

Witness Name: Laura Cozens

Statement No.: 4

Dated: 23rd September 2026

LAMPARD INQUIRY

FOURTH WITNESS STATEMENT OF LAURA COZENS

I, Laura Cozens, of Bee House, 140 Eastern Avenue, Milton Park, Oxfordshire, OX14 4SB will say as follows: -

Introduction

1. I am the Head of Patient Safety and Quality at Oxehealth Limited. I have been employed by Oxehealth in this role since May 2022. I am a registered Mental Health Nurse and have been since 2011.
2. Prior to working with Oxehealth I spent nearly twenty years working in the National Health Service (NHS) in various positions, lastly as a Senior Clinical Manager within High Secure Forensic Services.
3. I hold a Bachelor of Science Degree in Mental Health Nursing (obtained in 2011) and a Postgraduate Diploma in Clinical Forensic Psychiatry (obtained in 2020).
4. I have provided three Statements to the Inquiry so far. The first was in response to a Rule 9 request from the Lampard Inquiry dated 22nd January 2025.
5. The second Statement (dated 28th August 2025) responded to matters raised in:
 - a. the first and second witness statements of Zephan Trent dated 25th

March 2025 and 9th May 2025;

- b. the first witness statement of StopOxevision dated 24th March 2025;
 - c. and the transcript from the private hearing of Hat Porter dated 14th May 2025, which was received electronically on the 16th July 2025.
6. The third statement responded to a Rule 9 request from The Lampard Inquiry dated 22nd January 2026.
7. This fourth statement is provided in response to the evidence the Inquiry heard at the July hearings specially focussing on the evidence given by Jill Archibald – Nursing expert on observations and use of technology and Professor Christl Donnelly and Dr Maria Christodoulou - academic statisticians in the University Department of Statistics in Oxford.
8. The Oxevision system provides a number of distinct capabilities designed to support patient care:
 - **Remote vital signs observation:** a registered medical device, enabling staff to obtain pulse and breathing rate information without entering the patient's room, which can be particularly valuable at night or where direct interaction may be difficult or distressing.
 - **Alerts to manage risks:** providing location and activity-based warnings and alerts configured by each partner organisation, according to the needs of its wards and patient population.
 - **Retrospective incident review:** where enabled, providing objective information that can assist organisations in understanding serious incidents and strengthening clinical governance and accountability.
 - **Sleep monitoring:** a registered medical device, providing information about patients' sleep without requiring repeated physical disturbance.
 - **Digital observations:** supporting the recording and management of routine patient observations.
9. The Digital Observations capability was co-developed with Essex Partnership University NHS Trust (EPUT).

10. Oxehealth's position is and always has been that the Oxevision system is an assistive technology designed to augment clinical awareness and clinical judgement. Oxevision has been developed in collaboration with patients, carers, doctors and nurses.
11. Oxevision is not intended to replace staff presence or therapeutic engagement, nor to reduce staffing. Its purpose is to support patient safety, assist prioritisation of care and enable more meaningful therapeutic interactions. It complements, rather than replaces, clinical judgement and direct patient contact.
12. Oxehealth is a responsible technology company which works collaboratively with its partners and welcomes constructive conversations about the system and its use.
13. During the July hearings evidence was heard about the design, assumptions and methodology of the business cases prepared in conjunction with the proposed purchase of Oxevision by EPUT. It was noted that potential cost savings associated with the proposal had been presented as part of those business cases.
14. However, the value of implementing Oxevision is not limited to potential cost savings, and a range of other anticipated benefits were also identified. These broader considerations have informed decisions by organisations to purchase Oxevision and in some cases to renew existing contracts.

Jill Archibald – Nursing expert on observations and use of technology

15. Ms Archibald stated that she felt that the 8 National Health Service England (NHSE) Principles for digital technology in mental health were essential to help govern the use of Vision Based Patient Monitoring Systems (VBPMS) and that between these and the Care Quality Commission (CQC) guidelines there is an adequate and sufficient set of standards governing the use of VBPMS, such as Oxevision.

