consent, the relevant
3 record took a significant time to locate; that there was
4 no record of ongoing consent being sought; that welcome
5 packs contained no information about Oxevision; and that
6 only brief posters were displayed. Mr Trent accepted
7 that EPUT 'should have done better', and confirmed that
8 in response to the CQC findings, EPUT had introduced
9 a specific field on the electronic patient record and
10 the admission checklist to confirm that consent had been
11 'actively sought'. He confirmed [that's you, Mr Trent]
12 that the earlier implied consent approach was 'really
13 not the right way to do this'."

14 I'd like to pick up one matter about that now.

15 Dr Denman refers in her report in relation to
16 consent to "a failure of clinical oversight at EPUT in
17 relation to the concept of consent, with some kind of
18 fundamental misunderstanding arising in relation to the
19 notion of implied or implicit consent. I do not think
20 this issue was addressed correctly, which, from the
21 start, should have been to operate an opt-in system for
22 obtaining consent."

23 Am I right in thinking that at least with hindsight
24 you accept what Dr Denman said?

25 **MR TRENT:** So, can I say something about the timing there

1 and how these things fit together?

2 **Q.** Yes, do.

3 **MR TRENT:** So you have the CQC Report in July 2023 and there
4 are must-do actions around consent. As is expected of
5 NHS Trusts, we have a CQC action plan that's then
6 overseen through governance within the Trust. And that
7 CQC action plan then resolves certain -- a significant
8 change to the SOP, so you see that going from Version 8
9 of the SOP to Version 9, 9.1 --

10 **Q.** I'm going to ask you to pause there for two reasons.

11 **MR TRENT:** Yes.

12 **Q.** First of all, SOP is Standard Operating Procedure?

13 **MR TRENT:** Yes, that's right.

14 **Q.** Secondly, I'm going to ask that you speak a little bit
15 more slowly so we can capture what you're saying.

16 **MR TRENT:** My apologies.

17 **Q.** No, I apologise for interrupting. Please continue.

18 **MR TRENT:** Not at all. I'll speak more slowly.

19 So we have the CQC report in July and it requires
20 the Trust to make improvements, and as common with other
21 Trusts in that situation we put in place an action plan
22 that's overseen through the governance and you can see
23 that in the minutes of the Quality Committee, for
24 example.

25 There is a specific strand of that which is about

1 reviewing the Standard Operating Procedure, and that
2 improvement process and the action plans and the
3 evidence are submitted to the CQC, and we also set up,
4 following -- around this time, we have the Quality
5 Together meetings with the Integrated Care Board so you
6 have a number of different organisations overseeing
7 and -- the changes EPUT has made, and EPUT's Standard
8 Operating Procedure Version 9 and 9.1 is recorded as
9 being a full document review and consent review.

10 So we consider at the time that we have addressed
11 the concerns of the CQC. They don't say anything
12 different to us on that, and their subsequent report
13 doesn't raise the same issues on consent.

14 So at the time, we believed that we were doing
15 things in the right way.

16 Now, as I've said before, and you've quoted me, and
17 paragraph 7 of my second statement is really clear about
18 this, the EPUT Board recognises we could and should have
19 done better in the past, and consent is one of the areas
20 where we said that. So with the benefit of hindsight,
21 I can agree with Dr Denman. At the time, we took what
22 we thought were reasonable actions, working with our
23 regulators and others, and we thought that we'd
24 addressed the issues that had been raised.

25 Q. When you say, "We should have done better in the past",

1 what does that actually mean?

2 **MR TRENT:** Well, I think, you know, we've highlighted in
3 previous evidence, and I think Dr Denman says the same,
4 that while there was patient involvement right at the
5 beginning, it dropped off. While there was stronger
6 clinical engagement at the beginning, it dropped off.
7 And so these are opportunities that, with hindsight,
8 should have been corrected sooner, and may have led to
9 differences.

10 You know, we had regard at the time to the available
11 national guidance, which was the Nurse Director's
12 Guidance, there was no other guidance available at that
13 time, and our understanding was that NHS England had
14 contributed to that guidance by way of review and
15 comment that had been incorporated. So we believed we
16 were having regard to relevant guidance at the time.

17 **THE CHAIR:** But the nub of this issue is whether or not
18 patients are adequately asked whether they agree or
19 don't agree to being the subject of this monitoring,
20 and, as I hear it, no one said to themselves at that
21 time: this is clearly a relatively intrusive
22 intervention, should we not be asking patients directly
23 whether they agree to it? Is that right?

24 **MR TRENT:** I think that's right, Chair. You know, we had
25 this model of implied consent, we were trying to inform

1 patients about it, but I think your remarks are correct.

2 **MR GRIFFIN:** My recollection, but we can check this, is that
3 NHS England weren't actually involved in the Nurse
4 Directors Forum -- we can check that -- but your
5 understanding is that they were?

6 **MR TRENT:** Well, the understanding of Trusts, and I have
7 seen an email that demonstrates this, was that
8 NHS England had provided comment on a draft of that
9 document and those comments had been incorporated. Now,
10 I accept, as Mr Harry said on Monday, NHS England did
11 not endorse that document in any formal way, so Trusts
12 took their engagement to some extent, and I wasn't part
13 of that, to mean that at least they didn't object to it.
14 And there was no other guidance or no other statement to
15 say that it was the wrong guidance. So it was the
16 available guidance at the time that was specific to
17 vision-based monitoring, and so we had regard to it and
18 so did many other Trusts.

19 **Q.** Dr Suresh, do you know to what extent EPUT considered or
20 grappled with what "implied consent" actually meant in
21 practice for the purposes of the operation of Oxevision?

22 **DR SURESH:** I don't have knowledge of this personally. Not
23 only was this before my time, but I was also not in this
24 role at the time.

25 **Q.** Do you agree with Dr Denman, Dr Suresh, that there

1 should have been an opt-in explicit consent approach
2 from the start?

3 **DR SURESH:** I do agree, because Oxevision is a significant
4 decision, and as Chair mentioned, a significant
5 intrusion into patients' privacy, and therefore the
6 consent processes should have been more explicit.

7 **Q.** The CQC inspections that I've just referred to from 2022
8 and 2023 identified repeated failures concerning
9 consent. Did EPUT reconsider at that time whether an
10 implied consent default on model was appropriate, rather
11 than simply seeking to improve the recording and
12 implementation of that model?

13 **MR TRENT:** So the key versions of the Standard Operating
14 Procedure, where you see us reviewing the consent
15 approach, are Version 8, which follows the publication
16 of the Nurse Directors Guidance, and then Version 9.1.
17 So that's, I think, October, November 2022, and then end
18 of October/beginning November '23, a year on. So both
19 of those are recorded as full document review and
20 consent review.

21 Now I wasn't part of those reviews, so I rely on the
22 documents, but consent was explicitly considered in the
23 approval of those. Whether the option in the way that
24 the Chair put it just now was considered, I can't say.

25 **Q.** Thank you.

1 **DR SURESH:** May I add a couple of things to this? The issue
2 of consent has evolved quite significantly, particularly
3 since the implementation of the Mental Capacity Act
4 2005. So during the period being examined by this
5 Inquiry, consent has become more formal, more
6 sophisticated, and CQC has been focusing on it a lot
7 more. For example, as a clinician you have to take
8 consent for quite a lot of things, not just Oxevision,
9 for instance, any form of treatment, any form of
10 intervention, including, you know, care packages, moving
11 to a residential home, for instance. So consent forms
12 a significant part of the practice, particularly in
13 mental health.

14 **Q.** That's helpful. Thank you, Dr Suresh.

15 Two things arise from that, of course, Oxevision is
16 coming in 15 years after the Mental Capacity Act; is
17 that correct?

18 **DR SURESH:** That's correct, yeah.

19 **Q.** Secondly, it brings to mind a recommendation Dr Denman
20 has made, you may be aware of it, and that is that
21 consent is such a significant issue that it may be
22 appropriate for specific responsibility for consent to
23 be given to a Board member, and when questioned, she
24 suggested that might be either the Chief Medical or the
25 Chief Nursing Officer; did you hear that?

1 **DR SURESH:** I did hear that.

2 **Q.** Do you have any views on that?

3 **DR SURESH:** Yes, I think I agree broadly with the principle
4 of that, particularly mental health consent can be
5 a significant issue and consent depends on somebody's
6 mental capacity to be able to make that decision. So
7 before taking a consent you have to assess someone's
8 capacity, particularly where the capacity may be in
9 doubt, and that is quite a significant chunk of work in
10 mental health.

11 And because capacity can fluctuate, you know, even
12 within hours, but certainly over a period where
13 a patient may be mentally unwell, they may lose their
14 capacity temporarily but they might gain it back later.
15 So assessing capacity and consent is quite a constant,
16 in mental health settings.

17 So I would agree that it is good to give that issue
18 a higher profile, potentially at Board level, and
19 I agree that either the Chief Medical Directors or the
20 Chief Nursing Officers, either of them would be an
21 appropriate person at Board level to take the lead on
22 that.

23 **Q.** I believe that Dr Denman thought there may be a link
24 with the Caldicott Guardian role, for example, do you
25 agree with that?

1 **DR SURESH:** There is. I mean, Caldicott Guardian is more
2 about protecting confidential patient information and
3 making sure that there are processes in place to protect
4 any person-identifiable information. So this could sit
5 adjacent to that and there could be synergies with the
6 two.

7 **Q.** I believe her recommendation wasn't necessarily limited
8 to mental health but across the piste?

9 **DR SURESH:** That's right. But I suppose, particularly in
10 mental health, it's an issue, because in physical health
11 settings, most patients are able to consent in most
12 situations, and they're able to be part of the
13 discussion in terms of autonomy and choice, but in
14 mental health settings because the mental disorder
15 itself can affect someone's capacity and consent it
16 becomes slightly more nuanced, and that's where the
17 Mental Health Act gives us the ability to override
18 someone's consent, if I can put it that way, because
19 a lot of treatment under the Mental Health Act happens
20 where the patient may be either unwilling to have the
21 treatment or unable to give consent to that treatment.

22 **Q.** Is it right, though, that just dealing with the powers
23 of the Mental Health Act, one needs to bear in mind that
24 they relate solely to mental ill health and not to
25 physical health conditions?

1 **DR SURESH:** That is correct, except for two caveats, if
2 I may?

3 **Q.** Please.

4 **DR SURESH:** I know Dr Denman touched on this. The Mental
5 Health Act allows you to treat a physical disorder that
6 is either an immediate antecedent or an immediate
7 consequence of the mental disorder, as long as it can be
8 reasonably established that there is a link between the
9 two. The two classic examples are someone who has got
10 a urinary tract infection, an older person, perhaps, who
11 develops delirium, which is an acute confusional state,
12 so you can treat the urinary tract infection, which
13 often causes delirium, under the Mental Health Act
14 because there is little point in treating the mental
15 disorder without treating the primary cause because the
16 mental disorder may not necessarily improve.

17 At the other end of the spectrum we have the
18 immediate consequence of a mental disorder, and
19 Dr Denman I think spoke about anorexia nervosa where
20 a patient with eating disorders may have nutritional
21 deficiencies that need to be corrected quite emergently
22 and that means administering IV fluids, sometimes even
23 artificial nutritional support. Those are covered under
24 the Mental Health Act but this is case law rather than
25 the statute itself.

1 **Q.** Just dealing with similar points about the extent of the
2 Mental Health Act powers, would that -- would the
3 principles you've just been discussing also apply to
4 a mental health inpatient who is under heavy medication?

5 **DR SURESH:** Yes, if they are detained under the Mental
6 Health Act, it applies to all the patients who are
7 detained.

8 **Q.** I suppose what I was saying was that incapacity or
9 concerns arising from the fact that a patient with
10 mental ill health is heavily medicated.

11 **DR SURESH:** Yes, I mean, again, when someone is heavily
12 medicated it is often quite difficult to engage them in
13 a capacity assessment. The Mental Health Act does not
14 give blanket powers to treat anybody, even though
15 somebody may be detained, good practice is to ensure
16 that we involve them as much as possible, and their
17 families, in the decision about shared care. Just
18 because someone is detained, doesn't necessarily mean we
19 can force any treatment on them. If they are still able
20 to take part in, you know, consenting to that treatment,
21 that should still happen.

22 **Q.** Thank you.

23 **DR SURESH:** But there may be situations where they might be
24 unable to take part in that discussion.

25 **Q.** Thank you.

1 I'm going to move on to the recent PHSO complaint.
2 Before I do, can I just remind you both to speak
3 a little bit more slowly, again for the same reason,
4 just so that everyone can capture what you're saying.
5 **DR SURESH:** Apologies.
6 **MR TRENT:** -- (overspeaking) -- may I say something on the
7 recommendation?
8 **Q.** Yes, please.
9 **MR TRENT:** And this is coming from my perspective as
10 a non-clinician. The Inquiry's focus on consent and
11 digital technology is extremely timely, I think, for all
12 Trusts at the moment. There's significant growth and
13 change in technology with artificial intelligence and
14 other things. And so, I think to your question of is
15 this relevant nationally, more widely, to Trusts, and
16 I work in an acute Trust which is a mental health Trust,
17 beyond mental health? I think absolutely it is.
18 Because these questions of consent, Kallur has addressed
19 a number of specific elements to do with mental health
20 care but I think, you know, with new technology, I think
21 they're applicable, and when we reflect on the history
22 of EPUT's implementation, I think having that as an
23 additional principle to the Caldicott Guardian or
24 reflected in some other way, may have allowed
25 a different challenge to be brought earlier.

1 So I can see clear application, not just here but
2 across multiple settings and more widely across the
3 country. And I say that from the perspective of someone
4 with expertise around the technology and digital side of
5 things.

6 **Q.** Thank you.

7 As I said, I'd like to move on now to the PHSO
8 complaint. This is covered in your main statement from
9 paragraph 17 and also in the supplementary statement.

10 Dr Suresh, I'll direct my questions about this to
11 you, please.

12 **DR SURESH:** That's correct.

13 **Q.** As always, Mr Trent, if there's anything you want to
14 add, please let me know.

15 First of all, is the PHSO the Parliamentary and
16 Health Service Ombudsman; is that correct?

17 **DR SURESH:** That is correct, yes.

18 **Q.** And indeed, we heard evidence last year from a past CEO,
19 Sir Rob Behrens. Was a complaint made by a person known
20 for these purposes as Ms B, and did it relate to her
21 experience as a mental health inpatient on an EPUT ward
22 in the period 2021/2022?

23 **DR SURESH:** That is correct.

24 **Q.** Did her complaint relate to the use of Oxevision in her
25 room during her admission for mental health care,

1 including that she did not consent to the use of
2 Oxevision and staff said that there was no process for
3 turning it off when she requested this, and staff did
4 not give her information about Oxevision, could not
5 answer her questions about it, and gave her no resources
6 to explain about its use; is that correct?

7 **DR SURESH:** That is correct.

8 **Q.** I'd like to look now at part of your supplementary
9 statement which covers this. Could we put up the
10 supplementary statement at page 2, paragraph 7 to 8.
11 Thank you, they're on our screen.

12 Just starting with paragraph 7:

13 "The PHSO issued its final report on 27 March 2026,
14 partly upholding Ms B's complaint. The PHSO's findings
15 included that EPUT should have sought Ms B's informed
16 consent to the use of Oxevision, having assessed her as
17 having capacity to consent; that the Trust should have
18 revisited the question of consent as her condition
19 improved; that EPUT's approach did not meet the
20 standards set out in GMC Guidance; that the version of
21 the SOP then in force was internally inconsistent as to
22 whether consent was required; and that there was no
23 clinical record of discussions with Ms B about the use
24 of Oxevision, including in circumstances where Ms B had
25 likely requested that the system be switched off."

1 Now, is it right that the PHSO referred to some GMC
2 Guidance, General Medical Council Professional
3 Standards, for making and using visual and audio
4 recordings of patients which has been in effect since
5 2011?

6 **DR SURESH:** That is correct.

7 **Q.** And in fact updated in 2024?

8 **DR SURESH:** That is correct.

9 **Q.** Does that guidance say that medical professionals must
10 make recordings only where they have appropriate consent
11 or other valid authority to do so?

12 **DR SURESH:** It does.

13 **Q.** And does it spell out in more detail what that should
14 mean in practice?

15 **DR SURESH:** It does.

16 **Q.** Has EPUT subsequently accepted that this guidance
17 applies to the use of Oxevision at EPUT, and indeed,
18 I think your most recent SOP makes reference to it, and
19 incorporates it; is that correct?

20 **MR TRENT:** **(The witness nodded).**

21 **DR SURESH:** That is correct.

22 **Q.** Are you aware from the PHSO decision that the Trust's
23 use of Oxevision was a source of considerable concern
24 for Ms B?

25 "Staff did not seek her consent, explain its use, or

1 provide information about the system. This exacerbated
2 her feelings of anxiety, vulnerability, and fear."

3 Are you aware of that part of the PHSO decision?

4 **DR SURESH:** I am.

5 **Q.** Has the Trust accepted that, and the PHSO's further
6 findings?

7 **DR SURESH:** It has. In fact, there was a letter from our
8 then Chief Executive to the PHSO, copied to Ms B.

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

10 "The PHSO recommended, among other things, that EPUT
11 carry out a re-review of the SOP and its approach to
12 consent by 24 June 2026 by reference to GMC Standards
13 and NHS England Guidance; that EPUT communicate the
14 outcome to relevant bodies; and that EPUT take
15 additional steps regarding patient communication, staff
16 training and observations, and produce an action plan
17 for improvements to complaint-handling and
18 record-keeping."

19 Could we address the review of the SOP mentioned
20 there. So the version of the SOP that the ombudsman was
21 looking at was not the most recent one that you have; is
22 that correct?

23 **DR SURESH:** It wasn't, no.

24 **Q.** Is it Version 12 that I considered with Mr Trent last
25 year?

1 **DR SURESH:** I think --

2 **MR TRENT:** Yes, it was that version, yeah.

3 **Q.** Did the PHSO say this:

4 "The current SOP [so Version 12] departs from the

5 GMC and NHS England guidance because it says when a

6 patient with capacity declines consent for Oxevision,

7 this is ultimately a decision for the Nurse in Charge or

8 a doctor, and requires MDT approval. This means that

9 under the Trust's SOP, it may refuse to turn off

10 Oxevision for a patient with capacity who does not

11 consent to it. We consider that this is not in line

12 with the guidance."

13 Now, did SOP Version 12 require that Oxevision

14 should be switched on in a patient's bedroom for up to

15 six hours after their arrival on the ward for

16 assessment?

17 **DR SURESH:** It did.

18 **Q.** And in fact, was that a reduction from 72 hours in

19 earlier versions of the SOP?

20 **DR SURESH:** It was.

21 **Q.** But did Version 12 continue to stipulate that the

22 ultimate decision as to whether it should be kept on

23 would be the MDT's and not that of a capacitous patient?

24 **DR SURESH:** It did. But with informed consent.

25 **MR TRENT:** I think I'll add one thing on this, and we've

1 explained it in further detail in the joint statement,
2 the main statement. The SOP is clearly intending, and
3 it says that it should be switched off as soon as
4 practicably possible if a patient withdraws consent and
5 I think the points of -- it should be reviewed by the
6 MDT or referred to the MDT if there were concerns. So
7 I think what -- now, we've accepted the PHSO, so we
8 accept the findings, and agree with them now. But at
9 the time, and this is what I explained, I believe,
10 a year ago, the provisions in the SOP to essentially
11 refer to the MDT decision were meant to be an
12 exceptional case, not the norm. And I think the SOP
13 tried to make that clear.

14 Now, as I say, we've accepted the finding here, but,
15 you know, with reference to the six hours as an example.
16 That was expressly an upper limit, not a target. The
17 SOP makes it clear it should be switched off as soon as
18 practically possible at that time.

19 **THE CHAIR:** Dr Suresh, you just made a caveat to your answer
20 to Mr Griffin when asked about whether the ultimate
21 decision would be with the MDT under that version of the
22 SOP and then you said, "but with informed consent". But
23 presumably if the MDT has overridden your desire as
24 a patient to have the system turned off, it's not going
25 to be with informed consent; it's going to be without

1 your consent.

2 **DR SURESH:** I think that was one of the internal

3 inconsistencies in the SOP that the PHSO commented on.

4 The SOP said, within the same version of the document,

5 that the patients can give informed consent but at the

6 same time, the decision to switch it off was not

7 necessarily based on that --

8 **THE CHAIR:** So --

9 **DR SURESH:** -- so it highlighted that inconsistency which we

10 have since corrected.

11 **THE CHAIR:** Yes, so it was nonsense?

12 **DR SURESH:** Yes, it was inconsistent.

13 **THE CHAIR:** Thank you.

14 **MR GRIFFIN:** Can we move on from the recent PHSO decision

15 and EPUT's response to it, now to TIAA.

16 Now, we've just been discussing TIAA in terms of the

17 correction that you've asked us to make. Can we come on

18 to consider that issue more generally. Is the --

19 I think my questions need to be directed to you,

20 Dr Suresh, is that correct, looking at recent TIAA

21 audits?

22 **DR SURESH:** Yes, we can both contribute to that.

23 **Q.** Now, this is something you address in the main statement

24 from paragraph 231. Just to remind ourselves of the

25 correction. You've previously suggested in the written

1 statement that TIAA are external auditors but you now
2 correct that; that's not the case, yes?

3 **DR SURESH:** That is correct, yeah.

4 **Q.** Did the TIAA audits consider the consent position as it
5 was operating under EPUT's SOP Version 12 from
6 April 2025 and published, I think, the next month on the
7 7 May?

8 **DR SURESH:** It did.

9 **Q.** What I want to do is ask you about the TIAA October 2025
10 audit. From your statement, you say this, that:

11 "Testing was undertaken across five wards [which you
12 name]".

13 And I'd like to look with you at the principal
14 findings of the audit, please.

15 Please put up the EPUT TIAA Assurance Review of
16 Consent for Oxevision, second page. Thank you. Would
17 you expand -- I think that's fine like that, thank you.

18 Can we see here "Overall assessment" and in the
19 orange circle "Limited assurance", and at the bottom,
20 "Scope" -- thank you very much.

21 Just looking at the bottom of that page, please. Do
22 we see "Scope":

23 "The overall objective was to provide assurance on
24 the effectiveness of the consent processes in place
25 within the Trust. This review focused on the

1 arrangements for consent for Oxevision."

2 So we see the scope and the ultimate conclusion is

3 one of limited assurance; is that correct?

4 **DR SURESH:** Yes.

5 **Q.** Is that your reading of this?

6 **DR SURESH:** That is correct, yeah.

7 **Q.** Now could we expand the top right-hand box, please.

8 Thank you. "Key strategic findings". Thank you.

9 So, I just want to read these out, please:

10 "The Trust has in place an Oxevision Standard

11 Operating Procedure (SOP), which clearly outlines the

12 processes in place for obtaining consent for the use of

13 Oxevision, training requirements and roles and

14 responsibilities clearly identified as part of the

15 process.

16 "Audit testing identified that for four of 10 staff,

17 the competency checklist was not evidenced as no

18 response was received from the relevant Ward Manager

19 within the timeframe of the audit.

20 "Testing of a sample of 17 patients across five

21 wards, in June and July ..."

22 So that would have been June and July last year;

23 correct?

