Shared learning bulletin

An independent investigation following the death of an infant

Introduction

This bulletin provides an overview of findings from an investigation to identify learning into the care of a non-English speaking mother (M) (who had a learning disability and mental health concerns) and her infant. We examine the adequacy of the care pathway available. Agencies and teams who might benefit from this bulletin include: NHS England; Integrated Care Boards (ICBs); Child and Adolescent Mental Health Services (CAMHS); adult mental health services; midwifery; health visiting and perinatal mental health services.

Case background

Following an episode of psychosis, M had been under the care of an early intervention in psychosis team until the age of 19 when she was discharged to the care of her GP. She had been diagnosed with schizophrenia and a learning disability.

English is not M's first language; she can understand some words but does not speak English.

M later became pregnant. She had moved home, and her new GP referred her to the perinatal mental health team (PMHT) in Trust 1 requesting assessment and advice about the continued prescription of antipsychotic medication during pregnancy. An initial assessment with the PMHT took place a month later. A family member also attended but an interpreter had not been booked, so there was no direct communication with M.

M was placed under the care of a consultant perinatal psychiatrist and allocated a care coordinator (CCO) under the Care Programme Approach (CPA). The PMHT were involved in multi-agency meetings to discuss M's capacity to consent to a caesarean section and to plan for aftercare when her first child was born. The baby was born later that month and was noted to be well cared for.

Four weeks later, the PMHT consultant saw M, her baby and a man described as her husband at an outpatient appointment. M described her perceptions as normal; however, she seemed to be responding to unseen stimuli, although denied this. Three months later the PMHT consultant referred her to secondary mental health services (provided by Trust 2). A consultant psychiatrist review was recommended.

M was re-referred back to the PMHT by her midwife three months later because she was pregnant again. An assessment was carried out by her CCO that month. She was then reviewed by the PMHT consultant, with her husband attending. They both said they did not need input from the PMHT and wanted the transfer to secondary mental health services to go ahead as planned.

Because of service delivery issues, the assessment by secondary mental health services did not take place until a telephone review six months later. By this time M had delivered her second child. It was agreed a new CCO would be allocated, and weekly duty calls would take place. Neither of these actions were implemented. Phone calls of concern were made to Trust 2 by health visiting services twice over a further three months. These concerns were not escalated by the duty team or discussed in multidisciplinary team (MDT) meetings.

Early the following year, M was seen face-to-face for the first time since her referral to secondary mental health services (10 months earlier); an interpreter also attended. It was reported that her husband did most of the talking, no psychotic symptoms were observed.

Psychotic symptoms were observed at the next appointment and the plan was to arrange an appointment solely with M and an interpreter. However, the service only offered care up to the age of 25, so she was to be referred to Trust 1 adult services for mental health care instead because she had just turned 25 years old. Two months later, the referral to adult services had not taken place and therefore no risk assessment or care plan had been completed. There was no further contact with M until after the ambulance service had attended M's home address following reports of an unresponsive child who later died. M's mental health was assessed, and she was detained under the Mental Health Act 1983.

Key findings

Information not shared between primary care services

When M moved house, and changed GP, the adolescent history that outlined the extent of M's needs was not communicated between primary care services.

M's GP appropriately referred her to the PMHT in early 2019. It was known that she had a psychotic illness and a possible learning disability, but the extent of her learning disability was not communicated to them.

Later requests by primary care services to mental health services to clarify the extent of her learning disability were not successful.

Symptoms described as "*memory problems*" were not explored.

A lack of professional curiosity about her presentation

Mental state examinations were carried out using an interpreter or with a family member interpreting. The outcomes of the examinations were largely impressionistic instead of being formal mental state assessments.

The PMHT should have made it clear, and reiterated to the other agencies involved, there was:

- Schizophrenia
- A learning disability
- Potential mental illness and domestic abuse
- Very significant functional impairment.

