The UK and Ireland Confidential Enquiries into Maternal Deaths

What they tell us about our management of perinatal mental illness

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MBRRACE-UK

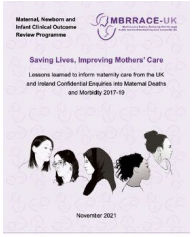
Perinatal Mental Health Network Scotland
National Managed Clinical Network

NHS
National Services Scotland

1. Background to the Confidential Enquiries

2. Lessons learned

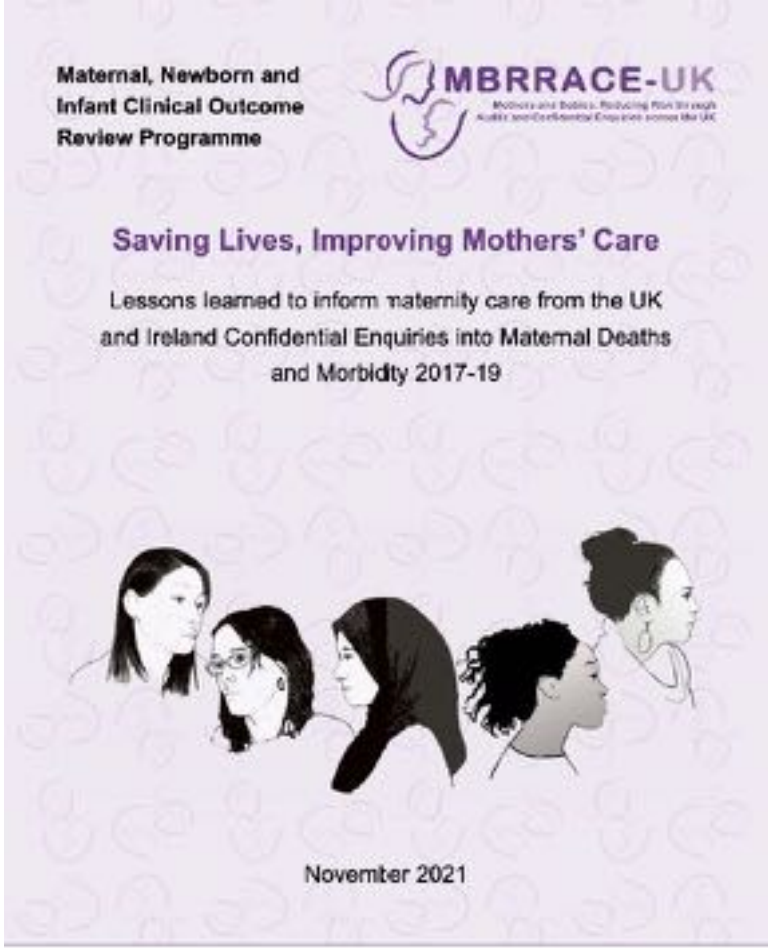
3. Maternal suicide and perinatal mental illness as a ‘template’ for risk management in general



- Quantitative and qualitative methodology
- Standardised reports, case note audit (but limited mental health notes access)
- All maternal deaths, incl. late deaths and data linkage
- Clinicopathological evaluation of cause of death

Recurrent findings

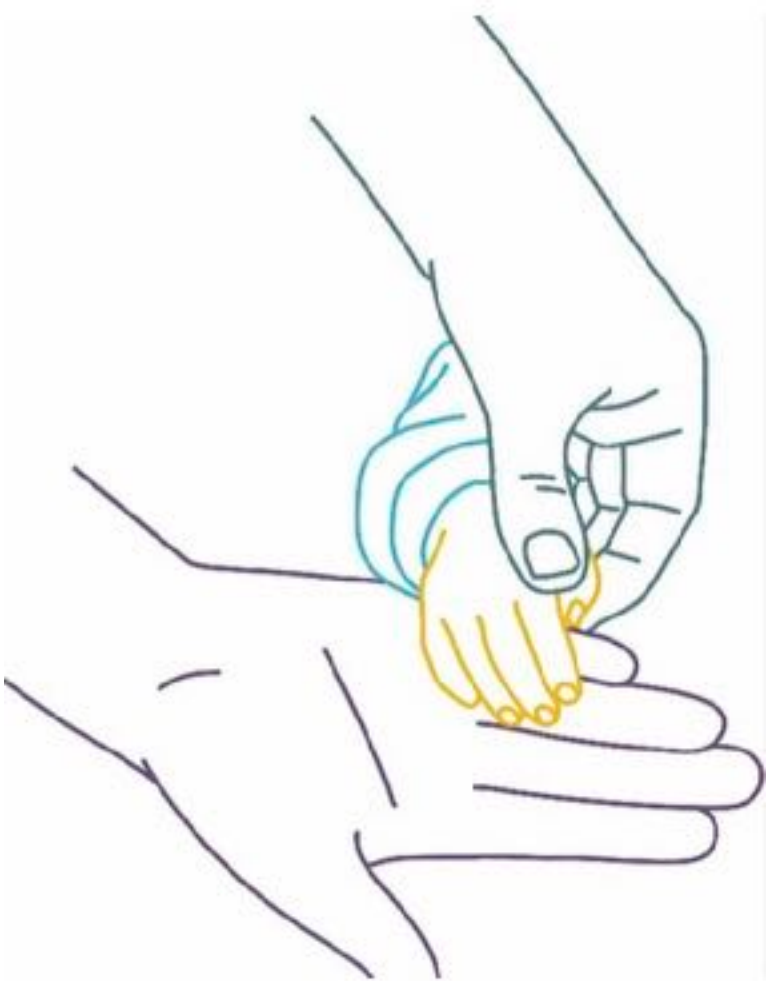
- Suicide one of the leading causes of maternal death
- Majority have mood disorders
- 2/3rds received sub-optimal care

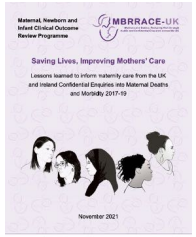


The women who died

"The methodology used by the Enquiry goes beyond counting numbers. Its philosophy, and that of those who participate in its process, is to recognise and respect every maternal death as a young woman who died before her time, a mother, a member of a family and of her community. It does not demote women to numbers in statistical tables; it goes beyond counting numbers to listen and tell the stories of the women who died so as to learn lessons that may save the lives of other mothers and babies, as well as aiming to improve the standard of maternal health overall."

