Parliamentary and Health Service Ombudsman

Case reference: C-2118934
Complaint about: Essex Partnership University NHS Foundation Trust
Complaint made by: Miss B
Decision date: 27 March 2026

Our decision

1. Through our investigation, we have found it a failing Essex Partnership University NHS Foundation Trust (the Trust) did not seek Miss B's consent for the use of the electronic monitoring system Oxevision or re-visit these discussions throughout her admission. This prevented her from being able to decline its use. It also did not switch off Oxevision when she asked staff to do so.

2. On review of the records, we have seen no evidence staff gave Miss B information about Oxevision or provided resources to explain its use in the ward. We find this a failing.

3. In terms of staff completing in-person observations, we have not seen cause to conclude that staff left Miss B for long periods of time at night on her own. However, there is no record in Miss B's care plans to explain how staff were using Oxevision to support their monitoring of her. We consider this lack of record keeping is a failing and this has prevented the Trust and us from being able to explain how staff were using the system during her admission.

4. We understand the Trust's use of Oxevision was a source of considerable concern for Miss B. Staff did not seek her consent, explain its use or provide information about the system. This exacerbated her feelings of anxiety, vulnerability and fear.

5. On review of how the Trust responded to Miss B's complaint, we find it only partly responded to the issues she raised and provided some incorrect information. We recognise this means Miss B has unanswered questions and this is a source of distress for her.

6. We partly uphold this complaint and recommend the Trust acknowledges the failings we found and how they affected Miss B. We ask the Trust to pay Miss B £925 in recognition of the impact she has suffered and create an action plan setting out how it will improve its complaint handling.

7. Since the events in question, the Trust has implemented a new Standard Operating Procedure (SOP) for its use of Oxevision. It now seeks patient consent for its use. However, we consider the SOP still departs from national guidance. We therefore recommend the Trust re-reviews its SOP for its guidance on consent.

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8. The Trust has also since introduced mandatory training for staff for Oxevision and has strengthened its guidance around staff communication about the system. We ask the Trust to explain these changes to Miss B, and how it is assured the improvements it has since made will help prevent anyone else having the experience she had.

9. We are sorry to hear of how the events we have investigated have affected Miss B, it is clear she feels strongly about what happened and her complaint is important to her. We hope our recommendations will go in some way to bringing resolution for what she has been through, and reassurance other patients will not have her experience.

The complaint

10. Miss B complains about the Trust and its use of the electronic monitoring system Oxevision in her room during her admission for mental health care between 2021 and 2022, specifically:

- she did not consent to the use of Oxevision and staff said there was no process for turning it off when she requested this
- staff did not give her information about Oxevision, could not answer her questions about it and gave her no resources to explain about its use
- staff relied on watching her on camera instead of carrying out regular in person observations as they were supposed to.

11. Miss B further complains the Trust's complaint response contained incorrect information and failed to engage with the concerns she raised around Oxevision.

12. Miss B says the use of Oxevision violated her right to privacy and made her feel vulnerable, frightened and at risk of abuse. She says staff could not reassure her about its use which meant she had a lot of unresolved concerns. She says this added to her anxiety and paranoia and led to a deterioration in her mental and physical health.

13. Miss B says staff's reliance on Oxevision made her feel that they were not caring for her. She says staff left her alone to struggle at night and this made her feel vulnerable and frightened.

14. Miss B says the Trust's handling of her complaint caused her further frustration and distress because it did not answer all her questions or address her concerns.

15. As an outcome for her complaint, Miss B wants the Trust to improve its procedures around the use of Oxevision and the information it provides to patients so no one else has the experience she did. She also seeks a financial remedy.

Background

16. Miss B was admitted to the mental health unit at the Trust in October 2021. During her admission, the Trust used the electronic monitoring system Oxevision to monitor Miss B. Oxevision is a device that is positioned on the wall in the patient's room. It uses an infrared-sensitive camera to measure a patient's pulse and breathing rate. It also generates warnings and alerts for staff when certain events occur, such as when a patient exits their room or enters their bathroom.