24 **DR SURESH:** That's correct.

25 **Q.** "... where Oxevision was in use, identified significant

1 exceptions such as a lack of evidence of completed
2 admissions checklist within six hours of patient's
3 admission for 21 patients.

4 "It was confirmed that as of the time of audit
5 fieldwork, there were no oversight arrangements for
6 senior management/committee to regularly review data in
7 relation to consent for Oxevision. The implementation
8 plan for Oxevision did include steps to 'agree audit and
9 assurance plan', and to align Tendable audits to new
10 SOP)."

11 Now, we'll come back and discuss the Tendable audit
12 in a moment, but you explain in your main statement,
13 this is paragraph 177, that EPUT's own internal audit
14 processes have identified that the revised consent
15 framework has not been consistently applied in practice.

16 Where you say that in your main statement, are you
17 actually referring to the findings of the TIA audit or
18 more widely?

19 **DR SURESH:** No, TIA audit.

20 **Q.** Would you accept that what this means effectively is
21 that although processes had improved on paper in
22 Version 12 of the SOP, they hadn't actually improved in
23 practice?

24 **DR SURESH:** That is what the data seems to suggest.

25 **Q.** Could you take that down, please.

1 Was a follow-up review of consent for conversation
2 conducted by TIAA, providing a draft report in May 2026?

3 **MR TRENT:** Yes.

4 **DR SURESH:** **(The witness nodded)**.

5 **Q.** We're going to look at it in a moment.

6 **MR TRENT:** Yes, it was.

7 **Q.** You say in the main statement that this related to a
8 review undertaken in February this year -- and is that
9 correct?

10 **MR TRENT:** Yes, that's right.

11 **Q.** Does the report actually remain in draft or was it
12 subsequently finalised?

13 **MR TRENT:** It has subsequently been finalised but the
14 substantive conclusions remain the same.

15 **Q.** So if we look at the draft version it should give us an
16 idea of what the final version said?

17 **MR TRENT:** Yes.

18 **Q.** Thank you. Would you put up the TIAA Assurance Review
19 of Follow-up of consent for Oxevision -- thank you very
20 much. This is the second page.

21 So can we see at the top "Overall assessment,
22 limited assurance"?

23 So that's overall assessment remained the same; is
24 that correct?

25 **MR TRENT:** Yes.

1 **DR SURESH:** (The witness nodded) .

2 **Q.** Can we also see, if we drop down, "Key strategic
3 findings" include these:

4 "The governance framework, the follow-up review
5 concludes limited assurance over arrangements to obtain
6 and evidence patient consent for Oxevision, indicating
7 improvement is required to manage associated quality and
8 governance risks. Review of audit reporting (Tendable)
9 also indicates operational barriers and low engagement
10 affecting assurance."

11 Do we also see "Compliance"?

12 "Recordkeeping remains inconsistent. In a sample of
13 25 patient records, 44% lacked an admission checklist
14 evidencing informed consent, with further gaps in
15 documenting consent discussions and patient views in
16 care plans and [in] clinical notes."

17 Would you accept therefore that the TIAA audit
18 reflects some of the problems that had previously been
19 highlighted by the CQC and the PHSO, but in relation to
20 practices last year and indeed this year?

21 **MR TRENT:** Yes, and I think that's exactly why the Senior
22 Management at EPUT commissioned an additional audit
23 here, because we received limited assurance -- there was
24 a management action plan in response to the first report
25 which is documented in the report, and that includes

1 additional Tendable audits and other interventions, and
2 we want to test whether or not that's been effective.
3 It hasn't been effective to the extent that we had
4 anticipated or intended, and so then we take further
5 actions following the second TIA report. And this
6 coincides -- the reason I think this is exhibited in
7 draft is because -- and I'm sure you will come to
8 this -- the Rapid Review is conducted before the report
9 is finalised, so it's used at that point, in response to
10 the PHSO.

11 So then, you know, there's a series of further
12 changes and improvements that lead us to where we are
13 today with 13.4.

14 **MR GRIFFIN:** Understood. Thank you. And indeed, we will
15 come on to that.

16 But Chair, we've reached 11.15. May I suggest we
17 break now until 11.30.

18 **THE CHAIR:** 11.30.

19 **(11.15 am)**

20 **(A short break)**

21 **(11.30 am)**

22 **THE CHAIR:** Mr Griffin.

23 **MR GRIFFIN:** Dr Suresh, Mr Trent, we're dealing with the
24 issue of consent. And just before the break we were
25 talking about the TIAA process. Can we continue on

1 consent now, please.

2 You refer in the main statement to further relevant
3 reviews concerning the approach to consent and indeed
4 other matters taking place in 2025. You refer -- this
5 is in your main statement at paragraph 187 -- to
6 a patient, carer and staff focus group in March 2025, in
7 which, as you say, patient participants reported being
8 unaware of their rights in relation to Oxevision and not
9 knowing that the system could be switched off when
10 discussing consent, and also raised privacy concerns.

11 You also refer, this at paragraph 189, to EPUT's
12 patient experience and participation function which
13 conducted a dedicated Oxevision, patient and experience
14 survey in September and October 2025.

15 Now, is that distinct from the TIAA audit we've just
16 been discussing?

17 **MR TRENT:** Yes, that's a separate process and that's led by
18 the Trust Director of Patient Experience and
19 Participation.

20 **Q.** Thank you. You talk about it in this way in the main
21 statement:

22 "The co-produced survey was administered by Matrons
23 across multiple inpatient services within the Urgent and
24 Inpatient Care Unit over one week, and a total of 46
25 responses were received across several wards from

1 current patients and service users. The findings
2 highlighted varied levels of understanding, acceptance
3 and concern with implications for consent processes,
4 therapeutic engagement, and privacy safeguards."

5 Now, with that in mind, and the matters we were
6 addressing before the break, would you accept that there
7 was, over a number of years, multiple red flags being
8 raised over EPUT's approach to consent and Oxevision?

9 **MR TRENT:** I think each of these different points of
10 evidence highlights where issues and concerns are
11 raised, and you see those at different points in the
12 minutes of the Steering Board and you see also
13 corresponding actions from the Trust in terms of the
14 tier management plan, and in this case, you've got
15 Version 12 of the SOP and an implementation plan and
16 training plan as well.

17 So I think these issues continued to crop up through
18 an extended period and you continue to see the Trust try
19 and address those, but as we accept, and, you know, as
20 we've said now, you know, we've changed the approach
21 quite fundamentally in the last version and the Board,
22 in approving that, has accepted that the previous
23 versions are not where we should be.

24 **Q.** Dr Suresh, do you agree with that?

25 **DR SURESH:** I do, yeah.

1 Q. Thank you.

2 Dr Suresh, could we look now at a report you
3 prepared for the Board of Directors dated 7 May 2025.
4 The purpose of the report was to update the Trust Board
5 on changes to the consent process and other matters.

6 Could you put up EPUT020850, page 3, please?

7 This is part of the report you prepared from last
8 year. Can we see this:

9 "Since Oxevision was first implemented at the Trust
10 there have been a number of changes to how the system is
11 used. These changes have been informed by learning from
12 serious incidents/patient safety incident
13 investigations, findings from coroner's court including
14 Prevention Future Deaths Reports, and feedback from
15 staff and patients. In a number of respects, past use
16 of the system has fallen below what we would expect now.
17 in particular:

18 "Consent to use to of the Oxevision system should
19 not have been implied at admission, and should have been
20 explicit informed consent."

21 Now, does that go back and encapsulate a point we
22 addressed before the break about the appropriate consent
23 model that should have been adopted from the start?

24 DR SURESH: It does, but can I just see the title of this
25 report? Because you said this report is from May 2025.

1 Q. Yes.

2 DR SURESH: And it's in my name. I just wanted to double
3 check.

4 Q. Can we go to page 1 of the report, please, and highlight
5 the top or expand the top. Does that give you the
6 information that you need?

7 MR TRENT: Yes, this was my report to the Board.

8 Q. Oh, I apologise.

9 MR TRENT: And this is the same report that I document in my
10 second statement at paragraphs 7 and 8.

11 Q. So these questions should be addressed to you?

12 MR TRENT: By all means, yes.

13 Q. Yes.

14 MR TRENT: And it pre-dates Dr Suresh's tenure as a Medical
15 Director.

16 Q. Happily, Dr Suresh answered the first question. Are you
17 happy with his answer to the first question?

18 MR TRENT: Yes, that's right.

19 Q. Shall I switch over to you now, Mr Trent?

20 MR TRENT: Yes, of course.

21 Q. Shall we read on and very happily we've gone on to the
22 page, just following on from that, the report says:
23 "There should have been better communication and
24 information sharing to ensure that information was
25 provided to patients, families and carers in a clear,

1 concise and person-centred way which allowed them to be
2 involved in decision making about the use of Oxevision
3 in their care.

4 "Greater consideration should have been given to the
5 impact of Oxevision on those who have suffered and/or
6 continue to suffer trauma.

7 "There should have been processes in place to allow
8 for continued patient, family and carer engagement and
9 feedback on the system."

10 And so on.

11 Would you accept the various points that you set out
12 in the report there, Mr Trent, are all significant?

13 **MR TRENT:** Absolutely.

14 **Q.** Are you -- and this is a question really for both of
15 you -- are you able to tell the Inquiry why you think
16 EPUT got consent so wrong over such a long period of
17 time?

18 **MR TRENT:** So, if I may start and then hand to Dr Suresh.

19 I think, when you look over this period, and this is
20 a new technology, at the outset, we've got the CQC
21 describing it as outstanding practice, we've got results
22 that look impressive that are being reported not by EPUT
23 but by other organisations, we've got the Trust Board in
24 its first business case talking about its emerging
25 patient safety agenda and you have Safety First, Safety

1 Always strategy, that's one of the first strategy
2 documents Paul Scott puts in place after his
3 appointment.

4 You've got, and I think Dr Denman talked about this,
5 you've got a new technology which is thought, for
6 various reasons, to improve patient safety and focus on
7 that. You don't have specific guidance around it.

8 **Q.** Can I ask you to pause there. I'm going to come on and
9 ask you about that particular point a little later on so
10 you'll have an opportunity to address that more fully.

11 **MR TRENT:** Thank you for that guidance.

12 But I think the lack of the specific guidance is
13 a contributory factor in EPUT not making the right
14 decisions. However, we've acknowledged, and I think
15 you've made the point plainly, the GMC Guidance is
16 there, and there are other points of reference. And
17 when we say here -- and the Trust Board endorsed this
18 fully -- we could and should have done better, it's with
19 regard to those other things.

20 And I don't think EPUT was alone in that. When you
21 look at Trusts across the NHS and even now with
22 Mr Harry's evidence, you know, ten Trusts being
23 referred, EPUT's not one of those now. Their assessment
24 was that our latest SOPs are in line with the
25 principles, but our previous ones wouldn't have been.

1 So, I hope that answers your question.

2 **Q.** That's helpful.

3 Dr Suresh, is there anything further you would like

4 to say?

5 **DR SURESH:** I just wanted to add that at the beginning of

6 the implementation, as we have said in our joint

7 statement, the focus was more on implementing the new

8 technology rather than giving due attention to consent

9 processes and other things that may have been the

10 unintended consequences, as it were, of the technology.

11 **Q.** Thank you.

12 Would you take that down, please.

13 Mr Trent, I think it was you who, just before the

14 break, referred to the Rapid Review.

15 **MR TRENT:** Mm-hm.

16 **Q.** What I'd like to do is come on to that now, please.

17 Following the PHSO report and the TIAA audit, did

18 EPUT go through a process to address the various

19 concerns that had been identified?

20 **MR TRENT:** Yes, it did.

21 **Q.** Dr Suresh, you helpfully cover this in the supplementary

22 statement. Am I right in thinking I should direct

23 questions about the Rapid Review to Dr Suresh, or is it

24 again for both of you?

25 **DR SURESH:** I will attempt to answer them, but Mr Trent can

1 come in if he wants to.

2 **Q.** Thank you.

3 **DR SURESH:** But I'll mainly take all the questions.

4 **Q.** Thank you. Because I think you're one of the people
5 behind the Rapid Review; is that right?

6 **DR SURESH:** That is correct, yeah.

7 **Q.** You say in your supplementary statement in paragraph 10
8 that the Rapid Review was conducted and shared with the
9 Executive Team on 20 May this year; is that correct?

10 **DR SURESH:** That is correct, yeah.

11 **Q.** Did that review identify concerns regarding consent
12 arrangements, privacy and safeguarding concerns, and
13 a range of operational issues?

14 **DR SURESH:** That is correct.

15 **Q.** Did it recommend that EPUT immediately refocus Oxevision
16 as an assistive technology and to move it into an opt-in
17 system only, with the system being off by default?

18 **DR SURESH:** It did.

19 **Q.** Did it also recommend that the system be set to
20 "Default: off" as soon as practicable, operating as an
21 opt-in system only, where clinically agreed and
22 supported by informed written consent or relevant lawful
23 authority?

24 **DR SURESH:** That is correct.

25 **Q.** Did the Executive Team agree with these recommendations?

1 **MR TRENT:** **(The witness nodded) .**

2 **DR SURESH:** I think it accepted the recommendations. Sorry,

3 yeah, that's it.

4 **Q.** And did the Executive Team also agree that a wider

5 independent review would be commissioned concerning the

6 use of Oxevision at EPUT?

7 **DR SURESH:** That is correct.

8 **Q.** We'll come on to that shortly.

9 You mention in the statement that the Trust

10 recognises the seriousness of the concerns identified in

11 the Rapid Review and accepts that immediate and

12 sustained action is required. Do you maintain that now?

13 **DR SURESH:** Yes, I do.

14 **Q.** At paragraph 56 of your witness statement you say:

15 "The Trust accepts the two-step process recommended

16 for the Rapid Review. First, the MDT must agree that

17 LIO may be of clinical benefit for the individual

18 patient and that its use can assist in the delivery of

19 that patient's care plan; and second, only once that

20 clinical determination has been made, the patient's

21 informed written consent is sought, supported by

22 a personalised care plan that defines how LIO may assist

23 in care delivery and provides a full explanation of how

24 the system works."

25 Should the two-step process that I've just set out

1 from your statement have been put into place well in
2 advance of May 2026?

3 **DR SURESH:** It should have, with hindsight, but as Mr Trent
4 and I mentioned before, a lot has changed about
5 Oxevision in the last few months, particularly in the
6 last six months, since the -- starting with the PHSO
7 report which led to the review of the Standard Operating
8 Procedure, then the commissioning of the Rapid Review,
9 which was only conducted over a couple of days by a very
10 senior doctor and a senior nurse, so it did not have the
11 full methodology, if you like, of being able to consult
12 with all the stakeholders. That then led to the
13 commissioning of the Independent Review which is a much
14 wider scope.

15 **Q.** I will come on to that in just a moment.

16 I'm just going to pause and ask if the pace is now
17 good for the typist.

18 It is, thank you.

19 I'd like to look at a couple of documents concerning
20 the process we're discussing before we come on to look
21 at the Independent Review, please, with you, Dr Suresh.

22 Could we put up the Executive Committee Summary
23 Report "Rapid Review Briefing Report on the use of LIO
24 Assistive Technology" from page 4, this is, as I've
25 said, from 20 May this year.

1 Can we see two options were contemplated; is that
2 right, Dr Suresh?

3 **DR SURESH:** That is correct.

4 **Q.** "The review has considered the following options:
5 "Option 1: To pause the use of the system.
6 "Option 2: To continue with immediate controls put
7 in place ..."
8 Which is the recommended option.

9 **DR SURESH:** That's correct.

10 **Q.** May I ask you about option 1, first?

11 **DR SURESH:** Yeah.

12 **Q.** Do we see below that pros and cons of option 1?

13 **DR SURESH:** Yeah.

14 **Q.** "Pros: complies with human rights legislation", yes?

15 **DR SURESH:** Yes.

16 **Q.** "Cons", I'm going to read this out:
17 "Potential increase in safety risk and incidents as
18 without automated alerts, there may be a higher risk of
19 falls or self-harms. Some patient families and staff
20 may [that should probably be "feel", shouldn't it]
21 [feel] less safe without monitoring in place especially
22 those patients with a history of sexual trauma."
23 Would you explain a little bit more of what option 1
24 would have involved if that had been the option that was
25 chosen?

1 **DR SURESH:** It would have meant an immediate pause of the
2 system across the organisation.

3 And giving time for a more detailed evaluation.

4 **THE CHAIR:** Sorry, can I just ask there, it mentions how it
5 would have possibly caused safety risks without
6 automated alerts, it doesn't make reference to the issue
7 of the suspension of the vital signs. Was that
8 considered in any way to be something that might
9 influence the decision? It appears it wasn't --

10 **DR SURESH:** It probably wasn't.

11 **MR GRIFFIN:** May I follow up on that question, please. Does
12 that mean that the vital signs function wasn't seen as
13 particularly significant?

14 **DR SURESH:** I think, if I go back to my own practice as
15 a consultant, the vital signs, there are only two of
16 them: respiratory rate and the pulse rate. By
17 themselves, they probably do not add a lot of value
18 to --

19 **Q.** I'd like to come back, actually, a little later on to
20 ask you about NEWS2 and vital signs in a little bit
21 further detail, so may I pick up on the point and we can
22 develop it a little later on in the context, in fact, of
23 what you've said in your statement.

24 **DR SURESH:** Yeah.

25 **Q.** Thank you.

1 Can we look at option 2.

2 **DR SURESH:** Yes.

3 **Q.** Do we again see a pro and con analysis?

4 **DR SURESH:** Yeah.

5 **Q.** Pros:

6 "Maintains benefits of the system, addresses the

7 risk through immediate controls, and enables continued

8 evaluation. Allows for a more personalised approach to

9 patient care with mitigations in place."

10 Correct?

11 **DR SURESH:** That is correct, yeah.

12 **Q.** Do we see "Cons":

13 "Challenges of a rapid implementation plan and

14 changes to clinical practice."

15 So that was the recommended option.

16 **DR SURESH:** Those were the two -- yeah, sorry, that was --

17 option 2 was the recommended option.

18 **Q.** And was that the option chosen by the Executive Team?

19 **DR SURESH:** It was.

20 **Q.** Did it result in an interim position at the Trust as

21 we've just seen, with new instructions sent out to

22 staff?

23 **DR SURESH:** That is correct.

24 **Q.** Did a memo go out making clear that the new approach was

25 that the Oxevision system is off when a patient is

1 admitted, yes?

2 **DR SURESH:** Yes.

3 **Q.** It can only be switched on when the MDT decides that

4 it's beneficial to support the individual's care plan

5 and informed consent has been obtained, correct?

6 **DR SURESH:** That is right.

7 **Q.** Or a Mental Capacity Act best interests decision

8 supports use, yes?

9 **DR SURESH:** That's correct.

10 **Q.** Did that approach stay in place until the latest version

11 of the SOP was released?

12 **DR SURESH:** I think following the Rapid Review there was

13 a memo that went out I think in my name under Chief

14 Nursing Officer to make sure staff are reminded that

15 Oxevision is a supplement to patient care rather than

16 a replacement for in-person observations and engagement.

17 The actual Version 13.4 of the Standard Operating

18 Procedure, which now makes it a two-step process for

19 switching it on, the clinical determination of whether

20 it adds any value, and then the patient consent,

21 capacitous patient consent, that was implemented at the

22 end of August, I believe it's 24 August 2026.

23 **Q.** And we'll come on to that version, the latest iteration

24 of the SOP in a moment. My question was a rather more

25 basic one and it's this: does the new approach set out

1 following option 2, and as encapsulated in the memo,
2 effectively carry on and inform the latest version of
3 the SOP?

4 **DR SURESH:** That is correct. It was a developing piece of
5 work.

6 **Q.** Thank you.

7 Before we move on to look at the -- or for me to ask
8 you about the latest version of the SOP, can we now come
9 on to discuss the Independent Review.

10 **DR SURESH:** Yes.

11 **Q.** You address this in the supplementary statement, that's
12 at paragraph 42 on. Did you, Dr Suresh, and the Trust's
13 Chief Nurse actually commission the review?

14 **DR SURESH:** We did.

15 **Q.** Can you explain why you did that?

16 **DR SURESH:** Because of the concerns around consent, the
17 implementation of the previous versions of the Standard
18 Operating Procedure, and the PHSO report, the Rapid
19 Review identified that we needed to look at consent and
20 other issues in relation to Oxevision in greater detail.
21 The Rapid Review, if I remember correctly, was carried
22 out over a two-day period, and it was led by a senior
23 doctor and a senior nurse within the Trust, but it did
24 not -- it could not reach out, because of the rapidity
25 of the review that had to be carried out, to all the

1 stakeholders involved.

2 And therefore, it was felt that a much wider review
3 involving not only patients and families who are
4 receiving the use of the system, as it were, but also
5 other staff who may have something valuable to
6 contribute, looking at the usage reports, and also
7 potentially looking at learning from other organisations
8 who may have a slightly different practice.

9 So the wider review is addressing all of those, or
10 using that methodology in order to come to a more
11 definitive conclusion or a set of recommendations.

12 **Q.** Thank you. Has that review commenced?

13 **DR SURESH:** It has commenced, it is ongoing at present. It
14 is scheduled to report some time next month.

15 **Q.** And will that be the final version of the report?

16 **DR SURESH:** I'm not sure because as a Trust we are fully
17 independent of the report.

18 **Q.** Well, I'll come on and ask you about that, but you're
19 expecting to receive the report next month. What is the
20 process, then, at EPUT?

21 **DR SURESH:** Initially, there will be a factual accuracy
22 test, so we'll receive the report most likely in draft.
23 Once it is checked for factual accuracy there will be
24 a final version of the report which will have to go
25 through the Trust governance processes. Because myself

1 and the Chief Nursing Officer commissioned the report,
2 it'll be received by us in the first instance. We will
3 then have to take it to our Executive Team and other
4 forums within the organisation to look at the
5 recommendations, consider them, and decide on the
6 appropriate action.

7 **Q.** Now, you were about to tell us who's conducting the
8 review. It's referred to as an Independent Review.

9 **DR SURESH:** Yes --

10 **Q.** Why is that?

11 **DR SURESH:** It has been conducted by King's Fund and
12 supported by an organisation called NCCMH, the National
13 Collaborating Centre for Mental Health, which is part of
14 the Royal College of Psychiatrists, so it is independent
15 in that sense, but I think it's mainly led by King's
16 Fund supported by NCCMH.

17 **Q.** So you've described in your statement it in this way:
18 "The King's Fund is lead and independent Chair with
19 responsibility for the final report and NCCMH
20 responsible for evidence review and lived experience,
21 engagement and analysis."

22 **DR SURESH:** That is correct.

23 **Q.** And is EPUT feeding information to these two
24 organisations as they request it?

25 **DR SURESH:** It is. The methodology is decided by the

1 investigators or people who are conducting the review.

2 I believe they have interviewed a number of staff within

3 EPUT in order to gain their experience and understanding

4 of how the system works.

5 **Q.** Subject to issues such as patient confidentiality, is

6 there information that EPUT is refusing to provide to

7 the independent review?

8 **DR SURESH:** Not that I'm aware of.

9 **MR TRENT:** **(The witness shook head) .**

10 **Q.** In this review are all options on the table, including,

11 for example, the option 1 we just saw, to pause or stop

12 the use of Oxevision at EPUT completely?

