Monday, 2 February 2026

(10.00 am)

Opening remarks by THE CHAIR

THE CHAIR: Good morning and welcome to everyone joining us here in person at Arundel House in London, and those who are following these proceedings virtually.

This hearing, beginning today and ending on Monday 16 February, will focus on oral evidence from bereaved families. Over the course of this hearing, the family witnesses will share their experiences and recollections of the mental health inpatient care received by their family member. We will shortly be hearing a statement from Counsel to the Inquiry, Nicholas Griffin KC, who will speak in more detail about the evidence we'll hear during this hearing.

I wish to offer my appreciation to all the family members giving evidence today and over the coming weeks. I understand that providing evidence to a public inquiry may be difficult and upsetting for many people. I wish to remind everybody that emotional support services, overseen by the Inquiry's chief psychologist, are available.

Anyone who needs assistance during the hearing should please contact my Inquiry team, who will help them to access this support.

The evidence given by bereaved families is vital to the Inquiry's understanding of the key issues and its concerns within the scope of our work, and I am grateful to them all for their time and effort in engaging with the Inquiry.

I and my Inquiry have recently provided a range of new and helpful information about the structure and work of the Inquiry and how this will drive the Inquiry forward to its completion. These documents follow on from the one-day virtual hearing on 8 December during which legal representatives addressed me on the draft investigative strategy and a number of procedural matters, and I'm very grateful to the legal representatives for their written and oral submissions.

I wish to talk briefly about these recently published documents and draw out and repeat some of the key points arising from them.

My response to the submissions made on 8 December was published on the Inquiry's website on 26 January. It provides a clear picture to Core Participants and others engaging with the Inquiry about our important work from now up until the end of the hearings.

One of the key messages I took away from the 8 December hearing was the desire for more information about the Inquiry's work. So, in response, the Inquiry

has published its updated investigative strategy. Its full title is the "Statement of Approach on investigating illustrative cases of those who have died", and it also outlines the thematic areas we'll be investigating.

For anyone interested in the details of the Inquiry's work, I would recommend reading the full document, which is available on the Inquiry's website. The Inquiry has also published a high-level timeline, which provides an overview of the life of the Inquiry, including the work up to now and looking forward; provided a diagram, setting out in broad terms our Inquiry work areas, which are established to meet our Terms of Reference. It shows how the work areas operate together to drive the Inquiry forward.

In addition, the Inquiry has committed to providing a regular report on the work of the Inquiry, which will be published on the Inquiry website, and we have made available an indicative hearings plan, which provides more information about how we're arranging our hearing blocks right through to the end of our hearings.

As set out in my response to the 8 December submissions, I have decided to make some alterations to the Inquiry's hearing timetable.

In order to allow sufficient time to undertake our

investigative work and collate related evidence, I have directed that the hearing listed in April this year will no longer go ahead. In its place, two further hearings will be added to the end of our current hearing blocks. This will take the Inquiry's hearings into mid-2027.

The first hearing related to systemic issues will now take place in July this year. The change in timetable is partly needed due to the delay in the Inquiry receiving material. This relates to both witness statements and documents.

Unfortunately, such delays have impacted the ability of the Inquiry to progress investigations and other work as quickly as I would like. My team will continue to work closely with those who are requested to provide information to ensure that this Inquiry continues to make progress and that I'm able to meet my Terms of Reference.

I do have statutory powers to compel evidence and I will use those powers if I consider it necessary to do so.

This February hearing, which begins today, will be the final hearing that's dedicated solely to family evidence. Following this hearing, and building on what we've heard from families, the Inquiry's focus will move to investigating systemic issues in respect of inpatient

care.

We will adopt a thematic approach to our investigations. The thematic areas are set out in our investigative strategy. They include, amongst others: sexual safety; neurodevelopmental orders; observations and the use of technology; and Child and Adolescent Mental Health Services.

The thematic areas will be kept under review. The first thematic hearing will be, as I've said, in July, and it's intended to focus on the following themes: assessment and admission, observations and the use of technology, co-occurring health conditions and older adult care, sexual safety and safeguarding.

More information on the thematic areas the Inquiry plans to hear at each future hearing can be found in the indicative hearings plan, which is included in my response to submissions made on 8 December.

I am aware that there are some Core Participant bereaved family members, who, for various reasons, have yet to provide a statement to the Inquiry about their experiences. I want to reassure those families who wish to engage that I welcome their input in other ways. The Inquiry will continue to offer flexibility and support to all those family Core Participants wishing to contribute.

As the hearing is no longer taking place in April, I have asked my team to make that time available for me to consider recorded evidence sessions with bereaved families and with those with lived experience, should they wish me to do so.

For many individuals, particularly those who are vulnerable, recorded evidence can be the best way to provide evidence in a less formal environment, at a time which is convenient and with appropriate support. After Easter, I will carefully review all statements and recorded sessions and decide whose, when and what further evidence will be sought from families and those with lived experience.

For that reason, I have allocated up to three days in either the July and/or the October 2026 hearings for evidence from bereaved families on areas that I consider would assist me. No family or individual with lived experience will be compelled by me to provide evidence to this Inquiry: a decision to provide evidence is a matter entirely for them.

I also wish to reassure Core Participants that all deaths relating to Core Participants will be included within the illustrative cases and will be investigated by my team. For anyone interested in how the Inquiry is going about its work, both now and in the future,

I recommend reading the full documents which are available on the Inquiry's website. I will continue to keep our processes under review throughout the life of the Inquiry and to consider the submissions of Core Participants and those engaging with it.

The Inquiry's Terms of Reference require me and my Inquiry team to undertake a thorough investigation of the systemic issues and failings relating to the deaths of mental health inpatients in Essex, between 2000 and 2023. Systemic failings in mental health inpatient care have been identified in other parts of the country too, as is evident from the Health Secretary's announcement in December of a statutory inquiry into the mental health services at Tees, Esk and Wear Valley NHS Foundation Trust.

It's important, wherever possible, that my recommendations are national, as well as local, in scope. By understanding what happened, I can make recommendations to help ensure that the same failings do not happen again in Essex or in the rest of the country.

The policy and regulatory landscape in mental health care is developing as this Inquiry progresses and it will continue to develop all the way through to the publication of my final report. My Inquiry team will keep a watchful eye on these matters and my report will

be set into the landscape that exists at the time of publication.

The Inquiry is in a strong position to carry out the remainder of its wide-ranging work with the help of its Core Participants and witnesses. There's a lot still to do but, by following and implementing the approach set out in the recently published documents that I've talked about today, I'm confident that I'll be able to deliver on my Terms of Reference and provide a report which contains meaningful recommendations for lasting change.

Before I hand over to Counsel to the Inquiry, I wish once again to thank all those who will be giving evidence to this hearing and who have given evidence at previous hearings over the past year and a half. I'm very grateful for their participation, their time, and their candour.

I'd also like to thank Kate Ward, who, until December, was this Inquiry's Secretary, and Trisha Rich, who will shortly move on from her role as Deputy Secretary. They have both served this Inquiry since its inception as a non-statutory inquiry, through its conversion through to a statutory inquiry and up to this year. I'm very grateful for their work and their dedication. I also take this opportunity to introduce the new Secretary to the Inquiry, Helen Gibson, who is

sitting to my right, and the new Deputy Secretary, Deborah Browne.

Both are here today and will be present for much of the February hearing. I know that Helen and Deborah are happy to introduce themselves to those here at Arundel House who may wish to meet them.

I will now hand over to Counsel to the Inquiry, Nicholas Griffin KC.

Opening statement by MR GRIFFIN KC

MR GRIFFIN: Thank you. This is the Lampard Inquiry's sixth public hearing.

Chair, you have referred to the information recently provided by the Inquiry, including your response to the submissions made by Core Participant lawyers in December, and in the Inquiry's updated investigative strategy, its "Statement of Approach on investigating illustrative cases of those who have died". The Inquiry has also just published a disclosure update.

These documents, as you said, are available on the Inquiry website. They are also hyperlinked in the written version of this opening statement, which will shortly go on to the website. Together, they provide an update on the progress of the Inquiry's work and information, as you've said, about its future timeline and plans. For that reason, this opening statement will

be a short one, in which I focus on the subject of this hearing, rather than repeating what you have said and matters that have been covered in those recent communications.

In July and October of last year, the Inquiry heard powerful evidence from the families of those who died whilst receiving mental health care from trusts in Essex. From that important evidence, there emerged a number of common themes and clear lines of enquiry, careful consideration of which is already well under way. These hearing is the last of the three that will be dedicated primarily to hearing evidence from the families and friends of those who have died.

Over the coming weeks, the Inquiry will hear oral evidence from 13 further families and friends of those who have died. I want to reiterate, as I have done at each of these three bereaved family hearings, that the Inquiry is immensely grateful to each of those witnesses for their strength and courage in coming forward to share their accounts. As you have made clear, Chair, the unique experiences, recollections and observations shared by the families and friends of those who have died form a fundamentally important part of the basis for the Inquiry's work. Those families and friends, and those that each of them lost, remain at its core.

Throughout this hearing, the Inquiry will be listening to evidence that may be deeply distressing. For many of those following the Inquiry, the experiences of the families we are about to hear from will resonate with the trauma and grief they too have suffered, and continue to suffer, or of experiences of mental ill health or mental health inpatient care.

Chair, you have just mentioned that emotional support is available for anyone who requires it. The wellbeing of those participating is extremely important to this Inquiry.

For those in the room, please know that you are welcome to leave at any point during these proceedings. Each day, present in the room will be two support staff from Hestia, an experienced provider of emotional support. The Hestia support staff can be identified by their orange lanyards and scarves. A private room where you can talk to Hestia support staff is available throughout the hearing. Or, if you would prefer, please speak to a member of the Inquiry team so that we can make arrangements for support from Hestia for you. We are wearing purple coloured lanyards.

For those watching online, information about available emotional support can be found on the Lampard Inquiry website at lampardinquiry.org.uk and under the

"Support" tab near the top right-hand corner. You can also contact the Inquiry team's mailbox on contact@lampardinquiry.org.uk for this information.

We want all those engaging with the Inquiry to feel safe and supported.

I am assisted at this hearing by three members to the Counsel to the Inquiry team: Rachel Troup, Priya Malhotra and Natasha Lloyd-Owen. We have been working closely with briefed families and friends and with their legal representatives to help to support and prepare them for their evidence.

As I have explained at previous hearings, my counsel team works closely with the Lampard Inquiry Solicitor Team, under Catherine Turtle, as well with the Inquiry's Secretariat. Chair, as you've just mentioned, the Secretariat is under the new leadership of Helen Gibson.

My colleagues and I work for you and are instructed by you, Chair, to assist you in your important task, and we do so independent from all other organisations and individuals.

I'd like, once again, to introduce the lawyers who are representing Core Participants.

Representing briefed families and those with lived experience: Bates Wells, with their instructed counsel, Sophie Lucas; Bhatt Murphy with Fiona Murphy, King's

Counsel, and Sophy Miles; Bindmans with Brenda Campbell KC and Tom Stoate; Hodge Jones & Allen with Eleena Misra KC, Dr Achas Burin, Rebecca Henshaw-Keene, Jake Loomes, and Annahita Moradi; Irwin Mitchell, Leigh Day and Deighton Pierce Glynn, all with the same counsel, Maya Sikand KC and Laura Profumo.

Representing Core Participant organisations: Bhatt Murphy for INQUEST with Anna Morris KC and Ciara Bartlam; Browne Jacobson for Essex Partnership University NHS, or EPUT, with Eleanor Grey KC and Adam Fullwood; Kennedys for North East London NHS Foundation Trust or NELFT, with Valerie Charbit; DAC Beachcroft for NHS England with Jason Beer KC and Amy Clarke; Government Legal Department for the Department of Health and Social Care with Anne Studd KC and Robert Cohen; Mills & Reeve for the Integrated Care Boards with Samantha Broadfoot KC; the Care Quality Commission Legal Services Team for the CQC with Jenni Richards KC and Rachel Sullivan; the Health and Safety Executive's Legal Services Division for the HSE with Tom Green KC; Bevan Brittan for LIO, formerly Oxehealth, with Fiona Scolding KC; Essex County Council Legal Services for Essex County Council; Essex Police Legal Department for Essex Police; Cygnet Healthcare Limited Legal Team for Cygnet Health; Weightmans for British Transport Police; and in-house

representation for St Andrew's Healthcare.

In this hearing the Inquiry will hear about the following people who have died:

Georgina Sefton, who died on 10 June 2006, aged 29. We will hear evidence this morning from her mother, Ann Sefton.

Daniel Lee Marcovitch, who died on 11 January 2022, aged 44. We will hear evidence later today from his father, Simon Marcovitch.

Milan Radovanovic, who died on 25 July 2018, aged 25. We will hear evidence from Milan's mother, Anastasija Fuller.

Terry Dicks, who died on 16 April 2018, aged 46. We will hear evidence from Terry's mother, June Dicks.

Tillie-Anne King, who died on 8 March 2020, aged 21. We will hear evidence from her mother, Lisa Bates.

Malgorzata Elzbieta Breczko-Nowak, known as Gosia, who died on 27 June 2019, aged 41. We will hear evidence from her friend, Stuart Ringer.

Paula Parretti, who died on 6 January 2002, aged 46. We will hear evidence from Paula's sister, Samantha Cook.

Marion Michel, who died on 4 March 2022, aged 56. We will hear evidence from her sister, Karen Michel.

Benjamin Morris, who died on 28 December 2008, aged

20. We will hear from Benjamin's mother, Lisa Morris.

Christopher Mark William Irwin, known to his friends as Teddy, who died on 2 May 2023, aged 34. We will hear evidence from his mother, Sonia Edwards.

Glenn Holmes, who died on 7 July 2012, aged 19. We will hear evidence from Glenn's sister, Amanda Cook.

Rocky Stenning, who died on 19 July 2018, aged 26. We will hear evidence from Rocky's sister, Kristal Stenning.

The Inquiry will also hear evidence in private session from one further family witness, to whom you have granted a restriction order.

