

27th July 2026

FAO: James Duncan, Chief Executive; Marie Smith, Associate Nurse Director; Angela Faill, Head of Information Governance and Medico-Legal

[CC: NHS England, CQC, Northumberland County Council child safeguarding department]
[Bcc: Stop Oxevision legal team]

Re: Use of Oxevision/LIO in Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW)

Dear CNTW,

We are writing to you as the national campaign group Stop Oxevision, who have campaigned for the last three years against the use of the video-based monitoring system Oxevision/LIO (henceforth Oxevision). We are writing this letter to express our grave concerns regarding the continued use of Oxevision within CNTW, and to call on the Trust to **suspend its use of Oxevision within all patient bedrooms, seclusion rooms and s136 suites with immediate effect.**

We are aware that after two years of discussing changes to the consent processes, on 20th July 2026 CNTW changed its Oxevision policy to an 'opt-in' consent model – however, **this does not go far enough to address the legal, safety and safeguarding issues associated with the technology.**

Due to the nature of the concerns this letter raises, we have also raised a child safeguarding referral to Northumberland County Council (ref: 101010328204, dated 18.07.26) with whom we will share a copy of this letter.

Part 1: Summary of concerns about Oxevision/LIO

Oxevision/LIO – [which constitutes a type of restrictive practice](#) – is a video surveillance technology developed by for-profit company LIO, who renamed themselves from “Oxehealth” following the growing controversy associated with their technology, its safety, legality and its ‘supporting’ evidence-base.

The use of Oxevision is currently subject to investigation as part of the [Lampard Inquiry](#) (to which Stop Oxevision continue to contribute to as witnesses) and has been considered in

multiple Prevention of Future Deaths reports and coronial proceedings. Over July, the Lampard Inquiry heard evidence from bereaved families who have [called for the technology to be banned](#). It also heard from EPUT staff reflecting concerns about Oxevision's lack of therapeutic value and associated risks whilst two expert statisticians from the University of Oxford told the Inquiry that [there is a lack of evidence to demonstrate any safety or economic benefits of the technology](#). Furthermore, the [Lampard Inquiry heard from a consultant mental health nurse based at CNTW, in her role instructed as an expert witness](#). Her evidence was informed by her experience with the use of Oxevision within CNTW. The inquiry heard that 24-hour video recording in what would otherwise be expected to be a private space can cause significant distress and introduce new safety concerns yet has very narrow clinical use. This significant infringement on patient rights in the absence of benefit raises significant concerns regarding how proportionate any use of Oxevision can be claimed to be.

Since we began our campaign we have heard devastating stories from patients who have been subject to Oxevision. This includes people deciding not to seek care for fear of the technology, and increased hostility between staff and patients where it is used. Patients have also told us of having to sleep in bathrooms or communal areas to avoid the cameras, and being re-traumatised and having their paranoia worsened. There have also been numerous instances in which patients have been subjected to Oxevision/LIO without their consent (see: Stop Oxevision's bank of [lived experiences of Oxevision](#) and North East Together's [2024 research report on patient, staff, and carer perspectives on Oxevision](#)).

In 2023, after lobbying from campaigners, [NHS England wrote to all NHS Trusts](#) acknowledging national concerns and instructing Trusts to ensure their use of the technology was "lawful and fair". The letter stated:

"It is our view that Vision-based monitoring systems should never be implemented in a blanket way [...] we are, therefore, asking all services to please review, clinically and ethically, current VBMS practice within your organisation to ensure your use of these technologies aligns with the principles of least restrictive, compassionate, therapeutic and personalised care."

Subsequently, NHS England published [guidance](#) on the use of digital technologies. In 2026, the Parliamentary and Health Service Ombudsman (PHSO) issued a ruling in relation to a complaint a patient termed 'Miss B' [raised against Essex Partnership University NHS Foundation Trust](#) that it had made several failings in relation to its use of Oxevision. This included the failure to seek 'Miss B's' consent; the failure to respect her wishes in requests for the camera to be switched off; and an inadequate provision of information about the technology. The PHSO also gave careful scrutiny as to whether Oxevision had been used in place of in-person observations. The PHSO identified that the Trust had not followed the guidance set out by NHS England or the GMC, and [the Trust was ordered to make changes to its policy and provide a financial remedy to the complainant](#). [As lawyers for Stop Oxevision have highlighted](#), this presents a "clear legal risk" to NHS Trusts.

