

Tuesday, 20 October 2026

(10.01 am)

Opening remarks by MR GRIFFIN KC

MR GRIFFIN: ... firstly, emergency response and resuscitation, and secondly, observations and the use of technology.

You directed your team to investigate these two areas without delay because of your concern that the issues arising may hold implications for the safety of current patients. These issues may also be of national impact, reaching beyond the boundaries of Essex.

You determined that these investigations could not wait, and that subject to the evidence you received, you may wish to consider making interim recommendations.

Starting today, Chair, you will be receiving submissions from lawyers acting on behalf of the Core Participants on the topic of potential interim recommendations relating to these themes.

The submissions will be in two parts. Today, you will hear focused oral submissions on key points. You will then receive more detailed written submissions, which are due by Friday, 30 October.

There may be aspects of today's submissions that are difficult to listen to, for example, if they refer to evidence of self-harm or suicide. For those following

1 the hearing online, information about the emotional
2 support that is available can be found on the Lampard
3 Inquiry website at lampardinquiry.org.uk. The "support"
4 tab is near the top right-hand corner.

5 Chair, we're grateful for the continued engagement
6 of Core Participants and their legal teams. Your
7 decisions and directions about the hearing today and the
8 way in which the written submissions are to be provided
9 have been communicated to Core Participants. The
10 process for today will be this: I will call each
11 advocate forward. Would they then please introduce
12 themselves and explain for whom they act.

13 They will then each have a maximum of 25 minutes to
14 address you on interim recommendations relating to the
15 two themes.

16 Chair, a running order has been distributed together
17 with indicative timings, but as soon as one advocate has
18 finished, we will move on to the next, with the
19 exception of two breaks that have been built in to the
20 schedule. Advocates are kindly asked both to keep to
21 the topics of important focus today and not to exceed
22 their allotted 25 minutes' time. I may intervene, for
23 example to let an advocate know if they are about to
24 exceed their time, although I hope that will not be
25 necessary.

1 Chair, we move therefore now to the first of the
2 submissions and to Peter Mant, King's Counsel.

3 **Submissions by MR MANT KC**

4 **MR MANT:** Thank you.

5 Chair, I am instructed by Hodge Jones & Allen who
6 represent the largest group of bereaved families and
7 lived experience participants in your Inquiry. We are
8 very grateful for this opportunity to make oral
9 submissions on interim recommendations.

10 You've heard and received extensive evidence about
11 deaths and other harms that have been contributed to by
12 inadequate emergency response and issues relating to
13 Oxevision technology.

14 My clients desperately want to prevent other
15 families going through what they've endured, and it's
16 for that reason that we, on their behalf ask, you to
17 make interim recommendations now to address present and
18 some continuing risks.

19 In relation to emergency response, we invite you to
20 make national recommendations about minimum standards
21 and also local recommendations to ensure that EPUT meets
22 those standards.

23 Our proposed emergency response recommendations
24 focus first on ILS training and second, on simulations
25 and drills.

1 In relation to Oxevision, we say that the time has
2 come to halt its use. As a minimum, your interim
3 recommendations should include a recommendation that
4 EPUT safely suspends use of the technology and instead
5 focuses on delivering effective face-to-face therapeutic
6 observations and care. I will go on now to address you
7 first on emergency response and then on Oxevision.

8 In relation to emergency response you've heard
9 compelling evidence, in particular from Adam Benson
10 Clarke of RCUK and also from Professor Jasmeet Soar,
11 that in an emergency response, every second counts.
12 Most cardiac arrests in mental health settings are
13 secondary cardiac arrests. What this means, and
14 Mr Griffin KC addressed you on this in his closing last
15 week, it means that the patient's heart stops beating at
16 the end of a process of physiological change that's
17 caused by a trigger event. In a mental health setting,
18 those trigger events may be things such as overdose or
19 ligature, to name but two. The best chance of the
20 patient surviving is to intervene before the cardiac
21 arrest occurs.

22 What Professor Soar explained is that preventative
23 intervention should follow an A-E approach. Potential
24 life-saving measures include things such as insertion of
25 a supraglottic airway and other interventions that are

1 taught on an ILS course but do not form part of the BLS
2 course. And it's for that reason that the first
3 responder must be ILS-trained.

4 Professor Soar said that an ILS-trained member of
5 staff should be available at all times, 24/7, to respond
6 to an emergency within the first minute. We agree.

7 We know from the illustrative cases that the first
8 responder is often a healthcare assistant. Both
9 Mr Benson Clarke and also Professor Soar was supportive
10 of healthcare assistants being trained in ILS. They
11 were clear that ILS training does not require specialist
12 knowledge or skill. Police officers, lifeguards and
13 other non-clinical workers routinely do this training
14 and they perform well. You heard from Professor Soar
15 also about the importance of other members of the team,
16 not just the first responder, being appropriately
17 trained.

18 He described the roles that must be performed in an
19 emergency response and stated that it's not possible for
20 one person ILS-trained to perform all the necessary
21 tasks.

22 So the evidence that you heard on these matters is
23 relevant to all mental health settings, and it's for
24 that reason that we invite you to make national
25 recommendations about minimum standards for emergency

1 response. We suggest that your recommendations should
2 include the following: 1, an ILS-trained member of staff
3 must always be available 24/7, seven days a week, to
4 attend within one minute any medical emergency; 2,
5 further ILS-trained members of staff must be available
6 to attend on an urgent basis to support emergency
7 interventions started by the first responder; and 3, ILS
8 training must not be restricted only to registered
9 staff.

10 Now, we say that national recommendations are
11 required because although there is existing guidance,
12 that guidance is not clear or consistent or
13 comprehensive on response times or levels of training.
14 The NICE guideline NG10, for example, focuses only on
15 restrictive practices.

16 Our proposed recommendation 1 would ensure clarity
17 that ILS-trained staff must be available to attend
18 emergencies in all mental health settings, whether or
19 not the emergency is associated with restrictive
20 practice. It would also clarify the necessary response
21 time, that vital first minute.

22 In relation to our second recommendation, that there
23 must be more than one ILS-trained member of staff, I've
24 already summarised Professor Soar's evidence, and it's
25 not sufficient to have single ILS-trained member of

1 staff responding to an incident. More than one
2 ILS-trained member of staff is required because of the
3 tasks that need to be done. They include leadership,
4 A-E assessment, airway management, and other roles only
5 trained on that course.

6 And then the third recommendation. Why is it that
7 the training should not be limited only to registered
8 staff?

9 The EPUT witnesses, Mr Archer, Dr Suresh, suggested
10 that they didn't think it appropriate to train
11 healthcare assistants because they lack pre-existing
12 knowledge of anatomy and physiology. But that
13 suggestion was rejected, resoundingly rejected, by
14 Professor Soar, who is the very man who designed the
15 course.

16 Professor Soar vividly described in his oral
17 evidence, and I quote now, that:

18 "The only anatomy you need to know is that these
19 things go into the mouth and behind the tongue, and
20 there's a windpipe and a food pipe behind the tongue".

21 So hardly the sort of high- level knowledge beyond
22 the skills of an experienced healthcare assistant.

23 EPUT's current position is also impossible to
24 reconcile with its own past practice of training HCAs in
25 enhanced emergency skills, which included the very

1 things such as airway management that are now only
2 covered as part of the ILS training.

3 Chair, you heard from Dr Adamson of NHS England.
4 She expressed concern about potential harms that could
5 be caused by training HCAs to a higher level. But the
6 basis of her concern was always unclear, and we invite
7 you to reject her evidence in this regard.

8 Dr Adamson is a cardiologist and it was apparent
9 that her approach focused primarily on cardiac arrest,
10 primary cardiac arrest, which accounts for only a small
11 proportion of deaths in mental health settings.

12 Professor Soar was emphatic in his rejection of the
13 concern that training HCAs in ILS would do more harm
14 than good, when, absent the sort of interventions that
15 are taught on an ILS course, a patient will inevitably
16 die.

17 It may be suggested also that national
18 recommendations are premature because NHS England is in
19 the process of reviewing its own training standards. If
20 that is an argument that is advanced, we would strongly
21 reject it. On the contrary, we submit that having heard
22 evidence on emergency response and resuscitation, the
23 Inquiry is very well placed to make recommendations now,
24 and those recommendations are required to address
25 immediate and ongoing risks.

1 NHS England's new training standards are, as the
2 evidence made clear, a work in progress, and the Inquiry
3 can help to shape national policy. Indeed, we suggest
4 that it would be timely to make national recommendations
5 now so that they can feed into NHS England decision
6 making and inform training standards before they're set
7 in stone.

8 So that's our position on national recommendations.
9 And whilst we do focus nationally, we also invite you to
10 make recommendations that are specific to EPUT.

11 You heard that EPUT currently seeks to ensure that
12 least one ILS-trained nurse is present on every ward at
13 all times. This level of staffing is manifestly
14 insufficient to meet the one-minute immediate response
15 standard, and makes no allowance for the needs for
16 additional ILS-trained staff to assist with the
17 response.

18 The EPUT witnesses simply had no answer to the
19 question: "What happens when that one member of staff
20 takes a break or goes to the toilet?" We therefore ask
21 the Inquiry to recommend that EPUT amends its policies
22 and reviews its training and staffing levels to ensure
23 that it meets our proposed national recommendations.

24 That's our position on ILS training.

25 I'll turn now to address you on simulations and

1 drills. ILS training is important but it is -- on its
2 own, it is not sufficient. Emergency response in cases
3 in which my clients' loved ones died were often
4 characterised by disorganisation and indeed panic.
5 Whether or not the staff had been trained, in the
6 moment, they did not know what to do or where to locate
7 equipment.

8 The evidence that you heard from various corporate
9 witnesses this month also underlined that resuscitation
10 events are rare in mental health settings. Regular
11 simulations and drills are therefore essential.

12 All the witnesses that you heard from in fact agreed
13 on this point, but currently there are no national
14 Standards about how often simulations should take place,
15 what they should include, or how often individual staff
16 members should attend them. And it is in those
17 circumstances that we invite you to make the following
18 national recommendations in respect of simulations and
19 drills.

20 1. Emergency response simulations and/or drills
21 must be conducted at sufficiently regular intervals to
22 enable all patient-facing staff on mental health wards
23 to participate with confidence in an emergency response
24 team.

25 2. Learning from simulations and/or drills must be

1 recorded and implemented.

2 3. Staff must be required to attend a minimum
3 number of the simulations and/or drills each year.

4 Now, RCUK and/or NHS England should be the people
5 invited to develop national guidance to address these
6 high-level matters, and compliance could then be
7 monitored by the CQC. But pending development of that
8 national guidance, EPUT must put in place its own local
9 policies.

10 Until a few months ago, EPUT simply had no systems
11 at all for ensuring that simulations and drills were
12 undertaken across all of its wards. You heard evidence
13 that under the microscope of your Inquiry, EPUT has
14 started to require each ward to conduct three-monthly
15 simulations, and started to audit compliance with that
16 standard.

17 EPUT also said that staff attendance would be
18 monitored locally. However, there is no policy or
19 standard in place for determining how often staff should
20 attend, or how poor performance will be managed.

21 Now, monitoring staff attendance alone will not be
22 meaningful or effective unless there are policies in
23 place that set minimum standards for how often staff
24 attend, and for managing poor performance and
25 non-attendance.

1 We therefore ask the Inquiry to make an
2 EPUT-specific recommendation that they set minimum
3 standards for staff attendance pending any national
4 guidance.

5 Other issues that arose from this month's evidence
6 included a lack of three-yearly audits and annual
7 reports, despite these being express requirements of
8 EPUT policy; over-reliance on one person, Mr Archer, and
9 his personal knowledge of themes and issues; and
10 problems effectively recording resuscitation events on
11 Datix.

12 Chair, we understand that the Inquiry will be
13 undertaking further investigations of incident reporting
14 in Datix. We do not at this stage, therefore, ask for
15 any interim recommendations on this particular matter.
16 Nonetheless, the lack of audits and annual reports and
17 over-reliance on Mr Archer are a matter of current
18 concern.

19 Dr Suresh and Mr Archer in their oral evidence
20 relied significantly on quarterly reports. Those
21 reports were only disclosed after they gave evidence,
22 and what became clear is that they are very repetitive
23 and high level. They do not record detail of specific
24 incidents, or lessons learned from either incidents or
25 simulations.

1 So we do invite the Inquiry to consider also making
2 an additional interim recommendation that EPUT includes
3 in its quarterly report this level of specific detail
4 about incidents and recommendations, or alternatively,
5 that it develops a new system for capturing key
6 information and learning points from resuscitation
7 events and simulations, pending any final
8 recommendations on incident reporting and corporate
9 learning that you may make in due course at the end of
10 the Inquiry.

11 I also note that there were, throughout the
12 evidence, assurances given to you, Chair, that various
13 changes would be made. I won't list them all now, but
14 what I do say is that it's important that the Inquiry
15 keeps an eye on and monitors compliance with those
16 assurances.

17 Chair, you announced last year that you plan to
18 establish a Recommendations and Implementation Forum, or
19 RIF. This innovative approach was strongly welcomed by
20 many of my clients.

21 Effective implementation of recommendations is
22 essential to achieving the meaningful change that they
23 will seek. And we therefore suggest that EPUT's
24 compliance with all of the assurances that it's given,
25 as well as national and local implementation of any

1 interim recommendations that you make following these
2 hearings, should be monitored and reviewed by the RIF.

3 Those are my submissions on immediate response.

4 I'll turn now to observations and technology. And I can
5 be briefer in my submissions on this topic.

6 You will hear in due course from others on the use
7 of Oxevision. There's broad agreement between the RLRs
8 representing bereaved families and lived experience
9 clients about the risks and harms to which this
10 technology gives rise.

11 Chair, you and your team have conducted an extremely
12 thorough investigation into use of the Oxevision system
13 in Essex. That investigation has revealed clear
14 evidence of harm and an ongoing risk of harm with
15 little, if any, evidence of meaningful benefit to
16 counterbalance that risk.

17 The evidence shows that there was and continues to
18 be confusion amongst patients, staff and management
19 about how Oxevision should be used and its remit as an
20 assistive technology.

21 In practice, it has far too often been used as
22 a substitute for in-person observations. Its use, we
23 know, has led to frequent missed opportunities for
24 therapeutic engagement between staff and their patients
25 and that's in circumstances where therapeutic engagement

1 is something that your experts agree is absolutely
2 critical to treatment and recovery.

3 Use of this technology has also contributed in
4 material ways to other harms, and in some cases to
5 deaths of patients, due to its misapplication and abuse
6 of the system. And its use has led to quite egregious
7 breaches of patients' privacy, dignity and human rights.

8 Against this clear evidence of harm, there is
9 a striking lack of evidence of any real clinical
10 benefit. Dr Denman was clear on the lack of
11 statistically significant research supporting its
12 rollout and ongoing use. She further explained that
13 it's not a system that can in most cases provide support
14 for clinical decision making, general psychiatric
15 assessment, risk management, or to determine a patient's
16 required observation levels.

17 There was some suggestion of potential benefits in
18 very niche areas. Oxevision witnesses referred to
19 "real-life data". However, upon questioning what became
20 clear is that this amounted to nothing more than
21 unverified anecdote, and it's in those circumstances
22 that we submit the balance of risk falls plainly in
23 favour of an interim recommendation that EPUT's use of
24 Oxevision should now be suspended safely, and
25 a refocused effort made to improve provision of

1 in-person, face-to-face observations and care, or, as
2 Jill Archibald said, observations, and I quote, are
3 "human, relational, and patient-centred".

4 Ms Archibald went on to say that "Observations can
5 and do save lives, but it really boils down to the
6 quality of them. When it's become procedural or
7 surveillance, that's when we've completely lost the
8 meaning of it."

9 We agree.

10 The investigations revealed other concerns about
11 cost effectiveness and exposed weaknesses in the system
12 for regulation of vision-based technologies. These are
13 matters on which my clients may ask you to make final
14 recommendations in due course. However, they're not
15 matters on which we rely in support of the interim
16 recommendations specifically.

17 The interim recommendations that we propose are
18 intended to address the most immediate patient safety
19 concerns. My clients ask you to make those
20 recommendations now to reduce the risk that other
21 patients will suffer harm, and that other families will
22 lose loved ones to avoidable deaths.

23 Thank you.

24 **MR GRIFFIN:** Thank you. We hear now from Maya Sikand,
25 King's Counsel.

1 **Submissions by MS SIKAND KC**

2 **MR GRIFFIN:** You should unmute, please, Ms Sikand.

3 **MS SIKAND:** Sir, a hundred apologies.

4 Chair, I make these submissions on behalf of the
5 Core Participants represented by Leigh Day, Irwin
6 Mitchell and Deighton Pierce Glynn.

7 We and our lay clients have listened carefully to,
8 and reflected on the evidence on those two topics of
9 concern, and do wish to propose some recommendations
10 designed, we hope, to ameliorate the ongoing risk to the
11 current safety of patients in the two areas that you
12 have focused on in the October hearings.

13 With that targeted focus in mind, although the
14 attention of this Inquiry is directed towards EPUT, it
15 is also right to note that some of the issues raised in
16 these two areas of concern go well beyond one Trust.
17 Your counsel has recognised that should you make
18 recommendations, they are likely to have national
19 impact.

