Report for the Lampard Inquiry:
Observation and Engagement and the Use of Vision Based Patient Monitoring Systems

This report is prepared by:
Dr Chess Denman

INQY028221_0001

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Executive Summary

Scope and approach

This report was written following a letter of instruction from the Lampard Inquiry. I was asked to consider observations in general and the proper role of vision-based patient monitoring systems (VBPMS) in the context of their introduction and use at EPUT. I was not asked to consider nursing aspects, research appraisals, or technical issues.

Families and Carers

Suicide and an unexpected death are among the hardest experiences anyone can be asked to bear. They leave unanswerable questions, regrets, things unsaid and things now unsayable. I hope that this report, however technical, has kept all the people involved respectfully in mind. I offer my condolences to all the families and carers of those whose deaths the Inquiry was set up to consider, and I hope that care will improve because of the Inquiry's work.

Observations: purpose, limits and quality

Observations are a complex mental health intervention that combine information gathering, safety checks and therapeutic intervention. They are a clinical activity that should have a defined purpose, be practical, documented, collaborative, proportionate and flexibly reviewed. Decisions about them should synthesise information as widely as possible from a range of sources.

Much though we would wish it, risk cannot be evaluated precisely; although we can identify groups of patients at risk, current knowledge is insufficient to predict who will act in a risky way and when. Further, observations are an imperfect way of increasing patient safety. Intermittent observations, for example, cannot prevent self-harm which is too rapidly fatal to be detected in time in many cases. Continuous observation is restrictive, unnatural (and potentially alienating) and fallible. Notwithstanding, we ask that decisions about observation level be more accurate and more successful than they are.

Nevertheless, the general measures taken on inpatient wards have been demonstrably successful in preventing deaths[1]. Any further developments that would better restrict the availability of means of self-harm without unacceptable and harmful intrusions on the autonomy and dignity of patients offers our best hope of further improvement.

Oxevision

One reason Oxevision may have been taken up by so many organisations is because it appeared to offer the chance to reduce deaths by using remote monitoring to further restrict the availability of means without having to deprive patients of their possessions. However, the system provides only limited information, and while it generates alerts, these are not always responded to or accurate. The system measures pulse and respiration remotely. While this seemed on the face of it a sensible thing to do, it should on closer inspection have been identified as being far less informative than it might have at first appeared. This is because the system does not allow a full evaluation of physical health that could predict deterioration (as the NEWS2 score can do), and because ligature events cannot be detected even by continuous tracking of these parameters.

In certain settings, the system may have utility. It allows night-time checks of pulse and respiration without waking a patient. These are routinely performed in mental health trusts at at least hourly intervals. It may also have value in settings where for some reason it is impossible or unsafe to examine a patient physically in person. These examples of utility are, however, limited in scope. In my view (which I acknowledge is not shared by all psychiatrists), intermittent (i.e. hourly) nighttime checks of pulse and respiration alone add nothing to the clinical management of a sleeping patient. Further, the position of a patient who cannot be safely met with in person is so serious that rectifying that state must be an urgent priority. The benefits from the technology are therefore limited.

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

The OxeObs system is a separate module that allows for a much more auditable entry of observation data and the ability to review, after the event, what happened in particular

[1] NCISH (2013), Patient Suicide: The Impact of Service Changes, Manchester: University of Manchester; NCISH annual reports (inpatient suicide down by roughly two-thirds across the period), https://sites.manchester.ac.uk/ncish/reports/.

situations. This allows for retrospective audit and accountability, which is important, but does not by itself improve the quality of observation or engagement.

EPUT implementation and oversight

EPUT's implementation of the Oxevision system followed enthusiastic reports from other areas. However, there was never a coherent clinical rationale for the implementation of the system, and evaluation of its impact, effectiveness and drawbacks lagged behind enthusiastic adoption rather than leading it. Patients were not involved in the development or roll-out of the system or the standard operating procedures that regulated its operation in the trust. Often, presentations at higher levels in the trust focused on the system's benefits while minimising the drawbacks.

As time passed, the trust's governance structures did react to accumulating concerns related to how alerts were handled, and whether staff were using the facility to see patients while taking pulse and respiration measures in order to check on them remotely. Sequential revisions of the standard operating procedure did try to remedy some of these concerns, but the trust's observations and engagement policy never referred to or incorporated the system.

There was a substantial and sustained failure to seek valid consent for use of the system. The trust relied on a frankly incorrect understanding of what constitutes a medical intervention and the nature of valid consent, and instead relied on a flawed understanding of the term "implied" consent. There were successive revisions to the consent process, but only in the most recent period have patients been offered the correct model, which requires explicit consent and is "opt in". The failure to understand and implement adequate and clinically acceptable consent procedures was not only the case at EPUT[2], and represents a severe failure of responsible care for patients who were not treated in line with good medical practice.

Recommendations

Review, reconsider and revalue the practice of observation and engagement in mental health services.

Prepare for new technology by considering whether mental health mandates a wider framework for considering what constitutes a medical device.

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[2] See for example the Witness Statement of Britta Klinck of Oxford Health [OHFT024268].

Value consent as highly as confidentiality and make correct consent processes the concern of a designated board member.

Only implement novel services or therapeutic practices in co-production with patients and with clear research evaluation in place before implementation.

INQY028221_0006

Introduction

Instructions

I have been instructed by Baroness Lampard to provide an expert report to an Inquiry investigating the deaths of mental health inpatients under the care of NHS Trusts in Essex between 1 January 2000 and 31 December 2023. I am asked to provide a report for the Inquiry that covers the nature and use of clinical observations on inpatient wards and, further, to consider the use of technology, including vision-based patient monitoring systems ("VBPMS") such as Oxevision as part of observation practice. The Inquiry's Expert Nurse, Jill Archibald, has reported on nursing standards and clinical operational implementation and I was asked to provide a psychiatric perspective.

For some areas of my report, I am asked to apply the standard expected of a competent psychiatrist exercising reasonable professional judgement in relation to observations, and to consider how psychiatric assessment, formulation, clinical judgement and risk assessment should inform decisions about observations. I am further asked what role technology can play to support psychiatric care, but also what its limits may be and what safeguards may be needed. Where practice varies, I am asked to say whether the variation is within a reasonable range of professional judgement. I am asked to distinguish between minimum standards, accepted good practice and emerging practice, and to differentiate practice for voluntary and detained patients.

Next, considering matters from the perspective of the medical director of a mental health trust, I am also asked to review material sent to me by the Inquiry and to consider the clinical decisions made as Essex Partnership University NHS Foundation Trust ("EPUT") deployed the Oxevision system.

I have been provided with a number of case summaries prepared by the Inquiry which illustrate issues relevant to the matters under consideration along with underlying documents supplementing the summary, and I am asked to consider and to refer to these cases in a way that demonstrates the themes in my report.

Finally, I am asked to identify areas for improvement in psychiatric services nationally and, where applicable, to make recommendations.

The author

I am Dr Francesca Marie Carola Denman. My professional qualification is as a consultant psychiatrist in psychotherapy, but I also have an endorsement in general adult psychiatry, and I am an approved clinician and section 12(2) approved practitioner under the Mental Health Act 1983. Previously, I was, for eight years, the medical director of my employing mental health trust.

My main clinical practice has been working with people who suffer from problems related to emotional instability and personality difficulties, many of whom also have had severely adverse childhoods or later traumatic experiences. I have treated patients with these problems both as outpatients in the NHS Beacon site for personality disorders implemented in my trust, and as the consultant in charge of an inpatient unit the trust subsequently set up.

I have also, for many years, reported for coroners and in other capacities on the clinical management of patients. In my capacity as medical director, I was particularly responsible for understanding serious untoward incidents from a clinical perspective.

My CV is attached at Appendix 1.

Materials

I was sent a range of materials to provide me with the information needed to contribute to the Inquiry. These are listed at Appendix 2. I confirm that I have reviewed the entire set of documentation even if I have not referred to a document specifically in my report.

Limits

I was asked in my instructions to bring the perspective of both a consultant psychiatrist and a trust's medical director to the matters I was asked to discuss. I have tried to do that but there are some explicit limits I would like to set out.

I do not have expertise in the technical details of installing and validating clinical systems or electronic patient records; in that area, I would defer both to the relevant technical expert and to someone with experience as a trust's Senior Information Risk Owner (SIRO).

I am not qualified to discuss the close operational practicalities of delivering care on an inpatient ward, and I would defer to a nursing colleague in this area. Indeed, I was given a copy of the comprehensive report of Ms Archibald, which covers these areas.

I have also considered some matters relating to research and audit, since this properly lies within the expertise of a trust's medical director. However, I have only made brief mention of the formal research conducted in relation to the Oxevision system. The statistical evaluation of that research is a matter where I am aware the Inquiry has had appropriate expert evidence, to which I defer.

A number of patients whose case summaries I have been asked to consider were children. Child and adolescent mental health is a specialist area. Because of my past training and my own specialist interest in emotional instability and personality difficulties, conditions that often emerge in mid to late adolescence, I have some experience of working with colleagues in Child and Adolescent Mental Health Services (CAMHS) settings. I have allowed myself to comment on these cases, but only to the extent that I felt confident of my ground. If further consideration of these cases is felt necessary, it should be directed to a CAMHS consultant.

Approach to individual cases

In the case summaries I was provided with, the names of patients and staff are preserved. I have taken the decision to refer to each patient by their name to preserve their memories.

I have focused in these illustrative case summaries solely on issues that relate to observations practice. Several of the cases raise issues of clinical and specifically medical management, or the management of a patient who needs resuscitation, but I have not commented on those aspects of care.

Terminology

Throughout this report, I have referred to people with mental health problems under the care of mental health services as patients. I am aware this is a contested term, with some people preferring the term service user or client, and others using the term lived experience. I do not think any term is entirely right or captures the experience of being unwell, uncertain, possibly at the mercy of others, but also the only true expert on the nature of one's internal personal experiences. I have settled uneasily for the term "patient" to mark out that the position of people in the care of mental health

services is more specific than that of the user of a service or the client of a professional, and to refer back to the history of medical care for mental health problems that we know stretches back to prehistoric times.

1 Section 1 — Guidance and standards for psychiatrists

Psychiatric guidance, standards and developments

1.1 As documented in Ms Archibald's report, there is a sustained body of guidance to nursing staff from a range of regulatory bodies that covers expectations in relation to observations on inpatient mental health wards. She documents the evolution of guidance about observations and the assessment of risk over time, and I would expect medical staff to be aware of the broad thrust of that guidance in terms of understanding how risk should be assessed and the kinds of observations that can be realistically managed in inpatient settings and what they can reasonably be expected to achieve.[3]

1.2 However, what is absent is guidance specifically aimed at medical staff in relation to observations or even in relation to the assessment of risk. Indeed, overall, there is little guidance for psychiatrists to cover any but a minimum of basic expectations as to their involvement in the care of patients admitted to psychiatric wards, with the exception of the regulations that deal with confidentiality, capacity, consent and the application of the Mental Health Act.

1.3 I have attached as an appendix (appendix 3) a detailed review of all relevant guidance in this area related to psychiatrists. There is a general consensus that observation practice should be something agreed by the multidisciplinary team, and there have been some debates about the utility of various forms of observation.

1.4 One area where there is detailed guidance is in relation to making recordings of patients, although this arose largely by historical accident.[4]

1.5 The other richer area is the set of Royal College of Psychiatrists College Centre for Quality Improvement (CCQI) guidelines. This covers ward and service standards

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[3] See Section 4 of the Expert Report of Jill Archibald, pages 12-16 [INQY025967].

[4] General Medical Council (2011) *Making and using visual and audio recordings of patients*. London: General Medical Council. Available at: https://www.gmc-uk.org/professional-standards/the-professional-standards/making-and-using-visual-and-audio-recordings-of-patients (Accessed: 26 August 2026).

and is accompanied by inspection and accreditation visits.[5] The standards were introduced to help improve the quality of care in general, and the advice is not directly aimed at psychiatrists but at whole services.

1.6 Professional standards for doctors were reissued throughout the period: The General Medical Council's *Good Medical Practice* was published in 2001, 2006, 2013 and 2024.[6] Within that period, *New Ways of Working* (2005) reshaped the consultant role within multidisciplinary teams, and Royal College accreditation of inpatient wards began in 2006.

1.7 *New Ways of Working*, reported in 2005 by the Department of Health, the National Institute for Mental Health in England (NIMHE) and the Royal College of Psychiatrists, changed what consultants were expected to do. Instead of holding personal medical responsibility for every patient on a large caseload, the consultant became the senior clinical decision-maker of a multidisciplinary team: concentrating on the most complex cases, supervising and advising colleagues, and sharing responsibility with experienced non-medical staff who carried their own caseloads. Decisions about matters such as observation levels therefore became team decisions with consultant input rather than instructions from a single responsible doctor. This is relevant when judging who was expected to decide what at different points in the period.[7]

Chronology 2000 to 2026

1.8 In order to set the events discussed in this report in the context of developments in mental health care that relate to observations and technology, I have set out below a timeline of major relevant events that occurred over the period covered by the Inquiry.

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[5] Royal College of Psychiatrists, College Centre for Quality Improvement (2025), *Quality Standards for Acute Inpatient Services for Working Age Adults*, 9th edn, CCQI 504 (standards 53 and 54 cover therapeutic observation), https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation.

[6] General Medical Council, Good Medical Practice, 2001, 2006, 2013 and 2024 editions; Department of Health and Royal College of Psychiatrists (2005), New Ways of Working for Psychiatrists; RCPsych College Centre for Quality Improvement, AIMS accreditation (from 2006).

[7] Department of Health, National Institute for Mental Health in England and Royal College of Psychiatrists (2005), New Ways of Working for Psychiatrists: Enhancing Effective, Person-centred Services Through New Ways of Working in Multidisciplinary and Multi-agency Contexts, London: Department of Health.

1.9 1998

Adverse childhood experiences study.[8] This helped lay the foundations of what later became trauma-informed practice (section 5).

1.10 1999

SNMAC practice guidance.[9] This defined the observation levels that remain recognisable today (section 2). Early-period observation practice falls to be judged against it.

1.11 2000

GMC confidentiality guidance.[10] The GMC issued guidance on confidentiality, which it revised in 2004. Its cautious reading shaped how little families were then told (section 4).

1.12 2001

Safety First.[11] The National Confidential Inquiry called for the removal of ligature points (section 2). This began the means-restriction drive that transformed ward safety.

Good Medical Practice.[12] A new edition was issued. Further editions followed in 2006, 2013 and 2024. These editions set the professional baseline for judging conduct in each era.

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[8] Felitti, V.J. et al. (1998), 'Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the Adverse Childhood Experiences (ACE) Study', American Journal of Preventive Medicine.

[9] Standing Nursing and Midwifery Advisory Committee (1999), Practice Guidance: Safe and Supportive Observation of Patients at Risk, London: Department of Health; NICE (2005), CG25

[10] General Medical Council, Confidentiality: Protecting and Providing Information (2000, revised 2004).

[11] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness NCISH (2001), Safety First: Five-Year Report of the National Confidential Inquiry, London: Department of Health.

[12] General Medical Council, Good Medical Practice, 2001, 2006, 2013 and 2024 editions; Department of Health and Royal College of Psychiatrists (2005), New Ways of Working for Psychiatrists; RCPsych College Centre for Quality Improvement, AIMS accreditation (from 2006).

1.13 2002

National Suicide Prevention Strategy.[13] This established a target relating to inpatient suicide (section 2). Inpatient suicide became a national priority.

Medical devices legislation.[14] The UK Medical Devices Regulations were introduced (section 8). The definition of a medical device criticised in section 8 dates from here.

1.14 2004

Confidentiality.[15] The GMC revised its confidentiality guidance. Family involvement remained tightly constrained (section 4).

1.15 2005

Observation guidance.[16] NICE restated the established observation levels (section 2). The levels stayed stable; what changed later was the introduction of variable timing for intermittent observations.

New Ways of Working.[17] This reshaped the role of the consultant psychiatrist. The consultant became the senior clinical decision-maker within a multidisciplinary team, concentrating on complex cases and supervising and advising colleagues. Experienced non-medical staff increasingly carried their own caseloads. Decisions such as observation levels therefore became team decisions made with consultant input, rather than instructions issued by a single doctor.

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[13] Department of Health (2002), National Suicide Prevention Strategy for England.

[14] Medical Devices Regulations (2002).

[15] General Medical Council, Confidentiality: Protecting and Providing Information (2000, revised 2004); Confidentiality (2009); Confidentiality: Good Practice in Handling Patient Information (2017).

[16] Standing Nursing and Midwifery Advisory Committee (1999), Practice Guidance: Safe and Supportive Observation of Patients at Risk, London: Department of Health; NICE (2005), CG25; NICE (2015), NG10, Violence and aggression: short-term management, https://www.nice.org.uk/guidance/ng10; Department of Health (2015).

[17] New Ways of Working for Psychiatrists; RCPsych College Centre for Quality Improvement, AIMS accreditation (from 2006).

1.16 2006

Ward accreditation. Royal College accreditation of inpatient mental health wards began. Ward standards became inspectable against national criteria.

Good Medical Practice.[18] A revised edition was issued. See the 2001 entry.

1.17 2007

Mental Capacity Act.[19] The Act came into force (section 6). Before this, capacity decisions rested on the common law.

Best Practice in Managing Risk.[20] Department of Health guidance endorsed the structured risk-assessment tools then in standard use (section 2). Stratifying risk was orthodox practice at this date - relevant to the early cases.

1.18 2008

Mental Health Act changes.[21] In November, amendments made by the Mental Health Act 2007 replaced the responsible medical officer with the responsible clinician. A revised Code of Practice was also issued (section 6). Cases before November 2008 sat under the responsible medical officer framework.

1.19 2010

Triangle of Care.[22] This established a framework for involving carers in mental healthcare (section 4). Involving carers became an articulated national expectation.

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[18] General Medical Council, Good Medical Practice, 2001, 2006, 2013 and 2024 editions; Department of Health and Royal College of Psychiatrists (2005), New Ways of Working for Psychiatrists; RCPsych College Centre for Quality Improvement, AIMS accreditation (from 2006).

[19] Mental Health Capacity Act (2005)

[20] Department of Health, Best practice in managing risk: the assessment and management of risk to self and others in mental health services.

[21] Department of Health (2015), Mental Health Act 1983: Code of Practice

[22] Worthington, A. and Rooney, P. (2010), The Triangle of Care. Carers Included: A Guide to Best Practice in Acute Mental Health Care, London: The Princess Royal Trust for Carers and the National Mental Health Development Unit.

1.20 2012

National Early Warning Score.[23] The Royal College of Physicians published the first NEWS (section 2). Before this, wards used locally designed charts.

Oxehealth.[24] The company was spun out of the University of Oxford (section 7). The company whose system sections 7 and 9 consider.

1.21 2013

Observation practice in South Essex.[25] Local policy had moved away from fixed 15-minute checks towards observations conducted at irregular intervals (Najim 2013; section 2). The irregular-interval pattern EPUT later formalised.[26]

Good Medical Practice.[27] A revised edition was issued. See the 2001 entry.

1.22 2014

Trauma-informed care.[28] Substance Abuse and Mental Health Services Association (SAMHSA) codified its approach to trauma-informed care in the United States (section 5). The framework UK practice later borrowed.

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[23] Royal College of Physicians, 'National Early Warning Score (NEWS) 2' (19 December 2017), https://www.rcp.ac.uk/resources/national-early-warning-score-news-2/.

[24] Oxford University Innovation, Oxehealth: supporting safer patient care (spin-out 2012; adoption by roughly half of English mental health trusts), https://innovation.ox.ac.uk/case-study/oxehealth-supporting-safer-patient-care; Oxehealth CE Class IIa accreditation announced 20 September 2018, https://www.businesswire.com/news/home/20180920005021/en/.

[25] Najim, H., Saleem, K., Al Shirbiny, B. and Ezeasor, N. (2013), 'Analysis of clinical observation on acute psychiatric wards', Psychiatria Danubina, 25(Suppl. 2), pp. S178-S181, at p. S178 (South Essex policy of checks at irregular intervals), https://hrcak.srce.hr/file/386972.

[26] Essex Partnership University NHS Foundation Trust (2023), Therapeutic Engagement and Supportive Observation Policy (Inpatients), CLP8, version 4.2 (initial issue date 30 March 2018), p. 10 (four irregular checks per hour), https://lampardinquiry.org.uk/wp-content/uploads/2025/05/MK2-029-CLP8-Therapeutic-Engagement-and-Supportive-Observation-REDACTED_Redacted_FINAL.pdf; versions before the Inquiry are exhibited at [EPUT027721] and following.

[27] General Medical Council, Good Medical Practice, 2001, 2006, 2013 and 2024 editions; Department of Health and Royal College of Psychiatrists (2005), New Ways of Working for Psychiatrists; RCPsych College Centre for Quality Improvement, AIMS accreditation (from 2006).

[28] SAMHSA (2014), SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

Information sharing.[29] The Department of Health issued its consensus statement on information sharing and suicide prevention (section 4). Listening to families was affirmed as compatible with confidentiality.

1.23 2015

Consent.[30] The decision in *Montgomery* changed the law governing consent (section 6). The standard against which later consent practice, including that for the use of Oxevision, is judged.

NICE guideline NG10.[31] NICE issued its guideline covering violence, aggression and observation (section 2). Still the guideline in force.

Mental Health Act Code of Practice.[32] The revised Code devoted chapter 26 to observation (sections 2 and 6). The first Code to deal with observation in this detail.

1.24 2016–2017

Risk prediction. Evidence increasingly challenged the reliability and clinical usefulness of predicting and stratifying suicide risk (section 2). The evidential basis for the change in guidance that followed.

1.25 2017

NEWS2.[33] The revised National Early Warning Score was published in December (section 2). The main physical health standard considered in this report.

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[29] Department of Health (2014), Information Sharing and Suicide Prevention: Consensus Statement; updated by DHSC (2021), https://www.gov.uk/government/publications/consensus-statement-for-information-sharing-and-suicide-prevention.

[30] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; General Medical Council (2020), Decision Making and Consent (implied consent in routine examinations).

[31] NICE (2005), CG25; NICE (2015), NG10, recommendation 1.4.11.

[32] Department of Health (2015), Mental Health Act 1983: Code of Practice

[33] Chen, L., Sun, Y., Kuek, S.Y., Chew, M.F., Tan, H.L. and Ho, S. (2025) 'Predictive performance and temporal dynamics of National Early Warning Score 2 (NEWS2) in detecting clinical deterioration in general ward: a large-scale validation study in Singapore', *Resuscitation Plus*, 26, 101120.

1.26 2018

EPUT observation policy.[34] The first version of CLP8 required four irregular checks per hour for enhanced observation (section 2). The EPUT policy referred to in sections 2 and 9.

Oxehealth accreditation.[35] Oxehealth's vital-signs software obtained CE accreditation in September (section 7). Spot measurement only - never continuous monitoring.

CQC inspection.[36] In December, a CQC inspection praised the use of sensor technology (section 7).

Risk stratification.[37] The National Confidential Inquiry advised against stratifying patients by predicted risk (section 2). The official turn against risk scoring.

1.27 2019

NEWS2.[38] Its use became mandatory in acute and ambulance trusts (section 2). No equivalent mandate reached mental health trusts.

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[34] Therapeutic Engagement and Supportive Observation Policy (Inpatients) (CLP8): Version 1 [EPUT027721]; and Version 2.5 [EPUT027714]

[35] Oxford University Innovation, Oxehealth: supporting safer patient care (spin-out 2012; adoption by roughly half of English mental health trusts), https://innovation.ox.ac.uk/case-study/oxehealth-supporting-safer-patient-care; Oxehealth CE Class IIa accreditation announced 20 September 2018, https://www.businesswire.com/news/home/20180920005021/en/.

[36] Care Quality Commission (21 December 2018), Coventry and Warwickshire Partnership NHS Trust: wards for older people (inspection report); Rethink Mental Illness (November 2023), Our Position on Oxevision, https://www.rethink.org/news-and-stories/media-centre/2023/11/our-position-on-oxevision-the-new-monitoring-system-in-mental-health-units/.

[37] NCISH (2018), The Assessment of Clinical Risk in Mental Health Services, Manchester: University of Manchester.

[38] NHS Improvement (April 2018), Patient Safety Alert: Resources to support the safe adoption of the revised National Early Warning Score (NEWS2) (adoption required in acute and ambulance settings by March 2019), https://www.england.nhs.uk/2018/04/safe-adoption-of-news2/. [Add the trust physical health / observation policies before the Inquiry that adopt NEWS2, e.g. EPUT's.]

Digital technology standards.[39] NICE introduced evidence standards for digital health technologies (section 8). The first framework against which a system like Oxevision could be evaluated.

1.28 2020

Decision Making and Consent.[40] The GMC issued its revised professional guidance on consent and decision-making (section 6). The current statement of consent practice, including implied consent.

1.29 2021

Information sharing.[41] The consensus statement on information sharing and suicide prevention was updated (section 4). The version cited in section 4.

Shared decision-making.[42] NICE published its guideline on shared decision-making (section 6). This became the expected norm, including for psychiatric medication.

Digital technology assessment.[43] The NHS introduced its digital technology assessment criteria (section 8). Assessment criteria for buying digital tools.

1.30 2022

Trauma-informed practice.[44] An official definition of trauma-informed practice was published (section 5). The concept only now acquired an official UK definition.

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[39] Evidence Standards Framework for Digital Health Technologies; NHSX (2021), Digital Technology Assessment Criteria (DTAC); NHS England (7 February 2025), Principles for Using Digital Technologies in Mental Health Inpatient Treatment and Care, PRN01510.

[40] General Medical Council, Seeking Patients' Consent: The Ethical Considerations (1998); Consent: Patients and Doctors Making Decisions Together (2008); Decision Making and Consent (2020).

[41] Department of Health (2014), Information Sharing and Suicide Prevention: Consensus Statement; updated by DHSC (2021), https://www.gov.uk/government/publications/consensus-statement-for-information-sharing-and-suicide-prevention.

[42] NICE (2021), Shared decision making, NG197, https://www.nice.org.uk/guidance/ng197.

[43] NICE (2019, updated 2022), Evidence Standards Framework for Digital Health Technologies; NHSX (2021), Digital Technology Assessment Criteria (DTAC); NHS England (7 February 2025), Principles for Using Digital Technologies in Mental Health Inpatient Treatment and Care, PRN01510.

[44] Office for Health Improvement and Disparities (2022), Working Definition of Trauma-Informed Practice, https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice

Risk stratification.[45] NICE instructed practitioners not to use risk-stratification tools to predict suicide or determine treatment (section 2). Practice which had been the orthodoxy in 2007 was now proscribed.

1.31 2023

Monitoring technology.[46] Rethink Mental Illness published its position statement on surveillance and monitoring technology (section 7). Consideration of Oxevision, including its benefits, risks, and concerns entered the mainstream of psychiatric discussion.

1.32 2024

Evidence concerning surveillance technology.[47] A systematic review found insufficient evidence to support the use of surveillance technologies in mental healthcare (section 7). The evidence gap underlying sections 7 and 10.

Culture of Care Standards.[48] NHS England's standards required inpatient services to adopt trauma-informed approaches (section 5). Trauma-informed care became a national inpatient standard.

Good Medical Practice.[49] The latest edition came into effect. See the 2001 entry.

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[45] NICE (2022), NG225, Self-harm: assessment, management and preventing recurrence, https://www.nice.org.uk/guidance/ng225.

[46] Rethink Mental Illness (November 2023), Our Position on Oxevision, https://www.rethink.org/news-and-stories/media-centre/2023/11/our-position-on-oxevision-the-new-monitoring-system-in-mental-health-units/.

[47] Griffiths, J.L. et al. (2024), 'The use and impact of surveillance-based technology initiatives in inpatient and acute mental health settings: a systematic review', BMC Medicine, 22, 564

[48] NHS England (2024), Culture of Care Standards for Mental Health Inpatient Services, https://www.england.nhs.uk/long-read/culture-of-care-standards-for-mental-health-inpatient-services/.

[49] General Medical Council, Good Medical Practice, 2001, 2006, 2013 and 2024 editions; Department of Health and Royal College of Psychiatrists (2005), New Ways of Working for Psychiatrists; RCPsych College Centre for Quality Improvement, AIMS accreditation (from 2006).

1.33 2025

Digital technology principles.[50] NHS England published its principles for digital technologies in February (section 7). The first national rules for systems like Oxevision.

CQC guidance.[51] The CQC issued its brief guide to monitoring technology in August (section 7). Consent and no-substitution expectations made explicit.

Mental Health Act 2025.[52] The Act received royal assent in December (section 6). Commencement lies ahead; the 1983 Act governed the whole period.

[50] NHS England (7 February 2025), Principles for Using Digital Technologies in Mental Health Inpatient Treatment and Care, PRN01510

[51] Care Quality Commission (updated 20 August 2025), Brief Guide: Digital Contactless Patient Monitoring Technologies.

[52] Mental Health Act 2025.

2 Section 2 — The role and purpose of observations

Purpose of observations from a psychiatric perspective

Different clinical purposes

2.1 The term "observations" has come to refer to a collection of different activities when used in mental health care. Probably the history is that the term comes from its use in physical health, where it "*became the practice*" to evaluate patients regularly and to take basic readings of bodily functions, and tracking those evaluations sequentially often gave significant help to clinicians in working out what was wrong, how the patient was doing overall, and what interventions to try next. Observations were safe, simple tests done on everybody and were distinguished from investigations, which were done specifically and for some particular purpose.

