

WITNESS NAMES: Dr Kallur Suresh and Mr Zephan Trent

DATED: 30 June 2026

LAMPARD INQUIRY

SUPPLEMENTARY STATEMENT RE RULE 9(114)

INTRODUCTION

1. We, Dr Kallur Suresh and Zephan Trent, make this supplemental statement further to our joint corporate witness statement dated 22 May 2026 ("Original Statement"), which was provided on behalf of Essex Partnership University NHS Foundation Trust ("EPUT") in response to the Lampard Inquiry's Rule 9(114) request concerning EPUT's use of the LIO system (formerly known as Oxevision).
2. This supplemental statement is made as a corporate response on behalf of EPUT. It is based on information available to EPUT and includes matters not within our personal knowledge, where we have relied on documents and information provided by colleagues within the Trust.
3. This supplemental statement incorporates developments arising from the period since the Original Statement was made, including the finalisation of the revised Standard Operating Procedure (version 13.3), the development of the LIO relaunch plan and associated implementation and milestone plans, the extraordinary LIO Project Board meetings held on 16 and 22 June 2026, the commissioning of an independent review of LIO assistive technology, and EPUT's formal response to the PHSO's recommendations dated 24 June 2026. The purpose of this statement is to update the Inquiry as to those developments.

CONTEXT OF THE ORIGINAL STATEMENT

4. The Original Statement was provided in response to the Lampard Inquiry's Rule 9(114) request seeking further information about EPUT's historic and current use of the LIO system. It addressed, among other matters, the Parliamentary and Health Service Ombudsman ("PHSO") Final Report concerning the complainant referred to as "Miss B", the findings and recommendations of a rapid review undertaken by Dr Ambiga Ravi and Angela Wade, and the steps taken by EPUT including a review of the Standard Operating Procedure ("SOP").
5. Unless otherwise stated, references in the Original Statement to the SOP were to version 12, which was the version in force at the material time. As noted in earlier statements, Oxehealth has rebranded as LIO; references to Oxehealth and to LIO in both the Original Statement and this supplemental statement should be read interchangeably.
6. In the Original Statement, EPUT confirmed that it would keep its approach under active review and would keep the Inquiry informed of material developments. This supplemental statement fulfils that commitment in relation to the developments described below.

PHSO Final Report: findings in relation to Miss B

7. As set out in the Original Statement, the PHSO issued its Final Report on 27 March 2026, partly upholding Miss B's complaint. The PHSO's findings included that EPUT should have sought Miss B's informed consent to the use of Oxevision, having assessed her as having capacity to consent; that the Trust should have revisited the question of consent as her condition improved; that EPUT's approach did not meet the standards set out in GMC guidance; that the version of the SOP then in force was internally inconsistent as to whether consent was required; and that there was no clinical record of discussions with Miss B about the use of Oxevision, including in circumstances where Miss B had likely requested that the system be switched off.
8. The PHSO recommended, among other things, that EPUT carry out a re-review of the SOP and its approach to consent by 24 June 2026, by reference to GMC standards and NHS England guidance; that EPUT communicate the outcome to relevant bodies; and that EPUT take additional steps regarding patient communication, staff training and observations, and produce an action plan for improvements to complaint-handling and record-keeping.
9. The matters described in paragraphs 12 and 13 above were addressed in the Original Statement. The PHSO Final Report was exhibited to the Original Statement as **KSZT01-**