20 We urge that you don't hold back from making
21 recommendations with a national focus where the evidence
22 is that patient safety is more widely at risk from an
23 absence of national policy or gaps in that policy. It
24 appears that your scrutiny of EPUT in the context of
25 observations and technology has made some contribution

1 to EPUT bringing about some overdue and necessary
2 changes to its use of Oxevision, particularly in the
3 area of consent.

4 Chair, there is no guarantee that other Trusts who
5 are using Oxevision will make similar changes, and their
6 patients may be equally at risk from the issues of
7 concern identified in these hearings.

8 Chair, before I get into the detail of our
9 suggestions, I want to make a couple of preliminary
10 observations, if I may. First, I want to make the point
11 that none of our cohort of lay clients have been
12 directly affected by the use or misuse of Oxevision, and
13 you will, of course, give primacy to those who speak
14 from lived experience when determining whether or not to
15 recommend either a pause or a cessation of the use of
16 Oxevision.

17 Secondly, Chair, there is bound to be some
18 repetition in what we say and what others with similar
19 interests may say today. We simply haven't had the time
20 to coordinate our views on recommendations, but Chair,
21 it may be you take the view, where there is repetition,
22 it only strengthens the justification for a particular
23 recommendation.

24 Moving to the issue of emergency response and
25 resuscitation. Chair, our clients have listened with

1 concern to evidence around the adequacy of training for
2 staff on EPUT wards, the extent to which those staff are
3 able to keep those skills up to date between annual
4 refresher training and the systems in place for
5 monitoring training and subsequent emergency response
6 events. The evidence in this area, combined with
7 Professor Soar's expert view, was clear, and, Chair,
8 should not be the subject of any dispute.

9 As Mr Mant has already said, Professor Soar's direct
10 description in his written and oral evidence was that an
11 ILS responder being available immediately, 24/7, is the
12 minimum requirement for safely responding to an
13 emergency.

14 Professor Soar identified which of EPUT's policies
15 required amending to achieve this. He identified which
16 of EPUT's policies required amending -- sorry, he also
17 agreed with the common-sense point that it would seem to
18 be difficult to achieve that minimum requirement with
19 just one ILS-trained staff member per shift, taking into
20 account required breaks.

21 Chair, every witness who was asked about this
22 stressed the importance of simulations of emergency
23 response for staff on mental health inpatient wards, in
24 particular due to the relative rarity of resuscitation
25 events. Importantly, Professor Soar flagged the need

1 for training as a team to respond to high-stress events.
2 He described a reasonable frequency of training would be
3 an annual big dose of training supplemented by similar
4 top-ups, including through simulations. Despite this,
5 Chair, we note that EPUT has no minimum requirement for
6 how often individual staff members should attend
7 simulations, and there are no current national Standards
8 on carrying out simulations for ensuring staff have
9 minimum attendance at simulations, although Dr Adamson
10 of NHSE stressed that the new training framework for
11 staff was still under development.

12 The lack of nationwide guidance on best practice was
13 evident. Mr Archer, Head of Deteriorating Patient
14 Pathways at EPUT, told us that he was really unsure what
15 happens in other mental health Trusts but was keen for
16 that to be part of his learning journey. He supported
17 the idea of national Standards of medical emergency
18 simulations. In our view, Chair, regular simulation
19 training for mental health inpatient staff is
20 a straightforward, easy-to-implement measure which will
21 have a direct impact on the quality of emergency
22 responses as and when needed.

23 Chair, when setting a minimum frequency of
24 simulation training the Inquiry will be conscious of the
25 burden of additional training on frontline staff but

1 will need to balance that against a baseline to ensure
2 that staff are not going a year or more without
3 refreshing their skills.

4 We know that EPUT already requires wards to run
5 simulations at least every three months. Mr Archer
6 suggested in evidence that having staff attend at least
7 twice a year was reasonable, although that evidence was
8 given on the fly, as it were, without consulting with
9 operational teams. We suggest attending two simulations
10 per year is an achievable minimum goal which should in
11 any event be built on with different types of top-up
12 training described by Professor Soar.

13 We'd therefore ask you, Chair, to make the following
14 recommendations: 1, that EPUT must ensure that an
15 ILS-trained member of staff is always available to
16 attend within one minute any medical emergency; 2, that
17 EPUT must impose a mandatory training requirement for
18 all employed staff, be they permanent or bank, to attend
19 emergency scenario simulations, at least every six
20 months. 3, NHS England should include a requirement in
21 its new national training framework that all staff on
22 inpatient wards must participate in emergency scenario
23 simulations at least once every six months.

24 Chair, additionally, given the risks associated with
25 restraint and rapid tranquilisation, and our lay

1 clients' interests, we have focused on some
2 recommendations in this area. Ensuring that staff are
3 able to identify deterioration after rapid
4 tranquilisation or restraint requires those staff to
5 have a particular skillset. You will recall that
6 Professor Soar set out in his expert report that such
7 patients require a close clinical monitoring of vital
8 signs, hydration, and consciousness, and continuous or
9 very frequent observations because of the risk of
10 over-sedation causing respiratory depression.

11 Chair, the leading national guidance, the NICE
12 guideline NG10, which is -- the long name -- Violence
13 and aggression: short-term management in mental health,
14 health and community settings, sets out that staff
15 trained in ILS and a doctor trained to use resuscitation
16 equipment should be immediately available to attend an
17 emergency if restrictive interventions might be used.

18 NG10 also specifies that after rapid
19 tranquilisation, side effects and pulse, blood pressure,
20 respiratory rate, temperature, level of hydration and
21 level of consciousness must be monitored every hour
22 until there are no further concerns about their physical
23 health status, or every 15 minutes in specific
24 circumstances.

25 But Chair, nowhere does it explain who should do

1 this monitoring or set any frequency within that initial
2 hour or thereafter. According to Professor Soar, as
3 well as having someone with ILS training to help with
4 emergency rescue, the person given the drug needs to
5 have knowledge of the drugs being given and the
6 consequence of their effects. Dr Denman also recognised
7 this.

8 And Chair, as you know, Professor Soar carried out
9 a review of EPUT's existing policies relating to
10 resuscitation, and in relation to rapid tranquilisation
11 he identified two specific issues of concern. First, he
12 identified that RM05, EPUT's policy on restrictive
13 interventions and physical restraint, refers to NG10 but
14 not to the recommendation in NG10 for immediate access
15 to ILS-trained staff, which he described as a blind spot
16 on safe staffing requirements.

17 Second, he observed that three different monitoring
18 frequencies were given for monitoring patients after
19 rapid tranquilisation in CG52, the EPUT clinical
20 guidelines for the pharmacological management of acutely
21 disturbed behaviour. Both policies had expired and
22 required updating.

23 Professor Soar considered there should be
24 a standardised observation tool for patients who had
25 received sedation across a range of settings which

1 should be clear and easy to follow. He thought that
2 developing such a tool should be straightforward, and it
3 was a good time to act now, because NG10 was under
4 review.

5 Chair, we recommend the following further
6 recommendations to you. NICE policy NG10 should be
7 updated to make explicit that, 1, patients who have been
8 subject to restrictive intervention must be monitored by
9 a clinically-trained professional for at least the first
10 hour after sedation, and 2, to include a standardised
11 minimum for the frequency of that monitoring.

12 These proposals should be considered in the current
13 review of NG10, which is due to be completed in
14 January 2027.

15 We also suggest, Chair, that EPUT makes specific
16 changes to its policies to ensure they are consistent
17 with the guidance in NG10. We consider that EPUT should
18 amend its policy RM05 to directly reflect the guidance
19 in NG10, paragraph 1.4.4, that staff trained in
20 Immediate Life Support and a doctor trained to use
21 resuscitation equipment should be immediately available
22 to attend an emergency if restrictive interventions
23 might be used.

24 Chair, we also consider that EPUT should amend its
25 policy CG52 to include standardised intervals at which

1 patients should be checked after receiving rapid
2 tranquilisation.

3 Moving on to observations and technology. Of course
4 all mental health inpatients will be subjected to some
5 level of observations whilst they are being treated.
6 Chair, the Inquiry will be well aware of the issues
7 raised by numerous bereaved families and those with
8 lived experience about the adequacy or otherwise of
9 observations carried out by EPUT and its predecessor
10 Trusts. Whilst our clients share the concerns of many
11 others in this Inquiry about the use of technology in
12 observation practice, Chair, Dr Denman's evidence was
13 not limited to the use of technology.

14 She gave clear evidence about the lack of clear
15 guidance in relation to observations for psychiatrists
16 and the urgent need for further research and academic
17 analysis about the role of observations in order to
18 consider what best practice in this area looks like, to
19 work towards national Standards for observations and
20 engagement. She was frank that observations and how
21 they are monitored required, what she called,
22 a re-think.

23 From our clients' perspective, there is an
24 evidential gap, and the Inquiry needs to further explore
25 whether current observation practice nationally is

1 properly justified by evidence and whether it is even
2 basically fulfilling the goals of both managing clinical
3 risk and building relationships with patients.

4 We are mindful of the fact, Chair, that the Inquiry
5 may have completed its investigations into the efficacy
6 of observations generally, and we therefore endorse the
7 following recommendation made by Dr Denman, which was as
8 follows: all relevant regulators and professional
9 bodies, alongside service users, families and carers,
10 should work together on a full-scale review into
11 observation engagement policy. This should include
12 in-depth consideration of the relationship between
13 observations and therapeutic engagement.

14 Chair, we also wish to draw the Inquiry's attention
15 to the particular issue of observation practice and
16 policy which arose out of Dr Denman's evidence.

17 Dr Denman was clear in her report to this Inquiry
18 that family and carer information should influence risk
19 assessment and clinical decision making wherever
20 possible, and in oral evidence she was direct that this
21 included decisions around observation levels and in the
22 context of decisions such as VBPMS. She echoed
23 a repeated theme across this Inquiry, and evident in the
24 experience of RCPs in particular, that:

25 "Families often feel strongly that they should have

1 contributed to the care of their loved ones and made
2 a difference [she said] and very, very often they are
3 right."

4 Dr Denman told you, Chair, that nothing stops her
5 listening to the family, nor even reaching out to the
6 family, regardless of whether or not consent was
7 granted.

8 She said she'd be very, very surprised and indeed
9 very critical of a Trust who hadn't got that principle
10 embedded in their policies.

11 We know that the NICE guideline NG225 on self-harm
12 assessment, management and preventing recurrence
13 specifies that a practitioner should be aware that even
14 if the person has not consented to involving their
15 family or carers in their care, family members or carers
16 can still provide information about the person.

17 Chair, a key issue across the bereaved family
18 evidence that you have heard prior to these October
19 hearings has been the failure of EPUT to take into
20 account the views of family members in all aspects of
21 mental health care, but particularly in terms of
22 assessing risk and how that translated into setting
23 observation levels, in particular lowering them without
24 family input.

25 Chair, it is clear to us from these experiences that

1 failure to take account of family input in mental health
2 inpatient care is a contributor to very real patient
3 safety risks.

4 Whilst these issues will also be explored in other
5 modules, they raise very real issues now in respect of
6 observation practice, and the safety of decisions made
7 to change a patient's level of observation. We
8 therefore submit that you, Chair, could and should
9 recommend that EPUT's policy on observations,
10 therapeutic engagement, and supportive observation
11 clinical guideline is amended to explicitly incorporate
12 a reminder to staff that families can be a proactive
13 source of risk information, and that such information
14 can form part of the documented evidence of assessed
15 current need. For example, this could be incorporated
16 at paragraph 2.3 of the current policy. So, we say,
17 Chair, a recommendation should be EPUT's therapeutic
18 observation policy should be amended to include specific
19 reference to the benefits of gathering information from
20 family members regardless of consent.

21 I move on now, Chair, to observations and
22 technology.

23 Chair, it feels basic to say that any technology
24 used in any inpatient setting should be safe. In other
25 words, that all potential risks of using a new

1 technology, including its misuse, should be considered
2 and mitigated in advance of rollout. Secondly, any
3 technology should be consented to by the patients on
4 whom it is proposed to be used, subject to capacity.

5 Finally, any new technology should meet
6 a cost-benefit analysis. To state the obvious, there is
7 no point using technology for technology's sake and
8 without a proper evaluation before such significant
9 expenditures are made.

10 Chair, it has been troubling to hear from the
11 evidence to the Inquiry about Oxevision generally, and
12 within EPUT, that these extremely basic standards have
13 not been met. Our clients share the concerns of, and
14 endorse those other CPs have, who have, or will today,
15 emphasise to you the need for immediate restrictions on
16 the use of Oxevision without significant safeguards in
17 place. And especially that all providers using
18 Oxevision should operate an opt-in consent process,
19 including ensuring patients are told about the risks
20 associated with misuse of Oxevision.

21 Chair, we are particularly concerned, however, about
22 the apparent absence of any adequate national framework
23 for evaluating such costly technology before it is
24 deployed in mental health facilities across the NHS. In
25 closing submissions to these October hearings, CTI

1 described the Regulatory Framework for the Deployment,
2 Implementation and Use of Technology as "complex".
3 Chair, respectfully, at the conclusion of the evidence,
4 this would seem to be an understatement. This Inquiry
5 has received evidence from the MHRA, the CQC, and NHS
6 England, NICE and many others and despite the many
7 potential regulatory agencies with an interest in
8 deployment of new technology in healthcare settings,
9 there is no agency who has taken the lead and who is
10 therefore able to cohesively assess our clients' basic
11 queries about safety, consent and cost effectiveness,
12 rather than relying on a Trust-by-Trust analysis.

13 Chair, I'm running out of time, but the
14 recommendation that we suggest in relation to a national
15 framework is this: we say there should be one national
16 framework and lead agency to be tasked with appraising
17 the safety, ethics and cost effectiveness of new
18 technologies before they are deployed in mental health
19 settings. The MHRA, NICE, and NHSE should urgently
20 liaise to consider if or how they can effectively work
21 together to plug the regulatory gap which has resulted
22 in the duplication of assessments of Oxevision across
23 individual NHS Trusts, and Chair, report back to you
24 within a stipulated period. We suggest six months but
25 of course that is entirely a matter for you.

1 Those are our submissions to you, Chair. Thank you
2 for listening to them.

3 **MR GRIFFIN:** Thank you. We hear now from Sophy Miles,
4 please.

5 **Submissions by MS MILES**

6 **MS MILES:** Madam Chair. I'm instructed, with Fiona Murphy
7 of King's Counsel by Bhatt Murphy Solicitors and we are
8 privileged to act for the families bereaved by the
9 tragic and avoidable loss of Bethany Lilley and Edward
10 Jackson in the care of EPUT, and also for X4, who will
11 assist your Inquiry with his lived experience of mental
12 health services within Essex. The overarching
13 motivation of all of our clients is to ensure that other
14 patients and families do not have to suffer as they
15 have.

16 However, the topics of observation and resuscitation
17 do have particular resonance for the family of Bethany
18 Lilley, who died on 16 January 2019. And her avoidable
19 death features many of the topics being considered by
20 your Inquiry, observations and resuscitations being only
21 two.

22 Madam Chair, the root cause analysis report into
23 Bethany's death, which was carried out by EPUT, referred
24 to a theme of observations being downgraded without
25 appropriate assessment or involvement of all members of

1 the treating team. And Madam, the root cause analysis
2 report can be found at BHAT010883.

3 Dr Denman said that the decision to reduce Bethany's
4 observations on the day of her death without a clear
5 understanding of risk was rightly the subject of
6 criticism. It was in no sense an example of positive
7 risk taking, and Dr Denman was clear that any such
8 decision should have been a nuanced, multidisciplinary
9 decision informed by a knowledge of risk, as well as
10 presentation. And that was Dr Denman's evidence on
11 12 October.

12 In her own report, Dr Denman noted that the last
13 observation due for Bethany before she was found
14 unresponsive had not in fact taken place. But that
15 a falsified record had been made. That's her report at
16 INQY028221, page 35.

17 Bethany's family considers that the observations in
18 Bethany's case were a tick-box exercise, evidence that
19 they happened, rather than a record of the quality of
20 interaction and engagements.

21 And turning to resuscitation, Bethany was found
22 unresponsive at 19.45 on 16 January by a support worker.
23 The support worker called for help, and a registered
24 agency nurse arrived immediately. That nurse had Basic
25 Life Support training. The RCA criticised the following

1 aspects of the unsuccessful resuscitation attempt: the
2 Registered Nurse, who was the only qualified person
3 present, left Bethany with support workers while the
4 nurse went to call the crash team. CPR and
5 mouth-to-mouth resuscitation started, but there was no
6 attempt to secure an airway until the crash team arrived
7 seven minutes after Bethany had been found, and the
8 report found that the nurse should have prioritised
9 that. And the ambulance should have been called
10 immediately after calling the crash team.

11 So that is the context for Bethany's family in which
12 these submissions are grounded.

13 Madam Chair, all the clients whom I represent have
14 been greatly assisted by the briefing on recommendations
15 and implementation that you obtained from Dr Emma
16 Ireton. Dr Ireton comments on interim recommendations
17 and she says, at page 8 of her report, that they can
18 play an important role, particularly where urgent risks
19 are identified or where early action is needed to
20 prevent further harm. They can allow inquiries to
21 respond to time-sensitive issues and they must be
22 grounded in evidence that is sufficiently developed to
23 support early action.

