

THE LAMPARD INQUIRY

WITNESS STATEMENT OF DERRICK STERLING TRIMBLE

Rule 9 of the Inquiry Rules 2006

Final witness statement

A. Introduction and professional background

1. My name is Derrick Sterling Trimble. I make this statement in response to the Lampard Inquiry's request for evidence concerning my experience of the use of Oxevision, now known as LIO, and Oxevision Observations within Essex Partnership University NHS Foundation Trust (EPUT). Where I refer to matters outside my direct knowledge, I identify the basis of my understanding or the limits of what I can confirm.
2. I hold a Master of Business Administration, a Bachelor of Science in Business Administration and an Associate of Arts in Instructional Technology from educational institutions in the United States. Before joining EPUT, my employment was primarily in the United States and included training, business development, project management and contract management. That experience provided relevant skills in training design and delivery, implementation, stakeholder engagement and project governance.
3. I first worked at EPUT as a Clinical Management Systems Trainer and then as a Senior Clinical Management Systems Trainer. My EPUT employment began on 29 July 2016. I was seconded into the Clinical Management Systems training role in December 2016 and was promoted to Senior Clinical Management Systems Trainer on 31 March 2017. In those roles I supported staff in the use of electronic patient record systems, mainly Paris. Electronic patient record is abbreviated in this statement as EPR.
4. After a break in service beginning in June 2019, I returned to EPUT as a bank worker in January 2021 to support the then Oxevision project manager. My work between January and April 2021 was therefore undertaken in a bank and project-support capacity. It included implementation support, liaison with wards and Oxehealth, support for training and other project activity allocated to me. I became a Project Support Officer in April 2021 and a Project Manager in September 2021.
5. I did not bring pre-existing specialist knowledge of Oxevision to EPUT. My knowledge developed through my work from January 2021 onwards. This included liaising with ward staff, clinical leads and Oxehealth; support for implementation and training; management of the Oxevision Observations proof of concept and deployment; support for EPR integration; response to operational issues; and later subject-matter and business-as-usual support within the IT Directorate.
6. My primary responsibilities are those of a project manager. In relation to LIO, my work has included coordinating projects and system changes; supporting technical aspects of the Trust standard operating procedure; monitoring platform use and report flows; escalating technical or operational issues; supporting authorised requests for clear video data; reporting to project and governance groups; and providing business-as-usual support. I am not clinically qualified. I do not determine clinical policy, observation levels, capacity, best-interest decisions or the clinical response to an individual patient.

B. Terminology, scope and source of evidence

7. Oxevision was the name used for the platform during much of the period addressed in this statement. The platform is now branded LIO. LIO is a brand name and not an acronym. I use Oxevision when describing historical events or documents and LIO when referring to the current platform or supplier branding.
8. Oxevision Observations has also been described as OxeObs, eObs or digital observations. In this statement I use OxeObs for consistency. OxeObs is a software function within the platform for digitally recording observation rounds and producing observation history reports.
9. The Inquiry's Relevant Period ends on 31 December 2023. I have nevertheless included later developments where they explain the current position or inform my recommendations. I identify dates where they are known. Current LIO curated Instructions for Use references do not necessarily establish what an earlier product version stated or did during the whole Relevant Period.

10. I have referred to current Instructions for Use for Vital Signs, Activity Tracker and Seclusion. The documents available to me are VS.IFU.359, Vital Signs Instructions for Use, version 88.0, applicable to platform version 3.1.3; AT.IFU.427, Activity Tracker Instructions for Use, version 20.0, applicable to platform version 3.1.3; and SLN.IFU.473, Oxevision Seclusion Instructions for Use, version 12.1, dated 23 January 2025. I understand that documents referred to in this statement should be identified in the Exhibits List. I leave the final form of that list and whether documents should accompany the statement to the Inquiry and my legal representative.