17. The Trust's website says it introduced Oxevision to improve its monitoring as part of an in-patient safety strategy. In a report from the Trust's Executive Operational Committee (EOC) to its board in 2020, it recommended the roll-out of the system following an initial trial on four wards. Feedback from patients said one-to-one staff observations could feel restrictive and punitive, and night-time checks could be intrusive and disruptive. The report considered benefits of Oxevision included monitoring vital signs in the dark without attaching devices to the patient. It can also collect data for reporting purposes.

18. Following surveys of staff and patients, the EOC also set out the early advantages seen in using Oxevision, including:

- staff and patients reported feeling safer, with a reduction in serious incidents
- it was allowing staff to use their judgement when to intervene with patients, which was improving their therapeutic relationships
- operational value to the Trust because it allowed staff to carry out fewer one-to-one observations and they could complete faster observation rounds; it anticipated this leading to a reduction in staff costs.

19. Miss B initially had one-to-one staff observations. The level of her observations reduced in January 2022. The Trust discharged Miss B home in July 2022.

Evidence

20. We have looked at all the relevant information we received from Miss B, and information from the Trust. This included the complaint correspondence, clinical records and further communication with all parties to discuss the complaint.

21. We also got advice from a mental health nurse who has been qualified for over 30 years and has worked in a variety of adult settings in secondary mental health services.

22. We use relevant law, policy, guidance and standards to inform our thinking. This allows us to consider what should have happened. We have referred to the following standards:

- General Medical Council (GMC): 'Making and using visual and audio recordings of patients', May 2011, and December 2024 updated guidance

- NHS England: ‘Principles for using digital technologies in mental health inpatient treatment and care’, February 2025
- Essex Partnership University NHS Foundation Trust: ‘Standard Operating Procedure for the use of the OxeHealth Oxevision (non-contact technology) In EPUT Inpatient bedrooms, seclusion rooms and HBPoS facilities’, Version 7 (September 2021), and Version 12 (May 2025)
- Essex Partnership University NHS Foundation Trust: ‘Engagement and Supportive Observation Policy (Inpatients)’, January 2020, version 2.3, amended January 2022
- Essex Partnership University NHS Foundation Trust: ‘Engagement and Supportive Observation Trustwide Procedure’, March 2018, amended January 2021
- Parliamentary and Health Service Ombudsman: ‘NHS Complaint Standards – summary of expectations’, April 2023.

Findings

Consent

23. Miss B says staff did not seek her consent for the use of Oxevision to monitor her. She also says she was in crisis when she was admitted and so would not have been in a state to have had this conversation, but staff should have re-visited this through her admission to check her consent for the use of the system.

24. The Trust’s SOP in place at the time of events advised staff should tell patients and carers, ‘Oxevision monitoring is part of normal practice for [the] inpatient service and that consent for its use whilst within inpatient services will not be required’.

25. In terms of the information Oxevision records and stores, the Trust’s SOP explains Oxevision records a pixelated video when there is a red alert. Actions such as a patient leaving their room, being in their bathroom for three minutes, or lingering at their doorway for more than three minutes will cause a red alert. Until staff address this, ‘the pixelated image remains visible’.

26. When staff use Oxevision to take vital signs, they can see a clear image for 10 seconds. The SOP explains the system saves this ‘raw and unblurred video footage’ for 24 hours, after which it automatically deletes this. Within this 24-hour period, staff or other organisations can request to see the data if a situation or incident occurs that needs investigating. Oxevision does not record sound.

27. The GMC’s professional standards for ‘making and using visual and audio recordings of patients’ says medical professionals must ‘make recordings only where you have appropriate consent or other valid authority for doing so’.

28. The standards further explain medical professionals 'must get the patient's consent to make a recording that forms part of the investigation or treatment of a condition or contributes to the patient's care'. They 'should explain to the patient why a recording would assist their care, what form the recording will take, and that it will be stored securely'. They should also 'record the key elements of the discussion in the patient's medical record'.