2.2 In mental health, observations came to mean, at one and the same time:

a) A process of checking on the location and level of wellbeing of patients according to some regular schedule;
b) An intervention specifically designed to keep patients who were at risk themselves safe from that risk; and
c) The institution of some regime of physical health observations in patients where there were concerns.

2.3 Only in this last area did observations at all resemble their use in physical health care settings. Instead, in the context of mental health, where a patient's mental life is so central to their care, the concept of "observing," as in "taking readings," had such sharp limits that it had to give way to observing as "experiencing with" or at least "checking in". The concept of engagement came partly to embody this aspect of observations.[53]

2.4 This added complexity to the nature of some kinds of observations, then drove a further extension in the way they were used. Because the experience of being approached by someone who is interested to know how one is and who wishes to

[53] Walker, L., Reynolds, T., O'Shaughnessy, M. and Pereira, S. (2005), 'Safe and supportive observation in practice: a clinical governance project', Mental Health Practice, 8(8), pp. 13-16, doi:10.7748/mhp2005.05.8.8.13.c1859; cited in Jill Archibald, Report for the Lampard Inquiry: Observation and Engagement and the Use of Vision Based Monitoring, para. 3.2, fn. 4, p. 12 [INQY025967_0012].

help is itself impactful, and because it is impossible simply to gather information about another person without at least in part intervening, observation practice also became, albeit in a small way, a therapeutic practice.

2.5 Therefore, overall, the clinical purposes of observation are in my view:

a) To provide clinicians with rich and appropriate clinical information that helps them tailor and improve treatment;
b) To evaluate and help manage clinical risks;
c) To assist in building trusting relationships with patients; and
d) To promote small joint activities that improve mental health.

Intended clinical benefits

2.6 It follows from the above that the intended benefits of observations are:

a) Being able to use rich clinical information to understand a patient's situation more fully and to deliver more accurate care;
b) Being able to use rich clinical information to try and promote clinical safety;
c) Being able to use repeated, consistent involvement to promote a trusting and working alliance with patients; and
d) Being able to deliver a repeated experience of increased self-understanding and self-compassion.

2.7 The ability of observation and engagement to deliver the intended benefits is considered in section 3.

Therapeutic care, not solely risk management

2.8 Inherent in the model of observations set out above is a theory of observation practice that is rooted in the idea of reciprocal relationships between patients and clinical staff in which the fact of those relationships is used to drive increased self-knowledge and strengthen compassionate self-management. While this way of putting things might sound high-flown, the interactions it seeks to describe can seem very simple but yet be highly skilled.

Illustrative example:

"A ward decided to change the first round of observations after morning handover so that each patient was offered a cup of tea or coffee in bed by the nurse who was looking after them that day. The staff member would knock, pop their head round the door and ask if the patient would like a cup of tea and how they took it, while introducing themselves as the patient's nurse for the shift. Bringing the tea let the staff member ask how the patient had slept, maybe mentioning that the night staff had said they might have had a rough night and allowed the patient space to self-observe and think how their night had been and how they felt"

The outcome of this round of observations was, at once, building trust and delivering care, observation and maintaining safety, and the gathering of a critical piece of psychiatric information i.e. how well someone slept. This illustrates the multiple functions of observations.

2.9 Overall, therefore, it would be most correct to say that observations should be an indivisible part of therapeutic psychiatric care, and that if observations are not integrated in this way, then they will neither be therapeutic nor safe.

Inpatient care observations, risk and risk management

Inpatient context and the central place of risk

2.10 My focus so far has been on the function of observations as therapeutic and information-gathering activities. However, the way in which they have chiefly been raised in investigations and which has caused concern has been their role in managing clinical risk. With the widespread closure of large numbers of mental health beds,[54] which coincided with a strong national focus on treating patients at home if at all possible,[55] modern inpatient care has become very largely a question of managing risk.[56] Only a small number of patients are admitted for a specific

[54] NHS England KH03 time series. There has been about a 45% reduction in psychiatric beds between 2003 and the present day.

[55] Crisis-team gatekeeping was introduced as national policy in England in 2001, through the Department of Health's *Mental Health Policy Implementation Guide National Audit Office*. With broad roll out in 2004-5 National Audit Office.

[56] Howard, L.M., Rigon, E., Cole, L., Lawlor, C. and Johnson, S. (2008) 'Admission to women's crisis houses or to psychiatric wards: women's pathways to admission', *Psychiatric Services*, 59(12), pp. 1443–1449; Langan, J. (2008). The risks of risk assessment. *Advances in Psychiatric Treatment*, *14*(6), 430–437. doi.org; Jacob, D., Holmes, D., & Buus, N. (2017). Safety in psychiatric inpatient care: The impact of risk management culture on mental health nursing practice. *Nursing Inquiry*, *24*(4), e12199. doi.org.

procedure such as electroconvulsive therapy (ECT) or the initiation of a particular drug. Therefore, when patients are admitted to an inpatient ward, the most likely reason will be that there does not seem to be any other way to try and help them with their mental health problem safely.

2.11 While there are a range of relevant risks that might be the reason for admission, including risks to others, risks from physical health conditions and safeguarding risks (there is a growing body of evidence showing these risks are seriously underestimated),[57] the paradigm risk is self-harm and suicide.

What observations are intended to do

2.12 Observations intersect with risk because their information-gathering purpose allows for greater information that can feed into risk evaluation; they allow for direct prevention of risky behaviour, and they can deliver therapeutic risk reducing intervention.

2.13 For example, during an observation, a nurse may notice that a patient is distressed and agitated. As agitation is a risk indicator for suicidal behaviour,[58] the nurse can now intervene, perhaps suggesting some distraction and individual time, or inviting the patient to sit in a communal area, as well as considering medication options if need be.

2.14 Equally, on some occasions observations will interrupt an act of self-harm, at which point direct prevention and medical aid can be delivered.

Baseline and precautionary observation arrangements

2.15 In normal practice, all patients on wards are observed at a minimum of once an hour unless they are on leave. The reasoning behind this is precautionary. It represents a basic safety stop that ensures that, on a busy ward, every patient has at least one touchpoint per hour. Patients do abscond from wards, and this is a

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[57] On physical health risks: Chesney, E., Goodwin, G.M. and Fazel, S. (2014), 'Risks of all-cause and suicide mortality in mental disorders: a meta-review', World Psychiatry, 13(2), pp. 153-160; Hayes, J.F., Marston, L., Walters, K., King, M.B. and Osborn, D.P.J. (2017), 'Mortality gap for people with bipolar disorder and schizophrenia: UK-based cohort study 2000-2014', British Journal of Psychiatry, 211(3), pp. 175-181. On safeguarding risks: Care Quality Commission (2018), Sexual Safety on Mental Health Wards.

[58] Busch, K.A., Fawcett, J. and Jacobs, D.G. (2003), 'Clinical correlates of inpatient suicide', *Journal of Clinical Psychiatry*, 64(1), pp. 14–19.

moment when it can be established that all the patients are where they are expected to be.[59]

2.16 **Diana Hammond**[60]

60, died 3 December 2005 · Finchingfield Ward, the Linden Centre, Chelmsford · North Essex Partnership University NHS Foundation Trust

Diana had a longstanding diagnosis of an affective disorder over many years, with a history of impulsive self-harm, with two known serious attempts of self-harm recorded. These involved placing herself in front of a slow-moving train and an overdose. Diana's daughter Jackie also recalls that she had attempted suicide on a number of occasions. She had previously had multiple admissions to hospital.

After becoming seriously unwell, Diana was admitted to hospital on 16 November 2005 with low mood and suicidal thoughts. By 29 November, she was improving albeit with variations in her mood. She wanted to be treated with ECT and this was started on 2 December. However, that afternoon she absconded from the ward and was noticed to be missing during an observation check on another patient.

Diana's daughter said later that observations had not been done properly.

Diana had been struck by a train. She died the following day.

In Diana's case, hourly observations, if done properly, might have identified that she had absconded and so possibly allowed for her to be found before she got to the railway line.

2.17 Sitting above the routine hourly observations conducted on every patient are various forms of more frequent observations. In general, these are often either

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[59] The hourly baseline for all inpatients is set at trust level rather than in national guidance: for example, Leicestershire Partnership NHS Trust, Supportive Observation and Engagement Policy, v12.2: 'Level 1 General Observation - Here and Well Check (hourly) - this is the minimum level of observation for all patients in inpatient areas'. EPUT's equivalent is the Therapeutic Engagement and Supportive Observation Policy (CLP8) [EPUT027721 and later versions] The hourly baseline is consistent with NICE (2015), NG10, recommendation 1.4.11, which defines low-level intermittent observation as 'the baseline level of observation in a specified psychiatric setting' at once every 30 to 60 minutes; see also Department of Health (2015), Mental Health Act 1983: Code of Practice, paras 26.28-26.35, and NHS England (28 August 2025), Enhanced therapeutic observation and care: developing a local policy.

[60] Case Summary of Diana Hammond [INQY025340].

observations at roughly 15-minute intervals (or more frequently in some settings). Lastly, there is the option for continuous observations.

2.18 Observation guidance itself has been fairly stable. At the start of the period under consideration by the Inquiry, the governing document was practice guidance issued in 1999. This defined levels of observation which were very similar to current practice: general checks, intermittent observation at 15 to 30 minute intervals, within eyesight, and within arm's reach.[61] NICE guidance restated similar levels in 2005. The Mental Health Act Code of Practice was revised in 2008 and again in 2015, with chapter 26 of the 2015 Code covering observations. NICE updated its guidance in 2015, and that guideline remains current. One practice detail did change during the period: fixed 15-minute checks gave way to intermittent checks at irregular intervals, so that patients could not predict when the next check would come. In South Essex, checking at irregular intervals was policy by 2013,[62] and EPUT's Therapeutic Engagement and Supportive Observation Policy (CLP8, first issued 30 March 2018) requires four irregular checks per hour for enhanced (level 2) observation.[63] A psychiatrist at any point in the period would have recognised broadly the same observation framework.

2.19 The Code of Practice's treatment of observation did change between editions. The 1999 Code dealt with observation briefly in its chapter on patients presenting particular management problems. The 2008 Code covered it within its chapter on safe and therapeutic responses to disturbed behaviour. The 2015 Code went further: paragraphs 26.28 to 26.35 expect each hospital to have an observation policy that specifies levels, who may set and change them, and how observations

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[61] Standing Nursing and Midwifery Advisory Committee (1999), Practice Guidance: Safe and Supportive Observation of Patients at Risk, London: Department of Health; NICE (2005), CG25; NICE (2015), NG10, Violence and aggression: short-term management, https://www.nice.org.uk/guidance/ng10; Department of Health (2015), Mental Health Act 1983: Code of Practice, chapter 26.

[62] Najim, H., Saleem, K., Al Shirbiny, B. and Ezeasor, N. (2013), 'Analysis of clinical observation on acute psychiatric wards', Psychiatria Danubina, 25(Suppl. 2), pp. S178-S181, at p. S178 (South Essex policy of checks at irregular intervals), https://hrcak.srce.hr/file/386972.

[63] Essex Partnership University NHS Foundation Trust (2023), Therapeutic Engagement and Supportive Observation Policy (Inpatients), CLP8, version 4.2 (initial issue date 30 March 2018), p. 10 (four irregular checks per hour), https://lampardinquiry.org.uk/wp-content/uploads/2025/05/MK2-029-CLP8-Therapeutic-Engagement-and-Supportive-Observation-REDACTED_Redacted_FINAL.pdf; versions before the Inquiry are exhibited at [EPUT027721] and following.

should be conducted, recorded and reviewed, with attention to privacy, dignity and principles of least restriction.[64]

2.20 The period of time during which such "enhanced" observations are carried out can vary: it might be a matter of days or targeted at a particularly risky time of day. While these increases in observation level are decided on an individual basis, there are particularly risky times for all patients where increased observation is almost always applied.

2.21 These would include situations such as:

- A period of time after being admitted to the ward or transferred between wards.
- When a patient has had to be restrained and given parenteral[65] medication.
- When a patient has been secluded.

Physical-health deterioration and NEWS2

2.22 Lastly, it is important to return to the use of observations in their original sense as health interventions for physical health conditions. There has been a lot of work in physical health care settings looking at how to detect patients whose health status is deteriorating, as this is something that can be easily missed. The outcome of that work is the National Early Warning Score 2 (NEWS2); this was introduced by the Royal College of Physicians in 2017,[66] updating earlier work. Six parameters are measured: respiration rate, oxygen saturation, systolic blood pressure, pulse, temperature, and consciousness level and each is assigned a score from 0-3. The higher the score, the more concerning the patient's condition. There is good evidence that concerning NEWS2 scores predict a patient's deterioration.[67] The NEWS2 is extremely important in psychiatric practice because the measures are simple and the scoring is standardised. The fact that it reliably predicts deterioration and has clear levels that mandate action means that staff in mental health units who do not necessarily have a great deal of physical health training or

[64] Department of Health (1999), Code of Practice: Mental Health Act 1983, chapter 19; Department of Health (2008), Code of Practice: Mental Health Act 1983, chapter 15; Department of Health (2015), Mental Health Act 1983: Code of Practice, paras 26.28-26.35.

[65] Parenteral medication is medication given intravenously or intramuscularly not orally.

[66] Royal College of Physicians, 'National Early Warning Score (NEWS) 2' (19 December 2017), https://www.rcp.ac.uk/resources/national-early-warning-score-news-2/.

[67] Chen, L., Sun, Y., Kuek, S.Y., Chew, M.F., Tan, H.L. and Ho, S. (2025) 'Predictive performance and temporal dynamics of National Early Warning Score 2 (NEWS2) in detecting clinical deterioration in general ward: a large-scale validation study in Singapore', *Resuscitation Plus*, 26, 101120.

experience can easily apply it. This also means that any measure that is not the NEWS2 (for example just pulse and respiration) must be treated with great caution, and the NEWS2 should be preferred if at all possible.

2.23 Physical health monitoring was standardised late in the period. In the early years, physical health observations were done on locally designed charts. There was no national early warning score until NEWS in 2012, updated to NEWS2 in 2017.[68] NEWS2 was required in acute hospital and ambulance trusts from 2019. There has been no equivalent mandate for mental health trusts; adoption there has come through local physical health and observation policies, and it is now the expected standard in inpatient mental health care.[69] Physical health observations from the early part of the period cannot fairly be judged against NEWS2.

How risk assessment should inform decisions

2.24 It might be hoped that there is a clear line to be drawn between assessing risk, subsequent to that assessment knowing how likely a risky event is, and then, as a result, being able to intervene in a way that is known to reduce risk.

2.25 Sadly, this is simply not the case. We do not have even moderately accurate ways of assessing the risk of suicide, self-harm, absconsion or harm to others. While static predictors of risk (age, sex, mental health diagnosis, past risk history, social disadvantage, and physical illness) and time-dependent predictors (current mental state, recent events, and degree of rapport with staff on the ward) reliably tell us that someone is at increased risk, they also tell us that very many people are at risk – far more than the number who actually do something risky. This makes such indicators very hard to act on – for example by restricting someone's freedom – without having to act in relation to a large number of people who would never need or benefit from that restriction. Worse, the risk factors fail to reliably pick out the individuals who later go on to do seriously harmful things.[70]

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[68] Royal College of Physicians (2012), National Early Warning Score (NEWS); Royal College of Physicians (2017), NEWS2, https://www.rcp.ac.uk/improving-care/resources/national-early-warning-score-news-2/.
[69] NHS Improvement (April 2018), Patient Safety Alert: Resources to support the safe adoption of the revised National Early Warning Score (NEWS2) (adoption required in acute and ambulance settings by March 2019), https://www.england.nhs.uk/2018/04/safe-adoption-of-news2/. [Add the trust physical health / observation policies before the Inquiry that adopt NEWS2, e.g. EPUT's.]
[70] Franklin JC et al. Risk factors for suicidal thoughts and behaviours: a meta-analysis of 50 years of research. *Psychol Bull* 2017;143:187–232. This longitudinal study showed prediction was little better than chance and that accuracy had not increased over 50 years.

2.26 As this fact came to be appreciated, guidance changed to discourage the practice of stratifying risk into high, medium, and low as inaccurate and misleading because high numbers of patients categorised as low or medium risk showed risky or suicidal behaviour.[71] This finding led to strong advice not to use such simple classifications and instead to adopt more flexible, discursive, individualised, and holistic assessments of risk. It was hoped that these dynamic assessments would provide more accurate predictions of future behaviour. However, this has simply never been properly tested, and the question as to the predictive power of our new risk assessments is unanswered.

2.27 The way in which risk assessment was approached did change. Initially, perhaps by analogy with successful scoring systems such as the APGAR for neonates,[72] structured risk assessment tools and the stratification of patients into high, medium and low risk were standard practice and officially encouraged.[73] From the mid-2010s, evidence accumulated to show that ratings did not predict who would come to harm. As a result, NCISH advised against stratification in 2018; NICE followed suit, categorically stating in 2022 that risk tools should not be used to determine management.[74]

2.28 The consequence is that we have a modern practice of holistic risk assessment in the form of a host of more or less structured sets of guidance or semi-structured tools, but no tool has been supported by a study showing its predictive power. Most of the risk assessment structures in modern practice look as though they should be helpful, but we do not know that they are.[75] The experience of clinical

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Carter G et al. Predicting suicidal behaviours using clinical instruments. *Br J Psychiatry* 2017;210:387–95. This depressing study showed that no "high risk classification was clinically useful".

[71] National Institute for Health and Care Excellence (2022), *Self-harm: assessment, management and preventing recurrence*, NICE guideline NG225, https://www.nice.org.uk/guidance/ng225; Chan, M.K.Y., Bhatti, H., Meader, N., Stockton, S., Evans, J., O'Connor, R.C., Kapur, N. and Kendall, T. (2016), 'Predicting suicide following self-harm: systematic review of risk factors and risk scales', *British Journal of Psychiatry*, 209(4), pp. 277–283

[72] Apgar, V. (1953), 'A proposal for a new method of evaluation of the newborn infant', Current Researches in Anesthesia and Analgesia, 32(4), pp. 260-267.

[73] Department of Health (2007), Best Practice in Managing Risk, London: DH.

[74] Chan, M.K.Y. et al. (2016), 'Predicting suicide following self-harm: systematic review of risk factors and risk scales', British Journal of Psychiatry, 209(4), pp. 277-283; NCISH (2018), The Assessment of Clinical Risk in Mental Health Services, Manchester: University of Manchester; NICE (2022), NG225, Self-harm: assessment, management and preventing recurrence, https://www.nice.org.uk/guidance/ng225.

[75] National Institute for Health and Care Excellence. *Evidence review for risk assessment and formulation. Self-harm: assessment, management and preventing recurrence: Evidence review G.* London: NICE;

teams is that they are often surprised by risk events and that, while they can then look back and think about what might have been missed, similar factors are present in patients who did not do anything serious.

Prediction, prevention and restriction of means

2.29 Paradoxically, even though we cannot predict risk well, we might still be able to reduce it. There is one really clear risk factor where reduction is reliably associated with a reduction in risk, namely the availability of means. Reducing the availability of means reduces suicide rates.[76] This is an incredibly important finding and acting on it has demonstrably reduced inpatient suicides.

2.30 This finding holds true on an epidemiological level and lies behind simple but helpful interventions, such as putting poisonous medication in blister packs; it also holds true in inpatient settings, with substantial reductions in deaths by hanging on wards achieved following the successive drives to reduce the availability of fixed ligature points.[77]

2.31 Over the period there has been a relentless focus on suicide prevention by means of restricting the availability of ligature points.[78] The National Confidential Inquiry recommended the removal of non-collapsible curtain rails and other ligature points in 2001, and the 2002 national strategy set a target for inpatient suicide.[79] Ligature point removal continued through the 2000s. Inpatient suicides fell by roughly two-thirds over the period, with a documented fall in deaths by hanging on

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September 2022. NICE Guideline No. 225. ISBN 978-1-4731-4702-7. "*This sets out the evidence review in relation ot the guidance. Notably the authors write Please note that the included studies do not meet the inclusion criteria, in the sense that there were no studies that compared risk assessment (RA) plus risk formulation with RA alone or no RA, and no studies comparing RA alone with no RA. Instead, the evidence included were from studies comparing RAs conducted by different professionals, which may have resulted in differences in risk formulation. These studies were included because they were the best evidence available*".

[76] Hawton, K., Knipe, D. and Pirkis, J. (2024) 'Restriction of access to means used for suicide', *The Lancet Public Health*, 9(10), pp. e796–e801.

[77] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) (2013), *Patient suicide: the impact of service changes: a UK wide study*, Manchester: University of Manchester.

[78] Hanging and self-strangulation are the most common method of inpatient suicide: Hunt, I.M., Bickley, H., Windfuhr, K., Shaw, J., Appleby, L. and Kapur, N. (2012), 'Ligature points and ligature types used by psychiatric inpatients who die by hanging: a national study', Crisis, 33(2), pp. 87-94; NCISH annual reports, https://sites.manchester.ac.uk/ncish/reports/.

[79] NCISH (2001), Safety First: Five-Year Report of the National Confidential Inquiry, London: Department of Health; Department of Health (2002), National Suicide Prevention Strategy for England.

wards.[80] As fixed high-level points were removed, deaths shifted towards low-level ligature points - doors, furniture and fittings below head height - from which suspension is still possible. Guidance now expects ligature risk assessment to cover low-level points, while accepting that they cannot all be removed.[81]

2.32 Arguably, the success of these drives has been because they have been blanket measures. No prediction of suicidal risk has been required; instead, all inpatient wards have, over time, had fixed ligature points stripped out, removing a previously available means of suicide.

2.33 **Stephen Neville**[82]

68, died 18 December 2021 · Beech Ward, Rochford Community Hospital · EPUT

Stephen had diagnoses of severe, treatment-resistant depression, anxiety and agitation. He made repeated attempts at suicide and self-harm. Stephen deteriorated and needed treatment with ECT.

On 16 December 2021, Stephen was admitted to Beech Ward. His admission had not been arranged with the bed management team. Upon admission, staff focused only on the admission for ECT and did not engage with Stephen's family members to seek further information relevant to his present risk. Stephen was placed on level 2 observations (four checks per hour, at irregular intervals).

On admission, a doctor assessed Stephen and prescribed venlafaxine, mirtazapine and lorazepam as required up to a maximum of 3mg a day, including his regular dose. However, on 17 December 2021, the Associate Specialist Psychiatrist stopped the regular dose of lorazepam and reduced the 'as required' dose, prescribing promethazine instead as needed for anxiety. The doctor was unaware that Stephen had been prescribed lorazepam daily for the past 14 months, having not reviewed the available medical records. The doctor did not discuss or explain his decision to reduce Stephen's lorazepam prescription to him

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[80] NCISH (2013), Patient Suicide: The Impact of Service Changes, Manchester: University of Manchester; NCISH annual reports, https://sites.manchester.ac.uk/ncish/reports/.

[81] Hunt, I.M. et al. (2012), as above (doors were the most commonly used ligature points); Care Quality Commission, Brief guide for inspection teams: ligature anchor points, ligatures and other means of self-harm using fixtures and furniture; Department of Health, Health Building Note 03-01: Adult Acute Mental Health Units (design guidance on reducing ligature risk).

[82] Case Summary of Stephen Neville [INQY025675].

or his family. The sudden reduction in his dosage was not identified as a risk or included in a risk assessment.

The following day, Stephen's medication was again amended, changing his Lorazepam to as required from regular and substituting another drug by a doctor who was not aware of his full medication history.

On the morning of 18 December 2021, the nurse administering medication informed Stephen that his prescription of lorazepam had been stopped, seemingly unaware that lorazepam was available on a reduced "as required" basis. Stephen was observed every 15 minutes by the healthcare assistant (HCA) on shift and was observed to be "in good spirits" between 09:00 and 10:00. The HCA handed over to a nursing colleague to continue level 2 observations.

Stephen was noted to be missing from his room at a further check at 10:55. However, the Serious Incident Reporting Form considered as part of the independent investigation into Stephen's care suggests that the incident occurred as early as 10:38. He was subsequently found in the communal shower area, where he had deployed a trouser cord as a ligature from a known fixed ligature point. Stephen was found unconscious and died that day.

There were a number of different failings in Stephen's management, including failures in relation to medication and to conducting observations correctly, but the presence of a fixed ligature point provided Stephen with the means to take his life.

2.34 At the most basic level, observations can help reduce risk simply by preventing risky acts. They do that by reducing the availability of means. For that to work, they need either to physically prevent an individual from acting to harm themselves, and this would be the case with 1:1 observations, or reduce the opportunity for harm when observations are more infrequent.

2.35 The difficulty is that the most certain form of observation practice that would prevent the availability of means - one-to-one observations - is intrusive, unnatural and impractical given that we do not know with high certainty who is at risk or when. Even conducting four observations an hour is a difficult and staff-intensive activity if it is to be done with the appropriate degree of care and attention. Since we cannot reliably pick out patients who are at risk, and we cannot and should not implement high levels of observations on all patients, we are left attempting to

make decisions about observation levels to add safety to patients' care on the basis of the best assessment of risk we can manage.

Limitations of static factors, diagnosis and historical incidents

2.36 I am asked specifically about the limitations of relying solely upon static risk factors, diagnosis or historical incidents. It is obviously right to include both trait and state markers in the assessment of risk. A trait marker is a longstanding factor such as gender. A state marker is a shorter-term factor such as an acute crisis. In practice though, a more common error is to downplay the significance of past presentation or historical information and to accept an apparently reassuring current mental state as a correct indicator of risk. The accounts of families after serious incidents can be that staff were overly influenced by the patient's presentation at a particular point in time, whereas the family's historical knowledge either of the patient's presentation over the immediately preceding hours or days or of the progress of a similar illness in the past should have been taken into account and raised concerns.

Changes requiring reassessment

2.37 Risk changes over time. We hope that, in time, patients will respond to treatment while they are on the ward, and one frequently overlooked intervention that is designed to reduce risk is to treat the underlying illness actively. Because risk can change, it needs reassessment on a regular basis, and this is the function of regular ward reviews and multidisciplinary team meetings. Reviewing observation levels at these times is a good way of making consensus decisions about how observations can be changed.

2.38 More difficult is knowing how to respond to a new piece of information such as a sudden bad event or a clinical incident. These may or may not be times when intervention to anticipate increased risk downstream is helpful. It might seem incredible to suggest that when risk increases, observation levels should not increase too, but because anxiety produces upward pressure on observation levels, people with fluctuating risk can experience a ratchet effect whereby observation levels are driven higher and higher and then are not reduced. Efforts to try and deal with this situation (often called "positive risk taking")[83] may involve considered decisions not to increase observation levels if possible.

[83] Department of Health (2007), Best Practice in Managing Risk, London: DH.

2.39 A detailed discussion of the issue of "positive risk taking" lies outside the scope of this report. It is best at this stage to state that reviews of observation levels should involve the same processes and considerations that were involved in instituting them initially. That is to say, the gathering of information from all sources and the taking, ideally collectively, of the best decision under the circumstances.

2.40 **Bethany Lilley**[84]

28, died 16 January 2019 · Thorpe Ward, Basildon Mental Health Unit · EPUT

Bethany had a history of multiple mental health problems stretching back to the age of 16. She self-harmed, had ADHD and problems with substance abuse. Bethany also had a diagnosis of emotionally unstable personality disorder (EUPD). She had many admissions to hospital and sometimes was detained under the Mental Health Act. Bethany was vulnerable. There were safeguarding concerns in relation to abuse, rape and trafficking.

In January 2019, Bethany was admitted to hospital having self-harmed and taken an overdose. During her admission, she absconded, returning without any trousers and reported having been raped. She was nursed on continuous level 3 (1:1) observations. Bethany self-harmed by cutting her arm and required acute hospital care. After receiving treatment, she could not return to her original mental health ward and had to go to a different one. This ward did not know that Bethany was meant to be on level 3 observations or that she had recently self-harmed, and on transfer she was placed on level 2 observations. Her observations were then reduced to level 1.

Then, on 15 January, having had leave in the morning, Bethany was found unresponsive at 19:43, with a scarf secured tightly around her neck. Although an observation was recorded as having taken place at 19:00, it was concluded at the inquest that this did not take place and that a falsified record had been made. All attempts at resuscitation failed, and Bethany died at 20:26.

The reductions in Bethany's level of observations may have been made without a clear understanding of her level of risk because the ward she was returned to did not have full the information from her previous ward. Those reduced observations

[84] Case Summary of Bethany Lilley [INQY025680].

were also not conducted correctly. This was rightly the focus of investigation and the subject of criticism. However, it is also true that Bethany's observation level could have stayed at a 1:1 level for a very long period of time. At some point, the generally accepted practice of positive risk taking (i.e. taking a risk by reducing observation levels or allowing leave in the hope of promoting a patient's autonomy and thereby their recovery) would have had to be implemented. Because positive risk taking is by definition taking a risk, there will inevitably be tragic occasions when the risk materialises.

Decisions on need, level and review

Factors relevant to commencing observations

2.41 Many of the factors relevant to clinical decision-making when starting observations have already been reviewed. They depend on the purpose of the observations and the setting in which they are conducted. Where safety is concerned, the underlying motive is always the hope of detecting distress and being able to intervene in advance or disrupting active self-harm and preventing a serious outcome. The patient's history, mental state, past incidents and their own feeling about observations are all relevant factors.