C. Description of the platform

11. The platform is installed in single-occupancy rooms. A wall-mounted housing contains a camera and infrared illumination. Ward staff interact with the platform through a touch-screen monitor in the ward office and configured tablet devices. A local server and associated network equipment support the installed system. The precise functions available depend on the room, ward and service configuration.
12. The principal functions used at EPUT have included Vital Signs, Activity Tracker, Seclusion and OxeObs. Vital Signs enables contactless spot-check measurements of pulse rate and breathing rate within the limits described in its Instructions for Use. Activity Tracker analyses room activity and location information and may provide configured room states, warnings and alerts. Seclusion provides a reporting tool for configured seclusion environments. OxeObs supports the digital recording and reporting of observation rounds.
13. The platform is room-based and cannot verify the identity of the person in the room. A patient must be associated with the appropriate room within OxeObs before observations can be recorded against that room and patient configuration. More than one person in a room, a change in room arrangement, an obstruction or an area outside the camera's view can affect the interpretation of room activity.
14. The Vital Signs function is a contactless spot-check device for pulse and breathing rate within the measurement ranges specified in its Instructions for Use. It does not provide alarms for irregular or ceased breathing, is not a continuous vital-sign monitor and must not be relied upon as the sole means of assessing a patient's physical health. Clinical staff remain responsible for applying Trust policy, professional judgement and other appropriate means of assessment.
15. When a user initiates a Vital Signs measurement, a clear live view is displayed for a limited period to enable the user to confirm that the patient is still and that the measurement markers are on the person. The current Vital Signs Instructions for Use states that the clear live view closes automatically after 15 seconds. Measurements are then submitted to the platform, subject to successful connectivity and the applicable workflow.
16. The platform also generates room activity and report information. I have used the term clear video data, abbreviated as CVD, for preserved video obtained through an authorised request. I understand that routine platform video is subject to a short local refresh period and that preservation has to be requested before the material becomes unavailable. The precise technical data flow, encryption and supplier-access arrangements are governed by the relevant data-protection documents, service agreement and authorised CVD process. I do not seek to give an expert account of encryption architecture beyond those documents.
17. Ensuite bathroom areas are configured with a digital privacy mask. Its purpose is to prevent staff from viewing the patient within the masked area through the platform while allowing configured room or bathroom status information to be generated. This is intended to protect privacy and dignity in an area where visual monitoring would be particularly intrusive.
18. The privacy concerns to which I referred arose through my professional involvement in implementation, governance discussions, staff engagement and patient-facing information rather than from a formal research study. They have principally concerned the presence of video-based monitoring in a bedroom, the circumstances in which a clear view may be displayed for an authorised function, and privacy in areas such as ensuite bathrooms. I do not

present those concerns as representing the view of every patient or member of staff nor am I able to evidence written communications that establish these perceptions.

19. The platform is not CCTV and should not be used as a surveillance system. Staff are expected to use it within the Instructions for Use, Trust standard operating procedure, training, privacy requirements and their professional duties. The platform supports care and risk management but does not replace physical attendance, therapeutic engagement or clinical judgement where those are required.

D. Room states, warnings and alerts

20. The Activity Tracker displays room states on the fixed monitor and tablet devices. The current Activity Tracker Instructions for Use distinguishes warnings from alerts. Warnings are orange tiles and visual only. Alerts are red tiles, audible, and continue until reset by a user. The available room states and their timings depend on the local configuration.
21. Configured states used within EPUT have included In Room, In Bed, In Bathroom, In Blindspot, At Door, Leaving Bed, Out of Bed, Multiple People, Out of Room, No Activity, Connection Lost, Camera Off, Out of Monitored Area, Acquiring and Interfered With. Not every state is enabled on every ward. Configuration reflects the service, room type, patient population and clinical authorisation.
22. Examples of service-specific configuration include At Door in some child and adolescent mental health or specialist settings, No Activity in configured seclusion, and Out of Bed or Out of Room activity configurations in older-adult services. The current Instructions for Use states that an In Bathroom warning may escalate to an alert if the platform continues to detect bathroom occupancy. The timing is locally configured; where I refer to a three-minute threshold, I mean the EPUT configuration relevant to the wards concerned and not a universal product threshold.
23. A warning informs staff that a room condition has changed and requires them to apply their knowledge of the patient and professional judgement. An alert requires the response prescribed by the Trust's standard operating procedure. Where physical attendance is required, staff must attend the room and satisfy themselves as to the patient's safety before resetting the alert.
24. The platform permits an authorised user to select Reset and silence the alert across all ward devices. The Trust requirement not to reset an alert from the ward-office monitor is a procedural requirement intended to prevent the monitor being used as a substitute for the required physical response. I do not suggest that the platform technically prevents a reset from the fixed monitor.
25. Replay Last Alert, where enabled, allows authorised staff to review blurred video associated with the most recent alert. The current Activity Tracker Instructions for Use describes ten minutes of blurred footage, consisting of five minutes before and five minutes after the alert, available for up to twelve hours. At EPUT this has been used in older-adult services to support review of unwitnessed falls. It is not a replacement for incident investigation or clinical assessment.
26. The Activity Tracker may misinterpret the movement of a second person as the movement of the person occupying the room. In particular, if one person is in a bathroom or blind spot and a second person enters and leaves, the displayed room state may be inaccurate. The current Instructions for Use cautions users not to rely on the In Bathroom or In Blindspot state in that circumstance. EPUT training and the standard operating procedure should be read with that limitation in mind.
27. The current Activity Tracker Instructions for Use states that users can reduce the volume on the touch-screen monitor and are responsible for restoring it, while mobile-device volume returns automatically to 75 per cent after 60 seconds if altered. Separately, the Trust standard operating procedure requires audible alert volumes not to be muted or reduced so that alerts cannot be heard. The procedural requirement and the technical capability should not be confused.