I referred a moment ago to common themes that have arisen. Chair, many of the issues raised by the families and friends we are about to hear from will, by now, be sadly familiar to those who have been following this Inquiry, echoing the voices of the families we heard evidence from in both July and October. The issues that we will hear about include but are not limited to:

Failures adequately to assess and admit and failures to admit at all;

A lack of availability of beds in inpatient units;

Inadequate, inappropriate and, in some cases, non-existent communication and engagement with families,

at all stages of assessment, admission, inpatient treatment and discharge;

Failures to plan and coordinate care, allocate staff to any coordination role or to take any oversight;

Inappropriate medication and over-medication, including on discharge in cases where overdose was a known risk;

Wholesale failures for vulnerable people young people at the crucial period of transition from Child and Adolescent Mental Health Services, or CAMHS, to adult mental health services;

Failures in communication and coordination between service providers, including health services, Social Services, criminal justice system teams and prisons;

Mismanagement of co-occurring physical health conditions and associated mental health difficulties;

Failures in communication and coordination between physical and mental health services;

Failure to prevent patients from absconding;

Repeated failures to adhere to, or even to activate, missing persons protocols when alerted to patients having absconded or having failed to return from leave;

Failures to consider or make appropriate safeguarding referrals, including in the context of sexual safety;

Failures to refer for specialist treatment for eating disorders;

Mismanagement in relation to all aspects of care for substance misuse;

A lack of understanding about, and a dismissive approach to, addiction more generally, including in the case of self-harm and severe symptoms;

Rudeness and a lack of care from staff;

Clear deficiencies in the control of access to high-risk items, including knives;

Inadequate and unfocused risk assessments;

Disorganisation, understaffing and a lack of continuity in care; appointments that had been relied on cancelled at the very last minute with no alternative support provided;

Poor and inadequate investigations by trusts;

Trust defensiveness and an unwillingness to identify problems, still less to learn from events.

In my opening statements for the July and October hearings, I explained that the witness statements provided by each witness giving evidence will stand in full as their evidence. That remains the case for this hearing. As before, each witness will be asked questions by the members of the counsel team I have named. Counsel will help each witness to expand on what

they have written and to highlight their gravest concerns about the care and treatment of those they have lost.

Those witness statements will then be published on the Inquiry's website once each witness has given their evidence. May I say once again, for the avoidance of doubt and for clarity, that copies of the statements that are published will be redacted in line with the Inquiry's published approach. That approach sets out three main categories where redactions may be applied:

Staff names -- in order to ensure fairness, these names will be redacted on a temporary basis.

Detailed evidence about methods of self-harm, injury or death, particularly where the details could be considered instructional -- to minimise risk and to protect the public from potential harm.

Information that is personal in nature where it's not considered by you, Chair, to be relevant or necessary to be made public.

I move now to the timetable for this hearing. In this week and next week, the Inquiry will sit on Monday, Tuesday and Wednesday. In the third week, the Inquiry will be sitting on Monday only. That's Monday, 16 February. The timetable for the hearing can be viewed on the Inquiry website.

As a general rule, during this hearing, we will begin at 10.00 am and finish before 4.00 pm each day, though there may be days on which there is an earlier finish. There will be a short break in the mornings, and in the afternoons, in which teas and coffees will be provided for those who are attending. There will also be a one-hour break for lunch each day. Those timings will always be subject to change. The Inquiry works flexibly in order to support witnesses and may therefore take additional breaks or make other arrangements wherever appropriate.

As with all of the Inquiry's hearings, it is not necessary to attend in person in order to watch or follow the evidence. Arrangements have been made for Core Participants and their representatives, where not attending in person, to watch the hearing live on a secure weblink. For the wider public wishing to follow remotely, the hearing will be live streamed on the Lampard Inquiry YouTube channel. Please note that, as before, the footage on that channel will be streamed with a ten-minute delay.

I am about to finish my opening remarks. I will then suggest we rise for 15 minutes before I hand over to my colleague, Rachel Troup, and we hear from our first witness. Ann Sefton's evidence, and that of Simon

Marcovitch later today, will inevitably touch on troubling matters. I refer back to what I said at the start of this statement about the support that is available for those present here at Arundel House or watching remotely.

Chair, I conclude by reiterating that your Inquiry team remains wholly committed to doing whatever it takes to assist you in your scrutiny of the provision of mental health inpatient services in Essex and in formulating recommendations for real, long-term change.

Chair, I suggest that we rise now and come back for our first witness at 10.55.

THE CHAIR: Thank you, 10.55.

(10.38 am)

(A short break)

(11.15 am)

MS TROUP: Thank you, Chair. Could we have the witness sworn, please.

ANN SEFTON (affirmed)

Questioned by MS TROUP

MS TROUP: Thank you, Ann. We're going to take it slowly and I don't want you to worry about asking me to stop or take a break if that's what you need to do, all right? You'll just tell me.

A. Okay.

Q. All right. First, I'm going to ask you to give your full name, please?

A. Ann Sefton.

Q. Thank you. Ann, I want to introduce what you're talking about and what you've come to give evidence about.

A. Okay.

Q. You are the mother of Georgina Sefton --

A. Yes.

Q. -- who died on 10 June 2006 --

A. Yes.

Q. -- when she was 29?

A. Yes.

Q. At the time of her death, Georgina was an inpatient at the Linden Centre --

A. Correct.

Q. -- but had failed to return from leave; is that right?

A. Yes, yes, that's right.

Q. So, by way of background, you have submitted to the Inquiry a witness statement and you have a copy of it in front of you, yes?

A. Yes.

Q. Your witness statement, Ann, is 19 pages long and, if I can ask you to turn, please, to page 18, which is the very end of it. It's not the last page, in fact, but the second to last page?

A. Yes, statement of truth.

Q. Yes, so just to confirm that your statement is dated 22 December 2025 and that is the page where you made a statement of truth and signed?

A. Correct.

Q. Thank you. Are you content, sitting there now, that your statement is true and accurate?

A. Yes.

Q. Thank you. That witness statement, as you know, because you and I have discussed it, now stands as part of your evidence to this Inquiry?

A. Yes.

Q. What I don't intend to do over the next hour or so is take you through it line by line. You and I will go through it but we'll just talk through some of the most important matters that you want to raise.

A. Yes.

Q. All right?

A couple of things that I think it's important for us to note at the start of you telling us about what happened to Georgina: first of all, you and your husband have long engaged with this Inquiry and with the Essex Mental Health Inquiry before we became the Lampard Inquiry?

A. That's correct.

Q. You and your husband, when this was a non-statutory inquiry, came and gave an evidence session back in May 2022, correct?

A. Yes.

Q. You also, Ann, attended throughout this Inquiry's commemorative hearings at Chelmsford in September 2024?

A. That's right.

Q. You gave, at that time, a very moving account about Georgina's life and about the impact of her death on you and your family?

A. Yes.

Q. I think, in fact, you and I read that together, if you remember, we sat side by side --

A. Yes.

Q. -- and together read that account.

A. Mm.

Q. So the first thing that I wanted to note is to tell you again that we are extremely grateful to you for coming forward and giving evidence in all of these different ways.

There are a couple of other things I want to note before we go on and the first is that you tell us in your witness statement that some of the matters we're going to cover are not things that were known to you at the time --

A. Okay.

Q. -- because a lot of the time, during Georgina's care and treatment, you and your husband didn't know what was happening?

A. No, they didn't tell us anything.

Q. So the period we're going to concentrate on is in 2006 and we'll talk through a little bit about the background to Georgina's mental health worsening and how she came to be at the Linden Centre but, in really brief terms, Georgina had two periods of inpatient admission at the Linden Centre --

A. Yes.

Q. -- and those were between 13 January and 21 March 2006 --

A. Yes.

Q. -- and then she was discharged --

A. Yes.

Q. -- which we'll come to. Then she was back again by 3 April 2006 and was an inpatient of the Linden Centre, despite periods of absconding or not returning from leave, until the day that she died on 10 June 2006?

A. Correct.

Q. Quite a bit of the information that you have about Georgina's care and treatment, as I understand it, has in fact come to you from the Trust's Serious Incident

Report; is that right?

A. Sorry?

Q. The SUI report?

A. I never got that.

Q. So you have seen it now but I think the point we wanted to make is that you did not see any report from the Trust in 2006?

A. No. No, we didn't --

Q. Did you know that an investigation was taking place into the circumstances --

A. No.

Q. -- of Georgina's death?

A. No.

Q. The first time I think that you became aware that such a report existed was when this Inquiry told you so?

A. That's correct, yes.

Q. And the first time that you saw that report was when it was sent to you by this Inquiry?

A. Yes.

Q. So some of the information that you give us is lifted directly from that Trust report?

A. That's correct.

Q. One of the other things I think it's important for us to note is that you have spotted that in that report there is a reference to -- or the Trust say that, in that

report, Georgina's care and treatment is "well documented". That's the phrase that is used.

A. I doubt that very much.

Q. You doubt it?

A. Yeah.

Q. One of the things that you have made clear in your witness statement is that, if that is the case, you would like to see those documents --

A. Yes, I would.

Q. -- so that you can understand what it is that went wrong and what was happening during that period?

A. Yes, I would.

Q. The other thing about that report, and we'll come on to this, is that you consider, I think, that, in terms of actually addressing the most serious concerns that you have about Georgina's care and treatment, the report is entirely insufficient?

A. It is.

Q. And we will come on to this Ann, I think there are aspects of it that you consider to be insulting, frankly?

A. I do.

Q. Thank you. I am going to move to take you fairly briefly through the background and the lead-up to Georgina being admitted to the Linden Centre --

A. Okay.

Q. -- all right? So you tell us in your witness statement that, as a teen, Georgina began to self-harm --

A. Yes.

Q. -- and that, at first, it wasn't very severe.

A. *(Witness nodded)*.

Q. But that it did escalate following the death of your son, Tony?

A. Yes.

Q. Tony died in a motorcycle accident in May 2003?

A. That's correct.

Q. In fact, I think it was 14 May; is that right?

A. That's right, yeah.

Q. That date was, for understandable and obvious reasons, one that would become a trigger for Georgina --

A. Yes.

Q. -- much later --

A. Yes.

Q. -- or as time went on.

You've told us in this witness statement, and you've told us in your commemorative evidence, a little about the closeness between Georgina and her brother.

A. Tony, yeah.

Q. I think one of the things that you say -- we don't need to go to it -- is that, quite apart from suffering the

impact of his loss, Tony's death represented an enormous loss in particular to Georgina because he was such a source of comfort to her?

A. Yes.

Q. I'm so sorry.

A. It's all right.

Q. You tell us that after that, after May 2003, you consider that to have been one of the turning points, and that there was quite a marked deterioration in Georgina's mental health after your son's passing?

A. That's correct.

Q. You also tell us, and I'll cover this fairly briefly, Ann, that, at some time thereafter, Georgina became caught up in a relation that was extremely abusive, both mentally and physically?

A. Very abusive, yes.

THE CHAIR: Can I ask you, were there issues of substance abuse/misuse, alcoholism before Tony died?

A. Yes, there was.

THE CHAIR: Thank you.

MS TROUP: Thank you. I'll come to that, I think, because you mentioned those too in your commemorative evidence. I'll come to that. You can identify, obviously, that being in that relationship -- and you describe it as something of a toxic cycle, she was sort of unhealthily

dependent on that abusive partner.

A. Yes, she was.

Q. And that obviously worsened the mental health issues --

A. Yes.

Q. -- she was already suffering?

A. Yes, it was.

Q. You also tell us, thinking about trigger points and points at which things became worse for Georgina, that her daughter was removed from her care at two years old?

A. Yes.

Q. Ann, you're very clear in your witness statement that that event was the major catalyst that led to a downward spiral; is that right?

A. Yes, it was.

Q. One of the things you say is that, after that event, Georgina just could not cope?

A. She couldn't.

Q. At that time, Ann, was Georgina living at home with you?

A. Yes, she was.

Q. As the Chair has just mentioned, you do go on to tell us quite a bit about the fact that Georgina suffered over quite a long period from addiction issues?

A. Yes, she did.

Q. When did those begin? Can you remember?

A. I can't remember.

Q. Don't worry.

A. She was young. I can't remember.

Q. She was young. I wanted to pick up on it because it's not in this witness statement but one of the things that I remember from your commemorative evidence is that you told us that you had made efforts for her to be admitted to rehab.

A. That's correct.

Q. Was that before Georgina became a patient at the Linden Centre in 2006?

A. Yes, it was.

Q. One of the things you told us, that I just wanted to ask you about, was that one of the rehab units -- and I'm not sure you identified it -- said that they could have a place for her but that first she would need to be clean of drugs?

A. Clean, yes.

Q. Tell us about that, what you can remember.

A. They basically said she had to be clean for -- was it -- three months before they'd take her in. So I said what's the point of a rehab clear centre. For three months she's got to be clean? You need to help her because they weren't prepared to do it.

Q. They weren't prepared to do it?

A. No.

Q. Sorry, I didn't mean to interrupt you, because to your mind -- I don't want to put words into your mouth -- but to your mind, the whole purpose of entering rehab --

A. To help her, yes.

Q. -- to get clean and to help her to do that?

A. That's right.

Q. Can you remember when that was, compared with January 2006 when things that got bad enough that you approached --

A. I really can't remember.

Q. That's all right. It doesn't matter.

A. Sorry.

Q. No, I promised you it wasn't a memory test and it really isn't.

So you also tell us, just setting out the background, that --

THE CHAIR: Was that a private rehab centre? Can you recall?

A. No, it wasn't private, was it? No, it was to do with NHS but they turned round and said that she had to be clean. So I said, "Well, if you're a rehab centre, why has she got to be clean? You're supposed to help her".

THE CHAIR: You'd found that through your GP, had you?

A. I think so ... no, did we -- we took her there ourselves.

We found out this place was a rehab centre and we took her there and that's what they came out with. Couldn't believe it.

MS TROUP: So you physically took her there to ask them if she could be admitted there?

A. Yes, we did.

Q. And the response was no.

A. Yes, twice we took her there.

Q. All right. Thank you, that's really helpful.

You also tell us in your witness statement that Georgina made a number of attempts to take her own life.

A. Yes, she did.

Q. I know, and we're going to come to it, that, in particular, on 9 January 2006, she made an attempt to take her life and that is what led you to the Linden Centre. Can you remember, Ann, before that, before 9 January 2006, had she made attempts to take her life?

A. Yes, I think she did. I have to keep looking at her dad.

Q. That's all right. That's all right. He's helping us.

If you could look, please, I just want to show you what I'm looking at, at page 2 of your statement and at the bottom paragraph, the last one on the page which is paragraph 9.