175. The further steps taken by EPUT in response to the PHSO's findings are described at paragraphs 10 to 33 below.

Rapid review commissioning and the "default off" decision

10. As set out in the Original Statement, a rapid review led by Dr Ambiga Ravi and Angela Wade was shared with the Executive Team on 20 May 2026. That review identified concerns regarding consent arrangements (including a limited assurance audit position), privacy and safeguarding concerns, and a range of operational issues. The rapid review recommended that EPUT immediately refocus LIO as assistive technology and adopt a two-step process comprising: (i) MDT agreement as to clinical benefit; and (ii) informed written consent (or, where a patient lacks capacity, a best interests decision or, where applicable, the framework under section 63 of the Mental Health Act 1983).
11. The rapid review recommended that the system be set to "default off" as soon as practicable, operating as an opt-in system only, where clinically agreed and supported by informed written consent or relevant lawful authority.
12. At the Executive Team meeting on 20 May 2026, it was determined that: (i) the SOP re-review required to meet the PHSO deadline of 24 June 2026 and a wider independent review were to be treated as distinct exercises; (ii) a wider independent review would be commissioned with agreed terms of reference, including the views and lived experience of patients; (iii) legal advice was to be obtained on human rights compliance in respect of the proposed revised SOP; and (iv) a robust implementation plan was required for any change to the default position and SOP, including rolling staff briefings and training with evidence of attendance. The Trust accepted the two-step process recommended by the rapid review and recognised that immediate and sustained action was required.
13. These matters were addressed in the Original Statement. The rapid review briefing report was exhibited to the Original Statement, together with the minutes of the Executive Team meeting convened to consider the rapid review and an urgent memorandum from the Chief Medical Officer and Chief Nursing Officer setting out the actions to be taken pending a full review and revised SOP.

4. LIO Relaunch Plan, 11 June 2026 (Exhibit KSZT01-179)

14. We exhibit the LIO relaunch plan dated 11 June 2026 as **KSZT01-179**. That document was produced following the Executive Team's consideration of the rapid review findings and the PHSO outcome.

15. The relaunch plan was produced to govern the process of relaunching LIO remote monitoring technology across EPUT's mental health ward environments. It describes the need to implement actions following the ombudsman outcome regarding privacy and the rapid review of LIO compliance and usage reports.
16. The relaunch plan provides that EPUT will move to a default "OFF" position when a patient is admitted to a ward. Where use of the technology is being considered that this consideration is to take place in the context of MDT risk assessment and care planning. The system is not to be considered where the patient's personalised care plan does not identify a purpose for LIO's assistance in care delivery.
17. If LIO functionality is identified as potentially beneficial following the MDT assessment, its use must be confirmed by obtaining the patient's informed written consent (or, where the patient lacks capacity, by an MCA best interests' decision). That discussion must include an explanation of the benefits, functionality, limitations and implications of the system.
18. The relaunch plan sets out an aim, to be achieved following Executive Team approval, for, ward and clinical staff to be trained and assessed as competent to: explain the system to patients; apply a needs-led assessment approach; secure MDT agreement; and obtain and document informed written consent or a best interest's decision where required. The assurance measures set out in the plan include: a training completion target of, or above 95% of relevant staff; a target of 100% for "default off" on admission; and a target of 100% compliance with the requirements around assessment, consent documentation, and MDT agreement in all cases where LIO is used. Ongoing monthly reporting is required against those measures.
19. The relaunch plan defines the MDT required for that purpose as, at a minimum, two clinical professionals who are assessing and planning care, typically the ward nursing and medical team members, but capable of extending to the wider clinical team. The relaunch plan sets out a clear structure of roles and responsibilities: Executive leadership is responsible for strategic oversight and assurance; the care unit core four leadership team for shared accountability and oversight; the Deputy Director of Quality and Safety for delivery of the implementation plan; and matrons, ward managers and ward consultants for local delivery, monitoring, quality controls, quality assurance and competency sign-off for, ward-based staff. The plan also provides for a detailed project plan with actions, leads and indicative timeframes; weekly progress review during the six-week implementation period through care unit meeting structures; and monthly reporting to care unit assurance forums, with subsequent escalation to the LIO Project Board. For sustainability, the plan requires

embedding the revised approach into ward induction programmes, ward training cycles, and Trust policy documents and electronic patient records documentation.

