

Witness Name: Zephan Trent

Statement No.: 2

Dated: 9 May 2025

Rule 9 reference: EPUT Rule 9 (3c)

LAMPARD INQUIRY

SECOND WITNESS STATEMENT OF ZEPHAN TRENT

I, Zephan Trent, will say as follows: -

Introduction

1. I am the Executive Director of Strategy, Transformation and Digital within Essex Partnership University NHS Foundation Trust ('EPUT') and I have held this position since April 2022. Since 15 July 2022, I have also held the position of Senior Information Risk Owner (SIRO).
2. I hold BA(hons) and MSc degrees and I am a CFA® Charterholder. I am not clinically qualified.
3. I have been in employment with EPUT since April 2022 and I report directly to the Chief Executive Officer ('CEO'), Paul Scott.
4. I would like to offer my sincere personal condolences to anyone who has lost loved ones while receiving care from mental health services in Essex. This statement aims to address questions from the Lampard Inquiry about safety at EPUT. No part of this statement is intended to diminish the impact that the tragic loss of life will have had on families, loved ones and the EPUT staff that cared for them.
5. I have provided a First Statement to the Inquiry in response to a request for evidence with reference Rule 9 (3c) dated 21 March 2025. The request was to provide the Inquiry with information about Oxevision (or similar digital observation technology), CCTV and Body Worn Cameras. I make this supplemental statement in relation to recent developments and changes to EPUT's Standard Operating Procedure and use of Oxevision technology on inpatient wards, as I said that I would at paragraph 42 of my First Statement.
6. This statement updates the Inquiry on changes to the consent process and patient involvement for Oxevision following review of the latest guidance from NHS England, published in February 2025, and feedback from a patients, carers, and staff focus group held by the EPUT patient experience team in March 2025. It reflects the latest position agreed by the EPUT Board of Directors regarding the use of Oxevision at the Trust on 7 May 2025.

7. The EPUT Board of Directors recognises that in a number of respects, past use of the system has fallen below what we would expect now. EPUT accepts that it could and should have done better.
8. Since Oxevision was first implemented at the Trust there have been a number of changes to how the system is used. These changes have been informed by learning from serious incidents / patient safety incident investigations, findings from coroner's court including prevention of future death reports, and feedback from staff and patients. In particular:
 - Consent to use of the Oxevision system should not have been implied at admission, and should have been explicit informed consent.
 - There should have been better communication and information sharing to ensure that information was provided to patients, families and carers in a clear, concise and person-centred way which allowed them to be involved in decision making about the use of Oxevision in their care.
 - Greater consideration should have been given to the impact of Oxevision on those who have suffered and/or continue to suffer trauma.
 - There should have been processes in place to allow for continued patient, family and carer engagement and feedback on the system.
 - There should have been better training for staff on the use of Oxevision and how it works to enable them to have more informed conversations with patients, families and carers.
 - There should have been greater oversight at the outset of the practical use of Oxevision on the wards, in particular to address alarm fatigue and to ensure that each alarm was always actioned by a face to face visit with the patient and that alarm volume settings were not adjusted by staff.
9. In acknowledging these deficits, EPUT has been able to reflect, learn and make appropriate changes. I describe the most recent changes below.

Background

10. As set out in my first statement, the Oxevision system was first implemented at EPUT in 2020 following demonstrations to clinicians at EPUT Lab in 2019. An 'Early Insights and Implementation Lessons Learned' report including patient and staff feedback was presented to the Executive Operational Committee in August 2020. In September 2020 a paper was submitted to the Trust Board of Directors recommending the further roll-out, purchase and installation of Oxevision to support quality and safety across a number of the Trust's inpatient mental health wards. The Trust has continued the roll out of Oxevision across inpatient and specialist inpatient wards in a number of phases since then. This includes the Time to Care business case presented to Board in June 2023, which detailed the further rollout of Oxevision onto EPUT wards.