16. Oxehealth warmly welcomes the publication of those principles and guidance, all of which are consistent with Oxehealth's view of the appropriate use of the Oxevision system.
17. Oxehealth is, however, conscious that NHS Trusts are navigating between multiple sets of principles and guidance (NHSE Principles, CQC guidance and the National Mental Health and Learning Disabilities Nurse Directors Forum) in relation to digital technologies such as VBPMS.
18. While these existing frameworks are largely similar, there are minor differences between them which may create some operational ambiguity and local practice variance.
19. Oxehealth also acknowledges that the way organisations have used the Oxevision platform has developed over time, as with any new technology or system introduced within a healthcare setting.
20. There have been different models of consent and approaches in different NHS Trusts with respect to how the platform has been deployed.
21. Oxehealth fully supports evidence-based learning on how the platform is used in practice.
22. Oxehealth would advocate the development of a single, clear and consistent national framework that brings together and aligns the existing principles and guidance into one coherent set of guidelines, ensuring there are clear, measurable and actionable recommendations across four key operational areas:
 - a. Patient involvement, consent and objection
 - b. Staff training
 - c. Role of technology
 - d. Governance, Assurance and Auditability
23. To achieve a coherent set of guidelines, Oxehealth would suggest that a nationally representative and independently led working group should be established to integrate the existing guidance from CQC, NHSE and the

Nurse Directors Forum. The working group should include a broad range of expertise and lived experience including

- a. NHSE/CQC
- b. Senior clinical leadership (including those who have experience of implementing the technology within their organisations)
- c. A range of people with lived experience and their families (including those who have experience of inpatient services and the technology)
- d. Frontline staff (with direct patient contact and the end users)
- e. Relevant legal/ethical expertise
- f. Technology providers

- 24. This single national framework covering the key operational areas would be consistent with the five recommendations the inquiry heard from Ms Archibald in July.

Patient involvement, consent and objection

- 25. Oxehealth believes that there is a careful balance to be struck between privacy and autonomy on the one hand and managing clinical priorities including safety within mental health inpatient services on the other.
- 26. Oxehealth recognises and takes seriously that some patients have had negative experiences of vision-based patient monitoring. However, it is equally important to recognise that patient experience is not uniform. Other patients have reported valuing aspects of the technology, including the ability to be monitored without repeated physical disturbance.
- 27. The diverse patient views reflect their materially different experiences and preferences. The experience or views of an individual patient is important evidence of that individual's preferences but should not automatically be treated as being representative of the views or interests of the whole patient group. A balanced approach is essential to understand what is working well, what is not and where improvements are needed to ensure that future use of VBPMS is informed by the complete set of patient experiences.
- 28. A national set of guidelines should contain robust protocols for informing and

involving patients, explicitly outlining how individual circumstances should account for considerations such as

- a. informed patient consent
- b. clinical risk assessment and management
- c. the application of the Mental Capacity Act and best interests decision-making in individual cases
- d. The application of the Mental Health Act and its Code of Practice in individual cases
- e. advanced decision making
- f. keeping decisions under appropriate review
- g. effective recording and audit of decisions.

29. This should ensure there is greater national clarity and consistency.

30. The Government will be consulting on the Mental Health Act Code of Practice at some point over the next year. It may be appropriate for guidance to be placed into the Code of Practice to aid clinicians alongside any national standards or framework that NHS England or its successor bodies, or the regulators consider are appropriate.

Staff training

31. Clinicians and staff working within the NHS are required to complete statutory and mandatory training courses, as outlined within the UK Core Skill Training Framework. Some courses can be completed via E-Learning but others will require a face-to-face classroom session which can include an element of simulation (such as basic life support)

(<https://www.skillsforhealth.org.uk/integrated-solutions/core-skills-training-framework/#england>).

32. Staff working within Mental Health Trusts, especially inpatient services, also have to complete specialised courses specific to the area in which they work (such as Prevention and Management of Violence and Aggression).
33. Training provided by Oxehealth is in relation to the product performance/functionality and how to use it practically. Training on when and how to use it is the responsibility of the NHS Trust deploying the Oxevision platform in accordance with their own Standard Operating Procedure (SOP).
34. As of June 2026, Oxehealth's product training model changed, to enable providers to host the Oxevision product training content on their own local Learning Management System (LMS) where all training is held centrally for staff.
35. This enables providers to -
 - a. Deliver their local SOP training directly alongside the product training and to store other Oxehealth related documents with the product training i.e. the SOP and SOP engagement material.
 - b. Track staff compliance with training (LC's second statement, para 34-35).
36. A national set of guidelines should consider the expectations for initial and refresher training on VBPMS, ensuring this covers not only substantive Trust staff but also any bank or agency staff.

