

Monday, 12 October 2026

(10.00 am)

(Proceedings delayed)

(10.05 am)

THE CHAIR: Mr Griffin, good morning.

MR GRIFFIN: Good morning, Chair.

We move this week to consider witnesses of relevance to the issue of observation and technology.

My colleague Ms Harris addressed you about this when she delivered her opening statement at the beginning of last week and of course we heard from Gareth Harry of NHS England last week in order to accommodate his availability. We now move on to consider the further observation and technology witnesses.

Today, the Inquiry will hear from Dr Francesca Denman, an expert Consultant Psychiatrist. Dr Denman will provide opinion from her perspective on observation practices generally in mental health inpatient settings as well as her views as to the role and capabilities of vision-based patient monitoring systems, such as the Oxevision system.

As with previous days, Chair, there may be aspects of the evidence today that are difficult to listen to. For some people, it may not be possible to sit through both sessions, and anyone in the Inquiry room should

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Lampard Inquiry Observation and Engagement and the Use of Vision-Based Patient Monitoring Systems?

A. Yes.

Q. Do you have it in front of you?

A. I do.

Q. Is it dated 13 September 2026?

A. Yes, it is.

Q. Is it 132 pages long, not including its two appendices?

A. Yes, it is.

Q. I understand there are a couple of corrections that you would like to notify to the report. Can we deal with those first, please?

A. Yes.

Q. If we turn to page 35, can we see a reference there to Bethany Lilley?

A. Yes.

Q. Can we see, immediately below that, that she died on 16 January 2019?

A. Yes.

Q. If we drop down to the third paragraph after that, should the date given there be 16 January and not the 15th?

A. Yes, it should.

Q. Can we correct that, then, please.

If we turn to page 122, and we go to paragraph 9.91,

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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 all who require it. Present here again today are Hestia's emotional support staff, and they are currently in the room wearing orange scarves.

There's a private room where anyone who needs emotional support can talk to Hestia. If you prefer, you can speak to a member of the Inquiry team. We're wearing purple lanyards. And we'll point you in the right direction.

For those following the hearing online, information about the emotional support that is available is available on the Inquiry website at lampardinquiry.org.uk. The "support" tab is near the top right-hand corner.

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

I'll ask now that Dr Denman gives the affirmation, please.

DR FRANCESCA DENMAN (affirmed)

Questioned by MR GRIFFIN KC

MR GRIFFIN: Would you provide your full name, please.

A. Dr Francesca Marie Carola Denman.

Q. Have you provided the Inquiry with a report for the

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do we see a sentence about two-thirds of the way down starting "There would be some value"? Paragraph 9.91 on page 122.

A. Yes.

Q. A sentence starting "There would be some value in being able to track pulse and respiration rates since a falling respiratory rate can be a sign of dangerous sedation and a rising respiratory rate is a cardinal symptom of sepsis".

Do you there go on to say:

"But I note that NELFT considered that the value was not great enough and is phasing out the use of the Oxevision system in these areas."

Should that part of the starting "But I note" to the end of the sentence be deleted?

A. Yes.

Q. Is that because it doesn't represent what happened at NELFT?

A. Exactly.

Q. As we heard in July, is the true position this: that whilst NELFT has decommissioned Oxevision's use in most wards, it remains in use and on by default in seclusion and Section 136 or health-based places of safety rooms?

A. Yes, it does.

Q. If we go to page 131, please and the italics at the

4

1 bottom of the page, can we see there:

2 "I confirm that I have made clear which facts and
3 matters referred to in this report are within my
4 knowledge and which are not", it says, should that
5 actually be "not"?

6 A. Yes, it should.

7 Q. And we'll make that correction too. Just staying with
8 the wording in italics, please, as we've seen, does this
9 report include your confirmation that you've made clear
10 where facts and matters are or are not within your
11 knowledge, and that where they are within your
12 knowledge, you confirm them to be true? And finally
13 that the opinions you've expressed represent your true
14 and complete professional opinions on the matters to
15 which they refer?

16 A. That is correct.

17 Q. Do you confirm that again today?

18 A. I do.

19 Q. Have you signed the report?

20 A. Yes, I have.

21 Q. The report and the three appendices that come with it
22 will stand as part of your evidence today, Dr Denman,
23 which means I don't need to ask you today about every
24 aspect of them. You've provided a summary of your
25 experience in the report, that's at page 8. But also,

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1 purposes of the Mental Health Act?

2 A. Yes, I am.

3 Q. Have you treated patients both as outpatients and as the
4 consultant in charge of an inpatient unit?

5 A. Yes, I specialised for much of my professional life in
6 treatment of patients with what was then called
7 emotionally unstable personality disorder, and as part
8 of that work I was fortunate enough to be involved in
9 setting up of an inpatient ward that specialised in the
10 care of patients -- female patients with that condition.
11 And I've also, as part of my trainings in General Adult
12 Psychiatry, looked after inpatient patients on a general
13 adult ward.

14 Q. Between 2012 and 2021 were you Medical Director of CPFT?

15 A. Yes, I was.

16 Q. Would you explain what that role entailed, please?

17 A. It's a requirement of NHS Trusts that the board of the
18 trust, should have on it clinical representation in the
19 form both of a senior nurse and a senior doctor. The
20 Medical Director or sometimes Chief Medical Officer, the
21 titles are equivalent, is the board member who is -- who
22 serves the function of being the doctor on the board.
23 They're a member of the Executive of the Trust.

24 Q. Would someone holding that role regularly also be
25 Caldicott Guardian?

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1 you've provided your CV as an appendix,

2 appendix-number 1. Can we deal with aspects of that
3 now, please.

4 A. Yes, of course.

5 Q. Are you a Consultant Psychiatrist?

6 A. I am.

7 Q. Do you work at Cambridgeshire and Peterborough
8 Foundation Trust or CPFT?

9 A. That's correct, yes.

10 Q. Is CPFT an NHS psychiatric service providing care to the
11 population of Peterborough and Cambridge?

12 A. It is.

13 Q. And have you been a Consultant Psychiatrist there since
14 1996?

15 A. Yes, I have.

16 Q. What are your areas of specialty?

17 A. I trained originally as consultant psychotherapist or
18 medical psychotherapist, the term has changed over the
19 years, which means that I trained as a consultant
20 psychiatrist and then did specialist training in
21 psychological treatments. Subsequently I then gained
22 something now defunct, called an endorsement, in General
23 Adult Psychiatry which means that I also have
24 qualifications in that area.

25 Q. Thank you. Are you an Approved Clinician for the

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1 A. Very frequently they are also the Caldicott Guardian,
2 which means they have responsibility for decisions to
3 share information, clinical information, where that is
4 not directly a patient care decision.

5 Q. Did you hold that role, as well?

6 A. I did.

7 Q. And were you, whilst acting as Medical Director, also
8 a working clinician?

9 A. Yes, I was.

10 Q. We'll be hearing evidence on Wednesday this week from
11 Dr Kallur Suresh, who is Executive Chief Medical Officer
12 at Essex Partnership University NHS Foundation Trust, or
13 EPUT. Is that essentially the same role as the role
14 you've just been describing?

15 A. Yes, he's my opposite number, as it were.

16 Q. So they're just two different ways of explaining or
17 calling the same role?

18 A. Yes.

19 Q. Has CPFT introduced Oxevision into its inpatient wards?

20 A. No.

21 Q. Does it follow that you've not had personal experience
22 of the use of Oxevision in an inpatient ward?

23 A. No, I haven't.

24 Q. Was a formal decision made by your Trust not to procure
25 the technology at a time when you were not Medical

8

1 Director?

2 A. The -- I stopped being Medical Director before my Trust

3 started to consider, formally consider, the procurement

4 of that system.

5 Q. Thank you. Are you also a Fellow of the Royal College

6 of Psychiatrists?

7 A. Yes.

8 Q. Do you have any academic roles?

9 A. I have or had, because I'm retired from it, a role as

10 a lecturer at Cambridge University briefly, and at

11 Anglia Ruskin.

12 Q. And what, in brief, were those roles? What were you

13 teaching?

14 A. Psychiatry.

15 Q. Do you also have wide experience of providing reports

16 for, and appearing as an expert witness in inquests, and

17 civil and criminal cases and in cases before the General

18 Medical Council?

19 A. Yes, I do.

20 Q. You say in your report, and this page 8, that you do not

21 have expertise in the technical details of installing

22 and validating clinical systems or electronic patient

23 records. Should we bear that in mind when you give your

24 evidence today?

25 A. Yes.

9

1 A. Yes.

2 Q. Have you been provided with -- in fact, do you list it

3 in Appendix 2 to your report?

4 A. Yes.

5 Q. Does that include information provided by EPUT and

6 Oxehealth and others in the form of witness statements

7 and a variety of exhibits such as minutes of board and

8 other meetings?

9 A. Yes.

10 Q. And also, have you been provided with case summaries by

11 the Inquiry concerning individual deceased and documents

12 that underlie and inform them, including evidence in the

13 form of witness statements and transcripts of oral

14 evidence from bereaved family members?

15 A. Yes.

16 Q. As you know from that material, the Inquiry has received

17 evidence relevant to the issue of observation and

18 technology and in connection to it at previous hearings.

19 We heard in October last year from a witness from

20 EPUT and also from Oxehealth. And we'll hear more of

21 that evidence later this week. We also received

22 evidence from the organisation Stop Oxevision, and in

23 July this year we hearing from Ms Archibald, and we also

24 heard from the Inquiry's health statisticians about the

25 evidence base in relation to VBPMs.

11

1 Q. You add that you're not qualified to discuss the close

2 operational practicalities of delivering care on an

3 inpatient ward, and that you would divert -- defer to a

4 nursing colleague in this area. And I think you're

5 aware of the evidence we received in July from

6 Jill Archibald, a Consultant Nurse?

7 A. Yes, I am.

8 Q. Have you been asked to provide a report for the Inquiry

9 that covers the nature and use of clinical observations

10 on inpatient wards, and further, to consider the use of

11 technology, including vision-based patient monitoring

12 systems or VBPMs, such as Oxevision, as part of

13 observation practice?

14 A. Yes.

15 Q. And is your report actually largely structured around

16 the areas your instructions asked you to address?

17 A. Pretty much, yes.

18 Q. Thank you. In your report, have you considered matters

19 either from the perspective of a competent psychiatrist,

20 or of the Medical Director of a Mental Health Trust,

21 depending on the particular issue you're addressing?

22 A. Yes.

23 Q. Have you been provided with, and read all of, a large

24 amount of information for review, for the purposes of

25 providing your report?

10

1 At this hearing, in addition to your evidence, we'll

2 be hearing, as I said, from -- more from EPUT and

3 Oxehealth. And indeed, we're in the middle of hearing

4 from certain regulators, as well.

5 A. (The witness nodded).

6 Q. Today we will be discussing technology that we've been

7 referring to as Oxevision.

8 I suggest that for the sake of simplicity we

9 continue to refer to it as "Oxevision" although I think

10 there's been a rebranding and its name may technically

11 have changed.

12 At the risk of over-generalisation, the company,

13 which was called Oxehealth, is now known as LIO, and

14 I suggest we refer to either depending on what seems

15 appropriate.

16 A. Yes.

17 Q. I would like to move, then, to start asking you

18 questions about your report, please. And to start with

19 the issues of general observations.

20 A. Sure.

21 Q. You cover, in Section 1 of the report, guidance and

22 standards for psychiatrists. And we've covered this

23 area in a little detail before and I think it's

24 Appendix 3 to your report, includes an overview of

25 relevant guidance and developments; is that correct?

12

1 A. Yes.

2 Q. With all that in mind I just want to ask you about one

3 area that we haven't covered previously, if that's okay.

4 Before I do that, you do, in the report, address the

5 issue of the absence of relevant guidance. Can I ask

6 you about that first? This is what you say, it's

7 paragraph 1.2 of the report at page 11. What you say is

8 this:

9 "... what is absent is guidance specifically aimed

10 at medical staff in relation to observations or even in

11 relation to the assessment of risk. Indeed, overall,

12 there is little guidance for psychiatrists to cover any

13 but a minimum of basic expectations as to their

14 involvement in the care of patients admitted to

15 psychiatric wards, with the exception of the regulations

16 that deal with confidentiality, capacity, consent, and

17 the application of the Mental Health Act."

18 So you referred there to "medical staff". What did

19 you mean by that term?

20 A. I meant doctors, consultants and junior doctors who

21 attend them.

22 Q. You referred to an absence of guidance in relation to

23 observations and risk assessment more widely. Does that

24 stand true for the whole of the period this Inquiry is

25 considering, so from 2000 to the end of 2023?

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1 A. Yes.

2 Q. Has it actually subsequently been updated in 2024?

3 A. Yes.

4 Q. In December 2024?

5 A. Yes.

6 Q. Can I ask you this: to whom do the GMC Professional

7 Standards apply?

8 A. So the GMC Professional Standards at the minute apply to

9 doctors, registered medical practitioners.

10 Q. Would you expect psychiatrists to be aware of this

11 guidance?

12 A. Yes.

13 Q. To what extent would nurses and others who work on an

14 inpatient ward, but who aren't doctors, be expected to

15 be aware of this guidance?

16 A. I would not expect them to be aware of this guidance.

17 Q. Does the guidance set out what to consider if a medical

18 professional is making or using visual or audio records

19 of patients?

20 A. Yes.

21 Q. Does it in fact include eight key principles of good

22 practice?

23 A. Yes.

24 Q. Now, you address this in Appendix 3 of -- to your

25 report, but does the guidance, for example, say this:

15

1 A. There's no shortage of guidance generally, but

2 specifically aimed at psychiatrists, in their role as

3 psychiatrists, there is a general and enduring shortage

4 of guidance.

5 Q. In your view, is there an urgent need for further

6 research and academic analysis around the role of

7 observations in order to consider what best practice in

8 this area looks like?

9 A. Yes. That's a more general statement. I think that

10 generally about observations.

11 Q. And in fact, later on in your report, do you make

12 a recommendation concerning the conduct of observations

13 more generally?

14 A. Yes.

15 Q. We'll come back and address that in due course.

16 Further, do you consider a goal of any such review

17 should be to develop national standards for observations

18 and engagement?

19 A. Yes, I do.

20 Q. Just coming back to the guidance we haven't previously

21 addressed in these hearings, you refer in your report to

22 the General Medical Council, or GMC, Professional

23 Standards Guidance from 2011 on making and using visual

24 and audio recordings of patients. As we see, did that

25 originally come into effect on 9 May 2011?

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1 "When making or using recordings, you must respect

2 patients' privacy and dignity, and their right to make

3 or participate in decisions that affect them. This

4 means that you must give patients the information they

5 want or need about the purpose of the recording, make

6 recordings only where you have appropriate consent, or

7 other valid authority for doing so, make sure that

8 patients are under no pressure to give their consent for

9 the recording to be made, where practicable, stop the

10 recording if the patient asks you to or if it is having

11 an adverse effect on the consultation or treatment."

12 A. Yes.

13 Q. Do you suggest that this is guidance that should be

14 taken into account when considering technology such as

15 VBPMs?

16 A. Yes.

17 Q. Now, we have heard of a recent PHSO, Parliamentary and

18 Health Service Ombudsman report, concerning EPUT, where

19 this guidance was considered. Are you aware of that

20 recent report?

21 A. Yes, I am.

22 Q. It was issued on 27 March 2026. Did that decision

23 relate to a complaint raised by a person referred to as

24 Ms B --

25 A. (The witness nodded).

16

1 Q. -- an inpatient at EPUT, and use of Oxevision in her
2 bedroom?
3 A. Yes.
4 Q. Did her complaint concern her admission between 2021 and
5 2022?
6 A. Yes.
7 Q. More specifically, did it relate to the use of Oxevision
8 including that she did not consent to its use, and staff
9 said there was no process for turning it off when she
10 requested this?
11 A. Yes.
12 Q. And staff did not give her information about Oxevision,
13 could not answer her questions about it, and gave her no
14 resources to explain its use?
15 A. Yes.
16 Q. Did the PHSO in fact uphold much of the complaint?
17 A. Yes, it did.
18 Q. And was part of the finding by the PHSO that the
19 guidance we've just been talking about was relevant and
20 had not been adhered to?
21 A. Yes, it was.
22 Q. I'd like to move with you, please, to the role and
23 purpose of observations, which you discuss in Section 2
24 of your report. That's from page 22.
25 Now, we've addressed some of this in previous

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1 and each is assigned a score from 0-3. The higher the
2 score the more concerning the patient's condition.
3 There is good evidence that NEWS2 scores predict
4 a patient's deterioration."
5 So as we've previously heard, there are six separate
6 measurements that need to be taken as part of NEWS2.
7 A. Yes.
8 Q. Is it the combination of all six measurements that
9 provides the basis for predicting deterioration?
10 A. Yes.
11 Q. Just reading on:
12 "The NEWS2 is extremely important in psychiatric
13 practice because the measures are simple and the scoring
14 is standardised. The fact that it reliably predicts
15 deterioration and has clear levels that mandate action
16 means that staff in mental health units who do not
17 necessarily have a great deal of physical health
18 training or experience can easily apply it."
19 Can I just pick up on that point about physical
20 health training in a mental health context, and this may
21 actually pick up a little bit on some of the evidence
22 that we heard last week. What kind of physical as
23 opposed to mental health training would you expect staff
24 on a ward to have?
25 A. Yes. On a multidisciplinary ward you would expect staff

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1 evidence, but I would like to pick up on a few areas
2 with you now, please.
3 A. Sure.
4 Q. First of all, physical health deterioration, please, and
5 what we've been referring to as NEWS2. Does that stand
6 for the National Early Warning Score 2?
7 A. Yes.
8 Q. Could we look at part of your report now and this is
9 going to be the first time I put something up on the
10 screen. From time to time, Dr Denman, I will do that so
11 we can all see what I am asking you about.
12 Would you put up the report of Dr Denman at page 28,
13 please -- that's perfect.
14 So we're looking at paragraph 2.22 there at page 28.
15 Can we see there that you say this, from near the top of
16 that paragraph:
17 "There has been a lot of work in physical health
18 care settings, looking at how to detect patients whose
19 health status is deteriorating, as this is something
20 that can be easily missed. The outcome of that work is
21 the National Early Warning Score 2 (NEWS2); this was
22 introduced by the Royal College of Physicians in 2017,
23 updating earlier work. Six parameters are measured:
24 respiration rate, oxygen saturation, systolic blood
25 pressure, pulse, temperature, and consciousness level

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1 to have a range of experience. Those nursing staff who
2 are mental health trained may only have limited physical
3 health training as part of their overall training as
4 mental health nurses. Some nurses are dual trained,
5 which means that they will have both physical and mental
6 health training. But that is not the norm.
7 Q. So might the NEWS2 measurements have particular
8 significance in a mental health inpatient unit?
9 A. I think they're helpful, they're simple, they're
10 standardised, they're relatively easy to do accurately
11 and tell you what to do next.
12 Q. Just sticking with physical health for a moment, what
13 role would you expect the psychiatric -- the doctor, the
14 medical team, to play in relation to physical health on
15 an inpatient ward?
16 A. Yes. So one of the things to do next is get the on-call
17 doctor to come and see the patient. In a psychiatric
18 hospital there will always be an on-call doctor, ideally
19 on site, sometimes shared between more than one site,
20 but available, and they are the first line of defence,
21 if you like, for physical health.
22 Very often they are junior doctors which means --
23 bluntly -- sometimes they're closer to physical medicine
24 than their consultant masters. Some of them may be GP
25 trainees, but all of them will have done a year of

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1 training as FY doctors, and I would expect them to be
 2 able to do the most important thing, which is say, "We
 3 need to transfer this patient, I'm out of my depth", but
 4 also to do simple things like "Let's take the following
 5 measurements, watch and wait" or "I think this needs
 6 further investigation, let's organise some of that."
 7 **Q.** Thank you.
 8 **THE CHAIR:** Can I just interrupt --
 9 **A.** Sure.
 10 **THE CHAIR:** -- and ask you, you haven't said this
 11 specifically but you've implied that it's a useful tool,
 12 NEWS, on a mental health ward because many of the staff
 13 will not have physical health training. Are you clear
 14 that it is appropriate and can be used by staff with
 15 limited physical health training?
 16 **A.** It's widely used on psychiatric wards and I would
 17 expect -- and nurses are trained in its use.
 18 **THE CHAIR:** And healthcare assistants, would you expect them
 19 to be able to use it?
 20 **A.** I would expect a healthcare assistant to be able to use
 21 it. The measurements that are asked for are pretty
 22 automated even -- the hardest, if you like, would be
 23 blood pressure where you have to get that right, get the
 24 cuff on in the right place, but the days of listening
 25 carefully with a stethoscope have now been replaced with

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1 stood by the bedside and taken the patient's pulse and
 2 counted their respiration so it's not giving you no
 3 information; it's just that if you're beside the bed you
 4 might as well gather it all.
 5 **Q.** In fact, I'll come on to ask you about situations in
 6 which just the two measurements may have utility
 7 a little later on --
 8 **A.** Yes.
 9 **Q.** -- when we come on to talk about VBPMS, and Oxevision.
 10 How regularly should NEWS2 measurements be taken?
 11 **A.** That entirely depends on the situation in which you find
 12 yourself. So in this room, no times at all a week.
 13 With a patient who's deteriorating, you're very worried
 14 about them, you might in fact now be so worried you'd
 15 monitor them continuously, between those two settings,
 16 what's reasonable? On the whole, you'd set the rate of
 17 monitoring depending on the nature of the ward, the
 18 nature of the condition that the patient had, and
 19 probably also on a general precautionary principle, as
 20 well.
 21 **Q.** Now, I've looked at some Royal College of Physicians
 22 guidance on NEWS2 called Standardising the Assessment of
 23 Acute Illness Severity in the NHS from December 2017,
 24 which recommends a minimum frequency of monitoring at
 25 12-hourly intervals. Would that be a fairly standard

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1 electronic systems which frankly are more reliable. So
 2 yes, it's a really-easy-to-gather set of data.
 3 **THE CHAIR:** Thank you.
 4 **MR GRIFFIN:** Can we just finish reading the paragraph.
 5 **A.** Sorry.
 6 **Q.** We can see:
 7 "This also means that any measure that is not the
 8 NEWS2 (for example just pulse and respiration) must be
 9 treated with great caution and the NEWS2 should be
 10 preferred if at all possible."
 11 So "treated with great caution", as we've heard
 12 before and will come on to address later, the virtual
 13 signs function -- vital signs function of Oxevision
 14 measures just two of the six measurements, those two
 15 that you've set out there. But to what extent can just
 16 those two measurements, taken together but without the
 17 other two -- without the other four NEWS2
 18 measurements -- reliably predict deterioration of
 19 physical health?
 20 **A.** Well, we don't know, because the study data is on the
 21 NEWS. We haven't got study data on just two
 22 measurements. Obviously, if you're choosing between two
 23 measurements and no measurements, then you'd choose the
 24 two. If you're choosing between two measurements and
 25 the NEWS2, you'd choose the NEWS2. Doctors have long

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1 starting point?
 2 **A.** Well, that would be a fairly standard starting point for
 3 an inpatient unit and it's a good measurement. I'm not
 4 sure that I would require every psychiatric patient to
 5 have a 12-hourly NEWS score. Psychiatric patients can
 6 be very physically worrying and very ill, and their
 7 psychiatric illness and the medications that we use to
 8 treat psychiatric illness make them physically at risk.
 9 But, in a fit, young, not very highly medicated man or
 10 woman, I wouldn't necessarily measure their NEWS score
 11 every 12 hours. I'd think that far more than was
 12 reasonable.
 13 **Q.** So in short, it's very person specific?
 14 **A.** Yes.
 15 **Q.** Now, we can see that the NEWS2 guidance is from 2017.
 16 Now, was there a precursor to that guidance called NEWS?
 17 **A.** Yes.
 18 **Q.** Was that 2012?
 19 **A.** Yes.
 20 **Q.** What was the situation? Did that address, for our
 21 purposes, essentially the same things?
 22 **A.** Roughly.
 23 **Q.** What happened before 2012, particularly in the context
 24 of mental health inpatient units?
 25 **A.** In general, doctors would prescribe observations, and

24

1 would come around and set out what observations they
 2 thought relevant for the patient. So they would be
 3 called to see a patient, for example, with worries about
 4 their blood pressure and they would say, "Let's measure
 5 the blood pressure, maybe sitting and standing once
 6 every 12 hours or so". So it was done, as it were, at
 7 medical advice.

8 **Q.** But for the purposes of this Inquiry, should we note
 9 a change of approach in the guidance from around 2012?

10 **A.** No, that's going too far. What happened in practice was
 11 that essentially our nursing colleagues, because it was
 12 they that did the introducing of this, not -- it wasn't
 13 smart doctors at all -- became increasingly to adopt the
 14 NEWS, and it became standard practice, through that
 15 period but not as a result of a bang, there's guidance
 16 that says, "Do it."

17 **Q.** For our purposes, so that we don't judge actions against
 18 inappropriate benchmarks, are you able to suggest
 19 a rough time when the NEWS or NEWS2 measurements became
 20 the standard measurements in a mental health inpatient
 21 context, or am I trying to pin you down unfairly?

22 **A.** You are, I'm afraid. And in fact, I think you'd be
 23 better asking Jill Archibald, actually, that question
 24 because she's likely to have a firmer grasp on it
 25 than I.

25

1 is a big advantage and then lets you begin to do
 2 analyses which would have been very laborious by hand.

3 **Q.** We'll be hearing further information from the specific
 4 context of EPUT on Wednesday where we'll hear more about
 5 the development of an EPR and, indeed, we may touch on
 6 later today the Oxevision observations module that EPUT
 7 have access to. But as I say, we can come on to talk
 8 about that a little bit later.

9 **A.** Yes.

10 **Q.** What I'd like to do now, though, is please take you to a
 11 different part of your report from paragraph 2.25, where
 12 you refer to the difficulty in assessing risk of
 13 suicide, self-harm, absconsion or harm to others.

14 Just a general question to begin with. What do you
 15 mean by that? What is the difficulty of assessing risk
 16 in that particular context?

17 **A.** When we assess the likelihood of an event, there are two
 18 possible things that we can look for. We can look for
 19 the probability that the event will occur -- that we
 20 guess the event will occur, and it does occur, or the
 21 probability that we guess the event won't occur and it
 22 doesn't occur. In order to be really good at predicting
 23 an event, you need to be good both at saying that it
 24 will occur when it does, and at saying that it won't
 25 occur when it doesn't.

27

1 **Q.** So we'll -- as necessary, Chair, we'll pick that up
 2 separately.

3 Thank you very much.

4 May I just check that volumes are all okay and
 5 everyone can hear all right?

6 You go on in Section 2 of your report to describe
 7 the different levels of observations. You suggest that
 8 observation guidance has been fairly stable over the
 9 period covered by the Inquiry. Is that correct?

10 **A.** Yes.

11 **Q.** Now, we'll come back to observation levels shortly.

12 You identify -- this is at paragraph 2.18 -- that
 13 there is a requirement in guidance for observations to
 14 be recorded. Do you consider that an electronic
 15 recording or note-taking system could be of assistance,
 16 particularly to reviewing observation records?

