Witness Name: Stop Oxevision

Statement No.: 2

THE LAMPARD INQUIRY

SECOND WITNESS STATEMENT OF STOP OXEVISION

This statement is provided in supplement to the First Witness Statement of Stop Oxevision, dated 24 March 2025. This 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: Introduction

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.

1.2. Following receipt of a request under Rule 9 of the Inquiry Rules dated 21 February 2025, we provided a witness statement to the Lampard Inquiry to assist with the investigation of the use of technologies including Oxevision on mental health wards. That statement is dated 24 March 2025. Having provided it to the Inquiry, Stop Oxevision was invited to give oral evidence during the April – May 2025 public hearings.

1.3. A decision was made by the Inquiry Chair, Baroness Lampard, on 9 May 2025 to postpone hearing Oxevision evidence which was due to be heard on 14 May 2025 because EPUT introduced a second witness statement of Zephan Trent, dated 9 May 2025. For personal reasons it was necessary for me, Hat Porter, to provide my oral evidence about Oxevision, as planned on 14 May 2025. In the event, this was in a private hearing with the Chair on 14 May 2025. That evidence was recorded in full with the intention that it be broadcast by the Inquiry publicly when evidence would be heard publicly about Oxevision. As a decision had been made to postpone the Oxevision evidence to provide the Inquiry more time for a proper review of the new EPUT evidence, I was not given an opportunity to answer questions about the new evidence.

1.4. As a result, I, Hat Porter, have provided this further statement on behalf of SO. As with the previous statement, much of this statement is written in the collective "we" to reflect the common position of SO, but I have also shared personal experiences at points in this statement on my own behalf.

1.5. We are providing this supplementary statement to address a number of discrete issues which have arisen in this new disclosure provided by the Inquiry, or have otherwise developed, since the provision of our First Witness Statement, with the hope that this information will further assist the Chair with her investigation and fulfilment of this Inquiry's Terms of Reference. It also seeks to address three areas that I was asked about during my oral evidence, in which I was invited to provide further evidence on to assist the Inquiry.

1.6. I have begun this statement by addressing those three areas before addressing EPUT's new evidence, in the form of the Second Witness Statement of Zephan Trent, and finally discussing a number of new developments in respect of Oxehealth.

Section 2: Analysis of Figures

Early Insights Report

1.1. In my May 2025 oral evidence to the Inquiry on behalf of Stop Oxevision, I referred to analysis that I had conducted of figures included in EPUT's Early Insights Report. I provide below some further detail to assist the Inquiry in its consideration of this data.

1.2. The "*Early Insights and Implementation Lessons Learned*" report (exhibit **LC/31**) is a document produced by EPUT and Oxehealth summarising data collected following the implementation of Oxevision on two wards (Ardleigh and Peter Bruff). The document, and associated data, was used by Oxehealth to promote their product and by EPUT to present to its Board of Directors, in support of a recommendation that the implementation of Oxevision should be expanded to more EPUT wards. This data is presented in Zephan Trent's First Witness Statement, without analysis of the methodological limitations of the study (paragraph 19).

1.3. In summary, the Early Insights Report includes statistics relating to two separate questionnaires provided to staff and patients regarding the use of Oxevision, reporting data from 33 staff members and only 15 patients. Staff were asked to rate the extent to which they agree with a

statement on a 6-point scale, whilst patients were asked to do the same but using a 5 point scale ((1) strongly disagree, (2) disagree, (3) no opinion, (4) agree, (5) strongly agree). Although a 3/5 rating was described as having "no opinion", it is conceivable that respondents who selected this rating, did so to reflect having mixed or uncertain feelings. However, in summarising the responses of patients, EPUT has excluded all patient respondents who opted for option 3 on the questionnaire form. Excluding the responses of some patients in this way has arguably skewed the figures cited in the report. For example, where the report states that 75% of patients surveyed felt that the system keeps them safer, this figure was obtained by excluding the perspectives of 3 patients. Recalculating the percentage including all 15 of the responses provided by patients, the percentage is notably lower at only 60%. Similarly, while the report asserts that 45% of patients surveyed felt that the system *"gives them a greater sense of privacy and dignity on the ward"*, when the 4 respondents who were excluded by EPUT (because they selected option 3) are included, the real figure is in fact just 33%.

1.4. This approach to analysis of data obtained through Likert scales is far from typical, and where there are discrepancies between how patient and staff responses were handled, it is important that those discrepancies are justified. We note that there are also peculiarities and issues with how data has been presented in academic studies in support of the use of Oxevision, and refer to our First Witness Statement where this is discussed further.

<u>EPUT monthly usage reports</u>

1.5. The monthly usage reports (exhibit ZT-041) were reports generated by Oxehealth detailing the usage of Oxevision across all wards in the EPUT estate for July 2024.

1.6. Again, in preparation of giving oral evidence I reviewed and analysed the EPUT monthly usage reports. I discussed this in brief in the course of my oral evidence, but I provide further detail regarding these reports below to assist the Inquiry further in its investigations.