E. Oxevision Observations

28. OxeObs was developed through a proof-of-concept process involving EPUT clinicians and Oxehealth. Its purpose was to reproduce the Trust's observation-recording requirements digitally. Five wards from different service types contributed to the design and testing. My role was to manage the project, coordinate stakeholders, support testing and progression, and manage the route to approval and deployment. Clinical colleagues led the clinical design and acceptance decisions.
29. Oxevision and OxeObs were not introduced for the purpose of reducing the number of observation rounds required for a patient. The level and frequency of observations are clinical decisions governed by Trust policy and the individual patient's care and risk arrangements. OxeObs provides a digital method of recording the observations that staff are required to undertake.
30. The baseline design reflected the Trust's Engagement and Supportive Observations record. Staff use a ward tablet during the observation round. The patient is assigned to the appropriate room, the staff member signs in using the available process, selects the relevant patient and records the observation, including the required location, status and any relevant comments. The observation history provides a chronological record and can be viewed or exported.
31. Executive approval to proceed was given on or about 17 October 2022, after which training and deployment followed. I use "on or about" because I am relying on the project record and my recollection and have not independently verified the exact approval date against the formal decision record.
32. I cannot identify from the material presently available to me the precise first ward go-live date for OxeObs following executive approval. My evidence is that approval was followed by training and deployment across enabled wards.
33. OxeObs replaced the paper observation-recording process on enabled wards. It removed several paper-handling steps, including reliance on paper sheets, later scanning, physical storage and retrieval. My view that this can release staff time is based on removal of those tasks and implementation experience. I do not have a time-and-motion study demonstrating a specified increase in time spent with patients.
34. OxeObs produces observation history reports. These have been distributed to ward managers, matrons, some delegated administrative staff, a restricted-access shared mailbox used for EPR processing, and to me for monitoring the flow of reports. Ward recipients may review the material for local audit. I am not the clinical owner of the observation process and cannot confirm how every ward conducts shift review or clinical audit in practice.

F. Connectivity, platform restarts and Pending Observations

35. Tablet devices depend on the Trust's wireless network to communicate with the local platform. The fixed ward-office monitor has a different connection arrangement. A tablet may therefore be affected by local wireless coverage even when the fixed monitor remains available. Vital Signs measurements taken on a portable device also require reliable connectivity for successful submission.
36. A "Connection Lost" display does not, by itself, establish that the Trust's Wi-Fi has failed. The current Activity Tracker Instructions for Use states that the platform may restart from time to time and that rooms display "Connection Lost" during the restart. It says that restarts typically take one minute but may take up to three minutes. In other circumstances, tablet connectivity may also be affected by local wireless-network conditions.
37. A Room Refresh is a user-initiated restart of the relevant room process where the Activity Tracker has incorrectly determined the location of the occupant or another person. During refresh, the user may see Connection Lost and Acquiring before a new room state is determined. The current Instructions for Use recommends verifying the room state after the process and contacting LIO if inaccurate states recur.