Revised SOP and Implementation Plan: draft version 13 (Exhibit KSZT01-181), extraordinary Project Board review, and finalised SOP v13.3 (Exhibit KSZT01-18x)

20. We exhibit the Executive Committee paper dated 16 June 2026 titled "LIO Project Plan and Draft SOP", which includes the draft version 13 SOP and the associated implementation plan, as **KSZT01-180**.
21. That paper was presented to the Executive Committee on 16 June 2026 and states that the documents were produced following actions requested by the Executive Team and are intended to reflect EPUT's current expectations following internal review and audit reporting, aligned with GMC and relevant national guidance.
22. The draft version 13 SOP identifies NHS England's "Principles for using digital technologies in mental health inpatient treatment and care" as the central guiding document. It also references GMC professional standards, which require appropriate consent or valid lawful authority for recordings, and specify that the key elements of the discussion with the patient should be recorded in the clinical record.
23. The draft SOP's operational guidance provides that LIO must be in a "default OFF" status on admission. Activation of the system requires: MDT agreement; a discussion with the patient to obtain informed written consent (including an explanation of the system's functionality, limitations, implications and data use); confirmation to the patient of their right to withdraw consent at any time; and, where the patient lacks capacity, a capacity assessment and best interests' process.
24. The draft SOP reiterates that LIO has two core functions: ambient alerts, and non-contact monitoring of pulse and respiratory rates. The SOP notes that the vital signs monitoring function requires approximately 15 seconds of clear camera view, and that patients are not alerted through the LIO system itself when the vital signs function is in use.
25. The draft SOP provides that LIO must be switched off where consent is withdrawn, or where there is no ongoing reason for its use following care plan changes or MDT review.
26. The draft SOP sets out training and competency expectations, which include ensuring that staff understand that patients may withdraw consent at any time and that alerts from LIO require in-person contact with the patient. The draft SOP also sets out documentation

requirements, together with Datix reporting requirements and duty of candour obligations in specified circumstances.

Extraordinary LIO Project Board meetings: 16 June 2026 (Exhibit KSZT01-181) and 22 June 2026 (Exhibit KSZT01-182)

27. We exhibit the minutes of the extraordinary LIO Project Board meeting held on 16 June 2026 as KSZT01-182. We also exhibit the minutes of the extraordinary LIO Project Board meeting held on 22 June 2026 as KSZT01-183. Those meetings were convened specifically to oversee the review and final sign-off of the revised LIO SOP, as part of the governance process described in paragraphs 25 to 31 above.
28. The focus of the extraordinary board meeting on 16 June 2026 was the collective review of the new LIO SOP v13.0. The meeting was attended by the Executive Chief Operating Officer (who chaired), the Director of IT&T, the Executive Nurse, the Clinical Change Manager, the Director of Contracts, the Deputy Medical Director, the Deputy Director of Quality and Safety, the Director of Nursing and AHP Information Officer, and the Consultant Psychiatrist and Chief Clinical Information Officer, among others. A detailed page-by-page review of the latest draft of the SOP was conducted, addressing version control, clarity of language, and alignment with national guidance, with actions assigned for further amendments and clarifications. The meeting confirmed the importance of version control.
29. A significant discussion at the 16 June meeting focused on the process for obtaining and recording informed written consent from patients. Concerns were raised about the practicality and robustness of collecting, storing, and auditing written consent forms, referencing previous issues with lost paperwork. The ECT consent process was referenced as a model, and it was agreed that a robust, auditable process involving both paper and electronic records was needed, with ward managers accountable for weekly audits. The roles and responsibilities of ward managers, consultants and the wider MDT regarding consent and system activation were also discussed, with the Deputy Medical Director tasked with drafting bullet points to clarify the consultant's role and to define accountabilities, including out-of-hours processes and MDT involvement. It was agreed that written consent would be required and that a process to capture and scan consent to the system needed to be developed.

