THE LAMPARD INQUIRY

FIRST WITNESS STATEMENT OF STOP OXEVISION

This statement is provided in response to a request under Rule 9 of the Inquiry Rules dated 21 February 2025. The statement is provided on behalf of Stop Oxevision, c/o Bindmans LLP, 236 Gray's Inn Road, London, WC1X 8HB. The statement will say as follows: -

Section 1: Structure, Purpose and Aims of Stop Oxevision

1.1. Stop Oxevision ("SO") is a national campaign founded in the spring of 2023 which aims to raise awareness of the serious harms caused by the use of Oxevision, and other vision-based monitoring systems ("VBMS") including body worn video cameras, on mental health wards across NHS Trusts in England, including EPUT.

1.2. We are a network of former and current NHS in-patients. We volunteer our time to campaign for greater oversight of the use of video monitoring technology, as well as safe, therapeutic, trauma-informed treatment of people in mental health wards which respects our rights, autonomy, dignity and privacy.

1.3. We have called on NHS England and individual NHS Trusts, including EPUT, to halt the rollout of Oxevision whilst an independent review is conducted into the legality and the potential risks associated with the use of video monitoring technology within psychiatric inpatient settings.[1]

What is Oxevision?

1.4. In order to fully explain the purpose of SO, it is important to understand what Oxevision (or other VBMS) is and how it works on mental health inpatient wards. Oxevision is a vision-based patient

[1] https://stopoxevision.wordpress.com/about/

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. Depending on the location of the tablet or screen, it is also possible that non-medical staff, other patients or visitors to the ward can also view patients in their bedrooms.

3.1. There is no way for a patient to know when they are being actively observed on camera by staff members or others. While Oxevision advertise that live video feed can only be accessed for a maximum of 15 seconds at a time, SO is not aware of any safeguard that prevents staff from simply selecting access to the feed multiple times to circumvent this. Such observations are therefore often undertaken without the patient's knowledge and for an undefined period. Our research also suggests that the recording and viewing of footage is often without a patient's active consent.

1.5. The Oxevision cameras measure pulse and breathing rates of patients, although it only gives medically reliable results when staff do a manual "spot check" and when the person is lying still, with sufficient exposed skin, and if there is only one person in the room. The system cannot take measurements if there are multiple people in the room, if the subject is moving or if they are covered, for example by lying under a blanket. This is outlined in instructions for use of the system produced by Oxehealth exhibited at SO1.

1.6. 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. Data collected can be pulled into a graph to measure activity, for example, how long someone is spending in the bathroom. Oxevision can also be customised by Trusts to provide various "alerts". These alerts are raised to bring staff attention to potentially risky situations. 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.

1.7. The system's manufacturer, Oxehealth Limited, was incorporated in 2012. In the 13 years since, the deployment of the Oxevision system has grown rapidly. The technology was originally marketed for police custody suites,[2] and baby monitors,[3] before targeting mental health wards from 2015 onwards. Oxehealth advertises on its website that it now partners with 50% of NHS mental health trusts, operates on over 100 sites globally, and has been involved in 70 million hours of patient care.[4]

1.8. EPUT was an early adopter of Oxevision, introducing the system in 2020 in response to the identification of serious failings in the delivery of safe and therapeutic treatment, by patients, families and in CQC reports. Presenting Oxevision as a solution to serious patient safety failings, especially around patient observations and staffing issues, EPUT installed Oxevision across all its inpatient wards.

1.9. The SO campaign emerged out of conversations within patient networks regarding lived experiences of the use of Oxevision, the serious harms and safety concerns that patients, former patients, and health care workers were raising about what was described as 'surveillance technology', and concerns about how new technologies and innovations were being adopted and promoted for use in healthcare settings without adequate scrutiny, oversight, or supporting evidence.

Section 2: First-hand Experiences

2.1. SO has collated, and continues to collate, an evidence base regarding the use of Oxevision and other surveillance technologies on wards, with a particular emphasis on sharing the stories of patients who are or feel unable to speak in their own names. We aim to collectively amplify those voices and the shared concerns about the use of such systems.

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[2] https://www.youtube.com/watch?si=DckOOWC_cm11CHgr&v=bAphISoduE8&feature=youtu.be
[3] https://buildingbetterhealthcare.com/oxehealth-advances-baby-safety-with-camera-based-vital-signs-monitoring--105769
[4] https://www.oxehealth.com/?r=0

2.2. The majority of the accounts obtained by SO have been obtained from current or former inpatients, but some have also been obtained from staff members and bereaved relatives (though these are not included in the table at Annex 1).

2.3. The table at Annex 1 is not an exhaustive reflection of the accounts obtained by SO. We have only included accounts which have either been published previously, or where we have been able to obtain consent from the relevant individual to the sharing of their experiences. As this statement has been prepared in a limited timeframe, and as the individuals working with SO are often highly vulnerable, it has not been possible to obtain such consent from every individual who has spoken to us previously.

Section 3: Concerns

3.2. SO's concerns regarding the use of Oxevision and other vision-based monitoring technologies on mental health wards can be broadly divided into the following categories:

a. Privacy and consent

b. Impact on patient mental health

c. Staffing issues

d. Lack of oversight

e. Discrimination and disproportionate impact

f. Academic research (addressed below in Section 4: Research)

Privacy, consent and restrictive practice

3.3. Placing a camera directly in patient bedrooms, capable of monitoring patients 24 hours a day without their knowledge and constantly recording their activities, represents a very significant invasion of the privacy of those patients. As illustrated by the lived experiences of patients outlined in Annex 1, many patients experience this as intrusive, undignified, dehumanising, and traumatising.

3.4. Unlike in-person observations, remote checks via Oxevision and other surveillance systems can be and routinely are conducted without a patient's knowledge. This means that patients have no way of knowing when a staff member may be checking on them or observing them and have no sanctuary from that observation in a room that is, ordinarily, a place of privacy. Patients may be undressing, privately observing religious rituals, they may be masturbating, or carrying out any number of day to day activities for which there is a reasonable expectation of privacy - and yet be completely unaware in doing so that staff are watching them. Alternatively, a patient's belief that they are, or may be, being watched or their activities recorded can have extremely intrusive and negative impact on a patient's intimate moments, as well as a longer-term impact on their mental health and wellbeing.

3.5. Accounts collated by SO include frequent references to a lack of safeguards to mitigate the impact on patient privacy, or prevent abuse of surveillance systems – for example, a lack of consideration

of the visibility of Oxevision screens to other patients, and no means in place to prevent staff from potentially recording footage for personal use in circumstances where staff are able to use personal electronic devices on wards while accessing Oxevision video feeds.