38. During development of OxeObs, the project considered the way staff moved around wards with tablets and between wireless access points. A Pending Observations function was developed so that observation entries could be held during a temporary interruption in connectivity rather than requiring staff to stop recording immediately.
39. My understanding is that Pending Observations are intended to upload once connectivity is restored. I have not located an Instructions for Use document for OxeObs and have not personally tested this function in the live environment. I am therefore unable to confirm from my own knowledge whether the later upload occurs automatically in every circumstance, whether any user action may be required, or the circumstances in which an upload might fail. I also cannot confirm from my own knowledge the maximum period for which observations are held pending upload.
40. Because the behaviour of Pending Observations concerns the completeness of clinical records, the authoritative account should come from the applicable OxeObs technical documentation or confirmation from LIO. I do not rely on the Vital Signs Instructions for Use as evidence of OxeObs behaviour; the products have different workflows. The Vital Signs document states that a failed submission may present a Retry option, but that does not establish how Pending Observations operate.
41. Following concerns at Longview Ward in 2021, investigation identified that wireless access points were positioned above the ceiling in a way that reduced signal strength, including their orientation and the effect of metal ceiling framing. The mitigation work included considering a safe method of improving coverage, repositioning access points to face downwards within approved protective covers, and installing additional access points. A report dated 23 June 2021 was prepared for the Executive Team by David Lawrence, then Associate Director for IT Technical Strategy and Projects and Information Security Manager. I currently hold a draft rather than the final report.
42. The Trust subsequently undertook wider Wi-Fi improvement work at Oxevision sites and installed additional access points where required. The Time to Care wards planned for later installation were prioritised for Wi-Fi improvements during 2024 and 2025. I am not presently aware of recurring Wi-Fi reports from Oxevision-enabled wards, but that is a statement of my awareness rather than evidence that no individual incident has occurred.
43. I cannot presently identify, from the records available to me for this statement, a named Oxevision-enabled ward other than Longview at which a comparable recurring Wi-Fi problem was established. My reference to wider Wi-Fi improvement work should not be read as evidence that every upgraded ward had experienced an Oxevision connectivity incident.
44. Ward staff are encouraged to report suspected platform or connectivity issues through the LIO support route so that they can be triaged to the appropriate supplier or EPUT technical team. EPUT's formal IT route is the IT service desk and Hornbill system. Oxevision-related Datix reports may also lead to escalation. In my role I have frequently been copied into concerns and have followed them through with LIO or EPUT IT.
45. In an earlier draft I referred to keeping Jan Leonard informed where an issue appeared to present increased risk. That reference was intended to describe an escalation or awareness route and not to suggest that she was responsible for the technical investigation. I have not verified her formal role or title from the documents available to me for this statement and therefore do not seek to give evidence about her formal responsibilities.

G. Data, reports, retention and access

46. The platform creates room activity information, Vital Signs measurements when that function is used, OxeObs records and reports, and seclusion reports where that function is enabled. Live room-status information is displayed on platform devices. Reports may be exported or distributed according to the configured process.
47. Routine reports were not created solely for the Lampard Inquiry. They support operational processing, monitoring and audit. Under normal arrangements, records are managed in

accordance with EPUT records-management requirements. Following the Inquiry's preservation requirements, relevant source documents and reports have been retained rather than deleted through the usual lifecycle until the Inquiry advises otherwise.

48. OxeObs information has been retained through the relevant EPR process, a restricted-access shared mailbox used for processing, and a restricted-access SharePoint repository used for preservation and overflow. The shared mailbox has a storage limit, which was one reason for establishing the SharePoint repository. Daily reports are ordinarily processed into the relevant EPR on working days, but I would not treat a target processing time as proof that every individual report was processed by that time.
49. Where an incident or authorised external process requires preservation of video, EPUT may request the relevant material from LIO before it becomes unavailable through the normal refresh process. Examples from my experience include investigations into patient deaths, criminal matters, coronial or inquest work, patient allegations and other properly authorised requests. Preserved material is managed through restricted-access arrangements.
50. CVD obtained by EPUT has been stored in a restricted-access SharePoint repository. Older material was also received on encrypted USB devices that were subsequently archived securely. I have acted as the business owner of the restricted repository. Permanent or temporary access is controlled through the Trust's information-governance and authorisation process. I do not grant access solely on my own authority.
51. External disclosure requests are processed through the appropriate Access to Records and legal or information-governance routes. Where disclosure is authorised, secure transfer arrangements are used. The receiving organisation is responsible for its own retention and destruction requirements after lawful receipt.
52. I understand that LIO personnel may process platform data for authorised support, performance or requested-data purposes, subject to the relevant contracts and information-governance controls. I do not have sufficient technical knowledge to describe access to encrypted data or decryption processes with precision and rely on the Data Protection Impact Assessment, information-sharing agreement, service agreement and CVD procedure for the authoritative position.