30. The meeting agreed to replace the term "co-production" with "working in collaboration with staff and patients" to better reflect the intended collaborative approach during implementation and evaluation. Alignment with national guidance was confirmed, with a plan for a gap analysis to be conducted to ensure full compliance before submission to the PHSO. The group agreed on an implementation timeline of a six-week period to deliver the plan's requirements, followed by a two-week handholding or rollout phase, with the aim for the new process to commence from 29 July 2026. A follow-up extraordinary meeting was scheduled for 22 June 2026 to finalise the SOP after further review and gap analysis, with a view to final sign-off on that date.
31. The purpose of the extraordinary board meeting on 22 June 2026 was the final sign-off of the LIO SOP. The meeting was chaired by the Executive Chief Operating Officer and attended by a senior cross-disciplinary group including the Director of IT&T, the Executive Nurse, the Head of Complaints, the Director of Nursing and Clinical Governance, the Deputy Medical Director, the Deputy Directors of Quality and Safety, the AD Mental Health Inpatient, and the AD Mental Health and Urgent Care. The Chair acknowledged that Angela Wade's and Dr Ravi's rapid review report had supported the urgent review of the SOP and that the Project Board had agreed that a safe implementation period was required for the whole workforce to receive training and understand the changes to practice in adherence to the latest national guidance that informed v13.3. A comprehensive implementation was accordingly developed, led by the Deputy Directors of Quality and Safety and the Director of IT&T, to ensure the whole workforce working in inpatient settings were fully sighted of the changes and prepared for implementation of the new SOP.
32. Following final review, the meeting agreed to remove two paragraphs related to outcome measurement from the SOP and to relocate them to the implementation plan, on the basis that current systems did not support outcome tracking and that those measures required further development. A key change identified at the meeting was the requirement for MDT oversight of system usage, with the importance of agreeing and defining the metrics to be used, and how they would be used, emphasised. It was agreed that the SOP should state that it must be read alongside the implementation plan, and that a six-month review date for the SOP should be added. In relation to the recording of consent, it was confirmed that the nurse in charge must be responsible for adding confirmation of consent to the system, and that written consent will be scanned into the system for accurate recording. The group agreed that the final document was approved. It was further agreed that a consent form would need to be designed and that policies would need to be aligned to include a separate LIO consent form as part of the implementation plan.

33. Following review by DPO on 30 June 2026 SOP v13.3 (Exhibit KSZT01- 183) was amended to correct obsolete references to managing Clear Video Data reflecting the move from USB – based Clear Video Data management to secure cloud – based processes, incorporating enhanced governance, DPO approval, Share Point Storage, controlled access and revised arrangements for internal release of footage. This correction was made following review and input from the DPO and subsequently approved by The LIO Steering Board Chair 30 June 2026.
34. We now exhibit the finalised Standard Operating Procedure for the use of the LIO platform, version 13.4 ("SOP v13.4"), as KSZT01-184. SOP v13.4, titled "Standard Operating Procedure for the use the LIO platform: a vision-based remote patient monitoring technology (Formally Oxevision) V13.4 Final", was authored by Angela Wade, Director of Nursing, DIPC. It represents the finalised version of the SOP following the review process described at paragraphs 24–33 above and supersedes the draft version 13 that was before the Executive Committee on 16 June 2026 (KSZT01-180).
35. In addition to the matters already addressed at paragraphs 20–33 above by reference to the earlier drafts, SOP v13.4 contains the following material provisions. The SOP sets out that EPUT's requirements are structured in accordance with the eight NHSE (2025) digital technology principles: (1) human rights approach; (2) consent and capacity; (3) equity of access; (4) co-production; (5) therapeutic and personalised care; (6) safety planning; (7) evidence base; and (8) treatment outcomes. In relation to the human rights dimension, the SOP provides that the LIO system must be used in accordance with the Human Rights Act 1998 and that all staff have a legal duty to understand the Act, respect and protect patients' human rights, including the right to life, liberty and security, respect for private and family life, and freedom from inhuman or degrading treatment. The SOP also requires that the use of LIO must not reduce the time staff spend with patients or negatively impact the therapeutic relationship, and that the system should never be used as a solution to low staffing numbers in terms of reducing the need for staff to spend time with patients.
36. SOP v13.4 sets out more detailed roles and responsibilities than earlier versions. In relation to ward consultants specifically, the SOP requires that the ward consultant must be consulted and involved in the decision to activate LIO, ensuring there is a clear, documented clinical rationale specific to the patient; that the consultant must ensure capacity assessments and, where required, best interests decisions relating to LIO use are undertaken appropriately; and that the consultant, or an appropriate deputy (SAS doctor or higher Specialty Trainee), must be involved in the weekly MDT review of continued LIO

