Wednesday, 14 May 2025

HEARING IN PRIVATE

(10.55 am)

THE CHAIR: Good morning.

MS TROUP: Could we have the oath, please.

HAT PORTER (affirmed)

Questioned by MS TROUP

THE WITNESS: I only have truth as far as I know, like I don't know everything. But what I say will be what I know -- I will be true to what I know.

THE CHAIR: So before I ask Ms Troup to take you through your evidence, I want to say a few words. You have attended today to provide evidence on behalf of the organisation Stop Oxevision and I am grateful to you for attending and for sharing your evidence.

The Inquiry is receiving your evidence live in a private hearing. It's the intention of the Inquiry that the witness statement which you have provided to the Inquiry, together with a recording of your oral evidence today, will be made public in due course, once the Inquiry deals with the evidence of Oxevision at a later date.

I want to stress that your evidence is of no less importance because it's given in this private format.

May I though remind everybody in this room that

there is a restriction order in place which requires this evidence to be private until that later date.

As I believe has been explained to you by my team, there may be instances where the Inquiry may need to redact areas of your evidence. These include any restriction order which may be in place or under the Inquiry's Privacy Information Notice. Where that does occur, these will be to the minimum, as is required, and my team will liaise with you and your legal team.

Now, I look forward to hearing your evidence.

A. Thank you for confirming that.

THE CHAIR: Ms Troup.

MS TROUP: I am going to start you by asking you, please, to state your full name for the record.

A. Yes. My name is Hat Porter.

Q. I understand that throughout your evidence today you would like to be addressed as Hat -- is that right --

A. Yes, please.

Q. -- and that your pronouns are they/them?

A. Yes, please.

Q. Good. Now, Hat, you are giving evidence today on behalf of Stop Oxevision, which is a national campaign, as we understand it, made up of a network of both current and former NHS inpatients --

A. Mm-hm.

Q. -- who volunteer their time towards that campaign. I am going to summarise what I understand to be the main aims of that campaign, you must stop me and correct me if I give that summary badly, or I miss something important out?

A. Okay.

Q. We will come on to more details about the campaign but, for now, for an overview for those watching, is this right: one of the principal aims is to raise awareness of the harms that can be caused by the use of Oxevision technology in mental health inpatient wards; is that right?

A. Yes, I can expand a little on that but perhaps will wait until you have kind of through the other things first and I can just give a little --

Q. Absolutely. This is a short introductory summary so that those watching have an idea of what the campaign is and what you are about?

A. Yes.

Q. The campaign calls, in particular, for greater oversight of the use of Oxevision, and similar technologies in inpatient facilities, and my understanding is that, as part of that, the campaign works to collect and collate firsthand accounts from inpatients as to the use of that technology and the impact of it.

A. Yes.
Q. Is that a fair summary?
A. Yes, so that is a fair summary. So I would just add a couple of points. So we have kind of named the campaign group "Stop Oxevision" but we do kind of have more broad concerns around other kind of surveillance devices and systems used in hospitals as well. So that includes CCTV cameras, that includes body-worn cameras. There are also other systems. There's one that's called Care Protect and kind of various other --
THE CHAIR: What is that other one called?
A. It is called Care Protect --
THE CHAIR: Thank you.
A. -- and it was previously used by the Priory but we have found it very difficult to kind of get so much more information about it.

So, in that sense, we have kind of named it Stop Oxevision because, not wishing to be marketing for them, but they are kind of, like, the -- you know, the most prevalent one across --
Q. The principal?
A. Yes, but our concerns are kind of broader than that.
Q. Yes.
A. But one of the other things that I would say is that, whilst we focus on Oxevision, we do feel that this is

a -- it's not a kind of like isolated example and our concerns kind of extend to, more broadly, how new kind of technologies and "innovations" and things are kind of rolled out without due scrutiny, consideration of the legality, without a lack -- without evidence.

Q. That's very helpful. Thank you.

Can I ask you, Hat, I'm sorry, to move the microphone a little bit closer towards you?

A. Which one?

Q. Either, I think. Just because I understand, I am being advised, it is coming up a little bit quietly.

A. Okay. That's fine. I'm sorry, I move around a little bit so if I move away I can come back.

Q. That's no problem. I will remind you if you are coming away from it.

A. Thank you.

Q. That's really helpful, thank you. Just to set matters in context now, in terms of today's evidence, by way of background, as part of its work, the Inquiry sent to Stop Oxevision a Rule 9 request under the Inquiry Rules and you provided a witness statement in response to that request?

A. We did, yes.

Q. For those that may be following, the witness statement you provided is at page 1339 of the core bundle that's

been disclosed. It's 31 pages long and I see that you have a copy of it in front of you.

A. This.

Q. Good. If we can have a look at page 31, that's the very end of the statement, we can see that statement is dated 24 March 2025, yes?

A. Yes, yes. I have got the unsigned version printed but yes, I think so.

Q. Yes, so the version that you have and that I have, and that all those to whom it's been disclosed will have, in fact has your name blanked out and that is because, at the time that this witness statement was disclosed, there was a restriction order in place, in respect of your name, which has now been lifted?

A. Yes.

Q. So in those slightly odd circumstances, can you, an obvious question but can you confirm that this is your witness statement and was signed by you?

A. Yes.

Q. Thank you. I am going to ask you questions about your witness statement and we will go through it but I am not going to take you through it line by line --

A. Yes, that is fine.

Q. -- because it stands as your evidence to this Inquiry already.

A. That's fine.
Q. Last, by way of background, to make absolutely clear, as the Chair has already explained, your evidence is being recorded today on Wednesday, 14 May, following the receipt by the Inquiry last Friday -- so Friday, 8 May -- of a second witness statement from EPUT in relation to the use of Oxevision technology, that neither you nor your legal representatives have had time to consider in full; is that right?
A. Yes. I mean, I spent the whole weekend going through it but I have not had enough -- enough time.
Q. No.
A. But, yes.
Q. I understand and, for that reason, your evidence today will focus on your witness statement that was made on 24 March and, principally, Hat, on the concerns that you have raised on behalf of the campaign in relation to the use of Oxevision and other vision-based monitoring systems, as you have already explained.
A. Yes.
Q. What I would like to do, please, is take you first to paragraph 1.4 of your witness statement, which is at the bottom of the first page and, to set your evidence in context, I want to take you through what you said here about what Oxevision is.

So if we look at the second line --

A. Yes.

Q. -- halfway through the second line, you say there:

"Oxevision is a vision-based patient monitoring system which requires infrared sensitive cameras to be installed in inpatient bedrooms on mental health wards. These cameras constantly record footage of patients in their bedrooms and the system enables staff to remotely view patients in their bedroom at any time, via a tablet or screen located on the ward."

Yes?

A. Yes. That is correct. So it is -- has kind of a few different functions, in that it is a video camera and allows kind of footage of patients in their bedrooms or within seclusion rooms to be recorded.

Q. Yes.

A. It does also take pulse and breathing rate measurements.

Q. Yes. Thank you. You have set that out very helpfully at paragraph 1.5 on page 2 of your statement. You explain there that the technology measures pulse and breathing rates. But you also explain, and this is important, I think, to set it in context, what the technology doesn't do, what it can't do?

A. Yes.

Q. So you help us to understand that there that it can only

give, you say, medically reliable results when staff do a manual spot check, when the person is lying still with sufficient exposed skin for that to occur --

A. Yes.

Q. -- and if there is only one person in the room?

A. Yes.

Q. So if there's more than one person in the room the system can't take those vitals; is that right?

A. Yes, that is correct, and I would also just add something that we haven't put in our statement but that is in some of the other witness statements, is just to emphasise that it only gives a reading of pulse between 50 to 130 beats per minute, which if somebody's pulse was lower or higher than that, as far as I know, it wouldn't give a reading at all.

Q. I understand. So as far as you are aware, it can only give a reading within that range?

A. Yes.

Q. That's helpful, thank you. In terms of the operation of the system, again, you have summarised it very helpfully for us at paragraph 1.6, which is at the bottom of the page, where you tell us this:

"Depending on which alerts are enabled on the system, staff can receive notifications if the patient is in the bathroom, out of the room, at the door, on the

edge of their bed, out of bed, or if another person enters the room."

You also explain there that:

"Data that is collected can be then pulled into a graph to measure activity and make comparisons, for example ..."

The example you give is how long someone is spending in the bathroom because, obviously, the technology doesn't operate in the bathroom, right?

A. Yes. So that's correct. So the -- yes, it kind of generates these like activity reports, which sort of show the like frequency that somebody -- like, the number of times someone goes to the bathroom --

Q. Yes.

A. -- and also kind of the duration of time spent in there, which is quite a personal thing.

Q. Yes.

A. And also the kind of, yes, periods of sleep someone has.

Q. Periods of activity or inactivity, and so on?

A. Yes, I think, like, the kind of time someone's asleep.

Q. Yes. You also explain here, which I think is important to understand, that the way in which the alerts are set up can be customised by the particular Trust that is using them, so different types of alerts can be used or not used, essentially; is that right?