3.6. Despite the stark impacts on patient privacy of the use of such surveillance systems, SO has found that there is a lack of transparency on many wards regarding their use, including arrangements for obtaining patients' informed consent to be filmed, as well as how any refusal or withdrawal of that consent is responded to. Such explanations as are available are inconsistent and unsatisfactory.

3.7. SO has made requests under the Freedom of Information Act 2000 to various NHS Trusts that use Oxevision, including for information relating to patient consent to the use of VBMS and the patient engagement process in obtaining that consent.[5] 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 or of the patient's rights to 'opt-out'.

3.8. The Oxevision Standard Operating Procedure, released by EPUT in response to our Freedom of Information request in 2023, exhibited at SO135, outlines at 5.2 that:

> *"Oxevision is continually switched on and monitored in every bedroom as part of the safety care plan. Therefore all patients are opted in upon admission as part of the standard ward practice."*

3.9. SO is not aware of whether this Standard Operating Procedure has since been changed, or whether other iterations of the same document since the system's introduction may have differed.

3.10. The use of surveillance on mental health wards is a form of "Restrictive Practice".[6] Advice issued to mental health providers by NHS England (exhibited at SO376) following Stop Oxevision's open letter regarding the use of Oxevision in inpatient settings (exhibited at SO377), confirmed that: *"any VBMS which operates as a form of surveillance should never be implemented in a blanket*

[5] See Exhibit List SO7-SO374
[6] See Exhibit List SO375

way and that any decisions to use VBMS in patient bedrooms should be made in a person-centred way, with the patient themselves where they have capacity to make a decision or through a Best Interest process compliant with the Mental Capacity Act 2005 where they lack capacity to consent". NHS England called on all services to ensure that *"any decision to use such systems has a legitimate aim and is both lawful and fair. Their use must also be proportionate to the aim. We are, therefore, asking all services to please review, clinically and ethically, current VBMS practice within your organisation to ensure that your use of these technologies aligns with the principles of least restrictive, compassionate, therapeutic and personalised care"*.

3.11. NHS England also encouraged Trusts to review *"what records are kept about the decision to use and the use of such systems, what information is provided to patients, their families and staff about the use of such systems, how informed consent is obtained, and how information gathered through Vision Based Monitoring systems is stored, accessed and utilised".* However, patient accounts shared with SO have made reference to limited, and at times completely inaccurate, information being shared by Trusts regarding their surveillance systems – with patients having been wrongly informed that the system did not include a camera, for example.[7] Some patients and former patients have shared with SO that they only learnt about Oxevision and how it worked from our campaign, having wondered during their admissions what the box on the wall of their room was.[8]

3.12. It appears from some of the accounts shared with SO that some wards rely upon the presence of posters about Oxevision to provide information to patients about the system,[9] rather than discussions about the system forming part of individual patients' onboarding admission processes. This approach is in itself deficient, in SO's view, because it is not patient-centric or personalised. However, even if use of a poster was capable of being a sufficient means of informing patients about the use of a surveillance system in their bedrooms, SO have identified significant limitations in the posters actually being used.

[7] See for example accounts of Anonymous 3, Published 3, and Published 5
[8] See for example account of "Katie"
[9] See for example account of Anonymous 1

3.13. Posters used by Trusts regarding the Oxevision system, obtained by SO in through Freedom of Information requests, often contained information that is inaccessible, contains complicated jargon and is not easy to read.[10] These posters may have been updated since the Freedom of Information responses were supplied. However, none of the posters SO have seen in response to our Freedom of Information requests explained that data is shared with Oxehealth; only two posters informed patients that the technology tracks when and how often they go to the toilet; and seven of them did not even include the word camera, instead using vague and confusing terms like "optical sensor". The EPUT poster received by SO, for example, do not explain that video footage from the Oxevision system is recorded, do not mention that the system includes an activity tracker, do not mention that video footage is retained in the event of an incident, and do not mention that Oxehealth has access to data collected.[11] The ability of patients to provide informed consent is totally undermined where they do not have access to information which would ground that consent.

3.14. A particularly stark omission, not only from the EPUT posters, but the majority of the posters received by SO in response to our Freedom of Information requests, is any mention of the right of patients to object to the use of the system, or the process they can follow in order to do so, or in order to raise concerns.

3.15. That lack of transparency ensuring informed consent is compounded by a lack of clarity about procedures to withdraw consent, which is another common theme reflected in many patient experiences shared with SO. Indeed, even where patients seek to withdraw consent for the use of Oxevision or other systems in the privacy of their bedrooms, some have shared with us that they have been faced with refusal to switch the system off.[12] Responses from several of the Trusts to which SO have made Freedom of Information requests, reveal that they had no policies in place relating to obtaining informed consent or the subsequent withdrawal of consent. Some indicated there was no option to opt out, and some, including EPUT, made clear that even where consent

[10] See for example exhibits SO52, SO53, SO68, SO94, SO103, SO128, SO166, SO225, SO253, SO309, SO310, SO314, SO315, SO327, SO358, SO359, SO360, SO361, SO362, SO374.
[11] Exhibit SO128
[12] See for example accounts of Anonymous 3, Anonymous 1, Published 1 (on some occasions), Published 2, Published 4, and Published 5

was withdrawn by a patient, this may not result in the system being switched off in any event. The EPUT Standard Operating Procedure disclosed to SO (exhibited at SO135), for example, states:

> *"However if a patient refuses the use of the Oxevision system in their room, the responsible clinician should be informed. The system is not to be switched off until an MDT meeting within 72 hours has taken place, here they will decide whether to withdraw the use of the assistive technology if in the best interest of the patient, taking into account the balance with individual preference, safety management, mental capacity and other alternatives, just as they would for other treatment approaches."*

3.16. Of additional concern, as illustrated by the patient experiences in Annex 1, is the fact that withdrawals of patient consent or raising of patient concerns can be met with hostility by ward staff,[13] and on at least one occasion, threats to raise observation levels.[14] Patients have shared with SO that their objections to the use of surveillance systems are often viewed by ward staff as obstructive, and they have been required to justify their objections including by disclosure of distressing historical trauma which they otherwise may not have wished to discuss. Even where the system is switched off, a red light displays on the unit in the patient's bedroom regardless, meaning that patients have no way of knowing whether the camera is on or not, or indeed, as one patient has shared with us, whether the camera has been switched back on despite their objections.[15]

