Name of witness: Ms Ann Sefton
Statement No: 1
Exhibits: Appendix 1
Date: 22 December 2025

LAMPARD INQUIRY

RULE 9 WITNESS STATEMENT OF MS ANN SEFTON

I, **MS ANN SEFTON**, date of birth **[I/S]**, of **[I/S]** **[I/S]** will say as follows:

1. I make this statement pursuant to a Rule 9 request for evidence that I received from the Lampard Inquiry on 10 April 2025 in relation to treatment provided to my late daughter, Georgina Sefton, whilst she was under the care of North Essex Mental Health Partnership NHS Trust ('NEMHP'), which later merged into the Essex Partnership University NHS Foundation Trust ('EPUT'). Georgina was born on 24 September 1976 and died on 10 June 2006, aged 29.

2. This statement is made from my own memory of events, knowledge and belief. To assist me, I have seen the Serious Untoward Incident ('SUI') Report dated 22 June 2006 that was provided to me by this Inquiry. However, I would like the Inquiry to obtain Georgina's full NEMHP/EPUT medical records (including and especially from the Linden Centre) as I strongly believe the SUI report that was prepared after my daughter's death is insufficient in investigating several of the most serious concerns I have about her care and treatment, which I go through in this statement. I am also told in the SUI report that Georgina's Care Programme Approach ('CPA') was *"well documented"*, as were her ward reviews, care plans and risk assessments so I would like to see these documents for myself. Upon receiving further disclosure, I may wish to provide additional evidence in support of my statement and therefore reserve my right to do so at this stage.

History and Background

Early signs of Georgina's struggles

3. Georgina began self-harming when she was a teenager, not very severely, but it escalated into something more serious after we lost our Tony in 2003. Tony was my

only son and Georgina's older brother. He died at age 32 on 14 May 2003 in a motorbike accident.

4. Tony and Georgina were extremely close; they were just 6 years apart. As her big brother, he really seemed to take her under his wing. They spent lots of time together; they went fishing, he taught her how to improve her drawing and he was always the first person she went to whenever she had a problem. So, when we lost him, Georgina also lost that source of comfort and support and I think the impact of that, along with his actual passing, caused her mental health to deteriorate.

5. Around the same time, Georgina was also in a relationship with a man [I/S], and he was utterly awful to her. He subjected her to both mental and physical abuse, and at a time when she was already struggling with her mental health, this abuse unfortunately caused her to develop an unhealthy and dependent attachment to him.

6. [I/S]

[I/S] Those circumstances, and his death caused an even more worsening of her mental health issues.

7. Georgina then gave birth to [I/S] Savannah, and she was over the moon; she loved that baby so much. It devastated her when social services got involved and removed Savannah from her care at just 2 years old.

8. The handing over of Savannah happened at our house. After social services left, Georgina was in such a state. Without a doubt, losing Savannah was the primary catalyst for Georgina's downward spiralling because it all truly went downhill for her after that. Contact with Savannah turned into "mailbox visitation" only, so a few letters back and forth, that was it, then once they put her on the adoption list, everything stopped and Georgina just could not cope.

Diagnoses and symptoms

9. Georgina was addicted to drugs for a long time, mostly cocaine. She was also in and out of homelessness. She suffered with a complex set of mental disorders but was never formally diagnosed until she went to the Linden centre. I believe she had bi-polar, borderline personality disorder and depressive disorder. Her mental health

issues resulted in her trying to take her own life on numerous occasions. Usually that involved her cutting her wrists, arms and neck. The SUI report also acknowledges that in the lead up to her death there were instances of her suffering low mood, suicidal ideation and episodes of deliberate self-harm. She also occasionally suffered psychotic symptoms according to the SUI report:

"she stated that at times her deceased partner spoke to her and told her to kill herself."

Linden centre

10. Our involvement with the Linden Centre began after Tony died. I was deeply depressed and so was referred to a doctor there named Dr A. He was truly exceptional — he supported me in ways I will never forget, so later when I realised that Georgina desperately needed help I turned to him and he immediately agreed to see her.

11. On 9 January 2006, Georgina tried to take her own life and this led to a meeting with staff at the Linden Centre, including Dr A, on 12 January 2006. Georgina shared that she was feeling *"very low"* and was experiencing suicidal thoughts. It was decided that she should be admitted as an informal patient under section 5(2) of the Mental Health Act 1983. Once Georgina became a patient at the Linden Centre, Dr A became her psychiatrist.