A. Yes.

Q. You tell us there that Georgina suffered with a complex set of mental disorders but that she wasn't formally diagnosed until she got to the Linden Centre?

A. Yeah, they said she was borderline --

Q. Yes.

A. I can't remember what they said: borderline something.

Q. You've recorded it here. What you say is:

"I believe she had bipolar, borderline personality disorder" --

A. That's right, borderline personality disorder, that's it.

Q. -- "and depressive disorder."

Can you tell me, Ann, it doesn't matter particularly, but were you aware of those diagnoses being given at the time?

A. No.

Q. So is this something you've learned from the report much later?

A. Yeah.

Q. Because we're talking about 20 years ago now.

A. We are.

Q. So is it the case that, during the time that Georgina was a patient of the Linden Centre and in all the years following her death, you had not known of any formal diagnosis --

A. They didn't tell us anything. I tried to help but they didn't seem interested.

Q. All right.

A. That's the impression I got, anyway.

Q. Yes. We'll come back to that. Because one of the things you tell us -- actually, we might do that now. One of the things you tell us, and this runs through the whole of your witness statement, is that you, as a family -- Georgina was an adult, so during the period we're talking about we're not talking about a child, and from January to June 2006 she was 29 years old. Nonetheless, she had a supportive family who were trying to take care of her.

A. Always. Always.

Q. Yes. You tell us that at no stage were you kept in the loop as to what was happening with her?

A. The only thing I ever got was a telephone call, asking me where she was.

Q. Yes. We'll come on to that. So you tell us -- we don't need to go to it, I don't think, I don't want to keep flicking backwards and forwards through the witness statement --

A. No.

Q. -- but you were never included -- you must correct me if this is wrong -- you were never included in any plans

for her care?

A. No.

Q. You were never told of any diagnosis?

A. No.

Q. You were never told what medication she was taking?

A. No.

Q. You had no input into her care and treatment?

A. They didn't tell us anything, to be honest. I don't know why.

THE CHAIR: When you visited, did anybody approach you and ask you about her or tell you --

A. No, nothing. All they done was walk past -- we was in a room. They kept walking past the room. I think they were sort of listening.

THE CHAIR: Do you ever recollect actually asking directly for information about her and not getting it.

A. I don't know whether I directly asked. I can't remember. But there was a lot of staff on but no one ever sort of came in the room and said anything. The only thing I'd get was the phone calls: "Where's Georgina?"

MS TROUP: Yes, we'll come to those, and I think one of the other things when we come to talk a little bit about the environment at the Linden Centre, one of the things you've said is that, although there was staff around,

often they were in the office.

A. Or talking with each other.

Q. Talking with each other?

A. Yes.

Q. Yes, and not really engaging as far as you could see --

A. No, not with the patients, no.

Q. With the patients or with you?

A. No.

Q. Just going back for a moment to the diagnoses that you didn't know about at the time, one of the other things you tell us is that you have learned that, occasionally, it appears to have been recorded that Georgina suffered from psychotic symptoms?

A. Yeah, I didn't know that.

Q. One of the things that the Trust's report tells us is that at times, Georgina reported, whilst she was an inpatient, that her deceased partner was speaking to her and telling her to take her own life.

A. To kill herself, yeah.

Q. That is not something that you were aware of at the time?

A. No.

Q. All right, thank you. Ann, I think, is this right: you came to know of the Linden Centre because, in the aftermath of your son's death, you yourself suffered

from a very deep depression?

A. Depression. *(Witness nodded)*

Q. You sought help and received help from a particular psychiatrist at the Linden Centre?

A. Yeah. "Dr A".

Q. Dr A, yes. As you know, we're not mentioning staff names during this part of the evidence, so we'll refer to him as "Dr A". I'm sorry, I realise it feels a little bit cloak -- feels a bit odd.

A. A very good doctor.

Q. A very good doctor. Tell us about that.

A. Thorough. He was thorough.

Q. You felt well taken care of --

A. By him, yes.

Q. -- and well supported?

A. By him, yes. Only by him.

Q. After Georgina made an attempt to take her life on 9 January 2006, is this right: you decided that, having had that experience yourself with Dr A at the Linden Centre, you would take Georgina there in the hope that he would also be able to help her?

A. I spoke to him first and he said, "Bring her, I'll see her".

Q. Yes, so you called him?

A. Yes.

Q. As a result, she was reviewed by Dr A on 12 January 2006?

A. Yes.

Q. Then a decision was made to admit her the next day?

A. Yes.

Q. Can you remember which ward or unit at the Linden Centre Georgina was first admitted to?

A. I can't remember the names of them. There was a few.

Q. Yes.

A. I can't remember the names. I'm sorry.

Q. That's all right. As I said, I promised it's not a memory test. I think there were possibly a couple of different wards that Georgina went between, and we'll come to it, but I think she also spent a short period in the Psychiatric Intensive Care Unit?

A. I don't know.

Q. We'll come to it. I think you do identify that but that possibly has come to you from the report?

A. Mm.

Q. In general terms, Ann, before we get into the detail, do you consider -- we've set out the two periods of inpatient admission that Georgina had -- did you see any improvement over that period --

A. None. None at all.

Q. -- at any stage?

A. No.

Q. When Georgina was first admitted on 13 January, you tell us that she showed very little improvement?

A. That's right.

Q. You also say, knowing as we do that Georgina had problems with addiction and those, I think, were drugs and alcohol --

A. *(Witness nodded)*

Q. If you want to look at it, Ann, I'm, at the moment, on page 3 of your statement at paragraph 12. You don't have to follow it but just so you know where I'm up to.

So you tell us there that, despite her admission, she continued to drink alcohol --

A. Yes.

Q. -- and her mood remained very, very low.

A. Very much the same, yeah.

Q. You say that her treatment had to be escalated and she was then detained under Section 3.

A. Yeah.

Q. So she moved from being a voluntary patient to a patient under formal detention?

A. Yeah.

Q. Again, I want to check with you: did you know that at the time, that she had been detained under Section 3? Did she tell you that?

A. I can't remember that either. I'm sorry.

Q. No, please don't apologise. That's all right.

A. It's a long time ago.

Q. Of course. Of course it was. I can't remember what I did last Thursday and I'm asking you things that happened 20 years ago, so please don't apologise. If you look at paragraph 13, you say that -- and I think this may have come to you from the records because, in that first line of paragraph 13, you say:

"Her mental stability then apparently did improve following treatment in the ward's ICU."

So there had obviously been a move into the intensive care unit --

A. Yeah.

Q. -- and when you say, "apparently did improve", am I right in thinking that you didn't see any improvement?

A. I didn't see any improvement, No.

Q. You tell us that by March, Georgina was granted leave for two days?

A. Yeah, I found that difficult to understand, being as she was in such a state.

Q. Tell us -- so she had been admitted on 13 January and by March clinicians had seen fit to grant leave?

A. Yes.

Q. How often were you able to visit her in that period of

admission?

A. I could actually visit her whenever I felt like it, really.

Q. Yes.

A. But --

Q. How often did you see her in that period? How often did you go to the Linden Centre?

A. I can't even remember that.

Q. That's all right. Do you think it was regularly?

A. Oh yeah, oh yeah.

Q. So weekly?

A. Every two weeks, maybe.

Q. Every two weeks.

FROM THE FLOOR: No, every two or three days.

A. Oh, sorry, two or three days, Rachel. Sorry.

MS TROUP: No, that's all right.

A. My memory ain't what it used to be.

Q. That's all right, it just helps me to understand how frequently you were there to get an impression of the ward, so it helps us to understand when we come on to the --

A. Sorry, to stop you --

Q. No, go ahead.

A. She wasn't in the ward. She used to come into a room and I used to sit in the room and she used to come in

there and talk to me.

Q. Yes.

A. But all the staff would be in a separate room. You never really -- I mean, I could see them from way back but they never really came in the room.

Q. How do you remember her being during that period? You've told us that you hadn't seen any improvement?

A. No, I hadn't.

Q. So by March, if you were visiting every two or three days from mid-January until March, as far as you were concerned, her mood remained very low?

A. Extremely -- exceptionally low, yes.

Q. Did Georgina talk openly with you during those visits about how she was feeling and how --

A. Yes, she spoke to me but other patients in the room would only be listening.

Q. Yes.

A. So she wasn't too amused by that because you didn't get a private room.

Q. I see.

A. It was like everyone was in there, if you know what I mean, apart from the staff.

Q. Yes, so all the patients and visitors were in the same room?

A. Yes.

Q. And your impression is that she felt constrained by that --

A. Yeah.

Q. -- to talk openly with you --

A. She didn't like it.

Q. -- no -- about such personal, private matters?

A. Well, yeah, of course.

Q. Yes. You also tell us that on 14 March 2006, if you want to see it, it's in paragraph 13 on page 3, Georgina was aware that that was the date that was scheduled for her daughter's adoption hearing?

A. I think so. I can't remember that date either.

Q. No, that's all right. You say there she was still utterly beside herself --

A. Oh, she was in a terrible state.

Q. -- about losing her daughter?

A. Yeah, yeah.

Q. So if she knew of that date, presumably that date was of itself a trigger point for her?

A. Yeah, it was leading up to the court hearing but she was in a really bad state.

Q. Yes. Nonetheless, what you tell us is that, on that same day, so 14 March, her Section 3 treatment order under the Mental Health Act ended and, seven days later, on 21 March, Georgina was discharged from the Linden

Centre?

A. I didn't understand that either, to be honest.

Q. No.

A. Such a short period of time.

Q. Can you tell us -- we've discussed a little the fact that you as a family were not consulted about any aspects of Georgina's care and treatment -- when did you -- in relation to this discharge on 21 March, can you remember when you first came to learn that that was happening? Were you told in advance?

A. No, Georgina said she was going out.

Q. So she called you or she told you while you were visiting?

A. I went up there and she said, "Oh, I'm going out to meet a friend". I went, "Oh, right".

I didn't understand that either, because they let her out after all this.

Q. Yes. So when Georgina was discharged on 21 March 2006, do you know -- and I think the answer might be no but I just want to check with you -- what risk assessments took place or what checks took place before she was released?

A. I don't know. I couldn't tell you.

Q. Do you know -- I'm aware from your witness statement that Georgina had had, and went on to have, some periods

of homelessness. Do you know whether she had an address to be discharged to?

A. No, the only place she could go was with me and her dad.

Q. But nobody asked you about that?

A. Nobody asked us. Nobody told us. We didn't know anything.

Q. Where did she go on 21 March?

A. I don't know. I don't know.

Q. One of the things you tell us in your witness statement was that one of the reasons that that discharge was so shocking to you was that she was no better?

A. No.

Q. She was still using alcohol and drugs --

A. Drugs, yes.

Q. -- in the Linden Centre --

A. Yes.

Q. -- and during periods of leave, and the words you used, Ann, are that they decided to release her back into the very chaos she had been begging for help to escape?

A. Yes, that's correct.

Q. As it turns out, not very much later, she was re-admitted to the Linden Centre on 3 April 2006?

A. Yes.

Q. I just want to cover this with you because there is a section here where you were slightly involved because,

as I understand it, and you must tell me if I have this wrong, in early April 2006, Georgina was in a homeless shelter?

A. Right.

Q. And what you tell us in your witness statement is that you recall going there on the 2nd to visit her at the homeless shelter?

A. Yes.

Q. And I think there was some incident where another resident of the shelter said something to you?

A. Was abusive.

Q. Was abusive to you?

A. And she attacked him.

Q. Georgina attacked him?

A. Yes.

Q. You were present when that took place?

A. Yes, I was.

Q. Georgina was acting to protect you, I think.

A. *(Witness nodded)* You think correctly. She was trying to protect me.

Q. Yes. Police attended and Georgina was arrested?

A. That's correct, yes.

Q. There's some suggestion in the records that there was then an allegation that she had assaulted a police officer?

A. I don't know about that.

Q. All right. So we'll look at it actually, if you take a look, please, can you turn to page 4 and to paragraph 16, which is the third paragraph down.

A. Yeah.

Q. I'm conscious, Ann, we're taking this from the SI report but what it tells us in the last few lines, this is directly quoting from that report, that on arrival at the Linden Centre she told staff that she had recently been evicted from her hostel, had been involved in a fracas, and allegedly assaulted a policeman, although she had no memory of this.

A. *(Witness nodded)*

Q. Now, that is important because when Georgina was admitted to the Linden Centre on 3 April 2006, in spite of that information, she was assessed, you tell us, as not being a danger to herself or others?

A. Yeah. I don't understand that either.

Q. No, to you that makes no sense?

A. None at all.

Q. She had been arrested for being involved in a physical fight with someone?

A. That was the fellow that said something to me. I can't even remember what he said but he was abusive.

Q. Yes. So to you, it makes no sense to then, just a day

later, to say that she doesn't present a danger to herself or anyone else?

A. No, that don't make no sense at all.

Q. Yes. I think, when Georgina went back to the Linden Centre on 3 April, she was not under Section. She was admitted as a voluntary patient; is that right?

A. Apparently.

Q. You tell us, I think, that she knew herself at that time --

A. She wasn't well.

Q. -- that she wasn't --

A. She wasn't well.

Q. What did she say to you about that? Can you remember?

A. No.

Q. It's all right. One of the things I think that happened in this second inpatient stay at the Linden Centre is that you either knew at the time, or have become aware, that Georgina repeatedly was able to self-harm?

A. Yes.

Q. Those incidents that we'll come to, can you recall whether you were aware of those at the time or whether that is something you've learnt later?

A. I learnt later because there was one incident where she asked for a razor to shave her legs in the bath, and she actually cut all her wrists and had to be rushed to A&E

for 23 stitches in her arm.

Q. Yes. When that happened, were you told at the time? Did someone call you and say your daughter's in A&E?

A. No, I think Georgina called me.

Q. From A&E or later?

A. I can't remember whether it was from A&E or what but she said, "Mum, I'm in trouble".

"What's the matter?"

And then she said, "I'm in A&E".

Q. Yes.

A. I mean, 23 stitches. They gave her an open razor knowing she was a self-harmer. I don't understand that at all.

Q. Thank you. So she had 23 stitches on that occasion. When Georgina told you that she had -- well, let's take it in order. So you tell us in your witness statement that just four days after being admitted on 7 April she made some cuts to her right arm with three deep lacerations --

A. Yes.

Q. -- that were so bad that she had to go to A&E at Broomfield. Am I right in thinking that no one called you to tell you about that?