H. Development, roll-out and changes in use

53. I was not working for EPUT when the original pilot wards were selected or when the earliest strategic decisions were made. I cannot give first-hand evidence about why the original wards were chosen or how the initial business decision was reached. The last pilot ward, Peter Bruff Unit, went live on 23 April 2020, before my involvement began.
54. By the time I joined the project in January 2021, the subsequent roll-out schedule had already been established. I later supported business cases and scoping work but did not make the executive decisions about which wards should receive the platform. Later, Time to Care wards included Meadowview, Kitwood, Tower, Edward House and Robin Pinto. The seven wards at Brockfield House were considered separately in the context of planned environmental works and the private finance initiative (PFI) arrangements.
55. The core intended purpose of the platform has remained broadly consistent, but staff understanding and the incorporation of individual functions into ward practice have developed over time. Developments have included service-specific configurations, Replay Last Alert, OxeObs, EPR integration, user-authentication work, changes to training and governance, and software upgrades.
56. In my experience, the proof-of-concept and implementation work was effective in enabling clinical and operational users to test workflows, identify practical issues and refine OxeObs before wider deployment. I cannot quantify its effect on patient experience and I cannot identify a single point at which all staff acquired a common understanding of how best to use the platform; that understanding developed progressively through implementation, training, experience, feedback, incident learning and governance changes.

57. Reporting showed patterns of Vital Signs attempts that, in my view, warranted review of how the function was being used. I am not clinically qualified to determine an appropriate clinical frequency. Historically, the reporting did not provide reliable individual attribution, so it could show ward-level activity but not always identify the named person responsible for each interaction.
58. My reference to the volume of Vital Signs attempts was based on LIO reporting that I reviewed, rather than on a clinical threshold. I do not present underlying reports exhibited with this statement and therefore do not give specific numerical examples here. I would rely on the relevant reports for any precise figures, dates or ward-level comparisons.
59. In late 2025, specialist-services staff were required to submit a Datix report where the Vital Signs function was used for a purpose other than taking vital signs. After that change, the number of attempts recorded on those wards reduced substantially in the reports I reviewed. I describe that as an operational observation and not as evidence of the clinical reason for each earlier attempt. I have not located the contemporaneous specialist-services instruction that would allow me to state the exact date or documentary basis of that requirement with certainty.
60. As of 27 April 2026, EPUT was using version 3.1 of the LIO platform. Upgrades have been introduced to improve performance, usability and reporting. I am not aware of an authorised use outside the service agreement, Instructions for Use, standard operating procedure and training. Where patterns have raised governance questions, the Trust has responded through reporting, training, Datix or other controls.
61. In an earlier draft I distinguished some requested changes as “enhancements” rather than “limitations”. I recognise that the distinction can depend on the effect of the issue in practice. A proposed usability or workflow improvement may be an enhancement, whereas a constraint that affects safe or effective use may properly be regarded as a limitation. I do not intend the word “enhancement” to minimise a safety, governance or operational concern.