A. Yes. So I think, within some of the older adult wards, I think some of those systems have an additional function which alerts to if the person is at the edge of the bed.
Q. Yes.
A. And, as far as I am aware, these kind of alerts aren't activated for all wards. That would just be for some specific wards.
Q. Is your understanding, in the example you have given, in relation to older adult wards, that that alert might be set as some sort of preventative measure in relation to falls?
A. Yes, as far as I'm aware.
Q. Yes.
A. Obviously that does rely on staff then kind of responding.
Q. Acting on, yes.
A. And I would just also mention that there are quite a number of different technologies and products which can assist in management of fall risks. So, for example, you can have a bed sensor mat which would do a kind of equivalent function, obviously without a camera.
Q. Yes.
A. So, in that sense, we will come on to this later, but

one of the really important principles within the Mental Health Act and within the Mental Capacity Act is kind of the least restrictive option.

Q. Yes.

A. And so one thing that we have kind of thought through the campaign is that if -- that there are other ways to manage falls risk which might be less intrusive than having a video camera recording somebody.

Q. Yes, that is helpful. Thank you.

A. Yes.

Q. Going back to paragraph 1.6. You explain at the end that, obviously, alerts can be raised, they can be customised, as we have just discussed, and the purpose of those alerts is to bring the attention of staff to potential risk?

A. Mm-hm.

Q. You say at the end, in the last two sentences:

"When an alert is raised for a room, the tile on the displays turns red and there is a pop up in an alert box at the side of the screen. An audible message plays repeating 'Oxehealth alert', until the alert is manually reset."

So just for the benefit of those who are perhaps not familiar with this technology, what you are talking about is what appears on the screen in front of the

member of staff, yes?

A. Mhmm.(The witness nodded)

Q. When you say "manually reset", just help me: in order for that alert to stop alerting, the member of staff would need to physically do something to turn it off; is that right?

A. Yes, to my knowledge. And I might just take a pause here and -- to explain I was very, very nervous about making the oath because the information and the understanding that we have is so limited because of the lack of transparency from providers, from Oxehealth, about exactly how the technology works.

Q. I see.

A. So it very much feels like we are kind of trying to piece things together to the best of our knowledge. But in many ways what is presented feels like it's kind of intentionally very obscure.

Q. I see.

A. So what I can kind of offer is the best of my understanding from what I have been able to piece together. However --

Q. Understood.

A. -- I --

Q. But, Hat, that is what is most helpful to us.

A. Okay.

Q. You can only offer us your own knowledge and understanding and that is what is of value.

A. Okay.

THE CHAIR: Can I ask: have you personally been subject to observation via Oxevision?

A. No, I haven't. So myself I have had -- kind of became involved in the campaign through my own experiences of treatment in mental health wards. But I -- the, like, Trusts in my area don't use Oxevision, so it's not something that I have, like, personal experience of. Other individuals within our kind of core campaign group do.

THE CHAIR: Thank you.

A. Yes.

MS TROUP: In terms of the functionality of Oxevision, it is very helpful that you have explained that there is actually -- the knowledge that you have is perhaps sort of pieced together from what you can glean. But before we move on, is there anything else at all that you would like to add about the functionality of this technology: what it can and cannot do, how it works?

A. Yes. So again, this is really, like, challenging to pin down because there is a lot of misinformation and a real lack of clarity about some of these things. So what we have heard from our accounts from patients, who have

kind of explained their experience and explained the information they have been given, there's real inconsistencies, people have been told that it's kind of not a camera or -- and we might come on to this later.

Q. We will.

A. -- but, yes, some the kind of -- or what I perceive to be deliberately obscure language, using terms like "optical sensor" or "infrared sensor", and things, which don't explicitly kind of discuss the camera, has led to kind of misunderstandings. There is also quite a few sort of caveats to how the actual technology works.

So one example, in relation to the alerts, is that if -- the technology can't distinguish between different human beings. So if a person -- if a patient is in the bathroom, an alert says "Patient has been in the bathroom for more than three minutes", and then a staff member enters the room. It does -- it's not able to distinguish that that's a staff member entering, in comparison to the patient leaving, and I believe that if, hypothetically, the patient's in the bathroom, staff member walks into the room, then leaves the room, it might then show the room as being empty.

Q. Yes, I understand.

A. Yes.

Q. That's helpful, thank you.

A. I also think if -- the other caveat is that, if somebody walks -- comes into the room but goes straight into the bathroom, it doesn't necessarily register it, so it might still show empty room.

Q. It might miss that?

A. So those are some of the kind of caveats, in that sense. There are also a sort of -- so the technology kind of works, it has sort of multiple elements and because it -- so there's obviously the video camera function and the alerts functions.

Q. Yes.

A. The way it reads pulse and the way it reads respiration breathing rate is slightly different. So for breathing rate, I believe, if somebody is fully covered by, like, bed covers because that detects movement, it might still be able to kind of detect that. But with the pulse, this works by using a process called photoplethysmography, which is kind of -- it is basically looking at the different like absorption of, like, the light and how that changes as somebody's heart beats and kind of -- that's from my very crude understanding, I am not an expert.

But that means that there needs to be, kind of like, sufficient amount of skin for it to be able it take that. So if somebody was fully covered by bed covers,

it wouldn't be able to take the pulse.

Q. Yes.

A. Additionally there are some other things where it's not able to -- it's not able to read. If someone has, like, heavy scarring or tattoos, which would include me, it --

Q. It might affect the --

A. Yes, it would affect -- or if somebody had poor circulation or was wearing lots of make-up, I think, and -- where was I going with that? Oh, yes, and then the other really big caveat is that the person is required to be still.

Q. Yes.

A. So where the technology is kind of used through the day, it's quite unlikely that the person will be still enough for that reading to be taken and if I -- if I may be allowed just to refer to one of the exhibits, I can't remember whether it was -- I think it was submitted by Oxehealth but it is the monthly usage reports.

Q. Right.

A. And they kind of show both the kind of numbers of times that, like, vital signs have been accessed or attempted.

Q. Yes.

A. But one of the other things it showed was the kind of -- the amount of times vital signs were attempted and the amount of times they were actually read.

Q. Yes.
A. And that was only for one of pulse or respiration rate, and so one of the wards -- I know that was Ardleigh Ward I think the percentage was around 26 per cent of the time, the vital -- only at least one of the vital signs was actually showing, which I think is quite important in emphasising because there's often this kind of discussion from trusts and from the company who market this product that, you know, it is all about these vital signs.
Q. Yes.
A. But, actually, if we are hearing that so infrequently it's actually able to take that, it slightly undermines that suggestion.
Q. Yes, I see. That's very helpful. Thank you.
A. And can I please add just one other thing about that?
Q. Absolutely, please go ahead.
A. And this is slightly something that I picked up from the more recent witness statement from EPUT, but has kind of, you know, continually been kind of prevalent in the narrative about the kind of benefits of Oxevision, is the kind of, like, value of this technology in terms of monitoring patients' physical health. But I guess the two kind of points to raise there is: (1) it's useful to know somebody's pulse and it is useful to know

somebody's respiration rates but these only are -- that can only tell you so much about somebody's health. So when there are phrases like "it allows us to confirm that patients are physically well", obviously that's quite concerning because somebody could be extremely unwell but these pulse and respiration rates are showing as kind of within the normal range.

Q. Yes.

A. Particularly with the technology only kind of showing the pulse between 50 and 30 -- 50 and 130 beats per minute, if you have a look at a NEWS chart, a National Early Warning Signs chart, you can kind of see that actually those parameters kind of exclude the areas that you would be most concerned.

Q. Yes.

A. Below 50, you would be concerned about bradycardia and, obviously, like, a pulse of 120 is not very good, but like -- I don't know what mine is right now but it's probably quite high, so!

Q. Take your time, take your time.

A. Yes.

Q. So I understand. So the range then means that areas that would perhaps be of most concern fall outside of it?

A. Yes, I think so. And the other thing just to point to,

and I am really sorry I can't remember exactly which of the exhibits, but it's one of EPUT's exhibits.

Q. Yes.

A. And it relates to their policies and it shows that, even whilst using Oxevision, they still have a requirement to do a set of manual physical observations --

Q. Yes.

A. -- in addition, and that would be using a pulse oximeter, which takes both oxygen saturations and pulse at the same time, and then, yes, the respirations would be done by kind of a staff member kind of manually counting someone's breaths.

So whilst, you know, there is a lot of kind of marketing and narrative around the technology as being valuable and kind of confirming patients' physical health, we need to be kind of cautious to not overstate the value of these measurements and also to emphasise that they are -- even the trusts themselves are aware that they still need to kind of do the manual --

Q. Alongside?

A. Yes.

Q. Yes.

A. Yes.

Q. That's very helpful, thank you. I want to ask you something about -- you tell us, if you look at the top

of page 3 of your witness statement, please.

A. Yes.

Q. One of the things that you tell us there, talking about Oxevision technology in general and how it began and how it grew and the rapid growth in its use.