3.17. SO is aware that the CQC has also raised concerns about the consent processes employed by EPUT in respect of its use of Oxevision, including in its 2023 report (exhibited at SO378) a requirement for the Trust to *"ensure patients understand the use of the contact-free patient monitoring and management system, including why it is used and how information will be stored and accessed"* and to ensure that *"care and treatment is provided with the consent of the patient around the contact-free patient monitoring and management system"*.[16] The CQC noted that on inspection of Galleywood, Willow and Peter Bruff Wards in November 2022, there were no records

[13] See for example account of Published 2, and Published 6
[14] See for example account of Published 2
[15] See for example account of Published 1
[16] Exhibit SO378 p8

of consent in those patient records that were sampled. Moreover, welcome packs on two further wards (Kelvedon and Ardleigh) included no information about the use of Oxevision.[17]

3.18. SO also has concerns about the retention and use of footage captured by Oxevision and other vision-based monitoring systems. Although it is clear that there is a capacity for footage to be clipped and retained, the circumstances in which this may occur, the processes which apply, the timeframes for retention and the use to which the footage can be put, remain unclear. As discussed in detail below at §5.10, SO has become aware of footage from Oxevision cameras having been used in academic studies without either the consent or knowledge of the patients concerned. The footage in question was collected from the inpatient wards of a number of Trusts, including EPUT. These concerns apply to all forms of video recording on mental health wards. The CQC noted in their 2023 inspection report in respect of EPUT, for example, that body worn video footage was being used for training purposes.[18] The report did not address the question of whether the footage was anonymised, how footage for training purposes were selected, or whether the fact that footage was being retained and shared for these purposes was made clear to patients.

3.19. Of equal concern, is the awareness raised by organisations such as the National Survivor User Network[19] regarding the way in which the use of surveillance cameras on mental health wards can feed into the *"criminalisation of distress"*,[20] with concerns that footage may be selectively clipped so as to decontextualise what is captured, and that surveillance systems are used on mental health wards as a means of collecting evidence for criminal prosecutions of patients in distress. SO shares these concerns, particularly in light of the account of patients which describe ward staff exploiting blind spots in vision-based monitoring systems, or selectively switching off body worn video cameras in order to ensure their own conduct is not captured on footage.[21] It is also staff, rather than patients, who control when footage is retained, further resulting in a power

[17] Ibid p102
[18] CQC Inspection Report for EPUT Dated 12.07.2023 p88 and p96
[19] The National Survivor User Network is a network of people and groups with lived experience of mental ill-health, distress and trauma working to redistribute power and resources in mental health. See: www.nsun.org.uk
[20] See, for example: https://committees.parliament.uk/writtenevidence/40801/pdf/
[21] See for example accounts of Anonymous 3 and Anonymous 1

imbalance in respect of future use of footage and opening at least the possibility of footage being retained without patient consent or notification for use in staff training, or subsequent investigations.

Impact on patient mental health

3.20. In its guidance on the use of Restrictive Practices published in March 2024, the CQC emphasises the *"significant impact"* that the use of Restrictive Practices can have on *"a person's mental health, physical health, and their emotional wellbeing"*.[22] This is reinforced by first-hand accounts shared with SO, where patients report not only discomfort at the prospect of monitoring via a surveillance system such as Oxevision, but also an exacerbation of their symptoms of mental ill health, and a resurgence of historic trauma, as a result of the introduction of the system.[23]

3.21. SO has found no evidence in the course of its research that there was any 'lived experience' involvement in the earliest stages of creating the Oxevision technology. Of note, the system's development was initially targeted at settings completely distinct from mental health wards. Until last year, Oxehealth hailed "Experts by Experience" on its website,[24] describing that group as a lived experience advisory group, but it did not provide any transparency regarding the recruitment process for that group or the criteria for selection, It is not clear, for example, how many of those "Experts" are current or former mental health patients with experience of Oxevision. SO is concerned that rather than meaningful co-production, which would require lived patient experience and involvement from the outset of developing this project, the "Experts by Experience" were invited, perhaps even selectively invited, to contribute only after the fact, in a retrospective mitigating or justifying exercise.

3.22. Accounts shared with SO include descriptions of patients taking extreme steps to avoid surveillance and regain some measure of control and privacy when subjected to such vision-based monitoring systems, including reports of patients avoiding sleeping in their rooms or their

[22] https://www.cqc.org.uk/publications/monitoring-mental-health-act/2022-2023/restrictive-practices
[23] See for example accounts of Anonymous 1. Anonymous 3, Published 1, "David", "Aisha", Published 2, Published 3, and Published 4
[24] https://web.archive.org/web/20230719222023/https:/www.oxehealth.com/about-us

beds, or avoiding using the bathroom out of fear that cameras would see them in a state of undress.[25]

3.23. Far from making patients safer, the patient experiences SO has collated, indicate that the use of vision-based monitoring systems not only makes patients feel unsafe, but also may contributes to greater risks to their safety. By way of example, patients report changes in their patterns of self-harm to exploit loopholes or blind spots in the system, or the use of novel methods of self-harm which cannot be remotely monitored using a system such as Oxevision, such as dietary restriction.[26]

3.24. Notably, the concerns raised in patient experiences shared with SO, about a worsening impact on patient mental health, are echoed in other studies. In a 2023 study by North East Together, exhibited at SO379, participants reported feelings of being watched or 'spied on' and of intrusion and distrust which, for many, exacerbated their pre-admission distress.

3.25. There is emerging academic research regarding the adverse impacts of surveillance-based technologies,[27] but it is not difficult to understand how vulnerable patients, particularly those with traumatic histories, or with paranoid beliefs, are likely to be negatively impacted by the introduction of ever-present surveillance technologies into their personal living spaces. This negative impact can only be enhanced in circumstances where, as the accounts SO have received suggest, limited, misleading, or inaccurate information about the functioning of the system is available, and where patient objections to its use are more likely to be problematised, than to be respected and implemented.

Staffing issues

3.26. SO is concerned that Oxevision and other VBMS 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 on mental health wards. In that context, the introduction of such systems risks widening pre-existing and underlying cracks in the system, which continue to go unaddressed.

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[25] See for example accounts of Anonymous 3, Anonymous 2, Published 1,
[26] See for example accounts of Anonymous 1, Anonymous 3, Published 1, Published 4, Published 2, and "David"
[27] See for example: Desai, S. (2022) Surveillance practices and mental health: the impact of CCTV inside mental health wards Milton Park, Abingdon, Oxon: Routledge, exhibited at SO380

3.27. While Oxevision's policy states that the system does not replace therapeutic engagement, the evidence collated by SO suggests that this is exactly what is happening in practice. Patient accounts, as illustrated in Annex 1, frequently reference a reduction or absence of in-person therapeutic engagement by staff on wards where systems such as Oxevision are employed.[28]

3.28. The use of the Oxevision system and other VBMS on wards to allow the conduct of remote observations and checks on patients, at best reduces, and at worst removes, the opportunity for therapeutic engagement between staff and patients. In the absence of face to face engagement, patients are unaware that staff are remotely checking on them, and have no opportunity to engage with staff as a result, because the staff member conducting the check is not present. In the context of national shortages in staffing for mental health wards, and the high pressure environment many wards present, it is unsurprising that the introduction of a system like Oxevision – which offers real time access to all patients in from one device – may be relied upon by Trusts or by staff as an alternative to in-person engagement, even where this is plainly to the detriment of patients.