17 **A.** Oh yes. I think that that's -- is likely to be
 18 extremely helpful. Because very large amounts of
 19 psychiatric note taking is now electronic, the thing
 20 that gets separated and lost is a paper record of
 21 observations. And not being able to find them is, if
 22 you like, a mark of not reviewing them regularly,
 23 because they're just separate, often in more or less
 24 well organised trolleys on the ward. So being able to
 25 put them together with the electronic, clinical record,

26

1 The rarer or the more rare an event is, the more
 2 stringent that becomes. And the more taxing it becomes.

3 So that even if you're quite good at predicting it,
 4 predicting the probability of an event, if it's a very
 5 rare event, you need to be very good at predicting it in
 6 order to pick out reliably the individuals who will be
 7 subject to that event and not to pick out individuals
 8 who will not.

9 In relation to almost -- almost everything in
 10 psychiatry, but particularly rare events like suicide or
 11 harm to others, mostly, most brutally in relation to
 12 suicide, we have some factors that suggest increased
 13 risk so we know that, for example, male sex and physical
 14 health problems, just to pick two, increase your risk of
 15 suicide. But they don't reliably pick out people who
 16 will take their lives, nor do they reliably rule out
 17 people who will not. And so, although we know there's
 18 an association, we can't use it in order to target
 19 interventions more than minimally.

20 **Q.** You say in your report, this is paragraph 2.25 still,
 21 that:

22 "We do not have even moderately accurate ways of
 23 assessing the risk of suicide, self-harm, absconsion or
 24 harm to others."

25 You refer to static predictors and time-dependent

28

1 predictors but say this:
2 "... they also tell us that very many people are at
3 risk -- far more than the number who actually do
4 something risky, [which] makes these indicators very
5 hard to act on."

6 Now, does that pick up the points you were just
7 saying --

8 A. Yes.

9 Q. -- previously?

10 A. Yes.

11 Q. So there is some information but actually it's very
12 difficult to use in a meaningful way to predict risk?

13 A. Yes. If I were to act on people who have high levels of
14 risk, I would be acting in relation to quite a lot of
15 individuals for whom that risk will never materialise,
16 but worse, if I don't act because somebody's level of
17 risk is moderate or low, I will miss some individuals
18 for whom that risk will materialise, despite the fact
19 that it's moderate or low.

20 Q. What I want to ask you about now is this: is whether the
21 approach to the identification of risk, and the reaction
22 to it, has changed over the time we're considering. So
23 from 2000 to the end of 2023?

24 A. Yes, of course. So an absolutely core driver in all of
25 this has been a longstanding confidential inquiry into

29

1 constructing an experiment that looks at different
2 groups of different individuals. By using the word
3 "group" I've already started to stratify.
4 So perhaps the most optimistic development from that
5 has been a move from risk assessment to safety planning,
6 which is to look at everybody's individual factors of
7 risk to think about how those factors that apply to that
8 individual might be translated into a plan to help them
9 be safer. And again, that's an unimpeachably sensible
10 thing to do but we don't have formal evidence that shows
11 it's effective.

12 Q. Just to take stock, we start with a process of risk
13 stratification and acting on the basis of that, and we
14 move to a more holistic approach considering a patient
15 holistically as you've said.

16 A. (The witness nodded).

17 Q. What I'd like to do just because it was very helpful,
18 you've covered a lot of ground, but what I'd like to do,
19 just to distil some of the points with you, is to look
20 at a document. You mentioned 2022 and I know that's of
21 significance because of a NICE guideline that was
22 produced at that time, entitled "Self-harm, Assessment,
23 Management and Preventing Recurrence."

24 September 2022; correct?

25 A. Yes.

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1 suicide and homicide, and the hope of that in the early
2 part of this inquiry's time period was that we would be
3 able to categorise risk or stratify risk, for example,
4 just into completely basic levels of high, moderate and
5 low, that that would guide action. But what came out of
6 the confidential -- and tools were developed to do that.
7 So you'd see in notes people classifying risk as high,
8 moderate or low, people filling in various checkbox
9 forms that tried to set out risk and tried to come up,
10 if not with a score, at least with the,
11 a categorisation, and out of the confidential inquiry
12 and other work it became clear that those risk
13 stratification systems were misleading. And guidance
14 changed over the period to decisively move against using
15 those systems. I think that's finally 2022, but
16 practice was moving before then. And what was put in
17 its place is unimpeachably sensible, which is a holistic
18 and dynamic assessment of risk. So risk could change,
19 and also risk is probably best thought of as by taking
20 the individual in the round.

21 That's undoubtedly sensible and unquestionably the
22 right thing to do, but we've got no evidence that it
23 works. And that's because it would be very, very hard
24 to gather that evidence in that the factors being very
25 individualised, you already start with a difficulty in

30

1 Q. What I'd like to do is look at that now. Could you put
2 up Online Source 1, please.

3 Oh, one step ahead of me, thank you very much.

4 So this is taken from there. "Why the committee
5 made the recommendations."

6 Now, the reason I want to go to this with you is
7 because I think it may summarise some of the points
8 you've just made but would you correct me if I've got
9 that wrong?

10 A. (The witness nodded).

11 Q. Just reading it now:

12 "The committee agreed that risk assessment tools and
13 scales cannot accurately predict risk of self-harm or
14 suicide, and that determining access to treatment or
15 hospital admission based on inaccurate risk assessment
16 tools could lead to repeat self-harm, distress and lower
17 patient [care]."

18 So is that addressing the earlier approach, the
19 stratification of risk, and so on?

20 A. Yes.

21 Q. Reading on:

22 "The committee agreed that the potential harms of
23 risk stratification, including the implication that risk
24 is static instead of dynamic, outweigh any benefits it
25 has as a clinical communication tool or an adjunct to

32

1 clinical assessment, so agreed that risk stratification
 2 should not be used."
 3 Again, covering what ground you've covered with us:
 4 "The committee agreed that assessment of a person's
 5 needs, vulnerabilities, and safety should be a part of
 6 every assessment and that 'risk' should not be used to
 7 determine care management in isolation of other factors.
 8 They agreed that all staff should use their clinical
 9 judgement when assessing someone who has self-harmed and
 10 they should refer to the non-specialist assessment
 11 recommendations for what to do in the event that they
 12 are concerned about the person and their safety.
 13 Additionally, mental health staff should conduct a risk
 14 formulation to place the person's safety considerations
 15 in context with their strengths and difficulties."
 16 Now, does that encapsulate, in those 3 paragraphs on
 17 the screen, the various matters that you were just
 18 explaining to us?

19 A. Yes.

20 Q. Could you take that down, please.

21 So this is 2022. Is that when the approach changed
 22 in this way?

23 A. It was changing before then. So the -- the
 24 dissatisfaction with risk stratification had appeared in
 25 psychiatric literature and was known to psychiatrists

33

1 When North Sea gas came in, it's actually not that
 2 beastly and not that fatal so the rate of suicide
 3 dropped and it became clear that how easy it is to take
 4 your life, the availability and means of doing it, is
 5 really an important driver of suicide rate.

6 And that lay behind even simple interventions like
 7 putting medicines in blister packs. They're just harder
 8 to open up and get lots of tablets. And so not, as is
 9 still the case in America, you just get a great big
 10 bottle of medicine and open the top, pour them into your
 11 hand. And on inpatient wards it led to a relentless
 12 focus on fixed ligature points. These are places from
 13 which you can -- forgive me, it's horrible -- you can
 14 suspend yourself, and wards -- my entire time as Medical
 15 Director and certainly my early years as Medical
 16 Director, going round wards, looking at fixed ligature
 17 points, making sure that shower curtains would come away
 18 when you, you know, if you tried to put weight on them,
 19 hooks, coat hooks that were Velcroed to the wall, that
 20 kind of thing.

21 Q. And over what period are you able to say was the -- did
 22 the focus on fixed-ligature points take place?

23 A. Oh, certainly from before 2012 and still, with, as time
 24 has passed, moving from ligature points in general,
 25 which were the first sort of target, then to what are

35

1 for some time before then. I think, on this occasion
 2 the NICE Guidance was catching up.
 3 Q. Just for our purposes, when we're considering events at
 4 EPUT, am I right in thinking that for much of the period
 5 we're covering it will be the earlier risk
 6 stratification approach that was applicable rather than
 7 the more holistic approach you've been describing?

8 A. Yes.

9 Q. Can we move now to consider another aspect of the
 10 report, this is from paragraph 2.29: reducing the
 11 availability of means. So you've talked about the
 12 difficulty of predicting risk well, but you say in the
 13 report there may still be a way of reducing it and
 14 that's by reducing the availability of means.

15 Would you explain what you mean when you say that,
 16 "reducing the availability of means"?

17 A. Yes. It used to be thought that suicide -- people would
 18 take their own lives by some method, and that if you
 19 removed a method of suicide, they would use another
 20 method. But it became clear through work on things like
 21 substituting North Sea gas for town gas that the rate of
 22 death by suicide is very linked to the availability of
 23 means. Town gas was very poisonous, and is the
 24 origination, if you'll forgive me, of the rather
 25 horrible phrase of putting your head in a gas oven.

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1 called low-lying ligature points, taps, toilet seats --

2 Q. Understood. But you may be aware that EPUT was
 3 prosecuted under the Health and Safety Act in relation
 4 to deaths that were caused by people using
 5 fixed-ligature points. And those were deaths occurring
 6 between 2004 and March 2015. Now, would at least some
 7 of those deaths have taken place whilst there was this
 8 focus on reducing fixed-ligature points?

9 A. The later ones, yes. Remember that the technology to
 10 reduce the number of ligature points had to be
 11 developed, so -- and in some cases it's difficult to
 12 introduce. So I don't know EPUT's history terribly
 13 well, but, for example, if you are going to remake how
 14 a bathroom is set up so that the taps, for example,
 15 don't provide a low-lying ligature point, that's
 16 actually quite a major piece of work, the taps, the
 17 lavatory --

18 Q. I think what we'll do, if possible, is stay away from
 19 specific methods of suicide.

20 A. Yes, of course. I beg your pardon. Yes, all I'm saying
 21 is that to do that work required time and so there's
 22 a period of time where you see Trusts implementing
 23 increasing measures to remove ligature points, but also
 24 not to turn their wards into sort of bizarre wastelands,
 25 so you need to try to maintain dignity and somewhere to

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1 hang your coat.

2 **Q.** And I should make clear that whilst the prosecution was
3 aimed at EPUT it related to activity under a precursor
4 Trust.

5 Just on to a slightly different point, please.

6 You've suggested that there are times where resource
7 pressure requires reducing observation levels. When
8 this occurs, does it present a risk to patient safety?
9 You address this at paragraph 2.44.

10 **A.** Yes, so it's best to see this as a balance. And also,
11 you may want to take evidence from a nurse, because this
12 is, in a way, a nursing consideration. If -- conducting
13 one-to-ones, so continuous presence with a patient
14 observations, requires not just one but several members
15 of staff to be available. It takes -- well, first of
16 all, it ties up a member of staff, but actually you need
17 to rotate the member of staff. You can't just have one
18 person doing it for many hours.

19 Conducting four-times-an-hour observations with too
20 many patients on a ward turns doing four-times-an-hour
21 observations into a kind of regimented process where
22 there's people to get round.

23 So if there's a loss of intensive observation on
24 a ward, you will need more staff. Those staff have to
25 be found, and they may not be people who are familiar

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1 could not return to her original mental health ward, and
2 had to go to a different one. This ward did not know
3 that Bethany was meant to be on level 3 observations, or
4 that she'd recently self-harmed, and on transfer, she
5 was placed on level 2 observations, which were then
6 reduced to level 1.

7 We'll come on to the different levels in a moment.

8 That on 16 January, Bethany was found unresponsive
9 at 19:43 with a scarf secured tightly around her neck.
10 That although an observation was recorded as having
11 taken place at 1900, it was concluded at the inquest
12 that this did not take place, and that a falsified
13 record had been made, and that all attempts at
14 resuscitation failed and that Bethany died at 20:26.

15 You also observe in the report, Dr Denman, that the
16 decision to reduce Bethany's observation levels without
17 a clear understanding of risk and without full
18 information, was rightly the focus of investigation and
19 the subject of criticism. But you note also this: that
20 at some point, the generally accepted practice of
21 positive risk taking would have to be implemented.

22 What is positive risk taking, please?

23 **A.** Yes, before I say anything else, please accept my
24 apologies for the incorrect date. That sort of thing
25 matters to people, and it matters to Bethany's family

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1 with the ward or the patients. That's actually not good
2 news. It may be necessary but it's a disadvantage, and
3 it's one you might need to balance against the need for
4 observations. And I was trying in this paragraph to
5 preserve the clinical judgement of the senior nurse on
6 the ward who thinks: "For all my patients on this ward,
7 how am I going to do the best for them?" And not to
8 simply say: "You've got to do this," irrespective of all
9 the other considerations.

10 **Q.** Thank you.

11 I asked Ms Archibald in July about the death of
12 Bethany Lilley. And at that time, we looked at part of
13 the evidence provided by her brothers, Alexander and
14 Paul Guille. You also address Bethany's case in your
15 report -- this is at paragraph 2.40. And I'd like to
16 ask you about aspects of that now, please.

17 Now, you set out the background to her death in the
18 report, including this: her admission to hospital in
19 January 2019, having self-harmed and taken an overdose.
20 Her ability to leave the ward during her admission and
21 her return without trousers, when she reported having
22 been raped. That she was nursed on continuous level 3,
23 one-to-one observations, that nevertheless she was able
24 to self-harm by cutting her arm and required acute
25 hospital care. That after receiving treatment, she

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1 and I'm sorry. That's careless of me.

2 Turning to the question you ask, positive risk
3 taking is a shorthand I rather dislike, but it embodies
4 the idea that observing somebody -- for some patients,
5 observing them very frequently or very continuously can
6 become a kind of trap, where it becomes increasingly
7 difficult to step that level of observation down. The
8 patient becomes more and more entangled with psychiatric
9 ward and with the psychiatric system, and that, if you
10 like, they become weakened by that. That's probably not
11 a great way of putting it, but let it stand. And that
12 at some point, one has to, with the patient's agreement,
13 step back enough to see how the patient will do and then
14 maybe step back some more, and that is the practice of
15 positive risk taking. So in this case, reducing
16 observation levels would be one starting step in that.

17 **THE CHAIR:** And that's about building resilience in the
18 patient?

19 **A.** It grew from the idea that you could do iatrogenic harm
20 by admitting some patients as inpatients and then by
21 increasing their level of restriction more and more and
22 more. I talk about it a bit later in a kind of ratchet
23 effect. And that that, in the long term, would do the
24 patient more harm than you would in the short term by
25 taking a risk and was perhaps by analogy with, say, the

40

1 treatment -- a risky treatment in medicine where you
 2 would accept that treatment for a condition like
 3 leukaemia would carry a risk with it but you were taking
 4 a short-term risk for a long-term gain.

5 **MR GRIFFIN:** Now, you've referred to iatrogenic harm and
 6 that's a term we have actually heard and has been
 7 described before but would you remind us what that is?

8 **A.** Harm from treatment. So harm by the very process of
 9 treating.

10 **Q.** Thank you.

11 Just going back to the Bethany Lilley's case, you
 12 also say elsewhere in the report that despite risk
 13 taking, there may be occasions where it's appropriate to
 14 make a considered decision not to increase observations.

15 Now, is that, in the context you've just described,
 16 of positive risk taking or are you talking about
 17 something else there?

18 **A.** No, that is in the context of positive risk taking.

19 **Q.** You explain in your report that reviews of observation
 20 levels should involve the same processes and
 21 consideration as were involved in instituting them
 22 initially. Would you explain why that is?

23 **A.** So how best to take a decision where there's a great
 24 deal of uncertainty, there are a large number of
 25 individual factors. One of the things that we know

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1 Bethany's observation levels was not an example of
 2 positive risk taking, nor was it undertaken in
 3 accordance with the approach you proposed?

4 **A.** Oh, definitely, it wasn't an example of positive risk
 5 taking, and if you'll forgive me, there was just another
 6 really simple problem, and that is, it's really a good
 7 idea to just change one thing at a time, and Bethany had
 8 moved ward and come back from an inpatient acute
 9 setting, and even that, even if -- even setting aside
 10 what had just happened to her before, which is terrible,
 11 just that fact, I would have kept everything else the
 12 same for a bit -- on the simple change one thing at a
 13 time. And I think they just didn't know.

14 **Q.** Thank you.

15 Would you also agree that the approach you propose
 16 ought to have included identification of other factors
 17 such as serious near-miss ligature incidents in early
 18 January, the assessment at 1.05 pm on 15 January that
 19 Bethany was at high risk of suicide and self-harm? The
 20 self-harm that had necessitated A&E treatment on
 21 15 January, the day before her death, and the transfer
 22 to a new ward, and involved Bethany's family, and the
 23 decision taken in an MDT environment?

24 Would you agree with all of that?

25 **A.** Yes.

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1 about taking that kind of decision is that human groups
 2 with a diversity of opinions do better than individuals.
 3 In Government, it's sometimes called red teaming.
 4 Someone will -- a group -- somebody will deliberately be
 5 asked to put the contrary position, in order to keep --
 6 to stop groupthink, to stop everybody just settling on
 7 the same thing quickly. And so when you change
 8 observation levels, you're managing risk. We've already
 9 said that risk is really uncertain, and so you want that
 10 diversity of opinion, and ideally, therefore, you want
 11 people who know the patient but a range of people with
 12 different opinions to come together and produce some
 13 kind of consensus.

14 **Q.** And that applies to the reviews of observations level
 15 just as it applies to instituting them in the first
 16 place; is that correct?

17 **A.** Yes.

18 **Q.** Now, taken together, should your evidence be understood
 19 in relation to Bethany as proposing a nuanced,
 20 multidisciplinary decision informed by a knowledge of
 21 historical risk, as well as current presentation, prior
 22 to a reduction in observation levels, especially in
 23 circumstances of increased risk?

24 **A.** Yes.

25 **Q.** Would you agree that what happened in relation to

42

1 **Q.** In the interests of clarity, would you confirm that
 2 you're not suggesting that the circumstances as at
 3 16 January 2019 were the point in time to institute
 4 a practice of positive risk taking? Could you confirm
 5 you're not suggesting that?

6 **A.** I do confirm that.

7 **Q.** Would you agree that there were specific indicators of
 8 imminent risk that ought to have allowed for
 9 intervention in relation to Bethany at least in the
 10 period between her attendance at A&E on 15 January, and
 11 her death the following day?

12 **A.** Yes.

13 **MR GRIFFIN:** Chair, we've been going for a little over an
 14 hour. May I suggest we take our pause, our mid-morning
 15 pause now.

16 **THE CHAIR:** Yes.

17 **MR GRIFFIN:** Can I suggest we come back at 11.25.

18 **THE CHAIR:** 11.25.

19 **MR GRIFFIN:** Thank you.

20 **(11.12 am)**

21 **(A short break)**

22 **(11.25 am)**

23 **THE CHAIR:** Mr Griffin.

24 **MR GRIFFIN:** Dr Denman, I'd like to now move on with you,
 25 please, to Section 3 of your report, which covers

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1 benefits and risks of observations, please. Could we
2 start with observation levels.

3 Now, this is something we covered with Ms Archibald
4 but can we just remind ourselves very quickly about the
5 different levels and then I'll ask you some more
6 detailed questions particularly about intermittent
7 observations.

8 Now, we referred with Ms Archibald to the levels as
9 set out in the 2015 NICE Guidelines: violence and
10 aggression, short-term management in mental health and
11 community settings.

12 And we started with level 1 observations. First of
13 all, what are these? Sometimes I understand that the
14 different levels are called something different in
15 different Trusts. What's the opening or baseline
16 observation?

17 A. So the opening or baseline observation is hourly.

18 Q. Moving then to what are alternatively referred to as
19 intermittent observations or sometimes level 2
20 observations; would you just explain what they are,
21 please?

22 A. Yes, level 2 observations has changed over time. It is
23 observation -- it was originally observation every
24 15 minutes, and became observation four times an hour so
25 as to allow to vary the interval.

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1 A. To spend time with somebody else, somebody you don't
2 particularly know well, and be with them all the time,
3 to watch them all the time, is just not a thing we
4 normally do. We would normally be with someone for some
5 purpose: dinner, or a conversation, or playing a game or
6 going for a walk. But just to be with you to be watched
7 all the time, that's a hugely unnatural experience for
8 both the patient and the member of staff.

9 Q. We talked previously, before the break, about positive
10 risk taking. Can I just ask you, can continuous
11 observations actually hinder or undermine attempts to
12 improve a patient's resilience and mental health?

13 A. I think continuous observations, because they're odd and
14 unnatural, because they involve or necessarily involve
15 a rotation of staff and because they convey a powerful
16 message about how ill, how unpredictable a patient is in
17 the eyes of the staff, come to have very powerful
18 meanings for patients, both when done with them and when
19 done in their presence with somebody else.

20 And those meanings can be very unhelpful. They --
21 for example, some patients are desperately worried that
22 they're not ill enough, that they're about to be
23 discharged, sent home, because they're not ill enough.
24 And for them, one-to-one observations can be the kind of
25 evidence to their inner voices or inner dialogue that

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1 Q. So was the purpose in that change deliberately to
2 introduce irregular and unpredictable observation
3 timings?

4 A. Yes.

5 Q. We'll return to that in a moment.

6 Then continuous observations, please. Sometimes
7 we've heard them referred to as level 3 and level 4;
8 would you just explain briefly what they are?

9 A. Yes, so continuous observations is exactly what it says
10 it is, somebody is with the patient continuously, and
11 they might be with them, line of sight, so always have
12 the patient in view, or arm's length, that's to say
13 always has the patient within arm's length.

14 Q. And do these involve one-to-one observations, and with
15 another member or members of staff available a little
16 further away?

17 A. I'd expect there to be other members of staff available
18 a little further away but one member of staff is with
19 that patient continuously. There are higher levels of
20 observation but they're very rarely used in NHS
21 psychiatric settings.

22 Q. You've referred to continuous observations as being
23 "unnatural".

24 A. Yes.

25 Q. Would you just explain what you meant by that, please?

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1 they are ill enough.

2 So having those observations stepped down will be,
3 for them, very bad news because it means "I'm about to
4 be abandoned, sent away, people don't believe I'm really
5 ill enough to deserve my observation level."

6 Q. You say in your report -- this is paragraph 3.2 -- that:

7 "... the brute function of mental health
8 observations in physically interrupting, in the case of
9 intermittent or 1:1 observations, acts of self-harm, so
10 as to actually prevent them from happening (or reduce
11 their seriousness). There are risks and drawbacks to
12 these benefits but they are benefits nonetheless."

13 Now, is that correct, that --

14 A. Well, it's terribly -- what I mean to say -- it's
15 terribly poorly drafted -- what I mean to say is that --
16 and I mean, by "brute function", if you are with
17 somebody continuously then you are reducing the
18 availability of means. You're literally preventing
19 somebody from hurting themselves.

20 Even intermittent observations will, at least a bit,
21 prevent people from hurting themselves. I'm sure we'll
22 come back to that. And that's what I mean by "brute
23 function". It's an advantage of them that you're
24 literally preventing the terrible thing from happening,
25 but there are drawbacks in terms of the psychological

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1 meaning of the observation level to the patient, and
 2 also with intermittent observations, as you'll see they
 3 can't do that job reliably.
 4 **Q.** We'll definitely come to that last point in a moment.
 5 But just on intermittent four-hourly, even if it's
 6 irregular four-hourly observations. They may interrupt
 7 an act of self-harm, mightn't they?
 8 **A.** Yes.
 9 **Q.** I'd like to look with you now at part of the Mental
 10 Health Act Code of Practice, please.
 11 Now, this is from 2015. Please put up to online
 12 source 2 from page 289. Thank you very much.
 13 Can we see here, Dr Denman, at paragraph 26.30:
 14 "There may be times when enhanced levels of
 15 observation are required for the short-term management
 16 of behavioural disturbance ordering periods of distress
 17 to prevent suicide or serious self-harm. Enhanced
 18 observation is a therapeutic intervention with the aim
 19 of reducing the factors which contribute to increased
 20 risk and promoting recovery. It should focus on
 21 engaging the person therapeutically and enabling them to
 22 address their difficulties constructively (eg through
 23 sitting, chatting, encouraging/supporting people to
 24 participate in activities, to relax, to talk about any
 25 concerns etc)."

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1 you just explain what you meant by that, please.
 2 **A.** Yes, an alliance is when I think that my -- I have an
 3 alliance with my caregiver when I think my caregiver is
 4 my ally, they're on my side, they're trying to help me,
 5 and they're rooting for me. A working alliance is when
 6 I think: I can work with this person. I can engage with
 7 them. Between us, we can do something that will help
 8 me.
 9 **Q.** Thank you. Can we just read on, so paragraph 26.31:
 10 "Enhanced observation may be provided on an
 11 intermittent basis with staff engaging with patients and
 12 observing their condition at irregular and unpredictable
 13 intervals of between 15 and 30 minutes. High use of
 14 intermittent observation on wards has been shown to be
 15 associated with low levels of self-harm and has been
 16 shown to be tolerated by most patients."
 17 Now, first of all, is it right that intermittent
 18 observations are seen as an opportunity for staff to
 19 engage with patients?
 20 **A.** Yes.
 21 **Q.** You say in your report that:
 22 "At a basic level, engagement can help staff realise
 23 that a patient is feeling actively suicidal this minute
 24 or help them work out with the patient that the worst
 25 time for such feelings is in the early mornings and that

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1 Now, we see here reference to enhanced observations.
 2 Is that everything above the baseline level, or level 1?
 3 **A.** Yes.
 4 **Q.** Enhanced observation is described there as
 5 "a therapeutic intervention". What is the significance
 6 of it being an intervention?
 7 **A.** Sure. So that's -- when I use the word "brute" in my
 8 paragraph 3.2, I meant brute as in just the physical
 9 facts of the observation. But enhanced -- observation
 10 practice involves engagement and engagement is being
 11 with a person mentally, seeking mental closeness with
 12 them, and seeking to understand what's going on for
 13 them, and to engage with and alter, at times, what's
 14 going on for them, which you and I would think of as
 15 relationship, can be really simple like offering someone
 16 a cup of tea or "Let's go for a walk." It could be what
 17 you and I would call a "deep and meaningful", you know,
 18 a conversation where the patient would talk about
 19 matters that engaged them very deeply. But either way
 20 it moves from "I observe you" to "I am with you".
 21 **Q.** And what I'm about to ask you may pick up on part of
 22 that but we can see the wording there is "a therapeutic
 23 intervention".

24 You've referred in your report to a staff member
 25 establishing a working alliance with a patient. Would

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1 at a higher level, engagement can help to promote
 2 behaviours and mental processes that reduce suicidal or
 3 desperate thoughts, both through reaching out to others,
 4 and through reaching out to oneself." [As read]
 5 So should we not underestimate the importance of
 6 engagement as they attach to physical observations?
 7 **A.** So every time a member of staff is with a patient, they
 8 have a chance to engage. Observations provide
 9 a regular, repeated moment when a member of staff is
 10 with a patient. And so they have a chance to engage,
 11 regularly, repeatedly.
 12 **Q.** We can see in the second paragraph that I've just read
 13 reference to "intermittent observations" and the
 14 suggestion there is that high use of them has been
 15 associated with low levels of self-harm. Is that
 16 something with which you agree?
 17 **A.** To be honest, I am not aware of the specific piece of
 18 literature they're referring to. I would expect it to
 19 reasonably be true, although not necessarily an easy
 20 association to prove causality in.
 21 **Q.** Can you take that down, please.
 22 I'm going to ask you now about paragraphs 3.34 and
 23 3.35 in your report, and sticking with the issue of
 24 intermittent observations. Some of the text there makes
 25 quite difficult reading so I'm going to take this as

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1 sensitively as I can.
2 It refers to self-harm and strangulation. So you
3 refer to intermittent, four-times-an-hour observations,
4 and you add this:

5 "While investigations has often focused on the
6 failure to perform these observations, that
7 all-too-frequent finding has obscured the systemic fact
8 that level 2 observations cannot be relied upon to
9 detect strangulation in time ..."

