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CORONER FOR NORTHERN IRELAND

CORONER MARIA DOUGAN

THE INQUEST TOUCHING UPON THE DEATH OF

ORLAITH QUINN

Introduction

1. The inquest proceeded in hybrid form, meaning that a mix of remote technology and live courtroom attendance was utilised. The case proceeded in a socially distanced court in Laganside Courts, Belfast, between 9 and 13 May 2022. During the inquest, I received evidence from a number of witnesses and I considered a number of statements admitted under Rule 17, together with voluminous hospital notes and records. It is not possible to recite all of the evidence in these findings, although all of the evidence has been considered before arriving at these findings.

Evidence

2. The Deceased Orlaith Quinn, born on 29 April 1985, at an address in Belfast, died on 11 October 2018.

3. Mr Ciaran Quinn, husband of the Deceased gave evidence to the inquest. He told the inquest that they had been together for 17 years and had three children together. Their third child was born at 09.23 hours on 9 October 2018.

4. Mr Quinn described how their first two children had been born by caesarean section and he felt the entire experience was "very traumatic" for the Deceased. After the births of their first two children, he stated the Deceased's mood dipped. After their second child was born the Deceased was prescribed sertraline by her GP which she stopped taking shortly after as "it made her feel worse" and "it just didn't agree with her". After a short time, he said, "she got back to herself". Mr Quinn stated that the Deceased suffered from slight anxiety at certain times but did not suffer from depression.

5. Mr Quinn told the inquest that at around 29 weeks, the Deceased found out that, Baby A was in breech position and that she would have to be born by caesarean section. He said she always wanted a natural birth. Mr Quinn explained that there

was a stark difference from the first half of her pregnancy when "she was loving, warm and excited" and then the Deceased's mood "drastically changed" and she became withdrawn and "lost an edge to her personality". In the last six weeks of the pregnancy, Mr Quinn continually asked what he could do to help and the Deceased replied that, "she will be better when the baby is here". Around this time, she was also affected by her grandmother's cancer diagnosis, the stress of applying for two jobs and her son not settling at school. Mr Quinn described how the Deceased had become withdrawn and worried. She had not been speaking to her friends as much as she used to and stopped wearing make up in the last month of her pregnancy. He put the Deceased's feelings down to nervous energy and he stated that he was "not hugely worried" about the Deceased's mental health as she kept reassuring him.

6. When Baby A was born on 9 October 2018 Mr Quinn described how happy the Deceased was and how she initially breastfed her baby which he described as "wonderful". It brought him great relief to see the Deceased bonding with the baby. Later, the Deceased had to bottle feed Baby A, commenting, "I cannot even feed that baby properly". This frustrated the Deceased and she became quite irritable and on edge. When he left to go home that night he described the Deceased as seeming perfectly calm.

7. On 10 October 2018, Mr Quinn arrived on E Ward to visit the Deceased and their newborn baby. He told the inquest that he brought the Deceased some food, which she took one bite of and then discarded. In the afternoon, Mr Quinn asked the Deceased to lie down in bed to sleep as she looked extremely tired. He described how the Deceased put her head on the pillow but then jumped up immediately. Mr Quinn told the inquest that what happened next was something he had never seen in the 17 years he had been with the Deceased. He said that the Deceased was "manic, uncontrollable, loud, speaking irrationally, would not listen to reason, she was "angry, upset and physically shaking". He went onto to say "she became extremely manic, she exploded with all these different emotions" and it was "almost like she was possessed by someone else".

8. The Deceased told Mr Quinn that there was something wrong with their baby, that Baby A was disabled, "not right", and that "she was going to need a wheelchair". Mr Quinn told the inquest that the Deceased kept saying the police were coming for her and that she was going to jail. The Deceased then told Mr Quinn that she tried to kill herself on Friday 5 October 2018 at home with the belt of her dressing gown. She stated that she tried to do it three times and on the third attempt, she lost consciousness but was not sure for how long and was convinced the baby had been deprived of oxygen.

9. Mr Quinn told the inquest that he was in total shock at the Deceased's words and how she was presenting physically. He said he tried to assure her that the baby was fine and he tried to calm her down as she was shouting. He said he was afraid, as that was not the "Orlaith he knew and loved". The Deceased told Mr Quinn that

she felt worthless and useless. Mr Quinn stated he could tell that she was extremely unwell. He telephoned the Deceased's mother, Mrs Siobhan Graham, and explained that something was wrong with the Deceased and that she needed to return to the hospital immediately.

10. Before the Deceased's mother returned, Mr Quinn described how the Deceased was still speaking irrationally and becoming angry when he was telling her that the baby was fine and healthy. The Deceased stated that all the anxiety she had and other negative thoughts and feelings had now passed to Baby A and she had ruined the baby's life. Mr Quinn stated that the Deceased was convinced that her stress hormones had transferred to the baby.

11. When the Deceased's mother arrived, the Deceased repeated everything she had told Mr Quinn. Mrs Graham then spoke with the nursing staff and she described how the Deceased was behaving.

12. Later that afternoon, the Deceased and Mr Quinn were taken into an office on the ward to speak to two members of the Psychiatric Liaison Team, Dr Robert Boggs, Associate Specialist Psychiatrist and Mr John Casey, Liaison Psychiatry Nurse. Mr Quinn stated that there were at least four interruptions during the assessment while the Deceased was answering questions. The door kept opening with staff trying to access the room. He could see that the Deceased was becoming visibly frustrated and agitated at the interruptions. He described how her bottom lip was trembling and eyes were constricted.

13. Mr Quinn described the assessment as more of an overview and that they did not "delve deep enough into what Orlaith was going through". Mr Quinn described how Nurse Casey was unable to keep up with the simple detail the Deceased was providing and that this unsettled the Deceased as she was constantly repeating her responses. Mr Quinn told the inquest that he believed this led the Deceased to lose faith in Dr Boggs and Nurse Casey and the assessment process.

14. Mr Quinn told the inquest how the Deceased provided all the detail about how she attempted to take her own life and how she had lost consciousness and then she had fear that "she had brain damaged Baby A and starved her of oxygen". He said she mimicked how she did it "to get the point across". She had to correct them several times on the details they recorded. She told them in the week and days before her scheduled caesarean section she could not sleep and was downstairs crawling around the living room, sweating, full of anxiety, in extreme mental pain and how she felt that her increased cortisol levels and stress affected her baby. Mr Quinn stated that was the first he had heard of this and that "she kept it all from me". He said, "the more worried Orlaith became the less she told me". The Deceased went on to say that, she blamed herself for her son, not settling in school and that she felt huge guilt about this.

15. Mr Quinn stated that Dr Boggs or Nurse Casey did not ask him any questions about the Deceased's earlier presentation and his assumption was they would read

the medical notes for all of this information. If spoken to on his own, he stated that he would have told Dr Boggs and Nurse Casey that, in his opinion, the Deceased was "gravely ill and without immediate treatment something serious could happen."

16. Mr Quinn told the inquest that he did not believe the assessment was given the attention or treated with the seriousness it deserved. He stated that, "there was no rapport or connection between them and Orlaith". He explained that at no point did Dr Boggs or Nurse Casey explain to the Deceased why she may be feeling the way she was or reassure her that they would keep her safe or make things better.

17. Mr Quinn described how, towards the end of the assessment, he asked what the plan for the Deceased was. He stated that they were told Dr Boggs and Nurse Casey needed to discuss the information provided in the assessment and that their colleague Dr Andrew Lok, Clinical Psychologist, and Nurse Casey would speak to the Deceased the following day. He stated that they were not told the diagnosis or that this information was being kept from them to prevent the Deceased looking it up. Mr Quinn stated that had he have known the diagnosis he would never have fallen asleep and would have made sure the Deceased never left the room that night.

18. At the end of the assessment, the Deceased asked if social services would be involved and Mr Quinn stated that an unconvincing response was offered, that social services would visit and that it was part of the process. Mr Quinn could see the Deceased becoming visibly upset at hearing this. He stated that the Deceased was very protective of her children and the thought of someone taking her children away would be the worst thing in the world for her. Mr Quinn stated that when they left the room, the Deceased said that she did not want to speak to them again. He believed she had lost all trust in them.

19. After the assessment, nursing staff told the Deceased that she was being moved to a side room on the ward and the reason provided by the Ward Sister was that it was for the Deceased's privacy. Mr Quinn stated that he asked Sister Angela Flanagan if he could stay with the Deceased that night to provide support. The Deceased was then moved to Room 2. Mr Quinn stated there was no mention of his presence being in a safeguarding capacity.

20. In the evening, Mr Quinn spoke with Midwife Felekoglu and she told him that Dr Boggs and Nurse Casey said that the Deceased may have puerperal psychosis (also known as postpartum psychosis). He stated that she did not provide any further information.

21. Mr Quinn told the inquest that he then had an emotional conversation with the Deceased when he told her not to leave him as he would be lost without her and could not live without her. The Deceased reassured him that she would be ok.

22. A reclining chair, a pillow and blanket were brought into the room for Mr Quinn and he and the Deceased agreed to take turns feeding Baby A throughout the

night. Mr Quinn recalled waking up at 01.38 hours and seeing the Deceased feeding Baby A and that was the last time he saw her.

23. Mr Quinn described how he woke up between 03.20 hours and 03.25 hours and realised the Deceased was gone. He telephoned the Deceased at 03.26 hours and there was no answer. He noticed that her slippers and dressing gown were still in the room and her phone was missing.

24. Mr Quinn then alerted the Midwives on the ward and a search commenced. He called the Deceased's mobile 17 times between 03.26 hours and 04.02 hours. He accompanied a security guard in the search and the guard received a message that the Deceased had been found.

25. Mr Quinn described the Deceased as the "most happy, loving, protective person you would have the fortune to meet". He stated that he struggles each day to accept her death. Mr Quinn described the Deceased as a "very beautiful woman" and she was the type of person that "would light up a room" and would lift everyone else's mood when they saw her, "she was just so infectious" and "had the most incredible wit and humour". "She was the most amazing wife" and the most "adoring and devoted mother that any child could wish to have." He concluded by saying that he sees "the hurt and pain" in his "children's eyes everyday not having her". "The hole that has been left in their lives losing Orlaith has been huge and will never ever be filled".

