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INVESTIGATION

SEPTEMBER 2016

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The Mental Welfare Commission (the Commission)

What we do

We protect and promote the human rights of people with mental health problems, learning disabilities, dementia and related conditions.

We do this by:

- Checking that individual care and treatment are lawful and in line with good practice.
- Empowering individuals and their carers through advice, guidance and information.
- Promoting best practice in applying mental health and incapacity law.
- Influencing legislation, policy and service development.

We acknowledge and appreciate the cooperation of all the organisations and staff in assisting us with this investigation, and particularly Ms OP and Baby A's father.

The subjects of this report have been anonymised as is our practice in our published investigation reports.

Incident overview

On 3 February 2015, Baby A died at nine months old. Baby A was suffocated by her mother Ms OP who had a history of postnatal depression following a previous pregnancy.

The death of Baby A was the subject of a police investigation and court case. In June 2015 Ms OP was convicted of culpable homicide. Psychiatric reports prepared for the court concluded that she was profoundly affected by postnatal depression at the time of the offence.

Reasons for investigation

The Commission was notified by NHS Board C (the health board responsible for Ms OP's care and treatment) of the case.

In June 2015 the Commission was formally asked by the Minister for Sport, Health Improvement and Mental Health to carry out a full investigation of the care of Ms OP.

The investigation was conducted under Part 2, Section 11 of the Mental Health (Care and Treatment) (Scotland) Act 2003¹. Section 11 gives the Commission the authority to carry out investigations and make related recommendations as it considers appropriate in a number of circumstances. Among these circumstances are those set out in Section 11(2) d.

Section 11(2) d relates to circumstances where an individual with a mental illness may have been subject to, or exposed to, ill treatment, neglect or some other deficiency in care or treatment.

The Commission delayed starting the investigation until November 2015 as NHS Board C was conducting an extensive Significant Adverse Event Review (SAER) of the case, and the findings of that review were required in order to determine the scope of the Commission's investigation.

¹ <http://www.legislation.gov.uk/asp/2003/13/section/11/enacted>

The terms of reference

To review the internal investigation carried out by NHS Board C.

To examine the care, treatment and support received by Ms OP from October 2006 up to the death of Baby A in February 2015, with particular reference to the 12 month period prior to February 2015.

To examine the adequacy of the response of primary care, specialist mental health services, local authority and other support services as appropriate.

To identify lessons to be learned and conveyed both locally and nationally.

To make recommendations as appropriate.

Method of investigation

This report draws on the findings and recommendations of the NHS Board C SAER and further investigation by the Commission.

We received case records from NHS Board C in relation to Ms OP and Baby A; these included general practitioner (GP) records, health visitor and community midwifery records and all mental health records. We received relevant care records from Local Authority A (the local authority where Ms OP lived) in relation to Ms OP and her children. We also requested and received information about the inquiries made by the Crown Office and Procurator Fiscal Service (COPFS) including psychiatric court reports and witness statements relating to the criminal investigation. We received the records from a postnatal depression support service (PDS).

We reviewed these records and the SAER conducted by NHS Board C and requested transcripts of interviews undertaken during this review.

We interviewed those we identified as key to providing information to help our investigation. This included NHS Board C staff, GPs, PDS staff, family and friends. We met all interviewees privately. We carried out one group interview with staff from the PDS. We explained the nature of our investigation and gave those we interviewed the opportunity to have someone of their choice accompany them to the interview. The interviews were audio recorded, and a transcript of each was sent to the relevant interviewee to check for accuracy.

The Commission investigation team

Ms Alison Thomson, Executive Director (Nursing) Chair

Dr Stephen Anderson, Consultant Psychiatrist

Ms Alison Smith, Casework Manager

In addition we benefitted from expert opinions:

Opinion in perinatal mental health from Dr Roch Cantwell, Consultant Perinatal Psychiatrist, NHS Greater Glasgow and Clyde

Opinion in General Practice from Dr Neil Kelly, Clinical Lead for Annan and Eskdale locality and the Clinical Director for e health, NHS Dumfries and Galloway

Background information

We obtained much of Ms OP's personal history from a review of the notes and discussion with her and those who know her.

Ms OP was brought up in urban central Scotland. Her parents separated when she was around four years of age. She left home at the age of 17.

Ms OP had three children; she had her first child at age 20.

Her second child was born when she was 27 years old. She had a normal pregnancy and was happy to be pregnant. She was initially well, but her mood began to drop and she became depressed. She lost a significant amount of weight. She suffered from postnatal depression and was seen as an outpatient by the community psychiatric nurse (CPN) and psychiatrist. She required an inpatient admission for around four weeks when the baby was eight months old. She was discharged from mental health services in 2008, had further brief contact in 2009, and then had no further contact until 2013.

Her third child, Baby A, was born in April 2014. At that time Ms OP lived with her partner and her other children. Ms OP had limited contact and a difficult relationship with her own mother and siblings. Ms OP and her partner separated some months prior to Baby A's death.

The care and treatment of Ms OP

Ms OP was registered with Medical Practice A. This is a large GP training practice with six full-time equivalent GPs and a practice population of around 9,000. She had been registered with the practice for at least twenty years.

In October 2013, Ms OP was referred by her midwife to the Perinatal Mental Health Services (PNMHS) as she was pregnant and had a history of postnatal depression.

In November 2013, she was seen by a specialty doctor in psychiatry, Psychiatrist 1, within the PNMHS.

Psychiatrist 1 noted significant risks to both mother and children in the previous postnatal period that included thoughts of killing herself and her baby. Psychiatrist 1 recommended close monitoring by midwife, health visitor and GP postnatally in conjunction with follow-up from a PNMHS community psychiatric nurse (the CPN).

At this appointment, Ms OP appeared well and discussed with the psychiatrist some early warning signs of depression.