3.29. The lived experience of patients in the table at Annex 1 illustrates that patients are being put at risk by poor staffing practices connected to the use of Oxevision on wards. Anonymous 1 provides highly concerning accounts of reliance on the Oxevision system as a substitution for in person observations, resulting in dangerous and distressing situations for her personally where she has been left unattended and without therapeutic support following lengthy episodes of purging in the bathroom, during and following an episode of seizure where her breathing was impaired by a blanket covering her face, and during and following the application of a ligature. Likewise, the description provided by Anonymous 3 of an incident of self-harm by another patient who was left in a distressed state without in person support because staff were of the view she could be remotely monitored using Oxevision, and because the presence of the camera in that patients' room was seen as evidence she was ligaturing "for attention", must raise fundamental and serious concerns that patients are being put at risk by the use of these systems on wards.

[28] See for example accounts of Anonymous 1, Anonymous 3, Published 1, "David", "Charlie", "Katie", and Published 3

3.30. SO is concerned that this is not just an abstract risk, or even a matter of individual abuse of a system, but an economic incentive for the employment of VBMS such as Oxevision. Oxehealth goes as far as to positively advertise that its system releases 3 hours of staff time for every 12 hour shift, and can save a net figure of $1.2M for a 300-bed provider.[29] An economic assessment of the "positive" impact of Oxevision on care costs highlights that particular savings accrue through a reduced need for additional staff to be employed to cover 1:1 patient engagement or observations.[30] Some Trusts have explicitly linked the installation of Oxevision to a reduction of staffing costs, including as a means of covering the investment of the system's installation.[31]

3.31. Promotional material developed by Oxevision in partnership with Trusts, including EPUT, as part of their *"Stories from the Ward"* series, also includes accounts of 1:1 observations being reduced by recourse to the technology.[32] A Case Study prepared in respect of EPUT's early implementation of Oxevision during the pandemic, but which has now been removed from Oxehealth's website, refers to benefits of the system's introduction including not just fewer observations, but also *"[f]aster observations rounds"*.[33] It should be noted that there is a lack of detail in these promotional materials as to the methodology, ethics approval, and peer review processes involved in their creation.

3.32. Whilst being on 1:1 constant or regular observations is undoubtedly restrictive for patients, the implications of implementing technology to compensate for low staff levels raises significant questions for the quality of patient care and intervention. Moreover, it gives rise to concerns about healthcare services evolving for the benefit of Trusts and their staff, rather than responding to the individual needs of patients. It is also misleading to suggest that the introduction of VBM technology, is a means of reducing a Restrictive Practice in the form of observations, when the technology itself represents another potentially more intrusive and less regulated form of

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[29] https://www.oxehealth.com/us/how-it-helps
[30] Exhibited at SO381
[31] See for example discussion of the case study of Coventry & Warwickshire Partnership Trust's use of Oxevision on Older People's wards in SO234 p13
[32] https://assets-global.website-files.com/5f567869171c90518f161723/648886320e73b52807edb195_Oxevision%20stories%20from%20the%20ward%20ACUTE.pdf See for example stories including "Lina" (Oxford Health NHS Foundation Trust), "Habiba" (Coventry and Warwickshire Partnership NHS Foundation Trust), "Sierra" (EPUT)
[33] https://web.archive.org/web/20230804103753/https://assets-global.website-files.com/5f567869171c90518f161723/631b45f6283325beaa647f42_EPUT_FFR_UK_D_1.1.pdf

Restrictive Practice, frequently imposed in a blanket manner, and, on the accounts of many patients that SO has spoken to, without the potential corresponding therapeutic value that face to face, or human to human observations can offer.[34]

3.33. We are also aware that alarm fatigue is recognised as a significant patient safety issue for most types of patient monitoring technology – and the same is true for Oxevison and other VBMS. Evidence at inquests has exposed delays in staff responding to alarms on mental health wards, even resetting them without making necessary checks on patient safety. This is not a new phenomenon. Alarm fatigue in hospital environments has been recognised as a significant area of concern in US, with the Food and Drug Administration announcing a targeting of the problem in 2011.[35]

3.34. This substitution of in person care for remote monitoring is leading, tragically, to fatal outcomes. SO are aware of at least two deaths of patients on mental health wards that use Oxevision, where inquests have concluded that in person checks were not taking place.[36]

3.35. SO are also concerned about the risk of staff misunderstanding or over-estimating the functionalities, or capability of VBMS such as Oxevision. Some of the patient experiences which have been shared with us suggest that staff on various wards do not have a good understanding of how Oxevision works. For example, Anonymous 3 and Published 1 were erroneously told during their admission that it was impossible to turn off the Oxevision system. Published 1 also noted that on different admissions to different wards, she frequently found that staff did not know how to disable the system. If a system can be switched off, or whether it can be switched off, may seem a simple question, however, lack of staff awareness of these issues can have potentially fatal consequences. A CQC report for Central and North West London NHS Foundation Trust provided a description of a death in a health based place of safety room at St Charles *"where staff*

[34] See for example accounts of Anonymous 1, Anonymous 3, and Published 1
[35] https://www.accreditationqualitycenter.com/articles/ahap-blog-joint-commission-and-fda-target-alarm-fatigue
[36] Inquest touching upon death of Henok Zaid Gebrsslasie (died 12 August 2021 under the care of Coventry and Warwickshire Partnership Trust), coverage available here: https://www.bbc.co.uk/news/articles/c4g05ewpk52o and Inquest touching upon the death of Morgan-Rose Hart (died 2 December 2023 under the care of EPUT), coverage available here: https://www.bbc.co.uk/news/uk-england-essex-67595301

had not sufficiently engaged and monitored the patient and had relied on Oxehealth (a patient monitoring system) which at the time was switched off".[37]

3.36. The failure to understand these systems, however, appears to go wider to this, and stray into a misunderstanding of what the system can do. Anonymous 3, for example, was advised by staff that if someone ligatured on their ward, they would know about it because of Oxevision. While Oxevision may allow staff to, for example, observe a patient via the camera functionality and see that a patient has ligatured, it does not actually alert staff to a ligature event taking place. It cannot alert staff to changes in oxygen or pulse levels. Oxevision can only take vital signs measurements when certain conditions are met, and at the prompting of staff. Anonymous 3 describes an incident where staff appear to have left a highly distressed patient who they knew had ligatured without any in person support because of a mistaken belief that Oxevision would notify them if the ligature was serious. It is unclear how staff considered that this would take place. SO are concerned that staff decisions to rely upon technology as a substitution for in person care may be founded on fundamental misunderstandings of what that technology is capable of doing, and that this is exposing patients to real and serious risks. This includes risks to physical safety – the patient described in Anonymous 3's account could have been seriously harmed in the absence of appropriate supervision where she had been left alone with a ligature in place.In order to deliver therapeutic, individualised care, SO are of the view that human engagement is a fundamental necessity. The reliance on technology as a substitute for human contact, or for human decision-making, places patients at risk.