26. Mrs Siobhan Graham, mother of the Deceased, gave evidence to the inquest. She visited the Deceased on the afternoon of 9 October 2018 and was of the view that the Deceased was quite detached when she spoke to her. On 10 October 2018, Mrs Graham visited the Deceased in the morning. She described the Deceased's bay as being in disarray, which was unlike the Deceased, who she described as a "perfectionist". She described how the Deceased was more anxious than the average person but "never had mental health problems".

27. Later that afternoon, Mrs Graham spoke to Mr Quinn by telephone. She described him as being very upset and he asked if she could get back to the hospital. The Deceased then explained to Mrs Graham everything that she told her husband. Mrs Graham described the Deceased as delusional and, in her opinion; she was clearly describing a psychosis. Mrs Graham told the inquest that she had worked for more than 30 years with Women's Aid and was aware of postpartum psychosis through her work. She stated that she "knew the symptoms of psychosis".

28. Mrs Graham was aware of the Deceased being upset after the birth of her first child and being prescribed sertraline after her second child's birth as she felt anxious. Mrs Graham told the inquest that, "I have never known Orlaith to be depressed". Mrs Graham described how, approaching the birth of Baby A, the Deceased came back from a dinner with friends and made the comment "I think that's the last time that I will ever see them". Mrs Graham stated that she later laughed about it and said, "what

the hell is wrong with me mum?". When asked if she was worried about the Deceased's mental wellbeing in the last weeks and months of her pregnancy Mrs Graham replied "extremely". She told the inquest the Deceased was "eating less and less" and was "very agitated and irritable". On another occasion, the Deceased did not take a new pram out of its box and the Deceased stated that "I don't think I'm ever going to push that pram". Mrs Graham said she did say to her daughter about going to see her GP but she replied commenting, "what is the point they will just prescribe anti-depressants".

29. Mrs Graham stated that she was worried the Deceased was going to experience post-natal depression. She said that "never ever in a million years" did she think, "we would be talking about a suicide". She described the Deceased as "the great pretender" meaning she hid what she was going through very well and was "so private".

30. Upon hearing the Deceased's revelations, Mrs Graham spoke with Midwife Laura Felekoglu and told her "I think our Orlaith is in the middle of a postpartum psychosis". Mrs Graham stated that Midwife Felekoglu replied, "I don't know, I'm just qualified". She then spoke with Midwife Shauna Torney and Dr Helen Goodall, and told them what the Deceased had disclosed and she asked for a psychiatric assessment. She also asked a Doctor to strip Baby A and examine her in front of the Deceased in an attempt to reassure her.

31. Midwife Felekoglu then attended the Deceased and asked the Deceased to tell her in her own words how she was feeling. Mrs Graham recalled telling another midwife, Sister Fidelma Conway, that she thought this was a postpartum psychosis.

32. Mrs Graham told the inquest that she sat with Baby A during the psychiatric assessment. After the assessment, the Deceased, Mr Quinn and Mrs Graham were not made aware of a diagnosis. Mrs Graham stated that she assumed that she would be spoken to so she could provide input into a safety plan. She stated that, to their knowledge, there was no safety plan or risk management plan put into operation. She said that if she knew that puerperal psychosis was a possible diagnosis "I would never in a million years have left her". She stated that, while in hospital, the Deceased had told seven staff members of what she had attempted to do.

33. Just after 05.00 hours on 11 October 2018, Mrs Graham received a telephone call from the police to tell her that the Deceased had died.

34. Midwife Laura Felekoglu gave evidence to the inquest. Midwife Felekoglu was the midwife responsible for the care of the Deceased and her baby from 07.45 hours to 21.00 hours on 10th October 2018. At this time, Midwife Felekoglu was qualified a few weeks. Midwife Felekoglu described how the Deceased was in Bed 15, which was in a four-bedded bay on Ward E. At 08.45 hours Midwife Felekoglu said the Deceased reported "feeling well". Later that morning Midwife Felekoglu stated that in conversing with the Deceased there was no indication of low mood or poor mental

health. She told the inquest that she received training in relation to mental health within pregnancy in her midwifery training through lectures and case studies and that she learned about the symptoms of postpartum psychosis in that training.

35. At approximately 13.00 hours, the Deceased's mother, Mrs Graham, spoke with Midwife Felekoglu and she repeated the Deceased's disclosures. Midwife Felekoglu told the inquest that she recalled Mrs Graham saying she thought her daughter was suffering from a psychosis, though she did not recall replying that she did not know what it was. Midwife Felekoglu escalated this information to Midwife Shauna Torney, the Band 6 Midwife in Charge. Mrs Graham then described to both Midwife Felekoglu and Midwife Torney what the Deceased had told her and that the Deceased had no history of poor mental health but described her as an anxious person. She also reported that the Deceased had just described feeling as though "she was not in her body".

36. Midwife Felekoglu was then directed by Midwife Torney to go and speak directly with the Deceased, as she was her patient. Midwife Felekoglu has written a detailed note of this information in the Deceased's maternity notes, however, it did not include Mrs Graham's suggestion of "psychosis" and I find that the note should have been comprehensive so as to include this detail.

37. At 13.20 hours, Midwife Felekoglu spoke with the Deceased. Her husband and mother were both present. She asked the Deceased to explain how she was feeling and to describe what happened on Friday 5 October 2018. Midwife Felekoglu told the inquest that the Deceased's demeanour appeared calm and she disclosed that she has always been anxious but from around twenty week's gestation her anxiety had worsened and she began to feel depressed. The Deceased told Midwife Felekoglu that she had researched the effects of maternal anxiety, depression and cortisol levels on the developing fetal brain. She explained that she felt everything was too much and her state of mind and the way she was feeling was causing brain damage to her baby. The Deceased reported to Midwife Felekoglu that on Friday 5th October her feelings became overwhelming and she felt that she could not bring a baby into the world who she believed she had damaged.

38. The Deceased disclosed to Midwife Felekoglu that on Friday 5 October she had attempted suicide three times by hanging at her home. She reported temporarily losing consciousness on the third attempt. She stated that this temporary loss of consciousness further heightened her anxiety and she believed that her actions may have deprived the baby in her uterus of oxygen. The Deceased expressed feelings of guilt as to how she could now love her baby in view of her having attempted to end both their lives.

39. Following this conversation, Midwife Felekoglu reported back to Midwife Torney who then spoke directly with the Clinical Psychologist, Mr Andrew Lok, as well as escalating the concerns to the Bed Manager, Sister Conway.

40. At 13.50 hours, Midwife Felekoglu spoke again with the Deceased and made a note of this in the Deceased's notes. She enquired whether there were any matters / circumstances underlying her feelings. The Deceased reported to Midwife Felekoglu that it may be associated with a sense of guilt about her youngest son who was struggling in school. The Deceased felt that her son's "struggles" were due to her actions or something she had done. She recalled her youngest son was also breech presentation in pregnancy, similar to her newborn baby. As a result of this association, she was concerned that her newborn baby would have similar problems to her youngest son. The Deceased stated that she believed "the baby's brain was riddled with anxiety and depression". The Deceased reiterated her feeling of being "out of her body" and explained how she was waiting for someone to realise that she had "brain damaged her baby". As a result, the Deceased stated that she felt like she needed to jump out of the window or run off the ward.

41. At 14.20 hours, Midwife Felekoglu attended the Deceased and she noted that the Deceased appeared more at ease having disclosed and discussed how she had been feeling.

42. At approximately 16.00 hours, the Psychiatric Liaison Team of Dr Boggs and Nurse Casey arrived and Midwife Felekoglu provided them with a detailed handover. Her recollection was that she had the notes in front of her on a desk and she read from them in full and "gave all of the information in them". She could not recall if they took the notes with them. At inquest, she stated that she did not think she told Dr Boggs and Nurse Casey of Mrs Graham's comment that the Deceased may be suffering from psychosis. She stated she could not be sure if she told them the Deceased had told her she had lost consciousness. Midwife Felekoglu showed them into a computer room to carry out the assessment.

43. On completion of the Psychiatric Liaison Team's assessment, Midwife Felekoglu requested a handover and management plan. She told the inquest that Dr Boggs stated that he did not think the Deceased was a danger to herself and that his impression was that the Deceased was not psychotic at this time but symptomatic of obsessional neurosis. He advised that the Deceased remained in hospital until Friday 12 October 2018. He recommended that if there was any deterioration in current state, the Psychiatry on-call was to be contacted and also that the Deceased was to be reviewed daily by the mental health team until discharge.

44. Midwife Felekoglu told the inquest that Dr Boggs recommended "watchful waiting and low stimulus environment" and that the Deceased's mother or husband should stay in hospital with her. Midwife Felekoglu stated that she had heard the term "watchful waiting" before and that it meant "just observation". She stated that that it did not mean a higher level of observation simply that if the Deceased "mentally declined" they were to escalate the matter to the psychiatric team or Dr Goodall if it was out of hours.

45. Midwife Felekoglu stated that she read Dr Boggs's note of the assessment but did not note his "no loss of consciousness" comment, which was contrary to what the Deceased had told her.

46. At 18.30 hours, the Deceased and her baby were moved to Side room 2 on E Ward which was decided by Sister Conway. Midwife Felekoglu confirmed to the inquest that from the nurse's station, you could not see someone leaving that room or leaving the ward.

47. At 20.10 hours Midwife Felekoglu asked the Deceased how she was feeling and she reported that she was feeling well. At the end of her shift at 21.00 hours, she showed Mr Quinn where the ward kitchen was. Mr Quinn enquired as to the Psychiatric Liaison Team's impression of the Deceased. Midwife Felekoglu informed him that they did not believe it was psychotic and that it was more obsessional neurosis and that they had advised she remain in hospital until Friday 12th October for further assessment. She said she attempted to reassure him that support was in place and that it would also be available in the community.

