www.joebingleymemorialfoundation.org.uk

the joanne (joe) bingley memorial foundation

Parliamentary Commission Into Maternal (Perinatal) Mental Health

Foreward - The History and Issues

In 2003 Following release of the public enquiry into the suicide of the psychiatrist Dr Daksha Emson and infanticide of her child, the government made promises that the NHS would deliver "Specialists In Perinatal Mental Health" to care for these women in crisis who suffer from postnatal depression, like Joanne Bingley.

The Royal College of Psychiatry even created the faculty of Perinatal Mental Health as a specialism.

More than 10 years later

- More than 35,000 mums are left suffering in silence every year (2)
- Mums are too scared to come forward for treatment for fear of having their child taken away (2)
- Dads are left supporting Mums who are too scared to seek help or turn to health care professionals (4)
- Health Care Professionals are still asking for "Specialists In Perinatal Mental Health and access to services so that they can support mums, dads and families suffering the mental trauma and crisis (4)

The sad facts are:

- The NHS has failed to commission services across more than 50% of the country (1)
- There are huge gaps and discrepancies in services throughout the UK (3)
- The stigma associated with suffering mental illness has not gone away
- Mental illness does not get "parity of care" with physical illness, despite the high risks to patients

According to The Confidential Enquiries into Maternal Death the highest cause of maternal death is suicide as a result of suffering depression and 86% are "avoidable deaths" based upon findings that it was possible to have identified the illness and provided treatment for the Mums to have made a full recovery.

SO WHY – has the situation for most patients remained unchanged for over 10 years?

The Joanne Bingley Case Study – A Reason to Act

Joanne (Joe) Bingley was a dedicated and caring nursing professional with 20 years nursing experience. She took her life whilst being treated at home for severe postnatal depression, leaving behind her 10 week old daughter Emily and her husband Chris.

Dads and Partners are left picking up the pieces when Mums suffer mental ill-health which has a significant impact on family relationships and the first "1001 Critical Days" of development for new born children.

Poor maternal mental health has profound and long lasting negative effects on the health, wellbeing and social circumstances of mothers, their children and their partners. Much of this suffering and long term harm is avoidable or treatable.

The Joanne Bingley Memorial Foundation established in Joe's memory, obtained charity status 1 year after her death on 30th April 2011. It raises awareness of PND issues whilst supporting the nursing professionals who have battled in vain to have the NHS implement "lessons learned" from so many "avoidable deaths".

Every death of a mum suffering from postnatal depression must be considered a "never event".

The Joanne (Joe) Bingley Case Study is a tragic example of how *"Lessons are Not Learned"*

Despite a history of psychological treatment for PTSD, her medical records describing treatment for postnatal depression following a previous miscarriage and increasing the risk of PND recurring to 50%.

Health Visitors never completed any of the mandatory Mental Health Risk Assessments.

Joanne's hospital records clearing describe her "inconsolable crying, feelings of failure and that the she did not want to go home" with the nurse recording Joe was "suspected suffering from postnatal depression".

Whilst staying in hospital a second time with breast feeding problems and showing signs of PND, risks assessments where not completed there was no referral to Specialist Perinatal Mental Health Services.

When Joe was eventually diagnosed with PND, confessing different ways she had considered killing herself and her baby, the Mental Health Crisis Team decided that home care was the preferred course of treatment for Joe who was to be treated her acute very severe postnatal depression.

According to NICE guidelines "home Care" has no measurable benefits other than cost savings over the preferred treatment option which is admittance to a Specialist Mother and Baby Unit.

They NHS Trust relied solely on Joe's husband (the father) and family for providing her 24/7 care, including being responsible for issuing her drugs as part of her treatment…. treatment lasting just 1 hour per day.

Joe's Treatment and Care Plan was provided to her husband Chris and the box ticked stating "copy of care plan provided to the Carer". Yet the Mental Health Crisis Team provided no written information to help or support Joe's Husband who was made responsible for providing her 24/7 care nor did they inform him of his legal rights as a Carer nor did they conduct a Carer's risk assessment, Carers Rights enshrined in law.

Even after his wife's death the Mental Health Crisis Team advised the Health Visitors to stay away from the grieving father (Chris Bingley) as they expected his family to provide the support, care and counseling he needed to overcome his grief and to care for his then 10 week old baby daughter.

Following the funeral, attended by over 400 guests that included many health care professionals, Joe's husband started to investigate his wife's poor treatment and the care standards that should be followed.

At the start of their internal reviews, the NHS managers and directors responsible for investigating the Serious Untoward Incident stated:

- *"These things just happen ……. We did nothing wrong"*
- *"Guidelines are just guidelines we don't have to follow them"*

Unsurprisingly the NHS Internal Reports concluded that they did nothing wrong!

An Independent Investigation conducted by eminent experts, including Margaret Oates (OBE), resulted in 21 recommendations and actions for improvements. *BUT like the "lessons learned" from many other Independent Investigations the NHS Trust responsible for Joe's death failed to implement them.*

The NHS Trust reported to Joe's husband that actions had been implemented, but after being told by NHS staff actions had not been implemented as the NHS trust had told him, Chris' requested the Care Quality Commission to investigate and only then was the truth revealed.