1.7. The following themes have emerged from that analysis:

a. The report lists the number of times "*vital signs*" were checked on each ward. As part of the process of checking vital signs, staff select to view a 15-second clear video of patients in their room. The use of Oxevision is significantly higher on some wards than others with some of

the female wards having markedly higher uses of Oxevision – in particular Ardleigh Ward where there were over 35,000 views made on patient rooms. In one 12-hour period on that ward on 28 July 2024, there were 1,676 attempts to take vital signs by staff. That is an average of 140 checks per hour. At full occupancy of 18 people, and assuming that these vital signs views were distributed evenly across patients, that would mean that staff had accessed footage of each individual patient on average more than 93 times in 12 hours. Those figures suggest that patients were viewing staff on Oxevision at the equivalent of once every 7.73 minutes. However, such an even distribution between patients seems unlikely, raising the prospect that staff may have been repeatedly taking a smaller number of patients' vital signs in order to facilitate near continuous access to video footage of those patients.

b. The report outlines the time taken for Oxevision alerts to be reset and shows a slow response rate to alerts raised by Oxevision on some wards such as Beech Ward, Cedar Ward, Willow Ward and Gloucester Ward.

c. The report states the percentage of times that at least one of pulse readings or respiration rates were successfully displayed when attempts were made by staff to take vital signs via Oxevision. A notably low percentage of purported attempts to take vital signs actually show either pulse or respiratory rate. On Ardleigh Ward, for example, for the whole month of July 2024 only 26.4% of the 35,665 times the camera view of the patient was accessed, ostensibly to take vital signs, actually resulted in at least one vital sign being displayed[1].

   By way of reminder, Oxevision's vital signs measuring capability is the purported main purpose for which the system is installed and used. However, the system is unable to take pulse or respiration readings in various circumstances, including where insufficient skin is showing, or the patient is moving, or multiple people are in the room. Only after a staff member has viewed a 15-second clip of live footage of a room, and confirmed that the conditions are such that a measurement can be taken, is it possible to proceed to actually attempting to take a measurement. The low rate of successful attempts to take vital signs via Oxevision therefore indicates two things. Firstly, that notwithstanding its marketed tools, the system is frequently

[1] Exhibit ZT-041, pg167

unable to provide a reading of a patient's pulse or respiration rate. Secondly, and perhaps more importantly, that it is likely that staff are accessing the vital signs function in order to access the camera function, rather than with the intent of taking vital signs, i.e. that Oxevision is being used in effect to provide near-constant video footage of patients.

1.8. We understand that the Inquiry plans to instruct an expert statistician to assist in its investigation, and we invite the Inquiry to draw on the expertise of that statistician to thoroughly scrutinise the figures cited in both the Early Insights and Monthly usage reports. The Inquiry may also wish to obtain further Monthly Usage Reports for EPUT wards to analyse whether these patterns hold true over a longer period of time.

Section 3: Neurodivergence

3.1. In the course of my oral evidence on 14 May 2025, the Chair asked me about the impact of Oxevision on neurodiverse individuals. I wish to provide some further information in this regard in this statement.

3.2. We would like to firstly stress that our primary position is that placing cameras in people's bedrooms or bathrooms is wrong and is likely to breach individual rights, which applies whether the individual in question is neurodivergent or not. This does not negate that there may be additional and disproportionate harms for neurodivergent people.

3.3. Neurodivergence is defined as *"having a mind that functions in ways which diverge significantly from the dominant societal standards of "normal""*.[2] Neurodivergence is therefore broad and encompasses a really wide range of ways in which people's minds work, including autism, learning disabilities, ADHD, and dyslexia, but also including multiple psychiatric diagnoses such as PTSD, OCD, bipolar, and schizophrenia.[3] As experiences of neurodivergence are so expansive – and invariably intersect with other forms of marginalisation - it is difficult to speak in general terms about the impact on neurodivergent individuals of systems like Oxevision. This is

[2] https://neuroqueer.com/neurodiversity-terms-and-definitions/
[3] See for example: https://autisticltd.co.uk/2024/07/15/what-comes-under-the-neurodivergent-umbrella/

precisely why care must be person-centred and tailored, taking into account individual needs and circumstances. Blanket implementation of restrictive practices such as Oxevision is likely to be in contravention of these principles.

3.4. Given that the issues of neurodiversity, learning disabilities, ward environment and the use of Oxevision / Oxeobs are all within the Inquiry's Terms of Reference, we highlight some of the specific harms Oxevision may pose to neurodiverse patients, and autistic people in particular. I am autistic, and as a group, all members of Stop Oxevision are neurodivergent.

3.5. Firstly, autistic people, people with learning disabilities, and other neurodivergent people often find it challenging to understand and process information and communicate our needs in systems which prioritise the ways in which neurotypical people communicate. This is compounded by the effects of burn out, experiencing a mental health crisis, and the failure of institutions to facilitate adjustments to provide information in a format that enables patients to process information and be able to make informed choices about their own care. This is particularly underscored in the case of Oxevision where complex and opaque language (such as denying the presence of a camera and referring instead to terms like "*ambient monitoring*[4]") may be especially challenging for neurodivergent people including those with learning disabilities, to understand. Neurodivergent and autistic people often find communication challenging and struggle to ensure they are understood by healthcare staff. It can be hard to advocate for yourself, and many people do not have supportive family or carers to advocate on their behalf, or if they do – as has been highlighted by the accounts of many bereaved CPs in this Inquiry to date – those voices are often marginalised and dismissed by staff. Studies suggest that autistic people can also feel pressured to make decisions that suit others[5]. This is likely to be exacerbated in circumstances where information provided about Oxevision by staff focuses on persuading patients or coercing patients into consenting to its use. Often, autistic people might be non-speaking or become non-verbal when distressed, which would make it very challenging to opt-out, or to articulate distress caused by the system.

[4] https://www.liohealth.com/
[5] college-report-cr228.pdf

3.6. Autistic and neurodivergent people are also more likely to have experienced trauma,[6] and can be made vulnerable to abuse and exploitation. This may enhance the risk of distress in relation to Oxevision if this is a trigger in relation to past trauma or increases patients' vulnerability to staff misusing the system.