A. Yes.

Q. One of the things you tell us is that it was not originally marketed for the purpose we are now discussing. I think, actually, you go on later in your statement -- we don't need to go to it -- to note that this technology was not initially marketed or designed for use on mental health inpatient wards. You mention there --

A. Yes.

Q. -- police custody suites and baby monitors.

What, in the view of the campaign, is the concern about that, if there is one? Perhaps a better question is: is there a concern about the fact that the initial purpose of this technology was not use in mental health inpatient facilities?

A. So from what I understand, it was kind of originally this -- you know, there was a kind of invention of this technology. But from kind of piecing together the timeline, it's quite clear that it was not originally intended to be focused on mental health wards.

Now, in and of itself, it's not an inherently evil thing to kind of create a technology and sort of spend some time working out the best usage for that. But we do have concerns. So one of them is that it kind of is marketed and kind of, I think, in some of the other witness statements, we have got sort of statements about how it was designed for inpatient mental health units, which --

Q. That's right, actually. We don't need to go to it but Zephan Trent in his first witness statement for EPUT does tell us -- for the record, I think it's at page 1301 of his statement, at paragraph 9 -- what he says is that Oxevision has been designed specifically for mental health care.

You would disagree with that, would you?

A. Yes, I would. So I would say that that isn't accurate. It was originally kind of created and then trialled in quite a few different settings and, if you go on the, like, Internet Archive Wayback Machine and look at Oxehealth's, like, original website, they had kind of -- I can't remember what it was called, it was, like, application consultants or something. So they had various different people who were advising about the different sort of settings that this technology might be used for.

If you also look at kind of -- yes, going back to some of those archived webpages and things, you can also see that the intention was originally for the technology to have, like, additional functions. So one thing that they looked into was adding a oxygen saturations function, adding temperature, adding potentially -- no, I am not sure if I am remembering that correctly, so I won't say that.

Q. That's all right.

A. So, yes, and kind of trialled it in sort of acute -- physical acute hospitals, neonatal intensive care, and things like that.

Q. Yes.

A. I think the sense that that kind of illustrates to me is that they realised that they couldn't quite get the technology to do exactly what they wanted it to be able to do, in terms of being able to kind of add all of these additional functions. If you look at the -- I believe it would be in the kind of Oxevision Service Use Manual, it kind of does identify that the -- oh, and the MHRA -- the Medicines and Healthcare Products Regulation Agency --

Q. Yes.

A. -- it kind of identifies that it should not be used for patients who are kind of, like, very clinically unwell,

or things like that. So I think, yes, in that sense, it is kind of important contextually that it wasn't specifically designed for psychiatric wards but it felt that it was a kind of population that occurred to them and a sort of use for the product that they identified.

And I think, if I may be allowed to say something which is based in my kind of sense and interpretation of that, is that patients in -- like, disabled people, patients in psychiatric hospitals, are put in such positions of vulnerability in having kind of rights sort of stripped away, whether that's through being detained under the Mental Health Act, whether that's through a kind of like societal disregard for disabled people and our rights as disabled people, and I think the sense that we have got is that, as "mad" and mentally ill people, we become a kind of convenient group where, in other cases we, through the campaign, have felt that there might be more outrage about this, if it was happening to a kind of different kind of population of people, and that we kind of face --

Often people say, "Oh, but I just thought you would have cameras in hospitals anyway, like, I didn't realise that that wasn't a thing". But I think it kind of speaks more broadly to a sense of how the lack of -- you know, the way that our rights are stripped away is kind

of accepted and not challenged so much.

So that's kind of one of the concerns that we have, is that they have -- and it is -- Oxevision is still used in some police custody suites.

Q. Yes.

A. And also within the kind of like extra -- like, I don't know the term for it really, but a kind of like medical wing of prison. So it is very much this kind of selection of people who have had rights removed and that's kind of something we will get on to later when we talk more about, like, consent and the sort of legality and things like that.

Q. Yes.

A. But ...

Q. I think later, we will come on to that, and I think, would it be fair for me to say, that your concerns in that regard about this particular population who may have had rights stripped away already, that actually also there's a vulnerability, in that the voices of that population might not be as loud for various reasons as of others?

A. No, the voices are loud, they are just not listened to.

Q. That may be a better way to put it --

A. But, yes.

Q. -- a much better way to put it.

A. Otherwise, yes.

Q. Can I ask you something now -- thank you, Hat.
I understand -- we don't, I don't think, need to read it because you have explained it beautifully -- but the Stop Oxevision campaign emerged from conversations amongst current and former inpatients; is that right?
A. Yes.
Q. It was founded in 2023?
A. Yes, "founded" feels a little -- a little too formal a term.
Q. Too formal. It began, maybe?
A. But yes, that is kind of when we began and I kind of amusingly remember really trying hard to not get myself dragged into another campaign. But, yes, that didn't happen. That didn't work out obviously!
Q. Here you are.
A. Yes. So I think I would like to, on that point, just speak to kind of -- I, yes, am very grateful for the opportunity to be giving this evidence but I also think it's very notable that it is our campaign group, Stop Oxevision, that have kind of done this work and have kind of developed the expertise that we have and kind of contributed to the changes and practices that we have. It's us --
Q. Yes.
A. -- it's not the kind of institutions who are charged

with regulations or oversight, you know. And we have heard in the previous hearings there was kind of discussion about the different kind of -- the different regulatory bodies and things and, honestly, I was more confused after watching all of that. And I think it, like, really just speaks to how there's this landscape of such an obscure and poorly-coordinated system of different providers, where there is a lot of, like, "We're not going to look at that because that's someone's else job and they are going to do that", but in the space between that, there are gaps where people are -- you know, patients, disabled people in hospitals, are left in real risk.

And so that is the space that our campaign has come from, out of the necessity --

Q. Yes.

A. -- because if we didn't do this nobody else was going to do it.

Q. Yes.

A. And I think that's something that's really, like, important to recognise because, whilst, as I say, I am, you know, glad that we are here to be able to do this, it's not a sort of sustainable way for our Health Service to be kind of held to account by bereaved families and patients, disabled people, people with

lived experience.

Q. Yes.

A. And --

Q. Yes, I understand. I think this is one of the reasons -- so that's very helpful. I'm interested to know -- so we have talked a little bit about the fact that part of the campaign's activity, a very important part of its activity, is to collect and collate firsthand experiences.

A. Yes.

Q. Could you tell us, just a little about how that is done, about the approach to doing that?

A. It's kind of more been through people kind of reaching out to us, people who are -- you know, sometimes we get emails from people who are currently on wards and are not sure, you know, how to navigate advocating for themselves --

Q. I see.

A. -- and that sort of thing. People who are kind of wanting to be able to share their experiences and the harms we face, so we do kind of use social media to have these conversations and to connect with people. Really sadly, through the campaign, some people have kind of also only learnt from the campaign what the weird box in their bedroom was and they have been so ill informed

about it that it was not through, you know, what it should be, like, you know it being explained on the ward. It was after that they were, like, "Oh, I didn't realise".

Q. Yes.

THE CHAIR: Do most people get in touch with you while they are on a ward or do they wait until after they come out of an institution?

A. I think a little bit of both and also lots of people kind of, you know, are in and out -- in and out of hospital, so might kind of contact at a point when they're in hospital and then get discharged and then get readmitted, and things like that. Yes.

MS TROUP: I would like to move, if you are happy to do that now, to the section of your witness statement which takes up the larger part of it, in which you take us through, very comprehensively, the major concerns of Stop Oxevision.

So just to give an overview, again to set it in context and for those watching or listening, you list those at paragraph 3.2 of your witness statement on page 6.

A. Yes.

Q. I will just read those so that there is a general overview. You say that the concerns can be broadly

divided into the following categories: privacy and consent; impact on patient mental health; staffing issues; lack of oversight; discrimination and disproportionate impact; and then, last, you have a section in your witness statement about research that has been analysed thus far.

A. Yes.

Q. So what I would like to do, I don't want to go through each concern line by line, but I would like to ensure that you have had the opportunity to explain each, in as much detail as you see fit, and also to expand on any of those concerns or give any further information?

A. Yes.

Q. We will take them in turn. So if we start with privacy and consent?

A. Mm-hm.

Q. You say -- and I am paraphrasing and you must interrupt me at any time, Hat.

A. Okay.

Q. At paragraph 3.3, you explain that, having a camera in a patient bedroom represents a very significant invasion of privacy. So that's the starting point of this concern.

A. Yes.

Q. You go on to observe in the next paragraph that a bedroom is ordinarily intended as a place of privacy?

A. Yes.
Q. But that, as a result of the use of this technology, it can provide no sanctuary to that patient from observation?
A. Yes. So, yes, one of the things that's just kind of -- is, yes, just frustrating at times in this campaign is that, like, nobody wants a camera in their bedroom that's, like, intrusive and sometimes, like, it just feels wild that people, like, don't quite understand that concept.