10 And you add that consciousness is lost in seconds.
11 You go on to say this:

12 "The problem is that the time between initiating a
13 fatal or terribly act of self-harm and that harm
14 resulting in irrecoverable injury is variable but
15 definitely less than 15 minutes."

16 And you add this:

17 "... even with somewhat unpredictable observation
18 timings, the chance of finding someone in time to save
19 a life is well under 50%."

20 And you raise, I think maybe separately, another
21 point, and that arises from intermittent observations as
22 they've most recently been used at irregular intervals,
23 and you refer to "bunching". Could you just explain
24 what the issue is there?

25 A. Yes. If I observed somebody four times an hour at

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1 the interval that they will, you know, that you can do
2 something, and that's about every five minutes, because
3 your chance, then, of being there in time to save
4 a life, is coming up towards 100. It won't be
5 completely 100 but it'll be coming up towards it.

6 That's different from seeing somebody intermittently and
7 detecting that they're feeling rotten and at increased
8 risk, and doing something about that, which is, if you
9 like, less brute, if you like, and more engagement-y.
10 But just in terms of if the function of the observations
11 is to -- somebody is at risk, it's unpredictable and we
12 want to save their life, then 15-minute observations are
13 not a reliable way of doing that.

14 Q. And if you were to increase observations to, say, every
15 five minutes, is there a different balance that needs to
16 be struck in terms of considering whether it's
17 appropriate in the case of a particular patient?

18 A. Well, I suppose I think about somebody opening my door
19 every five minutes and saying, "Are you okay?" That's
20 quite a different experience from someone coming round
21 four times an hour and saying, "Are you okay?"

22 THE CHAIR: Just going back to the point about the bunching,
23 is there also, conversely, an element of deterrent in it
24 because it's not a regular interval --

25 A. (The witness nodded).

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1 irregular intervals, then just as I will sometimes
2 observe them more frequently, or more close in time than
3 15 minutes, so, if you like, by logical extension, there
4 will be some longer periods of time, and the effect is,
5 the effect of that bunching, is, just paradoxically, to
6 reduce the chance that you'll be there at the critical
7 moment, if your aim of those 15-minute observations or
8 four-times-an-hour observations is to be there at the
9 critical moment.

10 Q. You later suggest in your report that the bunching of
11 observations in one time period inevitably requires them
12 to be extended in another; is that what you're
13 explaining just now?

14 A. Yes.

15 Q. You also say the safest interval for observations, and
16 this is reliably to detect ligaturing and acts of
17 serious self-harm, would be roughly at five-minute
18 intervals.

19 A. Yes. It's important to emphasise that what I'm looking
20 at is the chance that a member of staff will find
21 a patient who is currently self-harming in a way that
22 would be fatal and intervene and save their life, and
23 the chance of detecting that, if you want -- if that's
24 the aim of the intermittent observations, then in order
25 to do that reliably, you have to observe somebody within

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1 THE CHAIR: -- and therefore the patient may not choose to
2 harm themselves because they don't know whether somebody
3 might actually come and stop it?

4 A. Yes. I mean, that was the unimpeachably sensible and
5 right idea behind moving from regular, 15-minute
6 intervals to irregular intervals. The problem is, if
7 I, as the patient, know that I was seen at ten, after
8 ten minutes, after eight minutes and after five minutes,
9 I now know I've got a long time.

10 THE CHAIR: I understand. Yes. Thank you.

11 MR GRIFFIN: As we've seen, you've referred to the fact
12 that, I think with intermittent observations, there's,
13 as you put it, I think a 50% chance that you might be
14 able to intervene sufficiently early to stop something
15 very serious happening.

16 A. Yes.

17 Q. I suppose my question to you is this: isn't even a 50%
18 chance of successful intervention one that is worth
19 something?

20 A. Yes. Oh yes, for sure.

21 Q. And just to pick up on a point that you've already
22 started to talk about, the therapeutic element of
23 observations including intermittent observations,
24 wouldn't there be potentially learning from an
25 intermittent observation that might allow you to

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1 understand that someone is at particularly high risk,
2 and higher intervention level is needed?
3 **A.** Absolutely. And nurses -- well, one nurse I talked to
4 refers to that as having a Spidey sense, that they will
5 observe the patient, seemingly an innocuous interaction,
6 but they leave the room thinking: I'm just not happy.
7 And that's a very useful, really useful piece of
8 information, and the nurse might then well go back and
9 say, "Hang on a minute, why don't you come and have
10 a cup of tea?"

11 So I wouldn't want this very sort of mathematical,
12 physicalist analysis to be the be all and end all, it's
13 just that it's important not to ask 15-minute
14 observations to do something they cannot do.

15 **Q.** More generally in relation to observations, at
16 paragraph 3.38, you consider the need to focus
17 observations on known risky times.

18 How might a reasonable service ensure that
19 observations are focused on risky times?

20 **A.** They can and do. So an example would be knowing that
21 somebody feels particularly unhappy and worried in the
22 evenings and suggesting -- then there might be a whole
23 range of things you might suggest, or even require that
24 they're not in their room in the evening, because --
25 just be around us, that would be a very low-level

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1 **A.** Yeah, part of the team.

2 **Q.** Thank you.

3 Can we move now to nighttime observations, please.

4 Now, if I've understood your report correctly, there
5 is a link between the observations you make about
6 nighttime observations and what we've been discussing
7 about the utility of intermittent observations; is that
8 correct?

9 **A.** Yes.

10 **Q.** May I start by asking you what the purpose of nighttime
11 operations (sic) is, and to what extent it might be
12 different to observations during the day?

13 **A.** Yes.

14 **THE CHAIR:** Observations.

15 **MR GRIFFIN:** Observations -- sorry, what did I say?

16 **THE CHAIR:** Operations.

17 **MR GRIFFIN:** Definitely observations during the day, please.

18 **A.** So patients don't stop being, when it's night, and wards
19 quieten down, but it can be a very difficult time. It's
20 frightening to be awake when you should be asleep. All
21 of us find it frightening, actually, to be awake when we
22 should be asleep. It's also particular parts of the
23 night can be particularly difficult for some patients.
24 So classically, for patients who are depressed, early
25 morning waking, then lying in bed ruminating, and

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1 intervention, or step up the observation levels at
2 different times of day. So maybe one-to-one
3 observations while you're in your room, but only
4 15-minute observations while you're in communal areas.
5 So you can tailor the observation practice to the
6 patient's risk times.

7 **Q.** Thank you.

8 Does the use of temporary or bank or agency staff,
9 who may be less familiar with patients, pose a risk to
10 the therapeutic quality of those observations?

11 **A.** Yes. Yes, it does.

12 **Q.** How can that -- or can that, be mitigated?

13 **A.** It can be mitigated by a variety of interpersonal
14 measures which help. So one simple thing is that
15 a nurse who knows the patient introduces the bank and
16 agency staff to the patient "Hello, this is Jane, she's
17 going to be doing your observations. We've talked
18 together about how you are." That very small piece of
19 speech embodies the idea that we are a team, we have
20 talked about you, so you were in our minds even while
21 you weren't in the room. That's quite holding and that
22 might help that bank and agency member of staff be seen
23 by the patient as -- as it were, "in the know", it's not
24 the quite the way -- that's a way of putting it.

25 **Q.** Part of the team?

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1 really hard to face the day but awake. That's a very
2 bad time. And some patients find the evening difficult.

3 So observations at night stand the chance at least
4 of picking up a patient who's seemingly in bed but
5 actually awake and having a rough time. And doing
6 something about that -- if no other purpose than making
7 that period of time less beastly.

8 So that's one function of night, a very, very
9 important function of nighttime observations.

10 A historic function of nighttime observations that
11 has become less important over time, but still -- is
12 still important, is simply to be sure that the patient
13 is still there. So patients can and do abscond from
14 wards and it's really important to know that's happened.
15 It's harder now. Wards are much harder to leave than
16 they used to be but it's not impossible. And those, to
17 my eye, are the two main functions.

18 What's evolved as practice is that staff will check
19 patients about once an hour, and they have been tasked
20 with, even if the patient is asleep, making sure that
21 they are moving and breathing. And it's that bit of
22 nighttime observations about which I'm less certain of
23 their value.

24 **Q.** Thank you. Can we break that down, and we'll come on to
25 develop the point you've just made.

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1 A. Sure.

2 Q. But first of all, do you accept that there is a good

3 reason for nighttime observations to be conducted?

4 A. Yes.

5 Q. And you've given two reasons, but particularly, perhaps,

6 the one about engaging with an awake patient --

7 A. Yes.

8 Q. -- at a time of need.

9 Putting that example to one side, to what extent

10 would you expect there to be therapeutic engagement with

11 a patient during the night?

12 A. Well, if they're awake, a lot. And if they're asleep,

13 none.

14 Q. I'd like to look at a paragraph from your report with

15 you now, please. Could you put up page 53 of the report

16 and expand paragraph 3.40.

17 Thank you.

18 Can we see here:

19 "Observations can fail because the information they

20 are gathering has, in truth, no clinical utility. The

21 hourly overnight check that a patient is in bed and

22 alive seems only reasonable. There can be great value

23 in finding a patient at night who is awake and may be

24 distressed or ruminating."

25 Now, does that pick up on the point you've just been

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1 moving, what would you do if they weren't? I mean, it's

2 a horrible thought. It does happen. Your chances of

3 being in a situation where you could intervene in order

4 to save life are very, very small indeed. I'm not

5 saying they're zero, but if your aim was to save life,

6 by -- if it was -- if the aim by early observing early

7 was to save life, then that's not how you'd set about

8 that task.

9 Q. If I have understood your evidence correctly when we

10 were talking about intermittent observations, you were

11 separating out different aspects to observation: the

12 physical aspect and the therapeutic aspect that comes

13 from engagement.

14 A. Yes.

15 Q. Do we need to do the same here with what you're

16 suggesting now?

17 A. I'm separating out the task of: is this patient awake,

18 do I need to engage with them? Very, very important,

19 and sensible. Are they here? Also important and

20 sensible. But, actually, in my view, totally

21 understandable. But: are they alive? Sounds

22 unimpeachably like a good idea, but actually, if the aim

23 is to preserve life, that is not an intervention that

24 will do so.

25 THE CHAIR: What about a patient who is deteriorating, about

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1 discussing?

2 A. Yes.

3 Q. What I'd like to do now is to read the rest of that

4 paragraph which I think picks up on a point that you

5 were about to make.

6 "However, while it is universal practice and in my

7 view may be thought controversial, I consider that

8 checking than an apparently sleeping patient is still

9 actually alive is futile. This is because it is not,

10 sadly, a check which has any realistic chance of saving

11 a life because no level of intermittent observation

12 reliably detects or manages sudden death or choking."

13 You use a strong word there, "futile"?

14 A. Yes.

15 Q. But does this now brings us back to the points we were

16 discussing about intermittent observations not being

17 sufficiently frequent to sufficiently interrupt in time

18 an act of self-harm?

19 A. Yes, I need to say, my view is not standard. It's

20 controversial, and it is not standard practice. And the

21 Inquiry should know that. I've taken the liberty of

22 expressing it, but there will be people to disagree with

23 me. But, in a patient who is not a deteriorating

24 physical health case, and just asleep, if you observe

25 them and, for example, check that they're breathing and

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1 whom you have physical concerns?

2 A. Yes, then we're in a whole different ballpark. If

3 a patient is deteriorating, then we should be observing

4 them, we should be using the NEWS, and hourly may well

5 not be my frequency. It might be. But remember,

6 that's -- the NEWS for them will be quite intrusive. So

7 I'm going to have to come in and take their blood

8 pressure and their pulse and so forth. And in an acute

9 hospital or in an acutely unwell patient, that may be

10 necessary.

11 MR GRIFFIN: What we've covered, actually, with other

12 witnesses is the restorative benefits of sleep,

13 particularly for mental health inpatients, and if I've

14 understood you correctly, that is a significant element

15 in what you're saying, in that we need to balance that,

16 on the one hand, with the need to indeed interrupt or

17 make up a patient simply for the purposes of conducting

18 an observation.

19 A. Yes.

20 Q. Could that be taken down, please.

21 THE CHAIR: Can I ask you about a patient who is asleep.

22 You don't necessarily have serious concerns about them

23 deteriorating, but you want to keep an eye on them. And

24 short of doing NEWS, you want to just check that they

25 are breathing and comfortable. So we're in sort of the

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1 physical end of observation.

2 Would you advocate doing that but on a subtle basis,
3 for instance trying to open a door without actually
4 waking them up and listening to them breathing?

5 **A.** Sure. Perhaps the history of it would be helpful. What
6 I think happened was that patients -- nurses would go
7 round at night, would look through the window at
8 a patient, see that they were there, and move on. And
9 then there was some distressing experiences where, come
10 the morning, somebody would go in and say, "Hi, it's
11 time for breakfast" and so forth, and the patient wasn't
12 alive and had died indeed at some point in the night.
13 And that seems terrible and, you know, is very
14 distressing, and terribly distressing the thought that
15 they had not been alive while a nurse had been checking
16 them. And I think that was the source of: you must make
17 sure the patient is alive, and led to, are they moving
18 are they breathing? And that led to: well, you can't
19 really check that from a window, so nurses did indeed,
20 as it were, creep in with a torch and try and do that.

21 And that's -- you know, it seems like a really good
22 idea, but actually, what's the purpose of it? Are we
23 doing it to save life, in which case we have to catch
24 the person at the critical time? We might. There might
25 be a deteriorating or slowly drifting into something and

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1 And as a unit, they agreed to stop hourly nighttime
2 observations. Some of them are on 15-minute or
3 one-to-one observations, but for the ones who are
4 settled and can, as it were, can and have demonstrated
5 that they can make and keep a promise, that there won't
6 be -- they won't be woken and they will take
7 responsibility for coming out of their room and saying,
8 "I'm struggling". That's been a really helpful
9 intervention.

10 **Q.** But is that considered on a patient-by-patient basis?

11 **A.** Oh yes, because just as you would with a deteriorating
12 patient, you wouldn't want to do that, or with a patient
13 who was at risk of self-harming, you wouldn't want to
14 do it.

15 **Q.** We'll come back to consider nighttime observations when
16 we talk about VBPMS, but that's all the questions I want
17 to ask you about general observations on that topic.

18 What I want to do now, please, is to move on to
19 a couple of areas that arise from Section 4 of your
20 report, which covers psychiatric decision making about
21 observations.

22 First of all, would you explain what the role of a
23 psychiatrist is within MDT decision making concerning
24 observations.

25 **A.** I would say that the role of the psychiatrist within the

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1 we pick it up, but for sudden death, we won't. And if,
2 if our aim was truly that we wanted to detect patients
3 who were -- became suddenly acutely unwell in the middle
4 of the night, then we really need to monitor them
5 continuously or very frequently.

6 Again, it's a very mathematical sort of argument.

7 **THE CHAIR:** Thank you.

8 **MR GRIFFIN:** You explain in your report -- this is
9 paragraph 3.44 -- that some units have stopped hourly
10 observations at night.

11 In what circumstances would you say it's safe and
12 responsible to stop nighttime hourly observations? And
13 I think what I want to pick up with you is whether you
14 could take a blanket approach or whether this needs to
15 be much more focused?

16 **A.** Yes. So the unit I was thinking of, I didn't set it out
17 in my report, but the unit I was thinking of was the
18 unit that I used to run in my own Trust, now run or was
19 run until very recently by another very, very good
20 consultant, and he had a community meeting with the
21 patients who said, "We hate it, and it's futile and we
22 don't want it." And he -- these are patients who
23 self-harm a lot. And he said, "Well, how are you going
24 to make -- you know, what are you going to do? How are
25 we going to manage this?"

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1 MDT about observations will be different in different
2 areas -- different for different purposes of
3 observation. So where somebody has a physical health
4 problem and you're observing them because of the
5 physical health problem, I'd expect the psychiatrists to
6 have -- just to have the most interest -- "interest" is
7 the wrong word, the most knowledge and the most to
8 contribute and to say, "Let's do this" because they're
9 the physical health qualified member of the team. When
10 it comes to making -- deciding about observation levels
11 more generally, psychiatrists will be an important voice
12 but one amongst many.

13 **Q.** And when we covered a similar point in July with
14 Ms Archibald, she spoke about a change of approach over
15 the time this Inquiry is considering. Would you agree
16 that the more MDT global approach to decision making has
17 come later on within the period we're --

18 **A.** Yes.

19 **Q.** Are you able to say approximately when that would have
20 been?

21 **A.** No.

22 **Q.** Fine. We may have covered that with Ms Archibald. We
23 can check.

24 The other area I wanted to cover with you arising
25 from this is family and carer information. I want to

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1 look at it with you please from two different
2 perspectives: one is sharing information with a family,
3 and then I want to come on to the situation where the
4 family want to share information with staff.

5 But first of all, sharing information with the
6 family. And the question of patient confidentiality,
7 and how much families could be told and should be
8 listened to.

9 You say in your report and this is paragraph 4.25,
10 that the general approach to taking clinical decisions
11 has to be to have as much relevant information as
12 possible, and I think that's a point, actually, you've
13 already made. But you go on to say:

14 "Self-evidently, family and carer information should
15 influence risk assessment and clinical decision making
16 wherever possible."

17 Now, does that stand true specifically also in the
18 context of decisions concerning observations?

19 A. Yes.

20 Q. Would it also stand true in the context of decisions
21 concerning the use of technology such as VBPMS?

22 A. Yes.

23 Q. How much information would you expect families and
24 carers to be given about the use of technology such as
25 VBPMS?

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1 a difference. And very often they're right. Very, very
2 often they're right. And that has increased, that has
3 -- over time, that has driven more and more guidance,
4 more and more appreciation by staff that it's important
5 to share information with families -- and we'll come on
6 to, even more important, to get information from them.
7 But that has sat in tension with the small number of
8 patients who say firmly "I do not wish my information to
9 be shared with this person or that person" or "I don't
10 wish a bit of my information to be shared" and
11 sometimes, causing considerable anguish by saying that.

12 And the guidance has, over the years, moved from
13 "You must respect a patient's wish for confidentiality"
14 and then "You may share with families", to "You must
15 share with families as much as possible" and "You must
16 respect a patient's confidentiality", as it were. And
17 possibly pushing towards a situation where, if there was
18 extreme risk, you might not respect a patient's
19 confidentiality. Never quite getting that far, but
20 pushing at that edge.

21 Q. You identify that a patient's refusal to involve their
22 family could itself be identified as a risk factor.

23 A. Well --

24 Q. Please carry on.

25 A. I mean, I've thought very hard, you know, how must

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1 A. That would depend almost entirely on what they and what
2 the patient wanted. So I wouldn't expect them to be
3 given necessarily masses amount of information, but
4 I would expect them to naturally ask about a camera, for
5 example, in a room, "What's that?" or to be shown it
6 because it's, as it were, it's an object, and then for
7 the conversation to be: "This is what this is, this is
8 what it does, this is what we use it for."

9 Q. So we've veered a little bit into VBPMS, but I'm going
10 to draw back again and stick to observations, please.

11 A. Sure.

12 Q. You say this also in your report: that there are times
13 when patients do not want their family or carers to be
14 involved in decisions about their care or to be informed
15 about their care.

16 And then, in short, you say that successive guidance
17 documents over time have pushed at the boundary of what
18 in those circumstances clinicians and staff can actually
19 disclose to family members and carers. Would you just
20 expand on that a little bit, please?

21 A. Yes. Those who remain after a tragedy wish they had
22 been told more. Universally they wish they had been
23 told more. They feel very strongly that if they had
24 known more there was something they could have done,
25 they could have contributed, they could have made

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1 I follow the guidance, the best bit of GMC Guidance, and
2 make the care of the patient your first concern? How
3 must I follow that guidance? Well, I want to care for
4 my patient. Their family is -- they're going home,
5 maybe, to their family. Their family is central to
6 their care and you tell me "You may not speak with my
7 family" for example. And they're competent, and they're
8 not detained under the Mental Health Act. How may I do
9 that? And I thought to myself: well, at the very least
10 I should mark that as a huge marker of risk, at the very
11 least, I should say. To the patient, that puts you at
12 terrible risk, and to myself, that puts this patient at
13 terrible risk.

14 Q. And is that because potentially you don't have all of
15 the relevant and necessary information?

16 A. No, nothing stops me listening to the family nor even
17 reaching out to the family as long as they know the
18 patient's my patient, and saying, "Tell me your views."
19 There's nothing that stops me doing that. The patient
20 can't stop me acting in that way. But what it does --
21 what the patient's refusal to share information with the
22 family does is it stops me safety planning with the
23 family.

24 Q. Just picking up on what you've said, you've referred in
25 the footnotes to your report to the NICE Guideline on

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1 Self-harm: Assessment Management Preventing Recurrence
2 from 2022, I don't need to take you to it now, but it
3 includes that:

4 "Health care professionals should be aware that even
5 if the person has not consented to involving their
6 family or carers in care, family members or carers can
7 still provide information about the person." [As read]

8 Now, is that the point you were just making?

9 A. Yes.

10 Q. Has that -- I mean, how well has that been understood
11 over the period this Inquiry is considering?

12 A. Increasingly, it has been understood. So I would say at
13 the beginning of this Inquiry's period, there was -- the
14 focus was on maintaining confidentiality. You would
15 have experiences of relatives ringing up the ward and
16 staff saying, "I'm sorry, I can't tell you anything",
17 and putting the phone down.

18 Over time, and I would hope now universally, drummed
19 into staff repeatedly is the mantra: nothing, nothing
20 stops you saying, "Tell me about it. I really want to
21 listen to you." Nothing stops you saying: in general,
22 this is what happens to patients on the ward. So giving
23 general information. Nothing stops you answering
24 relatives' queries in a general sort of a way.

25 Nothing stops you going back to the patient right

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1 It's not clear to me how much that is a function of
2 the timetable of wards, just that families visit at
3 times when wards may have fewer senior staff on them.
4 Evenings, weekends. That kind of a time. We still, of
5 necessity, tend to have ward rounds and ward meetings in
6 the working week when families may find it hard to
7 attend.

8 I think Covid has done a lot to help that because
9 it's now all wards have the technology to bring a family
10 in on a video conference, thank goodness. But it took
11 Covid to do that.

12 Q. So that's happened really relatively late in our period?

13 A. Yeah.

14 Q. I want to move now to a couple of points arising from
15 the next section of your report, please -- that's
16 Section 5 -- addressing individual circumstances,
17 conditions, and settings.

18 Dealing, first, with the individual circumstances of
19 patients, please.

20 Now, in the report you set out a number of different
21 circumstances and conditions, including, for example,
22 autistic spectrum disorder, psychosis and trauma. And
23 you discuss them. You explain this, this is
24 paragraph 5.1:

25 "The core principle in respect of the way in which

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1 that minute and saying, "Look, your mum's on the phone.
2 Couldn't we all talk together?" All of that kind of
3 stuff.

4 Q. So one of the repeated themes that's come up in the
5 evidence so far at this Inquiry is of families and
6 carers trying to provide information to staff, and not
7 being listened to. From what you're saying, if
8 I understand you correctly, that's really not the right
9 approach?

10 A. No.

11 Q. In your experience, is there a consensus amongst senior
12 clinicians about this change in approach and the
13 benefits of engaging families?

14 A. Yes, and we have our nursing colleagues to thank for
15 this, because they introduced something which I would
16 expect pretty much every member of staff on the ward to
17 know called the Triangle of Care. The Triangle of Care
18 is the patients, the staff, and their family. And you
19 get good care when you have the whole triangle.

20 Q. Has this change of approach actually been properly
21 embedded at all levels within a multidisciplinary team,
22 in your view?

23 A. No, I don't think so. We still find families saying,
24 "We weren't listened to. We didn't have a chance to
25 talk."

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1 observations are conducted is that they should be
2 adapted to the individual circumstances of patients ..."

3 So would you just explain a little bit more about
4 that, please?

5 A. Yes. Observations can have very different meanings to
6 different individuals, and those individuals will have
7 different needs. And given that the observations, you
8 know, we've established that observations are actually
9 a multi-purpose activity, so they've got both a function
10 of gathering data and in effect doing a test -- is this
11 patient okay, and well -- but also of engagement, if you
12 don't adapt to the patient, just simple things like: do
13 they need a hearing loop in their room because they have
14 a hearing aid, or are they somebody for whom people
15 coming into their room is a frightening event because
16 they come from a cultural setting where the officialdom
17 arriving in your room is bad news. So you would adapt
18 by doing things in a different way for each individual
19 patient.

20 Q. Thank you. You also explain in your report the need to
21 engage with individuals as to how observations might
22 affect them and to work out how to minimise that risk.
23 Is it possible for the negative impacts of, for example,
24 level 3 or one-to-one observations, to outweigh their
25 safety benefits for a particular patient?

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1 A. Yes.

2 Q. Are those risks commonly understood and generally taken
3 into account when setting observation levels?

4 A. I would say it's of the nature of this sort of Inquiry
5 that you're seeing examples of failure. But actually,
6 there are lots of examples of success on inpatient wards
7 and that in general, one of the things that is often
8 impressive about the sets of notes that I read,
9 literally just reading one a couple of days ago, we see
10 full and very sensitive discussions about what are we
11 going to do in this circumstance, discussions with the
12 patient, what are we going to do in this circumstance?
13 What would suit you? We're worried about this.

14 So mostly or very often you can see very good
15 practice.

16 Q. So we've talked about individual circumstances of
17 patients. What I want to do now is just to ask you
18 about the different potential settings, different types
19 of unit and so on. You refer in the report to a wide
20 range of specific settings. For example, health-based
21 places of safety, older people's mental health wards,
22 and so on. And I'm going to pick up on aspects of that
23 a little later on but for present purposes I just want
24 to ask you one question, please. Is it also right that
25 the practice of observations will necessarily vary

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1 and can't do, what nighttime observations can and can't
2 do?

3 A. Yes.

4 Q. You also say that the concept of observation deserves
5 a re-think in its own right. This is paragraph 10.4.

6 What kind of re-think do you have in mind?

7 A. Yes, I suppose I began to ask as I wrote: is it right,
8 have we got it right? We've bolted engagement onto
9 observation. Is that the right way to do engagement?
10 Is it the right way to do observation?

11 So, for example, and stop me if I'm skipping into
12 the wrong place, but in some cases, the observation task
13 is actually so critical and so important and so -- needs
14 to be so focused that if you ask a member of staff also
15 to be natural and do engagement, you will distract them
16 from a really -- their single focus on observing for one
17 thing. So there, you see the bolting together may not
18 have helped us.