29. For adults that lack capacity, the guidance says health professionals 'must get consent from someone who has legal authority to make the decision on the patient's behalf before making the recording'.

30. Miss B's records from October 2021 show staff assessed Miss B as having capacity to understand information and the consequences of admission. They concluded that she was able to retain information about this decision and consider an argument for and against admission.

31. In-line with the GMC guidance, we therefore consider the Trust should have sought Miss B's consent for the use of Oxevision. We recognise Miss B did not feel she was well enough to be able to have such conversations on admission. Had she not had capacity for this, the Trust could have instead spoken to someone with appropriate legal authority for her. Staff should then have re-visited this decision as Miss B started to improve and to be able to engage in these conversations.

32. We do not consider the Trust's approach to consent met with the GMC guidelines we have referred to above. We find failing in this.

33. Miss B further complains that when she became more aware and concerned about the Oxevision system, she asked staff if they could turn this off but they said there was no procedure to be able to do so.

34. The GMC's professional standards for 'making and using visual and audio recordings of patients' says, 'where practicable, stop the recording if the patient asks you to'.

35. The Oxevision SOP said, 'if a patient refuses the use of the Oxevision […] system in their room, the system enables monitoring to be individually isolated with the monitor in the ward base stating 'turned off''. It said the nurse in charge will action the patient's request, and the clinical team should revisit this decision with the patients 'at agreed intervals', and 'this must be documented within the patient's record'.

36. There appears to be some conflict within the Trust's SOP in relation to this issue. On the one hand, it said that patient consent was not necessary for the use of Oxevision. On the other hand, it said it would turn off the system if patients refused to have it used. Without a

formal discussion to explain about Oxevision and seek consent, this would make it difficult for patients to decide if they agreed or declined to its use.

37. There is no record of staff conversations with Miss B about the use of Oxevision, on admission or at any time during her stay on the ward.

38. Consideration of the evidence available to us (the complaint Miss B made to the Trust and the accounts she has since shared with us of what happened) make it clear Miss B had increasing concerns about Oxevision. We consider it is plausible these concerns led to her asking staff if they could turn this off. While there is no record of a discussion, the Trust's lack of record keeping of any conversations about Oxevision means we have placed less weight on this absence in our analysis. We have not seen conflicting evidence that would cause us to question the account Miss B has shared with us.

39. On balance, we consider it more likely than not that Miss B asked staff if they could turn Oxevision off. In line with the Trust's SOP of the time and with the GMC guidance we have referred to, this request should have led staff discussing this with Miss B, and to turning Oxevision off. This did not happen and we find this a failing.

40. If staff had discussed consent for the use of Oxevision with Miss B or a person legally responsible for her on admission, it would have been an opportunity for them to decline to its use. There is also no evidence staff re-visited this conversation throughout Miss B's admission.

41. In terms of the impact of what happened, Miss B has told us having Oxevision in her room made her feel vulnerable and at risk of abuse, and she had concerns staff could misuse the images. She feels this impacted her mental and physical health and she changed her behaviours to try and protect herself from the technology. We are sorry to hear of the distress she suffered due to this.

42. We have considered the actions the Trust has taken since Miss B's experiences. It implemented a new Oxevision SOP in 2025. This says staff must seek consent from the patient, or a responsible person on their behalf, for the use of Oxevision.

43. The SOP says if a patient with capacity or the responsible person does not consent to the use of Oxevision, a decision to turn off the camera 'should **only** occur' if an appropriate clinician considers and decides this is clinically safe to turn this off. A multi-disciplinary team meeting then discusses and agrees the decision, 'in the best interests of the patient'.

44. The GMC updated its guidance for 'making and using visual and audio recordings of patients' in December 2024. This maintains that health professionals must only make recordings 'where you have appropriate consent'. It says they must not, 'make, or participate

in making, recordings against a patient's wishes, or where a recording may cause the patient harm'.