Psychiatrist 1 wrote directly to the CPN to request CPN input. In this letter, Psychiatrist 1 highlighted the previous mental health history with onset of recurrence of suicidal thoughts and thoughts of harming the children at around eight months postpartum. Psychiatrist 1 stated they had not arranged to review her again in clinic, but would be happy to offer another appointment or join the CPN on a visit if required.

This assessment letter sent to the GP practice was detailed and provided relevant information on past history, early warning signs and future management. Psychiatrist 1 also documented the risks in this letter.

Chronology

February 2014

The first contact from the CPN in this episode was a home visit in February, when Ms OP was 36 weeks pregnant and she was reported as looking forward to the birth.

April 2014

There was a telephone call from the CPN to Ms OP a week after Baby A's birth; in that call the CPN discussed early warning symptoms with Ms OP, but nothing untoward was detected. During a home visit by the CPN on 24 April 2014, Ms OP reported that she was under a lot of stress due to recent family disputes, but the CPN noted that no signs of depression were present.

May 2014

Ms OP was seen in May by GP 1 for Baby A's six week check. Her mood is described as having been good.

Ms OP was seen by the CPN, at which time she was feeling well and did not feel the need for further contact. She agreed to further phone contact. She was first discharged from PNMHS by the CPN when Baby A was seven weeks old. No discharge letter was sent at this time.

June 2014

Ms OP contacted the CPN in June asking for advice. Ms OP thought that she was 'just about coping' but was keen for additional support: the CPN agreed to start seeing her again.

During an appointment for Baby A with GP 2, Ms OP reported feeling stressed and asked to be referred to the CPN. She was referred by letter to PNMHS.

Later in June the CPN recorded that Ms OP was coping and managing the needs of all the children. There were no depressive symptoms noted, and she was not on any medication.

August 2014

Ms OP presented to GP 6 complaining of feeling tired all the time. There was no enquiry about depressive symptoms at this consultation. Ms OP was discharged for the second time from the PNMHS by the CPN on 27 August. She agreed to contact her GP if she had any concerns about her mood or mental health.

A discharge letter was not sent by the CPN to the GP practice until 8 December 2014, an unacceptable delay.

September 2014

Ms OP presented to the GP practice in late September, again, feeling tired all the time. There was no enquiry about depressive symptoms, and she presented three days later to GP 3 with low mood and said she was worrying about developing postnatal depression again. She was prescribed the antidepressant which she had been on during her previous episode of illness. GP 3 referred her to the health visitor at this time for more support. There was no follow-up appointment arranged with the GP at this time.

October 2014

Ms OP was seen by the health visitor at home in late October for Baby A's six-month check. The health visitor reported her as coping well at this time.

This was the last contact the health visitor had with Ms OP or Baby A.

November 2014

Ms OP was seen for initial assessment by the PDS following a referral from a local mental health charity that Ms OP had contact with. The assessing therapist from the postnatal depression support service (PDS) considered her to be suitable for counselling, and a date was agreed for her to return for a follow-up appointment in early January 2015.

December 2014

Ms OP was seen on the morning of 16 December 2014 by a locum GP, and they discussed starting the antidepressant that was prescribed in September 2014, which she had not been taking. Ms OP returned later the same day to see GP 4, as she did not think that she had a chance to explain her situation properly when seeing the locum GP that morning.

Ms OP thought that she would benefit from seeing the PNMHS CPN again and GP 4 agreed to contact her. Ms OP was denying thoughts of self-harm or harm to the children and stated that she had counselling in place.

GP 4 was aware of the previous admission to hospital, of the recent discharge from PNMHS and her antidepressant prescription. GP 4 documented he was advised by the CPN that the PNMHS could not see Ms OP as her baby was over six months old and that Ms OP was advised to consider counselling. GP 4 met Ms OP three days later for a review. Ms OP said she was feeling generally brighter and more supported at this point and had plans for activities over Christmas with the children.

After Baby's A's death, Ms OP told hospital staff that she had been having some very dark thoughts around this time and was extremely low in her mood, although this was not disclosed to anyone involved in her care at the time.

January 2015

Ms OP attended PDS to begin counselling sessions in early January with two subsequent appointments attended later that month.

The counselling staff said they had no indication that her mental health was deteriorating around this time or that she presented with any symptoms that would have made them contact the GP practice or PNMHS.

28 January 2015

Ms OP was seen by GP 5, who noted she was struggling with symptoms of depression. He increased the antidepressant and referred her by letter to the PNMHS.

GP 5 was aware of the advice given to GP 4 that the PNMHS could not assess Ms OP again as Baby A was over six months old, but decided to make a referral anyway.

GP 5's hope was to have some kind of response from the team within a week or two after they had been able to review his letter. GP 5 was aware of how to make an urgent psychiatric referral to general psychiatry, but did not think that Ms OP was an immediate risk to herself or others.

2 February 2015

Baby A was taken by Ms OP to GP 6 as she had an ear infection. This appointment was for Baby A and GP 6 later reported there was nothing in Ms OP's presentation at that consultation to cause concern.

3 February 2015

Around 11am Ms OP telephoned the PDS, because she was distressed about disagreements in relation to access to Baby A between herself and Baby A's father and wanted to speak with her counsellor. Ms OP was described as initially distressed, but calmed during this call and reassured the counsellor she and the children were safe. Around 3pm Ms OP made a 999 call following an overdose of antidepressants. Ms OP disclosed that she had smothered her baby.

The referral letter from GP 5 was received by the PNMHS on the 4 February 2015.

Issues arising

The following section looks at the key issues identified during our review of the care and treatment of Ms OP. It also draws on the findings of the NHS Board C SAER.

Primary care

The interview team met the five GPs who had contact with Ms OP during her last pregnancy and up until the date of Baby A's death in February 2015. There were 25 contacts between Ms OP and the practice following Baby A's birth, the majority face to face, but some telephone consultations. Not all of these consultations were in relation to her mental health, she had ongoing physical conditions which required regular GP attendance. Ms OP also attended on 10 occasions with Baby A. Ms OP had contact with nine different GPs, including locums, trainees and permanent members of staff, as well as with the practice nurse.