Role of technology

37. The NHS 10-year plan for England, identifies the need to move the NHS from analogue to digital by moving to “digitally by default” care and introducing modern technology across health services by 2028–2029 (<https://assets.publishing.service.gov.uk/media/6888a0b1a11f859994409147/fit-for-the-future-10-year-health-plan-for-england.pdf>).
38. Oxevision enables clinicians to obtain additional information about a patient.

Decisions about whether and how that information is used within an individual's care, including the frequency and nature of observations, remain clinical decisions for the healthcare provider.

39. The Mental Health Act Code of Practice (2015) remains the most widely cited reference, defining Enhanced Therapeutic Observation and Care (ETOC) as a therapeutic intervention aimed at reducing risk and promoting recovery through meaningful engagement (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF).
40. It is important to consider methods other than technology by which patients are observed and kept safe and how these themselves may involve intrusion into privacy, including staff entering bedrooms during the night.
41. The CQC, in their most recent Monitoring the Mental Health Act report published in March 2025, noted that such observation is intrusive but necessary for safety (LC/59, page 56).
 - a. *“Observation by staff, particularly during the night, is one of the more severe forms of such intrusion. But it is also a necessary aspect of safety on most wards and an expectation of nursing care”.*
42. Sleep disturbance is common in psychiatry wards, despite poor sleep worsening mental health and night-time observations are a known contributing factor. (<https://pubmed.ncbi.nlm.nih.gov/32329430/>).
43. Nighttime observations present recognised challenges. They can be disruptive for the patient, often waking them up, causing distress and interfering with rest which is crucial for recovery.
 - a. *“Their sleep was interrupted by (a) the light from torches shone into their faces by staff checking on their safety, (b) the noises produced by the opening and closing of bedroom/ward doors, and/or (c) staff talking to each other during the observation. Patients also reported that they found having somebody enter the room in the middle of the night intimidating and unsettling” (LC/78).*

44. The sleep well initiative at Cumbria Northumberland Tyne and Wear NHS Foundation Trust (CNTW) protected sleep time for c. 50% of risk-assessed patients with positive patient and staff feedback and reduced hypnotic issuance.
45. Oxevision supports protected sleep by providing non disturbing nighttime checks for all patient across a ward.
46. Therefore, a proportionality assessment should consider the benefits and potential harms of both the use and non-use of technology in the circumstances of the individual patient. The relevant comparison therefore is not between the use of technology and absence of intrusion, but between different methods of meeting the clinical and safety needs.

Product Road Map

47. There have been developments to the Oxevision system during the time covered by the Inquiry period, specifically to enhance auditability, traceability, operational control and patient centred care:
 - a. User authentication**

An improved security measure, ensuring users are identified when interacting with the platform.
 - b. Role based access controls**

Allows organisations to authorise access for certain roles and access to certain features, for example only allowing registered nurses access to the report functionality of Oxevision.
 - c. Alert personalisation**

Allows clinicians to assess which alerts are appropriate for which patients, and at what time in the case of bathroom and bed alerts. This assists with patient centred care and helps combat perceived alert fatigue, a subject raised during evidence presented at the Inquiry.
 - d. An Insights dashboard**

An off-ward management dashboard which provides organisations real-time access to their data to enable real-time auditability and traceability.
 - e. Vital Sign Attempt Notification**

Developed as a control measure to deter over-use of the vital signs feature and provide live management escalation to stop such over-use occurring.

48. These developments strengthen auditability, accountability and access controls, and support organisations in ensuring that the platform is used consistently with its intended clinical purpose and their local governance arrangements.
49. During evidence presented at the Inquiry, the topic of the 'red glow' from the illuminators contained within the housing unit was reported as having had a direct impact on some patients' experience of Oxevision. A multi-year project as part of Oxehealth's product road map is underway to review how the Oxevision hardware may be optimised, including the housing unit and the issue of the visibility of the near infra-red illuminators both during the day and at night. This project includes consultation with patients and clinicians.