use. Furthermore, where a patient withdraws consent, the consultant and medical team, in conjunction with the wider MDT, must consider what mitigations are needed to manage stopping LIO and whether the decision to withdraw consent is itself capacitous. SOP v13.4 additionally includes a revised training and competency framework, a record of competency checklist (Appendix 2), a requirement that any use of the clear view panel must be documented, discussed with the patient following duty of candour principles, and then reported via Datix with the rationale explained, and a governance, assurance and reporting structure mirroring that set out in the relaunch plan at KSZT01-179.

6. LIO SOP Action Plan v1.1 (Exhibit KSZT01-185) and LIO SOP Relaunch Project Milestone Plan (Exhibit KSZT01-186)

37. We exhibit the LIO SOP Project Planning Document, version 1.1, amended on 26 June 2026 ("the Action Plan"), as KSZT01-185. We also exhibit the LIO SOP Relaunch Project Milestone Plan, amended on 26 June 2026, as KSZT01-186. Both documents were described as revised versions of the milestone plan and project action plan circulated within EPUT on 26 June 2026, with the Action Plan described as being in the nature of a charter forming the basis for the terms of reference of the implementation project, and the milestone plan being the document to be used to track and monitor project progression.
38. The Action Plan was produced following the PHSO outcome regarding the right to privacy and the review of LIO compliance and usage reports. Its stated purpose is to implement actions to ensure appropriate use of LIO through obtaining patient informed written consent where the system has been identified as potentially beneficial to staff delivering personalised care. The Action Plan identifies three areas of patient care in which the system may be beneficial: (i) supporting staff to deliver a patient's personalised care plan where LIO functions are considered assistive; (ii) alerts relating to patient movement; and (iii) non-contact monitoring of pulse and respiratory rates. The Action Plan sets out five key objectives: (1) equipping staff with knowledge of the clinical purpose, benefits and risks of LIO; (2) ensuring LIO is off at point of admission; (3) standardising assessment, consent and documentation processes; (4) ensuring safe, ethical and proportionate use aligned with the Mental Health Act, the Mental Capacity Act and the SOP; and (5) monitoring compliance, uptake and quality of use.
39. The Action Plan sets out four key principles governing implementation: a patient-centred and least restrictive approach; opt-in through consent wherever possible; MDT decision-making and discussion with the patient and family where appropriate; and proportionate and clinically justified use with clear documentation and governance oversight. The measures of success set out in the Action Plan include: a training target of 90% or above

of relevant staff trained; a target of 100% of admissions with LIO in the default off position; 100% compliance with appropriate consent or capacity documentation; and 100% compliance with documented MDT agreement in all cases where LIO is used. Reporting and review is to take place through weekly progress review during the eight-week implementation period, with end-of-month audit reports, learning summaries and sustainability plans, followed by ongoing monthly Tendable audit and integration into business-as-usual governance.

40. The LIO SOP Relaunch Project Milestone Plan (KSZT01-186) sets out the detailed project management framework for the relaunch in nine stages. Those stages are:

Stage 1 - establishing assurance measures, including baseline data review and Datix configuration;

Stage 2 - communication and guidance, including governance document updates, training material revision and communications planning;

Stage 3 - rollout of user authentication and system requirements;

Stage 4 - staff training across senior, mid-level and ward levels;

Stage 5 - publication of Trust supporting documents, including Executive Team review and approval, and upload to Trust systems;

Stage 6 - patient engagement and staff involvement;

Stage 7 - monitoring and reporting against agreed metrics;

Stage 8 - digital safety log review during implementation; and

Stage 9 - transition to business as usual, including a project evaluation report after three months.