24 And with those comments in mind, our clients ask you
25 to consider issuing three interim recommendations. One

1 is at national level, directed to NHS England. And two
2 are directed to EPUT. I'll start with the national
3 recommendation.

4 The clients whom I represent ask you to recommend
5 that NHS England amends its new nationally mandated
6 Skills Framework on Resuscitation. That amendment could
7 take place in one of two ways and we leave the choice as
8 to which to adopt to you.

9 The first approach would be to recommend that there
10 are additions made to the proposed minimum competencies
11 for all mental health inpatient staff with
12 a patient-facing role. Those additional competencies
13 should be as follows: that all staff have the ability,
14 effectively, to escalate concerns around a deteriorating
15 patient, that all staff have the ability to deliver
16 rescue breaths using a two-person bag-mask technique;
17 all staff have the ability to manage airways and
18 breathing, including the insertion of a supraglottic
19 airway and all staff have the ability to respond to
20 self-harm incidents that potentially lead to cardiac
21 arrest.

22 The alternative approach, Madam Chair, would simply
23 be to recommend that the standard is amended by
24 requiring all staff with a patient-facing role in mental
25 health inpatient services to have ILS training by

1 Resuscitation Council UK or an equivalent provider.

2 Madam Chair, on 6 October you heard evidence from
3 Mr Thomas Simons, and from Dr Dawn Adamson, both from
4 NHS England, and you also had the benefit of written
5 evidence from both of them, Mr Simons' statement of
6 28 August, NHSE028083, and Dr Adamson's, from
7 30 September, NHSE028919.

8 And Mr Simons spoke about NHS England's programme of
9 reform to simplify the statutory and mandatory training.
10 There will be a new nationally mandated Skills
11 Framework, and that will set out the expected
12 competencies that all staff must demonstrate, and it
13 will then set out additional competencies that some
14 staff need to demonstrate, and there will be periodic
15 formal assessments of competence.

16 Mr Simons went on to explain, at page 16 of his
17 statement, that under the new framework, all staff are
18 expected to demonstrate the ability to summon help in an
19 emergency by calling 999, or 2222 in a hospital setting;
20 the ability confidently to commence CPR on any adult in
21 any environment; the ability to place and use an
22 automated external defibrillator. And these appear as
23 competencies for all in annex 1 of Mr Simons' statement.

24 And Madam Chair, if you turn to that annex, which is
25 at page 19 of Mr Simons' statement, there is a list of

1 responsibilities of a staff member, and it is worth
2 considering what these say. The responsibilities are
3 listed as saying:

4 "I act by summoning help when someone is choking,
5 having a cardiac arrest, or anaphylactic shock.

6 I report the emergency using the appropriate system. I
7 start by confidently -- I act by confidently starting
8 chest compressions when I encounter someone having
9 a cardiac arrest. I act by confidently using an AED
10 device when I encounter someone having a cardiac
11 arrest."

12 Pausing there, Madam Chair, you will see that the
13 premise upon which these competencies have been drafted
14 appears to assume that the member of staff is dealing
15 with someone who is already in a cardiac arrest and
16 I will return to the evidence of that shortly.

17 The additional specific competences which Mr Simons
18 also explained appear at page 16 of his statement and
19 these include the ability to manage airways and
20 breathing in specific clinical settings, the ability to
21 effectively escalate concerns about a deteriorating
22 patient, and the ability to respond to different
23 self-harm incidents that have the potential to lead to
24 cardiac arrest.

25 And essentially, Madam Chair, you will see that the

1 thrust of our proposed recommendations would be to move
2 some of these additional competencies into the list of
3 competencies that all inpatient mental health staff must
4 show.

5 And Madam, when Dr Adamson gave evidence on
6 6 October, she told you that in her view, a requirement
7 for all staff to receive basic resuscitation would be
8 sufficient in inpatient mental health services. She
9 identified the task of a first responder as being able
10 to recognise cardiac arrest and summon help. They
11 should be able to start Basic Life Support and, where
12 appropriate, apply a defibrillator.

13 But she went on to say that at that point she
14 expected the rest of the team to join and to be able to
15 do the additional competencies of airway management and
16 managing the cardiac arrest.

17 Madam Chair, with all due respect for Dr Adamson's
18 expertise as a senior cardiologist, we submit that she
19 misunderstood the particular risks that arise in
20 resuscitation in mental health inpatient settings.

21 Madam Chair, your Inquiry obtained two reports from
22 Professor Soar, an eminent resuscitation expert. And
23 those are numbers INQY028307, and INQY028308, and of
24 course you heard from him on 8 October.

25 I agree entirely with the summary of his evidence

1 provided by Mr Mant of King's Counsel. I just want to
2 draw attention to a couple of features of his evidence.
3 The majority of the cardiac arrests in mental health
4 services are secondary rather than primary. The best
5 prospect of survival depends on identifying
6 deterioration and intervening before cardiac arrest
7 occurs. And that airway obstruction is the fastest
8 cause of death. And Madam Chair, you may remember his
9 words to you, which is that "Nothing further down the
10 chain matters if you can't get oxygen into somebody's
11 body".

12 And he was clear that the skills needed in order to
13 manage most of the situations that might arise in an
14 emergency response in a mental health inpatient setting
15 include competent CPR, defibrillation, basic airway
16 interventions, including bag-mask ventilation and the
17 insertion of a supraglottic airway and skills for
18 immediate post-resuscitation care.

19 And he was very clear, as you've been reminded, that
20 there is absolutely no barrier to healthcare assistants
21 and other non-registered course staff taking the ILS
22 course, and many do so very successfully.

23 Madam Chair, Professor Soar expressed concerns about
24 the national mandated standards framework as it
25 currently stands, because it doesn't equip the first

1 responders with the additional skills that they need in
2 order to intervene and prevent the cardiac arrest
3 developing in the first place, and he didn't agree with
4 Dr Adamson's approach thinking that it was aimed more at
5 those with a primary cardiac arrest, as opposed to those
6 at risk of secondary arrest.

7 And Madam Chair, based on Professor Soar's expert
8 opinion, you are invited to conclude that the nationally
9 mandated Skills Framework on resuscitation as it
10 currently stands falls short of addressing the minimum
11 needs of mental health inpatients who are at risk of
12 suffering secondary cardiac arrest?

13 Indeed, if the role of the first responder in
14 a mental health setting is to identify a cardiac arrest,
15 as suggested by Dr Adamson, this is already too late.
16 The crucial interventions are those which try to prevent
17 the patient from going into cardiac arrest at all.

18 Madam Chair, Dr Adamson did explain that there would
19 be additional guidance to organisations about how they
20 would layer skills on top of the Basic Life Support for
21 certain staff, depending on what their role is.

22 We invite you to take the view that is not
23 a sufficient answer for three reasons. Firstly, there
24 is the risk that the misunderstanding about the
25 particular needs of patients on mental health wards may

1 continue into the preparation of the guidance.

2 Secondly, there's a qualitative difference between how
3 a provider will respond to the training requirements
4 which are mandated and those which are recommended, and
5 Professor Soar addressed this by analogy in his evidence
6 when he talked about the driver of compliance when
7 requirements are set out by the CQC, given its role as
8 the regulator.

9 And lastly, it is unrealistic to ignore the context
10 of stretched resources of mental health providers and,
11 indeed, this emerges quite clearly from some of the
12 documentation that Mr Simons produced, for example his
13 exhibit TS07, that's NHSE028078. That's a document
14 headed "Action needed to save up to 200,000 days of
15 staff time following changes to statutory and mandatory
16 training".

17 And exhibit TS12, that's NHSE028070, consists of
18 slides from a webinar on resuscitation under the new
19 framework. Slide 4, the headline prominently includes
20 the statement "Releasing 200,000 days of staff time".

21 Madam Chair, this recommendation is time sensitive
22 because, as we heard, the framework is due to be
23 implemented in April 2027. But Dr Adamson was clear
24 that the framework is still very much a work in progress
25 and the Inquiry is well placed to influence and improve

1 the new framework before it's implemented.

2 I'll turn now to the recommendations that we seek in
3 relation to EPUT. Madam Chair, firstly, we invite you
4 to recommend that EPUT amends its safe staff inpatient
5 policy, CLP 84 -- that's EPUT012027 -- to require that
6 at least two members of staff with ILS training are
7 present on each shift. And Madam Chair, you'll remember
8 Professor Soar's concern that none of the documents he'd
9 been provided with by EPUT included a requirement, an
10 expressed requirement, for an Immediate Life Support
11 trained person to be available on shift, available 24/7,
12 to respond in an emergency. And in his view, this gave
13 rise to a potential patient safety risk.

14 When asked about this, Mr Archer relied on the Safe
15 Staffing Model. That we take to mean the Safe Staffing
16 Policy, and this requires clinical staffing
17 establishments to be safe and appropriate and gives
18 guidance as to how that is achieved, but there is no
19 express prescription as to the ratio between registered
20 and non-registered staff to be rostered or any reference
21 to ILS training.

22 Madam Chair, you will remember you asked Dr Suresh
23 about the potential for a healthcare assistant to be
24 taking responsibility for what you described as the
25 "critical first minute".

1 Dr Suresh said that the healthcare assistants' BLS
2 training providers them with the immediate skills, with
3 the ability to stabilise the situation. Madam Chair, we
4 would invite you to take the view that this reflects the
5 same misunderstanding that was demonstrated by
6 Dr Adamson about what is required to prevent a secondary
7 cardiac arrest, and we invite you to prefer
8 Professor Soar's evidence that the additional skills are
9 needed for the crucial interventions in the first
10 minute.

11 And the mitigation that was put forward by Dr Suresh
12 and Ms Sheridan was that there would always be an
13 ILS-trained nurse on each ward. Ms Sheridan said that
14 EPUT's ratio of staff is now 50/50, but she conceded
15 there were occasions at night where only one ILS-trained
16 nurse was present on a ward, and there was no very clear
17 answer to what would happen if that nurse had to be
18 temporarily absent.

19 And we invite you to take the view that this
20 mitigation is not sufficient for all the reasons that
21 Professor Soar gave, and our clients' proposed
22 recommendation is that the Safer Staff Policy be amended
23 so that all inpatient staff rosters include at least two
24 members of ILS-trained staff.

25 Madam Chair, this should not be unduly onerous,

1 given what you've been told about the staff ratio at
2 EPUT, and it allows EPUT, if it chooses, to meet the
3 required ratio by extending ILS training to
4 non-registered staff.

5 Turning to observations. Our clients ask you to
6 recommend that EPUT's Medical Director, Executive Nurse
7 and Chief Operating Officer should take the following
8 steps: firstly, they should jointly review the
9 Therapeutic Engagement and Supportive Observation
10 Clinical Guidance, that's CG100, EPUT020921; that they
11 should complete a Trust-wide audit under paragraph 7 of
12 that policy; and that they should report their findings
13 to the Recommendations and Implementation Forum.

14 Further, we ask you to recommend that EPUT undertake
15 a confidential staff inquiry on the quality of staff
16 relationships with patients, the quality of staff
17 relationships with ward colleagues, whether ward teams
18 work together, and the degree of job satisfaction and
19 morale arising from the delivery of high-quality care.

20 Madam Chair, it was genuinely heartening to read and
21 hear the evidence of Dr Denman, who had an unwavering
22 focus on the need for a working alliance between staff
23 and patients and the vital importance of the quality of
24 therapeutic interactions within observations.

25 And you'll remember her comment that the true value

1 of observations lies in the element of engagement, but
2 all our audits and procedures focus on delivery and
3 timing, not quality. And this resonates with our
4 clients' concerns that observations can be a tick-box
5 exercise. Dr Denman considered there may be a case for
6 a full-scale review of current practice.

7 Dr Denman described the role of the Medical
8 Director, Nursing Director and Chief Operating Officer
9 as the clinical engine behind safe and efficient care,
10 and our clients invite you to recommend that those
11 individuals within EPUT review the current policy to see
12 how effective it is in building the vital working
13 alliance that Dr Denman identified.

14 And the policy should be audited Trust wide and that
15 should particularly interrogate how effectively staff
16 are using some of the prompts in the current policy,
17 which gives prompts for engagement and joint activities,
18 and contains engagement prompt cards.

19 And a report back to the Recommendations and
20 Implementation Forum will provide a valuable starting
21 point so that the forum can consider Dr Denman's
22 overarching proposal for a further review of observation
23 practice generally.

24 Dr Denman identified the core foundations for a ward
25 that can deliver therapeutic engagement, and here, she

1 identified two things irrespective of anything else.
2 She said firstly, staff on the ward like patients, they
3 like being with them, and they like each other and they
4 like working together; and secondly, they are genuinely
5 excited by, actively involved in, and take pride in
6 delivering high-quality care. Our clients consider that
7 the Recommendations and Implementation Forum will be
8 assisted by assessing the extent to which that kind of
9 culture is present in EPUT.

10 And lastly, Madam Chair, given the gravely
11 concerning evidence we have heard in relation to EPUT's
12 use of Datix, we were giving anxious consideration to
13 whether an interim recommendation should be sought in
14 relation to that. But we know that the Inquiry is now
15 obtaining further evidence on this topic. The clients
16 I represent welcome your counsel's confirmation that the
17 Inquiry intends to consider this in detail.

18 Our clients will do their best to assist you in this
19 task, and will return to this critical area for patient
20 safety in future hearings.

21 Thank you, Chair. Those are our submissions.

22 **MR GRIFFIN:** Chair, we come now to a pause. May I suggest
23 that we reconvene at 11.30. 11.30.

24 **THE CHAIR:** 11.30. Thank you.

25 **MR GRIFFIN:** Thank you.

1 **(11.15 am)**

2 **(A short break)**

3 **(11.30 am)**

4 **THE CHAIR:** Mr Griffin.

5 **MR GRIFFIN:** Thank you, Chair. We hear now from Brenda
6 Campbell, King's Counsel.

7 **Submissions by MS CAMPBELL KC**

8 **MS CAMPBELL:** Chair, these submissions on behalf of the
9 bereaved clients of Bindmans LLP focus on observations
10 and technology. That does not diminish the importance
11 of the resuscitation evidence. The inquests of Edwige
12 Nsilu, and Sophie Alderman revealed chaos and confusion
13 in emergency response, and in Edwige's case the
14 undertones of racial stereotyping. Our clients
15 therefore fully endorse the calls you have heard for
16 improved ILS training and deployment across the NHS and
17 independent provider wards, supported by routine
18 simulations and drills, including training on
19 resuscitating patients with darker skin tones.

20 However, Chair, to avoid duplication, our
21 submissions focus on observations and technology and, in
22 particular, the use of Oxevision.

23 Chair, based on the evidence, we urge you to
24 recommend that the use of Oxevision on mental health
25 inpatient wards is stopped nationally. We invited that

1 recommendation when I addressed you in December last
2 year, and the evidence since not only establishes the
3 legitimacy of that request, but it proves that nothing
4 short will suffice.

5 You have heard enough evidence, Chair, considered
6 enough false promises, reviewed enough so-called
7 research, heard of enough pilots and rollouts, enough
8 misuse of this camera-based technology. You have
9 learned of enough Trusts seeking to withdraw it, and
10 considered enough harm to patients to know that enough
11 really is enough.

12 The story of Oxevision is one of false promises and
13 assurances that found traction in an inadequately
14 regulated sector in which, as Hat Porter told you,
15 however loud patient voices are, they are not listened
16 to. It is a story of ever-diminishing claims in direct
17 proportion to ever-increasing scrutiny, such that you
18 can now safely conclude that the residual claims of
19 limited clinical benefit do not outweigh the significant
20 harm to patient safety, autonomy and privacy.

21 Chair, you have listened. When Stop Oxevision
22 presented the evidence from their painstaking work, you
23 immediately recognised the legitimacy of their concerns
24 and the need for further inquiry, and for that, our
25 bereaved clients are grateful. Our clients maintain

1 that Stop Oxevision has done society a great service,
2 exposing contradiction after contradiction from
3 Oxehealth, identifying unlawful and harmful practices by
4 Trusts, dispelling myths presented as fact, filling the
5 gap left by regulators and bringing patient voices to
6 the fore. Their concerns will be addressed in turn.
7 About the history of the technology [audio distorted]
8 achieved, the lack of transparency and misinformation,
9 technical and clinical limitations, harm to patients and
10 therapeutic relationships, the fragmented regulatory
11 landscape and flawed research. They have each been
12 validated by the evidence, such that our bereaved
13 clients now ask you to exercise your power to intervene.
14 Chair, the history of Oxevision. In his recent open
15 letter, the Chair of the Oxehealth Board pleads for more
16 time for this technology to prove itself, urging that
17 "healthcare technology cannot be expected to emerge with
18 perfect foresight." That plea belies the reality that
19 the technology was incorporated in 2012, making it over
20 14 years old. In that time, it was unsuccessfully
21 marketed to hospitals, neonatal units and police custody
22 suites before finding its niche in secure mental health
23 wards, originally and tellingly as Oxecam, a clear
24 reference to the camera that is its main function.
25 By 2019, the technology was being sold to EPUT with

1 the advice from Oxehealth that it where it was used in
2 the normal course of treatment, they did not believe
3 consent was needed, notwithstanding that the pilot
4 permitted Oxehealth to access and retain data, including
5 video images for research and development, and gave it
6 control over some publication relating to the system.