48. Staff Midwife Shauna Torney gave evidence to the inquest. On 10 October 2018, she commenced her shift at 07.45 hours as Ward Co-ordinator. At 13.15 hours, the Deceased's mother came to the staff base and expressed concern at the content of the conversation she just had with the Deceased. Midwife Torney advised Midwife Felekoglu to discuss this with the Deceased in the first instance and get confirmation of the information relayed by Mrs Graham. Midwife Felekoglu subsequently recounted the content of her conversation with the Deceased to Midwife Torney.

49. Midwife Torney took the decision to discuss the situation with the in-house clinical psychologist, Dr Andrew Lok who she described as the medical professional they go to if they have any concerns in relation to a patient's mental state. She outlined her concerns and asked him to see the Deceased as soon as he was available. Midwife Torney also updated Sister Conway who immediately contacted the Senior Obstetrician, Dr Helen Goodall, for an urgent review. At 13.50 hours, Dr Goodall reviewed the Deceased. Mr John Casey, Psychiatric Liaison nurse was contacted and requested to review the Deceased. Midwife Torney then updated the Ward Manager, Sister Angela Flanagan. At inquest, Midwife Torney stated that she did not read all of the notes including the detailed notes made by Midwife Felekoglu as she stated she did not have the time. She confirmed that as the Senior Midwife in Charge that day "in theory I probably should have read the entirety of the notes".

50. At inquest, Midwife Torney stated that she had heard of postpartum psychosis through some lectures and self-directed learning and that her understanding was it was more a manic state of mind with hallucinations. She told the inquest that she had no experience of postpartum psychosis in her practice. She said midwives would not have had a lot of knowledge of it and they were dependant on advice from psychiatrists. She stated that she did not hear the comment made by Mrs Graham of

"postpartum psychosis" or replying that she had never heard of it. She stated that she had yet to receive the new training on postpartum psychosis, which was being delivered by the Belfast Health and Social Care Trust.

51. Sister Fidelma Conway, Band 7 Service Co-ordinator, gave evidence to the inquest. She confirmed that in her role, she was responsible for the everyday running of the ward. At 13.30 hours on 10 October 2018, Midwife Torney informed her that the Deceased had just disclosed that she had tried to commit suicide on three occasions on the previous Friday. Sister Conway immediately went to the Deceased and asked her mother Mrs Graham to stay with her until she got a Doctor to review the Deceased stating "I didn't want the patient to be unattended at the bedside". Mrs Graham disputed this in evidence and did not recall anyone asking her to specifically stay with the Deceased. Sister Conway asked Dr Goodall to review the Deceased and she in turn asked Sister Conway to contact Psychiatry.

52. At 13.47 hours, Sister Conway contacted Mr John Casey, Band 7 Psychiatry and asked if someone could come and review the Deceased. He asked her to log the request with the Psychiatric Liaison Office, which she did. She was informed that they would see the Deceased as soon as they could.

53. At 15.28 hours, Sister Conway telephoned Mr Casey again to ask when they were coming to review the Deceased. He informed her that they would be there within half an hour. At 16.30 hours, Sister Conway returned to E Ward to check if Psychiatry had arrived and she was advised they were currently with the Deceased.

54. At approximately 17.45 hours, Sister Conway spoke with Dr Boggs. Nurse Casey had already left the ward. She asked Dr Boggs if the Deceased needed to be transferred to a Psychiatric Unit and he said no. She then went and got Sister Flanagan and Midwife Felekoglu and they listened to Dr Boggs's diagnosis and management plan. Dr Boggs informed them that his impression was obsessional neurosis and that he felt the Deceased was not psychotic; that the Deceased was to be transferred to a single room; that her husband should remain with her; for no medications to be prescribed at present; and that psychiatry would review her again the next day. Sister Conway told the inquest that she was not told of the differential diagnosis of puerperal psychosis by Dr Boggs nor of the fluctuating condition and associated risks. She told the inquest that was something she, the Deceased and her family should have been told.

55. Sister Conway told the inquest that she had heard of postpartum psychosis and experienced it three times in her career, the last time being 14 years ago. However, she was clear in her evidence, that at no time did anyone mention postpartum psychosis to her in relation to the Deceased. When Mr Quinn's evidence that the Deceased was "manic, uncontrollable, loud, speaking irrationally, would not listen to reason, she was angry, upset and physically shaking" was put to her, Sister Conway

confirmed that some of those behaviours, from her knowledge and experience, were in keeping with postpartum psychosis.

56. At 18.00 hours, Sister Conway helped transfer the Deceased from the main ward to Room 2, which was a single room. She stated that it was not appropriate for a family member to stay with a patient in a bay. She told the inquest that it was her choice to move the Deceased to Room 2, which was next to the sister's office. She stated that the sister's door was normally open and it had the "added advantage of being viewed two ways" and it had passing footfall. Sister Conway stated that all staff were made aware of why the Deceased was being moved and there was a "heightened awareness amongst staff". All staff were told that should they notice "anything untoward they were to report it". However, she stated that Dr Boggs did not tell her what a deterioration in the Deceased would look like or what the midwifery staff were to look out for. Prior to the assessment, the Deceased was being observed however after the assessment Dr Boggs did not advise the Deceased needed one to one observations and she conceded that therefore there was a change and a reduced level of observations. Sister Conway stated that had one to one observations been directed by Dr Boggs this would have meant the Deceased in a single room with a member of staff at all times. She explained that there are two categories of continuous or one to one observations, within eyesight and within arm's reach.

57. Sister Conway advised that she did not recall the term "watchful waiting" being said to her and that this was not a common term nor would she be familiar with it. She told the inquest that she recently received training by way of a bespoke perinatal mental health day that is specific to maternity staff and postpartum psychosis is included in that training.

58. Dr Helen Goodall, Registrar in Obstetrics and Gynaecology, gave evidence to the inquest. At approximately 13.35 hours on 10 October 2018, Dr Goodall was informed by Sister Conway that a patient on E ward was acutely suicidal. She immediately attended E Ward to assess the Deceased. When she arrived, the Deceased was in bed and her baby and mother were present along with Midwife Felekoglu. Dr Goodall asked the Deceased's mother to leave and she spoke with her alone "to give her some privacy" and to conduct the interview on a one to one basis so she "might be more at ease to be able disclose information in private to me". She stated she needed to gather the relevant information to handover to the psychiatric team.

59. The Deceased disclosed that she had been feeling anxious and depressed for the past five months but had not sought any treatment for this. She admitted to having tried to hang herself three times on the preceding Friday, 5 October 2018. She said the trigger for this was her concern that her mental health symptoms had increased her blood cortisol levels and caused harm to her unborn baby. Dr Goodall told the inquest that the Deceased did inform her of a loss of consciousness which Dr Goodall did not

record in her notes of this conversation. At inquest, she agreed that this was important information, which she should have recorded.

60. The Deceased told Dr Goodall that after this suicide attempt, she had felt better, although partially out of touch with her surroundings, until the morning of 10 October 2018. At this point, she felt like running away. She had considered jumping out of the window beside her bed on E ward but she assured Dr Goodall that she did not feel like that now. The Deceased reassured her that she had no thoughts of harming her baby, her other children or her partner at any stage. The Deceased explained to Dr Goodall that she had a past history of anxiety and depression but had never required medication or sought advice from a Psychiatrist.

61. Dr Goodall told the inquest that on examination the Deceased appeared calm and composed and was not restless or agitated. Following this assessment, Dr Goodall called Mrs Graham back to her bedside and explained to the Deceased that she would contact the hospital Psychologist, Dr Lok and the Psychiatric Liaison Team. When leaving, Dr Goodall stated that she asked Mrs Graham to stay with the Deceased until other healthcare professionals attended as a safeguarding measure and for support. She then opened the curtains around the Deceased's bed so that she was clearly visible to ward staff. She stated that these actions were based upon an assessment of risk, the risk being if the Deceased tried to leave the ward or tried to harm herself.

62. Dr Goodall discussed her findings with Sister Conway and Midwife Felekoglu. At approximately 13.50 Dr Goodall telephoned the Psychiatric Liaison Team and she was assured that they would prioritise the case and review the Deceased as quickly as possible. After the call, she discussed her assessment with Dr Lok. He agreed that Psychiatry input was the most appropriate intervention at present.

63. Sister Angela Flanagan, Ward Sister, gave evidence to the inquest. At approximately 13.30 hours on 10th October 2018, Midwife Torney informed her of the Deceased's disclosures. At approximately 15.30 hours, Sister Flanagan was given a detailed history of events by Midwife Felekoglu. At approximately 15.50 hours, Midwife Felekoglu gave a verbal handover to Dr Boggs and Nurse Casey. Sister Flanagan was present. Sister Flanagan told the inquest that Midwife Felekoglu did communicate to Dr Boggs and Nurse Casey that the Deceased had lost consciousness on the third attempt. Sister Flanagan explained to the inquest that there was no dedicated room for the assessment to take place. She chose the computer room for the assessment and she stated that it was "almost inevitable staff will come in" as the room also stored equipment. She told the inquest that, in hindsight, there should have been a note placed on the door stating "do not enter, meeting in progress".

64. When the Deceased was being assessed by Dr Boggs and Nurse Casey, Sister Flanagan spoke with Mrs Graham who discussed how concerned she was about her daughter and how she wasn't herself in the last few weeks. Sister Flanagan described

how she explained to Mrs Graham that it was within psychiatry's remit to prescribe medications and it was not within her remit. It is Mrs Graham's evidence that Sister Flanagan told her the Deceased would be prescribed medication "she would get her some meds to settle her for the night". Sister Flanagan added that she did not recall being told of the possibility of postpartum psychosis by Mrs Graham. I prefer Mrs Graham's evidence on these two points.

65. Following the assessment, Sister Flanagan, Sister Conway and Midwife Felekoglu, were told by Dr Boggs of the working diagnosis of obsessional neurosis and of his recommendations. Sister Flanagan told the inquest that she and Sister Conway specifically asked Dr Boggs if one to one observations were required and he replied, "no, that wasn't required".

