**Witness Names: Dr Kallur Suresh and Zephan Trent**

**Dated: 22 May 2026**

**LAMPARD INQUIRY**

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**WITNESS STATEMENT IN RESPONSE TO RULE 9(114)**

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## Introduction

### Dr Kallur Suresh

1. I am a Consultant Psychiatrist and Executive Chief Medical Officer at Essex Partnership University NHS Foundation Trust ("EPUT"). I have held this post since 1 December 2025. Prior to taking this role I was the Deputy Medical Director for the West Essex Care unit since April 2017. Prior to that I was a Consultant Psychiatrist and West Area Medical Director at North Essex Partnership University NHS Foundation Trust ("NEP").

2. I started working at NEP in 2004, initially as a Consultant Psychiatrist for older people in the Harlow area. In 2005, I was appointed as Associate Medical Director for West Essex. I held this role until the merger of NEP and the South Essex Partnership University Foundation Trust ("SEPT") in April 2017.

### Zephan Trent

3. I am the Executive Director of Strategy, Transformation and Digital within 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).

4. I hold BA(Hons) and MSc degrees and I am a CFA® Charterholder. I am not clinically qualified.

5. I have been in employment with EPUT since April 2022 and I report directly to the Chief Executive Officer ("CEO"), Paul Scott.

### Corporate Response

6. This statement is provided on behalf of EPUT in response to the Lampard Inquiry's request for evidence pursuant to Rule 9 of the Inquiry Rules 2006 (EPUT Rule 9(114)), which seeks further information concerning EPUT's historic and current use of the Oxevision system.

7. EPUT has been invited to submit a written statement addressing the questions set out in the Annex to the Inquiry's letter dated 22 January 2026, together with any relevant supporting documents.

8. The statement is provided in the form of a corporate statement. It is filed as an unsigned draft in the first instance so that the Inquiry may consider whether there are any additional matters it would like to be addressed before the statement is finalised. Once finalised, it will be signed by both Dr Suresh and Mr Trent.

9. Dr Kallur Suresh, as Chief Medical Officer, provides clinical oversight and is responsible for the clinical content of this statement. He retains overall responsibility for the evidence provided. Zephan Trent, as Executive Director of Strategy, Transformation and Digital and Senior Information Risk Owner, addresses EPUT's digital, governance, in relation to the Oxevision system, drawing on his evidence provided in his three previous statements in response to Rule 9(3c) and Rule 9(3d).

**Approach to the Rule 9(114) request**

10. In preparing this response, EPUT has sought to address the questions posed by the Inquiry by drawing upon the information available to it, including governance documentation, Standard Operating Procedures, audit records, Board and committee papers, monthly usage reports, Datix incident reports, and staff and patient engagement materials held in electronic form by the Trust. Where relevant, this response also draws upon information contained within the three previous statements submitted by Zephan Trent in response to Rule 9(3c) and Rule 9(3d), together with the relevant supporting exhibits disclosed with those statements.

11. In providing this witness statement, the authors have provided responses to the Inquiry's questions on behalf of EPUT. Not all matters addressed are within the personal knowledge of either author. Reliance has therefore been placed on information and documents provided by colleagues. The contents of the statement are true to the best of the authors' knowledge, information and belief.

12. In order to identify the information relevant to this request, EPUT has conducted searches across the Trust's shared drives, databases and systems holding relevant documentation.

13. The searches for information relating to this Rule 9 request have included contact with multiple teams and senior colleagues across the Trust, including those responsible for clinical governance, digital and information governance, quality and safety, and patient experience. Where particular sections of this statement have required input from colleagues with specialist knowledge of specific areas, this is identified within the body of the statement.

14. Unless otherwise stated, all references to the Standard Operating Procedure within this statement are references to version 12.

15. Since the preparation of earlier statements, Oxehealth, the provider of the Oxevision system to EPUT, has rebranded as LIO. All references to Oxehealth within this statement and in earlier statements should accordingly be read as references to LIO, and vice versa.

16. This statement addresses EPUT's use of the LIO system in the following order. It opens with a summary of the Parliamentary and Health Service Ombudsman's Final Report concerning a complaint by "Miss B" about her 2021–22 inpatient admission, which was received on 27 March 2026 and which the PHSO partly upheld. It then sets out the findings and recommendation of a rapid review on the use and governance of the LIO system. The statement then turns to the chronological and reflective account of how the system was introduced, deployed, governed, and reviewed, including the evolution of the consent framework, audit and oversight arrangements, usage data analysis, data protection, and human rights considerations. The decision to conduct a further review of practice and the use of Oxevision, to review the SOP and to give effect to the default off position, recommended by the rapid review and reflected throughout this statement, forms the immediate context for all that follows.

**Parliamentary and Health Service Ombudsman (PHSO) complaint: Miss B**

17. The following section summarises the findings of the PHSO's Final Report dated 27 March 2026 concerning a complaint by "Miss B" about EPUT's use of Oxevision during her inpatient admission in 2021–22. The complaint and the PHSO's findings preceded the rapid review described in the Section immediately below.

18. The Final Report from the PHSO dated 27 March 2026, **[Exhibit KSZT01-175]** is directly relevant to the matters identified in the rule 9 request. The PHSO partly upheld Miss B's complaint.

19. Paul Scott, the Trust's Chief Executive, responded as follows, "The Trust has carefully considered the provisional findings and confirms that it agrees with the views set out, as well as the proposed recommendations and associated timescales" (which are referred to later below). EPUT's Complaints Process, including responses to the PHSO, is the responsibility of the Executive Nurse and ultimately the Chief Executive.

20. Miss B was an inpatient at a Trust ward c [I/S] Oxevision was in use on the ward during her admission. Miss B complained that the Trust had failed to obtain her consent for the use of Oxevision, had failed to provide her with information about the system, had failed to switch it off when she asked staff to do so, and had failed to address her concerns adequately through the complaints process.

21. The Trust's SOP in force at the time of Miss B's admission advised staff to inform patients and carers that Oxevision monitoring formed part of normal practice and that consent would

not be required. As the Trust has acknowledged elsewhere in this statement, earlier iterations of the SOP adopted an implied consent model.

22. The PHSO had regard to GMC guidance on the making and use of recordings of patients, which requires clinicians to obtain appropriate consent or other valid authority before making recordings, to explain the purpose, form and storage of recordings, to record the key elements of consent discussions in the clinical record, and — where an adult patient lacks capacity — to obtain consent from a person with legal authority to provide it.

23. The PHSO found that Miss B was assessed as having capacity in October 2021. The PHSO concluded that the Trust should have sought her consent for the use of Oxevision and should have revisited that consent discussion as her condition improved throughout her admission. The PHSO concluded that the Trust's approach did not meet GMC guidance and that this was a failing.

24. The PHSO identified an internal inconsistency within the SOP then in force: it stated simultaneously that consent was not required and that the system would be turned off if a patient refused. The PHSO concluded that this was an inconsistency that would have made it difficult for patients to make a meaningful decision about Oxevision without a formal discussion and without access to adequate information.

25. The PHSO noted GMC guidance that, where practicable, recording should stop if a patient asks for it to do so. Having considered the available evidence, the PHSO concluded that it was more likely than not that Miss B had asked for Oxevision to be switched off and that this had not happened. The PHSO found no record in the clinical notes of any conversations between staff and Miss B about Oxevision at any point during her admission. The PHSO concluded that this was a failing.

26. The Trust's position was that staff would have informed Miss B verbally about Oxevision, but the PHSO noted that there was no formal mechanism for recording such conversations at the time (a checklist now exists). The PHSO was unable to confirm from the evidence available whether posters about Oxevision were displayed on the ward during the relevant period, as the Trust could not evidence this.

27. Having considered all of the available evidence, the PHSO concluded that Miss B had likely asked questions and raised concerns about Oxevision during her admission but had not received the information she sought, and that staff had not documented those discussions. The PHSO concluded that this was a failing.

28. The PHSO found that the absence of adequate information about Oxevision intensified Miss B's anxiety and distress and contributed to further paranoia and concern on her part.

29. The PHSO found that staff did not document in Miss B's care plans how Oxevision was being used to support her monitoring during her admission. The PHSO concluded that this lack of documentation prevented the Trust from being able to explain, either during its own complaint investigation or during the PHSO's review, how the system had been used during her care, and left Miss B with unanswered questions and ongoing uncertainty about what had taken place.

30. Having reviewed observation charts, key-card data and clinical advice, the PHSO found that the records supported that staff were completing in-person observations during Miss B's admission. The PHSO did not find evidence that staff had left Miss B alone for extended periods at night or that they were over-relying on Oxevision for observations, and no failing was found in relation to this aspect of Miss B's complaint.

31. The PHSO acknowledged that the Trust has implemented a new SOP since the events giving rise to Miss B's complaint and that the Trust now seeks patient consent for the use of Oxevision. However, the PHSO concluded that the current SOP still departs from national guidance and recommended that the SOP and the Trust's approach to consent be re-reviewed.

32. The PHSO had regard to NHS England's February 2025 Principles for using digital technologies in mental health inpatient treatment and care, which state that technology use must be based on consent. The PHSO concluded that the Trust's current SOP departs from this principle and from GMC guidance because it permits circumstances in which the Trust may decline to switch off Oxevision even where a capacitous patient has not consented to its use, subject to clinical and MDT decision-making.

33. The PHSO found it unclear, given the Trust's own position within the SOP that Oxevision complements rather than replaces in-person observations, why the Trust considered there may be circumstances in which it would not be clinically safe to switch the system off. The PHSO concluded that the Trust had not fully addressed what went wrong in Miss B's case or taken sufficient steps to prevent recurrence.

34. The Trust notes that the exceptional circumstances mechanism within the current SOP was introduced in recognition that clinical circumstances may arise in which Oxevision serves a patient safety function that cannot immediately and safely be replicated through alternative means alone, and the SOP makes clear that this must not be a routine position, must be documented, and that staffing or resource considerations cannot justify retaining the system in use against a patient's express wishes. Nonetheless, the Trust accepts the

PHSO's recommendation that this mechanism, and the SOP's consent approach as a whole, requires re-review.

35. By 24 June 2026, the Trust is required to re-review its SOP and approach to consent with reference to GMC standards and NHS England guidance, and to write to Miss B, the PHSO, NHS England and the CQC to set out the outcome of that review, the rationale for any changes made (or any decision not to make changes), and how the changes will be implemented and monitored.

36. By 24 June 2026, the Trust is required to write to Miss B to explain what changes have been made to patient communication, staff training and observations as a result of the complaint, and to explain how the Trust monitors staff compliance with those changes, providing a copy of that letter to the PHSO.

37. By 24 June 2026, the Trust is required to produce a structured action plan addressing improvements to both complaint-handling and record-keeping processes in relation to Oxevision. The action plan must identify specific actions, responsible persons or teams, implementation timescales, and the measures by which impact will be monitored and assessed, and must be shared with the PHSO on completion.

38. The Trust notes that the PHSO acknowledged the introduction of mandatory staff training for Oxevision and the strengthening of guidance around staff communication about the system. The PHSO further noted that the Trust now has a checklist for staff to confirm that the Oxevision conversation has taken place with patients, reflecting that no formal mechanism for recording verbal information provision existed at the time of Miss B's admission. The Trust will build upon these improvements in carrying out the remedial steps required by the Ombudsman.

**Rapid Review Briefing Report on the use of Oxevision/ LIO**

39. The review was led by Dr Ambiga Ravi Clinical Director for Clinical Governance and Consultant Psychiatrist, and Angela Wade Director of Nursing, Infection Prevention and Control. The rapid review drew on documents directly relating to LIO, including the PHSO Final Report, Trust policies, and involved direct discussion with frontline clinical professionals across different clinical areas and patient groups. Their report was shared with the Executive Team on 20 May 2026 and is attached as **[Exhibit KSZT01-176].** The minutes of the Executive Team meeting which was convened to discuss the report are attached as **[Exhibit KSZ01-177]**. The review identified the following key concerns.

40. In relation to the PHSO recommendation, the approach adopted by the Trust under the SOP in force at the time of the relevant admission did not meet GMC guidance on the obtaining of consent for recordings.

41. In relation to consent arrangements, the follow-up TIAA audit assurance review concludes Limited Assurance, over arrangements to obtain and evidence of documentation for Oxevision, indicating improvement is required to manage associated quality and governance risks. This is consistent with quality control audits undertaken through Tendable.

42. In relation to clinical use, the vital signs function was found to have limitations as a medical device, including inaccuracy, the inability to set patient-specific parameters, and the inability to support NEWS2 scoring.

43. Frequent alerts disrupt staff engagement with patients. The focus is changed to addressing the alerts rather than concentrating on the therapeutic engagement with the patient in front of them.

44. Privacy and safeguarding concerns through the viewing of patients' images without informed written consent and enabling potential image capture on another device.

45. In relation to alert functionality, a noticeable time lag in the delivery of alerts to handsets was reported.

46. In relation to vital signs attempts, the review of monthly LIO reports identified 306,085 vital signs attempts trust-wide in April 2026 and over 350,000 in March 2026.

47. The report puts forward two options for the Executive Team to consider

1. To pause the use of the system.
2. To continue with immediate controls in place.

48. The report also recommends an independent review to determine the organisational merits, system requirements, and practice requirements going forward.

49. The reviewers recommend the organisation immediately refocus on LIO's purpose as an assistive technology, with the following key actions.

50. The system should be set to default off with immediate effect, operating as an opt-in system only where there is a clinically agreed opportunity to assist care plan delivery, supported by

informed written consent (or a best-interest decision where the patient lacks capacity or a decision is made by the responsible clinician under section 63 of the Mental Health Act 1983).

51. LIO use becomes a two-step process: first, the MDT agrees it may be useful for that patient's care; second, the patient's informed written consent is sought after assessing their mental capacity. If either step is not satisfied, LIO will not be used.

52. Each patient must have a personalised care plan that defines how LIO may assist in care delivery, with full explanation of how the infrared camera records, views, saves, and destroys images.

53. A collective workshop for all ward managers, matrons, and ward consultants is proposed to address:

- Competence and consistency in gaining informed written consent
- Therapeutic engagement and fundamentals of care
- Privacy, dignity, and human rights in the context of assistive technology
- Competence in recording NEWS2 and non-contact physical health observations
- Strengthened clinical governance and professional practice assurance reporting through the Trust's governance structures
- Ongoing plans to listen to and act on patient and staff feedback

54. In order for any changes to be implemented there needs to be a process of EIA and QIA, clinical safety case and hazard log needs to be updated, training is updated, communication to ward staff, updates to posters and leaflets, risk mitigations.

55. Following receipt of the rapid review, the Chief Medical Officer and Chief Nursing Officer will be issuing an urgent memo to relevant clinical staff setting out immediate actions to be taken pending the full review and implementation of the revised SOP. **[Exhibit KSZT01-178]**.

**Current Position**

56. At the Executive Team meeting on 20 May 2026 the following matters were determined.

57. That a further review needed to be undertaken. That the SOP review required to meet the PHSO deadline of 24 June 2026 and the wider independent review of contactless monitoring were distinct exercises that must not be conflated. It was acknowledged that a full independent review was unlikely to be completed before 24 June 2026. The reviewed

SOP would accordingly represent an interim position, subject to the outcome of the wider review. The wider independent review of contactless monitoring was to be commissioned by the Executive Team with clear terms of reference to be agreed and approved by the Executive Team. The Executive Team acknowledged the recommendation to commission that wider review and accepted it. The review would be inclusive of patient views and those with lived experience. The Executive Team confirmed that it remained open-minded as to the outcome of the wider review and would approach it without prejudice to any particular conclusion. The wider review's terms of reference should also address relevant evidence not directly referenced in the rapid review paper, including the patient engagement review previously undertaken, Datix analysis, Tendable audit data over time, and the previous work of the clinical lead for Oxevision and the Deputy Director of Quality and Safety.

58. That legal advice needed to be sought as to whether the proposed revised SOP — and in particular the approach to be adopted under it — would be compliant with human rights legislation. The Executive Team was clear that neither the report authors nor the Executive Team could make a determination of compliance with human rights legislation without legal advice, and that the rapid review paper should not be read as containing any such determination. It was noted that under option one (pausing the system entirely), there would be no human rights implications in respect of the system's use; however, any revised SOP adopting the default off position under option two required independent legal assessment to provide the necessary assurance.

59. That any change to the default position of the LIO system, and any consequential amendment to the Standard Operating Procedure, required a robust implementation plan including a rolling programme of staff briefings and training sessions for all relevant ward-based staff, with evidence of attendance, to be shared with the Executive Team for oversight, assurance and approval by 2 June 2026. The Executive Team was clear that previous iterations of the SOP had been accompanied by a robust training programme and that any change to the SOP must be similarly supported. The Executive Team noted that agreement of the default off position raised two issues requiring careful management: the practical implementation of the switch in default position itself, and the associated changes to the consent arrangements that would flow from it. It was emphasised that any change in clinical practice must be implemented safely and that, in consequence, whilst implementation was expected to commence ahead of 24 June 2026, it may not be complete by that date given the number of wards involved. The implementation plan was to be shared with the Executive Team for oversight, assurance and ultimate approval. The Executive Team noted the need for accountability to be maintained and for timelines to be clearly tracked through the Executive Team's oversight arrangements.

60. That there was a need to consider whether the matters identified in the rapid review required a specific corporate risk register entry in respect of LIO, given that the report's cover sheet had noted the impact on multiple strategic risks. The Executive Team agreed that there needed to be a focus on rolling out the right process and providing assurance that this had been done correctly. The clinical hazard log, which followed a different governance route, was also to be reviewed to ensure that the matters identified in the rapid review were appropriately reflected and, where necessary, updated.

61. In addition, a number of further workstreams are required before any revised SOP can be fully implemented, including an updated Equality Impact Assessment and Quality Impact Assessment; an updated clinical safety case and hazard log; revised staff training; updated communication to ward staff; and updated patient-facing materials including posters and leaflets. These workstreams will be progressed as part of the implementation plan and will be overseen by the Executive Team.

62. The Trust accepts the two step process recommended by the rapid review. First, the MDT must agree that LIO may be of clinical benefit for the individual patient and that its use can assist in the delivery of that patient's care plan; and second, only once that clinical determination has been made, the patient's informed written consent is sought, supported by a personalised care plan that defines how LIO may assist in care delivery and provides a full explanation of how the system works. A patient who has been told by their clinical team that the technology may offer them a specific, identifiable benefit relevant to their individual circumstances is in a materially better position to engage meaningfully with the consent process than a patient who is simply informed on arrival that monitoring is currently active and asked whether they wish it to continue. That framework, properly implemented and supported by a robust revised SOP, training programme, and governance structure, represents an approach that is consistent with human rights principles, with national regulatory guidance, and with the Trust's own stated commitment to person-centred, trauma-informed care.

63. The Trust recognises the seriousness of the concerns identified in the rapid review and accepts that immediate and sustained action is required. The position set out in this statement represents the Trust's current position as at the date of submitting this statement. The Trust will continue to keep its approach under active review, informed by the implementation plan, the wider review, and the ongoing work of the SOP review group. The Executive Team has committed to maintaining clear lines of accountability, oversight and assurance throughout that process, and to keeping both patients and the Inquiry informed of material developments.

64. The chronological and reflective account that follows in this statement explains how LIO came to be deployed, how the governance and consent framework evolved over time, what the audit and oversight processes identified, and how usage data has been analysed. That account is provided as necessary background to the Inquiry's questions under Rule 9(114), and should be read in light of the current position set out above.

## Patient Safety and Risk of Harm from Oxevision Use

### Background to the decision to use Oxevision

65. This section describes the context in which EPUT first considered and then decided to trial the Oxevision system. It provides the background against which the governance decisions, consent framework, and oversight arrangements described in subsequent sections were developed.

66. This section has been drafted with the assistance of the Chief Information Officer, who previously held the role of Director of ITT, Business Analysis and Reporting, and who accordingly holds the corporate memory from the period during which the use of Oxevision was being considered by EPUT.

67. Many safety incidents related to patients who self-harmed or who were suicidal. One of the ways in which these patients were kept safe was the use of observation. This was often reliant on one-to-one observation, which can itself be seen as intrusive, restrictive and at times punitive.

68. Similar to the national picture (see data collected by NHS England from 2016 to 2024 - https://digital.nhs.uk/supplementary-information/2025/self-harm-incidents-for-inpatients-in-psychiatric-wards), EPUT had seen an increasing number of incidents relating to self-harm, and of particular concern were those involving ligatures. EPUT had a significant ligature management programme underway, which had included the introduction of door-top alarms. Whilst that programme had been successful in preventing a number of incidents, it did not address all concerns including patients who use non-anchor ligature methods.

69. Consistent with NHS England’s general encouragement to use technology to support the provision of safe and compassionate care EPUT had been seeking to identify innovative solutions to the challenges associated with self-harm incidents and high levels of observations, in order to improve patient safety and quality of care.

70. It was also identified that on older persons' wards, patients who are at risk of falls are often placed on one-to-one supervision. Patients with dementia often find this practice unsettling and can become agitated as a result. This can be particularly distressing for such patients during the night, when having a member of staff observe them whilst they sleep may increase challenging behaviour or itself increase the risk of falls. There are other cohorts of patients that can also find one-to-one observations highly intrusive and distressing.

71. When considering digital innovation that might support the Trust's safety programme, EPUT looked to developments at University College London Partners ("UCLP"). UCLP had a mental health arm looking at digital innovations that could support mental health organisations, and one of the products identified through that network was Oxehealth's Digital Care Assistant, later known as Oxevision.

72. In Zephan Trent's First Statement in response to Rule 9(3c) dated 21 March 2025, the decision-making process is described at paragraphs 12 and 13.

**Historical Consideration of Potential Harms (Pre-Implementation)**

73. EPUT understands that Oxford Health NHS Foundation Trust used the system first, and that UCLP was speaking to NHS Trusts about the product. EPUT heard about Oxevision through that network. Oxford Health produced insight reports of their findings, and Trusts typically trialled the system on the basis of those findings.

74. At the time of EPUT's consideration, two reports had been published by NHS Trusts — Coventry & Warwickshire Partnership NHS Trust and Oxford Health NHS Foundation Trust — on the real-world evidence of the Digital Care Assistant (the name by which Oxevision was then known). Those reports stated that deploying the Digital Care Assistant delivered the following benefits:

- 33% reduction in falls at night;
- 56% reduction in A&E demand;
- 71% reduction in enhanced observations, with 7,800 clinical hours saved annually;
- staff reporting improved patient safety and confidence;
- carers reporting greater peace of mind;
- the system being rated as an example of outstanding practice by the Care Quality Commission ("CQC"); and

- patients reporting feeling safer, sleeping better and experiencing greater privacy.

75. As with NHS England one of the CQC's strategic priorities is to encourage innovations in technology as a driver of improvements in the quality of care (Driving improvement through technology - Care Quality Commission - https://www.cqc.org.uk/publications/themed-work/driving-improvement-through-technology). The CQC publishes case studies of innovative developments which use technology to deliver care differently and more efficiently. The Digital Care Assistant was one of the CQC's published case studies (Digital care assistant - Care Quality Commission - https://www.cqc.org.uk/publications/themes-care/digital-care-assistant). Following a December 2018 inspection at Coventry and Warwickshire Partnership NHS Trust, the CQC noted the use of the Digital Care Assistant for monitoring movement and vital signs in patient's bedrooms as outstanding practice resulting in reduction of falls.

76. As a result of this information and following discussions with clinicians and mental health senior management, EPUT decided to conduct a trial of the system on four wards to support the rest of the safety plans for the organisation. From the outset, EPUT pursued this technology as a support to, not a substitute for, in-person care and treatment for their patients.

77. In Zephan Trent's First Statement at paragraph 14 it describes the demonstrations of the product and the discussions that were had between clinicians, senior management and other Trusts that were already using the product. Whilst the authors of this statement are not aware of those discussions it should be noted that neither were directly involved in them and do not know the detail of what was discussed. It should also be noted that none of the Board members from the pre-implementation period are current employees at EPUT and we have not been able to obtain any information directly from them.

78. Initial patient feedback was presented to the Executive Operational Committee, and on 30 September 2020 a paper was submitted to the Trust Board of Directors recommending the further roll-out of Oxehealth to support quality and safety across a number of the Trust's inpatient mental health wards.

79. The decision to implement Oxevision was signed off by the Executive Team (which includes clinicians and those with clinical backgrounds) in 2020. The early papers were primarily focused on the practicalities of implementation rather than a systematic assessment of potential clinical harms. However, early implementation feedback (described in more detail in Zephan Trent's First Statement in response to Rule 9(3c) at paragraphs 16 to 21), was that 75% of patients felt that the system kept them safer and

70% of patients felt that staff cared for them better when the system was there as an additional tool. Exhibit ZT-027 Oxehealth Ward Implementation Update - August 2020, also records early impact on privacy and dignity and notes that staff need to take into account the presenting behaviours as well as the patient's own individual context. The report records that for individuals engaging in self-harming behaviour, staff highlighted that they find the system very helpful as patients can get the help they need without being put on close observations that significantly impede their privacy.

80. It is acknowledged that there is a balance to be struck when implementing new and innovative technologies, and in Zephan Trent's Second Statement at paragraph 8 it was acknowledged that greater consideration should have been given to the impact of Oxevision on those who have suffered and/or continue to suffer trauma.

81. EPUT acknowledges that the potential for harm arising from the use of the Oxevision system was not explicitly addressed in the reports presented to the Trust Board, although it may have been discussed and considered by the Executive Team in the course of their decision-making. It is important to note at this stage that, irrespective of the assistive technology deployed, the responsibility for ensuring the safety of patients and for the appropriate delivery of care and treatment at all times remains with the clinicians to whom those patients are allocated, including their responsible nurses and doctors. Oxevision is, and has always been, an assistive technology designed to support clinical staff in the discharge of their duties; it does not alter or diminish the clinical responsibilities that rest with the relevant practitioners.

**Current Consideration of Potential Harms**

**Processes for Assessing Risk of Harm from the Presence and Use of Oxevision**

82. This section describes the governance and clinical framework that was in place for the use of Oxevision, including Standard Operating Procedure version 12 (in force from 7 May 2025), the consent and capacity assessment process, the best interests decision-making framework for patients who lack capacity, and the documentation and reporting requirements that applied. The rapid review's findings regarding the adequacy of these arrangements are addressed above. The framework described in this section is subject to the outcome of the independent external review and the SOP re-review, and should be read in that context.

83. EPUT gave consideration to the risk of harm to patients from the presence and use of Oxevision, including harm arising from the system's interaction with a patient's mental state and the potential for self-harm escalation, through a number of clinical and operational

mechanisms. This consideration had been substantially developed and formalised since early 2025 and was incorporated into clinical decision-making at both Trust-wide and individual patient level. The adequacy of these mechanisms is now subject to the independent external review.

84. In January 2025, Executive Directors requested that a focus group be held with patients, carers and staff to hear about people's experiences of using Oxevision within the adult inpatient setting. The focus group, which was held on 25 March 2025, identified a number of concerns relevant to potential harm, including that patients, friends and family were unclear as to the overall purpose and benefit of Oxevision and were unaware of the physical health monitoring element of the system, and that there were concerns around the use of Oxevision and its impact on privacy. These findings were reviewed by the Oxehealth Project Board and were presented to the Quality Committee on 10 April 2025. In line with the Trust's Board Approved Strategic Plan and Quality of Care Strategy, the Quality Committee agreed that the approach to the use of Oxevision should be trauma-informed (Second Statement of Zephan Trent, paragraphs 15, 16, 18, 19).

85. In furtherance of that trauma-informed approach, the Quality Committee agreed that EPUT 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, in order to reduce the risk of trauma for patients (Second Statement of Zephan Trent, paragraph 16). EPUT understands that LIO is working on new housing for the equipment but is awaiting further updates.

86. In relation to the physical hardware, the camera unit in each room has a small red power light that remains visible at all times; this indicates that power is being supplied to the unit rather than that the camera is active. EPUT understands from Oxehealth that this design element cannot be altered. However, Oxehealth have agreed to work on new housing designed to alleviate concerns about privacy, subject to consultation and feasibility, and MHRA revalidation. The outcome of the design is a matter for LIO, not EPUT. In the interim, EPUT has increased its communication with patients about this element of the physical system to provide reassurance (Third Statement of Zephan Trent dated 9 May 2025, paragraph 43).