12. She was admitted on 13 January 2006. During her time there, she showed little improvement — she continued drinking alcohol and her mood remained persistently low. Her treatment soon had to be escalated, and she was moved from an informal section 5(2) arrangement to a section 3 detention under the Mental Health Act.

13. Her mental stability then apparently did improve following treatment in the ward's ICU, and by March, she was granted section 17 accompanied leave for 2 days. However, she did relapse again, she always would, a big trigger this time was her daughter's adoption hearing which was scheduled for 14 March 2006. She was still very beside herself about losing Savannah so anything regarding her was always extremely difficult for Georgina.

14. Despite her relapse and obvious vulnerability, on that same day, her section 3 treatment order ended and she was discharged from the Linden Centre 7 days later,

on 21 March 2006. By the time of her discharge Georgina was nowhere near recovered yet she was allowed to leave with no stability and no support when she was still drinking and using drugs. They decided to release her back into the very chaos she had been begging for help to escape.

15. Her final admission to the Linden Centre came only a few weeks later, on 3 April 2006. At the time, she had been living in a homeless shelter and I would visit her there from time to time. The day before, on 2 April 2006, I went to see her and I remember a man at the shelter saying something abusive towards me, Georgina heard him, immediately reacted and ended up attacking him. Security were called, followed by the police, and Georgina was arrested.

16. At that point, she knew she was deeply unwell and so made a decision to admit herself for treatment. The very next day her dad and I took her at her request to the Linden Centre. The SUI report notes that on arrival she told staff *"she felt safe in the Linden Centre. She had recently been evicted from her Hostel and had been involved in a fracas and allegedly assaulted a policeman, although she had no memory of this."*

17. Georgina was admitted to the Linden Centre at 2:30PM on 3 April 2006 on the basis of her *'low mood, feeling suicidal, and…an attempt on her life by lacing her throat.'* She was assessed as <u>not</u> being a danger to herself or others, which was completely ridiculous and shows the level of incompetence involved given that the day before she had been arrested for having a physical fight with someone. Upon arrival she admitted to drinking three litres of vodka per day for the previous two weeks, she also said she *'regretted'* being alive and felt that there was *'no meaning to her life'*.

18. Whilst at the Linden Centre, Georgina was able to continue to harm herself due to the lax care by staff. On 7 April 2006 for example, just a few days after her re-admission, she cut her right arm with 3 deep lacerations that were so bad she had to be transported to A&E Broomfield for suturing and medical care.

19. On another occasion, Georgina asked a staff member for a razor to shave her legs, **they gave her one,** and she used it to cut up her wrists. She had to have 23 stitches for that injury.

20. During this admission also, Georgina formed a close friendship with another inpatient, someone she connected with because they both related to each other's struggles. This patient died by suicide on 10 April 2006 and Georgina took her death

very badly, which in the context of the other deaths in her life and her spiralling mental health issues, was completely understandable and ought to have been foreseeable by staff.

21. She was thereafter assessed and according to the SUI report, it was determined that she was at an increased level of risk and so her treatment order was changed to section 3 again and she was placed on 1:1 observations.

22. Georgina was permitted to attend the friend's funeral, which she did, along with the staff that escorted her. She is reported to have told staff *"it should have been her being buried so that she could have joined her deceased partner."* The SUI report says that after this incident she became subdued for a few days.

23. The 14 May 2006 is the anniversary of our Tony's death. As a family we all really struggle around this time and for Georgina it was the same. My knowledge is that Georgina did not express any suicidal ideations on Tony's anniversary, however on 15 May 2006 she did reportedly cut her forearm.

24. Georgina was able to abscond during her time on the ward and was reported to the police as 'missing' on several occasions, it would happen so frequently that the Linden centre was almost like a revolving door for Georgina. She would sometimes come back the same day but sometimes not and there was no telling where she would go during those absconsions. I would know nothing about the absconsions, except every now and again I would get a call from someone on the ward asking me if I've seen my daughter recently. I would say "what, aren't you the ones that are supposed to be looking after her?!" and instead of answering me, they would just cut the phone.