66. Sister Flanagan stated that after the handover and after Dr Boggs had left the ward, she read Dr Boggs's entries in the maternity notes. She noted in Dr Boggs' note that a "watchful waiting" approach was recommended and that no medication was required at that stage. Sister Flanagan told the inquest that she was aware that Dr Boggs indicated in the records that the Deceased's presentation was obsessional anxiety, but psychosis could not be ruled out. Sister Flanagan told the inquest that Dr Boggs did not verbally tell her about puerperal psychosis during their handover. She stated that she would have wanted to have been told this differential diagnosis to "put alternate plans in place" as she was aware of the need to plan for the more serious diagnosis. She also stated that Dr Boggs did not use the words "watchful waiting" but that she read that in the records. She said that was not a term, which was used in midwifery. When asked, Sister Flanagan stated that she was familiar with the term puerperal psychosis from training and in practice and she had experienced it once before.

67. Sister Flanagan spoke to the Deceased and her family following the assessment. She stated that the Deceased was nursing her baby and was relaxed, smiling at her baby and engaged openly with her. She conveyed the plan to move her to a single room as suggested by Dr Boggs. Sister Flanagan explained that it would be a calmer environment in the single room and that Mr Quinn would be able to stay. At 18.30 hours, the Deceased moved to Room 2 in E ward. Sister Flanagan described how her office was next to Room 2 and for the remainder of her shift she based herself there, as she knew the Deceased was next door as part of her own personal care plan. She said this was "my own personal practice for the rest of my shift". At 20.45 hours during handover, the Deceased passed her office door on the way to the toilet and she smiled in acknowledgment of Sister Flanagan's presence. Sister Flanagan told the inquest that she did not record this "personal practice" in the notes but does recall telling Sister Cleland in a "by the way" manner.

68. Dr Robert Boggs, Associate Specialist Psychiatrist, gave evidence to the inquest. On 10 October 2018, he was at the Mater Hospital when he became aware of the Deceased's case. Dr Boggs and Nurse Casey were responsible for delivering the

Liaison Psychiatry Service that day. He explained that the Liaison Psychiatry Service within the Belfast Health and Social Care Trust assessed the psychiatric needs of patients on the various wards across the four Trust sites. He told the inquest that they were asked to assess the Deceased because of the disclosure of prior attempts of suicide. He told the inquest that he had come across postpartum psychosis in practice once before when he was a Senior House Officer. He stated that through his education, he knew the characteristics, presentation and risks associated with postpartum psychosis. He accepted that postpartum psychosis was a recognised psychiatric emergency; its presentation can fluctuate and that it is associated with maternal suicide and poses a risk to a child.

69. Dr Boggs attended E Ward shortly after 16.00 hours. He stated that their attendance with the Deceased was "fairly fast" as the target response time is within 48 hours.

70. Dr Boggs stated that he received a verbal handover from Midwife Felekoglu and Sister Flanagan. Dr Boggs told the inquest that before the assessment he had heard the words "postpartum psychosis" used in relation to the Deceased and that he was asked, "to come and exclude it". He could not remember whom the comment was attributed to. He stated that if he had been told that the Deceased's mother used those words, he said he would have spoken to Mrs Graham to elicit more information. However, without knowing this, he said, "I didn't feel I needed to speak to her at that time".

71. Dr Boggs told the inquest that he did not read the Deceased's notes prior to the assessment and that Midwife Felekoglu was reading from them and conveying the information verbally during the handover. He said he could not remember if he or Nurse Casey brought the notes into the assessment room. He said he did read the maternity notes before completing his note after assessing the Deceased. He told the inquest that he remembered being told that the Deceased attempted hanging three times but he "could not be certain" he was told that the Deceased lost consciousness on the third attempt. When asked at inquest, whether loss of consciousness would be significant in terms of indicating a degree of determination in respect of a suicide attempt, he replied that, in his opinion, whether there was a loss of consciousness is "not the germain point", it is "tethering or not tethering which is the germain point". He believed tethering a ligature was more significant in relation to intention.

72. Dr Boggs assessed the Deceased with Nurse Casey in the presence of her husband. They were both brought into the computer room by midwifery staff. When asked why he did not speak to them individually, he replied, "I took what I was given". Dr Boggs added, "I didn't see sufficient evidence to see them on their own". I find that as the Psychiatrist leading the assessment it was Dr Boggs's responsibility to take charge and ensure the assessment was conducted correctly. Since the Deceased's death, Dr Boggs told the inquest that he has changed his practice and he now insists on seeing patients on their own first.

73. Dr Boggs conducted the interview and Nurse Casey kept contemporaneous notes. They were interrupted on four occasions and he stated that "it gets in the way of the flow". Dr Boggs stated that the Deceased told him her thoughts of jumping out a window on the morning of 10th October were based on worry that she had harmed her baby the previous Friday when she looped her dressing gown cord around her neck and hand tightened it. She said it was not suspended or attached to any ligature point. The Deceased told Dr Boggs that that she lifted her arm up three times, tightening the ligature. She stated that she performed this act impulsively when her husband was in the home but did not disclose it to anyone at that point. Dr Boggs stated that the Deceased described the act as impulsive and that she regretted it. Dr Boggs reported that the Deceased said that it was "ridiculous" and that she had no intention of repeating it. She said she was relieved her baby was unharmed. In his detailed note following the assessment, Dr Boggs noted "no LOC", however earlier in the day the Deceased told midwives she had lost consciousness. I find that had Dr Boggs read the notes prior to the assessment he may have noted this. When asked if the Deceased giving contrary accounts would cause concern in relation to her presentation or openness, Dr Boggs stated that "in hindsight that was more significant" than he thought at the time. He said that he felt that she had been open and honest with him.

74. Dr Boggs told the inquest that both the Deceased and her husband described a pattern of anxiety she had suffered from around 20 week's gestation. In particular, the Deceased was worried that her underlying anxiety problems would somehow, through raised cortisol levels, cause damage to her child. She said she had researched this on the internet in an obsessive fashion. Dr Boggs stated that the Deceased further reported that she suffered increased anxiety from 29 weeks when she was told her baby would have to be delivered by caesarean section as it was in breech position. The Deceased reported that she felt "not a mother" as much as she wanted to be because she could not deliver her baby naturally and described guilt associated with this.

75. Dr Boggs told the inquest that in past psychiatric history, the Deceased stated that she had never been seen by Psychiatric Services. She had been prescribed anti-depressants by her GP after the birth of her second son. She stated that she recovered without medication. There was no previous history of self-harm or suicide attempts.

76. In relation to family history, Dr Boggs stated that a family member had attempted suicide by hanging and that this person had recovered. When questioned about anxiety, the Deceased detailed that she had been anxious regarding the safety of her two sons for a long time. She stated that they were seldom let go far from reach, as she was fearful that they would come to harm. She stated that she was worried about her son settling poorly in school and was feeling guilty about this. Dr Boggs stated that the Deceased described a longstanding obsessional pattern of cleaning within her home.

77. On mental state assessment, Dr Boggs stated that the Deceased appeared a little fatuous at the start of the interview but settled quickly and thereafter was warm, spontaneous and making self-depreciating jokes. He stated that the Deceased's speech was spontaneous and coherent with normal tone and volume. Dr Boggs stated that the Deceased's mood was subjectively low and anxious; objectively she was warm and reactive after the initial few seconds. Dr Boggs stated that the Deceased felt life was worth living and that she was looking forward to going home with her baby. Dr Boggs recorded that the Deceased expressed no ongoing suicidal thoughts during the interview, having previously called tightening the dressing gown cord at her neck ridiculous and expressing regret about it. She expressed no thoughts of harming her husband, her older children or her baby.

78. Dr Boggs described how throughout the assessment the Deceased comforted her husband when he became tearful. He stated that he drew reassurance from this as her "ability to be empathetic towards him", to physically comfort him "is not something that is associated with a patient who is psychotic", "it is a very human warm gesture". Dr Boggs explained that, at the time, as far as he was concerned he was experiencing an "openness" and honestness". However, Dr Boggs conceded that, in hindsight, the presence of Mr Quinn may have prevented the Deceased from providing detail and she may have been reluctant to make open disclosures in order to protect her husband.

79. Dr Boggs described how the Deceased did not have characteristics of a delusional but rather of an obsessional thought. Dr Boggs stated that he did not elicit any other characteristic experiences suggestive of psychosis, namely ideas of reference, delusions or passivity phenomena and he did not observe the Deceased responding to external stimuli. When asked at inquest about the Deceased meeting the criteria for psychosis, he replied "definitely not", "what I was seeing was developing obsessional thoughts" in relation to the protection of her children and the disclosure about a family member combined with the fact that "she was creating a new self" as she now had a baby girl.

80. Dr Boggs told the inquest that at that time, his working diagnosis was obsessional neurosis. Dr Boggs stated that he had a differential diagnosis of puerperal psychosis. His entry in the Deceased's notes states, "This appears to be more an obsessional anxiety presentation rather than a puerperal psychosis. However, the latter cannot be outruled one day postpartum". When Mr Quinn's description of the Deceased's behaviour was put to Dr Boggs, Dr Boggs agreed that it was a very different presentation from the Orlaith he was speaking to. When asked if Deceased presented to him in the same way as to Mr Quinn earlier in the day, might he have taken a different view, Dr Boggs replied "no might". Dr Boggs told the inquest that if he had all of the information available to him and in particular, Mr Quinn's evidence, he would have formed a different view of the Deceased's diagnosis. He confirmed that he would have diagnosed the Deceased with puerperal psychosis. Dr Boggs

expressed his "profound regret" at not asking Mr Quinn and Mrs Graham if there was anything else they would like him to know about the Deceased.

81. At the end of the assessment, the Deceased asked about the involvement of social services. Dr Boggs recalled Nurse Casey telling the Deceased that a social worker would get involved but this was normally for support. After hearing, it was confirmed by the Trust that a UNOCINI (Understanding the Needs of Children in Northern Ireland) referral was not made to social services in respect of the Deceased's children, in particular, Baby A.