13 **DR SURESH:** It does. The review has full independence to

14 come up with the recommendations as they see fit, based

15 on the evidence and assessment of the system that they

16 gather through their investigation process.

17 **Q.** And it will then be for EPUT to decide whether or not to

18 accept the recommendations?

19 **DR SURESH:** I think that is how the governance process

20 works. But we would really consider the recommendations

21 seriously, and of course we may have, Chair, from

22 yourself, some interim recommendations as well by then.

23 All of those will inform our decision going forward.

24 **Q.** Thank you.

25 Can I turn to a related matter, please. When

1 Mr Trent gave evidence last year he told the Inquiry
2 that EPUT had commissioned Anglia Ruskin University to
3 complete an independent study of a multisite evaluation
4 of the use of vision-based monitoring systems and
5 body-worn cameras in mental health inpatient wards, but
6 that the report had not yet been completed.

7 Now, I think Ms Cozens suggested yesterday that the
8 study is still ongoing, if she was referring to the same
9 study. Is that correct?

10 **MR TRENT:** Yes, that is correct.

11 **Q.** Do you know when that report, when that study will be
12 finalised and reported?

13 **MR TRENT:** So I spoke to Professor Nolan last week to get an
14 update precisely because I anticipated this question.
15 Her work, she's liaising with the director responsible
16 for research at EPUT. So I don't have a direct
17 involvement in that. But she is expecting to extend her
18 study.

19 Now, she was saying to me she hoped that she would
20 be able to conclude and publish next year. She also
21 said to me and she agreed I could say this to you, if
22 she could be of any assistance to the Inquiry she was
23 very happy to do that.

24 **Q.** To what extent does the Independent Review that you've
25 just commissioned actually cover ground that she's meant

1 to be covering?

2 **MR TRENT:** I mean, there's clearly matters of overlap.

3 Professor Nolan's work was -- is based on her

4 presentations and I've exhibited one of those before,

5 it's based on surveys of staff and patients. And

6 I think we discussed last year some of the interim

7 findings around that, which, you know, broadly, set

8 concerns around privacy versus potential benefits around

9 safety and with differences in assessment between staff

10 and patients on those.

11 So I think it is covering related ground, but the

12 timing of the two is unlikely to overlap, and, you know,

13 Professor Nolan is the determinant of that research.

14 It's independent and we've heard previously has the full

15 ethics approval and oversight you'd expect of that.

16 **Q.** Will you keep the Inquiry updated as to both the

17 Independent Review and the Nolan review?

18 **DR SURESH:** We will.

19 **MR TRENT:** Yes, of course.

20 **Q.** Can we move on, as I said we would, to the latest

21 version of the SOP. This is Version 13.4; is that

22 correct?

23 **DR SURESH:** That is correct, yeah.

24 **Q.** Again, should my questions be directed at you,

25 Dr Suresh?

1 **DR SURESH:** Yeah.

2 **Q.** Now, is this latest iteration of the SOP in part
3 a response to the findings of the ombudsman and the
4 other matters we've just been covering?

5 **DR SURESH:** That's correct.

6 **Q.** Have both the NHS England principles and the GMC
7 Guidance now been taken into account?

8 **DR SURESH:** They have.

9 **Q.** I'd like to look at part of the new SOP with you,
10 please, Dr Suresh.

11 Would you put up EPUT026149 at page 7.

12 Thank you.

13 So this is Operational Guidance for Use. I'd like
14 to just read from part of that, please.

15 **DR SURESH:** Yes.

16 **Q.** "On Admission:

17 "LIO must be in a default OFF status and confirmed
18 as OFF at the point of a patient's admission.

19 "Assessment and personalisation:

20 "LIO is considered if its functionality could assist
21 staffing in delivering the patient's personalised care
22 plan.

23 "The system will not be considered for use if the
24 personalised care plan doesn't indicate an opportunity
25 for its assistance in care delivery.

1 "Activation Requires:
2 "MDT agreement following assessment and care
3 planning ... "
4 I think that encapsulates or picks up on the points
5 that you were making earlier, Dr Suresh; is that
6 correct?
7 **DR SURESH:** That's correct.
8 **Q.** Do we basically see them summarised there?
9 **DR SURESH:** Yeah.
10 **Q.** Opt in with off by default, and also now needs to be
11 addressed at an early stage as part of the care plan?
12 **DR SURESH:** That is correct.
13 **Q.** And agreed with the MDT?
14 **DR SURESH:** Yes.
15 **Q.** Can we just look a little bit more at what is said lower
16 down. So the second bullet point.
17 "Patient discussion to gain informed written
18 consent. This discussion must include explanation of
19 system functionality, limitations and implications to
20 the patient, supported with patient information
21 leaflets. Explanation of how the patient's data is
22 stored and how the patient can gain more information
23 about the system, [for example], Patients should be
24 informed that EPUT has a Standard Operating Procedure
25 ... which is available on request."

1 And as we can see further points being made,
2 including, at the bottom of the page:

3 "That the patient is assumed to have mental capacity
4 ...

5 And if we go -- thank you -- to the bottom bullet
6 point at the top of the next page:

7 "Where agreed by the patient and applicable, staff
8 must also communicate to relatives, carers and
9 supporters to ensure their clear understanding of the
10 LIO platform."

11 **THE CHAIR:** Could I ask, what do you understand by
12 "limitations of the system"? What should the patient be
13 being told about the limitations?

14 **DR SURESH:** Some patients may have concern that they are --
15 staff are able to see them all the time in clear video,
16 so that's a limitation of the system. But also, that
17 that is not the only way we monitor patients. That
18 there will be in-person checks, as usual, in addition to
19 the monitoring through the system.

20 **THE CHAIR:** So it's your understanding of this that it
21 would, as it were, cover, perhaps, misuse of the system
22 by staff being able to access clear view?

23 **DR SURESH:** It probably does cover, but not very explicitly.

24 **THE CHAIR:** Do you think it should be more explicit in
25 requiring potential misuse to be made apparent to staff?

1 **DR SURESH:** I would agree that that would be a concern that
2 many patients might have and it would be helpful to
3 cover that aspect of the monitoring.

4 **THE CHAIR:** Thank you.

5 **MR GRIFFIN:** Do you know if it's actually covered at the
6 moment?

7 **MR TRENT:** So I can add a point here that may be of
8 assistance. I was at Ardleigh and Gosfield on The Lakes
9 last week and as part of the implementation plan around
10 this, colleagues have developed staff prompts to support
11 staff in having these conversations with patients and
12 those prompts include making it clear to patients: "This
13 is how the system should be used by staff and it
14 shouldn't be used differently than that."

15 So there has been -- this is obviously the official
16 document but then additional resource is developed for
17 staff to assist them in those conversations with
18 patients.

19 **MR GRIFFIN:** Chair, please.

20 **THE CHAIR:** Well, there's a slight difference between saying
21 to somebody "This is how it should be used, it shouldn't
22 be used otherwise", and actually pointing out how it
23 might be used otherwise. Did your prompts suggest that
24 that might be made explicit to patients?

25 **MR TRENT:** I think they were clear about how it should be

1 used and it shouldn't be it used otherwise. And
2 I think, you know, this would be common around a number
3 of things. I don't think they go through any
4 possible -- potential misuse.

5 **THE CHAIR:** Misuse.

6 **MR TRENT:** And I think, actually, there's lots of potential
7 misuses of all sorts of things in life and we don't
8 always set them all out. But the clear implication of
9 saying, "This is how it should be used properly" is that
10 you can expect it to be used properly, and we've, as
11 I've said before, professional standards and oversight
12 also require staff to use these things properly.

13 **THE CHAIR:** Thank you.

14 **MR GRIFFIN:** Is part of the information provided that the
15 system, if activated, will be on and recording 24/7?

16 **MR TRENT:** That's in the patient leaflet I talked about
17 earlier.

18 **Q.** So they'd be expected to read that rather than have
19 a staff member inform them about it?

20 **MR TRENT:** Oh no, the prompts also say that, yeah.

21 **Q.** So that's now part of the whole package?

22 **MR TRENT:** Yeah, and I think, you know, there's been an
23 extensive bit of implementation and this goes back to
24 what Dr Suresh said about the decision at the Executive
25 Team was that there needed to be a careful

1 implementation plan here because these kind of
2 considerations need to be considered with things put in
3 place. So the staff prompts was something that, you
4 know, that wasn't discussed in the Executive Team, but
5 the project team that did the implementation worked that
6 through in order to ensure consistent support to staff
7 to consistently support patients.

8 Q. Thank you. Are patients told what will happen to the
9 data that the system produces and who will have access
10 to it?

11 MR TRENT: So I'm going by the prompts and by the policy and
12 by some of the materials, including the patient leaflet.
13 They are given information that's intended to be
14 accessible and staff are meant to engage with them in
15 a way that patients can engage with. There's a video as
16 well, and there's links to the Privacy Notice. Has that
17 gone to the level of technical detail you'd see in the
18 DPIA and other documents? No. But I think it is clear
19 that there is that 24-hour recording and, you know, in
20 the video, for example, it says, "This may be used to
21 learn from patient safety incidents".

22 Q. Thank you very much for that.

23 I'd like to address a couple of specific points with
24 you now, please, arising from the new SOP in relation
25 both to patients with capacity and without capacity.

1 Just to ensure that I've understood the new stance. May
2 I start by asking you about what should happen where
3 a patient is capacitous.

4 **DR SURESH:** Where a patient is assessed to have the
5 capacity, first of all, that should be documented in the
6 patient records, and their consent sought for
7 specifically in this instance, Oxevision monitoring.
8 And assuming the MDT has determined already that it is
9 useful to -- it's a useful adjunct to patient care,
10 depending on what the patient says, that should be
11 carried out. If the patient chooses not to have it on,
12 it should remain switched off, and if the patient
13 chooses to have it on, then it can be turned on.

14 **Q.** The point I suppose I was trying to get to is this: the
15 final word now for a patient with consent as to whether
16 the system is switched on is the patient's and not the
17 MDT's?

18 **DR SURESH:** Yes, that's right. So there is almost like
19 a 50/50 balance, if I can say. First, the team has to
20 determine that it is useful for the patient. Only then
21 is the patient asked about their consent and then the
22 instruction follows.

23 **Q.** So it may not even get to the patient if the MDT thinks
24 it wouldn't be a good idea for a particular individual,
25 they may not even get the option to have it switched on?

1 **DR SURESH:** It may not, yes.

2 **Q.** Thank you.

3 There's -- can we move now to patients without

4 capacity.

5 **DR SURESH:** Yes.

6 **Q.** There is a flowchart or an infographic as it's called in

7 the SOP that I haven't found entirely easy to understand

8 so I'd like to ask you about this. My understanding,

9 though, looking at the infographic and reading the SOP,

10 is that if a patient without consent -- without

11 capacity, forgive me, does not consent to the use of

12 Oxevision, that also is final even though they don't

13 have capacity. Have I got that correct?

14 **DR SURESH:** If they don't have capacity according to the

15 Mental Capacity Act there has to be a best interests

16 decision, because the very fact that they may lack

17 capacity or they are assessed to lack capacity makes

18 their consent not valid, but in spite of a patient being

19 assessed as not having capacity, there is still a duty

20 of care on the treating team to engage them as far as

21 possible in making decisions about their care.

22 So there is a legal side of it, and then there is

23 the care side of it, if that makes sense.

24 **Q.** That does make sense, and I understand the process

25 you've just described. But we've seen at another Trust,

1 Leicester, I think, that a patient without capacity who
2 refuses consent to the use of Oxevision, their word is
3 still final. My understanding from the infographic in
4 the SOP, is that that's saying the same thing. I was
5 hoping not to have to put it up so maybe what we could
6 do is to ask you to look at it over lunch and let me
7 know if you disagree with my assessment.

8 So, this is appendix 5, infographic to support LIO
9 usage on page 19 of the latest SOP.

10 **DR SURESH:** I will.

11 **Q.** Rather than go through the infographic together now.

12 Since EPUT moved to the opt-in model, has the Trust
13 collected any data, assessing how many patients do now
14 consent to being monitored by Oxevision under the opt-in
15 model?

16 **MR TRENT:** So we're obviously very early in the
17 implementation of that. September was the first full
18 month. I have received a report yesterday which was the
19 first time it was available, on the overall utilisation,
20 but it hasn't been through the Project Board yet to be
21 validated and discussed. The Project Board is next
22 week.

23 At a high level -- and of course, this needs to go
24 through that proper governance -- it shows
25 a significant -- two significant changes are apparent

1 from the report. One is a significant number of wards
2 are showing almost no or no vital signs, in other words,
3 that indicates that patients have declined consent, and
4 that has been put into practice. And the second is that
5 where patients have clearly consented, and, you know,
6 I saw this in practice at Ardleigh and Gosfield, the
7 number of vital signs attempts have come down
8 significantly.

9 Now, those are two broad conclusions and they
10 haven't been scrutinised so I'm being candid with you
11 and providing you with what I know now but it does need
12 to be analysed through the Project Board properly.

13 Q. So we need to take the information with the caveat
14 you've just explained?

15 MR TRENT: Yes.

16 Q. It is going to be discussed, did you say next week?

17 MR TRENT: The Project Board is scheduled, the next one, I
18 believe, for Wednesday next week.

19 Q. Would you provide the minutes of that meeting to the
20 Inquiry as soon as they are available?

21 MR TRENT: Yes, of course and we can provide that report as
22 well.

23 Q. Thank you.

24 MR TRENT: And in that, you know, you can make the
25 comparisons I've just described, and indeed, when it

1 goes to the Project Board, they will consider the
2 conclusions more fully from it.

3 **Q.** And I think this follows, but finally in relation to the
4 SOP, is it right that that is now also subject to the
5 ongoing Independent Review and the conclusions reached
6 there?

7 **DR SURESH:** Yes.

8 **MR TRENT:** Yes.

9 **Q.** We've mentioned Tendable audits and I'd like to come on,
10 please, to ask you about those. Is it right, Mr Trent,
11 that I should direct my questions about this to you?

12 **MR TRENT:** In the first instance. And if there's anything
13 that pertains to clinical matters, I'll defer to
14 Dr Suresh.

15 **Q.** Thank you. You explain in the main statement, this is
16 paragraph 107, that:

17 "EPUT uses an electronic clinical audit platform
18 called Tendable as a practice quality control monitoring
19 mechanism. The audit requires a staff member to review
20 a minimum of three patient care plans to determine
21 whether the patient's choice regarding Oxevision is
22 documented within their care plan, whether the use of
23 Oxevision is discussed regularly with the patient, and
24 whether the camera's status recorded in the patient
25 notes accurately reflects the actual status of the

1 system ...

2 "The audit [you say] further requires checking the
3 Oxevision equipment, materials and governance
4 arrangements on the ward, and includes a review of staff
5 understanding of the SOP and Oxevision product training
6 requirements. As part of the audit, the staff member
7 completing it is required to speak to a minimum of three
8 patients on the ward and to ask specific questions and
9 to provide assurance that the SOP is being followed in
10 practice ... Results of the audits are reviewed by ward
11 managers [you say] and matrons to make sure practice is
12 in line with the SOP, or take any necessary actions to
13 improve practice as required."

14 Now, is that all still accurate?

15 **MR TRENT:** Yes.

16 **Q.** You've provided a number of audits to the Inquiry dating
17 from the period October to December 2024?

18 **MR TRENT:** (The witness nodded).

19 **Q.** They relate to five wards. How often are the audits
20 conducted?

21 **MR TRENT:** So, I think this has changed over time, but in
22 our statement we refer to those being every two weeks.

23 **Q.** Yes.

24 **MR TRENT:** And when I referred earlier to management actions
25 in response to the TIAA internal audit one of the things

1 there was the development of additional audits and also
2 that bi-weekly requirement on the audits, and the
3 reporting around it.

4 **Q.** But at the time, so we're looking at some -- I'll look
5 at an example with you in a moment from 2024, at that
6 time would it have been two-weekly?

7 **MR TRENT:** I'm not sure, from memory.

8 **Q.** Understood.

9 **MR TRENT:** I'd need to refer back to the statement to be
10 precise. Apologies.

11 **Q.** Would you put up EPUT024186 and show the full page.

12 So, this is the Tendable audit report for
13 Grangewaters Ward from 18 October 2024, and we can see
14 that's at the top, can't we?

15 **MR TRENT:** Yes.

16 **Q.** This one has been conducted by a staff nurse, we can
17 see, and we see near the top of the first page, "100%".
18 What does the 100% there indicate?

19 **MR TRENT:** So, you see in the bottom left corner of this
20 document -- the first page of this document it says,
21 "1/6", so that indicates there's six pages of this audit
22 report, and it has a number of sections with specific
23 questions, and the "100%" there is essentially a summary
24 of the answers to the questions below.

25 **Q.** It's the overall score?

1 **MR TRENT:** It's the overall score and it's effectively
2 adding up -- and I've seen this document in full -- all
3 aspects of this particular audit report are reported as
4 compliant and therefore it's showing 100%.

5 **Q.** So is 100% the maximum score indicating there's
6 a positive result?

7 **MR TRENT:** Yes, that would be a positive result based on --
8 for that particular audit, yeah.

9 **Q.** For that audit, thank you.

10 Do we see also -- this just under the "100%":
11 "Patients are aware of Oxevision and their consents
12 are taken before use in their rooms. Staffs are
13 competent with Oxevision and can use the tablets for
14 documentation of observations."

15 Now, is that a sort of overall summary from the
16 staff member completing the form?

17 **MR TRENT:** I think that's about the purpose of this audit
18 here.

19 **Q.** So who would have included the text I've just read out?

20 **MR TRENT:** I'd need to check that against another one. I'll
21 have to come back to you, I'm afraid.

22 **Q.** Understood.

23 **MR TRENT:** I mean, I do believe that's the purpose of the
24 audit, but we'll need to check it.

25 **Q.** Would you check over lunch and if there's any change to

1 your answer would you let me know?

2 **MR TRENT:** Of course, of course.

3 **Q.** Thank you. We can see at the bottom of the page "3", a
4 box numbered 3 which relates to consent, and again we
5 can see that the score in relation to consent is 100%;
6 correct?

7 **MR TRENT:** Yes, and down there to the left it's saying 1, 2,
8 3, so those are the individual patients. It says, "Is
9 there evidence the patients/carers have been informed of
10 the use of Oxevision?" And it is documented. So this
11 is showing that that staff member has spoken to three
12 different patients and in each case they've said, "Yes,
13 there is evidence of that", and that's why that section
14 is then showing 100%.

15 **Q.** I see. So 1, 2 and 3 is patients 1, 2 and 3?

16 **MR TRENT:** That's right, and, you know, 3 out of 3, is
17 therefore 100% in that section.

18 **Q.** Would you put up the whole of the next page, please.
19 And again, on this page do we see a lot of 100%s and
20 green yeses?

21 **MR TRENT:** Yes, that's right, and so that reflects that that
22 staff member has reported that they have gone through
23 each of those questions and recorded the individual
24 assessment of each of those.

25 **Q.** Can we see, for example, in the middle of the page, "Is

1 there evidence that the use of Oxevision is discussed
2 with patients/carers during their regular MDT review,
3 ideally on a weekly basis or when there is significant
4 change in presentation?"

5 Then we see "Yes, yes, yes," and "100%", correct?

6 **MR TRENT:** That's correct.

7 **Q.** Could you put up the whole of the next page, please.

8 Again, lots of yeses and 100%s, correct?

9 **MR TRENT:** That's right.

10 **Q.** Would you put up the whole of the next page, please,
11 page 4. A lot of 100%s and green yeses, again, correct?

12 **MR TRENT:** That's right.

13 **Q.** Do we see, for example, four questions down "Can you
14 explain Oxevision to me as you would to a patient/carer
15 upon admission?"

16 "Yes, yes, 100%", yes?

17 **MR TRENT:** Yes, this here, this is now in the staff section.

18 So this nurse has spoken to two of her colleagues, or
19 his colleagues, or their colleagues, and has said, "Can
20 you explain Oxevision to me?" And they've been
21 satisfied that the answer is appropriate and in line --
22 or with reference to the operating procedure.

23 **Q.** Can we go over the page, please. Do we see at the
24 top -- so again, I think this may still be within the
25 staff side of questioning -- "Can you" -- I think that

1 must be "Can you tell me in what circumstances would you
2 be required to request CVD footage?" That's the Clear
3 Video Data footage, isn't it?

4 **MR TRENT:** That's correct.

5 **Q.** "And also explain to me how you request CVD footage."
6 Correct?

7 **MR TRENT:** Yes.

8 **Q.** So there's two questions there and it looks like both
9 staff members have answered similarly: when there is an
10 incident, and when an incident occurred, correct?

11 **MR TRENT:** Yes.

12 **Q.** But they don't explain how you request CVD footage, do
13 they?

14 **MR TRENT:** No. No, they don't. I mean, it's only a short
15 summary of what's been said so I can't say more than
16 what's written there.

17 **Q.** Understood. Subject to that caveat, it looks as if
18 they've answered half of the question.

19 **MR TRENT:** Well, I don't know because the process for
20 requesting the CVD is documented, so it's in the process
21 for responding to an incident so they may have said
22 it's -- you know, I'd use the document, they may not.
23 I agree, there's only a limited answer there. The
24 person who's conducted this audit has nonetheless
25 considered that to be complete. So --

1 Q. But isn't that the problem? Now I understand your point
2 that we can't be entirely sure exactly what was said,
3 but this is an audit that's given or returned 100%
4 score. Would you accept there's a possibility that the
5 100% actually isn't appropriate?

6 MR TRENT: From what's there it hasn't provided that further
7 specific written evidence. However, I would put some
8 weight on the fact that the staff nurse has done this
9 with their -- all of the professional expectations upon
10 them and they would be expected to do this properly.
11 So, you know, I do put some weight on the fact they've
12 given that 100%, but I accept your point.

13 Q. The point which I'm going to ask you a little about more
14 about in a moment is that this form, and indeed, as we
15 see, most of the others, return a very rosy picture of
16 compliance across the wards considered during this time.
17 And I'm going to come on to ask you how accurate you
18 think that actually is, so that's where we're going with
19 this.

20 Shall we look at the last page just so we've seen
21 the whole of the form. So there's no feedback. Was
22 that possibly -- because there's three boxes there,
23 would that possibly be from patients?

24 MR TRENT: I would think so, yeah.

25 Q. Thank you.

1 Would you take that down.

2 In fact, you have helpfully provided 25 audit
3 reports to us, and if you look at them all, 18 returned
4 100% results, six returned results between 90 and 95%
5 and one returned a result showing 83%.

6 Do you have any views about how accurate you think
7 those returns are as against the actual level of
8 compliance on the wards at this time?

9 **MR TRENT:** I think, you know, audit is a method of assurance
10 and these clinical audits are a method of assurance.
11 They're not the only method of assurance the Trust
12 relies on. There's the reviews of data and, you know,
13 we've talked already about independent audit and other
14 things like that, Quality and Safety meetings. There
15 will be supervision and oversight from Matrons reviewing
16 this. So I do expect our staff -- and I'm sure
17 Dr Suresh would comment if he thinks differently -- to
18 use their professional judgement, to work in
19 a professional manner and follow our policies and
20 procedures and to report their audits correctly.