GP 4 was able to see Ms OP for three consecutive appointments in December 2014. This is really the only consistency she had in her contact with general practice during the period in question.

It would be difficult for individual GPs to have a good assessment of her mental state over time with the lack of consistency. It would be best practice to have more consistency, but the reality in a large, busy practice is that this is difficult, especially when patients want to be seen quickly.

Identification of risk within GP records

The GPs all told us that they use their electronic patient records system to look at the immediate alerts and significant past medical history screen as well as the last three or four consultation entries before seeing a patient, so they have some awareness of their background. They would not routinely look at the correspondence section of the system which is separate from the current clinical notes.

The risks identified in the perinatal assessment letter from November 2013 were not highlighted in a way that would readily be seen by a GP before seeing the patient. The assessment letter itself is stored in a different part of the system, so unless it is highlighted on the risks/significant history page, or a GP specifically looks for it to check on the findings and recommendations, it will not be seen during a consultation.

The summary/alert screen that is seen when first accessing a patient record would be an appropriate place to highlight these risks. If GPs had been fully aware of the past history and associated risks, and of the outcome and recommendations of the PNMHS assessment letter, then it would have been appropriate for Ms OP to be referred to the PNMHS in September 2014 as well as, or rather than, to the health visitor. However, the GPs were still under the impression that she was under the care of the PNMHS as they did not receive the discharge letter until December 2014. Baby A would have been five months old at this point and still within the inclusion criteria of the service. This was a missed opportunity for Ms OP to access the PNMHS and to receive appropriate care and treatment for her condition.

Prescription of antidepressants

GP 3 prescribed antidepressants in September 2014 and considered that review in one month was clinically appropriate as a referral was being made to the health visitor for additional support. The British National Formulary² recommends that patients are reviewed every one to two weeks when first starting an antidepressant, particularly when there is a previous history of suicidal thoughts and behaviours, as there may be an increase in suicidal thoughts when commencing an antidepressant or when changing dose.

The NICE³ Guideline ‘Depression in adults: recognition and management⁴’ suggests that when starting an antidepressant, if there is no risk of suicide, the person should normally be reviewed after two weeks and then seen regularly, every two to four weeks for three months or so. If there is thought to be an increased risk of suicide, such as if there is a past history of suicidal thoughts or behaviours, then the person should normally be reviewed after one week and then frequently thereafter.

When antidepressants were prescribed in September 2014, Ms OP was advised to make an appointment in four weeks time. In line with BNF and NICE guidance, she should have been reviewed earlier, especially in view of her past history. An earlier review may have picked up that she was not taking her prescribed medication.

Follow-up on referrals

The NHS Board C SAER states that the referral to the health visitor was recorded in the GP notes, but not found in the health visitor record. However, we were able to see the handwritten referral letter in the health visitor notes: the health visitor confirmed that she had received this referral letter.

² [The British National Formulary is a publication which reflects current best practice as well as legal and professional guidelines relating to the uses of medicines](#)

³ [The National Institute for Clinical Excellence \(NICE\) produces evidence based guidelines on how particular conditions should be treated.](#)

⁴ [National Institute for Health and Care Excellence \(2009\) CG90. Depression in adults: recognition and management](#)

There is no system in place to check whether referrals have been picked up or acted on, either within primary care (i.e. the health visitor) or to secondary care (i.e. mental health services). GPs make many referrals, and it is not possible to ensure that they personally check whether these have all been acted on. If there is no system, then the referring GP may assume that the patient is being seen and appropriately treated and supported in another part of the health service when they are not. Unless the patient re-presents or asks the GP what has happened to their referral, then it may not be known that a referral has not been received or acted on by the service in question.

GP 3 referred Ms OP back to the health visitor for additional support after agreeing with Ms OP's concerns that she might be developing a depressive illness again. However, an appointment was not made by the health visitor until four weeks later on 22 October 2014 when Baby A was due a routine six month development check. There was nothing recorded in the health visitor records to indicate action in response to the referral or any feedback to the GP following the visit.

Primary care and PNMHS contact

GPs had some awareness of the referral and exclusion criteria for the PNMHS and were aware that they could find other information about the service in an online referral guideline for many clinical services within NHS Board C.

It is possible that the lack of awareness of the remit of the service would not have been an issue if the discharge letter from the service had given clear guidance and recommendations on assessment and follow up on risk, including guidance on how to access mental health services if required. This was a recommendation of the NHS Board C SAER.

At the time of contacting the CPN, GP 4 was not aware of the six-month cut-off for the service. He was aware that there was a PNMHS and was aware that he could find information about this online, but did not look at this as he planned to discuss Ms OP with the CPN who knew her. He assumed that as they knew her, they would be able to see her again.

GP 4 was satisfied that, as the CPN knew Ms OP well, the advice he was given was appropriate. He states that he wanted her to be seen, but as the CPN knew her and her background well, the advice was taken as appropriate.

PNMHS

The PNMHS in NHS Board C provided a community psychiatric service for women with mental health problems related to pregnancy, childbirth and early motherhood. The service was delivered by a specialist perinatal psychiatry consultant, specialty doctor in psychiatry and two community psychiatric nurses, with sessions from an occupational therapist, social worker and psychologist within the team. In addition, a senior charge nurse fulfilled a dual role across the in-patient mother and baby unit and the PNMHS.

Services offered by the team included mental health and risk assessment, care coordination of women, appropriate time limited treatments and interventions jointly agreed with women, collaborative working with women and, wherever possible, their families.

There was no duty system in place, but the PNMHS would attempt to provide referral advice. They would also attempt to be able to discuss referral queries and ongoing clinical issues whenever appropriate. There was a weekly referrals intake meeting where referrals were discussed and triaged.

Women who were referred but were felt to need a priority response would be seen with more priority, but the service had no ability and was not set up to respond urgently or to crisis.