82. Dr Boggs told the inquest that he emphasised to the Deceased and her husband that he felt this was likely to be a less serious problem but told them he could not rule out a more serious one. He stated that he deliberately did not mention his working diagnosis of obsessive/compulsive disorder (an obsessional neurosis) or the possibility of the exclusion diagnosis of puerperal psychosis as he stated he did not want the Deceased searching the internet for potentially unreliable information about these conditions as the Deceased had with her initial anxiety symptoms. Dr Boggs was clear in his evidence that he told the Deceased and her husband that he was specifically not telling them a diagnosis for that reason. This is contrary to the evidence given by Mr Quinn. Dr Boggs told the inquest that he views his words now as "clumsy". He went on to say that, at the time, in his view, not telling the Deceased the diagnosis was "a reasonable option", however "I do not anymore".

83. After the assessment, Dr Boggs stated he conveyed the outcome of the assessment to Midwifery staff and documented it in detail in the maternity notes. He stated that he spoke directly to Midwife Felekoglu, Sister Conway and Sister Flanagan and later with the Liaison Midwife, Midwife Darrah, regarding the outcomes and the intended plan. He left the ward around 17.40 hours. Sister Conway and Sister Flanagan stated that during this handover Dr Boggs did not refer to the differential diagnosis of puerperal psychosis. He explained to the inquest that when he gave the handover he was "half way through making notes" of the assessment. When asked why he did not speak to them again once he had completed his notes, he said "it didn't occur to me to tell them" and on reflection he should have.

84. Dr Boggs stated that he proposed the Deceased should stay on the ward overnight for review again in the morning by Psychiatric Services. He anticipated that she would likely be referred to the Home Treatment Team. He recommended no medication but rather watchful waiting and that the Deceased should be observed in a low stimulus environment in a side ward and suggested that a family member may stay with her for support rather than in a safeguarding role. Dr Boggs described the term "watchful waiting" to mean the Deceased should be observed in her normal activities to ascertain whether she was unusually quiet, withdrawn or suspicious or responding to anything strange or unusual. He presumed this term would have been understood by the maternity nurses. Dr Boggs did accept that this term would mean more to a psychiatric team than a maternity team.

85. Dr Boggs held the view that his immediate plan for the Deceased's care overnight was sufficient and he did not regard, from his assessment, that the Deceased was an active suicide risk. Dr Boggs stated he was reassured that the Deceased was engaging and she stated that she was not feeling suicidal. Dr Boggs considered that the maternity ward had trained staff present throughout the night and that the Deceased was in a place of safety.

86. When it was suggested to Dr Boggs that when a differential diagnosis is made, the management plan should be based on the more serious diagnosis, he agreed. He stated that whilst he gave a differential diagnosis, he was very confident that it was obsessive compulsive disorder, "that was the evidence I had". Dr Boggs opined that had he made a management plan for the differential puerperal psychosis, which he acknowledged he should have, it would have directed that the Deceased be under one to one observations, "at the very least".

87. When asked about seeking collateral history from the Deceased's husband and mother independent of the Deceased, Dr Boggs stated that he did take a collateral history from Mr Quinn during the Deceased's assessment. He stated that it is not routine practice to actively seek collateral history from two different people. It is normally taken from the nearest relative, which was Mr Quinn. Dr Boggs considered that he had obtained sufficient collateral history to prepare his treatment plan. Dr Boggs did accept in evidence that he did not obtain independent collateral history. He also accepted that he should have obtained information from Mrs Graham.

88. Dr Boggs stated that he had to handover on three different occasions and the lack of a single handover point was unhelpful for ensuring continuity of care and clear communication. I agree with these comments.

89. Mr John Casey, Specialist Practice Liaison Psychiatry Nurse, gave evidence to the inquest. He told the inquest that in his 33 years as a mental health nurse, he had no previous experience of assessing postpartum psychosis. On the afternoon of 11th October 2018, Nurse Casey received a phone call from Sister Fidelma Conway. She requested psychiatric input for the Deceased and Nurse Casey conceded at hearing that he may have been told that the Deceased attempted suicide. He agreed to see the Deceased on return to the RVH and he asked Sister Conway to make a formal referral through the One Point of Referral system.

90. Dr Boggs told the inquest that he recalled a reference made to postpartum psychosis before the assessment. Nurse Casey told the inquest "I do not recall that at all, I just remember the referral information".

91. When driving back to their base in the RVH, Nurse Casey received a phone call from Ms Linda Taylor, Liaison Team Line Manager, following a formal referral from Sister Conway. Ms Taylor asked if they would have time to see the Deceased. At around 16.00 hours Dr Boggs and Nurse Casey arrived on E Ward and received a handover from Midwife Felekoglu and Sister Flanagan. Nurse Casey told the inquest

that he did not recall being told that the Deceased lost consciousness. He stated that he did not read the maternity notes before the assessment as "we got a very good handover from the midwife". He stated that if he knew about loss of consciousness, he stated it "adds a concern" and may have suggested the Deceased was "guarded" in the disclosures she made to him and Dr Boggs.

92. During the assessment with the Deceased and her husband, Dr Boggs led the mental state assessment and Nurse Casey recorded a written history. Nurse Casey told the inquest that his role was to record what was said in the patient's psychiatry notes and to assess the mental state of the patient and to form an opinion.

93. Nurse Casey stated that when the Deceased entered the room she stated "It's OK now I have talked about it and its fine now". The Deceased explained that she had been worried about the physical symptoms experienced during pregnancy and that this would have an effect on her baby and she described this as a precipitant to her attempt at self-strangulation prior to admission. The Deceased described tying a dressing gown belt around her neck for 3-4 seconds and pulling it tightly without loss of consciousness.

94. The Deceased then described an 8-month history of initial insomnia secondary to anxiety symptoms prior to delivery. She talked about her current anxieties regarding her newborn and how they were similar to her second pregnancy with her son. She described herself as an overprotective mother to both her sons. She stated that she did not enjoy the latter stages of her pregnancy with Baby A and when asked she reacted very positively that she was delighted to have a baby girl. During the assessment Mr Quinn became upset and was tearful and stated that he had been largely unaware of how the Deceased had been thinking and feeling recently.

95. Nurse Casey told the inquest that the Deceased was a little anxious at the start of the assessment but was smiling and reactive. She was spontaneous in conversation with some use of humour and there was no evidence of any formal thought disorder. The Deceased described life as worth living but still had some fears that she may have harmed her daughter. Nurse Casey recorded that the Deceased clearly denied any current suicidal ideation, plan or intent and there was evidence of future planning. Nurse Casey told the inquest that there was no evidence of any psychotic symptoms. Nurse Casey's notes did not record the Deceased's thoughts about jumping out of a window and running away from the ward. Nurse Casey acknowledged that this was a significant omission as it indicted potential suicidal ideation. When Mr Quinn's evidence was put to him about a lack of "rapport" with the Deceased, Nurse Casey explained that he did not "notice anything untoward" and "I didn't think anyone was unhappy with the consultation". Nurse Casey agreed that the number of interruptions during the assessment was less than satisfactory. He agreed with Dr Boggs' comments that in hindsight, the Deceased should have been spoken to on her own and a collateral history taken separately.

96. Nurse Casey recorded in his notes that the impression following assessment was "anxiety state with obsessional symptoms". Nurse Casey explained that this was not specifically told to the Deceased but, in fact, this was his interpretation of what Dr Boggs meant. He stated that the plan for the Deceased was to remain in hospital overnight for further psychiatric review the following day with the potential for referral onto psychiatric services if needed on discharge. There were no immediate safeguarding concerns. Nurse Casey did not record what exactly was told to the Deceased and her husband and he stated, "I didn't know why I didn't record that". He acknowledged that if puerperal psychosis was a differential diagnosis it should have been included in his notes and that the care plan, also acknowledged by Dr Boggs, lacked detail. He stated that if puerperal psychosis was a differential diagnosis, the care plan should have reflected the most serious condition and should have directed one to one observations.

97. Nurse Casey stated that he told the Deceased that the social worker would want to speak to her regarding child protection concerns and that there was nothing to worry about and that it was for support. He said, "I did feel that she didn't take it that well." When asked at inquest if a UNOCINI referral was made, Nurse Casey told the inquest "I was told it was made" and he explained that it is the responsibility of the first person who is alerted to the concern to make the referral. I am not persuaded by Nurse Casey's evidence on this issue. When asked if it forms part of the management plan, he replied, "not necessarily" unless there is some risk to the child and it did not have to form part of their documentation. At inquest, after hearing all the evidence, Nurse Casey conceded that, with all the information, a risk assessment should have been considered in relation to Baby A and a UNOCINI form completed.

98. Nurse Casey left E Ward at 17.20 hours. This was before Dr Boggs provided a handover to the midwives or completed his notes. Nurse Casey confirmed that he did not know of Dr Boggs's differential diagnosis, "I wasn't sure", "he didn't actually say that to me but I assumed that that is what he meant when he said it could be more a serious thing to the family". I am not persuaded by Nurse Casey's evidence that he "assumed" Dr Boggs would diagnose puerperal psychosis. Throughout Nurse Casey's time dealing with the Deceased, those words were never used.

99. Nurse Casey told the inquest that the psychiatric risk assessment is an additional document, which should reflect what was already identified and documented at initial assessment. He stated that while it is practice to complete the risk assessment as soon as practicable; it would not always have been done immediately following assessment. He explained that it was not completed for the Deceased because the assessment was completed beyond the end of the working day and that it was his intention to complete the risk assessment on the following morning. He went on to say that the psychiatric management plan was outlined in his psychiatric notes and in the maternity notes by Dr Boggs and within both there was no identified risk to the Deceased or others at this time.

100. Midwife Lisa Darrah, Midwifery Coordinator for Perinatal Mental Health and Social Complexity in Pregnancy, gave evidence to the inquest. On the afternoon of 10th October, Midwife Darrah received a telephone call from the Head of Midwifery, Mrs Brenda Kelly, informing her that the Deceased had expressed thoughts of suicide and she requested that Midwife Darrah ensured the appropriate professionals were involved in the Deceased's care.