Factors relevant to increasing or decreasing observation levels

2.42 In general, it is normal practice to increase observation levels to four times an hour or one-to-one observations when patients are thought to be at greater risk. The alteration is always a matter of actual or anticipated variation in the short term, rather than longer-term risk factors. They will include the patient's current level of psychological distress and symptoms, and the history and frequency of past incidents.

2.43 Wherever possible, these decisions should be collaborative. A precautionary principle would suggest that in the shorter-term, decisions about increasing observations can be made by people with less seniority (indeed by someone with no seniority in the immediate situation – as in "this person is acutely distressed, it is not safe to leave them alone"), whereas decisions to reduce observations might be more wisely made during the day in the multidisciplinary team and after due consideration.

2.44 There may also be non-patient factors involved in decisions about reducing observations. It is possible for wards to become overloaded with observation requirements. In such circumstances, there will need to be consideration of who can have their observations reduced. This might seem appalling, but limitations in resources are real, and when resources are limited it may be better not to attempt the semblance of observations that cannot, in truth, be backed up by coherent engagement. However pressing the situation, I would expect a decision driven by resource limitation to involve senior on-call staff.

Factors relevant to discontinuing observations

2.45 Observations are never "discontinued" while someone is an inpatient, nor should they be. There is huge value in having a regular tick of contact with every patient on the ward on a regular basis.

3 Section 3 — Benefits and risks of observations

Contribution to safety and therapeutic care

3.1 The way in which mental health observations contribute to patient safety and therapeutic care can be thought of as ascending through a range of levels of complexity and certainty.

3.2 At the lowest, most physical health-focussed and most certain level, physical health observations using NEWS2 are good predictors of a patient's physical deterioration, and allow staff to act, seek help and advice from an on-call psychiatrist or GP, or in the most urgent situation, call an ambulance. Equally basic is the brute function of mental health observations in physically interrupting, in the case of intermittent or 1:1 observations, acts of self-harm so as to actually prevent them from happening (or reduce their seriousness). There are risks and drawbacks to these benefits, but they are benefits nonetheless.[85]

3.3 Just as there are targeted physical health observations, there may also be targeted mental health observations; these might more often be set up by psychologists than by psychiatrists to track behaviour or monitor mood, and they are most often used in specialist settings such as eating disorder units and wards for patients with learning disability.

3.4 At a more complex level, there are important contributions to safety and the beginnings of contributions to therapeutic intervention from the more complicated interactions between staff and patient which occur with each observation. By seeking mental closeness and a reciprocal relationship, staff obtain richer clinical information about patients and a greater understanding that may inform an individualised evaluation of risk, allowing for a more intelligent way of reducing means of self-harm or, better yet, altering the patient's level of mental distress.

3.5 This sounds complex but might be no more than noticing a patient is agitated and wringing their hands, offering some PRN (i.e. as required) medication, and having the patient come and sit with staff in a common area and do some simple distracting activity while the medication takes effect.

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[85] Royal College of Physicians (2017), National Early Warning Score (NEWS) 2; Chen, L. et al. (2025), 'Predictive performance and temporal dynamics of NEWS2 in detecting clinical deterioration in general ward', Resuscitation Plus, 26, 101120. Both are cited in section 2.

3.6 Lastly, right at the top level, observation in its fullest form is a complex intervention that aims to deliver a therapeutic intervention that builds trust, self-observation, and compassionate self-understanding and, by so doing, increases mental resilience and reduces risk.

Observation as an engagement opportunity

3.7 Because every in-person observation is an interaction between people, it is always, whatever else, a moment of connection. This means that observations can be a moment, short or long, of engagement.

3.8 These points of engagement do not always need to be protracted or emotionally intense. Just being asked how one is feeling by someone who conveys a real desire to know the true answer makes one ask that question of oneself. It therefore promotes a moment of self-observation and self-reflection. For many patients, because of their mental health difficulties, such moments are rapidly superseded by anguish, self-blame, or more abnormal phenomena such as:

> I am feeling terrible, restless, I must do something to end my distress.
>
> I am in hospital but my family need me, I have let them down.
>
> This person is asking me questions because they are spying on me, I can't trust them.

3.9 If the member of staff can respond to that moment with a response that is thoughtful, compassionate and empowering, then they immediately convey the possibility that the patient's mental state is something that can be thought about and improved. Even a response as simple as "Gosh, it's really important you told me that. That must feel really rotten. Let's think about what we can do" or "I am so glad you managed to tell me what you are worried about. I am not a spy; I am here to help you. Is there any part of you that can believe that?" can have a major impact.

3.10 Importantly, from a psychiatric perspective, the member of staff and the patient also have new information about how the patient is thinking and feeling that will help to guide treatment, even if only in a small way. In such interactions, a guarded patient may reveal that they are having psychotic experiences that would never come out in a formal psychiatric interview. Or the fact that a patient is restless and

anguished may be recognised as the symptom called agitation, which is associated with more severe depressive states and signals an increased degree of suicidal risk.

3.11 Equally importantly, a small piece of therapy has been delivered, one that can be repeated again and again. This "piece of therapy" is a moment of building the alliance between patient and staff and of promoting the internalisation of a relationship that strengthens the part of a patient which is able to self-observe and self-manage.

3.12 While observations are not the only moments of contact between patients and staff, they are regular, low-level, repeatable, and frequent. This feature of observations distinguishes them from longer psychiatric interviews, therapy sessions, and joint activities on the ward. These factors can seem to devalue the engagement part of observations but are actually an important strength. Observations carry much lower interpersonal risk, and are lower-stress moments of engagement. Precisely because less is at stake, more information may be gained and more cumulative intervention delivered.

3.13 It goes without saying that this kind of observation practice has to be done in person because remote observation is not reciprocal. Even when observation is done in person, it needs to be done in a way that conveys to the patient a wish to engage. There are many ways to ask "how are you feeling today?", not all of which convey a desire for a truthful answer.

3.14 I am asked about what happens when observations become task-focused, procedural or focused on monitoring presence rather than understanding the patient. The first thing to say is that this may not always be a bad thing. Staff do need to know if a patient is not present, and if they find that is the case, they need to act. Equally, staff need to apportion time between multiple competing inputs and needs in a setting where resources are frequently insufficient; in those circumstances, procedures that ensure regular things are done regularly are important, and derive their original inspiration from things like surgical checklists.

3.15 The key is acknowledging that those procedural activities which are easier to time and those relational activities which are not can come into tension with each other, and to be clear about the consequences which arise as choices are made about what to prioritise in busy clinical environments.

3.16 Madison Naylor[86]

14, died 27 September 2019 · Larkwood Ward, the St Aubyn Centre, Colchester · EPUT

Madison began to experience difficulties with her mental health when she started secondary school. She was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and had been referred for assessment of Autistic Spectrum Disorder (ASD). Madison's mental health declined, with admissions and overdoses culminating in her being detained under the Mental Health Act in July 2019, first using section 2 and then section 3 of the Act.

Madison ligatured frequently.

In the evening of 25 September 2019, Madison was found with bedding ripped and tied around her neck. This was cut off by staff. Madison also tied three ligatures during the night using a ripped towel, clothing and a ripped blanket. She was on level 2 observations at the time.

The following day, Madison ligatured further. Her mother had told the ward about Madison's concerns in relation to potential contact with someone who had bullied her, but the information was not passed on.

On 27 September 2019, in the evening, Madison ligatured in her bed space. She then spent time in a communal area, but was told she could return to her bed space if she remained on level 2 observations.

When a staff member entered Madison's room, she asked the staff member if she could spend some 1:1 time with her, but the staff member was due to begin level 3 observations for another patient and offered to see if she could find another staff member to spend time with Madison, but Madison did not want this.

Some minutes later, patients told staff they could hear noises in Madison's room, and she was found having ligatured. Madison resisted having it removed, but it was cut off, and Madison's room was searched for items that could potentially be used to self-harm. Then Madison was left alone in her room. The staff member who was responsible for Madison's observations was also assigned the role of environment

[86] Case Summary of Madison Naylor [INQY025678].

nurse (alternatively termed security nurse) that evening. Part of his role as the environment nurse included retrieving items for patients.

The staff member went to the nursing office to collect equipment to take Madison's vital signs. He was subsequently asked to retrieve some lip balm for another patient and did so before returning to Madison's room.

When the staff member returned to Madison's room, she had tied a fatal ligature with a piece of torn blue blanket.

Madison was pronounced dead by paramedics at 23:57. She was fourteen years old at the time of her death.

In Madison's case, the routine of the ward and the allocation of duties meant that her request for individual time with a particular member of staff could not be fulfilled. Then, when she had been found, the need for someone to be with her continuously was not appreciated and the staff member prioritised retrieving a lip balm for another patient. It is possible that patients can be distressed by such occurrences, should they perceive staff as passing over them or prioritising others.

3.17 It can be seen that it is perfectly possible to observe a patient without engaging, or without engaging very much. On occasions, for instance where high levels of vigilance or concentration are needed to perform the observation, or where actions are required by necessity to be done at speed, that may be appropriate. However, the risks and potential harms arising from such circumstances should be recognised, and steps taken to mitigate them. If those risks are not identified then no such steps can be taken, and there is a risk that the benefit of engagement is inadvertently lost.

Therapeutic engagement in inpatient psychiatric care

3.18 In psychiatry, we are trying to understand and help a patient's mental life and thought processes. Those processes stand, in some sense, like the inside of someone's body does to a physical health doctor. But those processes differ from bodily ones in three ways. First, we can only look in through communication; second, the act of looking is immediately to change, for better or worse, the mental life of the patient; and last, there are actually two observers. For it is not only the doctor or staff member who looks, but the patient too must look. All of

that, and the skills needed to achieve it, have been packaged up into a number of psychiatric terms historically, but engagement is a good term.

3.19 Put simply, the only way we can know anything of significant worth about patients is to look. The only way we can look in is by asking, and the only way we will get a helpful answer is if we engage.

3.20 Engaging, however, is a complex process, built on a natural human ability, namely relating. To engage, we seek to relate to the patient in a way that builds trust, mental closeness, and aims at a working alliance. It is worth unpacking each of those elements. Trust is a mutual contract that in getting close neither party will use the closeness to hurt the other. Mental closeness refers to the idea that at least one aim of one person in the relationship is to understand more deeply what the other is truly thinking and feeling, rather than simply settling for a polite or defensive response. The concept of a working alliance embodies the aim of establishing common purpose between the patient and the member of staff where both believe that the member of staff is the patient's ally in the task of getting better and that both are working to achieve that end.

3.21 The importance of engagement clinically lies in its ability to generate rich information and in its intrinsic ability in and of itself to promote mental health.

3.22 The information gathered by engagement in this way is sometimes called "The mental state" (a not particularly expressive shorthand). All psychiatric diagnosis is founded on the history of a patient's successive mental states. While the concept of a "diagnosis" has had something of a rough ride in the past (because of the impact of labelling and stigma), diagnosis allows us to use common factors between patients and the accumulated experience of past patients to predict the future course of mental illness and to guide treatment, including tracking its progress over time.

3.23 Without the information that comes from a clear description of a patient's "mental state", a proper diagnosis cannot be made, treatment cannot be tracked, and even though the assessment of risk is imperfect, it would be even more so without this information.

3.24 The benefits of engagement do not end with the unilateral gathering of information. When things go well, engagement builds a working alliance; it promotes self-observation and self-management by a patient who can use relationships with

others and with themselves to internalise the idea that mental health problems are tractable and will respond to treatment. It is not only that there are others out there who wish one well and have ways of helping that happen, but also that one might wish oneself well and build mental processes that build mental health.

3.25 This means that the relationship between engagement and clinical safety is multifaceted. At a basic (and important level), engagement can help staff realise that a patient is feeling actively suicidal this minute, or help them work out with the patient that the worst time for such feelings is in the early mornings. At a higher level, engagement can help to promote behaviours and mental processes that reduce suicidal or desperate thoughts, both through reaching out to others and through reaching out to oneself.

Potential harms of observation not done appropriately
Areas where current practice creates risk

3.26 Observations are designed to gain clinical information, promote safety, to promote trusting relationships, and potentially to deliver small payloads of therapeutic intervention. Any of those aspects can fail. When these things fail, there are harms.

3.27 Brutally, the most common way in which observations fail at present is that they are not done, or are done in the most cursory fashion. We are not talking here about a lack of engagement, but a lack of any sort of observation.

3.28 Repeated evidence from inquests and from inspections of observation records shows absent or falsified recording.[87] The problem is longstanding: the national study of suicides under observation in 2006-12 found that in some deaths the

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[87] Courts and Tribunals Judiciary (2024) *Mahamoud Ali: Prevention of Future Death Report*. Ref. 2024-0379, 10 July.
Care Quality Commission (2024a) *Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust*. Published 26 March 2024, section 'Safety of services' "*CCTV audits carried out by NHFT uncovered alleged incidences of poor patient care and falsification of mental health observations, which led to these suspensions*"
Care Quality Commission (2024b) *Central and North West London NHS Foundation Trust: Acute wards for adults of working age and psychiatric intensive care units*. Inspection report, published 21 February 2024, "*staff had not carried out high-level intermittent observations and that they had falsified records to indicate that they had.*"

prescribed observations had not been carried out as specified.[88] This is a known problem, and efforts to address it have included staff training, senior staff working night shifts, the use of closed-circuit television (CCTV), and, in the case of the OxeObs system (the electronic observation-recording module packaged with Oxevision), electronic recording of observations.

3.29 Observations can fail when the wrong conclusions are drawn from them. One sad but quite frequent event is that the process of observation involves first checking the patient 's room but they are not immediately visible and do not answer a knock. Staff can assume that the patient must be out on the ward somewhere (this will very often be the case), but tragically the patient is actually in their bathroom where they are at risk or have done something terrible.

3.30 **Edwige Nsilu**[89]

20, died 5 February 2020 · Colne Ward, St Andrew's Healthcare, Essex.

Edwige was a patient with a very protracted history of inpatient care starting at about the age of 16. Edwige had been treated in a large number of different settings. She could be behaviourally disturbed, with the police being involved, but she was also extremely vulnerable to sexual and other forms of exploitation, and there had been a number of safeguarding events. Edwige started to deteriorate in December 2019; she was tearful, discontinued her medication, reported flashbacks, and hallucinations, but also reported an anonymous call from someone who said he had raped her and wanted to apologise. Edwige reported an increase in her hallucinations on 8 January 2020, and there followed nine instances of threatened, attempted, or actual ligature tying, including an incident that required an emergency medical response. Some of Edwige's observations at the time described her presentation as "behavioural" or "for attention".

On 13 January her observations were increased to 15-minute observations and on 21 January, having punched herself in the face, ligatured and attempted to assault staff, she was placed in seclusion. Edwige tied two further ligatures on 23 January and appeared to have a non-epileptic fit. There were further ligatures on 26 and 27 January, and Edwige said a relationship with a male patient on another ward had ended and that she wanted to kill herself. Edwige said she was hearing voices, was

[88] Flynn, S., Nyathi, T., Tham, S.G. et al. (2017), 'Suicide by mental health in-patients under observation', Psychological Medicine, 47(13), pp. 2238-2245 (also cited later in this section).
[89] Case Summary of Edwige Nsilu [INQY026111].

not compliant with medication and said she had torn a mattress to use as a ligature. She asked to be moved to a medium secure ward and said she needed 2:1 observations.

In the early morning of 3 February 2020, at around 06:09, Edwige tied a ligature, which was removed with ligature cutters. Edwige then remained on intermittent 15-minute observations and requested her as-required (PRN) medication as she was struggling with her emotions. Edwige's last recorded observation was at 15:30 on 3 February 2020. The HCA conducting Edwige's observations left the ward to conduct a patient search in reception, and handed the task of conducting observations to a nurse. That nurse stated that they recollected "seeing Edwige at 15:45 but did not record due to being distracted with another patient and so retrospectively completed the 15:45 entry in the observation records after the fatal incident". It is possible this record was unreliable and that Edwige had not been observed for the 25 minutes preceding her tying the fatal ligatures.

At approximately 15:55 another patient entered Edwige's room followed by a nurse. Edwige was found collapsed on the bedroom floor having tied three ligatures around her neck.

Edwige died at Basildon University Hospital on 5 February 2020 after life support was withdrawn.

Edwige had a very long pattern of self-harm and ligaturing. She had asked to be transferred to a secure unit and to have 2:1 observation. But for a young woman such may have been the first step in a trajectory of lifelong institutional care, in a unit likely far from home.[90] If Edwige could have been kept safe without such extreme measures, she may have been able to be managed locally, and with less restrictive care.

3.31 Observations can be harmful directly even when done perfectly. An important example of this is the use of 1:1 observations. These may be necessary to preserve life, but they are never straightforwardly beneficial. While this intervention is called "observation," it would be far better described as "being with" or accompanying. The intervention is unnatural in that it is not a normal way of relating; it often

[90] Bateman, A.W. and Krawitz, R. (2013) 'Structured clinical management: inpatient treatment and prescribing', in *Borderline Personality Disorder: An Evidence-Based Guide for Generalist Mental Health Professionals*. Oxford: Oxford University Press, pp. 124–142. Chapter 6: 'Structured clinical management: inpatient treatment and prescribing

involves hourly or two-hourly changes of nurses (to limit fatigue) and is not devoid of adverse side effects. Patients can feel intruded upon, and their privacy is certainly infringed to a very great extent. Patients can feel distrusted and spied on, but also exhausted by the social expectations of having constant company. Some patients may become increasingly desperate because the urge to self-harm gets stronger and stronger, with more and more of their mind being taken up by ways to trick and evade their observer. Other patients, particularly those with emotional dysregulation, can become dependent on high levels of observations. One mechanism for this is that patients can be berated by inner voices that they are putting it on, are not really unwell, and should pull their socks up. The 1:1 observations become evidence to offer those inner voices to prove that the patient is unwell.[91]

3.32 While continuous observations are intended to keep patients safe in ways that cannot be assured with intermittent observations, patients can and have died while being continuously observed.

3.33 **Johnson Omotoyinbo**[92]

56, died 5 November 2023 · Priory Hospital Suttons Manor, Essex · Partnerships in Care Ltd (Priory Group)

Johnson had a diagnosis of treatment-resistant paranoid schizophrenia and diet-controlled type 2 diabetes.

In the lead-up to his death, Johnson's care plan required administration of level 3 (1:1) observations at all times because of his risk of choking, as he had a history of swallowing dangerous objects such as a chess piece.

On 4 November 2023, Johnson was found to have had blue gloves in his pocket, which were removed.

On 5 November 2023, the staff member looking after Johnson removed a pair of blue gloves he was wearing and disposed of them in a bin, but Johnson managed

[91] Bowers, L. and Park, A. (2001), 'Special observation in the care of psychiatric inpatients: a literature review', Issues in Mental Health Nursing, 22(8), pp. 769-786; Veale, D. et al. (2020), 'The psychiatric ward environment and nursing observations at night: a qualitative study', Journal of Psychiatric and Mental Health Nursing, doi:10.1111/jpm.12583.

[92] Case Summary of Johnson Omotoyinbo [INQY025344].

to return to the bin unaccompanied and obtain something, which he put in his pocket. Two minutes later, he put something in his mouth and then put fingers in his mouth and was heard choking.

CCTV shows that at 05:38 the healthcare assistant removed his blue disposable gloves and disposed of them in a domestic bin in the dining area; at 05:42 Johnson left the lounge, followed seventeen seconds later by the HCA; at 05:44:25. Johnson returned to the dining area unaccompanied, opened the bin, removed something and put it in his pocket; at 05:46 he placed something into his mouth; at 05:49 he made a choking noise. Whilst there were lapses in Johnson's observations, he was nevertheless able to fatally self-harm despite a close degree of supervision.

Ultimately, paramedics were called, but Johnson was pronounced dead at 07:10.

Continuous observation in this situation required a member of staff to do two quite opposite things. On the one hand, they needed to be exceptionally vigilant because of Johnson's risk, but on the other hand, they had to be natural and relate to Johnson. Combining those two tasks inherently creates a risk. His case demonstrates how even short moments of inattention can lead to a fatal outcome.

3.34 Even more common are failures in intermittent four times an hour observations. While investigation has often focused on failures to perform these observations,[93] that all-too-frequent finding has obscured the systemic fact that level 2 observations cannot be relied upon to detect strangulation in time: consciousness is lost in seconds, and some mechanisms of strangulation produce nothing audible or visible from the doorway.

3.35 Although observations four times an hour are common practice and widely supported, my own view is that for most groups of patients the reliance that is placed on them is too great and is unsafe. The problem is that the time between initiating a fatal or terribly damaging act of self-harm and that harm resulting in irrecoverable injury is variable but definitely less than 15 minutes. It can be as little as 3-4 minutes.[94] This means that even with somewhat unpredictable observation

[93] Flynn, S., Nyathi, T., Tham, S.G. et al. (2017), 'Suicide by mental health in-patients under observation', *Psychological Medicine*, 47(13), pp. 2238–2245.

[94] Sauvageau, A., LaHarpe, R., King, D. et al. (2011), 'Agonal sequences in 14 filmed hangings with comments on the role of the type of suspension, ischemic habituation, and ethanol intoxication on the timing of agonal responses', *American Journal of Forensic Medicine and Pathology*, 32(2), pp. 104–107

timings, the chance of finding someone in time to save a life is well under 50%.[95] Things improve if a patient gives some sign of emotional distress at the time they are observed that allows for intervention before the fact, but there are a substantial number of cases where this is not the case. A common thread in many of the cases I reviewed for this Inquiry is that while risks were high, there was not a specific indicator of imminent risk that allowed for intervention immediately in advance.

3.36 There have been attempts to mitigate the difficulties with four-times-an-hour observations. They were originally at 15-minute intervals, and it was noticed that a patient could rely (in that circumstance) on not being checked again for a known (and sufficient) amount of time. The SNMAC guidance of 1999 set intermittent observation at 15 to 30 minute intervals; NICE carried similar levels into its 2005 and 2015 guidelines.[96] The move to four checks an hour at irregular intervals developed through the 2000s and 2010s but has never been formally codified. South Essex checked at irregular intervals by 2013, and EPUT's CLP8 policy fixed four irregular checks per hour from 2018.[97] However, the problem with somewhat randomised intervals is that the bunching of observations in one time period inevitably requires them to be extended in another. Patients can work that out, but also (and counterintuitively) in terms of pure mathematical probability the chance of detection in the critical interval is somewhat reduced by this pattern of bunching and rarefaction.

3.37 **Melanie Lowe**[98]

41, died 2 March 2016 · Chelmer Ward, the Derwent Centre, Harlow · North Essex Partnership University NHS Foundation Trust

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[95] Basis of the estimate: with checks on average every 15 minutes, a window of t minutes between the start of a fatal act and irrecoverable injury is caught by a check with probability of roughly t/15. The 3-4 minute lower bound at footnote 11 gives 20-27%; the chance only exceeds 50% if the window is longer than about 7-8 minutes, and discovery must still leave time for rescue.

[96] Standing Nursing and Midwifery Advisory Committee (1999), Practice Guidance: Safe and Supportive Observation of Patients at Risk, London: Department of Health; NICE (2005), CG25; NICE (2015), NG10, recommendation 1.4.11.

[97] Najim, H., Saleem, K., Al Shirbiny, B. and Ezeasor, N. (2013), 'Analysis of clinical observation on acute psychiatric wards', Psychiatria Danubina, 25(Suppl. 2), pp. S178-S181, at p. S178; Essex Partnership University NHS Foundation Trust (2023), Therapeutic Engagement and Supportive Observation Policy (Inpatients), CLP8, version 4.2 (initial issue 30 March 2018), p. 10.

[98] Case Summary of Melanie Lowe [INQY025677].

Melanie was 41 when she died and had two children aged 13 and 10. She had a history of mental health problems with a diagnosis of somatisation disorder and anxiety. Melanie had a history of inpatient care under the Mental Health Act and had been swallowing plastic wrappers and tissues and pushing them down her throat with a pen. Then, in 2016, she was again unwell, being detained under section 136 of the Mental Health Act, treated by the crisis team but ultimately admitted under section 2 of the Mental Health Act to a distant ward.

Melanie was on level 3 observations but admitted to hiding and taking significant amounts of tablets she had taken onto the ward and had to be transferred to an acute hospital where she tried to abscond twice and was also trying to make herself sick. On her return to the ward, Melanie's observations were reviewed at her request and reduced to level 1 by a junior doctor who seemed unaware of her behaviour in the physical health hospital.

At 07:00 the day after her return to the mental health ward, she was seen, but she was then found at 07:35 having asphyxiated herself with rolled-up tissue paper. Melanie died when her life support was turned off in the evening.

The report of the CQC inspector dated 14 January 2019 set out that there was evidence of flaws in individual staff members' risk assessment processes, and adherence to Trust search and observation policies. However, it was recorded that "[i]t is unlikely based on staff's view of her presentation that ML's death was avoidable if staff had more accurately assessed ML and only reduced her level of observation to level 2 instead of level 3".[99]

In Melanie's case, the rapidity with which asphyxiation would have been fatal means that even properly conducted level 2 observations only stood about a 1/3 chance of intervening in a way that would have prevented the outcome.[100]

3.38 **Adam Steel**[101]

36, died 14 October 2021 · Peter Bruff Unit, Colchester · EPUT

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[99] The reference to level 3 observations repeats an error in the original CQC document. It should read 'level 1'.

[100] Basis of the estimate: on the timings in Melanie's case, asphyxiation of this kind is likely to be irrecoverable within about 5 minutes; with checks on average every 15 minutes, the chance that a check falls within that window is about 5/15, or one third.

[101] Case Summary of Adam Steel [INQY025345].

Adam's first contact with Essex Mental Health Services was in 2004 at the age of 19 when he was diagnosed with bipolar affective disorder. He first experienced a psychotic episode in 2005. Between 2004 and 2015, Adam had 4 or 5 severe manic episodes interspersed with periods of depression, but had managed to maintain full-time employment despite his illness.

In September 2021, Adam's mental state deteriorated, with his family describing him as anxious and agitated. Then, in October 2021, Adam's medication had to be changed because he had signs of a cardiac complication that is associated with a potentially fatal heart rhythm. Adam's health continued to deteriorate and he had to be admitted to hospital. As an inpatient, Adam was actually on level 2 observations, but it is not certain these were done correctly. Adam's family feel with considerable justification that Adam was not checked in person and that the Oxevision system was used to view him remotely. Adam was dead in the morning.

A post-mortem examination found that Adam had died from "multi-organ failure, hypertensive, ischaemic heart disease, liver fibrosis and fatty liver and obesity". However, Paul, Adam's father, obtained a report from a cardiologist who examined Adam's medical history and concluded that Adam's death was more likely the result of "a ventricular arrhythmia such as VT [ventricular tachycardia], or Torsades de pointes" than multi-organ failure.

The details set out above are not the only concerning issues in relation to Adam's care because his medication management may not have been correct. However, Adam died suddenly in the night; he should have been checked regularly, and he was not. This is a source of anguish and distress to his family, but if he died from a ventricular arrhythmia, even if four-hourly checks had been performed correctly, they would almost certainly have been insufficient to prevent the outcome.

The problem is that the safest interval for observations would be at roughly 5-minute intervals.[102] A few patients are observed this frequently in the context of eating disorder units where the aim is to limit purging. The frequencies of intermittent observation that would reliably detect unheralded ligaturing would be extremely difficult to deliver, and the balance between the risk of harm from that

[102] Derivation: with irrecoverable injury possible within 3-4 minutes (footnote 11), checks would need to be only a few minutes apart to have a realistic chance of interrupting an unheralded act; intervals of about 5 minutes are the practical limit and are used, for example, on eating disorder units around meal times.

sort of contact being greater than the risk of the ligaturing moves towards harm. It is very disruptive and unnatural to be interrupted every five minutes.

Better interventions try to focus observations on known risky times (often evenings or early mornings). However, implementing this requires careful attention to detail and needs to be very well embedded as part of the way care is implemented on the ward.

3.39 **Elise Sebastian**[103]

16, died 19 April 2021 · Longview Ward, St Aubyn Centre, Colchester · EPUT

Elise Sebastian was 16 years old when she died after tying a fatal ligature while an inpatient at the St Aubyn Centre. Elise had struggled with bullying and physical health issues in the past, including kyphoscoliosis, myoclonic seizures and ongoing serious bowel problems, At the time of her death, Elise was awaiting diagnostic assessment of Ehlers-Danlos Syndrome, as well as awaiting surgery for internal rectal prolapse, which she was told would be a six-month wait. Elise's parents believe these factors significantly contributed to the development of her mental health problems.

On 2 March 2021, Elise jumped from a bridge into a river while out for a walk with her support worker, having recently been discharged from hospital. On 4 March 2021, Elise was readmitted to EPUT's Longview Ward and detained under section 2 MHA 1983.

Between 7 March and 15 April 2021, Elise was involved in 13 ligature incidents. She had also absconded.

On 13 April 2021, Elise's observations were increased from level 2 to level 3 (constant observation) during periods of isolation.

On the evening of 17 April 2021, Elise ate dinner in a communal area and then went to her room where she would need to be continuously observed.