The PNMHS was reviewed in 2012 by an independent expert in perinatal mental health: the review concluded that the community team was understaffed and an increase in the number of CPNs would enable the team to case manage more women, particularly after delivery.

A peer review carried out in 2014 by the Royal College of Psychiatrists identified challenges for the PNMHS including: the lack of a full time manager, pressures on the team in terms of resources, a limited amount of medical and nursing input considering the large geographical area and birth rate and the need to develop a more robust system for clinical supervision of caseloads.

Age limit referrals to PNMHS

The PNMHS community team accepts referrals for women whose babies are up to six months old.

The referral guidelines of the PNMHS are in line with service standards for perinatal community mental health services set by the RCPsych PQN⁵. Their standard is that 'teams assess all women who are suffering from a new episode of serious or complex mental illness (in pregnancy and until six months postpartum with follow up to 12 months).'

⁵ [Royal College of Psychiatrists Quality Network for Perinatal Mental Health Services \(2014\). Service Standards: Second Edition, Perinatal Community Mental Health Services](#)

The Scottish Intercollegiate Guideline Network⁶ (SIGN) 127 - management of perinatal mood disorders,⁷ is silent on this.

One of the inclusion criteria of the local PNMHS community team operational policy (2012) was – ‘women in the early postnatal period (up to 1 year) who have been suffering from a severe depressive episode or any other significant maternal mental health difficulties.’

The operational policy also said in its exclusion criteria – ‘women whose babies are over six months old.’ This information is repeated in the service’s current operational policy (2015) at page five. These statements are clearly contradictory.

The Quality Network standard is for an age limit of six months for ‘new episodes.’ Ms OP was known to the PNMHS in this pregnancy and postnatal period so this could be considered the same episode.

PNMHS contact with Ms OP

Ms OP was seen by Psychiatrist 1 in November 2013 when she was around five months pregnant following referral from the community midwife who had identified the history of previous postnatal depression. We found the assessment letter sent to the GP practice was detailed and provided relevant information on past history, early warning signs and future management. However, this letter was not sent to the GP practice until 7 February 2014, an unacceptable delay. We were told this was due to the delay in making contact with the previous CPN and time management.

Psychiatrist 2 was the lead clinician in the PNMHS, but had no contact with Ms OP. Psychiatrist 1 and 2 both told us that they did not think that a pre-birth planning meeting was required in this case. Psychiatrist 2 explained that other PNMHS services do not have these meetings routinely.

SIGN 127 recommends having a detailed plan for the late pregnancy and early postnatal psychiatric management of women with a high risk of postnatal major mental illness. The view of the PNMHS psychiatrists was that, as the previous episode started very early after birth, Ms OP should receive close follow up, particularly in the first postnatal month.

In Ms OP’s case, the PNMHS psychiatrists thought that if a depressive illness were to develop, this would happen more slowly and would be picked up and managed. They did not think that a pre-birth planning meeting would add to the plan in Psychiatrist 1’s assessment letter. Such a meeting would, though, have raised awareness with the health visitor and GPs about the previous risk, and highlight the need for close monitoring and early referral to PNMHS or to the mental health assessment service at Hospital 1.

⁶ [The Scottish Intercollegiate Guidelines Network \(SIGN\) develops evidence based clinical practice guidelines for the National Health Service \(NHS\) in Scotland.](#)

⁷ [Scottish Intercollegiate Guidelines Network SIGN 127 \(2012\). Management of Perinatal Mood Disorders, a National Clinical Guidelines](#)

Following assessment in pregnancy by Psychiatrist 1, the CPN was the only member of the PNMHS who regularly met with Ms OP and there was no further contact with a psychiatrist.

Ms OP was discharged by the CPN in August 2014. The discharge letter was not sent to the GP practice until 8 December 2014. This is clearly an unacceptable delay and the CPN gave no clear reason for this other than it was an oversight.

The discharge letter did not highlight any of the previously identified risks. The discharge from the service was not discussed with anyone else in the PNMHS. Ms OP was discharged by the PNMHS with no formal risk assessment having been undertaken.

Health visitor

From the health visitor notes and our interview, it is clear that the health visitor was aware of Ms OP's previous history of postnatal depression and hospital admission, but not aware of any detail or previous thoughts of harming the children. All health visitor records indicate Baby A's excellent development and attachment with her mother.

The 'Edinburgh postnatal depression screening tool' is a widely used questionnaire which was developed to help identify women suffering from postnatal depression. Ms OP was offered Edinburgh postnatal depression scale screening⁸ at six weeks and six months after Baby A's birth, but she declined this. We appreciate that Ms OP did not want to complete this, but given her previous history of postnatal depression, we think this should have been pursued further and enquiry made about depressive symptoms at each contact. This was not done.

The health visitor had no contact with the PNMHS CPN and was not clear about the level of engagement Ms OP was having with the PNMHS.

The level of mutually agreed support by health visitors for the child and his or her family is set by a tool known as the health plan indicator (HPI)⁹. It allows health visitors to allocate to a 'core and additional programme of support', depending on a child's assessed level of need. One of the examples given in the HPI for the additional support requirement is mental health problems. An additional HPI indicates that the child (and/or their carer) requires sustained (greater than three months) additional input from professional services to help the child attain their health or development potential.

For Baby A, the HPI was assessed as core by the health visitor at the initial visit. This was never changed.

By assigning as 'core' this meant that Baby A and Ms OP received the universal level of health visiting support. Assigning as 'additional' would result in receiving additional health visiting support.

⁸ [Cox, J.L., Holden, J.M., and Sagovsky, R. \(1987\) Detection of postnatal depression: Development of the 10-item, Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786](#)

⁹ [NHS Scotland \(2011\) A new look at Hall 4, the early years good health for every child](#)

Given Ms OP's previous history of post-natal depression and also concerns she expressed to the GP about Baby A's feeding and reflux, the case could have been assigned as 'additional'. Even if that had not been done initially, in later visits Ms OP also mentioned financial difficulties and relationship problems to the health visitor. Either at this stage and certainly after the GP referral in September 2014, we believe the case should have been assigned as 'additional'.