In May 2026, [Bindmans LLP wrote to the Information Commissioner's Office](#) (ICO) requesting that they conduct a full expedited investigation including consideration of; the lawfulness of data processing and characterisation relating to Oxevision, the use of patient data for secondary purposes (such as research and product development), and the data arrangements between Trusts and Oxehealth/LIO. This letter follows complaints raised by Stop Oxevision in 2024, as a result of which a research study at London South Bank University had its [ethical approval retracted by the NHS Health Research Authority](#). The NHS research ethics board found that the Trusts involved in the study had shared identifiable video of patients without their knowledge or consent. This makes clear the fact that **the blurred video routinely shared through Oxevision is not, as Trusts and the manufacturer assert, anonymous, but remains identifiable despite blurring**. Subsequently, in June this year, the [ICO confirmed that it has launched an investigation](#) into data protection issues pertaining to Oxevision.

In 2024, [the NIHR Mental Health Policy Research Unit published a systematic review](#), commissioned by NHS England, concluding that there was **insufficient evidence to suggest that vision-based monitoring systems (including Oxevision) increase safety or reduce costs**. Research pertaining to the efficacy and experiences of Oxevision [overstates its benefits, omits key information](#), and is often steeped in [\(sometimes undeclared\)](#) vested interests.

There is also relevant local research which indicates the harm that Oxevision is causing in CNTW. In 2023-4 North East Together (a local network of people with lived experience of mental ill-health) undertook [a body of research to explore patient, staff, and carer perspectives on Oxevision](#). Participants raised widespread concerns about their privacy, emotional safety, consent, and affected relationships between patients/staff. **91% of participants in the North East wanted Oxevision to either be paused or stopped entirely**; this figure rose to 100% for those who had direct experience of Oxevision.

As the Lampard Inquiry heard, there is a lack of robust and reliable evidence to suggest the value associated with Oxevision. The research we **do** have indicates the potential for, and existence of, grave harm. It is clear that Oxevision does not and cannot keep patients safe, yet CNTW continues to place patients at risk of harm through its ongoing use of the technology.

Part 2: Concerns relating to Cumbria, Northumberland, Tyne and Wear (CNTW) NHS Foundation Trust's use of Oxevision/LIO

In 2020, CNTW agreed to pilot Oxevision on three wards. The technology was installed and 'went live' between December 2020 and March 2021. Whilst the original pilot was based on three wards, the 2020 business case illustrates that at this point, well ahead of the Trust having installed, trialled or evaluated the technology, CNTW was already considering installing Oxevision across more wards¹. Indeed, during this supposed 12-month 'pilot' period, CNTW began installing Oxevision on a further six wards, including four CAMHS wards – without having conducted any independent evaluation.

From mid-April 2021², a business case was developed to support a plan to install Oxevision on a staggering further 40 wards (amounting to a total of 576 beds) across the Trust³. Although Oxevision had been in use for only a year, and the singular evaluation appears to be in the form of a brief promotional report produced by the manufacturer, the business case was approved in June 2022⁴. Despite the Trust's plans to install the technology on all its wards – including learning disability and autism wards, rehabilitation wards, CAMHS units, older adult, secure and specialist services – there is no evidence of any consideration of the diverse patient populations or the specific needs, risks and consideration for each ward type.

This rapid and exponential expansion – costing the Trust well in excess of a million pounds annually⁵ – appears ill-considered, disproportionate and constructed in haste. CNTW's use of Oxevision across such a significant number of wards makes the Trust the second most prolific user of Oxevision in the country, alongside TEWV and EPUT, who use it on the first and third greatest number of wards respectively.