19 And in other circumstances where we're talking about
20 a -- the impact of observations on patients, are we in
21 fact -- is this way of engaging the right way to be with
22 a patient? And in particular, one-to-one observations.
23 Would it be better if, instead of having a nurse sitting
24 with a patient while they're asleep and the patient
25 going "I'm awake but I don't want to say I'm awake

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1 between the different settings?

2 A. Hugely.

3 Q. Thank you.

4 I'd like to look at some of the reflections that
5 you've set out later on in your report on the points
6 we've been discussing and in fact I want to look now at
7 a recommendation you make because I'd like to deal with
8 general observations in the round now.

9 So if we look at paragraph 10.3, so that's page 128,
10 you say that:

11 "Observation levels carry more weight than they can
12 bear."

13 What did you mean by that?

14 A. So really, really often, I will be asked to review sets
15 of notes where something has happened and there will be
16 a suggestion that the observation level was wrong or
17 that a risk assessment was incorrectly carried out. And
18 I'm looking at those notes thinking: I don't know. And
19 a more honest answer is: I don't know.

20 We don't often -- the whole process of setting
21 levels and having guidelines and so forth doesn't give
22 much space for "I don't really know."

23 Q. Please correct me if I've got this wrong: does the point
24 also pick up on some of the points you've made already
25 about, for example, what intermittent observations can

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1 because I just -- I don't want any more conversation" --
2 are you with me? So you end up in sort of, I call them
3 sort of railway carriage events with a member of staff
4 and a patient sort of not talking to each other. Have
5 we got observation -- is observation, actually, there
6 working against engagement, when it would be better if
7 there was a looser practice of "Come and sit with us."
8 Just be in the main area. But we don't have
9 a technology for that. We don't have audits and record
10 sheets and: was that done properly? And so it tends not
11 to be prescribed like that.

12 Q. Does it boil down to this: that the two different
13 elements that we've been discussing of the technical
14 aspect of, for example, one-to-one observations to
15 ensure someone doesn't come to harm on the one hand, and
16 the more the therapeutic engagement side on the other,
17 that they're not necessarily always -- they don't
18 necessarily always go hand in hand?

19 A. They may be good bedfellows but they may not be. And
20 our need for making sure that things are done correctly
21 and in a sensible and routine way can sometimes lead to
22 rigidities in the system that I think might -- could be
23 opened up or we might need to think about how to
24 open up.

25 THE CHAIR: You talked earlier about the brute sort of

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1 deadening effect of regular observations, so would you
2 say that in many cases or most cases or very few cases
3 that can be mitigated, alleviated by using it as an
4 opportunity for therapeutic engagement? Or indeed just
5 engagement?

6 **A.** I think it needs persistent creativity to do that. And
7 so I set out in my report the particular example of
8 a ward which I thought was fantastic, where they did the
9 first observation in the morning by saying, "Do you want
10 a cup of tea? How do you take it?"

11 **THE CHAIR:** Yes.

12 **A.** And actually it's all done. The observation is -- do
13 you see what I mean? But also, so much more packed into
14 that moment. You know, "What has your night been?
15 Let's have a cup of tea."

16 But as you pressure up the level of observations,
17 the number of observations, the risk attendant on the
18 observations, that -- you put -- you know, you start to
19 pull away from that.

20 **THE CHAIR:** Thank you.

21 **MR GRIFFIN:** Could we look at a recommendation that you've
22 suggested. Could you put up the report at page 129 and
23 expand paragraph 10.4, please. So we can see the
24 recommendation there at the bottom of the page. You say
25 this:

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1 **Q.** You've mentioned that, in terms of notes that are taken
2 in relation to observations, they usually don't capture
3 what they should completely capture if a full picture is
4 to be presented by them, if understand you correctly?

5 **A.** Yes.

6 **Q.** Could any better systems be put in place to help
7 information or changes identified during observations to
8 be recorded and flagged to the MDT?

9 **A.** Well, one of the things that I talk about a bit is the
10 idea of joint tools. So this is an idea from a brand of
11 psychotherapy I was trained in. The idea that we create
12 tools, humans create tools to help them do stuff and one
13 of the things that we create are tools to help us
14 understand ourselves, language being the biggest example
15 of that. Observations, if you like, could be a joint
16 tool, that is a tool that the staff use and that the
17 patient uses. And I could see, in the use now of
18 electronic technology, which means that many people can
19 view and add to a text, that, instead of having
20 "I observe you, I engage with you", patients also could
21 contribute to an observation plan and indeed maybe write
22 some of their own observations, if you see what I mean.
23 We've got opportunities to create a joint tool rather
24 than a delivered object.

25 **Q.** Thank you.

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1 "There may be a case for a full-scale review of
2 current practices of observation and engagement. In my
3 view, this would need to involve regulatory bodies such
4 as the CQC, which looks at compliance in these areas, as
5 well as the relevant professional bodies, and should
6 also have significant service user, family and carer
7 involvement."

8 Now, clearly that picks up on points you've been
9 making this morning. Is there anything more you'd like
10 to say to the Chair now about this suggested
11 recommendation?

12 **A.** Well, just to apologise because it's a bit grandiose.
13 I do think, I was trying to hint at, a common theme
14 through much of what I think about, and what -- that we
15 inspect what's inspectable, that we have audit logs and
16 so forth. But we may be hitting the target and missing
17 the point, and that a review of that, and thinking about
18 how we might -- how we might more creatively marry
19 observation and engagement, deliver both of those
20 aspects of care, could help us to be a bit more flexible
21 in the delivery of both engagement and of observations.

22 I've got my specific hobby-horses that I ride, as it
23 were, but other people will have other, helpful things
24 to say, which might range widely beyond what I've
25 suggested.

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1 I want to move, Dr Denman, with you now away from
2 general observations and to effectively the second half
3 of your report and technology, please.

4 So as you're aware, we've heard evidence from
5 Jill Archibald about VBPMS. So I don't need to cover
6 everything with you now, but I would like just to have
7 a brief reminder of what we're dealing with.

8 Could you put up, please, EPUT026149 at page 18.
9 And expand up to "Can staff use the system to see into
10 your room?"

11 So this is from the most recent Standard Operating
12 Procedure at EPUT so it's a recent document. But I just
13 want to use it as a convenient way to remind ourselves
14 what we're dealing with in some of your subsequent
15 questions, please.

16 Can we see this -- so, this is a poster. I think
17 it's an appendix to the SOP for -- and it's a poster
18 that should go up inwards across EPUT.

19 "Our contactless monitoring system.

20 "How do staff use the system to support your care?

21 "The system gives staff information about your heart
22 rate, breathing rate, and your location and movement."

23 So, first of all, Oxevision is installed exclusively
24 in bedrooms; is that correct?

25 **A.** Yes.

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1 Q. And is it right that the system has essentially two
 2 different functions: one of them is non-contact
 3 monitoring of pulse and respiratory rates.
 4 A. (The witness nodded).
 5 Q. And the other is this system of alerts concerning
 6 patients in their bedrooms?
 7 A. Yes.
 8 Q. We can see then on the poster the unit, the Oxevision
 9 unit. Do we see on the left there a camera, and on the
 10 right, infrared lights which I think are also referred
 11 to as "illuminators"?
 12 A. Yes.
 13 Q. Then do we see this:
 14 "Ward staff can only see a clear view of your room
 15 when measuring your heart and breathing rate for up to
 16 15 seconds.
 17 "They can also see a blurred view of your room for
 18 up to 15 seconds when they receive a notification."
 19 So the system, does it, provides access to staff,
 20 both to a view of the patient that is clear and also in
 21 slightly different circumstances, a view of the patient
 22 that is blurred or pixelated?
 23 A. Yes.
 24 Q. Would you take that down, please.
 25 What I want to do with you first, please, in the

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1 as it were: who will see the information? What use will
 2 it be put to? What happens if somebody sees the
 3 information who shouldn't see it? Because this could
 4 potentially be an image of me in, you know, without many
 5 clothes on, for example, and there might then be -- so
 6 I would expect to be given probably without having to
 7 ask for it, some information governance information, and
 8 then I think probably, beyond that, I would expect to
 9 give the patient any more information that they asked
 10 for, whatever it was, but I might leave it at that.
 11 THE CHAIR: Can I be clear, you think patients should be
 12 told what the risks are of it being used in
 13 inappropriately? So you talked just about information
 14 being given to others who it shouldn't be given to.
 15 A. Yes. Simply by blunt analogy with, if I'm about to have
 16 an operation --
 17 THE CHAIR: What the downsides are?
 18 A. -- there are risks and those -- I mean, your area, not
 19 mine, case law on how much that risk has to be for
 20 a doctor to share it, but if a patient might reasonably
 21 think it's a risk that would upset them, that's kind of
 22 my homespun way of thinking about it.
 23 THE CHAIR: Thank you.
 24 MR GRIFFIN: You say this at paragraph 6.5, just to sum up
 25 what you've been explaining to us:

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1 context of technology, is to ask you about capacity and
 2 consent.
 3 Now, it's right to say, Dr Denman, that capacity and
 4 consent have been significant issues so far in the
 5 Inquiry's consideration of VBPMs, and indeed of the
 6 operation of Oxevision at EPUT.
 7 A. Yes.
 8 Q. We've covered quite a bit of ground about this in
 9 previous hearings. I do, though, have a couple of areas
 10 I want to raise with you. We've touched on this
 11 already, about the type of information you would expect
 12 a patient to be given by staff about Oxevision before
 13 they're in a position meaningfully to consent to its
 14 use. Can we cover that in a bit more detail now,
 15 please.
 16 A. So I've taken Oxevision to be an element of the
 17 patient's care. That means that they need to consent to
 18 it, and in order to consent, you have to know what
 19 you're consenting to. So in order to consent to
 20 Oxevision you would need to know there is a unit in your
 21 room that has a camera in it that uses infrared to take
 22 a picture of you and essentially to set out the
 23 information that has -- we've just shared. I would
 24 expect the patient, then, to have natural questions and
 25 I'd probably seek to answer them before they were asked,

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1 "In order to consent, [patients] must know what it
 2 does, how it will be used, why it is being used ..."
 3 And what you've just been covering now with the
 4 Chair:
 5 "... and what risks there might be."
 6 A. Yeah.
 7 Q. Is that all correct?
 8 A. Yeah.
 9 Q. Do you also consider that patients should be told that
 10 Oxevision, if it's activated in their bedroom, is
 11 capable of recording clear video continuously, ie
 12 24 hours a day, seven days a week?
 13 A. Yes, if it is. Yes.
 14 Q. Moving on, please, but staying with capacity and
 15 consent, you've suggested in your report, and this is
 16 from paragraph 9.28, that you would have expected the
 17 system to be used only with explicit consent from
 18 patients.
 19 A. (The witness nodded).
 20 Q. Can I pick up on a couple things that may flow from that
 21 with you now, please.
 22 A. Yes.
 23 Q. You say this:
 24 "For any clinical intervention, patients are
 25 entitled to review consent for the intervention."

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1 So, first of all, like observations generally, the
 2 use of VBPMS is itself an intervention; correct?
 3 A. Yes.
 4 Q. "There simply no option to do this. In my view, this
 5 was simply never defensible."
 6 Would you explain what you meant by this, please?
 7 A. Yes, of course. So before I do, I'm aware that this is
 8 not a universal view. Other organisations who have
 9 introduced this system haven't taken this view, but my
 10 view is this is a clinical intervention, and I would
 11 expect to be -- as a patient, I'd expect to consent to
 12 it, or not to consent to it, and I can't see any reason
 13 why that wouldn't be the case.
 14 Q. Is there any difference, in terms of what you've just
 15 said, where a patient is voluntary, as opposed to
 16 detained? Does that make any difference to what we're
 17 discussing?
 18 A. So there's two different things. There's having
 19 capacity or lacking it, and there's being a voluntary
 20 patient or being detained under the Mental Health Act.
 21 For a patient who is detained under the Mental Health
 22 Act, there is warrant to treat them against their will
 23 where that treatment is for their mental health. So --
 24 and they can, in principle, be treated against their
 25 will, but we try not to. So I would expect a patient

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1 of that one encapsulated is treatment for anorexia where
 2 we do physical health things to patients. But you can't
 3 just do physical health things. I can't say to a
 4 patient who's detained under the Mental Health Act "I've
 5 decided you need to have your gallbladder out and you
 6 don't -- I'm sorry, you just have to." Because that's
 7 a purely physical health operation.
 8 I would expect, with the use of VBPMS, that there
 9 would be some physical health-like things that could be
 10 wrapped in under mental health and some that could not.
 11 And, as I say, I'd be running screaming to my Mental
 12 Health Act law administrator saying, "Help".
 13 Q. To the extent that the Inquiry wishes to investigate
 14 more about this particular point, we may have taken you
 15 to the edge of your knowledge and expertise; is that
 16 right?
 17 A. Yes.
 18 Q. Thank you.
 19 One of the perspectives of the earlier Standard
 20 Operating Procedures for Oxevision at EPUT was this:
 21 that the consent model that was adopted was for implied
 22 consent. Could you explain your understanding of what
 23 was required, and give us your views as to whether that
 24 was appropriate or not?
 25 A. Do you mean my understanding of what EPUT required?

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1 detained under the Mental Health Act not to have the
 2 right to say, "I refuse to have Oxevision on in my
 3 room", but for that to be discussed with them and for it
 4 only to be, as it were, forced on them if there was
 5 some -- if that was the least -- what's called the least
 6 restrictive option, if that was the best thing for them
 7 and because they're detained under the Mental Health Act
 8 and because it's for their mental health, then it's
 9 deemed by the clinicians the least restrictive thing
 10 to do.
 11 Q. Can I ask you a little bit more about this point about
 12 what the Mental Health Act powers encompass.
 13 Mental health, not physical health.
 14 A. Yes.
 15 Q. So if there were elements of VBPMS, which were directed
 16 really only at physical health, to what extent would it
 17 be appropriate to rely on Mental Health Act powers to
 18 use the system against a patient's consent?
 19 A. Yes, so that's the sort of question that would send me,
 20 as a Medical Director, running screaming to my Mental
 21 Health Act law advisor for help. So forgive me if
 22 I just give you a homespun understanding.
 23 But the idea is that you can require somebody to
 24 have physical treatment if that is part of their mental
 25 health treatment, and the area of treatment that is sort

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1 Q. Your understanding of what EPUT required under the
 2 implied consent model?
 3 A. My understanding is that a patient was admitted and the
 4 system was on, and they had to ask for it to be turned
 5 off. In practice, that's, I think, what was happening.
 6 And there were requirements right from the beginning
 7 that patients should be given that information, but also
 8 right from the beginning worries that patients weren't
 9 always being given that information. And the concept of
 10 implied consent was somehow used to legitimate that
 11 process. Implied consent is just if I say to a patient
 12 "Is it okay if I take your pulse?" and they hold out
 13 their hand, I take their pulse, and their holding out
 14 their hand implies that they consent. It's just consent
 15 but I'm not writing it down in a consent form or, you
 16 know, the fact that they've walked into the room to sit
 17 down with me implies that they're consenting for us to
 18 talk together.
 19 And I think what happened in EPUT was that the
 20 phrase "implied consent" came somehow to mean something
 21 more than that and to somehow legitimated that it could
 22 be on and they would be consenting to it unless they
 23 positively asked for it to be turned off, whereas my
 24 understanding is there's only one kind of consent: it's
 25 consent and that my responsibility, as a medical

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1 professional, is to be sure that when somebody consents
2 to something that is not obvious and it's not obvious
3 that they're consenting, that we have an explicit
4 discussion, that I say, "This is happening" and you say,
5 "Yeah, okay, that's all right."

6 **THE CHAIR:** You can't consent to what you don't know --

7 **A.** No.

8 **THE CHAIR:** -- is what you're saying?

9 **A.** Yes.

10 **MR GRIFFIN:** Chair, I think it's right to note that Mr Trent
11 has acknowledged that the earlier implied consent
12 approach was, as he's put it "really not the right way
13 to do this", but I just wanted to ask Dr Denman about
14 it, as well.

15 Chair, we're coming up to a break. I'm about to
16 move on to a new topic concerning technology, but
17 I wonder whether actually, before I do that, now might
18 be the time to break.

19 May I ask this, please: could people be back by 1.30
20 from lunch? I know that's slightly different from what
21 we would normally do, it's just because there is a fair
22 amount of ground to cover with Dr Denman. This seems
23 like a convenient time to break, but that should give us
24 sufficient time in the afternoon.

25 **THE CHAIR:** Thank you. 1.30.

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1 that that decision is made within 72 hours, or, in
2 a more recent iteration of the SOP, six hours. But
3 ultimately the situation was this: that a patient with
4 capacity who refuses consent to the use of Oxevision
5 doesn't have the final say. That's stays with the
6 clinicians.

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

8 **Q.** Do you have any observations about that approach?

9 **A.** Well, that's not consistent with my view, that this is
10 something that, if you have capacity, and you don't
11 consent, then it can't be forced on you.

12 **Q.** We have various minutes from various board committees
13 which I know you've seen. May I just ask you about one,
14 please. This is the minutes of the EPUT's board of
15 directors meeting on 24 November 2021. It includes
16 a reference to a presentation on Oxevision.
17 A Non-Executive Director -- I'm not going to go to the
18 minutes, I just want to ask you something arising from
19 them, but a Non-Executive Director queried how the issue
20 of consent from patients was dealt with, in particular,
21 what happens should a patient not consent to the use of
22 this monitoring tool? So that's what's brought up in
23 2021.

24 Oxehealth's then Head of Insight and Benefits
25 Realisation, who was present at the meeting,

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1 **MR GRIFFIN:** Thank you.

2 **(12.42 pm)**

3 **(The Short Adjournment),**

4 **(1.31 pm)**

5 **THE CHAIR:** Mr Griffin. Thank you.

6 **MR GRIFFIN:** Dr Denman, before the break, we'd moved on to
7 technology, and VBPMS. And I was asking you about
8 consent.

9 **A.** Yes.

10 **Q.** What I'd like to do with that in mind is just to ask you
11 some brief questions about the Standard Operating
12 Procedures that were put in place at EPUT, with
13 a specific focus on consent.

14 We've touched on bits of this already, but just to
15 take it a little bit further, please. We have seen in
16 EPUT -- I'll call them SOPs, Standard Operating
17 Procedures -- until very recently, the final decision
18 about whether the system should be on or off being left
19 to the clinician or the MDT rather than the patient.
20 I want to ask you just about that.

21 So the system we have seen -- until the most recent
22 SOP -- involves the system being on when the patient is
23 admitted. Even where a patient with capacity objects to
24 the use of Oxevision, the decision whether to keep it on
25 or switch it off is the MDT's not the patient's, and

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1 suggested -- and this is how it is captured in the
2 minutes:

3 "There is a robust process in place on admission to
4 provide information to patients regarding the use of the
5 monitoring tool. Patients are able to decline consent
6 if they wish." [As read]

7 Do you regard the reference to a "robust process" as
8 accurate in 2021?

9 **A.** There's some evidence that that's not the case in that
10 there are reports from patients that they haven't
11 received the information. It's extremely difficult to
12 make a clear evaluation because, in any system, even
13 a robust system, you're going to get some failures, do
14 you know what I mean? But the board did have some
15 evidence, or the implementation board did have some
16 evidence that there were failings in that system at that
17 point.

18 **Q.** Can I move on with you to the most recent version of the
19 Standing Operating Procedure at EPUT. I am going to ask
20 questions about this later this week with EPUT
21 witnesses, I think it's version 13.4, but the approach
22 has changed. Have you read the latest version of the
23 SOP?

24 **A.** Yes, I have.

25 **Q.** In short, does the Trust now require a formal written

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1 consent before the system is even switched on, from
 2 a patient?
 3 A. Yes.
 4 Q. Do you consider that the Trust's current approach and
 5 SOP is compliant with the national guidance you've seen?
 6 A. Yes, I do.
 7 Q. I want to move on to a recommendation that you've made
 8 in the report concerning consent. You say, and this is
 9 at paragraph 10.6:
 10 "We need to be clear-eyed about consent."
 11 You add this:
 12 "The Oxevision system is not the first example of an
 13 innovation in mental health practice where we have not
 14 taken the right approach to consent ... in everyday
 15 practice, we frequently do not admit, even to ourselves,
 16 or to patients, when our decisions are driven at least
 17 in part by resource constraints ..."
 18 Then you go on to say this:
 19 "Consent is the first line of defence safeguarding,
 20 autonomy and dignity ..."
 21 Would you explain a little bit more about what you
 22 mean by it being the first line of defence?
 23 A. Well, my -- if I don't consent to something and it is
 24 forced on me, or I don't know whether I'm -- what I'm
 25 consenting to, if you see what I mean, or whether

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1 justify this."
 2 I'm going to ask you to expand generally on that to
 3 the extent you want to, but also to ask you specifically
 4 about this potentially new role for a board member.
 5 A. Yes. So I suppose the first thing I ought to say is
 6 a disadvantage of this is that boards would hate it, in
 7 that quite often boards feel, whenever there's
 8 a problem, it's -- somebody in the board has to deal
 9 with it. But I do feel that, in the area of mental
 10 health in particular, consent is so complicated, it's so
 11 often linked with capacity, there are so often really
 12 difficult questions about both forcing treatment on
 13 people, but also whether they can truly consent to
 14 things, what they're consenting to, and I am mindful of
 15 both this area where I think my own view is this wasn't
 16 got right, but also, there have been other areas in
 17 mental health, I've suggested one in my report, but
 18 there have been others, and we do quite often narrow
 19 patients' options because of resources and we aren't
 20 always entirely straight about that with them.
 21 I just think that patients would feel more trusting
 22 of medical staff, and indeed psychiatric staff in
 23 general, and feel more that staff were their allies if
 24 we paid more attention to consent. Because if you don't
 25 think your doctor or your nurse or your mental health

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1 I could have another option, then my autonomy has been
 2 violated just by, as it were, just immediately. So --
 3 and I can't -- I can't protest, I can't do anything. If
 4 I'm ignorant, I can't do anything, and if it's been
 5 forced on me, then my options may be very terrible, like
 6 I could leave -- I could say, "Well, I'm leaving" but
 7 normally in medicine, we try to accommodate patients who
 8 don't consent to things. We try to go a middle way.
 9 I mean, the classic example with that would be
 10 people who, Jehovah's Witnesses, who until very recently
 11 couldn't receive some blood products. There are things
 12 you can't do but, you know, you have a negotiation and
 13 everybody comes to some middle way, hopefully.
 14 Q. As I said, I want to ask you about a recommendation that
 15 you suggested and can we look at that now. Would you
 16 put up the report at page 130 and expand the
 17 recommendation at the bottom. Thank you.
 18 This is what you say:
 19 "There may be a case for issues of consent to be the
 20 explicit responsibility of a Trust board member in the
 21 same way that issues of confidentiality are through
 22 a Trust's Caldicott Guardian. The seriousness of
 23 ensuring consent is understood and correctly obtained,
 24 the complexity of the issues involved and the way in
 25 which errors have occurred in more than one area may

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1 professional is your ally, then you're in a really bad
 2 place because you're being looked after by people who
 3 you don't trust, and that's terrible.
 4 Q. Also, we know from your evidence and we'll hear from
 5 Dr Suresh, as well, that the Caldicott Guardian role is
 6 often linked to the Medical Director role.
 7 A. (The witness nodded).
 8 Q. Do you think there would be an argument for suggesting
 9 that this consent responsibility should sit at that high
 10 level?
 11 A. Oh yes, I think so.
 12 Q. So it should be at Medical Director level; it would be
 13 another specific responsibility for a Medical Director?
 14 A. I could see it being a Medical Director responsibility
 15 or potentially a Nursing Director responsibility. I can
 16 see arguments for both.
 17 Q. But it would be at that level?
 18 A. Yes.
 19 Q. How do you think that role might be discharged in
 20 practice?
 21 A. So I suppose that I thought of it by direct analogy with
 22 the sorts of things that I did as a Medical Director and
 23 Caldicott Guardian, which was that people would bring to
 24 me difficult issues and I gathered around me a group of
 25 people with whom I could consult on those difficult

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1 issues. I quite often wrote at some length back to
 2 people, or went to see them to talk to them about the
 3 difficult issues involved very frequently with the
 4 Caldicott Guardian, it is about information sharing in
 5 situations of risk or situations of safeguarding and
 6 I felt it was my responsibility as Caldicott Guardian to
 7 make people very aware of what they could share, how
 8 they should share it, and also to stand up for members
 9 of staff who had taken difficult decisions and say, "If
 10 you've documented it, if you've taken a good faith
 11 decision, I'll stand behind you." And I think that's
 12 really helpful. I think staff experienced it as
 13 supportive -- at least I hope they did.

14 Q. I'm going to move on to a new area. First, is there
 15 anything else you'd like to say specifically about the
 16 recommendation that you've suggested there?

17 A. Only that I feel a bit sheepish about recommendations in
 18 the sense that it's, you know, for others to know
 19 whether they're a good idea or not.

20 Q. Thank you.

21 I'd like to move on now to questions about Section 7
 22 of your report which addresses technology and
 23 psychiatric care.

24 You say there, this is at paragraph 7.7:
 25 "The intended clinical purpose of the system within
 101

1 So it's on your screen, as well, Dr Denman.

2 A. Yes.

3 Q. This is what you say in the report:
 4 "It is certainly the case that VBPMS could provide
 5 relevant information. If a patient is in their bathroom
 6 for too long, this is a risk area, and so this may be
 7 relevant information. Equally, doorways can provide
 8 difficult-to-eradicate ligature points, and so this too
 9 could be a risk area. Patients who have safeguarding
 10 risks may be at increased risk if someone else is in
 11 their room."

12 So am I right in thinking that you recognise that
 13 the system of alerts as a concept, but also specifically
 14 as offered by Oxevision, could be of assistance?

15 A. Yes.

16 Q. You go on to say this:
 17 "All these are potentially relevant pieces of
 18 information, but they are neither exhaustive (risk can
 19 occur in other areas) nor are they specific -- people
 20 can easily spend more than three minutes in the
 21 bathroom."

22 Would you mind just explaining what you mean there?

23 A. Well, I imagined that I might spend more than three
 24 minutes in the bathroom and that then an alarm would go
 25 off, and then people are going to come and see if I'm
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1 inpatient mental health care as described in the
 2 Oxevision literature is enhanced risk management and
 3 a better experience for patients (better sense of
 4 safety, better sleep, improved sense of wellbeing).
 5 I consider these to be reasonable aims, and the
 6 literature for the system describes a 44% reduction in
 7 self-harm, 48% reduction in falls, 37% reduction in
 8 assaults, and 24% reduction in restraints."

9 What I'd like to do to start with in this section is
 10 to ask you about possible benefits of VBPMS and
 11 Oxevision in particular.

12 A. Just forgive me, I'm lost in terms of which section
 13 you're on.

14 Q. This is Section 7.

15 A. Yes.

16 Q. And we've just been looking at 7.7 at page 77. And in
 17 fact I'm just about to ask you about 7.10 on the same
 18 page.

19 A. I see, it's my fault, I've misaligned my pages.

20 Q. Have you got that in front of you?

21 A. Yes, I have now.

22 Q. So we've touched on Oxevision system of alerts and
 23 notifications, but I'd like to look at part of the
 24 report with you now, please.