101. When she visited the ward, the Deceased was being assessed by Dr Boggs and Nurse Casey. When she returned to the ward, the assessment was complete and Dr Boggs informed her that he believed the Deceased was presenting with obsessional anxiety rather than puerperal psychosis, however, he could not rule it out at that time. He stated to her that "he didn't believe Mrs Quinn was psychotic or suicidal in any way". Dr Boggs reported his plan and Sister Flanagan stated that this had been communicated to the midwifery staff on E ward. Midwife Darrah told the inquest she had training in postpartum psychosis and had encountered it once in practice. When asked, she agreed with the statement that it is the most serious condition on the spectrum stating "because of the risk to the mother and child". She stated that she had heard the term "watchful waiting" which Dr Boggs used however, she was not familiar with it in a maternity setting.

102. Midwife Darrah told the inquest that at present, a quarter of midwives have received the Trust's mental health training which covers postpartum psychosis. She stated that the training would be offered every three months going forward.

103. Ms Sharon O'Prey, Health Care Support Worker, gave evidence to the inquest, which was admitted by way of Rule 17. She was working a night duty on 10th October 2018. She received a handover and introduced herself to the Deceased and her husband. At approximately 12 midnight she spoke to the Deceased on the corridor. At 03.20 hours, Mr Quinn asked her if she had seen the Deceased. She immediately checked the nearby toilets and alerted other staff. She remained with Baby A whilst a search for the Deceased took place.

104. Midwife Fiona McKee gave evidence to the inquest, which was admitted by way of Rule 17. She came on duty at 20.30 hours on 10 October as the Midwife in Charge. She received a handover from Sister Flanagan. It was highlighted to her that the Deceased had been assessed by the Liaison Psychiatry Team and that their impression was that the Deceased was symptomatic of obsessional neurosis and that Mr Quinn would be staying overnight with the Deceased for support.

105. At 21.45 hours, Midwife McKee visited the Deceased who stated that she "felt more like herself". She brought a recliner, pillow and blanket into the room for Mr Quinn as he was staying overnight. At approximately 01.00 hours, she walked past the Deceased's room and the light was on. At 03.25 hours, she was in the Admissions Unit when Midwife Corr telephoned her to say that Mr Quinn was searching for his wife. Midwife McKee then joined the search.

106. Nurse Kathleen Cardwell gave evidence to the inquest. On Wednesday 10 October 2018, she was on night duty in the neonatal intensive care unit. At approximately 02.45 hours she went on her break and when returning she met the Deceased at the doors into nursing administration. Nurse Cardwell asked the Deceased if she was okay to which the Deceased responded by saying she was looking for a toilet. Nurse Cardwell stated that she was "looking down a corridor and did appear to be lost". Nurse Cardwell directed her to the closest toilet, which was in the McAfee complex. The Deceased thanked her and turned in the direction of the toilet. Nurse Cardwell described the Deceased as being "very calm". At around 03.15 hours, Nurse Cardwell met a midwife who asked if she had seen anyone and she directed her to where she directed the Deceased.

107. Bank Midwife Catherine Corr gave evidence to the inquest. On 10th October 2018, she was one of the four staff on night duty. Midwife Corr stated that Midwife McKee informed her that the Deceased and her husband and baby were in Room 2 and that her husband was staying overnight. During her verbal handover from Midwife Felekoglu, Midwife Corr asked if the Deceased was on one to one observations and she was told she was not. Midwife Corr stated she asked this question as she knew the Deceased had said she attempted suicide and had suicidal thoughts. Whilst not on one to one observations, Midwife Corr stated that she was more observant of the Deceased as compared to other patients as "I thought it would be useful and Midwife Felekoglu said it would be a good idea". At handover, Midwife Felekoglu did not mention postpartum psychosis and Midwife Corr told the inquest she specifically asked if it was postpartum psychosis as "a point of clarity for me" as she had experience of it in a patient once before. Midwife Felekoglu told her she could not confirm this.

108. Midwife Corr told the inquest that she would have wanted to have known the differential diagnosis and she agreed with Dr Boggs's evidence that one to one observations should have followed a diagnosis of puerperal psychosis. She described how, on one to one observations, the patient is never left and if they attempted to leave the matter would be elevated.

109. Midwife Corr told the inquest that in relation to the office in which the Deceased's room was beside "we don't use that sister's office at night". Sister Conway had told the inquest that that room was chosen as it was beside an office, which was occupied, however she did not clarify that it was not used by anyone else when Sister Flanagan's shift had finished. Midwife Corr said the night staff work out of the nurse's station on the ward. I am not persuaded by all of Sister's Conway's reason's, in evidence, as to why Room 2 was chosen.

110. At 03.25 hours, Mr Quinn came to Midwife Corr and told her his wife was not in her room. Mr Quinn was extremely upset. Midwife Corr informed other midwives of the situation. Midwife Corr noted that the fire escape door was slightly opened and informed the security team of this. Midwife Corr and Sister Cleland agreed that the

police should be informed immediately. Approximately one hour later, they were informed that the Deceased had been found.

111. Midwife Melanie Cleland gave evidence to the inquest. She came on duty as Night Sister at 20.30 hours on Wednesday 10 October 2018. She received a handover from Sister Flanagan in which the Deceased was brought to her attention. This was also recorded in the "daily state" which is a handover sheet shared between the service coordinators. It did not record that there was a differential diagnosis of puerperal psychosis. Midwife Cleland accepted that if one to one observations had been directed by the Psychiatric Liaison Team, the Deceased would have been observed at all times, within eyesight or arm's length and if the Deceased attempted to leave the ward she would have been accompanied and the matter escalated.

112. While Midwife Cleland was in the Admissions Unit at approximately 03.25 hours, she overheard a call from Midwife Corr to Midwife McKee stating that the Deceased was missing. She went to E ward immediately and contacted the security team and other staff to assist with the search. She then telephoned the PSNI and reported the Deceased as a missing vulnerable person. Shortly after 04.00 hours, Midwife Cleland was called to attend the McAfee Complex where the Deceased had been found.

113. Dr Adeeb Khan, Senior House Officer, gave evidence to the inquest. On 10th October 2018, he commenced his shift as Senior House Officer in the Obstetrics Department at 20.00 hours. He received a handover which included a discussion of the Deceased's medical history but he stated that he was not told the Deceased's diagnosis or care plan. At 04.09 hours he responded to a shout for help from a staff member and he immediately went to the McAfee Lecture Theatre. He was taken to the Deceased who had clothing tied around her neck, which was tied to a sloping handrail. Dr Khan described her body as hanging from the hand railing with both of her knees bent and legs making contact with the floor. Her body was cold and pale with extensive purple discolouration of her legs and a mottled appearance. Whilst not recorded in the medical notes, Dr Khan told the inquest that he pronounced life extinct at 04.13 hours. At inquest, he acknowledged that he should have recorded this important information.

114. Midwife Brenda Corry told the inquest that at approximately 03.40 hours, Night Sister Cleland came to the Delivery Suite and asked her to help in the search for the Deceased. Along with Midwife Christine Peddle, Midwife Corry searched the McAfee Complex (a teaching and meeting room area). They opened the double doors of the corridor leading to the McAfee Lecture Theatre. The corridor was in darkness and they discovered the Deceased behind the doors. She told the inquest that it was "a quiet and secluded place" and no staff would have any reason to be there during the night.

115. Constable Aaron Bingham gave evidence to the inquest. At approximately 04.05 hours on Thursday 11 October 2018, he was tasked to attend the Royal Victoria Hospital following a report that the Deceased had gone missing from the maternity ward. Whilst on route he received a message that the Deceased had been located and was Deceased. He arrived at 04.20 hours and observed the Deceased in the corridor leading towards a lecture theatre. The Deceased's purse and mobile telephone were beside the Deceased.

116. Dr Nuala Devlin, the Deceased's GP, gave evidence to the inquest. In 2010 and in 2014, the Deceased attended the practice with anxiety. After the birth of her first child in 2010, the Deceased was noted on 21st June 2010 to be stressed at the thought of leaving her child and returning to work. On 19th July 2010, she was noted to be "stressed" with a low appetite and poor sleep but no medication was required. She then commenced a phased return to work.

117. In August 2014, following the birth of her second child, the Deceased attended her GP with the note stating "history of anxiety" and "feels worse since baby was born" and "no depression". She did not feel able to return to work and she agreed a trial of a B Blocker, Propranolol, which Dr Devlin explained was more for the physical symptoms of anxiety rather than an anti-depressant. On 8th September 2014, the Deceased attended her GP again and her medication was changed to Sertraline. At review on 2 October 2014, it was noted that the Deceased's anxiety and mood had much improved and she had planned to go to work the following week. Dr Devlin told the inquest since October 2014 there were no further consultations regarding mood or anxiety. She told the inquest that the Deceased last attended the surgery on 17 September 2018 and she made no complaints in relation to mental health issues at this appointment.

118. Dr Peter Ingram, the Assistant State Pathologist for Northern Ireland, gave evidence to the inquest. He conducted an autopsy on the Deceased on 12 October 2018 and thereafter produced a report.

119. Dr Ingram told the inquest that death was due to hanging. There was a ligature mark on the left side of her neck and the ligature had exerted sufficient pressure on the neck to have interfered with breathing and the flow of blood to and from the head thereby resulting in death. Dr Ingram opined that unconsciousness would probably have occurred quite rapidly "within 30 seconds or so" with death supervening shortly thereafter.

120. When asked about the Deceased's previous attempts at hanging on Friday 5 October, in particular, the description recorded in the infant record and management of care, of "went fuzzy – no loss of consciousness"; Dr Ingram told the inquest that "sounds like she was at the point of losing consciousness". In other records, the Deceased recorded that she did pass out. Dr Ingram commented that this is consistent with an attempted hanging and loss of consciousness.

121. The report of Forensic Science Northern Ireland showed that at the time of her death there was no alcohol in the Deceased's body. A sample of blood was further analysed for a range of common pharmaceutical medicines and drugs of abuse but only a low concentration of the painkiller paracetamol was detected.

Expert Evidence

122. Dr Neta Chada, Consultant Psychiatrist, instructed by the Belfast Health and Social Care Trust and Professor Eleni Palazidou, Consultant Psychiatrist, instructed on my behalf, both gave evidence to the inquest.