11. The implementation of the Oxevision system has been overseen by the Trust's Oxehealth Project Board. The use of Oxevision is set out in the Trust's *Standard Operating Procedure for the use of Oxehealth Oxevision and Oxevision Observations* (the SOP). The SOP identifies and explains the processes to be followed when using the Oxevision system. EPUT has had a SOP in place in relation to the use of the Oxevision system since 26 March 2020. Over time the SOP has been reviewed and changes and amendments have been made to ensure that it remains up to date and to incorporate learning and improvements to the use of the system. The latest document is version 12, which was approved by the Oxehealth Project Board on 30 April 2025 and came into effect on 7 May 2025.

12. The latest Standard Operating Procedure (SOP) was updated following:

- review of new NHS England guidance on use of digital technology in mental health inpatient treatment and care (February 2025)
- feedback from a patient, carer and staff focus group facilitated by the Trust's patient experience team, which took place in March 2025
- external legal review and comment on proposed drafting of the SOP.

NHS England guidance on use of digital technologies in mental health inpatient treatment and care (February 2025)

13. On 7 February 2025 (updated on 25 February 2025) NHS England issued guidance on use of digital technologies in mental health inpatient treatment, including 8 principles for digital technologies (such as Oxevision), to help clinicians consider whether use of a digital technology is the most appropriate, effective and least restrictive method of caring for or treating a patient in inpatient mental health settings. The guidance is titled: *Principles for using digital technologies in mental health inpatient treatment and care (February 2025)*. As set out in my first statement at paragraph 42, EPUT was reviewing this guidance as at 21 March 2025.

14. The principles set out in NHS England guidance are as follows:

- Human rights approach - Any digital technology must be used in accordance with the Human Rights Act (1998) including the right to life, liberty and security, respect for private and family life and the right to be free from inhuman or degrading treatment. This will involve a careful balancing of rights.
- Consent and capacity – the use of digital technologies must be based on consent or if the individual cannot consent then a best interest decision making process should be followed.
- Equity of access - providers must ensure patients are supported to benefit from digital technologies if there is evidence that it may enhance their care and treatment and support their personalised safety plans. Providers must safeguard against the discrimination of patients in relation to their protected characteristics when considering the use of or deciding to use any digital technology.
- Co-production - An ongoing partnership and collaboration between people who design, deliver and commission services and people who need and use the services.
- Therapeutic and personalised care - Digital technologies for care, treatment and safety must enable inpatient settings to provide therapeutic and personalised care. Digital technologies that support staff to spend more time with patients through 'releasing time to care' can be useful.

- Safety planning – digital technologies may help to manage personal safety risks for patients however building rapport and a therapeutic relationship are key to helping people be and feel safe.
- Evidence base - Providers should adopt a robust process for critically considering and assessing the evidence base specific to the type of service or ward, prior to purchase and implementation of any digital technology. Whilst it should be noted that EPUT procured and implemented Oxevision prior to this guidance, EPUT undertook a pilot project and sought feedback before rollout.
- Treatment outcomes - Providers must have a process of regularly measuring the impact and benefit of the use of any digital technology on patients' care and treatment outcomes.

15. On 10 April 2025 the Quality Committee received a report outlining the early findings from patient engagement relating to Oxevision and the Trust's review of the NHS England guidance. The Quality Committee report is exhibited as **[ZT2-098]**.¹ The committee agreed that EPUT needed to improve its consent processes and the information provided to patients to inform their consent during and after admission, and that changes needed to be made to the SOP to ensure that when consent is withdrawn the system is deactivated as soon as practicable with appropriate clinical oversight.

16. In line with the Trust's Board Approved Strategic Plan and Quality of Care Strategy, the Quality Committee agreed that the approach should be trauma informed. The committee also agreed that the Trust should engage with Oxehealth regarding options for the introduction of physical or other barriers that visually indicate to patients when the Oxevision system is deactivated to reduce risk of trauma for patients. EPUT has written to Oxehealth to start work on this and a meeting has been scheduled to take place before the end of May 2025.