41. For Stage 4, individual staff training is targeted for completion by 29 July 2026. Stage 5 provides for Executive Team review and approval on 7 to 8 July 2026, with the SOPHIA and intranet versions of the SOP to be uploaded thereafter. The monitoring metrics in Stage 7 include a training completion target of 95% or above of staff trained within the six-week lead period; 100% of admissions with LIO in the default off position; 100% of LIO activations supported by appropriate informed written consent or capacity documentation; and 100% of LIO activations with documented MDT agreement as part of personalised care planning. Monthly reporting is to be through LIO usage reports, Datix incidents, PALS, complaints and HR conduct reports, with an improved trajectory from the April 2026 baseline.

Independent Review of LIO Assistive Technology: Briefing Report, 16 June 2026 (Exhibit KSZT01-187) and Terms of Reference (Exhibit KSZT01-188)

42. We exhibit the Executive Committee briefing report dated 16 June 2026 titled "Briefing Report — Independent Review of LIO Assistive Technology (formerly Oxevision)" as **KSZT01-187**.
43. That paper, presented to the Executive Committee on 16 June 2026, identified risks relating to patient safety, clinical practice, governance and organisational credibility, including variation in consent arrangements and documentation, and ethical and human rights risks. It proposed the commissioning of an independent review to determine whether LIO is being used safely, effectively and lawfully by EPUT and whether it remains the most appropriate technology for the purposes for which it is deployed.
44. The paper asked the Executive Committee to: approve in principle the commissioning and funding of an independent review; approve the draft terms of reference, subject to refinement; support the proposed independent delivery model involving the King's Fund (as lead and independent chair, with responsibility for the final report) and the National Collaborating Centre for Mental Health (NCCMH, responsible for evidence review and lived experience engagement and analysis); and approve notification to the Lampard Inquiry by 30 June 2026.
45. The proposed scope of the independent review as set out in the briefing report includes: consent, capacity and human rights compliance; patient dignity and privacy; staff training and cultural drivers; governance, audit and oversight; and information governance and data use. Discussions with the King's Fund and the NCCMH had taken place in early June 2026. A proposed start date of July 2026 was identified, with an indicative review period of 12 weeks, and a notification to the Lampard Inquiry was proposed by 30 June 2026 (via this written supplemental statement). The terms of reference for the independent review were in draft at the date of the Executive Committee briefing report and have since been developed further. We now exhibit those terms of reference as KSZT01-188.
46. The purpose of the independent review, as stated in the terms of reference, is to undertake an independent, robust and transparent review of the use of LIO as a remote patient monitoring technology to assist care delivery within EPUT's inpatient mental health services, and to determine whether LIO is being used safely, effectively, ethically and lawfully, and in a way that supports high-quality, person-centred care. The review will assess the use of LIO across all adult, older adult and CAMHS mental health inpatient settings within the Trust where the system has been installed, including all inpatient wards, seclusion rooms, and Health-Based Places of Safety. The review will be comprehensive and will include the perspectives and lived experience of patients, families, carers and nominated persons, and staff across all disciplines.