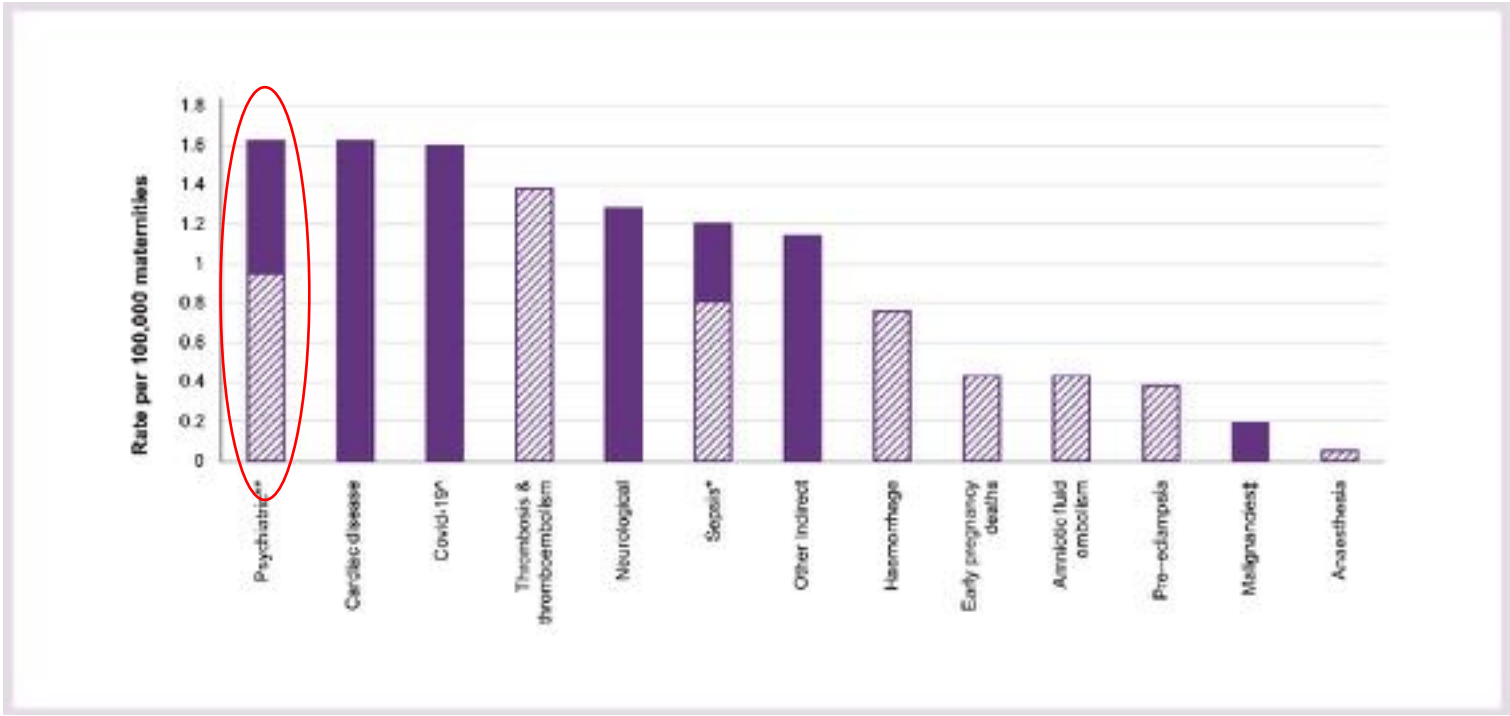
Gwyneth Lewis
Past Chair, Saving Mothers Lives Writing Panel

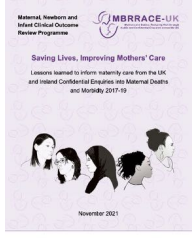




Maternal mortality by cause

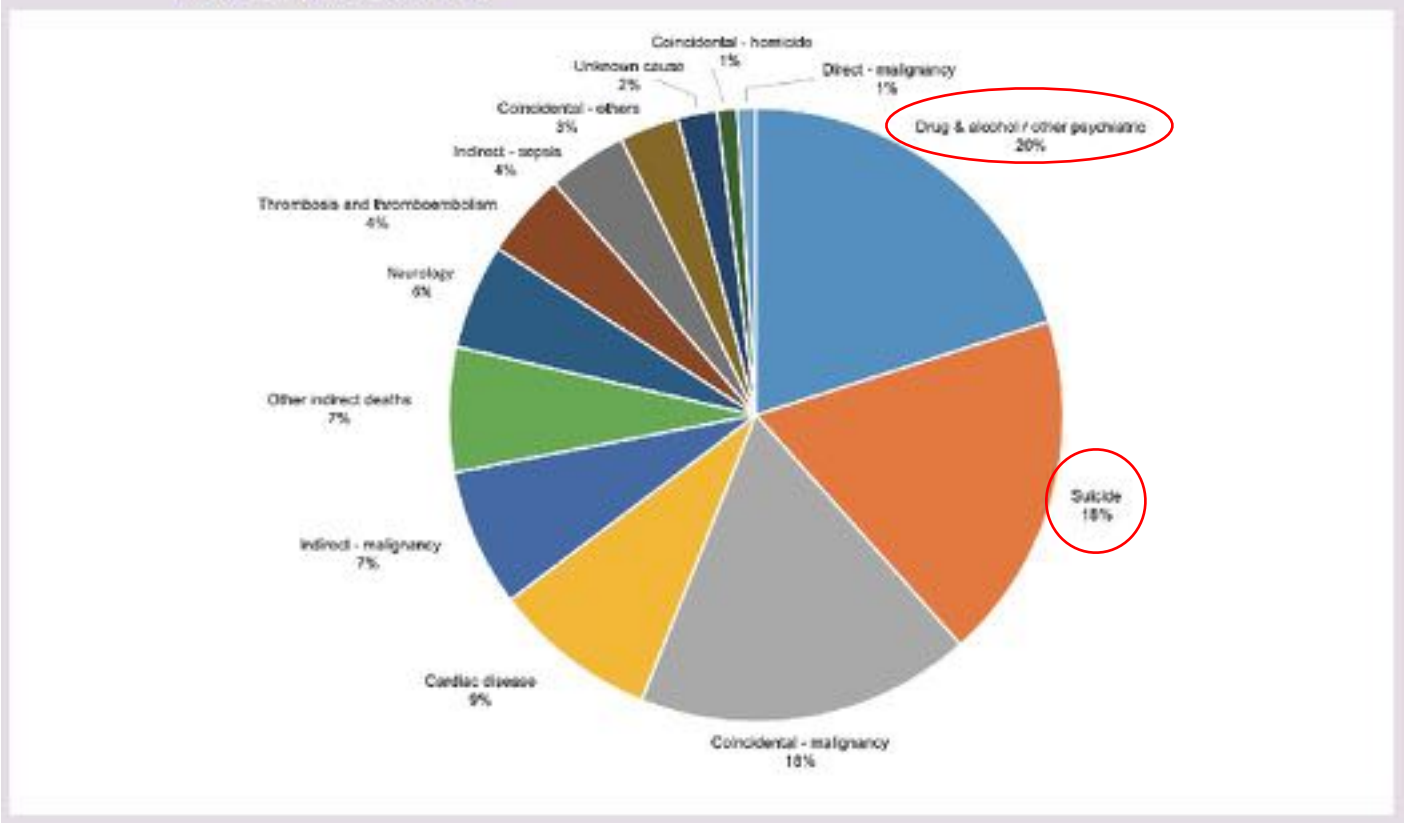
SLIMC 2022

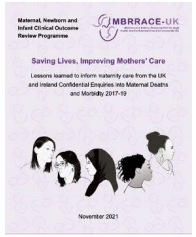




Cause of death (six weeks - one year)