The -- so a lot of the kind of marketing materials and sort of, yes, the language that the Trusts use in relation to this is kind of saying that, actually, Oxevision kind of improves privacy because it might be used then in replacement of kind of having a staff member, so on one to one, having someone there all the time --
Q. Yes.
A. -- or kind of intermittently checking.

But I think there are a few things to note. So (1) if there is a camera, you have no way of knowing when somebody is looking at that and, obviously, that means that -- yes, like, so normally when I have been on wards, you can kind of predict when the staff are coming to do a check, so you can, like, plan when you are going

to get changed, plan when you are going to -- yes, because --

Q. Organise your activities around?

A. Yes, yes, so that you can kind of maintain that and, obviously, if a staff member kind of walked in and you were, like, getting dressed or something you would be aware of that.

Q. Yes.

A. However, with Oxevision, there is no way of knowing when somebody is looking at that. So it kind of instills the sense that, although someone isn't necessarily permanently looking, there is always the potential. So it kind of -- yes, it is that sort of -- the, like, kind of panopticon and that sort of sense of instilling this constant sense of surveillance.

And that's where we have had kind of accounts of people and you know we have got our patient experience table, which will be considered subsequently, and I won't go into examples but, you know, where people have gone to great lengths to sort of hide from the cameras because they are so sort of impacted by this sense of just having that there sort of always potentially watching.

Q. Yes.

A. And, yes, I guess the quotes here people described it as

intrusive, undignified, dehumanising and traumatising.

Q. Yes, and those are from accounts that you have received as a campaign from inpatients?

A. Yes. Yes.

Q. Do you consider that there are any steps that could be put in place -- just thinking about this general concept of the intrusion and the invasion of privacy that you have described, do you consider that there are any steps that could be put in place, if not to secure adequate privacy at least to improve the impact on patients?

A. I mean, it would probably help to not have a camera in the bedroom.

Q. Fair enough.

A. Like, yes. And, as well, if I might add at this point, because of the layout of some of the bedrooms, and this is specifically relevant to Essex, we are aware that some of the cameras are able to see, like, the bathroom door area and in mental health wards they don't tend to put proper doors on the bathroom, so there are kind of.

THE CHAIR: In Essex or elsewhere they don't put proper doors on bathrooms?

A. Oh, it is kind of like a general thing, like most wards. So you will either have, like -- sometimes it's a kind of like half door and sometimes they might have, like, a curtain. Sometimes they just take the whole door and

there's no -- there's no door to the bathroom, or they also have these -- I don't know how to explain it, it is like a saloon, yes.

MS TROUP: A saloon?

A. Like, you know, the little --

THE CHAIR: Swing doors?

A. Yeah, swing doors.

MS TROUP: Like a cowboy film,

A. Yeah but then they fall off.

MS TROUP: as we are going into the bar in a cowboy film? I know what you mean.

A. Yes.

Q. Oh, that only cover a certain section of the door --

A. Yes.

Q. -- but not the bottom or not the top?

A. Yes, that's it.

Q. Saloon is a very good description.

A. Yes, it's really -- yes, I mean, it's one of the things that you have to spend a lot of time on a mental health ward to understand.

Q. Yes.

A. But, yes, because of that, some of the Oxevision cameras are then able to kind of see, as far as we are aware, kind of into the bathroom space.

Q. I see.

A. And I believe this was in Zephan Trent's first statement, but they do discuss how they worked with Oxehealth to add a privacy filter, which I believe is

a kind of like blurring over the bathroom door. But, obviously, the patient doesn't know kind of what that kind of looks like.

Q. Yes.

A. Seclusion rooms. So in seclusion rooms they -- I feel like it is just too hard to explain -- like, they don't have a separate area for a bathroom --

Q. Understood.

A. -- or sometimes people don't have access to a toilet at all and, in those cases, in particular, the sort of toilet area can be seen and sometimes I think there is like a little, like, blurred square over where the bathroom is but, like, you know, there's real limits to that.

Q. Also, as you say, the person using that facility wouldn't be aware of what that looks like to the staff member who may or may not be watching?

A. No, no.

Q. Understood. One of the other key matters that you go on to mention -- it's at paragraph 3.5, but we don't need to read it we can just discuss it -- is a lack of safeguards in place to mitigate the impact on patients of this invasion of privacy and also to prevent any abuse of the system?

A. Yes.

Q. So a couple of the examples you give are that, where personal electronic devices, staff are allowed to use those on the wards, there is no means in place, for example, to stop staff from recording whatever footage is being seen on the staff tablet of a patient bedroom. That's one of your examples.

A. Yes.

Q. You also -- this is a little bit earlier in your statement -- point out that, because the footage comes through to a screen or a tablet that a staff member is attending or not, depending on where that is placed, that footage might well be able to be seen by non-medical members of staff or other patients or, indeed, visitors to the ward?

A. Yes, and --

Q. Hang on. Let me just take you to one of your other examples, and then we can discuss them all in the round; is that all right?

A. Yes, that is fine, if I remember them by the time you go through them.

Q. I will remind you, I will remind you. Well, it's really to take -- let's see how we go, I think it will make sense. The other thing that you highlight, crucially, is that where our understanding is that the footage that is captured is 15 seconds at a time, but what you point

out is that, as far as you are aware -- and I appreciate that you have explained very clearly that there is a lack of transparency around the functionality of the technology -- but what you say is that there's really nothing to prevent a member of staff continually pressing, so that the 15 seconds is simply extended and extended to whatever duration a member of staff might wish to view it for?

A. Yes, that's correct and, helpfully, my past self has written this here but, if you look at EPUT's monthly usage figures --

Q. Yes.

A. -- we can see that, on Ardleigh Ward, on 28 June, between 8.00 am and 8.00 pm it was used 1,676 times, assuming -- assuming full occupancy of the ward, that would be the equivalent of checking all patients every 7.73 minutes.

My maths could be, like, a little bit wrong, but --

Q. I can't check your maths!

A. But --

Q. That's not a possibility.

A. But as you can see there -- and, you know, that again would be assuming that those checks were distributed evenly across all patients -- this is being -- it's not kind of just that the "check vital signs, view image for

15 seconds" is used kind of on an infrequent basis; that's very frequently.

Q. Yes.

A. And yes, that was -- so that one was the ward where -- and the ward and the day where it appeared to have been used the most from the monthly usage reports. But we could see that kind of that was a pattern across many wards, where we -- you know it's quite clear that it's being accessed on multiple occasions.

Q. Yes.

A. So I guess that's probably slightly different to what we were speaking about in terms of some of the safeguards because, obviously, one of your other kind of key areas of consideration in the Inquiry is around, like, sexual violence. And so one of the kind of concerns that we have is that there is nothing in place to stop staff kind of using the system maliciously to kind of, you know, view patients in their bedrooms.

Q. Yes.

A. And the other thing that's always really concerned me is that the -- I feel really horrible saying all of this, like I'm giving people -- yes, I don't know.

The alert system basically provides an alert when a person has been in the bathroom for three minutes or more, which isn't that long, to be fair.

Q. No.
A. And so, you know, it might be that the person is in the bathroom and that they are at risk but it's also likely that they might be having a shower and there is nothing really in place there to stop staff using that ...
THE CHAIR: Maliciously?
A. Yes, yes, which is very concerning within the wider context of sexual violence in wards.
MS TROUP: Yes. I think my broad question to you, and it may be that your answer is the same as the answer you gave a few minutes ago: do you think there are any particular safeguards that should or could be put in place, for example to prevent potential abuse of the system or sort of malicious use of it, as you have described?
A. Yes, not having cameras in people's bedrooms.
Q. Thank you. Bear with me for one moment.
A. That's all right.
Q. I think I would like to move on, I want to check with you actually, Hat, because I think I explained to you I am not great on time but I think we have been going for almost an hour and I wanted to check with you whether you would like to continue or whether you would like take a short break?
A. I am happy to continue for a little while and then would

like a break. I think -- I know, you originally sort of suggested we might talk for around an hour or an hour and a half.

Q. I did.

A. But I think we may have underestimated how much I have to say.

Q. That's fine.

A. If you allow me to kind of continue and speak to everything, like, I would appreciate that --

Q. Of course.

A. -- because there is so much to get across.

Q. I understand that.

A. Yes, maybe in a little while we can take a break.

Q. Fine. Do you want to just let me know or shall we perhaps say 12.00. Shall we say we will go on for another 10 minutes? It's also the case that a transcript is being taken and so there are others that need to take a break but, if you are happy --

A. Yes, of course!

Q. If you are happy to go on for 10 minutes, that would be good. Great, thank you.

A. Yes, sorry I do, I have a lot of words.

Q. You mustn't apologise.

I would like to start on the topic of consent now because this obviously falls within the first major

concern about privacy and consent.

A. Sorry to interrupt, I am just going to say that I have like a lot of notes about consent so that might take a bit longer than 10 minutes, if that's okay.

Q. Yes, we don't need to finish that topic in 10 minutes. I didn't mean to suggest that but we can make a start, are you happy to do that?