A. You're right. No one called me.

Q. There was then the incident that you told us about where

she asked a staff member for a razor to shave her legs --

A. Her legs.

Q. -- and was given one?

A. Yes.

Q. You know about that from Georgina herself?

A. Yes, I do.

Q. That's the occasion on which she attended to have 23 stitches?

A. That's right.

Q. I think I know the answer to this, Ann, so I'm sorry if I'm asking you stupid questions but --

A. That's all right, okay.

Q. -- as far as you're aware, was there any purpose in Georgina being allowed a razor? Was it part of some plan or therapy?

A. I couldn't tell you what they were thinking. I really couldn't tell you. I don't understand what they were thinking but I couldn't tell you what they were thinking.

Q. Because, by that stage, very obviously, Georgina cutting herself was a known and obvious risk.

A. Yeah, it was. She'd done it for years.

Q. You also tell us that, also in early April, a friend of Georgina's who was another patient on the ward --

A. Died, yeah.

Q. -- died --

A. Yeah.

Q. -- and that too caused a significant deterioration?

A. She was a good friend of Georgina's but, when she died, Georgina was devastated.

Q. Yes. She went to the funeral, I understand it?

A. She had to beg them to go to the funeral. She went to the funeral with -- I think someone from the Linden Centre went with her.

Q. Yes.

A. That's all I know but she was in a really bad way with it.

Q. Yes. Were you still visiting her at that time?

A. Was I still?

Q. Visiting Georgina?

A. Oh yeah. Oh yeah.

Q. With the same regularity: so every two to three days?

A. I would never stop visiting Georgina. She's my daughter.

Q. Of course. What you know now -- and this has come from the Trust's report -- is that, after her friend's funeral, an assessment was carried out and it was decided that Georgina was at an increased level of risk and she was put onto one-to-one observations?

A. Apparently.
Q. Now, you tell us a little bit about that later in your statement, that the one-to-one observations, Georgina told you, were no such thing?
A. No.
Q. Tell us what she told you about that. What actually took place?
A. I don't think she ever saw anyone one-to-one.
Q. No?
A. She just used to go in her room and shut the door and that was it --
Q. Yes.
A. -- which lowered her mood again. So --
Q. Because she was isolated or she was alone?
A. I think she felt alone and isolated.
Q. Yes. You also know, from the records, that we've noted obviously that 14 May is the anniversary of your son Tony's death --
A. That's correct.
Q. -- and that there was another incident for self-harm for Georgina on 15 May?
A. Yeah. She was there when her brother died.
Q. Yes. In general terms, to you, I think -- and I don't want to use my own words, I want you to use yours -- but it's just unfathomable that someone who is expressing

thoughts of suicide and is so low could be able, in an inpatient unit, to harm themselves so repeatedly and so very badly?

A. Yeah. I mean, I don't think the Linden Centre knew about -- I don't know whether they knew about Tony. But no one came with her from the Linden Centre when her brother was dying. Because he had the accident and then, the following day, he died.

Q. Yes. One of the other things I'm keen to talk through with you is that what you tell us is that Georgina absconded from the ward so frequently --

A. Yeah.

Q. -- that the way that you describe it is that she used it like a revolving door?

A. Yeah.

Q. She was in and out, essentially, whenever she felt like it?

A. The only thing I knew was whenever the Linden Centre phoned me up and said, "Do you know where Georgina is?" And I went, "Why would I know? You're supposed to be looking after her". I just couldn't understand it.

Q. So is this right: in the whole of that period, the only calls you ever received from the Linden Centre --

A. Asking me where she was.

Q. -- were to ask you if you knew where she was?

A. Yes.

Q. Do you have any idea, looking back now -- and I know it was a very long time ago -- how many times that happened?

A. Well, quite a few. It was quite a few.

Q. Yes, and presumably on each occasion that made you question what care was being taken of her?

A. Of course, yes.

Q. Can you recall whether you ever spoke to anyone about that, whether you ever tried to approach a member of staff and say, "What is happening here? Why do I keep getting these calls?"

A. No, the only time I spoke to them was over the phone and said, "Why are you asking me? You're supposed to be looking after her. You should know where she is".

Q. Yes.

A. "Why should I tell you where she is when I don't even know?"

Q. "How could I know?"

A. Yes.

Q. Yes, I understand. One of the things you tell us is that, when you would say to them in these calls, "Well, hang on a moment, how would I know where Georgina is, you are supposed to be looking after her", you say here:

"Instead of answering me, they would just cut the

phone."

A. Put the phone down, yeah.

Q. So literally the phone would be put down?

A. Yeah.

Q. Thank you.

A. To me, they wasn't interested. They wasn't really interested or else they wouldn't have put the phone down, would they?

Q. I see. We know from the report that that Georgina absconded or left the ward on 18 May 2006 and again on 20 May 2006.

A. *(Witness nodded)*

Q. One of the things you tell us is that Georgina continued to struggle with her very serious addiction issues throughout that period --

A. Correct.

Q. -- and that she would often use drugs or alcohol whilst out on leave or having absconded --

A. Yes.

Q. -- would return to the ward and test positive for drugs?

A. Apparently so.

Q. That isn't something you knew at the time?

A. No.

Q. And as a result, you don't know whether any changes to her care planning or any particular assessments were

carried out to assist her with those addiction issues?

A. I didn't know anything about her care plan. I wasn't informed.

Q. Ann, there came an incident, I think, on 20 May 2006, when Georgina was away from the ward. She had either left the ward or failed to return after a short period of leave.

A. Mm-hm.

Q. And she reported to you afterwards that she had been sexually assaulted whilst out on leave?

A. Yeah, she had to go to a rape centre.

Q. Yes. Now, when Georgina spoke to you about that incident -- to be clear, so that had happened away from the ward --

A. Yes.

Q. -- but Georgina was, at the time, an inpatient of the Linden Centre?

A. She was supposed to be.

Q. Yes. You told her to report that matter to the police?

A. To the police, yes.

Q. And did she?

A. Yes.

Q. As far as you know, you tell us here the police opened an investigation but nothing ever came from it?

A. I've never been told nothing, no.

Q. You went with her to the rape centre?

A. To the rape centre, yeah. I met her there.

Q. As far as you are aware, had Georgina informed staff at the Linden Centre about what had happened to her?

A. I don't know. I gathered she did.

Q. You gather she did?

A. Mm.

Q. Where do you gather that from, Ann?

A. I can't remember the conversations.

Q. No, that's fine but can you recall whether Georgina told you that she had told staff about it.

A. I think so, because was she was actually found in a park with no undergarments on.

Q. Yes.

A. So she partly remembered the attack but I don't know, to be fair.

Q. No, I understand. In any event, it was you that accompanied her --

A. I went there to meet her at the rape centre, yes.

Q. And it was you that took her back to the Linden Centre?

A. Yes, it was.

Q. Can you remember how she seemed at that time?

A. Low. Very, very low mood. She was actually crying --

Q. Of course.

A. -- because of what had happened.

Q. Yes.

A. Because where they were doing swabs and that, she kept saying, "Mum, Mum, Mum", and crying.

Q. Yes, but you were there with her?

A. Yes.

THE CHAIR: Sorry to go back to this, but you went with her to the rape crisis centre?

A. She was there.

THE CHAIR: She was there?

A. She went there and I got a phone call from her and I went to the rape centre where it was, on Springfield Road. I remember that.

THE CHAIR: Right, okay, so you --

A. And I went upstairs to where they were examining her.

THE CHAIR: Yes.

A. She wasn't happy about that.

THE CHAIR: No. So you don't know that the staff were told by her or by you that that's where you were going.

A. No, I don't know, in fairness.

THE CHAIR: Okay. Thank you. Sorry.

MS TROUP: No, not at all.

Again, am I right in saying that you don't know whether or not any kind of safeguarding referral was made?

A. I don't know.

Q. No. We come, then, to 27 May, so less than a week after that incident, and you have learnt from the records that Georgina's observations were reduced to general observations?

A. Well, no one was looking in on her, so I gather that was the case.

Q. Yes. What did Georgina say to you, if you can remember, about her relationships with staff or their treatment of her?

A. She didn't seem to think they cared because they were never in with her, never asking her any questions. Just in that room -- there was a separate room, and they were all -- it was like a mothers' meeting. They was all in there.

Q. All the staff together?

A. Yeah, there was quite a lot of them going in there. But I can't remember.

Q. No, that's all right. As far as you're aware, did anyone sit with her and talk things through? Was there any kind of attempt at any sort of talking therapy?

A. Not to my knowledge. Not in front of me, either.

Q. No. We know from the records that on 30 May there was a review, a review was carried out, and a decision was taken that Georgina would be discharged from her detention under Section 3.

A. Mm.

Q. You've put a section of the Trust's report into your witness statement that says, as follows:

"No psychotic symptoms, was mentally stable, no suicidal thoughts and was not depressed."

Then this sentence:

"She had no regrets regarding her inappropriate actions over the weekend."

I think that's a reference to another absconding from the ward?

A. I'm sorry, you see me laughing. It's because of what you're saying. I just -- it just -- I can't understand it.

Q. No.

A. As a normal person, I can't understand it.

Q. Tell me -- it may seem obvious, but tell us why. I know you're not laughing in humour, Ann --

A. No.

Q. -- you're laughing because it's so ludicrous to you what I'm reading.

A. Well, of course it is, yeah.

Q. But tell us, if you can, why?

A. What do you mean "why"?

Q. What is so ludicrous to you about it? I know it's an obvious question.

A. They're saying this and that happened. I never see anything happening.

Q. Yes.

A. So I don't know where they're coming from.

Q. As far as you were aware, it was absolutely not the case that she was not depressed?

A. She was depressed.

Q. Yes.

A. Very depressed.

Q. You say that the decision to discharge her from her Section 3 --

A. I can't understand that.

Q. No.

A. Especially as she was a self-harmer, like -- and different things she'd done whilst being at the Linden Centre. For instance, she tried to hang herself in the Linden Centre in the bathroom, with a towel.

Q. How do you know about that?

A. Georgina told me herself. She said, "Mum, I done a terrible thing", and she went on about it. She started crying about it and she told me.

Q. Yes, as far as you know --

A. None of the staff told -- sorry. None of the staff told me.

Q. No. Do you know whether staff knew about that incident?

A. Well, they must have known about it because they undone her.

Q. She told you that they had, in fact, undone a ligature --

A. Yes.

Q. -- and --

A. Yeah.

Q. -- and taken her down. I see. Do you know whether that was in her first period as an inpatient or the second?

A. I couldn't tell you. I can't remember.

Q. Thank you. Leave was granted again and you tell us that she left the ward on 1 June, came back on the 2nd, at about lunchtime, and this is from the records, and tested positive for both cocaine and opiates?

A. Yes.

Q. So very obviously the addiction issues were still in play?

A. Of course, yes.

Q. She left again on 3 June and returned, and this is where you say:

"As I have said, she was able to use the Linden Centre like a revolving door and none of them seemed to care."

A. No, plus the patients were taking in drugs and hiding them in a ceiling. You know, the ceilings that you

could push up.

Q. Yes.

A. What are they called?

Q. With the tiles that you can push up?

A. Yeah, yeah. They used to push them up and hide the drugs in there.

Q. Tell me how you know about that.

A. Georgina told me.

Q. So she told you that patients were bringing --

A. In drugs and hiding them.

Q. -- drugs into the ward?

A. Yeah.

Q. Including Georgina, I think?

A. Including Georgina, yes.

Q. And she told you where they were being hidden?

A. Yes. I told the staff. What they done about it, I do not know.

Q. How many times -- was it just once that you approached the staff to say, "Drugs are being brought onto the ward"?

A. I didn't actually tell the staff; I told Dr A.

Q. I see.

A. Dr A, who you mentioned there, I told him, and he informed the staff.

Q. I see. So did you tell Dr A, the psychiatrist, about

that while Georgina was still an inpatient?

A. Yes, I did.

Q. And you told him where those drugs were being hidden?

A. Yes, yes. I said I'll take him down and show him where the part of the ceiling tile was being moved.

Q. Yes, I see.

A. But they knew what to do. The patients knew what to do.

Q. I see. And, as far as you can remember, Ann, what was his reaction?

A. He was disgusted. Absolutely disgusted.

Q. Yes. As far as you know, after you telling him about it, did anything change? Did that stop?

A. No, nothing changed.

Q. One of the things you say to us about the ward environment is that -- and again, I don't want to put it in my words, but there were a lot of like-minded people in terms of other patients with addiction issues --

A. Yes.

Q. -- and that you can see that that might be helpful in some circumstances but that, where the patients are basically left to their own devices, the opposite happens?

A. I think you've got it right there. They were left to their own devices --

Q. Yes.

A. -- which I wasn't happy with.

Q. It's, again, a very obvious question, but tell us why? What was the effect on Georgina?

A. Well, she didn't seem to care either.

Q. Yes.

A. She just got on with it.

Q. Yes, and her addiction issues didn't improve?

A. Not at all.

Q. Her mental health issues didn't improve?

A. No, not at all.

Q. I want to talk a little, please, about the last time that Georgina left the ward.

A. Okay.

Q. What we know -- and this is from the records, so I want to make clear all of this you have learnt afterwards --

A. Yes.

Q. -- Georgina left the ward on Friday, 9 June?

A. I went to see her that morning.

Q. I see. How was she that morning?

A. She seemed to be in a good mood. She'd been out and bought some new clothes to go into London, because I said to her, "Oh, you look lovely". All in white, she was.

Q. She told you, I think, that she was going to see a friend in London?

A. Yes, she did. She didn't mention the name of the friend but she said she was going to visit a friend.

Q. Yes.

A. I thought she was coming back, obviously.

Q. Yes, of course. So she -- we know from the records that she left the ward at about 2.00 pm and told staff that she was going to London.

A. Yes.

Q. She wasn't asked where she was going --

A. No.

Q. -- or who with?

A. Or the address, nothing.

Q. Or anything about a return time?

A. No.

Q. As it -- she didn't return?

A. No.

Q. What we know is that by 8.05 pm the staff nurse coming onto the evening shift noted that Georgina was not on the ward --

A. Yeah.

Q. -- and the notes tell us that, at that time, staff were not unduly concerned, as Georgina had done similar things in the past?

A. Apparently so.

Q. Yes. It's recorded that the staff nurse at that time

considered that there was no indication that there should be any raised concerns or immediate risks?