7 And so, Chair, it began. What followed was, we
8 contend, a supplier-led installation rather than
9 a genuine evaluative pilot. No pre-installation
10 assessment of clinical suitability; no stop-go stage; no
11 meaningful consideration of patient feedback or staff
12 concerns. In overview, however, the evidence shows that
13 amongst other things, staff -- Oxehealth staff were
14 over-represented on Project Boards, while EPUT clinical
15 staff were underrepresented.

16 Early supplier-derived SOPs described Oxevision as
17 "technology for conducting observations", and re-stated
18 that patient consent was not required. Their flowcharts
19 directed staff to "take an observation", viewing
20 unsuspecting patients remotely to confirm location,
21 pulse and breathing rate, and to check in-person only if
22 concerns arose. Nothing, Chair, prohibited its use for
23 level 1 or level 2 routine observations.

24 Project Board minutes revealed extraordinarily high
25 usage while successful Vital Signs readings were

1 commonly only 50 or 60%. One ward exceeded 3,000
2 attempts in a week. 200 to 400 observations a day was
3 said to show the system "being used as intended".

4 Minutes recorded that nighttime observations were to
5 be covered by the Oxehealth system.

6 Accelerated rollout decisions followed, Chair,
7 alarmingly in tandem with announcements of a NHSE
8 prosecution and [audio distorted] possibly, as you've
9 heard, in response to year end budgets. As Dr Denman
10 opined, data was used to gather support for the system
11 rather than for balanced evaluation. Minutes recorded
12 that staff behaviours needed to change, revealing that
13 Oxevision was expected to replace existing observation
14 practice, not to operate as an adjunct.

15 By May 2021, there were reports of alarms being
16 turned down on wards, of staff believing the system
17 detected if a patient stopped breathing and of child
18 patients on a children's ward being seen in the bathroom
19 naked or undressed.

20 Although early privacy documentation acknowledged
21 systematic monitoring comparable to CCTV, and patient
22 unawareness, and excessive data retention, it was only
23 after regulatory intervention, the ombudsman's ruling
24 and this Inquiry's scrutiny that EPUT moved from no
25 consent to implied consent with default usage, to an

1 opt-in model. A journey, Chair, that has taken
2 six years.

3 And within those years, on 17 April 2021, Elise
4 Sebastian, aged 16, tied a ligature in her room on an
5 EPUT CAMHS ward at the St Aubyn Centre and died two days
6 later.

7 On 14 October 2021, Adam Steel, aged 36, died
8 unexpected in the Peter Bruff Unit at Colchester
9 Hospital. On 6 July 2022, after missed observations and
10 an Oxevision bathroom alert being reset without
11 attendance, Morgan-Rose Hart was left unattended for
12 about 50 minutes and tied a ligature. She died six days
13 later aged just 18. On 10 July 2022, Michael Nolan,
14 aged 63, suffered a fatal foreign body airway
15 obstruction. The inquest found that HCAs consistently
16 used Oxevision as a substitute for observation and
17 engagement, and that training didn't convey to staff
18 that Oxevision wasn't an alternative to in-person
19 observation and engagement.

20 And on 19 August 2022, Sophie Alderman moved from
21 her bedroom to her bathroom with a ligature around her
22 neck. Three minutes after she was last detected in her
23 room, an alarm sounded but went unresponded. Sophie was
24 found seven minutes later only when an HCA independently
25 checked on her.

1 Her mother, Tammy, told you her fears that Sophie
2 believed Oxevision would bring staff to save her.

3 Chair, lack of transparency, misinformation and
4 consent. Hat Porter's starting point was simple:
5 a camera in a bedroom is a very significant invasion of
6 privacy, affording patients no sanctuary and no means of
7 knowing when they are being watched. Yet despite the
8 coercive power imbalance on psychiatric wards and
9 Oxehealth's opaque retention of footage, Trust materials
10 repeatedly used deliberately obscure language such as
11 "optical sensor" and "ambient monitoring" with seven
12 Trust posters obtained by FOI omitting the word "camera"
13 altogether.

14 Their striking similarity leads to the inescapable
15 conclusion that they were manufactured templates adopted
16 without sufficient consideration of what patients were
17 entitled to know.

18 Lack of transparency was also a repeated feature of
19 NHS England's internal correspondence and its
20 correspondence with the MHRA in 2021 and '22, which even
21 then noted the tension in Oxehealth claims that the
22 system was not used for reviewing patients when, in
23 Vital Signs mode, you can view people whenever you like
24 and either take or not take a spot measurement.

25 In Gareth Harry's evidence you heard that NHSE

1 sought to "appeal to Oxehealth's better nature" to
2 reduce staff and patient misunderstanding and obtained
3 only "weak changes".

4 That obfuscation was, and we contend, is, so
5 pervasive that it cannot be accidental. Indeed, Chair,
6 it has afflicted your Inquiry. Asked about patient
7 consent to recording and storing footage, Ms Cozens
8 repeatedly referred to the now withdrawn national
9 guidance from the Nurse Directors Forum, described by
10 Oxehealth as co-produced with NHSE. Yet, in a recently
11 disclosed email to NHSE about that guidance, a forum
12 member wrote: "I was not aware that Oxehealth had any
13 access to the recordings. I think we should have this
14 confirmed with them. That aspect is very worrying. We
15 were not informed."

16 Despite Ms Cozens' assurances in evidence last year
17 that Oxehealth does not under any circumstances retain
18 Clear Video Data, a more recently disclosed spreadsheet
19 on Oxehealth's processing of patient data records that
20 at least until August 2022, Oxehealth stored and used
21 clear video footage from patient bedrooms. The Inquiry
22 has no reason to believe that any patient properly
23 consented to that use.

24 Chair, in her evidence, your expert witness,
25 Ms Archibald, stated that even accessing pixelated

1 images should not be treated as non-intrusive, because
2 "the patient has no idea that you've just looked into
3 their bedroom" and that "24-hour filming is neither
4 absolutely necessary nor justified."

5 Dr Denman considered that only explicit consent to
6 such practices would suffice.

7 Where Leicestershire Partnership Trust used genuine
8 opt-in practices, fewer than half of patients
9 consulted -- consented and NELFT's review found "little
10 evidence that consent was fully informed, voluntary and
11 free from coercion."

12 Yet monitoring, viewing and recording patients in
13 their bedrooms without consent persisted at EPUT up to
14 and during this Inquiry, and but for patients and
15 campaigners, might persist still.

16 The Inquiry is invited to conclude that this is not
17 accidental. The technology was described to patients,
18 regulators and customers in materially misleading terms
19 so repeatedly that it could not be inadvertent.

20 Chair, technical limitations and limited clinical
21 value. Jill Archibald was clear that the Vital Signs
22 function covers only two of the six NEWS2 parameters and
23 cannot and does not replace physical health monitoring.
24 It fails where a patient moves, is covered, or has
25 scarring or tattoos. Dr Denman described it as

1 clinically "your use of last resort".

2 All of this, Chair, reflects the evidence that Hat
3 Porter gave you over a year ago.

4 A decisive concession came last week from Dr Suresh,
5 who agreed with Ms Porter and your experts, that for
6 mental health inpatients, vital signs add little value;
7 at its most basic the function tells us that somebody is
8 alive.

9 Oxevision's marketed primary clinical purpose is, on
10 EPUT's own account, of marginal clinical value at best.

11 Dr Denman accepted only very limited utility in
12 seclusion, for example after restraint or sedation,
13 where NEWS2 cannot be obtained in person, and then for
14 the shortest possible time. Even there, there is no
15 need for a camera, because Oxevision should not be
16 relied upon for remote observations. The patient should
17 always be within sight.

18 In health-based places of safety, she would also
19 want "eyes on the patient", considering remote
20 observation useful only if that was impossible.

21 Chair, misuse revealed by usage reports. Usage data
22 confirms what system became in practice. Stop
23 Oxevision's evidence pointed out that on Ardleigh Ward,
24 as recently as July 2024, less than 27% of approaching
25 36,000 camera views yielded a vital sign result

1 consistent with staff obtaining near constant video
2 footage of patients. Trust-wide data showed many wards
3 obtaining vital signs in fewer than half of attempts,
4 supporting concerns that the system is being used for
5 visual checks. And that analysis now appears accepted.

6 Mr Trent and Dr Suresh acknowledged the concern that
7 staff "might be inappropriately using the Vital Signs
8 function to get a clearer view of a patient". But does
9 reference to inappropriate usage by staff not deflect
10 from clear institutional responsibility? Beverly
11 Switzer's evidence was that on coming on shift, she
12 always used it to check where everybody was, and only
13 after Adam Steel's death were staff then stopped and
14 required to check visually, although it should have been
15 an extra check, staff, including Ms Switzer, used it as
16 one of their four hourly checks, and that was not unique
17 to EPUT.

18 TEWV conceded that before 2024, such checks were
19 "they weren't used for the purpose of taking somebody's
20 pulse; they were used for the purpose of being able to
21 see that the patient was okay."

22 And of course they were, Chair, because as Dr Denman
23 told you, the system consistently tempts staff to use it
24 in an incorrect way.

25 Asked last week to recognise the possibility for

1 abuse inherent in that aspect of its design, Ms Cozens
2 said that mental health staff are not bad actors, and
3 pointed to recent safeguards of individual staff log-ins
4 identifying who viewed a bedroom or reset an alert.

5 But that answer, Chair, fails to recognise that
6 using the system to observe patients, far from being
7 recognised as abusive, was marketed as its very purpose,
8 including, Chair, to you. In its opening statement,
9 EPUT lauded Oxevision as allowing staff continuously to
10 track Vital Signs, monitor activity, and conduct
11 observations.

12 Any repositioning by EPUT or Oxehealth that such use
13 is inappropriate reflects not proactive patient
14 protection, but the clearest and most self-serving
15 reversal under public scrutiny.

16 Chair, displacement of therapeutic engagement, over
17 reliance and alarm fatigue. Here again, Hat Porter's
18 evidence that Oxevision displaces in-person therapeutic
19 engagement, that staff overestimate its capabilities,
20 that alarm fatigue leads to alerts being reset or muted
21 without checks has been borne out entirely. This may be
22 the most tragic area of convergence.

23 Mr Trent accepted last October that staff have
24 over-relied on Oxevision at times, and that observation
25 through a screen means therapeutic contact will be lost.

1 He accepted that Elise Sebastian's death reveals staff
2 meeting alerts, with alarm fatigue "one possible
3 analysis". The inquest into Morgan-Rose Hart's death
4 found observations were "mainly completed via
5 Oxevision", and a bathroom alert was reset without
6 attendance.

7 Frontline witnesses agreed. Brian O'Donnell
8 described to you alerts sounding constantly, and agreed
9 this could definitely lead to muting and said the system
10 "can lend towards some people being lazy."

11 Dawn Lowe said staff were "just carrying on and
12 ignoring it". TEWV described its alerts as
13 unmanageable. Victoria Sebastian, having learnt that
14 relevant systems or alarms were not working or not
15 responded to properly when her daughter died, told you
16 that the system is not fit for purpose on a mental
17 health unit.

18 Dr Denman identified the naive vision that looking
19 at a patient on a screen establishes their safety, and
20 warned that "the technology is used to make a promise
21 that can't be fulfilled."

22 Hat Porter also described to you the panopticon-like
23 sense of constant surveillance, the lengths patients go
24 to hide from cameras, and the particular vulnerability
25 of detained patients, survivors of sexual violence, and

1 neurodivergent patients, a disproportionate impact not
2 considered at all, EPUT having declined to undertake an
3 equality impact assessment.

4 Ms Archibald agreed. The camera can increase
5 patient paranoia. She had seen patients scream at the
6 device, and for trauma survivors, filming can be very
7 traumatic. She described a pregnant patient sleeping in
8 an interview room to avoid the camera and considered
9 remote observation of a woman by a male staff member to
10 be "more distressing than in person because you're not
11 aware of when and how frequent it's happening."

12 Tammy Smith described Sophie's fear of being tracked
13 or spied upon. Yet, this in intrusive technology spread
14 to up to 50% of NHS Trusts, although mercifully, an
15 ever-reducing figure.

16 Why? Why did it spread? Because, despite recent
17 assurances that patient voices must be central,
18 Dr Denman told you patients were not involved in the
19 development or rollout of the system or the Standard
20 Operating Procedures. Professor Donnelly stressed that
21 lived experience must be built in at the outset. It was
22 not. Chair, the voices were loud, but they were not
23 listened to.

24 In terms of the least restrictive option and less
25 intrusive alternatives, Hat Porter reminded you that the

1 least restrictive option is a core principle of both the
2 Mental Health Act and the Mental Capacity Act, and that
3 less restrictive options exist. Dr Denman stated that
4 the system should be imposed on a detained patient only
5 where it is genuinely the least restrictive option, and
6 doubted whether Mental Health Act powers extend to
7 physical health functions.

8 It's unclear, Chair, how Oxevision could ever be the
9 least restrictive option. Of the benefits Oxehealth
10 continues to promote, in respect of falls, TEWV accepted
11 that bed pads might be cheaper and less invasive. Ian
12 Arthur described EPUT's own use of mattress, floor, and
13 edge-of-bed sensors. In respect of vital signs
14 measurements, Dr Denman identified wearables and RFID as
15 camera-free options.

16 For nighttime observations, Ms Archibald and
17 Dr Denman agreed that nighttime vital signs measurements
18 are unnecessary, that rooms should permit patients to be
19 viewed from the window of the door of the bedroom, and
20 that some patients find nights incredibly difficult for
21 various reasons and may benefit from more in-person
22 support.

23 Most strikingly, Chair, Ms Archibald stated that
24 Oxevision is "not an essential piece of equipment to
25 keep somebody safe and although less physically

1 intrusive, may be a much greater infringement of
2 privacy."

3 EPUT's own Professional Nurse Educator, Zoe Bunting,
4 described it as "directly contrary to a least
5 restrictive practice" and "incredibly intrusive."

6 Chair, the fragmented regulatory landscape. Hat
7 Porter described a rapid expansion into NHS mental
8 health Trusts amid "a fundamental absence of critical
9 engagement, a simultaneous lack of oversight and was
10 recognised only as a result of patient activism."

11 The regulator's evidence shows that DHSC is reliant
12 on the work of the ALBs, that the CQC neither analyses
13 technology nor assesses manufacturers' claims yet
14 labelled Oxevision as "outstanding practice" in 2018,
15 and engaged with its risks only after Stop Oxevision's
16 approach in August 2023, and that NICE and BSI disclaim
17 responsibility for wider patient impacts. NHS England
18 accepted it has no proactive monitoring responsibility,
19 recorded an internal alarm that device regulation is not
20 as robust as medication regulation and responded to
21 non-compliant Trusts identified by Stop Oxevision merely
22 by informing the CQC.

23 Hat Porter's evidence captured that fragmentation.

24 They said: "There's this landscape of such an
25 obscure and poorly coordinated system of different

1 providers where there's, like, a lot of 'We're not going
2 to look at that because that's somebody else's job, and
3 they're going to do that' but in the space between that,
4 there are gaps where people are, patients, disabled
5 people in hospitals are left at real risk, and so that
6 is the space that our campaign has come from, out of
7 necessity, because if we didn't do this, nobody else was
8 going to do it."

9 Chair, Dr Suresh told you that evaluation of
10 technology should occur at a higher level than
11 providers, before wider NHS use. Coming from the
12 Executive CMO of one of Oxehealth's largest clients that
13 should be your canary in the coalmine. He referred to
14 the NICE two-stage model. Stage one: does it work?
15 Does it do what it says? Stage two: is it deployable
16 across the NHS in terms of cost effectiveness, ease of
17 use and added value to patient care? Remarkably, you
18 have heard that no evidence -- you have heard no
19 evidence that either stage was applied to Oxevision
20 before such widespread adoption.

21 But you now know the answers to those questions.
22 Does it work? No. It offers no protection to patients
23 against self-harm or strangulation. Can it be justified
24 in terms of cost effectiveness, ease of use, and added
25 value to patient care? No, as the evidence, including

1 the work of your statisticians confirms.

2 And of the integrity of the evidence base that you
3 have been presented, Chair, Hat Porter again forewarned:
4 the evidence base would not withstand scrutiny. Papers
5 continue to be retracted as this Inquiry progresses.
6 All four economic papers disclose conflict of interest
7 and the Inquiry's statisticians found no evidence even
8 of moderate weight supporting clinical effectiveness.
9 The claimed 44% reduction in self-harm fell to a
10 statistically non-significant 22% when the Oxevision
11 ward was examined alone.

12 Nor did the promise, Chair, of savings materialise.
13 TEWV never achieved its projected 1 million annual
14 saving; Leicestershire found no clear financial benefit;
15 Dr Denman said EPUT's financial case depended on using
16 the system in the very way it was said not to be used,
17 and asked to justify the 4.3 million expenditure,
18 Dr Suresh accepted that evidence of what Oxevision had
19 prevented was not available.

20 Chair, Dr Suresh's two-stage NICE model merits your
21 close consideration in recommendations, including, we
22 say, in future hearings on regulation and governance,
23 particularly when considering future technology. But it
24 offers no refuge or rescue to this technology. The
25 questions are already answered, and Oxevision offers

1 nothing to the future of mental health inpatient care.