A. Yes, that is fine.

Q. All right. So just to set it in context again, you tell us on page 7 of your witness statement that one of the things the campaign has done is to make Freedom of Information Requests to various trusts about their operational procedures in relation to the use of Stop Oxevision and you say there, in the second half of that paragraph -- I am so sorry, 3.7 -- that:

"Responses from several trusts, including EPUT, suggest that they rely on a model of implicit consent to the use of the system. In other words, the starting point for many patients is that they are presumed to have opted in to agreement of the use of the system in their bedrooms without any direct explanation of the system itself or of the patient's right to opt out."

A. Mm-hm.

Q. You have gone on in the next paragraph to quote from EPUT's Standard Operating Procedure that came to you as

a result of a Freedom of Information Request in 2023, which, as it was at the time, confirmed that all patients are opted in on admission as part of the Trust's standard procedure, essentially?

A. Yes, and I can update because I think we say at point 3.9 that we weren't aware whether the Standard Operating Procedure had been changed.

The first lot of evidence documents included EPUT's February 2025 -- I could be wrong on the month, I believe it was February 2025 -- policy which remained unchanged with the process of kind of implicit consent. If a patient were to object, it would be kept -- the system would be kept on for up to 72 hours --

Q. Yes.

A. -- until a decision had been made from the staff. So that was correct at that time. Obviously ...

I won't say anything else.

Q. That's all right. You are very welcome to. I want to ask you quite broadly, and I do realise that, having just agreed that we'll take a break at 12.00, this answer is likely to take you past that, so we are going to stop at 12.00, but I want to ask because I would very much like to hear it from you in your own words, and it may be an obvious question or perhaps a better way to put it is a question with an obvious answer: could you

just explain what is the problem with this model of implicit consent?

A. So I -- you're the barristers but, like, implicit consent isn't really a thing. Like, you know, for consent to be true and legal it needs to be given without coercion, it needs to be informed, it needs to be specific, ongoing and to not be kind of assumed unless otherwise withdrawn.

So I think the phrase "implicit consent" is -- I can't really think of a word. Like, it doesn't really hold up, you know. It's not consent if it's implicit.

Q. Yes.

A. Like ...

Q. Yes. Thank you. We are going to come back to some issues that underlie what you say there. I think I want to look now, within this topic, at the concerns you raise about lack of clarity in relation to the withdrawal of consent --

A. Mmm.

Q. -- or the ability to withdraw consent, or what people know about that. So -- I'm so sorry, patients know about that.

A. Yes.

Q. If you could look with me, please, at page 9 of your witness statement and, in particular, paragraph 3.15,

you tell us there that:

"The lack of transparency ensuring informed consent is compounded by a lack of clarity about what procedures might be in place to enable someone to withdraw their consent."

You tell us there that that's a common theme in some of the accounts that the campaign receives from patients?

A. Yes. So I guess, like, the first point is you can't withdraw consent that's never been given in the first place.

Q. Indeed.

A. So that's kind of the key issue with the sort of opt out system. If you have never kind of -- yes, you can't withdraw consent that was never given. It needs to be informed and so, as I have kind of raised before, we have been working on this campaign for two years and I don't feel confident in my knowledge of how the system works, what it does, all of these things --

Q. Yes.

A. -- which kind of highlights the kind of complexity of it but also the lack of transparency about what it does, how it works, how information is shared, who has access to the information.

And the other thing to point out there is that we

also know from kind of the accounts that we have heard from patients and from documents that there is a discrepancy between what Oxevision is licensed to be used for and the way that it's actually used in practice --

Q. I see.

A. -- which has implications in terms of invalidating the possibility of genuine informed consent because, if someone's consenting to something being used in one way and it is actually being used in a different way, that's not consent.

Q. Yes. You tell us at the bottom of paragraph 3.15 that, again in response to your campaign's Freedom of Information Requests, responses from several trusts reveal that there was no policy in place whatsoever in relation to withdrawal of consent, or indeed to obtaining informed consent in the first place, yes?

A. Yes. So this is something that we have observed having kind of changed since our campaign, where some trusts have kind of subsequently amended their policies in regards to consent, and we can kind of speak later to how our belief is that that doesn't -- that's not sufficient to address the issues and concerns that we have with the technology.

But, initially, most of the trusts didn't have any

kind of clear process in place and, in regards to consent for information sharing, the kind of --

Q. I am going to come on to information --

A. Okay, we can talk about that later. Yes, that's fine.

Q. If that's all right just because I think it will help you to take us through it because, as you say, it is a complex issue with a lot of facets and I think I will take you, after we have had a break, to concerns and issues around data sharing and the processing of information.

A. Yes, absolutely. On -- sorry, I am not allowed to just ask myself my own questions, am I?

Q. I think you absolutely are, yes. Go ahead.

A. So just again, kind of further in terms of the consent, one of the real things that I cannot stress enough is that the kind of possibility of genuine consent is so undermined within the context of a psychiatric hospital, where coercion is so, like, kind of prevalent and where people have so, like, little awareness of their rights and might not be in a position to be able advocate for themselves.

Q. Yes.

A. So whilst, you know, the Trust might term this as informed consent, it's -- you know, the possibility of that in a system where your rights are so removed is

really undermined and we kind of have heard this as well in terms of kind of the -- let me start again.

I think the kind of -- it opens a lot of space for the potential for staff to kind of encourage and coerce patients into giving consent, in that sense, and --

THE CHAIR: I think I have got the point it is a very coercive environment, in which this could be manipulated?

A. Yes, and I suppose like from our own experiences, there are so many things that you kind of agree to doing that you know are -- you know, at the time you don't recognise how -- that you have a right to say no to those things, and, yes, there's kind of sort of threats of like punishment and sanctions and things for not kind of complying with certain things.

MS TROUP: On that subject, again, perhaps -- I am so sorry, I should have made this clear -- I think the issues that you have raised in your witness statement around hostility, or hostile reactions to concerns raised by patients, I am going to take you through separately --

A. Okay.

Q. -- because you have got a whole paragraph about that, which is very helpful. Then we will move on to some of the concerns you have raised about data sharing and data being processed.

I wonder, Chair, if I could suggest that we take a break now. I'll leave the amount of time up to you of course.

THE CHAIR: Shall we say 10 minutes? 10 minutes, yes.

(12.01 pm)

(A short break)

(12.23 pm)

THE CHAIR: Ms Troup.

MS TROUP: Thank you.

Hat, as long as you are content, I would like to move on to something we mentioned just before the break about the retention by providers and use of footage that is recorded by Oxevision.

A. Yes.

Q. If we look at page 11 of your witness statement, and paragraph 3.18, what you say starting in the second line is that there is a capacity -- and I am paraphrasing -- for footage to be clipped and retained but that the circumstances in which that might occur, the processes which might apply and the use to which any such footage might be put is unclear. Yes?

A. Yes, and obviously that speaks to the previous point about informed consent.

Q. Indeed. You give an example -- I don't think we need to go to it -- later on in your statement -- for the

record, it's at paragraph 5.10 -- about the campaign having become aware of footage being used in academic studies, without the consent of those who are pictured in it?

A. Yes. So this was a study. It wasn't looking at the sort of effectiveness of the technology but what it was using was the blurred footage to kind of -- I think what they were seeking to do was identify kind of precursors to self-harm or kind of aggressive behaviour and things.

But this meant that the blurred video footage of patients was shared with a research team. I think, to my knowledge, they actually then found that the footage wasn't -- they weren't able to kind of do what they had sought to do with that.

Q. Yes.

A. But, obviously, that is concerning because that's not something that's been mentioned in any of the policies that I can identify. It's not mentioned in any of the Data Protection Impact Assessments either and, yes, obviously there are kind of significant implications.

So just to note, in our -- so we made a complaint to the HRA, which is the Health Research Authority --

Q. Yes.

A. -- the NHS Research Ethics Board and they kind of, in response to our complaint, sort of decided that the

blurred footage wasn't adequately anonymised.
Q. Yes.
A. I would just like it point to one of the exhibits, which is the complaint that we submitted to --
THE CHAIR: Yes, we are aware of that.
A. Yes, and the Inquiry have obviously made the decision to redact the face of the blurred footage, which kind of, again, speaks to the sort of limitations of that and how it could still be identified.
MS TROUP: Yes, and indeed we might say, or you must tell me if you agree, that, even where an image is blurred, it doesn't necessarily make it anonymous, even if a face is blurred.
A. Yes, absolutely.
Q. I think in relation to that correspondence that you are talking about, that we have indeed seen, the NHS Health Research Authority, in response to your complaints about that particular study, I think it's the case that the favourable ethical opinion that had been indicated was suspended, yes?
A. That is correct. The study had actually been given ethical approval and had finished but the ethical approval was kind of still retracted at that point. What I would emphasise there is that we -- whilst we agreed with the decision to retract that ethical

approval, we do have concerns that that was kind of offered in the first place, and that --

Q. Yes.

A. -- scrutiny wasn't given particularly within the context of Essex Mental Health Trusts where there are kind of you know ongoing concerns and, to the magnitude of having such an Inquiry, that there wasn't kind of consideration given to whether or not it was safe and appropriate to sort of endorse the Trust as the research site.