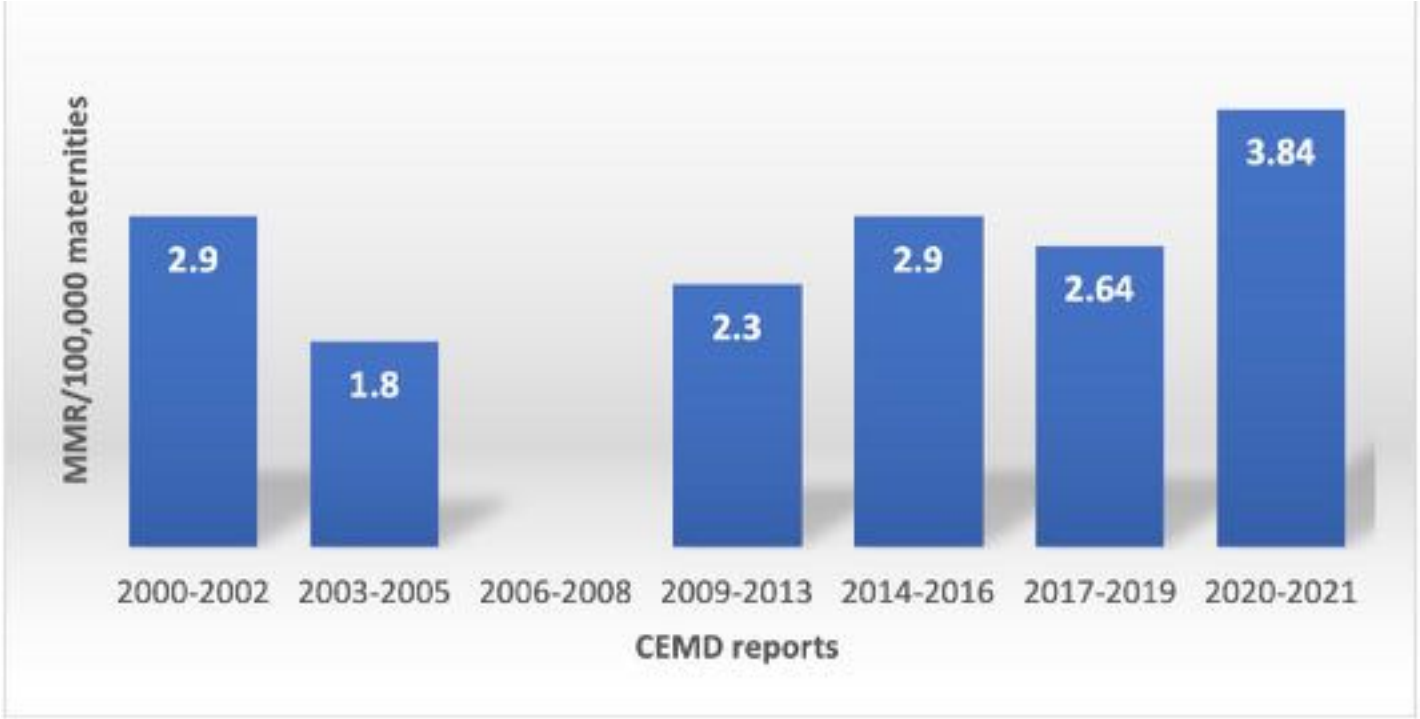
SLIMC 2022





Maternal mortality rates - suicide

CEMD 2000-2021



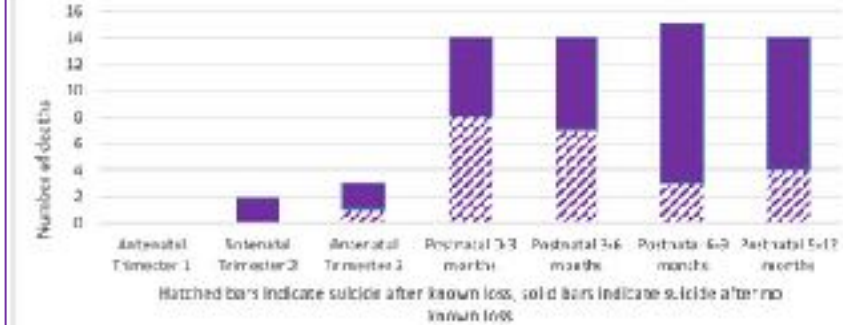
Mode and timing of suicide

SLIMC 2021

Table 4.3: Mode of death by suicide, UK and Ireland 2017-19

Mode of death	Number of women (%) N=58
Hanging	36 (62)
Overdose	11 (19)
Traffic/train	5 (9)
Fall from height	3 (5)
Carbon monoxide poisoning	1 (2)
Drowning	1 (2)
Suffocation	1 (2)

*For 4 women the mode of suicide could not be ascertained



Underlying diagnosis

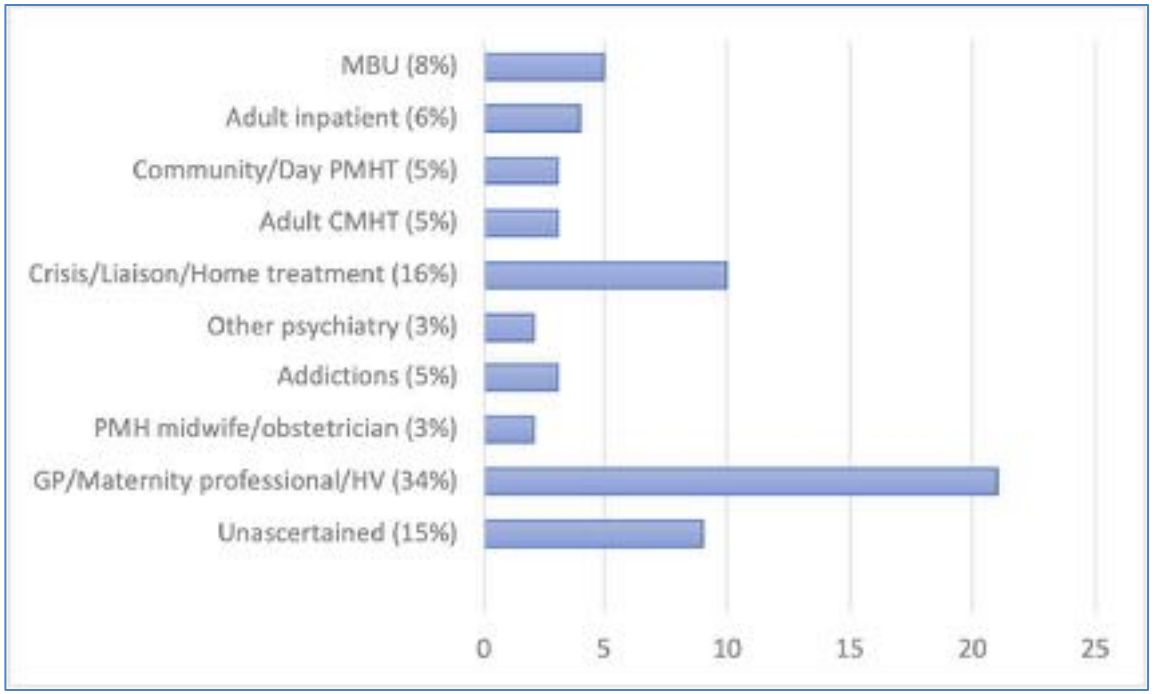
SLIMC 2021

UNDERLYING DIAGNOSIS	N (%)
Sufficient information to establish diagnosis	47* (100)
Previous treatment for mental ill health in primary or secondary care	40 (85)
Depressive disorder (incl. 6 probable/definite psychosis)	26 (55)
All probable or definite psychosis • Depressive disorder (6) • Postpartum psychosis (3) • Bipolar affective disorder (2) • Schizophrenia/schizoaffective disorder (2)	13 (28)
Substance misuse	4 (9)