17. EPUT has reviewed the NHS England guidance and made changes to its Standard Operating Procedure for Oxevision ("the SOP") to ensure continued alignment with the latest national guidance as set out at paragraph 22 below. EPUT has also undertaken a review of findings from a focus group that was held by the patient experience team

¹ Please note that date stated on the summary cover sheet of this exhibit is incorrect. It refers to 13/02/2025 when in fact the meeting took place on 10/04/2025 which is when the paper was presented.

with patients, carers, and staff to consider feedback about people's experience of using Oxevision within the adult inpatient setting. This information formed part of the review of the SOP and is described in more detail below.

Patients, carers, and staff Focus Group

18. In January 2025 it was requested by Executive Directors that a focus group be held with patients, carers, and staff as a listening opportunity to hear about people's experience of using Oxevision within the adult inpatient setting. As set out in paragraph 79 of my previous statement, in February 2025, the Oxehealth e-Obs Project Board, approved a proposal for EPUT's patient experience team to facilitate focus group with patients, carers, and staff, in order to better understand the experience of Oxevision and how it can be improved. The intention of the focus group was to create a space in which staff, patients, and carers can come together to co-reflect, and discuss thoughts and ideas which could enhance the Trusts understanding of the use of Oxevision, whilst identifying opportunities for improvement. The focus group was jointly chaired by the Deputy Director of Quality and Safety for Inpatient and Urgent Care and the Associate Director of Patient Experience on 25 March 2025.

19. EPUT was able to review the information from the focus group and make the following findings **[ZT2-98 – Quality Committee Report Appendix 1]**:

- Patients, friends, and family were unclear of the overall purpose and benefit of Oxevision. They were unaware of the physical health monitoring element of Oxevision and the added benefit this brings in the context of patient safety. Staff participants recognised that we could do more to explain what Oxevision is, how it is used and discuss it more openly with patients and families.
- The group agreed that the process for explaining Oxevision wasn't as effective as they would like it to be, and felt that discussing this on admission wasn't always the right time, and the posters in the wards were rarely accessed. The group felt that having posters in the rooms, having peer workers explain it, and discussing it in community meetings would improve the level of understanding across services.
- The system allowed staff to pick up issues, including physical health issues early, and respond more quickly, which sometimes resulted in life saving actions. A

specific story was raised about the reduction of falls incidents at night specifically within older adult services.

- When discussing consent, the patient participants were unaware of their rights, and did not know that Oxevision could be turned off. However, they did recognise the benefits of Oxevision and its ability to support staff to monitor physical health and to keep people safe.
- There were some concerns around the use of Oxevision and its impact on privacy.
- When discussing the potential impact of Oxevision on staff behaviour and in particular therapeutic engagement the whole group agreed that Oxevision is a supportive technology to enhance patient safety and should be used in conjunction with the human element, not replace it.
- A patient participant shared an experience of Oxevision saving their life in an attempted suicide.
- The group acknowledged the value of the focus group and agreed that more focus groups, and other ways of listening to patients and families would be important moving forward, to improve how the Trust uses Oxevision.

20. Using the information gained from the focus group the Oxehealth Project Board was tasked to:

- Create a more accessible (coproduced) information pack for patients, families, and friends, to better understand the purpose of Oxevision. This should include a clear explanation around consent, physical health observations, the benefits, what can be seen on the cameras, how Oxehealth is used to support therapeutic engagement.
- Strengthen externally facing communications, myth busting and sharing the positive impact around physical health monitoring and reducing falls etc. Sharing stories from people in services that have had a positive experience with Oxevision.

- Review the process for information sharing with patients about Oxevision, not just on admission but this should be discussed regularly with people, in ward review, community meetings etc.
- Establish an Oxevision involvement group which meets regularly to inform and direct the Oxehealth project board based on the lived experiences of patients and families. This should include a structured schedule of engaging with patients and families who have experienced Oxevision directly, through focus groups, 1-2-1 interviews, and feedback forms.
- Create a network of Oxevision champions in services, using peer workers where possible, to support people with understanding of the Oxevision system, to answer any questions, and capture feedback to share with the involvement group.

21. These recommendations were endorsed by the Quality Committee on 10 April 2025 and approved at the Oxehealth Project Board on 30 April 2025. The Project Board will oversee their implementation.

