Belfast Health and Social Care Trust

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TRUST BOARD SUBMISSION TEMPLATE

MEETING	Trust Board Public Meeting	Ref No. 5.2
DIRECTOR	Heather Jackson	Date 7th July 2022
• Item 5.2 Mrs Quinn Coroner's Case		
Purpose	• *To update Trust Board on the outcome of the Mrs Quinn Coroner's Inquest and action taken by the Trust following Mrs Quinn's death*	
Corporate Objective	• *Safety and Quality* • *Collaborative Working*	
Key areas for consideration	*To provide an overview on learning from this incident and on the actions implemented by the Maternity and Mental Health teams. This includes actions around:* • *Service Design* • Training • *Governance* • *Infrastructure*	
Recommendations	• *For noting*	

Mrs Orlaith Quinn Coroner's Case

1. Background

Mrs Orlaith Quinn was an inpatient in the Royal Jubilee Maternity Hospital (RJMH) following the birth of her 3rd child. Mrs Quinn tragically ended her life by suicide within the RJMH on 11 October 2018. A review found Mrs Quinn was likely suffering from an emerging puerperal psychosis. As well as the life changing impact on Mrs Quinn's husband, children and family, her death had a devastating impact on the staff within the maternity and mental health services.

A Serious Adverse Incident review with an independent chairperson was undertaken by the Trust with learning outcomes identified and implemented. A Coroner's Inquest was held on 9 – 13 May 2022.

The Coroner, Ms Dougan, concluded that Mrs Quinn's death was on the balance of probability both foreseeable and preventable. The Inquest identified several missed opportunities for diagnosis and care and that improvements were required in relation to communication between midwifery and mental health staff and consistency was required between the daytime and night time handover within maternity. The Coroner also identified improvements required to the infrastructure of the maternity hospital.

2. Learning Outcomes

A number of learning outcomes have been identified and implemented since the incident occurred.

2.1 Service design

2.1.1 A working protocol has been developed to guide midwifery and medical staff in RJMH how to manage the interface with psychiatric liaison, with particular reference to the observations required and the care to be given to patients who have had a psychiatric assessment but are to remain in the care of maternity services.

2.1.2 The night-time handover has been improved to ensure it is multi-disciplinary and consistent with day-time handover. There is review of all women on delivery suite, induction of labour area, antenatal wards and postnatal wards. Night- time handover involves obstetric, anaesthetic and labour ward staff. The start-times of Midwifery night-time co-ordinators has been adjusted to allow these individuals to attend.

2.1.3 Improvements have been made to strengthen the interface between mental health and maternity services. Flow charts outlining referral criteria and pathways of care have been shared with all staff. Funding has been secured and recruitment of a lead obstetrician for mental health is underway.

2.2 Training

2.2.1 Training has been held for all Mental Health medical trainees and for all members of the Mental Health Liaison Team in understanding the distinctive features and risks associated with perinatal mental illness. This training is now part of induction for all new medical trainees in Mental Health.

2.2.2 Training has been delivered to the Mental Health Liaison Team on:

- Improving communication with maternity staff.
- Improving communication with family members/ carers.
- Taking an independent collateral history

2.2.3 A training programme has been developed and is now part of rolling training for all staff in RJMH on awareness of perinatal psychiatric complications and the management of the associated risks.

2.2.4 Training has also been provided to staff in RJMH on the Missing Persons Protocol.

2.3 Governance

2.3.1 To provide assurance that change has been successfully implemented and embedded into practice, the following audits of training and practice has been added to the rolling mental health audit programme:

- Taking an independent collateral history
- Communication of advice regarding a patient's diagnosis/differential diagnosis as well as the management and safety plan.

2.3.2 There has been audit of antenatal appointments focusing on assessment of mental wellbeing.

2.3.3 There was a discussion of the incident at both Maternity and Mental Health Patient Safety and Morbidity and Mortality meetings.

2.4 Infrastructure

2.4.1 An appropriate office space, providing sufficient privacy and dignity, has been made available for mental health staff to conduct interviews with patients and family members.

2.4.2 There has been a review of CCTV in RJMH with additional cameras being installed in 2022/23.

Belfast Health and
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Case review: Monitoring /Tracking Report

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Date & Number of Action Plan: **Case Review.**

Ref No:

Unique Identifier or source	Incident Reference: BHSCT/SAI/18/081	Tracking	

Current Status Grading:

Achieved	Partially achieved	Not achieved

Meeting dates:

Recommendations for the Service:

Ref	Recommendations	Current Position	Actions required	Responsible lead(s)	Timescale	Evidence of progress/ completion	Current Status
1	All mental health staff providing psychiatric liaison and out of hours input into maternity services should have specific training at induction and throughout their continuing professional development in understanding the distinctive features of, and risks associated with, perinatal mental illness.	Training has most recently been provided to medical trainees on 3rd June 2020 and again (to a new cohort) at induction in August 2020. Training was provided to new members of the Mental Health Liaison Team on 9th July 2020	Training for current MDTs within mental health will be complete by 30th June 2020	Dr A	30th June2020	The training programme has been added to induction of senior trainees, and will take place at induction every 6 months	
2	Taking an independent collateral history in the practice of psychiatry is crucially important in order that vital information is not missed. The psychiatric team involved in this case, and the liaison service in general, must demonstrate how this aspect of their practice will be improved in order to achieve and maintain an acceptable standard.	This is standard part of any mental health assessment, however, a specific training programme to improve the practice has been developed and delivered to staff in the Mental Health Liaison Team. The mental health assessment proforma has been amended to allow for regular audit.	Training programme	Dr B	30th June2020	Audit of practice will take place as part of a rolling audit programme	

