

Witness Name: Gareth Harry

Statement No.: 2

Dated: 27 August 2026

LAMPARD INQUIRY

SECOND WITNESS STATEMENT OF

GARETH HARRY

I, Gareth Harry, of NHS England, Wellington House, 133-135 Waterloo Road, London, SE1 8UG, will say as follows:

1. This corporate witness statement was drafted on my behalf, and with my input, by external solicitors acting for NHS England in respect of the Rule 9 request received on 13 August 2026 (the **"Rule 9 Request"**). The Rule 9 Request goes beyond matters which are within my own personal knowledge. As such, this statement is the product of drafting after communications between those external solicitors and a number of senior individuals in writing, by telephone and by video conference. I do not, therefore, have personal knowledge of all the matters of fact addressed within this statement and have not been able to personally review each document exhibited. However, given the process here described, I can confirm that all the facts set out in this statement are true to the best of my knowledge and belief.
2. This corporate statement has been produced with input from a number of colleagues across NHS England and following a targeted review of documents collated to date. This statement is accurate to the best of our knowledge, but we cannot exclude the possibility that it will require updating as further evidence emerges through our ongoing process of internal investigation and document review. NHS England will of course notify the Inquiry as soon as practicable if information comes to light that would have been included in this statement if it was available before the deadline for its production.
3. I make this statement further to my First Witness Statement dated 20 May 2026 (**"First Statement"**).

4. NHS Trusts and NHS Foundation Trusts are referred to collectively as “Trusts” in this statement unless otherwise stated.

Career and experience

5. A full description of my career and experience can be found in my First Statement. In summary, I am currently NHS England's National Delivery Director for Mental Health, Learning Disability and Autism, and have held that role since June 2022.

Procurement and oversight

6. Purchasing and procurement decision-making falls to individual providers (Trusts and independent providers) that are commissioned to provide health services in England, as they are separate, independent bodies. This includes decision-making around the procurement of digital technologies such as vision-based monitoring systems (“**VBMS**”).
7. Each Trust will have their own policies and/or procedures in relation to their own procurements and purchasing arrangements, and governance arrangements. The oversight and assurance process for the procurement of digital technologies begins with individual Trusts. Each Trust is responsible and accountable, through its Board and leadership, for the provision of services and for any technology procured to support those services. This responsibility is supported by internal governance arrangements designed to provide assurance regarding the quality and safety of services and to ensure compliance with applicable legislation. Applicable legislation in this regard includes data protection, human rights and the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014 (the "**2014 Regulations**"). In addition, as public bodies, Trusts are subject to, and must comply with, the requirements of public procurement legislation.

8. As set out in my First Statement at paragraph 18, this process also includes ensuring that patient safety risks are managed, which means that Trusts should be undertaking robust risk assessments to identify product-related clinical risks. A clinical risk management plan should then be developed to mitigate any identified risks, with those risks documented in a clinical safety case and reviewed through local governance processes prior to deployment and implementation.
9. The Care Quality Commission (the "**CQC**") inspects Trusts and independent sector providers, and exercises civil and criminal enforcement powers, as well as the power to conduct special reviews and investigations in certain circumstances, under the Health and Social Care Act 2008. However, and as explained at paragraphs 22 to 24 of my First Statement, NHS England coordinates closely with a range of national bodies to support the identification, monitoring and mitigation of emerging risks associated with new technologies. See paragraph 31 below for more information relating to the Digital Safety Review Group.
10. Separately, as set out in the Second Witness Statement of Clare Panniker dated 15 July 2026:
 - a. Integrated Care Boards ("**ICBs**") are the local statutory bodies responsible for commissioning and arranging the delivery of the majority of NHS services within their geographic areas. During the Relevant

Period, ICBs (and their predecessor organisations) exercised oversight of the quality and suitability of services provided to their local populations in their capacity as commissioners; and

- b. NHS England is responsible for directly commissioning specialised services.
11. More broadly, NHS England draws on information from NHS Trusts, ICBs and the CQC to understand the performance and risks of individual providers. Therefore, whilst systematic risk may get raised through these processes, general oversight and day-to-day concerns will typically be dealt with at a local level between providers, commissioners and the CQC.

NHS England guidance

12. As set out in paragraph 25 of my First Statement, NHS England has published guidance on the use of digital technology. This includes:
- a. the NHS Digital Technology Assessment Criteria (the "**DTAC**") [**Exhibit GH/004**]: An assurance framework used to assess and assure digital health technology products, covering clinical safety, data protection, technical security, interoperability and usability and accessibility. As set out in paragraph 30 of my First Statement, the DTAC is NHS England's national framework for assessing digital health technologies. Its purpose is to ensure that digital technologies meet minimum national standards before being adopted by providers of NHS-funded care. It is designed to be used by healthcare organisations to assess suppliers at the point of procurement or as part of a due diligence process. Although DTAC

establishes the mandatory national baseline for the procurement of digital health products intended for deployment within NHS settings (as part of NHS Procurement Policy), compliance with the DTAC is not a statutory requirement.

b. the What Good Looks Like (the "**WGLL**") Framework [**Exhibit GH/005**]:

A framework directed at all NHS leaders and Integrated Care Systems that will enable them to accelerate digital and data transformation, with seven success measures, including safe practice and empowering citizens. The framework draws on existing strategies, commitments and policies to provide a longer-term structure for how digital transformation across the seven pillars¹ should be delivered and assessed. It is not a statutory requirement or mandated, it reflects best practice and NHS England would expect providers of NHS funded care to have regard to it.

c. the Digital Maturity Assessment (the "**DMA**") [**Exhibit GH/006**]: The DMA is an annual self-assessment for NHS Trusts and Integrated Care Boards in England. It aims to assess digital maturity against the WGLL framework, identifying strengths, areas for development and opportunities for improvement in digital services, while providing a national baseline for measuring progress and informing decision-making. The DMA is not, however, a statutory requirement and does not itself create legally binding obligations.

¹ Well led, Ensure smart foundations, Safe practice, Support Workforce, Empower people, Improve care, and Healthy populations

Digital Principles

13. The principles for using digital technologies in mental health inpatient treatment and care (the "**Digital Principles**") were published in February 2025 [**Exhibit GH/038**].
14. The Digital Principles are clear that:
 - a. the implementation and use of digital technologies (which includes VBMS) requires case-by-case assessment and consideration as to whether a particular digital technology is appropriate and lawful for a particular patient; and
 - b. a failure to ensure that such assessments are being undertaken with reference to lawful use (as set out in the Digital Principles) may make the use of digital technologies in inpatient mental health settings unlawful and their use may be challenged by the patient or others.
15. In particular the Digital Principles highlight that using a digital technology as a 'blanket approach' to care, applied to all patients on a particular ward, or in a particular department, has the potential to be unlawful. Responsibility for ensuring that the use of VBMS is lawful in each instance is a matter for the deploying Trust.
16. At the time the Digital Principles were developed there were no standards, guidance or frameworks specifically around vision-based monitoring, however, relevant national documents were identified with the help of digital and procurement colleagues and mentioned in the principles These include:
 - a. the DTAC;
 - b. NICE Evidence standards framework for digital health technologies [**Exhibit GH/007**]; and

- c. NHS Data Security and Protection Toolkit **[Exhibit GH/040]**.
17. Since publication of the Principles, the CQC have released their *Brief Guide: Digital contactless patient monitoring technologies in mental health in-patient services* **[Exhibit GH/041]**. NHS England worked closely with the CQC in development of this guidance.

Promotion across the system

18. Following publication, the Digital Principles were promoted through NHS England's usual communication routes which includes bulletins and regional networks **[Exhibit GH/042]**.
19. Regional teams were also informed that Trusts could contact NHS England directly with any queries. Following this, Surrey and Borders Partnership NHS Foundation Trust² and Hertfordshire Partnership University NHS Foundation Trust³ made contact seeking advice on the implications of the Digital Principles and whether their use of VBMS was consistent with them. Both were directed to the section of the Digital Principles which explains the circumstances in which the use of VBMS may be considered unlawful.⁴
20. In addition, following promotion through the regional teams, NHS England presented the Digital Principles **[Exhibit GH/043]** at:
- a. the North East and Yorkshire Host Commissioner Forum on 26 March 2025; and

² This was a meeting with Interim Chief Nurse on 10 March 2025.

³ This was a meeting with Deputy Chief Nurse on 24 February 2026.

⁴ These interactions were not minuted or recorded.

- b. the South West Peer Learning Network on 3 June 2025.

Legal status

21. Paragraphs 67 to 77 of my First Statement sets out details regarding the Digital Principles. Whilst the Digital Principles are not legally binding they do direct Trusts to relevant legal and regulatory frameworks, including the Mental Capacity Act 2005, the Mental Health Act 1983, data protection legislation and the Human Rights Act 1998.
22. Trusts (and providers of NHS funded care) are required to comply with this legislation generally in respect of their service delivery. Such compliance is not limited to the use of digital technology generally, or VBMS specifically. If the use of digital technologies is inconsistent with those requirements, this may give rise to legal or regulatory consequences.
23. The Digital Principles also recognise that inappropriate use of digital technologies may affect a provider's compliance with the requirements of the 2014 Regulations, which are overseen by the CQC.

Compliance with Digital Principles

24. An audit to consider compliance has been considered, however, it was agreed that further fact-finding should first be undertaken. This has included engagement with regional teams to verify information received from Stop Oxevision **[Exhibit GH/044] [Exhibit GH/045] [Exhibit GH/046] [Exhibit GH/047] [Exhibit GH/048] [Exhibit GH/049] [Exhibit GH/050] [Exhibit GH/051] [Exhibit GH/052]**. As part of this work, NHS England will also continue its engagement with the CQC **[Exhibit GH/053]**.

25. Further work will also be informed by recommendations arising from the Inquiry to maximise the value of any review.
26. Non-compliance with the Digital Principles does not, in itself, result in regulatory or enforcement action.

