IN THE SURREY CORONER'S COURT

IN THE MATTER OF: KAREN JANE BINGHAM

The Inquest Touching the Death of KAREN JANE BINGHAM

A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • **Philip Astle Chief Executive South East Coast Ambulance Service** • **The Chief Constable Surrey County Constabulary**
1	**CORONER** Caroline Topping HM Assistant Coroner, for the County of Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** The inquest was opened on the 28th November 2017 and resumed before a Coroner with jury on the 4th February 2020. It concluded on the 18th February 2020 and the jury returned a narrative conclusion as follows: Karen first came in to contact with the Mental Health Services on 13/10/2014, when referred to Waverley CMHRS after an overdose. In March 2015 she was diagnosed with Emotionally Unstable Personality Disorder. The personality disorder is characterised by a highly unpredictable, rapidly changing emotional state, suicidal ideation with risk of self harm. In Karen's case this was exacerbated by alcohol. Karen's mental disorder was also exacerbated by being the defendant in harassment proceedings and by her perception of being let down by the Criminal Justice System. On

occasion, contact with the Police and Criminal Justice System triggered self injurious behaviours.

Karen had made a perjury allegation, and the CIO Officer investigating this allegation was aware of the above triggers.

On 09/10/2017, Karen called police saying she was going to hang herself. Police officers attended her home within 20 minutes and cut her down from a noose. Karen had been drinking and going through her legal paperwork and was found standing on a bannister, with a noose around her neck. Karen spoke to the attending police constable about her legal investigations including the perjury allegation.

The attending police constable raised concerns that Karen was at high risk of suicide, especially if the on going legal investigations did not give her the result she had hoped for. The PC attempted to escalate this concern using a 39:24, an LOI marker, and an email addressed to the CID Detective Sergeant, the Detective Constable investigating the perjury allegation, and the Surrey Police Professional Standards Department.

The CIO Investigating Officer and Detective Sergeant did not follow Surrey Police Protocol which required them to involve partner organisations (SABP) when dealing with Karen. They did however decide that news about the perjury investigation should be conveyed in person.

On 18th November 2017, the CIO Investigating Officer accompanied by a colleague attended Karen's address, [redacted] Farnham, having arranged for Karen's friend to also be present. Karen was informed that her perjury allegation was being filed due to lack of evidence. The officers left Karen with her friend. Both officers felt that Karen was ok and had taken the news better than expected. Karen's friend also felt she was ok and left her alone around 15.15.

During the afternoon of 18/11/17, after her friend left, Karen consumed some alcohol and sent an email at 16.05 to the CID Investigating officer discussing her legal case and thanking the officer for her investigation. It is unclear when this email was drafted. It was entitled 'Final Statement' and closed with the words 'none of it matters anymore. This is what she wanted'. Karen's intent in sending this email is unclear and it was not read by the officer until much later.

At 16.15, Karen called the police on 101 and told the switchboard that she had been trying to hang herself and had broken her hand. The police contact centre called her back and although Karen assured the call handler that she was ok and did not require assistance, the call handler felt that an emergency ambulance and police response was required.

At 17.43 the ambulance crew arrived and were let in to the property by Karen's friend who had just arrived. Karen's friend entered the house with the ambulance crew and Karen was found hanging from the loft hatch. Her knees were bent with her feet trailing on the floor behind her.

The paramedics attempted to resuscitate Karen, however she was asystolic, cyanosed and could not be revived. The Critical Care Paramedic called ROLE (Recognition of Life Extinct) at 17.59 on 18th November 2017.

Matters the jury finds are probably causative:
In respect of the safeguarding plan put in place when telling Karen about the outcome of the perjury investigation on 18th November 2017:

	1.Sufficient information was not obtained to inform safeguarding plan. 2.There was a failure to invite SABP to contribute to the plan. 3. There was a failure to put Karen's lay supporter on notice of the purpose of the visit on 18th November 2017, the concerns about Karen's reaction, and to discuss any role that person was expected to play in the safeguarding plan. 4. There was a failure to put in place an adequate multi-agency safeguarding plan. Matters the jury finds are possibly causative, not found established on the balance of probabilities: 1. There was a lack of knowledge among police officers involved with Karen regarding how and when to add an update Location of Interest and warning markers on NICHE, PNC and ICAD. 2. The failure to add recent sufficient information to these markers possibly compromised the ability of the Police Contact Centre and Force Control Room to make an informed decision on 18/11/17. 3. It is possible that, had accurate up to date information been recorded, a Grade 1 police response might have been dispatched, despite Karen's assurances to the police call handler that she was now ok. 4. Had a Grade 1 police response been dispatched it could possibly have materially affected the outcome. The jury concludes Karen met her death by accident. The cause of death was 1a Hanging
	CIRCUMSTANCES OF THE DEATH These are fully set out in the narrative conclusion see above.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – The evidence showed that: 1. Police training in respect of mental health does not provide information as to the type of behaviours associated with common mental health conditions. 2. Those responsible for the dispatch of emergency services in the police and ambulance services do not have a sufficient understanding of the triaging and dispatching processes used by each other's service nor their response times.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your

	organisation has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 25th May 2020. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons; [redacted] Surrey and Borders Partnership NHS Trust Surrey County Council Adult Social Care I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Signed:** **Caroline Topping** **Dated this 30th March 2020.**