Barnsley Hospital NHS
NHS Foundation Trust

CHANGING LIVES

PERINATAL MENTAL HEALTH 15/05/19

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

- Lessons learned to inform maternity care from the UK and Ireland
- Confidential Enquiries into Maternal Deaths and Morbidity 2014–16
- November 2018

The women who died 2014-2016

- Maternal suicide is the third largest cause of direct maternal deaths occurring during or within 42 days after delivery
- Leading cause of direct deaths occurring within a year after the end of pregnancy
- 114 women died from mental health causes (4.57/100,000 maternities)
  - 71 women died by suicide (2.9/100,000 maternities)
  - 43 women died in relation to drug or alcohol misuse

The women who died 2014-2016

Characteristics	Frequency (%) for women dying by suicide
Median age	30 years old
UK/Irish citizen	53 (75)
Ethnicity White Ethnicity BME	61 (86) 7 (10)
Domestic abuse *missing data for 42 (59%)	17 (24)
Known to social services	28 (39)
Received any antenatal care	61 (86)
Received recommended antenatal care	22 (31)
Booked after 12 weeks	15 (21)

History taking

- 10% of women experience a mental health problem during pregnancy or postpartum

- For almost one fifth of women who died in 2016, there was no evidence they had been asked about a history of mental health problems.

Communication of previous history

A woman died by hanging four months after delivery. She had a prior history of depression, eating problems and self-harm, but this was not passed on to maternity services. Maternity services were therefore unaware of a return of her eating difficulties in pregnancy. In the postpartum period she disclosed concerning thoughts about ending her own, and her children's lives, but this information was not shared among professionals. She was seen by a range of different professionals but her care was not well co-ordinated, leading to a poor response to worsening mental ill health.

Red Flags

A woman died by hanging several months after the birth of her first child. She had prior treatment for depression, appropriately detected by maternity staff. She reported early postpartum mood lowering and her GP altered her antidepressant treatment and made a referral to mental health.

She expressed strong beliefs that her baby deserved a better mother than her, repeating these to the health visitor and mental health team. She described worsening suicidal thoughts of a violent nature but they were described as 'fleeting' by mental health staff. She was accepted for intensive home treatment but died before that commenced.

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Gatekeeping

A woman died by violent suicide several months after the birth of her second child. She had a prior history of depression and a family history of suicide. She engaged poorly with recommendations (for medication and counselling) to manage low mood in pregnancy, but, despite repeated assessments by maternity staff and her GP, it was felt she did not meet the threshold for referral into secondary care mental health services.

Specifically, she did not score highly enough on standardised assessment tools used as part of the referral criteria and not all maternity staff could access direct referral.

Prescribing issues – de-prescribing

- *A woman died violently in her third trimester. She had a previous history of anxiety and depression, with depression in a previous postnatal period. She had been prescribed venlafaxine prior to the pregnancy to good effect, but it was stopped on discovering the pregnancy, either by the woman herself or by her GP. No alternative was suggested and there does not appear to have been any specialist service within her area.*
- *She developed worsening anxiety, and then depression, with a range of physical complaints, poor coping and suicidal ideation. As her symptoms worsened, she was referred to a low intensity psychological therapies service. She returned to her GP asking to restart her previously effective venlafaxine.*
- *It is clear from the consultation notes that her GP was very reluctant to prescribe and placed responsibility for the decision entirely on the woman, documenting an explanation of the risks, but not the benefits, of taking medication. She died a week later on the day she was due to undergo a mental health assessment.*

Opioid prescription

A woman with complex problems including an emotionally unstable personality disorder, diabetes, a gastric band and chronic pain became pregnant despite an implant. She was delivered early because of intrauterine growth retardation and discharged home with a large supply of tramadol for pain relief. A few days after giving birth she died and at postmortem was found to have a fatal level of tramadol and other drugs in her blood.

Our team

- Consultant Obstetrician and Gynaecologist
- Specialist Midwife
- Crisis team
- Staff training
- Information leaflets
- Team working – GP, Perinatal mental health team