25. I am aware that she absconded on 18 May 2006 and again on 20 May 2006, and upon her return on 21 May 2006, "*she reported that she had been woken in the park in Hackney by an old female friend. She was feeling discomfort in her genital areas, had a love bite on her neck and her knickers were missing. Georgina was told by the unit staff to report this, but she needed to time to think this through.*" She spoke to me about the incident and I told her to report it to the police, which she did. She was so terrified after that. The police opened an investigation but nothing ever came from it.

26. I even remember attending a GU clinic on Springfield Road with her to do tests. Nobody from the Linden centre came or even bothered to make sure she knew her

way and was okay, she had to go on her own and I met her there. When we were done, I also took her back to the Linden centre.

27. Georgina's observations were reduced to general observation on 27 May 2006. Then on 28 May 2006 she absconded again, and this time "*she ended up in A&E presenting with a bumped head, but she left A&E before being seen to, and returned to the Linden Centre. The missing persons report to the Police was cancelled.*"

28. Then just 2 days later, on 30 May 2005 Georgina underwent a review in which staff recorded that she ***"had no psychotic symptoms, was mentally stable, had no perceptual abnormalities, no suicidal thoughts and was not depressed. She had no regrets regarding her inappropriate actions over the weekend .... It was agreed that she be discharged from the Section 3 MHA 1983 and should she return to the unit drunk she should be discharged to Bed & Breakfast and she should be randomly breathalysed whilst on the Unit."***

29. This decision was made *after* Georgina had reported being raped, after her recent absconsions and despite her mental health being in a severely deteriorated state. It should have been abundantly clear that she was still deeply unwell, yet staff either failed to recognise this or chose to completely ignore it. Then to top it off, following the termination of her compulsory treatment order, she was granted unescorted leave from the ward once again.

30. She left the unit that same day and when she returned on 1 June 2006 she tested positive for both alcohol and cocaine. She was also reportedly extremely depressed. Before she was even informed of her test results she left the ward again. She was due back by 18:00 but phoned staff to say she would not be returning, that she would be staying with "a friend", she provided no name, address, or further details for where she was going. She eventually returned to the Linden Centre the next day, on 2 June 2006 at 13:35 and again tested positive for cocaine and opiates.

31. On 3 June 2006, Georgina left the ward again and on her return she confirmed she had drank alcohol. As I have said, she was able to use the Linden centre like a revolving door and none of them seemed to care.

32. On 5 June 2006 Georgina self-harmed on the ward. On 7 June 2006 Georgina attended a Hostel assessment. On the same day she was contacted by Hackney Police who wanted to interview her the following week in regard to the alleged sexual assault.

33. On 8 June 2006, Georgina went on leave to Chelmsford and returned after shopping. She was accepted by the Hostel and they told her the room would be ready in three weeks. Her observation levels were also reduced.

Georgina's last absconsion

34. On Friday 9 June 2009, Georgina appeared settled and "*well kempt*" according to the SUI report. She appeared to be of no particular concern to staff. Then, the SUI report notes that '*Georgina advised the staff nurse that she was going to London at around 14:00 hrs'.* She again gave no indication of when she would be returning, yet staff took no steps to question this, stop her or advise against her leaving. Georgina simply stated that she had her mobile phone with her and would contact the unit if she needed to — and this was accepted without any challenge.

35. At 20:05, at the start of the evening shift, she was noted by the nurse on duty to be *"already out on commencement of duty".* By 22:35, she had still not returned to the unit, so staff tried her mobile but there was no answer so they left a voicemail.

36. It is reported in the SUI report that by this time Georgina had not been heard from for at least 8 hours, yet "*staff were not unduly concerned as Georgina had done similar things in the past; for example she had absconded from the ward on the 20 May 2006, had gone to Hackney Police Station and reported she was missing from the ward."* They mention the absconsion on 20 May 2006 here but fail to mention that when she returned that time, she reported having been sexually assaulted by someone. Despite knowing this, the report states that on this occasion ***"Staff Nurse had no indication that raised concerns with regard to any immediate risks or harm should Georgina undertake this leave".***

37. On 10 June 2006 the next day, Georgina had <u>still</u> not returned to the Linden Centre. At 06:05, the charge nurse recorded that they needed to inform the duty doctor that morning. Yet not contact was subsequently made that morning.