Professor Christl Donnelly and Dr Maria Christodoulou - Health statisticians

50. Professor Christl Donnelly and Dr Maria Christodoulou from the Department of Statistics in the University of Oxford concluded that the evidence so far published in clinical academic journals and conference proceedings provides only limited and cautious support for the use of Oxevision and related VBPMS in mental health inpatient settings.
51. This conclusion should be understood within the context of the limitations of the available published evidence base and should not be interpreted as establishing that Oxevision is ineffective, unsafe or of no benefit.
52. The limitations identified within the published literature do not indicate an absence of evidence nor should they diminish the evidential value of the

extensive experience of clinicians, patients and healthcare providers who have used the technology in practice in multiple NHS Trusts, a relevant source of evidence which also has to be considered.

53. Professor Christl Donnelly and Dr Maria Christodoulou recognised that a randomised clinical trial is difficult to undertake within a mental health inpatient unit. They recommended, however, that further independent, randomised, adequately controlled research ought to be attempted before stronger conclusions could be drawn.
54. Generating randomised controlled evidence for interventions deployed at ward level in inpatient mental health settings will present significant practical and methodological challenges. Most of the evidence for medical technology therefore consists of pragmatic real-world studies tailored to the technology. For example, I'm not aware of any randomised controlled trial (RCT) of pulse oximetry that shows it improves patient outcomes, even though it is near-universal at ward level in acute care settings.
55. Oxehealth nevertheless accepts the recommendation of the Inquiry's expert statisticians that additional research should be undertaken. Oxehealth is willing to provide an independent research bursary (£100,000) to an appropriate qualified university, Health Innovation Network, or accredited research body to support an independent multi-site study into de-identified incident data and the safety impact of Oxevision in inpatient mental health settings.
56. Any study having access to this bursary would be conducted independently of Oxehealth, subject to appropriate governance and ethical oversight. In particular the research protocol, methodology, outcome measures and analysis plan would be developed and agreed independently by the research body without direction or influence from Oxehealth.
57. The researchers would retain full and independent publication rights, including the right to publish the study findings irrespective of whether the

results support, contradict, or show no material impact as a result of, the use of Oxevision.

58. The purpose of the bursary would be solely to facilitate independent research into incident data and patient safety, and it would not be conditional upon any particular outcome or conclusion.
59. If helpful, Oxehealth could provide full access to aggregated, de-identified multi-Trust safety and incident data from our partner NHS Trusts subject to the agreement of the relevant partner organisations and applicable information-governance requirements.
60. Oxehealth would see any research outcomes as an opportunity to develop best practice in the use of VBPMS in mental health settings, information which would be openly accessible to all technology providers and all organisations implementing VBPMS.

Observations

61. The evidence heard in July raised legitimate and important questions, which Oxehealth takes seriously. In response we have proposed practical and achievable suggestions to augment the research evidence base and align national guidelines in agreement with the Inquiry's expert witness recommendations.
62. Following preparation of these proposals, LIO discussed them with a group of senior executive representatives from five NHS Trusts currently using Oxevision. The purpose was to test whether the proposals reflected the challenges experienced by Trusts in practice and to invite feedback before they were finalised.
63. The proposed national framework and further independent research were both positively received by those who contributed to the discussion. In particular, participants were supportive of the principle of bringing existing guidance together into a clearer and more consistent national framework,

recognising the value of greater clarity for Trusts in governing the use of VBPMS.

64. There was also interest in participating in a future multi-site research study. Meeting attendees considered it important that Trusts with substantial practical experience of using and governing VBPMS should have an opportunity to contribute constructively to the development of both the evidence base and future national guidance, alongside other relevant stakeholders.
65. However, Oxehealth does not consider that legitimate questions about consistency of implementation across different Trusts or the robustness of the published evidence base provide a basis for assuming that use of the technology should cease while this work is undertaken. The proportionate response should be to augment the evidence base, improve national consistency and ensure that the technology is used with appropriate safeguards according to clinical need and individual circumstances.
66. Oxehealth is also aware, through discussions with partner organisations, that the current scrutiny surrounding VBPMS, including the Inquiry process, is influencing decisions about whether the technology should continue to be used. This creates a potential unintended consequence: patients, carers and staff who value the technology may experience changes to their care before the Inquiry has reached its conclusions. Here are some examples of feedback received through partner organisations from patients, carers and staff describing the impact that withdrawal of the technology would have on them
 - a. *'It would be really sad to lose something so beneficial'*
 - b. *'I don't know how we would zone (observations) safely without the support of Oxevision' (in relation to current staffing levels and cost)*
 - c. *"families and carers would be very upset and potentially distressed to know that Oxevision is being removed from the wards as they believe that the platform positively impacts the care of their loved ones".*
67. As set out in my second statement at paragraph 14 –

Oxehealth has been involved in four inquests in relation to four patient deaths at EPUT. At each of the inquests, Oxehealth was invited to give evidence. During three of the inquests Oxehealth was given Interested Person (IP) status. In each of these cases Oxevision was installed within the patient's bedroom.