2 **MR GRIFFIN:** Please bring to your submissions to an end.

3 **MS CAMPBELL:** And so Chair, in conclusion, the evidence
4 presents a coherent picture. A technology was
5 introduced at speed on supplier-led evidence, a base
6 that has since been discredited. Described in language
7 that concealed its nature, imposed without consent, used
8 in practice for remote observations and permitted to
9 displace human engagement on which safe care depends.
10 Its harms have fallen hardest on detained, traumatised,
11 neurodivergent patients, and no regulator assumed
12 responsibility for it.

13 Oxehealth suggests, Chair, in their open letter,
14 that you should recommend a national working group to
15 discuss these issues further, and produce yet more
16 guidance. We say, Chair, that another talking shop
17 14 years after the technology was incorporated is
18 insufficient to safeguard patients and unnecessary on
19 the evidence you have heard.

20 So we invite you, Chair, to expressly recommend that
21 the use of Oxevision on mental health wards and
22 seclusion be stopped. Reflecting, there but for the
23 grace of god go I, Dr Denman told you it was more luck
24 than judgement that her organisation did not roll out
25 this technology. The same may be true of other Trusts.

1 But we cannot rely on luck where patient lives are at
2 stake. It is --

3 **MR GRIFFIN:** That is time now, please, Ms Campbell.

4 **MS CAMPBELL:** -- (overspeaking) -- time to exercise
5 judgement, Chair, and that is what we invite you to do.
6 Thank you.

7 **MR GRIFFIN:** Thank you.

8 We hear now from Anna Morris, King's Counsel.

9 **Submissions by MS MORRIS KC**

10 **MS MORRIS:** Chair, I appear alongside Ciara Bartlam,
11 instructed by Charlotte Haworth Hird of Bhatt Murphy
12 Solicitors and make these submissions on behalf of the
13 charity INQUEST.

14 As the Inquiry has recognised, INQUEST provides
15 advice and expertise to bereaved people in relation to
16 state-related deaths. INQUEST has taken an active role
17 in assisting the Inquiry in these October hearings,
18 including by providing numerous relevant questions via
19 the Rule 10 process.

20 INQUEST recognises from its casework and campaigning
21 the importance of the two key issues upon which you are
22 considering making interim recommendations:
23 Resuscitation and observations and the use of
24 technology.

25 But, INQUEST also urges the Inquiry to analyse,

1 through the lens of these issues, some of the consistent
2 thematic threads that run through failures in care
3 provision within mental health settings, namely:
4 failings in accurate incident reporting, poor data
5 collection, failures of candour, poor reflective
6 practices and learning, insufficiencies in training and
7 staffing capabilities, failures in patient-led care,
8 engagement with families and insufficient oversight from
9 external investigative and regulatory bodies.

10 In terms of interim recommendations, Chair, INQUEST
11 makes two headline submissions: first, the training of
12 all healthcare assistants in Immediate Life Support
13 training, and second, the cessation of use of Oxevision
14 in mental health settings.

15 We also make a number of practical submissions that
16 sit alongside those headline submissions. I'll deal
17 first with the evidence you heard in relation to
18 resuscitation in your first week of October hearings and
19 back in July.

20 Chair, you can be in no doubt of the urgency of this
21 issue, and the need for an interim recommendation that
22 goes to the heart of patient safety. Within the time
23 frame of this Inquiry, and as recently as August of this
24 year, there has been another death from a ligature
25 incident in Essex. Cardiac arrests, whether secondary

1 to ligature or some other cause, may happen relatively
2 infrequently but when it does happen, the results are
3 the most catastrophic, not just for the patient and
4 their relatives but for staff and other patients on the
5 ward.

6 INQUEST's core submission is that all HCAs working
7 within mental health wards should receive Immediate Life
8 Support training and that this training must be both
9 classroom based and involve simulation exercises. This
10 submission recognises and reflects the evidence you
11 heard from Professor Soar that in mental health
12 inpatient settings the first staff to reach
13 a deteriorating or collapsed patient must have the
14 broadest set of practical skills as it must not only
15 recognise the emergency but also call for help and start
16 the ABCDE or CPR as appropriate.

17 He told you in the clearest terms that the first
18 person that gets to you has the best chance of saving
19 your life.

20 Professor Soar emphasised to you that it should be
21 guaranteed that there should be an immediate response to
22 an ILS-trained person 24/7, and he highlighted that this
23 would be difficult to achieve with only one ILS-trained
24 nurse on a ward, particularly if they're engaged on
25 a break or engaged with other tasks. Ann Sheridan from

1 EPUT acknowledged in her oral evidence that although
2 rare, it is currently possible to have just one
3 ILS-trained nurse on a shift at night. The risk of that
4 ILS-trained nurse not being available within a minute is
5 mitigated if all HCAs are ILS-trained.

6 Professor Soar told the Inquiry in his oral evidence
7 that it was logical to give all HCAs ILS skills, given
8 that they make up the large proportion of the workforce
9 who would be first responders. Professor Soar's
10 evidence is at odds from the proposition advanced by
11 Dr Adamson from the NHSE in her oral evidence that
12 unregistered staff being trained in ILS could lead to
13 harm.

14 Professor Soar said he saw no reason why HCAs could
15 not receive ILS training, as HCAs often do clinical work
16 and ILS training is taught in non-clinical settings.

17 Louise Borton from EPUT in her written evidence
18 noted that in September 2022, within EPUT, enhanced
19 emergency skills were available to both registered and
20 unregistered staff. In her view, this supported patient
21 safety, and it was the transition to the ILS course
22 which was offered to registered staff only that reduced
23 the opportunity for unregistered staff to develop and
24 maintain enhanced emergency response skills.

25 This undermines, Chair, the suggestion that

1 unregistered staff cannot and should not be expected to
2 perform any additional steps and utilise the equipment
3 covered by ILS training.

4 Of course, Chair, there must be recognition of the
5 training burden that Dr Adamson highlighted, but
6 training must be seen alongside preparation to apply
7 that training in real-life scenarios. So-called
8 over-training only becomes an issue if the training
9 itself still leaves staff underprepared for a real-life
10 response. As Louise Borton recognised in her written
11 evidence, some of the most significant challenges in any
12 emergency response tend to relate to systems,
13 communication, equipment accessibility, escalation
14 processes, and the application of learning.

15 These issues require ongoing review through
16 simulation, audit and organisational assurances if
17 improvements are to be sustained.

18 Therefore, Chair, INQUEST invites you to consider
19 making the following related and national
20 recommendations. First, regular refresher sessions at
21 intervals of at least once every six months with
22 protected time for training. The second part, Chair,
23 makes it important and embedded that systems will have
24 that time protected to ensure that all staff receive the
25 training that they need, even in busy clinical

1 situations.

2 Second, all staff to engage in a minimum number of
3 simulations throughout the year, including scenarios at
4 weekends and at evenings. Of course it is right, Chair,
5 as Rebecca Lingard highlighted, that staff find
6 emergency response situations very stressful, even with
7 training, because they are not utilising those skills
8 daily. Simulations must meaningfully address this, and
9 properly prepare staff with the real-time responsibility
10 and resilience that they need to act immediately and
11 decisively in a crisis.

12 Third, improved systems for checking that training
13 has been completed as required. Nicholas Archer's
14 evidence cannot have given you confidence, Chair, that
15 EPUT adequately understand or monitor who has attended
16 simulations and when.

17 Fourth, all training and scenarios should include
18 bank and agency staff. Mr Archer did not substantively
19 address this issue in his evidence despite being asked
20 whether bank and agency staff were involved in
21 simulations and how this was monitored.

22 Fifth, there should be an absolute bar on any staff
23 member who is not compliant with mandatory ILS training,
24 where required for their role, being included in the
25 numbers for ILS-trained staff on any shift until that

1 training has been completed as required.

2 Chair, you've received written evidence from
3 numerous providers from across the UK. The vast
4 majority of these comparator Trusts only require doctors
5 and nurses to have completed ILS training, and there
6 appears to be real divergence in simulation practice.
7 INQUEST caseworkers see the impact of poor or delayed
8 emergency response every day in their work. It is one
9 of the most common issues in their casework in mental
10 health inpatient deaths. And this supports our
11 submission that these must be national recommendations.

12 But more important than the response itself is the
13 prevention of the incident that led to the medical
14 emergency. As Professor Soar told the Inquiry, the best
15 way to guarantee survivable outcomes in the context of
16 secondary cardiac arrests is to prevent them from
17 happening in the first place, and therefore, INQUEST
18 urges the Inquiry to make a recommendation that there
19 should be strict national policies on the immediate
20 removal of all ligatures when observed in use by
21 patients in inpatient settings, in recognition, Chair,
22 of the fact that there is, in reality, no safe way to
23 tie a ligature.

24 We also urge the Inquiry to make a recommendation
25 that all patients considered to be at risk of ligature

1 and/or choking should be observed by those with ILS
2 training. Of course, Chair, if all HCAs are
3 ILS-trained, then this will require no further staffing
4 calculation or ratio assessment, which is especially
5 important in settings with high acuity and high levels
6 of patients identified with a risk of ligature.

7 Finally on this topic, Chair, we return to our
8 opening remarks about this topic being a lens through
9 which the Inquiry can view key themes and failings.
10 INQUEST urges you to make an EPUT-specific
11 recommendation for improved data collection and analysis
12 internally. Rebecca Lingard told the Inquiry that ELFT
13 doesn't hold any information either as to how HCAs are
14 first on the scene but this could specifically be
15 tracked from incident reporting. We also ask you to
16 make a further national recommendation that data is
17 collected nationally on the number of cardiac arrests in
18 inpatient mental health settings.

19 Professor Soar said in his written report that there
20 was no formal data collection for cardiac arrests in
21 mental health settings, but that it is feasible with
22 funding and data linkage expertise to identify those
23 events and create a report based on the two voluntary
24 audits of cardiac arrests.

25 Without this bedrock of data, Chair, on how many

1 cardiac arrests there are and who is responding, there
2 can be no real learning.

3 Chair, I now move to INQUEST's second topic of
4 recommendations: observations and the use of technology.

5 Chair, you must make your findings and
6 recommendations on the evidence and the quality and
7 consistency of that evidence matters. It matters when
8 considering what weight to attach to any given piece of
9 evidence and it matters when considering whether to
10 attach any weight to it at all. In the context of the
11 evidence supporting the use of Oxevision to assist with
12 the patient observations, over the last year of your
13 Inquiry and the interrogation of its evidential
14 foundation for safe use, has created a collapse of the
15 house of cards.

16 Ms Campbell has carefully and eloquently taken you
17 through that evidence but just to highlight a few key
18 points: when Ms Cozens first supplied written evidence
19 to this Inquiry on behalf of Oxehealth in March 2025,
20 she lauded the quote "extensive evidence base
21 demonstrating the clinical and operational value of
22 Oxevision." She told you about the evaluations that
23 consistently showed that the technology supports staff
24 to deliver improvements in safety, quality and
25 efficiency on mental health wards. The key findings you

1 were told included reductions in the rates of patient
2 safety events, including self-harm, falls and
3 restraints; enhanced physical health monitoring, time
4 and cost savings, and improvements in both patient and
5 staff experience.

6 Those assertions were mirrored in the context of
7 Oxehealth's website, the materials that were given to
8 providers to support their business cases, in the
9 evaluations that Oxehealth helped to curate and in the
10 published research which was said to independently
11 expand the many benefits of this new technology which
12 would save cash-strapped mental health providers tens of
13 thousands of pounds per ward per year.

14 Oxehealth Ltd, now LIO, has been involved in almost
15 every exercise designed to publicly promote the benefits
16 of the Oxevision system. Theirs is a masterclass in
17 marketing and brand development, but is an absolute
18 scandal for patient safety.

19 The submissions that you've already heard on behalf
20 of the bereaved families and people with lived
21 experience have exposed the fundamental flaws in the
22 so-called evidence base and two further points arise.
23 First, and most importantly, INQUEST give full credit to
24 Stop Oxevision for their tireless work in bringing to
25 light the many limitations and patient safety risks. As

1 Ms Campbell, King's Counsel highlighted from Hat
2 Porter's evidence, if they hadn't done it, no one else
3 would have done.

4 Second, the question must be, has any mental health
5 provider actually realised the sort of savings in
6 staffing costs and time that were sold to them as
7 a benefit before they purchased the Oxevision product?

8 Chair, the Inquiry has heard that for the majority
9 of patients in mental health wards it is unnecessary to
10 take physical health observations once an hour. The
11 norm you've heard is once every 12 hours at EPUT, and as
12 Dr Suresh told you, the most Vital Signs function can do
13 is tell you if a patient is alive. But on a mental
14 health ward, as you've heard, it cannot tell you if they
15 are safe. It cannot tell you if they are well.
16 Therefore, the actual benefits of the Vital Signs
17 function don't exist.

18 As these hearings have proceeded to hear evidence,
19 the emphasis has shifted to the benefits of the
20 Oxevision Activity Tracker and this is where the data
21 really matters. So Laura Cozens is right in one
22 respect: it is crucial that you take a truly balanced
23 view of the evidence.

24 Both she and EPUT have relied heavily on the
25 real-world data for mental health providers and in

1 particular on the figures to the 1,453 Datix incidents
2 at EPUT where Oxevision was said to have "assisted staff
3 to make more timely interventions when required and
4 therefore assisted in preserving life."

5 Your counsel, Mr Griffin, King's Counsel, has
6 already laid out the deficiencies in that data in his
7 closing statement last week but there is another
8 important point. Even if the data were reliable, the
9 use of Oxevision did not prevent a single one of those
10 1,453 serious incidents from occurring.

11 As Dr Suresh pointed out, almost 1,000 ligature
12 incidents occurred despite Oxevision being in use. The
13 downward trend in ligature incidents that have been
14 extolled by EPUT also turned out to be a complete
15 fiction. There was not, actually, a downward trend
16 overall, and if there had been, correlation does not
17 equate to causation as Zephah Trent conceded.

18 Bad data, Chair cannot make good evidence, and yet
19 that is what you are being asked to give weight to.
20 Statistics such as these should never have been
21 celebrated and yet they have been spun by one
22 stakeholder, EPUT and one stockholder, Laura Cozens, as
23 a reliable sign of success.

24 Notably in this Inquiry you have only been supplied,
25 Chair, with evidence by the manufacturer of benefit and

1 not of harm. Only Stop Oxevision and the bereaved
2 families and the lived experience patients have provided
3 you with data as to the significant harm caused by
4 Oxevision. It's not known how many patient safety
5 incidents have related to its misuse. It's not known
6 how many people have died while Oxevision were installed
7 in their bedroom, either locally or nationally on
8 independently verified data.

9 It has been left to Stop Oxevision and those with
10 the lived experience of the harms of this technology to
11 raise the alarm to present you and the public with the
12 data they have, but it should not have fallen to them
13 alone.

14 What you have heard is that in May 2021, the then
15 Deputy Director of Patient Safety at NHS England wrote
16 a report based on the analysis of 136 serious incidents
17 connected to Oxevision use, which uncovered significant
18 patient safety risks. Remarkably, Chair, that analysis
19 was not initially provided to your team by NHSE itself.

20 Apparently, they only became aware of the existence
21 of the report through the disclosure that had been
22 received from the MHRA. That may indicate a lack of
23 candour on behalf of NHSE or a lack of competence.
24 Either way, it's astounding that that evidence was not
25 brought to your attention, Chair, either sooner, by NHS

1 England or Oxehealth itself, and it's highly concerning
2 that the same sort of analysis has not been repeated
3 since.

4 The NHSE analysis contained examples of all the key
5 patient safety risks connected with this technology and
6 yet providers nationally were not told about them either
7 by NHSE or MHRA. Alongside the misuse of the system,
8 there are two common misunderstandings of the system
9 that are dangerous to patient safety, and, Chair, as
10 Dr Denman told you, they are also very easy mistakes to
11 make.

12 These misunderstandings were brought about through,
13 first, a misleading claim on the Oxehealth website that
14 Vital Signs systems could reduce self-harm, and second,
15 a misunderstanding by staff that the system would alert
16 them to clinical deterioration when it could not.

17 Both of those misunderstandings have a potentially
18 fatal consequence on an inpatient mental health ward,
19 and immediate action must be taken to ensure that no
20 staff member, patient or carer can rely on a false
21 impression of what a system can do.

22 What this Inquiry has exposed, Chair, is a lack of
23 candour by a technology manufacturer and a careful --
24 and a lack of careful and due consideration by providers
25 before implementing new technologies, and a lack of

1 robust regulatory oversight and scrutiny.

2 The actual impact in the failings in the relation to
3 the implementation and use of Oxevision can be
4 quantified in the devastation that has been caused to
5 the bereaved families from whom you've heard firsthand
6 evidence in your Inquiry and the evidence before you
7 from Stop Oxevision. Ms Campbell has unambiguously
8 presented the case for the immediate cessation of the
9 use of Oxevision and INQUEST supports this submission.

10 We also urge you to recommend -- so we recommend the
11 full and safe suspension of the Oxevision system
12 nationally.