Involvement of the Social Work Department

Following Baby A's death, an initial case review was held by the Local Authority A child protection committee. The initial case review determines whether or not a significant case review is merited.

The initial case review meeting concluded unanimously that the criteria for conducting a significant case review by the local authority were not met and that the incident did not give rise to serious concerns about professional and/or service involvement or lack of involvement. We do not find fault with this decision.

Ms OP had contact with, and support from, the social work department when her other children were younger. No-one involved in the case, including the health visitor, CPN and GPs, identified any child protection issues or other concerns within or out with the family home that would have led to a referral to social work services.

Ms OP identified the childcare support she received when her middle child was a baby as having been helpful, and if she had regular ongoing contact with the health visitor or CPN this may have been identified as a need and arranged.

Views of Baby A's father

We had the opportunity to speak with Baby A's father, and we thank him for meeting us.

Fathers play a key role in the perinatal period, particularly the early detection of deteriorating mental health, so it is essential they are included in the care and treatment plan and offered support in their caring role.

This case was complicated in that Ms OP and her partner separated shortly after the birth of Baby A and by their own admissions their relationship was extremely strained. From around September 2014 communication between the couple was only through legal letter or e-mail.

Baby A's father knew Ms OP had suffered from postnatal depression previously, and as a couple they had discussed this. He was aware of her admission to Hospital 1 during her previous illness, but not aware of the severity of her illness at that time: he feels he should have been told how unwell Ms OP had been and particularly that she had thoughts of harming the children in that previous episode.

We understand his views about this. Unless Ms OP chose to tell him in detail about her previous history there was no indication for any of those working with her to share this information with him.

It is possible to breach the right to confidentiality if there are serious concerns about the welfare of a child. Ms OP had expressed thoughts about harming her children during her previous episode of illness but did not act on these. During this episode of illness she did not express any thoughts of harm to herself or his child to any professional. Divulging her previous history without her prior consent would have been a breach of confidentiality and there were no indications that this was necessary.

Views of Ms OP

We met privately and had an extended interview with Ms OP and we are grateful for her cooperation.

Ms OP was able to tell us about her previous episode of depression with her middle child. Although things were difficult when her middle child was very young, she felt the support she received at that time was helpful; regular contacts with a CPN, regular outpatient appointments and support with childcare.

Ms OP and her partner had planned to have a baby, and she was keen to let us know that Baby A had very much been a planned and wanted baby. Ms OP did not enter into pregnancy lightly, and thought long and hard about the difficulties she had had when her middle child was a baby and if she could cope if she became ill again.

Ms OP remembered feeling very stressed and low in mood, particularly as Baby A was getting older. She thought that as she was keeping her house in a good state, the children were well cared for and Baby A was flourishing, and she thought that this would perhaps have given an indication to others that all was well. She did wonder why other symptoms; her weight loss, repeated complaints of low mood and number of GP attendances etc were not picked up and acted on.

The involvement of the Postnatal Depression Service

The referral to the PDS counselling service came through a non-statutory agency, so whilst the therapy team were aware of her previous history of postnatal depression, they did not know of her previous thoughts of harm towards the children when unwell.

They were clear that Ms OP was not presenting to them with depressive symptoms that would cause them any particular concern. She was going through some difficult times, but appeared to be benefitting from the sessions.

We found the counselling service to be professional, very experienced and to have documented their interactions with Ms OP thoroughly.

Predictability and preventability

There is thought to be a 20-30% risk of recurrence of postnatal depression following a subsequent pregnancy.

Infanticide is extremely rare; however some studies suggest that thoughts of harming one's child are much more common.^{10 11}

During the period covered by this investigation, Ms OP at no time expressed to any care professional any thoughts of harm to herself or her children, either spontaneously or when questioned.

However, in her previous episode in 2006 and subsequent outpatient appointments, a noted feature was her initial good facade and ability to put on a good front when this was often masking depressive symptoms and thoughts of harming herself and her children.

Psychiatrist 2 was clear that perinatal mental illness generally follows similar timescales in subsequent pregnancies. The expectation, therefore, was that if Ms OP were to become unwell again following the birth of Baby A, this would follow a similar pattern to that which took place after the birth of her second child. This would suggest that depressive symptoms would appear within the first few weeks following the birth. This is noted in Psychiatrist 1's assessment letter which identified the need for close follow up, particularly in the first perinatal month.

It was clear that those who assessed her thought that Ms OP had an incompletely treated depressive illness very soon after the birth of her second child, with deterioration at around eight months, requiring admission to hospital. It was assumed that as she had not developed a depressive illness immediately after the birth of Baby A, there was less risk of illness developing subsequently and that ongoing monitoring by the specialist PNMHS was not required.

It was thought that Ms OP was past the stage that she had developed a depressive illness previously, so there was no ongoing requirement for perinatal expertise. It was not made clear, however, that referral should be made to general psychiatry should she become unwell at a later stage.

There were significant stressors following the birth of Baby A, a strained relationship between the parents and disagreements about access and custody, and these were documented by the different professionals who saw Ms OP.

¹⁰ Barr, J.A., Beck, C.T. (2008) Infanticide secrets: qualitative study on postpartum depression. *Canadian family physician* 54: 1716-1717

¹¹ Jennings, K.D., Ross, S., Popper, S., *et al.*, (1999). Thoughts of harming infants in depressed and non-depressed mothers. *Journal affective disorders* 54: 21-28

The NHS Board C significant adverse event review highlights that the PNMHS were very much focussed on biological symptoms of depression (e.g. sleep and appetite disturbance, poor concentration and memory loss) and appeared to take less of an overall view of the whole psychosocial situation.

However, with the level of staffing in the service, it would be extremely difficult to case manage women with significant postnatal mental illness as well as providing the longer term psychosocial role which might have been of benefit in this particular situation. The PNMHS are clear that they cannot provide this role and cannot keep patients on if they are not requiring, and actively engaged in, management of a particular episode of illness.