Revised SOP

22. The principal changes to the SOP in the latest version (version 12) relate to consent. In line with the NHS England guidance, the latest SOP takes a human rights approach with a focus on individual informed consent at the point of admission and throughout treatment and/or assessment on mental health wards with consent to be recorded explicitly in the patient record. This is a significant change from the previous approach of informed implicit or implied consent where patients were provided with information about the system and consent was implied unless an objection was made. The specified time limits for responding to the withdrawal of consent by a patient have been changed from a maximum of 72 hours to a maximum of 6 hours and the updated SOP is clear that the system should be switched off as quickly as practicable and safe **[ZT2-99 – Oxevision SOP]**.

23. Key changes include:

- A move from implicit to informed consent – this means all patients must be provided with clear, accessible information about Oxevision so they can give informed consent for the system to remain switched on. An informed consent and patient

capacity flow chart is included in the SOP with clearer guidance where there are concerns or doubts about a patient's mental capacity to consent.

- A stronger commitment to working in partnership with patients, their relatives, carers, nominated persons, and representative groups within the organisation to ensure clear communication and understanding of the Oxevision system. The SOP is clear that it is imperative that staff inform patients of the presence of the Oxevision system, gain patient consent for use as soon as possible, and confirm awareness of the use of Oxevision and Oxevision Observations with our patients.
- Admitting nurses are required to have clear and detailed conversations with patients when they arrive on the ward, explaining the purpose of Oxevision, how it works and what data is collected and how it is stored. Patients must be made aware of their right to withdraw consent to the use of Oxevision at any time and where they can find further information about Oxevision.
- The admitting nurse is to gain informed patient consent for the use of Oxevision and document their consent in the admission checklist within six hours.
- New reference to the Culture of Care Standards for mental health inpatient services (2024) and the promotion of a person centred approach to safety; getting to know the patient, building rapport and the therapeutic relationship are key to helping people be and feel safe.
- Additional emphasis that conversations regarding the use of Oxevision in patient care is not a "one-size-fits-all" model and must take into account the local variation in services as well as the individual needs of patients', relatives, carers, nominated persons preferences and their choices. Any reasonable adjustments that may be required to support their understanding of the system and giving consent to the same must be carefully considered on a case-by-case basis.
- Requirement that if a colleague has a clinical reason to conduct an additional therapeutic engagement and supportive observation or vital sign check, this must be recorded on the Oxevision Observation function with an explanation as to why the concern needs to be documented.
- Patients should be informed that EPUT has a Standard Operating Procedure (SOP) for the use of Oxevision which is available to them on request.

24. The adoption of the latest SOP is supported by the following:

- Clinical Safety Case and Clinical Risk Management Plan **[ZT2-100-101]** describes how EPUT will conduct clinical risk management to ensure patient safety with respect to services provided and the interrelated and interactive activities that will occur to ensure that the Oxevision/OxeObs meets the requirements of DCB0129 application in the manufacture of health IT systems and DCB0160 its application in the deployment and use of health IT systems (approved by Clinical Safety Group on 29 April 2025 and Oxehealth Project Board on 30 April 2025, final sign off from Safety of Care Group expected on 22 May 2025).²
- Quality and Equality Impact Assessments **[ZT2-102-103]** - The Quality Impact Assessment (QIA) is required to ensure that we have the appropriate steps in place so that any organisational change mitigates adverse impact as far as possible on the quality of care we deliver. The Equality Impact Assessment (EIA) is designed to make sure that our policies, services and functions do not discriminate in line with the Equality Act (2010). The author must gauge the impact of what they propose against marginalised and minority groups.
- Data Protection Impact Assessment **[ZT2-104]** - This document describes supports the mitigation of potential data protection risks identified to an acceptable level before using or sharing (processing) data that identifies individuals (personal data).
- Trust Privacy Notice - Privacy - Essex Partnership University NHS Foundation Trust - This document informs individuals about how their personal data is collected, used, and protected by EPUT.
- Implementation Plan for SOP Version 12 **[ZT2-105]** sets out the key milestones to be achieved to fully implement the new SOP.