87. In addition to these measures, the revised Standard Operating Procedure (version 12, in effect from 7 May 2025, ZT2-099) includes additional emphasis that conversations regarding the use of Oxevision in patient care are 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 and nominated persons, their preferences and their choices. The SOP further provides that any reasonable adjustments that may be required to support a

patient's understanding of the system and giving consent must be carefully considered on a case-by-case basis (Second Statement of Zephan Trent dated 9 May 2025, paragraph 23).

88. With respect to the potential impact of Oxevision on staff behaviour and in particular therapeutic engagement, the March 2025 focus group agreed that Oxevision is a supportive technology to enhance patient safety and should be used in conjunction with the human element, not as a replacement for it. This understanding is central to EPUT's assessment of the risk of harm from the system's use (Second Statement of Zephan Trent dated 9 May 2025, paragraph 19).

89. At the individual patient level, the assessment of potential harm from Oxevision is integrated into the clinical processes that take place on admission and throughout the patient's stay. On admission, nursing and medical staff conduct a general assessment of potential harm to the patient, which includes consideration of the impact of Oxevision. Where that assessment identifies a risk that the presence or use of the system may cause harm to the patient, Oxevision may be switched off for that patient. This determination is made on a case-by-case basis with involvement from the MDT.

90. EPUT recognises that at the point of admission, patients are likely to be at their most distressed and that safety is the initial clinical priority. It may not be possible at the point of admission to determine whether the presence of Oxevision may cause harm to the patient; however, this is kept under review through ongoing nursing and medical engagement with the patient. As part of routine clinical practice, the clinical team conducts an ongoing assessment of all factors that may affect a patient's mental state, safety and wellbeing. This assessment is not confined to their clinical presentation, environmental factors and, where Oxevision is deployed on a ward, the potential impact of the systems presence and use on the individual patient. The clinical team's primary objective is to treat the patient's underlying symptoms, including, where relevant, symptoms of paranoia or other presentations that may be affected by the presence of Oxevision. The potential impact of Oxevision on the patient's presentation is considered as part of this clinical assessment, but is balanced against the safety benefits that the system provides. EPUT acknowledges that there are multiple factors that may affect a patient's mental state, including but not limited to the presence of monitoring technology, and the clinical team endeavours to evaluate all such factors, including Oxevision, as part of the patient's ongoing care.

91. Where a patient raises concerns about the presence or use of Oxevision, clinical staff will in the first instance seek to address those concerns through explanation and reassurance. If the patient's concerns cannot be resolved through reassurance, or if the patient continues

to express distress, the Nurse in Charge can turn the Oxevision system off in the patient's bedroom and put in place alternative measures to ensure the patients safety. The MDT will then determine whether the system should remain deactivated for that patient and, if so, what additional mitigations are required to be put in place to ensure the patient's safety in the absence of Oxevision monitoring. (see sections 1.5.1, 1.5.2, and 1.6.1 and Appendix 1 of SOP v.12).

**Identification, Assessment and Recording of Oxevision-Related Risks and Response**

92. This section addresses the steps taken by EPUT when it is identified that a patient may be harmed by the presence or use of Oxevision, and the processes by which EPUT identifies, considers and records circumstances in which it is concluded that the use of the Oxevision system may pose a risk of harm or distress to an individual patient, including the mechanisms for identifying and assessing such concerns, the circumstances that may trigger such conclusions, and how those conclusions inform decisions regarding the continued use, modification or deactivation of the system.

93. The SOP v.12 requires that staff inform patients of the Oxevision system's presence, obtain patient consent for its use, and confirm the patient's awareness and understanding of the system. Where a concern arises that a patient may come to harm from the presence or use of Oxevision, the steps taken by EPUT depend upon whether the concern is identified at the point of admission or during the course of the patient's stay. The processes applicable at each stage are set out below.

94. At the point of admission, all patients must be provided with clear, accessible information about the use of Oxevision, including its purpose, how it works, and what data is collected. This information must be shared in a format that is personalised and tailored to the individual patient's understanding and communication needs, including consideration of any reasonable adjustments that may be required. Patients are encouraged to ask questions and to express any concerns. The patient is informed that the Oxevision system is currently in an active state and that they will be required to give informed consent for it to remain active, failing which the system will be switched off within six hours. The current SOP reflects a move from implicit to informed consent, requiring that all patients are provided with sufficient information to enable them to give informed consent for the system to remain switched on. An informed consent and patient capacity flowchart is included within the SOP to provide clearer guidance in circumstances where there are concerns or doubts about a patient's mental capacity to consent (Second Statement of Zephan Trent, dated 9 May 2025 paragraphs 22–23; SOP v12, sections 1.5.1 and 1.5.2).

95. Where there are concerns or doubts about a patient's mental capacity to consent to the use of Oxevision, the Nurse in Charge ("NIC"), together with the responsible clinician or duty doctor, is required to assess the patient's capacity with reference to sections 2 and 3 of the Mental Capacity Act 2005 ("MCA 2005"). If there is reason to believe that the patient lacks the mental capacity to make the relevant decision, the clinical team should proceed to make a best interests decision that takes into account all clinical and other relevant factors regarding whether the use of Oxevision is in the patient's best interests. A Multi-Disciplinary Team ("MDT") meeting should then be arranged to review this decision as soon as is reasonably possible (SOP v12, section 1.5.2).

96. If consent is not given on admission, or is subsequently withdrawn during the course of the admission, the Oxevision system can be individually isolated by the NIC using the monitor to select 'Camera off' for that patient's bedroom. A decision to deactivate the camera should only be taken where the NIC or doctor deems the action to be clinically safe prior to an MDT decision meeting. If the NIC or doctor considers that deactivation would not be clinically safe, the Oxevision system will remain active and the clinical rationale for that decision must be explained to the patient and clearly documented in the patient record (SOP v12, section 1.5.2).

97. Where the matter proceeds to an MDT decision meeting, the team will reach a joint decision concerning the continued use of the system for that patient. Any such decision must be made in the best interests of the patient, taking into account all relevant factors, including the patient's wishes and feelings balanced against safety management considerations, clinical best interests, and any other material factors. The assessment must be conducted openly and with honest communication, incorporating the views of the patient, their relatives, carers, nominated person and advocate. If the MDT determines that Oxevision should be turned off for the patient's room, the NIC must individually isolate the function using the monitor to select 'Camera off". This decision must be clearly communicated to the patient, their relatives, carers, nominated person, advocate and staff, and clearly documented in the patient records (SOP v12, section 1.5.2).

98. All clinical decisions regarding informed consent or objections to the use of the Oxevision system must be documented within the patient's clinical record. The individualised care plan must be updated accordingly, and a Datix report must be completed. The patient's informed decision regarding the use of Oxevision is reviewed, assessed and documented at least once weekly, whether in ward review or MDT review (SOP v12, section 1.5.2).

99. Where the Oxevision system has not been switched off within six hours of a patient declining consent, a clinical rationale for the continued use of the system must be recorded

in the patient's records, and deactivation must be achieved as soon as clinically practicable (Second Statement of Zephan Trent, paragraph 26; SOP v12, section 1.5.2).

100. In out-of-hours circumstances, where a patient does not consent to the use of Oxevision or where capacity is queried on admission, an MDT meeting should take place as soon as clinically practicable, involving the NIC and the on-call doctor as a minimum. The purpose of that meeting is to reassess the risk, review the existing management plan, and determine further actions. In some circumstances, particularly where the identified risks are considered significant, the decision to switch off the Oxevision system may be deferred until a revised risk management plan has been put in place. The reasons for any such decision must be explained to the patient and their carer, recorded clearly in the patient records, and the consultant in charge must be informed as soon as possible (SOP v12, section 1.5.2).

101. In the event of a technical failure or malfunction of the Oxevision system, staff are required to continue to provide patient care without the support of the system. There may be a requirement to review individual care plans during the period of technical failure to maintain patient safety with alternative methods. (SOP v12, section 1.5.3 and 1.6.1).

102. The SOP emphasises throughout that conversations regarding the use of Oxevision in patient care must not follow a uniform model but must take into account local variation in services and the individual needs, preferences and choices of patients, their relatives, carers and nominated persons. Any reasonable adjustments required to support a patient's understanding of the system and the giving of consent must be carefully considered on a case-by-case basis (Second Statement of Zephan Trent, paragraph 23; SOP v12, section 1.5.1).

103. Where it is considered that the presence or use of Oxevision may be causing or contributing to harm to a patient, the matter is referred to the MDT for discussion (out of hours the MDT clinical members would be nurse and doctor as a minimum.) The MDT will consider the available options for mitigating the identified risk, which may include direct engagement with the patient to address their concerns, the involvement of an advocate to discuss the purpose and operation of the system with the patient, adjustments to the manner in which the system is used, or, where appropriate, deactivation of the system for that patient. Deactivation is not necessarily the first or only response; the clinical team is required to consider the full range of available interventions and to reach a decision that appropriately balances the risk of harm from the continued use of Oxevision against the risk of harm that may arise from its discontinuation. There is a duty of care to remove, reduce, mitigate causes of harm as soon as identified.

104. One of the mechanisms for identifying whether Oxevision may pose a risk of harm or distress to an individual patient is the informed consent conversation at the point of admission. However, the identification of potential harm is not confined to that initial interaction. EPUT has established a number of ongoing mechanisms to ensure that concerns are identified, recorded and acted upon throughout the patient's stay, and that compliance with the SOP is monitored at both ward and Trust level. In particular, consent to the use of Oxevision is formally reviewed on a weekly basis by nursing staff during one-to-one sessions with the patient, applying the same process and questions as those used at the point of admission. Where any change in the patient's capacity or consent is identified during that review, the matter is escalated to the MDT for further discussion and agreement. In addition to these formal weekly reviews, nursing staff engage with patients on a daily basis as part of routine clinical care, and any concerns raised by a patient regarding Oxevision during those interactions may be escalated informally to the Nurse in Charge or Ward Manager for consideration. Where the Nurse in Charge determines that the Oxevision system should be turned off for an individual patient, alternative mitigation measures must be put in place to ensure the patient's safety, which would ordinarily include in-person supportive observation. Any decision to decrease the level of observations must be discussed with a doctor of appropriate seniority; this is not a decision that rests with any single individual's clinical judgement. The Nurse in Charge may make the initial decision, but this must be discussed with the responsible doctor as soon as possible, thereby ensuring that appropriate checks and balances are maintained throughout the decision-making process. EPUT is committed to working in partnership with patients, their relatives, carers, nominated persons and representative groups to ensure clear communication and understanding of the Oxevision system (SOP v12, section 1.5.1).

105. Patient consent and views relating to Oxevision must be recorded in the patient's individualised care plan. Reviews of consent must be detailed and agreed with the patient and their support network, recognising that both consent and mental capacity may change during the course of an admission (SOP v12, section 1.5.1). Decisions made based on the patient's capacity, are taken in relation to best interests which will consider the balance between safety, trauma and privacy/dignity.

106. Oxevision forms part of the standing agenda during ward community meetings, providing a forum for patients and members of the MDT to engage in open discussion regarding the system. Patient discussions during ward review meetings regarding the use of Oxevision are required to take place routinely and to be recorded in the patient records (SOP v12, section 1.5.1).

107. EPUT uses an electronic clinical audit platform called Tendable as a practice quality control monitoring mechanism. The audit requires a staff member to review a minimum of three patient care plans to determine whether the patient's choice regarding Oxevision is documented within their care plan, whether the use of Oxevision is discussed regularly with the patient, and whether the camera status recorded in the patient notes accurately reflects the actual status of the system (Third Statement of Zephan Trent, paragraph 32).

108. The audit further requires checking the Oxevision equipment, materials and governance arrangements on the ward, and includes a review of staff understanding of the SOP and Oxevision product training requirements. As part of the audit, the staff member completing it is required to speak to a minimum of three patients on the ward and to ask specific questions to provide assurance that the SOP is being followed in practice (Third Statement of Zephan Trent dated 2 September 2025, paragraphs 33–35). Results of the audits are reviewed by ward managers and matrons to ensure practice is in line with the SOP, or take any necessary actions to improve practice as required.

109. On 25 March 2025 and 3 October 2025, quality walkarounds focused on Oxevision were undertaken by the Deputy Director of Quality and Safety and the Quality Matron for Mental Health Inpatient wards. During these walkarounds, staff and patients were asked about their understanding of Oxevision and the consent process, in order to verify that the requirements of the SOP were being applied consistently across all wards.

110. Finally, where any patient safety incident occurs on a ward where the Oxevision system is installed, regardless of whether the incident is connected to the use of Oxevision, it must be clinically responded to immediately and without delay, in accordance with policy and procedures. All such incidents must be reported using Datix, EPUT's incident reporting system. When completing the Datix report, staff are required to record whether the Oxevision system played a role in alerting staff to the incident or otherwise assisted in the clinical response, and to provide details in the relevant comments field. This requirement ensures that EPUT is able to capture data on the contribution of Oxevision to incident detection and response across all wards on which the system is deployed (SOP v12, section 1.5.5).

111. The processes described above are subject to ongoing review and development. The scheduled review of SOP v12, which was due to take place in October 2025 as part of its routine review cycle, has been delayed following a limited assurance rating issued by a TIAA audit of compliance with the current SOP, which highlighted variability in practice and areas where compliance with expected processes and documentation standards were not consistently met. Further detail about the TIAA audit is provided later in this statement.

112. Enhanced internal fortnightly assurance reporting to the Executive Team has been in place since late 2025 to support compliance oversight during the interim period, and a further internal re-audit was completed in February 2026, the results of which are currently awaited.

113. In March 2026, EPUT re-instated a Clinical Ethics Committee to provide dedicated ethical oversight in relation to the use of digital monitoring technologies, including Oxevision. On 12 March 2026, the Committee was provided with Terms of Reference to consider ~~the~~ specific questions relating to the use of the Oxevision system under the Mental Health Act and the Mental Capacity Act and whether the default position should be that the Oxevision system is switched off at the point of admission and only activated upon the giving of informed consent. On 31 March 2026 the Ethics Committee met to consider its Terms of Reference and make recommendations. The Trust's solicitor was present during this meeting and legal advice was provided. All, or any, legal privilege attached to that advice and/or arising from this meeting is not waived by the Trust at this time. The outcome of the ~~at~~ consideration by the Ethics Committee will inform any further revision to EPUT's approach to the default-on configuration and the consent framework. Against that governance backdrop, the following sub-section summarises how risks associated with the use of Oxevision have been identified and recorded in EPUT's formal risk documentation and Board oversight processes.

**Documented Risk**

114. This section addresses the internal risk assessments, safety cases, clinical risk logs and Board papers that document or consider the risks of psychological harm, self-harm escalation and paranoia arising from continuous monitoring through the Oxevision system.

115. EPUT's formal clinical risk management framework for Oxevision comprises the Clinical Safety Case ("CSC") and the Clinical Risk Management Plan ("CRMP"), previously exhibited at ZT2-100 and ZT2-101 respectively. These documents describe how EPUT conducts clinical risk management to ensure patient safety in connection with the use of the system. Clinical hazards are identified from the overall risk analysis and added to the Clinical Hazard Log, with each hazard assigned a likelihood of the harm occurring. The CSC, including the Hazard Log, is discussed and approved by the Clinical Safety Oversight Group and the Project Board.

116. The Hazard Log **[Exhibit KSZT01-001]** documents risks and controls that are relevant to patient safety including:

117. Risk that staff use the system as a replacement to physical face to face engagement with the patient.

118. Staff are trained and the SOP is available on the intranet for staff to refer to if they need a refresher. A culture of therapeutic engagement and observation is fostered on wards, and the system is to be used as a support tool.

119. Risk that patient dignity could be compromised leading to impact on wellbeing.

120. The use of Oxevision is discussed with patients on admission and throughout their stay on the ward. Patients can withdraw consent for the use of Oxevision. Staff are trained on how to use the system.

121. EPUT acknowledges that the CSC, CRMP and Hazard Log, whilst comprehensive in their treatment of a broad range of operational and clinical risks associated with the Oxevision system, do not contain discrete hazard entries expressly directed at: (i) the risk that the act of continuous visual monitoring may itself cause or exacerbate psychological harm in patients with pre-existing paranoid presentations; or (ii) the risk that monitoring a patient who engages in self-harm may lead to an escalation in the frequency or severity of those events. The hazards formally documented in the clinical risk management documentation address related issues, including the risk that Oxevision may be used as a substitute for face-to-face engagement; the risk that patients may be unaware of its use; and the risk that its use may impact upon patient privacy and dignity.

122. At the individual patient level, risks that the use of the Oxevision system could result in psychological harm, self-harm escalation or paranoia arising from continuous monitoring are documented in the patient's clinical records with appropriate actions. As previously stated in Zephan Trent's First Statement at paragraph 47, there have been multiple occasions on which the request to switch off Oxevision has been agreed by clinicians owing to patients feeling paranoid or expressing concern that the system would increase their anxiety.

123. EPUT's Policy CLP8 - Therapeutic Engagement and Supportive Observation Policy, previously exhibited at **ZT-001** (new version CG100 now exhibited as **[Exhibit KSZT01-002]** contains a clear and explicit recognition that the act of monitoring and observation may itself cause harm to patients. In particular, the policy expressly states that "the possibility of self-harm by patients under supportive observation must never be underestimated, as it is unlikely that closer observation will eliminate the desire for a patient to do so. In fact, patients who habitually self-harm are likely to experience an increase in frustration during periods of reduced opportunity to self-harm." The Policy recognises the

risk of psychological harm and re-traumatisation from observation. It states that "decisions about what level of observation a patient requires will be based and supported by documented evidence of assessed current need" and that clinical teams must "factor any information with regards to the patient's trauma history" and "consider how restrictive interventions, such as high levels of observation, may impact on them in harmful ways such as re-traumatisation. For example, a patient with a history of interpersonal trauma, such as domestic violence or sexual abuse, may experience re-traumatisation as a result of being constantly watched on observations, or when otherwise restricted or even secluded; this is because feelings associated with past traumatic experiences, such as being unable to escape, being violated, or lacking control over their lives, may be recreated and re-experienced in the present as a result of the restrictive intervention."

124. Reviews of supportive observation must "consider how observation can be undertaken in a way which minimises the likelihood of individuals perceiving the intervention to be intrusive and must consider their trauma history" and "how observation can be carried out in a way that respects the individual's privacy as far as practicable and minimises any distress."

125. EPUT therefore recognises that that observation itself, whether in person or by technology, carries a potential for harm and distress which must be weighed in clinical decision-making and focus on how the clinical staff will make observations supportive to the patient. As previously stated in Zephan Trent's First Witness Statement at paragraph 57, the MDT must balance the potentially distressing effect on the individual of increased levels of observation, particularly if these are proposed for many hours or days, against the identified risk of self-injury or behavioural disturbance, in line with Trauma Informed Principles.

126. Turning to the treatment of these risks in Board-level documentation, Board papers are produced for EPUT's Executive and Operational Committees. A review of those papers indicates that the specific risks of psychological harm, self-harm escalation or paranoia arising from the use of Oxevision were not explicitly discussed or documented at Board level. All references to harm within these documents concern harms that Oxevision is presented as designed to prevent — namely self-harm (including by ligature), falls, unexpected deaths, violence and aggression, and the disturbances caused by human observation practices. The documents characterise Oxevision in terms of its intended contribution to patient safety and experience.

127. However, the Board does consider safety risks through the Board Assurance Framework ("BAF"), which is the most senior risk register in the organisation and records the Trust's most strategic risks, including quality and safety. The BAF is reported in the public Board

papers and demonstrates that there has been oversight of safety risk at Board level throughout the relevant period. At that level, Oxevision is one component of how inpatient services are provided, and the Board would not ordinarily have engaged in detailed discussion of the risks associated with a specific system unless a particular issue had been escalated. The absence of detailed Board-level documentation addressing the specific risks of psychological harm or self-harm escalation from continuous monitoring does not, therefore, necessarily mean that those risks were not considered by clinicians and operational staff in the course of their clinical practice; rather, it reflects the level at which the Board engages with operational risk. There is reference to some consideration of whether patients expressed ‘irritations’ in response to extra observation with Oxevision in the combined Part 1 Board papers of January 2022 (exhibited later in the statement). The Trust's response to that consideration referred to evidence that irritation is greater with closer in-person observations, which are associated with reduced privacy and dignity.

128. The Project Board minutes contain greater engagement with patient concerns than the Trust Board or Executive Team papers. Whilst these discussions are predominantly focused on issues of consent and dignity rather than a formal risk assessment of psychological harm arising from monitoring, they do reflect an awareness among those involved in the operational governance of Oxevision that the system's presence and use could give rise to concerns relevant to patient wellbeing.

129. In some of the earlier Project Board meetings, in particular those of February 2020 and July 2020 (which are both exhibited later in the statement) discussions took place regarding concerns about notifying patients already suffering from paranoia about the presence of bedroom monitoring equipment, and patient feedback was received describing fear and apprehension about being filmed. Those discussions included an explicit recognition that continuous visual monitoring had the potential to exacerbate or provoke paranoid symptoms in acutely unwell patients. EPUT acknowledges that these discussions were not translated into formal documented risk assessments of the potential for psychological harm from continuous monitoring. However, the clinical reality is that the management of such risks necessarily involves the exercise of clinical judgement at the individual patient level: the priority of keeping a patient safe must be weighed against the risk that monitoring may exacerbate symptoms such as paranoia, and that balance is struck by the clinical team on a case-by-case basis as part of routine clinical practice.

130. The Project Board also receives and discusses both Monthly Usage Reports and Self-Harm Reports. Whilst self-harm incidents are traced in conjunction with Oxevision data, the discussion of self-harm in those meetings is confined to the use of Oxevision as a tool

to reduce and detect self-harm incidents, rather than to any consideration of whether the presence of the system may inadvertently worsen self-harming behaviour.

131. The Project Board also reviews the Hazard Log during its meetings. The minutes of 30 April 2025 (exhibited later in the statement) record that the Hazard Log was reviewed and identified the risk of human rights breaches where patients were unaware that monitoring was taking place. The minutes of 26 September 2025 (exhibited later in the statement) record an increase in Oxevision units being covered by patients in secure services, which constitutes an indicator of distress or objection to continuous monitoring that is directly relevant to the risk of psychological harm.

132. In summary, whilst EPUT's governance documentation does not contain discrete, documented assessments of the specific risks of psychological harm, self-harm escalation or paranoia arising from the use of Oxevision, the Trust's position is that these risks have been considered by clinicians and operational staff as part of the broader clinical assessment of patient safety. The risks associated with observation — whether conducted in person or by technology — are recognised in EPUT's CG100 clinical guidelines for therapeutic engagement and supportive observations, and the clinical teams responsible for the care of individual patients are required to exercise their professional judgement in balancing the safety benefits of monitoring against the potential for harm to the individual patient.

**Capacity and Best Interest Decisions**

133. EPUT's approach to best-interests decision-making in connection with the use of Oxevision for patients who lack capacity is principally governed by version 12 of the Standard Operating Procedure for the use of Oxehealth Oxevision and Oxevision Observations, previously exhibited as ZT2-099, and by the Trust's obligations under the Mental Capacity Act 2005 ("MCA"). Paragraph 26 of the Second Statement of Zephan Trent dated 9 May 2025 sets out the consent process for the use of Oxevision and Oxevision Observations. The following paragraphs address how EPUT assures compliance with the MCA requirements of necessity, proportionality and least restrictive intervention when making best-interests decisions regarding the use of Oxevision for patients who lack the mental capacity to consent to its use.

134. The principal changes to the SOP in version 12 relate to consent. In line with 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.

135. 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. 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.

136. If 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 using the monitor to select 'Camera off' for that patient's bedroom.

**Necessity**

137. Where a patient is assessed as lacking the mental capacity to consent to the use of Oxevision pursuant to sections 2 and 3 of the MCA 2005, the clinical team must determine whether the use of the system is necessary for the patient's care and treatment. In accordance with the SOP and the best-interests process described above, the Nurse in Charge and the responsible clinician or duty doctor are required to consider the patient's individual clinical presentation, including but not limited to their assessed risk of falls, self-harm, ligature use, absconding, and physical health deterioration. The determination of necessity is informed by the patient's current risk assessment, care plan, and any relevant clinical history. The clinical rationale for concluding that the use of Oxevision is necessary must be clearly documented in the patient's clinical record. Where the MDT concludes that the clinical objectives can be met without the use of Oxevision, the system should be deactivated for that patient.

**Proportionality**

138. Where the use of Oxevision is determined to be necessary for a patient who lacks capacity, the clinical team must ensure that the use of the system is proportionate to the patient's assessed needs and risks. The Oxevision system does not permit selective activation of specific monitoring functions for individual patients; rather, the alert configurations (such as leaving-bed alerts or bathroom duration alerts) are determined centrally on a ward-by-ward basis, informed by the clinical profile and needs of the patient cohort on each ward. At the individual patient level, the system operates on an activated or deactivated basis: the Nurse in Charge is able to turn the system off immediately for an individual patient's room, but cannot modify the specific alert settings applicable to that room independently of the ward-level configuration. Proportionality is therefore assessed at two levels. At the ward

level, the alert configuration is set by reference to the clinical data and risk profile of the patient population on that ward, ensuring that the monitoring functions deployed are appropriate to the types of risk most commonly presented. At the individual patient level, the proportionality assessment is binary: the clinical team, through the MDT, must determine whether the use of the Oxevision system as configured on that ward is proportionate to the individual patient's assessed risks and needs, or whether the system should be deactivated for that patient. In making that determination, the MDT is required to weigh the safety benefits that the system provides for the individual patient — including falls detection, self-harm alerts and contactless vital signs monitoring — against any identified risk that the system's presence or use may cause harm or distress to that patient, having regard to the patient's clinical presentation, their wishes and feelings (insofar as these can be ascertained), their trauma history, and the availability of alternative, less restrictive means of achieving the same clinical objective. Where the MDT concludes that the use of Oxevision is proportionate to the patient's assessed risks, the clinical rationale for that conclusion must be documented in the patient's clinical record. Where the MDT concludes that the monitoring is not proportionate — for example, where the patient's risk profile does not warrant continuous monitoring, or where the system is assessed as likely to cause or exacerbate psychological harm — the system must be deactivated for that patient and alternative safety measures put in place.

**Least Restrictive Option**

139. Section 1(6) of the MCA 2005 requires that before any act is done or decision made on behalf of a person who lacks capacity, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action. EPUT recognises that this principle must be applied when determining whether to use Oxevision for a patient who lacks capacity to consent to its use.

140. In many clinical scenarios, Oxevision may itself represent the least restrictive option when compared with the available alternatives. One-to-one observation — the principal alternative for patients at risk of falls, self-harm or other harm — can itself be experienced as intrusive, restrictive and distressing, particularly for patients with dementia, patients with a history of interpersonal trauma, and patients who find the constant physical presence of a staff member unsettling or who experience increased agitation as a result. In such cases, the use of Oxevision as an assistive clinical tool, deployed alongside and in support of in-person care, may be less restrictive of the patient's autonomy, privacy and freedom of movement than the imposition of continuous one-to-one observation, whilst still supporting staff to identify and respond to safety concerns.

141. However, EPUT acknowledges that the characterisation of Oxevision as the least restrictive option cannot be applied as a blanket assumption. The assessment must be conducted on an individual, case-by-case basis, taking into account the patient's specific clinical presentation, their wishes and feelings (including any previously expressed views), their trauma history, and the nature and severity of the identified risks. The MDT must actively consider the available alternatives — including intermittent supportive observations at defined intervals, environmental modifications, enhanced therapeutic engagement, and other interventions — and satisfy itself that Oxevision is the least restrictive means of achieving the clinical objective for that individual patient. This assessment, and the reasons for the conclusion reached, must be documented in the patient's clinical record.