The service standards for perinatal community mental health services of the RCPsych PQN recommend that for women seen in pregnancy, a plan is developed and shared which documents the nature of the risk and condition. The risk assessment tool should be specifically designed for perinatal mental health services and should be updated every three months, or 'as appropriate' and at discharge. At the time of discharge, the standard is that the discharge letter will include an assessment of mental state as well as risk to mother and child. Women at high risk should be seen regularly until the period of maximum risk has passed.

Psychiatrist 2 informed us that the service had invested in an electronic risk assessment tool that could not be integrated with the NHS Board C IT systems, and noted that even with a specific perinatal risk assessment, there may have been little change in risk scores in Ms OP's case. Risk assessments would have highlighted her past significant history, and other 'static' risks, but may have been less good at identifying day-to-day changes in mental state.

The NHS Board C SAER found that 'the patient was discharged by the PNMHS following telephone consultations and with no formal risk assessment having been undertaken.' It recommended 'an evidence based assessment and evaluation tool' and that the service policies and procedures 'standardise risk assessment.'

The NHS Board C's improvement plan notes FACE Assessment Tool has now been introduced.

NHS Board C SAER

The terms of reference for this investigation include assessing the quality of the SAER completed by NHS Board C. We have also received an action plan in relation to these recommendations.

The majority of those we met who had seen the SAER commented that it was a robust investigation and the report was critical but fair, and appropriate learning points identified.

We agree with the key findings and recommendations in the NHS Board C SAER and these can be found in [Appendix one](#). The Commission's investigation team has identified some further issues, reflecting the fact that our remit was wider than the internal review.

The Commission has been in regular contact with NHS Board C who have confirmed that the majority of the recommendations have now been completed. The Commission will continue to liaise with NHS Board C in relation to completion of the outstanding recommendations.

MWC key findings

There was very limited communication between the different agencies involved in Ms OP's care and treatment. There was no contact at any time between the health visitor and the PNMHS.

There were missed opportunities for referral to the PNMHS and to adult mental health service. Although there was some uncertainty by GPs over the age criteria for referral to the PNMHS, this did not preclude referral to adult mental health services for assessment if indicated.

There was significant and unacceptable delay in sending both the initial PNMHS assessment letter and the subsequent CPN discharge letter to the GP. The discharge letter did not meet the requirements of the RCPsych PQN standards in relation to discharge letters.

Following assessment in November 2013, there was no further contact with a psychiatrist and the discharge by the CPN from the service in August 2014 was not discussed with anyone else in the PNMHS before discharge.

Psychiatrist 1 identified postnatal risks and documented these in a letter to the GP. Because of the way this information was entered into the GP clinical system and the number of consultations Ms OP attended, it is unlikely that anyone seeing Ms OP after April 2014 would have paid attention to the letter.

The assessment letter written by Psychiatrist 1 was thorough and detailed, containing most of the information recommended in the SIGN guideline for a detailed plan for early postnatal psychiatric management. However, the risk management plan could have been more explicitly highlighted in the letter.

A pre-birth planning meeting would have highlighted the history, risks and appropriate management plan to all involved and might have reduced the risk of this information being 'lost' within the GP system. The PNMHS holds pre-birth planning meetings for women considered to be at high risk of abrupt onset of psychosis postnatally. Although Ms OP did not have a psychotic illness previously, there were significant risk issues following a previous pregnancy.

Ms OP's mood was assessed at each contact by the CPN but she was not routinely asked about thoughts of harm to herself or the children. Given her previous history it would have been appropriate to enquire about these thoughts at each professional contact.

The health visitor was aware of the previous history of postnatal depression, but not aware of Psychiatrist 1's assessment and Ms OP's previous history of thoughts of harming herself and her children when unwell. Psychiatrist 1's letter indicates it was copied to the health visitor, but we found no evidence of this in the health visitor notes.

There was no system to follow up on referrals made by the GPs to the health visitor or other services.

There was a high number of different GP contacts which created difficulty in ensuring adequate arrangements for continuity of care.

At the time that Ms OP had contact with the PNMHS, concerns had been raised about the team's resources and their ability to achieve the RCPsych PQN standards. The SAER identified there was no dedicated nurse team leader responsible for the direct management and supervision of nursing staff in the community team, but did not highlight any other deficit in the team's resources. These had previously been raised during independent reviews of the service and we do not feel these have been adequately addressed in NHS Board C's SAER.

The case should have been allocated an additional health plan indicator which would have provided more continuous health visitor involvement than was provided on a core programme.

There was an unacceptable delay of four weeks from the point of GP referral to the health visitor meeting with Ms OP.

There was no record made by the CPN of professional advice given.

Review following prescription of antidepressants was not in keeping with NICE guidance.

Recommendations

All joint health and social care bodies

All joint health and social care bodies should:

(For health board areas that have perinatal mental health services) ensure that there is enough flexibility in referral criteria so that women with significant histories who have been seen within the service can be re-referred until the child is one year of age.

Ensure that there are clear pathways to access specialist perinatal mental health expertise within their board area, including pathways for urgent assessment by local mental health teams as appropriate.

Ensure that specialist perinatal mental health services complete a late pregnancy and early postnatal care plan in late pregnancy (28-32 weeks) for women at high risk of postnatal major mental illness, as detailed in Sign Guideline 127. This should be shared with maternity services, community midwifery team, GP, health visitor, mental health services and the woman herself. All letters should be structured in a way that highlights the risk and management plan at each contact.

Ensure GP systems identify and highlight risks from perinatal mental health service assessments, these are Read¹² coded and alerts set up on practice systems including a Key Information Summary (KIS)¹³ to capture and share information.