3.7. There is also a risk that the introduction of cameras can further isolate neurodivergent individuals who may already be struggling with lack of privacy, or feelings of being overwhelmed in ward environments.[7] This was illustrated in the account of someone with experience, as provided in the patient experience table annexed to our First Witness Statement. They described being left without access to basic items such as food when, due to sensory overload, they were unable to leave their bedroom, yet as Oxevision decreased in-person contact with staff, they did not have opportunities to request things from staff. Additionally, we already know from the accounts shared with us that the installation of Oxevision on wards can lead to a reduction in in-person therapeutic engagement by staff. This can also leave individuals – neurodivergent and otherwise – feeling isolated and lonely.

3.8. Studies have indicated that restrictive practices are also overused against people with learning disabilities and / or autism.[8] In line with this trend, there is a risk that Oxevision, as a restrictive practice, is likely to be overused against the same populations, even where they object to its use. Likewise, studies have also indicated that autistic patients report high levels of being dismissed or not listened to, and experiencing challenges in communicating their needs.[9] All of this may further contribute to Oxevision being used against patients' wishes, or "*consent*" being manufactured through coercion.

3.9. Whilst we have outlined some ways in which Oxevision may have disproportionate negative impacts for neurodivergent people, we are concerned by the lack of evidence that Oxehealth (as

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[6] See for example https://neurodivergentinsights.com/autismandtrauma/?srsltid=AfmBOoq5uf13k8kEkib9picA5WkxlcPer6RMb0WvJljFf_x9YMwWPuGD

[7] See for example https://medium.com/illumination/what-does-the-panopticon-theory-have-to-do-with-autism-eb103a072375

[8] https://www.cambridge.org/core/journals/bjpsych-open/article/systematic-review-of-inpatient-psychiatric-care-for-people-with-intellectual-disabilities-andor-autism-effectiveness-patient-safety-and-experience/097AEFDA01F2378846B7BDF89A70FED4

[9] Autistic patients' experiences of the hospital setting: A scoping review - Greenwood - 2024 - Journal of Advanced Nursing - Wiley Online Library

the manufacturer and operator of the technology) and EPUT (as the consumer of the product) have given adequate consideration to the matter. The use of systems like Oxevision might negatively and / or disproportionately impact upon neurodivergent individuals. It is not acceptable for neurodivergent people to be subjected to a highly invasive technology without due consideration of the risks and harms it may pose. Nor is it acceptable for it to be left to neurodivergent people to advocate for our own and others' rights when this has not been considered by Trusts, private companies, and Regulators. Technologies which are marketed for use on populations where there is likely to be a high prevalence of neurodivergence, including on inpatient mental health wards,[10] should have had these questions considered by manufacturers, regulators, and Trusts ***before*** they are introduced .

3.10. It is the responsibility of manufacturers to ensure their technology is safe for those it will be used upon. It is the responsibility of Regulators to confirm and oversee that safety, and ensure that any evidence base for claims about safety is sound and robustly scrutinised. As public bodies, it is the responsibility of Trusts to ensure that the technologies that they purchase, at significant public expense, are safe for the vulnerable individuals in their care. They are also legally obliged to give due consideration to potentially disproportionate impacts against people in relation to protected characteristics, including disability, and to mitigate those impacts where they arise.

Section 4: Second Witness Statement of Zephan Trent

4.1. As stated in my oral evidence, and written submissions made to the Inquiry, we were extremely concerned, distressed and frustrated by the late disclosure of further important witness evidence by EPUT and the resulting decision by the Chair to postpone all evidence relating to Oxehealth. The decision to provide that statement at that time appeared and continues to appear to be an attempt by EPUT to avert or forestall criticism. We note that the original planned hearing of the Oxevision evidence, in mid-May, which was de-railed by EPUT's late disclosure, came at the

[10] See for example: The Prevalence of Autism Spectrum Disorders in Adult Psychiatric Inpatients: A Systematic Review - PMC and Approaches used to prevent and reduce the use of restrictive practices on adults with learning disabilities: a realist review

same time as considerable ongoing adverse publicity regarding EPUT's use of Oxevision arising from a then-ongoing inquest.[11]

4.2. Additionally, it is notable that EPUT's policy changes – and their statement detailing these – appear to have been produced *after* EPUT and their legal team would have been provided with witness statements and evidence in relation to the then-forthcoming hearings in this Inquiry, including SO's evidence. It remains our view that the second statement and associated documents were issued as a direct response to SO's First Witness Statement.

4.3. Zephan Trent says that changes have been implemented as a result of *"leaning from serious incidents / patient safety incident investigations, findings from coroner's court including prevention of future death reports, and feedback from staff and patients"*. He also claims that the changes made were in response to NHS England's new "*Principles for using digital technologies in mental health inpatient treatment and care*". However, all of this material was available to EPUT at the time of making their First Witness Statement, which did not include these changes.