142. EPUT acknowledges the tension between the default-on configuration of the Oxevision system and the least restrictive principle under the MCA. The SOP provides that the system is active at the point of admission and that consent is sought within six hours. For patients who lack capacity, this means that the system may be operational before a formal best-interests assessment has been completed. The SOP addresses this by requiring the Nurse in Charge and the responsible clinician or duty doctor to make an initial clinical safety assessment, and by requiring an MDT meeting to be arranged as soon as reasonably possible to review the decision. EPUT considers that this approach is justified on the basis that the initial period of monitoring serves a protective function during the assessment phase, when the patient's risks may not yet be fully understood, and that the requirement for prompt MDT review ensures that the continued use of the system is subject to a formal best-interests assessment within a reasonable timeframe.

143. As described above, the Clinical Ethics Committee established in March 2026 has been asked to consider the specific question of whether the default position should be that the Oxevision system is switched off at the point of admission and only activated upon the giving of informed consent. That question is directly relevant to the application of the least restrictive principle under the MCA 2005, and the outcome of the Committee's consideration will inform any further revision to EPUT's approach to the default-on configuration and the consent framework as it applies to patients who lack the mental capacity to consent to the use of the system.

**Review and Reassessment**

144. Best-interests decisions regarding the use of Oxevision are not static. The MCA 2005 requires that best-interests assessments are kept under review, particularly where there is reason to believe that the person's capacity or circumstances may change. In accordance

with the SOP, the use of Oxevision is reviewed at MDT meetings and during the patient's ongoing care planning. Where a patient's clinical presentation changes — for example, where their risk profile reduces, where they regain capacity, or where the monitoring is observed to cause distress or to exacerbate their symptoms — the MDT must reassess whether continued use remains necessary, proportionate and the least restrictive option. Assurance that these requirements are met in practice is provided through the Matron's Oxevision Consent Audit, which is conducted on a monthly basis. The audit addresses the following areas: (i) whether a consent discussion is recorded in the clinical record as part of the admission process within six hours in accordance with the SOP, including whether the patient has been informed about the 24-hour active camera in their bedroom; (ii) whether the patient's understanding of the purpose, safety rationale and benefits of Oxevision monitoring has been assessed and recorded, including an assessment of the patient's capacity; (iii) whether patient preferences and views regarding Oxevision are recorded and integrated into the patient's care plan, including reference to consent for the use of the 24-hour active camera; (iv) whether reasons for non-consent or withdrawal of consent are clearly documented, and whether the care plan reflects alternative observation arrangements where consent has been withdrawn; (v) whether consent status has been regularly reviewed across clinical documentation, including MDT reviews, ward community meetings and one-to-one sessions, and whether consent is reconfirmed when observation levels or risk assessments change; (vi) whether any changes to consent or patient preferences are recorded and communicated to all staff via handover and MDT reviews; and (vii) whether the relevant staff member has completed training covering consent for Oxevision and the requirement to inform patients about the 24-hour active camera, including whether there is evidence of refresher or updated consent training within the preceding 12 months, and whether the staff member is confident in explaining the purpose and privacy aspects of the monitoring and understands the procedure for documenting and responding to withdrawal of consent.

145. In addition to the monthly Matron's audit, ward-level audits are conducted on a weekly or fortnightly basis, providing a further layer of operational assurance that the consent framework and best-interests decision-making processes are being applied consistently in practice.

**Documentation and Recording**

146. EPUT acknowledges that best-interests decisions regarding the use of Oxevision are primarily recorded in individual patient clinical records. Historically, this has meant that monitoring and oversight of such decisions were not captured in a centralised or easily auditable format. EPUT has taken steps to improve the recording and oversight of these

decisions, including the introduction of the Tendable audit system, which includes questions about whether patients have refused Oxevision, and the requirement in the current SOP for clinical rationale to be clearly documented in the patient record. Where the Oxevision system is deactivated for a patient, a Datix incident form is completed to further support thematic review Trust wide. EPUT recognises that further work may be required to ensure that the specific MCA analysis — including the assessment of necessity, proportionality and least restrictive option — is consistently and clearly recorded in a manner that facilitates audit and oversight.

147. EPUT acknowledges that there is an inherent tension between the default-on configuration of the Oxevision system at the point of admission and the least restrictive principle under the MCA 2005. That tension reflects a broader and well-recognised challenge in inpatient mental health care: the need to reconcile the imperative of patient safety with the obligation to adopt the least restrictive means of achieving the clinical objective. EPUT's position is that these two considerations cannot always be fully reconciled at a single point in time as clinical assessment and decision making is dynamic and personalised. At the point of admission, patients are frequently at their most acutely unwell, their risk profile may not yet be fully understood, and the clinical priority is to ensure their immediate safety. The default-on configuration is designed to address that clinical reality by ensuring that monitoring is available during the period when the patient's risk is at its highest and when the clinical team has the least information upon which to base a risk assessment. The least restrictive principle, whilst a fundamental obligation under the MCA 2005, necessarily operates within the context of the clinical team's overriding duty to ensure patient safety. EPUT does not regard the default-on configuration as displacing the least restrictive principle; rather, it reflects a clinically justified prioritisation of patient safety during the initial period of admission, subject to the safeguards set out in the SOP, including the requirement to seek informed consent within six hours, the ability of the Nurse in Charge to deactivate the system where clinically appropriate, and the requirement for prompt MDT review. As the patient's care progresses and their risk profile is better understood, the clinical team is required to keep the use of Oxevision under ongoing review and to apply the least restrictive principle in determining whether the monitoring remains necessary and proportionate for the individual patient. As set out above, the EPUT Clinical Ethics Committee has been asked to consider the specific question of whether the default position should be that the Oxevision system is switched off at the point of admission and only activated upon the giving of informed consent. The outcome of that consideration will inform any further revision to EPUT's approach.

148. EPUT is not currently able to provide the Inquiry with the numbers or proportions of incapacitous patients for whom Oxevision was identified as potentially harmful, for whom the system was turned off, or for whom it was kept on pursuant to a best interests decision. Data concerning the capacity status of individual patients and the outcome of best interests decisions made in connection with the use of Oxevision is not a metric that is currently recorded or reported centrally within the Trust's information systems. As set out above, best interests decisions regarding the use of Oxevision are recorded in individual patient clinical records, and the patient's capacity and consent status is revisited and documented on at least a weekly basis in accordance with the SOP. However, because this information is held within individual patient records rather than in a centralised or aggregated format, it is not readily identifiable or capable of being interrogated from the Trust's existing systems in a manner that would enable EPUT to provide the specific quantitative data sought by the Inquiry. To produce such data, it would be necessary to undertake a manual review of individual patient records in order to identify those patients who were assessed as lacking the mental capacity to consent to the use of Oxevision, to determine whether a best interests decision was recorded in each case, and to ascertain the outcome of that decision — including whether the system was identified as potentially harmful, was deactivated, or was maintained in use pursuant to a best interests determination.

**Proportionality and Least Restrictive Alternative Assessment**

149. This section addresses the process by which EPUT considers whether the benefits provided by the Oxevision system, including falls notifications and prevention, are achievable by less restrictive measures consistent with the Trust's obligations under the Mental Health Act 1983 ("MHA"), the Mental Capacity Act 2005 ("MCA") and Article 8 of the European Convention on Human Rights ("ECHR"); how that assessment is conducted; the guidance and policy framework available to clinicians; how such assessments are documented; and how they are reviewed over time and revisited when a patient's clinical presentation or expressed wishes change.

150. EPUT does not maintain a separate standalone policy governing clinical decisions made under the MHA or MCA 2005 in relation to the use of Oxevision specifically; rather, clinicians are expected to apply the relevant legislative frameworks as part of their routine clinical practice. This expectation is supported by mandatory training requirements. All clinical staff are required to complete safeguarding training, and clinical staff additionally complete Level 3 training modules, which include Safeguarding Adults Level 3 (incorporating MCA, Deprivation of Liberty Safeguards and PREVENT), Safeguarding Children Level 3 (incorporating Looked After Children and PREVENT), and Mental Health Act training for registered mental health staff. These training requirements ensure that

clinicians possess the requisite knowledge to apply the principles of necessity, proportionality and least restrictive intervention when making decisions about the use of Oxevision. In addition, the Standard Operating Procedure (version 12) provides specific procedural guidance on the consent process, capacity assessment, best interests decision-making, and the circumstances in which the system may be deactivated or maintained, thereby supplementing the legislative framework with practical, Oxevision-specific guidance for clinical staff. The assessment of whether the benefits of Oxevision are achievable by less restrictive means, and the clinical rationale for the conclusion reached, must be documented in the patient's clinical record and is subject to review at each MDT meeting and whenever the patient's clinical presentation or expressed wishes change.

151. Consent to the use of Oxevision is discussed regularly with patients throughout their admission. The use of the system is considered on an individual basis, taking into account the patient's expressed wishes, their current risk assessment, their capacity to make decisions regarding the use of the system, and, where the patient lacks the relevant capacity, the outcome of a best interests decision conducted in accordance with the MCA 2005. This individualised approach ensures that the continued use of Oxevision is subject to ongoing clinical scrutiny and is not maintained as a matter of default once initial consent has been obtained or a best interests decision has been made.

152. As part of their daily clinical practice, clinicians consider whether the use of Oxevision remains beneficial to the individual patient and whether the clinical objectives served by the system could be achieved by alternative, less restrictive means. For patients detained under the MHA, decisions regarding the use of Oxevision are made in accordance with the principles applicable to care and treatment under sections 2 and 3 of the Act, and with due regard to the guiding principles set out in the MHA Code of Practice, including the least restrictive option principle and the requirement to maximise patient autonomy. For patients who lack the mental capacity to consent to the use of the system, the assessment is conducted within the best interests framework under the MCA 2005, which requires that regard is had to whether the purpose for which the intervention is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

153. In a number of clinical scenarios, the use of Oxevision may itself constitute the least restrictive means of achieving the relevant clinical objective. For patients who are assessed as being at risk of falls, the system's capacity to provide continuous contactless monitoring and to generate automated alerts can negate the need for continuous one-to-one observation, which could be a more restrictive intervention that requires the constant

physical presence of a staff member in close proximity to the patient. One-to-one observation can be experienced as intrusive and distressing by patients, particularly those with a history of interpersonal trauma or those whose clinical presentation is such that the presence of an observer exacerbates agitation or distress. In such cases, the use of Oxevision may represent a proportionate and less restrictive alternative that maintains patient safety whilst affording the patient greater privacy and autonomy. However, this assessment cannot be applied as a blanket assumption; it must be made on a case-by-case basis with reference to the individual patient's clinical needs, wishes and circumstances.

154. It is relevant to the assessment of proportionality and least restrictive alternative that Oxevision is a multifunctional assistive tool and not solely an observation system. In addition to its monitoring and observation capabilities, the system enables clinical staff to take contactless vital signs measurements of heart rate and breathing rate, provides automated falls detection and alerts, and generates notifications in response to identified safety concerns. These functionalities mean that the system serves a range of clinical purposes that would otherwise require multiple separate interventions, some of which may individually be more restrictive than the use of Oxevision. The clinical team is required to consider the full range of functions that the system provides for the individual patient when assessing whether the benefits of its use are achievable by less restrictive means.

**Risk of Reduced Therapeutic Engagement**

155. EPUT is aware of the concerns about the risk that use of Oxevision might reduce opportunities for therapeutic engagement with patients. It was accepted in oral evidence on 14 October 2025 that conducting observations via a screen — rather than in person — carries the risk that the opportunity to establish a therapeutic relationship with a patient will be lost. By reference to previous inquests and Prevention of Future Deaths reports, it was accepted that in those cases the clear and concise message that it was not an alternative to face-to-face supportive observations and engagements had not been effectively conveyed to staff and that there had been limited therapeutic engagements or attempts to engage with a patient. Some patient feedback recorded via iWantGreatCare further evidenced this concern in practice, with patients reporting that "staff looking at Oxyhealth all day… it's less personal… we need more staff during the day." This feedback was acknowledged by EPUT in oral evidence as reflecting concerns raised by some patients about reduced personal and therapeutic contact and the pressures of staffing levels.

156. When the Trust's "Time to Care" (TTC) programme was developed, EPUT identified the need for alternative approaches to staffing to release more time to care, including freeing

up time for ward staff and considering the use of technology to free up staff time to focus on direct care. Phase 1 was designed to better understand the staffing problems and shape changes to improve care. In setting up TTC, EPUT recognised that the Trust was simultaneously implementing other initiatives including the 2020–2023 Oxevision Rollout, which sat alongside — and within the context of — broader transformation aimed at improving inpatient care. Accordingly, from its inception, TTC was the framework within which the Trust sought to ensure that technology supported, rather than supplanted, direct clinical and therapeutic contact with patients.

157. In Phase 2, TTC expressly aimed to optimise ward ways of working and "maximise the use of technology to drive efficiency and quality freeing up 5–10% of staff time for increased patient engagement," linking technology use — including Oxevision — to increased therapeutic and patient engagement rather than reduced contact. Digital enablement was critical to implementing TTC's staffing model objectives, with Oxevision described as a "key digital enabler." The further expansion of Oxevision was recognised in the Time to Care staffing models business case.

158. Under the TTC business case "Option 2," which was approved as the preferred option, EPUT prioritised a number of initiatives directly relevant to mitigating any risk that technology-driven observation could reduce therapeutic contact. These included the introduction of ward administrators (to reduce the administrative burden on clinical staff), peer support workers and family/carer ambassadors (to strengthen relational support), and activity coordinators (to support therapeutic engagement). EPUT's commitment to Option 2 prioritised roles focused on quality interactions with patients, families and carers, and the release of time for staff to drive quality, safety and patient engagement on inpatient wards.

159. It is important to note that EPUT uses Oxevision in the interests of patient safety; it is not used to deliver therapeutic engagement, which requires physical interaction with the patient. The Trust's approach to therapeutic engagement has not, therefore, changed as a consequence of the introduction of Oxevision, however it has been enhanced though the implementation of TTC and the updated Clinical Guidelines.

160. Notwithstanding the above, EPUT has acknowledged that greater oversight should have been in place historically to ensure that Oxevision did not in practice replace face-to-face responses to alerts or routine observations, and to address the risk of alarm fatigue. The Trust has accepted that training and communication around these risks should have been more robust, and that this is a lesson learned from serious incidents, inquests, and patient feedback.

161. Following learning from those inquests, EPUT made significant changes to its training process. Zephan Trent confirmed in oral evidence that there are now three key elements of the training process that were not in place at the time of the relevant deaths:

i. Oxehealth Academy (OxeAcademy)

162. Oxehealth delivers training to EPUT staff in relation to the operation and use of the technology via Oxehealth Academy, an electronic portal which provides access to comprehensive training videos and materials. This forms the first key element of the training process, delivered online by Oxehealth as experts in their own system and how it operates.

ii. EPUT's OLM Online Training

163. 110. The second element is EPUT's own OLM training, an online training course developed by the Trust that particularly pulls out elements of the Standard Operating Procedure.

iii. Staff-Led Competency Checklist Assessment

164. The third element is a staff-led assessment against the competency checklist, to make sure that staff understand how the system should be used in practice. This element is conducted in person by a senior member of staff through discussion with the member of staff being assessed.

165. Completion of all three elements is mandatory for all ward-based clinical staff, including temporary staff, and staff cannot use Oxevision until training has been completed. Training is annual, and new starters receive it as part of their induction.

166. As set out in the Second Statement of Zephan Trent at paragraphs 30–32, the content of training now expressly addresses matters relevant to the risk of reduced therapeutic engagement, including that Oxevision is not CCTV and that its use as such is likely to be a breach of the patient's right to privacy and dignity; how to share information about the system and its use with patients, relatives and carers, including supporting concerns and objections and obtaining consent; how to use Oxevision and Oxevision Observations to conduct observation rounds and manage observation levels; and ward-level application of the system, alerts, notifications and functionalities.

167. In addition to the training framework, SOP v12 includes an explicit requirement that where a colleague has a clinical reason to conduct an additional therapeutic engagement and supportive observation or vital signs check, this must be recorded on the Oxevision

Observations function with an explanation as to why the concern needs to be documented. This requirement is designed to ensure that face-to-face therapeutic engagement is not displaced by screen-based monitoring and that such engagement is recorded as part of the clinical record.

168. SOP v.12 also includes reference to the Culture of Care Standards for mental health inpatient services (2024) and the promotion of a person-centred approach to safety, emphasising that getting to know the patient, building rapport and developing the therapeutic relationship are key to helping people be and feel safe. These measures collectively reflect EPUT's current commitment to ensuring that the use of Oxevision supports, rather than diminishes, therapeutic engagement with patients. The Trust acknowledges the findings of the rapid review briefing report and this is being addressed as part of the current review.

**Consent processes**

169. This section addresses the evolution of EPUT's consent framework for the use of Oxevision, from the initial implied consent model through to the informed consent approach under SOP v12. It covers the following topics in sequence: the legal and rights assessments undertaken prior to and during deployment; the treatment of Oxevision under the Mental Health Act 1983; the Article 8 ECHR considerations; the shift from implied to informed consent; the auditing of compliance with the consent process, including the TIAA assurance review and internal audit findings; the voluntariness of consent for detained patients; data protection information provided at the point of consent; the CAMHS-specific consent process; and the best interests process for patients who lack capacity.

**Pre-Implementation Legal/Rights Assessments**

170. This sub-section addresses the legal and rights assessments undertaken prior to and in the early stages of Oxevision deployment, including EPUT's consideration of the Mental Health Act 1983, the Mental Capacity Act 2005, and Article 8 of the European Convention on Human Rights. It also describes the evolution of those assessments as legal understanding and regulatory guidance developed, and addresses the PHSO's and rapid review's findings regarding consent.

171. A review of EPUT's governance documentation from the period of Oxevision's adoption and rollout indicates that the governance and rollout process was principally focused on patient safety, clinical benefit and operational implementation. In the Executive Team papers, the technology was assessed and endorsed as a patient safety innovation, with

consent addressed in the context of staff engagement and cultural change as part of the broader implementation process. Privacy considerations were addressed by reference to the comparative benefits of Oxevision over traditional one-to-one observations, which are widely recognised as more intrusive and restrictive of patient privacy and dignity. In the Trust Board papers, the use of Oxevision was considered within the Trust's existing clinical and operational governance framework. The Board's consideration of consent was directed towards ensuring appropriate clinical governance arrangements were in place for the use of the system. The monitoring was treated as distinct from covert surveillance, reflecting the Trust's understanding that patients were informed of the system's presence and use. In the Project Board papers, discussions took place regarding patient privacy, dignity and consent in the context of the system's deployment. The consent question was addressed within the operational framework applicable at the time, and the monitoring was consistently distinguished from CCTV on the basis that patients were made aware of the system and its purpose and that live feed was not continually available or being watched by staff. EPUT acknowledges that, viewed with the benefit of hindsight and in light of subsequent regulatory guidance — including the NHS England guidance — a more detailed analysis of the human rights implications of continuous monitoring, including specific consideration of Article 8 of the European Convention on Human Rights, the application of section 63 of the Mental Health Act 1983, and the adequacy of the consent framework for patients who may lack the capacity to give meaningful consent, would have strengthened the governance process. The subsequent development of SOP v12, which adopts a human rights approach with a focus on individual informed consent, reflects the evolution of EPUT's approach in response to that learning.

172. That evolution is, however, ongoing. The scheduled review of SOP v12, which was due to take place in October 2025 as part of its routine review cycle, has been delayed following a limited assurance rating issued by a TIAA audit of compliance with the current SOP, which highlighted variability in practice and areas where compliance with expected processes and documentation standards was not consistently met. These matters are addressed in greater detail in the sections of this statement headed 'The TIAA Assurance Review' and 'Auditing Compliance with Consent Process'. In response, and as described above, EPUT established the Clinical Ethics Committee in March 2026 to provide dedicated ethical oversight in relation to the use of digital monitoring technologies such as Oxevision. The TIAA audit (October 2025) found consent documentation failures across the sampled cohort, and the May 2026 follow-up audit draft retained a Limited Assurance rating, with 44% of records lacking an admission checklist and inconsistent evidence of capacity assessments and MDT decision-making. EPUT is now taking forward the findings of the rapid review briefing report.

**Mental Health Act treatment**

173. EPUT's position is that Oxevision is an assistive clinical tool deployed to support nursing staff in the management of patient safety; it is not prescribed or administered as a treatment option for patients. However, EPUT recognises that the definition of "medical treatment" under section 145(1) and (4) of the Mental Health Act 1983 is broad, encompassing nursing, care, specialist mental health habilitation and rehabilitation including for the purposes of alleviating or preventing a worsening of the mental health disorder or one or more of its symptoms or manifestations. Case law has established that section 63 of the Act, which permits treatment for mental disorder to be given to detained patients without consent, extends to necessary and ancillary acts, including nursing care and monitoring, where those acts form part of the treatment for the mental disorder from which the patient is suffering. Observation and monitoring can form part of a patient's care plan both before and after treatment. Accordingly, where the clinical team considers, on a case-by-case basis, that the use of Oxevision supports the safety of an individual detained patient and forms part of the delivery of clinical management of that patient's mental disorder, its use may properly be regarded as falling within the scope of medical treatment within the meaning of sections 63 and 64 of the Act. EPUT is clear, however, that Oxevision is a technology designed to assist staff; it is not a substitute for face-to-face therapeutic engagement and supportive observation, which remain essential components of patient care.

**Article 8 ECHR**

174. It has been accepted in the Second Statement of Zephan Trent at paragraph 8 that changes, informed by learning and feedback, have been made to EPUT's approach to consent since Oxevision was first implemented.

175. In the oral evidence of Zephan Trent at the hearing on 14 October 2025, the findings of the CQC report dated 12 July 2023 on consent were put to Mr Trent in examination. The report recorded that EPUT had "assumed implied consent"; that the CQC was unable to locate evidence of consent in sampled records; that where one patient had refused consent, the relevant record took a significant time to locate; that there was no record of ongoing consent being sought; that welcome packs contained no information about Oxevision; and that only brief posters were displayed. Mr Trent accepted that EPUT "should have done better" and confirmed that, in response to the CQC findings, EPUT had introduced a specific field on the electronic patient record and the admission checklist to confirm that

consent had been "actively sought." He confirmed that the earlier implied consent approach was "really not the right way to do this."

176. Mr Trent accepted that the starting point under SOP v11 — whereby the system was on by default and patients were required to opt out — "was the wrong starting point" and that EPUT "should flip it round" to an opt-in model. EPUT has subsequently addressed this in SOP v12. In discussing the updated SOP, Mr Trent described it as taking a "human rights approach" with a "focus on individual informed consent," with consent to be explicitly recorded. He characterised this as a "significant change" from the prior implied consent model.

177. Notwithstanding the improvements introduced by SOP v12, EPUT's own internal audit processes have identified that the revised consent framework has not been consistently applied in practice. Following the routine review due in October 2025, a TIAA audit was conducted which awarded a limited assurance rating, finding variability in practice and areas where compliance with expected processes and documentation standards was not consistently met. In response, EPUT implemented enhanced internal fortnightly assurance reporting to the Executive Team, designed to identify improvement areas and monitor compliance more closely, and to strengthen operational oversight ahead of a planned re-audit. A further TIAA follow-up assurance review was undertaken in February 2026. The follow-up review, which remained in draft as at May 2026, continued to award Limited Assurance, confirming that the governance and compliance concerns identified in the initial TIAA audit had not been fully resolved and that significant improvement was required. The findings of that follow-up review were among the factors considered in the rapid review described above.

**Covert Monitoring**

178. EPUT's position is that the use of Oxevision does not constitute covert monitoring. The current training framework makes clear that the use of Oxevision as CCTV is likely to constitute a breach of a patient's right to privacy and dignity but that the same is justified as being necessary and proportionate in some circumstances. Training further covers how staff are to share information about the Oxevision system and its use with patients, relatives and carers, including how to support any concerns or objections raised in relation to the use of the system and the consent process.

**Early Clinician Involvement — Innovation Rather Than Consent Scrutiny**

179. The original impetus for Oxevision's adoption came from EPUT's clinical innovation group, known as EPUT Lab, which identified Oxehealth's Digital Care Assistant as a suitable

option following discussions with University College London Partners in April 2019, with clinicians receiving a demonstration of the product. Clinicians responded positively and discussions took place with EPUT's mental health senior management, leading to support for piloting the technology.

180. The clinician involvement at this stage was directed towards identifying a safe and clinically beneficial technology, rather than towards scrutinising the consent framework under which it would be used.

**Staff Feedback**

181. During the pilot period in 2020, EPUT sought structured feedback from staff through questionnaires, focus groups and one-to-one interviews. The early evaluation report presented to the Executive Operational Committee and the Board reported positive findings from staff, including that safety on the wards had improved, that there was a positive impact on therapeutic engagement and patient experience, and that there was operational value in terms of improved observation practice. These findings supported the Board's decision to approve further rollout to additional wards.

182. Engagement with staff was focused on clinical benefit and operational value.

183. Discussions subsequently took place with ward staff and the Quality Matron regarding the rationale for the Oxevision system being in an active state at the point of admission. A number of practical considerations were identified relating to patient safety and operational clarity on the wards. In particular, it was noted that patients frequently move between rooms during the course of an admission, and that if staff were required to deactivate the system in individual rooms at the point of discharge or patient transfer, there was a risk that staff across the ward would not have a consistent understanding of which rooms were active and which were not. By maintaining the system in an active state from the outset, ward staff were able to maintain a clear and consistent understanding of the status of each room, thereby supporting the safe oversight and management of the ward as a whole (Transcript of Zephan Trent evidence, page 117, lines 10–21).

184. In March 2025, EPUT convened a specific patient, carer and staff focus group as a "listening opportunity," and staff feedback from that group supported changes to the SOP, including changes to the consent model, overseen by the Project Board.

**Patient Feedback**

185. Patients' views on the use of Oxevision were formally sought during the 2020 pilots via questionnaires, focus groups and one-to-one interviews, and were included alongside staff feedback in the "Early Insights and Implementation Lessons Learned" reporting to EPUT governance (First Statement of Zephan Trent, paragraphs 16–19; Exhibits ZT-027).

186. The pilot feedback included positive patient-reported views, with majorities reporting feeling safer, improved wellbeing, better sleep, and feeling better cared for when Oxevision was present. Those evaluation findings, including patient experience elements, were provided to the Board and supported the decision to roll out Oxevision further. As with the clinical staff feedback, the patient engagement at this stage was directed towards assessing patients' experience of the technology and its perceived benefits, rather than towards scrutinising the consent framework or the impact of continuous monitoring on patient rights.

187. Patient engagement has since developed beyond the assessment of clinical benefit. In the March 2025 patient, carer and staff focus group, patient participants reported being unaware of their rights in relation to Oxevision and not knowing that the system could be switched off when discussing consent, and also raised privacy concerns. These findings directly led to actions tasked to the Project Board, including providing clearer explanations of the consent process and improving the information provided to patients beyond the admission stage.

188. More broadly, EPUT seeks ongoing patient feedback via iWantGreatCare and regular ward community meetings. The agenda for ward community meetings includes safety, ward environment and restrictive practices, and under each topic patients are asked how they feel, what they have observed and to provide any general feedback. Staff also explain restrictive practices and the management of risk on the ward.

189. In addition to these ongoing feedback mechanisms, in September and October 2025 EPUT's Patient Experience and Participation function conducted a dedicated Oxevision patient experience survey. The co-produced survey was administered by Matrons across multiple inpatient services within the urgent and inpatient care unit over one week, and a total of 46 responses were received across several wards from current patients and service users. The findings highlighted varied levels of understanding, acceptance and concern, with implications for consent processes, therapeutic engagement and privacy safeguards.

190. The survey identified a number of significant themes:

191. Understanding: There was mixed awareness of what Oxevision monitors — such as vital signs and movement — and whether it records video or sound, with some patients unaware

of its presence until prompted. Patients requested clearer explanations and visual demonstrations.

192. Consent and rights: There was significant variation in understanding of opt-out rights, with some patients assuming Oxevision was mandatory. Accessibility concerns were also raised, including the format of information leaflets for neurodivergent patients.

193. Safety perceptions: A majority of respondents felt Oxevision enhanced physical safety, for example through alerts for falls or breathing issues. However, emotional safety was still seen as dependent on staff presence and engagement, and there was strong concern that Oxevision may reduce face-to-face interaction.

