Depositions of Witnesses

Yorkshire to wit

taken on oath or affirmation this TWELFTH day of OCTOBER 2011 at BRADFORD ,

before me PAUL VERNON MARKS, one of the Coroners of our Lady the Queen for the County of West Yorkshire

upon an inquest touching the death of JOANNE VICTORIA BINGLEY.

PVM/WF

H.M. DEPUTY CORONER

At the outset of these proceedings I stated that the purpose of this inquest like all others is for me to determine the four questions required of me by law, namely who is the person who has died, how, when and where did their death come about?

In reaching my findings I have explained the standards of proof, namely the civil standard on the balance of probabilities, and the criminal standard of proof beyond reasonable doubt, which represents the evidential hurdle or threshold if I am to consider suicide or unlawful killing. I have explained previously that any verdict must not offend against Rules 36 or 42 of the Coroner's Rules 1984, specifically pursuant to Rule 42 ***'no verdict shall be framed in such a way as to appear to determine any question of a) criminal liability on the part of a named person or b) civil liability. With this in mind my findings are as follows:***

In this tragic case I am entirely satisfied that the deceased was Joanne Victoria Bingley, a lady born in Mirfield on the 17 th January 1971 and who was a Nursing Assistant by occupation. She died on the 30th April 2010, 200 yards north of Deighton Railway Station in Huddersfield. **I am entirely satisfied that the medical cause of death was multiple injuries which led to fragmentation of the body.**

I will now deal with my **findings of fact** but I must first stress and state that this is an extremely complex case.

1. Joanne Bingley had a personal and family history of mental health problems as well as significant adverse life events befalling her in the last 5 years of her life. **(Refer to Note1)**

2. She gave birth to a healthy baby girl Emily on the 18th February 2010 after a protracted and difficult labour extending over 4 days.

3. She experienced difficulty and anxiety about breastfeeding her daughter who cried in a most distressing way and was also losing weight. This caused Joanne to question her ability to be a good mother.

4. She had 2 admissions to the Birth Unit in February and March 2010 which helped her and the baby and a decision was made for Emily to be bottle fed subsequently.

5. Joanne Bingley found the Huddersfield Birth Centre to be a place of safety and was reluctant to leave.

6. The elements of a depressive illness developed with the difficulties Joanne had and perceived she had around breastfeeding and amongst other things caused her to question her ability to be a mother and to love her baby. **(refer to Note 2)**

7. Her mental health deteriorated through March 2010 and April 2010. She was prescribed antidepressant medication by her GP as well as a hypnotic agent as lack of sleep was a major component in her now diagnosed post-natal depression. She did not have post-natal psychosis however.

8. Certainly by the 22nd April her condition was such that she was referred to the Mental Health Services who responded promptly. At and around this time she was expressing suicidal ideation, low mood, anxiety and a poor sleep pattern.

9. At a meeting it was determined she could be treated at home. I have found as fact that no discussion of other therapeutic options took place. There has been a move away from the paternalistic 'doctor knows best' approach to medical practice that was prevalent up until the last 30 years of the 20th century to a more patient centred approach where the patient is empowered in the decisions surrounding his or her treatment. Without such involvement it would be argued that **informed consent has not been obtained in accordance with the General Medical Council's guidelines.**

10. A change in medication was affected by the Crisis Team.

11. The Crisis Team visited or contacted Mrs Bingley regularly and kept watch on her mental state.

12. There was a 24 hour helpline available in the event of any deterioration or development of worrying symptoms.

13. It is clear that Joanne Bingley's symptoms fluctuated.

14. One of the key dates was the 27th April 2010 when Joanne Bingley was visited by the Crisis Team. There is a conflict of evidence between the healthcare professional who attended and Mr Bingley with regard to a request for in-patient treatment. The concern documented and subsequently reported back at the Crisis Centre was problems related to sleeping. **Taking into consideration the documentation that did appear and the evidence given I have found that there was no convincing request for in-patient treatment.**

15. I have also found that on **the next critical date the 29th April 2010, Dr Afridi performed a thorough assessment in light of the evidence he elicited and concluded that some improvement had taken place in Joanne Bingley's mental state or at worst there had been no deterioration.**

16. I have accepted evidence that the dramatic decline in mental health culminating in Joanne's death on the railway lines is a matter of speculation but could be attributed to Joanne masking her symptoms or her energy levels increasing without a commensurate elevation of her mood.

17. The question of whether Joanne Bingley was taking her medication requires careful consideration. Her husband believed that she was but conceded that she may have later spate out or vomited up the tablets. The post-mortem toxicology has found no drugs within her system of any description. I have accepted that she was taken off fluoxetine but as it has a long half-life, that is to say it takes a long time to be eliminated from the body even after cessation of therapy, this leads me to conclude and find that at material times Joanne Bingley was not taking her antidepressant medication. This in a sense raises more questions than it answers in sofaras **the observation of the Crisis Team that she was improving cannot logically be ascribed to the effects of medication. It is therefore more likely than not that her mood and symptoms were indeed fluctuating and I find this as fact.**

18. Turning now to the Serious Untoward Incident Report. I have accepted the methodology used and the action plan formulated which is underwritten by regular review and audit. I have therefore concluded that no ongoing system failure exists.