4.4. The NHS England guidance was published in February 2025, significantly before the date of Mr Trent's First Witness Statement. A search on the Courts Tribunals Judiciary website's platform of prevention of future deaths reports notes only one issued to EPUT between the date of Mr Trent's First Witness Statement on 21 March 2025 and his Second Witness Statement on 9 May 2025, which does not mention Oxehealth at all.[12] This indicates that EPUT would have been aware of concerns raised in coronial proceedings, and of the NHS England guidance, in advance of preparation of their First Witness Statement regarding their use of Oxevision, but those concerns did not spark changes at the point at which they were issued. In his second witness statement, Mr Trent does not address why changes were not made earlier, when concerns were first raised by patients, campaign groups, regulator, in PFD reports, nor when the NHS England guidance was first issued. He also does not address whether deaths or serious harm to other patients could have been prevented if changes were made earlier. We note that a review of the Trust's Standard

[11] See for example, https://www.bbc.co.uk/news/articles/cgq32v7p1z3o

[12] https://www.judiciary.uk/prevention-of-future-death-reports/linda-sitch-prevention-of-future-deaths-report/

Operating Procedure for Oxevision was undertaken as late as 28 February 2025, without any substantial changes having been made.[13]

4.5. We invite the Inquiry to robustly scrutinise the records provided along with the statement, the dates of which appear to be inconsistent. For example, the Quality Committee's Summary Report is dated 13 February 2025 and notes the draft findings and recommendations of the patient, staff and carer focus group. However, in Mr Trent's Second Witness Statement, at paragraph 6, he appears to refer to the same focus group having been planned in February 2025, with Terms of Reference agreed only on 20 February 2025. There is also an appendix to the Quality Committee's report which includes a summary of the focus group reportedly held on 25 March 2025. This raises questions about how the key recommendations and points listed within the Quality Committee report could have been prepared with reference to events some 6 weeks before they were to take place.

4.6. In respect of the focus group itself, we note from the same document that only one focus group was held, and that this only consisted of 8 people, including staff, carers and patients – with an additional 2 people providing responses solely via email. This is a very small sample size, considering that EPUT is an employer of more than 5,000 staff,[14] and provides care to over 100,000 patients at any one time.[15] The notes supplied by EPUT do not make clear the proportion of participants who were patients with lived experience of Oxevision, rather than staff or carers. No detail is provided regarding how those participants were selected. The session itself was only 2 hours long and commenced with a presentation and video about the use of Oxevision which appears to have made frequent mention of the *"benefits[16]"* of the system. We note that the records of the focus group indicate that prior to the presentation participants *"were unclear of the overall*

[13] See version 11 of the Oxevision Standard Operating Procedure disclosed along with Zephan Trent's First Witness Statement

[14] https://www.eput.nhs.uk/about/trust/who-we-are/

[15] https://www.eput.nhs.uk/news/giving-essex-patients-a-voice-in-mental-health-transformation/

[16] Bundle 7a Oxevision Additional EPUT Exhibits : the summary report of the focus group (unexhibited in the electronic bundle) between pages 5 and 10 refers to "*benefit*", "*benefits*" or "*beneficia*l". The references are especially concentrated within the notes of the focus group itself, between pages 8 and 10, where there are 7 references in 3 pages.

purpose and benefit for Oxevision. They were unaware of the physical health monitoring element of Oxevision and the added benefit this brings in the context of patient safety".

4.7. There appear to be issues referenced in the Quality Committee Report which arise directly in response to concerns raised in our First Witness Statement, which suggests that these documents have been prepared at least in part in response to our original evidence to this Inquiry. For example, the report references the issue of patients being unable to tell if the camera on the Oxevision unit is on or off. This issue is not mentioned in the list of recommendations from the focus group. It is, however, referenced clearly in our First Witness Statement.

4.8. That EPUT would seek to make changes in response to concerns raised by SO would generally be something that we, as a campaign group, would consider positive. However, in light of the inaccuracies in date, the inconsistencies in content, the belatedness of action, the apparently superficial nature of the proposed changes, and the absence of a robust plan for managing the safety of such changes (which addresses a culture where poor staff practice has become embedded), we remain concerned that this evidence, and the underlying changes asserted, may be motivated by institutional defensiveness, rather than true candour and a willingness to learn lessons.

4.9. Many of the changes discussed by EPUT in the new disclosure appear to be superficial rather than resolving underlying issues. For example, although EPUT has now completed an Equality Impact Assessment ('EIA') of Oxevision's use (which should have been done prior to implementing the technology), its plan for mitigation includes little that EPUT has not already claimed should be happening on wards – recognising individual patient needs, ensuring all staff are trained, and that they follow the Standard Operating Procedure. These are not changes, nor are they substantive – they are minimum requirements for any healthcare policy or procedure – and they offer no practical means to mitigate *"less favourable impacts on specific groups"*.[17]

4.10. One example of a practical change that the EIA has proposed is to make provision for requests for members of the patients preferred sex to conduct Oxevision checks. However, this is not reflected in the Standard Operating Procedure and we are unaware of any mechanism

[17] Second Witness Statement of Zephan Trent para 25

implemented within the Oxevision system itself to prevent staff from conducting checks regardless. It is also unclear how this would work in response to alerts, for example – would an alert be ignored by male staff until a female staff member was available to conduct the check? Another example given is where a patient *"raises the need to comply with religious traditions such as the use of headwear in front of others, processes should be put in place"*. However, the EIA is thin on detail of what those processes should or even could be.

4.11. Some actions proposed by EPUT, particularly for completion by the Trust's Oxehealth Project Board, seem to be geared more towards promoting the benefits of the system, rather than addressing patients' concerns at all. This includes proposed actions like *"sharing the positive impact around physical health monitoring"* and selectively *"[s]haring stories from people in services that have had a positive experience with Oxevision"* as well as creating *"Oxevision champions in services"*.[18]

Change in consent procedures

4.12. The main substantive change EPUT has claimed to make is shifting from an *implied* to *informed* consent model. However, we continue to have concerns about how this will work in practice for the following reasons:

Information and consent

4.13. Firstly, in order for consent to be informed, patients need to have access to accurate and transparent information. As a starting point, for staff to communicate meaningfully to patients what the system is and how it works, they must have an understanding of the same themselves. The experiences of patients who have spoken to us, as the Inquiry is aware, do not reflect this, with patients repeatedly having been given inaccurate and conflicting information about what the system is capable of, and whether it includes a camera. For example, there are many patient testimonies reported in Oxehealth promotional materials and articles, which suggest patients are

[18] Ibid para 20

reassured by the technology believing this will alert staff to problems with their pulse, which is not accurate.[19]

4.14. Additionally, where staff use Oxevision in a way that deviates from what they describe to patients – such as using it to continuously or contiguously view video footage, rather than taking infrequent pulse and respiration rate measurements – this would also undermine any apparently informed consent from patients.