Commissioned research

27. At paragraph 63 of my First Statement I provided a copy of the table sent to providers which outlined plans for exploring the evidence base for the use of VBMS. The table is reproduced below for reference:

What we are doing:	How we are doing it:
Launch a national programme to support providers in developing the culture of care in inpatient settings	Co-producing a set of Core Commitments and Standards for the culture of care in mental health, learning disability and autism inpatient settings – these standards describe clear principles for ensuring that inpatient care is safe, therapeutic, compassionate, personalised and least restrictive, from which the development and use of any technological innovations can be considered and aligned.
Explore the evidence base for the use of VBMS	The Mental Health Policy Research Unit have been commissioned by DHSC and NHSE to draw together evidence (where it exists) for the use of surveillance technologies in mental health settings
	Completed a user-based research review of vision-based technologies in mental health settings
	Liaising with the British Institute for Human Rights to understand the human rights considerations regarding the use of cameras in health and care settings
Hold a set of workshops together with providers, academics and experts-by-experience to co-produce a set of principles regarding the role and use of digital technologies in inpatient settings	These principles will include consideration of key legal frameworks and focus on the following: ○ Therapeutic Relationship ○ Patient Voice ○ Restrictive Practices ○ Patient Outcomes and Experience ○ Safety ○ Releasing Time to Care

28. As set out above, the Mental Health Policy Research Unit were commissioned to "draw together evidence (where it exists) for the use of surveillance technologies in mental health settings." The systematic review was carried out by the National Institute for Health and Care Research Policy Research Unit in Mental Health and published on 29 November 2024 **[Exhibit GH/033]**. It is referred to in the Principles on page 2. The conclusion of their review was as follows:

There is currently insufficient evidence to suggest that surveillance technologies in inpatient mental health settings are achieving their intended outcomes, such as improving safety and reducing costs. The studies were generally of low methodological quality, lacked lived experience involvement, and a substantial proportion (28.1%) declared conflicts of interest.

Assessing the evidence base

29. The Digital Principles state that providers should adopt a "robust process" for critically considering and assessing the evidence base before purchasing and implementing digital technology, and proceed with caution where the evidence base is limited.
30. In earlier drafts of the Digital Principles **[Exhibit GH/054]**, further detail had been included in relation to what a "robust process" might involve, however, this was removed following stakeholder engagement through two virtual feedback sessions in July 2024 **[Exhibit GH/057]** **[Exhibit GH/058]** **[Exhibit GH/059]** **[Exhibit GH/060]** **[Exhibit GH/061]** **[Exhibit GH/062]** **[Exhibit GH/063]** **[Exhibit GH/064]** **[Exhibit GH/065]** **[Exhibit GH/066]** **[Exhibit GH/067]** **[Exhibit GH/068]** **[Exhibit GH/069]**. Stakeholders from providers emphasised

that responsibility for assessing and reviewing the evidence base for treatments and technologies rests locally, and that providers employ a range of approaches when undertaking such assessments.⁵ The Digital Principles therefore refer providers to the NICE Evidence Standards Framework for Digital Health Technologies (on page 8) only, to support and guide their local assessment.

Digital Safety Review Group

31. As set out in paragraph 24 of my First Statement, of the Digital Safety Review Group (the "**DSRG**") was established in January 2026. A copy of the terms of reference (the "**ToR**") are exhibited at: **[Exhibit GH/055]**.
32. The purpose of the DSRG as set out in the ToR is to:
"proactively identify and mitigate patient safety risks associated with third party digital health technologies utilised within the wider system by reviewing intelligence from multiple sources, including the Learn from patient safety events service (LFPSE), NHS England Service Desk, Cyber alerts, Regulation 28 reports, media, frontline and industry feedback...The group aims to prevent harm by addressing design, implementation, and operational issues early and, where systemic action is warranted, to recommend national responses (e.g., alerts, guidance, bulletins)."
33. The ToR also outline the duties and responsibilities of the DSRG, which includes consideration of referrals to appropriate regulators (the CQC, the Medicines and Healthcare products Regulatory Agency, the UK Health Security Agency, the Office for Health Improvement and Disparities) or NHS England

⁵ Written feedback collated on Microsoft Teams Forms is no longer accessible.

teams (Screening Quality Assurance, Commercial Medicines Unit, Estates & Facilities).

34. Escalations may also be made to NHS England's National Patient Safety Response Advisory Panel for the publication of patient safety alerts [**Exhibit GH/056**]. These alerts require action to be taken by healthcare providers to reduce the risk of death or disability.
35. The DSRG is chaired by NHS England's Deputy Director of Patient Safety (Digital). The other members are the Deputy Director of Patient Safety (Digital Clinical Informatics Safety Team), Digital Clinical Safety Specialist, and representatives as required based on the topics raised that month from the Chief Midwifery Information Officer, Lead Clinician for General Practice Information Technology, Pharmacy Senior Clinical Lead (Technology and Digital), and the Clinical Lead for Cyber Operations. Additional subject matter experts will be invited as required.
36. Oxevision has not been brought to the DSRG for review to date. This is not unusual, as products are considered where digital clinical safety support is sought or required. Depending on the outcome of the work referred to earlier in this statement, the product may be considered by the DSRG at a future date.

Statement of Truth

I believe the content of this statement to be true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed:

[I/S]

Dated: 27 August 2026