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3	Liaison psychiatry staff must communicate clearly and in detail their advice regarding a patient's diagnosis/differential diagnosis as well as the management and safety plan required, whilst always taking into account the understanding and capabilities of non-psychiatric staff if a patient is to be cared for in a non-psychiatric setting such as a maternity ward.	Training has been delivered to the Mental Health Liaison Team on improving communication with maternity staff.	Following training in June 2020 an audit schedule will be devised.	Dr C	July 2020	Audit of practice will take place as part of a rolling audit programme	
4	Where appropriate, partners and/or family members should be engaged with, by both psychiatric liaison and maternity staff, to ensure they fully understand the outcome of the psychiatric assessment.	Training has been delivered to the Mental Health Liaison Team on improving communication with family members/ carers.	Following training in June 2020 an audit schedule will be devised.	Dr C Dr A	July 2020	Audit of practice will take place as part of a rolling audit programme	
5	An appropriate office space, providing sufficient privacy and dignity, should be made available for mental health staff to conduct interviews with patients and family members.	Venues have been identified in the current maternity building.	Discussion with ward staff. Psychiatry confirm requirements. Future venues will be identified in the new Maternity hospital.	Lead Midwife A	July 2020	Senior midwifery staff are aware of the alternative venues in RJMS which are available.	

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6	A protocol should be developed to guide midwifery and medical staff in RJMS as to how to manage the interface with psychiatric liaison, with particular reference to the observations required and the care to be given to patients who have had a psychiatric assessment but are to remain in the care of maternity services.	Key psychiatry staff are involved in the working group. Observation policy for non-psychiatric setting currently being finalised in preparation for forwarding to Standards and Guidelines committee draft format.	Trial draft policy ongoing. Prepare for Standards and Guidelines.	Divisional Midwife A Divisional nurse A Dr A	Sept 2021 (for training)	Training commenced week of 4th January 2022 for midwifery staff. Will remain amber until through Standards and Guidelines.	
7	Serious perinatal mental health problems, such as puerperal psychosis, are associated with an increased risk of suicide. The Confidential Inquiry into Maternal Deaths has shown that suicide has been a leading cause of maternal death over the past two decades, however it should also be stated that maternal death is a relatively rare event. The awareness of perinatal psychiatric complications and the management of the associated risks should now be the focus of a multidisciplinary education programme in Hospital X which is informed by regional and national guidance as well as local learning from incidents and near misses.	A dedicated training programme is being developed which will be delivered to current staff in June 2020 thereafter this will be a rolling programme.	Training being facilitated virtually	Midwife A	July 2020	Dedicated training programme in place and running.	

8	The patient safety system in RJMS requires urgent attention as to how the risks associated with perinatal psychiatric complications are managed. There appears to be a lack of understanding amongst clinical leaders and managers about the importance of post incident reviews, their integration with the SAI reviews and the Morbidity and Mortality system, as well as the subsequent development of learning from those incidents.	RJMH. M&M discussion organised and presented at hospital audit meeting.		Dr D	Dec 2019	Complete.	
9	The clinical leadership within RJMS must give consideration as to how to improve the night-time handover in order to ensure that it is fully multidisciplinary and connected in a systematic manner across the entire unit.	Review of night-time handover. Requires multidisciplinary discussion	Meeting of multidisciplinary group has taken place 29/6/2020	Clinical Director A	August 2020	The night-time handover follows the same template as the morning handover with review of all women on delivery suite, induction of labour area, antenatal wards and postnatal wards. Night- time handover involves obstetric, anaesthetic and labour ward staff. The start-times of Midwifery night-time co-ordinators has been adjusted to allow these individuals to attend and contribute to MDT night-time handover.	

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10.	The mental health aspects of maternity services in RJMS appear disjointed and require reform. The current work undertaken by psychiatry and psychology, and from within midwifery, would best be organised as one perinatal service. It would also be advisable, as with other maternity services, that a lead obstetrician be appointed to contribute to such a service both in its design and its delivery.	It is recognised that clarity of purpose is required for the teams working within the overarching perinatal mental health model. Flow charts outlining referral criteria and pathways of care have been circulated to staff and displayed in relevant clinical settings. Funding to implement the regional perinatal business case has been secured and will strengthen the interface between mental health and maternity services. Recruitment for specialist posts is expected to commence in Spring 2021 and will include a 'lead obstetrician for mental health.	Recruitment of specialist perinatal posts to commence.	Dr A Divisional Midwife A Divisional nurse A Clinical Director A Co Director A Co Director B	Dec 2021	Flow charts outlining referral pathways disseminated. Funding to implement regional business case secured. Recruitment of specialist posts (including lead obstetrician) underway.	
11	Consideration should be given as to how developing mental health problems, such as anxiety, could best be elucidated at every opportunity throughout the antenatal period in addition to the initial booking visit.	Addressed in education package.	11.6.21- Not possible to deliver via NIMATs module. Regional focus on encompass. Plan to audit current practice in different midwifery settings and track progres	Dr A Divisional Midwife A	Oct 2021	Complete. Audits of A/N appointments focusing on assessment of mental wellbeing have been undertaken. Results awaited.	

12	Consideration should be given to a review of security in RJMS focussing on access into and out of ward E after hours.	Surveillance of all buildings on the RVH site is centralised and controlled by a central control room, managed by security staff under PCSS. The number to call in the event of a missing person/baby is 33470. This is the direct number to the central control room which is staffed 24/7. We have requested a review of CCTV in the current building.	A missing person's protocol has been developed to deal with events such as a missing distressed woman or a missing baby. A review of CCTV in the current building has been completed and we are seeking confirmation regarding the costs of installing additional cameras.	Service Manager	Aug 2021 (training & protocol use)	The missing person's protocol is in use. Training programme for staff has been delivered. Funding has been approved and signed off. Estates currently organising cable routes prior to installation.	

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