On CNTW's own admission, there was "limited" patient involvement during the initial pilot.⁶ This is despite the fact that the 2022 business case promised that *"a presentation of the system will also be made at the Service User and Care Reference Group to present the evaluation of the pilot and to announce the roll out more widely"*⁷. The Trust claims to have made improvements around patient involvement, yet this appears to have largely been limited to consultation on the posters. Where a decision had been made by the executive committee in 2022 to install Oxevision in every ward, signing binding multiple-year contracts, there was no scope for patients to have any influence on the initial fundamental decisions surrounding the installation of

¹ [Oxehealth: Digital Care Assistant Briefing Paper](#) (Jan 2020) pg.6

² [CNTW "Oxehealth Business Development Update"](#) states: "Oxehealth Business case has been in development since mid-April with Tommy Davies taking the lead on pulling the business case together. [...] This is the current proposed phasing roll out plan for 2022/2023"

³ [Oxehealth business case 2022](#)

⁴ Ibid.

⁵ For a total of 49 licences (including those that are not used) the trust contract is £1,298,500 a year. This does not include the installation fees for the monitors or infrastructure such as cabling, WiFi upgrades and server installation. This figure also does not account for the ongoing costs associated with running servers, or the salaries/time of staff working on the 'project'.

⁶ [From document titled 'CNTW Oxehealth SURG v2.3'](#)

⁷ [Oxehealth business case 2022](#) (pg.11).

Oxevision. This is consistent with a dysfunctional and hierarchical approach to management whereby decisions are made by the executive committee, in the absence of any patient and care involvement, before they merely “inform” patients (and Trust staff) once the decisions have already been finalised.

Indeed, not only were patients and carers not involved with the decisions regarding installing Oxevision, but there also appears to have been a total absence of involvement of ward-level management and patient-facing staff within these decisions. This resulted in staff raising concerns, persistent delays in the installation, and Oxevision being installed but seemingly not used in some wards⁸. Throughout 2024, we are aware that psychiatrists raised concerns about Oxevision, as illustrated in the ‘Oxevision Clinical Subgroup’ meetings, but these concerns were largely dismissed. In April 2024, a CNTW psychiatrist shared the following concerns:

“[psychiatrist] asked about the use of Oxevision in patient bedrooms and challenged whether it should be used at all. He asked whether it was solving a problem which didn’t need solving and if it was needed when there were other sensors in place and camera monitoring could be detrimental to mental health.”

The Trust’s ‘Group Nurse Director’ and lead for the Oxevision installation project responds:

“...the Clinical Subgroup can advise on functionality but has limited ability to change whether the system should be used in the trust or not and offered to pick up the discussion with [psychiatrist] outside of then meeting [sic].”⁹

This exemplifies significant concerns regarding the Trust’s hierarchical approach to decision-making surrounding the implementation of Oxevision. Decisions appear to have been imposed from the top-down without engagement with patients or staff, and, although installation has been consistently delayed, opportunities to pause and reassess the use of the system have seemingly not been effectively utilised.

By 2025, CNTW had installed Oxevision across 35 wards, in addition to seclusion rooms and 136 suites¹⁰. However, the installation appears to have been beset by delays meaning in 2025 Oxevision was still being installed in nine autism and older adult wards. As a result of these delays – which followed the Trust having signed contracts committing them to making payments – by 2024, CNTW were being charged £265,000 annually for Oxevision software ‘licences’ on wards where Oxevision was neither installed nor in use¹¹.

⁸ See: CNTW Oxevision usage reports; [CNTW internal audit report 2025](#)

⁹ [Oxehealth Clinical Subgroup Meeting minutes 10.04.24](#)

¹⁰ [FOI request \(ref:6513\) response](#) dated 16/10/2025

¹¹ [Oxevision steering group update slides 2025](#)

Legal and safeguarding issues

[Oxevision, and other video surveillance, is a restrictive practice](#). It involves a continuously-recording video camera within a patient's bedroom, invariably engaging Article 8 of the Human Rights Act. Despite this, it is unclear what legal advice the Trust sought prior to the 2020/2021 pilot, or the 2022 expansion. Whilst the 2022 business case does state that “the initial pilot went to the [ethics] committee but there were mixed views on the benefits for patients versus patients privacy and dignity”¹² It is unclear what, if any, actions were taken in relation to these “mixed views” and the Trust used Oxevision with an ‘implied consent’ model for three years. In reality, this model was *premised* on a lack of consent – patients had no option to object, and no possibility for the camera to be turned off.