The responsible staff member told police subsequently that she believed she had accompanied Elise to her room at approximately 18:10 and had then left her alone

[103] Case Summary of Elise Sebastian [INQY025342].

there. Data from the staff member's swipe card showed that Elise had swiped the staff member's card and had gained access through four doors leading from a communal area to the area of Elise's bedroom at 18:10. The staff member had returned to the communal area at 18:11. Asked why she did not go into Elise's room with her, she stated 'maybe I forgot that she was level 3'.

Elise created a ligature from torn bedsheets and was discovered unresponsive in her room at 18:39:55 by a staff member. This was 28 minutes after having entered her room, 22 minutes after having begun ligaturing and 18 minutes after having collapsed on the floor.

Elise was transported to Colchester Hospital, but her condition was not recoverable, and on 19 April 2021 her ventilator was switched off. Elise died a short while after.

There were many worrying features of Elise's care not detailed in this account, but central to the final events was that a member of staff had, at least on their own account, forgotten the plan for targeted 1:1 interventions. This highlights a tension between personalised and routine interventions. The more that interventions are tailored and the less they are routine, the more risk there is of failures in delivery.

3.40 Last in this category come night-time observations. Observations can fail because the information they are gathering has, in truth, no clinical utility. The hourly overnight check that a patient is in bed and alive seems only reasonable. There can be great value in finding a patient at night who is awake and may be distressed or ruminating. However, while it is universal practice and my view may be thought controversial, I consider that checking that an apparently sleeping patient is still actually alive is futile. This is because it is not, sadly, a check which has any realistic chance of saving a life because no level of intermittent observation reliably detects or manages sudden death or choking. I consider nighttime observations in greater detail, and the Oxevision system's role in conducting them, below at section 7.

3.41 Historically, at night, such observations involved looking to see if a patient was present in bed and asleep and checking that they were still alive (breathing or signs of movement). While this practice seemed sensible, patients could try to defeat it by making it seem there was a person in the bed.

3.42 **Kelly Campbell**[104]

17, died 12 February 2018 · Poplar Ward, Rochford Hospital (CAMHS) · EPUT

Kelly had a four or even five year history of self-harm, depression and anxiety. She had had eating disorder symptoms since the age of eight, with bingeing and purging, and was under the care of the eating disorders team.

Kelly was admitted to hospital first informally and then, when her condition deteriorated further, under the Mental Health Act. Kelly became increasingly disturbed with ligaturing as well as kicking, punching, and banging her head on doors. She concealed blades and threw a hot drink and other items at staff.

On 11 February 2018, it was recorded that Kelly was upset after a telephone call as she had heard that a friend had taken an overdose, although later in that evening she was recorded to be laughing and joking with staff. Kelly was recorded to have gone to her bedroom at around 22:30 that evening. Level 1 (hourly) observations were expected to be conducted throughout the night. The last observation, at midnight, had been a conversation while Kelly was in the bathroom, and she had not been seen. The observation at 01.00 was missed.

When staff conducted a check at approximately 02:00, they noticed a 'lump' in Kelly's bed; on closer inspection, this was made of clothes. Kelly was found suspended by a ligature in her bathroom, with a message written on the bathroom mirror. Kelly had **ligatured.** **[I/S]** **[I/S]** Despite attempts to resuscitate her, Kelly was pronounced dead at 02:45.

Kelly had a serious illness but the way she died shows that, terribly, she put considerable thought into ending her life. Would a correctly performed hourly check at 1.00am have saved her – it is possible, but sadly, not likely.

3.43 On other occasions, patients were not alive at the time they were observed, but this was not noticed. This resulted in checks at night becoming more intrusive. Patients found themselves woken by staff trying to check, as quietly as they could, whether they were still breathing; sometimes they were woken because of torchlight or because of the noise of the door.

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[104] Case Summary of Kelly Campbell [INQY026110].

3.44 As a result, there are units that have stopped hourly observations at night because they felt the balance between helpful and harmful had moved towards harmful.[105] As long as the patient is actually present in their room or on the unit (which is easier to ensure in a controlled access ward, which most units are these days), the reasoning behind this controversial decision is sound, if emotionally difficult to accept. If a patient is observed and is not alive, then sadly there is nothing that can be done for them unless they are, at that moment, dying. If they are alive and asleep, then there is nothing that should be done for them.

3.45 Finally, observations can be harmful to staff and, by extension, to the whole atmosphere of the ward and the context of clinical delivery in a way that rebounds back on clinical care.

3.46 The operational burden of observations on the staffing of a ward produces a downward pressure on observation levels if at all possible. This is combined with a focus on "positive risk taking," which is the idea of stepping patients down from high levels of intervention – taking a risk – so as to promote strength (there is a risk in lifting heavy weights but muscles will not get stronger if you don't) and development. Staff can be described disparagingly as being "risk averse" or patients as "dependent". Set against this, the consequences of clinical incidents with intensive investigations, external criticism, and frequent suggestions that observation levels were unjustifiably reduced creates a pressure to increase observations. Incidents also create documentary pressure, with increasing requirements for updating documentation, reporting and ensuring that decisions can be justified.

3.47 The combination of these opposing pressures is hostile to good clinical judgement. It has tended to create situations in which people express their views with greater certainty than can be justified, causing splits and conflicts in staff teams., Regulatory and governance responses are not always helpful because they too demand greater certainty in staff decision making than can be realistically expected. This kind of dilemma can produce a response of learned helplessness and a loss of morale amongst staff.

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[105] Veale, D. (2019), 'Against the stream: intermittent nurse observations of in-patients at night serve no purpose and cause sleep deprivation', BJPsych Bulletin, 43(4), pp. 174-176.

4 Section 4 — Psychiatric decision-making about observations

Governing principles and safeguards

4.1 Before considering how decisions about observations are taken, it is helpful to set up some general principles that govern those decisions. Observations are a set of repeated clinical interventions. This means that:

They should be practicable;
They should serve and continue to serve some defined clinical purpose;
They should be consented to and implemented collaboratively;
They should be helpful rather than harmful;
They should be flexible and able to respond to changes in the patient's condition; and
They should be documented.

4.2 Implementing those principles successfully needs the involvement of as much of the full multidisciplinary team as possible.

Safety, autonomy, dignity and least restriction

4.3 A core function of observations in psychiatric practice is to maintain patient safety. The difficulty is that observing people intermittently or continuously, if they do not consent, is a reduction in their autonomy, and whether they consent or not can intrude on privacy or threaten dignity. This may be necessary. In medical care, we may well accept indignities and intrusions in the service of clinical aims, and our caregivers do their best to make the experience as tolerable as they can. In mental health, some of that is embodied in the principle of least restriction,[106] which also covers the situation where there is no consent, and something is being imposed on the patient against their will.

4.4 Where a patient has capacity and is not detained under the Mental Health Act, we set the balance between autonomy and dignity vs intrusion and safety by explaining things to the patient and then doing what they choose in that regard.

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[106] Department of Health (2015), Mental Health Act 1983: Code of Practice, chapter 1: the guiding principles include the least restrictive option and maximising independence.

4.5 Where a patient does not have capacity, or is detained under the Mental Health Act, we take over that choice and (setting aside the legal complexities) set the balance by doing the minimum needed to achieve safety.

4.6 An illustrative clinical example is the situation of a patient who is at serious risk of self-harm and has a pattern of concealing objects in their possessions which they later use to harm themselves. Under those circumstances, it may be appropriate to search their room or remove items they own, or to search their possessions as they return to a ward. That is a substantial assault on their autonomy and dignity. It would not be done for every patient or for that patient at all times, but can be justified at times when the risk is serious.

Psychiatrists within multidisciplinary decisions

4.7 Psychiatrists in multidisciplinary teams bring a medical and psychiatric perspective to the work of the team. They will be focused on diagnosis, management, medication and treatment strategies. Often, psychiatrists will work in a small team that may include both a consultant and one or more junior doctors who are likely to be training either to become consultant psychiatrists or other sorts of doctors but will often bring skills that include familiarity with physical health aspects of care.

(a) The role of the Responsible Clinician

4.8 Where a patient is detained under the provisions of the Mental Health Act, they must have a responsible clinician. This need not be a doctor or consultant but does need to be an identified and suitably trained individual, and approval is administered through approval panels on behalf of the Secretary of State, following approved training.[107] Their task is to exercise statutory functions related to the Mental Health Act, and they retain responsibility for the case even when other professionals provide input.

4.9 Patients who are not detained under the Mental Health Act do not have a "responsible clinician" in the sense derived from the Mental Health Act, but very often patients on the same ward as detained patients or patients who have been

[107] Mental Health Act 1983, s.34(1) (responsible clinician) and s.145(1) (approved clinician); Mental Health Act 1983 Approved Clinician (General) Directions 2008.

detained at one stage will have the same clinician taking overall charge of their care.

(b) The Role of Consultant Psychiatrists and other psychiatric clinicians involved in patient care

4.10 As part of the multidisciplinary team, psychiatrists both contribute to and often synthesise information from a range of sources – both their own meetings with patients but critically also information from nursing staff who are with patients throughout the day and night and from other health professionals such as psychologists and occupational therapists who have skilled ways of interacting with patients.

4.11 That synthesis, which may be done formally at MDT meetings but is also done as needed, then informs decisions about treatment. Since the purpose of inpatient care is to treat mental health safely, a critical part of the synthesis is to consider how to manage the patient safely and, ideally, to construct a safety plan.

4.12 Safety is promoted by treating the underlying health condition causing risk,[108] but it also depends on reduction of means in relation to suicide, and this may involve decisions about restricting leave in some way, and in reducing suicidal risk while the patient is on the ward. Observations are one element of care that may be used for this purpose, and psychiatrists should have input along with the MDT in taking decisions about how frequently to observe patients.

(c) The interaction between medical and nursing observations and assessments

4.13 Perhaps the easiest form of observation to cover is observation in relation to physical health. I would expect the psychiatric team to take the lead on this. Where a patient's health is concerning, I would expect a doctor or sometimes a physical health qualified nurse to examine the patient, and they may institute a specific regimen of observations to guide the progress of treatment. Examples would include regular physical observation after a fall or possible head injury, or

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[108] Haw C, Hawton K. *Suicide is a complex behaviour in which mental disorder usually plays a central role*. Australian & New Zealand Journal of Psychiatry. 2015;49(1):13–15Rizk MM, Mann JJ. *An Update on Somatic Treatments for Suicide Risk*. American Journal of Psychiatry. 2026;183(6):382–400, Foster T. *Schizophrenia and bipolar disorder: No recovery without suicide prevention*. BJPsych. 2015;207:371–372.

the close observation of a patient who has been given rapid tranquillisation medication by injection.

4.14 Where physical health issues are the reason for observations, then medical staff would be expected to have the guiding hand in setting out what should be observed and when, and, further, how to interpret and act on those observations. I would expect a doctor working on an inpatient ward to know how to handle the immediate management of common medical conditions (for example a fall, a possible fracture or deep vein thrombosis (DVT), pain or an elevated body temperature) and, perhaps more importantly, to know the limits of their competence and how to seek help from colleagues where they are not sure what the best course of action would be. Part of that management can be to institute treatment and monitor progress or a decision to watch and wait, and under those circumstances regular observations will be needed. What is actually observed will depend on the medical condition being followed up.

4.15 One psychiatry-specific group of physical health conditions will be side effects of mental health medications. These are pharmacologically complex agents capable of causing significant side effects which can even be life-threatening. I would consider it a core part of the responsibilities of medical staff to be alert to and to set in place monitoring for such side effects in order to detect and manage them early.

4.16 A particularly important subset of medical conditions is best covered under the rubric of "the deteriorating patient". This refers to an individual who is declining over time in their physical condition. It may signal respiratory or other infection, sepsis, cardiac failure and a range of conditions more specifically associated with mental health, such as neuroleptic malignant syndrome, catatonic states and even encephalitis. I would expect medical staff to play a central role in setting up and following through on the sorts of monitoring which can hope to pick up deterioration before it is irreversible and to initiate transfer for acute physical care.

4.17 Medical staff will also have input to the level of observations or restrictions needed to manage psychiatric risk in inpatient settings. However, they will ideally not have the sole say in this area, except perhaps in the short term at night or the weekend, but will act as part of a multidisciplinary team. The reason for this is that judgements about risk, even with the closest of attention, are highly imperfect. They also carry significant consequences both if risk is incorrectly judged to be low and if risk is incorrectly judged to be high. The hope in involving a multidisciplinary

team is to increase the chances of a balanced and correct judgement, taking the best decision that can be made under the circumstances. For that reason, I would consider it a professional expectation that doctors taking decisions about risk should do so wherever possible in concert with others and that those others should, wherever possible, include members of the multidisciplinary team, the patient themselves and those who know and care for them.

(d) The circumstances in which psychiatric review would be expected to inform decisions concerning observation requirements

4.18 I have covered physical health issues above but would note again that the use of psychotropic medication is associated with specific physical risks that drive important components of observation practice.

4.19 In relation to mental health, the particular skillset that psychiatrists bring is the use of dialogue and careful conversation to set out, in a structured way, particular features of a patient's mental life which can indicate psychiatric illness. Specific symptoms or symptom patterns can indicate the presence and severity of mental health conditions. This evaluation in turn allows this patient's condition to be compared with knowledge about that sort of condition in general and then by return to the specific situation of the patient the hope of being able to understand risk, the progress of treatment and ultimately to give advice about the level of observations or other measures that might help to manage risk and ideally how long those measures might need to be in force.

4.20 I would also expect psychiatrists to have taken the time to read a patient's clinical record, paying particular attention to the evolution of their illness over time, to past illnesses and to illnesses in the family. This is important because that sort of historical information is also critical to evaluating risk and to working out how things are likely to develop in future.

4.21 Gareth Clarke[109]

4.22 Gareth had a history of mental health problems. He had both schizophrenia and a history of drug dependency. Gareth was admitted in February 2018 unkempt and with poor personal care. He deteriorated and had to be transferred to a distant psychiatric intensive care unit (PICU) on 10 March 2018. He was being nursed on

[109] Case Summary of Gareth Clarke [INQY025341].

observations every 15 minutes but had to be nursed in seclusion on several occasions. On 21 March, Gareth was restrained and secluded for about 3 hours. After this ended, Gareth was seen by staff playing football in the garden and being with other patients, but nothing was written in his notes. At 15.15, staff carrying out observations found Gareth hanging from a ligature from an air vent in his room. The paramedics attended, but Gareth's condition was irrecoverable, and he died that day. After Gareth's death it took some time for the trust to give the police the record of Gareth's observations. Gareth's mother wrote afterwards to the coroner saying that before Gareth was moved to Essex "he was on a constant watch". The investigation conducted after the event identified the availability of lethal means as the root cause of his death but said he had very few markers identifying him as a high suicide risk. However, after he died, staff were told that his uncle had recently died by hanging.

4.23 I consider that the availability of lethal means is clearly important, but I consider that, notwithstanding the conclusion of the investigation in Gareth's case, there were clues to his risk. Gareth's mother had information that was relevant about his previous care, as did the relative who told staff about Gareth's Uncle. It would fall to the consultant in charge of Gareth's care to know in some detail about his past care, and part of a full evaluation would have involved seeing his past clinical notes and speaking to Gareth's family. Any decision as to his level of observations should have been one that was informed by possession of all the facts.

4.24 I would expect psychiatrists to be both a vital member of the multidisciplinary team and someone who could autonomously make decisions about observation levels if that were needed.

Family and carer information

4.25 The general approach to taking clinical decisions has to be to have as much relevant information as possible and as many perspectives on that information and on the decision as possible. This is because, in situations of complexity and uncertainty, this is the best way to generate a well-considered decision. Self-evidently, therefore, family and carer information should influence risk assessment and clinical decision-making whenever possible. For sure, that influence should be felt most keenly when the decisions will have a direct impact on family and carers. Examples include admission, leave and discharge, but aspects of inpatient care are also areas family and carers will have views about, and their views should be taken into consideration. There are always times when

decisions need to be taken quickly and in those circumstances there may be less opportunity for consultation.

4.26 People who know the patient well know the patient well; it is exactly for that reason that their information about changes in presentation, behaviour or risk will be helpful.

4.27 There are times when patients do not want their family or carers to be involved in decisions about their care or to be informed about their care. This is a situation which has engaged mental health services and givers of advice and guidance over the past 20 years at least. In essence, when something terrible happens after the event, families often say that if they had known some fact about the patient, they could have intervened, maybe prevented what occurred, and this brings terrible anguish and also anger at services who did not inform them. Families and carers often feel they ought to have been informed even if the patient did not consent. Successive guidance documents have pushed at the boundary of adult patient confidentiality in extreme situations[110][111] (and the right does not extend to situations where there are obligations under the Children Act 1989 or there is a risk of serious harm to others).

4.28 The place of families and carers also changed over the period. GMC confidentiality guidance was revised in 2000, 2004, 2009 and 2017. Successive editions put growing weight on listening to those close to the patient. However, none weakened the rule that a capacitous patient's refusal to allow disclosure must be respected where the risk is only to the patient.[112] The Triangle of Care (2010) set out a

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[110] Department of Health and Social Care (2021), *Information sharing and suicide prevention: consensus statement*, 26 August 2021, https://www.gov.uk/government/publications/consensus-statement-for-information-sharing-and-suicide-prevention/information-sharing-and-suicide-prevention-consensus-statement.

[111] Earlier documents in the same direction: General Medical Council, Confidentiality: Protecting and Providing Information (2000, revised 2004), Confidentiality (2009), and Confidentiality: Good Practice in Handling Patient Information (2017); Department of Health (2014), Information Sharing and Suicide Prevention: Consensus Statement; Worthington, A. and Rooney, P. (2010), The Triangle of Care, London: Princess Royal Trust for Carers / National Mental Health Development Unit.

[112] General Medical Council, Confidentiality: Protecting and Providing Information (2000, revised 2004); Confidentiality (2009); Confidentiality: Good Practice in Handling Patient Information (2017). The 2017 guidance, paragraph 59: a doctor should 'usually abide by the patient's refusal to consent to disclosure, even if their decision leaves them (but no one else) at risk of death or serious harm'.

framework for involving carers in inpatient mental health care.[113] In 2014, the Department of Health and partner bodies issued a consensus statement on information sharing and suicide prevention, updated in 2021. It confirms that confidentiality is not a reason to refuse to listen to families, and that general information can always be given. Even so, a capacitous patient's refusal to consent to disclosure of their suicide risk will usually have to be respected where the risk is only to themselves.[114] The 2015 Code of Practice expects families and carers to be involved in care unless the patient objects.[115] Early in the Inquiry's relevant period, families were often told much less.

4.29 However, the formal position is that if a patient has capacity, then they have the right to say how and to whom information about their treatment will be communicated. One way of seeing this is to realise that in psychiatry, talking to other people in the patient's network is part of treatment, and we preserve the right of patients who have capacity to refuse treatment even when we consider that choice unwise, even fatally unwise.

4.30 That said, the number of occasions when there is a blunt and clear-cut confrontation between the rights of a potentially suicidal patient to withhold information about their intentions or state to carers and family is small. Far more common are situations where patients have not had the issue of confidentiality carefully discussed with them regularly or where compromises – limited sharing, for example – could have been discussed.

4.31 One way of ameliorating this situation is to consider a patient's refusal to share information and involve their family not just as a documented fact, but as a specific factor that increases risk and one that the team can work on reducing.

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[113] Worthington, A. and Rooney, P. (2010), The Triangle of Care. Carers Included: A Guide to Best Practice in Acute Mental Health Care, London: The Princess Royal Trust for Carers and the National Mental Health Development Unit.

[114] Department of Health (2014), Information Sharing and Suicide Prevention: Consensus Statement; updated by DHSC (2021), https://www.gov.uk/government/publications/consensus-statement-for-information-sharing-and-suicide-prevention. The 2021 statement: practitioners 'will usually be under a duty to respect a person's refusal to consent to disclosure of their suicide risk, if the person has the relevant capacity and they do not pose a risk to anyone but themselves'.

[115] Department of Health (2015), Mental Health Act 1983: Code of Practice, chapter 1 (guiding principles, including the involvement of patients, families and carers).

5 Section 5 — Individual circumstances, conditions and settings

Individual patient circumstances

5.1 The core principle in respect of way in which observations are conducted is that they should be adapted to the individual circumstances of patients because the activity will have different meanings for different groups of individuals. I attempt to deal with some of those circumstances here, but the overall lesson should always be to avoid assuming what the case is and to ask.

Cultural and social background

5.2 For some people from personal or cultural backgrounds where being checked up on or watched remotely is associated with hostility – for example, police activity – the experience of being checked on may be threatening or distressing. For others it may be comforting and a sign that one is not forgotten.

5.3 The correct remedy for this variability is to talk to patients about the meaning of the ward environment and ward routine both generally and in particular and the trick of it is to allow space for patients to say how they feel rather than just informing patients how things are done.

5.4 Certain groups of patients will more reliably have specific needs.

Autistic spectrum disorder

5.5 For patients with autistic spectrum disorder, both noise sensitivity and highly routine patterns of behaviour and predictability may be important; thus, being admitted to a new, often noisy environment with new routines and patterns can be profoundly destabilising. There are now specialist teams and also statutory duties[116] (under the Autism Act 2009 and section 181 of the Health and Care Act 2022) to help with this specific set of needs. If a more detailed opinion is required on this area, I would suggest advice from an appropriate specialist is obtained.

Psychosis

5.6 The longer-term prognosis of patients with serious psychotic illnesses depends critically on the extent to which those patients come to trust their caregivers,

[116] Autism Act 2009; Health and Care Act 2022, section 181.

including clinical staff, and see them as allies. This trust sometimes has to survive coercion in the form of the Mental Health Act and traumatic experiences of restraint and forcible medication. Because part of the purpose of observation is simple care and an enquiry into wellbeing, as opposed to a more formal conversation with a psychiatrist or even a 1:1 with a nurse, observations can be vital in building some degree of trust in someone who is not at all sure that those caring for them are on their side.

5.7 Further, patients with psychotic illnesses can be driven by beliefs and experiences that are not easy to infer from their setting or obvious things that have happened. They may have beliefs about what is happening to them that are not rooted in reality. They may also feel unable to tell others what they are thinking or feeling, or be profoundly suspicious of their caregivers. This makes skilful interaction critical. One frequent feature of routine observations in patients with psychosis is that it may give helpful clues to the fact that the patient is responding to hallucinations or has abnormal beliefs.

5.8 All of this argues strongly for the importance of observations and, moreover, engagement with patients who have psychosis. Where remote observation would limit that engagement, it may be detrimental. Also, because the specific belief or experience that one is being watched remotely, or that people can see or hear one's thoughts, is a feature of some psychotic illnesses, the fact that there are what appear to be cameras in a patient's room may play into that belief.

Trauma

5.9 There has been increasing realisation in mental health of the conditioning effect of previous traumatic experiences on people's reactions to situations in which they feel powerless, invaded or controlled. Furthermore, trauma responses are not always immediately visible to the external observer. Some people will freeze in a setting that reminds them of past traumatic experiences. This means that observation must be conducted sensitively, and the shorthand for this is that practice should be "trauma-informed". I think there are difficulties with this term because it is hard sometimes to know what it implies staff should do, and too great a worry about the possible unguessable impact of innocuous interactions can lead to unnatural or restricted behaviours.

5.10 Trauma-informed practice has become a major focus of service delivery with increasing force since about 2020. The idea grew from the Adverse Childhood

Experiences study of 1998 and was codified in the United States in 2014.[117] It began to enter mainstream UK mental health practice from the mid-2010s.[118] However, the Government published a working definition of trauma-informed practice only in 2022. Now NHS England's culture of care standards (2024) expect inpatient care to be trauma informed.[119]

5.11 The best way to guard against retraumatising someone is to ask what they might be sensitive to and how that risk might be minimised. That will vary from person to person. For some people remote observation might be less reminiscent of traumatic experiences than in-person observation, and for others the reverse might be true.

Insomnia

5.12 Poor sleep is a feature of psychiatric illnesses, particularly bipolar disorder and depression, but also anxiety. Furthermore, poor sleep tends to make psychiatric illness worse and sometimes quite dramatically so. For this reason, psychiatrists are willing to prescribe night sedation to patients with acute psychiatric illness much more liberally than doctors would in the case of someone who was not psychiatrically unwell.

5.13 However, it is also important not to put obstacles in the way of sleep. Inpatient wards can be noisy and disturbed at night, and patients can also be woken by intermittent observations where a member of staff has to come into their room to check on them.

5.14 This means that night-time observations have been a particular focus in relation to remote observation systems, and as long as it is felt necessary to confirm that a

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[117] Felitti, V.J. et al. (1998), 'Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the Adverse Childhood Experiences (ACE) Study', American Journal of Preventive Medicine, 14(4), pp. 245-258; SAMHSA (2014), SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach; Sweeney, A. et al. (2018), 'A paradigm shift: relationships in trauma-informed mental health services', BJPsych Advances, 24(5), pp. 319-333; Office for Health Improvement and Disparities (2022), Working Definition of Trauma-Informed Practice.

[118] Sweeney, A., Filson, B., Kennedy, A., Collinson, L. and Gillard, S. (2018), 'A paradigm shift: relationships in trauma-informed mental health services', BJPsych Advances, 24(5), pp. 319-333.

[119] Office for Health Improvement and Disparities (2022), Working Definition of Trauma-Informed Practice, https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice; NHS England (2024), Culture of Care Standards for Mental Health Inpatient Services, https://www.england.nhs.uk/long-read/culture-of-care-standards-for-mental-health-inpatient-services/.

patient is alive at night by checking on their breathing and movement in person, observation is likely to wake some patients.

5.15 However, there could be some drawbacks to remote observation in that for those patients who are awake, nighttime can be lonely and difficult. The chance to talk and perhaps have a hot drink can help and purely remote observation would not achieve this.

Evolving physical illness

5.16 Patients with mental health problems, while they are not physically ill to the same degree as patients in an acute hospital setting, are nevertheless potentially physically unwell. Mental illness has multiple physical effects and the medications used in the treatment of serious mental health problems have significant risks and side effects. Where patients are older or frail in some way – perhaps because of an eating disorder – they are likely to have physical health conditions. Patients may also take overdoses while on inpatient wards. This means that a function of observations has to be to try to detect physical health problems as they evolve.

5.17 Probably the single most important measure of evolving physical illness is that the patient says they feel unwell and they look ill, where looking ill is an amalgam of a host of small signs including body posture, movement and complexion. The most important follow-up measurement would be respiratory rate followed by oxygen saturation, temperature, blood pressure and least importantly pulse. I think the practical implication of this is that where there are concerns about physical illness, in-person observation is imperative.

Variation by inpatient setting

5.18 Just as the practice of observations will vary between patients, so it is likely to vary between settings, partly because the setting picks out a particular patient group but also because it can pick out a particular circumstance.

Section 136

5.19 Patients who have been brought to a place of safety by the police under section 136 of the Mental Health Act are particularly at risk. They can have no accompanying history – we may not even know their correct name – and have little

information to guide what to do next. Furthermore, potential physical health problems have not been excluded. All these factors provide strong arguments for not leaving such patients unattended.[120]

Seclusion and rapid tranquillisation

5.20 Patients who are so unwell that they have had to be secluded or forcibly medicated with the aim of rapidly altering mental state also need special care. Tragic deaths occur when patients are in seclusion. This is because the need to do these things to a patient is a sign that they are psychiatrically very unwell, but also because sedating medication delivered parenterally is risky, as the blood levels of medication can rise to a peak very quickly. Patients in these situations are generally subject to strict guidelines that require regular review, including regular consultant review for seclusion and constant or extremely regular in-person observation.[121] My view is that this is most safely done using the full NEWS2 scoring wherever possible.

5.21 There might be specific circumstances where there was very serious risk of agitating the patient or of them hurting themselves or others, where remote observation would be justified but for the shortest possible period. An example would be a patient in seclusion who was seriously assaultive to staff and required restraint every time staff entered the room.

Older People's Mental Health (OPMH) wards

5.22 Patients in older people's mental health wards are generally frailer and more physically at risk. Their mental health problems may also make them more vulnerable to injury, with problems arising from confusion, wandering, agitation, and simple mishap. Many psychiatric medications tend to lower blood pressure and can make it more likely that patients will fall. When patients do fall, there is a serious risk that they will sustain an injury, a common serious example of which would be a fracture to the neck of their femur. This injury in older people, while

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[120] Care Quality Commission (2014), A Safer Place to Be: Findings from Our Survey of Health-Based Places of Safety; Royal College of Psychiatrists (2011), Standards on the Use of Section 136 of the Mental Health Act 1983, College Report CR159.

[121] Department of Health (2015), *Mental Health Act 1983: Code of Practice*, chapter 26, paras 26.28–26.35 (enhanced observation) and 26.118–26.125 (observation during seclusion); NICE (2015), *Violence and aggression: short-term management in mental health, health and community settings*, NG10, recommendations 1.4.45 (monitoring after rapid tranquillisation) and 1.4.46–1.4.52 (seclusion).

treatable, can also be fatal. As a result, a constant focus in OPMH wards is falls prevention.

5.23 This is a well-researched area where, at present, the hoped-for benefits of assistive technology remain unproven.[122] Falls are rapid events, and the time to respond after a signal can be infeasibly short. The tension between keeping people active – which prolongs life and physical health but increases the risk of falls – and safeguarding patients against falling makes individualised assessment and the flexible deployment of different forms of prevention, along with a collaborative discussion about how much risk to tolerate, the most important interventions.