38. At 13:00, the charge nurse recorded that ***"Georgina has not yet returned [and] the duty doctor has yet to be informed of the situation".***

39. The SUI report notes that *"at 15:15 staff tried Georgina's mobile phone again and left another message."* After this attempt the on-call Consultant Psychiatrist was

contacted, I believe this was **Dr A**, and he advised for them to activate the missing persons protocol.

40. It was only at 17:30 that the missing persons protocol was finally activated, and the police were not contacted until 17:55 despite Georgina having been missing for 27 and a half hours by that point.

41. At 18:40, the ward received a phone call from Chelmsford Police Station advising that my daughter had been found dead. I do not know exactly how she died but she was found at an address in Hackney, London, where she had been visiting a friend.

42. We were not told by the Linden centre that Georgina had not returned to the ward, we were never told that she was missing, the ward did not even tell us when she had been found dead. The first we knew was on 10 June 2006 after the event when a police officer, who was the same police officer that dealt with us about Tony's death, knocked on the door and told us.

My views on the Linden Centre

Ward Environment

43. I do not feel as though Georgina was ever safe at the Linden Centre. In fact, I strongly believe that the environment itself posed a danger to her and the other patients there, and that the facility should have been closed a long time ago. During her time there, she continued to use drugs and I am certain the staff were aware that both she and other patients had drugs on the ward. Georgina had even bought "skunk" and cocaine from another patient before and nothing was ever done about it. They would often hide drugs in the roof, I can still remember the exact spot, and despite me reporting it to staff nothing was ever done about it.

44. Neither patients nor visitors were ever searched when entering or leaving the unit, there *was* a security officer at the front desk but he would never be doing much, meaning anyone could bring in whatever they wanted, whenever they wanted.

45. On arrival, you just get told to sit and wait before they let you in. One time I remember we were left to wait in a room with other inpatients and an inpatient said something about me and Georgina whacked him across the face. There were absolutely no safeguards in that place.

46. We had been led to believe that this was a 'secure unit' designed to support patients battling addiction and trying to recover, but it was anything but secure. The complete lack of basic safety measures made it a dangerous environment and this is why I believe it should have been closed down long ago.

Staff inadequacies

47. During visits, I always got the impression that the staff were not sufficiently trained to deal with the type of patients on that ward. How could we draw any other conclusion when Georgina was repeatedly able to smuggle drugs onto the ward and was repeatedly able to self-harm? As mentioned, I vividly remember when she was given a razor that she ended up using just to cut herself up. I couldn't believe it. How was that allowed to happen? How could someone working in a mental health facility give a **razor** to a patient that was a chronic self-harmer? It is obvious the staff were either unfit to care for these patients or just did not care about ensuring anybody's safety.

48. When we were there, we noticed that staff spent a lot of time in their office, not attending much to patients at all. Sometimes when we visited, they would also be listening in on our conversations with Georgina and yet would never interact directly with us.

49. As for the so-called 1:1 observations Georgina was placed on, they were also done with no care or effort. A 1:1 observation is supposed to involve a dedicated staff member maintaining <u>continuous</u>, direct supervision to ensure the patient's safety and prevent self-harm, but in Georgina's case, she told me that a particular nurse had been assigned to do her 1:1s but this nurse would just pop into her room occasionally, ask "*you alright, love?"* and leave moments later. That was the extent of the "continuous" monitoring Georgina said she received.

50. Another factor demonstrating their lack of training was the fact that Georgina was able to abscond repeatedly, sometimes for more than a day, and the very last time she absconded resulted in her death in the community which the ward had to find out about from the police. When she would go, she would also often come back testing positive for drugs and drink. The appropriate response to her absconding *should* have been increased supervision levels but that was never the case with them.

51. Even worse was the fact that there were numerous occasions when, despite her obvious risk, Georgina would be granted section 17 leave (sometimes unescorted), which she would again abuse by drinking and taking drugs when she left.

Unbelievably, after she absconded on 20 May and returned telling staff she had been sexually assaulted, no alarm bells rang. She was able to abscond again 8 days later and 2 days after that, she was discharged from her section 3 treatment order and granted unescorted leave again, which she then used to take more drugs and drink in the community.

52. On 30 May 2006, only 11 days before her death, Georgina's section 3 treatment order was abruptly discontinued. There was no consideration of the recent raised risk factors involved, including her suicidal ideation, the sexual assault and documented non-compliance. It was total and utter neglect on their part, throughout her so-called treatment, and on a repeated and brazen scale.