Had all this been used to develop a formulation, and shared with children's social care and maternity safeguarding, it would have been clearer to everyone that there were child protection issues requiring action.

Treatment plans were not underpinned by best practice guidance for psychosis, or for perinatal mental health care.

While there was recognition that M had learning disabilities, this was not incorporated into a clinical formulation to guide her care and treatment and to help services assess her.

Lack of communication with other agencies about parenting capacity

There was a missed opportunity to assess M's ability to safely parent, and to communicate concerns about how the combination of schizophrenia and a significant learning disability might affect her parenting capacity, taking account of M's history and the research evidence regarding schizophrenia and parenting capacity. This meant services were not clear about how M contributed to the care of her children, whether she was ever left alone with them and whether there was any risk from her husband.

Therefore, when the referral to adult mental health services was made, there was insufficient clarity from the PMHT about M's contribution to childcare and no formal agreement or guidance from children's services. There was no consideration about the impact of having a second child on her and the increased risk this may create.

There was no transition planning between Trust 1's perinatal mental health services and Trust 2's CMHT. In a complex case such as this, it would have been good practice to have a handover meeting or multiagency CPA review to plan the transition.

The responses by Trust 2's CMHT to the referral were inadequate, and M was left without appropriate mental health care oversight during her pregnancy, after the birth of her second baby, and up to her arrest. Although it had been recommended that M be cared for under CPA at the CMHT and allocated a CCO, this did not happen because of pressures on the service and staffing resources.

The CMHT did not respond appropriately to concerns from other professionals. These concerns were not escalated to MDT meetings for discussion.

Key findings (cont.)

Lack of curiosity about M's marital status, inconsistencies and vulnerabilities

A key feature of M's presentation was her inability to speak or understand English, which meant that she was always seen by professionals with an interpreter or with a family member present or interpreting.

In our view the language barrier masked the extent of her learning disability, and also the nature and degree of her psychosis. Mental health services relied heavily on information as presented from her father and husband. Assumptions were made that her husband would be motivated and be able to provide care for M and their children.

There was a lack of focus on how M viewed this situation, and how her husband saw things.

There were inconsistencies in the information provided by the family about M's circumstances and marital situation (including a suggestion M had an arranged marriage). M was unable to give any detailed information about the relationship or her marriage.

While there were safeguarding concerns about her ability to consent, no service was sufficiently curious to ask direct questions about whether M was being exploited in the marital situation.

Lack of focus on the lived experience of the children

There was a lack of consideration about the lived experience of children in the family and their safety.

There was a lack of understanding of the family's needs and the risks to both children.

The voice of her family, and later her husband, was dominant throughout her care in a way that did not allow her voice or the voices of her children to be heard or properly assessed.

Learning from the Triennial Analysis of Serious Case Reviews (SCRs) 2022

Nationally triennial analysis of SCR reviews (triennial-analysis-of-serious-case-reviews-2017-19-health-2022.pdf (researchinpractice.org.uk) have been carried out to identify trends, changes and challenges since 1998. They have highlighted many entrenched issues as contributory factors in serious cases over the years.

Specific issues highlighted by these SCRs which are relevant to this case include:

- A lack of sustained professional curiosity.
- The importance of a thorough assessment including a review of past history.
- Reluctance or inability to revise and update assessments in the light of new information or to see children's situations from a holistic perspective. The PMHT did not update their assessment with new information nor communicate this to other professionals in formal meetings.
- Practitioners losing sight of the child.
- Potential gaps in practitioners' cultural competence when challenging parents from different backgrounds.
- Problems with information sharing and inter-agency communication. This is especially seen in relation to risk, thresholds and the need for escalation. There was no system response from other agencies, despite them knowing that adult mental health services had not seen M and had not developed a care plan.
- Resource issues such as heavy caseloads and high staff turnover presenting challenges to developing a relationship with the family. Trust 2 did not provide timely assessments, or care and treatment after M's referral, despite knowing she was pregnant with her second child.
- The importance of reviewing the case if there is a significant change. Having a second baby is a significant change.
- Cumulative risk factors being present. For M these were schizophrenia, learning disability and possible domestic abuse.