The Care Quality Commission reported in April 2012

Following complaints raised by the husband of a patient who had deceased, having investigated the NHS trust responsible for the treatment of Joanne Bingley, the CQC reported ***the NHS Trust had failed to implement "lessons learned" from the recommendations and action plans of the Independent Investigation, including:***

- *The failure to provide adequate training to the required standard for staff*
- *The failure to employ as a lead a specialist perinatal psychiatry*
- *The NHS trust still had no trained, qualified or experienced perinatal specialists*
- *The failure to perform adequate risk assessments of both patient and carer*
- *Evidence of leaving at risk this specific user group (suicidal Mums suffering PND)*

Care Quality Commission Report: Mother's death highlights care system failures - 13 Apr 2012

3 Deaths in 4 years of mums referred as patients to the same NHS Mental Health Trust

Following the CQC report in April 2012, at least 2 further mums died suffering from severe postnatal depression / psychosis whilst receiving treatment at home by the same NHS Trust.

Jan 2013 Clair Tuprin, Sheffield
Treated at home for severe PND, jumps from John Lewis building in Sheffield

Dec 2013 Roaseanne Hinchlife,
Treated at home for puerperal psychosis, sneaks out and Jumps from Cliffs at Whitby

In October 2011 the Coroner ruled *that Mental Health Crisis Team failed to obtain informed consent, in breach of General Medical Council guidelines, as they never discussed or disclosed any options other than "Home Care". He stated as fact that if provided the specialist perinatal psychiatric care she would have been expected to have made a full recovery and would probable still be alive today.*

In Dec 2014 The NHS admitted a breach in their duty of care was the probable cause of death *and that hospital treatment in a mother and baby unit (such as Leeds) would have saved Joe's life.*

The NHS Litigation Authority Risks Management Handbook, *core standards set out that health care service providers implement "lessons learned" from Confidential Enquiries and Independent Investigations.*

The failure to implement the recommendations from Independent Investigations is arguably a breach of the NHS Constitution (Health Act 2009) that states patients can expect health care providers to implement "lessons learned" to demonstrate it is meeting the standards of a quality health care provider.

If the NHS was an airline it would be closed down…there are approximately 60 "avoidable deaths" of Mums suffering PND every year, 86% of which are avoidable if "lessons learned" were implemented.

Valuable lessons about how the NHS should improve patient safety by learning from mistakes are not being implemented and complied with, and the NHS attempts continue to cover-up mistakes made.

- *The CQC (or a designated body for patient safety) must have the authority to take legal action against those directors or trusts that fail to implement "lessons learned" or fail in their "duty of care"*
- *If any health care provider makes a mistake that causes preventable harm or death to patients for a second time it must be regarded as a 'never event'.*
- *The Care Quality Commission (CQC) must make greater use of investigations into serious untoward incidents and insist on an Independent Investigation of every "never event"*

REFERENCES

(1) Patients Association Survey Into Primary Care Trust Commissioning Of Perinatal Mental Health Services (March 2011)
(2) 4Children Survey (2012)
(3) NSPCC Report Into Perinatal Mental Health Care Services (June 2013)
(4) **Boots Foundation Survey Into Perinatal Mental Health Care Services (Oct 2013)** – conducted by Thommy's, Netmums and the Royal College of Midwives
(5) **Confidential Enquiries into Maternal Death –** mums suicide authored by Dr Margaret Oates (MBE)

Footnotes

1. Impact of the Government response to the Francis Inquiry report

For the NHS to 'place the quality of patient care, especially patient safety, above all other aims' we must have candour when mistakes happen and acknowledge all medical errors.

- *Only 24 per cent of the 140 possible contributory factors identified by the inquiry team had been identified in local investigations at the time of the incidents.*
- *So 76 per cent of the learning from the incidents had been missed; a situation that there is an urgent need to improve.*

As well as the new statutory duty of candour, greater use will be made of incident data, including a commitment for CQC to consider each hospital's review of serious untoward incidents as part of its pre-inspection activity.

NHS England is to launch a program of new patient safety collaboratives, which will be expected to provide expertise on learning from mistakes and help to provide a 'rigorous approach to transforming patient safety'.

The NHS culture will never change whilst the NHS fails to be truthful, continues to cover-up of past mistakes and NHS executives and senior managers are not held legally accountable for their failures.

2. Health and Well-Being Boards

Currently 97% of Health and Well Being Boards in England have failed to include any strategy on Perinatal (Maternal) Mental Health which means that families disadvantaged through mental illness are not receiving the treatment and support they require.

In Yorkshire, whilst health and well-being boards have recognised the importance of Mental Health and also early Infant Development in the continuing social deprivation of the region, none have recognised in their strategies perinatal mental health and in particular postnatal depression and the care standards that should be applied in providing perinatal mental health services.

- By gaining agreement to a strategy that is supported by patients and local support groups and that is prioritised by the Health and Well Being Boards, this will balance the Mental Health needs of mums and dads (and developing infants) and provide parity with the other pregnancy issues documented by health and well-being boards such as teenage pregnancy, breastfeeding, smoking. etc.
- By gaining agreement to a perinatal mental health strategy 3rd sector and volunteer support groups can continue to deliver the services they currently provide without the risk and fear of funding cuts and also develop new services required to fill the identified service gaps and needs.

A national policy and strategies for the implementation of Perinatal Mental Health Care Services is required with Parliament and the Department of Health held accountable for delivering improvements in the patient outcomes that they promised.