53. It was not a suitable place for anyone, let alone Georgina who was chronically unwell. It truly felt like a prison and I have heard other families say the same thing about their experience with this facility. It was a terrible place with a lot of people dying there, many of whom died long after my daughter passed away, demonstrating that for years they were absolutely learning no lessons. How a place with such a history of harm was allowed to remain open, with death after death occurring, is something I will never understand.

Recreational activities

54. We are unsure how Georgina spent most of her time on the ward, we do not know what sort of activities or rehabilitation options were made available to her, to support her recovery. I am aware that minimally, she spent some time on the ward painting, which she was very good at and so would have likely enjoyed.

55. We also know that she spent a lot of time with other patients, many of whom were struggling with the same addiction issues she had. In some ways, being around people who she could relate to should have been a good thing but because staff paid such little attention to what was happening on that ward, and because it was an inherently unsafe environment to be in, it became the opposite for Georgina. It was a recipe for disaster. Particularly when patients are able to bring drugs onto the ward, openly and repeatedly, and nothing meaningful is being done to stop it. Instead of being protected, Georgina was placed in an environment where her vulnerabilities were heightened and where the risks surrounding her were allowed to spiral completely out of control.

Care Management and Plans

56. I do not believe that Georgina was involved in the plans for her care at all. We certainly were never included.

57. The risk assessments that were conducted were not an accurate reflection of Georgina and her illnesses. For example, on her arrival on 4 April 2006, she was assessed as *'not being a danger to others'* which was obviously ridiculous considering the day before she had been arrested for having a fight, and there were numerous other instances of aggressive behaviour by her.

58. I do not believe Georgina's history and background were ever considered when planning for her care and treatment. If they had investigated her background, they would see a history of her getting progressively worse. This lack of engagement with Georgina resulted in them making reckless decisions about her care, such as granting unescorted leave when she was repeatedly absconding. They did not know anything about her and she told me numerous times that she did not get on well with staff.

59. As I've said, neither Georgina's dad or I were ever informed about any care plans involving Georgina or the extent of her input in them. We did not know what was going on a lot of the time and this meant we were unable to advise them of her history or help ensure her care plan was robust. The only time they would ever call me was to ask me where she was when she went missing, that happened repeatedly, but other than that I was never contacted, I received no updates about her treatment, progress, medication or anything else.

Treatment

60. I was unaware of any changes to her diagnoses as I was never kept in the loop about this. I was also not aware of what medication she was on. From reading the SUI report after the fact, I am aware now that she was on a whole host of medications:
    a. *Diazepam 10mg once in the morning*
    b. *Temazepam 20mg once at night*
    c. *Folic Acid 5mg once in the morning*
    d. *Vitamin B Co strong T thrice a day*
    e. *Carbamazepine Retard 200mg morning, 400mg at night*
    f. *Chlorpromazine 150mg thrice a day*
    g. *Sertraline 150mg in the morning*

h. *Quetiapine 100mg twice a day*

i. *Subutex 4mg in the morning*

And as required:

j. *Diazepam, ibuprofen and orphenadrine.*

61. We were given no clear idea of her diagnosis, we had no input, the staff were not making any efforts to know Georgina, there was extreme self-harm, access to drugs on the ward, no checks being done and she was at an escalating rate of risk throughout her time there.

After's Georgina's passing

62. We had absolutely no support from NEMHP or the Linden Centre after Georgina's death. No one contacted us. We did not even receive a simple condolence letter. We were left completely alone, expected to carry on as though our world had not just fallen apart.

Concerns and complaints; the quality, timeliness, openness and adequacy of responses to concern

Serious incident investigation

63. Firstly, I must mention that I was never given a copy of this SUI report by the Trust, the first I saw of it was through this inquiry process.

64. Secondly, I believe the SUI report is totally inadequate. Not only is it not possible to determine from the report whether interviews were conducted or what the terms of reference were, the conclusion drawn by Mrs **[I/S]** (the investigator) is frankly insulting.

65. After outlining, albeit briefly, my daughter's various absconsions, the sexual assault incident, her low mood, suicidal ideation, repeated self-harm (some requiring hospitalisation), continued spiralling drug and alcohol misuse, in her summary section she finds that:

"Georgina was addicted to elicit 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."