Child and Adolescent Mental Health Units

5.24 Admitting children to inpatient care involves separating them from their families or caregivers, potentially disrupting their schooling and subjecting them to a frightening degree of change. It is a last resort, and units are specialist and managed regionally by provider collaboratives. The legal structures in relation to capacity, consent, safeguarding and the Mental Health Act interact differently from their application in adults as responsibility moves between parents (or those with parental responsibility) and the developing child. There are a number of specific pieces of legislation – for one, the Children Act 1989 – which must be correctly applied. Finally, there are specific safeguarding risks in relation to taking video images of children as well as a grim history of such acts being done covertly by a consultant – Myles Bradbury jailed in 2014.[123]

5.25 It would seem to me that the meaning and value of observations in general and of remote observations in particular would be a very individual matter depending closely on the clinical case.

Eating disorders

5.26 The use of observations on eating disorder units is also highly specialist and as for children the units are commissioned by regional provider collaboratives. Patients on eating disorder units are there because they have a powerful drive to eat or restrict eating and to exercise in ways that are life-threatening. The motivation is

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[122] Morris, M.E., Webster, K., Jones, C., Hill, A.-M. and Haines, T. (2022), 'Interventions to reduce falls in hospitals: a systematic review and meta-analysis', *Age and Ageing*, 51(5), afac077,
[123] BBC News (1 December 2014), 'Doctor Myles Bradbury jailed for abusing young patients', https://www.bbc.co.uk/news/uk-england-cambridgeshire-30273548.

such that patients will go to great lengths to maintain their abnormal eating pattern, including using significant amounts of deception. Being very thin or purging a lot as well as the process of helping a patient gain weight (refeeding) are associated with very substantial physical health risks. Lastly, as patients do gain weight or have their abnormal eating pattern disrupted, the experience can be so distressing that other forms of self-harm emerge.

5.27 As a result, observation patterns on eating disorder units are often at high frequencies or timed in relation to meals.

5.28 As for children, the meaning and nature of observations on these units is highly specialist and designed specifically for those units. Assistive technologies may be helpful, but their use would need to be specially tailored to the clinical situation.

6 Section 6 — Capacity, consent and the Mental Health Act 1983

6.1 Issues concerning capacity, consent and the Mental Health Act 1983 are covered in considerable detail in the report of Jill Archibald,[124] and for the most part I agree with her discussion of the relevant considerations, and so I will not repeat them at length. Instead, I add relevant medical and psychiatric considerations.

Consent

6.2 In general, an informal patient must consent to treatment before it can be given, and whatever a patient's status in relation to the mental health act or with respect to mental capacity, it is always better to seek consent and better if it is given. Further, treatment consists of any intervention that is part of medical care. This means that being observed is a treatment[125] and patients are entitled to refuse it. It is common for patients to refuse physical health examination on admission to mental health units, and they are not required to agree. It is also common for a patient to refuse to talk to someone who wishes to interview them, and they are not required to agree.

6.3 In order for a patient to consent to an intervention, they need to know what that intervention is, how it will benefit them, and what the risks might be. We use the term "implied consent" to deal with situations where that information is self-evident to the patient, and the patient's agreement to the intervention is also self-evident. An example would be a patient holding out their hand so that a doctor or nurse can take their pulse. "Implied consent" is just consent. The point is worth labouring because the concept of "implied consent" is used a lot in relation to the introduction of the Oxevision system as though it were different to some other form of consent.[126]

6.4 The concept of "express consent" means simply that the patient explicitly says that they do consent. It generally extends to situations where some aspect of the intervention is not self-evident to the patient and needs to be explained. An example would be having a flu vaccination. Since one cannot know what is in a flu jab, this must be explained, and the main possible risks (although not every

[124] Expert Report of Jill Archibald, *Observation and Engagement and the use of Vision Based Monitoring*, [INQY025967] section 11 Legal Framework and Capacity to consent and Section 23, "Capacity to consent"
[125] Mental Health Act 1983, s.145(1) and (4): 'medical treatment' includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care; General Medical Council (2020), Decision Making and Consent.
[126] General Medical Council (2020), Decision Making and Consent (implied consent in routine examinations).

possible risk, however small) also set out. Generally, with flu jabs, the patient then gives verbal consent, but with more major medical interventions, because the fact of consent is so important, the patient may sign a consent form.

6.5 The practical implication of this is that the Oxevision system is an intervention and patients who have capacity and are not detained must consent to its use. In order to consent, they must know what it does, how it will be used, why it is being used, and what risks there might be. For example, because information is recorded and stored, there are potential risks of that information being released to unauthorised individuals inadvertently. There is a duty to be sure before using the system that the patient has been given that information in a form they can understand and has agreed.

6.6 Standards in relation to consent evolved with increased expectations about giving information over time. GMC guidance moved from Seeking Patients' Consent (1998) to Consent: Patients and Doctors Making Decisions Together (2008) and then Decision Making and Consent (2020), each asking for a fuller dialogue with the patient.[127] The Supreme Court's decision in *Montgomery* in 2015[128] changed the standard for consent from what a reasonable doctor would disclose to what a reasonable patient would want to know.[129] NICE recommended shared decision-making across the NHS in 2021[130], and shared decision-making about psychiatric medication is now expected practice. For detained patients, Part 4 of the Mental Health Act sets specific rules: medication for mental disorder beyond three months needs the patient's consent or a certificate from a Second Opinion Appointed Doctor (SOAD), and ECT has further protections introduced in 2008.[131]

Capacity

6.7 There are situations where patients lack the capacity to decide on an intervention at the time that it is delivered. The simplest example is the situation where a patient is brought into hospital unconscious. If, at the relevant time that a decision is to be made, a patient lacks capacity, then a decision must be made about what

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[127] General Medical Council, Seeking Patients' Consent: The Ethical Considerations (1998); Consent: Patients and Doctors Making Decisions Together (2008); Decision Making and Consent (2020).
[128] Montgomery v Lanarkshire Health Board [2015] UKSC 11.
[129] *Ibid*.
[130] NICE (2021), Shared decision making, NG197, https://www.nice.org.uk/guidance/ng197.
[131] Mental Health Act 1983, ss. 57, 58, 58A and 62; Department of Health (2015), Mental Health Act 1983: Code of Practice, chapters 24 and 25.

to do in their best interests. This needs to be done whether or not they consent to an intervention because a patient lacking capacity cannot give valid consent or dissent.

6.8 The law on capacity changed in the middle of the period being considered by the Inquiry. Until October 2007, capacity and best-interests decisions rested on the common law. The Mental Capacity Act 2005 then came into force and put both on a statutory footing but also provided for independent mental capacity advocates to support patients.

6.9 Without unpacking the legal situation in too much detail, there are some helpful extra points from a medical perspective that can be missed.

- Although people are presumed to have capacity and must therefore be actively shown not to have it, it is important in quite a few situations to confirm that a patient does have capacity, especially when a decision is complex or very serious. Checking that someone has capacity is not in itself an infringement of patients' rights.
- In evaluating whether someone has capacity the simple fact that what they wish to do is unwise, or not what the healthcare giver would advise, cannot be taken as meaning they do not have capacity.
- Where a patient does not have capacity the determination about what is in a patient's best interests is not simply a matter of doing what healthcare givers think best; it is a matter of determining, in so far as possible, what a patient would have thought in their best interests if they had capacity. The Mental Capacity Act 2005 requires the decision maker to consider "*(a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity), (b) the beliefs and values that would be likely to influence his decision if he had capacity, and (c) the other factors that he would be likely to consider if he were able to do so.*"[132]

6.10 The principle of least restriction protects patients who do not have capacity and who do not consent from having things imposed on them without care for how they will react.

6.11 In my view, given the nature of the Oxevision system and the way in which its functions can be replaced by direct human interaction, there would be very few

[132] Mental Capacity Act 2005, section 4(6).

situations where a patient who did not have capacity, and who was not consenting to the use of the system, should have it imposed on them.

The Mental Health Act

6.12 If an informal patient refuses an intervention, then if that intervention is necessary, there may be an assessment as to whether the patient should be detained using the provisions of the Mental Health Act. The fact of refusing an intervention is not evidence that a patient is detainable, and an independent, proper assessment using the criteria set out in the Act must be carried out.

6.13 Detention under the Mental Health Act provides some authority to compel a patient to have treatment, but the authority is limited. Firstly, it does not extend to physical health care – a detained patient is entitled to refuse a physical health intervention unless that intervention is directly treating a mental health condition (as for example may be the case when patients with anorexia are fed using a nasogastric tube[133]). Detention under the Mental Health Act also does not provide authority to deliver any treatment without further consideration. Instead, treatment needs to be the least restrictive possible option.

6.14 With that in mind, my overall view is that, with the exception of certain circumstances where remote observation was for some reason necessary to preserve life, the use of VBPMS in the case of a detained patient who was objecting would be hard to justify. Potentially, care for a very unwell, highly behaviourally disturbed patient who was being secluded and had been given rapid tranquillisation could be enhanced by the ability to measure vital signs. The argument would be that while regular full observation (using NEWS2) was preferable, the risk to the patient of entering their room and restraining them was so great as to justify the use of a lesser alternative such as repeated measurement of vital signs. However, I would consider this must be a short-lived situation because, if the patient's clinical measurements became concerning, then there would be a need to enter their room safely and so the urgent priority should be to create a situation where it was safe to go and see them, in person, and regularly.

[133] Mental Health Act 1983, s.63; B v Croydon Health Authority [1995] Fam 133 (nasogastric feeding as treatment for mental disorder).

7 Section 7 — Technology in psychiatric care

Role and function of VBPMS, including Oxevision

7.1 I have taken the term vision-based patient monitoring systems to cover systems designed to monitor individual patients in the clinical setting in order to improve clinical care rather than entities like CCTV in public spaces or body-worn cameras, which are primarily evidential tools. At the outset of this section I acknowledge that this report has been drafted with reference to the material I have considered in relation to this instruction, and with the benefit of hindsight. Notwithstanding this, the following discussion and analysis considers VBPMS from the perspective of what risks, in my view, could have reasonably been identified at the relevant time.

7.2 I consider here the role and function of these systems in general but the first thing to say is that in the UK there is essentially only one marketed technology, which is the Oxevision system. Furthermore, as far as I can tell, the UK is an outlier in the use of this technology, which has not yet been taken up globally,[134] although there is a European company (Kepler) that is looking at falls.[135]

7.3 The technology is recent. Oxehealth was created as a company by Oxford University's Institute of Biomedical Engineering in 2012, and its vital signs software obtained CE Class IIa accreditation in September 2018 for spot measurement of vital signs.[136] A CQC inspection report in December 2018 listed the sensor technology at Coventry and Warwickshire as outstanding practice, and adoption had spread to roughly half of English mental health trusts by the early 2020s. Concerns from patients and campaigners grew from 2022, and Rethink issued a position statement in November 2023 noting that "*Above all, use of this kind of technology should always clearly be in the best interests of the person being treated, who should have an informed choice and be able to withdraw consent at any time. Good and safe care is built on the principles of co-production, with*

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[134] Griffiths, J.L. et al. (2024), 'The use and impact of surveillance-based technology initiatives in inpatient and acute mental health settings: a systematic review', BMC Medicine, 22, 564; HSSIB (2024-25), Mental Health Inpatient Settings investigation series, https://www.hssib.org.uk/patient-safety-investigations/mental-health-inpatient-settings/.

[135] Kepler Vision Technologies B.V., Amsterdam, https://keplervision.eu/.

[136] Oxford University Innovation, Oxehealth: supporting safer patient care (spin-out 2012; adoption by roughly half of English mental health trusts), https://innovation.ox.ac.uk/case-study/oxehealth-supporting-safer-patient-care; Oxehealth CE Class IIa accreditation announced 20 September 2018, https://www.businesswire.com/news/home/20180920005021/en/.

people in services and providers working together to develop good standards of safe care."[137]

7.4 A systematic review in 2024 found insufficient evidence that surveillance technologies achieve their intended outcomes, and national guidance followed in 2025: NHS England's principles for digital technologies in mental health inpatient settings (February) and a CQC brief guide on digital contactless monitoring (August).[138]

7.5 Ms Archibald describes the capability of the Oxevision system in some detail.[139] The evidence given by Ms Cozens[140] also describes the Oxevision system as hardware that uses an infrared-sensitive camera that relays to screens and tablets information about a single individual in a room. It is able to provide alerts related to an activity tracker, which detects whether a patient is on the edge of a bed, in a blind spot (typically their bathroom) or near a door. The system can, when used by an operator, take a measurement of an individual's vital signs as long as certain requirements are satisfied, which include the ability to see a sufficient amount of the patient's skin so as to make the required measurements and whether the values measured are within a valid range. To assist in making those measurements, the system provides 15 seconds of clear view video data. The system has the ability to store information for review in the event of an incident, with rules about the duration of storage, the location of the servers and the retention of data.

7.6 I am asked to distinguish the technical capability, operational benefits and clinical outcomes of the system, but the material I have reviewed often conflates these

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[137] Care Quality Commission (21 December 2018), Coventry and Warwickshire Partnership NHS Trust: wards for older people (inspection report); Rethink Mental Illness (November 2023), Our Position on Oxevision, https://www.rethink.org/news-and-stories/media-centre/2023/11/our-position-on-oxevision-the-new-monitoring-system-in-mental-health-units/.

[138] Griffiths, J.L. et al. (2024), 'The use and impact of surveillance-based technology initiatives in inpatient and acute mental health settings: a systematic review', BMC Medicine, 22, 564; NHS England (7 February 2025), Principles for Using Digital Technologies in Mental Health Inpatient Treatment and Care, PRN01510; Care Quality Commission (updated 20 August 2025), Brief Guide: Digital Contactless Patient Monitoring Technologies.

[139] Jill Archibald, *Report for the Lampard Inquiry: Observation and Engagement and the Use of Vision Based Monitoring* [INQY025967], paras 19.4 and 21.1–21.10, especially para. 21.2 (pp. 65 and 72–74); see also paras 24.2 and 24.10 (pp. 82 and 84).

[140] First Witness Statement of Laura Cozens, 19 February 2025 [OXHE009031], paras 12–15, 18, 22–29, 32–35 and 131–135 (statement pp. 3–6 and 20–21).

elements. Further, I consider that the technical capabilities and operational benefits of the system lie in the domain of other experts, as set out previously.

7.7 The intended clinical purpose of the system within inpatient mental health care, as described in the Oxevision literature, is enhanced risk management and a better experience for patients (better sense of safety, better sleep, improved sense of wellbeing). I consider those to be reasonable aims, and the literature for the system describes a 44% reduction in self-harm, 48% reduction in falls, 37% reduction in assaults and 24% reduction in restraints.[141]

7.8 These would be exceptionally beneficial findings with very great clinical utility if they were substantiated. However, the Inquiry has also heard evidence from experts in relation to concerns about the validity of the evidence base that underpins those statements. Furthermore, the evidence gathered by EPUT itself does not really substantiate them. This does leave the clinical role and function of VBPMS in some doubt.

Potential benefits and risks of VBPMS

7.9 I have considered VBPMS in general above, but I comment below on specific potential benefits and risks associated with the use of VBPMS from a psychiatric perspective.

Information relevant to a patient's presentation, behaviour or physical state

7.10 It is certainly the case that VBPMS could provide relevant information. If a patient is in their bathroom for too long, this is a risk area, and so this may be relevant information. Equally, doorways can provide difficult-to-eradicate ligature points, and so this too could be a risk area. Patients who have safeguarding risks may be at increased risk if someone else is in their room. All these are potentially relevant pieces of information, but they are neither exhaustive (risk can occur in other

[141] Lio (formerly Oxehealth), 'How it helps', https://www.liohealth.com/how-it-helps (accessed August 2026). The page cites: Ndebele, F., Wright, K., Gandhi, V. and Bayley, D. (2024), 'Non-contact monitoring to support care in acute inpatient mental health', *Journal of Mental Health*, 33(3), pp. 320–325 (self-harm); Wright, K. and Singh, S. (2022), 'Reducing falls in dementia inpatients using vision-based technology', *Journal of Patient Safety*, 18(3), pp. 177–181 (falls); Ndebele, F. et al. (2022), 'Non-contact health monitoring to support care in a psychiatric intensive care unit', *Journal of Psychiatric Intensive Care*, 18(2), pp. 95–100 (assaults); Kekic, M., Rose, A. and Bayley, D. (2026), 'Enhancing safety in mental health hospitals: a multi-site evaluation of a contactless patient monitoring platform', *Mental Health and Digital Technologies*, 3(1), pp. 32–45 (restraints).

areas) nor are they specific – people can easily spend more than 3 minutes in the bathroom.

7.11 I struggle to see how repeated measurement of pulse and respiration assists more than minimally in relation to monitoring a patient's physical health. As described in section 3.40, I am critical of the practice of checking "vital signs" intermittently at night. In my view, the absence of a reading in relation to vital signs at night is most likely to be either an error or to signal that a fatal event has occurred. This is obviously a terrible thing, but it will be too late to do anything helpful. This view is controversial, because nighttime observations that include the specific requirement to check a patient is breathing are longstanding and universal nursing practice. Further, if it was critical that vital signs were monitored in this way, then I would struggle to see what the system added over and above the use of a wearable device.

7.12 Remote night observations that do not involve seeing a patient to determine if they are asleep or awake are of extremely limited utility. The value of observing a patient at night, is to see if they are awake and need support. I do not think a sleeping patient needs any form of observation.

7.13 If, in future, the system could be developed so that it could provide continuous pulse and respiration tracking, such a functionality might give useful information about a deteriorating physical state. This could certainly be the case for some conditions such as sleep apnoea (although CO2 levels are best)) or evolving respiratory depression, and I think such a system could be valuable to some degree in this area were that function to be available.

7.14 However, vital signs tracking could not help with detecting the first signs of self-strangulation or self-harm, allowing for early intervention. This is not something that has been suggested, but the hope of this was my immediate untutored thought when considering the Oxevision system clinically in my own organisation. Sadly, respiration and pulse rates are not reliable leading indicators of self-strangulation and brain damage, even fatal damage, can precede obvious changes.[142] I wondered if the hope of something like this lies behind the suggestion that 1:1 observation requirements might be reduced by such systems.

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[142] Sauvageau, A., LaHarpe, R., King, D. et al. (2011), 'Agonal sequences in 14 filmed hangings, with comments on the role of the type of suspension, ischemic habituation, and ethanol intoxication on the timing of agonal responses', American Journal of Forensic Medicine and Pathology, 32(2), pp. 104-107 (also cited at footnote 11 below): in filmed hangings loss of consciousness occurred within about 10-20 seconds, while

7.15 **Jason Standing**[143]

34, died 5 January 2022 · Hadleigh Unit, Basildon Mental Health Unit · EPUT

Jason had an extensive history of psychotic illness which began at the age of 13. He went on to have multiple inpatient admissions in North East London and Essex under the Mental Health Act (MHA) 1983. He had diagnoses of schizophrenia, psychosis and learning difficulties. He was also overweight and had type 2 diabetes, hypertension, irritable bowel syndrome, pressure sores, tachycardia and sleep apnoea. Jason was prescribed a sleep apnoea machine but declined to wear it.

Having been stable for some time Jason deteriorated and was admitted in a very seriously unwell state to the point of being thought early on to have encephalitis. He was treated with Clozapine (a psychiatric medication with considerable risks but also sometimes the only helpful treatment for patients with serious and difficult-to-treat illnesses) in doses higher than he had received previously, and he had improved enough to be transferred to the Hadleigh Unit. However, Jason's presentation began to deteriorate.

Between 29 December 2021 and 4 January 2022, he was noted as presenting as manic, unsettled, hallucinating and unpredictable, refusing food and medications.

On the evening of 4 January 2022, the administration of Jason's regular medication was attempted, but he was reluctant to take it. He eventually complied and was also given promethazine and lorazepam alongside his regular medication. Jason was on 1:1 observations.

At around 06:00 on 5 January 2022, a healthcare assistant conducting observations was unable to determine if Jason was breathing. He raised his concerns at the nursing station. A nurse checked on Jason and thought that he was fine. At or around 06:30, a different nurse checked, determining that Jason was not breathing. The ambulance service was called at around 06:30, and CPR was commenced. At 06:57, Jason was pronounced dead.

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breathing movements continued for minutes afterwards - changes in pulse or respiration lag behind the point of danger rather than leading it.

[143] Case Summary of Jason Standing, [INQY025343].

When data from the Oxevision system was reviewed, it showed deterioration in respiration from about 22:45, apnoeic episodes from about 03:00 and no movement or breathing from about 03:32. Paramedics who attended recorded the beginning of rigor mortis, which is consistent with this timing. The Oxevision system did not raise an alert to his respiratory activity as it was not configured to do this.

At the inquest into Jason's death the jury concluded that: "Staff did not understand 'the fundamental elements' of level 3 observations. Eyesight was obstructed by various objects meaning observations could not be carried out with the door closed or sitting on a chair. From 21:30 to 06:07, the door to Jason's room was closed, meaning breathing could not be observed. Nor was there any engagement with Jason. Observing from behind a closed door "displays a distinct lack of care which on the balance of probabilities contributed to Jason's death".

The jury found that "Had the signs of respiratory distress and airway obstruction been recognised in a timely manner, this would have prevented Jason from going into respiratory arrest and, on balance, he would have survived."

The cause of death was "Sudden Cardiac Death / Sleep apnoea and obesity, with clozapine and Promethazine co-toxicity."

Jason's medication may have contributed to making his sleep apnoea worse. Potentially, if the 1:1 observations had been done properly, the noise made by breathing in sleep apnoea, which can be loud, would have been detected (but this is not a sure sign to rely on). If the Oxevision system could have been configured to track deteriorating respiration, it could have alerted staff.

7.16 That said, it is important, as discussed, to be aware that the mechanism of serious harm and death in self-strangulation is not always one that reliably produces detectable changes in pulse or even respiration effort sufficiently early in the process before there has been significant injury.

Supporting clinical decision-making or risk management

7.17 I do not think that there is a high probability that the information the system provides supports clinical decision-making or risk management in many situations, but there are some exceptions that include patients in seclusion where

there is no other safe means of monitoring and potentially also temporal patterns in relation to fall risks.

7.18 There is also a case for utility in relation to risk management concerning falls and in providing alerts in relation to patient location, which may signal risk. The difficulty is that not all situations are covered, and that the system is often oversensitive, leading to alerts being generated and patients checked on when nothing untoward has happened. This generates risks both that staff will come to ignore the alerts, but also that patients will have a sequence of interactions with staff generated by a false alarm which may not be clinically productive.

Assisting with identifying changes in patient's presentation

7.19 Regular observations can assist in identifying changes in the patient's presentation, but remote observations are limited in their ability to provide relevant information. There will be some gain in specific situations as set out above, but not as a general rule.

Information relating to sleep, activity, or other aspects of patient's presentation

7.20 If a VBPMS system were able to provide reliable information about sleep, then this could be clinically important and could reduce risk and harm. Being awake at night is a lonely time and one when patients can experience significant anguish. A system that alerted staff to this fact would be helpful and allow them to offer comfort and support.

7.21 However, I would want to have evidence that less intrusive systems of measurement (such as a wearable device) would not be equally effective. The advantage of wearable devices is that they do not take video images, and also, they are inherently collaborative because the patient has to agree to wear them and has as much access to their data as the staff do.

Reduction in opportunities for direct therapeutic engagement;

7.22 A major fear in relation to the use of the system has been that staff would use a remote system rather than checking in person on the patient and that, thereby, the opportunity for therapeutic engagement would be lost. It is clearly the case that if staff were to act in this way, an opportunity would be lost (except at night when the

patient is asleep). Attempts can be made to mitigate the risk in this regard by instructing staff not to do this and by using the capacity of the system to check whether someone entered the patient's room to audit staff behaviour. As will be discussed later, the team implementing the Oxevision system at EPUT struggled with this risk and increasingly firmed up guidance in this area.

7.23 **Michael Nolan**[144]

63, died 10 July 2022 · Kelvedon Ward, Rochford Hospital · EPUT

Michael's mental health deteriorated sharply in 2019 following a bereavement. He developed health anxiety and worries about his finances and was treated with a range of antidepressants. He was then admitted, having been detained on section 136 after he stabbed himself at home. Michael was admitted under section 2 of the Mental Health Act on 23 June 2022. He reported agitation and impulsivity and was thought to be minimising his mental state because he wanted to be discharged.

Michael was placed on level 3 observations and later also consented to Oxehealth monitoring in his room.

On 29 June he was "getting to a place where he can be discharged" and denied having thoughts of suicide or self-harm. The assessing clinicians decided to reduce his observations to level 2 and contacted his family to discuss discharge planning. Michael's family raised concerns that Michael "keeps it bottled up" and Michael's son, James, recalls telling the 'doctor/s' that Michael could "...hide his feelings very well and so it was important to keep a close eye on him on the ward and not to just discharge him".

Michael was felt to have improved and on 7 July 2022, he took accompanied ground leave without incident, and no concerns were reported by nursing staff. Michael also engaged with occupational therapy activities whilst on the ward.

On 10 July 2022, the bathroom alert on the Oxevision system was activated at 07:11:43 and reset at 07:11:53 but nobody attended Michael's room. There was a breakfast call at 07:33 but this did not involve looking into Michael's room. Then

[144] Case Summary of Michael Nolan, [INQY025337].

after 07:35, Michael was found by ward staff in his bathroom, collapsed and not breathing. He had swallowed **a small item.**.

Attempts to resuscitate Michael were unsuccessful, and he was pronounced dead at 08:35.

At the inquest into Michael's death the jury concluded as follows:

"The HCAs responsible for Michael's care consistently used OxeVision as a substitute for observations and engagement, and, in many cases, failed to use OxeVision correctly....The observation records have been amended and show that Michael was observed in the bathroom and that there were 'no concerns' at 07:15 hours. The CCTV footage does not show that this engagement took place."

The alert was live for nine seconds before it was reset, and twenty-one minutes elapsed between the reset and anyone attending the room.

Michael's death is a clear example of the Oxevision system being used incorrectly. First, by failing to carry out in-person observations, an opportunity to detect Michael's distress, before he did a fatal thing, was missed, and second, an alarm expressly designed to signal presence in an at-risk area was turned off. The question is whether systems of this sort are so tempting to pressed staff that the risk can never be mitigated.

7.24 It is, however, worth noting that the degree to which observation conducted without the use of technology involved meaningful clinical engagement is by no means assured. Very sadly there are multiple reports across many trusts of absent or falsified records,[145] and CCTV review can reveal that observations were not performed or were conducted in a way that had no value.

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

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[145] Courts and Tribunals Judiciary (2024), Mahamoud Ali: Prevention of Future Death Report, ref. 2024-0379; Care Quality Commission (2024), Special Review of Mental Health Services at Nottinghamshire Healthcare NHS Foundation Trust; Care Quality Commission (2024), Central and North West London NHS Foundation Trust inspection report - all cited with quotations at section 3.

False reassurance or incomplete understanding of patient risk

7.26 The sharp limitations of the VBPMS in evaluating and managing risk should be relatively self-evident to a working clinician, making the chance of false reassurance low as long as staff are trained accurately and the system is used adjunctively as now envisaged. However, the documents I inspected in relation to implementation at EPUT showed evidence of misunderstanding in relation to the capabilities of the system, and also a false equivalence being made between level 2 observations and the system being active (see section 7.7).[146]

Encouraging undue reliance on technological outputs rather than psychiatric assessment and clinical judgement

7.27 I also consider that as long as the use of VBPMS as an adjunctive technology as opposed to the first-line technology is enforced, it is unlikely that there will be undue reliance on technological outputs. However, as described above, this was not how it was initially going to be used by EPUT.

7.3 Technology and therapeutic psychiatric care

(a) Whether technology can support psychiatric assessment, treatment or risk management

7.28 It is certainly possible to conceive of technologies that would support some aspects of psychiatric assessment, treatment and risk management but this is not mostly the case at present. As discussed above, the ability to track sleep and to detect if a patient is awake at night would obviously be helpful, although it is not clear that the full VBPMS functionality is needed for this. Were there a technology that would reliably detect the start of serious self-harm, then this would not only be helpful but likely also save lives. In certain patients, the ability to track somewhat more than just pulse and respiration continuously would likely alert staff to physical deterioration over time, and this would potentially also save lives.

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[146] First Witness Statement of Zephan Trent (Executive Director of Strategy, Transformation and Digital, EPUT), dated 21 March 2025, Rule 9(3c), [EPUT009024], §47 "*EPUT can confirm that there have been multiple occasions when the request to switch off the camera has been agreed to by clinicians. Examples include:*
• *A patient being concerned over privacy. The patient had capacity and was advised that they would be placed on level 2 observations when the camera was switched off.*
• *A patient described feeling paranoid about having Oxevision switched on in their bed space. The patient had capacity and was advised that they would be placed on level 2 observations when the camera was switched off*"

7.29 There is less of a case for technologies supporting psychiatric assessment, although there are some studies which suggest that patients may be more willing to talk openly with computerised chatbots than with staff, and if patients were willing to share some of those conversations later with their caregivers, this could be helpful.[147]

7.30 As far as I can see, those technologies lie in the future.

(b) Whether, and in what circumstances, reliance on technology may risk reducing opportunities for meaningful clinical interaction between patients and staff and (c) Whether the use of technology may affect how clinicians understand a patient's presentation, needs or risks

7.31 I consider that technology becomes an obstacle to meaningful clinical interaction between patients and staff when it is seen as a replacement for rather than a mediator of communication and interaction. Thus, using technology instead of talking is likely to be problematic, but using technology in order to talk better can be helpful and we have simple examples of the latter, such as hearing aids or continuous translation systems.