Review IT systems and consider the use of electronic referral systems, for example using the SCI gateway system¹⁴. Ensure that general practices review and consider improvements to their IT systems. This could include having two PC monitors to allow access to different electronic systems simultaneously. This would allow access to the GP clinical system and document management systems at the same time and reduce the risk of missing important information toggling between two systems on one screen.

Ensure GP practices, particularly large practices, consider identifying a “go-to” GP with a particular interest in perinatal mental health. This may help minimise inconsistencies in the approach and response of different GPs to perinatal mental health issues.

¹² Read codes are a clinical coding system widely used in the NHS since 1985.

¹³ The Key Information Summary (KIS) is a collection of information about a patient that is extracted from the GP clinical record and can be accessed by out of hours services and ambulance services so that key information can be shared (with the patient's consent)

¹⁴ SCI Gateway is an IT system that allows referrals to be sent from GPs to the appropriate service electronically

Review the protocols in place between primary care, specialist teams and other agencies to ensure effective communication and information sharing.

Ensure that there is local good practice guidance on discharge planning in keeping with the Service Standards developed by the RCPsych PQN.

Ensure that patients treated with antidepressants are reviewed in line with NICE and local good practice guidance.

For NHS Board C

In addition to the recommendations made in the NHS SAER we recommend that NHS Board C should:

Review the remit and staffing of the perinatal mental health service community team to ensure they can work towards meeting the quality standards of the perinatal network.

Review the PNMHS referral criteria to ensure that there is enough flexibility so that women with significant histories who have been seen within the service can be re-referred until the child is one year of age.

For Scottish Government

Priority should be given to establishing a national managed clinical network as recommended in SIGN 127 (2012) which states:

'A national managed clinical network for perinatal mental health should be centrally established in Scotland. The network should be managed by a coordinating board of health professionals, health and social care managers, and service users and carers. The network should:

Establish standards for the provision of regional inpatient specialised mother and baby units, community specialised perinatal teams and maternity liaison services.

Establish pathways for referral and management of women with, or at risk of, mental illness in pregnancy and the postnatal period.

Establish competencies and training resources for health professionals caring for pregnant or postnatal women with, or at risk of, mental illness, at levels appropriate to their need. Ensure that all pregnant and postnatal women with, or at risk of, mental illness have equitable access to advice and care appropriate to their level of need.'

Royal College of General Practitioners (RCGP) Scotland

The RCGP and the Centre for Mental Health in England produced a report, 'Falling through the gaps' in 2015.¹⁵ This report highlights the role of GPs in disclosure, identification and support of women who develop a mental illness in the perinatal period. The recommendations are equally pertinent to Scotland and we would recommend that the RCGP Scotland make similar recommendations to the Scottish Government.

The establishment of a managed clinical network would be well placed to lead on and advise how these recommendations could be implemented.

¹⁵ <https://www.centreformentalhealth.org.uk/falling-through-the-gaps>

Conclusion

This was a tragic case for all concerned. Whilst the number of women who kill their babies when unwell is extremely low, the devastating effect on the family and others cannot be underestimated. We must learn lessons from events such as this in order to reduce the risk of similar events occurring in the future.

During the course of our investigation we found several aspects of Ms OP's care and treatment that should have been better. There were a number of factors which, if addressed, would have increased the likelihood of Ms OP receiving appropriate care and treatment for her depression at an earlier stage.

Considering the number of people, agencies and services involved; there was very little communication between them, and it is unlikely anyone really had an overview of what was going on.

Ms OP often presented with a good facade and she did not express to any care professional any thoughts of harm to herself or her children either spontaneously or when being questioned directly. This gave unfounded reassurance to those who were in contact with her.

This case highlights the risk of clinicians relying on reassurances about thoughts of self-harm or harm to the children; particularly when mothers worry that judgements may be made about their ability to care for the child in the longer term.

It is vital that services identify women of childbearing age who are at high risk of perinatal mental illness if they become pregnant. The risks identified by Psychiatrist 1 in Ms OP's previous pregnancy should she become unwell again were not sufficiently highlighted to those who could have made a difference.

The combination of a previous history of thoughts of infanticide in the first postnatal year and deteriorating mental health during a time of stressful life events should have alerted those involved to the need for increased vigilance and support.

NHS Board C have taken steps to reduce the likelihood of a similar occurrence and indeed the recommendations made for GPs and others will be helpful in other cases, not just those of perinatal mental illness. However each case is unique and an increased awareness in those professionals who are most likely to effect change is required.

APPENDIX 1

NHS Board C review key findings

- Significant postnatal risks were identified at prenatal clinical assessment but these were not set out in a risk management plan.
- Known risks were not included in key information summaries (KIS) or READ coded.
- There was no clear identification of a relapse signature (description of the signs and symptoms specific to the patient, including the order in which they occurred previously). This was not flagged to GPs in subsequent consultations.
- The community PNMHS had no standard operating procedures including initial assessment and discharge planning procedures and standards with routine MSE.
- The patient was discharged by the community PNMHS following telephone consultations with no formal risk assessment having been undertaken.
- There was no dedicated nurse team leader responsible for the direct management and supervision of the nursing staff in the community PNMHS.
- There was no formal supervision of this case by a consultant psychiatrist; this was subject to the professional judgement of the CPN who had access to consultant advice and support and the opportunity of weekly discussion and supervision.
- There was a three month delay in dictating and issuing the discharge notification to GPs, the letter arriving after the patient first presented to a GP with depression.
- The discharge letter was lacking in detail, did not refer to the identified risks or provide a clear set of actions should there be a change in mental status.
- The patient did not disclose at any point that she had thoughts of harming children or herself despite being asked on numerous occasions.

An improvement plan was put in place to address these issues and the recommendations made included

- The community PNMHS appoints a nurse team leader to provide leadership and supervision to the community nursing staff and to work collaboratively with the community PNMHS consultant psychiatrist (implemented September 2015).
- The community PNMHS develops a set of comprehensive policies and procedures and adheres to evidence based assessment evaluation tool (introduced September 2015).
- The community PNMHS standardises its letters to GPs and others to ensure clear recommendations to manage identified risks including the use of alerts in general practice and for those risks to be included in key information summaries for access by out of hours service.