194. Privacy: Patients requested clearer signage, reassurance about non-recording, and greater transparency around data access, and emphasised the importance of privacy protections being explained at admission and revisited regularly.

195. Timing of consent: There was a consensus that consent should be discussed early in admission, but not during a crisis, with follow-up conversations recommended during ward reviews or once patients are more settled.

196. The recommendations arising from the survey are aligned with national best practice and are directed towards supporting safe, person-centred implementation. They include ensuring that opt-out rights are explained verbally and in writing at admission and revisited regularly during ward reviews, in line with the Mental Health Act Code of Practice (2015), and offering materials in multiple accessible formats — including easy-read, large print, coloured paper and video — tailored to diverse patient needs, in accordance with the NHS Accessible Information Standard. Taken together, the feedback from patients and staff underscores the need for clearer communication, accessible consent processes and reassurance around privacy.

197. The patient feedback described above has informed, and continues to inform, EPUT's ongoing programme of improvement. As set out elsewhere in this statement, the scheduled review of SOP v12 had been delayed pending the completion of strengthened assurance work, including enhanced internal monitoring in place since late 2025, a re-audit completed in February 2026 (the results are still in draft ~~the results of which are currently pending~~), and the establishment of the Clinical Ethics Committee in March 2026 to provide dedicated ethical oversight.

**Best Interests Process for Incapacitous Patients**

198. This sub-section supplements the framework set out earlier in this statement (under "Capacity and Best Interest Decisions") by describing the specific operational steps in SOP v12 through which that framework is applied in practice, including the consent and capacity decision flowchart and the process for communicating with patients who lack capacity. The process described below reflects the position under SOP v12.

199. The Mental Capacity Act (MCA) 2005 is the legal framework that supports acting and making decisions on behalf of individuals who lack the mental capacity to make specific decisions for them in England and Wales. Its five principles are: that everyone over the age of 16 can make decisions unless assessed otherwise; that all practicable steps must be taken to support someone to make decisions for themselves; that people can make unwise decisions if they have capacity; that all decisions made for someone must be in their best interests; and that the option chosen must be the least restrictive.

200. In accordance with the MCA and Trust guidance, capacity is presumed unless there is reason to believe that a patient lacks the mental capacity to make the relevant decision. The MCA 2005 and the Deprivation of Liberty Safeguards guidance, together with EPUT's own policies, require staff to recognise and take appropriate action where there is a concern regarding a patient's mental capacity and, where it may be necessary to lawfully deprive a person of their liberty, to consider whether the proposed course of action is the least restrictive means of achieving the legitimate aim (Second Statement of Dr Milind Karale, paragraphs 76 and 77).

201. Where concerns or doubts arise regarding a patient's mental capacity to consent to the use of Oxevision, the Nurse in Charge, together with the responsible clinician or duty doctor, is required to assess the patient's capacity with reference to sections 2 and 3 of the MCA 2005 (SOP v.12).

202. The consent flowchart at Appendix 1 of the SOP (v.12) sets out a clear decision pathway. The flowchart requires staff first to assess whether the patient has capacity — that is, the ability to understand and use relevant information to make a decision and to communicate that decision. At the point of admission, patients and their family members or carers are informed verbally and provided with written materials about the purpose, use and functionality of the Oxevision system. The system is currently in an active state at admission, and the patient is required to give informed consent for it to remain active; in the absence of such consent, the system will be switched off within six hours. However, as set out above, the Clinical Ethics Committee established in March 2026 has been asked to consider whether the default position should be that the Oxevision system is in an inactive state at the point of admission, with patients being required to opt in to its use. That

question is due to be considered at the Committee's meeting on 31 March 2026, and the outcome of that consideration will inform any further revision to the consent framework and the default configuration of the system.

203. Where there is reason to believe that a patient lacks the mental capacity to make the relevant decision, the Nurse in Charge and the duty doctor are required to proceed to make an initial best interests decision, taking into account clinical and all other relevant factors, as to whether the use of the Oxevision system is in the patient's best interests. A Multi-Disciplinary Team meeting must then be arranged as soon as reasonably possible to review that decision.

204. At the MDT meeting, the team reaches a joint decision regarding the continued use of the system. That decision must be made in the patient's best interests, taking into account all relevant factors, including the patient's wishes and feelings, safety management considerations, and clinical best interests. The assessment must be conducted openly and with honest communication, incorporating the views of the patient, their relatives, carers, nominated person and advocate, and ensuring that all parties are provided with sufficient information about the way the system works and its purpose to enable confidence in the decision reached.

205. Where a patient lacks capacity, the best interests decision is informed by a checklist of factors under s4 Mental Capacity Act 2005 that staff must consider. These include: consulting anyone named by the patient as a person to be consulted, and anyone engaged in caring for the patient or interested in their welfare; encouraging the patient's participation to the greatest extent possible; identifying the matters the patient would be likely to consider if making the decision themselves; ascertaining the patient's past and present wishes, feelings, beliefs and values; avoiding discrimination; and considering whether the patient might regain capacity such that the decision could be postponed. Staff must weigh the medical, social, psychological and emotional benefits of the proposed course of action, and must fully explore with the patient the advantages and disadvantages of the decision, providing comprehensive information about all potential risks and any reasonable alternatives, before determining the matter in the patient's best interests and recording their professional reasoning (Second Statement of Dr Milind Karale, paragraphs 81 and 82).

206. All clinical decisions regarding consent to, or refusal of, the use of the Oxevision system must be documented in the patient's clinical record and the patient's individualised care plan must be updated. The patient's consent status in respect of Oxevision is reviewed, assessed and documented at least once weekly as part of the ward review or MDT review process (SOP v.12 para 1.5.2).

207. All decisions must be clearly communicated to the patient, their relatives, carers, nominated person and advocate as appropriate. The use of the technology must be regularly reviewed with the patient and, where appropriate, with their family, carers and nominated person.

208. EPUT is committed to working in partnership with patients, their relatives, carers, nominated persons and representative groups to ensure that the purpose and operation of the Oxevision system are clearly communicated and understood.

209. In accordance with the SOP, every patient must be informed about the use of Oxevision and Oxevision Observations during the admission process and provided with the relevant Oxevision leaflet and EPUT Welcome Pack. Staff are also required to have a conversation with the patient's relatives, carers or nominated person, where appropriate.

210. Oxevision and Oxevision Observations form part of the standing agenda at ward community meetings, providing an opportunity for patients and members of the multidisciplinary team to engage in open discussion. Discussions regarding the use of Oxevision and Oxevision Observations during ward review meetings are to take place routinely and be recorded in the patient's clinical records.

211. Patients are involved at each stage of their admission, assessment, care planning and treatment review throughout their inpatient stay. Care reviews are attended by the patient, and family members and carers are invited to attend with the patient's consent. Where a patient does not consent to the sharing of information with their family or carers, this does not preclude the family from providing information that may assist in the patient's care (Second Statement of Dr Milind Karale, paragraph 361).

212. Careful and personalised consideration must be given to how information is provided to patients, relatives, carers and nominated persons, including the timing and method of communication. The approach to discussing the use of Oxevision in patient care is not a uniform one; it must take into account local variation in services as well as the individual needs, preferences and choices of patients, relatives, carers and nominated persons. Any reasonable adjustments required to support their understanding of the system and the giving of consent must be carefully considered on a case-by-case basis.

**Continued Use of Oxevision following a Best Interests Decision**

213. SOP v12 contemplates circumstances in which the Oxevision system may remain in use in relation to a capacitous patient who has not consented, pending a clinical assessment of whether it is safe to deactivate the system. EPUT wishes to make clear that this provision

is not intended to operate as a routine or default position; rather, it is designed to apply only in a limited and exceptional set of circumstances in which the immediate deactivation of the system would give rise to an unacceptable risk to the patient's safety. In all such cases, the clinical rationale must be clearly documented, the decision must be kept under active review, and the system must be deactivated as soon as it is clinically safe to do so. EPUT recognises that the application of this provision must be closely monitored to ensure that it does not, in practice, operate so as to undermine the principle that the use of the system for capacitous patients is based on consent.

214. Paragraph 1.5.2 of the Standard Operating Procedure [INQEPUT009884_0009], allows for Oxevision to remain in use in relation to a capacitous patient notwithstanding that they have refused to consent. This is not a routine occurrence and this provision of the SOP should only be used in exceptional circumstances where the concern for safety is paramount.

215. EPUT considered that this provision ~~is~~ was consistent with the principles of informed consent, subject to the safeguards set out in the SOP and the clinical governance framework. This is now under review and what follows is an explanation of how the exceptional circumstances applies in practice under SOP v12.

216. The decision as to whether Oxevision should remain in use in such circumstances is made by the Nurse in Charge along with the Responsible Clinician and escalated to the MDT, with patient safety as the primary consideration. Whilst this provision is most likely to be engaged in respect of patients detained under the Mental Health Act 1983, it may also apply to patients whose capacity to make the relevant decision is in doubt or whose clinical presentation gives rise to concerns that the withdrawal of monitoring would pose an unacceptable risk to their safety. In all cases, the decision to maintain the use of Oxevision contrary to the patient's expressed wishes must not be taken by a single clinician; it requires MDT consideration and must be supported by a clearly documented clinical rationale, principally grounded in patient safety. Where such a decision is made, the clinical team is required to continue to engage with the patient to understand the reasons for their refusal and to explain the clinical basis for the continued use of the system. The patient's capacity to give or withhold consent must also be kept under ongoing review in accordance with the MCA 2005.

217. As reflected in the Third Statement of Zephan Trent, SOP v12 was explicitly developed in response to the NHS England guidance [INQEPUT009000] and is intended to be consistent with it. The revised SOP was informed by both the NHS England guidance and

the Patient Engagement Focus Group, ensuring that its provisions reflect regulatory compliance and patient-centred design.

218. Staffing/resource considerations are not a justifiable reason to keep the system switched on.

219. EPUT does not record data in a format that would enable it to provide the Inquiry with the proportion of capacitous patients who refused consent for the use of Oxevision, or the proportion of such patients for whom the system was in fact deactivated. Due to the manner in which clinical information is recorded, it has not been possible within the time available to identify and provide examples of cases in which a capacitous patient refused consent yet Oxevision remained in operation, together with the justification recorded in each case.

220. Available audit data shows that, in the period from 7 May 2025 to the date of submission of the Third Statement of Zephan Trent, 84% of patients gave informed consent within six hours of admission and 1.1% declined to give consent.

**Patient Information Materials**

221. On admission patients are provided with a leaflet titled 'Introducing our contactless monitoring system' **[Exhibit KSZT01-003].** It informs patients that when they are in their bedroom, the system measures their heart rate, breathing rate, location and movement; and that staff can view this information on a screen in the nursing station or on tablets when they are walking around the ward. It also advises patients that staff can review reports about them, such as how long they have spent in bed, and that the system sends notifications to staff if they have been in the bathroom for a long time, to enable in person checks to be made. However, it makes it clear that the system does not show a continuous live video feed to staff. Staff can only see a clear view for up to 15 seconds when they are measuring heart and breathing rate and a blurred view for up to 15 seconds when they receive a notification and "view room" is clicked on. Staff / the system cannot 'see' into the bathroom. Recorded clear video can only be viewed by authorised staff if there has been a safety incident. The leaflet explains that the red glow on the unit in the bedroom is from infrared lights which help the system work in the dark, and that the red glow remains even if the camera is switched off.

222. On wards where Oxevision is in use posters are displayed at various locations. The poster **[Exhibit KSZT01-004]** highlights the circumstances in which staff can see a clear view and a blurred view of a room. It also advises patients to speak to a member of staff if they have any questions or concerns.

223. EPUT also relies on its staff to provide verbal information to patients.

224. EPUT provides the following materials to its staff to ensure that clear information is provided to patients, families and carers:

- Standard Operating Procedure (SOP) Oxevision Version 12 [ZT2-099] – the SOP acknowledges that the system is active at all times unless it has been switched off. It requires staff to tell patients that the system is on at the point of admission. The SOP states that "it is imperative that staff inform patients of system presence, gain patient consent for use, and confirm awareness of the use of Oxevision and Oxevision Observations with our patients." The required admission discussion explicitly includes "the patients' rights to withdraw consent at any time during their admission." The SOP states that the patient "will be required to give informed consent for this to remain on or the Oxevision system will be switched off within 6 hours." It frames the default-on status as provisional, conditional on consent or when there is a best interests decision. Importantly, the SOP adds a constraint that staff are not permitted to use the Oxevision Observation function to access patients without a clear clinical rationale, and this is monitored through the Tendable auditing system.

- Appendix to SOP - Oxevision Informed Consent Flowchart – includes the right to decline and the need for regular review with the patient to ensure consent for the use of the system remains during admission.

- SOP at a glance v.12 **[Exhibit KSZT01-005]** – highlights the need for informed consent and the procedure to follow if consent is not given or is withdrawn. Re-iterates that the camera feature is not designed or purposed for CCTV.

- Oxehealth-produced document directed at clinical staff – Instructions For Use – Oxevision Activity Tracker **[Exhibit KSZT01-006]** - The IFU explains that when the software is in a "Connected" state, "the software is receiving and analysing video". Only when a user has actively chosen "Camera Off" or "Camera Paused" does the software cease receiving and analysing video. When the system is in its default "Connected" state, the software is continuously receiving and processing the video signal from the camera — but that signal is not being rendered into a viewable image on any screen for a human to watch. Instead, the software is analysing the data to extract clinical information: heart rate, breathing rate, movement, posture, presence and location (so it can send a notification if a patient has been in the bathroom for a long time as an example). The output of this process is a set of data points and alerts, not a picture. A human staff member does not see anything unless they actively take a step to open a view — and even then, what they see and for how long is constrained by the system's

configuration and time limits i.e. 15 seconds, and the instructions provided to staff in the SOP.

- Oxehealth-produced document directed at clinical staff – Instructions For Use – Vital Signs **[Exhibit KSZT01-007]** - The IFU defines the default "Connected" state as one in which "the Oxehealth Vital Signs software is connected to the room and running, such that the software is receiving video and making estimations." When a staff member initiates the "Take Vital Signs" function, the screen will show clear live video of the room, for up to 15 seconds. After 15 seconds the screen will timeout and automatically close.

225. EPUT is mindful that the way in which the system is described in the materials and some patient feedback is indicative of confusion between digital monitoring and CCTV.

226. CCTV operates as a continuous, real-time video feed, typically recording and displaying footage constantly, and is often readily available or can be made readily available to designated staff members — such as security personnel — on a live and continuous basis, enabling those staff to monitor footage for extended and uninterrupted periods. CCTV is a passive surveillance system with no capacity to process clinical data or generate alerts based on physiological readings. Oxevision, by contrast, is a fundamentally different kind of system in its design and purpose and is registered as a Class IIa medical device. The system is not a constant video feed like CCTV. Staff can only see a 15-second video when they need to measure a patient's breathing rate and pulse or respond to an alert to check they are safe. There is no microphone. Oxevision cannot pick up any sound. Furthermore, access to captured video data from the Oxevision system is subject to a specific procedure; recorded clear video can only be viewed by authorised staff in the event of a safety incident, must be requested within 24 hours, and is automatically deleted after that period. This procedure ensures that access to captured video data is confined to the clinical and safety purposes for which the device is intended.

**Auditing Compliance with Consent Process**

227. The Standard Operating Procedure requires that every patient be informed about Oxevision, and that staff conduct a discussion with patients, carers, and families at the point of admission, with ongoing discussions forming part of the clinical record and care plan. The SOP v12 consent flowchart requires: providing patients with clear and accessible information; obtaining and documenting consent via an admission checklist within six hours; a capacity assessment by the Nurse in Charge together with the responsible clinician or duty doctor where capacity is in doubt; best-interests decision-making where

capacity is lacking; and switching the camera off where consent is not given or is subsequently withdrawn — unless the Nurse in Charge or doctor determines that doing so would not be clinically safe, in which case the rationale must be explained and documented.

228. As set out in the First Statement of Zephan Trent at paragraph 48 - 50, in October 2024, EPUT placed an Oxevision audit on its Tendable auditing system to support oversight of the Oxevision SOP and EPUT also introduced specific Oxevision-related questions into other existing audit processes to provide further assurance. These include: a Person-Centred Audit question ("Has this patient refused the use of Oxevision?"); a Ward Managers Audit escalation question; and a Matrons' Record Keeping Audit question concerning issues identified through the Person-Centred Audit.

229. The Tendable auditing process was further explained in the Third Statement of Zephan Trent at paragraphs 30 to 35. Paragraph 37 describes the amendment to EPUTs electronic patient record (EPR) admission checklist to record compliance with the SOP. Paragraph 36 details the Quality Walkaround process and how they ensure that the SOP is being applied consistently.

230. In oral evidence given on 14 October 2025, Mr Trent stated that patient experience work — comprising feedback compiled from 46 patients into a report — indicated "early findings" that EPUT did not have full compliance with SOP v12 at that time, and he accepted that SOP v12 was not being fully complied with. (Transcript Page 121 lines 10 – 20). In order to address this, an external audit and a broader programme of internal audit activity were commissioned, the findings of which are described below.

**The TIAA Assurance Review**

231. An internal assurance review was conducted by TIAA, the Trust's external auditors, with the overall objective of providing assurance on the effectiveness of the consent processes in place within the Trust, focusing on the arrangements for consent for Oxevision. The audit planning memorandum was issued on 23 June 2025, and the final report was issued on 28 October 2025 **[Exhibit KSZT1-008]**. Testing was undertaken across five wards: Beech Ward, Grangewaters Ward, Chelmer Ward, Christopher Unit, and St Aubyn Child and Adolescent Mental Health Services (CAMHS).

232. The overall assurance rating awarded was Limited Assurance, meaning that, in TIAA's assessment, the system of internal controls was generally inadequate or not operating effectively, and that significant improvements were required to ensure that risks were

managed and process objectives achieved. It is material to note that the internal audit undertaken by TIAA occurred shortly after SOP v.12 updates and during the early stages of training rollout, and also included a small number of records from the time period prior to SOP implementation.

233. The specific findings were as follows:

234. Consent documentation failures (Urgent — Priority 1): Testing of a sample of 17 patients admitted in June and July 2025 for whom Oxevision was used revealed significant exceptions. For nine cases, there was no admissions checklist and therefore no evidence of informed consent. In four cases where evidence of informed consent was seen on the admissions checklist, the checklist had not been completed within six hours of admission — completion was recorded at five days, seven days, one day, and eight hours after admission respectively. For ten cases, there was no evidence that consent was documented in the patient's clinical case notes, although in some cases conversations about Oxevision were recorded in the clinical record. For eleven cases, the patients' views relating to Oxevision were not recorded. This finding attracted an urgent priority grading, described by TIAA as a fundamental control issue requiring immediate action.

235. Best interests decisions and MDT requirements (Important — Priority 2): Testing of the sample of 17 patients identified two cases where patients lacked mental capacity to consent. For one of these cases, the best interests decision taken by the Nurse in Charge was not clearly documented. In addition, for both cases where patients lacked mental capacity to consent, a Multi-Disciplinary Team meeting was not evidenced to have taken place, as required by the SOP.

236. Ward review documentation (Important — Priority 2): Testing of the 17 patients identified that, in all cases, whilst there was evidence that regular ward review meetings took place, there was no record that discussions on the use of Oxevision and Oxevision Observations took place at the meetings. This is directly relevant to the SOP's requirement that a patient's consent status be reviewed, assessed and documented at least once weekly at ward or MDT review.

237. Absence of senior oversight arrangements (Important — Priority 2): As at the time of audit fieldwork, there were no oversight arrangements for senior management or committee level to regularly review data in relation to consent for Oxevision, whether through performance monitoring of consent data or through the outputs of internal audits.

238. Staff competency records (Important — Priority 2): For four of ten staff sampled, the competency checklist was not evidenced, as no response was received from the relevant

Ward Manager within the timeframe of the audit. It should be noted, however, that in all cases the staff had appropriately completed Oxevision training with a 100% pass mark, and training was displayed as completed on the Mandatory Training Tracker, with Oxevision training included in the local induction to inpatient wards.

239. The TIAA findings were considered by the Trust's Audit Committee on 7 November 2025 **[Exhibit KSZT01-009]**. The Director of Nursing and Clinical Governance provided an update, noting that the SOP for Oxevision had been implemented in June 2025 in response to recommendations from NHS England. In order to improve the overall audit opinion by January 2026, a number of actions had been agreed, including: the implementation of three additional audits covering Policy and Governance, Consent, and Staff Training; actions to embed accountability, drive culture on wards and improve understanding of audit processes; a review in conjunction with HR colleagues of the role of the matron in line with national standardised job descriptions; and the introduction of fortnightly compliance reports to the Executive Team, underpinned by Deputy Directors of Quality and Safety and matrons.

***Tendable Internal Audit Results — November 2025***

240. As part of the response to the TIAA findings, three additional in-depth audits were added to the Tendable platform covering: Oxevision Policy and Governance; Matrons Oxevision Consent; and Matrons Oxevision Staff Training. These audits were made available for completion from Friday 24 October 2025.

241. The results of the first week of these audits, as at 3 November 2025, were as follows.

242. The Policy and Governance Audit returned 100% compliance across all wards where it was completed, including Adult Mental Health wards and both PICU units.

243. The Matrons Oxevision Consent Audit disclosed significantly more variable compliance, with an overall score of 49.8% across Adult Mental Health wards. Individual ward scores ranged from 6.1% (Christopher Unit PICU) and 7.1% (Ardleigh Ward) at the lowest end, to 91.7% (Ruby Ward) and 82.8% (Hadleigh Unit PICU) at the highest.

244. The Matrons Oxevision Staff Training Audit returned an overall score of 79.1% across Adult Mental Health wards, with individual ward scores ranging from 0% (Ardleigh Ward) to 100% (Beech Ward, Finchingfield Ward, and Grangewaters Ward).

245. It was noted that not all ward matrons had completed the audits, meaning that not all areas were represented in the initial results. Variable compliance with consent processes was

identified, and each individual matron was required to develop and oversee an improvement plan to address identified gaps, with plans to be overseen through care unit governance processes reporting into the Accountability Forum. The weekly audit process was to continue until care unit leadership was satisfied that progress and compliance had reached above 95% for each area and that processes were fully embedded in practice.

***Fortnightly Executive Team Audit Reporting — January 2026***

246. With effect from October 2025, a fortnightly audit process was initiated to provide additional assurance to the Executive Team regarding implementation of the Oxevision SOP, and to track the impact of improvement measures at local ward level led by matrons.

247. The fortnightly report for the week commencing 26 January 2026, **[Exhibit KSZT01-010]**, noted that the overall direction of travel was positive, with more consistent admission discussions and follow-up on missed opportunities reported by wards. However, the report identified a number of operational barriers to full compliance: the clinical dashboard was not correctly reflecting completed admission checklists, particularly affecting high-turnover wards; the Matrons' Audit tool was considered unduly lengthy, with the consequence that completion had been delegated to other staff groups; and a significant number of wards had yet to submit their January 2026 audit returns. Specifically, no consent audit submission had been received for January 2026 from Ardleigh, Beech, Chelmer, Finchingfield, Galleywood, Gloucester, Gosfield, Roding, Ruby, and Stort Wards, and no staff training audit submission had been received from Ardleigh, Beech, Cedar, Chelmer, Gloucester, Gosfield, Hennage, Peter Bruff, Roding, Ruby, Stort, and Willow Wards.

248. The external TIAA follow-up re-audit was confirmed as scheduled for 16 February 2026, with the audit team based in Colchester and reviewing all five sites remotely. The follow-up assurance review report, which remained in draft as at May 2026, continued to award Limited Assurance. The findings of that follow-up review were among the factors considered in the rapid review described above.

**Voluntariness of Consent**

249. EPUT recognises the importance of respecting patient choice, including the choices of patients who are detained under the Mental Health Act 1983. Detention does not of itself remove a patient’s right to make decisions about matters that do not fall within the scope of compulsory treatment provisions. Where a patient lacks the mental capacity to make a specific decision regarding the use of Oxevision, EPUT is committed to ensuring that appropriate weight is attached to the patient's wishes and feelings in accordance with the best interests framework under the Mental Capacity Act 2005.

250. Whether a detained patient is able to give or withhold consent to the use of Oxevision depends on whether they have the mental capacity to make that decision. Some patients are detained precisely because they lack the capacity to make decisions about their care and treatment; in such cases, the decision regarding the use of Oxevision is made in the patient's best interests in accordance with the Mental Capacity Act 2005. Where a patient does have capacity, EPUT seeks to obtain consent in circumstances that are conducive to the patient being able to make a free and informed decision. In accordance with the principles of the Mental Health Act 1983 Code of Practice, staff are required to ensure that the discussion takes place at an appropriate time and in a setting that affords the patient privacy. Information must be provided in a manner that the patient can understand, and staff must take all practicable steps to address any factors that may impair the patient's ability to engage with the information, including any cognitive, sensory or communication difficulties. The patient must be supported to make and communicate the decision themselves; consent cannot be given on the patient's behalf by a family member or other third party.

251. EPUT acknowledges that there may be a perceived power imbalance between detained patients and clinical staff, and that this has the potential to affect the voluntariness of consent. The Trust takes active steps to ensure that patients mitigate this risk and to feel supported and confident in expressing their views and concerns to the MDT. Patients are offered the opportunity to prepare and submit their questions or concerns in writing in advance of clinical discussions. They may also be supported by a family member, carer, advocate or a member of staff of their choosing. In addition, patients are able to raise concerns through the Trust's formal complaints process. These measures are intended to ensure that the consent process is not merely procedural but reflects a genuine and informed exercise of patient choice.

252. EPUT takes steps to ensure that a patient's care is not adversely affected by whether or not they consent to the use of Oxevision or any other aspect of their care and treatment. Staff are bound by their respective professional codes of conduct — including the General Medical Council's Good Medical Practice and the Nursing and Midwifery Council's Code of Professional Standards — which prohibit any form of victimisation or differential treatment of a patient on the basis that they have refused consent, raised concerns or made complaints. A breach of these professional obligations may result in disciplinary action, including dismissal and referral to the relevant regulatory body. These standards are reinforced by EPUT's local policies, which set clear expectations regarding the equitable treatment of all patients regardless of the decisions they make about their care. Clinical and managerial supervision provides a further safeguard, offering a structured opportunity

to identify and address any concerns regarding staff conduct towards patients on the ward. These measures, taken together, provide both formal and informal assurance that patients are able to exercise their right to give or withhold consent without fear of adverse consequences for their care or their relationships with staff.

**Data Protection Information at Consent**

253. EPUT's consent process prior to the further review, is described in the Second Statement of Zephan Trent at paragraph 26. As part of admission, patients must be given clear and accessible information covering the purpose of Oxevision, how it works, what data is collected, and details of how the patient's data will be collected, stored and used. This must be explained in an accessible way.

254. Patient-facing materials, specifically the ward poster and patient leaflet, inform patients that routine staff viewing is limited to 15-second windows (clear for vital sign checks; blurred following notifications), and that recorded clear video is stored for 24 hours and is only accessible to authorised staff in the event of a safety incident. The leaflet states that the system does not show a continuous live video, that ward staff can only see a clear view of the patient's room when measuring heart and breathing rate for up to 15 seconds, and that they can see a blurred view for up to 15 seconds when they receive a notification.

255. On privacy safeguards and data retention, the leaflet states that in addition to the 15-second time limit on viewing, there is no sound capability and staff cannot hear anything happening in a patient's room, nor see inside the bathroom. The leaflet then sets out further privacy measures:

- The healthcare provider receives weekly reports on how often staff have used the system, so that it can be assured the system is being used correctly.
- Recorded clear video can only be viewed by authorised staff if there has been a safety incident, and it must be requested within 24 hours; patients have the right to be informed if this happens.
- All clear video is only kept for 24 hours and is then automatically deleted, and is handled following NHS rules and the law.

256. The leaflet states that patients may notice a red glow from the unit caused by the infrared lights, which help the system work in the dark, and that these lights stay on all the time, even if the camera is switched off.

**CAMHS Consent Processes**

257. This section addresses the consent process applicable to patients within EPUT's Child and Adolescent Mental Health Services (CAMHS), including how consent is obtained from CAMHS patients and those with parental responsibility, and the differentiation between young people who are assessed as Gillick-competent and those who are not.