Lack of oversight

3.37. As outlined above, the use of Oxevision and other VBMS has grown rapidly in recent years. Over the course of the last 10 years, Oxehealth's VBMS has been deployed across half of all NHS Trusts, including since 2020, EPUT, impacting the experiences of many inpatients receiving mental health treatment – individuals who are at a particularly vulnerable stage in their lives. SO is concerned 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

[37] SO382 p27

of oversight from regulatory bodies. SO is and remains particularly concerned that the regulatory bodies have been slow to recognise and respond to the concerns being expressed by the patients, their families and the staff whom these systems directly impact.

3.38. Notwithstanding that the Oxevision system has been marketed to mental health wards since 2015, SO has identified at least 6 CQC Trust inspections between 2018 and 2022 where, although the CQC identified the use of remote patient monitoring tools such as Oxevision, the specific question of patient consent to the employment of those systems is not discussed at all.[38] In its 2022 inspection report of West London NHS Trust's High Secure Hospitals, the CQC stated:

> *"Patient consultations had taken place around the introduction of remote monitoring of vital physical health signs. Whilst this was a clinical matter, the security team were involved in initial patient consultations because they did not want patients to confuse the vital signs monitoring with CCTV and think that the hospital was reneging on its promise not to have CCTV in bedrooms and bathrooms. Patient identifiable data did not leave the hospital site, it remained on internal servers unless specifically required for inquests. Only anonymised patient data was shared with the system provider. We found patients were well-informed about the remote monitoring."*[39]

3.39. While superficially reassuring, SO is aware from Freedom of Information requests made to West London NHS Trust that Oxevision is used in all inpatient bedrooms by the Trust. If, as would appear to be the case, the CQC is referring above to Oxevision when describing a "remote monitoring" system, this raises real concerns for SO that patients at the Trust were being provided with at best disingenuous information about the functioning of the system, and that the CQC do not appear to have interrogated this appropriately. We note that Oxehealth formerly included on its website express reference to the system as *"Not CCTV"*, though this appears to have since

[38] CQC Inspection Reports for Coventry and Warwickshire Partnership NHS Trust dated 21.12.2018, Derbyshire Healthcare NHS Foundation Trust dated 06.03.2020, Kent and Medway NHS and Social Care Partnership Trust dated 24.02.2022, East London NHS Foundation Trust dated 13.01.2022, South London and Maudsley NHS Foundation Trust dated 20.08.2021, and North East London NHS Foundation Trust dated 26.08.2022 (all exhibited at SO383 – SO388

[39] CQC Inspection Report West London NHS Trust High Secure Hospitals dated 23.06.2022 p24 (exhibited at SO389)

been removed.[40] As detailed above, while Oxevision can be used to monitor vital signs in limited circumstances (where a patient is alone in a room, not moving, and has sufficient visible skin), the system clearly includes a camera and records footage which is stored by Trusts and can be retained. There is no neat delineation between Oxevision and other CCTV systems in so far as both record video footage and retain this.

3.40. It was not until 2023, that NHS England wrote to Trusts regarding the use of VBMS.[41] It was not until 2025, that the Royal College of Psychiatrists called for the implementation of Oxevision and other VBMS to be halted[42], and that the Secretary of State for Health and Social Care confirmed that NHS England planned to publish new guidance on the use of such systems[43]. These steps, albeit belatedly taken, are responses to, and as a direct result of, a decade of campaigning by survivors, and groups like SO, raising repeated and serious concerns about the ongoing impacts of VBMS on patients. However, they do not go far enough.

3.41. On 7 February 2025, NHS England published its *"Principles for using digital technologies in mental health inpatient treatment and care"*.[44] SO immediately observe that these principles begin on a weak foundation – they are unenforceable, and provide no safeguards for patients or staff, and no obligations or accountability processes to ensure Trust compliance. The principles do not clearly define what constitutes "digital technology", do not reference Oxevision by name, and do not acknowledge or recognise the grave harms that have been associated with this technology. In SO's view, the principles fail to address fundamental legal and ethical issues with Oxevision and similar technologies. Without direct, decisive action that ensures real-world safeguarding and accountability, private and 'for-profit' technologies will continue to sell these potentially harmful, but attractively cost-saving systems to Trusts. In the absence of transparency and accountability, claims of 'human rights approaches to care', and 'high-quality evidence' will remain untested, inauthentic and unenforceable.

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[40] https://web.archive.org/web/20230324040549/https:/www.oxehealth.com/us/oxevision
[41] Exhibited at SO377
[42] https://www.bbc.co.uk/news/articles/cq8kqzgel2no
[43] https://members.parliament.uk/member/5271/writtenquestions#expand-1757996
[44] Exhibited at SO390

3.42. In SO's open statement on the publication of the principles, we called upon NHS England to take a clearer position on Oxevision and similar technologies, and to commit to the development of enforceable regulation around their usage.[45] We continue to await a response.

Discrimination & disproportionate impact

3.43. SO is concerned about the risk of discrimination in the use of Oxevision, and the inadequate consideration of how the use of Oxevision and other VBMS can impact upon people by reference to the nine protected characteristics enshrined within the Equality Act 2010.