7.32 Thinking about how we can use technology well helps to understand how it might become an obstacle. The concept of "shared tools for self-reflection" introduced by Anthony Ryle can be really helpful.[148] This concept was originally constructed out of the idea that language can be thought of as an example of humankind's fairly unique ability to use tools and that it is a tool for communication and self-reflection. Anthony Ryle emphasised writing and the construction of paper-and-pencil diagrams or letters between patient and therapist. But the concept of tool use could easily be extended to observation practice where instead of observations being gathered on a patient either remotely or passively, patient and nurse jointly decide what to write in the observation record. Technology could

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[147] Lucas, G.M., Rizzo, A., Gratch, J., Scherer, S., Stratou, G., Boberg, J. and Morency, L.-P. (2017) 'Reporting mental health symptoms: breaking down barriers to care with virtual human interviewers', *Frontiers in Robotics and AI*, 4, article 51

[148] Ryle, A. and Kerr, I.B. (2020), Introducing Cognitive Analytic Therapy: Principles and Practice of a Relational Approach to Mental Health, 2nd edn, Chichester: Wiley-Blackwell;
Denman, C. (2001), 'Cognitive–analytic therapy', *Advances in Psychiatric Treatment*, 7(4), pp. 243–252

assist here if patients had access to the growing record of observations and could look back over them.

7.33 So, by contrast, to the extent that technology takes information away from patients and detracts from staff closeness to patients, it will reduce the chance patients have to interact meaningfully with their treatment and to influence its course.

7.34 Technology can therefore affect how clinicians understand a patient's presentation, needs or risks both positively and negatively; the trick is always to see technology as a tool and to ask to what use it is being put.

The appropriate psychiatric role for VBPMS

7.35 I consider that in an appropriately consenting patient who is able to collaborate with staff in constructing a care plan that locates the use of VBPMS as part of their care and in which they are actively involved, the system could provide some data about sleep (such as whether they are up and moving about) some limited information about risk and for some patients its ability to detect location could be incorporated into part of a safety plan.

7.36 Setting this out in more detail, there is a clinically meaningful distinction between: (i) technology which supplements or supports observations undertaken as part of psychiatric care; and (ii) technology which is relied upon as a substitute for direct clinical assessment and interaction. The idea of technology as a joint tool creates the circumstances in which it can supplement and support observations and patient care. An illustrative example might be of a patient who has ruminative suicidal thoughts of attempting to drown themselves in their bathroom sink and has regular compulsive urges to do so. For that patient, a conversation about how terrible those thoughts are, how they cannot always communicate them and what staff can do to help could generate the idea that a VBPMS system, if turned on, would warn staff if the patient had gone into their bathroom, and they could then come and help the patient leave and talk. There would be advantages to this because the patient might well have access to thoughts and feelings about the urge which were less immediate to them during other parts of the day or when asked about it by their psychiatrist in a ward round. Together patient and staff could design an intervention that would hope to move from staff intervening to empowering the patient to walk in the other direction from their bathroom out of their room to ask for help.

Reliance inconsistent with responsible practice

7.37 VBPMS is not helpful in relation to general psychiatric assessment or more than minimally in relation to clinical formulation and decision making. This is because the information they provide is only a tiny fraction of the information needed to make those evaluations.

7.38 I do not think VBPMS systems currently have any real utility in informing decisions concerning observation levels, including in decisions to commence, increase, reduce or discontinue observations. There may be value from gathering and reviewing longitudinal data or numbers of incidents, but this comes from having good data recording and tracking software rather than from video-based patient monitoring capabilities. Even in the area of physical health, I would not be confident to use Oxevision data alone, but would want sequential NEWS2 findings.

7.39 I therefore take the view that there are no circumstances where VBPMS can replace clinical assessment or formulation, clinical judgement or therapeutic engagement either individually or separately.

7.40 I also consider that there are almost no circumstances under which sole reliance on VBPMS would be consistent with responsible clinical practice. Direct clinical observation generates more information more meaningfully. Even in extreme situations where remote monitoring is all that is possible, such as with a patient who is highly agitated and disturbed in seclusion, the patient would be watched constantly.

Particular psychiatric risks of VBPMS

7.41 In this section, I consider risks that VBPMS systems are introduced in order to produce operational efficiencies or to reduce staffing pressures. These systems can only do this if they speed up or substitute for what nursing staff is already doing.

7.42 Put this way, even if this aim could be achieved safely, there would seem to be no benefit to such systems other than to save money, but it should not be assumed that operational benefit is purely a matter of saving money. Wards can become highly pressured environments, and if many patients require frequent or continuous observation, then staffing pressures can become acute. Wards have

safer staffing complements,[149] but even these can be overwhelmed by fluctuating need.

7.43 While additional staff can be found, they may not be familiar with the ward, and so the quality of care can decline. On a pressured ward, staff may already not have time for therapeutic engagement.[150]

7.44 So, if it were genuinely the case that VBPMS could reduce pressure on wards safely, then the overall amount of therapeutic engagement on the ward might actually increase. I consider that the only way this sort of benefit could be realised would be with the use of active video monitoring that would have to take the place of some four-hourly or one-to-one observations.

7.45 There might be use cases for a VBPMS system in this sort of way, as long as it was with consent and clearly evaluated as the least bad option in extreme circumstances. Of course, the worry would be that what was once a sensible exceptional move then becomes a routine recourse.

Further risks

7.46 **Misunderstandings:** I think there is a risk of undue reliance on technological outputs rather than psychiatric judgment, and some evidence that it has occurred, driven by a misapprehension by a staff member about the functionality of the system. There is an example from implementation in EPUT of a staff member who thought the system would give an alert if the patient stopped breathing, which was not true.[151] Further, on another occasion a patient who did not consent to the use of the system was told they would therefore be placed on observations four times an hour.[152] While this might have been justified in that the fact of not consenting to the use of the system might have been an indicator of the patient's risky state of

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[149] National Quality Board (2016), Supporting NHS Providers to Deliver the Right Staff, with the Right Skills, in the Right Place at the Right Time: Safe, Sustainable and Productive Staffing.

[150] See the Madison Naylor case summary example in section 3.2, which illustrates this conflict between another observation duty and a patient's request for contact.

[151] Minutes of the EPUT Oxehealth Project Board meeting, 21 April 2021, [EPUT027578], page 4 [EPUT027578_0004], item 8.0 (Any Other Business — Longview Ward incident / SOP review) "*IC: Staff believe that the system was monitoring if a patient does stop breathing, but not the case. This may require more training and information for staff.*"

[152] First Witness Statement of Zephan Trent (Executive Director of Strategy, Transformation and Digital, EPUT), dated 21 March 2025, Rule 9(3c), [EPUT009024], §47.

mind, I was worried that the thought was that the system was as good as, or was being used instead of, observations four times an hour.

7.47 **Covert viewing**: The system can produce a live, clear view image of a patient in their bedroom. That image can be reproduced, and whether it is looked at depends on who has access and what they decide to do. Potentially, the image could be reproduced by a member of staff filming it on a mobile phone.

7.48 **Unauthorised use**: Apart from criminal acts by staff, there is also the risk that staff may use the capabilities in the system in ways that are not authorised, and this has surfaced in the anxieties about the multiple attempts by staff to take vital signs, which far exceed the required number. It is an inescapable worry that staff are using the clear view capability to check on patients. Ironically, if this was driven, for example, by a staff member's intuition that something was not right as an additional check – say, after having just talked with a patient, it might be helpful if the feeling of disquiet was not enough to pull the staff member back in person. As with operational benefits, the risk is that what is done with benign intent on a few occasions becomes a routine recourse and replaces richer engagement.

7.49 **Increased psychiatric symptomatology**: as discussed, there is a risk that the fact of remote video access to a room – even if it is not turned on – would be very frightening and disturbing to some patients.

7.50 **Sophie Alderman**[153]

27, died 19 August 2022 · Willow Ward, Rochford Mental Health Hospital · EPUT

Sophie was under the care of Southern Health NHS Foundation Trust in Southampton from 2015 to 2021, both as an inpatient and in the community, and had a complex mental health history. She was diagnosed with emotionally unstable personality disorder (EUPD), schizoaffective disorder, post-traumatic stress disorder (PTSD) and obsessive-compulsive disorder (OCD). She had, at one stage, developed neuroleptic malignant syndrome (a very serious complication of psychiatric medication). She struggled with self-harm, hallucinations and suicidal thoughts.

[153] Case Summary of Sophie Alderman [INQY025336].

Sophie was admitted to hospital on 29 April, initially informally but ultimately under section 3 of the Mental Health Act.

On 3 May 2022, Sophie is noted to have told staff that the camera in her room was being monitored by the government. This is understood by her mother to be a reference to the Oxevision system installed in bedrooms on her ward. Sophie's mother said that she had had a lifelong concern about cameras.

After she was discharged on 23 June 2022, Sophie was assessed and disclosed that she was hearing voices, not taking her medication, wanted to die, had tied a ligature in the morning and had lied to the hospital when she said she was feeling better. Sophie was admitted under section 3 MHA, with a plan to nurse her on 1:1 level 3 observations awaiting treatment on a ward bed. Sophie was transferred to the Basildon Mental Health Assessment Unit (MHAU).

There were numerous difficult incidents during Sophie's admission, including absconding and behavioural disturbance, and she had to be medicated under restraint.

On 19 August 2022, Sophie was informed that her planned Mental Health Tribunal hearing to appeal her section had been postponed. Sophie was recorded as being upset at the delay. Sophie was granted unescorted leave at 12:15 and 14:20. At 15:59, Sophie had a physical altercation with another female patient in which she sustained an injury. At some point in the afternoon, Sophie expressed a desire for a "chat" with a staff member, who was unable to assist because the ward was particularly unsettled. She returned to her room unaccompanied at 17:10, and was seen banging her head at 17:19. She was briefly spoken to by the Senior Sister and offered her PRN medication and a chance to talk, which Sophie declined, asking staff to leave. Shortly after staff left, Sophie tied a ligature around her neck. Between 17:23 and 17:26, Sophie was able to ligature and stopped moving. At 17:29, an Oxehealth bathroom alert signalled that it had been three minutes since Sophie was detected in the bathroom. This alarm was reset 11 minutes and 20 seconds later. Staff did not attend Sophie's room until 17:36. On attending, the ligature was removed. Attempts to resuscitate were unsuccessful, and Sophie was pronounced dead at 18:25.

As with many of the cases I reviewed, there is much to say about Sophie's care, but an important concern is Sophie's lifelong problem with cameras which, combined with the fact that Sophie had psychotic symptoms, does raise a

concern about the impact of camera-based systems on patients with paranoid difficulties.

7.51 **Alert fatigue:** Very frequent alerts with a low ratio of helpful indications to noise provide staff with a behavioural conditioning routine that desensitises them to the alert.[154] This mechanism is low-level and very hard to train against because behavioural conditioning happens below the level of conscious thought.[155] Staff faced with competing demands will be conditioned to deprioritise an alert. Tuning down the system, by contrast, risks failing to signal an alert when one was vital.

When VBPMS may support care, and when not

7.52 Overall, therefore, VBPMS may in the future support psychiatric care more substantially. This will only be when its capabilities have improved. I have sketched out above some possibilities and worked through some ways in which this might happen in section 8. At present, a firm case for the use of VBPMS is harder to make. The case at present is not absent, but it is not great. I note that it was used in a targeted way by Oxford Health NHS Foundation Trust for an individual patient and for a particular setting.[156] I suspect that with current capabilities, VBPMS will have its best uses in specific niches.

7.53 Equally, there are situations where reliance on VBPMS would clearly be inconsistent with responsible psychiatric practice. These are protean, but the two most important in my view are when a patient does not consent and when the system substitutes for a proper assessment.

7.54 It is inconsistent with responsible professional practice to use VBPMS when the patient does not consent to its use. Even where a patient is detained or lacks capacity, I consider that a very particular case would need to be made to overrule a patient's objections to the system.

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[154] Sendelbach, S. and Funk, M. (2013), 'Alarm fatigue: a patient safety concern', AACN Advanced Critical Care, 24(4), pp. 378-386.

[155] Wolfe JM, Horowitz TS, Van Wert MJ, Kenner NM, Place SS, Kibbi N. Low target prevalence is a stubborn source of errors in visual search tasks. *J Exp Psychol Gen*. 2007;136(4):623–38; Manzey D, Gérard N, Wiczorek R. Decision-making and response strategies in interaction with alarms: the impact of alarm reliability, availability of alarm validity information and workload. *Ergonomics*. 2014;57(12):1833–55

[156] Oxford Health — Britta Klinck, Chief Nursing Officer, witness statement dated 28 May 2026 (OHFT024268; 11 pages with 20 exhibits)

7.55 It is inconsistent with responsible professional practice to use a VBPMS system as used as any kind of substitute for a full clinical assessment of physical or mental health. Its use may be appropriate in some circumstances in relation to mental health observations.

Alternative and less restrictive technologies

7.56 I suspect strongly that there will be a range of future devices not yet conceived that will need to be considered as advances in the area of remote monitoring and AI-assisted medicine are developing with considerable speed.

7.57 The two areas that seem both less restrictive and closest to being developed at present are wearable technologies and enhanced note-taking.

7.58 Wearable devices have been trialled in physical and mental health. They include fall detectors but also devices that track pulse, respiration, and blood oxygenation.[157] To my mind, these devices offer a different pattern of risks and benefits to VBPMS. Importantly, they could be much more collaborative devices in that their output is as visible to the patient as it is to staff. Unlike the VBPMS system, they do not have validated accuracy in medical settings, but a wearable device capable of estimating peripheral oxygen saturation, skin temperature, pulse and respiration rate does not seem something beyond the bounds of possibility. More intrusively, there would also be the possibility of tracking the location of an individual, which, if they were to consent to it, would allow them to be found more rapidly and potentially could allow patients greater freedom of movement in situations where they might have been subject to restrictions. Patients could remove these devices or share them, which would create problems.

7.59 Another type of device that would not be too far in the future would build on the OxeObs system, but instead of being simply a way in which staff can record observations, done on patients, it could become a joint journal between patients and staff, with more room for tracking mood, wellbeing and agreeing jointly what should be set down as the outcome or learning from each interaction. This would

[157] Downey, C.L. et al. (2018), 'The impact of continuous versus intermittent vital signs monitoring in hospitals: a systematic review and narrative synthesis', International Journal of Nursing Studies, 84, pp. 19-27; Hickey, B.A. et al. (2021), 'Smart devices and wearable technologies to detect and monitor mental health conditions and stress: a systematic review', Sensors, 21(10), 3461.

make observations more something done with patients and would allow for the construction of personalised joint tools for self-reflection that enhance self-understanding.

7.60 It is important that only when and if systems of this sort are designed and deployed in real situations will it be possible to evaluate their true pattern of benefits and disadvantages. Even then, these will only become apparent after a period of use and evaluation. This means that, as we develop future technologies, regulatory regimes must not be so restrictive or risk-averse that nothing can be deployed for fear of some adverse consequence. The way to minimise risk is to try things on a relatively small scale, to involve researchers and formal evaluators early, and to co-produce developments with patients and their carers.

8 Section 8 — Implementing and monitoring new technology

Evidence expected before adoption

8.1 New technology is both a device that needs to work properly and an intervention that needs to be clinically beneficial and not harmful.

8.2 The evidence that a new technology works properly lies partly in the hands of the Medicines and Healthcare products Regulatory Agency (MHRA), and where a device falls within their purview, I would expect it to have the relevant certification and for the trust to have the relevant regime to deploy the device and ensure it works properly. The necessary regulatory authorisations that may be required for the deployment of a technology is a separate question to whether it should be deployed in any given clinical environment. The latter question, in deciding whether to adopt and use new technology, is for the trust to determine.

8.3 The use of technology represents a new clinical intervention. While there is a formal process for some kinds of clinical innovation (for example, new surgical procedures have specific National Institute for Health and Care Excellence (NICE) guidance), for many others there is no formal guidance. The formal routes include NICE's interventional procedures programme dates from 2003, but this covers procedures only. Frameworks for evaluating digital technologies arrived with NICE's evidence standards framework in 2019 and the NHS digital technology assessment criteria in 2021, and mental health-specific principles only in 2025. For most of the Inquiry period there was no framework against which a system like Oxevision could have been evaluated.[158] However, I note that the MHRA has recently announced a three-year project looking at digital mental health technology that may well rectify this gap.[159]

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[158] NICE interventional procedures programme (from 2003); NICE (2019, updated 2022), Evidence Standards Framework for Digital Health Technologies; NHSX (2021), Digital Technology Assessment Criteria (DTAC); NHS England (7 February 2025), Principles for Using Digital Technologies in Mental Health Inpatient Treatment and Care, PRN01510.

[159] *https://www.gov.uk/government/collections/digital-mental-health-technology*
"The project will improve outcomes for people with mental health conditions by enabling access to safe and effective digital mental health technologies. This will be achieved by ensuring that digital mental health technologies are regulated through continuous evaluation to minimise risk.... The results of this project will include various published guidance documents to make clear the regulation and evaluation of these technologies for patients, the public, healthcare professionals and developers."

8.4 Furthermore, there have been a lot of interventions in psychiatry often piloted by enthusiasts on the basis of clinical reasonableness, with formal and trial evidence for their effectiveness following behind pioneering developers. Examples would include new psychotherapies, assertive outreach[160] and crisis intervention and home treatment teams. The history of such innovations has mostly been helpful, but it has not always been happy or benign.[161]

8.5 As the medical director of a trust, therefore, I would expect an organisation to adopt a stratified but balanced approach.

8.6 For a major new intervention treating a known condition or situation that was going to be adopted widely by the trust, I would expect that the trust would be acting in line with positive NICE guidance for the management of the condition or situation under consideration and that the intervention was actively recommended by NICE.

8.7 For a major, potentially important but novel intervention with potential for significant clinical impact but also potentially unforeseen problems, I would expect that the intervention would only be adopted within a trust as part of a formal research trial with an academic sponsor where the protections for patients come from the rigours of the application and ethics processes.

8.8 For a new clinical innovation with less severe implications, I would expect that there be a core sponsoring clinician or group of clinicians who took central authority for the intervention and for there to be at least some reasonable evidence that the intervention had been used elsewhere or, if entirely novel, had a rational foundation. I would expect there to be a pilot, ideally co-produced with patients, with full consent and the opportunity to opt out. I would expect that audit and evaluation were built in from the start and that clear end points were defined, both to discontinue the pilot early if harms emerged or to discontinue or expand

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[160] Department of Health (2001), Mental Health Policy Implementation Guide (assertive outreach and crisis resolution/home treatment service models);

[161] From 2013 Serenity Integrated Mentoring (SIM), an integrated recovery programme focused on individuals using police ambulance and mental health crisis services with specially trained police officers working alongside mental health professionals. The SIM programme was taken up by NHS England and spread nationally between 2018 and 2020 via the Academic Health Science Networks. After protest in relation to confidentiality and coercive elements to care and concern about the nature of the evidence base NHS England issued a position statement in March 2023 stating that SIM and similar models must no longer be used. See NHS England (10 March 2023), *NHS England position on serenity integrated mentoring (SIM) and similar models*, PRN00317, https://www.england.nhs.uk/long-read/nhs-england-position-on-serenity-integrated-mentoring-and-similar-models/.

the pilot if it was beneficial once benefits were clarified. An advantage of building in audit and research from the start is that it forces clarity of thought in relation to aims and outcomes.

Clinical principles governing adoption and use
Relevant regulatory approval

8.9 No system should be deployed without relevant regulatory approval. Some parts of the Oxevision VBPMS system are considered medical devices, but others are not. For example, the movement and alert system does not fall under the MHRA definition of a medical device,[162] and also probably does not fall under the patchwork of regulations that govern clinical data systems. I do not think there is a standard of expected accuracy or evidence that existed before this aspect of the device was rolled out.

8.10 When adopting new technologies, the starting point should be to consider the clinical intervention rather than the technology as the primary entity. Technology must do what it actually says it will do but its use is a clinical intervention and should be evaluated as such. It therefore goes without saying that there must be a clinical purpose that the technology is intended to serve.

8.11 In terms of whether the use of technology should be supported by an adequate clinical evidence base, I have set out above the limits of clinical evidence in relation to new interventions. It is important to understand that this is not unique to mental health or to technology-based interventions. There would be a fairly large number of innovations and developments in physical health settings, such as ways of organising wards, the introduction of urgent treatment centres and hospital at home interventions, that have been introduced in advance of clear evidence of their benefit.

8.12 I consider that in relation to any new intervention, the balance of benefits and harms is exceptionally difficult to predict in advance. Furthermore, this is more so in mental health than in any other area of medicine, as the evaluation by clinicians

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[162] The MHRA Guidance, "Borderlines with medical devices and other products in Great Britain" Updated 29 June 2026
"Telecare alarm systems are unlikely to be considered medical devices, however some specific telehealth systems or products used with such systems may come within the remit of the UK MDR 2002." https://www.gov.uk/government/publications/borderlines-with-medical-devices/borderlines-with-medical-devices-and-other-products-in-great-britain, section 9 (Software).

of benefit and harm may not align with patients' evaluations. This means that new interventions should be introduced by co-production cautiously and patiently, with a sharp eye for unforeseen difficulties.

8.13 There are no circumstances in which a less restrictive or more therapeutic alternative should not be preferred to any clinical intervention if one exists. The key at a personal level is always to see the objective as some clinical aim – keeping patients safe when they pose a risk to themselves, gathering important clinical information and then working through with patients and other members of the multidisciplinary team how best to do that in the individual case. At an institutional level, the analogous decisions are working out what tools and practices can be safely deployed given competing demands and attempting to keep some equity between different clinical imperatives.

Family and carers' information

8.14 I have deferred commenting on the involvement of family members or carers in relation to the use of VBPMS until the point at which I had already discussed the system. Family members and carers should always be involved in decisions about the care of patients where those patients consent to that information being shared. There can be difficult situations where that consent is not given, but that is beyond the scope of this report. With consent, it is appropriate to give family members and carers the same information about the nature, use and drawbacks of the system that would be given to a patient when seeking their consent about the system. Quite a good way to think about it would be to consider how family and carers would expect to talk with medical staff about a surgical procedure.

8.15 The wisest course of action, if it can be achieved, is to talk to patients with their family carers while also giving everyone the chance for individual conversations.

8.16 Patients can vary in how well they are able to predict their future mental states or accurately remember past ones. Family and carers will offer a richer source of memory and may well be able to make guesses at how the future will go. This makes their information especially important. Where family and carer information cannot be obtained, then I consider this is itself a risk factor.

8.17 Sometimes family and carers may disagree with a proposed course of action. This disagreement needs to be listened to and taken seriously. It should always cause pause for thought. That said, ultimately, clinical staff must "make the care of

patients [their] first concern"[163] and act based on their best professional judgement.

Safeguards

8.18 I have found it difficult to comment on the safeguards that should exist to ensure that VBPMS supports, rather than undermines, good psychiatric care in relation to the current capabilities of VBPMS systems because of their current sharp limitations. With that in mind, I have taken the liberty of conceiving of an example of a system that, were it to exist (it does not), any medical director would dearly wish to deploy, and I have supposed that it turned out the system required video images to be made and perhaps at times viewed by staff.

8.19 This would be a continuous monitoring system that was capable of detecting very early on that someone was harming themselves and alerting staff to that fact extremely early on so that rapid intervention would be possible.

8.20 It remains important to maintain clinical judgment as the primary basis for decision-making, and necessary to carry out ongoing clinical review of whether continued use remains justified for the individual patient. Even a system with the capabilities I have suggested will not be suitable for every patient. There will be circumstances when it may do more harm than good. Examples will include patients who are made very frightened, distressed, and disturbed by the thought of being monitored by a machine, and also patients who are preparing for discharge, where there is a need to help the patient rely on themselves to be safe, as they will have to at home. So the system needs to be deployed in service of clinical aims and with the clinical decision as to its continued deployment kept under review.

8.21 Technology must be used consistently with therapeutic care and least restrictive practice, with safeguards required to prevent technology from displacing clinical judgment or therapeutic engagement. The first main safeguard against too much restriction is valid consent. However good the system was at detecting harm, it should still only be deployed in a patient with capacity who consents to its use or who is detained under the provisions of the Mental Health Act. Where a patient does not consent, then those who care for them must do their best to make things safe in other ways (the situation here is exactly analogous to treating people with a fixed objection to blood transfusions), while at the same time explaining the risks

[163] General Medical Council, *Good medical practice* (GMC 2024), p. 7

involved. Even when a patient does not have capacity or is detained under the provisions of the Mental Health Act, their dissent would need to be carefully considered and accommodated if this could be done safely. This is exactly what we do with patients who are detained and are not willing to take medication – we offer latitude, persuasion, options, and only use coercion as a last resort.

8.22 The issue of therapeutic engagement would also be critical and would, to my mind, involve a complete reworking of the whole context and nature of observation practice. The main principle would be that patients need a care plan around intervention. This would be a co-produced, regularly revised document which would talk about engagement – something that would happen regularly, frequently and not only at times of crisis and safeguarding, which would be something that happened at the point of crisis. I would think it likely that a core part of any such plan would be encouraging the patient to do things other than ligaturing to signal crisis and, were I in charge, would likely want them to have a button in their room that they could press which would set the system off independently of ligaturing.

9 Section 9 — Implementation of Oxevision at EPUT

9.1 Material reviewed and perspective

What material has been reviewed?

9.1 The material I have reviewed consists of a set of contemporaneous documents from the trust Board, its subcommittees and from a specific project board set up to implement the Oxevision system.[164] Along with this, I have reviewed the sequential implementations of policy relating to the system embodied in successive standard operating procedures and,[165] alongside them, the relevant standard operating procedures that cover observation and clinical engagement.[166]

9.2 I have also reviewed detailed witness statements covering the perspective of the Oxevision team working with the trust (in particular of Laura Cozens, Head of patient safety at LIO), the trust's medical and operational director and a patient group with significant worries about the introduction and use of the system.[167]

9.3 My perspective in looking at these records has been that of a medical director.

What a medical director does

9.4 It is therefore worth clarifying what the role of the trust's medical director is. The boards of NHS trusts are required to have both a nursing and a medical director as executive members.[168] Jointly, those two individuals provide the board with clinical advice and would take primary responsibility for the safety, quality and effectiveness of clinical care.

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[164] EPUT Oxevision Roll out Bundle Index [INQY027833].

[165] See EPUT SOPs on Oxevision at: Versions 1-11 at Exhibits 28-40 of the First Statement of Zephan Trent [EPUT009024]; Version 12 [EPUT009884]; and Version 13.5 [EPUT026149].

[166] See Therapeutic Engagement and Supportive Observation Policy (Inpatients) (CLP8): Version 1 [EPUT027721]; Version 2.5 [EPUT027714]; Version 3.2 [EPUT027718]; Version 4.1 [EPUT009028]; and sV1 [EPUT027710].

[167] See First, Second and Third Statement of Zephan Trent [EPUT009024, EPUT009026, EPUT010154 respectively]; Joint Witness Statement of Dr Kallur Suresh and Zephan Trent and Supplemental Statement [EPUT023595, EPUT026141 respectively]; Tenth Witness Statement of Dr Kallur Suresh [EPUT022570]; First, Second, and Third Statement of Laura Cozens [OXHE009031, OXHE009987, OXHE020533 respectively]; and First and Second statement of Stop Oxevision [STOX009054, STOX010163 respectively].

[168] The National Health Service Trusts (Membership and Procedure) Regulations 1990, Regulation 4(1).

9.5 Normally, directors of nursing will have a considerable staff and will be in charge of the formal machinery of board oversight for quality, such as the reports that go to the trust quality committee. Medical directors often hold a number of significant roles such as responsible officer for revalidation, Caldicott Guardian, and are likely to have significant input into research, clinical audit and any clinical effectiveness groups.

9.6 However, the medical director of a trust is often a working clinician who does not have dedicated staff other than one or possibly two deputies who will also be working clinicians.

9.7 Overall, this means that a medical director is able to function as a clinical advisor to the board and may often spot innovations that the trust should consider or clinical risks they should mitigate, but the systematic, detailed process of governance would not be their strongest area of contribution to board processes.

9.8 As a medical director, I would have taken a keen interest in the introduction to wards of a device such as Oxevision. I would have reviewed policy carefully, gathered information and feedback from consultants and tried to understand the boundaries of clinical use but I would likely have left the detailed installation and roll-out of the system to the nursing directorate because they had the capability to deliver that oversight and because the system would be primarily used by nursing staff.

9.9 Accordingly, I have considered the expectations and role of the medical director in the implementation of EPUT from the perspective of how I would have approached it in my capacity as Medical Director:

What is the clinical purpose of the system;

What is the evidence it meets that purpose;

How the system would be deployed clinically;

Whether the system can cause harm;

A clinically oriented understanding of relevant research.

Initial implementation and scale-up

(a) Was Oxevision introduced to address clearly identified clinical needs?