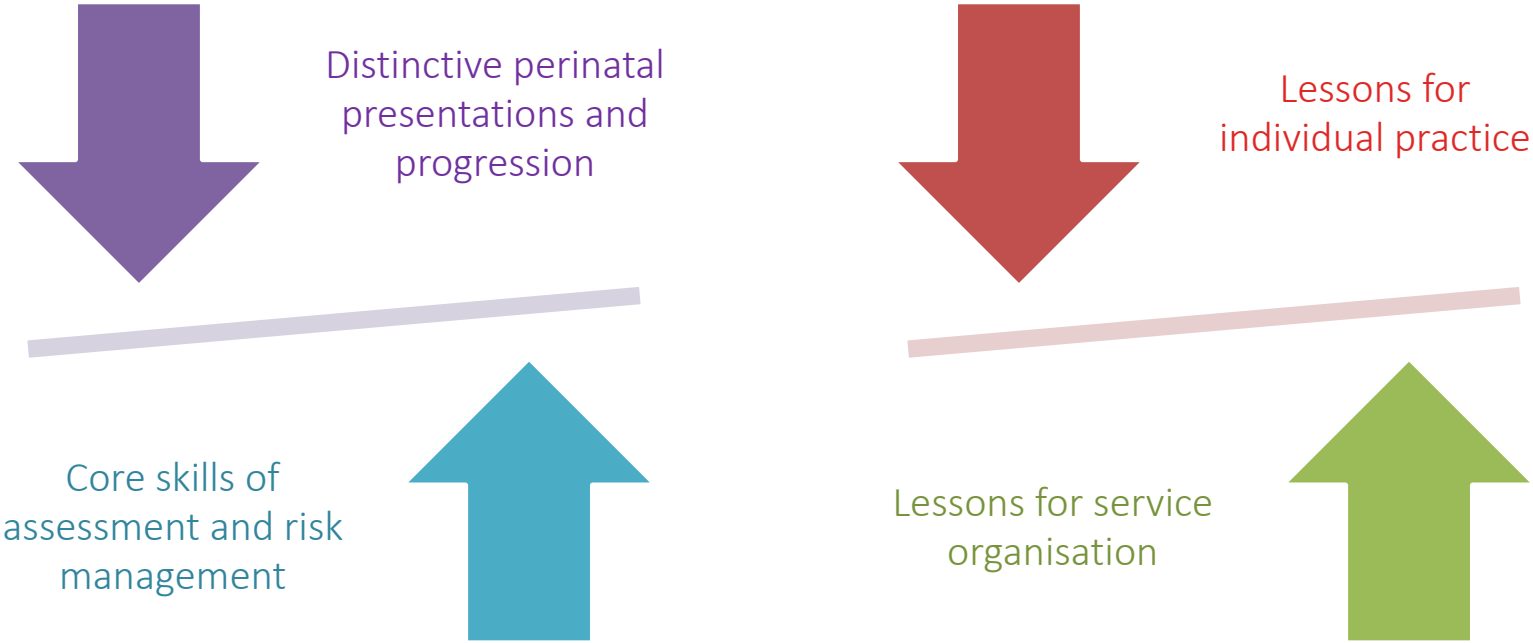
*Total suicides - 62

Highest level of care

SLIMC 2021



Lessons learned from the Enquiries

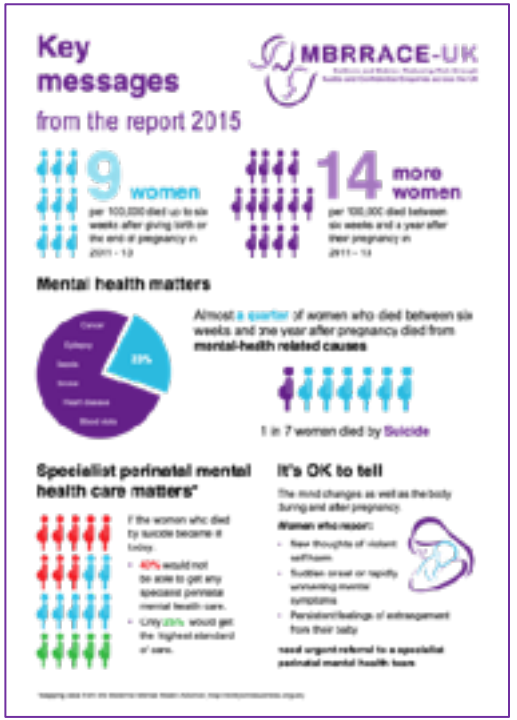


Red Flags

SLIMC 2015

INDICATORS OF SUICIDE RISK

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



Key messages from the report 2015

MBRRACE-UK

9 women

14 more women

Mental health matters

Almost a quarter of women who died between six weeks and one year after pregnancy died from mental-health related causes

1 in 7 women died by Suicide

Specialist perinatal mental health care matters*

It's OK to tell

Symptom pattern/ progression

Older woman, no past psychiatric history

Day 7 Weepy and anxious
Day 11 Crisis team involved; agitated; not sleeping; overvalued ideas of guilt and incompetence
Day 12 Midwife has problems contacting psychiatrist
Day 13 Death by violent means

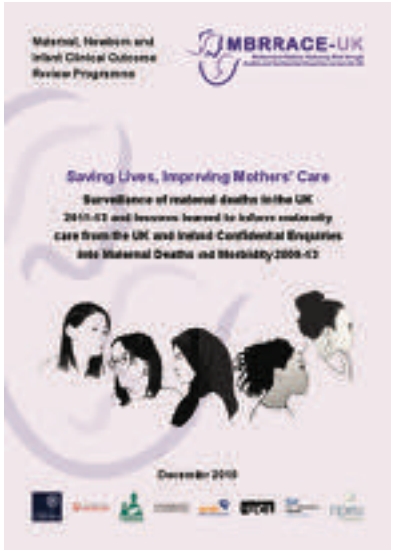
SML, 2006-08

A woman in her 30s died violently within two months of the birth of her first baby. She had no previous psychiatric history but developed what appeared to be rapid onset anxiety and depressive symptoms three weeks after giving birth. She became more depressed with preoccupation about her baby's health and her belief that she was inadequate as a mother. She self-harmed by lacerating her arm and was described as guarded in most assessments. The offer of admission to a Mother and Baby Unit was declined and she was managed by the home treatment team.

SLIMC, 2017-2019

Mental state change and risk assessment / management

SLIMC 2015



‘Anxiety’ at first presentation

Lack of recognition of escalating symptom pattern

Assessments of serial presentations ‘in the moment’

Use of terms such as ‘impulsive’, ‘no planning’, ‘children protective’ when assessing suicide risk behaviour

Reliance on patient reports despite evidence to the contrary

Diagnostic 'stickiness'

Risk assessment of mental state change

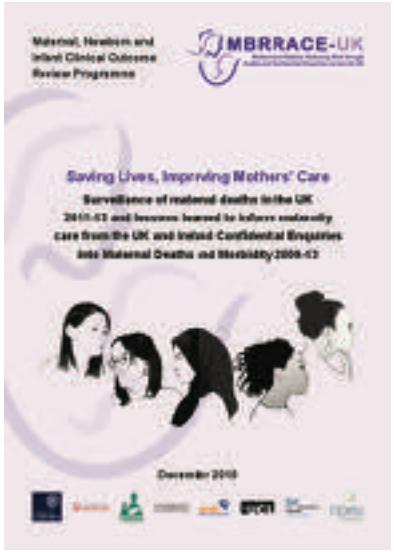
A woman died from violent causes some weeks after delivery. Throughout her normal pregnancy she became increasingly anxious and, by the end of pregnancy, had bizarre delusional beliefs about her health. At no point was psychiatric referral considered. Following delivery, her mental state deteriorated, and she self-presented to the Emergency Department agitated and expressing bizarre beliefs about her health. Her symptoms were clearly documented at her psychiatric assessment but a diagnosis was made of an anxiety state. The community mental health team to whom she was referred declined to accept her. She died shortly afterwards.