Of further concern, **until October 2024, CNTW had chosen to not have the functionality of the system that would allow staff members to locally turn off the Oxevision camera, or to even pause its recording**. Instead, the camera was turned on, recording 24/7 with no option for ward staff to deactivate this in the event of a patient objection or where it was causing distress. This seems to remain the case for seclusion and 136 suites. Although some changes were made, the new model from 2024 – which appears to have persisted until this month – still did not seek patient consent but followed the [‘guidance’ written by the Mental Health Nursing Directors Forum](#), of which a member of staff from CNTW was a contributor. [These guidelines have now been withdrawn](#), and this blanket use of Oxevision identified within a complaint raised to the PHSO as not being in line with national guidance. This also raises concerns regarding the impact of the use of such video surveillance under the Human Rights Act and data protection law.

Until October 2024, at CNTW, in order to deactivate a camera, the staff would be required to raise this with Oxehealth/LIO directly who would remotely deactivate the camera and then re-activate it when required. Whilst we don’t know whether this happened in practice, and it appears the camera was always left to record irrespective of the distress and harm it may cause patients, **that an external company has remote access to configure video cameras within patient bedrooms raises further security, safeguarding and safety concerns**.

Throughout 2023, staff raised concerns that there was no option to even pause the video camera whilst patients were undertaking personal care or ‘private time’¹³. Patients, utterly understandably, refused to get changed in front of the camera and a complaint was raised by a patient’s family. Yet the Oxevision Clinical Subgroup remained unwilling to allow the system to be turned off with the steering group expressing “unease about this” and that “turning off the system is not an option”¹⁴.

The use of Oxevision involves continuous video recording and sharing this footage with an external company. Clear video of patients in their bedrooms can be accessed by Oxehealth

¹² [Oxehealth business case 2022](#) (pg.10).

¹³ [Oxehealth Clinical Subgroup Meeting minutes 29.03.23](#)

¹⁴ [Oxehealth Clinical Subgroup Meeting minutes 26.04.23](#)

as part of addressing issues with the technology¹⁵ and blurred video is shared and retained by Oxehealth for an uncertain period, consisting of multiple years. Therefore, whilst CNTW may have felt “uneasy” about pausing the cameras, they were quite willing to force patients to be video recorded, and to share such video with an external company without any safeguards or clear governance. In the case of the Trust’s children’s wards, the Trust appears to have offered false reassurance **whilst allowing children to get changed or have “private time” in front of a video camera operated by an external, unregulated company**. The minutes from a meeting in April 2023 read:

“Lotus [a CAMHS ward] have a solution where by adolescents put a card on the door to say they’re not happy for the system to be used when they require private time. Obviously clinical risk impacts how staff deal with the information but that’s just one solution. However turning the system off or covering it up is likely not to be an approved option. RH [initials of Oxehealth staff member] confirmed other trusts have used the card system as an approach.”¹⁶

Yet, irrespective of the card children were encouraged to put on the door, the video camera in their bedroom continued to record this “private time” and share that video with Oxehealth. **It is our view that this raises inexplicable safeguarding concerns, and may have direct implications under laws prohibiting the making and distributing of indecent images of children.** Indeed, a “Clear Video Report” from January 2023¹⁷ indicates that CNTW permitted Oxehealth to access at least 2.6 hours of clear video of a child in their bedroom on one of the Trust’s CAMHS wards. This footage was recorded between 20:00-22:00 on two separate evenings and had been independently identified, selected and accessed by Oxehealth. This document illustrates that **CNTW have video recorded a child without their consent and subsequently, without their knowledge, permitted an external company to identify, view and retain clear video of the child in their bedroom on two evenings**. There is no way to be certain of the exact content of this video, who this was viewed by, and for what purposes. Particularly in the context of child and adolescent wards, this represents a major safeguarding risk and significant departure from the Trust’s fundamental responsibilities to protect those in its care.