9.10 The evidence I have reviewed suggests that the trust became interested in the use of technology to help clinical care after the Care Quality Commission (CQC) was

noted to have praised the use of the technology on older people's wards at Coventry and Warwickshire Partnership NHS Trust as outstanding practice.[169] The trust already had a positive experience of deploying CCTV in communal areas and also giving staff body-worn cameras in some instances.[170] Further explorations involved a clinician visit to view the system, and the aims seem to have been to document movement and vital sign information, reduce disruption to night care, support physical health management for patients in seclusion, generate alerts, and gather retrospective incident data.[171]

9.11 The trust board was presented with information that the system worked in darkness, could see movement and could measure vital signs.[172]

9.12 The Board paper of 30 September 2020, which recommended the further roll-out of Oxevision included the aims of fewer 1:1 observations, positive risk-taking in stepping down observation, faster night rounds and possible staffing and length-of-stay efficiencies.[173]

9.13 The difficulty with evaluating whether Oxevision's introduction addressed clearly identified clinical needs is that the documentation I have been provided with does not appear to articulate a unified, coherent rationale for the implementation of the system. Instead, a range of advantages are proposed and then, over time, reduced to be more modest. As far as I can tell, the process seems to have been that Oxevision showed clinicians what their system could do[174] and then clinicians began to think about benefits it might confer rather than installing the system to solve a specific problem.

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[169] See First Statement of Zephan Trent, 21/03/2025, at paragraph 12 [EPUT009024] and KSZT01-094: EPUT Board of Directors Part 2, Agenda Item 8b: PHSO and HSE Steering Group Assurance Report, 30/10/2019, at page 19 [EPUT020830] referring to Care Quality Commission (21 December 2018), *Coventry and Warwickshire Partnership NHS Trust: Wards for older people with mental health problems* (inspection report), https://api.cqc.org.uk/public/v1/reports/10635747-0719-4f53-a97a-95b3797bbb34; CQC (26 April 2022), 'Digital care assistant' (innovation case study), https://www.cqc.org.uk/publications/themes-care/digital-care-assistant.

[170] See details of implementation of CCTV and BWC implementation in First Statement of Zephan Trent, 21/03/2025 at paragraphs 83-124 [EPUT009024].

[171] KSZT01-094: EPUT Board of Directors Part 2, Agenda Item 8b: PHSO and HSE Steering Group Assurance Report, 30/10/2019, at pages 18-19 [EPUT020830].

[172] *Ibid* at page 19.

[173] ZT1-084 Board Paper on Oxehealth Digital Care Assistant, 30/09/2020, pages 4-7 [EPUT009011].

[174] First Statement of Zephan Trent, 21/03/2025 at paragraph 14 [EPUT009024].

9.14 That said, there were a number of identified potential benefits:[175]

- To observe patients at night without disturbing their sleep
- To manage older patients at risk of falling
- To manage patients whose physical health might deteriorate but where observing them in person might be impossible
- To reduce ligature incidents on wards.

9.15 In my view, there were a number of difficulties with these benefits which do not appear to have been addressed. First, the clinical need to observe patients at night and check they were alive was never truly considered in a fair way. Instead, clinicians seem to have assumed that it would be advantageous to be able to remotely determine that a patient was breathing and had a detectable heart rate.

9.16 Second, while there is obvious benefit to preventing falls in frail patients, there seems to have been no evaluation of whether Oxevision was the best way to do this.

9.17 Certainly, the trust had been shown data by Oxevision from another trust suggesting it was associated with a reduction in falls. The trust was also mindful of a CQC report inspecting Coventry and Warwickshire Partnership NHS Trust's wards for older people with mental health problems, which listed[176] the sensor technology under "outstanding practice".[177]

9.18 Third, the case for using Oxevision to monitor physical health in patients who might deteriorate, but where observing them in person was not possible, was not identified as being both highly specific and therefore uncommon and extremely risky.

9.19 If a patient is so psychiatrically disturbed and unwell that it is unsafe to enter their room, that is a truly terrible situation. Oxevision could provide benefit, but only alongside 1:1 observation and the most important thing is to get to a situation where the patient can be seen in person for a proper evaluation. The risks to this

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[175] ZT1-084 Board Paper on Oxehealth Digital Care Assistant, 30/09/2020, page 5 [EPUT009011].
ZT1-084 Board Paper on Oxehealth Digital Care Assistant, 30/09/2020 [EPUT009011_0005] ('33% reduction in falls at night (Older Adult ward)') and [EPUT009011_0010] ('48% reduction in falls in bedrooms') - Oxehealth benchmark data from other sites presented to the trust.
[177] Witness Statement of Dr Kallur Suresh and Zephan Trent, 22 May 2026, [EPUT023595], §§74–76

group of patients of serious physical harm are large, and managing them requires expert skill and attention.

9.20 This kind of situation does occur in psychiatric intensive care units (PICUs) and sometimes seclusion units, and I would have expected that there would have been careful discussion with the consultant(s) managing PICU or seclusion areas about the possible benefits of the system in their areas.

9.21 Finally, in relation to reducing ligature incidents, this element appears in various ways in the early documentation, both directly but also in terms of items like "supporting positive risk taking" and reducing 1:1 observations.[178] This makes it clear that less in-person observation was envisaged as a potential benefit of the system at some stage. I do not think that a planned reduction in in-person observations ever occurred. I also think that the fact it did not essentially destroyed any financially based case for using the system. I think a senior clinician should have been able to identify that in order to replace either 1:1 observations or four-times-an-hour observations, then, at a minimum, a video feed of the patient would have been necessary either continuously or at intervals of approximately four checks per hour (which was not how the system was intended to be used). Therefore, the fact that the only way the system could conceivably have led to reduced 1:1 or four times an hour observations would have required using it in a way entirely inconsistent with how it was intended to be used. This should have led to immediate concern and could have prompted a rethink.

9.22 Taken together, these points show that, while some clinical needs were identified, the way in which the system would meet them was not set out clearly.

9.23 I consider that the system certainly appears to have clinical relevance. The case in relation to older people's wards was most clearly made in terms of a need, to protect patients from falls and demonstrating a way in which the system might do that by detecting movement.[179] In other areas and for other patients there were gestures at clinical needs, but the strongest points were, in my view, in relation to increased operational efficiency e.g. faster night rounds, staffing efficiencies etc.

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[178] As above, see ZT1-084 Board Paper on Oxehealth Digital Care Assistant, 30/09/2020, page 5 [EPUT009011], and subsequent reference to the use of Oxevision in EPUT's Ligature Incidents reports at [EPUT020910; EPUT020842; EPUT020843; and EPUT020841].

[179] See ZT1-084 Board Paper on Oxehealth Digital Care Assistant, 30/09/2020, page 5 [EPUT009011].

(b) Was the implementation and roll-out approach consistent with expected practice?

9.24 There was at the time of roll-out no standard "expected practice" in relation to the introduction of a new technology or methodology in either physical or mental health settings beyond the underlying regulatory requirements for medical devices, which were satisfied in the case of the Oxevision system.[180][181] Given the variety of different possible innovations that might be used in medical settings, it would likely be impossible to specify expected practice.

9.25 However, the trust set up a project board to oversee the implementation of the system, which was, in my view, the right way to implement a complex project. I have not been shown a document which set the terms of reference for the board or its anticipated membership, but in practice the board had minutes and certainly had rules about being quorate. With reference to the minutes I have been provided, the board's intended membership was large, it was chaired by an executive director, had relevant technical and Oxehealth members as well as consultant psychiatrists, and senior nurses from the wards involved in the trial.[182] I consider that the construction and anticipated membership of the project board was consistent with good practice in rolling out the system.

9.26 The problem in relation to the composition of the board is that the membership appears to have rapidly collapsed; already at the first meeting there were eight apologies for absence,[183] and by the second and third meeting that collapse continued, with no consultants attending further meetings and inconsistent nursing attendance.[184] However, there was a clinical workstream mentioned, and there are mentions in that workstream of patients having privacy concerns and

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[180] The position has now changed and there are guidelines. NHS England (7 February 2025), *Principles for using digital technologies in mental health inpatient treatment and care*, PRN01510, Principle 7: Evidence base. Available at https://www.england.nhs.uk/long-read/principles-for-using-digital-technologies-in-mental-health-inpatient-treatment-and-care/#principle-7-evidence-base

[181] First Statement of Zephan Trent [EPUT009024], para 9 (the Vital Signs software is registered as a Class IIa medical device with the MHRA); First Statement of Laura Cozens [OXHE009031], paras 20-21 (MHRA Class IIa clearance of the Vital Signs software, September 2018).

[182] See for example KSZT01-014 Oxehealth Project Board Meeting Minutes, 06/01/2020 [EPUT020908] and subsequent minutes exhibited to the Joint Statement of Dr Kallur Suresh and Zephan Trent.

[183] KSZT01-014 Oxehealth Project Board Meeting Minutes, 06/01/2020 [EPUT020908].

[184] KSZT01-015 Oxehealth Project Board Meeting Minutes, 03/02/2020, page 1 [EPUT020909].

patients with paranoid illnesses who "have questioned this, but once they were more settled they were accepting of the system".[185]

9.27 Therefore, I can see that some aspects of the roll-out were consistent with good practice, but in my view, there were serious omissions.

9.28 Firstly, I would have expected the system to be used only with explicit consent from patients. Use of the system was a clinical intervention deployed in order to care for patients, but it was not obvious what it did. For any clinical intervention, patients are entitled to refuse consent for the intervention. There was simply no option to do this. In my view, this was never defensible.

9.29 Secondly, there was mention of possible harms from the system because some patients who were very unwell had questioned it.[186] I think that the board was too easily satisfied that all was well at this point. I would have expected, at the very least, that when the point was raised by patients, it would have been investigated and some form of monitoring for harms instituted.

9.30 Thirdly, I would have expected a pre-specified set of parameters of evaluation to be incorporated into the roll-out before the deployment of the systems there to be built-in evaluation from before the deployment of the system against a pre-specified set of parameters. Some of these would have been practical and technical – did the system work as intended? (The minutes show there was detailed consideration of practical and technical issues.) But equally and importantly, I would have expected clinical parameters. Indeed, reading the board minutes over this period, it is actually quite hard to work out what the system is being used for at all.

9.31 Lastly, it would have been good practice to involve patients and carers in the initial planning and deployment of the system, and in its implementation and evaluation.

9.32 The pilot was supported by a standard operating procedure (SOP) and there is evidence that these were revised during the pilot phase.[187] However, there was no mention of the Oxevision system in the relevant iterations of the Therapeutic

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[185] KSZT01-019 Oxehealth Project Board Meeting Minutes, 02/07/2020 [EPUT020904].

[186] See for example KSZT01-019 Oxehealth Project Board Meeting Minutes, 02/07/2020 [EPUT020904].

[187] See ZT1-032 Draft SOP v1 for the use of Oxehealth (non-contact technology) In EPUT Inpatient bedrooms and seclusion rooms, 26/03/2020 [EPUT004786] and ZT1-033 SOP v2 for the use of Oxehealth (non-contact technology) In EPUT Inpatient bedrooms and seclusion rooms, 22/05/2020 [EPUT004785].

Engagement and Supportive Observation Policy (Inpatients) (CLP8) in place at the time.[188]

(c) Did the pilot provide a sufficient basis for scale-up?

9.33 There was explicit trust board consideration of the Oxevision system.[189]

9.34 The Trust board was told that the benefits of the system were so great that the roll-out should occur as soon as possible before the completion of a more detailed review.[190] The paper presented to the board contained the following statement: "*Oxehealth's Digital Care Assistant has been proven to reduce patient risks as well as enable a better patient experience including better sleep, feeling safer and a greater sense of privacy at night.*"[191]

9.35 The data from Coventry and Warwickshire was presented again, as was data from an early insights report; this said there had been "*fewer incidents and less harm to patients,*"[192] but what it actually presented was survey data reporting patient and staff impressions of the system. Furthermore, some of the statements about the system, such as that there were fewer 1:1 observations and positive risk-taking in stepping down observations, were entirely unsubstantiated, and the mechanism by which those changes might have occurred was not investigated.

9.36 The paper did not present any information about possible harms or risks from a further roll-out.

9.37 The rationale for rapid rollout before completion of a full business case was that this would delay implementation by six months until 1 April 2021.[193]

9.38 I consider that there was evidence that the system had been positively received by staff and there was anecdotal evidence that patients also felt safer with the

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[188] See Therapeutic Engagement and Supportive Observation Policy (Inpatients) (CLP8): Version 1 [EPUT027721]; and Version 2.5 [EPUT027714].

[189] EPUT Board of Directors Part 2, agenda item 7a, Oxehealth Digital Care Assistant Summary Report, 30/09/2020, [EPUT020827]; Board paper on Oxehealth Digital Care Assistant, 30 September 2020, EPUT009011 (OCROXEVISION, p. 25).

[190] ZT1-084 Board Paper on Oxehealth Digital Care Assistant, 30/09/2020, page 2 [EPUT009011].

[191] *Ibid* at page 5.

[192] *Ibid*.

[193] *Ibid* at page 2.

system.[194] However, there remained no detailed description of the use of the system or the ways in which the claimed benefits were being realised, no firm data to support the most important claims, and no notes of caution which I would[195] have expected in a balanced evaluation.

9.39 Overall, I think the pilot provided sufficient evidence to justify its continuation, but not for expansion, and a wiser move would have been to set up a proper, formal, co-produced clinical evaluation of the system with objective outcome measures, and to treat previous data as encouraging results from an initial shakedown period.

(d) Were operational impacts considered before adoption?

9.40 I consider that there was extensive discussion of the technical and infrastructure impacts of adoption and detailed work on system implementation in terms of ensuring operations that were technically reliable. This is not my area of expertise, but my review of Oxehealth board papers showed that this was the most consistently discussed and carefully managed part of the project.[196]

9.41 I would also consider that there were quite close discussions of how the system was used on the wards in terms of operations and staff training about how to use the system, how to log in and such like.[197]

9.42 What appears to be absent is any great discussion prior to adoption about the real mechanisms by which staff time would be released, or observation practice changed. An exception to this was night rounds, where staff said that these were faster and that improved sleep was important.[198]

9.43 The discussions in the board quite often mention the construction and deployment of a “benefits realisation plan”, and one was constructed but seems

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[194] *Ibid* at page 5.
[195] *Ibid* at page 4.
[196] See Oxehealth Project Board Meeting minutes exhibited to the Joint Statement of Dr Kallur Suresh and Zephan Trent from KSZT-014 - KSZT01-031.
[197] *Ibid*.
[198] ZT1-084 Board Paper on Oxehealth Digital Care Assistant, 30/09/2020, [EPUT009011_0007]:
page 3 "97% of staff agreed that they disturbed patients' sleep less at night using this device, and patients have noticed that they are being disturbed less at night."
"62% of patients felt that the system helps them get better sleep at night."
page 4 "88% of staff reported that their observation rounds at night were faster."

never to have been followed through.[199] Similarly, there are discussions of more detailed evaluations, but these do not seem to have been implemented with any consistency.

(e) Were patient-centred care, dignity and least restriction considered?

9.44 Between February and July 2020, there was some consideration of patient concerns, but with a focus on quelling these and reassuring the board on that score.[200] There was no discussion of consent – at this stage the consent model seems to have been that patients had to actively refuse to have the system used and were given leaflets about it.

9.45 The case made for scaling up the system in September focused on less disturbed sleep, which was patient-centred, and on the potential for reduction in 1:1 observations, which would have been less restrictive if it was capable of being delivered, but there was no suggestion that the use of VBPMS was itself a restriction.[201]

9.46 Therefore, to an extent, dignity and least restriction were part of the case for adoption, but only partially so and key considerations were not in view.

(f) Were staff and people with lived experience appropriately involved?

9.47 The trust's own retrospective evaluation of this issue is that there was engagement of patients, but this concentrated on experience and perceived benefit rather than on consent and patients' rights.[202] There is clear evidence of involvement of staff and patients in seeking feedback from the pilot programme, but I have concerns about how patients who were asked their opinion gave their consent to being involved and whether there was any co-production of the process by which feedback was sought.

9.48 Furthermore, while senior nursing staff and the staff in charge of relevant wards did attend some of the project boards, based on the minutes I have been provided

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[199] See for example KSZT01-019: Minutes of EPUT Oxehealth Project Board meeting, 02/07/2020 [EPUT020904].

[200] See Minutes of EPUT Oxehealth Project Board meeting on 14/02/2020, 24/04/2020, and 02/07/2020 [EPUT020906, EPUT020905, EPUT020904 respectively].

[201] ZT1-084 Board Paper on Oxehealth Digital Care Assistant, 30/09/2020, pages 4-7 [EPUT009011].

[202] Joint Witness Statement of Dr Kallur Suresh and Zephan Trent, 22/05/2026, at pages 41-43 [EPUT023595].

with, after the first board meeting there was almost no medical attendance. The absence of doctors from the board's deliberations became a focus but not one that seems ever to have been resolved. Clinical staff are poor proxies for the involvement of patients, but they could have provided some patient-centred insights or advocated for patient involvement.

(g) Was the risk of replacing clinical assessment and engagement considered?

9.49 The minutes of the board in July 2020 show that staff were reminded to use the system as an adjunct to normal practice, so it is clear that the risk had materialised and also that the trust was aware of it.[203] The problem is that there was an internal contradiction in the idea that the system would reduce 1:1 observations, lower observation levels and produce faster observation rounds and reduce staffing, as against the implementation of it as an adjunctive rather than a substitute system. My reading of the minutes is that this contradiction was never really appreciated by the board. For example, in April 2021 the board recorded that some staff had an incorrect belief that the system would monitor whether a patient stopped breathing,[204] which they correctly noted was not the case, but it is difficult to reconcile this correction with their hope that 1:1 observations could be reduced when the Oxevision system had no ability to conduct continuous observations.

9.50 Overall, therefore, I think that the need for clinical assessment and engagement was appreciated, but the tension between this need and the underlying financial business case that was made for the system was never acknowledged.

Subsequent use, oversight and responses

Was ongoing clinical oversight consistent with expected practice?

9.51 I have reviewed the totality of the relevant board minutes and relevant documentation collectively below.

9.52 The Oxevision project board meetings following the expansion of the system between 2020 and 2022 were primarily concerned with technical implementation.

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[203] KSZT01-019: Minutes of EPUT Oxehealth Project Board meeting, 02/07/2020, page 2 [EPUT020904].
[204] Minutes of EPUT Oxehealth Project Board meeting, Part 1, 31 January 2025, EPUT020868.

However, there was continued attention paid to training of staff and the establishment of sensible resources for staff to assist them in using the system.[205]

9.53 However, the board never had meaningful representation from medical staff, and nursing representation was inconsistent, with the minutes showing good representation in early 2020, but then between June 2021 and June 2022 only one of the eleven meetings had a matron present. Thereafter, attendance from nursing improved chiefly because a clinical matron who later became quality improvement mental health lead was a consistent attender; a director of nursing first attended in October 2023 and attended regularly from September 2025.[206]

9.54 Clinical considerations circled around successive revisions of the standard operating procedure, where the main issues were concerns over staff accessing video of a patient, and later there were concerns related to consent.[207] The issue of gathering effectiveness data was also discussed fairly often, but mainly from the perspective of trying to gather support for the efficacy of the system rather than in relation to a balanced evaluation.

9.55 The board's responses to issues became increasingly reactive to reports of concerns from patient groups, coroners, the Parliamentary and Health Service Ombudsman (PHSO) and then later this Inquiry, and at times were frankly defensive, with one board meeting referring to setting up meetings with patients to discuss the system but referring to a *"Need to avoid detrimental feedback where possible"*.[208]

9.56 Because of their overarching governance role, I set out below my review of the meetings of the trust board and its subcommittees that I have been provided with from November 2021 onwards, which relate to EPUT's ongoing assessment of the Oxevision system.

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[205] See, for example, Minutes of the EPUT Oxehealth Project Board meetings, 21/04/2021 [EPUT027578_0004] (training video on the intranet; "did you know"/FAQ material commissioned for ward staff)

[206] I reviewed the attendance record at project board minutes in the Oxevision Roll Out Bundle [INQY027833]: of the eleven meetings between June 2021 and June 2022, only the minutes of 13 October 2021 (Part 2) [EPUT027532] record a matron present; a director of nursing first appears in the minutes of 25 October 2023 [EPUT027535], and attended regularly from September 2025 [EPUT020859; EPUT027621; EPUT020857].

[207] See for example Minutes of the EPUT Oxehealth Project Board meetings, 21/04/2021 [EPUT027578_0004] there was discussion of staff use of the screen resulting in a patient being seen in the bathroom and another getting dressed

[208] Minutes of EPUT Oxehealth Project Board meeting, Part 1, 31 January 2025, EPUT020868.

9.57 On 24 November 2021, there was a trust board meeting when Oxevision was presented but the medical director was not present.[209]

9.58 On 9 December 2021, the quality committee met with the medical director in attendance but did not discuss Oxevision.[210]

9.59 On 10 November 2022, the quality committee met with the medical director in attendance but did not discuss Oxevision.[211]

9.60 On 9 February 2023, the quality committee met with the medical director in attendance and the standard operating procedures for Oxevision were discussed.[212] *"MA presented the revised Standing Operational Procedures (SOP) which has been strengthened following the recent inspection of two of our mental health units by the CQC and their concerns raised around the recording of consent. Key areas that have been strengthened include; process focusing on patient, carer, friends and family communication, matters of consent, expectation of use of equipment, monitoring and compliance and strengthening and giving clarity on expectation for patient safety incident reports to be completed on Datix."*[213]

9.61 On 26 July 2023, the board of directors with the medical director in attendance there was discussion of Oxevision but only to comment on widening the roll-out.[214]

9.62 On 10 April 2025, the quality committee met with the medical director in attendance[215] and an update on changes to the Oxevision system was presented in response to new guidance from NHS England (NHSE).[216] There is explicit mention

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[209] KSZT01-086: Minutes of the EPUT Board of Directors Meeting held in Public, 24/11/2021, [EPUT020838].
[210] KSZT01-077: Minutes of the EPUT Board of Directors Quality Committee Meeting, 09/12/2021, [EPUT020846].
[211] KSZT01-078: Minutes of the EPUT Board of Directors Quality Committee Meeting, 10/11/2022, [EPUT020845].
[212] KSZT01-079: Minutes of the EPUT Board of Directors Quality Committee Meeting, 09/02/2023, [EPUT020844].
[213] *Ibid* at page 5.
[214] KSZT01-090: Minutes of the EPUT Board of Directors Meeting - Part 1, 26/07/2023, [EPUT020833].
[215] KSZT01-103 Minutes of the EPUT Board of Directors Quality Committee Meeting, 10/04/2025, [EPUT024192].
[216] NHS England (7 February 2025), *Principles for using digital technologies in mental health inpatient treatment and care*, PRN01510, https://www.england.nhs.uk/long-read/principles-for-using-digital-technologies-in-mental-health-inpatient-treatment-and-care/.

that the medical director had been engaged and there was a plan to update the Lampard Inquiry. The recommendations included a review of the standard operating procedure and to "*Endorse the early findings that the Trust needed to improve its consent processes and the information provided to patients to inform their consent during and after admission; including changes to ensure that if consent was withdrawn the system would be deactivated as soon as possible with the appropriate clinical oversight. Endorse the proposal to engage with Oxevision regarding options for the introduction of physical or other barriers that visually indicated to patients when the Oxevision system was deactivated to reduce risk of trauma for patients.*"[217]

9.63 On 7 May 2025, there was a trust board extraordinary meeting.[218] The medical director was not present or noted as absent. The minutes show that the consent model proposed was a 72-hour opt-out, and the subsequent discussion shows the focus was mainly on the issue of consent.

9.64 On 7 November 2025, there was an audit committee report.[219] The medical director was present. Agreed audits for the Oxevision system were discussed and the trust seems to have responded to these issues as they arose rather than being able to surface them in advance. I consider that there seems to have been relatively little clinical involvement in managing the concerns.

9.65 On 14 November 2025, there was a quality committee meeting and the interim medical director was present.[220] This received a "deep dive" report into Oxevision with concerns about the results of external audits.[221] There was an explicit discussion of consent: *"ZT noted the Chair of the Lampard Inquiry had asked why Oxevision was switched on from the start rather than switched off from the start and did not feel the Trust's explanation was adequate, therefore this point should be considered as part of the current review. MJ reflected on how other areas of clinical practice did not commence until consent was given by the patient, and*

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[217] KSZT01-103 Minutes of the EPUT Board of Directors Quality Committee Meeting, 10/04/2025, at page 8 [EPUT024192].
[218] ZT3-09 Board of Directors Meeting Notes, 07/05/2025, [EPUT010150].
[219] KSZT01-009 Minutes of EPUT Audit Committee - Part 1, 07/11/2025, [EPUT020912].
[220] KSZT01-107 Minutes of the EPUT Board of Directors Quality Committee Meeting, 14/11/2025, [EPUT024190].
[221] KSZT01-095: EPUT Quality Committee, Agenda Item 7.2: Oxevision progress update for Quality committee regarding SOP implementation, 14/11/2025, [EPUT020828].

asked AG/ZT to arrange for this question to be discussed by the Safety of Care Group and provide the outcome to this Committee."[222]

9.66 Overall, therefore, there was a degree of clinical oversight, and the medical director consistently attended the quality committee. However, at board level, there was inconsistent clinical oversight of the Oxevision system, with attention only really being focused on the system after concerns were raised. Overall, there was a general lack of clinical challenge related to the functioning of the system and its intended purpose and no consistent response to issues of potential harm.

9.67 I have discussed the specific issue of consent elsewhere.

Were EPUT's responses to concerns consistent with expected practice?

9.68 In 2022, there were concerns raised in general about the Oxevision system. This was discussed in the Oxevision board, and there was work on a strategy to highlight positive aspects of the system with communications to staff. It was proposed that the clinical group, which it would seem had fallen into abeyance, be reconvened.[223]

9.69 Next, the CQC, which visited in November 2022, raised concerns about the documentation of consent and also that welcome packs on two wards did not contain information about the system. The quality committee said that the issue would be covered in an action plan and there is some evidence of subsequent alterations.[224]

9.70 In May 2025, the trust board considered the trust's response to serious incidents, prevention of future deaths reports from coroners and staff and patient feedback. At that point, it was accepted that implied consent should not have been used and covered problems in responding to alarms, among other issues. The trust

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[222] KSZT01-107 Minutes of the EPUT Board of Directors Quality Committee Meeting, 14/11/2025, at page 9 [EPUT024190].

[223] Minutes of the EPUT Oxehealth Project Board meeting, 16/03/2022 [EPUT020891_0003]–[EPUT020891_0004], item 8.3 (Publicity): "Working with a company to develop a strategy for publicity to highlight the positive aspects of Oxevision"

[224] Minutes of the EPUT Board of Directors Quality Committee Meeting, 10/11/2022 [EPUT020845], pages 4–5 [EPUT020845_0004]–[EPUT020845_0005].

responded with a revised standard operating procedure and a programme of subsequent audits. There was only limited assurance from those audits.[225]

9.71 In March 2026, the PHSO partly upheld a complaint from Miss B about her admission relating to a failure to switch off the Oxevision system and a rapid review was conducted; this found limited assurance on consent, limitations in the vital signs function and disrupted therapeutic engagement, as well as safeguarding concerns.[226]

9.72 I consider there was some response to concerns but that it was limited, reactive and considerably delayed.

9.73 **Morgan-Rose Hart**[227]

18, ligatured 6 July 2022, died 12 July 2022 · Chelmer Ward, the Derwent Centre, Harlow · EPUT

Morgan-Rose had a history of problems as a child with diagnoses of Autism Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD), anxiety, depression and body dysmorphic disorder and an emerging diagnosis of Emotionally Unstable Personality Disorder (EUPD).

During Morgan-Rose's time as an inpatient on a CAMHS ward a Grade 2 agency worker is reported to have fallen asleep while conducting Morgan-Rose's level 3 (constant) observations. Morgan-Rose tied a ligature whilst she was being observed in this way.

Morgan-Rose turned 18 on 25 May 2022. On 15 June 2022, she was transferred to Chelmer Ward, an acute adult ward at the Derwent Centre, run by EPUT. She was detained under section 3 of the Mental Health Act.

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[225] Board of Directors Report, 07/05/2025 [EPUT010149], page 3 [EPUT010149_0003]; Minutes of the EPUT Extra-Ordinary Board of Directors Meeting held in Private, 07/05/2025 [EPUT020849], pages 1–4; EPUT Quality Committee, Agenda Item 7.2: Oxevision Deep Dive and Progress Report regarding SOP implementation, 14/11/2025 [EPUT020828], page 5 [EPUT020828_0005].
[226] KSZT01-175 PHSO Report re complaint on EPUT patient consent for use of Oxevision , 27/03/2026, [EPUT023600].
[227] Case Summary of Morgan-Rose Hart [INQY026109].

During the three weeks she spent on Chelmer Ward, Morgan-Rose's observations were reduced from level 3 observations on 30 June 2022 to level 2 (enhanced observations), requiring a member of staff to see and engage with Morgan-Rose six times an hour.

On the 6 July 2022, Morgan-Rose's last clinical observation took place at 14:06.

At approximately 15:00, Morgan-Rose received a delivery of flowers. When Morgan-Rose opened the card which accompanied the flowers, she did not recognise the sender. It is unclear whether the flowers were intended for her.