SML, 2006-08

Thoughts / acts of violent self-harm

Woman with prior depression in postnatal period

SLIMC 2015



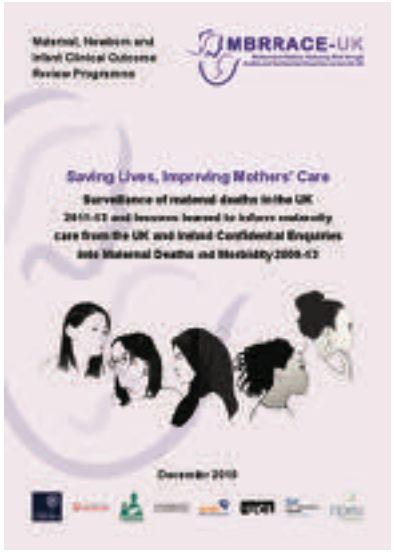
Prior history of PND and again after this child → Found on bridge with rope few weeks after birth

A/E – 'no ongoing suicidal intent' → Local review – 'death completely unexpected'

Estrangement from the infant

Woman with no prior psychiatric history

SLIMC 2015



GP within 12 days – depressed mood and wishing baby adopted → Repeated thoughts of ending her life to health visitor

Talked of going overseas, killing herself, not loving baby but evidence to contrary → Death by violent means within a few weeks of birth

Amber Flags

SLIMC 2017

INDICATORS OF RISK OF RECURRENCE

Any past history of psychotic disorder

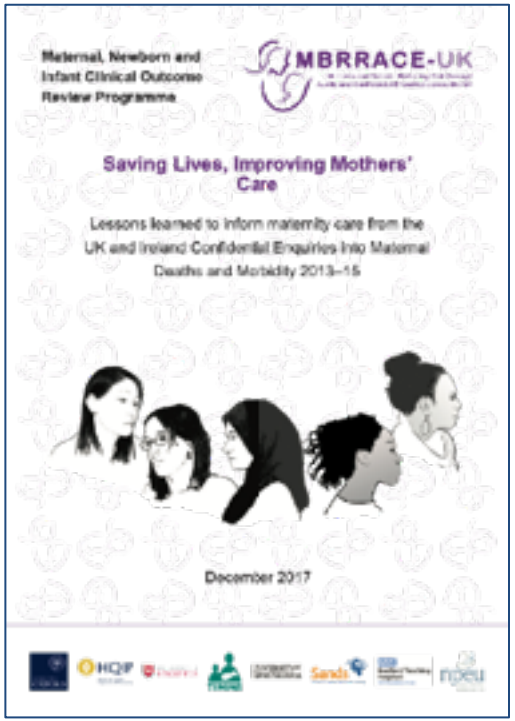
1

2

Close monitoring if family history / refer if + current mood disorder

Personal and familial patterns of (re)occurrence

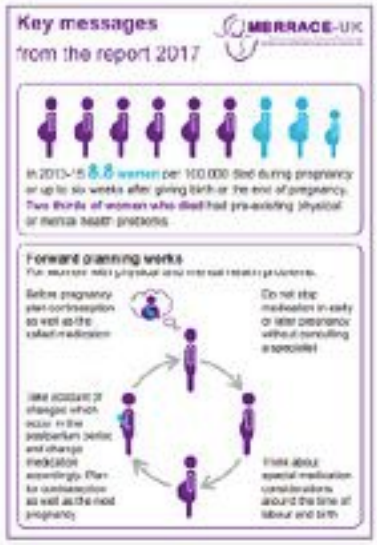
3



Forward planning for future risk

Misattributing risk

SLIMC 2017



A woman experienced postpartum psychosis, requiring MBU admission, after the birth of her first child.

Her delivery had been traumatic with significant blood loss.

At the point of MBU discharge her illness was explained to her as being due to her traumatic delivery and that she could be seen in future pregnancy ‘should further problems arise’.

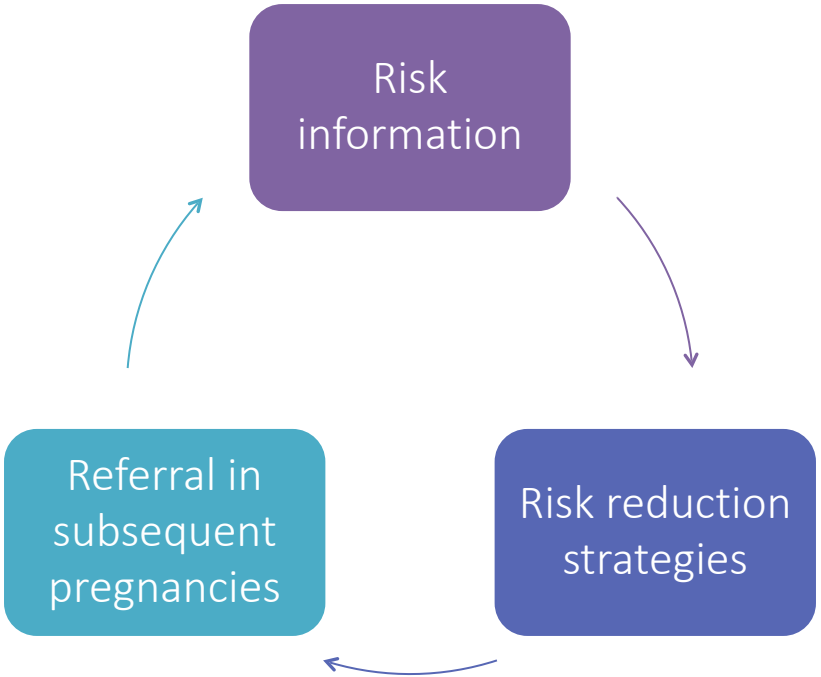
Forward planning for future risk

2017

RECOMMENDATIONS

Following recovery, it is the responsibility of the treating team to ensure that all women experiencing postpartum psychosis receive a clear explanation of:

1. Future risk
2. Availability of risk minimisation strategies
3. Need for re-referral during subsequent pregnancies



Other themes

- Communication, documentation and information sharing
- Grade of assessor
- Consideration of inpatient care
- Care by multiple teams
- Partner / family involvement
- Loss or threatened loss
- Leave and early discharge vulnerability
- Education and training for non-specialist staff
- Misdiagnosis/misattribution of physical symptoms

Consideration of inpatient care

Rapidly changing mental state

Violent suicidal ideation

Pervasive guilt

Estrangement from infant

Psychosis

Care by multiple teams

Evidence of psychotic depression in months before death- 2 overdoses with suicidal intent

Seen by at least 5 different mental health teams, each reaching different conclusions

E.g., on three consecutive days:

Day 1 (Team A)	Day 2 (Team B)	Day 3 (Team C)
Symptoms of psychosis	'No role' for mental health team	Admission with suicidal thoughts

Partner/family involvement

Failure to listen to relatives

Failure to educate relatives about seriousness of perinatal mental illness

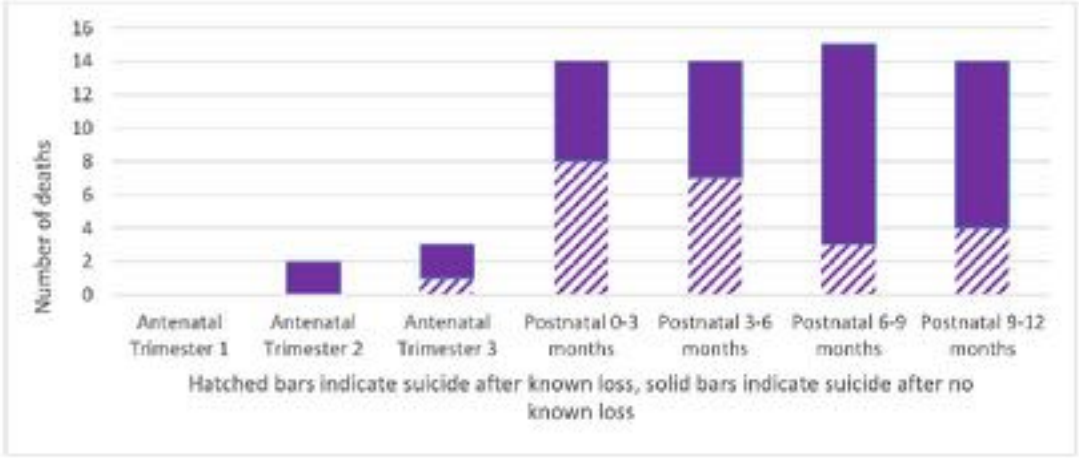
Asking relatives to manage risk at inappropriate levels