The lack of consideration of risks, harms and patient impact

As demonstrated through the Trust’s own documents, there was a stark lack of meaningful assessment of the risks associated with Oxevision. Yet these concerns have materialised from the very early stages of the technology’s installation without any evidence of there being possible safeguards and mitigations for these – beyond a full deinstallation of the devices. Whilst the 2022 business case includes a brief risk assessment outlining the “high” risks associated with patient and workforce acceptance and data security, it classifies these as being

¹⁵ [CNTW Oxevision DPIA 2024](#)

¹⁶ [Oxehealth Clinical Subgroup Meeting minutes 26.04.23](#) (pg.5)

¹⁷ [CNTW Oxehealth Clear Video Data Report](#) dated 25.01.23

of “low” likelihood. Subsequently, **no** clear action is outlined to mitigate these risks¹⁸. The only issue CNTW identifies as ‘very high’ risk is the risk to the Trust’s reputation if “the system is portrayed as intrusive to privacy as per other Trusts”¹⁹. **Framing this as an institutional risk demonstrates greater concern for the Trust’s reputation than the reality of the “intrusive” technology, its potential to cause harm, distress, and retraumatisation for patients, and its implications under the Human Rights Act.**

In its business cases from both 2020 and 2022, CNTW relied heavily on promoting the ‘benefits’ of Oxevision for conducting observations of patients remotely. This involved explicitly ‘reducing night time disturbance’ and allowing 1:1 observations to be ‘stepped down’. This follows the Trust’s initial intended use of Oxevision as a means to conduct visual checks on patients remotely. A ‘Practice Guidance Note’ (PGN) from 2024/5 discusses using Oxevision to “conduct” observations – offering details of the process to follow and when a patient is required to be checked in person²⁰. The PGN does not discuss the impact this practice would have on patient safety, levels of engagement, or how staff can appropriately ensure someone is safe without checking them in person. This is supported by an Oxehealth produced flowchart illustrating the process for “Oxehealth (Oxevision) Assisted Observations”²¹.

Furthermore, an evaluation report related to the pilot quotes a nurse stating “*Using the system for checks at night is so much quicker*”, whilst a ward manager stated: “*We had a patient diagnosed with EUPD at high risk of self-harming using ligatures. Although this would usually result in increased observation levels, NICE guidance suggests giving these patients more autonomy so that people can help-seek during periods of distress. The Oxehealth alert system allowed us to have her on a lower level of observation*”²². **We have been unable to locate any records of the Trust having considered the potentially catastrophic risks of Oxevision being used to reduce patient observation levels and replace in-person checks.**

A further ‘benefit’ of Oxevision outlined in the document is that during the pilot period, the installation of Oxevision allowed an increase in the number of patients on the ‘SleepWell Initiative’²³ – a Trust initiative (developed by a sleep but not mental health or patient safety expert who has done paid work for Oxehealth) which includes not conducting observations on patients between 12am and 6am – or 8am on CAMHS wards^{24,25}. This raises significant

¹⁸ [Oxehealth business case 2022](#) (pg.20)

¹⁹ Ibid.

²⁰ [Practice Guidance Note](#) 2025

²¹ [Appendix to Practice Guidance Note](#)

²² [Oxehealth Benefits realisation 2021](#) (pg.13)

²³ Ibid.; [Oxehealth business case 2022](#)

²⁴ https://www.whatdotheyknow.com/request/sleep_well#incoming-3477334;
<https://pubmed.ncbi.nlm.nih.gov/38764399/>

²⁵ **For the avoidance of any doubt, our position is that the Sleep Well Initiative is unsafe and not in line with the responsibilities of psychiatric inpatient services to conduct, at a minimum, hourly observations of all patients, throughout the day and night. It is our view that if a patient requires a hospital admission, they require an appropriate level of observation; anything short of this risks amounting to neglect.**

concerns that Oxevision is seemingly used to further justify not providing an appropriate level of support to patients, with potentially devastating consequences.

Whilst the Trust meeting minutes appear to suggest, in contradiction with Trust's own documents, that CNTW has shifted its practices to theoretically not permit Oxevision to be used to conduct patient observations, they also illustrate that these issues continue in practice. Given **this was the express basis upon which the Trust first introduced the technology and there is a lack of any safeguards to appropriately mitigate this risk**, the safety implications of Oxevision being relied on as means to replace appropriate in person care remain as pressing as ever.