4.15. We emphasise that the possibility of true, free and informed consent is compromised in settings such as psychiatric hospitals where there is a significant power differential between staff and patients. This means it is easy for staff to coerce patients into 'agreeing' to things they do not want. This is especially the case where staff will find it 'easier' for patients to have Oxevision on and may encourage this in their own interests or where patients are concerned about negative impacts if they withhold consent. EPUT has provided no detail at all regarding how it intends to ensure that patients are not pressured into consenting to Oxevision. Patients are often unaware of their rights and not in a position to be able to advocate for themselves whilst extremely unwell. It can be hard for people to realise they have an option to object to something such as the use of Oxevision.

4.16. I wish to draw on my own experiences of treatment in psychiatric hospitals to emphasise the prevalence of coercion within these settings. When on a CAMHS ward (which was not operated by EPUT), together with other patients, I was coerced to sign care plans and CPA meeting minutes to indicate our agreement to their content, even though we had not been involved in writing them. This coercion would take the form of threatening us that we would not be allowed leave, or have visitors, until we had signed. My experience was that that sort of coercion was normalised on mental health wards, and was present in many other elements of treatment. It is in this context that we highlight the risk that patients may be coerced into giving 'consent' to the use of Oxevision. We have provided the Inquiry with evidence from patient experiences shared with us of the coercive and at times threatening approach adopted by staff on some mental health wards to try to pressure patients to accept the use of Oxevision.

[19] See for example Dewa et al (2024)

4.17. EPUT's new Standard Operating Procedure includes a requirement for weekly review of any patient refusal of consent to the use of Oxevision. We question whether similar weekly reviews will be required where consent has been given. If not, this strikes us as planned attempts to pressurise patients into accepting use of the system.

4.18. Moreover, with the repeated emphasis throughout Mr Trent's statement of the need to ensure patients and others understand the "*benefits*" of the system, it seems likely that this theme, rather than a frank disclosure of the reality of the system, may characterise many conversations. By way of illustration, we note with dismay the ongoing attempts by EPUT to distinguish between Oxevision and other video monitoring systems such as CCTV.

4.19. The dictionary definition of CCTV is *"a system that sends television signals to a limited number of screens"*.[20] However, due to developments in technology and changes in how these systems work, the term 'video surveillance systems' is now more accurate.[21] While Oxevision may not use television signals, the footage it live records is accessible via various devices on a ward such as tablets and stationary monitors. The footage can be accessed by staff at will on those devices and to the best of our knowledge, based on the disclosure we have received to date from the Inquiry and our previous research, there is no mechanism to limit the number of times in a row that footage is accessed. The footage recorded is also retained on a server in an uninterrupted format, which can be accessed after the fact within certain time limitations – not unlike CCTV. Any attempt to draw a harsh distinction between CCTV and Oxevision is likely to be misleading. As a minimum, in order for patients to be able to meaningfully provide real informed consent, they need to have the correct information available.

4.20. Furthermore, while the NHS England Digital Principles outline the importance of properly informing a patient how their data is handled,[22] SO know from our own research, lived experience, and from patient experiences shared with us, that this has not been sufficiently carried out, nor does the infrastructure exist to do so. The example of data (video footage) being sent to academics for the purpose of 'research' without patient's knowledge or consent highlights this;

[20] https://dictionary.cambridge.org/dictionary/english/cctv
[21] https://www.college.police.uk/guidance/investigation/investigative-strategies/cctv
[22] Discussed further in our First Witness Statement

despite this being against ethical guidelines and research procedure. There is a wider lack of awareness of how data is processed or used; this was clear throughout the Trusts' Oxevision DPIAs. Many do not disclose the fact that data is held offsite on Oxehealth servers, and that this is accessible to Oxehealth staff. Unless the full extent of data-sharing for research, commercial development, software updates and incident analysis is explained in detail (which we have seen no evidence of, and is often actively obscured), any consent to data sharing will not be fully informed.

Use against consent

4.21. Secondly, EPUT's new Standard Operating Procedure continues to permit the use of Oxevision against patient consent where the patient is assessed to lack the mental capacity to provide consent, and a decision is taken by the MDT that this is in the best interests of the patient.

4.22. It is notable that the question of capacity does not appear to be factored in if a person does agree to the use of Oxevision. There is no discussion of the possibility of a "best interests" decisions against the use of Oxevision, where an individual does not have capacity to make a decision about its use. The consideration of capacity and best interests appears to be one-sided. There also does not appear to have been any consideration of how elements of Oxevision, and in particular data sharing referenced above, could ever be considered to be in a patient's best interests.

4.23. If Oxevision is truly being used as an assistive technology, and one that does not replace human interaction, as EPUT and Oxehealth maintain, it is not clear what factors would support overriding a patient's refusal of consent. It is hard to envision circumstances where it could be clinically unsafe to turn off the system. We have already highlighted in our evidence to the Inquiry the lack of academic or clinical evidence base for the safety and value of Oxevision. As outlined in our original statement, Oxevision cannot provide an alert to, for example, someone having fallen or self-harmed. The circumstances in which it can take vital signs measurements are highly limited and require engagement by staff, which could in any event be done manually on in-person attendance on a patient. Visual checks on patients – which according to EPUT and Oxehealth are not the intended function of the system – could and, according to EPUT policy, should be

conducted in person in any event. The disabling of Oxevision in a patient room only becomes a safety issue in the event that the system is being improperly or overly relied upon by staff and used to conduct observations that should be conducted in person.