Partner/family involvement

A woman died of an overdose several months after termination of pregnancy. She had developed a range of physical health concerns and received repeated investigations, but the possibility of a mental health cause does not appear to have been considered. Her family became increasingly concerned for her mental state and contacted her GP repeatedly describing a range of depressive symptoms and social withdrawal consequent on her physical health worries, which prevented her from going out. She had indicated to the GP that she did not want information about her health disclosed to her family and, for that reason, the GP would not see her relatives. Accounts were given to the practice of her engaging in self-harm and the family attempted to communicate their fear that she might end her life. They had contacted a mental health professional who also alerted the GP to their concerns, but she died on the same day.

SLIMC, 2017-2019

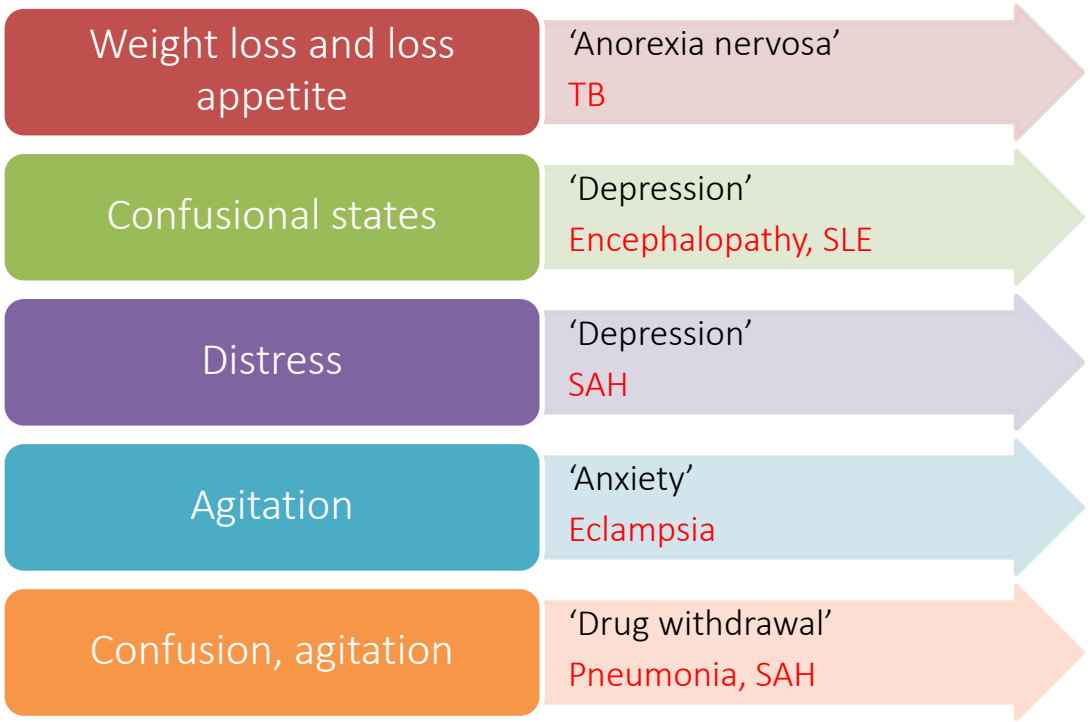
Loss or threatened loss



SLIMC 2021

- Pregnancy or neonatal loss
- Child protection proceedings or removal into care
- Delayed or refused termination

Misdiagnosis / misattribution of physical symptoms



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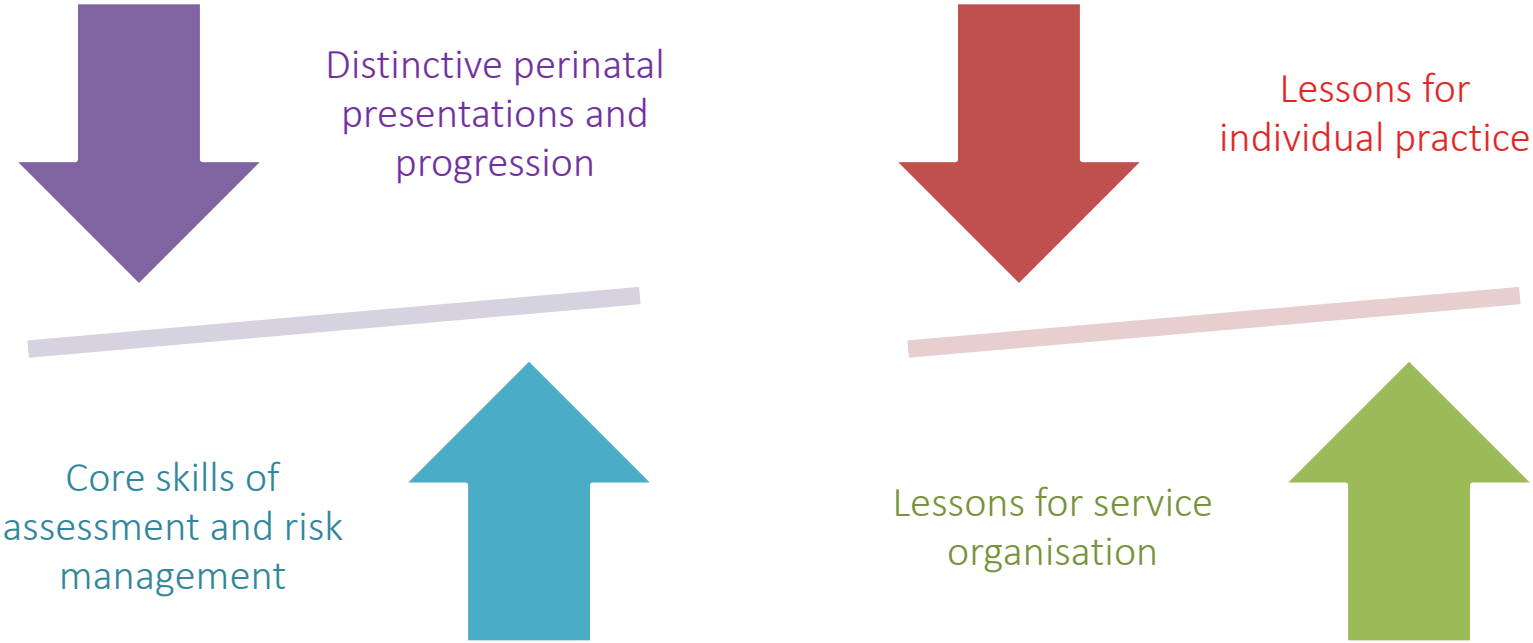