A. Apparently.

Q. Yes. Your view on that is what?

A. I think they're a load of rubbish, the Linden Centre. Sorry.

Q. That's all right.

A. They are rubbish. No child should go into the Linden Centre. I've sat and watched people dying there still: young men, young women. It's been in the newspapers, it's been on the TV. The Linden Centre should be closed down.

Q. In fact, that's one of the recommendations you list towards the end of your statement?

A. Yes.

Q. So we'll come to that. We know that by the following day, 10 June, Georgina had obviously still not returned to the ward?

A. Yes.

Q. At 6.05 am a nurse recorded that the duty doctor should be informed that she remained absent?

A. That was a long time, wasn't it, after she'd been missing?

Q. Yes.

A. A long time.

Q. Yes.
A. The day before, she went missing.
Q. At 1.00 pm, a charge nurse recorded that "Georgina has not yet returned and the duty doctor has not yet been informed"?
A. Yes.
Q. The staff tried her mobile phone at 3.15 pm but there was no answer --
A. Mm-hm.
Q. -- and it was at that time, you think, that Dr A himself advised that the missing persons protocol should be activated?
A. Activated, yes.
Q. In fact, that didn't happen until 5.30 pm, so we're now 27 hours or so after Georgina had left the ward?
A. That's correct.
Q. What you now know is that less than an hour after that the ward received a call to say that Georgina had been found?
A. I didn't know that.
Q. No.
A. All I know is that a policeman knocked on my door.
Q. And that was in the evening on 10 June?
A. That's correct.
Q. I think, Ann, it was, in fact, the same officer that --

A. That told me about Tony, yes.

Q. -- that had come to notify you of Tony's death?

A. Yes.

Q. At that time, did you have any contact whatsoever from the Linden Centre?

A. None.

Q. Between that date and now, have you had any contact from the Linden Centre?

A. No, no.

Q. Am I right in thinking that not only did you not know that an investigation was taking place --

A. No, I didn't know.

Q. -- but that you didn't -- there was no letter of condolence?

A. Nothing.

Q. I know that there was an inquest into Georgina's death, and that the verdict recorded was one of misadventure.

A. I don't think the coroner was too happy with what he wrote.

Q. Yes. Well, say that again, I'm so sorry: he wasn't too happy with?

A. There was a nurse that was supposed to be one-to-one with Georgina. I don't know her name.

Q. That's all right. We wouldn't say her name anyway.

A. But apparently what they've done is they moved her to

Scotland. So he said, "She's out of my jurisdiction, I can't bring her back".

Q. Yes.

A. So, I mean, I understand the judge. I felt sorry for him really because he wanted to question her.

Q. Yes.

A. But he couldn't because they couldn't bring her back.

Q. Yes, I understand. What the coroner recorded is this:

"Georgina Pauline Ann Sefton died as a result of misadventure, the risk for which was not managed by a detailed care plan for her leave from the ward."

A. Yeah.

Q. From that, I think, you take that the coroner was making an adverse comment about the fact that a proper risk assessment had not been carried out?

A. That's correct, yes.

Q. I think you wish that the coroner had gone a little further and you would have liked him to see -- you would have liked to see him talking about the other areas of incompetence that you have identified; is that fair?

A. That's fair.

Q. Yes. I think I know the answer to this too: in the aftermath of Georgina's death, were you or your family offered any kind of support?

A. No.

Q. You were contacted by no agency or organisation?

A. No, none at all.

Q. Before we go on to the things that you would like to say about recommendations for change, I want to talk through a little bit with you about the ward environment and the things that you have identified as the most serious concerns. We have covered them, obviously. But I think, in general, and this is a phrase that you use in your witness statement, it's your view that the Linden Centre itself, as an environment, posed a danger to Georgina.

A. Yes, I do think that.

Q. In what ways? Tell us a little bit that.

A. Because they didn't go in and talk to her. They didn't ask her what she was thinking or feeling. It wasn't that one-to-one, as they said it was. That's incorrect. In fact, they're liars.

Q. Yes. You identify obvious issues with security and safety?

A. Yes.

Q. You've told us about class A drugs being brought onto the ward and hidden?

A. I mean, how could the patients do that if the staff were checking them correctly? Which they wasn't.

Q. Yes.

A. So -- and all the patients knew where to get them drugs in that ceiling. They knew.

Q. Yes.

A. They used to crawl up the side of the room, we call it a room -- it was a hallway -- to get to the drugs.

Q. I understand. You identify, obviously -- and we've spoken about this -- not only access to sharp and dangerous items, but patients being given blades?

A. Yeah, I mean, I don't know how they give her a razor-blade considering she was a person that used to cut herself, self-harm.

Q. Yes.

A. I can't understand that at all.

Q. You identify -- and I think you think what is at the basis of this is a lack of training, or what it shows is a lack of training -- in Georgina being able to abscond so frequently from the ward?

A. Well, obviously they didn't care because it would be written there, I suppose. They didn't care.

Q. As far as you're aware, at no stage after a period of absconsion or not returning from leave, was another risk assessment carried out --

A. No.

Q. -- and increased levels of supervision, for example, imposed. That just didn't occur?

A. Nothing happened, no.
Q. She would just go off again the next day?
A. Yeah, when she wanted to.
Q. Yes. The other thing that you tell us, and we've covered this a little bit, is that not only were you and your husband not involved in or told about what was happening with Georgina or how she was, or any aspect of her care and treatment, but nobody asked you about her background and what had happened in her life?
A. Nobody asked nothing. I think the staff are very -- they're not trained. They're not trained correctly.
Q. Because in your mind, Ann, is this right: in order to help someone who is as unwell as Georgina was, you would need to know about that person?
A. Of course you would, yeah.
Q. You would need to know what has happened in their lives, what other things have caused them trauma, for example?
A. And there was several things that caused trauma to Georgina. Several things.
Q. Nobody, in your view, looked at the overall picture and thought, "Hang on, this is getting worse, this" --
A. I don't think they did, no.
Q. Yes.
A. Not that they ever voiced anything to me. The only thing they ever voiced to me is, "Do you know where she

is?", on the telephone.

Q. Yes. One of the things that I think is most painful to you are aspects of the Serious Incident Report that you received from this Inquiry that speak about Georgina and her addiction issues in a way that is -- it's insulting to you, I think -- let me read it to you and you can tell us, rather than me doing it.

One of the things that is said here is that:

"During her stay on the unit she had periods of being settled and utilising her care plan, together with taking her prescribed medication. Staff were encouraging her to use different coping strategies."

A. I don't know if they were.

Q. Did Georgina ever mention to you that that was happening?

A. No.

Q. In fact, I think she said to you that she felt that they were not involved in any aspect of her care?

A. She was quite close to me and she used to tell me quite a bit, obviously, as you know, about the drugs in the ceiling, et cetera.

Q. Yes.

A. But she never ever mentioned anything like that to me.

Q. No. The report also says this:

"Georgina was addicted to illicit drugs and had made

some inroads into dealing with her addiction. However, she found the self-discipline required and the motivation very difficult to maintain."

Now, what you say about that part of the report is what inroads can be being spoken about?

A. She should be helped, not hindered the way she was --

Q. Yes.

A. -- and they're all in a little room, chatting, chatting.

Q. Yes.

A. She should have been helped. She wasn't.

Q. The report goes on to say:

"In contrast, Georgina had to follow her feelings and this resulted in her absconding from the ward, being abusive to staff, self-harming, using illicit drugs and drinking alcohol, and following those events was normally remorseful for her behaviour."

Now, this is the part of the report which I think is most insulting to you. Am I right, Ann, in thinking that that's because she was an addict? She needed assistance?

A. She needed help.

Q. The way that this is phrased, I think, to you, looks like someone saying, "Oh well, she preferred to go with her feelings on that day".

A. Exactly. I mean, different things they write, I don't

understand why they write these things because these things ... I'm just a normal person, I'm a mum and, to me, it didn't make sense at all. Like, they released her and they should never have released her. She was in such a state. She should never -- and a self-harmer.

Q. Yes.

A. I mean, fancy asking for a razor and they give her it? 23 stitches later, she's in A&E.

Q. When you see this kind of wording in the report -- it maybe that you don't think this, I'm just interested -- do you think that the fact of Georgina's addiction issues was sort of concentrated on too much by clinicians at the expense of actually treating her underlying mental health issues?

A. I think she should have been helped all the way.

Q. Yes.

A. They should have spoke to her about help. As I say, they didn't speak to her at all. I don't know why.

Q. In general terms, and you will tell me if this is wrong, in your mind there are clear areas of incompetence in failures to help Georgina --

A. Big time.

Q. -- and those include failed responses to her absconding --

A. Staff training.

Q. -- staff training, the failure to manage the risk of attempts on her own life and self-harm, inadequate risk assessments; is that right?

A. Yes.

Q. Inappropriate grants of leave?

A. Mm.

Q. The discharge we've just spoken about, when, in your mind --

A. They should never have discharged her.

Q. Thank you. And then the matters we've covered in terms of safety on the ward and security, and the drug issues?

A. Yeah.

Q. I want to take a look now with you at the recommendations that you have put down in your witness statement and you can look at them if you want to, they start at page 15, paragraph 74. So the first, Ann, is, I think, we might call it your headline point, and that is what?

A. That the Linden Centre should be closed down.

Q. Yes?

A. There's many deaths up there since Georgina died, and it's always on the news, it's in the newspapers.
I mean, how is this happening to young children?

Q. Yes. One of the things that I think you and I have discussed, or I've discussed with you and your husband,

is that to you it is particularly painful, given that Georgina's life ended 20 years ago now --

A. Yeah.

Q. -- to be here 20 years on, giving this evidence?

A. And nothing's happened at all. They promised they were going to change. Nothing's happened. Nothing.

Q. You next, looking at paragraph (b) on page 16, go on to say that you think that staff should be accountable for their actions?

A. Their actions, yes.

Q. Tell me a little bit more about that.

A. Well, obviously, if they'd been observing her or going in and talking to her, they'd have been able to put a point forward. They didn't because they didn't go in there. All they were was in that room over there. I could take you to the room right now. It stayed in my mind so badly. But they didn't monitor her properly. Well, I don't think they did, anyway.

Q. No. Thank you.

Then, really importantly, one of the things you say is that there must be recognition of the vital role that a patient's family play in helping with their treatment.

A. They should be informed. The family should be informed. That way they could give an opinion or say, "This happened or that happen, can you help her?" or him,

whatever.

Q. Yes.

A. But obviously that didn't happen.

Q. And where there is a supportive family, like yours, you would have been able to identify past events or trigger points? You'd be able to tell them if your input was -- if somebody was asking you, you would have been able to share with them what things might be particularly --

A. Or what to look out for, yes. But they didn't. They didn't ask us anything.

Q. You say here:

"Had the team worked with us from the beginning, we could have helped build a clearer pure of Georgina's needs and risks. Instead, she was kept in isolation, without the benefit of the insight, context and support that we as her family could have provided."

A. The only support she got was from the patients inside the Linden Centre.

Q. Many of whom were very unwell themselves, obviously.

A. Exactly. So they all give their opinion but you don't know whether it's a right opinion or a wrong opinion.

Q. Yes.

A. We would have given a right opinion, being her mum and dad.

Q. Yes.

A. I can't answer that.

Q. I understand. The sadness for you and your husband, I think, is that you were there to provide it.

A. Oh yeah.

Q. You were there to provide the background and the help?

A. Absolutely.

Q. Then, Ann, just going over the page to the top of page 17, the other thing, Ann, I think we have covered this, is that thinking about the fact that Georgina was able to hurt herself on the ward, able to abscond pretty freely, it seems, that patients were able to bring drugs into the ward, your baseline view about that is that staff should be better trained?

A. Well, they should be better trained. Then they'd know what to look for, wouldn't they?

Q. Yes.

A. I mean, if you was told something, wouldn't you know what to look for? I mean, I don't know. I think they're all mad or they're -- I think they're mentally disturbed.

Q. Ann, I think I've come to the end of my questions for you. I know that we're going to take a look -- we're going to show some photos of Georgina.

A. Okay.

Q. But before I ask for those to be put up, thank you for

your evidence today. Is there anything else that you would like to say now?

A. No, just about the Linden Centre. I'm very, very disappointed and hurt with the Linden Centre.

Q. Yes.

A. I mean Dr A was very, very good. I'll say that. He was good, but they obviously didn't listen to him either, and the length of time it took them, when she went missing, to inform him, for him to say, "Inform the missing persons".

Q. Activate the missing persons protocol?

A. Yeah, yeah. I mean, I think that's pretty disgusting, I really do. And I feel sorry for anybody that puts their child in the Linden Centre. I feel for them because I know what they're going to go through.

Q. Thank you.

A. You're welcome.

MS TROUP: I think what we're going to do now is I'm going to ask for the photos to go up and then we'll take a break and I'll see whether there are any further questions for you --

THE WITNESS: Okay.

MS TROUP: -- either from your lawyers or from others and, if there aren't, you'll be free to go.

THE WITNESS: Okay.

MS TROUP: So could I ask that we have the four photos of Georgina now, please.

(Photographs were displayed)

Q. Is that your son, Tony?

A. Yeah, yeah. They were quite close.

Q. Yes?

A. And that's what we used to call her "Baby G".

Q. Baby G?

A. Georgina.

MS TROUP: Yes. Thank you.

THE CHAIR: Mrs Sefton, thank you very much indeed for coming.

THE WITNESS: Thank you for listening.

THE CHAIR: No, I'm very appreciative of the efforts --

THE WITNESS: I'm really grateful you've listened and I'm sure you'll take it in, knowing you.

THE CHAIR: I'll remember, don't worry.

THE WITNESS: Thank you, and thank you, Rachel.

MS TROUP: Thank you, Ann.

I think, Chair, as long as you're content, we'll rise now and see if there are any other questions for Ann, and, if not, we'll be back at 2.00 pm. Thank you.

(12.29 pm)

(The short adjournment)

(2.03 pm)

MS MALHOTRA: Good afternoon.

THE CHAIR: Good afternoon, Ms Malhotra, over to you.

MS MALHOTRA: Thank you, we are ready to proceed this afternoon.

Simon would like to be referred to by his first name and for his son Daniel to be referred to by his first name, and for him to take the oath. I wonder if that could be done now, please.