25. In assessing the equality impact of the SOP it was identified that there were potential less favourable impacts on specific groups, however, mitigations have been identified to reduce these risks. Mitigations include recognising that that every person will have individual needs that need to be understood and planned with the person as part of

² DCB0160 is a clinical safety standard established by NHS England. It forms one half of a pair of standards to manage clinical risk in the manufacture and implementation of healthcare technology or health IT systems. DCB0160 sets out the requirements for effective clinical risk management in health organisations responsible for deploying, using, maintaining, and decommissioning Health IT Systems. The overarching aim of clinical safety standards is to ensure patient safety by managing risks associated with digital health systems. DCB 0129 is the clinical risk management standard which manufacturers of health IT systems and apps need to comply with. The standard is governed by NHS Digital.

their admission journey, that all staff working on the wards should be trained in the use of Oxevision and must follow the SOP, and that there is ward oversight of Oxevision and audits are completed for assurance.

New consent process

26. Under the new Standard Operating Procedure, the consent process now operates as set out in section 1.5.2 of the SOP and the Oxevision Informed Consent Flowchart at Appendix 1 of the SOP [ZT2-099]. The process is as follows.

- As part of the admission process all patients must be provided with clear, accessible information about the use of Oxevision and Oxevision Observations. This must include, its purpose, how it works, and what data is collected. Information about the function and purpose of the digital technology should be shared in a format that is personalised and tailored to the person's understanding and communication needs. Details of how the patient's data will be collected, stored, and used must also be explained in an accessible way to ensure consent is fully informed.
- Patients are encouraged to ask questions, express any concerns, and are given the opportunity to fully understand how and why the system is used. The patient will be informed that the Oxevision system is currently in an 'on' state and they will be required to give informed consent for this to remain on or the Oxevision system will be switched off within 6 hours. If the Oxevision system is not switched off within 6 hours then a clinical rationale must be recorded in the patient's records and this must be achieved as soon as clinically practicable.
- Where there is no reason to believe that a patient does not have the mental capacity to consent to the use of Oxevision in connection with their care and treatment, consent should always be sought from the patient and the use of the technology regularly reviewed with them, and if appropriate, with their families and carers, nominated person.
- Consent for the use of the Oxevision system must be obtained and clearly documented in the clinical case notes, including the patient's response. The patient can be assumed to have the mental capacity to give consent unless there is evidence that there is reason to believe that they cannot.

- If there are concerns or doubts about a patient's mental capacity to consent, then the Nurse in Charge (NIC) along with the responsible clinician/duty doctor will assess the patient's capacity (with reference to number 2 and 3 of the MCA 2005). If there is reason to believe the person lacks mental capacity to make the decision they should proceed to make a best interests decision that includes clinical and all other relevant factors regarding whether the use of the Oxevision system is in the patient's best interests. Where there is reason to believe a patient lacks mental capacity a Multi-Disciplinary Team (MDT) meeting should then be arranged to specifically review this decision as soon as is reasonably possible.
- If the patient consent is not given on admission, or is withdrawn during the admission process or following the MDT clinical decision, the Oxevision system can be individually isolated by the Nurse in Charge (NIC) using the monitor to select 'Camera off' for that patient's bedroom. A decision to turn the camera off should only occur if the Nurse in Charge (NIC)/doctor deems the action clinically safe prior to a Multi-Disciplinary Team (MDT) decision meeting. If the Nurse in Charge (NIC)/doctor deems this to not be clinically safe then the Oxevision system will remain on and the rationale to be explained to the patient and clearly documented in the patient record.
- During the MDT decision meeting, the team will reach a joint decision concerning the use of the system. Any decision must be in the best interests of the patient, taking into account all relevant factors which are likely to include balancing their wishes and feelings against, safety management issues, clinical best interests and any other relevant factors. The assessment needs to be open and with honest communication including the patients/relatives/carers/nominated person/advocate views.
- During the MDT decision meeting, the team will reach a joint decision concerning the use of the system. Any decision must be in the best interests of the patient, taking into account all relevant factors which are likely to include balancing their wishes and feelings against safety management issues, clinical best interests and relevant factors. The assessment needs to be open and with honest communication including the patients/relatives/carers/nominated

person/advocate views, the way it works and purpose of the system so everyone involved can be confident of an informed decision. If the decision is for the Oxevision system to be turned off for the patient's room, then this needs to be actioned by the Nurse in Charge (NIC) by individually isolating the function using the monitor to select 'Camera off' for that patient's bedroom. This decision is to be clearly communicated to the patient, relatives, carers, nominated person, advocate and staff and clearly documented in the patient records.