19. I have accepted the finding of the report about communication problems but have found that it is mutually incompatible for the report to determine positive and negative findings in this way about communication. This is simply a non-sequitur.

20. An important component of the report was **the independent medical care advice commissioned from Dr Oates and Mr Ketteringham, both eminent experts in their field. I have accepted their view that the possibility of admission should have been part of the initial treatment care plan and discussed with the patient and her husband as a treatment option if she either became worse or did not improve. It is also their evidence that on the 27 April, if not before, there was clinical indication to be admitted to a Mother and Baby Unit. It would follow from this opinion that if admission had taken place Joanne Bingley in all probability would not have died on the date that she did or in the manner that she did.** It is not, however, certain whether this care would have taken place and certainly there is no evidence to suggest that Joanne Bingley would have been subject to compulsory admission under either Section 2 or Section 3 of the Mental Health Act 1983 thereby needing compulsory treatment. Though thus complex issues relating to causation are difficult to resolve on the facts that have been heard.

21. I have accepted in full the British Transport Police Report of the circumstances and this leads me to conclude that Joanne Bingley did intend to take her own life and I am satisfied on this to the necessary criminal standard of proof. **If there is any crumb of comfort to the family I am certain Joanne did not feel any pain and died instantaneously.**

I now must consider the verdicts.

I am not persuaded that a short-form verdict is appropriate here; specifically if I were to have considered suicide I do not find that the rider to which neglect contributed could be appended. The evidence and findings of facts do not achieve this very high threshold that is required of me to return such a verdict. **I have resolved to return a narrative verdict.** As we have discussed this must be a neutral factual statement which does not offend against Rules 36 or 42 of the Coroner's Rules 1984, and **it is not allowed to take into consideration matters which are not causally relevant.**

It may interest you to know that irrespective of any conclusions I make here today further action in other forum or not precluded by any interested party.

The narrative verdict is as follows:

Joanne Bingley died at 07.53 on the 30th April 2010 near to Deighton Station where she was struck by the Trans Pennine Express travelling from Hull to Manchester Piccadilly. Joanne was suffering from severe post-natal depression for which she was being treated at home and as a result of her illness deliberately stepped in front of the train intending to take her own life.

This concludes the formal part of this inquest. A number of things remain left for me to do however.

I would first like to thank the advocates for their learned submissions and the help they have rendered to the court during this extremely difficult and complex case. Of course now I wish to extend my sympathies to members of Mrs Bingley's family. **To lose a mother and be left with a little child who will not have known her mother must be a terrible feeling and I cannot begin to imagine how this has affected you. Hopefully today's proceedings will allow you some element of closure. I would also like to stress of how well you have all conducted yourselves in this very difficult circumstance and with great dignity.**

This now concludes the proceedings.

NARRATIVE VERDICT:
Joanne Bingley died at 07.53 on 30th April 2010 near to Deighton Station when she was struck by the TransPennine Express travelling from Hull to Manchester Piccadilly. Joanne was suffering from Post Natal Depression for which she was being treated at home and, as a result of her illness, deliberately stepped in front of the train intending to end her own life.

Notes on the Coroners Statement

Note 1 Joe's Health Visitors failed to perform any of the mental health clinical risk assessments and failed to refer her to the specialist perinatal psychiatric services available in Leeds

- Joe's family history, previous Cognitive Behaviour Therapy (CBT) treatment for post-traumatic stress (mental illness) meant a doubling of the risk of suffering from severe postnatal depression from the normal 3% to 6% for a first time mum.
- The medical records maintained by the Health Visitors clearly described Joe's previous miscarriage and treatment for depression. This previous history of postnatal depression meant an increase in risk of suffering from severe postnatal depression from 6% to 50%.
  i.e. there was a 1 in 2 chance Joe would suffer from severe depression after Emily was born.
- Despite the increased risk, Joe's designated Health Visitor failed to perform any of the 5 ante-natal or post-natal risk assessments as specified in the Kirklees Maternal Mental Health Care Pathway, a breach of National NHS Policies, NICE guidelines, and a failure to follow safe systems of work and Health and Safety legislation.
- The Health Visitor clearly recorded in Joe's records on the day 'it snowed', she telephoned Joe and discussed her previous history of miscarriage, and asked her all questions on her risk assessment form for that visit EXCEPT for the mental health risk assessment.
- **Due to time constraints these factors were not explored during the Coroners Inquest nor in detail by the Independent Investigation.**

Note 2 The Midwives recognised and recorded Joe was Suspected of Suffering PND whilst in Hospital but failed to refer her to the specialist perinatal psychiatric services or inform the Health Visitors.