SIMON MARCOVITCH (sworn)

Questioned by MS MALHOTRA

MS MALHOTRA: Thank you very much, Simon. Now, you're here to speak about your experience of Daniel's treatment in care. Dan died on 11 January 2022 when he was aged just 44 years old. He died by misadventure, as recorded at the inquest.

You've provided a witness statement dated 9 January of this year; is that right?

A. That's right.

Q. Have you had an opportunity to read it recently?

A. I have.

Q. Can you confirm that the contents are true and accurate?

A. They are.

Q. Thank you. Now, you describe in your statement -- I'm not going to ask you to look at it but very happy to take you to it if you want to be directed to it -- you

describe in your statement that Daniel became involved with drugs at around the age of 11; is that right?

A. Yeah, that's correct, yes.

Q. Just tell us, from your perspective, please, did his drug taking have any impact on his mental health?

A. Probably not at first but through his time spent in prison, definitely it did.

Q. You describe in your statement the separation between yourself and Daniel's mother, and that this also had an impact on his mental health. Can you explain, was that in his adult years that it started to manifest?

A. Yeah, he was about 11 that we split up. So Daniel's mum said, he's staying with me, and she took my other daughter with her. But I worked in the City, so Daniel had a key to our home. So, whilst I was at work, Daniel started to mix with people that were supplying drugs, and that's when it started for him, his life in that sort of state of mind, you know?

Q. Did Daniel have a mental health diagnosis that you became aware of?

A. Not then, you know, because he was just a normal everyday boy, but things started to go wrong once I found out he was mixing with a certain crowd through my neighbours, saying, "Your son's having loud music", and stuff like that, "on".

Q. I think in your statement you say that around -- in June 2021 you became aware of his diagnosis of emotionally unstable personality disorder; is that correct?

A. That's correct.

Q. You say in your statement he was also diagnosed with post-traumatic stress disorder; is that correct?

A. Yes.

Q. You became aware of that later, did you?

A. Yeah, much later.

Q. Do you know -- can you help us at all with whether he was on any medication for his mental health?

A. Well, in prison, when he got released the last time, and we went to the doctors, they prescribed him certain drugs, quetiapine was one of them, mirtazapine, and some other drugs, but I'm not familiar with what those drugs actually done to Daniel. It wasn't until we found a GP that knew Dan had mental health problems by interviewing Daniel. So that's when I actually understood, through his prison life, that he was a bit mentally unstable.

Q. So you mentioned Daniel spent some time in custody. When did you first notice a decline in his mental health? Can you help us with that?

A. Probably when he was in prison and being bullied, and getting beaten up and getting knocks to the head. He had a massive scar on his head. And getting released

from prison and then re-offended.

Q. Now, he first went to prison at the age of 16; is that right?

A. Yeah, Feltham.

Q. You've described already the sort of impact that it had but is there anything else you wanted to say about going into prison and coming out again, what sort of impact that had on his mental health?

A. Well, the problem with Young Feltham is you get big boys in there, okay. So with Daniel, he always could look after himself in a certain way, and there was this bully bullying all the prisoners, trying to take all their stuff, in the Young Offenders. And Daniel was in a cell and he had two choices: either to give him all his stuff or stand up to him. He stood up to him and the guy knocked six bells of ... out of him, yeah? But from that day on, that put bully never went near Daniel and other prisoners could see that that Daniel could look after himself. So that's when Daniel was -- first entered the prison system, called Feltham.

Q. Can you just help us understand, please, and you touch upon this in your statement, but whenever Daniel was released back into the community, did he face any challenges or barriers to reintegrating back into the community, that you observed?

A. Well, the answer to that is yes because, when a prisoner serves a part of his sentence, he comes out and he's got a probation officer who provides a service for his drug rehabilitation, for his rehousing and getting back into the community. But the problem with that is, he was on methadone, a substitute for his drugs, and when you're on a daily dose, everyone would go to Boots, but the problem with that is, that's everyone in the community that's taken drugs, and the probation officer is not involved in my son going back and mixing with that sort of clientele, if you can be honest. So it's just a rolling on feeling, you know?

Q. What about being able to take care of himself in the community? Is that something that Daniel struggled with?

A. Not early on. That come much later, you know, with all -- which we've discussed later on. But it was just re-offending, which I never understood, because his dad worked and I could provide for him, but I couldn't be involved with all these drug people.

Q. You mention -- we'll talk about it later, do you want to talk about it now and say what sort of impact that reintegration had on Daniel and, in particular, his mental health?

A. Well, in the prison system, it's not run by the prison

officers; it's run by the prisoners. And there's individual gangs and Daniel was always a person that wouldn't take any rubbish. So I'd go and visit him, and each time I visited him he was smashed to pieces: his eye out here, just face disfigured.

THE CHAIR: How often did you get to visit him?

A. Well, I split up with his mum. She tried for a couple of years but then she never saw Daniel. So I'd get a VO -- every two weeks, I could see Daniel.

THE CHAIR: That's a visiting order?

A. That's right.

THE CHAIR: Yes.

A. So he was in Chelmsford prison so he put -- like, I was only the visitor he had, so I'd see him every two weeks and, as I lived in Billericay at the time -- but I live in Basildon now -- it was perfect for me because it's not too far and I would see Daniel, and it was just like going to see your son every two weeks, innit? What happened in prison would be between him and the prisoners and the prison guards. But he was fine as a youngster going in and out of the system because he's young, he's -- what's the word? Not cocky, but that sort of way, when you're young.

THE CHAIR: Assured, yes.

A. That's the word probably, yeah.

MS MALHOTRA: I wanted to ask you about Open Road. You mention it in your statement. It's at paragraph 57, page 8, for anyone who is following your statement. I'm not going to ask for it to be put up, if you don't need directing to it --

A. Yeah, I'm fine.

Q. -- but do you just want to tell us what your understanding of Open Road was and how that organisation assisted Daniel?

A. Yeah, so when a prisoner goes to a certain area, it's a drug rehabilitation centre. So they can see Daniel's mental health, they can see what drugs he's been on in prison, prescribed by the prison doctor, and what course going forward to get him off drugs. So they would say, right, he can take methadone at certain milligrams, and then eventually come off. So Open Road provide a wonderful service, the people there are wonderful and hopefully he was going to come off drugs. But that wasn't the case.

Q. So they supported Daniel?

A. Yes, yes.

Q. Do you know what other agencies or organisations Daniel was involved with?

A. No, because of his drug abuse, Open Road was the only one I knew because it was in Chelmsford and, obviously,

he had his probation officer and he would stay in the halfway house because that was the rules. When you serve half your sentence you're on tag and you can only go out up to a certain time. I think it was about 7.30 of an evening, then he had to stay indoors. So Open Road was purely to support him in coming off drugs. So he would have a blood test, yeah, and if he'd been taking drugs he wouldn't -- they wouldn't give him methadone because he's not applying to the law of his probation what he's supposed to do.

Q. So just help us understand: did Daniel identify himself as having an addiction?

A. Oh, definitely.

Q. In your experience, aside from Open Road supporting him with methadone, in the way that you've described, how else was it being managed?

A. What, his drugs?

Q. Yeah, and his mental health in particular. How was that being managed?

A. Well, the thing with his mental health is when a person has an addiction, and people say within the prison -- so there's prison doctors and they supply him drugs, which I wasn't aware of, for his mental health. So I'm not aware that they're giving him mental health drugs through his care because they could see a problem.

Daniel, in prison, would still be the Daniel that was coming out. So his mental health, I never saw that because there was times when he'd come out of prison, "I'm angry", yeah? "I can't take it any more", you know. You got a home, a nice home, you want nice clothes, you got nice clothes, but I couldn't have any of these guys in my home.

And at a young age -- I got burgled twice and the second time said to my son "you're staying in the house until I get home from work and then you can do what you want to do". Then I get a phone call, I was at British Petroleum, BP, at the time, on a temporary contract and he rung me up and said, "We've been burgled again, Dad".

So after that, that's when he went to live with his nan and grandad, and I find out later on in life, through [redacted], my daughter -- oh, I shouldn't have said her name -- my daughter, that was the best years of his life, because his nan and grandad, he had respect for them. And I've seen photos which I never saw before, which my daughter give me and I said "I can't believe how happy", and my daughter would say she'd got him a bike, none of them people were allowed up there because his grandad was proper builder, you know, so he wouldn't allow anything like that.

And for them few years, which I found out when he

come out this time and we started to get to understand and know each other again, he explained to me that and all.

Q. Roughly how old was Daniel at the time that you're describing, when he was with his nan and grandad?

A. Between probably 17 and 20, even though he went to Feltham, yeah, he'd come back out with nanny and grandad.

Q. I'd like to move on to ask you about the time that Daniel became registered with a general practitioner, with a GP, on 9 June 2021, that's at paragraph 59, page 9 of your statement. Can you help us with the significance of Daniel being registered with the general practitioner at that time?

A. Right, now you've jumped now, say 20 years. So for the 20-year period he was in and out of prison. What's important about that is Daniel was in prison when Covid happened, okay? So a lot of the prison officers went down with Covid. So there was no visits, they were in the cells 24/7., food was brought to the cell and the prisoners would have a shower every two weeks for 15 minutes. But they was allowed to phone the parents so Daniel would phone me a lot.

Now, by Covid and no visits, the prisoners cold turkey. So for people who don't understand that, no

drugs was brought into the prison. So being locked up, everyone couldn't take drugs. So when my son was released, and for the first time, he said, "Dad, I've had enough. I can't do it no more". So we cuddled, and this was the process from him being released from prison, me having my son back and me trying to find from Open Road, to housing, to his doctors, so it had a big significance.

THE CHAIR: What did he mean by "I can't do it no more"?

A. Right, well, the intake of drugs, okay, the intake of beatings, the intake of -- I don't know whether I can say this -- of prison officers being abusive physically to my son. Yeah.

THE CHAIR: So you think he meant he didn't want to have that life any more?

A. That's right. So you've got to understand, there's other youngsters now coming to the prison, ain't they? Stronger, builder, whose never been in prison before, think they own the world, they can take on, and they was mature then at 40, yeah. So it's a totally different level. So when Daniel went to Young Feltham, he was that kid, yeah? "No one's telling me what to do".

Now, he's older, no drugs were taken in, so you haven't got that high, and he could understand the world, what was going on there. So that's what I mean.

MS MALHOTRA: So would you say around this time, him registering with the GP on 9 June 2021, that was a bit of a turning point for him, would you say?

A. Yeah, it was massive because he got released, he stayed with me in an over-60 shelter for a week, and then before he's released, the prison would say, "Right, where do you want to go?" And he said Chelmsford. So the clinic was Open Road for his drugs rehabilitation and then, through the help of them and various organisations, we got the doctors, okay? But the doctor could see the drugs he was on, and would ask Daniel, "Well, why are you on these mental health drugs?" And Daniel said, "I've been taking them for a while because I had mental health problems in prison", but -- which I wasn't aware of.

Q. I'm going to come back to the GP and the actions taken by the GP in a moment but I'd like to ask you about the 3 August 2021. It's described in your statement at paragraph 93, page 18, and what you describe here is Daniel being found unconscious by a member of the public.

A. Yes.

Q. Can you remember that?

A. Yes, now that was in Chelmsford.

Q. Can you tell us about that? What happened?

A. Well, this was once I knew, because of Daniel was telling me, that he was -- what's it called -- what's the lady called, who walked past him? An adult.

Q. Okay, a member of the public saw him?

A. Yeah, so Daniel was sleeping in a sleeping bag in Chelmsford and she walked past him, who could see, like, he looked a bit funny. So he was actually unconscious. So she called the emergencies which took him to Broomfield, and he overdosed.

Q. Now, can you help us with whether that was accidental or intentional?

A. I can't actually say whether -- either what it was, but the reason was -- is because he got kicked out of CHESS housing, and Daniel was aware that he couldn't live with me. So he was sleeping rough for about two days, and he was found unconscious. So they -- he went to Broomfield Hospital, they pumped him up, give him an injection, and then he rung me up and I said, "Dan, you know, I can't take it again".

But it was just a blip. Just a blip.

Q. Can you help us with whether Daniel had a mental health assessment following that admission to Broomfield Hospital?

A. I don't think he did. All I know is that -- because we haven't mentioned the Linden Centre yet --

Q. We'll come on to that.

A. Okay.

Q. I think, in terms of the chronology, that happens in the October. So we're just focusing on the summer, I think, the summer of 2021?

A. Not as far as I knew.

Q. Okay, tell us about where does the Linden Centre fit in?

A. Well, the Linden Centre filled in is when his doctor -- so imagine this time he's got released from prison, he's completely changed. Open Road, which was his rehabilitation drug clinic, saw a complete change, they said to me, "Your son is totally different now to how we've seen him in previous years." Yes? So that was a good sign.

Because I knew he had an appointment with Open Road and I said he hasn't got anywhere to live -- because when a prisoner serves his full sentence, the prison authorities haven't got to get him a probation officer or anything: housing, nothing. They just say, "Here's a ticket to the nearest station you want to go and off you go", okay? It's totally different when you serve half your sentence.

So I said he had nowhere to live. So Open Road had a rapport with CHESS Trust Housing, who then, after they saw Daniel -- first of all, they're analysing Daniel's

behaviour, they said, "Right, because of this interview you've had with us and we can see totally different, we've managed to get you an appointment with CHESS Trust Housing", which was wonderful for me. But he still had to go to -- he goes from Open Road to CHESS housing, they have an interview with him, and it was funny, they said, "You might have to share a dormitory", and he said, "I'm not sharing a dormitory!"

So remember, I'm not got any input, I just sit back, and the lady who's head of the Trust said, "See the door? If you don't want anywhere to sleep, you can sleep outside".

I stood up and said to her, "That's the best thing anyone has ever said to him. Put him in his place straight away", right?

So after another conversation, they accepted him. So he ended up in like a motel in Stock. So CHESS Housing bought the whole motel and it was all on the ground floor, but there he learnt how to come back in the community. So they would have to sit and have a meal together, yeah? And he would have to peel the potatoes one day. It was wonderful, yes? And then I would pick him up and take him to Chelmsford. So it was a very good experience, yeah?

From there, we had to get a doctor, okay, to find

the doctor's in the community and then, through the doctor's and Essex County Council, because Daniel was on ESA support for his mental health and then on PIP, Essex County Council found him a duty of care, okay? So they put him in temporary accommodation, which wasn't great, but you've got a roof over your head.

