Evidence Protocol for Families, Carers and Patients

This document describes the processes by which the Inquiry will obtain evidence from those individuals who wish to share their experiences of mental health inpatient care in Essex with the Inquiry. This will include family members, carers, trusted individuals, current and former patients as well as anyone else who has been affected by the issues which the Inquiry is investigating.

The Inquiry has also published a Privacy Information Notice which describes how the Inquiry collects and uses personal information, which is available here.

The Essex Mental Health Independent Inquiry (the "Inquiry") has been established to investigate deaths which took place in mental health inpatient facilities across NHS Trusts in Essex between 1 January 2000 and 31 December 2020.

The Inquiry's approach will be to listen, learn and make recommendations for the future.

The Inquiry wishes to speak to witnesses to hear about their experiences and opinions about what happened. The Inquiry will listen carefully to those who have been affected or were involved. Their voices and experiences will be at the heart of the Inquiry's work.

The Inquiry considers it is important that all family members that have been affected are given the opportunity to provide evidence if they wish to do so. The Inquiry is equally mindful that some families may not wish to participate in the work of the Inquiry and their privacy will of course be respected.

The Inquiry plans to meet with family members in private to allow them to give their account. The Inquiry will record these evidence sessions and produce a transcript that each witness can check and confirm to be accurate. The general approach of the Inquiry will be to treat evidence provided by family members and those affected by the issues which the Inquiry is investigating as **confidential.**

In some cases, the Inquiry may ask a witness if their evidence session can be reflected in a signed witness statement that could be disclosed to other witnesses and participants. It may also be published on the Inquiry website with any redactions that may be necessary. Where that occurs, the Inquiry will liaise with a witness before any part of their evidence is shared.

The Inquiry intends to hold public evidence sessions in 2022, at which evidence from the Trust and other stakeholders will be heard. Any family members who wish their evidence to be made public, or who would like to provide evidence at a public hearing will be provided with the opportunity to do so.

The Inquiry may also want to refer to evidence provided, use quotes or summarise a selection of evidence within its final report. Where appropriate the Inquiry may remove some personal details or refer to evidence on an anonymised basis. The Inquiry will also contact those individuals in advance to give them an opportunity to raise any comments or

concerns in that regard. Some information relating to those who have died is already known to the public. Where that is the case, the Inquiry will not usually anonymise their details.

As well as describing what happened, the Inquiry is keen to hear from witnesses about the lives of those who died, their childhoods, what they enjoyed doing, their relationships with others and how they will be remembered.

The Inquiry recognises that some witnesses may prefer to provide their account to the Inquiry in a different way, or with additional support. The Inquiry is happy to discuss any potential measures that can be put in place so that a witness can provide their evidence in a manner or within an environment in which they feel comfortable. Witnesses may also wish to be accompanied by a friend or other trusted individual who can support them. The Inquiry appreciates that some evidence may be distressing or difficult to give and will strive, at all times, to treat witnesses with sensitivity and compassion.

In considering the evidence it receives, the Inquiry will not seek to determine - and has no power to determine - any person or body's civil or criminal liability. Our aim is to examine fairly what happened and to consider whether there were any failings in care, safety or professional standards. Where any failings are identified, the Inquiry will make recommendations about how similar incidents can be avoided in the future.

In certain circumstances, the Inquiry may consider it necessary to refer matters to a regulatory body or to the police. Where practicable, the Inquiry will liaise with those concerned to seek their views as to the nature and extent of the information to be disclosed.

The Inquiry believes that many people will take an interest in its work and will be keen to know its conclusions. The Inquiry will complete its work with all due speed and thoroughness and intends to publish a report in Spring 2023. Throughout this period, the Inquiry will provide regular updates on its progress.

This protocol may be updated from time-to-time, with the latest version appearing on the Inquiry's website. If you have any questions concerning this protocol, please contact a member of the Inquiry Team on 0207 972 3500 or by email contact@emhii.org.uk

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