25 Would you put up page 77, paragraph 7.10, thank you.
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1 okay. If that -- if you have an alert that will --
 2 we'll come on to it, but if you have an alert that goes
 3 off often but then doesn't turn out to have meaning,
 4 people begin to neglect it.

5 Q. I'm going to come back and ask you about this concept of
 6 either alert or alarm fatigue in a moment?

7 A. Sure.

8 Q. But is that what you're getting at there?

9 A. Yeah.

10 Q. Would you take that down, please.

11 You also refer in your report to various specific
 12 settings. Now we've touched on that this morning and I
 13 said I was going to come back and ask you about it, and
 14 also now, the specific role that VBPMS, such as
 15 Oxevision, might play.

16 Can we start with seclusion and rapid
 17 tranquilisation, please. In what kind of
 18 circumstance -- can we start by -- I need to ask you
 19 a general question to start, but in what kind of
 20 circumstances might patients be secluded or forcibly
 21 medicated?

22 A. Yes, so patients who are very behaviourally disturbed,
 23 assaultive, maybe bashing into things, breaking things,
 24 hurting themselves, can need to be restrained.
 25 That's -- and then medicated. And then kept away from
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1 other patients for their safety and for the other
 2 patients' safety. This is super risky, so the
 3 restraining somebody is risky, giving them high doses of
 4 medication to sedate them is risky, and in a way,
 5 setting them apart from other patients is in a sense
 6 risky that you should be -- you know, you need to keep
 7 an eye on them. So that's the sort of circumstances
 8 that you're in.

9 **Q.** Just picking up on that, you say in the report that:
 10 "This kind of patient needs special care."

11 **A.** Yes.

12 **Q.** What did you have in mind?

13 **A.** I think they need one-to-one observation.

14 **Q.** Might there be circumstances where remote taking of
 15 vital signs or observations would be justified in the
 16 context of seclusion?

17 **A.** Yes, so if what is going to happen as soon as you enter
 18 a patient's room is that they are going to become very
 19 aroused and assaultive, then it may be wisest not to go
 20 in. Why is that? Well, because if a patient causes
 21 serious injury by assaulting somebody, that's very bad
 22 news for the person they've assaulted but it's also very
 23 bad news for them because they've just -- at the very
 24 least, they've just become a patient who committed
 25 a serious assault, and that will stay with them

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1 rate, and that's concerning.

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

3 **MR GRIFFIN:** One of the points that I think you've been
 4 stressing is that if you are viewing and taking vital
 5 signs remotely, this should not be for an extended
 6 period of time.

7 **A.** We should be working to repair that situation as fast as
 8 possible. So the -- just the fact that you can't go
 9 into somebody's room without something terrible
 10 happening is in and of itself a situation we need to put
 11 right as fast as possible because it's just a sign
 12 a patient is really ill.

13 **Q.** Do you see a role, a similar role, for VBPMs in
 14 long-term seclusion?

15 **A.** I have never been in the situation of looking after
 16 a patient who was in long-term seclusion and so unwell
 17 that no one could go into the room, but I am aware of
 18 a case where that was -- I mean, I am aware that there
 19 are cases. They're very specialist settings, and
 20 I would be very anxious about advising the Inquiry about
 21 those very specialist settings.

22 **Q.** I'd like to be clear about something, because there may
 23 be some confusion generally about this. And it's about
 24 the use of VBPMs, either to take vital signs
 25 measurements or to remotely view a patient. And

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1 potentially -- depends -- they may have committed
 2 a criminal offence which we could have avoided.

3 So there may be circumstances where you have sedated
 4 somebody, they've calmed down, you don't want to work
 5 them up again, and you therefore don't want to go into
 6 their room at least not more than you have to. That's
 7 a situation you want to repair as fast as possible.
 8 You're in a very dire situation if you can't go into the
 9 patient's room but it does happen. And under those
 10 circumstances, then you're going to be observing them
 11 from outside of the room, and any more information that
 12 you can gather -- so their pulse and respiration rate,
 13 for example -- is good news because it's more
 14 information and it will tell us at least something.

15 **Q.** Just going back to the NEWS2 measurements. In this
 16 particular scenario, have I understood it correctly, two
 17 measurements are better than no measurement?

18 **A.** Exactly.

19 **THE CHAIR:** But what good are those two measurements?
 20 Because you've explained earlier that they don't really
 21 add very much to your understanding.

22 **A.** So in this specific situation, I may well have just
 23 given the patient a relatively large dose of a sedating
 24 medication and the one thing I will see, if I measure it
 25 repeatedly, is potential reduction in their respiratory

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1 sometimes it's not entirely clear what is being referred
 2 to, whether it's one, the other, or indeed both. So can
 3 I just be clear with you, when we are talking about
 4 seclusion in the circumstances you're -- you've just
 5 been discussing, do you see a role for Oxevision because
 6 of the vital signs function, because of the remote
 7 observation facility, or for both?

8 **A.** Yes. I would expect to have eyes on the patient in this
 9 setting. So I wouldn't need the remote observation
 10 facility. Even though I couldn't go into the room, I'd
 11 expect to have eyes on the patient and I'd expect the
 12 room to be such that I could have eyes on the patient.

13 **THE CHAIR:** Through a window or a door?

14 **A.** Yes. So this, for me, is about taking -- this is
 15 a patient who I'm worried is going to deteriorate
 16 physically because I've just done something to them
 17 which is risky. And also, they could potentially have
 18 suddenly become aroused and disturbed for a medical
 19 reason I don't yet know what it is. I would really like
 20 to be doing their NEWS but I can't. So I'm going to get
 21 the best I can.

22 **MR GRIFFIN:** I'd like to move to a different setting,
 23 please, health-based places of safety or Section 136
 24 suites. Does Section 136 of the Mental Health Act allow
 25 the police to detain a person in a public place if they

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1 appear mentally disordered and in immediate need of care
 2 or control and take them to a place of safety?
 3 **A.** Yes.
 4 **Q.** Is this if the police think it's necessary to do so in
 5 the interests of that person or for the protection of
 6 others?
 7 **A.** Yes.
 8 **Q.** Does it follow that people who have been detained under
 9 Section 136 may be agitated and possibly unpredictable
 10 and/or dangerous?
 11 **A.** Yes.
 12 **Q.** What particular difficulties can exist when considering
 13 the observation of someone brought to a place of safety?
 14 **A.** So now you have a patient brought to a place of safety
 15 and you don't know anything much about them. You may
 16 know nothing. You might not even know their name.
 17 You're in a situation of no information, and you need as
 18 much as possible. Sometimes -- rarely, but sometimes --
 19 this is a physical health problem, but it just hasn't
 20 declared itself as that yet. For example, drugs or
 21 alcohol use, although that's generally a little bit more
 22 obvious.
 23 And you're not -- because of the way in which our
 24 services are structured, very often that place of safety
 25 is not immediately close to a physical health care

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1 provided nationally, and not always, they're not always
 2 ideal. They can't always be ideal.
 3 **Q.** Would Psychiatric Intensive Care Units be another
 4 setting in which there might be a role for this kind of
 5 technology?
 6 **A.** In the sense that -- well, certainly in the sense that
 7 seclusion is a much more frequent event there.
 8 **Q.** I want to move on to a different setting where slightly
 9 different matters might apply, please, and at that is to
 10 older people's mental health wards and potentially also
 11 to the question of falls.
 12 You suggest in the report that there is also a case
 13 for utility in relation to risk management concerning
 14 falls. That's paragraph 7.18.
 15 What particular considerations apply in older
 16 people's mental health wards?
 17 **A.** Yes. So older people in mental health settings have the
 18 same problems that older people do in general settings:
 19 they're frailer, and they also may be at risk of falling
 20 and because they're agitated, may be more unwise or
 21 impulsive in their movements.
 22 If you're a young person and you fall, you'll be all
 23 right. If you're an older person, you fall and you
 24 fracture a bone, particularly if you fracture your hip,
 25 there's really quite a substantial chance that will end

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1 setting, so you have to think what's the best you can do
 2 and our worry in 136 health-based places of safety is
 3 this is a patient with a physical health problem
 4 or developing one.
 5 **Q.** Could the vital signs function play a role in this kind
 6 of environment?
 7 **A.** So I'm very conflicted about it. I think it could play
 8 a role, but I would like to think that we would be
 9 staffing our health-based places of safety well enough
 10 to be able to be with the patient in almost all
 11 circumstances. I'm also mindful of the fact that it is
 12 only a very small number of people who are taken to
 13 a health-based place of safety and are then detained.
 14 It's in the single percentage figures. So the vast
 15 majority of this group of patients are actually going to
 16 be discharged and treated as though they were voluntary
 17 patients.
 18 **Q.** Just asking you specifically about the facility or the
 19 function to remotely view a patient. Do you see that as
 20 being of any utility in the HBPOS context?
 21 **A.** Only if it is physically structured in such a way that
 22 the patient could be in part of the room where I can't
 23 see. Again, this is an unknown situation. I'd want
 24 eyes on the patient.
 25 That said, health-based places of safety have to be

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1 your life. And so we really, really would like to avoid
 2 that. And falls prevention is a major concern of all
 3 older people's mental health wards, and there are
 4 technologies about it, but there's also a kind of
 5 whole-nursing body of thought about it.
 6 **Q.** Is there a role for VBPMs, such as Oxevision, in falls
 7 protection in this kind of context?
 8 **A.** So the argument would be that you could see whether
 9 somebody was on the edge of their bed, and could it set
 10 it up to see whether they were on the edge of their bed
 11 and about to get up and walk, and that that would put
 12 them at risk. Having set it up that way, you've got to
 13 be able to respond in time. And that would depend
 14 entirely on how you'd set the thing up, how much time
 15 you had to respond.
 16 **Q.** You say in Section 5 of the report that falls are rapid
 17 events and the time to respond after a signal could be
 18 unfeasibly short?
 19 **A.** Yes, I mean, I suspect it's going to depend literally on
 20 the layout of the ward.
 21 **Q.** But I think you're referring to an alert function, are
 22 you --
 23 **A.** Yeah.
 24 **Q.** -- in VBPMs such as Oxevision, that may be of assistance
 25 in this kind of scenario?

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1 A. Yeah.

2 Q. I've taken you to a series of specific settings and

3 asked you whether there might be a particular role there

4 for Oxevision, either the vital signs function or

5 another aspect of it. Are there any other settings that

6 you can think of where there might be a particular role

7 for technology of this type?

8 A. Do you mean this technology or technology of this type?

9 Q. You're right to pull me up on that. I mean Oxevision.

10 A. I do think that the ability to know whether somebody

11 else is in the room is useful, especially in settings

12 where there might be a worry about mixed sex. We've

13 worked hard and long to sex-segregate wards and

14 environments, but it doesn't always work, and sometimes

15 it may be better to admit someone to a less-than-ideal

16 environment than not to, but there are safeguarding

17 risks, and I would see that as being a potential

18 advantage of the system.

19 Q. So another aspect of the alert function --

20 A. Yes.

21 Q. -- of Oxevision?

22 A. Yes.

23 Q. Thank you.

24 **THE CHAIR:** And does that also play a role in child and

25 adolescent mental health settings?

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1 then that's a different matter and it might tell you

2 that the patient was awake because they'd be moving and

3 you'd be able to see that in the blurred-out view of the

4 patient but it won't tell you if the patient is lying in

5 bed, eyes open, ruminating, for example, and so that, in

6 my view, needs an in-person check.

7 Q. Can I separate out again the two functions that we have

8 been talking about.

9 A. Yes.

10 Q. Let's stay with -- I think you've been talking about

11 a remote observation; is that correct?

12 A. Yes.

13 Q. Do you see a role in the circumstances you've just

14 described for an observation conducted through a screen

15 in those particular kinds of circumstances, or are you

16 saying that someone should actually be in person and

17 checking?

18 A. I think it's easier to see, if you're -- well, it

19 depends what you're going to view. This is not

20 a current view, the way the system is used, but a clear

21 view of the patient, not for the purposes of measuring

22 their pulse and respiration but for the purposes of

23 looking at the patient, might tell you as much as

24 looking through a window. That might tell you that the

25 patient was awake or looked as though they were awake,

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1 A. Insofar as mixed sex or you might worry about people

2 being disinhibited maybe and wandering into each others'

3 rooms, yes.

4 **MR GRIFFIN:** I want to move on to talk about nighttime use,

5 please. We've already spoken about observations at

6 night. I want to move that forward now with you,

7 please, to consider the use of technology, particularly

8 Oxevision, at night and what role it might play.

9 You say in your report -- this is part of the

10 executive summary at the start -- that "Oxevision:

11 "... allows nighttime checks of pulse and

12 respiration without waking a patient. These are

13 routinely performed in Mental Health Trusts at at least

14 hourly intervals."

15 We've also separately already discussed the need for

16 sleep on a mental health ward. So just the starting

17 point, really. Do you see a role for remotely-conducted

18 observations or taking vital signs using Oxevision at

19 night, particularly?

20 A. So I don't. But my view is controversial. My own view

21 is that there is not an argument for, at night,

22 intermittently confirming that an otherwise unassuming

23 patient is alive. And that's what -- all that pulse and

24 respiration can do for you. If the technology was used

25 at night to confirm whether the patient was awake or not

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1 and lead you to go down or go round and tap on the door

2 and say, "Are you okay? Do you want a hot drink?" Hot

3 drinks figure large in my mind. You know, any number of

4 interventions. That would be a use for it. But why

5 wouldn't you just go and look through the -- do you see

6 what I mean? Why wouldn't you --

7 Q. That's what I was going to ask you. Is there any

8 advantage to conducting the observation remotely rather

9 than through the window in the door?

10 A. I don't think so myself.

11 Q. Thank you.

12 Can we come on, then, to the other aspect, the vital

13 signs measurements at night. Is there any particular

14 role for that aspect of the technology that you can see,

15 particularly at night as opposed to during the day?

16 A. Yes. So as I say, controversially, my view is that

17 unless I am worried about a patient's physical health

18 and they are -- I'm worried that they are quotes the

19 "deteriorating patient" in some way, there is no

20 argument for taking hourly pulse and respiration

21 readings just in general. I wouldn't ...

22 Q. Is that subject to the same caveats we talked about

23 before. So, for example, if someone is physically

24 unwell there may be more of a reason to be reviewing

25 them?

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1 A. If they're physically unwell there's more of a reason to
 2 review them, but if I'm worried about them, why am I not
 3 using the NEWS2?
 4 Q. Then the other point you've raised about people who are
 5 heavily medicated, there potentially being some facility
 6 in just the two vital signs measurements than the full
 7 six NEWS2 measurements; does that apply here at night?
 8 A. Well, it's -- two measurements are better than no
 9 measurements, but if I'm that worried, why would I not
 10 go for the six measurements? And in particular, I can
 11 quite quickly start adding measurements that would help
 12 me, like just their temperature.
 13 Q. When we're considering the use of VBPMs and Oxevision,
 14 this is either daytime or nighttime, is there -- in the
 15 settings we've been discussing or generally, is there
 16 a further consideration that we need to take into
 17 account, and that is whether some other form of
 18 technology might do the same job, but better?
 19 A. Well, I think so. Or rather, I think that we should be
 20 thinking about this, because I think one of the big
 21 advantages of this Inquiry and this kind of thing in
 22 general is that there are probably, soon enough, going
 23 to be technologies that could be very helpful. And it's
 24 not hard to start thinking of them, but there is nothing
 25 at the minute that's validated so we're into speculative

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1 for example, because it's contactless rather than
 2 requires a --
 3 A. Absolutely. As soon as I'm relying on a wearable
 4 object, the patient can immediately defeat the object by
 5 taking it off, or by sharing it with another patient
 6 saying, "Will you wear my watch for me?"
 7 Q. Yes.
 8 A. I suppose what I felt when I sort of finished the report
 9 is technology is coming, we need a way of -- we don't
 10 know what's coming. We need a way of managing new
 11 technology that's coming that doesn't stifle it because,
 12 do you see what I mean, because we're scared, but also
 13 doesn't fall into any of the traps that we could avoid
 14 by thinking about it, how to encompass new technology in
 15 advance.
 16 Q. We'll come on to that in a moment, actually.
 17 What I want to ask you about now is something
 18 different, and that's the extent to which this
 19 technology confers medical or physical advantages as
 20 opposed to mental health advantages.
 21 I think what I'm trying to do is to understand with
 22 you what is the category of advantage that this confers?
 23 Where does it come within the spectrum of physical
 24 health and mental health?
 25 You've said in your report -- this is

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1 territory. That's just a sort of preamble. But
 2 although they're not validated yet, most of us are
 3 wearing a piece of technology. So wearable watches, all
 4 these things claim stuff for themselves and I'm not an
 5 expert in what they can or cannot do reliably, but
 6 I would take a great interest in the sorts of
 7 information that I could get about somebody's movement
 8 level, and any information -- just ordinarily, how much
 9 they're moving their arms -- and information about --
 10 any more information that I could gather about, for
 11 example, their blood oxygen levels, their pulse and so
 12 forth. Those could potentially be measured by a more
 13 contactable device.
 14 Q. So a wearable device might have a role. You've
 15 mentioned, I think in the report, the possibility of bed
 16 pads, for example, in relation to falls prevention?
 17 A. So there is a whole falls prevention technology, and
 18 important, I think, but that's not my area of expertise
 19 and I'd want you to be advised by somebody who does that
 20 for their bread and butter.
 21 Q. But I've just introduced these questions with -- on the
 22 basis that one needs to consider alternatives to VBPMs.
 23 But does one also need to be balanced so that -- does
 24 one also need to consider whether, for example,
 25 Oxevision has advantages over these other technologies,

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1 paragraph 7.37 -- that:
 2 "VBPMs is not helpful in relation to general
 3 psychiatric assessment or more than minimally in
 4 relation to clinical formulation and decision making."
 5 Would you explain what you meant there?
 6 A. I couldn't see how, for example, compiling VBPMs data
 7 was going to help me know more about my patient in
 8 a reliable way. I could quite quickly see technologies
 9 that would, but the -- as currently implemented, this
 10 technology doesn't give me reliable -- the sort of
 11 reliable-enough information that would let me know more.
 12 Q. You've just said that you could foresee technologies
 13 that would. Can we be clear, are those technologies
 14 that don't yet exist?
 15 A. Yes.
 16 Q. Thank you.
 17 You've also said this in the report:
 18 "I do not think VBPMs systems currently have any
 19 real utility in informing decisions concerning
 20 observation levels."
 21 Could you expand on that too, please.
 22 A. Yes, I think I was making a rather stronger point there.
 23 One of the potential advantages that I think was in the
 24 mind of people when they implemented the system was that
 25 it would allow them to reduce one-to-one observations or

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1 possibly even reduce intermittent observations and
 2 I don't think that it does. I don't think that it's
 3 ever really been used, or has ever justified its use as
 4 anything other than an adjunctive system as opposed to
 5 an alternative system.

6 **Q.** We'll definitely come up to that point again in
 7 a moment, too.

8 But may I ask you this, then: what role do you see
 9 for Oxevision and VBPMS specifically in relation to the
 10 treatment of mental health and mental ill health?

11 **A.** So specifically in relation to the treatment of mental
 12 health and mental ill health, there are consistent
 13 reports from Trusts and from EPUT in particular that
 14 staff say it has allowed them to notice that somebody is
 15 self-harming and to go and intervene. It's very
 16 difficult, from the papers I've seen, to cache those
 17 reports out into actual either just a story about what
 18 happened, but obviously, if it's doing that, that's an
 19 advantage. Even if it's only doing it imperfectly.

20 **Q.** But that would rely on staff remotely viewing the
 21 patient either through the vital signs function or some
 22 other way?

23 **A.** My guess, is, but this is a guess, my guess is that
 24 sometimes when the alarm goes off, that somebody has
 25 been in their bathroom for more than three minutes and

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1 says, "Well, I do feel very risky in my bathroom, it
 2 particularly sets me off there" then you can say, "Well
 3 okay, let's make a plan, we'll be watching because
 4 that's how the system works, we'll be watching and we'll
 5 come, but why don't we also work on, instead of you
 6 going into your bathroom and doing something unsafe, you
 7 come out the door and we'll make that" -- do you see
 8 what I mean? -- "and we'll make that part of the plan,
 9 or you come to the door."

10 That's what I meant to try to, as it were, say to
 11 the patient "We've got this tool, how would it help you?
 12 Here's what it can do."

13 "Oh yes, it would help me like that."

14 Then we can move on maybe in this way.

15 **Q.** So as part of discussion with a patient at an early
 16 stage?

17 **A.** (No audible answer.)

18 **Q.** As I understand it and I can ask questions about this to
 19 EPUT witnesses later this week, the approach now does
 20 involve thinking about things that at the care plan
 21 stage?

22 **A.** Yes.

23 **Q.** So we can talk more about that if necessary.

24 **A.** Yes.

25 **Q.** What I'd like to do now, though, is to move on to

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1 staff go, they've been there because they're
 2 self-harming.

3 **Q.** So that brings us back to the alert --

4 **A.** Yes.

5 **Q.** -- function, and the points you've just been making,
 6 that could be a specifically mental health role --

7 **A.** Advantage, yes.

8 **Q.** Advantage.

9 **A.** And I'm presuming that you're right that just on
 10 occasion or maybe more than on occasion staff have
 11 used -- made a vital signs measurement that had a clear
 12 view of the patient, and they've seen that the patient
 13 is doing something terrible and been able to intervene.

14 **Q.** You -- just talking about times when it would be
 15 appropriate to use this kind of technology, you say in
 16 your report that there might be a particularly useful
 17 way of deploying it and you speak, for example, of
 18 discussing it at the care plan stage. Would you expand
 19 on that and what you were talking about there, please?

20 **A.** So there's -- patients are not just recipients of what
 21 we do to them; they're participants in their care, and
 22 for a patient who agreed to the use to the system, the
 23 best way -- the very best way to use it is to say to the
 24 patient "This is what the system can do. What do you
 25 think would help make you safe?" And if the patient

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1 potential limits to Oxevision and VBPMS.

2 You raise some of these in the report. You say
 3 this, and again, this is near the start of the report
 4 at page 4:

5 "The system also confers risks. These include alarm
 6 fatigue, and the risk that use of the system as
 7 a substitute for in-person observations would reduce
 8 therapeutic engagement and contact with patients. Sole
 9 reliance on VBPMS would therefore be inconsistent with
 10 responsible practice in almost all circumstances."

11 So there, you pick up on several different points.
 12 I want to deal with them in turn, please.

13 This point about therapeutic engagement and contact
 14 with patients. We've talked about it a little bit when
 15 we were talking about observations more generally.

16 But in your report you say, this is paragraph 7.31,
 17 that there are circumstances in which you consider
 18 technology acts as an obstacle to meaningful clinical
 19 interaction between patients and staff.

20 You say:

21 "... when it is seen as a replacement for, rather
 22 than a mediator of, communication and interaction."

23 What did you mean by that?

24 **A.** I mean the vision of somebody sitting in a remote office
 25 pressing a -- this is not how the system is used, but

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1 pressing a button, viewing the patient, thinking all is
2 fine, and going to think about something else. That's
3 the -- that's, if you like, the naive vision of how it
4 would replace interaction, because it's feeding the idea
5 that just looking at somebody gives you enough
6 information about them to know whether they're safe or
7 not.

8 **Q.** You say this a couple of paragraphs later, 7.33, and
9 tell me if this is essentially the same point or
10 a development of it, you say:

11 "... to the extent that technology takes information
12 away from patients and detracts from staff closeness to
13 patients, it will reduce the chance patients have to
14 interact meaningfully with their treatment and to
15 influence its course."

16 **A.** It's very slightly an elaboration of it, in that the
17 other side of -- so it's not just that a member of staff
18 or a clinician viewing a patient remotely is not getting
19 all the information that they could get; it's also that
20 the -- who I am and how I am, and my knowledge of who
21 I am and how I am, as fed back to me by a member of
22 staff, has been taken away from me. I don't know that
23 I've been viewed, I don't know that I've been in the
24 mind of another. And the knowledge that I've been in
25 the mind of the other is quite important to me because

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1 undertaken. The observation records have been amended
2 and show that Michael was observed in the bathroom and
3 that there were 'no concerns', at 07:15 hours.

4 "The CCTV footage does not show that the engagement
5 took place. If the observations and engagements had
6 been carried out correctly, there may have been
7 a different outcome." [As read]

8 This addresses certain -- various different points
9 but would one of them, Dr Denman, be the dangers of
10 over-reliance on VBPMs, and remote observation of
11 a patient in their bedroom?

12 **A.** One of them, yes.

13 **Q.** In your view, can the risk of over-reliance on the
14 technology be mitigated and its benefits realised
15 through appropriate guidance, training and clinical
16 governance?

17 **A.** Certainly, it can be mitigated, and certainly it can be
18 used more appropriately. The example we've looked at is
19 one where it was -- it's a particularly extreme example
20 of it not being used appropriately, and I suspect by
21 somebody who knew or may have known that they weren't
22 using it appropriately.

23 **Q.** You mentioned this afternoon already this concept of the
24 technology being assistive or an adjunct. I want to
25 deal with that now with you in a little bit more detail,

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1 then I can think thoughts like: ooh, I wonder how she
2 thought I was? Which is already a good thought to have
3 because it then makes me think: well, I wonder how I am.
4 How am I? That kind of thing.

5 **Q.** You refer in the report to Michael Nolan. He died on
6 10 July 2022 at Kelveden Ward in Rochford Hospital. You
7 set out in the report some details about the
8 circumstances leading up to his death which I don't want
9 to take you to now. Paragraph 7.23 for those who are
10 following.

11 But I would like to read from the narrative
12 conclusion reached by the jury at the inquest into his
13 death. That included this:

14 "There are serious concerns regarding the roles and
15 responsibilities of the staff during the night shift of
16 9 and 10 July 2022. There were serious failures to
17 carry out effective level 2 observations and engagement
18 on Michael. The HCAs responsible for Michael's care
19 consistently used Oxevision as a substitute for
20 observations and engagement, and in many cases failed to
21 use Oxevision correctly. The bathroom alert alarm at
22 07:11:44 seconds was reset at 07:11:53 seconds and the
23 CCTV records show that no one attended the room until
24 07:33 which was a call for breakfast and was only for
25 a period of time two seconds. No visual engagement was

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1 please.

2 You refer in the report, actually, to the technology
3 as an "adjunctive aid", that's paragraph 7.25.

4 Am I right in thinking that where people talk about
5 "adjunctive" or "assistive", it's effectively the same
6 thing?

7 **A.** What I meant was alongside what we normally do.

8 **Q.** You say this in the report:

9 "... in proportion to the degree to which the system
10 is used as an adjunctive aid rather than the main method
11 of observation, any cases which could be made for its
12 ability to reduce the burden on staff and thereby ease
13 operational pressures or to deliver hoped-for cost
14 reductions is reduced."

15 What did you mean by that?

16 **A.** I meant that the Oxehealth literature and the Trust's
17 case for adopting the technology was in part that it was
18 going to save money, which is not a bad thing, if the
19 money can then be better spent, for example making the
20 wards, you know, more staff -- you know, it's good thing
21 if you use the money we're given as best as possible.

22 But it can only release those savings, or in very
23 large part, those savings are staffing savings and they
24 can't be released if it's as well as, as opposed to
25 instead of.