What inroads is she talking about here? Again, I have not seen complete records but given that Georgina's drug use only escalated, I fail to see the basis for this conclusion. She then continues:

"During her stay on the Unit, she had periods of being settled and utilising her care plan together with taking her prescribed medication. She did use the prescribed 'as required' medication frequently and staff were encouraging her to use different coping strategies for her anxiety and self-harm feelings. Georgina stated that she felt safe on the unit."

This is entirely bias. Staff did not encourage my daughter by any means, and even if that was the case, which it definitely was not, she went on to self-harm repeatedly on that ward. She was even given the tools to do so at times, for example when she was foolishly given a razor. She may have had periods of being "settled" but this was few and far between, for the most part she was spiralling, absconding, testing positive for drugs on her return, showing aggression towards staff and going missing regularly.

Finally, the summary says what I believe is one of the more egregious parts of this report:

"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 these events was normally remorseful for her behaviour"

My daughter was an addict, it was not a case of her *"following her feelings",* she was suffering with addiction and was simultaneously being failed by this service. They did not provide any specialist support or the meaningful engagement she desperately needed to get better, and because of that inadequate care, she kept relapsing. Furthermore, this section of the report conveniently only focuses on Georgina's actions, which in itself reflects the uselessness of their care, but worse than that, it is blatantly dishonest because it ignores the failures of staff altogether.

66. Then in her conclusion, the investigator says "*it may be useful to have guidance as to how long staff should wait until they report an informal patient as missing"* but claims *"this is subject to a multi-disciplinary discussion and is made upon assessment of vulnerability."* To confirm, we were never given any update following this, as to

whether the guidance was formalised. We were never contacted at all about anything.

67. This conclusion is the only conclusion the investigator manages to draw in the entirety of the SUI report. One single recommendation — despite the long, alarming list of failures that exist in my daughter's case. It is outrageous that she could not find anything meaningful to address and so it is impossible to see this report as anything other than a joke. It reads as yet another glaring failure by NEMPH, another instance of them turning a blind eye, downplaying, and effectively excusing the very failings that cost my daughter her life.

Inquest proceedings

68. Georgina's death certificate states her cause of death as:

"*1a. Morphine Intoxication*
2. Borderline (unstable emotional) Personality Disorder and Polysubstance Abuse"

69. The verdict given by the coroner at her inquest was the following:

"*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."*

70. Further, I am aware that he put in the inquisition section entitled "how the accident happened", the following:

"at about 13:13 on 09.06.06 she (the deceased) asked to and was given unconditional permission to travel to London except for an unspecific later return. The risk for this was assessed informally. It was not recorded in the records. It was not discussed with any other healthcare professional. Her consultant would have allowed limited day "leave" on conditions for her contacting her and return by a specific return. She travelled to London (Hackney). She had probably intended to return to Chelmsford but told an associate that she did not have enough money. She spent the night with him and they both used drugs. She had not been habitually using opiate drugs for sometime. She probably took what would have previously been a recreational dose in a regular user, but she had lost tolerance. She took it voluntarily and deliberately but not with the intention of ending her own life."

He further noted that:

"She was found dead by her associate at 06:00am on 10.06.06. There had been no action to contact her until 8pm on 09.06.06 and the missing patient procedure was not implemented until after she was dead on Saturday 10th June 2006."

71. The coroner was frustrated himself with the Trust's care of Georgina. It is important that he included in his verdict that Georgina's risk of accidental death was not *"managed by a detailed care plan for her leave from the ward."* However I do wish he went further in pointing out the numerous areas of incompetence that occurred, that I believe led to her eventual passing, including (i) the failed responses to her absconding, (ii) the inadequate risk assessments, (iii) the failure to manage risk of suicide and self-harm, (iv) the inappropriate grants of leave and discharge, and (v) the total neglect in allowing patients there to smuggle in drugs and engage in self-destructive behaviours under watch.

72. We had no support during Georgina's inquest, and to this day I am not entirely sure whether I was even legally represented. There was an advocate who spoke on our family's behalf, but looking back, I was given so little attention and information that I still do not know who that person actually was. We felt completely alone throughout the process.