3.44. We are aware from the Freedom of Information requests which we have conducted that some Trusts, such as EPUT, at the time of providing their response to our requests, had not even conducted Equality Impact Assessments for their use of Oxevision. Other Trusts have conducted Equality Impact Assessments which appear limited in their reach and efficacy. For example, Cambridgeshire and Peterborough NHS Foundation Trust does not appear to have referenced any protected characteristic groups in its Equality Impact Assessment, nor considered the particular impacts the system may have on any such groups.[46] The Equality Impact Assessment conducted by Devon Partnership Trust, meanwhile, concludes that while various protected groups access its services, none will be impacted by the introduction of Oxevision – a conclusion reached without any engagement or consultation with any of the protected characteristic groups in question.[47]

3.45. By contrast, Tees, Esk and Wear Valleys NHS Foundation Trust have concluded in its assessment that there are potential for particular negative impacts upon six of the nine protected characteristic groups, including noting:

a. Service users with disabilities may have their mental health particularly negatively impacted by the system;

b. Service users with learning disabilities may not be able to fully understand how the system will impact on their privacy and dignity and may not be able to meaningfully consent to its use;

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[45] https://stopoxevision.wordpress.com/2025/02/11/empty-words-false-promises-and-window-dressing-an-overview-nhs-englands-new-digital-principles/
[46] Exhibited at SO32
[47] Exhibited at SO109

c. The dignity and privacy of female service users may be impacted by male members of staff conducting Oxevision checks on them while they are, for example, partially clothed;

d. Transgender patients may be outed if they are observed by staff when undressed;

e. The privacy and dignity of children, who may be observed via Oxevision while undressing, may be compromised.

3.46. However, beyond noting that individual care plans should reflect any reasonable adjustments introduced, this Equality Impact Assessment does not offer potential solutions, nor outline how individual patients will be consulted on their care or even made aware of these risks. There is also a failure to recognise the risk that cameras may particularly negatively impact upon groups such as survivors of sexual violence and/or domestic abuse.[48]

3.47. Given the widespread and increasing use of VBMS on mental health wards, it is a matter of particular concern that little, if any, regard appears to be given to the disproportionate and potentially discriminatory impact of the technology on individuals with protected characteristics.

Section 4: Research

4.1. SO is deeply concerned by the flawed academic basis for the promotion of systems like Oxevision.

NIHR Review

4.2. The bulk of the existing academic research on Oxevision has recently been reviewed by members of the National Institute for Health and Care Research (NIHR) Policy Research Unit in Mental Health (MHPRU), based at King's College London and University College London, in a peer-reviewed article published in BMC Medicine in November 2024.[49] (An earlier version of this article was published in April 2024 on medRxiv, a repository of publishing preprints in the health sciences). **[I/S]**, part of SO, is one of the co-authors of the review and the paper draws on SO's work in several respects. The need for a review of the research on surveillance technologies is explained in part by reference to the significant ethical, privacy, safety and health

[48] Exhibited at SO355

[49] Griffiths, J.L., (et al). (2024). The use and impact of surveillance-based technology initiatives in inpatient and acute mental health settings: a systematic review. *BMC Medicine*, 22(1). doi:https://doi.org/10.1186/s12916-024-03673-9. Exhibited at SO391

concerns raised by SO regarding the use of VBMS in mental health settings.[50] The paper also makes use of lived experience accounts published on SO's website and information gathered through FOIs on the consent policies for Oxevision held by different Trusts.

4.3. The article entitled, '*The use and impact of surveillance-based technologies in inpatient and acute mental health settings: a systematic review'*, critically analyses the available academic research into VBMS, assessing the quality and impartiality of available evidence used to reach conclusions as to the efficacy and safety of VBMS. It also reviews research into other surveillance technologies used in inpatient settings, such as CCTV and body worn video. It is a useful overview of the research into Oxevision of which SO is aware, and upon which Oxehealth relies to promote its product. The paper raises serious issues concerning the quality, impartiality and conclusions of the existing academic research conducted on the use of Oxevision.

4.4. SO refers to this review article in the *article 'Misrepresentation of data in Oxehealth research papers'*, which is published on our website.[51]

4.5. The authors of the study note that this is the '*first systematic review of a range of surveillance technologies in inpatient mental health settings*', including of VBMS generally and Oxevision specifically.[52] The paper concludes that '*there is currently insufficient evidence to suggest that surveillance technologies in inpatient mental health settings are achieving the outcomes they have been employed to achieve'*.[53]

4.6. The paper reviews nine studies on VBMS and management:

a. Dewa et al. *"A service evaluation of passive remote monitoring technology for patients in a high-secure forensic psychiatric hospital: a qualitative study"*. BMC Psychiatry. 2023. [The only study which does not report a conflict of interest and which is identified as of high quality]

b. Oxehealth. Patient experience with Oxevision. 2022. [This article appears to have since been withdrawn from its website by Oxehealth] (Exhibited at SO392)

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[50] Ibid (20)
[51] https://stopoxevision.wordpress.com/2025/01/06/misrepresentation-of-data-in-oxehealth-research-papers/
[52] SO391 at (2)
[53] Ibid (52)

c. Clark et al. *"Non-contact physical health monitoring in mental health seclusion"*. Journal of Psychiatric Intensive Care. 2022. (Exhibited at SO393)

d. Buckley et al. *"Economic impact of a vision-based patient monitoring system across five NHS mental health trusts"*. PLOS Digital Health. 2024. (Exhibited at SO394)

e. Malcolm et al. *"Economic evaluation of a vision-based monitoring and management system in addition to standard care for adults admitted to psychiatric intensive care units in England"*. J Med Econ. 2022. (Exhibited at SO381)

f. Malcolm et al. *"Economic evaluation of a vision-based patient monitoring and management system in an acute adult and an older adult mental health hospital in England"*. J Med Econ. 2022. (Exhibited at SO395)

g. Ndebele et al. *"Non-contact monitoring to support care in acute inpatient mental health"*. J Ment Health. 2023. (Exhibited at SO396)

h. Ndebele et al. *"Non-contact health monitoring to support care in a psychiatric intensive care unit"*. Journal of Psychiatric Intensive Care. 2022. (Exhibited at SO397)

i. Barrera et al. *"Introducing artificial intelligence in acute psychiatric inpatient care: qualitative study of its use to conduct nursing observations"*. Evidence Based Mental Health. 2020. (Exhibited at SO398)

4.7. All of these studies were UK-based, and focused on Oxevision. Eight out of nine studies reported conflicts of interest – they were either funded by Oxehealth or co-authored by its employees. SO note that many of these articles were also co-authored by psychiatrists working at Coventry and Warwickshire Partnership NHS Trust, another early adopter of the system. Eight out of nine of the studies were rated 'low quality' based on the Mixed Methods Appraisal Tool.[54] The one study assessed as high quality was the only one which did not report any conflicts of interests.