258. The consent framework for the use of Oxevision in CAMHS is consistent with the process applied across all other EPUT inpatient services. However, there are specific variations in the assessment of capacity and the involvement of parents, carers and those with parental responsibility, reflecting the particular legal and clinical considerations that arise in the care of children and young people.

259. For young people aged under 16, the clinical team assesses whether the young person is Gillick-competent **[Exhibit KSZT01-011]—** that is, whether they have sufficient understanding and intelligence to comprehend fully the nature, purpose and consequences of the proposed use of Oxevision, such that they are able to make an informed decision in relation to it.

260. As with all other inpatient services, the young person is provided with information about the Oxevision system and afforded the opportunity to discuss its use with staff, so as to enable them to make an informed decision.

261. Where a young person is assessed as Gillick-competent, they are entitled to give or withhold consent to the use of Oxevision. Where the young person's decision differs from the wishes of their parents or those with parental responsibility, staff support the parents to understand the young person's right to make that decision. The young person's consent status is kept under ongoing review throughout their admission, in accordance with the weekly review process described below.

262. Where a young person is assessed as not being Gillick-competent in relation to the decision to consent to the use of Oxevision, staff discuss the use of the system with the young person's parents or carers, and the decision is made collaboratively with the person or persons holding parental responsibility.

263. Where those with parental responsibility do not give consent for the use of Oxevision, the matter is referred to the MDT for discussion with the parents or those with parental responsibility. The MDT considers whether the young person's safety can be adequately managed without the use of the system, including through the use of in-person observations and any other appropriate care planning measures or mitigations.

264. Consent for the use of Oxevision is obtained at the point of admission and is reviewed on a weekly basis as part of the ward round. Young people and their parents are invited to complete a feedback questionnaire in advance of the ward round, in which they may raise any questions or comments they wish to have discussed as part of the care review. The feedback questionnaire includes a specific question inviting feedback on the use of Oxevision.

265. Where a young person or their parents raise a concern or request in relation to Oxevision between scheduled ward rounds, staff are required to engage in a discussion with the young person and their parents at the earliest opportunity. Any such request and the outcome of the discussion are referred to the MDT for consideration and recorded in the young person's clinical record.

## Training And Competency Assurance

### Staff Groups Required to Use Oxevision

266. Oxevision is expected to be used by ward-based inpatient staff groups. This can be broken down into the following staff groups:

Registered Nurses
Healthcare Assistants and Support Workers
Bank and Agency Staff

267. Any staff who are expected to use the Oxevision system must be trained in its use.

### Training Requirements and Delivery

268. The question of training requirements and delivery has been addressed in the evidence of Zephan Trent across all three of his witness statements (First Statement, paragraphs 54–55; Second Statement, paragraphs 30–32; Third Statement, paragraphs 28–29; Exhibits ZT-028, ZT-030 to ZT-040, ZT-089). The key aspects of EPUT's training framework are summarised below.

269. Each iteration of the Standard Operating Procedure has detailed the Trust's approach to training in respect of the Oxevision system. As set out in the First Statement of Zephan Trent, training was initially delivered at ward level by an experienced member of staff, with dedicated floorwalkers available to provide support when wards first went live with the system. The training framework has since evolved and, as described in the Second and Third Statements of Zephan Trent, current training is delivered through a combination of

channels: the Oxehealth Academy online training portal, which requires a 100% pass rate and provides access to training videos and materials together with a full audit trail; Microsoft Teams or onsite training delivered by an Oxehealth trainer during the implementation phase; annual mandatory training via the Trust's OLM system; and local ward induction briefings delivered by a designated Oxevision champion. This training is mandatory for all ward-based clinical staff, including bank and agency staff, and must be completed annually; new starters are required to complete it as part of their induction. Staff are further required to complete a competency checklist on an annual basis, and in respect of bank and agency staff, completed checklists are required to be sent to the temporary staffing team.

270. Staff are required to complete a competency checklist on an annual basis.

271. In respect of bank and agency staff, completed checklists are required to be sent to the temporary staffing team.

272. Oxehealth delivers its training through the Oxehealth Academy electronic portal, which provides access to training videos and materials together with a full audit trail. This training is mandatory for all ward-based clinical staff, including temporary staff, and must be completed annually; new starters are required to complete it as part of their induction.

273. As part of the Oxehealth-to-LIO rebranding, all Oxehealth Academy content and assessments will be updated and transferred into the Trust's OLM via ESR. Staff will be required to complete the three-part training programme on the OLM before they can be authorised to use the LIO platform (formerly Oxevision) on any ward equipped with LIO technology. The transition to the OLM is scheduled to take place in 2026. Once the training is live in the OLM, staff completion records will update automatically, reducing delays in training visibility and compliance reporting.

**Professional Conduct Training**

274. EPUT ensures that staff who use the Oxevision system are trained in, and held accountable for, maintaining the highest standards of professional conduct, including the requirements of respect, dignity and appropriate behaviour when viewing patients or accessing footage generated by the system.

275. Staff who hold a professional registration are required, both by the terms of their contractual employment and by virtue of their registration with the relevant professional body, to practise in accordance with established standards of professional conduct. For registered nurses, professional conduct is addressed formally through the preceptorship programme

and the ward manager development programme, both of which include specific reference to the standards of behaviour expected in clinical practice. In addition, nurses are required to revalidate with the Nursing and Midwifery Council every three years, a process which is aligned to the professional standards set out in the NMC Code and which requires demonstrable adherence to those standards throughout the revalidation period. Clinical supervision, which takes place on a monthly basis, provides a further structured opportunity to reflect on and reinforce professional practice and conduct, including in relation to the use of monitoring technologies such as Oxevision. Healthcare assistants and support workers, whilst not subject to individual professional registration, work under the delegated accountability of the registered nurse and are expected to adhere to the same standards of conduct. Their practice is overseen through line management, supervision and the competency framework described above.

**LIO/Oxehealth Training on Rights and Consent**

276. This section addresses EPUT's understanding of the extent to which human rights and consent are addressed in the training materials provided by LIO (formerly Oxehealth) in connection with the Oxevision system.

277. In order to address this question, it is necessary first to set out Oxehealth's position regarding the division of responsibility between itself, as the technology provider, and the deploying organisation. The evidence of Laura Cozens on behalf of Oxehealth is that each organisation using the system is responsible for developing its own standard operating procedures and privacy-related policies. Oxehealth's role, as described by Ms Cozens, is to provide supporting documentation — for example, materials describing data types, data flows, and governance arrangements — to assist customers in understanding how the system works and how patient data is processed. Oxehealth further states that it does not control or audit how individual customers use the system, and that it engages with customer Data Protection Officers and IT teams to support understanding and to enable each customer to conduct its own risk assessments and develop its own policies and procedures.

278. In respect of consent specifically, Oxehealth's stated position is that it does not advocate for any particular model of consent. Rather, Oxehealth emphasises that patients and carers should be informed of the system's use, and directs deploying organisations to relevant national guidance.

279. Against that background, EPUT's understanding is that the training materials provided by LIO/Oxehealth do not substantively address human rights or consent as discrete training

topics. The training delivered through the Oxehealth Academy is focused on system functionality and practical operation of the technology. Responsibility for training staff on when and how to use Oxevision — including training on human rights compliance, the consent framework, and the legal obligations arising under the Mental Capacity Act 2005 and the Mental Health Act 1983 — is treated by Oxehealth as resting with the deploying organisation. In EPUT's case, that responsibility is discharged through the SOP, the mandatory OLM training modules, quality walkarounds, and clinical supervision. The national guidance to which Oxehealth directs deploying organisations — principally the NDF guidance and the NHS England principles — does address consent and capacity at a policy level, but this guidance does not form part of Oxehealth's own training content. It is also material to note that the early Oxehealth signage and consent guidance issued in December 2019, which suggested that consent may not be required where the system is used in the normal course of treatment, has since been recognised as an inadequate basis for consent decision-making, as acknowledged by Ms Cozens in her oral evidence on 13 October 2025.

280. EPUT accordingly accepts that it bears responsibility for ensuring that its own training framework — delivered through the SOP, the mandatory OLM modules and clinical supervision — adequately addresses human rights and consent for all staff who use the system. The steps taken by EPUT to discharge that responsibility are described in the preceding sections of this statement and in the training and competency assurance framework set out below.

**Nurse In Charge Competency Checking Responsibilities**

281. The Standard Operating Procedure places responsibility on the Nurse in Charge for ensuring that all staff on shift are competent in the use of the Oxevision system. This section addresses the mechanisms by which the NIC discharges that responsibility, including the tools available to confirm training completion, the circumstances in which competency must be re-assessed, and the approach to assessing MDT members' competencies.

282. At the commencement of each shift, the Nurse in Charge must be satisfied that all staff on duty are competent in the use of the Oxevision system. Where the NIC is not so satisfied, the gaps in the staff member's knowledge are identified on their competency checklist and they may be required to repeat their mandatory training (First Statement of Zephan Trent, paragraph 54; Second Statement of Zephan Trent, paragraphs 30 and 31).

283. The NIC has access to a number of tools to verify staff competency. The primary mechanism is the Mandatory Training Tracker on EPUT's Intranet, which provides a visible record of whether each member of staff has completed both the Oxehealth Academy courses and the Oxevision OLM mandatory training module. In addition, the EPUT Ward Dashboard displays all substantive staff assigned to the selected ward under the Training/Supervision tile, enabling ward management to review training compliance at a glance. For individual checks — including in respect of temporary staff — the Mandatory Training Tracker allows searches for both substantive and bank or agency staff. The Oxehealth Academy electronic portal also maintains a full audit trail of training completion, which is monitored by the Oxehealth Project Board, and each ward receives a list of staff members who have been trained.

284. All staff are further required to demonstrate competency and record that demonstration on a competency checklist, which must be completed annually. In respect of bank or agency staff, the completed competency checklist is to be sent by administration support to the temporary staffing team. In respect of substantive staff, the completed checklist is to be kept in their staff file by their manager (Second Statement of Zephan Trent, paragraphs 30 and 31).

285. The combination of the Mandatory Training Tracker, the Ward Dashboard, the competency checklist records, and the ward-level list of trained staff provides the NIC with the tools necessary to satisfy themselves at shift level as to the competency of those on duty.

286. A staff member's competencies would require to be checked or training repeated in the following circumstances:

- where a staff member has not achieved the required pass mark, in which case they would not have completed their mandatory training and would accordingly not be permitted to use Oxevision;
- where the NIC forms the view that a staff member is not competent, irrespective of the reason; or
- upon the introduction of a new SOP.

287. The process for assessing MDT members' competencies does not differ from that described above. The NIC's assessment relies on the same mechanisms — the Mandatory Training Tracker, the competency checklist, and the Ward Dashboard — and the same standards of competency apply irrespective of whether the staff member is a registered nurse, a healthcare assistant, or another member of the multidisciplinary team.

**Untrained Staff Procedures**

288. Staff members who have not completed the required Oxevision training are not permitted to carry out supportive observation and therapeutic engagement using the Oxevision system. It should be noted, and this principle is reflected throughout this statement, that Oxevision is an assistive technology; it does not replace in-person supportive observations and therapeutic engagement, which remain the primary means by which patient safety is assured on the ward.

289. EPUT does not specifically monitor for the number of times a staff member has presented to work on a ward where Oxevision is in use, without having completed training on Oxevision. This would be tracked as part of the general training audits and would be picked up in supervision and would be escalated if required.

290. Where it is identified that a staff member has not completed the required training, arrangements are made for that training to be undertaken at the earliest opportunity. Where a staff member has not completed the training as part of their induction, they are required to do so before carrying out any observations using the Oxevision system.

291. Compliance with this requirement is captured through the fortnightly Oxevision training audit, which includes the question: " Does the patient confirm that they were informed about the 24-hour active camera in their bedroom as part of Oxevision?"

**Staffing Shortages and Reliance on Oxevision**

292. In respect of CAMHS services, EPUT has at no time used Oxevision as a substitute for, or alternative to, adequate staffing levels. Supportive observations are allocated to individual staff members in accordance with standard practice. No formal process exists to manage such a contingency, as the use of Oxevision in place of staffing is neither advised nor promoted by the Trust. Staffing levels are set based on patient needs and safer staffing guidelines, MHOST tools etc. Further information about staffing levels has been provided by EPUT in the statement of Rebecca Pulford in the response to Rule 9(26) at Section L.

293. More broadly, the Trust's position is that Oxevision is an assistive technology and is not, and has never been, used as a replacement for staffing. Any practice in which a member of staff relied upon Oxevision in substitution for in-person observations would constitute a breach of expected professional conduct and would be addressed through the appropriate management channels, including supervision and, where necessary, formal disciplinary processes in accordance with the Trust's policies.

294. The way in which EPUT identifies and monitors staffing shortages and mitigates for them is described in the response to Rule 9(26) dated 27 February 2026, from page 204 – 243. The primary mitigation for short-term gaps is the use of temporary staffing. The Temporary Staffing team support managers with short-term staffing requirements to cover gaps in service delivery, managing the internal staff bank and agency workers, supporting services with the fill of urgent shifts to maintain safer staffing levels, ensuring agency compliance with NHS standards and frameworks, and monitoring usage. The Temporary Staffing Reduction Plan is supported by the Board Assurance Framework and strategic risk register.

**Inappropriate Use Identification and Response**

295. For the purposes of this section of the response to Rule 9(114), the information and materials gathered are in respect of staff conduct investigations where there is a direct relevance between the allegations of misconduct and the use of Oxevision. The information in this section has been obtained from colleagues in the HR department and therefore is not within the personal knowledge of the authors of this statement.

296. During the Essex Mental Health Independent Inquiry and in preparation for responses to previous Rule 9 requests (in particular Rule 9(9)), an Excel database (the "HR master list") of employee relations cases, in particular for conduct, grievance, and HR whistleblowing, was compiled by:

- reviewing previous spreadsheets dating back to 2011 for SEPT and EPUT and extracting the data held;
- reviewing all electronic folders held under conduct and/or employee relations in NEP, SEPT, and EPUT shared HR drives;
- reviewing all archive boxes holding conduct and/or employee relations paper records for NEP and SEPT;
- reviewing all records held on Laserfiche for SEPT, NEP, and EPUT using the search criteria of "disciplinary records";
- and reviewing data held on ESR, in particular within the "Employee Relations Details" function.

297. The HR master list covers the period of the Inquiry reference period of January 2000 to December 2023.

298. The HR master list does not hold records of matters of conduct relating to agency workers, as agency workers are neither workers nor employees of the Trust and have a contractual relationship with the employment agency. Where concerns regarding the conduct of an agency worker are identified, the employment agency is responsible for formal disciplinary action; the Trust engages with the employment agency to support investigation and decision-making. Accordingly, the case data set out below covers EPUT's directly employed and bank staff only. To the extent that concerns about agency worker conduct have arisen in connection with the use of Oxevision, these would be escalated to the relevant agency by line management in accordance with the Trust's Temporary Worker Conduct and Complaints Policy.

299. Of the conduct cases reviewed, the following themed categories of allegations have been identified:

- Remote observation substituted for physical attendance: Relying on Oxevision as opposed to undertaking an actual physical check of a patient on observations at the required time(s). This is the most common theme arising from the cases reviewed.

- Incorrect use of or failure to hand over the Oxevision tablet: Incorrect use of the Oxevision tablet, or failure to hand over the tablet to the next person aligned to undertake observations.

- Failure to appropriately monitor the Oxehealth alert system: Failure to appropriately monitor the Oxehealth alert system, either through silencing the system, disabling the system, or wearing headphones through which the alarm could not be heard.

300. Concerns about staff conduct in connection with Oxevision usage may come to the Trust's attention through a number of routes. These include:

- Datix incident reporting: Where a patient safety incident is identified that has a connection to Oxevision usage (for example, a delayed response to a patient that is linked to reliance on remote observation), this may be reported via Datix and subsequently reviewed by the ward manager, matron, or quality and safety leads. Datix reports are triaged and may generate recommendations for HR referral where the circumstances disclose potential conduct concerns.

- Line management: Concerns about the conduct of an individual member of staff in connection with Oxevision use may be identified and raised by a line manager — for example, where a supervisor observes non-compliant behaviour or where a patient, carer, or colleague raises a concern.

- Tendable audit findings: The Tendable audit process includes assessment of compliance with the Oxevision SOP, including staff understanding and competency, adequacy of consent processes, and appropriate use of the equipment. Where an audit identifies concerns about practice at an individual level, this may generate a referral to line management or HR.

- Usage report data: Monthly usage reports distributed to ward managers and matrons may, when reviewed, indicate patterns of usage that are inconsistent with appropriate practice. Where a ward manager identifies data suggesting a particular member of staff or shift pattern is associated with anomalous usage, this may prompt a management enquiry that in turn results in an HR referral.

- Oxevision Project Board and Care Unit Quality and Safety meetings: Concerns identified at Trust-wide or care unit level through review of usage data may be communicated to ward managers with an instruction to investigate, thereby generating a governance escalation route into HR processes if warranted.

301. Where a conduct concern is identified through any of the above routes in respect of a directly employed or bank member of staff, the Trust's Disciplinary (Conduct) Policy applies. Where the concern relates to an agency worker, the Trust's Temporary Worker Conduct and Complaints Policy applies and the relevant employment agency is engaged as described above.

302. The Trust's approach to learning from conduct cases involving Oxevision operates at both individual and systemic level. At individual level, where a case is resolved through informal means — reflective practice or additional training — the learning is directed at the individual concerned, with the aim of securing a change in practice and ensuring full understanding of and compliance with the SOP. Where a formal sanction is imposed, this is accompanied by a clear statement of the conduct expectations going forward.

303. The Trust's decision to increase the frequency of Tendable audits from monthly to fortnightly, with an enhanced level of detail in respect of practice, training, and consent, also reflects systemic learning from the identification of compliance concerns across the Trust.

304. The steps taken by the Trust to enhance its auditing processes, to establish the Ethics Committee, and to commission the rapid review demonstrate a continuing commitment to learning from identified concerns and to taking appropriate steps to effect change where necessary.

**Vital Signs Monitoring and Alert Response**

**Room Configuration**

305. Oxevision is a fixed-installation device for use within single occupancy inpatient rooms and secured environments. Prior to installation, Oxehealth conducts a site survey of each room in which Oxevision is to be installed. Blind spot warnings are identified at site survey stage or in room reconfiguration. This initial survey is undertaken by Oxehealth and informs the system's calibration for that specific room, including the identification of any areas outside the camera's range (referred to as blind spots).

306. The beds are fixed to the floor in the majority of patient rooms. Profiling beds are not fixed and are only used where requested and require additional risk assessment (not necessarily related to Oxevision).

307. The combination of the initial Oxehealth site survey, routine ward monitoring by Ward Managers and Matrons, daily checks by the security nurse, and the requirement in the SOP to notify Oxehealth of any room configuration changes provides a layered framework for ensuring that the room environment remains consistent with the system's calibration.

308. Section 1.6.2 of the Standard Operating Procedure provides that Oxehealth must be notified should the room configuration be altered including repositioning of the bed space, and that a failure to notify Oxehealth of configuration changes will have an adverse impact on Oxevision performance and accuracy. The SOP further notes that movement of furniture a distance as small as 50cm can impact the system's accurate evaluation of a room configuration. All staff are trained in relation to the content of the SOP.

**Alert Response Data and Analysis**

309. The Monthly Usage Report provides data on response times to alerts generated by the Oxevision system. An alert is indicated by both an audible and visual signal on the ward tablet. The active alert types at EPUT are: Out of Room; Leaving Bed; Out of Bed; At Door; In Bathroom; and No Activity. Alert availability varies according to the clinical service: Older Adult wards typically enable Leaving Bed, Out of Bed, and Out of Room alerts; No Activity alerts are specific to seclusion rooms; and At Door alerts are most commonly enabled on CAMHS wards. The frequency and timing of alerts will naturally differ based on the nature and activity level of each ward, and these configuration differences also influence the overall number of alerts generated.

310. Response times of 0–15 seconds cannot be attributed to a single cause. In many cases, a response within this timeframe is entirely realistic: inpatient wards are compact environments in which staff can reach the alert location within seconds. For certain alert types — such as Out of Room or At Door — the patient may already be within the direct line of sight of staff at the point the alert activates. LIO has confirmed that EPUT's response times are broadly in line with those of its wider customer base.

311. The Trust has not to date established formal key performance indicators against which alert reset speed data is routinely benchmarked; however, the Monthly Usage Reports contain sufficient data from which performance averages and statistical process control analyses could be constructed. Monthly Usage Reports are shared with ward managers, matrons, service directors, and Oxevision Project Board members. Queries about specific ward practices or patterns in the use of the system are raised through Quality and Safety meetings or during Care Unit reviews. The detailed structure of the usage reports, the governance flow by which they are disseminated and reviewed, and the trends identified from the data are addressed in the Oxevision Usage Reports section of this statement.

312. In respect of steps taken to change or improve practice, the Oxevision Project Board devolved responsibility for addressing all monthly LIO reports — including usage, stopped room, mandatory training, and Datix reports — to the Care Units. This devolution ensures that the clinical leadership closest to ward-level practice is responsible for interrogating the data, identifying concerns, and taking remedial action. The measures taken in response to usage report data, including the structured intervention on the Brockfield House wards which produced a measurable reduction in inappropriate vital signs use, are set out in detail in Part B of this statement.

313. As set out above, the compact layout of inpatient wards means that staff can physically reach a patient's location within seconds of an alert activating. In many instances, the staff member may already be with or in close proximity to the patient at the point the alert is triggered — for example, where a patient leaves their room and is immediately visible to staff in the corridor. A staff member who has recently attended a patient may also be nearby when a subsequent alert is triggered, enabling a rapid in-person response. The Standard Operating Procedure requires that alerts are reset only following physical attendance and verification of the patient's safety. The Trust's position is that the alert reset data, taken in isolation, cannot distinguish between a compliant rapid in-person response and a non-compliant remote reset. However, the rapid review identified that a noticeable time lag in the delivery of alerts to handsets had been reported by frontline staff, and this will be reviewed by the LIO Steering Board.

314. The Trust's position, as set out in the Standard Operating Procedure v.12, is that the use of the Vital Signs clear-view video feed for any purpose other than the taking of vital signs observations is not permitted. The audit and oversight mechanisms by which compliance with this requirement is monitored are documented above. However, the Trust acknowledges that no specific analysis or investigation has been conducted to assess the extent to which staff may have been using the Vital Signs clear-view video feed to respond to alerts rather than attending in person. The discrepancy between vital sign attempts and successful vitals displayed — which is addressed in detail in the Oxevision Usage Reports section of this statement — is recognised as raising the possibility that staff may, on occasions, have accessed the 15-second clear-view video feed beyond the purpose of the vital signs workflow. The SOP had provided that where the Vital Signs function is used to take an additional observation, this must be documented in the patient's clinical record. The Trust had responded to this concern through explicit prohibitions in version 12 of the SOP, released on 7 May 2025, and through staff communications making clear that repeated use of the vital signs pathway to obtain continued clear views constitutes a misuse of the system. The effectiveness of those measures will be assessed as part of the further review recommended by the rapid review.

315. At present, it is not possible to digitally track individual staff activity on the LIO platform. However, EPUT understands from LIO that a project is in the planning stage to upgrade login procedures with a user authentication process. Once implemented, this will provide management with the tools to monitor individual system use, identify individual staff outliers, and take appropriate action where practice falls short of the required standard.

316. The Trust's position is that the Standard Operating Procedure requires staff to attend patients in person before resetting an alert. Alert resets are therefore expected to correspond to physical verification of the patient by a member of staff. The Trust does not accept that remote observation routinely replaces in-person response. However, the Trust recognises that there may be limited circumstances in which an alert is legitimately reset by a staff member who was not the person who physically attended the patient — for example, where a staff member attends a patient immediately upon hearing an alert but does not have a tablet, and a colleague resets the alert on their behalf following confirmation that the patient has been checked. Such instances would still constitute a response involving in person attendance and verification, albeit with the reset performed by a different member of staff.

317. Where a staff member is identified as having reset an alert without in person attendance, this constitutes a breach of the Standard Operating Procedure. Responsibility for

identifying and reporting such non-compliance lies at ward level, where the Nurse in Charge and ward manager are expected to monitor practice and escalate concerns through the appropriate management channels. The Tendable audit process, which is conducted on a fortnightly basis, includes assessment of staff understanding of, and compliance with, the requirement to attend patients in person before resetting an alert. Where non-compliance is identified, it is addressed through supervision, reflective practice, additional training, or formal disciplinary processes as appropriate, in accordance with the Trust's Disciplinary (Conduct) Policy.

318. The Trust recognises the importance of continuous improvement in the use and oversight of the LIO system. New features not previously available are being released by LIO to assist in this process, including the introduction of user authentication, which will enable the Trust to capture reliable system-level data on individual usage and to develop key performance indicators against which staff practice can be monitored. Where staff practices are identified as falling short of the required standards, the Trust will take appropriate remedial or disciplinary action in accordance with its established staff management procedures.

**Prevention of Over-Reliance on Alerts**

319. The Trust's safeguards against staff relying on Oxevision alerts as a substitute for required in-person observations operate through multiple control mechanisms. These include the Standard Operating Procedure v.12, which makes clear that Oxevision is an assistive technology and does not replace the requirement for supportive observations and therapeutic engagement at the frequency prescribed by the patient's care plan; the Trust's overarching CG100 Clinical Guideline; and the standards of professional practice to which all clinical staff are expected to adhere.

320. The Nurse in Charge is responsible for ensuring that supportive observations are allocated to individual staff members in accordance with the patient's prescribed observation level, and that those observations are carried out in person regardless of whether an Oxevision alert has or has not been generated. Compliance with this requirement is monitored through the Tendable audit process, and supervision at ward level. Where concerns about over-reliance on alerts are identified, these are addressed through the management channels described in the Inappropriate Use Identification and Response section above. In respect of staffing pressure, the Trust's position — as set out in the Staffing Shortages and Reliance on Oxevision section above — is that Oxevision has at no time been used as a substitute for adequate staffing levels. The mechanisms by which the Trust identifies and mitigates staffing shortages, including through the use of temporary staffing, are

described in the response to Rule 9(26) dated 27 February 2026. The Trust does not accept that staffing pressure provides a basis for departing from the requirement for in-person observations at the prescribed frequency.

**Blurred Video Footage**

321. At the request of the Inquiry EPUT has provided a single, short example of blurred video footage/anonymised video data generated by the Oxevision system, which is representative of the footage ordinarily viewable by ward staff when Oxevision produced an alert **[Exhibit KSZT01-012].**

322. The Oxevision system does not permit screen capture from a monitor or tablet; that function is not available within the system. The video clip provided is a ten-second clip of a patient who was active in their bedroom space. It was selected principally because it is derived from anonymised video data (AVD). The clip provided is a copy of the original data, produced using the Snipping Tool for video capture and editing; the source file was not altered.

323. The footage depicted in the clip is representative of what would be visible to a member of staff during an authorised review following a safety incident, or a Vital Signs view at the point of resetting an alert.

324. The SOP requires an in person response when an alert is raised. EPUT accepts that the Oxevision system makes blurred (anonymised) video footage available to staff on the ward tablet at the point an alert is generated.

325. EPUT is aware that staff do on occasions access the blurred footage when an alert is generated. The Trust considers that it is reasonable for a staff member to view the blurred footage as part of their response to an alert, as doing so may assist the staff member in arriving better prepared — for example, by enabling them to assess whether additional support or equipment is required, or whether a colleague should attend alongside them to assist the patient more fully or more quickly. Alerts are transmitted simultaneously to all tablets on the ward and to the nursing office monitor. In that context, viewing the blurred footage may serve a number of legitimate operational purposes: for example, where a staff member seeks to assess the nature of the situation before attending so as to provide a more effective response; where the Nurse in Charge uses the footage to coordinate the ward response to multiple simultaneous alerts; or where a staff member who is not the allocated responder wishes to confirm that a colleague has attended the patient's room. The fact that a staff member has viewed the blurred footage does not, of itself, constitute evidence that an in-person attendance has not taken place; rather, it may reflect good

practice in ensuring that the in-person response is as effective as possible. Ward managers and the Nurse in Charge are responsible for monitoring the use of this functionality and for ensuring that staff understand that every alert must be treated as requiring an immediate in-person response, with physical verification of the patient's safety before the alert is reset.