21 So on face value, I would take an audit result as
22 meaningful.

23 **Q.** These audits cover October to December 2024, they
24 include, as we've seen, consent. Don't we know, from
25 the other sources we've been discussing today, that

1 there were real issues with consent? Do you agree with
2 that?

3 **MR TRENT:** I do, but, you know, as I said earlier, in 2024,
4 we're prior to the 2025 guidelines. The latest
5 guidelines published are on a national basis and there
6 is also the letter. The Nurse Directors and staff here
7 are having regard to our SOP. So we may say now that
8 the SOP should have been different but colleagues here
9 are auditing against the SOP at the time, they're not
10 auditing against a different standard.

11 **Q.** So we've looked at documentation including, for example,
12 the PHSO report and the CQC investigations, which have
13 suggested that the approach to consent at EPUT was
14 wanting, and we've traced through a number of years a
15 number of different investigations or reports that have
16 led to a high degree of doubt, I would suggest, at EPUT,
17 as to compliance with appropriate consent processes.

18 Now, do you agree with all of what I've just said?

19 **MR TRENT:** Yes, we have gone through those things, and --

20 **Q.** If you pause there, I'll give you an opportunity to say
21 what you need to say --

22 **MR TRENT:** Okay.

23 **Q.** -- but I just want to follow this through with you,
24 please. So at the same time as we have processes
25 identifying real concerns with the approach to consent,

1 we have these Tendable audits returning 100% scores,
2 including in relation to consent. So my question is,
3 how accurate or how much weight do you think should have
4 been attached to these Tendable audits or should be
5 attached to them now?

6 **DR SURESH:** May I come in?

7 **Q.** Yes.

8 **DR SURESH:** As well?

9 **MR TRENT:** May I say one last point and then hand over to
10 you?

11 As I said a moment ago, audits are only ever one
12 point of evidence and they need to be triangulated and
13 considered with other things. You know, the findings of
14 the PHSO are found later but they do relate to time
15 before this, I agree with that. You've highlighted
16 yourself that not all of these audits are showing full
17 compliance, and we have accountability meetings and
18 other methods of oversight.

19 I mean, I start from a fundamental position that I
20 expect our staff to come into work, to do a good job, to
21 be good professionals, to follow their Codes of Practice
22 as applicable, and when they are undertaking an exercise
23 like this, to do it in good faith against the documents
24 available at the time. So I start from a position of
25 saying: those audits need to be given validity at the

1 first point of review and they need to be triangulated,
2 and where there are other areas that may differ from
3 that, or provide different insights, then those need to
4 be understood and, you know, there needs to be work and
5 our Matrons do do this with our staff nurses, to make
6 sure they know how to audit properly and to work with
7 them on that.

8 **THE CHAIR:** Before you come back, Dr Suresh, the
9 triangulation that you have referred to so far that
10 we've been taken through includes that internal audit,
11 the TIAA audit, which I know was at a later stage, it
12 was at a later stage, but that was finding that poor
13 record-keeping and a lack of engagement with the
14 Tendable audit. I think that it would be reasonable,
15 wouldn't it, to suggest -- I'm not saying it's
16 necessarily the case, but it would be reasonable to
17 suggest -- that perhaps audits which show 100%
18 compliance with the process, including record-keeping,
19 might have been perhaps done with a view to trying to
20 have a 100% compliance. It doesn't quite fit, does it,
21 with what we know about later reviews of process?

22 **MR TRENT:** I think, as you say, you know, the tier reports
23 challenge this because they say that when you do
24 a different audit, we're seeing some different results.

25 **THE CHAIR:** Yes.

1 **MR TRENT:** Now, that may be because the staff didn't
2 properly understand something. You know, I don't --

3 **THE CHAIR:** I'm not attributing it necessarily to malice or
4 ill intent, but it does, doesn't it, demonstrate that
5 it's not wholly reliable?

6 **MR TRENT:** Well, they're different data points and they're
7 in conflict and so that requires a further investigation
8 to understand why they're in conflict. And there are
9 different possible reasons for it. And I think, you
10 know, that's really driving the Rapid Review decision to
11 say: look -- and, you know, we've done two re-audits,
12 our management actions haven't seen an improvement, we
13 need to look at this again and we need to make further
14 changes.

15 And I think, you know, you're right, they are in
16 tension with each other. Certainly, Chair. Thank you.

17 **THE CHAIR:** Thank you.

18 **DR SURESH:** Can I just come in? I wanted to make a couple
19 of points around audits in general, not just this one.
20 One is they're ever a snapshot in time, for example if
21 you conducted an audit the next day on the same ward,
22 because you may speak to different staff, you might get
23 a different answer. So audits -- the other problem with
24 audits again, generally speaking, is that they are
25 sometimes a checking of whether something was documented

1 rather than something was done. Most of the time it's
2 easier to audit whether something was documented, and
3 I see lots of audits done by medical trainees as part of
4 their career development, and they can only audit
5 whether something was documented.

6 And the general understanding in the NHS is that if
7 something wasn't documented it wasn't done. That is how
8 certainly the coroners and other people view it. So
9 unless it is documented.

10 So I suppose the point I'm trying to make is that
11 there is a difference in the quality of audit if we are
12 documenting -- if we're auditing just the documentation,
13 versus really going into the quality of that audit,
14 which requires a much more narrative and a much more
15 time and much more detailed evaluation of whether
16 something was done well.

17 So the question is whether it was done at all and
18 whether it was done well. The first one is easier to
19 audit, the second one rather more difficult.

20 Sorry, I'll just say one more sentence. The purpose
21 of audits is also to pick up patterns rather than acting
22 on one individual piece of audit, if you like, because
23 we always have to confirm, once we have audited
24 something and found something either really good or
25 really poor, that has to be confirmed by further

1 evaluations which is going back to the triangulation
2 piece that Mr Trent talked about.

3 Thank you.

4 **MR GRIFFIN:** Just on the points that you've made, Dr Suresh,
5 and thank you very much for them, we -- the audits that
6 we've received are for a period from October to
7 December, and there's 25 of them and they're very
8 consistent in their -- in the responses. So whilst that
9 may still be a snapshot of part of a year, it is a
10 number of different audits across different wards over
11 two or three months so would you accept it's not a tiny
12 snapshot?

13 **DR SURESH:** It's not no.

14 **MR TRENT:** Yes.

15 **Q.** Also, you've helpfully outlined the scope of what audits
16 might cover to something very definitive that you can
17 tick a box about to the much more interactive type of
18 audit at the other end of the scale, if I've understood
19 you correctly?

20 **DR SURESH:** That's right.

21 **Q.** Would you agree that these Tendable audits sort of fall
22 somewhere between the two extremes, because there's some
23 tick-boxing going on, but there's also having to talk to
24 patients and staff members and record what they've said?

25 **DR SURESH:** That is correct. I think Tendable is one

1 platform for audit. There may be others available, as
2 well. But, like I said, most of the audits check
3 whether something was done or not, generally speaking
4 again, rather than how well it was done, if that makes
5 sense. That is going to be a much more involved and
6 much more elaborate, extensive piece of work.

7 **Q.** Understood. Thank you very much for that.

8 We've been told that there were over 1,400 incidents
9 between 1 April 2020 and 18 March 2025 in which
10 Oxevision alerted staff to an incident. Mr Trent, you
11 cover this in your first statement at paragraph 62.

12 Now we've just been talking about ticking boxes and
13 so on. Is it correct that the data was collected by use
14 of a tick box on the Datix form stating:

15 "Did the Oxevision system play a role in alerting
16 staff to the incident?"

17 **MR TRENT:** Yes, and it's helpful to go to that paragraph,
18 thank you, because it shows the table, which is
19 completely transparent. The first column is "Did they
20 tick the box?", and the second column is "Is Oxevision
21 referred to in the written narrative describing the
22 incident?"

23 So, you know, that's the specific evidence about the
24 cases. And we heard from Mr Trimble yesterday about
25 some of the things that those narratives have described.

1 **Q.** So just dealing what you've addressed, please, if we
2 look at the box, I'm not going to put it up on the
3 screen, but we can see that staff reported "yes" to the
4 question I've just set out 1,453 times, but that
5 diminishes by over half, doesn't it, to where Oxevision
6 is actually referred to in the written narrative
7 describing the incident?

8 **MR TRENT:** Yes, that's right.

9 **Q.** I just want to try to get a handle on the significance
10 of the information that you've put forward here, because
11 just following on from the type of question we've been
12 dealing with, how much information does that actually
13 provide you that allows you or indeed anyone else to
14 understand to what extent Oxevision has really been
15 involved in identifying, for example, an incident of
16 self-harm?

17 **MR TRENT:** So, you know, the evidence base is clearly
18 stronger on the cases with the narrative. I don't have
19 any dispute around that. And, you know, Mr Trimble
20 spoke about some of those and they describe in detail
21 specific incidents and how the system has been used in
22 those contexts.

23 Again, you know, coming back to our staff, we expect
24 them to record things accurately. It may -- you know,
25 the system -- they shouldn't tick that box unless it has

1 been involved. So it tells us something, depending on
2 the nature of the incident, what the -- the record
3 that's recorded will be proportionate to what the
4 incident is, and I can't say whether that means that
5 these incidents, the system was of limited value or not,
6 but the reason this is here and we've differentiated it
7 in the table is because the Project Board has had
8 oversight of this and the Project Board have said, "It's
9 not enough just to tell me there's a tick box. I want
10 to understand the substance of what's going on here."
11 **Q.** May I ask you a question, I may have asked you something
12 similar last year. Do you think you may afford too much
13 weight to staff getting it right when they complete
14 documents?
15 **MR TRENT:** Sorry, I'm not sure I understand that.
16 **Q.** You've been saying, I think a couple of times now, that
17 you would expect staff to do things right, for example
18 when we looked at the Tendable audit and now when we
19 talk about ticking the box about "Did the Oxevision
20 system play a role in alerting staff to the incident?"
21 My question was more general, though. I'm just
22 wondering whether you might assume that staff always get
23 it right when they complete these kinds of audits or
24 complete these kinds of returns?
25 **MR TRENT:** We know that our staff don't always get it right

1 and we know that that has had tragic consequences in the
2 past. And those consequences and outcomes are clearly
3 documented in coroners' findings. So I would not
4 suggest our staff get things right every time.

5 My point, more, was that we, like other NHS Trusts,
6 expect our staff to work professionally according to the
7 policies and procedures of our organisation and
8 according to the training and support they've had and
9 the supervision that they've had. So I would not expect
10 a staff member to tick a box on a medical record, and
11 whether it's a tick box or a written statement, it has
12 the same, you know, requirements around it: to be honest
13 and to exercise professional judgement. So I would not
14 expect staff to routinely check a box if it wasn't the
15 case. In fact, that would be something that their
16 supervisor would take up with them if they were doing
17 that wrongly. You know, that's the kind of thing that
18 we're clear with our staff: when you record a -- these
19 are medical records, you need to record them accurately
20 and we have policies that are very clear about that.

21 **Q.** Thank you.

22 **DR SURESH:** May I add something more to that, just one
23 thing. It is more likely that staff, because they may
24 be so busy caring for so many patients on the ward, that
25 is a more likely scenario rather than getting it wrong,

1 if that makes sense. Because as we are seeing, Datix
2 is -- asks us quite a lot of questions when reporting an
3 incident, and unless a particular field is mandatory or
4 asterisked, staff might go past that without necessarily
5 completing it fully.

6 **Q.** So are you effectively saying we need to be aware of the
7 various different things staff have to do on a ward at
8 any given time --

9 **DR SURESH:** -- (overspeaking) --

10 **Q.** -- and filling out a form has to be considered in that
11 context?

12 **DR SURESH:** That is correct, yes.

13 **Q.** Thank you.

14 Mr Trent, I'd like to turn to an issue that we
15 flagged before and I said I would return to, and that's
16 the issue of the use of new technology in hospital
17 Trusts and the linked issue of the availability of
18 guidance about it. Do you remember we talked about
19 this --

20 **MR TRENT:** Yeah.

21 **Q.** -- this morning? And you started to address it. You
22 mention in your main statement at paragraph 69 that:

23 "Consistent with NHS England's general encouragement
24 to use technology to support the provision of safe and
25 compassionate care, EPUT had been seeking to identify

1 innovative solutions to the challenges associated with
2 self-harm incidents and high levels of observations in
3 order to improve safety and quality of care."

4 You add later in the same statement that one of the
5 CQC's strategic priorities is to encourage innovations
6 in technology as a driver of improvements in the quality
7 of care.

8 And we touched on this when you gave evidence last
9 year. And of course, we now have the 10-Year Plan for
10 the NHS in England which, as I understand it, again
11 talks about a move from analogue to digital and so on.

12 Would you explain whether, or how, encouragement
13 from organisations such as NHS England and the CQC
14 influences hospital Trusts such as EPUT to consider and
15 take up new technology?

16 **MR TRENT:** So, I mean, we have regard to key publications.
17 You've referenced the 10-Year Plan. Every NHS Trust
18 Board will have regard to that. It's a clear national
19 document, it's endorsed by the Government, we're
20 a public-funded organisations, we are expected to have
21 regard to these things.

22 Both the CQC from a quality perspective and NHS
23 England through its functions as monitor and NHS
24 improvement through the provider licence regulate us as
25 Trusts, so of course we have regard to what they say.

1 And, you know, the practice of the NHS, as well, is that
2 we work closely with both of these organisations, as
3 you'd expect us to. And we respect both their expertise
4 and the fact that they have a different vantage point
5 than we do. And, you know, the structure of the NHS
6 reflects this. So we will work closely with our
7 regional team for NHS England and the East of England.

8 **THE CHAIR:** Can I just ask you to slow down just a bit.

9 **MR TRENT:** I'm so sorry, Chair.

10 We will work with both the regional team of NHS
11 England and the national team and they will work
12 together and so on.

13 So I hope I've answered your question, but there are
14 a number of reasons that we work with, and have regard
15 to, both of those organisations, and of course, other
16 national bodies, as well.

17 **MR GRIFFIN:** May I ask you two questions arising from that
18 and just to pick up on what the Chair has said, we'll
19 both moderate our pace, if that's all right.

20 So, the first of the questions I want to ask you is
21 this: do you perceive there to be a pressure on Trusts
22 such as EPUT to explore new technology?

23 **MR TRENT:** I wouldn't say a pressure. You know, we're
24 clear, as a Trust Board, we're accountable for our
25 services, and we have to make decisions that are right

1 and proper with regard to our Trust and that includes
2 our procurement decisions and everything else. So
3 I wouldn't say pressure. I don't think that's fair.

4 I think, you know, there's been work done at
5 a national level that's identified that technology can
6 have benefits in healthcare as a broad conclusion, and
7 Trusts in, being asked to implement the likes of the
8 10-Year Plan are expected then to look at the specific
9 deployments or opportunities in that space.

10 And I know that, you know, despite noting it as
11 outstanding practice at the time, CQC didn't formally
12 endorse any particular products; they just said, "We've
13 seen an outstanding practice."

14 **Q.** I'll come on to that a little later --

15 **MR TRENT:** And, you know, we have -- and those are things we
16 have regard to because, you know, we have confidence and
17 respect for those institutions. So when they say
18 something like that, we have regard to it. It doesn't
19 force us to do one thing or another. And it doesn't
20 pressure us to do one thing or another. But we do have
21 regard to it.

22 **THE CHAIR:** If, either regionally or nationally, the NHS or
23 CQC or any other national body approached you and
24 expressed displeasure at the way you had seized the
25 deployment or opportunities that you're talking about,

1 how much weight would that have with your organisation?

2 **MR TRENT:** A significant weight. So, you know, we, through
3 the Provider Oversight Framework, we meet regularly with
4 NHS England and discuss a wide range of aspects on the
5 Trust's performance, on quality and operational matters,
6 and so on. And NHS England would, you know, has and
7 does, raise issues with us through those meetings and,
8 you know, we would take those away and address them.

9 And I think, you know, the assessment that
10 Mr Harry's team made recently about compliance with the
11 2025 guidelines, I think that's a really helpful
12 exercise and that kind of feedback from NHS England --
13 I mean, I appreciate now that they've referred that to
14 the CQC for those 10 Trusts -- that's helpful to Trusts,
15 to have that independent assessment to say, you know,
16 "Here's a matter that we're concerned about and we'll
17 actually work with you to assess it and give it
18 a different vantage point."

19 And they do provide constructive challenge on all
20 number of things and I've seen that. I have worked at
21 NHS England previously, by the way, I think you'll be
22 aware of that. So I've seen that from both sides.

23 **THE CHAIR:** Do you feel accountable to them?

24 **MR TRENT:** Of course there's an accountability there.

25 I think that's built into what Mr Harry describes as the

1 ecosystem or the system of the NHS, and they are our
2 regulator from the perspective of the provider licence.
3 You know, CQC regulates on quality but that provider
4 licence, NHS England has significant powers. It can
5 remove directors of the Board and so on and so forth.
6 So there is an accountability there.

7 **DR SURESH:** May I add one more point?

8 **MR GRIFFIN:** Please do.

9 **DR SURESH:** I think, you know, technology we know is
10 advancing very fast. I think Dr Denman touched upon it
11 as well in her recommendations. But in mental health
12 care new technologies come not very often compared to,
13 say, general medicine or health care. So, whilst we
14 should embrace technology, something as significant as,
15 say, Oxevision for instance, which makes, you know --
16 which has a lot of aspects to it like consent and
17 privacy, dignity, human rights, et cetera, I think my
18 own view is that there should be an evaluation of such
19 technology at a higher level than the providers, because
20 if left to individual providers, we can go off in
21 different directions, as we have seen with Oxevision,
22 many Trusts have adopted different practices and
23 different approaches to something like this.

24 So, in terms of adopting technology, I think there
25 should be a process before the technology is put to

1 wider use within the NHS. It has to be evaluated, and
2 I, you know, often think of the model of the National
3 Institute of Health and Care Excellence, NICE, on this.
4 When a new drug comes to the market, they look at it
5 from two points of view. Number 1, does it work?
6 Does it do what it says? And number 2, whether it is
7 deployable across the NHS in terms of cost
8 effectiveness, ease of use, and also added value to
9 patient care?

10 I think that would be a very good model to apply for
11 new technologies coming in as well, so that providers
12 have some kind of a guidance or direction, and that not
13 only brings consistency across the NHS, but also
14 prevents potential safety gaps, as well, because if
15 there is unacceptable variation in practice in different
16 parts of the country, that is likely to create gaps one
17 way or another.

18 **Q.** I think you've anticipated my second question, which was
19 whether, or whether you consider that the Trust is
20 sufficiently supported to explore innovation and make
21 use of technology. But does the -- effectively, it's
22 a recommendation you're making, does that anticipate my
23 question and address it?

24 **DR SURESH:** It does. I mean, Trusts by themselves,
25 different Trusts have different research capabilities.

1 I mean, I head research within EPUT, and although we are
2 a research-active organisation, we are not as big on
3 research as, say, Oxford or Cambridge, for instance,
4 which have very well-established departments for
5 clinical research.

6 So I think that initial evaluation of technology
7 should come from a reputed national institution, in my
8 view, because providers have different capabilities for
9 research. But certainly, something like Oxevision, with
10 all its implications, it's not something we could do
11 a research on. I think there was a lot of discussion
12 around randomised control trials on Monday, I think, and
13 the value and benefits of that.

14 **Q.** And indeed yesterday?

15 **DR SURESH:** Yes. And that would be very challenging to
16 conduct within a provider organisation, because not only
17 do we not have the infrastructure, but also, the staff
18 expertise, and of course, the funding required for that.
19 So that should probably sit at a level higher than
20 providers.

21 **Q.** May I just make sure I've understood what you're
22 suggesting, and because we heard yesterday from
23 Ms Cozens about a recommendation that LIO were making
24 for a national framework for consideration of new
25 technologies of this type, if I've understood you

1 correctly, what you're suggesting is a little bit
2 different. And that is once a new technology has
3 evolved, that it specifically would be considered by
4 some body, that's more of a national body than an
5 individual provider, before that provider has to decide
6 whether to procure and implement it?

7 **DR SURESH:** That would be very helpful.

8 **g.** Have I summarised what you're suggesting correctly?

9 **DR SURESH:** Yes, you have, you have.

10 **MR GRIFFIN:** Okay.

11 Chair, we've been going for a little while since the
12 break. May I suggest that we pause now, and come back
13 in an hour at 1.50 rather than 2.00.

14 **THE CHAIR:** 1.50.

15 (12.52 pm)

16 (The Short Adjournment)

17 (1.50 pm)

18 **THE CHAIR:** Mr Griffin.

19 **MR GRIFFIN:** Chair.

20 Dr Suresh, Mr Trent, can we remember, all three of
21 us, to keep a reasonable pace as we speak for this
22 afternoon's session. Our stenographer has been doing
23 a sterling job across a number of hearings but we should
24 do our bit not to make it too difficult.

25 There were two pieces of homework that you heard

1 over the lunch break. Can we deal with those before we
2 move on to discuss other matters?

3 **DR SURESH:** Yes.

4 **Q.** First of all, the question that I'd asked, or the
5 suggestion that I'd put, was that under the most recent
6 SOP, if a patient without capacity refused consent for
7 the use of Oxevision, I suggested that was it, they'd
8 have the final word, even though they didn't have
9 capacity.

10 Quite correctly, Dr Suresh, you referred to the
11 position under the Mental Capacity Act and best interest
12 decisions but you were going to have look at the
13 infographic at appendix 5 to the SOP, and let me know
14 whether you agreed with my assessment of what that
15 actually shows.

16 **DR SURESH:** I had a look at it over the lunchtime. It's not
17 the easiest infographic to navigate your way through.
18 But what it essentially says is that if a patient lacks
19 capacity, then it should trigger a best interests
20 process, which is under the LIO active state in the
21 middle bit, and then once the best interest decision has
22 been made, that should be followed. It shouldn't
23 automatically trigger an "off" state, because by the
24 fact that the patient lacks capacity, we are then saying
25 they may not have the ability to make a decision that,

1 you know, in their best interests, if that makes sense.

2 That is then devolved to other people, including the
3 MDT, of course, in consultation with the family, or an
4 advocate if the patient is unbefriended, and together
5 they come to a consensus and that decision will have to
6 be implemented.

7 **Q.** May I ask you this: to what extent does the approach to
8 a patient without consent, to what extent is it
9 different in this latest SOP compared with the earlier
10 SOPs?

11 **DR SURESH:** I think it makes it more explicit that you have
12 to follow the Mental Capacity Act processes when someone
13 lacks capacity, and that then reminds staff to consult
14 other people, including patients' own past wishes if
15 they had been able to express it at some point in the
16 past when they might have had capacity and, of course,
17 taking the views of the family into consideration, given
18 that families often know the patients a lot better, and
19 would have known what the patient would have decided,
20 had they had capacity at that point in time.

21 That would be really important to take into the
22 decision-making process and, of course, again, the
23 clinical team would have already decided whether it was
24 useful for the patient or not because that is the first
25 step of our process.