Q. Yes. Thank you. Can I move, please, to what you say in your witness statement about the information that is provided to those being admitted to inpatient mental health facilities about what this technology is, what it can do and what the processes are.

A. Yes.

Q. To put it in context, and actually to highlight your key points, on page 8 of your witness statement at paragraph 3.11, just about halfway down, you tell us this:

"Patient accounts shared with Stop Oxevision have made reference to limited and at times completely inaccurate information being shared by trusts regarding their surveillance systems, with some patients having been informed that there wasn't a camera in this

technology."

Is that right?

A. Yes, that's correct and I think what we have observed from the posters is that these kind of often-used phrases, which appear to be deliberately opaque and kind of terms such as "optical sensor" or "infrared sensor", things like that, which sort of dance around the fact that it is a camera, it might have sort of additional elements, but it is a camera --

THE CHAIR: And one with a capacity to record.

A. Yes.

THE CHAIR: Yes, I get the point.

MS TROUP: Coming on to that topic, you talk in your witness statement about the fact that a number of trusts appear to rely -- or a number of units, I am so sorry -- appear to rely on posters to be the giver of information about what this system is. Before we move on to any of those posters or the limitations of the posters themselves, what do you, as a campaign, say is deficient about using a poster as the source of information to inform patients about what is happening?

A. Yes, it's kind of because that -- we don't necessarily know where exactly on the ward the poster is displayed, it's obviously not necessarily kind of easily made available to people. Obviously, when someone's

incredibly unwell, they are not necessarily walking around the ward looking to read information on posters. And I know we will come a little later on to some of the concerns in regard to kind of equalities and differential and disproportionate impacts.

Q. Yes.

A. But, obviously, if somebody had kind of, you know, limited ability to read written English, for a variety of reasons, that information would then be less accessible, particularly where it's using kind of quite complicated phrasing.

Q. Yes.

THE CHAIR: That also goes back to your point about circumstances in which somebody finds themselves, as a rule, in these facilities --

A. Yes.

THE CHAIR: -- and an environment where they feel disempowered.

A. Yes, absolutely.

THE CHAIR: Yes.

MS TROUP: One of the things that you tell us, just looking at page 9 and paragraph 3.13, is that, although some of them may or may not have been updated since your campaign sourced the posters that you have through Freedom of Information Requests, none of them explain

that data is shared with the manufacturer, Oxehealth.

A. Yes.

Q. Only two of the posters you have informs patients that the technology tracks when and how often they go to the bathroom.

A. Yes.

Q. Seven did not include the word "camera" and instead used this term you have described as opaque and confusing: "optical sensor"?

A. Yes.

Q. The EPUT poster -- and I don't think we need to go to it -- does not explain that the footage is recorded; is that right?

A. As far as I remember, I've not got it in front of me.

Q. Yes.

A. But, yes.

Q. It doesn't mention that video footage is retained if there is an incident --

A. Yes.

Q. -- and doesn't say anything at all about the fact that the manufacturer, Oxehealth, has access to the data that is collected by that technology?

A. Yes, and indeed that Oxehealth is the data processor.

Q. Yes.

Could you tell me this: what would you like to see,

as a campaign, instead of the posters that we have talked a little about, for properly informed consent to be given, or indeed not given; what would that look like? What do you think that process should look like or involve?

A. So I think, yes, as I have kind of outlined our position as a campaign, is that we don't believe that this technology is compatible with safe patient centred and, indeed, legal, like, treatment. So, in that sense, you could have all the posters in the world but we don't have a position that that would facilitate informed consent, in the context of the coercive environment for --

THE CHAIR: Let me understand this: your position is there could never be appropriate consent given; is that right?

A. Yes.

THE CHAIR: Thank you.

I think we should turn now to the other concerns. I am conscious of time.

MS TROUP: Very well.

THE CHAIR: I have read your statement so I have now got a full picture of your issues about consent, thank you.

MS TROUP: Of course.

I will turn then, Hat, to -- we are going to deal with this from page 13 of your witness statement, this is

another central concern that the campaign raised in relation to staffing issues.

A. Yes.

Q. The campaign's concerns, I think, are very well summarised in the first part of paragraph 3.26, where you say this:

"Stop Oxevision is concerned that Oxevision and other vision-based monitoring systems are being used as a superficial quick fix for wider systemic issues in mental health care, including inadequate levels of staffing and high levels of poor practice" --

A. Yes.

Q. -- "on mental health wards."

A. Correct.

Q. You go on to say -- and I won't read it all -- but you go on to say at the next page, at paragraph 3.28, that what these systems allow for is an absence of face-to-face engagement. This is remote monitoring, which either reduces or, at worst, removes the opportunity for face-to-face therapeutic engagement; is that a fair summary of the concerns?

A. Yes, that's correct, and then I would just like to point to one of the additional evidence documents, which is the EPUT and Oxehealth Early Insights and Implementation Lessons Learnt Report where there is an example of

a Ward Manager saying that now, having Oxevision, they are able it take the tablet that shows the Oxevision to a meeting, leaving just one member of staff on the ward.

So this is in the context of, like, kind of debriefings for staff after incidents and things. But what they are kind of suggesting -- and I have not got it in front of me –

CHAIR: Don't worry.

A. that having this technology has enabled them to leave just one person on a ward that might be for kind of up to -- or, like, 18/22 patients.

MS TROUP: A large number of patients.

A. Yes.

Q. Yes. Which, without that technology, wouldn't be something that would be considered acceptable, presumably?

A. Well, it is not acceptable with the technology.

Q. No, but it wouldn't be done then, let me put it in that way?

A. Shouldn't be done, yes.

Q. You also highlight, and I think this is crucial that we understand it, that part of the concern is that staff who are charged with using this technology may either misunderstand its capacities, overestimate --

A. Yes.

Q. -- and, therefore, over-rely on the technology. Can you tell us a little about your concerns in that regard?

A. Yes. So I think it speaks again to the point I made previously about some of the misconceptions around Oxevision, and one of them in particular is that there is a kind of interpretation from staff then passed on to patients, that the technology can kind of like alert to -- one of the phrases is, like, "alert to deteriorations in health", but it doesn't provide alarms to change, it can't read a pulse below 50, so it can't read a pulse of 0.

And, yes, I guess in that sense there is a kind of risk that people might kind of rely on and be reassured by technology to do something that it is not capable of doing.

Q. Yes.

A. And there is an example, which I presume we -- presume have put in the document from a CQC report and -- referencing an incident where the camera was actually switched off during the period in which a patient died. But that -- the only information about that is from a CQC report. But I guess that speaks to the grave risks of over-relying on technology.

Q. Yes. Including risks to physical safety of patients, yes?

A. Absolutely.

Q. Yes. In terms of the effect, one of the things you say

in this section of your witness statement is that there is a real concern that this technology either could be, or indeed is being, used as a substitute for proper patient care. Could you tell us a little about whether that is a theme in the accounts that the campaign has received?

A. Yes. That's a theme in the accounts that we've received from patients which, when we come to looking at our patient experience testimony table, will highlight, but also is a theme from some of the other documents that we have reviewed. So, particularly, one of the kind of marketing narratives around the technology is looking at how this can save costs in terms of reducing staffing.

Q. Yes.

A. And there's the example of -- I forget which trust it is. I don't want to misremember which trust but one of the trusts have kind of used the example from Coventry and Warwickshire and showed that they could save X number like three point something healthcare assistants by having technology instead of staff, which is obviously incredibly dangerous.

Q. Yes. Thank you. I think unless the Chair has any other questions at this moment on the issue of staffing, I would like to take you to one of the campaign's other central concerns about lack of oversight.

A. Yes.
Q. You have given a very helpful summary about the very rapid rollout of the use of this technology across various NHS Trusts and, if we look -- again, it's very well summarised there, in your witness statement. If we look at the very end of page 17, you say that:
"The campaign's concern is that this rapid expansion has occurred in the context of a fundamental absence of critical engagement with patients, trusts and the system manufacturers and a simultaneous lack of oversight from the regulatory bodies", who would be charged with that very oversight.
A. Yes.
Q. I have added those words, just to be clear.
A. Yes.
Q. "Stop Oxevision is, and remains, particularly concerned that the regulatory bodies have been slow to recognise and respond to the concerns being expressed by patients, their families and the staff whom these systems directly impact."
A. Yes. So the Care Quality Commission did identify in 2022 concerns about the lack of consent for the use of the technology within its inspection of Essex wards. But there were a number of inspections prior to that where Oxevision is mentioned in passing. But, without

kind of going into details, and in our -- in the witness statement we quoted the example from West London, where --

Q. From West London, yes.

A. Yes, so it's kind of -- it appears that CQC have kind of done multiple inspections but it's taken time for them to actually kind of look into these issues in more depth, which is very concerning and this kind of speaks to the point I raised earlier on about the fact that we have had to do this work in the absence of those who you would expect to be doing that.