4.8. A further paper on Oxevision was identified by NIHR which had been retracted by a journal due to an undeclared conflict of interest by the authors, who were employed by Oxehealth.[55]

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[54] http://mixedmethodsappraisaltoolpublic.pbworks.com/w/file/fetch/127916259/MMAT_2018_criteria-manual_2018-08-01_ENG.pdf

[55] The paper in question is Kekic et al. RETRACTED: Reduced self-harm on acute mental health wards following implementation of a vision-based monitoring system: Evidence from five NHS trusts". J Psychiatr Ment Health Nurs. 2024.

4.9. The NIHR review noted that the various studies identified aims of VBMS including less intrusive observations, improving safety and quality of care, monitoring risks and signs of agitation, preventing incidents, supporting care-planning, supporting compassionate and dignified care, and reducing NHS mental health care costs.

4.10. Three of the studies examined, calculated the costs of implementation, with a reduction in 1:1 observations being identified as the main driver of savings. Three studies reported lived experience involvement, but lacked methodological detail.

4.11. One of the studies looked at the pre-implementation perceptions of vision-based monitoring systems. It reported a conflict of interest and was assessed as low quality.

4.12. Six of the studies explored post-implementation perceptions of the Oxevision system. Five of those reported conflicts of interest and were assessed as low quality. Experiences of patients, staff, and carers were overall mixed, with some reporting less obtrusive observations and greater feelings of safety, and others raising ethical concerns, and reporting a negative impact on privacy, dignity, and human rights.

4.13. Seven of the studies reported on the effects of Oxevision on patient and staff safety, and patient clinical improvement, reporting that Oxevision reduced self-harm, reduced assaults, reduced costs, and in some cases reduced restrictive practices and improved symptoms of insomnia. The authors of each of those studies declared conflicts and the reports were assessed as low quality.

4.14. The NIHR review ultimately concluded that *"there is currently insufficient evidence to suggest that surveillance technologies in inpatient mental health settings are achieving the outcomes they have been employed to achieve"*, raising concerns about the low quality of research and high numbers of conflicts of interest. The review discussed possible causes of this including *"the financial interests of technology companies"* and noted that their 'lived experience' researchers highlighted discrepancies between the way surveillance technologies were described as being implemented in the literature, and their use in practice.

4.15. Beyond methodological concerns, the NIHR review also highlighted significant misrepresentations of data in Oxehealth studies, which had been replicated in other Oxehealth studies. For example, *"'the economic models used in two studies assume VBPMM [Vision Based*

Patient Monitoring and Management] reduces self-harm in patient bedrooms by 44%. However, the source for this figure, another Oxehealth study, reports a 44% relative reduction in self-harm rates in patients' bedrooms on two VBPMM wards compared to two control wards', whereas *'the actual reduction in self-harm rates on the VBPMM wards alone was only 22%"*.

4.16. Furthermore, in calculating self-harm treatment costs, the Oxehealth study used A&E fracture costs, rather than burn or cut treatment costs, which the NIHR review noted in a correction following contribution from SO, risked over-estimating costs savings.[56] Given these methodological limitations, the NIHR review concluded that claims about costs-saving were not currently supported by available evidence.

4.17. Finally, the NIHR review noted that given that any apparent costs savings were primarily driven by a reduction in 1:1 observations, there was a risk that *"the use of surveillance technologies to reduce staffing costs could result in decreased human interactions and so quality of care"*.

Research conducted by SO

4.18. As well as participating in and contributing to the most thorough review of research on the use of Oxevision to date, as is clear from the information set out earlier in this statement, SO has gathered lived experience accounts and conducted wide ranging FOI requests across Trusts to build up a national picture of the use of Oxevision by Trusts across the country and Trust policies and practices in relation to the technology. SO has analysed Oxehealth promotional material, CQC reports, and Oxehealth research to interrogate their claims of self-harm and costs reduction.

4.19. In conducting research, and in undertaking all of its work, SO is able to draw on the expertise of those with experience of academic research as well as lived experience of VBMS technology on wards.

4.20. SO has analysed the only study identified by the NIHR review which did not report a conflict of interest, Dewa et al 2023. SO considers that the evidence presented in this article does not support the conclusion drawn by its authors. The study in question is one of staff and patient attitudes to Oxevision at Broadmoor, a high secure psychiatric hospital. Despite acknowledging that both patients and staff raised concerns around *"big brother syndrome"*, privacy and dignity,

[56] https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-025-03979-2

knowledge and understanding, and imbalanced power dynamics in inpatient settings, the authors of the concluded that the technology was deemed generally acceptable on safety grounds which does not appear, to SO, consistent with those concerns.

4.21. Separately to the NIHR review, SO has also conducted an in-depth analysis of the Ndebele et al 2022 paper, referenced above at 4.7(h), which reports a 22% reduction in self-harm in bedrooms following the adoption of Oxevision. This study acknowledges itself that this figure does not *"reach statistical significance"*, i.e. that the researchers could not be confident that the results did not occur at random. The 22% figure in question also only occurs to reported incidents of self-harm, and reporting levels may vary based on a number of factors, and only to incidents in bedrooms. Whilst the introduction of cameras may lead to fewer incidents in bedrooms, this may result in more incidents in other areas of a ward.

4.22. SO also note that whilst there was a reported 22% reduction in reported self-harm incidents in bedrooms in the year with Oxevision as compared to the previous year, the previous year (the control ward) itself saw a 39% rise in rates of self-harm as compared to the year before that. In other words, the significant result of the study is that there was a bigger change in the rate of self-harm on the control ward than on the Oxevision ward, which cannot be attributed to the introduction of Oxevision.

Section 5: Formal Reviews and Complaints

5.1. SO has participated in a number of formal reviews concerning the use of Oxevision and other VBMS.

NHS England

5.2. On 21 July 2023, SO first wrote to NHS England to raise concerns regarding the use of Oxevision in inpatient settings, and to call on NHS England and individual mental health trusts to halt the rollout of the system pending an independent review of its legality, and potential risks. A copy of this letter is exhibited at SO376.

5.3. On 7 September 2023, NHS England wrote to providers of mental health services nationally, asking them not to use Oxevision in a blanket manner, and announced a review of the use of the system. A copy of this letter is exhibited at SO377.

5.4. On 26 February 2024, SO was invited by NHS England to address a "Digital Technologies" conference in Sheffield, in which concerns in respect of Oxevision's use were explored.[57]

5.5. In October 2024, SO received a draft copy of NHS England's *"Principles for using digital technologies in mental health inpatient treatment and care"*. We raised concerns by email in response and in a meeting with NHS England, including particularly the lack of clarity around the definition of digital technologies, and around the applicable legal framework.