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1 Q. You add this at paragraph 9.49:

2 "... there was an internal contradiction in the idea
3 that the system would reduce 1:1 observations, lower
4 observation levels, and produce faster observation
5 rounds and reduce staffing, as against the
6 implementation of it as an adjunctive rather than
7 a substitute system."

8 Does that pick up again on the point you've just
9 made?

10 A. Yeah.

11 Q. Should -- so if I've understood correctly, there is
12 a disconnect or a tension between, on the one hand,
13 saying the system will save time and money, and on the
14 other, saying it's assistive or adjunctive technology?

15 A. Yes.

16 Q. Should this technology -- this internal contradiction
17 have been identified at an early stage at EPUT, and, for
18 example reflected or considered at an early stage in the
19 business case for Oxevision?

20 A. I do think that a more clear-eyed view of it early on
21 would have revealed that. I think it -- it's so
22 difficult. I wasn't there, and we're all looking
23 backwards with the benefit of hindsight so it's very
24 hard to be confident that this isn't hindsight bias, but
25 I felt that could have been -- that should have been

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1 intervention to save life. And this is something you
2 cover at paragraph 7.14 in your report. This is what
3 you say:

4 "Vital signs tracking could not help with detecting
5 the first signs of self-strangulation or self-harm,
6 allowing for early intervention."

7 First of all, when you say "vital signs tracking",
8 what specifically are you referring to?

9 A. Mm, so it might help if you just -- if you just knew
10 about my very first knowledge and thought about the
11 Oxehealth system, which was when it became available.
12 I thought to myself: this is wonderful, I'm going to be
13 able to detect a patient who is at risk of dying from
14 self-strangulation. At that stage, because of the
15 reduction in ligature points, the self-strangulation
16 deaths were becoming overwhelmingly people who were not
17 using a fixed-ligature point, what do we do? People are
18 dying, how can we stop it? And my initial untutored
19 thought was, because I knew nothing about the system at
20 that stage: there's going to be vital signs tracking,
21 the vital signs will become deranged, an alarm will go
22 off, and we'll run in and save a life, this will be
23 fantastic. And I was roundly disabused of that by my
24 then Director of Nursing, a wonderful woman, who said,
25 "I don't think it will work like that."

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1 apparent earlier.

2 Q. Can we return to the question of vital signs and NEWS2
3 and the utility of taking two of the six measurements.
4 We may have covered most of this already; I just want to
5 make sure we cover every aspect.

6 You have previously said that any measure that is
7 not the NEWS2 must be treated with great caution. We
8 talked about that this morning. And we talked about
9 Oxevision actually just being pulse and respiration
10 measures. And just to be absolutely clear, where we're
11 not dealing, for example, with highly agitated patients,
12 in what circumstances would it be appropriate to check
13 just those two signs and not the other four?

14 A. Well, the first circumstance is where I have them, do
15 you know what I mean, where they're there and I'm
16 looking at them and I use them. But other than that, if
17 I'm designing how to follow up a patient and I'm worried
18 about them, I'm going to use the full NEWS2 because I'm
19 worried about the patient and I've got a validated
20 measure.

21 Q. We've already discussed your point that intermittent
22 observations should not be relied on to detect
23 self-strangulation in time properly to interrupt it.
24 With that in mind, can we come on to consider the role
25 of Oxevision vital signs in facilitating early

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1 And in fact it turns out that your vital signs are
2 just not reliably disturbed when you -- this is
3 a terribly tough subject -- they're just not reliably
4 disturbed when you ligature. They may be, but they're
5 not reliable for that. So that means that even if we
6 were continuously taking a patient's vital signs, we
7 wouldn't reliably know that they were self-strangling
8 and coming to harm from that. That's what I meant by
9 this paragraph.

10 Now, it's a problematic paragraph because at the
11 minute Oxevision doesn't say that it is continuously
12 tracking vital signs, although I think -- it's not
13 licensed to do that, although potentially it has that
14 capability.

15 Q. A couple of points arising there, but let's just stick
16 with the main point for a moment. You say at
17 paragraph 7.16:

18 "... the mechanism of serious harm and death in
19 self-strangulation is not always one that reliably
20 produces detectable changes in pulse --

21 A. Yes

22 Q. -- or even respiration effort sufficiently early in the
23 process before there has been significant injury."

24 Does that provide a little bit more information --

25 A. Yeah.

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1 Q. -- to the point you've just been making?

2 A. Yeah.

3 Q. You've mentioned some form of more continuous tracking

4 by Oxevision, and this is something that I covered with

5 Ms Cozens when she gave evidence last year. But, as I

6 understand it, what that is, it does not produce

7 medical-rated readings. What it is doing in the

8 background is seeking to take pulse and respiration, and

9 acting on the basis of the information it gathers in

10 that way, rather than as the result of a specific spot

11 check by a member of staff.

12 A. (The witness nodded).

13 Q. So I'm not sure to what extent that mirrors the kind

14 of -- is it continuous monitoring that you have in mind,

15 and you explain in some detail in the report?

16 A. Yes. So my hope was based on two wrong hopes. One,

17 that there would be reliable tracking, which there

18 isn't, at the minute, and the other is that were there

19 reliable tracking, it would give one an early warning

20 sign on which one could act and sadly, both of those are

21 wrong. But any doctor offered both of those in a future

22 technology would leap at it.

23 Q. What, if anything, does Oxevision add clinically where

24 physical observations are otherwise required?

25 A. I haven't understood the question.

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1 got that a bit more -- you'd be moving. High pulse

2 rates, people can be very agitated, you know, you can

3 tick along at a very high rate, it's not so important.

4 With respiratory rate, the two things that interest

5 you are a progressively falling or a progressively

6 rising respiratory rate, and there again, from memory,

7 it's low and high, you're already quite worried, if you

8 saw it moving progressively. Now, somebody can breathe

9 quickly for lots of reasons but the reason why we're

10 interested in a rising respiratory rate is that it's one

11 of the cardinal signs of sepsis, of the NEWS2, it is the

12 one that most reliably reflects sepsis. And I'd quite

13 like to take somebody's temperature, but as I say, you'd

14 look for a sequence of measurements and you wouldn't --

15 so the extreme range isn't terribly worrying to me, the

16 fact that it drops out of those ranges.

17 THE CHAIR: Thank you.

18 Thank you.

19 MR GRIFFIN: We've mentioned alarm or alert fatigue. We've

20 heard a little about this in previous hearings. You say

21 this at paragraph 7.51 in your report:

22 "Very frequent alerts with a low ratio of helpful

23 indications to noise provide staff with a behavioural

24 conditioning routine that desensitises them to the

25 alert."

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1 Q. Where you're in a situation with -- you have a patient

2 who is or may be physically unwell, and you're having to

3 conduct the more intensive NEWS2 type of readings, is

4 there anything that Oxevision can add clinically to that

5 scenario?

6 A. I don't think so, because unless you are -- that is all

7 you can do, Oxevision is just your use of last resort.

8 The NEWS2 will give you pulse and respiration, because

9 I'm going to go and stand next to the patient and take

10 their pulse and watch the rise and fall of their chest.

11 THE CHAIR: Can I ask you, what's your view on the effects

12 of this, the fact that as I understand it -- I could be

13 wrong -- it only takes vital signs readings within

14 certain parameters? In other words, extreme highs and

15 lows mean you don't get a reading out of vital signs?

16 A. So it's ... it depends -- we're talking about purely

17 physical health monitoring, my view is the only

18 situation in which that's helpful is where I can't do

19 anything better by way of taking more readings, and I'm

20 just looking at what Oxevision has given me, and I may

21 be looking at 15-minute readings or maybe more frequent

22 readings, the high and low ranges, with the exception of

23 pulse, I'll come back to, but the low range of pulse,

24 you'd be very worried long before you hit Oxevision's

25 low range -- I mean very worried, and you'd hope you'd

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1 Is that your succinct way of describing alarm or

2 alert fatigue?

3 A. Yes, I'm attempting to explain that this is really low

4 level. It's actually really difficult to reverse.

5 Conditioning routines act almost below consciousness.

6 Q. I'm coming to the end of my questions on this section.

7 You say, in the executive summary at the start of

8 the report, that you suggest that the benefits from the

9 technology are limited.

10 A. (The witness nodded).

11 Q. And later, in Section 7, you say you suspect "that with

12 current capabilities, VBPMs will have its best uses in

13 specific niches".

14 A. (The witness nodded).

15 Q. Where do you end up now, on the role of VBPMs, and

16 Oxevision in particular, in mental health inpatient

17 units?

18 A. My own view is that, in a normal inpatient ward, it's --

19 I would have difficulty going to a board and saying

20 I want to spend all that money. If I arrived -- so, you

21 know, if I was going to -- at a board meeting and

22 somebody said, "Shall we install it?" I'd say, "It's

23 very expensive, I'm not sure it's going to justify its

24 cost." If I arrived on a ward and it was installed and

25 somebody said, "Well, shall we turn it on, then?", I'd

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1 say, "Well, let's talk to individual patients about
2 whether it would contribute to their care because I can
3 see ways in which patients might feel safer with it,
4 want to use it in a particular way."

5 But I'd be surprised if the majority of the patients
6 on the ward would be using it.

7 **Q.** So I just mentioned something you say in the report
8 about the technology having its best uses in specific
9 niches. Are those the kinds of settings that I was
10 talking to you about --

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

12 **Q.** -- or is it something else?

13 **A.** No, it's those settings where you've got either you
14 can't go and see the patient -- go into the room with
15 the patient, that's one setting; and other setting is
16 potentially in the 136 suite, where you can't see the
17 patient.

18 **MR GRIFFIN:** Thank you.

19 Chair, I'm moving on to a new area of questioning.

20 This might be a convenient moment for a break. May

21 I suggest that we return at 2.50, please. Ten to three.

22 **THE CHAIR:** Ten to three. Thank you.

23 (2.35 pm)

(A short break)

25 (2.52 pm)

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1 showed that four EPUT wards went live with Oxevision in
2 2020.

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

4 **Q.** I assume those are the pilot wards?

5 **A.** Yes.

6 **Q.** Twenty-six in 2021, although my recollection is that
7 Mr Trent said there may be a little bit of double
8 counting there, so it may not be quite as high, but in
9 excess of 20 wards in 2021, six in 2022, and none in
10 2023, and seven in 2024. But we can see that there was
11 a peak following the pilot in the year 2021?

12 **A.** Yes.

13 **Q.** I just wanted to say that by way of background.

14 You point in the report to a number of potential
15 benefits identified by EPUT in its consideration of
16 Oxevision. I'd like to look with you now at an early
17 EPUT document considering those benefits.

18 Would you put up EPUT020830 at page 18.

19 This is from -- so what it should be, EPUT020830, at
20 page 18. Perfect. Thank you.

21 So this, Dr Denman, is from a report to the Board of
22 Directors on 30 October 2019 and we can see this:

23 "In addition, an exciting innovation project due to
24 be piloted during Q3 within the Trust, is Oxehealth.
25 Oxehealth's Digital Care Assistant ..."

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1 **THE CHAIR:** Mr Griffin.

2 **MR GRIFFIN:** Dr Denman, we're moving into the last area
3 that I want to ask you questions about, and it's
4 Section 9 of your report: the implementation of
5 Oxevision at EPUT.

6 Now, at the start of your evidence I said that you'd
7 be considering things from the point of view either of
8 a competent psychiatrist or a Medical Director. Is it
9 right that for this section, you have your Medical
10 Director hat on?

11 **A.** Yes.

12 **Q.** Thank you.

13 For the purposes of considering the implementation,
14 have you reviewed a range of material, including witness
15 statements, policy documents, and procedures, and
16 contemporaneous documents from the Trust Board its
17 subcommittees, and a specific project board set up in
18 connection with Oxevision?

19 **A.** Yes.

20 **Q.** Is the specific board the Oxehealth Project Board?

21 **A.** Yes.

22 **Q.** Can we start by considering the initial implementation
23 and scale-up of Oxevision at EPUT, please.

24 Now, by way of context, when Mr Trent of EPUT gave
25 evidence a year ago, we looked at a document which

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1 Now, we understand that's another name for what was
2 to become Oxevision.

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

4 **Q.** "Oxehealth's Digital Care Assistant is an innovative
5 solution improving safety and experience on inpatient
6 mental health wards."

7 Just dropping down in that paragraph we can see:

8 "It supports ward staff working on inpatient wards
9 and has been proven to reduce patient [safety] risks as
10 well as enable a better patient experience relating to
11 better sleep, feeling safer and a greater sense of
12 privacy at night."

13 **THE CHAIR:** Mr Griffin, it refers to improving or reducing
14 patient risks, not patient safety risks.

15 **MR GRIFFIN:** Thank you very much.

16 I'm going to go back:

17 "It supports ward staff working on inpatient wards
18 and has been proven to reduce patient risks as well as
19 enable a better patient experience relating to better
20 sleep, feeling safer and a greater sense of privacy at
21 night."

22 "In addition, the Digital Care Assistant provides
23 staff with objective data for reporting purposes, to
24 learn from serious incidents or near misses, for
25 auditing/assessment purposes. A number of NHS Trusts

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1 have deployed the Digital Care Assistant in seclusion
2 rooms to increase physical health monitoring, especially
3 post-rapid tranquilisation to reduce restrictive
4 interventions and improve adherence to physical health
5 monitoring policies. The Digital Care Assistant also
6 alerts to 'no activity' in an occupied seclusion room,
7 alerting staff earlier to potentially life-threatening
8 incidents."

9 So can we see here, Dr Denman, the claimed benefits
10 of the system appear to be wide, as expressed here,
11 extending from patient risk reduction to patient
12 experience, including at night, and the provision of
13 data?

14 A. Yes.

15 Q. It goes on to say this:

16 "Two reports have been published by NHS Trusts ...
17 on the real-world evidence of the Digital Care
18 Assistant. They state that deploying Digital Care
19 Assistant delivered the following benefits:

20 "33% reduction in falls at night;

21 "56% reduction in A&E demand;

22 "71% reduction in enhanced observations; 7,800
23 clinical hours saved annually;

24 "Staff reported improved patient safety and
25 confidence;

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1 meet them was not set out clearly."

2 This is your assessment of what took place during
3 implementation and at the early stage at EPUT.

4 A. (The witness nodded).

5 Q. Would you explain what you meant by that? "Some
6 clinical needs were identified but the way in which the
7 system would meet them was not set out clearly"?

8 A. So I -- this paper and the potential benefits identified
9 in the board paper are, you know, they set out these
10 effects of the system but it's never said in the system
11 how those effects are achieved.

12 Q. You say, and this is 9.22 in the report:

13 "... whilst some clinical needs were identified, the
14 way in which the system would meet them was not set out
15 clearly."

16 So does that succinctly summarise the point you just
17 made?

18 A. Yes.

19 Q. May I ask you about some more general points you've made
20 about the system's clinical benefits and implementation
21 at EPUT.

22 Before I do that, that can be taken down, thank you.

23 You've said -- this is 9.105 in the report -- that:

24 "... the Trust's enthusiasm for Oxevision was not
25 built on a realistic appreciation of the true clinical

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1 "Carers reported greater peace of mind;

2 "Rated as an example of outstanding practice by the
3 CQC;

4 "Patients reported feeling safer, sleeping better
5 and greater privacy.

6 "The Trust will be piloting this new technology on
7 Peter Bruff ward and Hadleigh ward. The pilot will take
8 place from 3-6 months from the date of commencement."

9 Now, there's reference there to the CQC considering
10 this to be an area of outstanding practice.

11 Chair, we will be hearing, and we have disclosed,
12 a statement from a CQC witness that addresses this point
13 and, in short, calls into question the evidence base
14 that led to that conclusion. But that's a matter that
15 we can address separately.

16 Just dealing with what we've been looking at, we can
17 see, can we, figures showing marked reductions in
18 patient safety incidents and presenting a very positive
19 view in other areas; would you agree with that?

20 A. Yes.

21 Q. Including a saving in thousands of clinical hours
22 annually by a reduction in enhanced observations?

23 A. Yes.

24 Q. Now, you say in the report that "While some clinical
25 needs were identified, the way in which the system would

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1 capabilities of the system."

2 What did you mean by that?

3 A. I think that if ... well, I suppose it's, in effect it's
4 a re-statement of what I've just said: that there were
5 wide claims made for the system's value, but it didn't
6 ever seem to me from the papers that I reviewed that --
7 exactly how those benefits were realised, the mechanism
8 of the realisation of the claimed benefits was ever set
9 out, and I, as a clinician, hoped that I would -- again,
10 this is with the benefit of hindsight -- hoped that I
11 would have looked at those claims and said, "Oh, how
12 does that happen, then?"

13 Q. One of the points you pick up on in paragraph 9.105 is
14 that:

15 "No one suggested that the ability to measure pulse
16 and respiration remotely, while seemingly a plausible
17 thing to do to, actually had little or no clinical
18 utility in a psychiatric setting." [As read]

19 Does that rely on the points that we were discussing
20 before the break?

21 A. Yes.

22 Q. You add this:

23 "Instead, the ability of the system to take pulse
24 and respiration rate readings became an opportunity to
25 check in on patients remotely, which the Trust was then

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1 at pains to prohibit".
 2 Is there anything more you would like to say about
 3 that?
 4 A. If you look through -- so in a way that's looking ahead
 5 quite a long way, but if you look through the way in
 6 which the Trust began to receive the data that it did
 7 receive from the system which was about its use, you saw
 8 very, very frequent uses of the ability to take pulse
 9 and respiration levels. That starts out with people
 10 going: great, people are using the system a lot, it's
 11 fantastic", and then people worry: well, hang on
 12 a minute, what are they using it for? And then the
 13 worry: oh, they're using it -- they're getting those 15
 14 seconds of clear view. Hang on a minute, that's not
 15 what it's meant to be used for. So it takes a while for
 16 that switch to occur.
 17 Q. I'll ask you in a moment about vital signs measurements
 18 and how they are considered at a particular stage in
 19 this process.
 20 One thing I do want to ask you about is an area of
 21 what you've termed to be good practice, which was
 22 setting up the Oxevision Project Board. Would you
 23 expand on that, please?
 24 A. Well, this was a big project. It had -- forgive me for
 25 using Trust speak -- a lot of stakeholder. So there

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1 That's 9.25.
 2 Does that capture the points you've just made?
 3 A. Yeah.
 4 Q. Now, there is one issue that you also address about what
 5 happened to a certain category of membership on that
 6 board. Would you explain what that was, please?
 7 A. So, as is the case with lots of meetings in my own
 8 organisation when I was Medical Director, these
 9 committees suffer what I think are called membership
 10 collapse. So people come to the first meeting, but
 11 there are lots and lots and lots of meetings and so the
 12 membership quickly diminishes down to the sort of core,
 13 interested people, and the problem with this committee
 14 was that the people who stopped coming were the
 15 clinicians, and they tried to address that by having
 16 a clinical group.
 17 Why don't clinicians come? Well, they've got wards,
 18 you know, they've got wards to look -- there's lots of
 19 calls on their time. And there may also have been at
 20 the early stages quite a lot of technical discussion,
 21 clinicians tend to be a bit short-tempered about
 22 discussions over wiring, and -- sort of geeks like me
 23 would have been interested but perhaps not the average
 24 working clinician.
 25 They tried to deal with that by setting up

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1 were a lot of interested individuals. It brought
 2 together both highly technological issues. The system
 3 requires, bluntly, a lot of wiring, just to start with,
 4 and sends a lot of data down line. So there was that,
 5 there was the need for clinical involvement, and
 6 I thought that a steering group that had all the
 7 relevant individuals was a good idea, regular
 8 governance. That seemed to me to be a great way to do
 9 it, and the initial proposed composition of the board
 10 seemed to me to have all the relevant individuals in it
 11 with the one exception of a service user and carer
 12 involvement, which it didn't have, but just to say that
 13 that's coming in during the period that this is
 14 introduced, but universal service user and carer
 15 involvement at Trust committee meetings would have not
 16 been completely widespread through the period of
 17 implementation, and also, we need to remember that,
 18 actually, quite a bit of the rollout of the system
 19 happened during the Covid pandemic.
 20 So just, you know, there would have been issues of
 21 who could do what.
 22 Q. You say:
 23 "I consider that the construction and anticipated
 24 membership of the Project Board was consistent with good
 25 practice in rolling out the system."

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1 a clinical group but it never seems to me to have really
 2 got under way, that group.
 3 Q. You say in the report that after the first board
 4 meeting, there was almost no medical attendance.
 5 A. Yeah.
 6 Q. What are the potential repercussions of that at EPUT
 7 when it comes to rolling out this technology?
 8 A. I think there's at least a chance that if there had been
 9 more doctors there, somebody would have put their hand
 10 up and said, "Hang on, I think we've got an issue on
 11 consent."
 12 Not because doctors are particularly perspicacious
 13 but because they'd have done some surgical -- do you see
 14 what I mean? They'd have seen some consent forms being
 15 signed and have thought about it. I think that more
 16 clinicians being present, somebody would have put their
 17 hands up and said, "I think some patients are going to
 18 worry about this because ..." and that's what I'd have
 19 hoped for from a clinician.
 20 Q. To what extent do you think longer clinical membership
 21 or attendance would have identified issues, for example,
 22 about the potential narrowness of what the vital signs
 23 function was delivering?
 24 A. The reason I haven't immediately pointed that out,
 25 I think they would have done, but I'm also aware, as

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1 I said this morning, is that my view is controversial
2 and don't want to sort of skew it all over that way
3 because my position isn't a standard one, but I think
4 somebody would have said, "Yeah, okay, cool but, you
5 know, that's quite a big sledgehammer to crack maybe not
6 such a massive nut."

7 **Q.** You have also said just before the break that perhaps
8 the strongest argument -- I'm sorry, I'm paraphrasing so
9 please correct me if I've got this wrong, but perhaps
10 the strongest argument for the deployment of Oxevision
11 would be in niche areas?

12 **A.** Yes.

13 **Q.** Now, do you think that is the kind of issue that might
14 have been identified at an early stage if there had been
15 more of a clinical attendance at these meetings?

16 **A.** You could really hope that a clinician present would
17 have said, "Well, I'm not sure about my ward but hang on
18 a minute, I know that Dr X would be very interested, let
19 me been him along, yeah, or her along."

20 **Q.** One of the areas where there's been concern, and you
21 address this in the report, is in relation to consent.
22 Now, we've addressed that already so I don't want to go
23 over that with you again.

24 You also have said this, this is paragraph 9.29 of
25 your report:

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1 staff explained that the system measures their vital
2 signs and this was accepted, only a couple of very
3 unwell paranoid patients have questioned this but once
4 they were more settled they were accepting of the system
5 and [an individual] reported that patients were feeling
6 more assured and safe with the system."

7 As I've said, this is from July 2020. What do you
8 think about the response in this paragraph to concerns
9 being raised by patients and the way they're addressed?

10 **A.** So I think it's an example in the records of a point
11 where there are -- there are worries raised about some
12 harms from the system, and it's presented in a way that
13 says, "But in fact it's settled."

14 The bit of the paragraph that sits uncomfortably
15 with me is "only a couple of very unwell paranoid
16 patients have questioned this but once they were more
17 settled they were more accepting of the system", which
18 makes me worry about when they weren't more settled. Do
19 you see what I mean? It's quick to say that they
20 settled and they were more accepting of it, but when
21 they were very unwell, was that part of them being very
22 unwell? That's what worried me about that paragraph.

23 **Q.** Just on that point, are you concerned by the
24 characterisation of objections from some patients as
25 associated with their mental health or paranoia?

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1 "... there was mention of possible harm from the
2 system because some patients who were very unwell had
3 questioned it."

4 And I want to consider that with you now by looking
5 at a document, please.

6 Could you put up a minute of the Oxehealth Project
7 Board from the 2 July 2020, this is EPUT020904 at
8 page 2. Thank you.

9 So just reading from this paragraph:

10 "Feedback from the patient groups in respect of the
11 new technology, as well as staff, was that there was
12 some apprehension initially and patients reported that
13 they were fearful of the videoing but staff have been
14 honest with the patients and they have taken this on
15 board -- they are already aware of the CCTV on the ward.
16 And once the new system was explained to the patient
17 there were more accepted."

18 As it says there.

19 So the suggestion here, as I understand it,
20 Dr Denman, is that the patients are more accepting once
21 certain matters are explained to them; would you agree
22 with that?

23 **A.** Yes.

24 **Q.** It goes on to say this:

25 "Patients were conscious of their privacy but the

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1 **A.** Oh no, I wasn't worried that the patient's view was
2 being dismissed because they were psychiatrically
3 unwell; I was worried that people said, "Oh well, when
4 they're a little bit more settled they don't mind it so
5 much" and I'm thinking: but hang on a second, they did
6 mind it when they were very unwell. We've got to worry
7 about that, because when you're very unwell, the last
8 thing we want is for you to be minding something that
9 might make you feel worse.

10 **Q.** You say this at 9.29 in the report:

11 "I think that the board was too easily satisfied
12 that all was well at this point."

13 **A.** Yes. I think, I'd have hoped that ears pricked up and
14 somebody said, "Ah, we need to get a handle on this.
15 Let's measure it" or, you know, "Let's try and document
16 any harms."

17 **MR GRIFFIN:** Would you take that down, thank you.

18 **THE CHAIR:** Sorry, can I just ask one question about that.

19 **MR GRIFFIN:** Can you put it back up?

20 **THE CHAIR:** Sorry. There seems to be a distinction between
21 CCTV on the ward and the NEWS system being explained to
22 patients.

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

24 **THE CHAIR:** As I read that, there's a distinction between
25 CCTV and the NEWS system on the ward?

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

2 **THE CHAIR:** Which is a little troubling because it sort of

3 skirts over the fact that there is a CCTV element to

4 this.

5 **A.** Oh, maybe -- so it would be -- need to be clarified but

6 I think my understanding is that common areas of the

7 ward have CCTV installed on them, and that that would be

8 of order of magnitude different from a camera in your

9 bedroom.

10 **THE CHAIR:** Yes, but nonetheless, the camera in the bedroom

11 is recording.

12 **A.** Yes, I agree with you and --

13 **THE CHAIR:** And there seems to be a suggestion that there

14 is --

15 **A.** It's not --

16 **THE CHAIR:** -- a significant distinction between this system

17 and the CCTV.

18 **A.** Yes, I think that's fair.

19 **THE CHAIR:** Yes. Thank you.

20 **MR GRIFFIN:** Thank you very much, would you take that down,

21 please.

22 Dr Denman, Oxevision Project Board minutes of

23 14 February 2020 record that staff remained not entirely

24 clear on how the system operates but that once it gets

25 started, "it will become clearer". They also record

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1 **A.** Yes.

2 **Q.** I want to move on now to the issue of evaluation,

3 please. You raise in your report your expectation that

4 there would have been built-in evaluation from before

5 the deployment of the system against a pre-specified set

6 of parameters.

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

8 **Q.** Would you expand on that, please?

9 **A.** Yes. This is a pilot and so we're going to take

10 decisions based on it so we need to have a way of

11 extrapolating from the pilot to say "Well, what decision

12 are we going to take and on what parameters will it

13 depend?"

14 And the right way to do that is to start by asking

15 what you're going to measure, set up the measurement

16 process, then implement the pilot, do some measuring,

17 and generally you incorporate an early stop in case

18 you're doing harm. Or indeed an early go, in case it's

19 so fantastic that you absolutely want it to go on. But

20 you do need to start with what you're going to measure

21 and set in place the mechanics for doing the measuring

22 before you start implementing the system.