13 In addition, Chair, INQUEST urges you to recommend
14 that there must be an urgent review by NHS England and
15 the MHRA of all patient safety incidents connected with
16 Oxevision, and alongside this, an urgent notice must be
17 sent to all providers alerting them to the evidence that
18 this Inquiry has gathered, and in particular, a succinct
19 summary of the opinions of your experts.

20 Chair, you are right to consider this is an urgent
21 issue. INQUEST is aware, through its casework of death
22 that has tragically occurred across the country where
23 Oxevision is in use, that there is no justification to
24 adopt the approach that's being proposed by the
25 manufacturer, which is to essentially kick the can down

1 the road with another review whilst maintaining the use
2 of Oxevision in the meantime. You already have plenty
3 of evidence of the harms that this technology has caused
4 and will continue to cause unless firm and decisive
5 action is taken now to end unsafe practices.

6 Chair, in conclusion, these recommendations cannot
7 wait and they do have a national impact. We also urge
8 you, when making interim recommendations, to bring the
9 Recommendations and Implementation Forum to life and
10 start its work in earnest. We remind you, Chair, of our
11 submissions in December 2025 which urged you to ensure
12 meaningful engagement of bereaved families and lived
13 experience patients within the implementation forum and
14 INQUEST looks forward to engaging in a meaningful and
15 practical way with the Recommendations and
16 Implementation Forum and your further investigations.
17 Thank you, Chair.

18 **MR GRIFFIN:** Thank you.

19 We hear now, Chair, from Anna Bicarregui on behalf
20 of NHS England.

21 **Submissions by MS BICARREGUI**

22 **MS BICARREGUI:** Chair, I appear on behalf of NHS England,
23 instructed by DAC Beachcroft.

24 Chair, NHS England welcomes the Inquiry's focus on
25 the emergency response and resuscitation and

1 vision-based monitoring systems in this phase of its
2 work.

3 NHS England has listened to the evidence with care
4 and wishes to thank all of those who have contributed.
5 And NHS England's thoughts remain with those families
6 and patients who have been impacted by these issues.

7 Chair, I should also add that the NHS England team
8 has been listening closely to the submissions made this
9 morning and will be in a position to respond to them in
10 its more detailed written closings.

11 Chair, we will endeavour to deal with proposed
12 interim recommendations directed to NHS England this
13 morning, and criticisms, for example, of its proposed
14 mandatory training reforms in those written submissions.

15 Turning then, Chair, to the emergency response and
16 resuscitation training.

17 The Inquiry has heard detailed evidence concerning
18 the emergency response and the training provided to
19 build the competence of staff working within mental
20 health settings. The Inquiry has heard evidence
21 regarding the level of training available in respect of
22 CPR and the importance of basic interventions being
23 undertaken early.

24 To quote the Inquiry's expert Professor Soar, "The
25 first person who gets to you has the best chance of

1 saving your life and if I turn up 20 minutes later with
2 all my fancy kit and skills, I'm not going to be able to
3 do things or get as good an outcome as maybe simpler
4 interventions done very early."

5 Chair, NHS England agrees with this statement. The
6 first person must be both competent and, crucially,
7 confident to deliver Basic Life Support. Competence
8 needs to be formally assessed, with supplementary and
9 more frequent simulation and practice rehearsal to build
10 confidence relevant to individual settings and services.

11 NHS England is proposing, as part of the mandatory
12 training review, that all relevant clinical mental
13 health staff should receive mental health resuscitation
14 response training.

15 The essential requirement is that staff possess the
16 core competencies necessary to recognise and respond
17 immediately to a deteriorating patient and then provide
18 Basic Life Support in the event of cardiac arrest.

19 The staff will be supported by local arrangements
20 that ensure timely access to a wider team who have
21 additional competencies, for example in airway
22 management, to a level of competence equivalent to RCUK
23 Immediate Life Support level. Advanced Life Support
24 will be provided either by cardiac arrest teams located
25 on site, or local ambulance services, depending on the

1 locality of the mental health unit.

2 The precise level of provision should be informed by
3 local risk assessment, taking account of the patient
4 cohort, ward environment, and the staffing model.

5 NHS England notes that current expectations already
6 require all mental health inpatient units, where
7 restrictive interventions might be used, to have
8 immediate access to staff trained to Immediate Life
9 Support level competency.

10 But Chair, as you have heard, an effective emergency
11 response depends on far more than technical competence
12 alone. The evidence highlighted the significance of
13 human factors in emergency response.

14 Effective emergency response requires clear
15 communication, leadership, teamwork, situational
16 awareness, familiarity with equipment, and sound
17 decision making under pressure.

18 NHS England considers that the evidence supported
19 the importance of regular assessments of competence,
20 simulation and practical rehearsal to maintain
21 competence and confidence, recognising that infrequently
22 used skills can deteriorate over time.

23 Chair, NHS England respectfully disagrees with the
24 suggestion that where a patient is in cardiac arrest, no
25 further harm can be caused. Outcomes can be

1 significantly influenced by the quality and the
2 timeliness of the initial response. There is a material
3 difference between a member of staff who is confident to
4 commence Basic Life Support and one who, having never
5 encountered a cardiac arrest, becomes overwhelmed by the
6 situation or unable to recall what they may have learned
7 in a classroom some time ago.

8 NHS England submits that ensuring all staff are
9 competent and confident in the delivery of Basic Life
10 Support is more likely to secure the prompt initiation
11 of essential interventions, including maintaining
12 oxygenation and circulation, whilst appropriately
13 competent staff with additional competencies -- I've
14 mentioned already airway management -- and then
15 paramedics with competencies at advanced life support
16 levels are summoned to attend.

17 Chair, this provides a proportionate and an
18 effective response ensuring that essential care is
19 delivered without delay whilst more advanced clinical
20 support is mobilised.

21 Given the unique factors at play in mental health
22 inpatient units, a dedicated mental health module is
23 under development, which will provide training to staff
24 in those settings and, as you heard, Chair, NHS England
25 expects that module to be published by April 2027.

1 NHS England therefore submits that the reforms
2 described by Dr Adamson and Mr Simons, and under
3 development, will provide an effective and sustainable
4 route to improvement in the emergency response in mental
5 health institutions.

6 Chair, the proposed approach should transform
7 training into real-world competence, and the confidence
8 to deliver an effective emergency response in Mental
9 Health Inpatient Settings.

10 Chair, turning now to the evidence concerning
11 observation practices within mental health settings and
12 the use of vision-based monitoring systems, including
13 Oxevision.

14 NHS England's position is that whilst a vision-based
15 monitoring system may provide an additional source of
16 information, it cannot replace human observation,
17 communication, therapeutic engagement and professional
18 judgement, which are all central to safe and effective
19 patient care. As Dr Denman stated: "observations cannot
20 be reduced to a process of surveillance".

21 Furthermore, a vision-based monitoring system should
22 only be used when appropriate discussions have taken
23 place with the patient regarding its use and the
24 patient's views have been considered, and consent
25 obtained.

1 Where a patient lacks capacity to make an informed
2 decision, the use of a vision-based monitoring system
3 must be made in accordance with the applicable legal
4 framework and in the patient's best interests.

5 Where appropriate, those with authority to make or
6 be consulted on such decisions, should be involved, and
7 the use of a VBPMS should remain subject to regular
8 review to ensure that it continues to be necessary,
9 proportionate, in the patient's best interests, and
10 takes into account any change in their capacity.

11 NHS England agrees with the evidence of Ms Cozens,
12 which emphasised the importance of ongoing conversations
13 with patients, families and carers, about both the
14 capabilities and, importantly, the limitations of VBPMS.
15 And NHS England also notes the importance of
16 transparency with patients and families regarding the
17 use of such systems.

18 Chair, it follows that NHS England does not support
19 the blanket use of VBPMS. The use must be justified on
20 an individual patient basis and kept under regular
21 review. In addition, NHS England does not support the
22 use of such systems where consent has not been obtained
23 or has been withdrawn, unless such use is expressly
24 permitted under the applicable legal framework, is
25 necessary and proportionate in the circumstances, and

1 the reasons are clearly recorded in the patient's care
2 plan.

3 Chair, you will know that this position is reflected
4 in NHS England's approach to the use of technologies in
5 mental health settings, as set out in its digital
6 principles. These principles are intended to establish
7 a consistent national standard for the commissioning and
8 the use of digital technologies in a rapidly developing
9 area. They're designed to support Trusts to make
10 appropriate decisions for local clinical circumstances
11 and patient needs, and within the relevant legal and
12 regulatory framework.

13 However, Chair, NHS England recognises the
14 importance of its national leadership role, and submits
15 that further consideration -- immediate consideration --
16 should be given to the development of joint national
17 guidance by NHS England, the CQC and the MHRA on the use
18 of vision-based monitoring systems and similar
19 technologies within mental health settings.

20 NHS England would therefore support an interim
21 recommendation to that effect. Any such guidance should
22 be underpinned by clear mechanisms for assurance and
23 accountability.

24 Chair, NHS England's position is that oversight
25 should be delivered through existing structures,

1 including the MHRA's Medical Device Regulatory
2 Framework, ICB commissioning and assurance functions,
3 and the CQC's established inspection, oversight and
4 enforcement powers.

5 Chair, I will close by reiterating that NHS England
6 will endeavour to assist the Inquiry by responding to
7 those proposed interim recommendations directed towards
8 NHS England this morning, and the criticisms of its
9 proposed reforms, in its written closing submissions.
10 Thank you.

11 **MR GRIFFIN:** Chair, that brings us to our lunch break.

12 I suggest that we rise and reconvene at 1.30.

13 **(12.29 pm)**

14 **(The Short Adjournment)**

15 **(1.30 pm)**

16 **THE CHAIR:** Good afternoon, Mr Griffin.

17 **MR GRIFFIN:** Chair, we hear now from Stuart Marchant.

18 **THE CHAIR:** Thank you.

19 **Submissions by MR MARCHANT**

20 **MR MARCHANT:** Good afternoon, Chair. I represent
21 Oxehealth Ltd who trade as LIO Health and who
22 manufacture the Oxevision system. You've heard evidence
23 about the use of its technology in the context of
24 inpatient mental health wards, and Laura Cozens, the
25 Patient Safety Manager, has given you extensive

1 evidence.

2 Oxehealth has sought to engage constructively with
3 the Inquiry and to provide it with relevant detailed
4 information. We submit that whilst important and
5 legitimate questions have been raised, the evidence does
6 not show that the system should be [audio disrupted].
7 Participants who seek this fail to recognise its utility
8 and worth to the very many mental health Trusts who
9 currently use it, including EPUT.

10 Any submissions made along those lines would not
11 follow the evidence, nor would they reflect the
12 difficult balance between autonomy and patient safety,
13 which comes into play acutely within mental health
14 wards.

15 So looking at whether an interim recommendation
16 should be made. Oxehealth welcomes the Inquiry's focus
17 on interim measures to protect patient safety. We
18 submit that any interim recommendations in this area
19 should be focused on establishing a single, clear,
20 national operating framework and mandatory training
21 standards, rather than imposing punitive or restricted
22 moratoria.

23 Technology does not operate in a vacuum. It's
24 intimately bound up with ward staffing, emergency
25 response and clinical culture, themes that this Inquiry

1 will continue to examine next year.

2 We're not suggesting that Oxevision is or should be
3 used for each patient and in each situation. It's not
4 a replacement for therapeutic engagement but can work to
5 assist staff and provide a valuable addition which can
6 help to reduce harms and save lives. Legitimate
7 questions about the implementation by Trusts or the
8 evidence base are not reasons for suggesting that the
9 system should be ceased. The appropriate and
10 proportionate response to the concerns raised is to
11 augment the evidence base, improve national consistency
12 through a consistent framework, and to ensure the
13 technology is used with appropriate safeguards in place.

14 As Oxehealth has said before, only four of the 2,000
15 deaths that you're examining took place whilst Oxevision
16 was in use at EPUT. None of them led to Prevention of
17 Future Deaths reports that attribute the cause of death
18 to Oxevision.

19 And in all of them, the technology worked
20 effectively but sadly was not operated correctly. In
21 some of inquests the technology enabled the Essex
22 coroner to be able to identify other failings in the way
23 the Trust operated. For example, one of the case
24 summaries identifies that the alerts worked effectively
25 but were ignored by staff. In fact, the Oxevision

1 systems has enabled the Essex coroner to discover flaws
2 and failures in the observations by staff and the
3 falsification of records. In that respect, important
4 features of the system have worked as intended: to
5 deliver truths and to deliver learning points.

6 Oxehealth submits that patient safety, privacy and
7 dignity are not competing priorities. It is perfectly
8 possible to operate the Oxevision as an assistive
9 technology whilst taking into account and ensuring that
10 dignity and privacy are maintained. Yes, there is
11 a careful balance to be struck, one that must also take
12 into consideration the need of Trusts to take steps
13 under their positive duty to the state -- of the state
14 to protect the lives of people in their care.

15 You have heard evidence, given under oath, that
16 Oxevision helps to save lives. The question is how to
17 balance the privacy against patient safety and sometimes
18 staff safety.

19 As was explained by Ms Archibald, and others to this
20 Inquiry, observations are carried out on all of those on
21 an inpatient setting. They are carried out at least on
22 a 60-minute basis as a baseline. The frequency and
23 invasiveness will be considerably higher where the
24 person is a risk to themselves and needs to be kept
25 within eyesight or even at arm's length. That is

1 a considerable intrusion on dignity and privacy but it
2 is seen as necessary and proportionate. The concerns,
3 legitimately raised, have to be seen in the context that
4 admission to a mental health ward is in and of itself
5 a significant intrusion into someone's personal liberty,
6 one that is based upon a careful plan about how to most
7 safely manage individually assessed risks.

8 Interventions can only take place against the wishes
9 of a competent patient if the criterion under Section 2
10 or 3 of the Mental Health Act are met. Under the
11 statutory Code of Practice of the Mental Health Act,
12 these powers should only be used if they represent the
13 least restrictive option. In other words, it's wrong to
14 think that statutory protections don't already exist.

15 VBPMs should be seen in this context: and as part of
16 the proportionate response to keeping individuals safe,
17 particularly where they are of significant risk,
18 a danger to themselves, and sometimes to others. Both
19 Dr Denman and Ms Archibald identified that mental health
20 care has lagged behind acute physical health care in its
21 use of technology. The NHS 10-Year Plan identifies the
22 need to find, use and enhance digital technology where
23 it will make care safer, more effective, and more
24 efficient. Given the need to prevent suicide within
25 inpatient settings, all technological developments that

1 help to reduce self-harm or other serious incidents
2 should be welcomed and seriously considered.

3 You've also heard the evidence of Mr Trimble and
4 Mr Trent of EPUT. And you've heard from other Trusts
5 who use the system. Mr Trimble's evidence, that he gave
6 last week, and he had read the Datix reports, and he had
7 read the written narratives, and he had spoken to the
8 frontline staff, whilst -- that it had saved lives.
9 Whilst there may be questions as to the analysis of the
10 number of incidents that EPUT had reported, there is no
11 doubt that it is being used to disrupt and prevent
12 incidents of self-harm, suicide and falls.

13 Ms Cozens' second and fourth witness statements also
14 identify and highlight that other organisations have
15 provided them with data that there were thousands of
16 incidents in which Oxevision supported staff to respond,
17 where otherwise serious harm might not have been
18 identified.

19 This data must not be ignored or sidelined. It
20 demonstrates real-world evidence of Oxevision's
21 usefulness within clinical settings. It's a key reason
22 why we say that Oxevision has been so attractive as part
23 of numerous Trusts' patient safety initiatives. It
24 should be very carefully weighed alongside
25 Professor Soar's written and oral evidence, which

1 stresses how crucial it is to be able to intervene so as
2 to prevent a patient who is self-harming from going into
3 secondary cardiac arrest.

4 You, Chair, saw evidence from some other Trusts who
5 provided you with written and oral evidence. East
6 London Foundation Trust, or ELFT, and North East London
7 Foundation Trust, NELFT, use Oxevision in some wards
8 albeit not across their estate. ELFT uses it within
9 seclusion areas identifying that it provides improved
10 physical safety by providing an additional safety net
11 between observations, with remote vital signs
12 monitoring, reducing -- sorry, with remote vital signs
13 monitoring reducing the need for unnecessary entry into
14 a seclusion room.

15 ELFT also identify that it's an additional safety
16 net within the alerts providing support for timely staff
17 responses and identifying the value of supporting
18 non-contact monitoring in high-risk environments.

19 NELFT uses it within seclusion and within its 136
20 suites.

21 The South London and Maudsley NHS Foundation Trust
22 use it in respect of particular patients where there was
23 a requirement for contactless monitoring. Even though
24 it no longer uses the system, it identifies that they
25 did not see any alarm fatigue, nor felt it posed a risk

1 of harm to patients or that the system was abused by
2 staff, and that there were no complaints of staff who
3 used it.

4 Whilst Leicestershire Partnership no longer uses the
5 technology, they identified that it did assist with the
6 improvement in sleep in those patients who opted in.
7 And again, Leicestershire did not find any evidence of
8 staff abusing the system and did not find that it posed
9 a risk of harm.

10 There are other Trusts which use Oxevision more
11 widely. The Inquiry has written and oral evidence from
12 Oxfordshire and Tees, Esk and Wear Valleys Trusts
13 respectively.