- NHS Board C issue guidance to all GPs that when receiving such identified risks from PNMHS, they set up alerts in vision and EMIS to record high risk associated with postnatal depression.
- NHS Board should recommend to all health boards in Scotland that they implement similar guidance for alerts and KIS. The recommendations are developed into an improvement plan by the management team.
- The community PNMHS develops refresher training available for health visiting, community midwifery and other appropriate healthcare staff to ensure a full understanding of the risks associated with PND and mental illness and their role in identifying and communicating such risks, and the role of the community PNMHS.
- Learning from the adverse event review be shared with those involved in the care of the patient and any support needs identified through reflective practice and clinical supervision.
- NHS Board should recommend to all health boards in Scotland that they implement similar guidance for alerts and KIS. The recommendations are developed into an improvement plan by the management team.

APPENDIX 2

About perinatal mental health

Depression and anxiety affect between 10 and 15% of women during pregnancy and in the first postnatal year.¹⁶

Severe perinatal mental illnesses, requiring input from specialist perinatal services, are not common. Research suggests the following rate of severe perinatal illnesses per 1000 maternities. Severe perinatal illness can be unpredictable: symptoms may develop very rapidly (over hours or days), fluctuations are common and risks can be significant.

Postpartum psychosis	- 2 per 1000
Chronic serious mental illness	- 2 per 1000
Severe depressive illness	- 30 per 1000

Postpartum psychosis is a severe mental illness that typically affects women in the week following birth and causes symptoms such as confusion, delusions, paranoia and hallucinations. The early postpartum period in particular is the time of highest risk in a woman's life for developing psychotic illness.

The effect of these illnesses can be devastating if they are not recognised and treated promptly. Perinatal mental illness may affect any woman during pregnancy or the postpartum year. Women with a history of significant depressive illness or postnatal depression are at increased risk of this recurring in subsequent pregnancies.

For women identified as being at risk, the risks of illness can be reduced through careful monitoring, preventative treatment where appropriate and early intervention with specialist support if symptoms arise. If symptoms are recognised and treated promptly, the impact of illness can be minimised.

Mental health assessment should include a review of previous history and take into account the findings of recent presentations and escalating patterns of abnormal behaviour.

Partners and other family members may require explanation and education regarding maternal mental illness and its accompanying risks.

¹⁶ [Getting it Right for Mothers and Babies. Closing the Gaps in Community, PNMHSs. NSPCC Scotland, Scotland Maternal Mental Health, April 2015.](#)

Saving lives, improving mothers care published in 2015 identified the following as red flag signs for severe maternal illness that require urgent senior psychiatric assessment.¹⁷

- Recent significant change in mental state or emergence of new symptoms.
- New thoughts or acts of violent self-harm.
- New and persistent expressions of incompetency as a mother or estrangement from the infant.

It recommends admission to a mother and baby unit should always be considered where a woman has any of the following

- Rapidly changing mental state.
- Suicidal ideation (particularly of a violent nature).
- Pervasive guilt or hopelessness.
- Significant estrangement from the infant.
- New or persistent beliefs of inadequacy as a mother.
- Evidence of psychosis.

Scotland has made provision in law for the care of mothers and their babies. Part 4 Section 24 of the Mental Health (Care and Treatment) (Scotland) Act 2003¹⁸ places a duty on health boards to provide “services and accommodation” for mothers who care for, and wish to be admitted to hospital with, their baby providing this is “not likely to endanger the health or welfare of the child”.

There are two specialist inpatient mother and baby units in Scotland. One in St John’s Hospital at Livingston¹⁹ and one at Leverndale Hospital in Glasgow²⁰. In 2013 a total of 96 women were admitted across the two units.

Mental illness remains one of the leading causes of maternal death in the UK.

Nationwide confidential enquiries into maternal deaths have been carried out since 1952. The latest confidential enquiry (December 2015) focussed on mental health and found that one in seven of all women who died during pregnancy or the postpartum year died by suicide. Almost a quarter of all women who died between six weeks and one year after pregnancy died from mental health related causes.

¹⁷ [Maternal, New Born and Infant Clinical Outcome Review Programme. Saving Lives, Improving Mothers’ Care. Surveillance of Maternal Deaths in the UK 2011-2013 and Lesson Learned to Inform Maternity Care from the UK and Ireland Confidential Inquiries into Maternal Deaths and morbidity 2009-2013. MBRRACE – UK December 2015](#)

¹⁸ <http://www.legislation.gov.uk/asp/2003/13/section/24>

¹⁹ <http://www.westlothianchcp.org.uk/article/2982/Perinatal-Unit>

²⁰ <http://www.nhs.gov.uk/your-health/health-services/mental-health-services/services/other-services/west-of-scotland-mother-baby-unit/>

Suicide has remained one of the leading causes of maternal mortality for over two decades. Extended suicide, involving both mother and baby, remains rare, as does infanticide. One of the main challenges to all health professionals is that the presentation of perinatal mental illnesses can be different from that of similar illnesses in the general adult population. Severe perinatal illness can be unpredictable: symptoms may develop very rapidly (over hours or days), fluctuations are common and risks can be significant.

Risks for babies

Evidence consistently demonstrates the importance of early relationships for babies' development, both cognitively and emotionally. It is now widely recognised that infant mental health is important. The potential impact of maternal mental illness needs to be considered when treating both a mother and her baby.

Extended suicide where a baby dies with the mother is a very rare occurrence. In the cases that were investigated, all of the women had a diagnosis of depressive disorder. There had been no expressions of thoughts of harm toward the baby. In the majority, there were child safeguarding issues which may have acted as a precipitant for the act.

Cases of maternal infanticide are also very rare. Non-psychotic depressed women are unlikely to commit infanticide. Should they do so, they are more likely to kill for what they consider altruistic purposes.





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