**Number of Alerts and Alarm Fatigue**

326. Prior to the introduction of the Oxevision system, the Trust did not have a predetermined baseline for the anticipated number of alerts that the system would generate. Alert parameters were adjusted on a ward-by-ward basis in response to the requirements of individual wards, with oversight provided by the Oxehealth Project Board.

327. In the absence of a predetermined expectation as to alert numbers, the Trust adopted an iterative approach in which early-adopter wards served as the primary source of learning. System parameters were adjusted in light of the experience gained on those wards, and the knowledge acquired through each successive implementation informed the configuration and staff guidance for subsequent ward deployments.

328. The risk of alarm fatigue was addressed directly by the Trust as and when it was raised by individual wards. By way of example, Henneage Ward identified concerns regarding alert frequency, and the project team worked through a number of trial configurations until an optimum alert rate was established. That rate was subsequently proposed to, and adopted by, the four other older adult wards then in operation. In particular, it was identified on older adult wards that the edge-of-bed alert was triggering with excessive frequency, owing to the tendency of many patients to sit on the edge of the bed; the alert parameter was accordingly adjusted to a leaving-bed alert. The lessons learned and the adjusted alert rates from this process will form the baseline configuration for the three additional older adult wards scheduled for implementation in 2026.

329. The project team received and acted upon feedback from early-adopter wards regarding the burden placed on staff by the requirement to respond to each alert. That feedback was escalated for clinical review and approval. No formal performance metric was established by which to measure staff efficiency before and after implementation on a per-ward basis.

**Alert Types and Clinical Benefit**

330. This section addresses how the specific notification types available within the Oxevision system, namely Out of Room, In Bathroom, In Blind Spot, At Door, Room Entry, Multiple Occupancy, Edge of Bed, and Leaving Bed, assist staff to identify and respond to patient safety concerns more quickly than would otherwise be possible through routine in-person

observation alone. The Oxevision system generates two distinct categories of notification: red alerts, which require an immediate in-person response and are accompanied by audible and visual signals; and amber warnings, which serve as advisory notifications to prompt staff awareness of a change in the patient's status or location. The distinction between these two categories is material to the staff response required: red alerts mandate physical attendance and verification of the patient's safety before the alert can be reset, whereas amber warnings are designed to inform staff situational awareness and prompt a clinical judgement as to whether an in-person response is required. Some notification types operate exclusively as amber warnings; others generate red alerts; and in the case of the "In Bathroom" notification, an initial amber warning escalates to a red alert after a defined period. The clinical benefit and classification of each notification type is described below.

331. Out of Room: This notification generates an amber warning on the ward tablet when a patient leaves their bedroom between the hours of 19:00 and 07:00. As an amber warning, it does not carry the same mandatory in-person response protocol as a red alert; however, it is designed to prompt staff to exercise clinical judgement as to whether an in-person check on the patient's location and wellbeing is required. The clinical benefit of this notification is that it ensures staff are made aware, in real time, that a patient has left their bedroom at a time when they are more likely to be in their room. This is of particular relevance for patients assessed as being at risk of absconding, self-harm, or nocturnal falls, and in such cases the clinical expectation is that staff will attend the patient in person to verify their safety.

332. In Bathroom: This alert sends an initial amber warning to the ward tablet when a patient enters the bathroom. If no activity is detected for a period of three minutes, the warning escalates to a red alert with audible and visual activation. A re-alert is generated every three subsequent minutes until the patient is verified as having left the bathroom. The clinical benefit of this alert is that it draws staff attention to a patient's prolonged presence in a high-risk area. Bathrooms and ensuites are identified in the Trust's Ligature Incident Analysis as among the highest-risk locations for self-harm and ligature incidents, and the escalating nature of this alert ensures that staff are prompted to conduct a physical check where a patient has remained in the bathroom for an extended period.

333. Room Entry: This notification generates an amber warning on the ward tablet when a second person enters an occupied patient bedroom. The clinical benefit of this notification is that it enables staff to identify promptly when a patient's room has been entered by another individual, which is of particular relevance to safeguarding, including sexual safety, and to the management of patients in settings where unsupervised contact between patients may present a risk. On CAMHS wards, this notification is of heightened importance

given the vulnerability of the patient population. Given the safeguarding implications of this notification, the clinical expectation is that staff will conduct a prompt in-person check of the room upon receipt of a Room Entry warning, notwithstanding that it is classified as an amber warning rather than a red alert.

334. Multiple Occupancy: This notification generates an amber warning on the ward tablet when more than one person is detected inside a patient's bedroom. The clinical benefit of this notification is that it enables staff to identify a potential safeguarding concern and to conduct a physical check of the room. This notification serves a complementary function to the Room Entry warning, providing ongoing notification where multiple individuals remain present in a bedroom rather than solely at the point of entry. As with the Room Entry warning, the safeguarding implications of this notification are such that the clinical expectation is that staff will attend the room in person to verify the patient's safety.

335. In Blind Spot: This notification generates an amber warning on the ward tablet when a patient has moved to an area of the room that falls outside the camera's calibrated field of view. The clinical benefit of this notification is that it notifies staff that the patient is in a location where the system is unable to monitor their status, thereby prompting a physical check. This is of particular relevance where the blind spot corresponds to an area of the room that may present a higher risk, such as near the door or in proximity to potential ligature points. Although classified as an amber warning, the fact that the system is unable to monitor the patient in a blind spot area means that an in-person check is the only means by which staff can verify the patient's safety, and the clinical expectation is that staff will attend accordingly.

336. At Door: This notification generates an amber warning on the ward tablet after 30 seconds when a patient is detected loitering in the main doorway area of their bedroom. As an amber warning, it does not carry the same mandatory in-person response protocol as a red alert; however, the clinical expectation is that staff will exercise judgement as to whether an in-person check is required, having regard to the patient's individual risk profile. On CAMHS wards, this notification is of particular relevance given the heightened need to monitor patient movement and the specific risks associated with patients congregating near doorways.

337. Edge of Bed and Leaving Bed: These notifications generate red alerts when the Oxevision system detects that a patient is at the edge of their bed or is making movements indicating that they are preparing to get out of bed. As red alerts, they require an immediate in-person response and physical verification of the patient's safety before the alert can be reset. These alerts are of particular clinical benefit on older adult wards, where the patient population is at elevated risk of falls. By alerting staff before or at the point at which a

patient leaves their bed, the system enables staff to attend the patient promptly and, where appropriate, to provide assistance with mobilisation. As noted in the Alert Volume and Alarm Fatigue section above, the alert parameter on older adult wards was adjusted from an edge-of-bed alert to a leaving-bed alert following feedback that the former was triggering with excessive frequency owing to the tendency of patients to sit on the edge of the bed.

338. The Standard Operating Procedure distinguishes between red alerts and amber warnings and prescribes different staff response requirements for each. Red alerts are described in the SOP as audible and visual alerts (referred to as a "red tile") that are triggered in specific circumstances requiring an immediate in-person response. The key provisions governing red alerts are as follows.

339. Red alerts are triggered in the following circumstances:

- The "In bathroom" warning escalates to a red alert after three minutes of no activity, with a re-alert occurring every three subsequent minutes until the patient is verified as out of the bathroom. At the three-minute threshold, the warning converts to a red alert with audible and red tile activation.

- Red alerts are generated where a patient is identified as being at the edge of their bed, or where the system detects movements indicating that the patient is preparing to get out of bed.

340. The SOP prescribes the following mandatory staff response to a red alert:

- Staff must conduct an in-person patient check before the alert is reset.

- During a red alert, a live 15-second anonymised (blurred) view of the patient's room is available on the ward tablet or monitor, but must be actively triggered by touching the device. Until the alert is reset, the audible signal remains active and the anonymised view remains accessible. The SOP makes clear that remote viewing by camera does not negate the requirement for an in-person clinical assessment. An alert may only be reset once the in-person assessment has been completed.

- The competency framework confirms this process: staff must always physically check the patient before manually resetting the Oxevision system using the "reset" button.

- Where the Oxevision system is installed in an inpatient environment and a clinical incident occurs (such as a fall or medical emergency), the incident must be responded to immediately as per routine clinical practice and without delay.

**Amber Warnings**

341. The SOP addresses amber warnings in more limited terms than red alerts. Amber warnings serve as advisory notifications that alert staff to a change in the patient's status or location. Unlike red alerts, amber warnings do not carry a mandatory in-person response protocol requiring physical attendance before the notification can be cleared. However, EPUT recognises that the absence of a mandatory in-person response requirement for amber warnings does not mean that no in-person response is expected. The clinical expectation is that staff will exercise professional judgement upon receipt of an amber warning and determine, by reference to the nature of the notification and the individual patient's risk profile, whether an in-person attendance is required. In particular, where an amber warning relates to a potential safeguarding concern — such as a Room Entry or Multiple Occupancy warning — or where the patient is in a location that the system cannot monitor — such as a Blind Spot warning — the clinical expectation is that staff will attend the patient in person to verify their safety. The SOP provides the following guidance in respect of amber warnings:

- Staff must only initiate a vital signs observation when the status tile is green and the patient status is "In Room" or "In Bed." Staff must not attempt vital signs observations when the status tile is amber or red. During a vital signs observation, a live clear image is viewable for the purpose of capturing vital signs, but must be actively triggered by touching the tablet or monitor, and the camera will time out after 15 seconds.

342. The SOP references the following warning-level notifications, which correspond to amber status indicators:

- An "In blind spot" warning, sent to the ward tablet or monitor to indicate that a patient is loitering in a blind spot within their room.

- An "At door" warning, sent after 30 seconds when a patient is loitering in the main doorway area of their room.

- A "Room entry" visual warning, sent when a second person enters an occupied patient room.

- An "In monitored area" or "Monitored area empty" warning, applicable where blind spots exist near doors.

343. In summary, each of the notification types available within the Oxevision system is designed to draw staff attention to a specific change in the patient's status or location that

may be indicative of a safety concern. Red alerts — generated by the In Bathroom (after escalation), Edge of Bed, and Leaving Bed notifications — require an immediate in-person response, with physical verification of the patient's safety before the alert can be reset. Amber warnings — generated by the Out of Room, Room Entry, Multiple Occupancy, In Blind Spot, At Door, and In Bathroom (initial phase) notifications — serve as advisory notifications that prompt staff to exercise clinical judgement as to whether an in-person attendance is required, having regard to the nature of the notification and the individual patient's risk profile. Whilst amber warnings do not carry the same mandatory in-person response protocol as red alerts, EPUT recognises that a number of amber warning types — particularly those with safeguarding implications, such as Room Entry and Multiple Occupancy, and those indicating that the system cannot monitor the patient, such as In Blind Spot — will in many cases necessitate an in-person check. The system's capacity to generate real-time notifications in respect of high-risk locations (such as bathrooms), patient movement (such as leaving bed or leaving the room), and safeguarding indicators (such as room entry or multiple occupancy) provides clinical staff with an additional layer of situational awareness that complements, but does not replace, the requirement for in-person observations at the frequency prescribed by the patient's care plan.

**Self-Harm and Ligature Risk Reduction**

***How the benefit of Oxevision in reducing the risk of self-harm, including ligatures, arises***

344. Analysis has been undertaken looking at wards where Oxevision has been installed to assess whether this has had an impact on ligature incident numbers, **Exhibit KSZT01-013** Ligature Incident Analysis report (April 2020 to March 2023).

345. In order to understand how Oxevision may contribute to reducing the risk of self-harm and ligature incidents, it is important to contextualise the profile of ligature incidents within EPUT inpatient settings during the period covered by the Ligature Incident Analysis report (April 2020 to March 2023).

346. 957 incidents reported during 2022/23 were recorded as having occurred in patients' bedrooms, which equates to 62.8% of the total incidents. Of the top 15 reported location types in 2022/23, the bedroom was by far the highest, followed by ensuites (115 incidents) and then the corridor (103 incidents).

347. The concentration of incidents in bedrooms and ensuites is directly relevant to how Oxevision may assist in the detection of incidents. The data about the locations of incidents highlights that the vast majority occur in the patient's bedroom, with bathrooms and ensuites being high risk areas. Oxevision's ability to alert staff to a patient being in the

ensuite, as well as its ability to alert staff if the patient is in higher risk areas of the patient bedroom for a long period (for example, by the door), could support earlier identification of incidents.

348. Oxevision's notification functions — specifically the 'in bathroom' escalating alert and the 'at door' amber warning — align directly with the locations and behaviours most commonly associated with ligature incidents in EPUT's inpatient settings. The 'in bathroom' notification is of particular relevance given the concentration of incidents in ensuites and the specific anchor points identified (bathroom fittings and bedroom doors): the initial amber warning escalates to a red alert after three minutes of no activity, thereby mandating an in-person response where a patient has been in a high-risk location for an extended period. The 'at door' amber warning, whilst not carrying the same mandatory in-person response protocol, prompts staff awareness of a patient's presence near the doorway area, enabling earlier intervention where the patient's risk profile warrants it.

349. On wards where Oxevision has been installed, it is the responsibility of the reporter to record on the Datix report whether staff were alerted by the system, using a specific field in the Datix report.

350. The Trust's analysis of the top ten reporting wards (self-harm/ligature) includes the number of incidents recorded where staff were alerted by Oxevision. Across all wards and the full period, Oxevision alerted staff in 93 incidents in 2020/21 (7.9% of all ligature incidents that year), 138 incidents in 2021/22 (12.4%), and 180 incidents in 2022/23 (11.8%).

351. The Ligature Incident Analysis report provides ward-level data for each ward where Oxevision has been installed, including the date of installation and incident trends for secured and unsecured ligatures across 2020/21, 2021/22 and 2022/23. A number of wards showed a downward trend (indicated as a reduction in total incidents since installation), including Ardleigh Ward (Oxevision installed 3 April 2020), Chelmer Ward (installed 4 August 2020), Christopher Unit (PICU) (installed 23 March 2021), Cedar Ward (installed 11 May 2021), Kelvedon Ward (installed 7 December 2021), Roding Ward (installed 23 September 2021), Longview Ward (installed 15 February 2021), and Henneage Ward (installed 16 July 2021).

352. The Trust considers the presence of a downward trend in ligature incidents on a number of wards following the installation of Oxevision to be an important and encouraging finding. Whilst the Trust does not suggest that this reduction can be attributed solely to Oxevision, the correlation between installation and a sustained reduction in incidents on multiple wards is notable and is consistent with the system contributing positively to patient safety outcomes. The Trust acknowledges, however, that a range of other factors will also have

contributed to changes in incident numbers on individual wards, including the Trust's focus on suicide prevention and reducing restrictive practice as quality priorities and the TTC operating model principles of trauma informed and therapeutic care using a fundamentals or care framework, periods of high reporting related to the acuity of particular admitted patients; increases in admissions of patients who require enhanced levels of engagement and supportive observations due to risks of self-harming and active suicidal ideation; patients with longer lengths of stay due to the complex nature of their presentation; length of stay on assessment units waiting for a treatment bed; high numbers of patients with particular diagnoses; patients copying self-harming behaviours from one another; and extremely high ward activity. The Trust's position is that the downward trends identified are a significant indicator of the potential benefit of the system, and that the data warrants continued monitoring and further analysis to better understand the extent of Oxevision's contribution relative to these other variables. During the further review recommended by the rapid review the benefits of the system will also be considered in order for the Trust to make informed decisions incorporating any patient safety features.

***Whether incidents of self-harm are being identified by use of the Vital Signs function***

353. The Trust does not have quantitative evidence or systematic analysis of the Vital Signs function being used to identify incidents of self-harm. However, the Trust is aware, through anecdotal reports from clinical staff, that there have been occasions on which a member of staff, in the course of using the Vital Signs function, has observed evidence of a self-harm attempt via the clear-view video footage and has been able to intervene at an earlier stage than might otherwise have been possible. The Trust acknowledges that this gives rise to a tension: the Standard Operating Procedure provides that the clear-view video feed available through the Vital Signs function must only be used for the purpose of taking vital signs observations, and any use of that feed for a purpose other than the taking of vital signs — including to check on a patient's safety — falls outside the permitted use of the system as defined by the SOP. The Trust therefore recognises that, whilst the earlier identification of a self-harm incident is a positive patient safety outcome, the means by which that identification occurred may not have been consistent with the SOP requirements governing the use of the Vital Signs function.

354. No Datix recording field currently exists to capture whether a self-harm incident was identified specifically via the Vital Signs clear-view video feed, as distinct from an Oxevision alert or other means of detection. The Trust is therefore unable to provide quantitative data on the frequency with which the Vital Signs function has contributed to the identification of self-harm incidents. The Trust's position remains that the Vital Signs function is not intended to be used as a means of monitoring patients for self-harm, and that any use of

the clear-view video feed beyond the taking of vital signs observations must be documented and is subject to the controls set out in the Standard Operating Procedure.

***Whether reliance on Oxevision has delayed, replaced, or reduced in-person observations, and how that risk is mitigated***

355. Oxevision is a supplementary tool to support patient safety and does not replace, and must not replace, required in-person supportive observations. Where instances of inappropriate reliance on Oxevision are identified, these are managed through existing supervisory and disciplinary processes in accordance with Trust SOP requirements.

**Datix Incident Analysis**

356. Where a Datix report is raised in connection with Oxevision, the report is received by both the Operations Oxehealth Specialist — Clinical Lead and the Oxevision Clinical Lead. Upon receipt, the handler is directed to the appropriate personnel within the relevant Care Unit for investigation and follow-up. The Care Units receive regular reports relating to Oxevision incidents and are responsible for reviewing those reports, identifying any trends or concerns, and taking appropriate action at local level. This process operates alongside the broader governance mechanisms described in the Inappropriate Use Identification and Response section above and the Oxevision Usage Reports section of Part B of this statement.

357. The Datix incident reporting form includes a specific field in which the reporter is required to indicate whether Oxevision was in use at the time of the incident. Where the field is completed affirmatively, the reporter is expected to include a descriptive narrative setting out how Oxevision contributed to the identification of or response to the incident. In practice, the Trust has identified that approximately half of all Datix reports in which the Oxevision field is marked as active do not include the accompanying narrative description.

358. The Trust has taken a number of steps to improve Datix reporting in respect of Oxevision. The Datix team has reiterated the requirement to include narrative descriptions during training sessions. The Operations Oxehealth Specialist — Clinical Lead routinely reviews Datix reports where a description of Oxevision use has been omitted and directs the handler to the relevant provisions of the Standard Operating Procedure, reinforcing the expectation that the circumstances of Oxevision's involvement in the incident are recorded in full.

359. In respect of whether incidents were identified in consequence of Oxevision alerts or the Vital Signs function, the Trust is not currently able to verify this distinction with confidence.

The Datix reporting form does not differentiate between incidents brought to staff attention by an Oxevision alert and those identified through the Vital Signs clear-view video feed. In the absence of an active user authentication process on the LIO platform, any attribution of an incident to a specific Oxevision function is dependent upon the accuracy and completeness of the individual staff member's account in the Datix narrative. The Trust is therefore unable to provide quantitative data on this point.

360. The Trust has not undertaken a formal comparative analysis of incident data between wards using Oxevision and those not using the system. No before-and-after implementation comparison or cross-service unit analysis has been conducted to date. The Trust acknowledges that such an analysis could provide valuable insight into the impact of Oxevision on incident identification and patient safety outcomes, and will give consideration to whether such work can be undertaken as the data set and analytical capability develop.

**Project Board Oversight and Governance Structure**

**Project Board and Leadership Roles**

361. This section addresses the respective roles of the Oxevision Project Board, the Operations Oxehealth Specialist — Clinical Lead, the Quality Matron, and the Deputy Director of Quality and Safety in monitoring the use of the Oxevision system and compliance with the Standard Operating Procedure. Each of these roles operates within a distinct layer of the Trust's governance framework, and together they provide a structured system of oversight spanning programme management, clinical assurance, ward-level quality monitoring, and strategic quality and safety leadership.

362. The implementation of the Oxevision system has been overseen by the Trust's Oxehealth Project Board. The Project Board is not responsible for the operational use of the system on the wards, as this is dealt with by the Care Units. The Project Board is a programme management body, not a clinical governance forum. Whilst data trends and concerns arising from usage reports may be raised in the context of the Project Board, clinical concerns identified from the data are expected to be addressed through Care Unit Quality and Safety meetings, Care Unit Accountability Framework meetings, and locally at ward level.

363. EPUT has an Operations Oxehealth Specialist – Clinical Lead whose role is to: provide quality insights and experience; audit ward-level activities to ensure compliance and effective operations; provide insights to clinical practices and the application of the project products; act as a next-level engagement point for escalations; provide clinical recommendations to the Project Board; and provide insight and coordination with the

Project Board to enable continuity in the delivery of Oxevision and Oxevision Observations during project development, delivery, and business as usual. (First Statement of Zephan Trent paragraph 64).

364. The Trust did not have a Trust Wide Quality Matron role. The Mental Health Inpatients Care Unit had a quality matron role from approximately January 2024 until 2025. That role was specific to the mental health inpatients care unit and was not a trust-wide position. More broadly, the Trust matron role incorporates quality leadership within its standard roles and responsibilities; accordingly, quality assurance at ward and service level is embedded within the matron function across the Trust as part of routine clinical governance, rather than being dependent upon a single trust-wide post.

365. The Deputy Director of Quality and Safety role has been in place since October 2022 as a member of the care unit leadership triumvirate, with joint leadership accountability alongside the Service Director and Deputy Medical Director. The role carries specific responsibility for the delivery of quality and safety governance within the care service group. The Deputy Director of Quality and Safety is accountable for ensuring that high quality, safe care is delivered within services and for providing professional leadership to the nursing workforce. The post holder is responsible for ensuring that clinical staff have the knowledge, capability, systems, and support to deliver care and embed lessons learned in practice for the improvement of patient care. The role includes leading on the development, maintenance, and improvement of clinical governance and patient safety systems and processes, and taking a Trust lead on specific work programmes including professional practice and the national safety priorities of reducing restrictive practice and, preventing suicides. The Deputy Director of Quality and Safety actively participates in and monitors all service issues relating to professional practice and clinical governance, ensures that all clinical teams participate in appraisal and clinical supervision, and ensures that standards of professional practice and behaviour are met within the service. In the context of Oxevision, the Deputy Director of Quality and Safety's role in monitoring use and SOP compliance operates through the care unit governance structures described above, including oversight of usage report data, Tendable audit outcomes, and the escalation of concerns through Quality and Safety meetings and Accountability Framework meetings. The structured intervention on the Brockfield House wards described in the Oxevision Usage Reports section of this statement, which produced a measurable reduction in inappropriate vital signs use, was led by the Deputy Director of Quality and Safety for Specialist Services and illustrates the practical application of this role in driving compliance with the Standard Operating Procedure at ward level.

**Project Board Minutes**

366. EPUT exhibits the available minutes of the Oxevision Project Board as **[KSZT01-014 to KSZT01-065].**

**Equality Impact Assessments**

367. The Trust prepared an Equality Impact Assessment ('EIA') dated 29 April 2025 designed to make sure that any policies, services and functions do not discriminate in line with the Equality Act (2010). The EIA was attached to the Oxehealth Standard Operating Procedure on submission to the Board/Executive Team to approve a proposed amendment and review. The author of the EIA was required to gauge the impact of the proposals against marginalised and minority groups.

368. To assist in preparing the EIA, the author sought the views of a variety of people to ensure the Trust aligned to the voices of patients, their loved ones and staff in any future changes and next steps. This was achieved by holding a focus group for people who have experienced the Trusts services and holding ward specific community meetings with current inpatients.

369. Separately from the EIA process, a focus group was held online on 25 March 2025 which included 8 participants (with a further 2 contributing via email) made up of a mix of staff, patients and carers/friends. The focus group was not convened specifically for the purposes of the EIA; rather, it was designed as a broader listening opportunity to hear about people's experience of using Oxevision within the adult inpatient setting. The intention was, as a group, to co-reflect and discuss thoughts and ideas which could enhance the understanding of the use of Oxevision.

370. As a priming exercise, the group were initially introduced to Oxevision via a short presentation and video, after which the questions and discussion began. Questions focused on participant's views of the purpose of Oxevision, experience of Oxevision, understanding of consent around Oxevision and suggestions of improved ways of working.

371. The full duration of the focus group was 2 hours, and a feedback summary report was produced based on thematic analysis and which outlines the key feedback and findings – **[Exhibit KSZT01-066].**

372. 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.

373. The feedback from this focus group was subsequently drawn upon by the author of the Standard Operating Procedure in producing v12, and was relied upon by the author of the

EIA, to inform decision making and ensure the changes made aligned with the views of patients, carers and staff prior to sign off.

374. The EIA describes the SOP review as informed by both the engagement sessions and the new NHS England national guidance. The changes made to the SOP included a review of the consent and capacity process and dignity and respect provisions, completed in co-production with patients, families, and staff, and informed by new NHS England guidance issued in February 2025.

**Oxevision Usage Reports**

375. EPUT exhibits the Oxevision usage reports for June, August, September 2024 and June-September 2025 inclusive, **[KSZT01-067 to KSZT01-073].**

376. Each monthly usage report provides, for every ward: (1) the number of vital sign attempts each day, split between day and night, with trend lines; (2) the speed of alert resets each day across the preceding month; (3) usage of each device over the month; and (4) a list of all devices assigned to the ward and whether — and when — each was last used. Key terms are defined in the report itself: "Alert Reset Speed" is the time between an alert being triggered and being reset; "Vital Sign Attempts" is the number of times a member of staff accesses the device and clicks "Take Vital Signs."

377. As Mr Trent explained at the October 2025 hearing, the "Vital Signs Attempts" metric captures each instance in which a member of staff accesses up to 15 seconds of clear-view video feed as part of the vital signs workflow — the clear-view feed being integral to the process, as staff are required to identify the red reference dots on the patient's body in order to obtain a reading; "Vitals Displayed" records the number of successful, complete vital signs readings obtained through that workflow.

378. From August 2025 usage reports also capture "Device Usage" (counting interactions with either vital sign or alert reset functionality) and "Oxevision Time Switched On" (the total time the system was active across all rooms during the month), expressed as a percentage.

**How EPUT interrogates data on vital signs attempts and on alerts and alert reset speed**

379. Oxevision usage reports are provided to matrons and ward managers on a weekly and monthly basis for local monitoring and discussion with staff. The reports allow matrons and ward managers to identify how Oxevision is being used by staff and show how many alerts have been raised and how quickly they were responded to, or reset, by staff. Ward managers and matrons consider whether there is a legitimate reason for higher usage e.g.

changes in patient acuity or patient movement and restlessness leading to failed vital sign attempts. In addition, the Oxevision Project Board oversees these reports on a monthly basis at Trust-wide level.

380. Each monthly usage report is structured to present both categories of data in a visual and tabular format at ward level. Under the heading "How many vital sign attempts have been made?", the reports display a daily bar chart split into day-time (08:00–20:00) and night-time (20:00–08:00) attempt volumes for the entirety of the preceding month, enabling matrons and ward managers to identify peaks, troughs, and changes in usage patterns over time. Under the heading "How many alerts have you had and how quickly are they reset?", the reports display daily total alert volumes alongside a stacked percentage breakdown of how quickly those alerts were reset, divided into four bands: 0–15 seconds; 16–120 seconds; 2–30 minutes; and 30+ minutes. The four reset-speed bands used in the August 2025 reports are: 30+ minutes, 2–30 minutes, 16–120 seconds, and 0–15 seconds. An all-ward summary table is also produced showing, for each ward, the total vital sign attempts and total vitals displayed for the month.

381. The usage reports are provided to the Care Unit leadership teams on a monthly basis. Oxevision is a standing focus within the Accountability Framework and is regularly discussed at Accountability Framework meetings. The information derived from the usage reports informs the Trust's approach to staff training, the audit process, including the decision to increase the frequency of audits from monthly to fortnightly, with an enhanced level of detail in respect of practice, training, and consent, and broader service improvement.