Civil claim proceedings

73. In 2007, with the aid of our solicitors at the time, we initiated a civil claim against NEMPH (under the Human Rights Act 1998) for the wrongful death of our daughter. The claim was settled in our favour in 2009 but no amount of money or empty words can ever replace my daughter or cause me to forgive those who so badly neglected her.

Recommendations for change

74. I have been asked to identify recommendations for learning. My recommendations are as follows:

    a. **The Linden centre should be shut down**. It was not just my Georgina that died under their watch, many other patients when on to die after being in that same ward. I recall that in the newspapers, we used to read what felt like a

death every week coming from that place. We found out about another family once and tried to reach out to them to support them because we knew how painful it was going through that experience ourselves. The place is just not fit for purpose, and when there are that many deaths occurring as a result of continuously dangerous and neglectful behaviours, I think serious thought needs to be had as to whether it needs to be closed down.

b. **Staff to take accountability for their actions**. The nurse that was supposed to be observing Georgina whilst on 1:1 observations when she cut her wrists and had to go to A&E, was transferred to Scotland after Georgina died and so escaped from having to account for her actions at Georgina's Inquest. I wanted very badly to hear from her; she was a main witness to Georgina's mental state and should have been made to account for her failure to monitor my daughter as she was supposed to. Instead, the Trust tried to blame Dr A when I know he was the only one who actually tried to stand up for us. It should be of great concern to this inquiry that there are many families who have had inquests and post-death investigation reports by this Trust that fail to address significant failures relating to our loved ones care. Witnesses should not be allowed to escape the country to avoid accountability and families should not be left without answers about how and why their loved ones passed away. This simply should not be happening and EPUT should be made to answer for it.

c. **There must be far greater recognition of the vital role families play in the care and safety of vulnerable patients**. I can categorically say that throughout Georgina's admissions, we were never meaningfully consulted or involved in decisions about her care or treatment. We believe this was simply because she was over the age of 18 — a technicality that, in practice, shut us out; the very people who knew her history, triggers, and her vulnerabilities better than anyone. Given her long-standing addiction issues, trauma and instability, our involvement should not just have been welcomed, it should have been actively sought. Had the team worked with us from the beginning, we could have helped build a clearer picture 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.

d. **Staff to be better trained.** The number one job of staff who are responsible for the mental healthcare of patients, must always be patient safety. If patients are allowed to bring drugs on the ward or abscond over and over again, that is not keeping patients safe. Training on safety must be a priority, and where staff are failing at this they should be removed from their post and replaced with informed and sufficiently skilled professionals.

List of documents for the Inquiry to obtain

75. At Appendix 1, I have outlined the limited documents I have in my possession that I have used to formulate this rule 9 statement. You will see that it is hardly anything and I am concerned that the SUI report does not go far enough in properly assessing the failures that occurred during my daughter's admissions. There are important records that EPUT must hold that this inquiry ought to obtain as part of its investigations.

76. To this end, the following is a full list of records that I have not seen that may be pertinent to obtain:
    a. All records held by the Linden Centre regarding Georgina's care and treatment (between 2005 – 2006), including but not limited to:
        i. All risk assessment and care plans formulated and relied upon
        ii. All psychiatric assessments, ward round reviews and doctors reports;
        iii. All documents regarding any changes made to her medication;
        iv. All written correspondence between Linden ward staff members and independent medical professionals regarding her care;
        v. Any and all witness statements or accounts taken from staff for either the SUI investigation or inquest proceedings;
        vi. The complete observation records, with a history of edits/metadata showing when they were last edited
        vii. All correspondence relating to the post-death investigation
        viii. A complete set of records from Broomfield hospital
        ix. EPUT's policies on: Missing Patients and Engagement and Supportive Observation Procedure.

Statement of Truth

I believe the contents of this statement to be true.

SIGNED [I/S] .....

MS ANN SEFTON

Dated 22 December 2025

WITNESS STATEMENT OF ANN SEFTON PURSUANT TO RULE 9 REQUEST FROM THE LAMPARD INQUIRY

APPENDIX 1 – LIST OF DICUMENTS WHICH I HAVE

Document	Date
Death Certificate	05.01.2010
Serious Untoward Incident Report	22.06.2002

Civil documents

Document	Date
Letter of Claim from civil proceedings	16.09.2009
Note of damages and quantum	22.06.2009