Concealed pregnancy and addiction

RCPsych addictions faculty meeting 29 April 2022

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Goals of talk

- I am the consultant for the Bridge House detoxification unit seeing many patients with complex needs including pregnancy
- Long interest in lifelong learning and patient safety
- Responded to a request from HSIB (Healthcare Safety Investigation Board) for an expert in addictions and perinatal psychiatry to provide an expert opinion in one of their investigations of maternal death
- This was a case of concealed pregnancy in patient attending addiction services
- Experience of being an expert to HSIB
- Reaching out to other experts like Prof. Murphy
- How to be an expert- Human Factors in Healthcare
- NO conflicts of interest to declare

Content of presentation

- About HSIB/ Maternal and neonatal deaths
- Invitation from HSIB to be an addictions / perinatal expert in case of concealed pregnancy
- Being in expert in a rare but emotive issue
- Standards in addiction services for pregnancy screening and monitoring

Background

- Interest in teaching, training, patient safety, lifelong learning.

- Always worked with patients with complex and multiple needs

- 2013 Expert investigator for independent homicide investigation. Complex investigation with two perpetrators with substance misuse/mental health and two victims. Experience of interviewing staff and managers, and perpetrator in prison, report writing
- Interest in "no blame" approach e.g. Human Factors approach. Focus on learning / looking at solutions

Airline safety investigations
Inquisitorial rather adversarial approach.
Aim to establish:

1. What happened –detailed timeline using interviews, Flight data recorder, cockpit voice recorder, other sources of information

2. How it happened –contributory factors e.g. pilot training, maintenance, weather – rarely one “route cause”

3. Focus on interaction between pilot, aircraft and circumstances/ environment including Human factors such as training, fatigue, spatial disorientation, cognitive overload

4. Establish recommendations to reduce or eliminate risk of event happening again

Investigations are of public record and easily accessed

About HSIB

- The **Healthcare Safety Investigation Branch** is a part of NHS England, established in April 2017, to operate independently of other regulatory agencies. It is intended to produce rigorous, non-punitive, and systematic investigations and to develop system-wide recommendations for learning and improvement and to be separate from systems that seek to allocate blame, liability, or punishment.
- From my understanding does not publicly publish individual incidents, rather reports of collective issues
- **See https://www.hsib.org.uk/who-we-are/reports-and-publications/**

Maternity investigations

- From 2018 HSIB has been responsible for the investigation of maternity cases which involve intrapartum stillbirth, early neonatal deaths or severe brain injury
- The UK Confidential Enquiry into Maternal Deaths (CEMD) is the longest running system for maternal death review and the methodology is regarded as the global standard.
- The process has evolved over 60 years from the original CEMD in 1954, to Confidential Enquiries into Maternal and Child Health (CEMACH) in 2003 and latterly the Maternal Newborn and Infant Clinical Outcome Review Programme (MNI-CORP) in 2012 which allowed further refinement
- programme has recently been extended to include enquiries into annually chosen topic-specific serious maternal morbidity (e.g. maternal sepsis, epilepsy)

Psychiatric / substance misuse in maternal deaths

- Overall maternal deaths have fallen from 90 per 100,000 women giving birth in 1952 to around 10 per 100,000 at present
- Tri-annual reports. As overall deaths fallen importance of psychiatric causes risen.
- Annual reports cover specific topics (e.g. sepsis, epilepsy, cardiovascular disease. 2018 report covered psychiatric issues

Women who died 2014-2016

- 114 women died in relation to mental health issues (4.57/100,000 maternities)
- 71 suicides
- 43 related to drug /alcohol use
- Of those cases investigated in detail limited information about ante natal care in many cases
- See examples

Judgements based on history

After a woman with known substance dependence had surgical management of an ectopic pregnancy no risk assessment for VTE was carried out despite clear risk factors. When she presented with shortness of breath and tachycardia the focus was on concern about possible withdrawal symptoms though the cause of her symptoms was the pulmonary embolism from which she died.

Care of women in prison

A woman in her 30s died within a few days of the birth of her child. She had significant polysubstance misuse and her older children were in care. She had a history of overdosing.

In pregnancy, she was seen by a prison psychiatrist and was followed up regularly. She repeatedly mentioned thoughts of self-harm, often linked to ongoing child protection procedures, but said that being pregnant was why she did not act on these thoughts. She last had contact with prison mental health services several days before delivery. She believed she would be able to remain in hospital with her baby after delivery until her baby was removed into care. However, she was moved back to prison without her baby but encouraged to visit daily and to express. Equipment for expressing was not always available to her in prison.

On the day she died, she was informed that she could no longer visit her baby, but could express milk. She had no contact with prison psychiatric services in the postnatal period.

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

Co-morbid depressive illness

A woman with emotionally unstable personality disorder and a history of drug misuse visited her GP some weeks after birth expressing suicidal thoughts. She was referred urgently to the community mental health team, who assessed her but did not accept her for treatment because she said she was drinking. They discharged her. One month later she died from an overdose.

Homicide and domestic abuse

Two women were killed by partners with known severe mental health problems. In one instance the woman's partner's problems remained unknown to maternity services. One of these women was never seen alone throughout her pregnancy and there is no evidence she was ever asked about domestic abuse. The second woman denied domestic abuse on questioning but presented multiple times during pregnancy and postpartum with minor injuries and other complaints which were never explained or explored.