45. We have also reviewed NHS England's 'Principles for using digital technologies in mental health inpatient treatment and care', published in February 2025. This says that any decision to use the technology 'must be based on consent from the patient (or a person lawfully acting on their behalf)'.

46. The Principles say if health professionals determine a person does not have capacity, they should seek consent for the use of the technology from a person with parental or lawful authority. If this is not possible, they should complete a best interests assessment, in-line with the Mental Capacity Act to make this decision. This should be fully documented.

47. It is our view the Trust's current SOP departs from the GMC and NHS England guidance because it says when a patient with capacity declines consent for Oxevision, this is ultimately a decision for the nurse in charge or a doctor and requires MDT approval. This means that under the Trust's SOP, it may refuse to turn off Oxevision for a patient with capacity who does not consent to it. We consider that this is not in line with the guidance

48. The SOP says this decision is determined by whether it is 'clinically safe' to turn off the monitoring. However, the SOP maintains that the use of Oxevision is to complement and not replace its observation policy. It is therefore unclear why the Trust considered there may be cases where it would not be safe to turn off Oxevision, and why it cannot rely on an appropriate level of in person observations to maintain patient safety when a patient does not consent to Oxevision.

49. On review of the Trust's 2025 SOP, we do not consider this meets with the relevant national guidance. We therefore do not consider the Trust has acted to fully address what went wrong, or to prevent this from happening again. This remains an impact to Miss B. We have therefore set out our recommendations at the end of our report to address this.

Information and resources

50. Miss B complains staff did not give her any information about Oxevision and, when she asked questions, they could not always answer her or gave her conflicting information. She says there were no resources available to explain how the Trust was using Oxevision.

51. The GMC's professional standards for 'making and using visual and audio recordings of patients' says when making or using recordings clinicians must, 'give patients the information they want, or need, about the purpose of the recording'.

52. The Trust's SOP for Oxevision that was in place at the time of events says, 'any queries the patient or family members have must be answered in full and a record documented in the patient's health record'.

53. The SOP also says, 'signage regarding the use of [Oxevision] must be displayed clearly in public areas within the building to ensure that patients and their carers are aware of its use'. It also says, 'further information will be provided to patients in the ward information pack provided on admission'.

54. In response to Miss B's complaint, the Trust said, 'it would have been beneficial for staff to have explained [about the Oxevision monitors] in further detail when you expressed concern' […]. Going forwards, to ensure that all patients are aware of the function of the monitors, Oxehealth will be explained in detail to all patients on admission or upon their transfer to the ward'.

55. The Trust has told us its staff would have informed Miss B about Oxevision verbally on her admission, but at that time, there was no formal way of recording they had done this. It now has a checklist for staff to tick to confirm they have had this conversation.

56. The only reference we have found in Miss B's records to Oxevision is on 23 May 2022. The note says, Miss B 'requested [Oxehealth] leaflet'. Miss B has told us she never received this.

57. In terms of signage in the ward, the Trust has told us it cannot provide evidence of posters being on display from the time of Miss B's admission. Miss B has told us she did not see any posters.

58. We recognise it is possible the Trust may have had posters on display, but Miss B may not have seen or noticed them. It is also possible she may not have seen the posters because the Trust did not have them on display. We do not have sufficient evidence to determine if the Trust had displayed the posters, in line with its SOP.

59. In terms of whether Miss B received the information she needed and wanted about Oxevision, we have considered the available evidence. She made a detailed complaint to the Trust about Oxevision, setting out specific concerns and questions about its use. In the communication we have since had with her, Miss B has shared consistent and detailed accounts of her complaint. She has told us of her growing concerns about the system while she was in hospital, and how staff responses exacerbated her anxiety about this. We find her accounts convincing and do not have reasons to doubt she raised these questions during her admission.