But I think one of the senses that we have in this campaign is that, if we weren't doing -- investing our time into Stop Oxevision, there is so many other things. And I think it's a really critical issue, particularly in the kind of age we are in now, with, like, rapid expansions and developments in technology; there needs to be a better process to keep on top of these and to make sure things are rolled out in a -- sorry.

THE CHAIR: Sorry to interrupt you, but has your organisation had direct contact with the regulators? Have you been lobbying them, as it were, about this?

A. Yes. We met with somebody from CQC about -- quite early into the campaign, so I would say maybe around 18 months ago, and had a little contact at that point, but never

had any other follow up from them, really.

THE CHAIR: They have not come back to you?

A. No. So, you know, we have made our complaints but they have been kind of remarkably and notably silent on the issue and I think -- yes, it kind of -- yes, I think that that sort of summarises -- is that enough?

THE CHAIR: Thank you.

MS TROUP: I might touch on that correspondence, in fact, that you have had with some of the regulators in a few minutes. But I think, is this right, your point is that it's about the fact that these regulatory bodies are only, despite the fact that inspections were continuing -- and we can see from your summary of the report in relation to West London, that you have quoted at paragraph 3.38, that there is recognition that this technology is being used but not in any fundamental aspect of analysis or examination of the impact of that, and it's only now, is this fair, that you think this issue is beginning to be recognised?

A. Yes, as a result of the activism of patients.

Q. Well, of your campaign and others, presumably?

A. Yes.

Q. I would like to go, Hat, if you are happy, to what you have to say -- or what the campaign has to say, I am so sorry -- about discrimination and the disproportionate

impact on certain groups in relation to the use of this technology.

I think -- you must tell me if I have this wrong -- your major and fundamental point is that the possibility of discrimination and the possibility of a disproportionate impact simply has not been considered adequately, if at all?

A. Yes. Not at all. So one of the things that we have asked for in Freedom of Information Requests has been equality impact assessments. EPUT responded that they don't -- they wouldn't do one of those. Obviously ...

THE CHAIR: Has that been the case elsewhere too?

A. Yes, and I would say that that is not just in relation to Oxevision but it's also kind of prevalent across policies. So, if you look, it's in one of the exhibits but EPUT's observations policy has an equality impact assessment, I believe, that identifies no disproportionate or differential impacts for any people in relation of protected characteristics.

But I would say that that isn't unique to EPUT and isn't specific just to Oxevision. This is very much a kind of widespread issue that equality impact assessments are either not done or they are done but just say there is no kind of --

MS TROUP: Nothing to see here?

A. -- different impact or, on the other hand, as we have kind of quoted at point 3.45 on page 20 --

MS TROUP: Yes, I am going to come to that. Go on, please go ahead.

A. So the other -- the other thing is that, in some instances, the equality impact assessments do identify risks but do nothing to make any, to actually address or mitigate the harms that they have identified.

THE CHAIR: So they just identify them and then move on?

A. Yes.

THE CHAIR: Okay.

MS TROUP: In relation to the particular assessment that you have cited there at paragraph 3.45, as you say, there has at least been an identification of the potential for particular negative impacts, but no suggested actions or plan to address any of those.

To summarise, they are listed as -- this is at 3.45 -- that service users with disabilities may have their mental health particularly negatively impacted by the system; that service users with learning disabilities may not be able to fully understand how the system, in fact, impacts on their privacy and dignity and may not be able to provide meaningful consent.

A. Mmm.

Q. Then there are concerns around dignity and privacy, both

for female service users, who might be impacted by male members of staff, and for transgender patients who may be outed by staff observing them at certain points?

A. Yes, and obviously that speaks to just how intrusive and, you know, emphasising that the technology -- the camera allows patients to be seen naked and have, you know, genitals observed --

Q. Yes.

A. -- which is obviously incredibly intrusive.

Q. Those concerns come from the particular assessment that you have cited. What I wonder was whether you as a campaign have anything further to say about any other particular negative impacts or disproportionate impacts that this technology could have on groups of people within protected characteristics?

A. Yes. I mean, point A there, "service users with disabilities", is interesting, as I think, arguably, the -- a large proportion of people admitted to a psychiatric hospital would meet the Equality Act definition of disability, which includes psychiatric conditions.

Q. Yes.

A. We -- yes, I think it's -- the thing is it exists within a context of real injustices within psychiatric services, how kind of institutional racism, like

gender-based violence, and how all of these things are enacted, the kind of problem with introducing a new technology into a system without addressing those harms is that it only becomes part of that --

Q. Yes.

THE CHAIR: Can I ask about neurodiversity. In particular, are there any observations you would want to make about the impact of Oxevision in relation to those with neurodiversity?

A. Yes, I think in particular, for like the learning disability context, as I have said, having posters and these have rarely been made available in formats such as Easy Read, there -- you know it impacts on people's ability to understand the system.

We have an example in the patient experience table, which I won't speak to, but kind of --

THE CHAIR: If you are struggling with it now, you can write in and let us know if there's anything you wanted to say about that in particular.

A. Yes. Okay.

MS TROUP: Thank you.

I think I would like to ask you now just a little about -- you have talked about this a few minutes ago, in terms of formal reviews and complaints in relation to the use of Oxevision, that the campaign has been

involved in. You tell us about those fairly comprehensively at section 5 of your witness statement, which starts on page 26, and there you detail -- and obviously we have considered this carefully -- the concerns and correspondence that have been raised with NHS England, the CQC and the ICO.

A. Yes.

Q. You also -- sorry, actually, just stopping there. In relation to the ICO, you tell us -- I think is this, you must tell me -- is any response to that particular complaint -- is that still outstanding?

A. Yes, I have an update on this. So I sent the complaint -- I can't remember what date, October.

Q. Yes, October 2024.

A. Yes, and so received a response about six months later saying that they were closing the complaint because I needed to have complained to Oxehealth first and I think this really speaks to what we heard in one of the previous evidence sessions about how complex the complaint process is and it's -- you know, if you don't complain in the right way -- and how many am I meant to know what the right way to complain is -- they just close it.

So I have responded to that, which I did yesterday, saying that I didn't feel in a position to be able to

make a complaint to Oxehealth whilst they are a Core Participant and I am a witness in an ongoing Inquiry.

Q. I see.

A. So we will see if they respond. But, for now, they have closed the request and I don't know what else to do about it.

Q. Yes. That's helpful, thank you.

There are also a number of complaints that you raised to a number of different journals in relation to articles about the use of Oxevision and, in particular, I think, in relation to the use of figures that you consider to be fundamentally misleading.

A. Yes, that would be correct. And, no, I don't have an update on any of those. I have chased them many times and don't have an update. But to speak more broadly to that point, that is something that we have observed through multiple kind of -- both, like, peer-reviewed academic publications but also the sort of more summaries of research, for example the Early Insights report, which is actually twice in one of the -- in the evidence packs, where there appears to be a kind of presentation of figures in a way which would be more favourable if you were seeking to kind of promote your technology, shall I say.

So the specific example that we raised some

complaints about related to the conflation of a absolute and a relative reduction, so this -- basically, they kind of have said that there was a 44 per cent relative reduction in self-harm but that was actually accounted for by the fact that the change in self-harm on the supposed control ward was greater than that on the Oxevision ward.

So what it's presenting is not that there was a 44 per cent decrease in self-harm but that self-harm just went up loads on one of the wards and down a little bit on the other.

Q. Yes.

A. In a kind of -- yes, obviously, like, methodologically there is kind of numerous issues with that but, to kind of take that more broadly, the concern is that the kind of like academic peer review or, like, scientific process is used as kind of marketing materials and is, as I think you said, you know, is misleading.

Q. Yes. Thank you.

A. And --

Q. No, go ahead. I don't want to interrupt.

A. If I may just say as well on that point because it was something that we identified in EPUT's first statement.

Q. Yes.

A. They speak to some of the figures from the early

insights report, and these kind of -- basically they have asked patients and staff to kind of rate certain things on a scale. For patients it was a scale of 1 to 5. But what they did was exclude the responses where people said 3, which methodologically is a bizarre thing to do. So where they have said 70 per cent of patients felt the system improved their wellbeing on the ward, that figure was achieved by excluding a third of the responses.

So I have recalculated that, if you include the people that said 3/5, to actually be 47 per cent and these figures are quoted in the original witness statement from EPUT, without giving the details of the methodology and the kind of unusual decision to kind of exclude some of those. And whilst the numbers in themselves are -- it's the kind of the principle of manipulating figures to present a more favourable opinion. Those figures were given to the Board of -- the Board of Directors, I think it would be, as part of the proposal to expand the rollout of --

Q. Yes.

A. -- Oxevision. But I think it speaks as well to the point about the kind of disrespect to patients' accounts, kind of, you know, when people are saying, "Well, this is what I thought of the system", and that's

being, you know, excluded because it's not so favourable, or it appears that that might have happened, that would be, yes, very concerning. But, yes, I have re-analysed that so you can have the correct -- or the percentages if we don't exclude people that said 3/5, if you would like that.