382. Oxevision vital signs usage has additionally been made a standing item on the Quality and Safety meeting for inpatient areas.

383. A further structured layer of audit-based interrogation exists through the Tendable audit system. The audit requires checking the Oxevision equipment, materials, and governance on the ward. Staff understanding of the SOP is assessed by interviewing a minimum of two staff members, and a minimum of three patients are spoken to as part of the assurance that the SOP is being followed. (Third Statement of Zephan Trent at paragraph 35).

**Trends identified from review of the usage reports**

***Vital signs attempts versus vitals displayed***

384. The most significant and persistent trend identified from the usage reports is the material discrepancy between the number of vital sign attempts recorded and the number of

successful vital sign readings ("vitals displayed") obtained. From the July 2024 data, Mr Trent agreed that the discrepancy between vital sign attempts and successful vitals displayed exists across all wards, is a theme that exists because it may take multiple attempts to obtain a successful vital signs reading, and is a wider issue not confined to July 2024.

385. At the October 2025 hearing, Mr Trent illustrated the discrepancy between attempts and successful readings using the July 2024 report: Cherrydown Ward recorded approximately 10,000 attempts against 4,200 vitals displayed (a 42% completion rate); Ardleigh Ward recorded 35,665 attempts against only 9,413 vitals displayed (approximately 25% completion)

386. The all-ward summary for August 2025 confirms this pattern continues across the Trust. In August 2025, Ardleigh Ward recorded 35,815 vital sign attempts against 13,711 vitals displayed (approximately 38% completion rate); Beech Ward recorded 22,204 attempts against 9,010 displayed (approximately 41% completion rate); Willow Ward recorded 20,364 attempts against 10,212 displayed (approximately 50% completion rate); Grangewater Ward recorded 20,351 attempts against 7,901 displayed (approximately 39% completion rate); Cherrydown Ward recorded 20,069 attempts against 7,545 displayed (approximately 38% completion rate); and Peter Bruff recorded 26,899 attempts against 12,264 displayed (approximately 46% completion rate).

387. The all-ward usage summary for August 2025 records a grand total of 459,320 vital sign attempts and 191,705 vitals displayed across the Trust, a 41.7% completion rate.

***Alert reset speed variability***

388. The Inquiry highlights "wide variability" in the proportion of Oxevision alerts reset within 15 seconds across wards and dates, citing July 2024 examples: Alpine Ward 94% on 23 July 2024; Grangewater Ward 78% on 1 July; Forest Ward and Willow Ward often below 50%.

389. In August 2025, Alpine Ward recorded proportions of alerts reset within 0–15 seconds rising to 94% and 84% on individual days. By contrast, Beech Ward in August 2025 recorded daily proportions in the 0–15 second band ranging between 62% and 76%. Willow Ward in August 2025 recorded daily proportions in the 0–15 second band ranging between 61% and 77%.

***Device usage***

390. The usage reports consistently reveal that device interactions are concentrated on a subset of assigned devices. In August 2025, Ardleigh Ward's device usage was concentrated on tablets 01, 02, 03, 12, 13, and 14, with the display unit recording 1,153 interactions and tablet 12 recording the highest tablet usage at 7,795 interactions. The reports also flag devices that were not used during the reporting month.

**Differences Across Wards and Over Time**

391. Ward-level differences may have legitimate explanations such as changes in patient acuity (higher acuity may mean more observations and more recordings), and circumstances affecting the completion or failure of vital sign attempts, for example patients moving around leading to more failed attempts. (Transcript of hearing 14 October 2025 page 28 line 15 – 24).

392. In the October 2025 hearing, the Ardleigh Ward reset speed data for the relevant period showed the majority of alerts being reset within 15 seconds on each day, with daily proportions ranging from 59% to 86% within the 0–15 second band.

393. Mr Trent acknowledged that whilst fast resets may reflect staff being near the patient or having recently checked, it is also possible that staff reset alerts before undertaking an in-person attendance, which would be contrary to policy. However, delayed resets are not inherently non-compliant: if staff attend a patient during a clinical crisis they may appropriately prioritise patient care before returning to reset the alert; a delay of over two minutes would, however, be too long if it indicated non-attendance. The report data cannot, on its face, distinguish between these scenarios.

394. Mr Trent acknowledged that the report data alone cannot determine the cause of the discrepancy: possible explanations include patient movement, multiple people in rooms, or inappropriate use of the system. Mr Trent accepted that the high attempt counts relative to vitals displayed raise the possibility that staff were accessing the 15-second clear-view video feed on repeated occasions beyond the purpose of the vital signs workflow — in effect using the "Take Vital Signs" pathway as a means of viewing patients via video without completing a vital signs check. He confirmed this would constitute inappropriate use.

**Measures Taken in Response to Usage Report data**

395. EPUT had taken a series of measures in response to the trends identified in the usage report data, including the use of Tendable audits and Matron audits focused on Oxevision and its use.

396. EPUT has strengthened oversight including Project Board oversight, Quality and Safety groups, and sharing reports with wards.

397. Usage reports are reported into care unit meetings. Whilst data trends and concerns arising from usage reports may be raised in the context of the Project Board, the Project Board's remit does not extend to clinical matters; the expectation is that clinical concerns identified from the data are picked up in the appropriate meetings, such as care unit Quality and Safety meetings, care unit Accountability Framework meetings, or more locally at ward level.

398. The governance flow for usage report data therefore operates on the following basis: reports are distributed to ward managers and matrons for local review; they are escalated to care unit Quality and Safety meetings and Accountability Framework meetings where trends are considered and action agreed; and they are overseen at Trust-wide level by the Project Board, which receives monthly reports. Oxevision vital signs usage has been made a standing item on the Quality and Safety meeting for inpatient areas.

399. In response to the risk that staff might take additional views via repeated use of the vital signs clear-view workflow beyond what policy permits, EPUT's latest policy and staff communications were made explicit that additional observations taken in this way are a misuse of the system. Where this does occur, it must be documented to explain why. The prohibition on repeated use of the system to obtain continued 15-second clear views is addressed via policy, training, and professional standards. The SOP was changed in version 12, released 7 May 2025, to call out this misuse issue explicitly, and this was further highlighted in staff communications.

400. In the Brockfield House wards within Specialist Services, usage report data shows that from November 2025 through to January 2026 there was a significant reduction in inappropriate vital signs use. This improvement was driven by a structured six-step intervention led by the Deputy Director of Quality and Safety for Specialist Services. The intervention comprised the following steps:

- Setting out the standards and expectations, and linking to observations and engagement guidance;
- Raising awareness with leads and staff, and urgency to change practice;
- Discussing with staff their practice and concerns, and why they may use the system in a particular way;

- Reiterating how the system should be used and, in particular, having conversations around patient consent, care planning, documentation, and raising an incident form where used inappropriately;

- Utilising relevant staff forums to have these discussions; and

- Using data to show improvements.

401. This example demonstrates that where usage report data is actively used to drive targeted, ward-level engagement — with clear standards set, staff forums utilised, and data tracked as a feedback mechanism — it can produce a measurable and sustained reduction in inappropriate use within a defined timeframe.

**How EPUT Assesses the Impact of Measures Taken**

402. EPUT uses data from the monthly usage reports to show improvements over time, including tracking whether interventions at ward and care unit level have resulted in a reduction in the metrics of concern. The Brockfield House wards example — showing a significant reduction in vital signs use across November 2025 to January 2026 — illustrates that this data-tracking approach enables the Trust to evidence the impact of targeted interventions with measurable outcomes over successive reporting periods.

403. EPUT is in the process of a further review to determine the system and practice requirements for any future use of LIO.

**Whether EPUT has identified indicators of inappropriate, excessive, or inconsistent use, and how these have been addressed**

404. The discrepancy between vital sign attempts and successful vitals displayed is acknowledged by EPUT. It is possible staff have repeatedly used the vital signs function but this is not indicative of inappropriate or excessive use. In order to avoid inappropriate or excessive use EPUT has responded through explicit policy requirements in SOP v12 and staff communications, alongside controls via policy, training, and professional standards. A review of monthly LIO reports conducted as part of the rapid review in May 2026 identified very high volumes of vital signs attempts trust-wide: 306,085 attempts in April 2026 and over 350,000 attempts in March 2026. The rapid review stated that Vital Signs attempts function may have been attempted to monitor patients pulse and respiratory rates, in accordance with the LIO SOP. This will be explored further by the independent review as it was not feasible to undertake a detailed analysis in the rapid review.

405. EPUT acknowledges the high number of vital signs attempts and has previously noted ~~but notes~~ that the data alone does not enable the Trust to determine the extent to which this is attributable to legitimate clinical reasons or to system misuse. There are a range of legitimate reasons why vital signs attempts may not result in a successful reading, including patient movement, interference from phones and tablets, the presence of light sources, attempts made whilst the status tile is amber or red, and technical failures.

406. The high proportion of alerts being reset within 0–15 seconds on certain wards has been noted as a potential indicator of staff resetting alerts remotely without attending patients in person. Mr Trent acknowledged that whilst fast resets may reflect staff being near the patient or having recently checked, it is also possible that staff reset alerts before undertaking an in-person attendance, which would be contrary to policy. EPUT has addressed this through SOP v12, staff communications, and the Tendable audit process, which assesses staff understanding of, and compliance with, the requirement to attend patients in person before resetting an alert. The rapid review further identified that a time lag in the delivery of alerts to handsets has been reported by frontline staff, and this will be considered further as part of the LIO Steering Board.

407. The information derived from the usage reports informs the Trust's approach to staff training, the audit process, including the decision to increase the frequency of audits from monthly to fortnightly with an enhanced level of detail in respect of practice, training, and consent, and broader service improvement.

**Board and Committee Oversight**

408. EPUT exhibits the minutes/papers from Trust Board, Quality Committee, Digital/Clinical Safety Group where Oxevision data/risks/benefits/incidents have been discussed, **[KSZT01-074 to KSZT01-106].**

409. EPUT exhibits the minutes of the November 2025 Quality Committee Oxevision ‘deep dive’, and any associated audit, **[KSZT01-107 and KSZT01-108].**

**Tendable Audits**

410. This section addresses the Tendable audit programme, including its scope, frequency, and the mechanisms by which compliance with the Standard Operating Procedure is monitored.

411. In Quarter 3 of 2024/2025, EPUT launched a new suite of Quality Assurance Audits via Tendable. The go-live date for Mental Health Inpatients was 9 October 2024, and for CAMHS/Secure wards, 2 December 2024. The Oxevision Audit is carried out on a fortnightly basis and may be carried out by a Qualified Staff Member or a Healthcare Assistant (HCA). Monthly reports are generated for all Quality Assurance Audits carried out on Tendable and shared with all ward managers, matrons, service managers, and the care unit leadership team, in preparation for discussion at the relevant care unit Quality Safety Group.

412. Individual audit reports for the period 9 October 2024 to 31 December 2024 for the following wards, on the dates set out below, are provided:

- Ardleigh: 28/11/2024 **[Exhibit KSZT01-109]**
- Grangewaters: 18/10/2024; 21/10/2024; 31/10/2024; 08/11/2024; 12/11/2024; 17/11/2024; 21/11/2024; 28/11/2024; 29/11/2024; 01/12/2024; 03/12/2024; 04/12/2024; 10/12/2024; 16/12/2024; 22/12/2024; 23/12/2024; 25/12/2024; 30/12/2024 **[Exhibit KSZT01-110 to KSZT01-127]**
- Peter Bruff: 24/10/2024; 18/11/2024; 28/11/2024 **[Exhibit KSZT01-128 to KSZT01-130]**
- Poplar: 31/12/2024 **[Exhibit KSZT01-131]**
- Alpine: 08/12/2024; 23/12/2024 **[Exhibit KSZT01-132 and KSZT01-133]**

413. It should be noted that within some reports, the question "Are there any problems with WIFI affecting the use of Oxevision tablets?" was recorded with a 'negative' response when 'No' was answered. This was an incorrect scoring error within the Tendable system, which was rectified in mid-November 2024. A 'No' response should have generated a positive (green) score; a 'Yes' response should have generated the negative score.

414. The Inquiry asks EPUT to identify the part of the Tendable audit form which is intended to assess compliance with the SOP provision that staff are not permitted to use the Oxevision Observation function to access patients without a clear clinical rationale, and to explain how it achieves that aim. The Standard Operating Procedure states [EPUT009884_0011]: 'Staff are not permitted to use the Oxevision Observation function to access patients without a clear clinical rationale. This is monitored through the Tendable auditing system'.

415. The part of the Tendable audit form [INQEPUT010153_0001] which is most directly intended to assess compliance with that SOP provision comprises three questions within the Staff Training and Feedback section. The Staff Training and Feedback questions are:

416. "Can you explain when it is appropriate to take vital signs?"

417. "Can tell me what you would do in response to an Oxevision alert?"

418. "Can tell me in what circumstances would you be required to request CVD footage? Explain to me how you request CVD footage."

419. These questions are posed directly to individual members of staff during the audit and are designed to test whether staff understand the circumstances in which it is and is not appropriate to access patient data through the Oxevision system. By requiring staff to articulate when it is clinically appropriate to use the various functions — including the vital signs and clear video data functions — the audit tests in practical terms whether staff understand the principle that access to patients via Oxevision requires a clear clinical rationale, as mandated by the SOP.

420. In summary, the Tendable audit form seeks to achieve compliance monitoring with the SOP provision in two principal ways. First, by testing staff knowledge: the direct questions posed to individual members of staff about when it is appropriate to use the various Oxevision functions — including the vital signs function and the clear video data function — test whether staff are aware of the restriction on using the Observation function without a clear clinical rationale. The questions asking staff to explain when it is appropriate to take vital signs, what they would do in response to an Oxevision alert, and in what circumstances they would be required to request CVD footage are all directed at assessing whether the individual has internalised the requirement that access to patients via Oxevision must be clinically justified.

**Equipment Functionality and Faults**

421. EPUT has a contractual arrangement with Oxehealth for the provision of ongoing technical support in respect of the Oxevision system. Service level agreements are in place governing the scope and timeliness of that support, and any issues identified with the equipment are reported to Oxehealth in accordance with those arrangements.

422. In practice, any failure or malfunction of the equipment would become apparent to ward staff almost immediately, given the extent to which the system is integrated into the day-to-day functioning of the ward. Where such issues arise, ward staff escalate the matter

promptly so that appropriate support can be requested and any necessary remedial action taken without delay.

423. Schedule 2 of the Oxehealth Service Level Agreement outlines the scope of support that LIO provides in respect of all LIO assets used by EPUT. Section 7.2 of the Oxehealth Service Terms for Hardware provides: “Save for damage to the Hardware as covered by section 7.3, all maintenance, repair and replacement of defective Hardware shall be at Oxehealth’s cost and shall be carried out in accordance with the SLA.” As a managed system, LIO is responsible for monitoring the platform for faults or failures. Any device failures — including failures affecting tablets or monitors — must be reported to the LIO Support Desk so that repair or replacement can be arranged in accordance with the agreed service terms.

424. If for any reason there is a technical failure or malfunction of the Oxevision system, staff should continue to provide patient care without the support of the Oxevision system. There may be a requirement to review individual care plans during the period of technical failure to maintain patient safety with alternative methods. The technical failure must be reported urgently but staff remain responsible for patient safety and clinical judgement must be used at all times.

425. When the Oxevision system is unavailable, business continuity processes are applied and clinical staff are to ensure that the CG100 Clinical Guideline is applied and patients' Therapeutic Engagement and Supportive Observations are recorded on paper and scanned into the electronic patient record.

**Contingency Planning**

426. EPUT has considered and planned for scenarios in which the Oxevision system is unavailable or its functionality is reduced, whether by reason of technical failure, contractual issues, safety concerns, or policy change. The Trust's position, as reflected in the Standard Operating Procedure, is that Oxevision is a supplementary tool which supports, but does not replace, the clinical requirements for therapeutic engagement and supportive observation under the CG100 Clinical Guideline. Accordingly, the Trust's contingency planning proceeds from the premise that patient care would remain safe in the absence of Oxevision, because the underlying clinical observation framework — including in-person observations at the frequency required by each patient's prescribed observation level — continues to operate independently of the system.

427. In the event that the Oxevision system becomes unavailable on a ward, whether through technical failure, planned maintenance, or any other cause, business continuity processes

are applied. Clinical staff are required to ensure that the CG100 Clinical Guideline is applied in full, and that all patient observations are recorded on paper and subsequently scanned into the electronic patient record. Individual care plans are reviewed during the period of unavailability to ensure that patient safety is maintained through alternative methods. Any technical failure is required to be reported urgently, and staff remain responsible for the exercise of clinical judgement at all times.

428. The Trust recognises that the unavailability of Oxevision would have operational implications for staffing, workload, and ward processes. In particular, the absence of the system would remove the capacity for non-intrusive contactless monitoring during night-time hours, which could result in those observations being more intrusive for patients, particularly during periods of rest. Ward staff would also be required to revert to manual recording processes, with a consequent increase in administrative burden.

429. The Trust has established systems and controls which manage the risks associated with the unavailability of the Oxevision system. These controls are not unique or specific to Oxevision but extend to cover its operation: they comprise the business continuity processes described above, the requirements of the Standard Operating Procedure, and the continued application of the CG100 Clinical Guideline, which together ensure that patient safety is not dependent upon the availability of the Oxevision system. In respect of financial implications, the Trust has utilised a business case process to determine whether to expand its use of Oxevision; however, it has not undertaken a post-implementation comparative cost analysis between the current model of care supported by Oxevision and a counterfactual scenario in which the system is not available.

**Data Protection and SIRO Matters**

**Data Protection Impact Assessments**

430. EPUT exhibits copies of all current and former DPIAs relating to Oxevision system (including Oxevision, OxeObs, Vital Signs), **[KSZT01-134 to KSZT01-137].**

**Service Agreements**

431. EPUT exhibits all service agreements between the Trust and Oxehealth/LIO, **[KSZT01-138 to KSZT01-140].**

**Data Protection - Ownership, Storage, Use, Access and Retention**

432. The Inquiry asks EPUT to describe its understanding as to who owns the rights to: (a) clear video data; (b) anonymised video data; (c) vital signs data; (d) OxeObs observation records; (e) user interface output data; (f) algorithm processed data; and (g) any other patient health record data produced within the system. Pursuant to clause 3.2 of the Oxehealth Service Terms, ownership of intellectual property rights in the data sets generated by the Oxehealth Software is governed by the Oxehealth Generated Data Guide set out at Schedule 3. In answering this section, the authors of the statement have relied on information provided by EPUTs Associate Director of Electronic Systems and Information Governance and Data Protection Officer. References to EPUT as Partner reflect the way in which EPUT is described in the Oxehealth Service Terms.

433. EPUT's understanding of ownership in respect of each category is as follows:

(a) Personally Identifiable Clear Video Data (CVD)

434. CVD is classified as personal data and is owned by EPUT as Partner. CVD constitutes the raw video or still footage captured by automatic operation of the Oxehealth Service when it contains images of data subjects, and is therefore personal data.

(b) Anonymised (Blurred) Video Data (AVD)

435. AVD is classified as non-personal data and is owned by EPUT as Partner. AVD is created during the automatic running of the Oxehealth system by applying an irreversible blurring technique to the raw video feed, such that no individual is identifiable from the video.

(c) Vital Signs Data / Patient Health Record Data (PHRD)

436. PHRD, which encompasses vital signs data generated by the Oxehealth Vital Signs module as well as other patient observation data generated through the Oxehealth Software modules, is classified as personal data and is owned by EPUT as Partner. PHRD generated by the Oxehealth Software during the course of patient observations may include vital signs, and other patient observation data such as location.

(d) OxeObs Observation Records (Patient Health Record Data)

437. Observation records entered via the OxeObs (Oxevision Observations) interface constitute Patient Health Record Data (PHRD) and are classified as personal data owned by EPUT as Partner. The purpose of PHRD is to provide clinicians with the observation data required to manage and care for their patients through the use of certain Oxehealth Software modules.

(e) User Interface Output Data (UIOD)

438. UIOD is classified as non-personal data and is owned by EPUT as Partner. UIOD is a representation of the data provided to clinicians via the user interface, and may include alerts, location information, or vital sign measures such as breathing or heart rate. UIOD does not contain Personal Data.

(f) Algorithm Processed Data (APD)

439. APD is classified as non-personal data and is owned by Oxehealth/LIO. APD is made up of mathematical results from various processing stages of the Oxehealth algorithms and does not contain Personal Data. Oxehealth owns all right, title and interest in APD, and for the avoidance of doubt APD constitutes Oxehealth Confidential Material.

(g) Other data — Staff Identification Data (SID) and System Performance Data (SPD)

440. Staff Identification Data (SID) is classified as personal data and is owned by EPUT as Partner. SID consists of names and email addresses of individual members of staff, processed and retained by the local secure server as part of user identification in Oxehealth's software modules.

441. System Performance Data (SPD), which is made up of system and user interface diagnostic data and does not contain Personal Data, is owned by Oxehealth/LIO.

442. In summary, the data categories owned by EPUT are: CVD, AVD, UIOD, PHRD, and SID. The data categories owned by LIO/Oxehealth are: Empty Room Video Data (ERVD), APD, and SPD.

443. The SLA Schedule 3 Generated Data Guide defines where data is stored, and Schedule 4 defines who has access to it and for what purposes. EPUT's understanding in respect of each data category is as follows:

(a) CVD — Storage

444. Day-to-day, CVD is stored on the local secure server at the Partner location (i.e. at EPUT) and retained for up to 24 hours before being deleted. This short retention period reflects the fact that CVD constitutes personal data containing identifiable images of patients, so it is kept for the minimum time necessary. In certain circumstances — specifically when a request or decision is made to "clip" the CVD (i.e., to save a specific segment of the footage, for example following a clinical incident or for investigative purposes) — the data

may also be stored on Oxehealth's secure server and on a Network Attached Storage (NAS) Device at the partner location.

445. The default position is that clear video footage is automatically overwritten after 24 hours, but if there is a reason to preserve a particular segment (such as for incident review, a coroner's inquiry, or police investigation), it can be clipped and retained in more permanent storage.

446. CVD collected from the local secure server is received by EPUT by encrypted transmission services. It is then downloaded to a local folder and uploaded to a restricted-access SharePoint folder and logged. The uploaded CVD is checked for quality, and the locally downloaded version is deleted so that only the SharePoint version is retained.

**CVD — Access**

447. Within EPUT, folder access to CVD is restricted to Lara Brooks (Legal), Claire Sladden (DPO), and Derrick Trimble (system manager). Access to view CVD or AVD requires DPO approval. Access within the Trust is view only.

448. As regards LIO/Oxehealth's access, CVD may be accessed by Oxehealth personnel for the following purposes: day-to-day operation (capture of CVD, storage, creation of AVD, and application of algorithms); performance issue resolution; and, at Partner's instruction, for the purposes of a Serious Incident Review.

449. External approved access — for example, by the Coroner's Court or Police — requires formal processes for evidence release, and on approval, CVD/AVD is uploaded via an encrypted service provided by the recipient.

(b) AVD — Storage and Access

450. AVD is created during the automatic running of the Oxehealth system by applying an irreversible blurring technique to the raw video feed so that no individual is identifiable from the video. This feed is compressed and encrypted and securely delivered via an encrypted transfer over an encrypted VPN connection to the Oxehealth remote servers, and, if required, to its secure servers. AVD may be used by Oxehealth to address potential performance issues and improve the Oxehealth Software.

451. Day-to-day, AVD is stored on the local secure server at the Partner location until it has been backed up to the remote server (Amazon Web Services, UK), where it is retained until the end of the contract term, until it is no longer needed, or until EPUT instructs

Oxehealth to delete it, whichever is earlier. On an occasional basis, AVD may be stored on Oxehealth's secure servers.

452. AVD may be used by Oxehealth to address potential performance issues and to improve the Oxehealth Software. The same internal EPUT access controls applicable to CVD apply to AVD.

(c) PHRD (including Vital Signs and OxeObs records) — Storage and Access

453. PHRD consists of patient information generated by the applicable Oxevision modules.

454. PHRD is stored on the local server and backed up to the remote server (AWS, UK) for the duration of the patient's stay, and following notification of a patient's discharge, for an additional period of up to 30 days on the local server and up to 60 additional days on the remote server for the purpose of providing data backups to EPUT. Thereafter it is deleted from both. PHRD may also be transferred back to EPUT's Electronic Patient Record (EPR) via a secure connection.

(d) UIOD — Storage and Access

455. Day-to-day, UIOD is stored on the local secure server at the Partner location until it has been backed up to the Remote Server (AWS, UK), retained until the end of the contract term, until it is no longer needed, or until EPUT instructs Oxehealth to delete it. UIOD may be used by Oxehealth to address potential performance issues, to improve the Oxehealth Software, to support serious incident reviews at Partner's request, and to generate reports and insights delivered to EPUT in respect of their use of the Oxehealth Software.

456. On request, Oxehealth/LIO can provide EPUT with a range of reports enabling EPUT to see how staff are using data, including monthly reports such as usage and stopped-room reports.

(e) APD — Storage and Access

457. Day-to-day, APD is stored on the local secure server at the Partner location until it has been backed up to the Remote Server (AWS, UK), retained until the end of the contract term, until it is no longer needed, or until EPUT instructs Oxehealth to delete it. APD may be used by Oxehealth to address potential performance issues and improve the Oxehealth Software. As Oxehealth's Confidential Material, APD is not accessible by EPUT.

(f) SID — Storage and Access

458. SID is stored on the local secure server at the Partner location and retained for up to 30 days after the associated data is deleted, and is then backed up to the remote server (AWS, UK) for a further 30 days before being deleted. SID is processed to provide an audit trail of those staff adding, viewing, and modifying reports.

(g) SPD — Storage and Access

459. SPD is stored day-to-day on the Remote Server (AWS, UK) and retained until the end of the contract term, until it is no longer needed, or until EPUT instructs Oxehealth to delete it. SPD is owned by Oxehealth and is used to address potential performance issues and improve the Oxehealth Software.

460. The Inquiry asks EPUT to identify, for each data type generated by the LIO system, whether it constitutes personal data and/or special category data, whether it is anonymised within the meaning of the applicable regulations, and the basis for EPUT's view. In responding to these questions the authors of the statement have relied on information provided by EPUTs Associate Director of Electronic Systems and Information Governance and Data Protection Officer.

461. EPUT has assessed each category of data generated by the LIO system against Article 4(1) UK GDPR (personal data), Article 9 UK GDPR (special category data, specifically health data), and Recital 26 UK GDPR (the test for anonymisation), together with relevant guidance published by the Information Commissioner's Office ("ICO"), including "What is personal data?" and "Anonymisation: managing data protection risk".

462. In applying that guidance, EPUT has proceeded on the basis that identifiability is contextual: data constitutes personal data if an individual is identifiable by any means "reasonably likely to be used", including by staff within the Trust. Derived and inferred data remains personal data where it relates to an identifiable individual. True anonymisation is a high threshold, and data is only anonymised where identification is not reasonably likely by any party, taking into account all relevant circumstances. Where there is doubt, EPUT adopts a precautionary and accountability-based approach, treating data as personal and, where applicable, special category data.

463. In respect of clear video data generated by the LIO system, EPUT considers this to be personal data and special category data, and it is not anonymised. The data comprises visual recordings of patients within clinical settings, from which individuals are directly identifiable. In line with ICO guidance, visual images of individuals constitute personal data where a person can be recognised, including by those familiar with them. The footage

relates to individuals receiving care and reveals information about their physical or mental health and behaviour; it is therefore health data within Article 9.

464. In respect of data described within the LIO system as "anonymised" video data, EPUT considers this to be personal data and special category data, and it is not anonymised but rather pseudonymised. Although the system applies visual transformation techniques such as pixelation or silhouette rendering, the data relates to a specific patient in a specific room at a specific time, and is accessible within a controlled clinical environment where staff can reasonably re-identify the individual. Applying Recital 26 and ICO guidance, EPUT considers that re-identification remains reasonably likely, particularly when the data is combined with other information such as ward knowledge, timing, and patient allocation. Accordingly, the data does not meet the legal standard for anonymisation and is treated as pseudonymised personal data. As it continues to relate to patient condition and behaviour, it remains special category health data.