I. Limitations and mitigations

62. The platform has important limitations. It does not replace clinical observation, professional judgement, therapeutic engagement or emergency response. It is room-based and cannot establish identity. Activity states may be inaccurate where a person is obscured, another person is present, the room arrangement changes, the camera is interfered with or the person is in a blind spot or other unmonitored area.
63. The current Activity Tracker Instructions for Use states that a room state may take up to 40 seconds to update confidently. It also states that no room states or safety notifications are available during certain error or disabled states. Staff must therefore follow the standard operating procedure and not rely on the platform as the sole means of assessing safety.
64. Changes to a room layout, including significant movement of a bed or large furniture, can affect performance. LIO must be informed of significant physical changes so that the configuration can be reviewed. Training and the standard operating procedure reinforce this requirement.
65. The In Bathroom limitation involving a second person has been included in supplier guidance and Trust governance. The mitigation is not an assertion that the product can always correct the displayed state; it is that staff are warned about the limitation, must respond physically where required and should not rely on the affected room state in the circumstances described.
66. Historically, platform interaction could not always be linked reliably to an individual named user. EPUT is implementing LIO User Authentication using organisational single sign-on for protected functions. A reliable audit trail is important because it can support investigation of unusual use, distinguish user actions from technical events, improve accountability and enable more targeted training and supervision. The roll-out remained phased in August 2026.
67. The Pause function is not currently active at EPUT. The current Activity Tracker Instructions for Use describes it as temporarily turning off the camera for a configured period, during which room states and safety notifications are unavailable, before the room automatically resumes. I

have recommended a clinical and governance review because temporary limitation of monitoring may support privacy and dignity in defined circumstances, but it also introduces safety and visibility considerations that must be assessed before implementation.

J. Training and competency

68. From the beginning of implementation, the Trust's position was that staff should be trained before using Oxevision. The method of delivering and evidencing that training changed over time. During earlier phases, Oxehealth delivered Microsoft Teams sessions for wards approaching go-live. Recordings were made available to support local cascade and staff who could not attend a live session.
69. OxeAcademy became a primary training source from December 2021. The knowledge element later moved into the Electronic Staff Record and Online Learning Module environment as course 364 LIO Platform (formerly Oxevision), on 27 April 2026. The current Vital Signs and Activity Tracker Instructions for Use also state that users must be trained before using those functions.
70. The distinction I draw is between a requirement that a person be trained before use and the later status of LIO training as a centrally tracked mandatory-training requirement. Centralised completion records are available from October 2023. My recollection is that LIO or Oxevision training appeared in the ESR mandatory-training tracker for relevant inpatient and bank staff around February 2024, but I have not located a contemporaneous document confirming that exact date and do not present it as certain.
71. Oxevision platform training covers the introduction to the platform, Vital Signs, activity, alerts and warnings, reports and configured service features. OxeObs training covers assigning a patient to a room, transferring or removing a patient, recording an observation, viewing or exporting observation history, and managing observations during low or absent Wi-Fi connectivity.
72. Training has been delivered online, through recordings and local cascade, through OxeAcademy or ESR learning, at go-live and through later refresher visits. During January and February 2024 [I/S], Trust Quality Matron, and I delivered refresher sessions across a number of EPUT inpatient sites, including Rochford Hospital, Basildon Mental Health Unit, The Lakes, St Aubyn Centre, the Derwent Centre, the Linden Centre, Thurrock Hospital and Brockfield House. These were site visits and were not intended to imply that every Oxevision ward was visited.
73. Those refresher visits took place during January and February 2024. I have not located a complete attendance record that would allow me to state reliably the exact number of individual sessions delivered at each site, whether every Oxevision ward at each site was visited, or a fixed repetition interval. My earlier reference to good attendance by ward managers and staff nurses was not intended to imply poor attendance by more junior nurses, healthcare assistants or support workers, and I cannot make that comparison without attendance records.
74. Competency checklists are local records of demonstrated knowledge and skills. They are maintained by wards rather than in a single central repository. Wards are expected to audit training and competency through their local assurance arrangements, including Tendable where available. I do not know the date on which the relevant Tendable audit first became available and cannot confirm the consistency of local audit practice across every ward.
75. In my opinion, the training was appropriate for teaching how to use the system, particularly because it is visually oriented and practical. I consider that practice using a safe simulation or dummy environment could strengthen learning. I am not qualified to determine the adequacy of the wider clinical education that underpins observation practice, NEWS2, capacity, consent, privacy, dignity or safeguarding. Those matters sit within professional standards, Trust policy, mandatory training and clinical competency.