4.24. We are also concerned that there does not appear to be clear, stated recognition of the potential exacerbating impact the use of Oxevision against a patient's consent is likely to have upon their mental health. We have provided the Inquiry with accounts from current and former patients who have expressed to staff their discomfort with monitoring via Oxevision and asked for it to be switched off, and who make clear the horrific impact that the decision by staff to continue to use that system regardless, has had upon them.

4.25. The fact that the technology may be used in the absence of consent also feeds into the coercive atmosphere in itself – consent is rendered meaningless where the message is effectively '*agree to this or we'll do it to you anyway*'.

Opt-out instead of opt-in

4.26. Thirdly, and fundamentally, the consent process remains opt-out rather than opt-in. This means that the camera is turned on until a patient objects, and an MDT agrees to respect their objection. Only then is it switched off. Failing to opt out, however, is not the same as consenting to the use of the system, and it is harder to advocate for yourself by asking for something already in place to be turned off, than to say that you do not want it turned on in the first place. This is particularly the case for people who are neurodivergent and those experiencing a mental health crisis.

4.27. Again, I have found in my own experience that this is a common practice on mental health wards. When I was in hospital, for example, I would often be asked if I consented to having various people present in meetings like student nurses, but the question would only come at the point of the meeting beginning, where the individual was already present sitting in the room in front of me. That meant it was often easier to 'consent' than to go through the process of objecting, regardless of my actual feelings in the matter.

Protected characteristics

4.28. Fourthly, there remains the need to consider how these consent processes may have differential and disproportionate negative impacts for some patients in relation to any of the nine protected

characteristics. For example, someone who does not speak English may be less able to provide informed consent on the basis that they may not have the same access to information on which to base their decisions.

4.29. Consideration would also need to be given to how this may work in practice on CAMHS wards for children who may find it more difficult to advocate for themselves given the additional power imbalances of age, or where parental consent may be sought instead of individual consent.

4.30. Furthermore, survivors of trauma and especially sexual trauma (which runs along gendered and racialised lines, and intersects with experience of disability) may experience challenges in understanding and exercising their right to consent. Experiencing trauma can affect an individual's recognition of their bodily autonomy, which can make it difficult to understand that it is even an option to object to something asked of you by someone in a position of power or authority over you, or to feel safe to do so.

Lack of action on underlying concerns

4.31. Finally, hasty changes to the consent processes do not address the underlying concerns expressed by SO and others regarding the use of vision-based monitoring systems on mental health wards. The misuse and, to a certain extent, the intended use of Oxevision and systems like it are frequently a symptom of underlying systemic issues of low staffing, poor training and absence of therapeutic engagement and environments on mental health wards. It is not a coincidence that promotional materials for Oxevision continue to advertise the costs savings in staffing hours of adopting the system, nor that patients on wards where Oxevision is used have reported to us in accounts shared with the Inquiry that staff engagement has become more infrequent on wards where the system is in use.

4.32. None of the changes detailed by Mr Trent address those underlying concerns. Instead of engaging in a frank public conversation about the efficacy, ethics, or safety of using Oxevision, it strikes us that EPUT's proposed changes are aimed at window dressing, doubling down on a supposedly cost saving technology into which they will already have sunk significant sums of public money.

4.33. We have concerns that in making such hasty policy changes, EPUT have not fully considered how these amended processes will be implemented in practice, or considered how staff may adjust to changes in practice having become accustomed to using Oxevision for a number of years. For instance the timeframes set out by EPUT illustrate that the changes were only communicated to staff *after* the new SOP came into effect, suggesting limited time for ward managers to consider how to enact changes in their service and communicate this to staff. Indeed, we have heard from patients with experience of EPUT services since late May 2025 that there are ongoing issues with patient consent not being sought for Oxevision with patients and even staff members being unaware of any policy changes. We are continuing to have discussions with these people, prioritising their privacy, safety and wellbeing and will look to update our 'patient experience table' in due course if required.

Section 5: Further information on Oxehealth / LIO Health

Re-branding

5.1. In August 2025, Oxehealth, the company which manufactures and markets Oxevision, announced its relaunch as "LIO Health". LIO, which appears to be both the name of the brand and the new platform, is advertised as *"a next-generation operating platform for mental health trusts"* that *"brings together* ***ambient monitoring, digital observations*** *and* ***management insights*** *in a single, unified platform"* (emphasis as taken from the website)[23]

5.2. What precisely is new about the LIO platform compared to Oxevision and Oxeobs, is not clear. Concerningly, the use of convoluted language which avoids clearly communicating to either healthcare providers, or more importantly, patients who will be subjected to the use of this technology, that it involves the installation of cameras in patient bedrooms, continues. Terms like *"ambient monitoring"* continue to appear deliberately and problematically vague.