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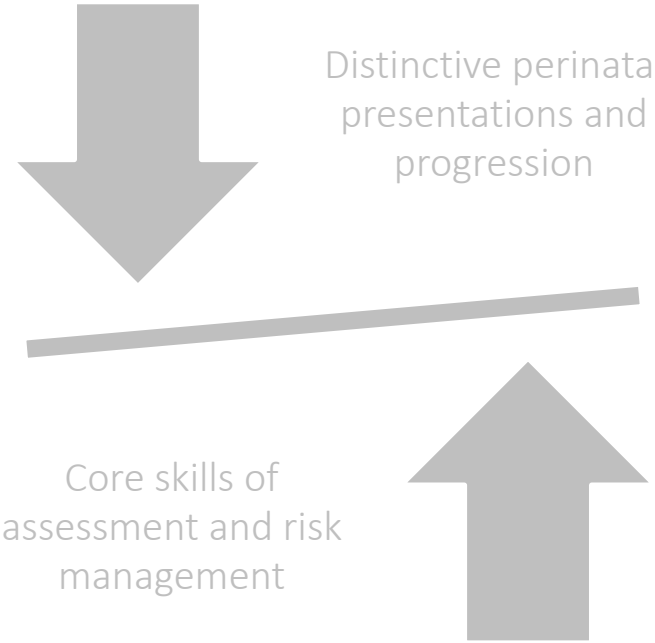
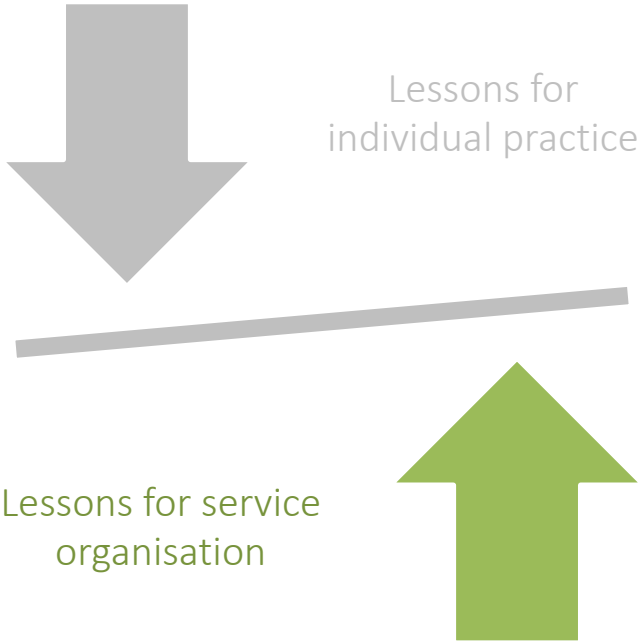
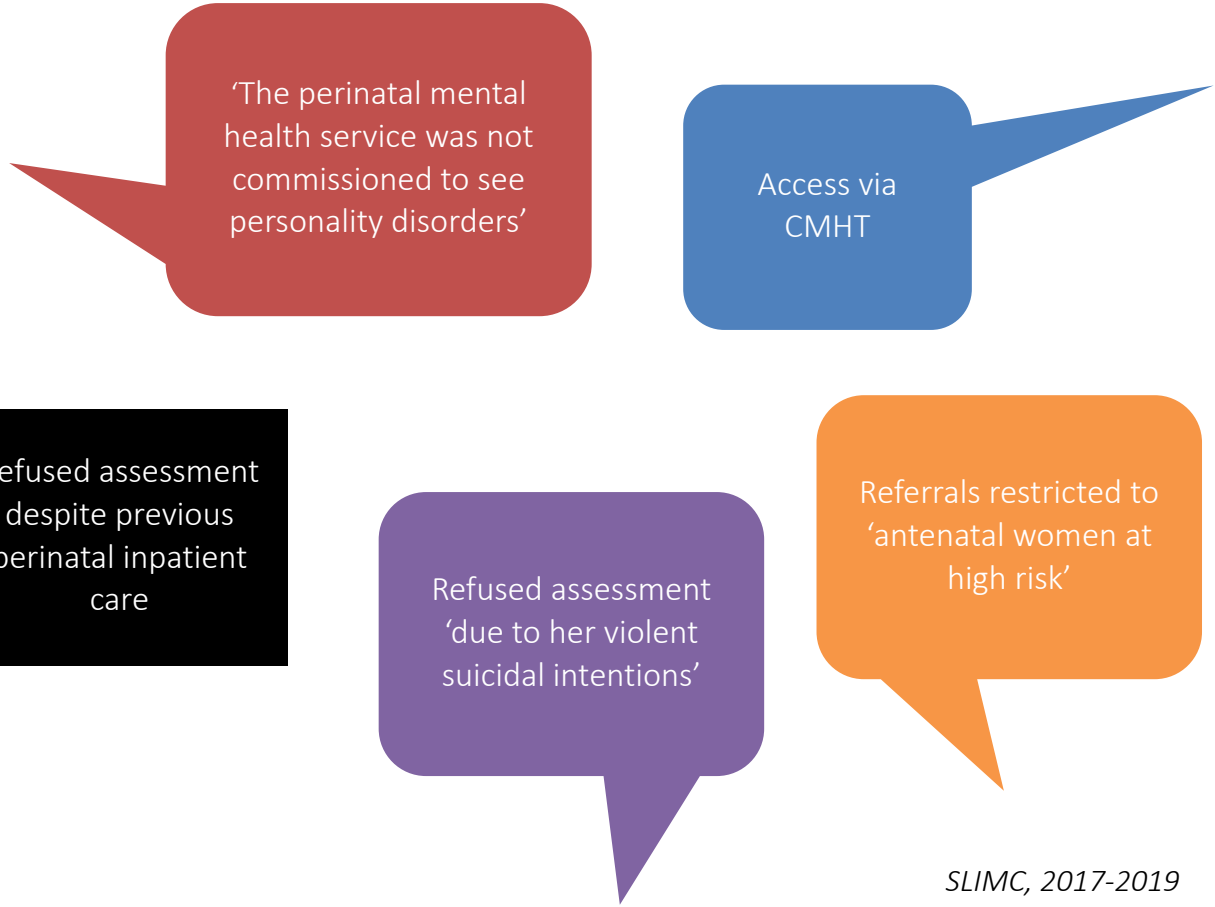




Specialist service response

- Lack of services
- Barriers to access
- Pathways into complex specialist care
- Transitions of care

Barriers to accessing specialist care



SLIMC, 2017-2019

Pathways into specialist care

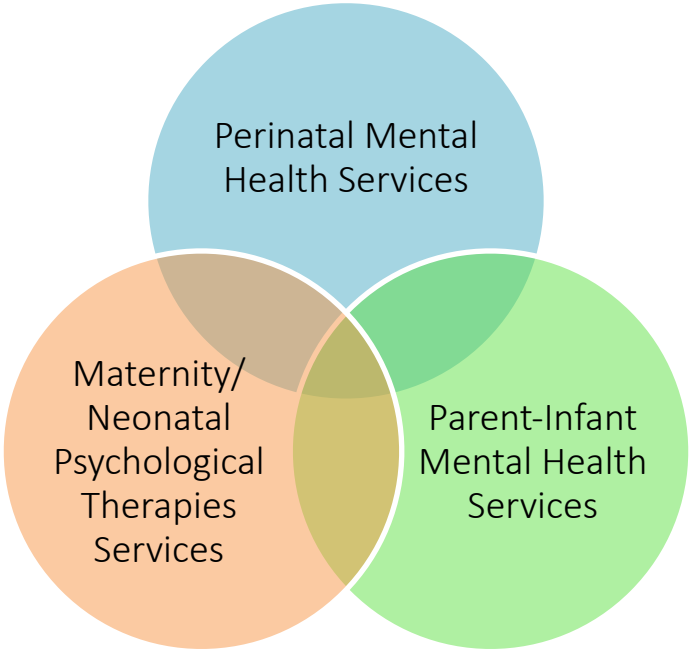
A woman who died violently in early pregnancy was seen by liaison services following an overdose. They believed she had already been referred to the perinatal mental health team, whereas in fact she had been referred to a specialist midwife.