60. We also consider the reference to Miss B asking staff for a leaflet about the system supports her account that she wanted more information than staff had provided and did not have a copy of a leaflet available to her. It is also reasonable to consider she likely asked staff questions about Oxevision when she was requesting the leaflet. Staff have not documented any details of this conversation.

61. While we do not know the details of what was discussed, we consider it is more likely than not that Miss B raised concerns about Oxevision and asked staff about its use during her admission. The Trust's complaint response indicates it accepts staff did not give Miss B the information she wanted.

62. In summary, we consider the evidence supports Miss B likely asked staff about Oxevision and they did not provide the information she sought. In line with the Trust's Oxevision SOP and the GMC guidance we have referred to, staff should have been able to respond to Miss B's questions and should have documented these conversations. We do not consider the evidence supports that this happened and find this a failing.

63. Miss B has told us the lack of information about Oxevision meant she had unresolved concerns, and her anxiety and distress about the system intensified. This led to her having further paranoia and concern. We are sorry to hear of how the lack of information caused her this additional worry. We have set out our recommendations to address this at the end of this report.

Observations

64. Miss B complains staff over-relied on watching the Oxevision monitors and did not complete in-person observations in-line with her care plan. She has said she started to notice the staffs' reliance on Oxevision from January 2022 when her mental health team put her onto lower-level observations. She says there were times at night she was struggling and in tears and staff should have been checking her every 15 minutes but she did not see anyone for hours.

65. Miss B believes that a reliance on Oxevision meant staff accorded less significance to in-person engagement and therefore gave her an impression, on those visits, of a lack of interest in her. We are sorry to hear of how difficult this was for Miss B.

66. In support of her concerns, Miss B has highlighted a 2023 inspection report about the Trust from the Care Quality Commission (CQC). The CQC regulates and inspects health and social care services in England. The 2023 report reviewed care on acute wards for adults of working age and on psychiatric intensive care units in 2022. The report comments, that across the wards, patients and carers said some staff at nighttime were 'uncaring'. Patients also reported 'staff observing them did not engage with them'. Miss B considers it important to

recognise the concerns she raises about nighttime observations were a general problem within the Trust, and she does not raise this in isolation. We have carefully considered the available evidence about Miss B's care to reach a view.

67. Leading up to 22 January 2022, Miss B was on level three observations. The Trust's 'Engagement and Supportive Observation Trustwide Procedure' says this is when a member of staff must keep the patient within continuous eyesight, with the patient always in either touching distance or viewing distance. From this date, her team moved her to level two observations.

68. The Trust's 'Engagement and Supportive Observation Trustwide Procedure' says for level two observations staff should visibly check the patient's location and safety 'at intervals that may range from every five minutes to a maximum of every thirty minutes with at least four checks within every one-hour period at irregular intervals'.

69. The Procedure says supportive observations 'do not stop at night', and staff have 'a duty of care to ensure patients are safe and not in distress either physically or emotionally'. It says they should explore 'any individual's distress'.

70. The Trust's Engagement and Supportive Observation Policy (Inpatients) says 'it is not acceptable to assume that a patient is sleeping from a visual check through a window', and staff should be able to confirm they can hear breathing sounds, or that they can see clear raising and lowering of the chest/ abdomen.

71. This policy also specifically refers to the use of Oxevision (introduced into the policy in January 2022): 'where assistive technologies are in use, such as Oxevision, to support observations of patients it should be clearly documented how these are to be used in the care plans for the patient with particular regard to consent and understanding from the patient recorded'.

72. The Trust's Oxevision SOP says it 'compliments [sic] the Trust's 'Observations and Engagement Policy' and does not replace it'. In its complaint response, the Trust said Oxevision, 'is in-situ as an addition to and not in place of observation checks'.

73. The SOP that was in place at the time of events also says Oxevision 'can only be used for patients risk-assessed as being nursed under level one or level two observations'. Level one observations are 'general observations' when staff should know the location of the patient, but they do not need to be kept in sight. This approach may explain why Miss B became increasingly aware of Oxevision when staff moved her to level two observations.