465. In respect of data produced by the LIO vital signs function, EPUT considers this to be personal data and special category data, and it is not anonymised. The data includes physiological measurements such as respiratory rate, pulse where available, and movement metrics, and is linked to identifiable patients within the Trust's systems. Under ICO guidance, such information clearly constitutes data concerning health. The data is not subject to anonymisation in clinical use.

466. In respect of records of patient observations made in the OxeObs system, EPUT considers these to be personal data and special category data, and they are not anonymised. These records form part of the patient's clinical observation record, including staff-entered observations, alerts, and responses, and are directly associated with identifiable individuals. They fall within health data under Article 9.

467. In respect of user interface output data, EPUT considers this to be personal data and, in the majority of cases, special category data, and it is not anonymised. This category includes dashboards, alerts, scores, and other system outputs presented to clinicians. Even where outputs are presented in abstracted or scored form, they relate to an identifiable patient and are used to inform care and clinical decision-making. ICO guidance confirms that data derived from personal data remains personal data where it relates to an individual. Where such outputs reflect or enable inference about health status, they constitute special category data.

468. In respect of algorithm processed data, EPUT considers this to be personal data and special category data, and it is not anonymised. This category includes processed or derived outputs such as behavioural indicators, risk flags, or pattern analysis. In line with

ICO guidance, derived or inferred data remains personal data if it relates to an identifiable individual. The outputs are generated from patient data and remain linked to specific individuals. As the outputs concern or enable inference about health or behaviour, they constitute health data under Article 9.

469. In respect of any other patient health record data produced or recorded within the system, EPUT considers this to be personal data and special category data, and it is not anonymised in operational use, save in strictly controlled secondary use scenarios where applicable. This category includes any additional data generated or stored within the system, such as metadata, audit logs, alerts, and integrations with electronic patient record systems. Where such data relates to an identifiable individual, it constitutes personal data under Article 4(1), and given the clinical context, it will generally constitute health data. Any anonymisation for secondary purposes would require a separate, case-specific assessment against Recital 26 and ICO guidance.

470. In summary, EPUT's consistent position, informed by ICO guidance, is that all categories of LIO system data listed above constitute personal data, as individuals are identifiable either directly or indirectly, including through contextual information available within the Trust. All such data constitutes special category health data, as it either directly records or enables inference about an individual's physical or mental health or condition. Data described as "anonymised" within the LIO system does not meet the legal standard for anonymisation under UK GDPR, because re-identification remains reasonably likely within the clinical environment and the data remains linked to individual care episodes. Accordingly, such data is treated as pseudonymised personal data, not anonymised data. EPUT adopts a deliberately cautious and consistent approach, aligned with the accountability principle and ICO guidance, and does not rely on anonymisation unless it can be demonstrated to meet the Recital 26 standard.

471. The Inquiry asks, for each data type, the circumstances under which EPUT and LIO are permitted to retain that data, how long they are permitted to retain it, and the purposes for which such data may be retained.

472. The retention parameters are governed by Schedule 3 (Generated Data Guide) and Schedule 4 (Description of Personal Data Processing) of the Service Agreement. EPUT's understanding for each category is as follows:

(a) CVD

473. Day-to-day CVD is stored on the local secure server at the Partner location on a rolling buffer of 24 hours, meaning that encrypted video from each room is held securely for 24 hours before being deleted and overwritten, making it irrecoverable.

474. Where CVD is clipped and extracted for performance issue resolution, it is retained until the performance issue is resolved (or until the end of the project if earlier), or, if required to support a medical device investigation, until that investigation is complete. Where CVD is clipped for a Serious Incident Review, it is not retained by Oxehealth unless specifically instructed by EPUT.

475. CVD requests should be made only to support an investigation into a serious incident involving actual or suspected harm to a patient or member of staff.

(b) AVD

476. Day-to-day, AVD is stored on the local secure server at the Partner location until it has been backed up to the remote server (AWS, UK), where it is retained until (i) the end of the contract term, (ii) it is no longer needed, or (iii) EPUT instructs Oxehealth to delete it, whichever is earlier. The same retention terms apply on an occasional basis when stored on Oxehealth's secure servers.

477. The practical retention period for AVD is therefore up to two years (the duration of the contract term unless earlier), subject to the circumstances described. AVD may be used by Oxehealth to address potential performance issues and improve the Oxehealth Software.

(c) PHRD (including Vital Signs and OxeObs data)

478. PHRD is stored on the local server and backed up to the remote server (AWS, UK) for the duration of the patient's stay, and following notification of a patient's discharge, for an additional period of up to 30 days on the local server and up to 60 additional days on the remote server for the purpose of providing data backups to EPUT. Thereafter it is deleted from both the local server and remote server. PHRD may also be transferred back to EPUT's EPR via a secure connection.

d) UIOD

479. UIOD is stored on the local secure server at the Partner location until backed up to the Remote Server (AWS, UK), where it is retained until (i) the end of the contract term, (ii) it is no longer needed, or (iii) EPUT instructs Oxehealth to delete it.

(e) APD

480. APD is stored on the local secure server at the Partner location until backed up to the Remote Server (AWS, UK), retained until (i) the end of the contract term, (ii) it is no longer needed, or (iii) EPUT instructs Oxehealth to delete it. APD may be retained by Oxehealth for the purpose of addressing performance issues and improving the Oxehealth Software.

(f) SID

481. SID is stored on the local secure server at the Partner location and retained for up to 30 days after the associated data (such as a Recent Incident Review record or patient observation data) is deleted, and is then backed up to the remote server (AWS, UK) for a further 30 days before being deleted.

g) SPD

482. SPD is stored day-to-day on the Remote Server (AWS, UK), retained until (i) the end of the contract term, (ii) it is no longer needed, or (iii) EPUT instructs Oxehealth to delete it.

(h) ERVD

483. Day-to-day, ERVD is stored on the local secure server at the Partner location and retained for up to 24 hours. On an occasional basis, ERVD may be stored on Oxehealth's secure server or on the Network Attached Storage Device at the location. Configuration and performance issue ERVD may be retained indefinitely by Oxehealth.

484. At the end of any contract or Order Form term, EPUT has the ability to download certain data from Oxevision (such as activity reports and vital signs reports). All other Partner data is deleted.

485. The Inquiry asks EPUT to outline the extent to which it understands that data may be used by LIO/Oxehealth to facilitate or develop new products, facilitate or develop existing products, or to be used in research.

486. EPUT's understanding, as informed by the Service Agreement and its operational engagement with Oxehealth, is as follows.

487. Schedule 3, clause 1.3, provides that EPUT grants a revocable, exclusive, royalty-free licence to Oxehealth for the duration of the term to use Non Personal Data for the purposes of refining Oxehealth's algorithms in order to successfully deliver the Oxehealth Service to

EPUT. This is a specifically bounded licence: its purpose is the delivery of the service to EPUT and is confined to Non Personal Data.

488. In terms of EPUT's operational knowledge, except where EPUT has collaborated in the development of a system enhancement (for example the OxeObs function), EPUT is not aware of LIO having used EPUT's non-personal data for product development or research.

489. EPUT is not aware of LIO using EPUT data for research purposes, save for where LIO has engaged with EPUT in researching specific issues relating to system performance or functionality.

490. The Inquiry asks whether and how patients are informed of secondary uses of their data beyond direct clinical care. In responding to these questions the authors of the statement have relied on information provided by EPUTs Associate Director of Electronic Systems and Information Governance and Data Protection Officer.

491. EPUT distinguishes between primary use, being direct clinical care, and secondary uses, which encompass uses beyond direct care such as service evaluation, system improvement, clinical audit, and research. Patients are informed of secondary uses through a combination of general transparency measures and, where applicable, specific additional controls, as described below.

492. EPUT provides patients with information about how their personal data may be used, including for secondary purposes, through its Trust-wide privacy notice. This notice is available on the Trust's public website and in patient information materials and ward-level documentation. It explains the types of data collected, including data generated by monitoring technologies such as LIO, the purposes of processing including both direct care and secondary purposes, the categories of recipients, the legal bases relied upon under UK GDPR, and patients' data protection rights. In line with Articles 13 and 14 UK GDPR and ICO guidance, the notice explains that patient data may be used for purposes including clinical audit and service evaluation, quality improvement and safety monitoring, and, where applicable and subject to additional safeguards, research.

493. EPUT is currently undertaking a comprehensive review of all existing privacy notices, and it is planned that a dedicated privacy notice for the LIO system will be published, providing clear and accessible information to patients about both the use of LIO for direct clinical care and any secondary uses of their data. In addition to the Trust-wide privacy notice, EPUT adopts a layered approach to transparency, recognising the clinical environment in which LIO is used. Patients are informed at a general level about monitoring technologies and data use through privacy materials, and additional contextual information may be

provided through ward-level signage, information materials, and discussions with clinical staff where appropriate. This approach reflects ICO guidance that information should be accessible, proportionate, and appropriate to the context and patient population.

494. EPUT does not treat all secondary uses in the same way. Internal secondary uses, such as clinical audit and service improvement, are considered compatible with the original purpose of direct care in line with UK GDPR principles. In such cases, data is typically minimised and access-restricted, and patients are informed of such uses via the general privacy notice. Where data may be used for research or shared externally, EPUT applies additional safeguards, which may include ethical approval processes, Confidentiality Advisory Group approval where required, data sharing agreements, and de-identification or anonymisation where appropriate. In those circumstances, patients are informed through the Trust privacy notice and, where applicable, through study-specific participant information or other targeted communications.

495. Where secondary use involves anonymised data, EPUT applies the standard set out in Recital 26 UK GDPR and ICO guidance. Only data that meets the anonymisation threshold is treated as anonymised; where that threshold is not met, the data is treated as personal data and all applicable safeguards continue to apply. Patients are informed at a general level that their data may be used in anonymised or de-identified form for secondary purposes. Patients are also informed, via the privacy notice, of their rights under UK GDPR, including the right to be informed, the right of access, the right to object where applicable, and the right to restrict processing in certain circumstances. Where national data opt-out policies apply, for example in relation to research or planning purposes, patients are signposted accordingly.

496. In relation to the LIO system specifically, EPUT's position is that LIO data forms part of the patient record and is subject to the same transparency framework as other clinical data. Patients are notified at a general level that monitoring technologies are used and that data may be used beyond direct care. Any secondary use of LIO-derived data is subject to the safeguards described above and is not treated as anonymised unless the strict legal standard under Recital 26 is met.

497. The position on data ownership and processing as set out in the Service Agreement has remained substantively consistent since the contractual framework was established.

498. The most significant operational change in relation to data handling has been the method by which CVD and AVD are transferred to EPUT. Prior to April 2024, CVD was collected from local secure servers and transported to the Trust by encrypted USB device. Since April 2024, EPUT has received CVD and AVD via encrypted cloud transfer services.

499. Starting in October 2022, EPUT embarked on a collaboration with Oxehealth to develop an electronic observation function within the Oxevision system (OxeObs). This came at EPUT's request, as a method of improving observation recording. The project team was heavily represented by EPUT clinical staff in its design and implementation. EPUT has been using OxeObs since August 2023, with OxeObs records integrated into the respective EPRS Monday to Friday with minimal human intervention.

500. EPUT's basis for the evolution of its understanding, as it relates to data use, is that the amount of data processed has increased significantly with ward expansion, the increase of patient awareness has been developed, and staff compliance has progressively improved. The Trust holds an increasing amount of data to support quality patient care.

501. A Clear Video Data procedure was developed by EPUT's DPO and Legal team during this period.

502. The Inquiry asks EPUT to outline any other patient data — for instance patient room numbers, names, timestamps, or OxeObs observation records — which EPUT shares with LIO/Oxehealth, including the processes by which it is shared and the circumstances in which that would be necessary.

503. Room numbers are used in the implementation of the system. However, room numbers within the Oxevision system do not carry patient-identifiable data, names, or patient-identifiable demographic data.

504. The DPIA confirms that patient summary data referenced from EPUT's internal server to enable staff to assign individual patients to rooms is not processed or accessible by Oxehealth or any third-party provider.

505. PHRD — which may include patient name, unique identifying number, vital signs, and other observation data such as location, presentation, observation level or protocol, and risk assessment information — is processed by the Oxehealth Software in the ordinary operation of certain software modules, including OxeObs. PHRD from EPUT may be manually input by Partner staff or pulled directly into the Oxehealth Software from EPUT's EPR.

506. PHRD may also be used by Oxehealth to generate reports and analysis for EPUT staff, including protocol adherence reporting. This may involve PHRD being transferred by secure internet connection to the Remote Servers (AWS, UK) and to Oxehealth's secure premises.

507. In respect of timestamps: timestamps are generated automatically as part of the system's ordinary operation and are embedded within UIOD (for example, timestamps associated with alerts, vital signs readings, and observation records). UIOD is classified as non-personal data and is stored on Oxehealth's servers, accessible to Oxehealth for the purposes described in Schedule 3.

508. In respect of OxeObs records: observation data recorded via OxeObs constitutes PHRD and is processed by Oxehealth in the manner described in Schedule 4. The Oxehealth Software captures and stores PHRD when it is manually inputted by EPUT staff, when it is pulled from EPUT's EPR, and when it is generated by the software during vital signs readings. PHRD is transferred to EPUT's EPR as part of routine patient record-keeping, either via direct secure connection or by email of PDF outputs to the appropriate team within EPUT.

509. Oxehealth processes all Partner Personal Data solely as data processor, acting on EPUT's instructions as data controller as set out in Schedules 3 and 4 and as necessary to perform the Oxehealth Service in accordance with the Agreement.

510. The circumstances in which data sharing with LIO/Oxehealth is necessary are: (i) day-to-day operation of the system; (ii) performance issue resolution; (iii) Serious Incident Review at EPUT's instruction; (iv) generation of reports and analytics for EPUT; and (v) backup and service continuity purposes.

511. EPUT is not aware of LIO/Oxehealth using EPUT patient data for the purposes of research, save for instances where LIO engaged with EPUT in addressing specific performance or technical issues relating to the system.

512. The Service Agreement provides that Oxehealth is required to process Partner Personal Data only for the purposes of and in accordance with documented instructions contained in the Agreement or received from EPUT, and not for any other purpose. Research use of patient personal data would therefore fall outside the scope of Oxehealth's contractual authority as processor, and would require EPUT's express written instruction or authorisation.

513. The DPIAs prepared in respect of the Oxevision system describe the purpose of the system solely in terms of patient safety monitoring and clinical observation, and confirm that the system is not used for any purpose other than direct clinical care. Research is not stated as an intended purpose within the DPIAs.

514. Were patient data to be used for research purposes, EPUT's understanding is that such use would require: (i) identification and engagement of the relevant Research Ethics

Committee; (ii) compliance with the requirements of the Health Research Authority; (iii) appropriate informed consent from patients, or a lawful basis for research without consent under UK GDPR and the Data Protection Act 2018; and (iv) EPUT's oversight and approval as data controller. EPUT would consider itself to have a responsibility to ensure that any such use was lawfully authorised and properly governed, regardless of whether the processing was undertaken by Oxehealth as processor or by EPUT itself.

515. EPUT is not aware of any ethics approval having been sought or obtained in relation to research use of Oxevision-generated patient data.

516. EPUT exhibits copies of all Video Data Reports produced by Oxehealth/LIO for EPUT, **[KSZT01-141 to KSZT01-170].**

**Oxevision data EPUT has retained as a result of the Inquiry's moratorium, and over what timeframe**

517. All Oxevision data received or created for repository, including Oxevision Observations, has been retained as a result of the Inquiry's moratorium on document destruction. This encompasses all categories of Oxevision-generated data, including vital signs readings, alert logs, observation records entered via OxeObs, CVD, and AVD. The moratorium has been applied across all data received from the inception of the system's operation at EPUT.

518. All clear video data (CVD) and anonymised video data (AVD) has been retained since 2020. CVD generated prior to May 2024 was stored on encrypted USB devices and held in a locked cabinet at the Legal office at the Lodge, with password control maintained by the system manager and the Legal team. That USB-based CVD was subsequently uploaded to SharePoint in a controlled folder accessible only to authorised personnel. The encrypted USB devices were retired to a locked cabinet held by Records Management at BMHU. All CVD and AVD generated from May 2024 onwards has been transferred to EPUT via encrypted cloud transfer through EGRESS.

519. Where authorised by the DPO, CVD has been disclosed to the Coroner's Court and the Police in circumstances where the applicable access to records procedures have been completed and approved.

520. EPUT confirms that the retained datasets may include material relating to deceased inpatients who are connected to Core Participants. AVD has been retained comprehensively since 2020. However, in respect of CVD, it is important to note that the default retention period for CVD is 24 hours, after which unclipped footage is automatically overwritten and rendered irrecoverable. CVD has therefore only been retained where a

decision was made at or around the material time to clip and extract the relevant footage, for example in connection with a serious incident review or investigation. EPUT is unable to confirm that all CVD of potential relevance to the Inquiry was clipped at the material time; accordingly, it is possible that CVD relating to incidents involving deceased inpatients connected to Core Participants was not preserved.

521. The Oxevision system does not identify persons with specificity. The system only registers that a person or persons are present in a room. AVD (blurred video) is not individually recognisable without additional contextual information. Blurred video clips are most useful when paired with an event log from the activity tracker, which records the time and nature of movements or events detected in the room.

522. The same principle applies to CVD. In CVD, a person's features are more defined and their identity is more distinguishable. CVD allows investigating persons to identify a person or persons in a room, provided they are within a monitored area at the relevant time.

523. The pairing of footage to an individual patient for the purpose of incident investigation is therefore achieved by reference to the following: (i) the room identifier — the Oxevision system is configured by room number, and staff assign individual patients to specific rooms within the system, enabling footage from a specific room to be associated with the patient recorded as occupying that room at the relevant time; (ii) the timestamp of the footage, cross-referenced with ward records including EPRS, bed management records, and OxeObs observation logs, to establish which patient was occupying the room at the material time; and (iii) where necessary, the activity tracker event log, which records specific events (such as alerts, warnings, and observed movements) and can be used to locate and contextualise footage of a particular incident.

524. The DPIA confirms that patient summary data referenced from EPUT's internal server to enable staff to assign individual patients to rooms is not processed or accessible by Oxehealth or any third-party provider. The association between a room and a patient is therefore an internal EPUT record-keeping function, not a function of the Oxevision software itself.

525. The differential retention periods reflect the distinct nature and use of each data type. AVD (blurred video) is retained for up to two years because it demonstrates activity in a room and can be used to confirm elements available in the activity tracker history. As it does not contain identifiable images, its extended retention presents a lower privacy risk whilst supporting longer-term incident review and pattern analysis.

526. CVD is retained for only 24 hours because, if an incident is identified, 24 hours is considered sufficient time to request the data where the urgency and type of incident warrant a CVD export. The 24-hour retention period also reflects the significant memory storage requirements of clear, uncompressed video data on the local secure server; retaining CVD for additional periods would incur both cost and potential system performance implications.

527. The Service Agreement expressly provides that requests for CVD should only be made to support an investigation into a serious incident involving actual or suspected harm to a patient or member of staff. The 24-hour window is consistent with the expectation that any such incident requiring CVD review will be identified and escalated promptly.

528. The retention periods were established by Oxehealth as part of the system design and are embedded in the service architecture; however, EPUT has the contractual ability to instruct earlier deletion of Partner-owned data. EPUT has not sought to extend the 24-hour CVD retention period, and has not sought to curtail the AVD retention period, in the ordinary course of operations. The moratorium on document destruction imposed by the Inquiry has suspended any routine deletion processes in respect of data already received and held by EPUT.

## Costs and Value For Money

### Total Expenditure and Value Assessment

529. EPUT's total gross expenditure paid to Oxehealth between 2020 and 2025 amounts to £5,164,771 (including VAT of £860,795) encompassing initial set-up costs, annual software licence fees, and annual service fees. As VAT is reclaimable for the Trust, the actual net spend totals £4,303,976.

530. The Trust Board's decision to invest in Oxevision was preceded by a thorough business case review process (see Exhibits ZT-086 and ZT-087), incorporating a clear and robust assessment across five key dimensions: the strategic case, the financial case, the economic case, the management case, and the commercial case. On that basis, the Trust was satisfied that the investment represented value for money.

531. The Trust has continued to evaluate the effectiveness of Oxevision through a number of means. Within the Time to Care business case, which sets out the Trust's safety priorities, Oxevision has been directly linked to over 1,400 recorded incidents in which staff indicated, via Datix, that "Oxevision played a role in alerting us to this incident." This evidences a tangible contribution to patient safety outcomes.

532. Furthermore, the Trust conducted a patient focus group in March 2025, bringing together patients, carers, and staff to discuss their experiences of Oxevision. The feedback received was, on balance, positive, with participants expressing support for the system's contribution to patient safety; one patient stated that "Oxevision saved my life." The Trust acknowledges, however, that the patient experience of Oxevision is not uniform, and that concerns have been raised in relation to both patient safety and the broader impact of the technology on the patient experience, including matters of privacy and dignity. The Trust takes those concerns seriously and has sought to address them through ongoing engagement with patients, carers, and clinical staff. Notwithstanding those concerns, the Trust's overall assessment, informed by the available evidence base including incident data, clinical feedback, and patient engagement, is that Oxevision continues to deliver meaningful value in supporting patient safety. These factors will form part of the further review carried out by EPUT prior to any final decision concerning the continued use of Oxevision.

**Incident Reporting and Learning**

**Patient Experience Reports**

533. EPUT exhibits to this statement the Patient experience report dated October 2025. - **[KSZT01-171 and KSZT01-172].**

**Alert Response**

534. The Revision Chronology table within the SOP records that V5 was effective from 20 April 2021 and was introduced with the stated reason of "Added Privacy and Dignity". This is significant, as the requirement not to reset an alert without physically attending the patient is rooted in the Privacy and Dignity provisions of the SOP. V5 first introduced the Privacy and Dignity section, and the wording at that time included a provision that remote viewing by video camera does not negate the requirement for a physical check where clinical attention is required.

535. V5 of the SOP states that, “during an alert (red, accompanied by audible and visual alerts), a pixelated view is available until the user presses “reset” to clear the alert. Until a reset is initiated, an alert remains audible and the pixelated image remains visible. Remote viewing by video camera does not negate the requirement for a physical check where clinical attention is required”.

536. V6 of the SOP (effective 7 June 2021) introduced, for the first time, an express requirement that staff must not reset an alert without first confirming patient safety. Section 4 of V6 states: "In compliance with Trust Duty of Care guidance, staff are required to respond to all alerts and warnings with the appropriate response. Resetting alerts without conducting visual confirmation of patient safety is a breach of safety protocols."

537. V7 of the SOP (effective 8 September 2021) retained this requirement in identical terms, again stating in Section 4 that: "Resetting alerts without conducting visual confirmation of patient safety is a breach of safety protocols."

538. V8 of the SOP (effective 10 October 2022) likewise retained this requirement in identical terms, with Section 4 stating: "Resetting alerts without conducting visual confirmation of patient safety is a breach of safety protocols."

539. This wording was developed further within V9 of the SOP with a clear requirement that staff must not reset an Oxevision alert without physically attending the patient was expressly documented. V9 of the SOP states: “remote viewing by camera does not negate the requirement for an in-person clinical assessment. Only when the in-person assessment is completed can an alert be reset”.

540. In addition, Appendix 2 to the SOP includes a competency checklist which requires staff to demonstrate how to manually disable an alert using the “reset” button after reviewing the patient in person.

541. In relation to the specific ‘in bathroom’ alert, V11 of the SOP states, “A warning is raised to indicate the patient has left the bedroom and entered the bathroom / ensuite area, which will escalate to an alert after 3 minutes of no activity with a re-alert occurring every 3 subsequent minutes until the patient is verified as out of the bathroom. At 3 minutes the warning will convert to an alert with audible and red tile activation. Staff must conduct an in-person patient check before the alert is reset by the staff member.

**Tablet Security Measures**

542. Patient privacy and dignity are guiding principles for the Oxevision system design, and the user interface has been designed by clinicians with this in mind. As set out in the SOP, staff are required to ensure patient privacy during the use of the system at all times, para 1.5.4. Although there is no express provision in EPUT’s Oxevision SOP requiring staff to take specific steps to avoid being overlooked when using the tablets, the following practical measures serve to minimise this risk: (i) the Oxevision tablets are only to be used for recording Therapeutic Engagement and Supportive observations, vital signs monitoring,

responding to alerts and warnings, and reviewing reports; (ii) as set out in the SOP, the camera feature is neither designed, purposed, nor intended to be used as CCTV, and staff are not permitted to use the Oxevision Observation function to access patients without a clear clinical rationale; (iii) Screen privacy filters (digital masks) are active for rooms with line of site to ensuite bathrooms.  and (iv) Location of the LIO monitors in the ward office are always coordinated with clinical staff for maximum privacy with ward staff at installation. We can move monitors where compromise has been identified.

543. Whilst there is no express provision in the Oxevision SOP requiring that tablets must not be left unattended, this requirement is addressed through EPUT's wider information governance framework. Information provided to all new starters explains that staff should not leave any IT equipment, including tablets, unattended — (IG) Information Governance for New Starters **[Exhibit KSZT01-173]**. In addition, RMPG09 — Security Procedure previously exhibited as ZT-081 provides that all Trust equipment must be kept in a secure place, particularly at times when departments are not staffed. The Hazard Log documents the risk of a device being left unattended either by mistake or due to an emergency situation on the ward, and records that this risk is covered in staff training and in Trust policy, as no device containing identifiable patient information should be left unattended.

544. Access to the Oxevision system via the tablets is controlled through individual staff logins and passwords. Tablets are locked to an IP address that does not permit external use or access. The Oxehealth User Authorisation Implementation Guide is attached as **Exhibit KSZT01-174.** A more robust system of user authentication is currently in project planning.

545. The Hazard Log documents the following risks and controls that are relevant to tablet security:

(i) Staff forgetting to log out after using a tablet: staff must follow the SOP and information governance policy when using the device. An allocation sheet is maintained for each shift which records which staff member is allocated to each tablet. If an observation entry is recorded against the wrong staff name, this can be identified by reference to the allocation sheet.

(ii) Staff logging in to the system using another staff member's name and email address: this can similarly be identified by reference to the allocation sheet.

546. The tablets are configured to lock automatically after 2 minutes of inactivity, after which the screen is secured and re-authentication is required before further use. This control is documented in the Hazard Log as a mitigation against the risk of devices being left unattended.

**Summary of Current Position and Next Steps**

547. The Executive Team has reached the following conclusions. First, a revised Standard Operating Procedure must be developed and approved through the appropriate governance process, supported by a robust implementation plan. The implementation plan is to be shared with the Executive Team for oversight, assurance and approval by 2 June 2026. The governance arrangements for approval of the revised SOP and implementation plan must be clear, with terms of reference agreed through the Executive Team.

548. Second, legal advice must be obtained as to whether the revised SOP, and in particular the approach proposed within it, will comply with human rights legislation.

549. Third, the Executive Team accepted the recommendation to commission a wider review of contactless monitoring within the Trust. That review is to be commissioned by the Executive Team, with terms of reference agreed and approved by the Executive Team, and will be inclusive of patient views and the views of those with lived experience. The Executive Team confirmed it remains open-minded as to the outcome of that review. The Executive Team was clear that the SOP review to be completed by 24 June 2026 and the wider review are distinct exercises and must not be conflated: the revised SOP will represent an interim position, subject to the outcome of the wider review. A full review cannot realistically be completed before 24 June 2026.

550. Fourth, any change to clinical practice must be implemented safely. The Executive Team was clear that the implementation of any revised SOP must be accompanied by a robust training programme — including a rolling programme of staff briefings and training sessions with evidence of attendance — and effective communication throughout services. Implementation is expected to commence ahead of 24 June 2026 but, given the number of wards involved, may not be complete by that date. Patient safety remains the primary consideration underpinning all decisions.

**Statement of Truth**

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

**Signed:**

**[I/S]**

Dr Kallur Suresh

**Executive Chief Medical Officer**

[I/S]

**Executive Director of Strategy, Transformation and Digital**

**Dated: 22 May 2026**