As Stop Oxevision have long highlighted – and as has been discussed nationally, including within the Lampard Inquiry, Prevention of Future Deaths reports and coronial proceedings – there are numerous safety concerns regarding the Oxevision alert system, including the risk of alert fatigue, alarms being ignored and muted and the presence of a so-called 'safety system' offering false reassurance to staff, patients and families. Throughout the years – as illustrated repeatedly through evaluations, patient feedback, meeting minutes and audits – the Trust has faced persistent issues with the Oxevision alarms. The risk of 'alert fatigue' generated by the extraordinarily high volume of alerts generated through Oxevision is noted within the early meeting minutes²⁶ with issues heightened by false alerts being triggered by factors such as the location of mirrors, windows and curtains, and patients standing or praying near the doorway²⁷. Meanwhile there have also been concerns about system failings, "bugs" and WiFi limitations impacting alerts²⁸, and a ward on which the alerts had never been audible²⁹. Of great concern, the early meeting minutes express warnings that Oxevision may risk *increasing* the risk associated with self-harm if patients were falsely reassured that staff would be monitoring them and be alerted that they were in need³⁰. **Each of these risks poses significant detrimental impacts to patient safety.**

Data Protection

Stop Oxevision have long raised concerns regarding the data processing arrangements implicated in the use of Oxevision, this is now subject to an ICO investigation. The technology records 24 hours a day, clear video is retained on a server which is physically located on trust premises but runs externally-owned software – involving remote access by the private company. In addition, blurred video and physiological measurements are shared with Oxehealth, who may retain this for a period of multiple years. **As outlined previously, this video, although blurred, remains identifiable personal information.** This vast amount of data sharing was described in one CNTW project meeting as: *"Unfortunately, we started pushing massive amount of data*

²⁶ [Oxehealth Clinical Subgroup Meeting minutes 01.02.2023](#)

²⁷ Oxehealth Clinical Subgroup Meeting minutes [12.04.23](#), [30.07.2025](#), [24.09.2025](#)

²⁸ [Oxehealth Clinical Subgroup Meeting minutes 24.09.2025](#)

²⁹ [CNTW internal audit report 2025](#)

³⁰ [Oxehealth Clinical Subgroup Meeting minutes 01.02.2023](#)

*down the fibre cables [sic]. Those fibre cables were working fine with some of our existing kit when we did the test however, we weren't putting anywhere near the amount of data that Oxehealth kit requires [sic]"*³¹.

The Trust's 2020 Data Protection Impact Assessment (DPIA) identifies a number of data protection risks associated with Oxevision – extensively explaining the level of access Oxehealth have to both blurred and clear video footage. Yet, it does not appear that CNTW reported the high risk data processing identified as associated with Oxevision to the ICO, [as it is legally required to do under GDPR](#). The ICO explain this legislation stating:

"If you have carried out a DPIA that identifies a high risk and you cannot do anything to reduce it, prior consultation with the ICO is required under UK GDPR. You cannot go ahead with the processing until you have consulted us."

Five years later, with no evidence of such consultation being initiated, CNTW continues to proceed with the high risk data processing (sharing video footage of patients in their bedrooms with an external party).

Additionally, as illustrated through the Trust's meeting minutes, there have been numerous data breaches in relation to the Oxevision tablets including *"an incident on a ward re an Oxevision Tablet. A patient has been handed an Oxevision tablet (mistakenly thinking it was a patient kindle) and had left it with the patient for approximately 11 minutes. The patient had drawn attention to this as they couldn't access the internet. They had been able to access 2 rooms during that time. They'd been able to access consent as the PIN to get into the tablet was attached to the back of the tablet [sic]"*³². A year later, concerns were again raised about a tablet having gone missing with concerns that the tablets may still have the password labelled on the back³³. In another incident, a patient was able to access the Oxevision desktop system and send an email to Oxehealth³⁴. It is unclear whether any of these incidents were reported as data breaches or what action has been taken to address these ongoing data protection risks.