74. To determine if the Trust was completing observations in line with Miss B's care plan, we have reviewed her observation charts while she was largely on level two observations between January and April 2022.

75. Miss B's care plan says staff would monitor her mental state continuously, attempt to build a therapeutic rapport with her and nurse her on the 'least restrictive level of observations based on her presenting risks'.

76. There is no reference in Miss B's medical records, care plans or observation charts of how staff were using Oxevision to assist in their monitoring her. We recognise the change to the Trust's policy came in in January 2022, advising staff should document this information in patient records and there may be a period during which this would start to be implemented. We do however consider there was sufficient time over the four-month period for staff to document this in Miss B's records.

77. Our mental health nurse adviser has commented staff were carrying out level two observations because Miss B was at high risk of self-harming behaviours. Our adviser has reviewed the observation charts and said they support staff were observing Miss B each hour, and with the relevant timings, in line with the Trust procedures for level two observations.

78. We have also reviewed data the Trust provided that shows when a staff member used their key card to either look in Miss B's room through the panel on her door or entered the room.

79. The Trust told us the key card data is not complete because the system deletes entries from staff who leave the Trust. It has also told us staff may also complete observations when the patient's door is open, or if they have sight through a visual observation panel in the door. This may mean they do not always use their key card to complete observations. We have reviewed the data with this in mind.

80. The key card data is extensive and so we have analysed a sample of dates across the four months and have focused on periods of time at night when Miss B said she sometimes did not see staff for hours. We have cross-referenced this data with Miss B's observation records.

81. Through doing this, we found that there are periods of time where the data largely corresponds to the observation charts, sometimes with more entries per hour from key cards than is documented in the charts. This may be due to staff entering Miss B's room for reasons other than completing observations.

82. There are however gaps across the key card data, and hours where the data does not correspond with the observation records. In part we can see this occurs under certain staff

names where they do not appear at all in any key card data. This suggests these members of staff may have since left the Trust and so the system has deleted their data.

83. We also note some of the observation charts say staff observed Miss B outside of her bedroom area, such as in the corridor, or she came to the staff office. This accounts for some missing entries in the key card data. We also acknowledge we do not know when Miss B's door may have been open, allowing staff to observe her without the use of their key cards, although we consider this was less likely at night time.

84. We recognise these explanations may not fully account for the gaps in the key card data. It is possible that, where there are entries in the observation records and no corresponding key card data, this may indicate that staff completed entries based on review of the Oxevision footage. We also note there are greater numbers of entries into Miss B's room in the daytime, compared to the night time hours. We have not however seen evidence of periods of several hours with no key card activity.

85. The observation records provide detailed entries. These include the following examples: on 24 March, Miss B was watching her iPad between 11-12pm; on 25 March she woke and read a book between 2-3am; and on 1 April, she woke to have a drink between 12-1am. There are records across the dates we reviewed of her reported to be in her bed area, of being calm and settled and of staff seeing her breathing and making movements as she slept.

86. We have also seen some notes that do not include any detail such as on 1 April, between 2-3am, when staff wrote they saw her in the bed area and completed 'visual observation'. Such records are repeated over some periods of time. However, a lack of detail in some of the entries is not sufficient evidence alone to determine staff were not observing Miss B in person.

87. Our mental health nurse adviser reviewed the records and commented that the recorded details of Miss B's behaviours while sleeping, such as a description of her breathing, support a conclusion that staff were completing in-person observations. Our adviser has not seen evidence in the records that staff completed the observations remotely.

88. In summary, we recognise there are some discrepancies across the data and we do not discount Miss B's account of what she experienced which we have been sorry to hear. We also acknowledge the 2023 CQC report that highlights concerns raised by other patients about the standard of nighttime observations completed by staff in different wards. In reaching our decision, however, we have relied on the information available to us which is specific to Miss B's case.