1 Q. So would it be right to say that there is a different
2 emphasis in the later SOP --

3 DR SURESH: That is correct.

4 Q. -- when it comes to patients without capacity?

5 DR SURESH: Yes, that is correct.

6 Q. Was there anything you would like to add to that,
7 Mr Trent?

8 MR TRENT: Only, I suppose, the obvious point that in this
9 SOP now, it's default "off", so while that process is
10 going on, the system is not on and obviously that's
11 a material change to previously when, while that process
12 was going on, the system would have still been on.

13 Q. Thank you.

14 The other matter that I put back from this morning
15 related to the Tendable audit that we looked at, and on
16 the first page there was a yellow text box and the
17 question was where that text would have come from. I'd
18 suggested the staff member completing the form would
19 have entered the text, and Mr Trent, you wondered
20 whether it was actually an aspect of the form itself.

21 MR TRENT: And you were correct, that was entered by
22 a member of staff and you can see that when you look
23 across a number of the different exhibited Tendable
24 audits where staff have put different comments.

25 Q. Thank you very much.

1 So, moving now back to the questions from this
2 morning, I was asking you about encouragement to use
3 technology and Mr Trent you referred in particular to
4 NHS England and CQC. Can we just continue with that?

5 **MR TRENT:** Of course.

6 **Q.** You referred to a CQC Digital Care Assistant case study,
7 and the results of that. May I just raise something
8 with you now.

9 So, this was the publication by the CQC, studies of
10 innovative developments which use technology to deliver
11 care differently and more efficiently, and it was an
12 aspect of that, the Digital Care Assistant was one of
13 the CQC's published case studies, following a
14 December 2018 inspection at Coventry and Warwickshire
15 Partnership NHS Trust, and the CQC noted the use of the
16 Digital Care Assistant for monitoring movement and vital
17 signs in patients' bedrooms as outstanding practice
18 resulting in reduction of falls.

19 Now, was that what you were referring to earlier?

20 **MR TRENT:** That's right, and you can see that in some of the
21 minutes and the papers, that's referred to by EPUT at
22 the time. So I'm not making a speculative link; that
23 was referenced by the Trust at the time.

24 **Q.** I think you add in the statement that this was amongst
25 the information that led EPUT to conduct a trial of the

1 system?

2 **MR TRENT:** Yes, and it wasn't on its own determinative but
3 it was a piece of evidence at the time that was
4 available that the Trust had regard to.

5 **Q.** It's right now to note that the Inquiry has recently
6 received evidence from Craig Howarth, a Deputy Director
7 of Operations for Mental Health in the north region for
8 the CQC, which addresses this case study.

9 **MR TRENT:** Yes, and I've read his statement.

10 **Q.** He's provided two witness statements --

11 **MR TRENT:** I've read both, yes.

12 **Q.** -- from June and September this year which have been
13 disclosed and, as you say, Mr Trent, it's helpful that
14 you've read them. They have been disclosed to core
15 participants and they'll shortly be available through
16 the Inquiry's website.

17 And in fact, Chair, tomorrow, my colleague Ms Hyde
18 will provide a summary of regulators' evidence we have
19 received over and above that which we hear from
20 witnesses themselves and this will be included in it.

21 Mr Trent, as you probably now know, Mr Howarth has
22 reflected on the process by which the CQC case study
23 report was completed. His view now is that, without
24 corroboration of some of the matters mentioned in the
25 report, he would not agree with the assessment that the

1 use of Oxevision represented outstanding practice and
2 we've accessed the CQC website and we don't see the case
3 study there anymore.

4 In brief, Mr Howarth appears to be saying that the
5 Digital Care Assistant case study was not as
6 evidence-based as it should have been.

7 Now, you've already told us that that wasn't
8 determinative on its own, and clearly, neither of you
9 were in position at the Trust right from the start. Are
10 you able to say to what degree that case study
11 influenced EPUT, and whether EPUT would have arrived at
12 similar conclusions to trial this technology if that
13 case study had not been available and said what it did?

14 **MR TRENT:** I mean, I think it's impossible to be back in
15 that time and know exactly what weight was given to
16 every individual reference. Clearly some weight was
17 given to it because otherwise it wouldn't have been
18 referenced in the papers and the documents at the time.
19 And, you know, by flipping that the other way around,
20 you know, we heard last Monday about the 136 incidents
21 and the analysis of the Deputy Director of Patient
22 Safety at NHS England. Well, had that analysis been
23 shared with the Trust, it would have had regard to it,
24 but it wasn't at that time.

25 So I think, you know, when you're looking back at

1 this with the benefit of hindsight, which is a powerful
2 benefit, both the things that were available and the
3 things that weren't available may have influenced the
4 way the Trust made its decisions but it's really very
5 difficult to determine that.

6 **Q.** Thank you.

7 I'd like to move on to a new topic, please, and
8 that's data protection. And Mr Trent, I think I need to
9 address my questions to you, is that correct?

10 **MR TRENT:** That's right.

11 **Q.** We discussed matters relating to data and data
12 protection last year, didn't we, when you came to give
13 evidence? And in your main statement provided this year
14 you provide quite a detailed section on data protection,
15 ownership, storage, use, access and retention. That's
16 from paragraph 432; is that right?

17 **MR TRENT:** That is correct.

18 **Q.** By way of introduction, are there various different
19 categories of data that are relevant when we discuss the
20 Oxevision system?

21 **MR TRENT:** Yes, there are.

22 **Q.** Do you list them in the statement?

23 **MR TRENT:** Yes.

24 **Q.** Do they include Clear Video Data, or CVD, and Anonymised
25 or Blurred Video Data or AVD?

1 **MR TRENT:** They do.

2 **Q.** At the start of your evidence today, we looked at that
3 SOP poster that showed you could get either a clear view
4 or a blurred view using the Oxevision system, didn't we?

5 **MR TRENT:** Yes.

6 **Q.** And as I say, one of the facilities is to get an up-to
7 15 second clear view of the patient in their bedroom;
8 correct?

9 **MR TRENT:** Yes.

10 **Q.** Is Clear Video Data, the raw video or still footage
11 captured by automatic operation of Oxevision?

12 **MR TRENT:** Yes.

13 **Q.** The same poster referred to the possibility of accessing
14 blurred video for up to 15 seconds, as well. Is
15 anonymised or Blurred Video Data also created during the
16 automatic running of Oxevision?

17 **MR TRENT:** Yes.

18 **Q.** Is blurring applied to the raw video feed?

19 **MR TRENT:** Well, when the staff are doing the vital signs
20 no, but I think if you're asking is it processed, yes.

21 **Q.** By operation of the system?

22 **MR TRENT:** Yes.

23 **Q.** Thank you. When we consider data protection, are there
24 two categories of data or information that are of
25 particular significance, namely personal data and

1 special category data?

2 **MR TRENT:** Yes.

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

5 **MR TRENT:** Yes.

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

10 **MR TRENT:** Yes.

11 **Q.** Is special category data a subset of personal data
12 that's particularly sensitive and therefore requires
13 extra protection?

14 **MR TRENT:** Yes.

15 **Q.** For example, does it include personal data revealing
16 health data?

17 **MR TRENT:** Yes.

18 **Q.** With that in mind I'd like to look at part of the main
19 statement with you.

20 Would you put up the main statement EPUT023595 at
21 paragraph 470. This is page 102.

22 I just want to read some of this with you, please:

23 "In summary, EPUT's consistent position, informed by
24 ICO guidance, is that all categories of LIO system data
25 ..."

1 So we've looked at two, but there are several more,
2 aren't there?

3 **MR TRENT:** Yes.

4 **Q.** "... all categories of LIO system data listed above
5 constitute personal data, as individuals are
6 identifiable either directly or indirectly, including
7 through contextual information available within the
8 Trust. All data constitutes special category health
9 data as it either directly records or enables inference
10 about an individual's physical or mental health or
11 condition. Data described as 'anonymised' within the
12 LIO system does not meet the legal standard for
13 anonymisation under the UK GDPR, because
14 re-identification remains reasonably likely within the
15 clinical environment and the data remains linked to
16 individual care episodes."

17 So if I've understood correctly, the analysis is
18 that all of the various forms of data, including the
19 clear video and the Blurred or Anonymised Video Data,
20 are special category personal data in EPUT's latest
21 analysis in any event; is that correct?

22 **MR TRENT:** That's right, and if I try and explain it, you
23 know, when something's blurred, a layperson might say,
24 "Oh, that's anonymous, I can't tell who it is." Well,
25 on its own you may not be able to tell who it is, but if

1 you know that that is a person in a particular room at
2 a particular time, then you might be able to identify
3 them. And the chances are, if it's somebody you know
4 well, you might be able to identify them even though
5 it's blurred, just through the way they move or look or
6 so on. So, we differentiate between data that is truly
7 anonymous, in other words you cannot re-identify the
8 person. So whatever you do, it's impossible to get back
9 to it, according to the standards of Recital 26.
10 I mean, "impossible" is perhaps the wrong word but
11 according to those standards.

12 **Q.** So you've mentioned Recital 26, is that an aspect of
13 GDPR that relates to the types of things we've been
14 talking about, including anonymisation?

15 **MR TRENT:** That's absolutely right. And here, you know, the
16 Data Protection Officer and I have discussed this
17 extensively. We consider it pseudonymised which means
18 we think there is the possibility of re-identification
19 when you have those other points of reference that I've
20 described like, you know, knowing the patient is on the
21 ward, et cetera.

22 **Q.** So from EPUT's perspective, anyway, it's probably
23 a misnomer to refer to it as anonymised data?

24 **MR TRENT:** Yes, and in the statement, where we're referring
25 to it as "anonymised/blurred" that's because we're

1 referring to the way it's described in Oxevision's
2 documentation rather than that's the conclusion that we
3 ourselves have reached.

4 **Q.** Thank you.

5 Now, can we just read on in that paragraph on the
6 screen. It makes the point you've just made that:

7 "Accordingly, such data is treated as pseudonymised
8 personal data not anonymised data."

9 That's the point you were making, correct?

10 **MR TRENT:** Correct.

11 **Q.** Then it says this:

12 "EPUT adopts a deliberately cautious and consistent
13 approach, aligned with the accountability principle and
14 ICO guidance, and does not rely on anonymisation unless
15 it can be demonstrated to meet the Recital 26 standard."

16 Which you've just talked about, correct?

17 **MR TRENT:** Yes.

18 **Q.** Is it actually right to suggest, as you do there, that
19 EPUT's approach has been cautious and consistent?

20 **MR TRENT:** Yes, so I had the discussion with the DPO because
21 I wanted to be as clear as possible about how long we've
22 had this view, and it's clear in the 24 DPIA and
23 subsequent. It's not clear in the 21 DPIA.

24 **Q.** Can we just pause there. So in later Data Protection
25 Impact Assessments, or DPIAs -- the approach from 2024

1 onwards; is that correct?

2 **MR TRENT:** Yes.

3 **Q.** The approach that you've just set out is the approach
4 that's reflected in the DPIA; is that correct?

5 **MR TRENT:** That is correct.

6 **Q.** Sorry I interrupted you but I just wanted to capture
7 that.

8 If we go to an earlier period, for example if we
9 look at EPUT's DPIA from 2021, would there be
10 a different approach there?

11 **MR TRENT:** I can't be clear from reviewing that document and
12 when I discussed it with our DPO, she advised me that
13 from a very early stage, she has -- because she has been
14 in this organisation throughout this implementation --
15 treated this data with the most cautious approach in
16 terms of security around it and so on, but she couldn't
17 point me to a particular point in time where it's
18 documented of this assessment.

19 **Q.** Can we look at the 2021 DPIA.

20 Would you put up EPUT024165, page 6. So, this is
21 a page from the 2021 EPUT DPIA. Do we see at the top it
22 says "Non-Personal Data", Mr Trent?

23 **MR TRENT:** Yes.

24 **Q.** Can we see "Anonymised Video Data"?

25 **MR TRENT:** Yes.

1 Q. So that's the Blurred Video Data, correct?

2 MR TRENT: Yes.

3 Q. "Oxehealth will anonymise the camera feed so that the
4 individual is not identifiable ... Anonymised video data
5 is required to ensure the Oxehealth service delivers the
6 contract purpose to the contracted standard."

7 As we see at the bottom of that paragraph:
8 "... the anonymisation prevents individuals being
9 identified."

10 And if we drop down to the bottom of the paragraph
11 on the screen:
12 "Anonymised Video Data, as well as other types of
13 data which are termed ... 'Non-Personal Data' do not
14 constitute personal data in circumstances where
15 Oxehealth does not have access to Salient Video
16 Data ..."

17 Now, is that a reference to Clear Video Data,
18 "salient"?

19 MR TRENT: Yes, it is.

20 Q. In respect of the same footage.
21 Now, this is the EPUT DPIA, and that DPIA as at 2021
22 anyway, is suggesting that the Blurred Video Data is not
23 personal data; would you agree?

24 MR TRENT: Yes, I do agree with that, yes.

25 Q. So there is an inconsistency. Is your evidence that

1 that is corrected over time?

2 **MR TRENT:** Yes, between 2021 and 2024 that's changed. The
3 '24 DPIA -- sorry, I'm speaking too quickly.

4 The 2024 DPIA, which I approved, a SIRO is clear and
5 is consistent with the evidence given today. This DPIA
6 takes a different approach: the assurance I've had from
7 the DPO is that she has always ensured that data related
8 to Oxevision has been treated in a secure way, as far as
9 the Trust's systems have worked.

10 So, for example, to make that clearer, where Clear
11 Video Data, for example, has been extracted from the
12 system, and where anonymised video data has been
13 extracted from the system, our DPO has advised me that
14 she has always treated both of those in the same way in
15 terms of how they've been saved for EPUT's purposes and
16 stored.

17 **Q.** I suppose various questions arise. How long has she
18 been Data Protection Officer?

19 **MR TRENT:** I couldn't tell you her start date but I know she
20 was around at the early stages of this implementation.

21 **Q.** Because I don't think she was DPO, for example at the
22 time of the assessment we're looking at at the moment?

23 **MR TRENT:** We need to go to check back to the document in
24 that case.

25 **Q.** We can do that because it's on the last page --

1 **MR TRENT:** Okay.

2 **Q.** -- but we can move on for now. What weight should the
3 Inquiry attach to what you've just told us, when the
4 printed assessment says something quite different?

5 **MR TRENT:** So I'm making a distinction here and I apologise
6 if that's unclear. The written assessment of the Trust
7 and the position of the Trust is as you have taken me to
8 in the document. The practical way in which the data
9 has been managed, so no one will complain if you treat
10 data with more security than is required. And so what
11 I'm saying is that the DPO has advised me that she's
12 always been on the cautious side of treating things with
13 more security than required rather than less.

14 So I'm not sure that this distinction is necessarily
15 assisting you, but that was the distinction I was
16 making. And so I have no disagreement, this is the
17 position of the Trust at that point in time.

18 **Q.** So the Data Protection Officer, at the time of the
19 assessment that's on our screen, was Trevor Smith?

20 **MR TRENT:** No, Mr Smith was the SIRO.

21 **Q.** Well, that may be correct. Well, can we go to page 20
22 of the document that's on the screen. Do you see
23 there -- let me read it out. We can see at the
24 paragraph that starts "Data Protection Officer
25 approval", and it says this:

1 "I am the Data Protection Officer for EPUT (the
2 'Partner').

3 "I have reviewed Oxehealth's Data Protection Impact
4 Assessment and I am satisfied that it complies with the
5 partner's [ie EPUT's] implementation of GDPR and other
6 data protection and privacy requirements."

7 It's signed, "Name: Trevor Smith". Description:
8 Data Protection Officer. Is that incorrect?

9 **MR TRENT:** That is incorrect. Mr Smith, at that time, was
10 the Senior Information Risk Officer and not the Data
11 Protection Officer.

12 **Q.** Understood.

13 Is perhaps an explanation for the identification of
14 Blurred Video Data as non-personal data this: that EPUT
15 was provided with a template DPIA by Oxehealth, and it's
16 used that here without appropriately reviewing its
17 content?

18 **MR TRENT:** So you're right to say that EPUT was provided by
19 a template -- provided a template DPIA by Oxehealth.
20 I do not take from the error in the title that that
21 infers that EPUT did not review that document.

22 **Q.** Can I interrupt you there. Although it'll be for others
23 to decide how significant that is, that's not what I was
24 referring to.

25 **MR TRENT:** No, okay, apologies.

1 Q. I was referring to the fact that the DPIA that we've
2 just been looking at identifies Blurred Video Data as
3 non-personal data.

4 MR TRENT: Yes, I don't think that does infer -- I think, at
5 that time, and I'm not employed at the Trust, but at
6 that time, this DPIA was reviewed by the DPO and would
7 have been advised to the SIRO. So as a SIRO you don't
8 just have a DPIA presented to you and say, "Sign this";
9 you rely upon the expertise of the Data Protection
10 Officer and that's clear in the training for SIROs and
11 that's why an organisation will have a Data Protection
12 Officer because that is a -- excuse me, because that is
13 a skilled role that requires specific expertise, and our
14 DPO is somebody who has that expertise.

15 Q. So just to be clear, the suggestion I'm making that EPUT
16 has just adopted a template without really checking it,
17 you're rejecting that and you're saying that your
18 assumption would be that the DPO at the time, or the
19 SIRO at the time, would have conducted an appropriate
20 review.

21 MR TRENT: That is correct.

22 Q. Thank you. Would you take that down -- oh, it is down.
23 Thank you.

24 I want to move on to something else but is there
25 anything else you would like to say on this point?

1 **MR TRENT:** No, I mean, I can make further enquiries of the
2 DPO to confirm to you that that assessment was done, but
3 I understand that it would have been.

4 **Q.** Okay. We can follow up afterwards about that as
5 necessary, is that correct?

6 **MR TRENT:** Yeah, and I think the point is, if a template is
7 provided by any organisation, that doesn't change who is
8 responsible for the DPIA. The DPIA is the
9 responsibility of the Trust, and we would review that
10 before signing it.

11 **Q.** Thank you.

12 **MR TRENT:** And make sure it's fit for our purpose.

13 **Q.** Dr Suresh, I want to move to just one quick point about
14 vital signs usage reports. Now, we've discussed these
15 a few times during the hearings this year and last year.
16 But in short, does Oxehealth provide EPUT and others,
17 indeed, who use the system with monthly usage report
18 capturing certain data about the operation of Oxevision
19 at that provider?

20 **DR SURESH:** It does, yes.

21 **Q.** As we've previously heard, the Oxevision system allows
22 staff remotely to take vital signs, namely pulse and
23 respiratory rate and we've just touched on that earlier
24 today, and the 15-second clear view of the patient is
25 afforded before that spot check is taken, correct?

1 **DR SURESH:** Yes.

2 **Q.** Now, Mr Trent and I looked at monthly reports last year
3 which disclosed a discrepancy between the number of
4 attempts made to take vital signs with Oxevision and the
5 smaller number of successful vital signs readings.
6 Mr Trent, you recall that?

7 **MR TRENT:** I do.

8 **Q.** And Dr Suresh, that's an issue that you're aware of; is
9 that right?

10 **DR SURESH:** I am, yes.

11 **Q.** So the concerns included that it was taking multiple
12 attempts to get a reading and that staff -- I put this
13 to Mr Trent last year -- it may also suggest that staff
14 might be inappropriately using the vital signs function
15 to get a clear view of a patient, not to take readings,
16 but for some other purpose, for example to conduct
17 a remote observation. Are you aware of those issues and
18 concerns?

19 **DR SURESH:** Yes.

20 **Q.** This is something I put to Jill Archibald when she gave
21 evidence in July and indeed, she covers in her report.
22 So I'm not going to go over that now but she looked at
23 some wards that had particularly high usage and reached
24 conclusions about that, and also, some wards that had
25 much lower usage. And she reached conclusions about

1 that.

2 One thing that was noticeable, though, is that she
3 had reference to three periods of usage reports. She'd
4 had much more in terms of disclosure but she chose three
5 periods. My recollection is that it was June 2024, the
6 monthly usage report for that month; June 2025; and
7 April this year. And her analysis was across those
8 three months in three separate years.

9 The difference between the usage reports in the
10 earlier years and in 2026 was this: that in the years
11 prior to 2026, the usage reports displayed both overall
12 vital signs attempts, and the number of successful
13 readings. So it was possible to make a comparison
14 between the two. But the 2026 usage report just had the
15 number of attempts. It no longer included the number of
16 successful readings taken. So it's no longer possible
17 to make that comparison.

18 Now, are you aware of that situation and do you have
19 any explanation for why that potentially important piece
20 of data is no longer included in the usage reports?

21 **DR SURESH:** If I remember correctly, that was discussed with
22 Mr Trimble yesterday in his evidence, I believe. But
23 I'm not sure of the reason why that data is missing.
24 But what I heard yesterday, if we're referring to the
25 same issue, is that it causes some kind of confusion

1 around the recording of the data. Sorry, I'm not sure
2 about that.

3 **Q.** Is the short answer that you're not -- you don't have
4 the answer?

5 **DR SURESH:** No, I don't.

6 **Q.** Do you have an answer, Mr Trent?

7 **MR TRENT:** No. I mean, the report's provided by Oxehealth
8 and the change was made by them, not at our request
9 so --

10 **Q.** You're clear about that?

11 **MR TRENT:** Yes. That was not something we requested.

12 **Q.** Thank you.

13 You refer in your own statement to the fact that
14 EPUT is in the process of implementing a User
15 Authentication Gateway. Which of the two of you should
16 address that?

17 **MR TRENT:** I'm happy to.

18 **Q.** Would you explain what this is, and what it will do,
19 please?

20 **MR TRENT:** Yes, and as I said earlier I was at Ardleigh and
21 Gosfield just last week where the pilot of this is
22 taking place. Essentially, what it means, and I think
23 the Inquiry has heard other evidence on this as well
24 this week, is that staff have to log in with their NHS
25 email address into the iPad and that's an improvement on

1 the approach prior to that, where staff would input
2 their name but there'd be no validation of that, and
3 they may put initials or something shorter.

4 So what we've got in the pilot phase, and we intend
5 to roll this out, it's in the implementation plan, is
6 that staff have to log in with their NHS email account
7 and I think that will allow better audit of whether
8 individual staff members are doing a more or less vital
9 signs and so on. And, you know, I heard that evidence
10 about Oxehealth now developing a tool to alert. Well, I
11 believe that would be useful once it's available. But
12 it obviously, it depends on the user authentication and
13 that's not something that's been offered by Oxehealth
14 until quite recently.

15 **Q.** So Laura Cozens refers in her statement, and I think
16 we've covered it earlier this week, to the development
17 of user authentication, describing it as an "improved
18 security measure ensuring users are identified when
19 interacting with the platform."

20 So is that the same as the gateway that you're
21 explaining to us at the moment?

22 **MR TRENT:** Yes, and I'd agree with that quote that you just
23 read.

24 **Q.** You've already addressed this in part but can I ask you
25 expressly: when in place, to what extent would user

1 authentication reveal or allow the Trust to investigate
2 potential misuse of the vital signs function?