5.6. On 7 February 2025, NHS England published its *"Principles for using digital technologies in mental health inpatient treatment and care"*. SO, supported by the National Survivor User Network, has published a detailed statement regarding ongoing concerns in respect of these principles, which are reflected in the concerns are set out above at § 3.38.[58]

Concerns raised to CQC

5.7. In December 2021, Tees, Esk and Wear Valleys NHS Trust produced a "Clinical Safety Case Report", which included reference to the CQC having cited the use of Oxevision as *"good practice"*.

5.8. On 24 August 2023, SO wrote to the CQC to ask for a meeting to discuss our concerns about the use of this technology as a blanket restriction and gross infringement of the rights and privacy of patients, and in particular to express concern about the CQC's apparent endorsement of the system's use.[59]

5.9. SO was invited to a meeting with the CQC following this correspondence and it is understood that the CQC commissioned an evidence review on the subject thereafter. The outcome of this review is not known.

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[57] https://stopoxevision.wordpress.com/2024/02/27/actions-are-stronger-than-words-we-raised-our-concerns-now-its-time-for-decision-makers-to-take-action/

[58] https://stopoxevision.wordpress.com/2025/02/11/empty-words-false-promises-and-window-dressing-an-overview-nhs-englands-new-digital-principles/

[59] A copy of this correspondence is exhibited at SO399

Concerns raised to Health Research Authority

5.10. On 15 July 2024, SO wrote to the NHS Health Research Authority (HRA), a government department responsible for protecting and promoting the interests of patients and the public in health and social care research. A copy of this correspondence is exhibited at SO400. In that correspondence, concerns were raised about the indication of favourable ethical opinion in respect of the a study titled *"Inpatient Safety in Mental Health"* (IRAS ID: 287453). We requested a review of this study, which was being conducted using data generated by Oxevision devices on inpatient wards operated by Trusts including EPUT. SO raised four areas of concern:

a. There had been at least two patient deaths in EPUT specifically during the research period of October 2021 to April 2023 in respect of which Oxevision was explicitly discussed in the subsequent coronial proceedings;

b. The study had not sought the consent of patients for their participation, or for the sharing of their personal data for the purposes of research or with people outside of their direct care team. SO noted that the study had stated that the data being examined from Oxevision was anonymised, and that the system was *"used as part of routine care"*. SO pointed to the frequent absence of explicit informed consent procedures for the use of Oxevision in routine clinical practice, and for the use of data generated by the system for research purposes, referring, among other sources, to the Standard Operating Procedures of the participating Trusts, their own Patient Information Sheets, and the 2023 CQC inspection report in respect of EPUT, to illustrate this;

c. While the study stated that data from Oxevision would be anonymised and pseudonymised before review, even blurred footage from Oxevision may allow for identification of individuals; and

d. The psychological harm and impact on patient welfare caused by systems such as Oxevision.

5.11. The HRA undertook an investigation into these concerns and the favourable ethics opinion, previously granted in 2021, was suspended following a lack of clarity on whether the Oxevision images being collected were in fact anonymous.[60]

Information Commissioner's Office

5.12. On 28 October 2024, SO submitted a formal complaint to the Information Commissioner's Office (ICO) regarding the use of Oxevision in psychiatric hospitals, focusing particularly on the volume of data being generated and processed which was arguable in excess of what could be necessary or proportionate, and the lack of informed consent for the use of the technology or the sharing of data collected by that technology. A copy of this complaint is exhibited at SO401.

5.13. This complaint is still extant and a response has not yet been received from the ICO.

Journal complaints

5.14. SO has also submitted a number of complaints to journals regarding articles about Oxevision which have included the potentially misleading self-harm costs figures, and the figures for reduction in self-harm rates as referenced at §4.15-4.16.[61] Complaints were made as follows:

a. To PLOS Digital Health on 13 September 2024 regarding *"Economic impact of a vision-based patient monitoring system across five NHS mental health trusts"* authored by Buckley et al. We were notified in October 2024 that the matter was under investigation by the publication ethics team and continue to await the outcome of that investigation.

b. To the Journal and Medical Economics on 15 September 2024 regarding *"Economic evaluation of a vision-based patient monitoring and management system in an acute adult and an older adult mental health hospital in England"* authored by Robert Malcolm et al. This complaint was not upheld. On 6 January 2025, SO was told that the Editor in Chief did not share its concerns, but there was no additional reasoning for this decision.

c. To the Journal of Mental Health (via correspondence with Taylor & Francis) on 14 September 2024 regarding *"Non-contact monitoring to support care in acute inpatient mental health"*

[60] https://www.hra.nhs.uk/about-us/news-updates/our-response-concerns-raised-about-inpatient-safety-mental-health-study/

[61] Correspondence in respect of each of these complaints is exhibited at SO402-SO404

authored by Ndebele et al. As of January 2025, we understand that this complaint remained under investigation.

Section 6: Challenges faced by SO

6.1. The main challenge that we have faced campaigning for SO has been the personal toll that it has taken upon all of us who are directly involved in the campaign's work. While the work of listening to, and collating patient experiences, and raising awareness about these systems is so important to us all, it also has an impact upon each of us. Many of us who volunteer our time to support SO do so in part because we have our own personal experiences of the mental health system, and the use of surveillance technologies on wards where we have been inpatients. This means that the subject matter that we focus on in the course of the campaign can be very personal and challenging for us. Listening to the stories of others, like those in the Annex 1, and attempting to give a voice to those who do not feel able to speak for themselves, is a powerful and vital experience, but it can also be extremely emotionally and mentally taxing. It can involve reviewing material or listening to accounts with very graphic details of self-harm and suicide methods, and very real suffering of very real people. All of this can have a very personal impact on each of us as individuals, which is one of the reasons that our campaign is so important – because it allows us to act collectively and to support one another when we are struggling.

6.2. Learning all that we have throughout our work about Oxevision and the use of other surveillance systems on wards has left some of us with more intense worries about cameras. Some of us have nightmares centring on Oxevision and cameras, because we spend so much time in the day thinking about it. Some get nervous when we see people with body worn cameras in public.

6.3. As with any campaign, SO has also faced setbacks, frustration, and distress, particularly when important concerns have been raised with various bodies such as NHS England and the CQC, and we have not yet seen these concerns adequately addressed. This leaves some of us struggling to have faith in these organisations that are meant to help keep patients safe, ensure they are receiving therapeutic and safe care and not being placed unnecessarily at risk. This

undermining of trust can extend to other figures of authority, like medical professionals, and on a personal level make it very difficult to access medical care when required because the foundational trust needed to reach out and ask for help has been so undermined.

STATEMENT OF TRUTH

I believe the content of this statement to be true.

Signed: [I/S] HAT PORTER

Name: Hat Porter

Dated: 24th March 2025