14 We'd also note on behalf of Oxevision that there are
15 many other Trusts who use the system from which this
16 Inquiry may not have heard, and comparator Trusts can
17 only be seen to provide a snapshot.

18 Ms Klinck, in her evidence in respect of
19 Oxfordshire, identified that the system helps staff
20 respond to incidents more quickly and identify incidents
21 which otherwise they may not have known about,
22 predominantly relating to self-harm and falls.

23 TEWV uses the system in over 50 wards. Again, the
24 main benefits include providing the nursing staff with
25 alerts in respect to falls, patient safety incidents,

1 and to promote sleep.

2 All of those Trusts have described how they use
3 their governance systems for oversight and to modify the
4 nature of alerts in their own organisations, if and when
5 it was thought, at any point, that alarm fatigue may be
6 an issue.

7 Oxehealth wishes to make the following overarching
8 points in relation to the evidence that you've heard.
9 The expert evidence of Dr Denman and Ms Archibald is
10 that the system is and can be a useful addition but not
11 a replacement for nurses in wards. Its use, in
12 particular, within seclusion, health-based places of
13 safety and older adult wards has been seen as valuable
14 and appropriate. The vital signs function, whilst not
15 seeking to replace the appropriate use of the NEWS2
16 system, and we would say that to think otherwise would
17 respectfully be a mistake when having regard to all of
18 the evidence, is useful in seeing changes in pulse and
19 respiration, which are of particular benefit in
20 situations where patients have received sedating
21 medication.

22 As Ms Archibald said, it can be there to guide staff
23 but not replace safe staffing.

24 Oxehealth agrees that assistive technology needs to
25 be used thoughtfully and for a clearly identified

1 purpose. It requires oversight and review. It should
2 add meaningful value to a patient's care and safety. It
3 agrees with the conclusion and recommendations reached
4 by Ms Archibald in her written evidence. Ms Archibald
5 and Dr Denman identified the need for sleep as an
6 important component in managing a patient's inpatient
7 care. Ms Archibald identified that it's very
8 challenging to balance the need to check on patients but
9 also ensure that they have at least some undisturbed
10 sleep.

11 As is identified, whilst it is not suggested that
12 the system of taking vital signs replaces nighttime
13 engagement, it can help in ensuring less disturbed
14 sleep.

15 Patient choice is and should be key where patients
16 have capacity to consent and where they do not,
17 Oxehealth agrees that the model should be used for
18 considering whether these technologies are appropriate
19 and proportionate to meet the needs of a patient's care
20 plan and then deciding if the system should be used in
21 consultation with the patient and their carer, so
22 essentially a best-interests decision.

23 Whilst some patients, as Ms Archibald identified,
24 found the use of CCTV, body-worn cameras and the
25 Oxevision system to be distressing, others find it

1 helpful and useful. As Ms Archibald identified, for
2 some patients and families the technology will provide
3 additional reassurance about safety and wellbeing which
4 is why informed consent, individualised assessment and
5 clear governance matter.

6 Whether there should be a specific board member who
7 deals with issues of consent which are widespread within
8 mental health provision is not a matter on which
9 Oxehealth can opine and so it submits this is something
10 that should only be considered if Trusts, NHS England
11 and the regulators consider it would be useful and
12 effective.

13 At several points in time the Inquiry has suggested
14 that staff may be deliberately misusing the system in
15 order to spy on patients. There is no evidence that
16 this is in fact the case. And if it were to be so, then
17 that would be a breach of professional guidelines and
18 would lead to immediate disciplinary action.

19 The Inquiry has also suggested that staff training
20 is insufficient to deal with alarm fatigue or turning
21 down alarm volumes, or (unclear) in the system's
22 capabilities which it does not.

23 This can be the case with any new piece of
24 technology or medical device, and competence and staff
25 training should be at the heart of implementing the

1 technology. Patient safety depends on the whole system
2 working together.

3 Oxehealth would also identify that OxeObs, as used
4 at EPUT, enables there to be digital recording of
5 observations, and given the need for electric (sic)
6 patient records and integration of information about
7 patients, this must be welcomed as a valuable tool.
8 Indeed, one of the major concerns raised by the case
9 summaries is information not being effectively passed
10 between staff or between wards, which digital
11 observations and records would have mitigated.

12 The CQC, who is the regulator of the quality of
13 health services and which has the responsibility for
14 oversight of the mental health system through the
15 publication of its annual reviews has examined and
16 provided guidelines for the use of VBPMs. It has
17 submitted that had there been sufficient concerns about
18 the use of this technology, then the regulator would
19 have taken steps, but it has not done so.

20 Likewise, NHS England, whilst not the regulator, as
21 a national body has oversight of the operation of NHS
22 Trusts overall. And it has worked with various
23 stakeholders to provide a set of guidelines which both
24 Ms Archibald and Dr Denman have viewed as sensible, and
25 with which no one has disagreed. The NHS Digital

1 principles had extensive engagement from those with
2 lived experience and their families before formulating
3 these guidelines. Gareth Harry, in his evidence, warned
4 against taking campaigning voices fully at face value.

5 Dr Denman questioned the value of observations,
6 although as she properly identified, her view is
7 controversial, not shared by many within her profession,
8 and is not something which is implemented in the vast
9 majority of inpatient settings, not just in England but
10 the entire world.

11 Whilst Oxevision and Oxehealth support any sensible
12 assessment of best practice, including observations, it
13 is currently a well-established practice identified and
14 recognised as necessary in the Mental Health Act Code of
15 Practice.

16 Oxehealth is a responsible organisation. It does
17 not shy away from intervention in this space by the
18 Inquiry. In unsolicited correspondence, it asked the
19 Inquiry to recommend that there should be a clear and
20 consistent national framework which brings together the
21 CQC, NHS England, and Nurse Directors Forum guidance to
22 create a single set. Suggestions are made to have
23 a broad range of expertise, including those with lived
24 experience, who have frontline experience of the system,
25 nursing staff with frontline experience of the system,

1 and other relevant stakeholders, including providers.

2 The framework should deal with issues of capacity,
3 of consent, of risk assessment, training, the limits of
4 technology, and of auditing, reviewing and governance,
5 and recording decision making.

6 Turning to the MHRA, the Inquiry sought to query and
7 question the patient safety record of Oxevision. It
8 should be recognised that there is no evidence that the
9 system has a poor safety record, or that there are
10 concerns about its efficacy. There have been four
11 Yellow Card reports over the course of five years,
12 during which period it had been operated in up to 50% of
13 NHS mental health Trust wards. In comparison, there are
14 reported to be the tens of thousands of Yellow Card
15 reports each year, which means that this is a *de minimis*
16 number.

17 When a Field Safety Notice has been raised, and
18 please note that the Inquiry does not have relevant
19 comparative data, these have been few. And the MHRA
20 evidence was that the manufacturer responded to them
21 appropriately. No regulatory action has been taken in
22 relation to Oxevision.

23 In a process of looking at what recommendations are
24 indicated now, it should be identified that the relevant
25 issues and information that was discussed with the MHRA

1 relate effectively to 2021 and 2022. There are no
2 current concerns, and the historical concerns, in large
3 measure, related to inaccuracy in respect of the website
4 and misunderstandings by staff about what the system
5 could do, rather than any flaw of the system in and of
6 itself, when used properly.

7 The BSI evidence also identifies only four incident
8 reports which relate to issues concerning power supply.
9 And again, the actions taken by the manufacturer in
10 response to this were seen as being appropriate. There
11 are no incident reports since December 2023.

12 The Inquiry has raised wider concerns as to whether
13 or not the regulatory landscape, which has different
14 bodies that undertake different functions in respect of
15 technology, is too fragmented to be able to deal with
16 new technology in a manner which is swift and effective.
17 Oxehealth would welcome a further discussion about how
18 and on what basis new technology is examined but would
19 identify that this would require wider and significant
20 systems change which may be more sensibly undertaken
21 after a wide-range review by the relevant bodies as to
22 how, and if, such cross-body assessments could operate
23 in practice.

24 Now looking at the role of technology, as has been
25 identified by both Dr Denman, Ms Archibald, and others,

1 who have given evidence in this Inquiry, mental health
2 has been a backwater in the adoption of technology, and
3 technology is recognised as being a useful tool in the
4 provision of modern mental health care.

5 Oxehealth considers that it has sought to amend,
6 alter, change and develop its technology over time to
7 meet patient need and has engaged responsibly with
8 relevant Trusts, regulators and other bodies. It has
9 its own Expert by Experience Board and seeks to
10 encourage Trusts to share data and information amongst
11 themselves.

12 Dr Denman criticises that evaluation was not built
13 in from the start. Oxehealth would identify that it has
14 sought to promote evaluation of the system both
15 internally and externally, as the relevant analysis of
16 the reports and publications by Professor Donnelly and
17 Dr Christodoulou show. Dr Denman, however, also accepts
18 that this has been the case with the new (unclear)
19 mental health interventions, and so it suggested that
20 whilst multisite evaluation may well have been a gold
21 standard, this may well be a counsel of perfection
22 which, given the limits of money and interest in
23 psychiatric research, was not possible, at least at the
24 time.

25 Furthermore, the suggestion that real-world

1 deployment must halt entirely until prospective
2 multisite academic studies are completed does not
3 reflect how the healthcare innovation setup is safely
4 integrated across the NHS. In digital health, robust
5 post-market clinical follow-up and iterative quality
6 improvement run alongside clinical practice. To freeze
7 or withdraw assistive technology from frontline clinical
8 teams while awaiting long-term trials would remove an
9 established safety net, directly increasing the risk of
10 unmonitored deterioration and potentially fatal harm.

11 The prudent, balanced approach is to mandate
12 rigorous national Standards and governance now whilst
13 funding and supporting independent academic research
14 concurrently.

15 The Inquiry has heard statistical evidence from
16 Professor Donnelly and Dr Christodoulou. It has
17 accepted that there have not been randomised control
18 trials involving Oxevision, but both experts identified
19 and recognised, as did Dr Denman, that such trials are
20 difficult to fund, and also difficult, and potentially
21 unethical, to run within mental health settings. Whilst
22 these may be the gold standard generally, they are not
23 possible in circumstances where they cannot be a
24 control. And in this case a patient would know if
25 Oxevision system was or was not in their bedroom which

1 would confound any effective control.

2 The Inquiry has also not had a wide range of
3 evidence to show what other forms of interventions in
4 mental health and physical health have been subject to
5 such gold standard trials and so should be extremely
6 cautious before determining that the evidence base is
7 inadequate compared to other treatments or forms of
8 technology. As Oxehealth identifies, it has sought to
9 fund research but has not sought to interfere with the
10 research outcomes, and sought to ensure that any such
11 research is subject to relevant peer review before
12 publication.

13 In respect of economic evaluations, Oxehealth has
14 identified a misunderstanding of what is meant by staff
15 cost savings. It does not mean that staff will be
16 needed to undertake fewer observations but that the
17 reduction in self-harm incidents and other patient
18 safety alerts will mean that there will be a need for
19 fewer staff dedicated to responding to those incidents,
20 or being taken away from wards to deal with them, or
21 potentially lower levels of observations required for
22 certain patients if their risks are identified as lower.

23 Oxehealth also identifies that a multisite study is
24 currently underway led by Professor Nolan at Anglia
25 Ruskin University. Those results are due to be

1 published at some point next year and it is suggested
2 that the Inquiry may wish to wait for those results
3 before making recommendations, or seek evidence from
4 Professor Nolan with respect to her emerging findings.
5 This type of study shows that academic engagement can
6 run concurrently with clinical deployment.

7 Oxehealth has offered on an open basis to provide a
8 bursary of £100,000 to fund an independent multisite
9 study into de-identified incident data and the safety
10 impact of Oxevision in inpatient settings. Any study
11 would be independent of Oxehealth and subject to
12 governance and ethical oversight, and the researchers
13 would retain full and independent publication rights,
14 including the right to publish findings irrespective of
15 the outcome of the research.

16 In conclusion, Chair, Oxehealth is hopeful that the
17 Inquiry will take a balanced approach to this
18 technology, recognising its benefits as well as the
19 safeguards which should be put in place or strengthened.
20 Where we think recommendations which promote responsible
21 use of the technology are helpful, we have raised them,
22 and we stand by them. Thank you.

23 **MR GRIFFIN:** Thank you.

24 Chair, we now hear from Mark Watson, King's Counsel,
25 and Adam Fulwood.

1 **Submissions by MR WATSON KC**

2 **MR WATSON:** Chair, I represent EPUT together with
3 Mr Fulwood. I will address you over the next 15 minutes
4 on the topic of resuscitation, and Mr Fulwood will
5 utilise the remaining time allocated to address you on
6 the issue of observations and technology.

7 As to the issue of resuscitation, EPUT recognises
8 the importance of the issues examined during this
9 hearing and accepts that there is a proper basis for
10 focused recommendations.

11 The evidence has identified historic gaps in
12 assurance, particularly in relation to reporting, audit,
13 simulation oversight, and the retrieval of incident
14 data, and EPUT accepts those issues require attention.

15 The question for the Inquiry is what recommendations
16 would most effectively improve patient safety and reduce
17 future risk. EPUT submits that recommendations should
18 focus on outcomes, competencies, and assurance
19 mechanisms, rather than prescribing a single staffing or
20 training model where the evidence does not establish
21 that only one model can safely achieve the required
22 outcome.

23 As to immediate response and first responders, there
24 was broad agreement in the evidence that where a patient
25 deteriorates towards secondary cardiac arrest, the

1 response must be immediate. Professor Soar's evidence
2 was that the person arriving first may have the greatest
3 opportunity to prevent cardiac arrest, and therefore
4 requires the skills, the confidence and the equipment to
5 begin an effective response.

6 EPUT also accepts that an HCA may be the first
7 person at the scene. EPUT's present model is designed
8 to ensure that at least one ILS-trained registered
9 professional is rostered on each inpatient ward for each
10 shift. That arrangement reflects the Trust's staffing
11 model, including its intended 50/50 balance between
12 registered and non-registered staff. In many instances,
13 multiple ILS-trained members of staff will be rostered
14 to the same ward. The evidence from ELFT demonstrated
15 a similar approach with enhanced resuscitation
16 competencies concentrated amongst registered clinicians
17 rather than mandatory ILS training for all HCAs.

18 EPUT accepts, however, that rostered presence alone
19 cannot provide complete assurance of availability in
20 every circumstance. The relevant question is therefore
21 not simply staffing numbers but whether providers can
22 demonstrate that appropriately trained emergency
23 response capability is reliably available in practice
24 24/7.

25 As to the HCA training and ILS, the evidence, we

1 submit, does not establish that mandatory ILS
2 certification for every HCA is the only safe means of
3 achieving the outcome I've just outlined.

4 Professor Soar accepted that organisations may
5 achieve the required outcome through different
6 arrangements depending upon staffing, configuration, and
7 local circumstances. NHS England similarly
8 distinguished between an immediate response capability
9 for patient-facing staff and more advanced interventions
10 undertaken by appropriately trained registered
11 professionals.

12 However, EPUT accepts the force of Professor Soar's
13 central evidence. The first responder must have the
14 training, confidence and equipment necessary to begin an
15 effective response. The RCUK standards identify CPR,
16 defibrillation and airway management as key elements of
17 that response. EPUT's existing arrangements ensure that
18 HCAs are trained and competent in CPR and
19 defibrillation. If the Inquiry concludes that
20 additional assurance is required regarding airway
21 management capability, EPUT would support training of
22 HCAs in basic airway interventions, including bag-mask
23 ventilation.

24 This would be a practical and deliverable
25 enhancement which directly addresses the concern

1 identified by Professor Soar, without mandating ILS
2 certification for every HCA.

3 EPUT therefore supports recommendation requiring
4 providers to identify foreseeable first responders,
5 define the competencies they require, provide
6 appropriate training and assessment, and test those
7 competencies through simulation.

8 Where a provider adopts training other than ILS, it
9 should be required to demonstrate that the necessary
10 competencies are nevertheless achieved and maintained.
11 As to simulation and practical testing, there was
12 particularly strong consensus in the evidence about the
13 importance of simulation. Evidence from ELFT, EPUT,
14 Professor Soar and NHS England supported the importance
15 of repeated practice and scenario-based learning. EPUT
16 accepts that a policy requiring simulations is
17 insufficient without reliable assurance that the
18 simulations take place, that they test relevant
19 scenarios, that they involve staff who may foreseeably
20 be first responders, and that they generate recorded
21 learning and result in appropriate follow-through.

22 EPUT already has arrangements in place to ensure
23 that simulation drills are carried out on inpatient
24 wards on a regular basis and it has Tenable audit
25 arrangements to ensure that these are taking place. The

1 evidence suggested that these arrangements are at least
2 equivalent to, or exceed those of ELFT. Additionally,
3 EPUT is in the process of reviewing its systems with
4 a view to implementing a recording process, to monitor
5 and ensure that all relevant staff participate in
6 simulation training on a regular basis.

7 EPUT would therefore support recommendations
8 requiring regular risk-based simulation training,
9 together with auditable arrangements recording
10 participation, learning, action points, and completion.

11 Providers should retain reasonable flexibility as to
12 the precise frequency and format of simulations, but
13 they should be able to justify their arrangements by
14 reference to risk and demonstrate, through evidence,
15 that those arrangements are effective.