At approximately 15:22, Morgan-Rose told staff that she was going to take a shower. At the time, Morgan-Rose was being monitored by way of observations but also the Oxehealth (now Lio) Oxevision system. An automated Oxevision alert was triggered at 15:31, alerting staff to the fact that Morgan-Rose was in the bathroom. The Oxevision alert was silenced and reset. It has never been established which member of staff silenced the Oxevision alert.

Despite the Oxevision alert, no physical check of Morgan-Rose was carried out. At 16:20, Morgan-Rose was found unresponsive in her bathroom, having ligatured with a material belt. Morgan-Rose was transferred to Princess Alexandra Hospital where she died six days later.

EPUT's own After Action Review "concluded... that observations were correctly carried out, that there were no indicators that Morgan-Rose planned to self-harm or ligature, and that the management of the incident was of a high standard and in line with policy". The inquest contradicted this. The CQC recorded from EPUT that "the incident was picked up by Oxevision and staff responded quickly" — which the case summary notes is incorrect.

In fact, Morgan-Rose had been left unattended for approximately 50 minutes, and it had been 2 hours and 14 minutes since her last recorded observation. During the inquest it was found that observation records from the day of Morgan-Rose's death had been falsified.

The inquest also found that staff were required "to see and engage with" Morgan-Rose six times an hour; but the jury found "no therapeutic engagement was made to see if Morgan-Rose was okay" and there were "limited therapeutic engagements or attempts to engage".

The Coroner's subsequent prevention of future deaths letter expressed concern about enforcing an in-person check after an alert and staff substituting Oxevision for face-to-face observation.

Morgan-Rose had a serious mental illness, but there were failings in her care both despite and because of the Oxevision system. While it is correct to say that the system was not used as designed or as described in the standard operating procedures, it is also correct to say that the system consistently tempted staff to use it in an incorrect way. Not only was use of the system incorrect, the immediate after-action review was also incorrect and falsely reassuring.

Although training, audit and procedural strengthening are ways to try and make sure systems are used as intended, where incorrect use is unsafe, the best way to prevent problems is to make incorrect use very difficult, if not impossible. This idea of fail-safe design tries to eliminate human factors or move them favourably and human error wherever possible. I do not think sufficient thought was given to human factors in the design and implementation of the system.

Was ongoing usage monitoring sufficient, including staff and patient feedback?

9.74 The general picture in relation to usage monitoring was that the trust relied on the data which the Oxevision system could produce but consistently pushed Oxevision to provide more specific information locked to individual users. However, a consistent pattern was the push for data showing positive change, as was reflected in repeated requests for staff to document on the Datix reporting system how Oxevision had helped them. The consistent feel of the minutes is to seek support for the value of the system rather than a sanguine evaluation of its capabilities.[228]

9.75 Throughout the period there were attempts to gather data, but these were scattered and not implemented with any degree of rigour. One formal research project with full ethics and research approval was started in collaboration with Anglia Ruskin University (ARU) but within the trust the pattern was of a series of rather ad hoc collections of data from staff and patients. At times this was noted –

[228] See for example Minutes of the EPUT Oxehealth Project Board meeting, 16/02/2021 [EPUT020901_0001], item 6.2: "Board wants some feedback to see that the system is making a positive change... Would like to see data pulled out to show how many incidents Oxehealth has helped avoid or reduce severity."

for example, the project board in April 2022 noted that a dedicated project board was needed to evaluate outcomes, but there is no evidence this was ever set up.[229]

9.76 The trust did try and monitor ward ligature trends but reported the data to itself in ways that obscured what was actually a mixed picture so that in November 2023 the fact that the analysis of the ligature risk programme showed no confirmed benefit, with trends moving up and down on relevant wards was not trusted but instead, the trust considered that the main problem was low rates of reporting.[230]

9.77 Although the minutes of the Oxevision Health Board noted in July 2020 that there were very high numbers of daily vital signs attempts,[231] this was interpreted as a positive finding and not viewed with any concern until January 2025 when the worry that this high usage might represent staff using the vital signs function to observe patients and check on them rather than to take a vital signs reading surfaced.[232]

9.78 Eventually, auditing the system became a target for the trust's audit committee, which commissioned an external audit (potentially as part of a rolling programme of external audits of clinical areas, which would be normal practice for most trusts) which reported in November 2025, producing results described as disappointing. At that point, there was significantly increased governance with consent and training audits, weekly/fortnightly tracking, and Executive oversight aimed at improving audit results. I consider that it was now five years after the introduction of the system and there had been significant work on training, deployment, and standard operating procedures. The Oxevision board had had multiple warnings about the use of the system, but only at this point was a systematic process of auditing put in place.

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[229] See for example Minutes of the EPUT Oxehealth Project Board meeting, 13/04/2022 [EPUT020890_0002], item 8.3: "Benefits realisation expectations for phases one and two, JL advised a dedicated project board is required to evaluate the outcomes."

[230] EPUT Finance & Performance Committee, Agenda Item 8: Analysis of Ligature Risk Programme's Impact Report, 19/10/2023 [EPUT020910], pages 14 and 22 [EPUT020910_0016] and [EPUT020910_0024]: the ward-by-ward Oxevision trend table shows arrows up, down and flat across the wards; the report concludes "it is unclear how effective OxeVision is due to the low reporting numbers. During 2022/23, only 11.8% of all ligature incidents, recorded OxeVision as having alerted staff."

[231] KSZT01-019: Minutes of EPUT Oxehealth Project Board meeting, 02/07/2020, [EPUT020904].

[232] Minutes of EPUT Oxehealth Project Board meeting, Part 1, 31/01/2025 [EPUT020868_0003], item 8.4 (Monthly Usage Report December 2024): review of vital signs attempts and alert response times, with concern that short response times 'may be staff turning off the alerts in the office' and that 'staff may not be following the procedure correctly'.

9.79 Overall, therefore, while the Oxevision system itself became increasingly capable of reporting on its activity at EPUT's request and, as a result, EPUT accumulated substantial usage data, there was no consistent effort to measure the effectiveness of the system beyond a range of ad hoc surveys of staff and service users' impressions of the system.

Were safety, privacy, consent and dignity addressed sufficiently?

Safety

9.80 The issue of safe operation of the system was a consistent focus of the trust throughout, and there is good evidence that the Oxehealth board tried to act on concerning reports. For example, as early as April 2021 the board noted concern that alerts were being muted. This followed a serious incident on a ward where the audible alert seems to have been turned off; furthermore, a senior nurse noticed that alert volumes were being turned down when she visited. The response was training changes and an SOP requirement to keep sound on, as well as discussion on setting alert levels on older people's wards. The trust's own retrospective judgement on the response at this time was that "*there should have been greater oversight at the outset of the practical use of Oxevision on the wards, in particular to address alarm fatigue and to ensure that each alarm was always actioned by a face to face visit with the patient and that alarm volume settings were not adjusted by staff*".[233]

9.81 The problem of reducing the alert volume remained despite these interventions, and in September there was also concern that alarms were being muted. The board discussed reducing the volume of alerts but also preventing an alarm from being reset until a room had been entered. Following a serious incident in December, the board revisited the resetting of a bathroom alert. "*Discussion held regarding changes to the features of the system to assist. suggested a reset to a further 3 minute alert, but could have wide ranging implications to the system. Another suggestion was to keep an amber alert open in this situation, but it was felt that staff engagement would be required in this type of situation. incident*

[233] Board of Directors Report, 07/05/2025 [EPUT010149_0003]

happened in July but no progress as yet, how long will this take to be implemented."[234]

9.82 There does not seem to have been effective action in this area, because the resetting of an alert was still problematic in October 2023 when the project board was still noting that an alert could be reset without a physical check and at that point a system of repeating three-minute alerts was agreed with training and information sharing to support the change.[235] While this was an improvement, there does not seem to have been any consideration of the maximum time to respond in such a situation if serious harm was to be prevented.

9.83 Concerns about alarm response times continued, and the project board returned to both short and long response times in January 2025, with a worry that an alarm was followed by use of the camera to view the patient remotely rather than attending in person. The trust itself noted that further concern in this area was that staff conduct cases had a common theme of remote viewing rather than in-person attendance.[236]

9.84 Overall, therefore, I consider that issues related to the safe operation of the system, which I have tracked by considering the issue of muting alarms without then attending to see the patient, were in view, and there were changes to the operational policy and to the training of staff but the project board never managed to implement a change that reliably altered behaviour.

9.85 The most recent version of the trust's standard operating procedure[237] has picked up risks to safety in terms of how alerts are responded to, reinforcing again that every alert must be attended to.

Privacy and dignity

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[234] Minutes of EPUT Oxehealth Project Board meeting, 26/10/2022 [EPUT027616_0004], item 7.5; Minutes of EPUT Oxehealth Project Board meeting, 14/12/2022 [EPUT027619_0003], item 8.3 (Bathroom Alerts, related to Chelmer SI 7/22).

[235] Minutes of EPUT Oxehealth e-Observations Project Board, 25/10/2023 [EPUT027536_0001], item 9.1 (Any Other Business): repeating three-minute bathroom alerts agreed from 30 October 2023; "highlighted a risk whereby staff can reset the alarm without having physically checked the patient, AG agreed and noted the risk"; "noted that training and information sharing is key with all staff".

[236] Joint Witness Statement of Dr Kallur Suresh and Zephan Trent, 22/05/2026, at pages 66 [EPUT023595].

[237] Supplemental witness statement of Dr Kallur Suresh and Zephan Trent, EPUT026141; Oxevision SOP version 13.4, EPUT026149.

9.86 Early on the trust did monitor concerns about privacy and dignity through the Oxehealth board, with an explicit consideration at the Oxehealth board on 21st April 2021 that there had been two incidents where checks had resulted in a patient being seen in the bathroom and another where a patient was getting dressed in the bedroom. This was managed by gender-specific monitoring and adding wording to the standard operating procedure. There are reports to the board of directors in November 2021 and to the quality committee in 2022 that mention the system is not CCTV and *"staff are not using the system to visually monitor patients"*.[238]

9.87 There was no effort to monitor gender specific monitoring and there could not have been such an audit as the system did not have user authentication to allow identification of the person who had viewed a room. This was as, of March 2026, still at user acceptance testing.[239]

9.88 The issue also appears to have been raised by patients in a quality committee in April 2025, when "misuse by staff" was reported as a theme, and privacy concerns also emerged in October 2025 in a patient experience survey.[240]

9.89 There was also work on who could look at the system and on knowing who had looked at it, and this was a consistent focus throughout the implementation and one that posed different challenges as the technology changed, with increasing implementation on remote devices where privacy was harder to ensure. For example, in March 2023 a ward had asked[241] for the monitor display to show patient names instead of room numbers, but this was refused because "patient privacy is key; provided patients cannot see the screens (fixed screens [in] the ward office), this would be acceptable".

9.90 The most recent developments with the system in early 2026 have focused on user authentication which would give a complete audit trail of access to the system,

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[238] Minutes of EPUT Oxehealth Project Board Meeting, 21/04/2021 [EPUT027578], page 4 [EPUT027578_0004], under "Patient privacy and dignity": "Incident on children's ward where staff member used the screen to do checks and patient was seen in the bathroom. Another incident where the screen was used and the patient was naked/getting dressed in the bedroom. Have added appropriate wording to the SOP."

[239] Minutes of EPUT LIO (formerly Oxehealth e-Observations) Project Board meeting, 02/03/2026 [EPUT027599], page 1 [EPUT027599_0001], item 9.1: "plan to use some samples as testers on the wards in a work group environment where the dashboard is being used. If that is successful will plan the rollout... first step it to have a few users to try it, then roll out to a whole ward."

[240] Oxehealth Steering Group papers, pp. 472–476, EPUT024126_0002 and EPUT024127_0003.

[241] EPUT Oxehealth Project Board, March 2023, EPUT027632_0002 (p. 690).

providing a significant safeguard against unauthorised use. Given the sensitivity of the data and the use of the system to provide an audit trail the lack of focus by the trust on user authentication from the start is hard to accept.

9.91 A revised standard operating procedure[242] refers to further safeguards in relation to storage of data and user authentication. There is a discussion of the use of clear view data to take pulse and blood pressure readings and a statement to the effect that this should be done "*where there is a personalized care planned rationale. The camera feature is neither designed, purposed, nor should be used as CCTV...*" I remain concerned that no potential "care planned rationale" is suggested. Correctly, the SOP says that NEWS2 should be used for physical deterioration. Importantly the system is now said, by implication, to alert to early warning signs affecting pulse and respiration in seclusion, long-term segregation (LTS) and health-based place of safety (HBPoS) rooms.[243] This implies that in LTS and HBPoS there is that functionality. There would be some value in being able to track pulse and respiration rates, since a falling respiratory rate can be a sign of dangerous sedation and a rising respiratory rate is a cardinal symptom of sepsis, but I note that NELFT considered that the value was not great enough and is phasing out the use of the OxeVision system in these areas.[244] I consider that where someone is at serious risk of deterioration, there might be highly specific situations where in-person observation of NEWS-2 was not possible, in which case any set of observations is better than no observations, but such situations are exceptionally rare.

9.92 I consider that there was work to address the privacy and dignity concerns about the video aspect of the system and later with being able to audit access; however, what strikes me as absent is any questioning of whether, given that the system was "not CCTV", there was any need for video imaging at all. The only rationale behind it seemed to me was that it was used to take pulse and respiration readings but the value of these was minimal.

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[242] Supplemental witness statement of Dr Kallur Suresh and Zephan Trent, EPUT026141; Oxevision SOP version 13.4, EPUT026149.

[243] KSZT01-184: EPUT Standard Operating Procedure on Oxevision, version 13.4 [EPUT026149], Appendix 1 (How the Platform Works), page 13 [EPUT026149_0013]: "LIO platform does not alert to early warning signs affecting pulse and respiratory rates other than in seclusion, LTS or HBPoS rooms."

[244] Transcript of Inquiry Hearing, Day 54, 21 July 2026, pages 160–161.

Consent

9.93 I consider that the issue of consent was never handled properly by the trust. At the implementation of the system the thought was that there would be what is termed implied consent: "*there needs to be a paragraph within the SOP for implied consent*".[245] What this consent might consist of is never discussed, and the concept of implied consent is also not spelt out. However, EPUT did ask for the ability to switch off individual rooms at this point, which means that there was a period when patients could not dissent at all.[246]

9.94 The position about consent then became inconsistent because on 24th November 2021 the board of directors was told that there was a "robust process on admission" that would allow patients to "decline consent if they wish," but still on 7 September 2022 the project board was reporting that the use of the system was with implied consent and that only one area had a specific consent form. This means that the assurance given to the board in November of a "robust process" was not correct.[247]

9.95 Later in November 2022, the CQC were concerned about consent to monitoring and capacity; even so, one board member suggested that the issue was a matter of data processing and that patients cannot withdraw their consent. At that point, the SOP for the system refers to "implicit consent" which is taken to mean that all patients are opted in by default until an MDT meeting held within 72 hours considers the situation and a decision is taken.[248]

9.96 During the implementation of the system, there were also examples of what felt to me to be potentially worrying practice in relation to consent. Mr Trent's first witness statement details that the system is switched on at the point of

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[245] EPUT020907, bundle p. 120 (timeline entry at 2 March 2020).

[246] Minutes of EPUT Oxehealth Project Board meeting, 02/03/2020 [EPUT020907_0005]: the swing beds at Chelmer 'will be the only rooms that you will be able to turn off so that if a room is being managed by another ward we can switch off the system', with the SOP to cover the issue.

[247] Minutes of the EPUT Board of Directors Meeting held in Public, 24/11/2021 [EPUT020838_0002] ('there is a robust process in place on admission... Patients are able to decline consent if they wish'); Minutes of EPUT Oxehealth Project Board meeting, 07/09/2022 [EPUT027615_0003], item 9.1 (a separate Oxevision consent form 'has been introduced in one area'; use of the system otherwise 'generally with implied consent').

[248] Minutes of the EPUT Board of Directors Quality Committee Meeting, 10/11/2022 [EPUT020845_0005]-[EPUT020845_0006]: the CQC challenge on consent and capacity, and the observation that 'we do not process data under a consent basis, which means that although a patient can object to the processing, they cannot withdraw their consent'.

admission. If a patient refuses, "*The system is not to be switched off until a Multi-Disciplinary Team (MDT) meeting within 72 hours has taken place.…"; "EPUT can confirm that there have been multiple occasions when the request to switch off the camera has been agreed to by clinicians. Examples include"*

- A patient being concerned over privacy. The patient had capacity and was advised that they would be placed on level 2 observations when the camera was switched off.
- A patient described feeling paranoid about having Oxevision switched on in their bed space. The patient had capacity and was advised that they would be placed on level 2 observations when the camera was switched off."[249]

9.97 From a clinical perspective, it would seem to me that the difference between having the system on and off would be that it was not possible to take readings of a patient's vital signs intermittently at night and that the system would not provide alerts when the patient was in their bathroom for more than three minutes or by the door for a period of time.

9.98 I cannot see how level two observations would have been the correct response. If the patient was sufficiently unsafe as to warrant level two observations, then they would have been so before the system was switched off, since it cannot detect self-harm unrelated to location.

9.99 From April 2025 the consent model changed again with the default state for the system to be "on", but if the patient does not consent then the system will either be switched off within six hours or a reason must be recorded in the patient's records, but later the SOP still reads, confusingly "*If the patient consent is not given on admission, or is withdrawn during the admission process or following the MDT clinical decision, the Oxevision system can be individually isolated by the Nurse in Charge (NIC) using the monitor to select 'Camera off' for that patient's bedroom. A decision to turn the camera off should only occur if the Nurse in Charge (NIC)/doctor deems the action clinically safe prior to a Multi-Disciplinary Team (MDT) decision meeting. If the Nurse in Charge (NIC)/doctor deems this not*

[249] First witness statement of Zephan Trent, at para 47 [EPUT009024].

to be clinically safe, then the Oxevision system will remain on, and the rationale to be explained to the patient and clearly documented in the patient record."[250]

9.100 This is ambiguous since, if a patient has capacity, they appear to be allowed to turn the system off, but only if it is clinically safe. However, if someone has capacity, then they are entitled to choose options for their care that are not what their caregivers would recommend.

9.101 I consider that the trust's stance arose from a failure of clinical oversight in relation to the concept of consent, with some kind of fundamental misunderstanding arising in relation to the notion of implied or implicit consent. I do not think this issue was addressed correctly, which from the start should have been to operate an opt-in system for obtaining consent.

9.102 The trust has now altered processes for consent in relation to Oxevision, requiring formal written consent for the use of the system.[251]

Overall opinion and themes

Overall opinion

9.103 The following section is with reference to the evidence base I have been provided with on the whole and to the preceding analysis of the individual issues. Overall, I consider that EPUT implemented Oxevision in a somewhat hurried way and certainly rolled it out without much evidence following a pilot phase. It is clear the motivation of the organisation at that point was that the system was genuinely so good that it would save lives and that delaying roll-out would be indefensible, but it is hard to agree with that conclusion.

9.104 Thereafter, the pattern of implementation is that the trust struggled over successive years to derive the clinical benefits they had hoped for from the system, while continuing to implement it on more and more wards and somehow failing to notice that the system did not deliver the advantages they had hoped for.

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[250] The passage is quoted in the First Statement of Zephan Trent [EPUT009024], p. 41, setting out the Oxevision SOP consent provisions; see also Minutes of EPUT Oxehealth Project Board meeting, 24/04/2025 [EPUT020863_0002] (discussion of the 'camera off' wording: 'Make sure wording is clear in the SOP').
[251] Supplemental witness statement of Dr Kallur Suresh and Zephan Trent, [EPUT026141]; Oxevision SOP version 13.4, EPUT026149.

9.105 Furthermore, I think the trust's enthusiasm for Oxevision was not built on a realistic appreciation of the true clinical capabilities of the system. At no stage did anyone suggest that the ability to measure pulse and respiration rate remotely, while seemingly a plausible thing to do, actually had little or no clinical utility in a psychiatric setting. The system seemed to provide the ability to monitor patients remotely at night, offering a better night's sleep, and this was the strongest case for its use, but no one asked what beneficial thing would happen if a patient's pulse or respiration was not readable at night. Instead, the ability of the system to take pulse and respiration rate readings became an opportunity to check in on patients remotely, which the trust was then at pains to prohibit.

9.106 The trust's attitude to consent also seems to me to have been driven by the feeling that the system was so beneficial that to turn it off would result in indefensible risk to patients. The system was not seen as a clinical intervention and there was an incorrect analysis of the concept of implied consent. I consider this was never justifiable and it is correct that this has now been altered to the use of explicit informed, signed, consent.

9.107 The ability of the system to provide alerts related to a patient's location within their room also became a double-edged sword, likely (although this was not monitored), because alarms would go off frequently but not signify anything that needed acting on. The trust was clear that the system was adjunctive, and this was important because, had they relied too much on the warning function of the system then ligature incidents which did not occur in a blind spot or near a door might have been missed more often than they in fact were.

9.108 A concern that has emerged and was very important for service users was that the use of the system may have acted to tempt some staff to engage less with patients – or not at all. There is some evidence that this did occur in minutes and patient testimonies. While I think this was a realistic concern, I worry that a focus on this aspect of the technology might deflect attention from the ways in which observations, as currently carried out without technological assistance, can also be perfunctory or even unhelpful.

9.109 An area where the system was at times helpful was after-the-event review of incidents, although worryingly there were two deaths where the trust seemed not to have used the data and produced a report that was falsely exculpatory[252]. The

[252] Morgan-Rose and Elise Sebastian case summaries.

introduction of OxeObs that allowed staff to enter information electronically and in a timed way and the integration of that system with the electronic patient record (which was a consistent aim but which proved technically challenging and which may not even now be complete) were important developments that did not have the same safety, dignity, privacy, and consent implications. While this recording function is not eye-catching and does, in fact, not need the complex machinery of cameras, it could be helpful in supporting the delivery and documentation of a function which we know from reviews of patient deaths is often not carried out to the required standard, which causes much anguish to relatives even where the failure did not have a causative impact on the fatal outcome.

9.110 I consider that this functionality could be built into any EPR system with an observations recording facility. As described in section 8, I consider that there would be opportunities for rethinking recording of observations to be more joint with patients and that technologies like mobile telephones and tablets could assist with this.

10 Section 10: Reflections and recommendations

10.1 EPUT was not the only trust to use Oxehealth, and the Inquiry has already heard from a range of trusts about their experience of and decisions about the system; they have also taken different decisions in relation to consent and how the system should actually be deployed, but with all trusts moving towards a more explicit consent system. Some have found the system disappointing.[253]

10.2 I think that the attraction in all cases was at least in part the hope that the system could reduce ligature and self-harm events because the decline of ligature events from fixed ligature points has left a stubborn residue of deaths from self-strangulation[254]. Intermittent observation, at four checks an hour, cannot reliably prevent such deaths, and one-to-one observation is intrusive and labour-intensive, and has still proved inadequate in some cases. The Oxevision system did promise to go some way towards that hope in relation to the alert system, but I wonder if the ability to take pulse and respiration values remotely was given more weight than it could bear. Even with continuous monitoring, pulse and respiration may not change measurably enough in self-strangulation to give a usable warning, and the system never achieved regulatory approval for continuous monitoring.[255]

Observations

(1) Observation levels carry more weight than they can bear

10.3 Changing observation level has come to be seen as having more potency and as being capable of being correctly calibrated to risk than is possible. In my view, the case for hourly checks at night is weak, and the case for four-times-an-hour observations is also shaky. Analyses of incidents after the event often focus on

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[253] Oxford Health NHS Foundation Trust: witness statement of Britta Klinck, Chief Nursing Officer, 28 May 2026 [OHFT024268], with exhibits including the trust's February 2023 internal evaluation of Oxevision; North East London NHS Foundation Trust: witness statement of Paul Calaminus, Chief Executive Officer, 20 May 2026 [NELFT019510], with exhibits including the trust's review report completed in July 2025.

[254] NCISH (2013), Patient Suicide: The Impact of Service Changes (fall in ward hangings after ligature-point removal); Hunt, I.M. et al. (2012), 'Ligature points and ligature types used by psychiatric inpatients who die by hanging', Crisis, 33(2), pp. 87-94 (residual deaths from low-lying points).

[255] First Statement of Laura Cozens, 19 February 2025 [OXHE009031], paragraphs 14, 20 and 23: the Class IIa clearance (MHRA, September 2018) covers spot-check measurement of pulse and breathing rate; the device does not provide continuous monitoring or vital-signs alerts.

observation failures or question decisions about the level set, and while accountability is important, we may be taking aim at the wrong target.

(2) The concept of observation deserves a rethink in its own right

10.4 The true value of observation lies in the element of engagement involved. Yet all our audits and procedures focus on delivery and timing, but not quality. At most, observers are required to write something brief on a form or, in the case of OxeObs, to make selections from a picklist. Possibly changing observation practice to be inherently collaborative would help. I also think that there is an argument for separating the task of delivering engagement from that of observation in situations of extreme risk because of the concern about task overload.

Recommendation

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

Technology

(3) Technology will advance, and we should be ready for that

10.5 The core problem with the Oxevision system is that the case that was built to justify its costs, which rested in part on efficiency and savings, cannot materialise while it is used as an adjunct to pre-technology practice. At the point at which a system could deliver, in some way, the real-time tracking that would allow detection of self-harm before serious injury ensued, the case for such a system would be very hard to resist. This means that we need to do the work now to understand how to react as capabilities develop and to develop a framework which allows for innovation but prevents untested/unregulated technologies being widely deployed until there is sufficient evidence of their benefits/safety.

Recommendation

It may be worth widening the scope of medical device regulation to allow it to cover technologically assisted interventions in mental health that are not currently captured. The current boundaries may not fit well the nature of technologically assisted interventions in mental health, as technologies in mental health, a way to validate and regulate them may need to be found. The MHRA is already looking at this with a grant from the Welcome Trust and the Inquiry could consider linking in with this work.[256]

(4) We need to be clear-eyed about consent

10.6 The Oxevision system is not the first example of an innovation in mental health practice where we have not taken the right approach to consent. The Serenity Integrated Mentoring (SIM) project was another powerful example,[257] but even now in everyday practice we frequently do not admit even to ourselves or to patients when our decisions are driven at least in part by resource constraints rather than purely patient benefit. Consent is the first line of defence safeguarding autonomy and dignity, and it pays to spend time ensuring patients give valid consent to treatments and interventions we propose.

Recommendation

There may be a case for issues of consent to be the explicit responsibility of a trust board member in the same way that issues of confidentiality are through a trust's Caldecott guardian. The seriousness of ensuring consent is understood and correctly obtained, the complexity of the issues involved and the way in which errors have occurred in more than one area may justify this.

(5) In common with innumerable mental health innovations, evaluation was not built in from the start

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[256] The Welcome Trust has funded a three-year MHRA–NICE project on the regulation and evaluation of digital mental health technologies; first outputs include MHRA (3 February 2025), Digital Mental Health Technology: Qualification and Classification, and MHRA (1 August 2025), report on adverse event reporting in digital mental health technologies, https://www.gov.uk/government/collections/digital-mental-health-technology.

[257] NHS England (10 March 2023), NHS England Position on Serenity Integrated Mentoring (SIM) and Similar Models, PRN00317 (concluding, after concerns raised by the patient-led StopSIM coalition, that key elements of the model should not be used), https://www.england.nhs.uk/long-read/nhs-england-position-on-serenity-integrated-mentoring-and-similar-models/; House, A. (2022), 'Serenity Integrated Mentoring and the High Intensity Network: a scheme that raises serious questions for practice and governance in UK psychiatry', BJPsych Bulletin, 47(1), pp. 1-4.

10.7 The implementation of the Oxehealth system had, at the time it was being introduced into EPUT, already been associated with research in Oxford which was an early adopter.[258] Implementation in EPUT could have built on this, and the wide dissemination of the Oxehealth system nationally also represented a missed opportunity for a multicentre trial. The oversight and ethics processes associated with research offer considerable protections when innovative practices are being developed, and had the opportunity been taken, we would, by this stage, have had much more helpful data both about the system and about observations in general than we currently possess.

(6) Co-production was never realistically contemplated

10.8 The involvement of patients came late in the introduction of the system, and it sometimes felt that they were being used for support rather than illumination. However, with the benefit of hindsight, it seems very likely that had co-production been built in from the start, many of the problems that were later encountered might well have been foreseen, as patients would have quickly asked questions like – who will see me? Can I turn it off? Does that mean a nurse will not come and ask how I am?

Recommendation

Where a new form of health care is being delivered that is not explicitly already recommended in the relevant guideline or national policy there should both be patient involvement at the earliest planning stage and there should be at least audit and evaluation and ideally formal research set up before implementation begins.

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are note. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

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[258] Barrera, A., Gee, C., Wood, A., Gibson, O., Bayley, D. and Geddes, J. (2020), 'Introducing artificial intelligence in acute psychiatric inpatient care: qualitative study of its use to conduct nursing observations', *Evidence-Based Mental Health*, 23(1), pp. 34–38.
Jorge, J., Villarroel, M., Tomlinson, H., Gibson, O., Darbyshire, J.L., Ede, J., Harford, M., Young, J.D., Tarassenko, L. and Watkinson, P. (2022), 'Non-contact physiological monitoring of post-operative patients in the intensive care unit', *npj Digital Medicine*, 5, article 4.

Signed: [I/S]

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Name: Dr Chess Denman