123. Professor Palazidou explained to the inquest that approximately 50 to 60% of women experience some emotional distress within the first few days of birth, sometimes called "baby blues" and it is nothing to worry about as it resolves over a period of a few days. Less commonly, approximately one in four women, develop mental health problems such as anxiety and/or depression in the weeks and months following the birth. A small number of women, approximately one to two per 1000 of women, develop the more serious puerperal psychosis. Dr Chada agreed that puerperal psychosis is much less common and occurs in about one in 500 live births and it is a condition that is well recognised.

124. Dr Chada explained that puerperal psychosis is a psychiatric emergency and that it can, at times, be difficult to identify immediately. It is more closely aligned to a bi-polar psychosis and it is variable, meaning that it can be "variable in the same person over a period of time". It can present with variable mood, delusions, hallucinations, and agitation. Professor Palazidou added that someone with psychosis means they lose touch with reality.

125. In relation to the Deceased's variability, Professor Palazidou explained that she believed the Deceased had developed a delusional state about her abnormal beliefs about her baby. She stated those beliefs would not necessarily disappear, what would change is the personal presentation, and the Deceased "was able to control whatever was going on in her mind and appear to other people to be calm and collected". Dr Chada agreed with Professor Palazidou, that the documented appearance of calmness was "covering up" by the Deceased. She stated, "that makes it very difficult for staff who are assessing" to diagnose. She stated that it is a condition associated with rapid fluctuations and "the thing about puerperal psychosis is that it is typically A typical". She said they normally expect to see it in day 3 or 4 but it can occur sooner, as in the Deceased's case. Professor Palazidou stated that puerperal psychosis usually presents within one to two weeks however, each individual is different. Deterioration can happen very quickly. As a result, Dr Chada stated that they rely on taking a good psychiatric history and they rely on collateral history taken from midwives and family. Professor Palazidou added that when assessing new patients, they "need to know everything there is to know that will help us and enable us to make a correct diagnosis and to make a plan of action that would be appropriate to the individual".

126. Professor Palazidou described how there have been many cases of maternal suicide and infanticide associated with patients with puerperal psychosis. Dr Chada told the inquest that suicide in pregnancy and postpartum is rare, however suicide in "puerperal psychosis has the highest rate in terms of the perinatal and postnatal period". When Dr Boggs's evidence that he drew reassurance when the Deceased comforted her husband during the assessment and showed empathy and engaged with humour was described, both experts agreed that patients with puerperal psychosis have the ability to retain empathy and that should not have been a reason to exclude the possibility of the diagnosis.

127. Both Professor Palazidou and Dr Chada told the inquest that the physical circumstances, in which the mental health assessment of the Deceased was performed, were not of adequate standard. The office used for the assessment failed to ensure privacy and there were frequent interruptions by staff. Dr Chada did point out that space availability in Belfast hospitals is a problem often encountered by the liaison mental health professionals when they are asked to carry out assessments of patients in non-psychiatric wards, as occurred in the case of the Deceased. Both Professor Palazidou and Dr Chada agreed that given the seriousness of the Deceased's case, more effort should have been made to identify a quiet space, free from interruptions. Professor Palazidou suggested that if there was no suitable space available, the ward staff could have been informed of a meeting taking place with a "do not disturb" sign at the entrance.

128. Both Professor Palazidou and Dr Chada agreed that the mental health assessment conducted by Dr Boggs and Nurse Casey was not of adequate standard on several grounds. Firstly, the Deceased was not offered to be seen on her own for at least part of the interview. Secondly, an inadequate history (including recent and past history, family history) was obtained. Professor Palazidou stated that the Deceased's history in relation to her last two pregnancies would have alerted a doctor who assessed her after the birth. She was "certainly more highly vulnerable to a reoccurrence". Dr Chada agreed that her history "increased the index of suspicion after this pregnancy". Thirdly, an inadequate assessment of current mental state was obtained. Professor Palazidou termed it "sketchy" while Dr Chada felt it was limited. Dr Chada stated, "I have no doubt this was a difficult assessment". She stated that it appeared to be a lengthy examination covering a number of areas, which is why she called it "limited" rather than "sketchy". Fourthly, Professor Palazidou felt there was a very poor assessment of suicidal risk, while Dr Chada felt the assessment of suicidal risk was incomplete, rather than very poor. Having regard to Mr Quinn's description of the Deceased's presentation on 10th October, Professor Palazidou said there was an imminent risk of suicide. Dr Chada disagreed saying, "I don't think we can confidently say there was an imminent risk", "there was a recognisable risk". Finally, both experts pointed out that no collateral history was sought from the family. Dr Chada felt that a collateral from the Deceased's next of kin, Mr Quinn, was sought, but was inadequate, as he was not spoken to on his own.

129. Both Professor Palazidou and Dr Chada agreed with the diagnosis of puerperal psychosis as being the appropriate diagnosis in the Deceased's case. Dr Boggs's working diagnosis on concluding his assessment was that of "obsessive compulsive disorder (an obsessional neurosis) with the possibility of the exclusion diagnosis of puerperal psychosis".

130. Dr Chada did not disagree with the diagnosis of obsessional neurosis as a possible differential diagnosis, though she did not think it was likely. Dr Chada stated that it was clear the Deceased was unwell antenatally, and that this increases the risks postnatally. She said it was impossible to say that the Deceased was psychotic antenatally, but that the shift from her mixed anxiety and depressive symptoms to her psychosis postnatally is well recognised.

131. Professor Palazidou disagreed with the second diagnosis of obsessional neurosis and considered it instead to be a depressive disorder with prominent anxiety or comorbid anxiety being present prior to the emergence of psychotic symptoms, possibly of 5 months duration (as per history given by the Deceased) which developed into puerperal psychosis, postpartum. Dr Chada agreed with Professor Palazidou that there was evidence of a depressive disorder with comorbid anxiety being present antenatally, which developed into puerperal psychosis postnatally.

132. Both Dr Chada and Professor Palazidou agreed that puerperal psychosis should have been considered as the priority diagnosis even if Dr Bogg's assessment failed to identify this as such (although considered the possibility), given the risks associated with this condition. Both agreed this to be important as it informs the management plan, which should consider the worst possible scenario and plan accordingly to ensure patient safety and wellbeing. That plan should have included the Deceased being placed on one to one observations.

133. Professor Palazidou told the inquest that if a patient is diagnosed with puerperal psychosis, ideally they should be admitted to a Mother and Baby Unit within a psychiatric unit. The purpose of the unit is to ensure that the bonding with the baby continues. As there is no Mother and Baby Unit in Northern Ireland, a mental health nurse should stay on the obstetric ward with the patient and carry out one to one observations, until she was transferred to a psychiatric ward. Dr Chada agreed that there would be one to one observations with trained psychiatric staff or obstetric ward staff until the mother could be transferred to an acute psychiatric ward or transferred into Home Treatment Crisis Response.

134. Both experts agreed that the risk assessment was limited and inadequate as it failed to consider all relevant factors involved (the presence of depressive and psychotic symptoms with severe anxiety, very recent history of suicidal ideas and attempts using drastic measures (asphyxiation and considering jumping out of a window), puerperal state, current suicidal ideation, family history of suicide. Dr Chada indicated that Dr Boggs and Nurse Casey had not identified psychotic thinking

in their assessment, though there was evidence to suggest this from the collateral and midwifery notes.

135. Professor Palazidou and Dr Chada agreed that the diagnosis and in particular the possibility of puerperal psychosis, as assessed by Dr Boggs and Nurse Casey, were not clearly communicated either to the Deceased or to her family. Both also agreed that the Deceased and her family, as well as the obstetric ward staff, should have been informed of the diagnosis of puerperal psychosis even if Dr Boggs considered this a possibility and not a primary diagnosis and they should have been made aware of the potential risks associated with such a diagnosis.

136. Professor Palazidou and Dr Chada agreed that the management plan drawn up was not reasonable and not sufficiently robust. Both agreed that continuous one to one supervision was required by a mental health professional until the assessment by the Consultant Psychiatrist the following day, which would inform arrangements for further assessment and management. Dr Chada considered it reasonable but not essential to offer medication although accepted that sedation or a benzodiazepine would have been useful. Professor Palazidou thought that given the Deceased's very disturbed and distressed mental state as observed by family and ward staff earlier in the day and severe insomnia of several days' duration, sedation was needed and would have been beneficial.

137. Professor Palazidou and Dr Chada agreed that although a side room offered a quieter environment, this was unsafe as it did not allow ongoing observation by nursing staff and offered an easier exit route from the ward. Dr Chada felt the side room would have been a good option if one to one observations had been instigated.

138. Both Professor Palazidou and Dr Chada agreed that the communication of the management plan was not reasonable. They both stated that the midwifery staff, family, in particular Mr Quinn, who was to stay the night with the Deceased, were not informed of the diagnosis (the possibility of puerperal psychosis as assessed) and were not made aware of the fluctuating mental state and possible risk of harm (both for the Deceased and her baby). Mr Quinn was unaware of the risks involved when the Deceased would be on her own for several hours during her "shift" with the baby.

139. Both experts stated that the nursing staff were given vague advice of "watchful watching" and were not given any clear indication as to what changes or signs they should look out for. Professor Palazidou stated that the nursing staff therefore proceeded to do the usual physical assessments they were accustomed to doing in their day-to-day work.

140. In relation to Social Services involvement, Professor Palazidou stated that the most effective way to explain this to a mother is to explain to her why she feels the way she does, to reassure her that this is a temporary state, that it can be treated and that Social Services will be supporting her. In summary, "to reassure the mother it is

for her benefit not to her detriment". Dr Chada agreed, stating that the mother should be informed that puerperal psychosis is a very treatable illness.

141. When asked about the intentions of the Deceased leaving the room that night, particularly as she did not take the belt of her dressing gown which she had used before, Dr Chada explained to the inquest that she found that difficult to understand. Professor Palazidou agreed, stating, "I suspect it wasn't planned". She added "her emotions were going up and down and I suspect she got extremely agitated and maybe the thoughts just overwhelmed her and she just ran off" and then she got to the point "that she felt couldn't cope with it and hanged herself". She concluded by saying that she did not think the Deceased was in a calm state to plan it.