5.3. Equally unclear to the general public, is the role of Artificial Intelligence (AI) in this technology. While there are few references to the system including AI on the Oxehealth / LIO Health website, and none on the patient information leaflets or ward posters SO have seen, in June 2025 Lord

[23] https://www.prnewswire.co.uk/news-releases/oxehealth-rebrands-as-lio-launching-next-gen-platform-to-transform-inpatient-mental-health-care-302527985.html?tc=eml_cleartime

Lionel Tarrassenko noted his registered interest in Oxehealth in the House of Lords, describing it as using *"AI for healthcare applications"*.[24] In 2018, Hugh Lloyd-Jukes, a then chief executive at Oxehealth, announced that data obtained from Oxevision's monitoring system would *"in time"* be fused *"together using artificial intelligence"*. Whether this has happened or not, how AI is used, who is controlling the data and whether patients are being consulted about this, remains unclear in the marketing and promotional material.[25] This is significant because without clarity and transparency about what the system does, or how the data collected by the system will be used, it is impossible for patients who will be subjected to the use of the system to give any meaningful consent to that use. It is also arguably incompatible with their own duties of care for their patients for healthcare providers to agree to the installation and use of a system, and the collection of their patients' data, where these details are actively obscured, and their consequences may not be fully understood.

5.4. Oxehealth/LIO' Health's new website, in their description of how the technology works, states that *"images captured by the cameras are automatically processed by machine learning algorithms and transformed into actionable information"*.[26] While arguably not widely known by the general public, machine learning is a subset of AI.[27]

5.5. The installation of technology utilising AI components without appropriate explicit disclosure raises a number of issues. Firstly, the details of the algorithm used by Oxehealth / LIO Health have never been made transparent. This works against what is increasingly recognised in the UK as ethical practice around the use of AI in public services (especially healthcare) - for example, the implementation of algorithmic impact assessments (AIAs), which can be used to carry out assessments of potential impacts.[28] Any such assessments cannot be carried out without Trusts necessitating transparent disclosure from technology providers before procuring AI-enabled systems. By obscuring the fact that this product contains AI and details around the algorithms

[24] https://hansard.parliament.uk/Lords/2025-06-13/debates/E608A68F-A1B4-47A8-82DD-30FFA499BB0F/details
[25] https://www.gov.uk/government/news/oxehealth-developing-a-better-way-to-care-for-dementia-patients
[26] https://www.liohealth.com/how-it-works as at 17 September 2025
[27] https://aws.amazon.com/compare/the-difference-between-artificial-intelligence-and-machine-learning/
[28] https://www.gov.uk/government/news/uk-to-pilot-world-leading-approach-to-improve-ethical-adoption-of-ai-in-healthcare See also https://www.adalovelaceinstitute.org/report/algorithmic-impact-assessment-case-study-healthcare/

used to train it, appropriate safeguards around this specific issue cannot have been put in place, or indeed be established for future decision-making.

5.6. Moreover, there is no accessible public disclosure about the datasets on which Oxevision's AI algorithms are trained. If it was conducted only on pre-existing datasets, this raises concerns about the size, diversity and appropriateness of such datasets and the potential for bias (i.e. skin tone, gender, age). If it is continuously trained on data from the technology being used in practice, this raises questions about whether patients knew their data was being used for such commercial means. Either way, information about the usage of AI, the nature of the algorithms, and the datasets used to train it should have been sought out by Trusts when deciding to implement the technology so that they could ensure patients had the information needed to be able to give informed consent.

5.7. In marketing the new platform, Oxehealth / LIO Health's CEO Todd Haedrich has squarely in his sights the continued and indeed expanded use of his company's system in mental health inpatient wards.[29] This is a doubling down on the shift in target market identified in our First Witness Statement for a technology that began life marketed at police custody suites and baby monitors. There is also a continued reliance on the potentially misleading statistics regarding, for example, alleged reductions in self-harm following installation of the system, which were discussed in detail in our First Witness Statement.

5.8. The rebrand has also been accompanied by an international expansion for Oxehealth / LIO Health. Figures cited in Global News Wire in August indicate that Oxehealth / LIO Health has *"expanded its footprint in the U.S. 500% since the start of 2025"*, and that the platform boasts the ability to save 27,500 hours of staff time and approximately $700,000 a year.[30] This focus on the profitability of the system as being contingent upon cutting staff hours only serves to underscore the ongoing concerns, as expressed in our First Witness Statement, that Oxevision and systems

[29] https://www.prnewswire.co.uk/news-releases/oxehealth-rebrands-as-lio-launching-next-gen-platform-to-transform-inpatient-mental-health-care-302527985.html?tc=eml_cleartime

[30] https://www.globenewswire.com/news-release/2025/08/13/3132348/0/en/LIO-Launches-Next-Generation-Inpatient-Mental-Health-Platform-with-Advanced-Rounding-Monitoring-and-Compliance-Tools.html

like it are being used as substitutes for in-person care and that one of the main drivers for their adoption is the economic incentive of cutting staffing costs.

5.9. Along with an expansion in the American market, Oxehealth / LIO Health has also, this year, launched in Australia, partnering with Alpha Global, a company which also supplies nurse call systems, and a radar sensor used for fall monitoring.[31]

5.10. The re-branding of Oxehealth as LIO Health comes at a time when criticism and critique of the system is garnering press attention. However, the LIO Health website remains extremely similar to the previous Oxehealth website, including in repeatedly citing the same academic studies, which we have previously detailed concerns about in our First Witness Statement. Irrespective of the clear and serious concerns we and others have expressed about its safety and impact on patient duty and privacy, Oxehealth / LIO Health continues to seek to expand its use without clear evidence of those concerns having been addressed.