So he could bid for a property. So everyone in the community could see a difference in my son and then, when we finally got the doctor's, and the doctor saw what drugs he was on and why he was on them, the doctor then asked for the prison to send all his reports, what drugs he was on, why he was on the drugs. And then, after a while, the doctor said, "Right I'm going to write to the Linden Centre, which is a mental health institute, because I think you need help".

Q. So then, turning to the Linden Centre, at paragraph 66, page 11 of your statement, you say it was 24 August 2021 -- I'm not going to trouble you too much about being exact about dates -- but you describe a time where you attended the Linden Centre?

A. Yeah, so we had an interview.

Q. Tell us about that, please?

A. So we goes on the interview, we're in room and there's a lady present. I'm -- so the lady is where you probably are, Daniel is either side and I'm probably

a bit further back. So she wants to know his story and, as a parent, I was just -- I was just listening to stuff, okay.

So we was there for about an hour and a half and then Daniel would open up, why he was on these drugs and, in the interview, which shocked me, Daniel was saying where he's self-harmed himself and where he tried to hang himself twice in prison. Now, the prison records will show that, okay, but I wasn't aware of it.

So, as a father, I'm sitting there, and he takes his top off to show the lady, the nurse, and I'm sort of looking, and it's the first time -- my son was slashing his arms, both, and they were really deep cuts. So it was quite an ordeal for me, if I'm honest.

Q. Of course, of course.

A. But the good thing that come out of it was the Linden Centre said to me, the father, and Daniel, "We can see you've got a problem but we won't take you on at the moment in-house. We'll form a plan to assess you in the community".

Q. I just want to go back to this, you've described it as an interview with a lady. Do you know --

A. An assessment.

Q. An assessment. It was an assessment, was it, so far as you understood?

A. Yes, an assessment.

Q. The lady, was she a nurse, a doctor or a health practitioner?

A. I wasn't sure but let's say, looking at the documents, she could have been a nurse, a practitioner, I don't know.

THE CHAIR: This was the assessment on 18 October or was this the earlier one recommended by the GP?

MS MALHOTRA: I think this is the earlier one on 24 August 2021, at paragraph 66. I think that's --

A. Yeah, because we only had one assessment, that's where a few of the dates might be wrong. So we just had one assessment was that interview with the Linden Centre.

Q. Because at paragraph 67, let's just see if we can have that on the screen to help you. Paragraph 67, page 11 of your statement.

A. Okay, "Daniel was interviewed" ...

Q. You say:

"On 12 October 2021, I believe Daniel was interviewed/assessed by EPUT ..."

When you refer to "EPUT", you mean the Linden Centre, do you?

A. Yes, because I don't know who EPUT are, and we talk about that later. As far as I'm concerned, it's the Linden Centre and that's who I dealt with. I don't know

who EPUT was before and I didn't know who EPUT was until much later after he died, when the Inquiry was going on.

Q. Okay. Now, I wonder, if we could just go to paragraph 66 on page 11. You say:

"On 24 August 2021, I recall" --

Sorry, paragraph 66.

A. 68, I'm on. Right, 66.

Q. 66:

"... I recall attending the Linden Centre, in person, along with Daniel, as I couldn't get through to EPUT on their telephone line, to arrange a mental health assessment for Daniel."

So I just wonder whether you're able -- were there two assessments or was it one, to the best of your recollection?

A. Right, there was one assessment where we had the interview, right? That was to say that Daniel -- from the Linden Centre. They said he needs help with his mental care, okay? That one is probably the assessment in the community by telephone, if that makes sense.

Q. So there was an assessment in the community by telephone?

A. Yeah, so what I mean by that is, they had a plan for Daniel. They would have a caseworker, who would phone him up and they would assess him through being out in

the community. Not an assessment like an interview where we sat down.

Q. Okay.

A. So that was their programme. Does that make sense?

Q. It does, it's just you say here that you attended the Linden Centre, so does that help jog your memory at all?

A. No.

Q. Okay. Not to worry. So possibly the hour and a half assessment that you've described was either in August or October, you're not sure?

A. No, I'm not sure.

Q. Okay that's fine.

A. But it definitely happened.

Q. Yes, and it was one assessment, not two?

A. Yeah, not two.

Q. Of course, I just wanted to clarify.

A. But the other assessment -- what I mean by "assessment" was we had the interview, which they took him on, and they were assessing him in the community. So maybe the wording is slightly wrong.

Q. Okay. But the assessment that you've described, which was an hour and a half with possibly a nurse, where Daniel disclosed self-harm --

A. Yes.

Q. -- and that's the first time that you heard about it --

A. Yes.

Q. -- that was at the Linden Centre or --

A. Yes.

Q. That was?

A. Yeah.

Q. And that was in-person?

A. Yes, yes.

Q. You were there with him?

A. So the doctor then wrote to the Linden Centre. We had an interview at the Linden Centre, which is the assessment, yeah? Which they assessed Daniel's mental health and they said, "We will take your son on but in the community, not in-house at the moment".

Q. Okay.

A. Okay?

Q. I'd just like to ask you about that and whether you had any views about Daniel being looked after in that way in the community, as opposed to as an inpatient?

A. Well, to be honest, it was fantastic that now he was going to get the help he needed. So I didn't find it unusual that they said, "We'll go in the community", right? I was just so happy that he was going to get the care and attention to help -- for his mental health.

Q. So did that happen?

A. No. I mean, unfortunately, it was a comedy of errors.

Q. Why do you say that?

A. Well, the way the interview was going to be done, that he would get a caseworker who would phone Daniel -- I'll go back a bit. On the interview at the Linden Centre, I said to them, "If you can't get hold of my son, you have my phone number".

So Daniel okayed it because he's an adult.

Q. So just pausing there, then. So you'd had a discussion with them that, if they couldn't get hold of Daniel, that they were to contact you?

A. Correct.

Q. Was that something that Daniel consented to?

A. Correct.

Q. Okay. And you provided them with your contact details?

A. Yes, I did.

Q. Okay. So I interrupted you but that was a conversation that you had at that stage?

A. On the interview, yes.

Q. Is that what happened in practice?

A. No. So, unfortunately, Daniel was issued with a caseworker and, unfortunately, he caught Covid, okay? So then instead of giving Daniel another caseworker -- because I don't know how the Linden Centre runs its affairs. Why they didn't give Daniel another full time caseworker who could phone Daniel and assess him in the

community regarding his mental health. So I think 'A' goes off with Covid, someone else phones Daniel, just asks how he is, then 'A' comes back off Covid, phones my son, so that would be two different phone calls, so this -- and says, "How are you getting on?"

Now, my son is a very polite person or he's got that mannerism, but also he's got that anger in him. He says, "Daniel, it's 'A'" -- I just remembered I can't say the name -- "I'm going on holiday".

So he's just been off with Covid, he's rung my son to see how he is and, in the same sentence, says, "I'm going away for two weeks, I'll phone you when I come back".

Now, the mental health team at Linden Centre could see my son has a problem and this is what was happening. Okay? So Daniel had, within a period of time, four different people phoning him up.

Now, surely they should have done home visits because the nurse who saw Daniel or the -- whatever they're called -- Daniel, had she seen him then, he blew up because he was over-prescribing himself on prescribed drugs, okay?

So it was either the fourth or the fifth call, I'm in my car with Daniel and another chap rings him up and says -- and Daniel answers, he says, "Oh, it's the

Linden Centre, I think, Dad".

So another chap rings up, he said, "I've just been asked to ring you up to see how you're going", right. So this is the Linden Centre care in the community.

So I've lost my temper, okay, with this chap, and really got angry, and the chap said, "Look, you don't have to be like that Mr Marcovitch, Simon. You don't have to be like that".

I said, "I keep on asking the Linden Centre to see my son and all you're doing is getting different people to ring him up".

He puts the phone down and literally two minutes, three minutes later, the head person of the Linden Centre -- a name I can't say -- said, "I do apologise". And I explained to her about my son bloating up. She said, "I'll sort everything out and we'll see him Monday", okay?

Unfortunately, he died that Monday. Okay?

Q. Before we talk about that, going back to the caseworker, you say that he had a different caseworker.

A. Yeah, different.

Q. You explained about 'A' going on holiday but, just in terms of the caseworker that he was assigned to, did that keep changing; is that what you're saying?

A. Correct.

Q. What was the frequency of contact that the caseworker had with Daniel, the different caseworkers?

A. Well, the problem is it was like they were talking as if to say, "Oh, how's your weekend been?" There was no professionalism in their care regarding my son. What I don't understand is the mental health care, or duty of care in the community, you can't just have various different people ringing up someone and just seeing how they're getting on in the community. You've got to have a plan to assess him, which they did say they was going to do, and through Daniel talking and behaving, they would have a plan for Daniel.

Q. So you say that they did say they were going to do that. Can you help us with when? Is that the first assessment?

A. Yeah, because it -- I took everything in, yeah? So I'm happy now he's going to be cared for. I don't know the mental health care, how they run things, what's going through their head. All I know is, through his doctors, who could see a problem, recommended him to the mental health care of the Linden Centre, and after that interview with them and Daniel explaining his life and the drugs he took and the medicine he's on for his mental care, that they was going to have a plan for him, and it started with 'A' who was going to be his

caseworker.

So imagine you've just got one person who speaks to Daniel, Daniel speaks back to him, and that person would say, "Ooh, I think we should have you in for a weekend and just assess you".

But having various different people talk to him, and then Daniel explaining to me, "Dad, these people just keep on ringing me". And the nasty bits which come into it was that they wrote to Daniel, because the drugs he was on is like, imagine an elephant wants to be tranquilised, you know, you see David Attenborough, yeah? They made Daniel zonk out, he was always tired, asleep. So if he didn't answer his phone, right, they sent him a letter -- which I've read and it said:

"As you're not answering your phone, if we don't hear from you within a week, we believe you don't want any duty of care for your mental health."

But they know the drugs he's on can have that effect.

Q. Can I just ask, then, in terms of your interactions with the health professionals who were involved with Daniel, was there any discussion about him being -- as an inpatient, either voluntarily or involuntarily, was there any discussion about a Mental Health Act assessment? Is that something -- that sort of language

you'd heard at all?

A. Yeah, but that was on the interview.

Q. Right.

A. All that was going to happen was in the community. You've got to understand that they was going to have one caseworker in charge of Daniel and they would assess him, through his mental health, whether it was necessary for him to come into the Linden Centre or to have care in the community. Okay?

They had my phone number. They didn't phone Dad, which they said they would do if they couldn't get hold of my son. Essex Council Housing had my number because Daniel, being an adult, had to give permission, yeah? So when he was being processed for housing, they said, "Oh, Mr Marcovitch, we've been trying to get your son".

I said, "Oh, he's asleep at the moment, how can I help you?" Okay? So all these other organisations worked for Daniel, but the most important for me, being his dad, was that he was getting mental health care, which never come forward.

Q. Just in terms of the mental health care, in your statement at paragraph 103, page 20, we don't necessarily look at it, you describe brief intervention. When you're talking about the interactions with the caseworker, is that the same thing as brief intervention

or is that something different?

A. No, that's what they're going to do for my son, because we've got documents which they sent to the solicitors but a lot of it was blacked out. So we -- I couldn't make sense of what, you know. So they've put blacked out --

Q. I think this is documentation you received afterwards?

A. Yeah, through Hodges, the solicitors.

Q. From EPUT, during the course of the inquest, was it?

A. Yeah. No --

Q. Before?

A. Oh, yes, yes, through the -- afterwards.

Q. Before we come to that, I just want to ask you around this time, where Daniel had the brief intervention, the caseworker and his care was being managed in the community, around that time, did Daniel ever express thoughts of harming himself or anything of that nature to you?

A. No, but I was aware he was buying prescribed drugs. That's when I got on to the Linden Centre, and I knew how urgent it was. He was swelling up. I've sent you the photos, yeah.

Q. So you were talking about the call that happened on the Friday, I think it was, the Friday before Daniel's sad death on the Monday and you've described how you were

annoyed, angry, during the course of that call. What was it that angered you?

A. Well, it's the first time I'm speaking to the Linden Centre, aren't I? So you imagine, if I wasn't there in the car and Daniel had answered the phone if he was out, they would have said, like it was a summer's day, "I've been told to ring you, Daniel, how are you?"

Now, on the interview, if they want to see Daniel, which the lady did, if she was in charge of Daniel and she spoke to Daniel, and she said, "Well, look, come in with your dad," and she saw him like that, she would know automatically by her experience that something ain't right.

So Open Road, his drug rehabilitation, they give him a blood test, yeah? They take blood. So if it's got any illegal drugs, he can't have methadone. He was always clean, okay?

Had the caseworker, the same one, spoke to Daniel, he would have known there was a problem. But when you've got various different people who don't know my son -- and I don't know how the Linden Centre of a morning meeting, whether they say, "Right, you Mr Jones, you phone up Daniel, you phone up Peter, you phone up and just see how they are", and they write a little thing, "After I spoke to Dan he seemed okay",

or whatever. That's not how it should be run.

Q. So I think if I summarise what you're saying, if I may, it was the quality of the interactions and the questions that Daniel was being asked that concerned you; is that fair?

A. Well, you know, I've expressed myself that there was no interaction with the Linden Centre and my son regarding his duty of care in the community because, if there was, I believe they would have had him in at least the weekend, so Daniel would be honest what he's up to and why he's doing that.

Q. Now, you describe in your statement in some detail -- I'm not going to take you through it -- the events of Monday, the 11th. I'm not going to ask you about that but I'd like to ask you about an interaction that you had, I think it was the day of Daniel's death where you spoke to healthcare professionals. Can you tell us about that?

A. It was either the day, or the day after, because I found my son dead. So we won't go into it because it's too much. I then contacted my daughter. She come with her husband but she wouldn't come on the property. She waited outside. I'm just hysterical. But my daughter was there because -- I will talk a little bit about it.

When I finally got into the property, because we had

to get a locksmith, because my son just bolted the doors, okay. I put my hand through the letterbox and the heating was on. But the locksmith managed to unbolt the doors and, as I've unlocked the door and gone in, he's on the floor.