3 **MR TRENT:** I think it would be a great asset on that, and
4 I would see this -- and having spoken to clinical
5 colleagues about it, senior nurses in particular, you
6 know -- and this goes with the Culture of Care Standards
7 and, you know, thinking about improving practice --
8 there's often opportunities for reflection. Now, if
9 a colleague appears to be using it more, maybe that's
10 a misunderstanding. They didn't take the right thing
11 from their training and there's an opportunity for
12 reflection and learning and improvement, and, you know,
13 that's the -- one of the ways the e-obs is used at the
14 moment, and I spoke to a senior nurse who oversees the
15 CAMHS service about this, she and her team use the e-obs
16 to identify gaps in observation much more easily
17 -- (overspeaking) --

18 **Q.** Sorry, I am going to ask --

19 **MR TRENT:** -- (overspeaking) -- sorry, with staff.

20 **Q.** You're referring to "e-obs", is that effectively the
21 same as Oxevision Observations?

22 **MR TRENT:** Yes, they mean the same thing. So this senior
23 nurse, what she does, every day, is she looks at the
24 electronic record to say: are there any gaps in this,
25 where observations haven't been done in the way they

1 should have been done, and then she uses that as an
2 opportunity to meet with any staff members, where she
3 has any concern, to review that practice. If that
4 happens more than once, and she tracks it, then she
5 looks at a disciplinary process.

6 But it's that insight from the data that allows the
7 reflection and the improvement with staff, and I think
8 this would provide the -- user authentication would
9 provide another way to identify anything that appears to
10 be inconsistent with policy, and to review that and if
11 necessary, take disciplinary action.

12 **Q.** You have just said, and I think Mr Trimble said this as
13 well, that this is only at a pilot stage at EPUT. When
14 is it going to be rolled out more widely?

15 **MR TRENT:** I believe the Clinical Safety Officer needs to
16 review the pilot results and then it would follow from
17 that. So I can't give you a timeline now but I know
18 it's in the implementation plan for the new SOP to do
19 that.

20 **Q.** Dr Denman has suggested in her report that the best way
21 to prevent problems -- that's with technology such as
22 Oxevision -- is to make incorrect use very difficult, if
23 not impossible. This idea of fail-safe design, she
24 says, tries to eliminate human factors or move them
25 favourably and human error wherever possible. So it

1 tries to eliminate human factors or move them
2 favourably, and human error wherever possible.

3 "I do not think [she says] sufficient thought was
4 given to human factors in the design and implementation
5 of this system."

6 Would you agree with that: that insufficient thought
7 was given to this kind of thing earlier on?

8 **MR TRENT:** I certainly agree with the first part about
9 failsafe, you know, that is absolutely right. And with
10 all technology development, you know, you should always
11 be looking at that: what are the possible ways this
12 system can fail? How do you protect against it?

13 The question of to what extent -- should more work
14 have been done on that earlier? I think that's really
15 a question for Oxehealth, because it's their product and
16 they have the engagement with many, many Trusts, not
17 just one. But we have consistently fed back things.
18 So, you know, like, I've given the example last year
19 about the housing of the unit to say could a -- we fed
20 back the question: could a screen be put in place to
21 reduce the potential traumatic impact of a camera
22 looking like it's on when it's not? Now, I know they're
23 looking at that but they haven't addressed it yet. And
24 there will have been lots of other bits of feedback.

25 So I think, how much focus on failsafe design,

1 that's a responsibility of the product developer and we
2 have fed back to that over the years.

3 **Q.** I'm just wondering to what extent it is fair, really, to
4 say this is an Oxehealth issue rather than an EPUT
5 issue. For example, EPUT identified a need for an
6 electronic observation system and was able to liaise
7 with Oxehealth for its development. Couldn't something
8 similar have happened about user authentication? Could
9 that not have been raised with Oxehealth at an early
10 stage for mutual development of something along those
11 lines?

12 **MR TRENT:** Well, it has been raised. It's in the minutes of
13 the Project Board. We've raised things about
14 authentication before, and I think, you know, we work
15 with all of our technology providers with the principle
16 of partnership because, you know, in a complex
17 environment like a healthcare provider, you're not just
18 buying something off the shelf and plugging it in;
19 there's a huge amount of work to implement it properly
20 and make sure it's used properly.

21 So we don't own the code, we don't own the product.
22 The supplier owns that. We can't go in and change the
23 code of the product; that's theirs. We do need to, and
24 that's where the Hazard Logs and the clinical safety
25 cases are so important, understand the risks, and we

1 need to feed back and work with the supplier.

2 So I think this is a partnership and it is
3 a relationship. But, you know, if you want to say:
4 well, who has the ability to change the product and make
5 it failsafe? Well, it's the people who own the code and
6 the product itself rather than the customer. We can
7 influence that but we don't own the product.

8 **Q.** Thank you.

9 I'd like to move on now to take stock of what we
10 know about the circumstances in which the Oxevision
11 system can be used. The most recent SOP that we've been
12 looking at says that there are two functions that the
13 LIO system provides to assist staff in delivering
14 a patient's personalised care plan. These are: four
15 main ambient alerts relating to patient movement in
16 their bedrooms -- I'll come back to that in a moment --
17 and non-contact remote monitoring of pulse and
18 respiratory rates.

19 Just going back to the alerts, four are listed. The
20 first is leaving the room or standing in the doorway.
21 The second is in the bathroom for more than three
22 minutes. The third is multiple occupants in room. And
23 the fourth is edge of, or leaving, the bed alert. So
24 this is from the version of the SOP from this year.

25 Is it right that the number of alerts has actually

1 reduced over time? So, for example, am I right in
2 remembering that there used to be an alert, for example,
3 for someone in a blind spot, or someone out of bed, as
4 well?

5 **MR TRENT:** I'd need to go back to validate that against the
6 SOPs.

7 **Q.** But the short point is, if I want to ask you about that,
8 those aren't questions you can answer at the moment?

9 **MR TRENT:** No, I'd need to --

10 **Q.** Is that right for you as well?

11 **MR TRENT:** I don't know whether you, Dr Suresh --

12 **DR SURESH:** That's correct, unless we are talking about
13 whether individual units can switch off various
14 functions.

15 **Q.** No, it's the more basic question as to whether the
16 number of alerts that are now available to EPUT have
17 reduced over time?

18 **DR SURESH:** No.

19 **MR TRENT:** -- (overspeaking) --

20 **Q.** So, we can follow up with that afterwards, yes?

21 This morning, Dr Suresh, I think you said that the
22 vital signs function does not add a lot of value, and
23 this was in the context of the Rapid Review briefing and
24 the two options that we looked at and the point that the
25 Chair put to you that option 1, which was to pause, when

1 you looked at the cons as opposed to the pros, the
2 concerns there seemed to -- well, clearly were related
3 to the loss of the alerts function, no mention of vital
4 signs. And in that context, you said you don't think
5 that the vital signs adds a lot of value.

6 I just want to ask you a little bit more about that,
7 please.

8 We've heard about the parameters in which pulse and
9 respiratory rates can be taken. So 50 to 130 beats per
10 minute, and 8 to 39 breaths per minute. And it's unable
11 to take readings outside of those parameters.

12 To what extent is that actually a limitation? How
13 often will there be situations in which a patient's
14 readings would be outside those numbers?

15 **DR SURESH:** It happens occasionally, not very often.

16 Because the heart rate has quite a wide range, in normal
17 people, as well. For example, 50 would be the lower
18 limit of, for example, if you're athletic, your heart
19 rate can be generally lower, because your body is
20 trained to work that way, et cetera.

21 Above 130 would be more risky if not identified, but
22 that covers, pretty much, I would say the vast majority
23 of patients that we encounter in mental health practice.

24 **Q.** And would it be the same for the breaths per minute, the
25 figures given there, 8 to 39?

1 **DR SURESH:** 8 to 39, yes. 12 to 16 is about the middle of
2 the normal range, if you like, but if it is 39 or more,
3 that patient would be very unwell. And before we look
4 at breathing as a sign of abnormality, there would be a
5 lot of other things going on, as well, that would be
6 picked up.

7 **Q.** Sorry, it's probably me. If a patient's breaths per
8 minute were above 39 or, indeed, if their pulse was
9 above 130, you would want to know about it?

10 **DR SURESH:** Yes, but that would be very obvious to the naked
11 eye. For example, to breathe at 39 times per minute,
12 you would have to be breathing really, really rapidly
13 and that would be quite obvious. For example, someone
14 who is asthmatic and is having an asthmatic attack or
15 someone in a state of cardiac failure, for instance,
16 they would have that kind of a rapid but shallow
17 breathing.

18 **Q.** Would that be easily recognisable through a window of
19 a patient in their bed, for example?

20 **DR SURESH:** It would be, particularly if it is rapid.
21 Slower ones, probably not.

22 **Q.** Dr Suresh, you explain in your statement that the
23 National Early Warning Score or NEWS2, and we've heard
24 what it is and you explain what it is, but rather than
25 going over a further explanation, it's right that it

1 takes six separate measurements and it's a combination
2 of all of those that produces a score; is that right?

3 **DR SURESH:** That's correct, yeah.

4 **Q.** And the vital signs function, as we've heard, picks up
5 on two of those measurements but not the other four?

6 **DR SURESH:** That's correct.

7 **Q.** Do you agree that the vital signs function does not
8 alert to -- sorry, the vital signs function in
9 Oxevision -- does not alert to clinical deterioration
10 and is not a replacement for NEWS2 measurements?

11 **DR SURESH:** It's not, like we heard from Dr Denman on
12 Monday, I think, you know, two alerts are better than
13 none at all, and clearly NEWS2, which takes six
14 measurements, is a lot better than two. So ideally, it
15 should be NEWS2, but in the absence of that where that
16 is not feasible, two would be better.

17 **Q.** So Dr Denman was -- we were exploring examples such as
18 health-based places of safety or seclusion; is that the
19 type of setting that you have in mind?

20 **DR SURESH:** That is correct, yes.

21 **Q.** Thank you.

22 **DR SURESH:** That is where patients can be often very
23 disturbed and an in-person observation may be either too
24 risky or not possible.

25 **Q.** Dr Denman suggested that vital signs could not help with

1 detecting the first signs of self-strangulation or
2 self-harm, allowing for early intervention. Do you also
3 agree with that?

4 **DR SURESH:** I do, yeah.

5 Can I just go back to the point, I don't know if
6 I answered it fully, you asked about whether it can
7 picks up patterns of deterioration.

8 **Q.** Does not alert to clinical deterioration.

9 **DR SURESH:** It does not, because it is a point-in-time
10 measurement and it takes a clinician who is trained to
11 interpret those individual measurements and connect the
12 data plots, as it were, data dots, in order to make that
13 assessment of any deterioration or improvement.

14 **Q.** The NEWS2 measurements, we asked Dr Denman how often
15 you'd want to take them. I think the short answer is
16 it's patient specific.

17 **DR SURESH:** It is.

18 **Q.** But she suggested if you have a relatively young and fit
19 person, it might be even less than once every 12 hours.
20 Is there a general minimum that is used at EPUT?

21 **DR SURESH:** I think it's twice a day for otherwise
22 physically well patients. But if their circumstances
23 warrant more often, then that is carried out.

24 **Q.** May I just stick with the situation where it doesn't
25 warrant more often in terms of NEWS2 measurements. Is

1 there any reason in that kind of case for frequent
2 taking of vital signs readings using Oxevision?

3 **DR SURESH:** All other things being equal, probably not,
4 because generally the kind of patients we admit to
5 mental health wards are physically quite well, except
6 for certain populations like older adults, who may have
7 multiple comorbidities, where it probably makes sense to
8 do it more often. But on an adult ward with relatively
9 fit and healthy young adults, more often than 12 hours
10 would not be warranted. And might even be considered
11 more intrusive.

12 **Q.** Thank you.

13 Putting aside the type of settings where you might
14 have a very agitated patient, that we've just touched
15 on, if vital signs is not a replacement for NEWS2, and
16 doesn't measure or alert to clinical deterioration, what
17 do you view its purpose as being?

18 **DR SURESH:** At its most basic, I think it tells us that
19 somebody is alive, if they are breathing and are, you
20 know, we can measure their heart rate. It can alert
21 a clinician to perhaps carry out a more rigorous
22 assessment, if their heart rate and respiratory rate is
23 elevated. That's a point in time, rather than
24 a pattern. The pattern is still down to the clinician
25 to make a judgement on.

1 Pulse rate by itself is probably not a very good
2 measure of physical health, you know, because there's
3 a huge range, and if we're talking about the populations
4 that are on general adult wards who are otherwise
5 healthy and not in a special situation. So I think
6 I would consider that as the main benefit, clinical
7 benefit.

8 **Q.** Thank you.

9 You cover, in the main statement, your
10 jointly-authored statement self-harm and ligature risk
11 reduction as well as whether incidents of self-harm are
12 being identified by use of the vital signs function, and
13 you say this. It's paragraph 352:

14 "The Trust considers the presence of a downward
15 trend in ligature incidents on a number of wards
16 following the installation of Oxevision to be an
17 important and encouraging finding."

18 May I ask you this, how is the Trust able to
19 identify that any downward trend in ligature incidents
20 is because of Oxevision as opposed to other factors?

21 **MR TRENT:** I think we can't determine the single causative
22 link there, and I mean, that paragraph perhaps needed to
23 make that caveat clearer, and as statisticians will tell
24 you, correlation or association does not equal
25 causation.

1 **Q.** Thank you.

2 Can I make sure everyone can hear. Yes?

3 **DR SURESH:** Can I just add one more?

4 **Q.** Please do, yes.

5 **DR SURESH:** Self-harm is a product of multiple confounding

6 factors or can be a product of multiple confounding

7 factors. Like Mr Trent just said, it's very difficult

8 to establish a cause-effect relationship between one

9 factor and an outcome because it really depends on the

10 patient cohort and the patient cohort may well vary

11 across the year or across time spans and also the kind

12 of risk that they exhibit, and of course the amount of

13 care available around them, as well.

14 **Q.** May I just ask you to pause there. You're talking about

15 a variation. Are you talking about a variation within

16 a single ward, or are you talking about the kind of

17 variation you might get as, for example, as between

18 a CAMHS and an older adult ward or are you talking about

19 both?

20 **DR SURESH:** It's kind of both. Even on a single ward, there

21 are times of the year when I can remember my ward to be

22 very disturbed simply because of the specific cohort of

23 patients that we had at that time and there are times

24 when it was relatively quieter, and that had probably

25 little to do with what factors were influencing it in

1 terms of the ward, because the ward was functioning in
2 the same way, you know, the amount of doctors, nurses,
3 et cetera, but it can simply be a product of the patient
4 risk and cohort, as well.

5 **Q.** Thank you.

6 I'd like to just continue with this topic by looking
7 at a document with you. This is a Ligature Incident
8 Analysis Report from 19 October 2023. The purpose of
9 the report was to provide ligature incident analysis
10 from incidents reported by EPUT inpatient mental health
11 services.

12 Could you put up the Ligature Incident Report. It's
13 EPUT020910 at page 17, and there we have the full page.

14 Now, is this Ligature Incident Analysis Report
15 a report that you are both familiar with?

16 **MR TRENT:** Only insofar as we've reviewed it as opposed to
17 having contributed to it at the time.

18 **Q.** Thank you very much.

19 So do we see at the top, "Oxevision:

20 "Analysis has been undertaken looking at wards where
21 Oxevision has been installed to see if this has had an
22 impact on ligature incident numbers. The trend
23 indicator is based on the overall numbers of incidents
24 since Oxevision was installed. Please note there are
25 nine units (ten including the various health-based

1 places of safety) which do not currently have Oxevision
2 installed, resulting in no trend analysis being
3 possible."

4 So do we need to look at this table with all of that
5 in mind?

6 **MR TRENT:** Yes.

7 **Q.** Is there either one of you I should be directing
8 questions about the table to?

9 **MR TRENT:** I'm happy to take questions in terms of an
10 analysis of the table but obviously clinical matters in
11 relation to ligature would be best detected to
12 Dr Suresh.

13 **Q.** I think my questions are more analytical, but Dr Suresh,
14 if there's anything you'd like to add, please do so.

15 Can we just work out first of all what this table is
16 showing. Can we see in the left-hand column a number of
17 wards with Oxevision installed; is that your
18 understanding?

19 **MR TRENT:** Yes, and next column says the dates it was
20 installed.

21 **Q.** And then do we see a series of columns with yearly dates
22 at the top?

23 **MR TRENT:** Yes.

24 **Q.** And then we get a series of numbers populating those
25 columns; is that correct?

1 **MR TRENT:** Yes.

2 **Q.** And do you understand those to be ligature incidents on
3 each ward, those numbers?

4 **MR TRENT:** Yes.

5 **Q.** And finally, can we see in the right-hand column "Trends
6 for ligature rates" by way of arrows that are either
7 pointing up or down or to the side, correct?

8 **MR TRENT:** Yes.

9 **Q.** Do those arrows signify whether the trend is up or down
10 or has stayed the same, as you understand it?

11 **MR TRENT:** Yes.

12 **Q.** Now, if one counts the different types of arrows we see
13 in the right-hand column, we get to this position: of
14 the 34 wards, 11 recorded an upward trend, 10 a downward
15 trend, and no change on three. Now, I said 34, but in
16 fact that includes some of the "Not applicable" results
17 so I retract that, but if one looks at the arrows we see
18 in the right-hand column, 11 are upward, 10 are
19 downward, and no change on three.

20 Would you agree with me, Mr Trent, that this table
21 and the analysis that is behind it does not suggest that
22 the Oxevision system was having much impact in terms of
23 ligature incidents?

24 **MR TRENT:** Yeah, I think it's difficult to draw that as
25 a strong conclusion. I mean, as -- looking at this

1 table as an analyst, I'd want to see this data with
2 statistical process-controlled charts so that you can
3 see the trend not just over years but over months, and
4 see whether you've got sustained special cause or common
5 cause variation in this. And you can see, you know, an
6 example of Longview Ward where things have gone down,
7 but right above it, Larkwood, has gone up. So I think
8 your point there is a reasonable one.

9 **Q.** Actually, my point was a rather more basic one, which is
10 that the number of up arrows are about the same as the
11 number of down arrows?

12 **MR TRENT:** And the reason that I'm responding to that by
13 reference to SPC is that when you look at national
14 guidance, for example, around making data count, the
15 guidance is clear, this kind of analysis should be done
16 with respect to more detailed trends and statistical
17 process control, and crude up and down arrows are just
18 what I've said, they're crude up and down. So I'm
19 saying really a better analysis should have been done of
20 this data.

21 One thing that is evident from it is that there are
22 many, many more unsecured incidents than secured, and
23 I think that relates to something I said earlier about
24 the Board papers early on in implementation of
25 Oxevision, which acknowledged that there's been

1 investment in physical estate and the Trust is looking
2 to improve safety recognising a national trend towards
3 unsecured ligature incidents. So, you know, that's one
4 thing that is clear from it. Beyond that, I agree with
5 you, it's difficult to draw the conclusions.

6 **Q.** Thank you very much.

7 I am going to move on to another topic.

8 Dr Suresh, is there anything you'd like to add to
9 that?

10 **DR SURESH:** I mean, just forgetting the table, Oxevision may
11 help if an incident has started, staff have viewed it
12 and are able to get there in time to prevent it from
13 being completed. I don't know how it can influence the
14 actual number of incidents happening but -- because
15 that's a factor dependent on patient risk and a lot of
16 other things.

17 **MR TRENT:** And I should say something else about the data
18 analysis. Since I joined the Trust, we have improved in
19 how we analyse data. So, we had a data strategy and our
20 data reporting now routinely uses statistical process
21 control charts and other methods which are more
22 sophisticated than this table we've just seen. So there
23 have been improvements in the Trust in the way it
24 analyses data since this report was presented.

25 **Q.** Thank you very much.

1 This question is really to either of you who is best
2 placed to answer it. It may be you, Dr Suresh. Are you
3 able to say whether any incidents of self-harm are
4 actually being identified by use of the vital signs
5 function?

6 **DR SURESH:** Sorry, I missed the last part of your question.

7 **Q.** Yes, shall I ask it again?

8 **DR SURESH:** Yes.

9 **Q.** Are you able to say whether any incidents of self-harm
10 are actually being identified by use of the vital signs
11 function?

12 **DR SURESH:** I don't have any figures to answer that question
13 specifically but it would probably be unlikely, given
14 that the two vital signs being measured by Oxevision may
15 not necessarily be an indication of an ongoing
16 self-harm.

17 **Q.** You say this -- (overspeaking) -- I do apologise.

18 **DR SURESH:** They are poor indicators of self-harm.

19 **Q.** You say this in the main statement at paragraph 353:
20 "The Trust does not have quantitative evidence or
21 systematic analysis of the vital signs function being
22 used to identify incidents of self-harm."

23 Is that correct?

24 **DR SURESH:** That is correct, yeah.

25 **MR TRENT:** I think the only -- you know, what could be

1 looked at further would be a detailed analysis of the
2 written Datix reports. So, we've talked about that
3 table earlier. That evidence exists on every one of
4 those incidents and that could be reviewed in detail.
5 Dr Suresh and I have not done that for this report. You
6 heard from Mr Trimble, he does review those reports.
7 A detailed analysis could be undertaken to test that
8 question specifically, but I'm not aware that it has
9 been, previously.

10 Q. Thank you.

11 Dr Suresh, we've spoken about the use of Oxevision
12 in settings where you may be more likely to have
13 agitated patients, such as health-based places of safety
14 or in seclusion, and there possibly being an additional
15 reason in that kind of setting for the use of Oxevision.
16 I just don't want to pass that by without giving you the
17 opportunity to expand on that if you would like to or
18 say anything more about that. And you could also
19 include a different kind of setting, that of older
20 adults, which is, as I understand it from this morning,
21 more within your own area of expertise and whether you
22 believe there may be a particular role for this kind of
23 technology there.

24 So I'm afraid it's quite a long question, but it's
25 about identifying particular settings where there may be

1 a particularly strong argument for the technology.

2 **DR SURESH:** Yes, I certainly agree that these more acute
3 places could benefit from a technology of remote
4 monitoring, simply because of the higher risks involved,
5 and also because of the fact that patients are there for
6 a very short period of time. For example, the
7 health-based place of safety, the current requirement is
8 to assess them and move them on to another ward if that
9 were appropriate or discharge them within 24 hours. It
10 used to be 72 hours but it is now become 24.

11 **Q.** I'm just going to ask you to measure your pace a little
12 bit, but thank you very much.

13 **DR SURESH:** Apologies.

14 So that is one place where it could add value.

15 The other one is seclusion, where patients, for
16 clinical reasons, have to spend a lot of time on their
17 own. And these are really acutely unwell patients who
18 might put themselves or other people at risk. So that
19 is a place where a more continuous observation would be
20 beneficial. And the third one, like you mentioned, is
21 older adult wards where falls is a particular issue,
22 patients leaving their rooms can be a risk for them, so
23 those kinds of alerts. And also spending more than
24 three minutes in the bathroom, for instance. That could
25 be -- I mean, in older adult wards the incidents of

1 self-harm tends to be lower for obvious reasons. These
2 are frail patients who may go to the bathroom and may
3 have had a fall, for instance. So those alerts would be
4 quite useful.

5 And the other particular one, from my own clinical
6 practice, is patients often complaining about their
7 sleep being disturbed. This is, you know, patients who
8 want to have a good night's sleep. They feel that the
9 quality of their sleep in the hospital is often worse
10 than it would be in their own homes, and for that
11 reason, some have even asked to be discharged because
12 they simply don't like being disturbed so often at
13 night.