23 **Q.** Let me see if I've understood. So the process would be

24 set up the built-in evaluation at the start?

25 **A.** Yes.

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1 that:

2 "Medical input needs addressing, behaviours need to

3 change."

4 Again, in inverted commas.

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

6 **Q.** You also, in your report, refer to an example from

7 implementation in EPUT of a staff member who thought the

8 system would give an alert if the patient stopped

9 breathing --

10 **A.** Mm.

11 **Q.** -- which was not true. And we as an Inquiry, have heard

12 from Ian Arthur, who was a matron on the Peter Bruff

13 Unit, when Oxevision was piloted on the ward in 2020.

14 In his evidence to the Inquiry, Mr Arthur told the Chair

15 that Oxevision can measure a patient's oxygen

16 saturations. Now, is that correct?

17 **A.** No.

18 **Q.** Would you agree that that's a basic misunderstanding of

19 the system which could actually be dangerous for patient

20 safety?

21 **A.** Yes.

22 **Q.** Would you agree that all of what I've just set out for

23 you suggests that the technology was being implemented

24 before staff properly understood how the system

25 operated?

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1 **Q.** Hold the pilot?

2 **A.** Yes.

3 **Q.** Then assess the results from the pilot against the areas

4 that you've identified at the beginning?

5 **A.** Yes, ideally you say at the beginning what your outcome

6 criterion is.

7 **Q.** Is that what happened at EPUT with the rollout of

8 Oxevision, as far as you've seen in the documents you've

9 reviewed?

10 **A.** No.

11 **Q.** You refer in the report to a benefits realisation plan.

12 For example, at 9.43, you say:

13 "The discussions in the board quite often mention

14 the construction and deployment of a 'benefits

15 realisation plan' ..."

16 What do you understand a benefits realisation plan

17 to be?

18 **A.** It -- well, in this case -- so a benefits realisation

19 plan is often a financial thing which the boards see

20 when an investment of some sort is planned or a change

21 of some sort is planned, and will it bring the benefits?

22 The benefits don't have to be financial benefits; they

23 can be clinical benefits or operational benefits. It

24 has -- carries the cast of justification. In other

25 words, how are we going to realise all the good -- how

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1 are we going to make sure we get all the good things
 2 that we hope we're going to get? So it has more of
 3 a justificatory feel to it than an evaluatory feel to
 4 it. Are we going to get benefits?
 5 If you see what I mean.
 6 Q. So we've got in the papers which you've probably seen
 7 the first draft of a benefits realisation plan at EPUT
 8 from June 2020, where the objective is given as this:
 9 "To evaluate the clinical operational and financial
 10 benefits of the Oxehealth Digital Care Assistant."
 11 A. Yes.
 12 Q. Does that pick up on what you were just saying?
 13 A. Yes.
 14 Q. Now, was one created at EPUT, a plan, as far as you're
 15 aware?
 16 A. So I've seen it a benefits realisation plan, it's a
 17 spreadsheet-type document that formed part of the papers
 18 I was shown. What I don't see is anything else other
 19 than that --
 20 Q. So you say --
 21 A. -- document.
 22 Q. -- in the report that one was constructed but seems
 23 never to have been followed through?
 24 A. Yeah.
 25 Q. Are you aware of other discussions about more detailed

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1 the observance. So I wouldn't -- you know, I wouldn't
 2 want anyone to think that my own house was well tidied
 3 in this regard.
 4 Q. Well, we'll come on in a moment to see exactly what
 5 happened at EPUT but you also say this at
 6 paragraph 9.54:
 7 "The issue of gathering effectiveness data was also
 8 discussed fairly often, but mainly from the perspective
 9 of trying to gather support for the efficacy of the
 10 system rather than in relation to a balanced
 11 evaluation."
 12 Is that correct?
 13 A. Yes.
 14 Q. I'd like to look at some further minutes with you now,
 15 please.
 16 Could you put up -- these are minutes from
 17 24 November 2021. Thank you.
 18 So what we see here are minutes of the Board of
 19 Directors meeting. This is part of a presentation about
 20 Oxevision in relation to the four pilot wards.
 21 So can we see here:
 22 "RH acknowledged the very positive initial findings
 23 and the encouraging reduction in assaults recorded. RH
 24 queried whether statistical analysis had been applied to
 25 understand the significance. DB confirmed that overall

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1 evaluations at EPUT during the implementation?
 2 A. So the Project Board come back repeatedly, they circle
 3 repeatedly around the "We need to get some evidence,
 4 we're generating data, we need to think about the data
 5 we're generating", and I may have this wrong, but from
 6 what I could see, various moments arrive when data has
 7 to be produced for some purpose and at that point quite
 8 quickly data is got together, and produced for that
 9 purpose, a board meeting or something like that.
 10 The point at which a much more serious and, of
 11 necessity, rather slow process starts is when university
 12 and EPUT go into partnership to do some formal research
 13 but that's rather later on, and I've not seen -- I mean,
 14 research takes a long time to do, and you have to wait
 15 for its outcome.
 16 Q. You say in the report that:
 17 "There are discussions of more detailed evaluations
 18 but these do not seem to have been implemented with any
 19 consistency."
 20 A. Yeah. I would perhaps add there, but for the grace of
 21 God, I've sat on -- you know, I've rolled out things in
 22 my own organisation with that -- please don't imagine
 23 that this -- this is quite common. Everybody says the
 24 right way to do it is to set up the evaluation first.
 25 It's very often honoured in the breach rather than in

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1 the data that underpins the results was reliable.
 2 However, further data would be required to show
 3 statistical significance."
 4 Now, DB was Oxevision's then Head of Insight and
 5 Benefits Realisation. So there was Oxehealth
 6 involvement at this stage. Do you understand there the
 7 difference between data both being reliable but not on
 8 its own enough to show statistical significance.
 9 A. No.
 10 Q. We can see:
 11 "AG advised that the system had now been rolled out
 12 across the mental health bed base and it was important
 13 to continue to learn to see what benefits it brings in
 14 a quality and safety space and so it is important to
 15 continue to explore where we can take this system."
 16 Do you have any -- that person, AG, is an EPUT
 17 executive. Do you have any view about the approach
 18 being advocated there? So "to see what benefits it
 19 brings and to explore where we can take the system"?
 20 A. I guess my concern, it's my overall concern, which is
 21 that it seemed to me that people wanted this system to
 22 be good and they were looking for evidence that it was
 23 good rather than starting out from the position of
 24 equipoise and going -- well, "good" is perhaps the wrong
 25 word. They wanted it to be achieving various goals,

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1 they looked for evidence that it was achieving those
2 goals. When they were doubtful about whether they'd
3 found that evidence, they tended to question the
4 validity of the evidence rather than -- do you see what
5 I mean? They tended to -- rather than to worry that the
6 goals weren't being met. When they found evidence that
7 they thought that the goals were being met, they tended
8 not to question too much whether that was real evidence.

9 **Q.** Jumping to near the end of your report you say this
10 about evaluation, this is paragraph 10.7:

11 "The implementation of the Oxehealth system had, at
12 the time it was being introduced into EPUT, already been
13 associated with research in Oxford ... implementation in
14 EPUT could have built on this and the wide dissemination
15 of the Oxehealth system nationally also represented
16 a missed opportunity for a multi-centre trial."

17 Now, I think you started to discuss this already:

18 "The oversight and ethics processes associated with
19 research offer considerable protections when innovative
20 practices are being developed, and had the opportunity
21 been taken, we would, by this stage, have had much more
22 helpful data both about the system and about
23 observations in general than we currently possess."

24 Now, you've said that research can take a long time,
25 but is there anything more you'd like to say about that?

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1 you do, the costs of organising it and setting it all up
2 and the machinery to do so is funded.

3 **THE CHAIR:** And again, would that suggest that perhaps it is
4 better done on a national scale by some national body?
5 I'm not saying that that national body exists or who
6 that might be, but an innovation that's going to be
7 rolled out to a very significant number of mental health
8 Trusts, should it really be left in the hands of one
9 Trust to justify its existence?

10 **A.** Certainly not one Trust, but a university or a group of
11 universities. I'd be -- I think you'd need evidence
12 from a clinical academic to tell you about the pros and
13 cons of national bids for money and -- you know,
14 national organisations like the King's Fund or the
15 Wellcome Trust who would perhaps be sponsors of that
16 work, rather than a jobbing clinician like me, not from
17 an academic background, because I suspect that a serious
18 academic will say, you know, will tell you all sorts of
19 detail would be really helpful.

20 **THE CHAIR:** Thank you.

21 **MR GRIFFIN:** I'd like to pick up one further point with you
22 connected with evaluation, please. You say this in your
23 report 9.77:

24 "Although the minutes of the Oxehealth Health Board
25 noted in July 2020 that there were very high numbers of

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1 **A.** I suppose the extra point I'm making here is that
2 anybody who's ever done medical research knows the
3 mighty size of a research ethics application, and the
4 degree of scrutiny that such applications are put to,
5 and indeed, for a multi-centre trial, an EMREC
6 application is an even mightier document. Those
7 processes, hugely bureaucratic and difficult though they
8 are, are very protective. The whole function of them is
9 that research should do no harm, and should generate
10 meaningful knowledge.

11 **THE CHAIR:** Does that suggest that it might be beyond the
12 capabilities or might be beyond what we ought to be
13 asking of an individual Trust, and that the
14 responsibility for that sort of evaluation ought to lie
15 elsewhere, or with a number of organisations?

16 **A.** I suppose that my hope was that Oxford University, which
17 had been part of the original research, would have --
18 I would have hoped -- reach out to them and say, "Look,
19 it's going round the country, shall we try and do
20 a multi-centre on this one?"

21 **THE CHAIR:** Yes.

22 **A.** The difficulty in this sort of work is that it's
23 expensive. You've got to get money for it. And so
24 you'll be competing with a load of other people looking
25 for national money, you may or may not get it, but when

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1 daily vital signs attempts, this was interpreted as
2 a positive finding, and not viewed with any concern
3 until January 2025, when the worry that this high usage
4 might represent staff using the vital signs function to
5 observe patients and check on them rather than take
6 a vital signs reading surfaced."

7 Does a high number of uses demonstrate anything
8 about whether Oxevision was being used appropriately, or
9 whether it produced clinical benefit?

10 **A.** If I've got a ward and I'm observing patients, then
11 I can set an upper limit on the number of vital signs
12 attempts by multiplying the number of patients by, let's
13 say, the highest number of vital signs attempt, that
14 would be everybody having their vital signs, say,
15 measured every 15 minutes -- I'm not saying that's what
16 would be happening -- and maybe doubling it for some
17 fails. So it would be mathematically possible to say if
18 a ward is doing more than this, they're definitely not
19 maybe using the system accurately or maybe using the
20 system for some purpose other than what's intended.
21 I don't think it occurred to the Oxevision Health --
22 that point occurred to the Oxevision Health Board.

23 And I'm not especially critical. It's kind of easy
24 to see, that one's easy to see in hindsight. But with
25 foresight I suspect I, too, would have fallen down the

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1 hole of thinking: great, they're using it a lot.
 2 It's quite a sharp point to say: oh hang on, wait
 3 a minute, they're using it too much.
 4 **Q.** You say:
 5 "It would have been good practice to involve
 6 patients and carers in the initial planning and
 7 deployment of the system and in its implementation and
 8 evaluation."
 9 I think, again, this is picking up on a point you've
 10 touched on. To what extent do you say or think they
 11 were involved at EPUT?
 12 **A.** So the Trust did a number of surveys of patients,
 13 I think meetings with patients, focus groups with
 14 patients, when they were gathering data. I never got to
 15 the bottom of how those groups were put together or who
 16 -- you know, what consent the patients gave, or what --
 17 or whether they knew what was happening to their data.
 18 But actually you just get a much better outcome for this
 19 kind of thing if you find some patient representatives
 20 and you have them in the meetings.
 21 And I think they will quickly surface things that
 22 you wouldn't notice, or would take you a while to
 23 tumble to.
 24 **Q.** You say in the report at 10.8 that:
 25 "... with the benefit of hindsight, it seems very
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1 there are -- you know, obviously sleep is a good thing.
 2 Had one-to-one observations been reduced in a way that
 3 was safe and helpful, that would have been less
 4 restrictive. But having a camera in your room looking
 5 at you, having staff able to view you remotely, that is
 6 a restriction on you. Sitting in room with a camera,
 7 you think, you know, simple things like: can they see me
 8 pick my nose? And that's really embarrassing and do you
 9 know what I mean, it feels bad instantly when you say it
 10 to yourself, but that -- I think people didn't put
 11 themselves in a room with a camera looking at them.
 12 That's what, I think.
 13 **Q.** What would a co-production have looked like in practice?
 14 **A.** When these systems are well developed, there is a body
 15 of patients who have taken interest in being -- they're
 16 variously named, experts by experience. There would be,
 17 first of all, both offered support from the Trust. So
 18 they're patients. They need support. They were asking
 19 them to do something for us, there would have been
 20 a structured method of support. There would hopefully
 21 have been some funding for patients at the very least
 22 for transport but also hopefully for their time, and
 23 ideally also some training for patients. There's no
 24 reason -- because you want them in the committee
 25 meetings, and there's no reason why a patient or an
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1 likely that had co-production been built in from the
 2 start, many of the problems that were later encountered
 3 might well have been foreseen ..."
 4 What did you mean there?
 5 **A.** Well, I suppose I guess the rest of the paragraph,
 6 patients -- the -- the very first thing the patients
 7 would have asked is "Who will see me? Can I turn it
 8 off? Does that mean a nurse won't come and ask how
 9 I am?" Just because those would be the immediate
 10 thoughts of a patient. And it just takes -- if you're
 11 not there experiencing it, it'll take you a while to
 12 tumble to that.
 13 **Q.** You say this at 9.45:
 14 "The case made for scaling up the system in
 15 September 2020 focused on less disturbed sleep, which
 16 was patient centred, and on the potential for reduction
 17 in 1:1 observations which would have been less
 18 restrictive if it was capable of being delivered."
 19 But you say this:
 20 "There was no suggestion that the use of VBPMs was
 21 itself a restriction."
 22 **A.** Yeah.
 23 **Q.** Would you expand on the significance of that, please?
 24 **A.** Yes, of course. So I was asked, was it patient-centred
 25 care and was least restriction considered? And, and
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1 expert by experience would know anything about Trust
 2 committee meetings or structures. So they need help to
 3 understand the context. But then they are full members
 4 of the committee and are able to see all the papers,
 5 able to comment and contribute to the discussion.
 6 By turn, we ask them to widen their vision just
 7 a little bit from themselves and to think of their, you
 8 know, to think of patients in general rather than just
 9 their patient experience. So it's a bit of a hybrid
 10 role, and it takes a little while to develop, but
 11 ideally in a Trust you have a group of people who fulfil
 12 that role and have some experience in doing so.
 13 **Q.** Thank you.
 14 I'd like to look with you now at your recommendation
 15 concerning evaluation and patient involvement.
 16 Could you put up the report at 131 and expand the
 17 recommendation under 10.8. Thank you.
 18 So it says this:
 19 "Where a new form of healthcare is being delivered
 20 that is not explicitly already recommended in the
 21 relevant guideline or national policy there should be
 22 both patient involvement at the earliest planning stage
 23 and there should be at least audit and evaluation and
 24 ideally formal research set up before implementation
 25 begins."
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1 I think that picks up on a number of points you've
2 already made, Dr Denman. Is there anything further
3 you'd like to say, specifically in light of the way
4 you've articulated the recommendation here?

5 **A.** Yes. I'm trying to square the circle again between the
6 fact that there are a whole range of innovations in
7 healthcare, single-sex wards, assertive outreach teams,
8 early intervention services, all sorts of innovations
9 whose underpinning ranges from formal, high-powered,
10 university-delivered research through to little more
11 than "We think it's a good idea that ..."

12 And we have to somehow make sure that what we do is
13 proportionate against the potential risk of an
14 intervention and its potential benefits, that protects
15 patients and delivers those benefits without freezing
16 the system in such aspect that nothing gets done. And
17 so I tried to cast a recommendation that looks at
18 grading up the seriousness of what you're doing, but
19 says the Trust will want to introduce things that are
20 not already in a -- in a guideline or national policy,
21 and how could this be done safely? So it's a bit
22 soggy worded but the idea being that you step up the
23 amount of oversight and evaluation as what you do
24 becomes more -- both larger and more serious.

25 **Q.** Thank you very much.

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1 So we can see there the background to the following
2 paragraphs about which I want to ask you some questions
3 about:

4 "The EOC discussed at length the impact of an early
5 implementation rather than waiting for the completion of
6 a more detailed review of the benefits of this system
7 that would be derived from analysis of all 4 pilot wards
8 over an extended period followed by the completion of
9 a full business case. This would delay the start of the
10 implementation until April 2021.

11 "However, as there was potential for safety
12 advantages to be gained for the trust through an early
13 implementation, the EOC agreed that, on the balance of
14 probabilities, the rollout should occur as soon as
15 possible as early results from the pilots plus evidence
16 provided by other NHS organisations gave sufficient
17 confidence that the risk of this investment was
18 minimal."

19 Now, the situation at this stage, as I understand
20 it, Dr Denman, but please tell me if you disagree, was
21 that the Trust had heard back from two of the four pilot
22 wards but not from the remaining two yet. And so what
23 was being suggested here was not to wait for analysis of
24 information from all four wards, but to press on with
25 rolling out Oxevision on the basis of the information

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1 Would you take it down, please.

2 You refer in your report to "EPUT consideration of
3 the Oxevision system, and that the Trust board was told
4 that the benefits of the system were so great that the
5 rollout should occur as soon as possible before the
6 completion of a more detailed review."

7 That's paragraph 9.34.

8 I'd like to consider that now, please, with you.

9 And I want to ask for a document to be put up, please,
10 EPUT020827, page 2. Thank you.

11 This is from a report to the board of directors for
12 30 September 2020, Dr Denman. The board was being asked
13 to consider a recommendation for the further rollout,
14 purchase and installation of Oxevision.

15 Just looking at part of what we have on the screen,
16 the EOC, I understand that's the Executive Operation
17 Committee -- previously agreed funding for four pilots,
18 for pilots on four wards, and we can see the four wards
19 there, and that the Oxevision system was installed in
20 the bedrooms there, and it goes on to say this:

21 "The findings of the pilot wards and additional
22 information on benefits gained by other organisations
23 were provided to the EOC. As a result of these
24 findings, the EOC agreed to support a recommendation to
25 roll out this product to a further 13 additional wards."

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1 from the two. Is that your understanding as well?

2 **A.** Yes.

3 **Q.** Can we see here concern of delay, to April 2021, arising
4 from a fuller review?

5 Now, do you think that there is anything significant
6 about that date, April 2021?

7 **A.** Well, I've taken an oath. It's the start of a new
8 financial year. I don't know whether -- that was, I'm
9 afraid, my instant thought when I saw that date.

10 **Q.** We have documents showing that Paul Scott, EPUT's then
11 CEO, reported to the Board of Directors for its
12 November 2020 meeting, so shortly after these minutes.
13 He referred to an Oxehealth Project Board with executive
14 oversight, which will "ensure that this initiative is
15 delivered at pace with an ambition to complete the
16 programme of installation within this financial year."

17 So might that provide some support to your
18 instinctive reaction?

19 **A.** Yes. I can understand -- well, Trusts can be under --
20 can be in the situation of having money available to
21 spend before the end of the financial year, which they
22 may lose, if they do not spend it, because the centre
23 will claw it back. It's not stupid to spend the money
24 on things you think are a good idea, but it may be
25 difficult to say that explicitly.

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1 Q. The minutes go on in this way -- sorry, this is the
 2 report to the Board of Directors, as I've said, not
 3 minutes:
 4 "In 2019/20 additional bank and agency shifts booked
 5 for observations on these 17 wards totalled nearly
 6 190,000 hours at an estimated cost [which is there
 7 given]. A reduction in the requirement for additional
 8 staffing should be facilitated by Oxehealth as
 9 identified by other organisations and EPUT pilots.
 10 "Additional system efficiency improvements may be
 11 achievable, such as a reduction in length of stay which
 12 could reduce Out Of Area bed requirements and
 13 a reduction in physical injuries with associated need to
 14 access acute healthcare services."
 15 Can we therefore see here the significant hoped-for
 16 benefits including the reduction in the requirement for
 17 additional bank and agency staffing and the associated
 18 potentially significant financial savings?
 19 A. Yes.
 20 Q. Is it correct that you've reviewed this report?
 21 A. Which report?
 22 Q. The one that we're looking at.
 23 A. Yes, it is.
 24 Q. Did you, when you did so, find any information about
 25 possible harms or risks from a further rollout in it?

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1 funding.
 2 Q. You say this at paragraph 9.103:
 3 "Overall, I consider that EPUT implemented Oxevision
 4 in a somewhat hurried way and certainly rolled it out
 5 without much evidence following a pilot phase."
 6 Do you stand by that now?
 7 A. Yes.
 8 Q. Just by way of conclusion, this is what you say in the
 9 Executive Summary to the report at page 5:
 10 "EPUT's implementation of the Oxevision system
 11 followed enthusiastic reports from other areas.
 12 However, there was never a coherent clinical rationale
 13 for the implementation of the system and evaluation of
 14 its impact. Effectiveness and drawbacks lagged behind
 15 enthusiastic adoption rather than leading it. Patients
 16 were not involved in the development or rollout of the
 17 system or the Standard Operating Procedures that
 18 regulated its operation in the Trust. Often,
 19 presentations at higher levels in the Trust focused on
 20 the system's benefits while minimising the drawbacks."
 21 Does that accurately summarise some of your
 22 principal conclusions in relation to the rollout of
 23 Oxevision at EPUT?
 24 A. Yes.
 25 Q. Is there anything more you'd like to add now?

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1 A. No.
 2 Q. What's your view of the approach advocated in this
 3 report of pressing on and not waiting for further
 4 information from the pilot wards?
 5 A. The board were presented with evidence and the people
 6 who presented them felt this was beneficial, I suspect
 7 they had the funding to do the rollout perhaps, and this
 8 is speculative, worried that they might lose it if they
 9 didn't get on with it.
 10 The difficulty is that even here, in those last two
 11 paragraphs, what's being proposed as the financial
 12 argument for the implementation to my eye requires a way
 13 of using the system which is explicitly not the way the
 14 system was going to be used. That's not entirely --
 15 that's not the whole argument financially. If you look
 16 right at the end, the -- I suspect that the reduction in
 17 length of stay, reduce of out-of-area bed requirements
 18 and a reduction in physical injuries might all link
 19 together. If you're reducing falls, then you're
 20 reducing, you know, you haven't got somebody who has now
 21 got a fractured hip, had to go and have that hip
 22 repaired, has now come back to your ward and is going to
 23 have a much longer stay.
 24 That seems to me to be, you know, an unimpeachably
 25 good thing, but I don't think that's all of that

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1 A. No, I think that's fair.
 2 Q. Dr Denman, this brings us to the final part of your
 3 report in Section 10, containing your reflections and
 4 recommendations.
 5 We've covered most of them already in the context of
 6 other areas, but there is one area I'd like to look at
 7 with you, please. This is at 10.5.3 where you say
 8 technology will advance and we should be ready for that.
 9 You explain, and this is at 10.5:
 10 "... we need to do the work now to understand how to
 11 react as capabilities develop and to develop a framework
 12 which allows for innovation but prevents
 13 untested/unregulated technologies being widely deployed
 14 until there is sufficient evidence of their benefits or
 15 safety."
 16 What did you mean by that?
 17 A. I felt very strongly that a great deal more technology
 18 is coming down the line, that it, at least for me
 19 personally, it was more luck than judgement that I
 20 didn't go "Goody, I'm going to have this in my
 21 organisation." And my organisation could equally have
 22 been enthusiastically rolling out something, and that it
 23 is time, I think, for us to think about technological
 24 innovation in psychiatry, both what could we be doing
 25 that's great and more of it? But also, how can we do it

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1 safely and sensibly?

2 And it seemed to me that the concept of a medical

3 device could be -- could and perhaps should now be

4 expanded to include more things and unless, if you like,

5 pulse measure-y things and more movement, sleep, mood,

6 all sorts of measure-y things. But that needs to be

7 done safely.

8 **Q.** You've made a recommendation accordingly. Could we look

9 at it, please.

10 Could you put up the report at page 130 and expand

11 the top paragraph, please.

12 At page 130. No, page 130.

13 **A.** It's right at the top.

14 **Q.** That's it. Thank you. Can we see there, at the top:

15 "It may be worth widening the scope of Medical

16 Devices Regulation to allow it to cover technologically

17 assisted interventions in mental health that are not

18 currently captured. The current boundaries may not fit

19 well the nature of technologically assisted

20 interventions in mental health as technologies in mental

21 health, a way to validate and regulate them may need to

22 be found. The MHRA is already looking at this with

23 a grant from the Wellcome Trust and the Inquiry could

24 consider linking in with this work."

25 Would you just explain what you meant by all of

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1 They've provided the Inquiry with notice of the areas

2 they wish to cover, and the Inquiry has notified them of

3 the time allocated in which to do so. It will be

4 important for advocates not to stray beyond the agreed

5 questioning, Chair. These questions have been

6 pre-agreed to ensure they cover certain specific areas

7 of greatest assistance to you. I may then have some

8 further questions for Dr Denman, as well.

9 May I suggest a 15-minute break and we resume at

10 4.10?

11 **THE CHAIR:** 4.10.

12 (3.55 pm)

13 (A short break)

14 (4.22 pm)

15 **MR GRIFFIN:** Chair, we now hear questions from advocates on

16 behalf of certain core participants, starting with Fiona

17 Scolding King's Counsel on behalf of LIO.

18 **Questioned by MS SCOLDING KC**

19 **MS SCOLDING:** Good afternoon, Dr Denman. I represent LIO,

20 otherwise known as Oxehealth Ltd for your purposes. I

21 am asking you a series of questions this afternoon.

22 They will jump around a bit so apologies in advance.

23 **A.** Sure.

24 **Q.** The first question I wanted to ask you is about the CQC

25 and NHS guidelines about the use of digital technology,

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1 that?

2 **A.** Yes. Well, what happened was that when I, right at the

3 beginning, when I was asked, you know, "What's the

4 frameworks? What's the guidance?", the MHRA came into

5 view, and Oxehealth has sought MHRA validation or

6 approval for its pulse and respiratory, so that's the

7 obvious place, but when you look at what they cover,

8 it's a very, very machinery-oriented, very --

9 organisation. And so I thought: well, maybe we need to

10 widen the concept of a device to include wearable

11 objects, maybe mobile phone apps, that kind of a thing,

12 device wider. And then, while I was drafting the

13 report, literally again quite by chance, I saw that the

14 Wellcome Trust and the MHRA have already had the idea

15 and have, I think, a three-year project. So it would

16 make, I thought, reasonable sense to find out what

17 they're doing and maybe link in with them.

18 **MR GRIFFIN:** Thank you very much.

19 Would you take that down, please.

20 Chair, I'm at the end of my questions for Dr Denman.

21 Do you have any questions at this stage?

22 **THE CHAIR:** No, I don't.

23 **MR GRIFFIN:** So, Chair, we'll pause now. When we come back,

24 there will be some questions from other lawyers

25 representing some of the Inquiry's core participants.