68. To our knowledge, no inquests (whether at EPUT or other providers) have found deficiencies in the Oxevision system or its design. In each case, the system has performed as designed and, in some cases, provided staff with additional situational awareness that they would not have had without it.
69. In all four EPUT inquests the Oxevision system performed as expected (for example, triggering the appropriate alert). It has been evident during all four of the inquests in which Oxehealth has been involved that the data provided by Oxevision has been useful in these cases.
70. This is also supported by Ms Archibald's evidence heard in July where she accepted that in the EPUT case studies she had received as part of her expert instruction, where patient deaths had involved an element of Oxevision use, the problem was the use/misuse of the technology by staff, and not the technology itself. That distinction reinforces the importance of considering technology as one component of a wider system of care in which product design, implementation, local governance, training, clinical judgment and staff response all interact.
71. As highlighted in my second statement, many providers often share examples where the use of Oxevision has improved the quality of care for patients, enhanced quality of life for patients and has assisted staff to make more timely interventions. This data is highly relevant to understanding how the technology is being used in real-world clinical practice and the potential consequences that its withdrawal would have. For example:
 - a. Organisation A: in 26 months there were 1,774 incidents for which Oxevision supported staff to respond to a situation where a service

user(s) could have otherwise come to serious harm.

- b. Organisation B: from 2021 to Feb 2025 there were 584 incidents of self-harm for which Oxevision supported staff to respond to a situation where a service user(s) could have otherwise come to serious harm.

72. Oxehealth also believes the Inquiry should consider the wider patient-safety challenges in mental health inpatient care and how technology can help address these. Recent public reporting of the inquest into the death of Hugo Flint-Cahan at Newham Mental Health Centre, run by the East London NHS Trust (ELFT), provides a particularly distressing example. The reported findings included failures to undertake required observations, falsification of observation records and delays in identifying and responding to a serious incident (<https://www.bbc.co.uk/news/articles/c750vqp1wlxo>).
73. While it is not possible to know whether the presence of Oxevision would have changed the outcome in this individual case, the circumstances illustrate how additional technological safeguards could potentially have identified or mitigated some of the failures described.
74. Depending on its configuration, Oxevision can provide real-time and auditable observation records, highlight when scheduled observations have been missed, provide alerts relating to patient activity and location, including patients leaving their bedrooms at night to prompt staff to assess whether they need support, and notifications to the presence of multiple people within a room.
75. The tragic death of Hugo Flint-Cahan is one deeply concerning example of a much wider pattern. Published Prevention of Future Deaths (PFD) reports repeatedly identify similar patient-safety concerns, including failures in observations, record keeping, staffing, risk assessment and the identification and escalation of deterioration.
76. PFD analysis of inpatient mental health deaths from 28/3/2013 to 5/6/2026 shows significant, recurring failing in observation practice (source here:

<https://pfdmonitor.org/topics/inpatient-deaths-in-mental-healthcare/>).

77. In total 356 reports were reviewed which focused on deaths where a patient was admitted to a dedicated mental health inpatient service. Those reports listed:

- 59 unreliable patient observation arrangements
- 30 unreliable recording of required observations in care and custody
- 15 unreliable observations of patients in specialist mental health units.

This wider evidence is important when considering the role of VBPMS in mental health inpatient care.

78. Any assessment of the use of VBPMS should consider not only potential impacts on privacy, but also the extent to which appropriately governed technology, used alongside therapeutic engagement and clinical judgement, can help address these known and recurring patient-safety risks.

79. The challenge for mental health services is not to choose between technology, patient rights and patient safety. Rather, it is to establish the conditions, safeguards and governance arrangements under which technology can be used responsibly so that it supports and strengthens both patient rights and patient safety.

I believe the content of this statement to be true.

[I/S]

23-Sep-2026 | 17:09 BST
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