K. Consent and patient objection

76. My contribution to versions of the LIO standard operating procedure has principally involved project coordination, technical confirmation and editing. Clinical colleagues, including Trust Quality Matron [I/S] and senior clinical or governance colleagues, determine the clinical process. I do not present myself as the author of the Trust's legal or clinical consent policy.
77. At the time of preparing this statement on 21 August 2026, SOP version 13.4 was due to be implemented on 24 August 2026 and was intended to introduce changes to the consent process. The historical account below is based on SOP version 12.8.8. I distinguish that historical position from the intended later process because the latter had not yet taken effect at the date of this statement.
78. Under SOP version 12.8.8, a patient with capacity was to be informed on admission about the use of Oxevision on the ward and provided with a patient information leaflet. The discussion was to be documented in the patient record, which might include the admission checklist, care plan, referral documentation, case notes or a combination of those records.
79. A patient could object to the platform being active in their room. Where the agreed immediate response was to switch the room off pending later review, the platform was capable of being switched off without waiting for the subsequent multidisciplinary team meeting. The Nurse in Charge was responsible for escalating the objection for multidisciplinary review and ensuring that the decision and discussion were documented in accordance with the SOP.
80. The later clinical process, including capacity, best-interest decision-making, review and any decision to switch the platform back on, is governed by the Trust's SOP and clinical decision-making. I can describe the technical capability to switch a room on or off, but I do not determine the clinical or legal basis on which that decision is made for an individual patient.
81. For several iterations of the SOP, the Trust used an implied-consent approach. During the 2026 review, the Trust developed a more explicit written process. The discussions included patient information and signature, nursing and medical accountability, out-of-hours decisions, repeat consent, withdrawal, best-interest decisions, the relationship with care planning and the circumstances in which the form should be used. The Quality of Care group agreed the consent form on 10 August 2026. My account of those discussions arises from my participation in the project governance process, not from legal or clinical expertise.
82. Subject to confirmed implementation, SOP version 13.4 was intended to introduce an informed written-consent process from 24 August 2026. This later process should not be described as if it applied throughout the earlier Relevant Period. Equally, the historical process should not be described in the present tense once it has been replaced.

L. Recommendations

83. Contactless room-state or activity information may, where clinically appropriate and permitted by the patient's observation plan and Trust procedure, allow staff to obtain information without entering the bedroom solely to obtain that information. This may reduce disturbance to a sleeping patient in some circumstances. It does not remove the requirement for physical attendance, direct observation or therapeutic engagement where the observation level, risk, clinical condition or Trust policy requires those actions.
84. Technology should support patient care, safety, accountability and proportionate reduction of administrative burden. It should be used as an adjunct to, and not a replacement for, clinical assessment, observation and therapeutic engagement.
85. I recommend completing individual User Authentication across all enabled wards. Reliable attribution can support investigation, governance, targeted learning and distinction between technical events and user actions.
86. I recommend clinical review of service configurations, including the EPUT threshold used for In Bathroom alerts, so that configuration remains proportionate to the risks and patient population

of each service. Any change should be clinically authorised and assessed against the applicable Instructions for Use and standard operating procedure.

87. I recommend that any implementation of a Sleep function be clinically evaluated, include patient engagement and be used only as an adjunct to clinical assessment. Contactless information may in some circumstances reduce disturbance to a sleeping patient, but it does not remove the need for physical attendance or engagement where the observation plan, risk, clinical condition or Trust policy requires it.
88. I do not have an approved Instructions for Use document for a Sleep function among the product documents on which I have relied for this statement. My recommendation concerns a proposed function intended to provide information about a patient's sleep over time. I therefore do not give a more detailed technical description of that proposed function than is supported by approved product documentation available to me.
89. I recommend a clinical and governance review of the Pause function before any implementation. That review should consider privacy and dignity, the circumstances and duration of a pause, how the pause is made visible to staff, the temporary absence of room states and safety notifications, and safeguards for resumption.
90. I recommend clearer national guidance on consent for contactless patient monitoring. My view is based on professional experience of continuing clinical, operational and governance discussion at EPUT about how consent should be obtained, evidenced, reviewed and withdrawn. I am not relying on an academic literature review and I am not clinically or legally qualified to determine the national standard.
91. Continued collaboration between patients, clinicians, technology providers, information-governance specialists and operational teams is important so that new functions are assessed fairly, limitations are understood and changes are implemented only where there is appropriate evidence, governance and benefit.

M. Statement of truth

I believe the contents of this statement to be true.

Signed:

[I/S]

Derrick Sterling Trimble

Dated: 21 August 2026