14 Some of the disturbance could be staff observing
15 them, and some of that could be from other patients who
16 may be disturbed at night. Sometimes the ward can be
17 noisy because of the cohort of patients we have. So for
18 all those reasons, they may not get good sleep. So we
19 try to maximise the amount of sleep somebody can get in
20 whatever way possible. Ideally without resorting to
21 sleeping tablets, because that's not a good way to get
22 sleep, because it can be habit forming.

23 So anything we can do to enable patients to sleep,
24 on whatever ward, but particularly older adult wards,
25 would be useful because sleep is -- we've heard about

1 the restorative benefits of sleep and in recovery from
2 mental disorders.

3 **Q.** Just picking up on the nighttime use of Oxevision, from
4 Mr Trent's evidence last year, my understanding was that
5 EPUT do not use Oxevision as a way to conduct remote
6 observations of patients at night. Is that correct,
7 Dr Trent? Sorry, Mr Trent?

8 **MR TRENT:** Yes, and the thing is they're not inconsistent
9 because the system could be used to help take
10 a measurement without physically disturbing the patient,
11 but the language nurses have used to me is they would
12 need to be professionally assured, the patient, that
13 they have taken the observation and that they're
14 satisfied with that. So we're clear in the SOP: you
15 need to attend in person.

16 **Q.** So I'm just trying to understand, Dr Suresh, how vital
17 signs or Oxevision as a technology, in the way it's used
18 at EPUT, assists patients to get a better night's sleep.

19 **DR SURESH:** Some patients do request not to be disturbed,
20 particularly those who have -- who are happy with
21 Oxevision monitoring, and who request not to be
22 disturbed at night. So clearly we try to accommodate
23 the patient's request in order to make sure that they
24 get a continuous night's sleep because this has also
25 been the subject of some of the complaints that we get

1 from patients and their families.

2 **THE CHAIR:** But in those circumstances you're just using it

3 for the taking vital signs?

4 **DR SURESH:** That's correct, yeah.

5 **THE CHAIR:** Not observing them through the day, the visual

6 technology?

7 **DR SURESH:** No, just for taking vital signs. And also to

8 make sure that they are left undisturbed for as long as

9 possible during the night. But as Dr Denman said, you

10 know, and I take some of her point in that, you know,

11 she has questioned the use of doing these routine

12 observations at nighttime particularly, I've seen that

13 in her evidence, as well.

14 **MR GRIFFIN:** Do you agree more generally, the need for

15 intensive in-person observation can be intrusive and

16 counter to good therapeutic practice?

17 **DR SURESH:** I do. It really depends on the individual

18 patient situation, but patients who are already

19 disturbed, that kind of intrusive in-person observation

20 can be even more provocative. But for patients who are

21 looking for -- who are in distress and who are looking

22 for engagement or talking to somebody and we can't

23 predict when somebody is ready to talk to somebody --

24 for some it may be in the middle of the night or for

25 some it may be another part of the day. So, you know,

1 that may not be considered as so intrusive. So it is
2 very difficult to give a blanket response to that.

3 **Q.** Is it EPUT's view that assistive technology can assist
4 in this regard, depending on the particular
5 circumstances?

6 **DR SURESH:** Yes, it can.

7 **Q.** You identify in the main statement, that's
8 paragraph 140, that:
9 "Remote observation can be the least restrictive
10 option when compared to the available alternatives."
11 Can you identify when that is the case?

12 **DR SURESH:** Sorry, did you say "least restrictive"?

13 **Q.** Shall I read that again?

14 **DR SURESH:** Please.

15 **Q.** You identify in the main statement at paragraph 140 that
16 "Remote observation can be the least restrictive option
17 when compared to the available alternatives."
18 Can you identify when that is the case?

19 **DR SURESH:** Certainly in the special circumstances we have
20 talked about where patients can be acutely disturbed, or
21 where patients can make a specific request not to be
22 disturbed through the night, it can be a less
23 restrictive option.

24 **Q.** Overall, is it EPUT's view that the system provides
25 clinical benefits to patients, or is that determination

1 subject to the review we heard about earlier?

2 **DR SURESH:** I think our current view is that it does provide
3 some clinical benefits, but clearly, we'll wait for the
4 outcome of the review to see what overall view it takes,
5 taking into account all the factors into consideration,
6 including patient and families' experience, as well.

7 **MR GRIFFIN:** Thank you.

8 Chair, we've been going for an hour since the lunch
9 break. We're doing well in terms of the number of
10 questions that remain. But I wonder whether, actually,
11 it would make sense to have a 15-minute break now.

12 **THE CHAIR:** Fifteen minutes.

13 **MR GRIFFIN:** That would be 3.15.

14 **THE CHAIR:** 3.15.

15 **(3.00 pm)**

16 **(A short break) .**

17 **(3.14 pm)**

18 **MR GRIFFIN:** Chair.

19 Dr Suresh, you say in your statement that there's
20 been no formal evaluation of vital signs effectiveness.
21 Would you agree that it's surprising that there hasn't
22 been one before now?

23 **DR SURESH:** I do, yeah.

24 **Q.** More generally, with regard to effectiveness, Dr Denman
25 observes in her report that the issue of gathering

1 effectiveness data was discussed fairly often at EPUT,
2 this is, but mainly from the perspective of trying to
3 gather support for the efficacy of the system rather
4 than in relation to a balanced evaluation.

5 Now, this is looking back at the rollout and perhaps
6 covering periods before either of you were in your
7 current posts but on the basis of what you know, would
8 you agree with what Dr Denman observed there?

9 **DR SURESH:** I do, but I'm also thinking that we don't have
10 a record of what it might have prevented, which would
11 have helped provide a more balanced view of the
12 effectiveness, if you like.

13 **Q.** Would you explain what you mean by that, please.

14 **DR SURESH:** When there is an incident, it is documented on
15 Datix or through other platforms, but when an incident
16 might have been prevented, we do not necessarily keep an
17 adequate log of those incidents. So it's very hard to
18 say what it has prevented as opposed to what has
19 happened despite it being there, if that makes sense.

20 **Q.** That does make sense. Thank you.

21 Is that a learning point in terms of data -- this
22 may be more for you, Mr Trent -- in terms of the kind of
23 data you might want to capture at the early stages of
24 deployment of this kind of technology?

25 **MR TRENT:** Yes, and I think -- I mean, Dr Denman, in her

1 evidence on Monday, spoke a lot about both what would be
2 best practice, and also, she reflected on what is common
3 practice, even in her own Trust, in terms of the quality
4 and consistency of evaluation in the deployment of new
5 technology and I felt that that was a fair analysis.

6 And, you know, to comment on this a little further,
7 at one end of the spectrum we've got high-powered, very
8 reliable, peer-reviewed studies, and at the other end,
9 you know, the NHS uses quality improvement
10 methodologies, things like QSIR and IHI, or the
11 Institute for Healthcare Improvement's model of
12 improvement, that is an often-adopted model, Virginia
13 Mason Production System, another, and NHS England's own
14 sponsored QSIR, Quality, Service Improvement models.

15 They don't -- they're considered a good practice,
16 but they're much faster to implement, much quicker,
17 because they go on plan, do, study, act, cycles of
18 improvement but in doing so they have less data and they
19 wouldn't meet the same evidential power of
20 a high-powered research study. And I think as a Trust,
21 and you see this at EPUT, over the period, you know, we
22 struggle with getting the right balance there. We heard
23 from Mr Trimble yesterday, he was clear and adamant,
24 he's not been asked to provide a bias dataset, he's been
25 asked to provide the data so it can be analysed.

1 And I think even in the early periods there's
2 a genuine interest in understanding whether this is
3 working or not. But I think when we review it with
4 hindsight, there could have been more structured, more
5 effective evaluation at an earlier stage of this.

6 At the Trust level, but, as Dr Kallur says, we
7 wouldn't be able to do some of the sophisticated studies
8 that might be possible at a national level. Our work
9 should have used more of the QI methodologies that were
10 available for Trusts and run that through more formally,
11 in that way.

12 **Q.** I want to make sure I've understood what you've said.
13 Are you suggesting that there wasn't an appropriate
14 template evaluation tool that could have been used in
15 the early stages of the rollout at EPUT, effectively?

16 **MR TRENT:** No, I'm saying that when we look back, the
17 evaluation clearly could have been better. And that
18 there are tools available which could have been deployed
19 at EPUT, like QI methodology, which would have been
20 within our gift in a way that a high-powered research
21 study may not have been in terms of the scale of that
22 but also the time. You know, Dr Denman spoke about
23 high-powered research studies do take significant time
24 and significant cost to do.

25 QI is the other end of the scale. You know, you can

1 implement a good quality improvement methodology with
2 a limited number of staff over a relatively short period
3 of time. It won't have the same statistical
4 significance but it is an accepted methodology of
5 improvement that's widely used in Trusts and it uses
6 data to drive that.

7 **Q.** One of Dr Denman's points was that she would have
8 expected an evaluation to have been agreed before the
9 rollout and then, after for example, the pilot, for the
10 results, the analysis arising from that to be checked
11 against the evaluation tool. I probably described that
12 badly, but you were there for that evidence.

13 So is what you're saying linked to that, in a way:
14 that appropriate evaluation tools should have been
15 considered at an earlier stage?

16 **MR TRENT:** Yes, and I agree with what she said, because, you
17 know, she said it would have been best practice. She
18 also said that's not always happening in other Trusts,
19 even in her own, you know, the Board papers at the time
20 articulated a clear intention around patient safety, but
21 one thing that's not there is, for example, a driver
22 diagram, which again is something you use in a QI
23 methodology, which says: this is how we expect to get
24 these outcomes.

25 So a driver diagram really breaks it down. It says,

1 if you're going to reduce ligatures, what are the things
2 that drive that? And they go step by step so, you know,
3 more observations, less fixed points, et cetera, and
4 then you can analyse each of them and that becomes your
5 methodology or your theory of change.

6 And I think that is as, you know, Dr Denman's
7 pointing to those kind of models, I think, in her
8 evidence. And I agree, those kind of models, actually,
9 they could have had application here. And when we look
10 back, that's a learning for us. We should have
11 looked -- we should have put clearer outcome measures in
12 place earlier and we should have evaluated those more
13 effectively than we did.

14 **DR SURESH:** Can I add one more point? Sorry.

15 Trusts that have been rated as outstanding in their
16 care by the CQC, for instance, have often adopted a QI
17 methodology, a continuous quality improvement. Like
18 Mr Trent said, often that is not based on robust
19 evidence. For example, I, as a doctor, could improve
20 the quality of care I provide in my outpatient clinic by
21 making just one change and that is, you know, an
22 iterative process over a period of time.

23 If it works, it does. If it doesn't, okay, what can
24 we learn from it? And then you implement the next
25 change using a PDSA cycle, and there is a lot of

1 encouragement in the NHS to actually use that for
2 continuous quality improvement. And this is often done
3 by, for example, resident doctors, student nurses,
4 psychologists, et cetera, to improve the quality of care
5 they provide within their own immediate setting.

6 So those kinds of improvements are not necessarily
7 based on robust evidence. Sometimes they work,
8 sometimes they don't. But if it works, carry on doing
9 it. If it doesn't, learn from it and do something else.

10 So I think there is always a tension between
11 a high-powered statistical study which, you know, which
12 is the gold standard, if you like, versus small
13 improvement that somebody can make within their own
14 service.

15 So, most of us lie somewhere along that spectrum, if
16 that makes sense.

17 **Q.** It does, thank you.

18 **DR SURESH:** And it's often difficult to get that balance.

19 **Q.** In her report, and in her evidence in July, Ms Archibald
20 said that she'd not seen evidence that VBPMs directly
21 influenced individual patient care in a systematic way
22 and that the data does not demonstrate that VBPMs
23 improved patient outcomes, or informed clinical decision
24 making.

25 Would you agree with that? Probably, Dr Suresh.

1 **DR SURESH:** I agree to the extent that we probably do not
2 have the data to actually make that assessment. Like
3 I said before, we measure or count what happens. We
4 don't always measure or count what does not happen or
5 what gets prevented. And that is a point not just about
6 VBPMS but other interventions as well. Generally, in
7 medicine. Negative events are not necessarily counted
8 or measured unless it's a serious one, but something
9 that happens is measured. Something that is prevented
10 is not measured, if I'm making sense.

11 **Q.** Yes. May I put something different to you now, based on
12 your own experience at EPUT but also your understanding
13 of what took place from 2019, 2020 onwards. Because
14 we're going to come on in a moment to talk about the
15 rollout, a couple more questions about that. But do you
16 think that EPUT actually procured Oxevision and was
17 using it to conduct observations remotely rather than
18 for any other function?

19 **MR TRENT:** I don't think that was its intention. I think,
20 you know, the Board papers at the time, the first
21 paragraph is about, you know, this is part of our
22 emerging patient safety strategy to improve our
23 services. So I think, you know -- and I think Dr Denman
24 reflected this -- there's a clear intent at the outset,
25 that this is going to improve patient safety, and

1 I think that's the driver, not that it's going to be
2 used as a remote monitor.

3 When you go back through the SOPs, over time, what
4 you see is more and more rigour on that point. The SOPs
5 consistently tightened to make it clearer and clearer,
6 I think, that it's not to be used in a remote way.

7 **Q.** Do you think that, once it was raised as an issue, even
8 if it wasn't the main reason or a reason for original
9 procurement and implementation, do you accept that EPUT
10 has been too slow to address it as an issue? You were
11 just talking about SOPs picking up on it as an issue,
12 but I am asking you something slightly different. Do
13 you accept that EPUT has been too slow to address it as
14 an issue?

15 **MR TRENT:** In my second statement, I said on behalf of the
16 Board of Directors that we could and should have done
17 better and I think that is a way in which we could have
18 and should have done better.

19 I also think that, you know, that when you look to
20 Mr Harry's evidence from Monday last week, and there's
21 136 incidents and the learnings from those, there were
22 other opportunities I think within the NHS system as
23 a whole to learn more systemically, in the early use.
24 So we didn't, for example, have -- we joined communities
25 of practice, and we're active participants in the Nurse

1 Directors Forum, but we didn't have an NHS Oxevision
2 benchmarking club going through all of the incidents
3 together. And I think, you know, when you look at this
4 from a systemic perspective as well as a Trust, and
5 I say this without any intention to change EPUT's
6 accountability, we're clear on the accountability and
7 where things have gone wrong here, but when we reflect
8 on the opportunity to learn, there are wider
9 opportunities to learn around how could we have learnt
10 from others more systemically in those early years to
11 get to some of the conclusions and mitigations quicker?

12 **Q.** Thank you.

13 Can we move now to some points I want to ask you
14 about in terms of the rollout at EPUT. You and
15 I touched on this last year, and we just need to remind
16 ourselves of the point that you joined the organisation
17 halfway through the rollout, effectively, and Dr Suresh,
18 your role, for at least some of the rollout, wasn't one
19 that was specifically in relation to the implementation
20 of Oxevision at EPUT. Do we just need to bear those two
21 things in mind when we're -- if we're discussing the
22 rollout now?

23 **DR SURESH:** Yes.

24 **MR TRENT:** Yes.

25 **Q.** Mr Trent, is it probably right for me to address my

1 questions principally at you?

2 **MR TRENT:** Yes, I'm happy to.

3 **Q.** You addressed this in your evidence, as I've said, last
4 year. More recently, the topic has been addressed in
5 some detail in the report of Dr Denman, and indeed, in
6 her evidence earlier this week. And you're aware of the
7 points that she raised there; is that correct?

8 **MR TRENT:** I am.

9 **Q.** I don't, therefore, need to go into detail about what
10 she said and the rollout now, but I do want to just pick
11 up on a couple of points, please.

12 Dealing, first, with the benefits identified at an
13 early stage. We saw an early document and I can put it
14 up if we need to -- let me know -- the report to the
15 Board of Directors on 30 October 2019, which set out a
16 number of benefits, wide benefits, that the technology
17 might afford.

18 Dr Denman's point was this, and if we need to, we'll
19 put it up on the screen and we can look through it. Her
20 general point was that the documentation that she'd
21 reviewed does not appear to articulate a unified,
22 coherent rationale for the implementation of the system.
23 Instead, a range of advantages are proposed, and then,
24 over time, reduced to be more modest.

25 Would you say that was an accurate assessment?

1 **MR TRENT:** As I've said earlier, I think there was a clear
2 strategic intent around improving patient safety,
3 there's references to the trend away from fixed point to
4 other ligatures at the time, and in the papers. And the
5 Safety First, Safety Always strategy that follows. So
6 I think there's a clear strategic intent. However, on
7 the specific benefits identified in detail, I agree with
8 Dr Denman, they're not. But I would make the point
9 I have, that I think there's a strategic intent that's
10 clear in the business case.

11 And I wasn't there so I cannot comment on the
12 discussion.

13 **Q.** I understand.

14 **MR TRENT:** That's me really just reviewing the documents.

15 **Q.** Another point she made, I think on the basis of
16 a specific document but I want to put the point
17 generally to you, is that some of these early documents
18 are looking at benefits but not mentioning risk at all.
19 Would you agree that there wasn't sufficient attention
20 to the negative side of the balance at an early stage?

21 **MR TRENT:** So in the Project Board there's risk registers
22 and there's concern around risks and, you know, you see
23 those through the minutes, risks are identified, they're
24 worked with the supplier to address those and mitigate
25 them in different ways. So I don't think there was an

1 absence of any consideration of risks.

2 I do think, with hindsight, and with what we know
3 now, a fuller analysis of risk should have been done at
4 an earlier stage.

5 **Q.** Dr Denman also has addressed or concluded that there was
6 a lack of involvement of patients and carers in the
7 Trust's consideration and implementation of Oxevision.
8 She said that the involvement of patients came late in
9 the introduction of the system and it sometimes felt
10 that they were being used for support rather than
11 illumination.

12 To the extent you're able to answer this, do you
13 agree?

14 **MR TRENT:** There's clear evidence at the outset, around
15 patient survey that's fed back to the Boards at the
16 time. I agree, there's then a gap for a significant
17 period of time, and that should have been addressed
18 sooner. And the Trust, you know, the Trust has
19 significantly invested in lived experience, the lived
20 experience and expert by experience team since that
21 time. So, you know, when I joined the Trust there was
22 around 30 lived experience ambassadors who are our
23 experts by experience who are paid to join meetings and
24 support us in lots of different ways.

25 **Q.** Can I just ask you to moderate your speed. Thank you.

1 **MR TRENT:** I'm sorry, am I going too fast?

2 We were at around 30. We're over 300 now. So
3 there's been a change in the Trust over this period.
4 But I agree with Dr Denman, you don't see enough patient
5 involvement after that initial survey, and then it's
6 only really in later years that we see that involvement
7 more systemically.

8 **Q.** She made a further point, she said this:

9 "It seems very likely that had co-production been
10 built in from the start, many of the problems that were
11 later encountered might well have been foreseen."

12 Do you think that is right?

13 **MR TRENT:** I mean, it's difficult to speculate on what would
14 have happened, but I agree with the premise that working
15 with experts by experience, that they bring an insight
16 that isn't otherwise in the room, and that insight may
17 have led to issues or risk being identified earlier.
18 And, you know, my experience, I had lived experience --
19 experts by experience on my strategy group. Brilliant.
20 You know, the constructive challenge and insight that
21 you get from having an expert by experience as not
22 someone you consult with but someone who is part of your
23 governance and oversight, is really valuable, and we
24 should have done that sooner.

25 **Q.** Thank you.

1 I'd like to move on to another point that Dr Denman
2 addresses and that is the pressure to rollout at pace at
3 an early stage.

4 Now, we can look at documents if we need to, but it
5 boils down to this: that a Board report -- a report to
6 the Board of Directors in September 2020, as I recall
7 it, after there was some analysis of two of the four
8 pilot wards suggested pressing on rather than waiting
9 for analysis to come in from the remaining two pilot
10 wards. Do you remember that?

11 **MR TRENT:** Yes. I mean, I wasn't there, but I remember the
12 document.

13 **Q.** You remember the documents. And Dr Denman's overall
14 point on this was that:

15 "... EPUT implemented Oxevision in a somewhat
16 hurried way and certainly rolled it out without much
17 evidence following a pilot phase. It is clear the
18 motivation of the organisation at that point was that
19 the system was genuinely so good that it would save
20 lives, and that delaying rollout would be indefensible,
21 but it is hard to agree with that conclusion."

22 Do you accept or agree that the rollout was hurried?

23 **MR TRENT:** I wouldn't describe it as hurried. I note that
24 the Board paper says there should be a further report at
25 the end of the financial year, in following up.

1 I think, you know, sometimes when you've got a programme
2 of change or implementation, you get the early data.
3 These things take a while to mobilise so you may want to
4 continue but you should return to the further data. So
5 in this case, the Trust should have returned to the
6 second two wards because there's always stop-go moments
7 in a project and there will be, and I think Derrick
8 spoke about this in his experience, there will be a lot
9 of work before you switch something on. So you might
10 decide to proceed with some of that work in parallel to
11 completing some of the analysis and I think that's the
12 judgement that was taken at the time.

13 But I wasn't in that room, so, you know, I think the
14 intention of the Trust was to implement a technology
15 that it believed at the time it had evidence would make
16 a difference.

17 **Q.** But the plan was to do a four-ward pilot. Before that
18 was complete, and the analysis was in, there was
19 a decision to roll it out I think to 13 further wards.
20 And you may recall there is the suggestion of pressure
21 to do something by the end of the financial year. Do
22 you not accept, in those circumstances, that there was a
23 hurried element during part of the rollout?

24 **MR TRENT:** I wouldn't use the word "hurried". I can see
25 clearly there's an intent to proceed at pace. I think

1 an assessment of whether that's hurried or at pace or
2 whatever may be an individual assessment. And I wasn't
3 there at the time, so, you know, I accept the Trust made
4 a decision to accelerate its rollout. It believed at
5 the time it had received sufficient evidence. I think
6 the evidence from the second two wards is clearly highly
7 relevant. And it should have returned to those. I'm
8 not sure I can say more than that, with hindsight.

9 **Q.** Understood.

10 Dr Denman and Jill Archibald have both raised
11 a further point that may be important and I want to ask
12 you both about it. In essence, it's that there should
13 have been, at an early stage, identification of a clear
14 tension between, on the one hand, a technology that was
15 going to be saving staff time and money, and on the
16 other, to a technology that was meant to be assistive
17 only. Do you understand the tension there?

18 **MR TRENT:** I ...

19 **Q.** What is your response to the question whether that
20 tension should have been identified at a much earlier
21 stage or at all?

22 **MR TRENT:** Look, I don't agree completely with how that
23 tension is characterised.

24 **Q.** Then please explain.

25 **MR TRENT:** So the tension that's described there is to say:

1 the only way you could save money is to have less staff.
2 I apologise for oversimplifying but I think that's a key
3 part of it. When you look at the cost drivers in
4 a mental health trust, two of your key things here are
5 how long are patients staying on the wards, because
6 every additional day on the wards has more resources
7 associated with it: the clinical team, the bed,
8 et cetera. And how intensive are the resources required
9 to provide the appropriate clinical treatment at any
10 given time?

11 And if you have a good clinical outcome for
12 a patient with a shorter length of stay or with a less
13 intensive model of treatment, that would be at a lower
14 cost without being a substitution of quality for cost.