- All clinical decision's regarding informed consent/objections of the use of the Oxevision system must be documented within the patient's record, the individualised patients care plan must be updated, and a Datix completed. The patient's informed decision of the use of Oxevision will be reviewed, assessed, and documented at least once weekly in ward review/MDT review. Should the patient, relatives, carers, or a nominated person and MDT agree to turn the Oxevision system back on, the Nurse in Charge (NIC) will action the MDT confirmation.
- When a patient asks for Oxevision to be switched on following a prior decision for the Oxevision system to be switched off , the Nurse in Charge (NIC) will authorise and action the Oxevision system in the patient's room to be returned to an active state. The Oxevision reactivation must be communicated to the clinical team looking after the patient at that time, documented in the patient's record, and cited in the handover documentation. The MDT to be notified as soon as clinically practicable.
- Out of hours – If patient does not consent/or capacity is queried on admission, an MDT should take place as soon as clinically practicable involving the NIC and the on-call doctor (as a minimum) to reassess the risk, the existing management plan in place and decide on further actions. In some circumstances especially when the risks are considered significant, the decision to switch off the Oxevision system may be delayed until the revised risk management plan is in place. The reasons for such a decision will be explained to the patient, their carer and recorded clearly in the patient records. The consultant in charge of the patient to be informed of the situation as soon as possible.

Implementation of new SOP

27. As noted in paragraph 24, an implementation plan has been approved to ensure key milestones are achieved [ZT2-105] these include changes to admission checklist on the electronic patient record to include a check box to confirm patient consent has been obtained, updating posters and welcome packs and development of the intranet page, as well as updates to the OLM mandatory training on Oxevision.
28. To support the implementation of the new SOP, staff were advised about the key changes and the publication of the new SOP in an all-staff message called Wednesday Weekly on 7 May 2025. This has been followed up in the ward managers briefing on 8 May 2025 and will also be included in the managers and senior leadership briefings on 9 May 2025.
29. Progress against the implementation plan will be overseen by the Oxehealth Project Board which will report on progress to the Quality Committee.

Training

30. As set out in paragraph 54 of my first statement, all staff who work in inpatient wards must be trained to use the Oxevision system. Mandatory training consists of the completion of the Oxevision and Oxevision Observations courses on Oxehealth Academy, and the Oxevision OLM. When staff have completed their mandatory training the completion status will be displayed in their Mandatory Training Tracker List on EPUT's Intranet. All mandatory training components require a 100% pass mark and need to be completed annually. Training in the use of the Oxevision system is included in the staff local induction to an inpatient ward. All staff that are new to Oxevision will be briefed by an Oxevision champion or a trained, competent staff member on the equipment, application, and relevant EPUT standard operating procedures. All staff, including bank and agency staff, need to demonstrate competency and record that demonstration on a competency checklist.
31. The Nurse in Charge of the ward must be assured that all staff on shift are competent in the use of the Oxevision System. If the Nurse in Charge is not satisfied, then the gaps in knowledge are identified on the staff member's competency checklist and they may be required to repeat their mandatory training.
32. Training includes issues such as:

- Oxevision is not CCTV. Use of Oxevision as CCTV is likely to be a breach of patient's right to privacy and dignity.
- How to share information about the Oxevision system and its use with our patients, relatives and carers, including supporting any concerns and objections to the use of the Oxevision system and consent.
- How to use Oxevision and Oxevision Observations to conduct observation rounds, periodic observations, managing observations levels.
- Ward level application of system, alerts and notifications, and functionalities.

Statement of Truth

The content of this statement is true to the best of my knowledge and belief.

Signed: 

Dated: 9 May 2025