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1 which I am assuming you have seen and considered as part

2 of your reporting process for --

3 **A.** Yes.

4 **Q.** -- this Inquiry; is that right?

5 **A.** Yes.

6 **Q.** And do you think they strike an adequate balance for

7 individual Trusts to consider whether or not they should

8 use the technology that we've talked about today?

9 **A.** I think they're sensible guidelines. I think that --

10 well, I think I would -- I think that, as I have invited

11 the Inquiry, I think it should be set in the context of

12 there being a range of technologies that are going to

13 come online over the next -- over the coming years and

14 so they need the flexibility to adapt to different,

15 different innovations as they come online.

16 **Q.** Okay. You identified that observations can maintain

17 a patient's privacy when they're unwell or disinhibited,

18 for example from fall reduction or reducing the harm to

19 others, or managing physical health conditions. Do you

20 agree that it is necessary to monitor these in any

21 inpatient mental health setting?

22 **A.** Do you know, I simply haven't understood the question.

23 I'm awfully sorry.

24 **Q.** I'm so sorry, it's probably my way of asking it. So

25 I apologise for that.

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1 Do you agree that it is appropriate for observations
2 to take place where patients are at risk of falls or
3 where they are likely or may cause harm to others?

4 A. Yes.

5 Q. Thank you. You accept in your report at paragraphs 2.9
6 to 2.11 that inpatient mental health care is very
7 focused now around risk management. Is it the case,
8 therefore, that provision should and ought to seek to
9 manage risk, and observations are part of risk
10 management --

11 A. Yes.

12 Q. -- as well as therapeutic intervention; is that right?

13 A. Yes.

14 Q. Thank you.

15 I'm now going to move on to a topic similar to that,
16 which is about risk assessment and risk tools. You
17 identify, and we've heard quite a lot of evidence from
18 you this morning, but it's set out in your report at
19 paragraphs 2.24 to 2.30 that risk tools are not very
20 successful, and your suggestion and your view is that
21 clinicians now use more holistic risk assessments, in
22 particular, trying to reduce the risk of people being
23 able to harm themselves by reducing what's going on
24 around them by way of their physical environment.

25 Is it not the case that observations remotely, which

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1 either make decisions so you may well lack capacity to
2 make decisions about your treatment or your mental
3 health condition may well mean that you are less able to
4 make those decisions for yourself.

5 Do you agree that within mental health care there
6 are often different considerations about autonomy, about
7 the extent to which people have autonomy, when there are
8 safety considerations in play, so that the balance is
9 often struck differently than it would be in our
10 day-to-day lives?

11 A. I certainly agree with that. There are a couple of
12 lines in that balancing picture, so it's not just
13 a question of shades, and maybe the lines are somewhat
14 arbitrary, but we draw a line in relation to whether
15 a patient is detained using the provisions of the Mental
16 Health Act, and we draw a line in relation to whether
17 a patient has capacity to take a decision at the
18 material time.

19 Those lines may be somewhat arbitrary but they're
20 there, if you like, to break up the idea that there's
21 just a uniform balance.

22 Q. Yes, thank you.

23 I wanted to ask, you identify in your report that
24 assistive technologies could be helpful in eating
25 disorder areas, and in areas which particularly treat

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1 could alert staff to unusual patterns of behaviour, can
2 help in risk management in that respect?

3 A. So there's two different things. There's assessing risk
4 and making predictions about what may happen, and then
5 there's managing risk, which is trying to reduce risk,
6 and the key area that we know is helpful in managing
7 risk is reduction of means.

8 Q. Yes.

9 A. And the areas that we hope are helpful in managing risk
10 are establishing therapeutic alliance with the patient,
11 a working alliance, and delivering treatments, which
12 I guess we haven't focused on here but, you know, you
13 hope treating the underlying condition. Would remote
14 observation -- is your question: would remote
15 observation be helpful in that?

16 Q. Yes.

17 A. So the answer is that it potentially could be helpful in
18 that. It depends what's observed and when.

19 Q. Okay.

20 A. Is that helpful?

21 Q. Yes, that's very helpful. Thank you.

22 Now, within mental health care there's frequently
23 a tension between safety and autonomy, and a degree of
24 restriction is often in place over one's autonomy
25 because your mental health is impairing your ability to

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1 those, but it would need to be tailored to the clinical
2 situation. Can you identify when the use of such remote
3 technology may be useful in that context?

4 A. So I was thinking about the fact that some patients with
5 eating disorders will exercise on their own, just pace
6 up and down their rooms or jump up and down. We worry
7 about that, partly because of the fact that -- their
8 calorie drain but also very largely with patients with
9 severe eating disorders, they're frail.

10 Q. Yes, and so the risk to their physical health, as well
11 as --

12 A. They might break something, yeah.

13 Q. Okay.

14 I wanted to ask you just three last questions about
15 clinical trials in the context of mental health
16 disorders. You identified the need for a research trial
17 with an academic sponsor wherever possible in respect of
18 mental health care, but do you agree that within mental
19 health medicine generally there are far fewer research
20 trials of the sort we might see quite commonly within
21 physical health?

22 A. Oh yes, I'm afraid so. There just isn't the money.

23 Q. And it's therefore difficult, often, to have the sort of
24 double blind randomised control trials that you would
25 see maybe as a matter of routine, for example, in drug

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1 introductions?

2 **A.** That's a different problem.

3 **Q.** Right.

4 **A.** So the issue with a randomised double blind controlled

5 trial is first, is that psychiatry from that point of

6 view is much more like surgery than it is general

7 medicine. When you're doing a randomised control trial

8 in general medicine you can give a patient two very the

9 same looking pills and they don't know what they're

10 receiving but more importantly, the uniformity of the

11 treatment is guaranteed to you by the pill that you're

12 giving. When you're doing a randomised control trial

13 in, say, surgery, first of all we've got to make sure

14 that the surgeons are all going to do the same thing;

15 and secondly, you can't really put someone to sleep,

16 pretend they've had an operation, and then wake them up

17 and then compare them with people who have really had

18 the operation.

19 So there are technical difficulties about doing

20 randomised controlled trials, in surgery, in psychiatry,

21 in areas where the intervention isn't given to you by

22 a company that's guaranteeing their sameness, and also

23 where you can't easily blind the patient.

24 **Q.** Okay. So in most psychiatric interventions it would be

25 unusual other than maybe drug --

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1 innovation in the way things are organised, tends to be

2 introduced fast, or in advance of the evidence, yes.

3 **MS SCOLDING:** Thank you very much. Those are all the

4 questions I have. Thank you.

5 **MR GRIFFIN:** Chair, we hear next from Eleena Misra King's

6 Counsel on behalf of the individuals represented by

7 Hogde Jones & Allen.

8 **Questioned by MS MISRA KC**

9 **MS MISRA:** Thank you, very much. Good afternoon, Dr Denman.

10 I have just one question for you but I wonder if I could

11 just very briefly put it into the context of the

12 evidence you've given this morning in particular.

13 So Dr Denman, you refer to the 2022 NICE Guidance

14 and I wanted to ask you about NHS England's subsequent

15 April 2025 Staying Safe from Suicide document which is

16 described by NHS England as best practice guidance for

17 safety assessment, formulation and management.

18 Now, in your evidence to the Inquiry this morning

19 you described how observations practice is relevant both

20 from a patient safety risk management perspective and

21 also as a therapeutic tool for engagement, and in terms

22 of risk assessment, you referred to the move towards

23 a more holistic and dynamic assessment of risk rather

24 than stratification of risk approach, which is certainly

25 what the NHS England document I'm referring to also

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1 **A.** Drug trials is where you see it most of all. In other

2 interventions, there have been famous trials in

3 psychotherapy attempting to give neutral treatments.

4 The trouble is the neutral treatments all turn out to

5 work really well.

6 **Q.** Right, okay. So it's much more likely that, in reality,

7 you are more likely to have, I think they're called kind

8 of pragmatic trials where people kind of you look at

9 real-life experiences and you're not able to randomise

10 things, within a lot of psychiatric practice or --

11 (overspeaking) --

12 **A.** Yes, or crossover studies, but you need an academic

13 expert for these questions, really.

14 **Q.** That's fine. Thank you.

15 The last question I wanted to ask is that often

16 technology, like much else in medicine, is introduced in

17 advance of clear evidence of benefit; is that not right?

18 Our system tends to operate by introducing something

19 first and then looking to see whether it works, rather

20 than looking to see whether it works and then

21 introducing it?

22 **A.** It hugely depends on what you're talking about. So in,

23 for example, surgical procedures, no. So there's now

24 a system for doing that, and increasingly medical

25 procedures. You're right that innovation, particularly

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1 endorses.

2 Now, that document, the NHS England document from

3 April 2025, does not refer to observations or to

4 technology, but amongst other things, it says, "Risk is

5 too variable to rely on static categories. It demands

6 nuanced relational care."

7 Now, in that context, if I may ask my question,

8 Dr Denman. I'm sorry for the long lead-up to it. If

9 and to the extent that you consider that NHS England

10 Guidance of April 2025 to be material, do you think that

11 this has any bearing on general observations practice

12 and whether there is a need for improved national

13 guidance?

14 **A.** Crikey. I hope I've indicated that -- and I worry it's

15 a slightly grandiose thought -- that I think that we do

16 need to think through the link between observations and

17 engagement, because while every observation is an

18 occasion for engagement, the balance between vigilant

19 observation and therapeutic engagement will change with

20 different situations, and so, in some situations we're

21 asking a member of staff to be highly vigilant for

22 a particular event that they're trying to prevent, and

23 under those circumstances, they -- you may -- brutally,

24 engagement may distract them, and there's a case in

25 point there.

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1 On the other hand, on other occasions, the need to
2 do the next thing, do the next thing, and tick it off,
3 can make staff seem preoccupied with ticking boxes and,
4 indeed, be preoccupied with ticking boxes when a patient
5 is actually wanting, you know, this is the moment they
6 could talk and so it would be nice. And so you need to
7 kind of keep that spectrum and maybe a re-think of how
8 we put those two together would be helpful.

9 Does that answer your question?

10 **Q.** Thank you, if I could just follow up, then. Do you
11 think it would be helpful to have some form of national
12 guidance on this?

13 **A.** The only reason I'm not saying yes absolutely is I don't
14 know whether yet we're ready for it but I think we need
15 to have the national conversation.

16 **MS MISRA:** Thank you very much, Dr Denman. That was my only
17 question.

18 **MR GRIFFIN:** Chair, the last advocate we'll hear questions
19 from is Brenda Campbell King's Counsel, on behalf of
20 those represented by Bindmans.

21 **Questioned by MS CAMPBELL KC**

22 **MS CAMPBELL:** Thank you, good afternoon, Dr Denman.

23 The only topic I want to ask you about is the
24 evidence that you've given about the future
25 technological innovations that are coming and how they
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1 would have given -- would have given a lead to "We need
2 to do something", and so, in Sophie's case it's easy to
3 see if rightly valued at the time. The difficulty is
4 that it's rightly valuing in advance, and particularly
5 in patients where the behaviours that we're thinking
6 about are very often very repeated, and where the
7 response -- I'm not saying this is Sophie's case, yeah?
8 Just so you are clear. But just where you have
9 a behaviour that's very repeated, it may even be more
10 subtle than just this behaviour and then that; it may be
11 picking up what you see as a sort of accelerating run of
12 behaviours, where you just get more and more of them,
13 and also, expressed hopelessness, and also the
14 experience of a physical symptom called agitation.

15 So under -- it may be that you need to pick up more
16 than this behaviour and then that.

17 The ability to do that is -- some nursing staff have
18 it -- just have it, as I say, I call it Spidey sense,
19 they're just uncannily good at it, but it's quite
20 difficult to train and therefore difficult to know quite
21 how to prescribe.

22 **Q.** But if staff can observe an overt sign of distress or
23 deterioration before an incident, and nevertheless fail
24 to pick up on it, is there any evidence that an
25 automated system identifying potentially more ambiguous
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1 need to be developed, but to be developed safely. And
2 you told us in your report, and indeed in your evidence
3 today, that pulse and respiration are not reliable
4 indicators of self-harm or self-strangulation by way of
5 example, and we know that current VBPMS can't,
6 therefore, detect the first signs of self-harm by those
7 means, but you do envisage future technology that you
8 describe as potentially very hard to resist, that may be
9 capable of detecting the beginnings of self-harm in
10 realtime.

11 And it is really about that that I want to ask you
12 a few questions.

13 One of the cases you were asked to consider was the
14 death of Sophie Alderman whose family I represent, and
15 staff had observed Sophie headbanging in her room
16 shortly before she tied a ligature but she was
17 nonetheless left in her room unattended.

18 Does Sophie's experience demonstrate that the
19 critical issue at ward level may be not a failure to
20 identify precursors to serious self-harm, but a failure
21 to respond to information already available through
22 real-time observation and engagement?

23 **A.** When we look back at patients who have taken their
24 lives, very often it's possible to identify things that,
25 if they had been rightly valued at the time, you know,
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1 behavioural patterns would improve the response rather
2 than possibly provide another alert that would be
3 misunderstood or deprioritised?

4 **A.** Oh, I see where you're coming from. I'm trying not to
5 pre-judge the development of a system that would be,
6 that would be helpful in this area. There is some
7 evidence, or quite a lot of evidence, actually, that the
8 experience of agitation that's motor restlessness,
9 feeling of being keyed up, not actually suicidal
10 thoughts, but just this restless feeling of not being
11 able to settle, it's often associated with people
12 wringing their hands, is very predictive. If I were
13 thinking how could I measure that then one individual
14 has gone and just asked people to rate how agitated they
15 are six times a day, for them, on the phone, just to
16 type -- that's quite predictive of a later suicide
17 attempt.

18 And I wouldn't want to say we would never do that,
19 or that's too automated. Does that -- that's why I'm
20 not immediately just saying "yes".

21 **Q.** Yes, I understand. But I suppose predicting this
22 potential future system, and we don't know what it would
23 look like or even whether it would come into fruition,
24 but is there a risk that staff could become over-reliant
25 on the technology to tell them when the patient needs
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1 intervention rather than using their own judgement?

2 **A.** Well, I'd hope that we'd mitigate that risk by the
3 concept of a joint tool. So it wouldn't be that staff
4 would use something to tell them X; it would be that we,
5 me and the patient together, would have something like
6 writing or a tool or a monitor that the patient could
7 see what was happening to them as much as the staff
8 could see what was happening, and so you're not -- you
9 don't end up with a technology as something done to
10 a patient by a staff member; you have a technology as
11 something that assists patient and staff member to think
12 about what's going on between them. And it's that shift
13 from the machine looking at the patient to the patient
14 and the staff member both having a tool that they
15 jointly use that I'm trying to get over here.

16 **Q.** And just picking up on the input and the patient
17 experience, in terms of features of that future
18 theoretical system --

19 **A.** Yeah, speculative system.

20 **Q.** -- the serious concerns about patient autonomy, about
21 dignity, about the decrease in therapeutic engagement
22 would remain serious concerns, no doubt?

23 **A.** Those concerns -- so for me, consent, informed consent
24 and joint working are, if you like, the cure of those
25 concerns. Because that's -- the patient and I are

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1 Director and the Chief Operating Officer who are kind of
2 the clinical engine of the organisation, that the board
3 would look to to make sure that care is being delivered
4 safely and efficiently, and there would be a very large
5 number of structures, both the Trust's Quality and
6 Safety Committee, you know, devolving down through, on
7 to the wards in training for staff, in providing --
8 making sure that staff had supervision and oversight in
9 doing regular audits of wards, in making sure that wards
10 had links with other wards.

11 When it comes to doctors, there are specific
12 structures to oversee the practice of doctors in terms
13 of the GMC and, on the whole, both have been helpful,
14 not for -- forgive me, GMC -- not so much for the GMC,
15 but the superstructure that surrounds them which is
16 essentially that doctors don't practise on their own;
17 they can't wander off into some kind of weird world of
18 whatever their special interest is. They have to
19 account for what they do to someone else. And those
20 structures are the ones I would expect a Medical
21 Director to make sure were healthy, working and
22 responsible for the delivery, then, of good quality
23 care.

24 **Q.** Thank you. What are the characteristics of a ward that
25 is best able to deliver a reasonable quality of

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1 allies rather than enemies in my world, as it were. And
2 if you aren't starting from that position, then you
3 haven't really got warrant -- you haven't got off base
4 camp yet, until me and the patient or the caregivers and
5 the patients are analysing the task of trying to help,
6 you haven't got the foundation that then allows you to
7 use any tool or indeed do anything very much.

8 **MS CAMPBELL:** Thank you.

9 **MR GRIFFIN:** Chair, Dr Denman, I have a few more questions
10 and then we'll finish.

11 **Further questioned by MR GRIFFIN KC**

12 **MR GRIFFIN:** Would the Medical Director have a role in
13 ensuring that psychiatrists on the wards had a good
14 understanding of best practice in the area of
15 psychiatric observations?

16 **A.** Yes.

17 **Q.** What are the steps that a reasonable Medical Director
18 would take to drive a consistent, reasonable standard of
19 therapeutic engagement, across the wards?

20 **A.** By the doctors involved, or by all staff?

21 **Q.** All staff.

22 **A.** Okay. So all staff, that would be a joint enterprise
23 with the Director of Nursing and also ideally, in
24 a well-functioning Trust with a Chief Operating Officer.
25 You know, it's the Medical Director, the Nursing

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1 therapeutic engagement?

2 **A.** Well, so two things immediately, irrespective of
3 anything else: the staff on the ward like patients and
4 like being with them, and the staff on the ward like
5 each other, and work together. That's the kind of
6 foundation, you know, that you can't -- you can't get
7 very far without that.

8 Then the next thing is that I would expect staff to
9 be excited by, actively involved in, and take pride in,
10 delivering high-quality care. So they feel they've got
11 good morale, but also they've got good morale
12 justifiably because they're doing a good job. After --
13 then there's a whole load of stuff to do with the ward
14 environment and so forth, but those two things are the
15 core foundation, in my view.

16 **Q.** Thank you very much.

17 Do you agree that wearables cannot provide the level
18 of reliability of the technology compared to Oxevision,
19 which is a dedicated medical device?

20 **A.** No, I don't think I do agree with that. I think they
21 provide a different balance of risks and benefits. As
22 matters stand, they are not regulated medical devices
23 and so, in that regard, they're not able to provide the
24 same measurements but they'll have a balance of pros and
25 cons as with all technologies.

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1 Q. Do you agree that wearables could -- would be dangerous,
2 if they're battery operated and batteries are easily
3 swallowed?

4 A. Oh, strong point, yes. So I definitely wouldn't want
5 something that would provide someone with a means to
6 harm themselves. It depends a bit, I suspect, on how
7 you manufacture the device.

8 Q. You suggested that a patient might identify their
9 bathroom as a place where they feel particularly at
10 risk, and agree a plan involving the system monitoring
11 them there, and staff coming in response.

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

13 Q. Have you considered that such an arrangement may itself
14 create a dangerous expectation on the patient's part
15 that entering that area will bring staff to them?

16 A. Well, yes, I have, and I'd imagine that this was
17 a conversation between a staff member and a patient
18 where the patient says, you know, "Where I feel really
19 tempted is there" and the staff member says, "Would it
20 help you if ..." And there's an agreement between the
21 two, "Let's try it out", but things could turn a darker
22 way, where the patient thinks: I can't speak, maybe,
23 instead of speaking, I'll go to my bathroom, and that's
24 a way of speaking. But then somebody doesn't come quite
25 quickly enough or the right person doesn't come.

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1 the patient's risk environment rather than simply
2 a means of managing that risk?

3 A. So we definitely mustn't make promises that we can't
4 fulfil and I think all of these questions are going to
5 that. The worry is that the technology is used to make
6 a promise that can't be fulfilled and I agree that with
7 that whole idea that if you -- if we agree this is what
8 we're going to do, we have to do it.

9 Q. Are there, as far as you're aware, movement monitoring
10 tools which do not require a camera or filming of
11 patients 24 hours a day, seven days a week, in their
12 bedrooms?

13 A. Currently there is one tool, and that's Oxehealth.
14 I think there's -- I think my report refers to one
15 other, which is European and looks at being on your bed.
16 But as matters stand today, there's one tool on the
17 market.

18 Q. The question, though, was about the existence of
19 technology that doesn't require a camera in your
20 bedroom, whether such technology exists in relation to
21 movement monitoring?

22 A. Well, it would be perfectly possible, even I with my
23 very limited knowledge know that it would be perfectly
24 possible to construct that sort of a system using RFID,
25 which are little devices around your room, and

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1 The way of dealing with that is always to talk more.
2 What happened? Why were you there? Was it -- do you
3 see what I mean? And for me, also the aim would be to
4 say, "Sometimes could you try coming out of the door
5 rather than going further in?" And I might well talk
6 with the patient about the imagery of coming out and
7 being outside of yourself and with other people as
8 opposed to going in; do you see what I mean? It might
9 be lots of ways I would approach that.

10 Q. In Sophie Alderman's case, her mother has described her
11 fear that Sophie may deliberately have crossed into the
12 bathroom believing that doing so would trigger an alert
13 and bring staff to her. But when the bathroom alert was
14 generated, there was no staff response. Does that
15 illustrate a potential harm in building a patient's
16 safety plan around their understanding that movement
17 into a monitored area will result in staff intervention?

18 A. No safety plan will survive it not being -- I mean, so
19 yes, and no. If plan is: we know you're really at risk
20 there and we're going to come running if you go there,
21 then you've got to come running.

22 Q. Thank you. If a patient is encouraged to incorporate an
23 alerting system into their safety plan, but the
24 technology can't ensure that staff will respond to the
25 alert, does the technology itself risk becoming part of

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1 a wearable of some sort.

2 Q. Thank you.

3 You've said that stepping down a level of
4 observations can, in and of itself, create a risk to the
5 patient --

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

7 Q. -- for example, because a patient may feel abandoned or
8 fear discharge. How do you suggest that risk is
9 mitigated so that the stepping down can take place
10 safely?

11 A. So the first, the principal thing to do is, no
12 surprises. So not suddenly, and second, agreed
13 collaboratively. Patients are your greatest allies as a
14 therapist but you have to agree things with them and
15 they have to understand why you're suggesting something
16 and work on the meaning of that.

17 Q. You told us about the change of approach in terms of the
18 Triangle of Care through which the significance of
19 family engagement with inpatient care has been
20 recognised. You said, however, that it was not fully
21 embedded in MDT decision making. Do you have a view of
22 how that can be achieved?

23 A. One of the things that I have thought about -- so there
24 are all sorts of ways. But one of the things which
25 I maybe hinted at and have thought about is, you know,

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1 should we think about the timings of events on the ward?
 2 Because I'm just very -- very often I'll read an account
 3 or speak to family members who have turned up on the
 4 ward and there's sort of no one there who can talk to
 5 them. And I think that's partly to do with it being
 6 evening or weekends. And so I think one of the ways in
 7 which -- just a very, very simple way -- is to think
 8 about what time we do things or can there be a space for
 9 family? That's one thing.

10 The other thing is, I think that there's been a lot
 11 of benefit from having groups for friends and family.
 12 So you've got a patient on the ward, that is somewhere
 13 for you to go, which isn't about information sharing,
 14 it's sort of, in a way, it's about empowerment. My
 15 daughter is on the ward too. Do you see what I mean?
 16 And just that having someone you can chat to in that
 17 way, I think, is extremely helpful.

18 The thing that psychiatrists, mental health staff,
 19 get really quickly desensitised to is -- wards are
 20 weird, strange, frightening places at the best of times
 21 and we just get used to them and it's very hard to stay
 22 alive to how odd it must seem to family, to patients, to
 23 suddenly arrive in this environment where you don't know
 24 where the loo is, and all sorts of things.

25 **Q.** Is your view that confidentiality does not preclude

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1 **A.** Okay, that's a very difficult question. I don't think
 2 any Standard Operating Procedure is the way that we
 3 should tell staff about systems. Standard Operating
 4 Procedures are sort of technical documents with all
 5 sorts of stuff in them that you don't -- that you as
 6 a member of staff don't need. What you need as a member
 7 of staff is simple information clearly presented that
 8 starts from your position that I'm on the ward with
 9 patients, what does the system look like? So the
 10 document that I saw was reasonably good.

11 SOPs, Standard Operating Procedures, you need them
 12 because you need to have a Standard Operating Procedure
 13 but they're not educational documents. So you've got to
 14 wade through, you know, a load of, if you'll forgive me,
 15 from the point of view of a member of staff, rubbish
 16 before you get to what -- you know, roles, and when the
 17 things are being -- you know, what the thing's expiry
 18 date is and which committees it's been through. A
 19 member of staff has no interest in that, rightly.

20 **Q.** The Inquiry has received various instructions for use
 21 from the manufacturer at Oxehealth that had been
 22 provided to EPUT which -- I think a longer document.
 23 Might that actually be the place for this kind of
 24 information?

25 **A.** Yes, or the other really good way of doing it is to get

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1 actively listening to and inviting relevant information
 2 about patients from families explicitly recognised in
 3 policy, as far as you're aware?

4 **A.** Yes. I'd be very, very surprised, and indeed very
 5 critical of a trust that hadn't got that explicitly down
 6 in policy.

7 **Q.** You've talked about the need to keep an eye on a patient
 8 after rapid tranquilisation and you've also said
 9 a patient in those circumstances needs one-to-one
 10 observation.

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

12 **Q.** Do you consider that such monitoring needs to be carried
 13 out by a clinician or nurse who is sufficiently
 14 qualified to identify the signs of respiratory distress
 15 arising from sedation?

16 **A.** Yes.

17 **Q.** You were asked about the EPUT staff member who thought
 18 the system would give an alert if the patient stopped
 19 breathing, which was not accurate. And also,
 20 misunderstandings that Oxevision could measure
 21 a person's oxygen saturations when it can't. Do you
 22 consider that the latest EPUT Standard Operating
 23 Procedure is clear enough for staff to be aware of its
 24 limitations of alerting staff to clinical deterioration
 25 in a patient?

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1 members of staff who use the system and are competent
 2 and confident in its use, and are ideally advocates for
 3 it, to write the documentation because they'll know what
 4 they want to impart. They'll be closest to what a nurse
 5 or doctor needs to know, as they arrive on the ward.

6 **MR GRIFFIN:** Thank you.

7 Chair, that's my last additional question for
 8 Dr Denman. Do you have any further questions?

9 **THE CHAIR:** I don't. Thank you very much indeed.

10 **MR GRIFFIN:** That's the end of Dr Denman's evidence.

11 **THE CHAIR:** Can I thank you very much indeed. Your evidence
 12 has been very clear to me, so thank you. I'm very
 13 grateful.

14 **THE WITNESS:** Thank you.

15 **MR GRIFFIN:** Chair, we reconvene tomorrow morning but at
 16 9.30, so earlier than normal, 9.30, when we'll hear
 17 evidence from Laura Cozens of LIO, and later, from
 18 Mr Trimble, who is a staff member at EPUT.

19 **THE CHAIR:** Thank you.

20 **MR GRIFFIN:** Thank you.

21 **THE CHAIR:** 9.30 tomorrow.

22 **MR GRIFFIN:** 9.30, please.

23 (4.58 pm)

24 (The hearing adjourned until 9.30 am the followed day)

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