47. The delivery model set out in the terms of reference provides for the King's Fund to act as Independent Chair and Lead, with responsibility for the final report; the NCCMH to act as Delivery Partner, responsible for research, engagement and analysis; and EPUT's role to be limited to evidence provision and subject matter input only. The NCCMH will provide a multi-disciplinary review team, including lived experience representatives and research capacity. The methodology will be a mixed-method approach including document review, quantitative analysis of usage, incidents and compliance data, qualitative engagement with staff, patients and carers, case reviews, and benchmarking against national best practice.
48. The outputs of the review will include an agreed review plan and methodology, an interim progress update, and a final report setting out findings, risk analysis, clear recommendations, an implementation framework, and a mechanism for tracking implementation of recommendations including arrangements for follow-up or re-review. The review report is intended to be suitable for board assurance, regulatory scrutiny, and public transparency.
49. The timeline set out in the terms of reference provides for the commissioning agreement to be concluded in June 2026, with an indicative review duration of approximately 12 weeks (subject to confirmation), and the final report projected for Autumn 2026. On the basis of a July 2026 start date and a 12-week review period, EPUT anticipates receiving the final report in approximately October 2026, consistent with the Autumn 2026 timeframe identified in the terms of reference.
50. Upon receipt of the final report, EPUT will be required to consider the findings and recommendations through its established governance structures before any decisions are made as to whether and how to implement any recommendations arising from the review. That process would be expected to include consideration at LIO Project Board, Executive Committee, and Trust Board level, as appropriate to the nature of any recommendations made. EPUT recognises that the independent character of the review requires that its findings be given proper and thorough consideration through those processes before conclusions are reached.
51. EPUT notes that the Lampard Inquiry has indicated that its October 2026 hearing sessions are intended, among other matters, to hear evidence from EPUT witnesses on observation and technology. The timing of the independent review and the governance process that follows is therefore likely to have a material impact on the ability of EPUT's witnesses to give comprehensive and final evidence to the Inquiry on observation and technology at the October 2026 hearings, in that the findings of the independent review and EPUT's

considered response to them may not be available at that stage. EPUT intends to keep the Inquiry informed of developments, including as to the progress and anticipated completion of the independent review, so that the Inquiry can make any directions it considers appropriate in relation to the timing and scope of witness evidence on these matters.

PHSO Response Letter and Action Plan, 24 June 2026 (Exhibit KSZT01-189)

52. We exhibit the letter dated 24 June 2026 from Trevor Smith, Deputy Chief Executive, to M [B] together with the action plan at Appendix 1 to that letter ("the PHSO Response"), as KSZT01-189. That letter constituted EPUT's formal response to the PHSO's recommendations and was sent to Ms [B] within the PHSO's deadline of 24 June 2026. A copy of the letter and action plan was shared with the Parliamentary and Health Service Ombudsman, NHS England, and the Care Quality Commission.
53. In the PHSO Response, EPUT offered its sincere and unreserved apologies for the failings identified by the PHSO in relation to Ms [B] care and the Trust's handling of her complaint, reiterating the apology previously provided. The Trust acknowledged that it did not seek Ms [B's] consent for the use of Oxevision (now referred to as the LIO system), did not ensure it was switched off when she requested this, did not provide clear information or explanations, and did not appropriately record how LIO supported her care. The Trust further acknowledged that its response to Ms B's complaint did not meet expected standards, did not fully address her concerns, was not sufficiently personalised, and included inaccuracies.
54. The PHSO Response confirmed the outcome of the SOP review. The Trust confirmed that it had undertaken a review of its LIO Standard Operating Procedure and its approach to consent, with reference to national guidance, through its established governance structures with oversight from the Executive Team and the LIO Project Board, with responsibility for the review assigned to the Director of Nursing and Deputy Medical Director. The review was described as forming part of a wider programme of work following the PHSO's findings and the rapid review. The review considered: how consent is sought, recorded and revisited; how patients are supported to understand and question the use of LIO; arrangements where a patient declines or withdraws consent; how LIO is referenced within care planning; and how compliance is monitored.
55. The key changes to the SOP confirmed in the PHSO Response were: introduction of a "default OFF" position on admission; requirement for MDT agreement before use; requirement for informed written consent prior to activation, or a Mental Capacity Act best

interests decision where applicable; a clear requirement that patients are informed of their right to withdraw consent at any time; strengthened requirements to record consent discussions and rationale within the clinical record; and a clear instruction that LIO must be switched off if consent is withdrawn or no longer clinically required.