Sleep tracker

5.11. Oxehealth / LIO Health now also advertise that their product provides *"Sleep monitoring"*. This element of the technology was registered as a medical device, although importantly not a diagnostic tool, under the name "Oxevision Sleep System" in around 2024. Information regarding how the system works is sparse, however it has been described in Oxehealth / LIO Health's application for approval from the US Food & Drug Administration as a *"custom-designed software assessing video footage collected using off-the-shelf cameras installed within single occupancy bed spaces within hospitals, general care and secured environments"* which uses *"[p]roprietary software-controlled algorithms […] to derive patient movement, activity and physiological sign data and then to obtain information on bed occupancy and sleep state from the analysis of this data"*.[32]

5.12. The only physiological data that we know that Oxevision systems are capable of collecting is heart rate and respiration rate, though the value and reliability of the readings it is able to give are debatable, as outlined in our First Witness Statement and above. By way of reminder, there are

[31] https://qumea.com/en/technology/
[32] https://www.accessdata.fda.gov/cdrh_docs/pdf23/K233618.pdf

many circumstances in which measurements cannot be taken including if a patient is moving, or if too much of their skin is covered – as, for example, if they are in bed under a blanket. If the analysis of sleep patterns is based upon this data, it is not clear how reliable those reports will be.

5.13. Moreover, heart rate variability is not a widely clinically recognised medical way of understanding sleep, sleep stages or diagnosing issues with sleep. It is a technique used usually by commercial companies in wellness-related products sold for use in the community like Fitbit and Apple Health. While this may be fine for a "healthy" person to track their sleep for various reasons, there is an argument that this is not appropriate in a psychiatric ward where many mental illnesses overlap and intersect with clinically relevant sleep disorders, or medication side effects that necessitate and deserve specialist diagnosis and intervention.

5.14. The Oxevision system is a constant monitoring system, it is attempting to take data about patients 24/7 in the background even before the proposed added sleep tracker. It tries to collect pulse and respiration data even outside the points where staff take 'spot checks'. As previously explained, it doesn't alert to changes in that data. It appears that the addition of a tracker will not require collection of any new raw data, rather it will try to use that data differently. However, as we have explained this data has so many caveats and limitations. We are concerned at the prospect of the use of potentially unreliable data being expanded in further decisions about care and treatment despite these limitations and despite it not being a clinical grade diagnostic tool.

5.15. We are also concerned at the prospect of data produced by this system being presented as objective when sleep is a particularly subjective experience, and an individual may express having had a poor night's sleep, for example due to nightmares, or feeling tired, due to chronic illness, fatigue, medication side effects, or burnout, despite what the data may show.

5.16. All of this also contributes to our further concern that, just because a system is capable of collecting data, that does not automatically mean that it should do so, or that doing so is lawful and proportionate under the GDPR. It is also worth noting that Oxevision previously generated 'activity reports' which detail patients' behaviour such as the times and frequency of visits to the bathroom and time spent in bed. However, as is demonstrated in the Monthly Usage Reports, these are not frequently accessed by staff. Many wards had not accessed these even once during

a month period. This suggests that these documents are not clinically useful and that collecting such data is not proportionate. We are concerned at the prospect that this data may also be used, without patient knowledge or consent, by Oxehealth / LIO Health itself for the purposes of ongoing product development.

5.17. If there are concerns about someone's sleep, Oxevision's Sleep System is not a clinical grade diagnostic tool, and therefore could not and should not take the place of proper sleep monitoring by a specialist team. Ultimately, it is most important to understand how someone perceives their sleep, and provide in-person attention so that they can be listened to and receive the care that they need. We are also concerned that further information would need to be communicated to individuals about how this system works, where the data is stored, and who / what systems it is processed by in order for them to be able to meaningfully consent to this further use of their data.

Falls prevention

5.18. Another aspect of Oxehealth / LIO Health's expanded marketing of its *"unified platform"*[33] is "*reducing falls*[34]". This is a pre-existing function advertised by Oxehealth / LIO Health but in light of the increasingly broad marketing of Oxevision's functions, we take the opportunity to outline our concerns in respect of this function in this statement for completeness, and to assist the Inquiry with its investigation of the use of the system holistically.

5.19. Our understanding is that the Oxevision system can be set up to generate an automated alert when a patient is sat at the edge of their bed, which may bring to the attention of ward staff that that individual may be about to stand up, or may be close to falling from their bed. We understand that this function is most likely to be enabled on wards where patients are at risk of falls due to mobility issues, including for example on dementia wards, rather than across the board on all mental health wards.

5.20. There are other devices which already exist which serve similar functions, albeit in different ways. For example, bed sensor mats can alert staff when someone gets out of bed, without installing cameras in their rooms. The use of a more restrictive system entailing 24 hour video recording

[33] https://www.liohealth.com/
[34]

should therefore require real and robust consideration and justification in circumstances where a less restrictive option is available.

5.21. As with many of Oxevision's functions, there is a real risk of overstating the technology's function. It does not alert if someone has fallen. It alerts if they are at the edge of their bed. If a patient fell whilst walking in their room, no alert would sound. As we have discussed previously, staff, patients and families risk being falsely re-assured where it is not made very clear what the limitations of the technology are – see for example references in our First Witness Statement to staff having told patients that the system could alert them to ligatures.

5.22. Likewise, it is important to note that even where an alert is sounded by Oxevision, this still requires timely intervention by an actual staff member. We know from data supplied by EPUT (and discussed above) that staff often do not respond to alerts in a timely manner, and from the evidence heard in recent inquests, alerts can frequently be ignored, muted, or reset without checks taking place. The risk of this happening is also higher in circumstances where there is a potential to have a huge number of alerts going off if this function is switched on for all or a substantial number of patients on a ward, and alert fatigue sets in.[35]

6. STATEMENT OF TRUTH

I believe the content of this statement to be true.

Signed [I/S]

Name: Hat Porter

Dated: 22nd September 2025

[35] For further details regarding alert fatigue, please see our First Witness Statement