Patient experience, feedback and ongoing failures

In November 2023 – *after* the trust had already committed to installing Oxevision on every ward – the Trust conducted a patient consultation³⁵. This was the first robust evaluation conducted independently of the manufacturer and included focus groups held with 75 patients. The brevity of the report prohibits any real understanding of the outcomes of this review. Whilst 'hopes' and 'concerns' are reported, the feedback appears to reflect significant issues associated with the technology including concerns about privacy, reports that it is *"Terrifying' to not know when I am*

³¹ [Oxehealth Clinical Subgroup Meeting minutes 26.04.23](#)

³² [Oxehealth Clinical Subgroup Meeting minutes 23.10.24](#)

³³ [Oxehealth Clinical Subgroup Meeting minutes 30.07.25](#)

³⁴ [Oxehealth Clinical Subgroup Meeting minutes 24.09.25](#)

³⁵ [Oxevision Patient feedback Report 2023](#)

*being watched*³⁶, that patients have to sleep in communal areas rather than their bedroom due to the presence of the camera. There were also concerns about data, “*mak[ing] staff complacent*”, *an impact on staffing levels and “loss of personal touch”*³⁷. Despite these significant concerns, the Trust continued installing Oxevision on ever increasing numbers of wards.

A further consultation was conducted in 2026 with 92 patients³⁸. As with the previous evaluation, the report is minimal and provides limited context. However, the concerns identified appear consistent with those reported in 2023, including the “increased anxiety and paranoia”, “invasion of privacy”, and patients not being aware of the presence of Oxevision. **Despite these concerns having long been known to the Trust, they were enabled to persist, utterly unmitigated.** [Evidence heard by the Lampard Inquiry](#) also highlighted significant distress faced by patients at CNTW as a result of Oxevision including patients shouting at the cameras, smashing the monitors, and the risk of informal patients discharging themselves due to the presence of the technology.

In 2025, CNTW commissioned an audit regarding the use of Oxevision which offered ‘limited assurance’, identifying a lack of compliance and the need for ‘immediate and fundamental remedial action’³⁹. The report raises countless concerns regarding the Trust’s ongoing use of Oxevision, including concerns that patients were not appropriately informed about Oxevision – “Patient leaflets were not consistently provided on admission”⁴⁰; five of seven wards had no leaflet stock; “admission/transfer checklists and welcome guides did not consistently reference Oxevision”; and “only two of seven wards displayed appropriate signage, risking non-compliance with UK GDPR and other privacy regulations”⁴¹. The audit identified additional issues with oversight and governance regarding how the system was used, including that clear video footage from the system was being requested without patient awareness and without approval from management. Significant limitations were also raised with regard to training, on some wards, there was no record of which staff members had completed training, whilst on one ward it was reported that only two thirds of staff had received training.

The Trust’s concerning audit, and what appears to be persistent concerns raised by patients, reflect the ongoing issues with Oxevision. Whatever the Trust had hoped to achieve through this installation – it has been ultimately unsuccessful – instead presenting a major safety, legal and reputational risk.

³⁶ Ibid.

³⁷ Ibid.

³⁸ [Oxevision Patient feedback 2026](#)

³⁹ [CNTW internal audit report 2025](#)

⁴⁰ Ibid.

⁴¹ Ibid. pg.11

Summary

Oxevision/LIO is a for-profit surveillance technology which is consistently failing patients, staff, and trusts across the country. We believe that all NHS trusts have a legal and ethical duty to protect their patients from the harm of these technologies. **Disquiet about the technology is rising, and over a third of the Trusts who previously used Oxevision have now ceased their use.**

CNTW's 2020 and 2022 business cases for the installation of Oxevision on all its wards made vague claims of safety, yet there is no evidence that it has ever delivered on these promises. Instead, the Trust has faced persistent issues throughout its installation. Whilst the Trust have attempted to improve the issues with Oxevision through scrutinising usage reports and making limited changes to policies, none of this is sufficient to address the inherent risks and harm posed by the system. It is our impression, from reviewing the Trust's own documents, that CNTW are merely attempting to engage in damage limitation having invested so widely in a technology which has failed to deliver on its bold promises. As Oxevision has been proven to be directly unsafe and harmful, continuing its use and attempting damage limitation for the remaining years of the contract is not an option. **We therefore urge CNTW to immediately cease the use of Oxevision all bedrooms, seclusion rooms and 136 suites operated by the Trust.**

We ask that the Trust responds to this letter in writing, stating when units will be turned off and explaining how the technology will be phased out. We would be more than happy to provide more information and can be reached at: stopoxevision@gmail.com.

Yours sincerely,
[Stop Oxevision](#)