The case I was asked about

HSIB contacted RCPsych addictions faculty asking for an addictions and / or perinatal expert in relation to a maternal death investigation

- Woman with longstanding opioid dependence. Despite obvious abdominal swelling she denied she was pregnant. Advised to see GP but had none
- She and foetus died at 36 weeks pregnancy

My role:

- I was asked to comment on care provided from case notes and interviews with some staff such as keyworker
- Advise on normal practice in terms of CDATs liaising with GP and in terms of screening for and monitoring pregnancy

Information provided

Information available:

- Expert opinion of a senior GP and CCG lead (patient had been deregistered by GP about 3 years previously as correspondence returned not at this address)
- Notes from emergency services at time of maternal death
- Time line provided by HSIB
- 72 hr report provided by CDATs management
- Some information regarding services policies and practice

My initial response I had heard of "concealed pregnancy"

e.g. footnotes in Patients notes about "abuse in childhood leading to Pregnancy which had been concealed and infant died"

but knew little about literature, significance overall, good practice

Wished to reach out to known experts like Sylvia Murphy Tighe

Process and Outcome of report 1

I Read into published SCR reviews of concealed pregnancy and previous maternal and neonatal death reports

- Even as a senior clinician with 20 years experience in addiction psychiatry I had limited knowledge of concealed pregnancy and associated risks
- I concluded it was likely that
  - most other staff will also have low levels of knowledge
  - High risk that similar outcomes would occur with concealed pregnancies in other community addiction services

Process and Outcome of report 2

Report mainly focused on lines of enquiry to follow / human factors approach e.g.

- Adequacy and degree of safeguarding training/ practices
- HR processes re: recruitment of medical staffing. Adequacy of provision of staffing, supervision
- Team meetings, information sharing, raising of risks about patients and responding timely
- Availability and access to equipment e.g. pregnancy testing
- Post incident support for staff
- Systems issues: case note management systems linkage to NHS Spine or other agencies, cuts in funding

SCRs in public domain

- I reviewed 5 Serious case reviews involving concealed pregnancy resulting in deaths of children.
- Previous concealed pregnancy is an important indicator in predicting risk of a future pregnancy being concealed; as is
  - Previous termination, thoughts of termination and/or unwanted pregnancy
  - Loss of a previous child (i.e. adoption, removal under Care Proceedings)
  - General fear of being separated from the child
- Substance-misusing people may avoid seeking help during pregnancy if they fear that this disclosure will inevitably lead to statutory agencies removing their child. It may be important to consider the role of collusion within the family

Outcome of investigations

- Shortly after I submitted my report Covid epidemic started. Lack of contact from HSIB for many months
- Enquired later – no record of case – chased several times. Report published July 2020 but I only received a copy end 2021
- Investigation mainly dealt with care issues around 999 call and transfer to hospital
- No specific mention of “concealed pregnancy”
- Little discussion of upstream issues around addictions services

My learning of 2022

- Importance of sharing learning about rare problems with serious consequences
  - Sharing experiences with other detox units
- Relevant: Bridge House as only NHS detox unit in SE England and therefore sees a number of pregnant patients
  - All such patients raise key issues around patient safety, inter agency liaison, practical issues, scenario planning and risk management, staff training

Pregnancy and Bridge house

- 27 year old, cocaine dependent, alcohol misuse, on CTO due to severe psychosis in past. Achieved goals of addictions treatment during 2 admissions. Became severely psychotic a few days before birth. Arguably focus too much on addiction rather than risk of perinatal mental health issues

- 36 year old twin pregnancy (first pregnancy) – planned C section. Admitted for detox from buprenorphine due to previous OTC opioid dependence. Complete detox but left unit early and delivered early – children removed at birth

Pregnancy and Bridge House 2

- 31 year old on methadone, dependent on prescription drugs. children previously removed. Detoxed quicker than expected but planned to self discharge early – community services refused to accept her so she stayed on unit completing original length of stay which she felt was helpful

- 37 year old. 6th pregnancy. 4 children in care. High risk pregnancy. Plan to remove child at birth. Partner recently imprisoned. Alcohol dependent, also on methadone, using on top. Previous diagnosis of rapid cycling bipolar disorder – became very depressed during previous detox but suffered adverse reaction to sertraline

Common themes in pregnancy cases

Issues

Usually a element of coercion/ pressure to attend detox/ stabilisation

Ambivalence about pregnancy and ; sobriety –"I cant cope with thought of motherhood without diazepam"

Multiple/ competing demands / services' expectations differ

Complex trauma, domestic violence

PTSD and other mental health disorders

Shadowy partners/ visitors

Probation /criminal justice risks

Housing uncertainties – e.g. patient in hostel but plan to move on to independent living with infant

Termination, miscarriage, early delivery

Practicalities – getting to midwifery appointments –who funds travel, late minicabs

Common themes in pregnancy cases: solutions

- Pre-admission inter agency liaison –email and MS teams etc
  - With and without patient – keeping patient goals / risks in mind e.g. rate of detox, length of stay
  - Practicalities esp. around midwifery care, ensuring local midwifery services involved
- Expect the unexpected: patient with TOP or missed miscarriage suffering Retained products of conception
- Time needed, planning admissions – only one pregnant patient at a time
- Training and knowledge– physiology of pregnancy, pharmacology in pregnancy
- Staff support and dynamics e.g. pregnant staff
- Managing visits to unit - friend, partner or abuser?