- The medical records state Joe was extremely anxious, distressed, did not want to leave the hospital and notes that midwife's suspicions Joe was suffering Postnatal Depression.
- The witness statements for the Coroner say there was a failure to pass on information at the shift changes and hence there was no referral made for Joe to receive a clinical risk assessment (a breach of safe systems of work and Health and Safety legislation).
- No information was passed to the husband or the patient of the midwives suspicions. The failure to inform either the patient or her husband (Next of Kin) of the suspicions she was suffering from postnatal depression could be argued to constitute a failing to obtain 'informed consent" to any subsequent treatment, as a full and proper discussion on risks and treatment options could not occur, in breach of NHS polices, NHS Constitution, care safety standards and various laws.
- The midwives did treat Joe for her inadequate production of breast milk by attaching her all day to a milking machine that left her physically bruised, exhausted and mentally in tatters. This treatment was supposed to improve milk production after 7 to 10 days.
- The image I saw when I returned to the hospital that day will haunt me till the day that I die. Joe was in tears, distraught, in pain, in anguish, and suffering. How could "breast be best" when our child had already spent 2 weeks screaming every night in hunger and my wife was left feeling a failure as a mum?

DUE TO TIME CONSTRAINTS, THESE ISSUES AND POTENTIAL CAUSUAL FACTORS WERE NOT EXPLORED DURING THE INQUEST NOR WERE THE COVERED IN DETAIL BY THE INDEPENDENT INVESTIGATION.

Evidence heard at the inquest:

- ***On 27th April 2010*** *- the first critical date identified by the coroner and the date when the Independent Investigation states Joe should have been hospitalised -* ***when Joe requested "PLEASE TAKE ME WITH YOU" her request was ignored*** *and brushed aside by the care worker treating her that day as just a flippant remark. When Joe left the session unexpectedly (withdrawing from treatment)* ***despite Joe's medical record detailing her suicidal plans, a decline in mental health and her obvious state of anxiety, the care worker never explored Joe's state of mind. Whilst sat in her car ready to leave, the husband knocked on the care workers window to explain Joe had left the property without telling anyone. Despite having recorded the husband's anxiety and distress in her notes, knowing his wife was suicidal, she told him to contact the police if his wife did not return and then drove away!***

Evidence not heard at the inquest but contained in the medical records:

- ***On 29th April 2010*** *– the next critical date identified by the coroner –* ***on the afternoon before Joe's death, the Health Visitors who saw Joe recorded her anxiety, failure to cope, that she could see no future, her feelings that the Crisis Team were wasting her time and not helping her, that she did not want to continue to see them (again withdrawing from service). The Health Visitors (HVs) were so concerned that they contacted the Crisis Team*** *to discuss Joe's mental state and treatment. But the Crisis Team Manager over-ruled the HV's as they when the Dr visited that morning he felt that Joe was improving or at least no worse.*
- Horrified to hear that the Crisis Team Manager was planning to withdraw their services and treatment of Joe, **the HVs felt they would not be able to cope and decided to raise the issue in by completing a "Risks And Needs Assessment".**
- *Findings of the Confidential Enquiry into Suicides has identified the leading risk factor 24hrs prior to a patient committing suicide are signs of or starting to withdraw from contact with services.*
- *As antidepressant drugs start to take effect, after approx 10 to 21 days, PND sufferers are at their highest risk of taking action as they become more cognitive, able to think clearly and therefore take 'action'. – Dr Andrew Kent, consultant perinatal psychiatrist, St Georges, University of London*
- ***Despite the concerns raised about Joe's mental state the afternoon before she died, the sudden and severe change in mood, the high risks to the patient and the known risk factors, no-one from the Crisis Team contacted the husband to enquire into and investigate Joe's then mental state or offer him advice, prior to the bank holiday weekend. In clear breach of action plans from previous Independent Investigations***
- ***On 5th May 2010*** *on returning back after the Bank Holiday weekend and on learning of the death of the patient (Joanne Bingley) the Crisis Team Manager's first reaction at 9am was to call the Health Visitors and state…* ***"At no point in time did Joanne report that she was going to self-harm to the Crisis Team. This was one of the indicators on her home care for Joanne with strong family support from grandparents and husband"****.*

The Coroner Statement is that "complex issues relating to causation are difficult to resolve on the facts that have been heard"……..

The failure to obtain 'informed consent" is covered by the NHS Constitution (Health Act 2009) is unlawful.

The failure to conduct clinical risk assessments constitutes a failing to follow 'Safe Systems of Work' as defined under the Health and Safety at Work Act, is unlawful.

HENCE THE NEED FOR A DETAILED, THOROUGH AND COMPLETE INVESTIGATION OF THE FACTS AND ISSUES