Q. Can I just ask you to pause there for a moment.

A. Okay.

Q. I just wondered whether we could, sorry, go back to the question I asked about the call that happened with the healthcare professionals either on that day or after. I think you attended, and --

A. Yes.

Q. -- had a discussion.

A. Yes.

Q. Is there anything you wanted to say about that?

A. Oh, yes, okay. But I'd like the Inquiry to know that when a parent finds his child --

Q. So incredibly upsetting and it's --

A. It's not upsetting; it's just hysteria, you know. I felt him -- and he was still warm, so I'm thinking he's alive. And then the locksmith puts the phone to my ear for the emergency services that says, "Turn him over, try mouth to mouth". Tried all that and then the emergency services come, and the police, and straight away said to me, "Your son's dead", and I said, "Well,

you ain't even touched my son, how do you know he's dead?"

But obviously through looking at him, they've had experience, haven't they? So I got a cloth and wiped all my son's face, and remember I'm hysterical. I got a pillow and I was kissing him and tears were rolling on top of him.

So that's important, because when a parent loses a child, under them circumstances, and after that, through the Linden Centre -- which I had a lot of trouble with. So my son's passed away, the undertakers come, police interview me. My son's taken away in a black bag, which is not very nice, and then I go home with my daughter.

She stays with me for a while and then when she goes I'm just bawling. So it was either that day, I can't remember, or the next day. It could be the next day or that day. I go to the Linden Centre, right? Now, I've had this call with them at the weekend -- when you go to the Linden Centre it's a secure place, so you go in one door, it's locked, then they ask you do you want to see -- I said can I see ...

Then they ask for a -- and then they let me in, and then I started to cry again, and she said, "What's the matter?"

I said, "What, you haven't heard?" I said, "My son's dead".

So she sits me down and another two ladies come round and this goes on for about 15 minutes, and then she said -- there didn't seem to be -- they was sorry, but they're shocked. They're thinking she's going to contact me that day and Daniel was going to come in.

So she suggests -- because I've asked about everything about the people involved in his case and that, and she said, "We'll sort this out".

So that's what happened. So they wasn't aware my son was dead. They wasn't aware he overdosed. They wasn't aware that Broomfield contacted them to say, "You've got a patient under your care, whether it was intentional or unintentional, who has overdosed". Okay? Where has this information got to?

Q. So what did they tell you about -- what were your expectations about what would have happened on the Monday? Was it for him to be formally assessed?

A. Yeah. Obvious, on that Friday, she spoke to me, she said, "I promise you it'll be sorted out for Monday", okay?

Q. What would be sorted out for the Monday?

A. Daniel.

Q. But what were they going to do?

A. Well, I don't know. She could have said to me on that Friday, by my language and by how angry I was, "Bring Daniel now", because I believe, had he gone then, and they saw him, they would have kept him in under secure 24/7 -- and, remember, Dan kept going to the doctors and saying, "These drugs are not working, I want you to change them", what he was on for his mental health.

But the doctor said, "It's not for me, you're under the Linden Centre. Only the mental health team can prescribe you different drugs".

THE CHAIR: Can I just ask, you say that Daniel was clean of illegal drugs.

A. Yes.

THE CHAIR: But he was overdosing on his prescribed medication.

A. Yes. So when I --

THE CHAIR: How do you know that?

A. Because he told me.

THE CHAIR: Okay.

A. Okay, and I could see --

THE CHAIR: You said that Open Road would not give him methadone if he were taking other --

A. No, no. Open Road would take a blood test for illegal drugs. So you know, like, coke, heroin, in the blood system. In his blood system would be the prescribed

mental health pills, what he's taking.

THE CHAIR: Yes.

A. So that would be in his body.

THE CHAIR: Yes.

A. No other -- because they're not illicit drugs, are they? They're prescribed drugs.

THE CHAIR: How do you know that they weren't finding anything else?

A. Because they wouldn't have give him methadone because if a person is taking methadone and he's full of coke or heroin and that, they'd say, "Well, you can't have methadone".

THE CHAIR: So you knew that from both Daniel and from --

A. Open Road because, remember, Open Road were wonderful. They knew Daniel.

THE CHAIR: Had you been explicit with the Linden Centre when you spoke to them that Daniel was overdosing on --

A. No.

THE CHAIR: So you didn't tell them that?

A. No, no. Because I never had the calls to talk to the Linden Centre until that day. That's why I was talking to our solicitors, if the mental health care has got recordings, okay, because they would see how angry and upset I was, that I said, "Well, my son has got a problem", yeah? I didn't say, "Well he's

over-prescribing on Pregabalin", or his drugs.

THE CHAIR: Did you tell them he was bloated?

A. Yes. I said, "He's swollen".

That was important. But I saw the difference. Because I got some photos of Daniel at Christmas, yeah, and he was quite slim-ish, yeah? He was always a big lump, but he was quite slim-ish in the face. But I knew by the -- because Daniel would ring me up and say, "Dad, you know I'm taking a bit more prescribed dose", and I said, "Well, I can see it in your face, Daniel".

But it comes to a point, you've got to understand, in all his life, in the 20 years he was in and out of prison, I thought I'd always get a call from the prison that "Your son's dead", yeah? Through the violence and what was going on. But in this six months, it didn't come into my head once that my son would be dead: ever. Because even though he was taking more prescribed drugs, the Linden Centre should have had him in. They would have seen that automatically by his appearance. And that's why I was so angry, when they actually rung on that Friday. But I didn't say he was over-prescribing on drugs, I just said, "He's bloated, he's angry, you have to see him. You just keep on having different people ring Daniel".

MS MALHOTRA: I'd like to ask you next about investigations

post-Daniel's death. Were you told about any investigation that there would be?

A. Well, when I went to the Linden Centre and spoke to that lady who was in charge, she said -- because I asked about, "Where's all the records regarding who spoke to Daniel and what they actually said after they spoke to my son?", you know. "On that call, Friday, when you saw how angry I was that you're just getting people to ring Daniel," she said, "I'll get all the information for you, Mr Marcovitch, and I will let you know when it's all ready, et cetera, et cetera, et cetera".

But, remember, I'm hysterical still. You've got to understand, your son's dead, right? They asked how I was. I said, "Don't worry about how I was, you should've been worrying about my son because he was under your umbrella for mental care".

Q. I'd like to ask you about the inquest. There was then an inquest into Daniel's death. Can you tell us about EPUT's engagement with that inquest?

A. Well, I want to go much before that because you've jumped -- you've gone too far. Baroness Lampard, what's important is that, after Daniel's toxicology report, they said, "We can give you a death certificate but we can't actually say why your son's passed away. So you can bury your son but, going forward, there'll be an

inquest regarding the death of your son."

In the meantime, we're waiting for the answers from -- which I found out were called EPUT, because I'm still under -- I didn't know who EPUT was but I do now, and when they answered the questions, then we'd have an inquest.

So they booked an inquest date, yes? There was no answers from EPUT yet. Okay? So the coroner rung me up and said, "We have to cancel that inquest", okay?

He then booked another date, because he asked me, can you be any dates. You know, I'm retired; I'm not working. In the meantime, I get a call from someone from EPUT, said -- so, remember, the coroner has asked EPUT to answer these questions. So they contact me on the phone and say, "I'm a lady on behalf of EPUT that you're asking specific questions about your son's care through the Linden Centre".

So I said, "Correct".

She asked me what I was asking and obviously she was typing them out. She said, "You should hear within two or three weeks from us".

It was coming near that inquest date again, and then the same lady contacted me. So they said, "We've sent you an email about all the questions you've asked and we've answered", okay?

So I looked at the email, I said, "They haven't answered not one question", and she said, "Yeah, but" -- it was the same lady, okay. So she knows how I was. So I was professional talking to her, not angry. She looks at the questions that I've asked, she looks at what she's typed and what the email they replied was, and her exact words was, "They've not answered any of your questions, have they?"

I said, "No".

The next inquest then was cancelled, okay? So we've had two inquests which are cancelled. I then get a call from the coroner's office, who said, "I've asked now EPUT to be representative at the inquest. They have to be there, and they have to answer the questions".

So I said the people from the Linden Centre, I want them there, yeah, so they could answer the questions.

So, as far as I was concerned, on that inquest, that the people involved, from the lady who interviewed Daniel, the person who was in charge of everyone and the caseworkers would answer, to put my mind at ease, what actually happened and the duty of care regarding my son Daniel.

I then goes to the inquest and, remember, this is a year now. So I just want it to end. I just want them -- do you understand? So I turn up at the inquest.

They've got a solicitor. Not one person is there who I asked for but a representative of EPUT. Okay?

It starts off where the coroner said there could be a conflict of interest. So I said, "And what does that mean?"

And the coroner said, "I used to work for that solicitors", okay?

Now, I just want the -- it's been a long year of suffering through my son's death and through EPUT making my life a misery. So I said to the coroner, "No, no, that'll be fine, I just need to get some answers today".

The lady then says to me, the coroner, "Mr Marcovitch, you cannot ask them when they come to stand up. You have to ask me the questions and I then report over to them".

Now, I did speak to my solicitors but you haven't had, Baroness Lampard, you heard the video, you know that it's recorded. You'll see how messed up it was, okay?

The chap from EPUT stands up. So first the policeman who was there when Daniel died gave his evidence and the coroner said, "You can go", right?

I've got no legal representative. Why have they got legal representative, right? I believe, had I had legal representative, the thing on his death -- his --

wouldn't be misadventure, and I'll give you the reason.

He gets up, I put the questions to the lady, the governor. She puts it. "Where's this person?", right?

He'd only answer the questions that he wanted to answer, which was a couple of the caseworkers that spoke to Daniel and the reply what they wrote down. So I've lost my temper, okay? I said, "They've put me through a whole year of this, to come to the inquest and not answer my questions". If you listen to the tape, to top it all, he sits down and then, you know at the end where they want to say about your son, commemorative stuff, their solicitor says to the coroner, "I think we should put on the death certificate" -- so it's all on tape -- "what he died from", right?

The coroner has looked at me and said, "Will you step outside, Mr Marcovitch?"

I think, "What's going on?" Right?

So they're all in there, I'm outside about ten minutes. What's going on? They call me back in, they said, "We've decided that your son has died misadventure", all right?

So the lady who does the old, you know, records it all, and it's being recorded -- because I've got a tape, you know, which I gave to the solicitor -- she could see I was broken down.

THE CHAIR: She could see you were?

A. Broken down crying, like really bad. So they go and she comes to me and I said, "What's misadventure mean?" And she said, "It could be a number of things", okay?

And then I went. And the death certificate: misadventure. And I haven't heard anything since.

THE CHAIR: Do you have a view about what that death certificate should say?

A. Well, if it would have said he died from an overdose, yeah, in the back of my mind, I probably would have thought it was better for me because then the Linden Centre -- I could say, "You were warned from Broomfield Hospital, his doctors", and even on the interview, she wrote "Daniel" --

THE CHAIR: "Risk of overdose".

A. -- "risk of overdose". So they was aware of it. But because I found my son dead and there was no illegal drugs in him but I know he was taking more, it didn't say "Yeah, X amount of more drugs in him", it was just prescribed drugs. So he died. But why did he die?

MS MALHOTRA: I'd like to ask you next about recommendations and what recommendations would you invite the Chair to consider.

A. I think the most important thing is honesty from mental health care, why it takes so long not to answer any of

your questions, because you're a parent and you want to know things.

Secondly, we must have a solicitor with us because what's important -- I know all cases in mental health, people die or people do things and it's not anyone's fault, yeah? It's just what happens in life. But we must have a solicitor give -- I could go back now, and I'm thinking right, they're not answering none of my questions, I've waited a year, we've had three cancellations of an inquest -- two cancellations and third one, let me take legal representative. Now, had I had a legal representative, I believe misadventure would not be on that certificate because, obviously, my solicitor would have asked EPUT questions and I don't know, legally, are they -- would they be allowed to answer them? I'm not sure what an actual inquest is really for if no one is going to attend and say, "This is what our caseworker's done, this is what happened, we could have done this differently, we wish we would have done it differently. We don't know whether it still had an effect on whether your son died or not". I don't know but having legal representative in my particular case would be so important.

MS MALHOTRA: I wonder if we could have up, please, paragraph 187 of your witness statement, page 35. Here

in your statement you list the recommendations and I just wonder whether this might --

A. What page was it?

Q. It's page 35, paragraph 186 onwards, so we can see there --

A. It says there:

"Several matters that I believe are" --

Q. That's okay, you don't need to read it out; I'm just going to summarise it for you. First, contact with next of kin; and then, second, continuity of care; third, taking proper history from family members; fourth, honesty, transparency and accountability; fifth, the inquest process and legal representation; and finally the impact on families.

A. Yes.

Q. Is there anything in addition to what's --

A. No.

Q. -- in your witness statement that you wanted to say?

A. No, that's really important, what's there.

Q. Those are all the questions that I have for you, Simon. Is there anything that I haven't asked you that you wanted to say?

A. This hearing is about parents trying to help other people in the future, okay? That a duty of care -- that it may not happen to their children. But what I don't

understand is, when we -- I went with my son to a mental health -- remember, I'm not qualified in that, and we're here to say this is what they should have done or -- what experience have we got with mental health? They're qualified, they go and get their exams. They know, by mixing with other cases, a duty of care they must provide. Is it for me to say well they should have done this or they should have done that? That's been going years, the mental -- it should be written in stone that "This is how we handle cases. This is -- if we're not sure, instead of waiting, we do this", yeah, and that's what should be happening, yeah?

My experience is that, you know, I haven't broke down today but I've cried a river, I'm telling you.

Q. Are you all right, Simon?

A. Yeah.

MS MALHOTRA: I don't have any further questions for you, Simon.

A. Okay.

MS MALHOTRA: Chair, do you have any more questions?

THE CHAIR: No, I don't have any more questions but I want to assure you that I've listened with great care to what you've said today.

THE WITNESS: Thank you very much.

THE CHAIR: If there's anything else that you wanted to say

that you don't feel you have said, you can always write to us and add to what you have said.

THE WITNESS: Thank you very much.

MS MALHOTRA: Thank you very much, Simon. We're now going to take a ten-minute break to see if there are any questions for you. If there aren't, that concludes your evidence.

THE WITNESS: Okay.

MS MALHOTRA: Can I take the opportunity to thank you very much for the witness statement that you've provided to the Inquiry and for giving evidence to us today. Thank you very much.

THE WITNESS: Thank you for your team today. Thank you.

MS MALHOTRA: Chair, if there are no questions, we return tomorrow at 10.00 am.

THE CHAIR: Thank you, Ms Malhotra, very much.

(3.17 pm)

(The Inquiry adjourned until 10.00 am the following day)

I N D E X