Recommendations

The independent investigation report set out a total of 16 recommendations.

Recommendation 1: GP read codes and information sharing

The GP surgery did not assign the appropriate read codes for mental health and learning disability. This meant that M's condition was not flagged when she changed GP services.

The integrated care board (ICB) should ensure that systems are in place so GP read codes for mental health and learning disability conditions are completed appropriately.

Recommendation 2: Perinatal mental health services initial assessment

The initial assessment was limited because previous history was not accessed.

Perinatal mental health services should carry out a thorough assessment, including any previous mental health history. This should include who gave the initial diagnosis and the course of her illness. For someone with a learning disability and schizophrenia, this should include an assessment of their ability to parent, carry out activities of daily living and more detailed enquiry about the relationship and possible domestic abuse. The outcome of these assessments should be communicated with all other professionals involved with the family (e.g. children's social care, Midwifery, HV, GP across all thresholds of need).

Recommendation 3: Transitions and handover from perinatal mental health services for high-risk and complex cases

There was no transition plan or handover of care after referral to the CMHT and the subsequent discharge from perinatal mental health services, which left M without any care provider.

Perinatal mental health services should agree contingency plans during a referral/handover to another service, continuing to work jointly, even if only for advice and to ensure liaison with maternity and health visiting. There should be professionals meetings to ensure all professionals come together to discuss and share information in complex/high-risk cases.

Recommendation 4: Use of interpreters in mental health services

The Accessible Information Policy does not include guidance about the use of interpreters and translation services in mental health services.

Trust 1 should provide policy guidance about working with interpreters and the provision of translation in mental health services.

Recommendation 5: Care plans and CPA reviews

CPA reviews, including reviews of care plans and risk assessments, were not carried out at the intervals expected by policy standards.

Trust 1 must ensure that:

- CPA and Royal College of Psychiatrists (RCP) Perinatal Quality Network standards in relation to care planning are maintained in the PMHT
- care plans and risk assessments are reviewed in line with policy expectations
- in complex/high-risk cases, care plans are made jointly by all the professionals involved – this should include maternity safeguarding, the health visitor and the children's social worker
- care plans are accessible to all the professionals involved

Recommendations (cont.)

Recommendation 6: Clinical formulation

There was no clinical formulation to help professionals involved understand M's presentation, or to guide care and treatment.

Trust 1 must ensure that the PMHT develop a working clinical formulation as part of their assessment.

Recommendation 7: PMHT GP letters

There was no routine discussion or opinion about risk in the update letters sent to the GP after outpatient reviews.

Trust 1 must ensure that the PMHT include risk assessment and management plans in outpatient letters.

Recommendation 8: Managing steps in the referral pathway

The pathway after referral was not managed and there was no ongoing communication with M.

Trust 2 must develop a structured process for ensuring the prioritisation of referrals and the robust management of steps in the referral pathway. It should develop standards for how communication with referred patients is managed during the referral process. This must be effectively monitored.

Recommendation 9: Transition from perinatal mental health services

There was no identified care pathway for a patient referred from perinatal mental health services, which meant M was allocated to a generic waiting list.

Trust 2 must develop a care pathway to manage the transition from perinatal mental health services to Trust 2 services. This should include a method for flagging these patients for MDT discussion at referral and during ongoing care.

Recommendation 10: Responses to external agencies by CMHT duty service

The CMHT duty service did not communicate with the internal MDT or senior managers when external agencies raised safeguarding concerns.

Trust 2 must provide clear guidance and protocols for CMHT duty services about escalating safeguarding enquiries made by external agencies.

Recommendation 11: CMHT administration standards

There were gaps in the recording of MDT meetings and correspondence. This resulted in a lack of continuity and senior oversight of the implementation of plans.