A woman with bipolar affective disorder, including previous postpartum relapse, whose diagnosis was recognised at booking, was then referred on to a specialist midwife and obstetrician, but not to a perinatal mental health service. No plan was put in place for mental health management. She died violently in late pregnancy.

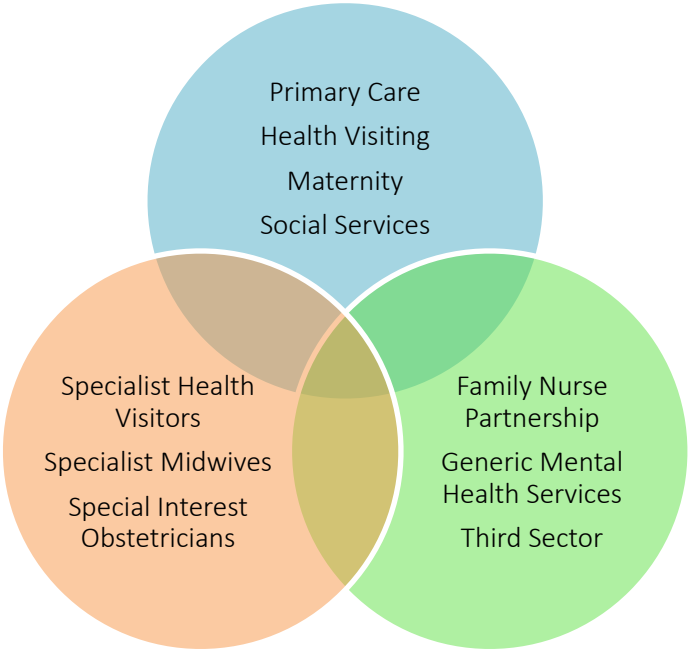
SLIMC, 2017-2019

Pathways into specialist care

Specialist Perinatal Mental Health



Enhanced and Universal Services



Transitions of c

A woman with a prior diagnosis of psychotic disorder was seen in pregnancy by general and perinatal mental health services. In the postnatal period she had worsening persecutory symptoms and her antipsychotic medication was altered. Some 10 months after delivery, her care was transferred to a different general psychiatry team due to change of address. She was seen at approximately 3–4 month intervals but it is striking that, despite her description of continuing symptoms causing distress and impairment of functioning, she was offered no further changes in management, or any attempt made to optimise her pharmacological management, over the course of the subsequent two years of records available to the Enquiry. This was despite her need to care for three children.

SLIMC, 2013-2015

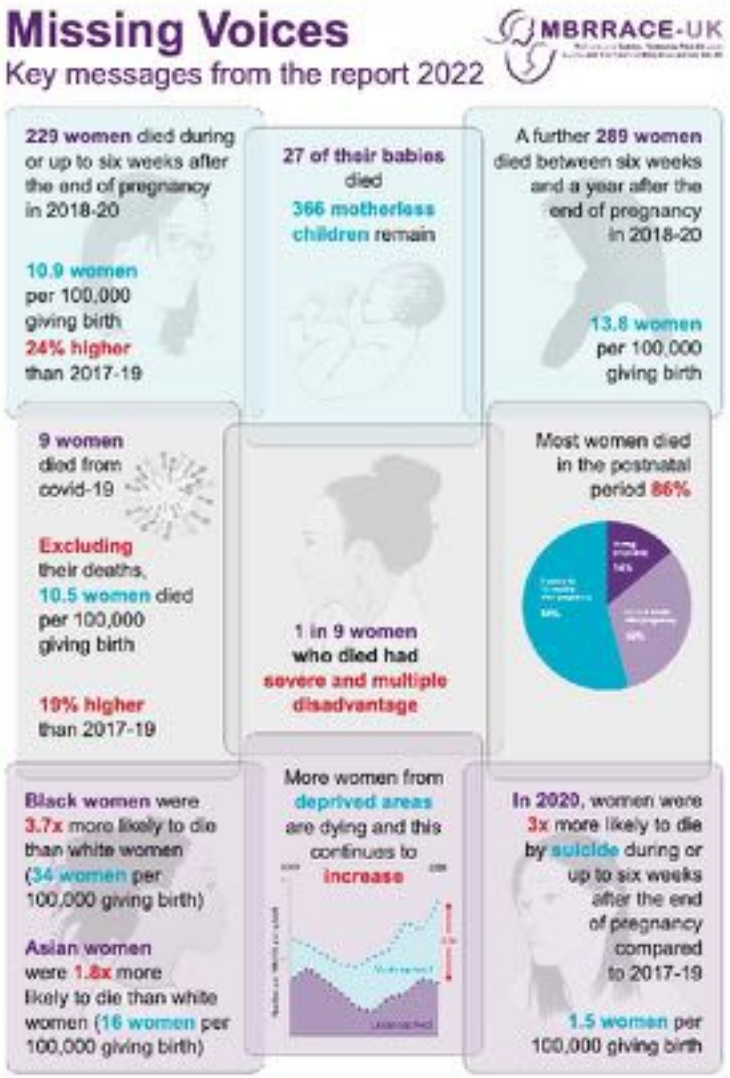
A woman with no past history of mental health contact died by violent means a few weeks after the birth of her first child. She was asked all appropriate questions about her mental health in pregnancy and received good antenatal and postnatal care. She left a suicide note but gave no indication at any point before her death of any mental health concerns.

SLIMC, 2014-2016

Good care

An older woman died by violent suicide several months after the birth of her child. She had a prior history of anxiety and depression. There were problems with her baby's development, diagnosed in pregnancy, leading to the woman developing more significant depressive disorder. She was well supported by maternity staff and appropriately referred to her specialist perinatal mental health service. She was seen rapidly by a community psychiatric nurse and, within a day, by the consultant. A plan was put in place for her management, including antidepressant medication, close follow up and mother and baby unit admission after delivery. On the mother and baby unit her severe illness presented a challenge to those attempting to form a therapeutic relationship with her. Consideration was given to ECT. Her admission was prolonged and a careful plan was made for gradually increasing time out, with good family involvement, but she took her own life while on leave.

SLIMC, 2014-2016



MBRRACE Report 2022

- Increasing rates of suicide
  3.84/100,000 maternities in 2020
  2.64/100,000 maternities in 2017-19
- Continuing increase in teenage suicide
- Multiple adversity and trauma

A message for all mental health services?

Specific biological vulnerability in context of major life event with profound cultural and social significance

Distinctive perinatal presentations and progression

Core skills of assessment and risk management

Summary lessons

RISK EVALUATION

"Is this different for this woman?"

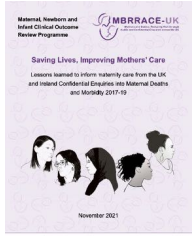
EDUCATION

"Does everyone have a good understanding of perinatal mental illness?"

COMMUNICATION

"Is there a shared awareness of risk?"

"What about the family?"



Gwyneth Lewis

Marian Knight

Channi Kumar

Margaret Oates

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

https://www.npeu.ox.ac.uk/mbrrace-uk/reports


EVER TRIED.
EVER FAILED.
NO MATTER.
TRY AGAIN.
FAIL AGAIN.
FAIL BETTER.
Samuel Beckett
'Worstward Ho'