15 And you see this in other industries as well. You
16 know, cost and quality, they're not a binary trade-off.
17 Actually, you make a better quality product, it can be
18 lower cost, because you remove the waste in the system,
19 to use the sort of the transformation or the programme
20 management language around that.

21 So I don't see it as a simple tension between one
22 and the other. What the Trust is looking at here is:
23 can we get better outcomes for our patients that may,
24 you know, not require the same resource, input to do
25 that? And this idea is taken later in the Time to Care

1 piece, the Time to Care business case as an example.

2 So, you know, two of the key interventions in the
3 Time to Care business case, we introduced activity
4 coordinators on our wards, and we introduced peer
5 support workers, both as paid roles. Now, we're doing
6 that because we believe that's going to support patient
7 care to get better outcomes, but at the same time,
8 that's also going to allow -- you know, is going to
9 support the length of stay coming down for patients so
10 they get a better outcome in a shorter space of time.

11 So we're not actually saying, "Take the staff off
12 the wards." We might actually say, "Put more staff on,
13 put different staff on" in order to achieve the outcome.

14 **Q.** In her report, Dr Denman spoke about less in-person
15 observations being envisaged, and we've certainly seen
16 documents saying that. And there's a potential benefit
17 of the system at some stage.

18 She goes on to say this:

19 "I do not think that a planned reduction in
20 in-person observations ever occurred. I also think that
21 the fact it did not, essentially destroyed any
22 financially based case for using the system."

23 Would you provide your views about that, please.

24 **MR TRENT:** So when you look over this whole period, EPUT
25 increased its staffing; doesn't decrease it at a Trust

1 level. And Mr Scott gave that evidence in his earlier
2 Position Statement, I think the first one. So we don't
3 see, as a Trust, that this reduces our staffing numbers.
4 And I think Dr Denman is right to characterise that the
5 focus becomes more around the patient safety benefits
6 than whether this is releasing a cost savings.

7 **Q.** Thank you.

8 Dr Suresh, finally in relation to rollout, I'd like
9 to ask you about the clinical oversight of Oxevision at
10 EPUT. Dr Denman has suggested this:

11 "Overall, therefore, there was a degree of clinical
12 oversight and the Medical Director consistently attended
13 the Quality Committee. However, at Board level there
14 was inconsistent clinical oversight of the Oxevision
15 system with attention only really being focused on the
16 system after concerns were raised. Overall, there was
17 a general lack of clinical challenge related to the
18 functioning of the system and its intended purpose, and
19 no consistent response to issues of potential harm."

20 From your own experience and what you have learnt
21 about the system and its implementation at EPUT, would
22 you accept this is a correct analysis?

23 **DR SURESH:** At Board level, I mean the Oxevision data, and
24 also the papers around any concerns on how Oxevision is
25 working were going to up to the Quality Committee, the

1 Quality Committee is a subcommittee of the Board,
2 chaired by a Non-Executive Director. And they would
3 then escalate any concerns to the Board, to a formal
4 Board meeting, which includes the Executive or
5 Non-Executive Directors, through their committee chair's
6 report which is a standing agenda item on the Board.

7 So I would say that if it went up to Quality
8 Committee, chaired by a member of the Board,
9 a Non-Executive Director, who provides constructive
10 challenge to Executive Directors in all matters relating
11 to patient care, that would have come to the Board's
12 attention.

13 **Q.** Sorry, were you going to say something?

14 **MR TRENT:** Yeah, can I check this because I read this
15 passage of Dr Denman's report and I interpreted her as
16 talking about here the Project Board rather than the
17 Trust Board, in the context. At the Trust Board level,
18 Dr Kallur has answered but there's also significant
19 evidence in the quality accounts each year of references
20 to Oxevision, including comments, I can't remember if
21 it's '21-'22, or '22-'23 from Healthwatch Essex which
22 are positive around Oxevision at that time. So it is
23 there at the Trust Board level, but I believe this
24 passage was really about the gap in clinical attendance
25 at the Project Board but I may be mistaken.

1 Q. Well, there's a point that's made about the collapse of
2 clinical attendance generally. Rather than addressing
3 that, may I pick up on one particular aspect of what she
4 said, and that's this:

5 "... attention only really being focused on the
6 system after concerns were raised," at whatever level.

7 Do you accept that that's an accurate assessment?

8 DR SURESH: Probably not, because, like Mr Trent said, the
9 Project Board did consider, you know, there was
10 Oxevision-focused Project Board meetings which was
11 attended by clinicians, a lot of nursing staff, because
12 Oxevision was mainly considered to be a nursing
13 observation and engagement tool, number 1. And also,
14 all the people who were providing project support to
15 this Oxevision project, plus I believe it had
16 representation from LIO, as well, Oxehealth
17 representatives as well.

18 Q. I think one of the points Dr Denman made was that the
19 medical or clinical element of attendance dropped off
20 quite quickly. But we don't need to cover that ground
21 now, unless you want to.

22 Is there anything else, I'm going to move on from
23 the rollout at EPUT to my final area of questioning, but
24 before I do, having heard Dr Denman's evidence and read
25 her report, are there any other points either of you

1 would like to make about the rollout at EPUT, and in the
2 context of what she said?

3 **DR SURESH:** Can I just say a little bit more about the
4 clinical oversight?

5 **Q.** Yes.

6 **DR SURESH:** Clearly with the new Standard Operating
7 Procedure there has been extensive clinical oversight,
8 for example myself and my Chief Nurse colleague were
9 heavily involved in the revision of the Standard
10 Operating Procedure. It has had input from the Chief
11 Clinical Information Officer, the Chief Nursing
12 Information Officer, as well, and a lot of other
13 clinicians who are operating on the ground about how a
14 change in the Standard Operating Procedure would
15 actually help advance patient care.

16 So the clinical oversight has certainly strengthened
17 in the last six months and we plan to continue to do
18 that going forward.

19 **Q.** Thank you.

20 **DR SURESH:** Pending the outcome of the independent report.

21 **Q.** Thank you very much.

22 Moving on, then, to the last area I would like to
23 cover with you today, and that's the question of cost.
24 We touched on this, Mr Trent, when you gave evidence
25 last year, and at that time you accepted that the total

1 cost to October 2025 of the contract with Oxehealth ran
2 into millions of pounds. You weren't able at that time,
3 do you remember, to give a more precise figure? But you
4 added that the figure for the 2024/25 spend was
5 approximately 1.2 million. Do you remember that
6 evidence?

7 **MR TRENT:** I do, yes.

8 **Q.** Now, in your main statement you've been able to provide
9 a figure for the total spend between 2000 and 2025; is
10 that right?

11 **MR TRENT:** Correct.

12 **Q.** This is paragraph 529.

13 **MR TRENT:** Yes.

14 **Q.** Is the total spend £5,164,771, including VAT?

15 **MR TRENT:** It is. As we say in that paragraph, the VAT is
16 reclaimable for the Trust. So the net cost to the Trust
17 in terms of our total resources, how much has been
18 committed to this, is £4,303,976. And I set that in the
19 context of an organisation that -- I think I gave the
20 turnover last time but it's in the order of £650 million
21 of turnover each year, and our annual accounts specify
22 that. So, we can give you the precise number.

23 **Q.** I understand. I'm just wondering how comfortable
24 a benchmark that is, or a comparison that is. This is
25 well over £4 million for an NHS Trust. That is

1 a significant amount, even compared to the annual
2 budget; would you agree?

3 **MR TRENT:** It's millions of pounds. It's a significant
4 amount of money. I mean, that's an amount over the
5 whole period --

6 **Q.** Yes.

7 **MR TRENT:** -- not in a single year. And I make the
8 benchmark because EPUT is one of the larger NHS Mental
9 Health Trusts in the country so if you're, you know,
10 you're comparing different organisations, the turnover
11 is -- it gives you a sense of the scale and the
12 organisation. This is a figure that's covering
13 a multi-year period.

14 It's also a figure that, when you look at this
15 through the lens of the standing financial instructions
16 of the Trust, expenditure over a million pounds is
17 reserved to the Board, and, you know, that does reflect,
18 again, the Trust's own assessment. If you're spending
19 over a million pounds, that's a substantial amount of
20 public money and it should have oversight of the Board
21 of Directors, which this did.

22 **Q.** You say in the main statement, from May this year, that
23 the Trust was satisfied that the investment represented
24 value for money. Given what we've covered today and the
25 ways in which you actually now understand Oxevision to

1 work at EPUT, would you continue to say that?

2 **MR TRENT:** So, we've commissioned an independent review and
3 we'll take into account all the findings of that. We
4 don't make value-for-money assessments on the fly so
5 I can't give you a value-for-money assessment here and
6 now, that needs to be an evidence-based process, and we
7 do that through the annual cycle of financial analysis
8 and reporting.

9 The Trust's previous assessments have been that
10 that's been value for money, and any new evidence will
11 be considered in future assessments.

12 **Q.** Dr Suresh, £4.3 million on this technology. What are
13 your views about that?

14 **DR SURESH:** That's a difficult question for me to answer but
15 I will attempt it anyway. You know, I think we have
16 seen evidence that Oxevision has saved individual lives.
17 I know 4.3 million is a quite a big sum of money for
18 a publicly-funded organisation, but if you're able to
19 make a difference for even some of the patients, that
20 would be of significant value for the individual
21 families. And, like I said, we probably haven't got at
22 present the evidence to say what Oxevision has actually
23 prevented, adverse incidents, et cetera. Once we are
24 able to have that data, if we're able to have that data,
25 then we can probably come to a more balanced assessment

1 of the value for money.

2 **MR GRIFFIN:** Dr Suresh and Mr Trent, those are the questions
3 I have for you at this stage.

4 Chair, do you have any further questions at this
5 stage?

6 **THE CHAIR:** Just one question. And I'm not sure if you can
7 help me with this. It's about the purpose of the image,
8 the blurred image which is produced when the vital signs
9 are -- the vital signs function is activated. As
10 I understand it, that image, which is blurred, is to
11 assist with identification of the patient, to ensure
12 that the patient is who they ought to be, as well as to
13 ensure that the patient is still and has flesh exposed
14 to use it.

15 If it is properly blurred, and therefore anonymised,
16 it doesn't fulfil that purpose, does it, because you
17 can't be sure you've got the right patient. Can you
18 help me with that conundrum?

19 **MR TRENT:** I think so. I think there may be
20 a misunderstanding there because the clear view happens
21 when you're doing the vital signs. The blurred happens
22 when an alert has come up. So when somebody is taking
23 the vital signs, they will see that in clear view
24 because they need to see the dots on the skin.

25 When you have an alert like in the bathroom or an

1 extra person in the room, that's when staff are able to
2 see the blurred. And so I understand the blurred in
3 that case is of value in terms of situational awareness.
4 So, you know, the alert might say there's two people in
5 the room, you could see the blurred, and you'd get
6 a sense of where they are. That's my understanding from
7 the instructions for use and the evidence from others.

8 **THE CHAIR:** Yes, yes. It's clear at the time that you do
9 the activation of the vital signs?

10 **MR TRENT:** Yes.

11 **THE CHAIR:** Right, okay. And in respect of the blurred
12 image, that is for situational awareness; that's not
13 necessarily for identifying the patient?

14 **MR TRENT:** No, and I think coming back to the
15 anonymised/pseudonymised point, you may not be able to
16 identify the patient or you may, given you know who they
17 are or you know the room. So the blurred, I think it's
18 a different function, that information.

19 **THE CHAIR:** Right.

20 **MR GRIFFIN:** May I just pick up on that.

21 The blurred view is available to a staff member
22 following a notification; correct?

23 **MR TRENT:** Yes, that's my understanding.

24 **Q.** But it will need to be, although it's blurred, it will
25 need to be sufficiently clear for a staff member to know

1 how to react to the notification when they access it; is
2 that correct?

3 **MR TRENT:** Yes, and you played the example that Oxehealth
4 had provided, and you could see from that, you could see
5 that a person walks into the room and lies on the bed.
6 So it was enough to see where a person was in the room,
7 for example.

8 I'm not the person to make an assessment of how
9 useful that is or not, but, you know, the intention of
10 that is to give some situational awareness when an alert
11 has been raised.

12 **Q.** Dr Suresh, do you have a view on the purpose of blurred,
13 the blurred video or the blurred view afforded to
14 a staff member following a notification, what its
15 purpose is, and whether it fulfils it?

16 **DR SURESH:** If it is around identifying the location of the
17 patient, for example they are in the bathroom, they have
18 come out of the bathroom, they are out of the door, edge
19 of the bed, et cetera, I think a blurred vision would be
20 enough to alert staff to take some action, but if we are
21 talking about vital signs measurement which requires the
22 two dots to be on the person, you know, we have to make
23 sure that it is the actual patient that we are taking
24 the reading from and not somebody else, because often on
25 mental health wards you could have a patient wandering

1 into somebody else's room. It happens very often on
2 older adult wards.

3 So when you have to take vital signs measurement,
4 you have to make sure that the infrared is focused on
5 the right individual, and that's where identification is
6 necessary. But for all other benefits of the system,
7 I think a blurred image would be good enough; that's my
8 understanding.

9 **THE CHAIR:** Can I just challenge you on that. What about
10 the case of the person being at the door, leaving the
11 room? That would require you to identify you've got the
12 right person, wouldn't it?

13 **DR SURESH:** No, they are not leaving the ward, they're
14 leaving the room but coming into the corridor. They
15 would still be on the ward but --

16 **THE CHAIR:** Yes, leaving their room.

17 **DR SURESH:** Leaving their bedroom, their door, but they're
18 coming into a common area, maybe a lounge area or a
19 corridor area where patients can walk through the
20 corridor, so they're not leaving the ward as in going
21 out of the hospital.

22 **THE CHAIR:** No. But you clearly want an alert for some
23 people that they're leaving the room and you want to
24 make sure you've got the right person who is leaving the
25 room, even if it is only to go into the corridor.

1 Otherwise, why do you have the alert at all?

2 **DR SURESH:** Yeah, I can understand what you're saying but if

3 there is only one person in the room and if they have

4 left, then --

5 **THE CHAIR:** You might or might not get the right person

6 leaving the room.

7 **MR TRENT:** I suppose one of the things about this is that

8 it's a prompt for a staff member to ascertain what's

9 going on and it's why we say you need to go in person.

10 And the point about the false alarms, you know, the

11 research paper that was attached to Denman said -- on

12 alarm fatigue -- talked about 72 to 99% of alerts, this

13 is based on physical health, their critical care, being

14 false, in other contexts as, you know, that's one of the

15 points she's -- that research was making but there is

16 still utility in the alert. And we see that in other

17 settings, you know, neonatal units. You know, there's

18 a high volume of alerts in a neonatal unit, and they're

19 there not to replace the staff but to assist the staff

20 and not every alert is going to lead to an intervention

21 that's beneficial to a patient but the alerting, you

22 know, it's one prompt to staff. It's not the only one.

23 **MR GRIFFIN:** Chair, may I suggest we take a pause now.

24 Dr Suresh, Mr Trent, there may be some further

25 questions I need to ask you, but may we take a break

1 until 4.15. Thank you.

2 **(4.01 pm)**

3 **(A short break)**

4 **(4.28 pm)**

5 **THE CHAIR:** Mr Griffin.

6 **MR GRIFFIN:** Dr Suresh, Mr Trent, just a few more questions,
7 please. I've looked at the most recent version of the
8 SOP and we can see, on the second page of that, and
9 indeed, I think, on most of the previous versions, the
10 number of previous iterations and in general terms, the
11 purpose of the further iteration; is that correct?

12 **DR SURESH:** **(The witness nodded).**

13 **MR TRENT:** Yes.

14 **Q.** Now, there have been 19 iterations of the SOP at EPUT
15 since the first one on 26 March 2020. Does it tell us
16 anything that the SOP has needed to be updated so many
17 times in this period?

18 **MR TRENT:** Yes, I think it does. I think it's evidence of
19 learning, changes and improvement over that time. It's
20 evidence of changes in national guidance. So, you know,
21 you can see changes that correspond to the publication
22 of those. You know, you've got changes that correspond
23 to the CQC action planning following the inspection at
24 EPUT and report from July '23.

25 So I think that change log actually does tell

1 a story of how this has changed over time, and what has
2 been learnt and put into practice over that, and I think
3 when you take that right to the very latest version, the
4 13.4, you know, Dr Denman, Jill Archibald, both of those
5 have spoken in much more favourable terms around 13.4.
6 Dr Denman felt it was consistent with the NHS England
7 Guidance of 2025. NHS England's own assessment in
8 Mr Harry's evidence in the spreadsheet he provided says
9 that NHS England assess it as compliant with 2025.

10 So I think, to me, it demonstrates that the Trust
11 has made improvements over that time.

12 **Q.** Are you in touch with other Trusts to understand a
13 little bit about their own Standard Operating Procedures
14 where they are also using Oxevision?

15 **MR TRENT:** So myself, not personally --

16 **Q.** The Trust?

17 **MR TRENT:** -- but the Trust, we've engaged consistently
18 through the Nurse Directors Forum, when that's engaged
19 with this.

20 **Q.** Let me pause you there because I do have a question.
21 Are you aware whether equivalent Trust policies have
22 been updated quite as frequently as EPUT's?

23 **MR TRENT:** Only insofar as I reviewed the witness statements
24 you'd received from other Trusts for this Inquiry, and
25 I could see that there was variation in those, I believe

1 NELFT had 38 or some similar number. Others less. And
2 I think to really make a comparison, you'd need to make
3 an adjustment for updates which were just technical
4 corrections and really focus on the substantive changes.
5 So counting the number of versions may not give that to
6 you.

7 Q. And just now on changes that are not purely technical,
8 as far as you're aware, has the SOP ever been updated in
9 response to, or in anticipation of, the findings of any
10 of the inquests the Trust has been involved in, which
11 engaged the use of Oxevision?

12 MR TRENT: So yes, I mean, there have been changes in
13 relation to learnings from tragic deaths that have
14 occurred at the Trust, and I've spoken about that a year
15 ago. For example, around the clarity of the policy in
16 responding to alarms, and when you look at the Version 9
17 and 9.1, for example, that update is being made --
18 there's three things happening at that time: that's
19 updates being made after the CQC Report, but it's also
20 happening around the time of the Morgan-Rose Hart
21 inquest as well. So, you know, the Trust is recognising
22 and did recognise failures in care, and reflecting on
23 that at the same time as it's updating the SOP.

24 Q. Thank you.

25 Can I move now to the Privacy Notice. We mentioned

1 this earlier in your evidence. I asked you whether the
2 Privacy Notice now expressly makes clear that if the
3 system is being used, it is on and recording 24/7.

4 The Privacy Notice has been checked, and no such
5 express statement was found. So would you accept that
6 if there isn't such an express statement in the Privacy
7 Notice, that's a failing?

8 **MR TRENT:** I need to review the precise wording, and I did
9 say earlier that my understanding was that was the
10 substance of both the Privacy Notice and the leaflet,
11 but I would need to check that to come back to you.

12 **Q.** Okay, thank you.

13 **MR TRENT:** Because I don't have it in front of me.

14 **Q.** Thank you. You talked about authentication on pilot
15 wards. How many -- so this is the user authentication
16 gateway that we were talking about. How many pilot
17 wards are involved?

18 **MR TRENT:** I believe it's two at the moment, Ardleigh and
19 Gosfield, that are on the pilot. But then it would roll
20 out after that.

21 **Q.** If or once user authentication is rolled out beyond the
22 two pilot wards, will the use of the tablet or monitor
23 by staff be audited regularly by the Trust?

24 **MR TRENT:** I mean, I would expect so. That determination
25 hasn't been made, but as I said earlier, you know, we've

1 seen in the evidence that Ms Cozens gave and her
2 statement that there is another Trust who has started to
3 use the Unusual Activity Alert -- or I forget the name.
4 We would absolutely be interested in using that once we
5 had the user authentication rolled out, because it
6 provides an additional control and mechanism of
7 oversight.

8 **Q.** So is it your understanding currently that the
9 inappropriate vital signs notification, or whatever it
10 is more precisely called, would function best only after
11 a user authentication facility was in place?

12 **MR TRENT:** Yes, I believe it's dependent on that, because in
13 order to be able to report reliably on which members of
14 staff have used the system an unusual amount, you need
15 to know who they are. And crudely, at the moment, you
16 know -- I have an unusual name, but suppose your name
17 was James, there may be another person putting "James"
18 in. We wouldn't be able to confirm it was the same
19 person.

20 **Q.** But in order to be able to determine or access
21 a function that alerted to inappropriate use, you would
22 need both the gateway, the authentication gateway, and
23 this further function, so the two separate functions
24 would be needed. You couldn't just do it with user
25 authentication?

1 **MR TRENT:** I think one depends on the other. You may be
2 able to do a manual analysis, but to have it as an
3 automatic report, it makes sense, doesn't it, you need
4 to know who all the users are in order to be able to say
5 which ones are using it more than the others. So yes,
6 I see that as a dependency.

7 **Q.** Thank you.

8 What are the consent processes for CCTV and
9 body-worn cameras at EPUT?

10 **MR TRENT:** So I think, I provided extensive evidence in my
11 earlier written statements around policies on CCTV.
12 I haven't, in preparing for today, gone back over that
13 because it wasn't the evidence indicated that we'd
14 cover. But I would refer back to and rely upon my
15 previous statements and the policies therein around CCTV
16 and I'd also refer to the Trust Privacy Notice.

17 **Q.** Thank you.

18 Can you tell us whether you are aware of any
19 evidence from EPUT of staff misusing the vital signs or
20 activity system in order to spy on patients?

21 **MR TRENT:** No, not to spy on patients. As I've said before,
22 we expect staff to behave properly and to follow our
23 policies and procedures. That said, we have documented
24 in the statement at the Inquiry's request, where there
25 have been disciplinary matters related to how Oxevision

1 has been used. So that's a part of the record we've
2 provided to you.

3 **Q.** Thank you.

4 You suggested in your evidence that there should be
5 a process run by a respected national institution --
6 this was you, Dr Suresh -- for appraising new
7 technologies, including VBPMS, before their adoption by
8 individual NHS Trusts. And you gave an analogy with the
9 NICE model for assessing new medications before they're
10 rolled out in the NHS; correct?

11 **DR SURESH:** That's correct, yeah.

12 **Q.** Were you referring to new technology relevant to mental
13 health care, or all new health technologies?

14 **DR SURESH:** I mean, my particular interest is in mental
15 health and given that the focus of this Inquiry is also
16 in mental health, I was referring to mental health
17 technologies, particularly because they don't come about
18 as often as in physical healthcare.

19 **MR GRIFFIN:** Thank you.

20 Chair, those are the additional questions I have for
21 Dr Suresh and Mr Trent. Do you have any further
22 questions?

23 **THE CHAIR:** No, I don't, thank you.

24 Could I thank you both very much indeed for your
25 evidence. It's been extremely helpful to me. Thank

1 you.

2 **DR SURESH:** Thank you, Chair.

3 **MR GRIFFIN:** Chair, we reconvene tomorrow at 10.00.

4 **THE CHAIR:** Tomorrow at 10.00.

5 **(4.39 pm)**

6 **(The hearing adjourned until 10.00 am the following day)**

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KALLUR SURESH (affirmed) 2

 Questioned by MR GRIFFIN KC 2