Trust 2 must ensure that administration support in CMHTs is operating appropriate standards.

Recommendation 12: Clinical quality standards

There was no effective coordination of the process of assessment, allocation and care planning for a new CMHT referral.

Trust 2 must develop effective systems to maintain oversight of:

- MDT meeting discussions
- CPA and CCO allocation
- standards for care planning, CPA and patient contact
- whether patients on CPA have a detailed risk assessment which is updated when changes occur.

Recommendation 13: Identifying new or pregnant mothers with serious mental illness

There was no system for flagging when extra attention was needed to monitor the mental health of pregnant or new mothers with a serious mental illness.

Trust 2 must develop a system for identifying and monitoring pregnant or new mothers with a serious mental illness and making this a criterion for inclusion in the CPA.

Recommendation 14: Clinical Risk Assessment and Management Policy

There was no Trust 2 Clinical Risk Assessment and Management Policy guidance.

Trust 2 must develop a comprehensive Clinical Risk Assessment and Management Policy.

Recommendation 15: Use of interpreters in mental health services

The policy for using translation services and interpreters does not include guidance on their use in mental health services.

Trust 2 should provide policy guidance about working with interpreters and the provision of translation in mental health services.

Recommendation 16: Perinatal mental health care in community teams

There was no consideration by the CMHT that M needed perinatal mental health care.

Trust 2 should provide training in child safeguarding and perinatal mental health for general adult mental health teams if the Trust policy allows women to be solely under the care of adult mental health teams during pregnancy/the early postnatal period.

Learning Quadrant

Individual/team practice

- Have I/we completed all appropriate GP read codes?
- Where there is a language barrier, have I/we considered the use of translation or interpretation services or easy read information?
- Have I/we reviewed care plans and risk assessments in line with policy expectations?
- Is there a care pathway for mothers with a serious mental illness?
- Have I/we listened to the patient (alone if appropriate) and to their children?
- During an assessment, have I/we developed a working clinical formulation?
- Am I/are we clear on the protocol for escalating safeguarding enquiries made by external agencies?
- Have all professionals shared information and agreed on a contingency plan in complex/high-risk cases when referring or handing over to another service?

Governance focused learning

- Is there clear policy guidance about working with interpreters and the provision of translation and when to seek advice for non-English speaking women/patients?
- Are we assured that services are professionally curious enough to safeguard children with pregnant women unable to voice themselves?
- How are we assured CPA and Royal College of Psychiatrists (RCP) Perinatal Quality Network care planning standards are maintained?
- Is there clear guidance and protocols for CMHT duty services about escalating safeguarding enquiries made by external agencies?
- Are we assured that adult mental health teams are trained in child safeguarding and perinatal mental health?
- Are pregnant or new mothers with serious mental illnesses included in the criteria for CPA?

Board assurance

- Do we have sufficient monitoring and quality processes in place for the referral pathway for secondary mental health services?
- Are there sufficient quality oversight and monitoring processes to provide assurance that standards for care planning and risk assessments are being met?
- Do we have sufficient oversight of patients with a learning disability and of the commissioning pathways for these patients when they are pregnant?
- Do we have sufficient oversight of the effective use of interpretation services for non-English speaking patients?

System learning points

- As an ICB, do we have assurance from services that there is a system in place to ensure GP read codes are completed appropriately?
- Do we need to examine our commissioning of services in identifying and monitoring pregnant or new mothers with a serious mental health illness?
- Does this include a clear care pathway for the transition from perinatal mental health services to CMHT services? And service standards?
- Are we, as an ICB, sighted on the needs of non-English speaking women and women with learning disabilities needing obstetric care?
- Are we confident that providers work well together to deliver care pathways for this group of women?
- Have we assurance from Trust Boards that the needs of non-English speaking women are sufficiently addressed in the delivery of obstetric and perinatal care?