89. We find the information in the observation records supports a view that staff were completing observations in person. We have not seen evidence across the records that indicates staff did not see Miss B in person for long periods of time at night.

90. Overall, while we recognise there are discrepancies across the data, in consideration of the available information and the clinical advice we have received, we find on balance the evidence supports the position staff were completing in-person observations and were not over-relying on Oxevision. This means we have not found failing here.

91. However, staff have not documented how the use of Oxevision was contributing to Miss B's care, in line with the Trust's Engagement and Supportive Observation Policy. This means the Trust has not been able to explain how it was using Oxevision in Miss B's care at the time of events, and it has prevented us from fully understanding this as part of our work. We find this lack of record a failing.

92. This failing leaves Miss B with remaining unanswered questions about how staff were using Oxevision to support her care. While we have not seen evidence to indicate staff were not completing in-person observations, Miss B continues to question whether staff completed her observation records in part through observing her through Oxevision. We recognise this on-going uncertainty for her stemming from the lack of record keeping. We consider the Trust should address this impact to Miss B, and we have set out our recommendations at the end of this report.

Complaint handling

93. Miss B complains the Trust's complaint response contained inaccuracies, particularly when addressing a complaint about treatment staff gave for her injured foot. She also says she felt the Trust did not fully engage with all her concerns and questions about Oxevision.

94. Our NHS Complaint Standards say when responding to a complaint, staff should 'give a clear, balanced account of what happened based on established facts'. Our complaint handling guide for carrying out an investigation says staff should first clarify a complaint with the complainant to make sure they fully understand this. To find out what happened, staff should gather the relevant evidence, including clinical records and staff statements.

95. Miss B told us she hurt her foot on her birthday in June 2022 while taking temporary leave from the ward to visit home. She complained to the Trust on 1 December 2022 about the care she received from the medical team, and that a mental health nurse told her she should not attend A&E.

96. In its complaint response dated 26 January 2024, the Trust advised, ‘we have not been able to find reference to a physical injury to your foot, therefore I am unable to respond to this any further’.

97. Miss B’s records show that on 9 June Miss B spoke to a nurse about the pain she had been suffering in her foot for the past three days after walking a lot on leave. There is a review from a doctor who then examined her. The records contain several accounts over the following weeks of further medical reviews, including from a physiotherapist, and to Miss B continuing to struggle with pain and staffs’ actions in response to this.

98. It is not clear why the Trust was unable to locate references to Miss B’s foot pain in her records when investigating her complaint. If staff were unsure of the dates when this occurred, it would have been appropriate for them to discuss this further with Miss B to clarify what happened. There is no evidence to show they did this. This meant the complaint response did not address what happened.

99. We do not consider the Trust’s approach meets with our Complaint Standards and we find this a failing. We recognise its response caused Miss B to feel it had not taken the time to investigate her complaint, leaving her with unresolved concerns.

100. Miss B further complains the Trust’s complaint response contained incorrect information and failed to engage with the concerns she raised around Oxevision.

101. In her complaint to the Trust in December 2022, Miss B raised concerns about the Trust’s use of Oxevision. She then sent a more detailed follow-up letter in February 2023. Miss B shared her personal experience of how the use of Oxevision affected her, and that she felt she was under surveillance. She asked for the Trust to improve how it shared information about Oxevision with staff and patients, for it to review its use of the technology, and if it could explore an option to turn Oxevision off.

102. Our guidance on carrying out an investigation says organisations should find out if something went wrong. If they do not find any concerns, staff should explain why. If they do, staff should explain what should have happened. To support their conclusions, staff can refer to relevant local policies, or national standards and guidelines.

103. In its complaint response, the Trust gave a general explanation of how Oxevision functions, that it supports staff in their work, and ‘has been proven to reduce patient risks’. It goes on to say that ‘all patients are advised about the Oxehealth monitors in their bedrooms, as well as posters being present around the ward’.