16 As to incident reporting, EPUT recognises the
17 concern arising from the difficulty encountered in
18 producing a reliable, historic dataset of resuscitation
19 events from Datix. The Trust apologises unreservedly
20 for the errors identified in the initial production of
21 that data, and for any distress caused to those
22 affected.

23 EPUT's current understanding is that the errors
24 arose during the processing and sorting of the
25 underlying data within a tight timescale. A full

1 explanation has been commissioned, and will be provided
2 to the Inquiry in due course. But at the same time, the
3 Inquiry has indicated that the operation and use of
4 Datix will be examined more fully at a later stage.
5 EPUT will fully assist in that examination.

6 At the same time, whilst a national dataset would
7 complement those local responsibilities for incident
8 reporting, it cannot replace them, and local providers
9 must continue to maintain systems capable of identifying
10 and reviewing their own events.

11 As to governance reporting and assurance, many of
12 the standards relevant to this topic of resuscitation
13 already exist, and the evidence has referred to the RCUK
14 standards in particular. The principal challenge
15 disclosed by the evidence is not simply the absence of
16 standards; it is their implementation and the ability to
17 demonstrate compliance and effectiveness. EPUT accepts
18 that it should have been able to evidence compliance
19 with review, and reporting requirements contained in
20 policy. However, EPUT does have in place quarterly
21 reporting concerning the management of the deteriorating
22 patient.

23 Those reports are relevant evidence of governance
24 and improvement activity. They record work relating to
25 training, policy, deterioration, physical health, and

1 organisational learning. However, it has accepted that
2 they are not audits in the conventional sense and that
3 they do not align with existing policy requirements.
4 Those are assurance gaps, and EPUT accepts that they
5 must be addressed. The Trust is in the process of doing
6 so.

7 Dr Suresh also accepted that there was merit in
8 making lines of accountability and responsibility more
9 straightforward and clearer, whilst at the same time
10 recognising that multiple teams need to be incorporated
11 into that process.

12 The evidence therefore supports recommendations
13 directed towards clearer accountability, reporting,
14 audit and assurance arrangements. EPUT does not,
15 however, accept the suggestion that Nicholas Archer is a
16 lone or unsupported figure. Whilst he plainly has
17 a significant role, he operates within a broader
18 governance structure involving the Patient Safety Team,
19 Deputy Directors of Quality and Safety, Professional
20 Nurse Educators, ward leadership, governance committees
21 and Board oversight. His team is also being further
22 strengthened with additional recruitment. Importantly,
23 his evidence was that where he was -- when he has
24 identified improvements, those proposals have been
25 supported and implemented without exception.

1 Further investment is already underway through the
2 recruitment of additional members of the physical health
3 and resuscitation faculty, which will strengthen
4 capacity and support the development of more systematic
5 approaches to audit, simulation oversight and learning
6 from events. This work will include the centralisation
7 of relevant information within a shared, accessible, and
8 organised data resource.

9 It should be noted that the comparator evidence from
10 ELFT did not disclose a materially more extensive or
11 centralised resuscitation governance model. This is not
12 to suggest that there is no scope for improvement within
13 EPUT's arrangements, but rather, it places the Trust's
14 existing arrangements and its own proposed improvements,
15 in their proper and fair context.

16 I now want to turn and address the issue that
17 recommendations should recognise the importance of local
18 governance and assurance. A recurring feature of the
19 evidence was that many of the relevant standards already
20 exist. The hearing explored, for example, NICE NG10,
21 RCUK Mental Health Quality Standards, NHS England
22 frameworks, CQC Brief Guides and local provider
23 policies.

24 The evidence suggested that the principal challenge
25 was often not the absence of standards but their

1 implementation, monitoring, and their assurance.
2 Professor Soar expressed this succinctly when he
3 expressed that implementation of policy into safe
4 patient care is really what matters. Accordingly,
5 recommendations should focus on governance, audit,
6 assurance mechanisms and implementation, rather than
7 simply generating new standards that largely duplicate
8 standards already in existence.

9 As to EPUT's own arrangements, EPUT has carefully
10 considered Professor Soar's evidence. Areas in which
11 policy wording or associated guidance may be capable of
12 clearer expression are being reviewed, and EPUT's
13 written submissions will provide further detail
14 regarding the steps being taken in response to those
15 observations.

16 As to national Standards, consistency and data, one
17 clear feature of the hearing was the complexity of the
18 regulatory landscape. The Inquiry heard evidence about
19 NICE, RCUK, NHS England, CQC and local policies, all
20 addressing overlapping aspects of emergency care. The
21 evidence from Professor Soar, NHS England and the CQC in
22 particular identified areas where guidance was not
23 always fully aligned. If recommendations are being
24 considered, EPUT submits that the evidence provides
25 a basis for recommendations directed at national

1 alignment of standards, including, for example,
2 alignment between NICE, RCUK, NHS England and CQC
3 guidance.

4 Professor Soar's evidence was also clear that there
5 is currently no dedicated national dataset for cardiac
6 arrests occurring in Mental Health Inpatient Settings.
7 He regarded such data as potentially valuable for
8 a number of obvious reasons. There is -- this is
9 therefore an area in which a recommendation directed at
10 national bodies could support sector-wide learning,
11 benchmarking and quality improvement, rather than
12 focusing solely on individual providers.

13 As to existing progress and interim recommendations,
14 we would add this: any recommendation should be framed
15 against the evidence that EPUT has not stood still. The
16 Inquiry has heard extensive evidence of revised
17 policies, increased ILS provision, strengthened
18 governance and reporting arrangements, improved
19 escalation processes, simulation programmes, new audit
20 measures and continuing investment in the physical
21 health and resuscitation workforce.

22 EPUT relies upon these measures as evidence of
23 active improvement, and as the foundation upon which
24 further assurance can be built. It does not suggest
25 that the introduction of those measures alone

1 demonstrate that every concern has been resolved. But
2 rather, they provide the framework through which
3 improvement can be demonstrated and sustained. Any
4 interim recommendations should therefore seek to
5 accelerate and support that improvement, rather than
6 proceed on the basis that the position today is the same
7 as the position many years ago.

8 In conclusion, EPUT submits that if interim
9 recommendations are to be made with respect to
10 resuscitation, they should be directed towards the
11 following: firstly, ensuring improved assurance of
12 immediate access to appropriately trained responders;
13 secondly, strengthening simulation and practical
14 emergency training; thirdly, improving governance, audit
15 and assurance mechanisms; fourthly, securing greater
16 consistency between national Standards; fifthly,
17 improving national data connection; and finally,
18 supporting local flexibility in how organisations
19 achieve those important outcomes.

20 The evidence heard during this hearing provides
21 a strong foundation for recommendations of that nature,
22 but what the evidence does not establish, we submit, is
23 a clear national consensus that safety requires
24 a single, prescribed staffing model, or mandatory ILS
25 training for all HCAs.

The appropriate approach is to define clearly the competencies, response and assurance required, and then to require each provider to demonstrate that its arrangements deliver those outcomes reliably, in practice.

Those are EPUT's submissions with respect to the topic of resuscitation. I will now hand over to Mr Fulwood who will address you on behalf of EPUT in relation to the issue of observations and technology. Thank you.

Submissions by MR FULWOOD

MR FULWOOD: Chair, I'm trying to start my video but it says the host has blocked it.

Good afternoon, Chair. I start where Dr Suresh began last Wednesday, with his sincere condolences and apologies to the families affected by the matters this Inquiry is investigating. EPUT adopts those words and repeats them today.

EPUT has been listening to the oral submissions and will carefully consider them, including the call for suspension, when preparing its written submissions.

Chair, EPUT accepts that consent should have been explicit and opted in from the start. It accepts the ombudsman's findings, and it accepts that evaluation, risk analysis and patient involvement should have come

1 earlier, and been stronger.

2 The wider national points I'm about to make are
3 made, as Mr Trent puts it, "without any intention to
4 change EPUT's accountability".

5 EPUT has worked hard to respond to the concerns and
6 challenges which arose when this new technology was
7 introduced. It has listened to patients, staff,
8 regulators, and the experts who commissioned, and that
9 has had a real and demonstrable effect. EPUT has
10 improved the way it uses this technology, and that use
11 now complies with the relevant national guidance.

12 Chair, EPUT continues to monitor closely and to
13 improve its use of the technology, and just to confirm,
14 its Board has agreed to commission further internal
15 audit of the current SOP. It will share its recent
16 usage data with the Inquiry once the Project Board has
17 analysed it. It intends to roll out user authentication
18 and new alerting, subject to clinical safety review, and
19 it has commissioned an independent review of lived
20 experience involvement, which is due next month, and as
21 confirmed, EPUT will share it with the Inquiry.

22 Chair, when considering any interim recommendations,
23 EPUT asks that you consider that any recommendations are
24 clear, practical, and identify how they will be funded,
25 that there is a responsible owner, and that they are

1 measurable, but also that they are supportive of
2 innovation. Any recommendation, we respectfully submit,
3 should not prevent or deter innovation, local or
4 national, that can improve care. Providers must remain
5 able to innovate locally with the right governance and
6 controls in place. As Dr Denman said, "We need a way of
7 managing new technology that's coming that doesn't
8 stifle it."

9 Finally, recommendations must be balanced. They
10 should weigh the clear need to adopt technology that can
11 improve care against the need to guard against its
12 risks.

13 Chair, the evidence has identified issues that are
14 likely to be relevant to most, if not all, healthcare
15 providers in the country, especially, but not only, in
16 mental health. And there are three strands of evidence
17 that we wish to highlight. In relation to the current
18 position, EPUT has moved to opt-in consent, the system
19 is switched on only where the patient consents.

20 Ms Archibald agreed that this is "a potentially
21 major change of approach". Dr Denman told you that in
22 her view, EPUT's current approach in SOP comply with the
23 national guidance she has seen. NHS England's own
24 assessment is the same.

25 There are similar issues, if not the same issues, at

1 other Trusts. We highlight that NHS England has
2 referred ten Trusts to the CQC, as they appear not to be
3 using the system in line with its principles. EPUT is
4 not one of them.

5 Dr Denman said it was "More luck than judgement that
6 her own Trust had not taken the same path".

7 Chair, as to the topics for possible interim
8 recommendations, EPUT highlight the following five
9 areas: firstly, in relation to consent, EPUT has
10 accepted a responsible Board member for consent is
11 appropriate. Rather than creating a new role, the duty
12 should be aligned with the Caldicott Guardian through an
13 additional principle within that framework that is built
14 into Caldicott Guardian training. That builds on
15 existing framework rather than adding another.

16 Dr Suresh saw "synergies" between the two, and
17 Mr Trent said such a role "may have allowed a different
18 challenge to be brought earlier at EPUT".

19 Any such recommendations should be clear about where
20 consent is needed and where it is not. Consent, as
21 a clinical decision to use the technology, such as the
22 system in the bedroom, is distinct from the legal basis
23 for processing health data. Under Data Protection Law,
24 that basis is ordinarily the performance of a public
25 task, and for good reason. A recommendation that

1 blurred the two would be disproportionate across the
2 wider NHS.

3 Next, written, informed and auditable consent to opt
4 in. EPUT supports this. The patient should be opted in
5 to these systems only with written and informed consent
6 and that consent should be auditable. This is now
7 EPUT's policy.

8 The system is off on admission, and for a patient
9 with capacity, the final word is theirs. But written
10 should not be paper alone, the technology for secure
11 digital signatures already exists and the recommendation
12 should allow for it.

13 Second, in relation to observations and engagement.
14 A national review of observation and engagement
15 practice. EPUT supports this. Dr Denman described
16 "a general and enduring shortage of guidance aimed at
17 psychiatrists on observation" and agreed that national
18 Standards should be the goal.

19 Vital Signs. EPUT supports the principle that vital
20 signs monitoring by these systems is never a substitute
21 for NEWS2 or for face-to-face checks. NEWS2 should
22 always be the preferred approach. Where these systems
23 are used for vital signs, that use should be restricted
24 to defined clinical settings with an individual clinical
25 rationale and the patient's consent. Clinicians should

1 define those settings which should include situations
2 where NEWS2 cannot safely be taken, such as seclusion.
3 They may also include older adult wards where Dr Suresh
4 described the value of checking patients at risk of
5 falls at night without waking them.

6 Our recommendation should not, however, rule out
7 individual measurements where they are clinically
8 indicated, or new and validated forms of measurement
9 that may become available in future.

10 Third, digital risk management. A proactive
11 national learning and alerts. National learning and the
12 alerting of providers should be more proactive. Where
13 a risk falls below the threshold for a patient safety
14 alert, an advisory notice or other notification should
15 be considered. In 2021, national bodies identified
16 material risks relating to Oxevision using data that
17 individual Trusts did not have. Neither those bodies
18 nor the suppliers shared that analysis with providers.
19 Later national guidance set out principles but did not
20 identify those specific safety risks.

21 Digital clinical safety. Digital clinical risk
22 management should have greater prominence in national
23 frameworks, guidance, regulation and funded
24 transformation programmes. The roles of Chief Clinical
25 Information Officers and Chief Nursing and Allied Health

1 Information Officers and Trust digital clinical safety
2 governance should be an explicit line of inquiry in
3 inspection, including the CQC's Well-Led inspections.
4 Trusts should train more Clinical Safety Officers and
5 develop that capability.

6 National funding for digital innovation should build
7 Trusts' clinical informatics and clinical safety
8 capability alongside new technology so that adoption has
9 proper clinical oversight.

10 There are three reasons in support of these
11 submissions. National guidance on these systems did not
12 refer to clinical safety cases, or digital clinical
13 safety frameworks, and the CQC's published inspection
14 reports on EPUT did not assess its digital clinical
15 safety function.

16 Dr Denman identified gaps in clinical, especially
17 medical, oversight, and said that this kind of falling
18 away is common. And EPUT's 2025 clinical safety case
19 and hazard log identify many, though not all, of the
20 risks now before you, and have been used to develop
21 mitigations.

22 The fourth topic or area is guidance, research, and
23 evaluation. A national framework for adopting and
24 evaluating digital monitoring technology. EPUT supports
25 this. It should include independent, controlled

1 evaluation with outcomes set in advance, taking place
2 before or alongside implementation, particularly where
3 a technology is novel or contentious.

4 The Inquiry's statisticians said the evidence needs
5 replication across "multiple Trusts" and "multiple
6 wards". No single Trust can supply that. The
7 evaluation should therefore be commissioned centrally,
8 and carried out by an independent evaluator such as an
9 established university with the infrastructure and
10 expertise to do it.

11 Dr Denman said much the same: "certainly not one
12 Trust, but a university or a group of universities."

13 Dr Suresh proposed a model similar to NICE's
14 appraisal of new treatments. Because new technologies
15 are likely to come to market at significant pace, EPUT
16 invites you to consider a new national body, an
17 institute for innovations in mental health, to assess
18 and evaluate them on behalf of the NHS.

19 **MR GRIFFIN:** Could you bring your submissions to a close,
20 please.

21 **MR FULWOOD:** EPUT also supports clearer, earlier national
22 guidance on specific technologies or categories of
23 technology, nationally produced templates for monitoring
24 effectiveness, and co-production and evaluation built in
25 from the outset, so that any decision to expand use is

1 informed by what the evaluation shows.

2 Finally, the fifth area is product design, controls
3 and regulation. In terms of marketing claims for
4 registered medical devices, they should be subject to
5 regulatory enforcement and the standard of evidence
6 behind them should be clearer, so that providers can
7 test them and rely on them. The MHRA's own engagement
8 with the supplier about its claim shows why. So do the
9 statisticians' evidence. They said that the
10 supply-funded paper's claim that the system was likely
11 to be cost saving was not statistically based. In terms
12 of alerting activity functions, the MHRA should give
13 specific guidance on monitoring and tracking devices,
14 including how far providers may rely on their alerts.
15 EPUT supports better regulation of these functions,
16 failsafe alert design, and duties on suppliers.

17 Nothing in the system prevents repeated clear view
18 checks. A Trust can configure the system and must
19 govern its use, and can press for change, but only the
20 owner of the product can make it failsafe.

21 **MR GRIFFIN:** Thank you. That's your time, Mr Fulwood. Can
22 you bring it to a close right now, please.

23 **MR FULWOOD:** Thank you.

24 Chair, as I said, EPUT will consider carefully any
25 recommendations you make on observations and the use of

1 technology. Thank you.

2 **MR GRIFFIN:** Chair, that's the last of today's submissions.

3 **Closing remarks by THE CHAIR**

4 **THE CHAIR:** Thank you, Mr Griffin.

5 I'm grateful to Core Participants and their legal
6 representatives for their time today and their continued
7 assistance to the Inquiry. I will consider all of
8 today's submissions in conjunction with the further
9 written submissions which are due by 30 October.

10 My team and I will also continue to review the
11 evidence received over the last two weeks and to
12 re-visit the disclosure received in advance.

13 This is all being done with care, objectivity, and
14 complete independence. I will reach conclusions over
15 the coming weeks. The likelihood is that you will hear
16 about those conclusions in the New Year.

17 I'm very grateful to you all. Thank you.

18 **(2.25 pm)**

19 **(The hearing concluded)**

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