142. Professor Palazidou described how puerperal psychosis is treatable and "the outcomes are very good". Dr Chada agreed that it is treatable and normally treatment takes weeks rather than days and people usually improve in weeks rather than months. Dr Chada emphasised that it is a "rare event" but "treated properly, you would expect recovery" and this would have applied to the Deceased. Professor Palazidou described how medication is essential and indeed the key treatment, "it cannot go away by itself". It would be medication quite quickly to treat the condition alongside other interventions. Dr Chada agreed that medication is essential, but the timing of it might be an issue. She stated that she does not normally start anti-psychotics immediately, maybe a sedative on the first night to enable a good night's sleep. She explained that she likes to observe the illness a little longer before prescribing mood stabilisers and/or anti-psychotics or sometimes ECT.

143. Professor Palazidou opined, that, on the balance of probabilities, had adequate attention been given to the suicide risk factors and appropriate measures taken to monitor the Deceased's mental state and behaviour, and in particular ensuring that she was being observed at all times, the Deceased's death could have been prevented. Dr Chada opined that she is well aware of the uncertainties of risk assessments and the unpredictability of suicide. However, she did accept that, on the balance of probabilities, had an appropriate plan been put in place, which included one to one observations, the Deceased would have been less likely to be able to take their own life. In the Deceased's case, Dr Chada commented, "that there were a number of inadequacies that came together".

Conclusions on the evidence

144. I find, on the balance of probabilities, that the Deceased's death on 11 October 2018 was both foreseeable and preventable. Had all of the available information in relation to the Deceased's presentation been obtained by Dr Boggs and Nurse Casey prior to and during the Deceased's mental health assessment, then I find, on the balance of probabilities, that the risk of the Deceased's death on 11 October 2018 would have been foreseen. In making this finding, I consider not only the expert evidence but also the evidence of Dr Boggs himself. He acknowledged that, had he

received the information in relation to the Deceased that was contained within her husband's statement, he would have reached a different conclusion and would have diagnosed puerperal psychosis. He acknowledged that one to one observation would have flowed from such a diagnosis. Had the Deceased been correctly diagnosed with puerperal psychosis as a primary diagnosis or, at the very least, an appropriate risk management plan taking account of the differential diagnosis of puerperal psychosis, been drafted and implemented, I find, on the balance of probabilities, that the Deceased's death on 11 October 2018 was preventable.

145. On the evidence before me, there were a number of missed opportunities, in the care and treatment of the Deceased, which I outline below, each of my findings I make on the balance of probabilities.

146. I find that the midwives caring for the Deceased, did identify the seriousness of the Deceased's disclosures and I find that they escalated their concerns in a timely and appropriate manner.

147. I find that the Psychiatric Liaison Team correctly triaged the Deceased's referral as urgent and I find that the Deceased was assessed by the Psychiatric Liaison Team, in a timely manner.

148. I find that the mental health assessment should have taken place in a private room or, at the very least, in a room with 'a do not disturb sign' placed on the door to avoid interruptions during the assessment.

149. I find that the Deceased should have been assessed on her own.

150. I find that the collateral history was incomplete and I find that a collateral history should have been taken from the Deceased's husband and mother, separately from the Deceased.

151. I find that Dr Boggs and Nurse Casey should have read the Deceased's maternity notes before assessing the Deceased, rather than relying on a verbal handover.

152. I find that Nurse Casey's record in the psychiatry notes lacked sufficient detail. This may have affected any subsequent management plan for the Deceased, however this did not affect the overall outcome.

153. I find that Dr Boggs should have diagnosed the Deceased with puerperal psychosis as the primary diagnosis rather than a differential diagnosis and that he would have done so, had he taken a fuller collateral history. However, even armed with the information that he did have, and with the differential diagnosis of puerperal psychosis that he reached, I find that the management plan that he instituted was lacking and did not adequately address the risk that the Deceased was suffering from puerperal psychosis.

154. I find that Dr Boggs's management plan lacked detail, used terminology unfamiliar to maternity staff and was inadequate. I find, that the plan should have reflected the differential diagnosis of puerperal psychosis, which was the more serious of the two diagnoses. I find, that the management plan for the Deceased should have included medication; transfer to a psychiatric ward, or at the very least one to one observations until a further psychiatric assessment was conducted the following day.

155. I find that Dr Boggs should have provided a full handover, to include the diagnosis and management plan, to the midwifery staff once he had completed his notes.

156. I find that the psychiatric risk assessment should have been completed by Nurse Casey immediately after the assessment. The lack of a clear and appropriate management plan in both the psychiatric notes and maternity notes highlighted the need for that document to be completed.

157. Given that the Deceased ought to have been diagnosed with a primary diagnosis of puerperal psychosis, or even operating on the basis of a differential diagnosis, I find that the Deceased should not have been moved to a side room in the absence of one to one observations being implemented. It prevented ongoing observation by nursing staff in the bay and it offered an easier exit route from the ward.

158. I find that communication between the Psychiatric Liaison Team and the midwifery teams during handover, lacked consistency and detail. I find that, Dr Boggs should not have had to provide a handover three times and guidance for handovers between the psychiatry service and midwifery service ought to be put in place.

159. I find that the diagnosis, management plan and rationale for same, should have been communicated to the Deceased and her husband.

160. I find that the various handovers between midwifery staff were inconsistent in the information discussed and a comprehensive structured approach should be adopted for both daytime and night time handovers. The lack of a clear management plan being conveyed to midwifery staff, led to a decision being taken by midwifery staff, in conjunction with the Psychiatric Liaison Team, to place the Deceased in a side room close to the sister's room, with the unwritten intention that this might provide some increased monitoring of her. However, this arrangement was ad hoc at best. It could only ever have provided short-term benefit as the room was not occupied overnight and, because its rationale was not recorded in the notes, it was not communicated at handover and, to whatever extent it had provided a benefit, that benefit lapsed.

161. Although not impinging on the death of the Deceased, I find that UNOCINI referrals should have been made by the midwifery staff, Dr Boggs and Nurse Casey.

I find that having made a differential diagnosis of puerperal psychosis, Dr Boggs and Nurse Casey gave little or no thought to the safety of Baby A and did not include her in the Deceased's management plan, or consider making a management plan to safeguard Baby A. I find that a risk assessment should have been completed in respect of Baby A.

162. I find that a Mother and Baby Unit should be established in Northern Ireland and at the very least the rapid expansion of perinatal services within the hospital setting as well as in the community. The Deceased's death highlights the need for obstetric wards to have much closer links with perinatal services.

163. I have considered whether the Deceased took her own life, the essential components of which are the act being voluntary, the Deceased's intention was to take her own life and the Deceased died as a result of her own act. I find, on the balance of probabilities, the balance of her mind being disturbed, the Deceased suffered from puerperal psychosis and on 11 October 2018 at approximately 03.20 hours, the Deceased attached her nightdress to a handrail and tied a noose around her neck with the intention of ending her life. That act rendered her unconscious and caused her rapid death.

164. A post-mortem was performed, and it records, and I find that death was due to:

1(a) Hanging

165. The above findings should be placed in the following context. At inquest, I heard evidence from Dr Peter Sloan, Consultant in Psychiatry and Chair of Division Mental Health Services and Dr Clifford Mayes, Consultant in Newborn Medicine and Chair of Maternity Dental and Sexual Health Services, in relation to a number of changes made in the Belfast Health and Social Care Trust following the death of the Deceased.

166. Dr Sloan highlighted a new training programme which has been introduced for all mental health staff providing psychiatric liaison into maternity services, to develop their understanding of the distinctive features of and risks associated with, perinatal mental illness. To date over 75% of the three main teams, that were been targeted, have attended that training.

167. Dr Sloan explained to the inquest that specific training on the practice of collateral history has been provided to the Mental Health Liaison Team. Furthermore, the Mental Health Assessment Pro Forma has been amended in relation to the collateral history section and the treatment plan section, which now includes prompts and acts an aide memoire.

168. The Trust recognised the need for staff to communicate clearly and in detail their advice in relation to diagnosis/differential diagnosis and management and

safety plans to patients, families and maternity staff. This has been addressed by way of specific training to the Mental Health Liaison Team.

169. A multidisciplinary education programme, which focuses on perinatal psychiatric complications and management of the associated risks, has commenced on a rolling basis. This training was referred to by Midwives during evidence. At present, approximately 25% of midwives have attended the training and Dr Sloan admitted that the COVID pandemic slowed down the roll out and that it will take some time until the training is complete in that entire workforce.

170. The Trust recognised that the mental health aspects of maternity services in the Royal Jubilee Maternity Service appeared disjointed and required reform. Dr Sloan commented that the Trust needs "to ensure the right patient gets the right treatment at the right time". To that end, flowcharts, which succinctly illustrate the various Mental Health Services, have been introduced so that all clinical staff are familiar with the services and referrals available. Work is ongoing with the Public Health Agency to ensure regional consistency in the further development of perinatal services throughout Northern Ireland.

171. Over the last 12 to 18 months, the increase in funding from the Department of Health in perinatal services has enabled the Trust to expand their Perinatal Mental Health Team by over "approximately 6 whole time equivalents".

172. Dr Sloan told the inquest that he understands that it is the intention that a Mother and Baby Unit will be built in Northern Ireland. However, the Trust, which would be responsible for the Unit, has yet to be decided and it is in the early stages of development.

173. Dr Mayes told the inquest that the lack of appropriate office space for mental health staff to conduct interviews has been examined. It is hoped that the move of maternity services at the Royal Jubilee Maternity Hospital into the new Maternity hospital in January 2023 will significantly alleviate pressures on space. The new Neonatal Unit will deliver 29 cots with scope for up to 45 and there will be bespoke consultation facilities.

174. Dr Mayes explained that a proforma outlining levels of observation in a maternity setting has been developed and implemented. There was a requirement to improve night-time handovers and Dr Mayes explained that the shift pattern of Bed Managers have now been readjusted to allow handovers with the full team.

175. Dr Sloan told the inquest that the tragic events that took place in October 2018 were devastating to him and his team. It is hoped that the improvements made by the Belfast Health and Social Care Trust demonstrate that the Trust has learned important lessons from the death of the deceased.