104. The Trust said it was sorry for Miss B's concern over the use of Oxevision. In terms of staff completing observations, it said it had made some changes in the way in which it works, and 'all staff have received training on the completion of observations and the expectations surrounding this'.

105. While the Trust shared some information about Oxevision and how it assists staff, it did not set out how it had considered Miss B's experiences and if the actions of staff met with expected standards. It did not explain its approach to consent or that it did have a process for turning Oxevision off should a patient request this.

106. We recognise the Trust acknowledged Miss B's concerns and apologised for this. However, Miss B wanted a detailed and personalised response, and we do not consider the Trust provided this. Early engagement with Miss B to further discuss her complaint would have likely helped the team fully understand her complaint and the information she sought, and this would have shaped the response to her.

107. We do not consider the Trust met with our Complaint Standards in its approach to investigating and sharing its findings with Miss B about Oxevision. We find this a failing. Miss B has told us the Trust's complaint response caused her frustration and distress because it did not answer her questions, or address what had happened.

108. We consider this impact remains unresolved for Miss B. We have therefore set out our recommendations to put this right below and hope this offers some assurance to Miss B of the difference her complaint will make for others.

Recommendations

109. We make recommendations in line with our Principles for Remedy which say public bodies should acknowledge failures, apologise, make amends, and use the opportunity to improve their services. The Principles say we aim to ensure the public body puts the complainant back in the position they would have been in had nothing gone wrong. If that is not possible, the public body should compensate them appropriately.

110. Our Principles for Remedy are reflected in the NHS Complaint Standards which say organisations should offer fair remedies to put things right and identify learning and use it to improve services.

111. In line with this we recommend the Trust writes to Miss B to acknowledge the failings we have found and to recognise the impact these have had on her. The Trust should send its letter by **29 April** and share a copy with our office.

112. In terms of the failing we have found in the Trust not obtaining consent for the use of Oxevision, or switching this off when Miss B requested this, we recommend the Trust re-reviews its SOP and approach to consent with reference to the GMC's standards and NHS England's guidance, as referred to in our report. It should write to inform Miss B, our office, NHS England and the Care Quality Commission (CQC) by **24 June** with the outcome of its review and with a rationale of any changes it plans to make, or not make, to its SOP.

113. The Trust's 2025 SOP sets out further information on the training staff using the Oxevision system must go through, and it has strengthened its guidance on the information staff should be sharing with patients. The Trust is also now using a further function of Oxevision in which it records patient observations electronically within the system itself.

114. We recognise these changes should improve patient experiences. We recommend the Trust writes to Miss B to tell her about the changes it has made to its approach to patient communication, staff training and observations.

115. The Trust should tell Miss B how it monitors staff compliance with these actions to ensure staff are meeting their responsibilities in line with the Oxevision SOP, and its Engagement and Supportive Observation policy and procedure. We ask the Trust to write to Miss B and our office by **24 June**.

116. Through our work, we have found failings in that the Trust did not document in Miss B's care plan how it was using Oxevision to support their monitoring. We have also noted the lack of records of any discussions staff had with Miss B about the use of Oxevision. It is not clear if the changes the Trust has since made to its services have addressed this issue.

117. To address the concerns with how the Trust managed Miss B's complaint, and with its record keeping, we ask it to complete an action plan to explain what it will do to ensure it improves its services in both areas. The action plan should set out:

- what the Trust will do, or has done, to prevent the issues from occurring again. If it has already made changes, it should explain how it has established these actions are appropriate to prevent this from recurring
- the name of the person or team responsible for each action
- when the actions will begin and when they will be complete (or when they occurred)
- how the impact of the actions will be measured and monitored.

118. We ask that the Trust completes this work by **24 June**. It should share a copy with our office.

119. To decide on a level of financial remedy, we review similar cases where the person has experienced similar injustice, along with our severity of injustice scale. Following this review,

we ask the Trust to pay Miss B £925 in recognition of the impact Miss B has suffered. It should make this payment by **29 April** and confirm to our office it has done this.