56. In relation to the implementation programme, the PHSO Response confirmed that the Trust had developed a structured implementation plan to support the implementation and embedding of the revised approach, comprising an eight-week implementation period focused on staff training, competency and embedding the revised processes in practice, followed by a further two-week period of enhanced support and oversight to ensure consistency in application and to address any issues arising during early implementation. Delivery of the programme is to be overseen through a weekly project meeting chaired by the Executive Chief Nurse and Executive Chief Medical Officer.

57. The PHSO Response addressed the Trust's approach to patient communication and information. The Trust confirmed that it had strengthened its approach so that patients are given a clear explanation on admission or transfer; provided with written information; supported to ask questions and raise concerns; reassured about how LIO is used alongside in-person care; and informed who to speak to if they have concerns. The Trust confirmed that it had developed and was implementing a range of patient information materials, including patient posters, written information leaflets and ward-based information resources explaining how the system works and how it supports care. The Trust's approach requires that information is provided in a way that is tailored to the patient's communication needs and that staff actively check understanding through discussion and engagement.

58. In relation to staff training, the PHSO Response confirmed that all ward staff working in inpatient environments are required to complete mandatory LIO training, including completion of formal training modules via the Trust's learning platform, achievement of a 100% pass mark, demonstration of competency through a structured competency checklist, and annual refresher training and re-assessment of competency. Training compliance and competency are to be monitored through Trust training systems, with a minimum expected compliance level of 95% or above of relevant staff.

59. The PHSO Response addressed observations and record-keeping. The Trust accepted the PHSO's finding of failure to record how LIO was being used within Ms B's care. The Trust confirmed strengthened expectations that care plans clearly reflect the use of LIO; patient discussions are recorded; and LIO supports but does not replace in-person

observations. Monthly governance reporting is to track compliance with consent, documentation and MDT processes, alongside training compliance and system usage.

60. In relation to complaint handling, the PHSO Response acknowledged the PHSO's findings in that regard and confirmed that the Complaints Team had undertaken formal training aligned to the NHS Complaint Standards, covering all aspects of identifying, investigating and resolving complaints, which was completed in April 2024. The Trust confirmed that a more structured and evidence-based approach to investigations had been introduced, including independently reviewing clinical records and evidence, considering relevant Trust policies and national guidance, and ensuring that responses clearly explain what happened, what should have happened, and any differences between the two.

61. The action plan at Appendix 1 to the PHSO Response (exhibited as part of KSZT01-189) sets out, in tabular form, the actions taken or to be taken against each of the PHSO's recommendations, with leads and timescales. The action plan covers: SOP review (lead: Director of Nursing and Clinical Director; timescale: June 2026); consent process (lead: Care Group Clinical Leads and Deputy Directors of Quality and Safety; timescale: implemented in SOP by June 2026, embedding through July–August 2026); patient information (lead: Deputy Directors of Quality and Safety; timescale: June–August 2026, phased implementation); staff training (lead: Deputy Directors of Quality and Safety, Ward Managers and Practice Educators; timescale: initial eight-week implementation period plus ongoing compliance); and care planning and records (lead: Ward Managers, Consultants and MDTs; timescale: implemented in SOP by June 2026, embedding through July–August 2026). The action plan also records steps in relation to complaint investigation (lead: Head of Complaints; ongoing since April 2024), complaint quality assurance (lead: Head of Complaints; from May 2026), and learning and governance (lead: Care Group Clinical Leads and Deputy Directors of Quality and Safety; from June 2026).

STATEMENT OF TRUTH

We believe that the facts stated in this witness statement are true. We understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed 

Name: Dr Kallur Suresh

Position: Executive Chief Medical Officer, Essex Partnership University NHS Foundation Trust

Date: 30th June 2026

[I/S]

Signed:

Name: Zephan Trent

Position: Executive Director of Strategy, Transformation and Digital / Senior Information Risk
Owner, Essex Partnership University NHS Foundation Trust

Date: 30th June 2026