Q. Yes, that is very helpful.

THE CHAIR: You will let us have that?

A. Yes.

THE CHAIR: Yes, thank you.

MS TROUP: Hat, we are coming close to 1.00. One of the things that I wanted to ask you to do -- there may be more questions for you, either from the Chair or the ordinary process, and I understand that your legal representatives are keen for us to do this as usual today, is that when I have come to the end of my questions for you, we take a short break of around about 10 minutes, so that you can consider whether there's anything additional you want to say and so that they can raise any additional questions that they would like me to put.

But, before we do that, I wondered if you might read to us, please, the final section of your witness statement, if you feel able to do so, which relates to the challenges that are faced by you and other

campaigners who volunteer your time to do this work. Are you happy to do that?

A. Yes. I might -- I'll start and see if it's going to take me a while and then we can, like, paraphrase it.

Q. Of course.

A. Yes.

"So the main challenge that we have faced campaigning for Stop Oxevision has been the personal toll that it has taken upon all of us who are directly involved in the campaign's work. Whilst the work of listening to and collating patient experiences and raising awareness about these systems is so important to us all, it has also impacted on each of us. Many of us who volunteer our time for Stop Oxevision ..."

Sorry, I actually find it hard reading out loud. Is it okay if I just summarise.

Q. Absolutely, that will probably be better.

A. So the point it is kind of speaking to is, like, the impact that it has had on all of our kind of own health at various points, and I think, like, it would also be fair to say that the worst part of that by far has been kind of the past few weeks in preparing for the Inquiry and disruption, and things has had the kind of -- at least speaking for myself, has had the greatest impact.

But, yes, in terms of one of the particularly

difficult things is that, in having to access some of the documents and things, it exposes us to content which is quite unsafe. So, obviously, reading through coroners' reports and stuff isn't a very safe thing to do for people who have their own kind of health problems and risks and things.

Q. Yes.

A. So that obviously has a really substantial impact and, obviously, it's important, again, as I have kind of repeated to contextualise the fact, that, ideally, it would not be us, as kind of disabled people, people with lived experiences of these services who are having to do this. We do this because the sense is that, if we didn't, there's not someone else who is doing that currently and the kind of gravity and magnitude and how much this has the potential to harm and traumatise and contribute towards deaths means that we feel kind of compelled to have to do that in the absence of others taking the responsibility and accountability that is needed.

But that's not a sustainable way to be doing this, and yes ...

THE CHAIR: I entirely see your point on that. For what it's worth, I must also acknowledge that it will not have been easy for you to come and give evidence,

I quite see that. No one finds these experiences easy, if I can offer you comfort in that respect, and you have made your points very clearly and I have taken them on board and I am very grateful to you for coming to do this. So thank you.

A. Thank you.

MS TROUP: If you are content, shall we take a short break, perhaps 10 minutes?

THE CHAIR: Yes.

(1.02 pm)

(A short break)

(1.15 pm)

THE CHAIR: Ms Troup.

MS TROUP: Chair, thank you Hat, I have three further questions for you.

A. Okay.

Q. None of them are terribly long. The first is in relation to one of the concerns that you have set out in your witness statement, which is the impact on patient mental health of the use of this technology.

A. Yes.

Q. Now, we did touch on that during the course of your evidence. But what I hadn't asked you about, and I would like to, is this: you told us a little about patients taking steps to avoid the camera, if and once

they are aware of it, and you go on to say in your witness statement -- if you want to look at it and for the record it is at 13, paragraph 3.23 -- that the firsthand experiences that your campaign has collated indicate that the use of this technology makes patients feel unsafe --

A. Yes.

Q. -- in the way that you have described.

But also might, in fact, be contributing to them being actually physically unsafe?

A. Yes.

Q. The example you give there is that some patients report changes in their patterns of self-harm to exploit blind spots or loopholes or the use of novel and different, different methods of self-harm that can't be monitored by a remote system?

A. Yes. So kind of self-harm is something that people do because it serves a kind of purpose. So if you sort of seek to stop that without addressing the kind of underlying kind of pain and distress that people are experiencing, it very often then leads to people kind of finding alternative ways, yes.

THE CHAIR: That was a point made in evidence earlier this week by the --

A. Yes.

THE CHAIR: -- psychiatrist, who is an expert.
A. Yes. A little clumsily I would say.
THE CHAIR: A little ... ?
A. Clumsily.
THE CHAIR: But it still got through to me, don't worry.
A. Sorry, I'm not here to criticise.
THE CHAIR: It's all right.
A. But, yes, it was raised, yes, yes.
THE CHAIR: I heard it.
MS TROUP: Thank you. The next question is about section 4 of your witness statement on research, which we haven't touched on but which has been very carefully considered and you can be assured of that.
A. Yes.
Q. I think what I would like to highlight is what you say, if you want to take a look at it --
A. Sorry, what page is it?
Q. I'm so sorry. At page 23 and in particular at paragraph 4.7.
A. Yes.
Q. Sorry. Go ahead. Ignore us. Sorry, go on.
Did I interrupt you?
A. No, I was sort of waiting for a question, but I can just talk to the paragraph in general.
Q. Please do.

A. This, it was just kind of emphasising the conflicts of interest within the research.

So obviously you have also kind of heard in previous hearings about the kind of concept of like evidence-based practice, but when we talk about evidence that needs to be independent and to a high standard.

When we are talking about a company that sells a product for profit they obviously have vested interests in kind of being able to present that in a way that will help them to help them get the sales and things that they want. So that's the kind of concern where there are conflicts of interest and obviously as I've kind of spoken to before there's then some sort of unusual methodological approaches and things.

Q. Yes.

A. Yes. I think -- so that was related to the --

Q. Well, in particular what you say there is that eight of the nine studies reported conflicts of interest in that they were either funded by Oxehealth or coauthored by its employees?

A. Yes. Yes, that's correct.

Q. Yes, thank you. My last question relates to some of the discussions we have had during the course of your evidence about Freedom of Information Requests.

A. Yes.

Q. You have talked a little too about the lack of transparency, the difficulty of sort of trying to piece together information to understand the functionality of the technology and its use and you have explained that a great deal of the information that your campaign has managed to obtain has come to you through Freedom of Information Requests.

At the outset of your evidence you mentioned finding it very difficult to get more information about private providers?

A. Yes.

Q. Can you tell us more about what the implications of that are if we move towards a system where healthcare is privatised more and more, the position that campaigns such as yours might find yourselves in when the Freedom of Information Act doesn't apply to a private provider and what you think might need to change in relation to that?

A. Yes. So one of the kind of things that's been really important in the work that we have done in the campaign is kind of to counter the lack of transparency. We've accessed documents and then made them available on a Google drive so that patients can then see what the policy is for the Trust and things. But there are so many barriers to that because often information requests

are kind of not responded to or withheld.

So one of the kind of key things is that often information is withheld on the basis of commercial interests.

Q. Yes.

A. So one thing is that we did a Freedom of Information Request to the MHRA to request the details about -- so Oxehealth I think say at points in their statement that Oxevision works for patients with all skin tones, they use the word skin "types" but skin tones, but we requested the evidence to kind of demonstrate, like, to understand what research had been conducted to consider this.

But that was, that request was refused on the basis of commercial interests and it then went through a public interest test and, yes, they maintained that it wasn't. So we haven't been able to access that.

Q. I see.

A. With regards to the private providers, so to my knowledge in England at the moment there are like 50 mental health trusts. One of those is Livewell Southwest in Plymouth, which is operated by a community interest company.

As a result, they don't technically come under the definition of a public authority of -- yes, they don't

come under the Freedom of Information Act. And so in relation to this campaign, but also others, I have done loads of FOIs to them and we don't get anything back on that basis.

But also we have lots of private providers such as Cygnet, Priory. One of them is -- so it was formerly known as Huntercombe, but now the Active Care Group, so they use Oxevision which we know from kind of some of their like websites and Oxehealth's marketing materials. But other than that we are not able to access information because we don't have -- they don't count as a public ... Yes, I can't remember.

Q. A public body.

A. Yes, a public body. So they don’t include in that, which means that they just withhold the information.

So like my feeling from this campaign and kind of other work that I've done would be particularly in the context of kind of increasing privatisation, that there needs to be a reconsideration of the definition of public authority to include healthcare providers which are funded by the NHS but operate independently because we rely so much on the very, very few tools that we have available to us to kind of counter this lack of transparency and accountability. And that is just kind of a block that does keep, it does keep coming.

So I'm glad to be able to raise that. I think it's really important.

MS TROUP: Thank you. Hat, I don't know, you may be glad to hear or not, that I don't have any further questions for.

I don't know whether or not the Chair has.

THE CHAIR: No, I don't. Thank you. I am very grateful to you for your time.

A. Thank you.

THE CHAIR: I am very grateful to you for your careful answers to the questions.

A. Sorry. Thank you.

Is that the end?

THE CHAIR: You are free to go.

(1.24 pm)

(The private hearing concluded)

I N D E X

HAT PORTER (affirmed) 1

Questioned by MS TROUP 1