North East London
Strategic Health Authority

NHS

REPORT OF AN INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF DAKSHA EMSON M.B.B.S., MRCPsych, MSc. AND HER DAUGHTER FREYA

Daksha's Last Note

Feel flat all the time - mornings worst
trying to force myself to be cheerful but feels FORCED
like behind a glass screen* losing touch with other people – no connection, speech forced, smiles forced, words hollow everything's an effort no drive or motivation
tired all the time thoughts churning all the time
forgetful, more accident – prone pulling on clothes, bath, cooking daily chores all an effort like climbing mountain
everyday phone up various people to get tasks done so something moving hoping for a change.
Getting more and more mixed up
No enjoyment in previous interests – psychiatry losing its fascination
Programs like Inspector Morse A touch of Frost etc which I used to enjoy before don't do anything for me anymore.
Used to enjoy listening to CDs
but music does nothing for me
Feel useless as a mother
as a wife
as a woman
See no hope for the future
Trying desperately to see hope for the future but becoming more + more difficult
sleep unrefreshing
food forced down because my baby needs nourishment
Focussing on my precious baby Freya – she means everything to me, I desperately want to be a good mother to her but I'm starting to feel I'm failing her in a big way, that everyone can see I'm a useless mother that I'm no good.
Finding it difficult to hand on to positive things anyone says, can't hang on to it for long – hits me in early hours of morning – thoughts churn round + round.
Starting to think that Dave hates me, wants me out the way, wants me to go crazy so he can get another wife who's better for him.
Finding it difficult to hang on to reality - am I bad + wicked?
I don't deserve good things, who am I kidding?
Is this all a bad dream or really happening?
Is there really hope for the future?
I've tried to put a smile on, to hand on to positive but getting more + more difficult to know what's real.
Losing reason? Losing sanity?
Freya needs me, I can't let her down. Need to get myself back to normal for her. She + Dave mean world to me – I need to sort myself out for them. Fear I'm cracking up.
No point in counselling cognitive therapy whatever, I couldn't take it in anyway or make use of –thoughts too mixed up, don't hang on to any one thread for long,
no clarity anywhere, not got will or energy

I've been down this road before, don't want to breakdown or end up on psychiatric ward having ECT. Want to avoid that at all cost – I've got my baby to think about. Got to keep going for her she's everything to me, more than life itself. She needs me + I'm going to be there for her*, whatever it takes.

Executive Summary

Dr Daksha Emson, a psychiatrist, and her daughter, aged three months, died following an extended suicide on 9th October 2000. A Panel of Inquiry was set up to investigate the causes of the deaths, and the issues arising from the Part 8 Review under the Children Act 1989 commissioned by the London Borough of Newham (Appendix 7.1) into the death of Freya Emson. The Inquiry Panel was asked to produce a report and to make any relevant recommendations.

Daksha was the eldest child of Indian parents and was born in Tanzania. The family left Tanzania when she was four and returned to India. They emigrated to England when she was nine. Her parents built a successful business in Newham while she and her two younger brothers followed academically successful careers at school and university. The family lived in a two-bed roomed flat, and for some of the time they also shared this with her father's parents.

Daksha was initially diagnosed with depression following an extremely serious suicide attempt when she was an eighteen-year-old first-year medical student. But after a manic episode later in her treatment, her diagnosis was changed to bipolar affective disorder. She continued her medical studies despite five hospitalisations and three courses of electro-convulsive therapy under the care of Dr Rosen, a Consultant Psychiatrist at Guy's Hospital; she emerged as an outstanding student, winning a number of prizes at the Royal London Hospital.

Once her illness had stabilised with the benefit of lithium carbonate and Prozac, she pursued a successful career towards becoming a Consultant Psychiatrist with only one episode of mania while she was a Pre-Registration House Officer. In 1991, during an elective to Ireland she met and fell in love with David Emson. Despite initial family opposition the two married, having both a civil ceremony and a Hindu wedding.

Throughout Daksha's post-graduate training she went to considerable lengths to conceal her illness from her supervisors with one exception late on in her training, and was seemingly aided in this by National Health Service staff who shared her fear that the widespread stigma against mental illness in the NHS would damage her career prospects. She did not conceal her mental illness history from Occupational Health Services but received no help, support or advice from them. For most of her career Dr Rosen managed her treatment; on his retirement Dr Rosen discharged her back to her GP with advice on management. She was at the time of discharge not on medication because she wanted to become pregnant. Her GP referred her to a local psychiatrist Dr Bhandari; they had an initial meeting instigated by Daksha, in the autumn of 1999. Their next appointment, also prompted by Daksha, was in May 2000 when Daksha was seven months pregnant. The relationship between Dr Bhandari and Daksha had the characteristics of many doctor-to-doctor relationships. She was not formally a patient of the Community Mental Health Team at her own request, in order to protect her anonymity in the

NHS. Despite her reticence with her employers, Daksha was open about her illness with her GP and her Consultant Obstetrician.

Following a successful pregnancy and the birth by caesarean section of her daughter Freya in July 2000, she bonded well with her baby. Owing to a furious argument between her husband and her father earlier in the year she lacked the full involvement of her family. Her relationship with David had become strained; thus in many ways she was isolated. A Health Visitor called in to see her; she kept appointments with her GP and started to attend a mother and toddler group. She also had occasional contact with a Community Psychiatric Nurse but that wasn't part of a formal programme of care. In September 2000 she went to see Dr Bhandari as she was sleeping badly, and he assessed her as not being depressed. At the beginning of October 2000 when she again visited Dr Bhandari, they agreed she was depressed and should go on an anti-depressant. He recommended she should go back on lithium carbonate and she agreed to think about stopping breast-feeding. He had previously given her his mobile number to call if she needed him.

On 9th October 2000 Daksha stabbed Freya, her 3 month-old baby, stabbed herself, covered both of them in accelerant and set it alight. Freya died of smoke inhalation; Daksha survived for a further three weeks in a burns unit, but died without regaining consciousness. The incident, which should be regarded as a single act of suicide, took place during a psychotic episode that was a consequence of her bipolar affective disorder, triggered by her post-natal condition and aggravated by psychosocial stresses.

Following the deaths, a Part 8 Review under the Children Act 1989 (Appendix 7.2) was established by the London Borough of Newham Area Child Protection Team. As the Part 8 Review was judged to lack focus on the child, the Review was itself the subject of a review by a child protection consultant, commissioned by the Director of Social Services in Newham. The independent consultant concluded that the Part 8 Review had not addressed some of the key issues concerning post-natal relapse and the centrality of the child's own welfare. Both reports went to Newham Social Services Area Child Protection Committee in July 2001.

The main Part 8 Review Report made a number of recommendations aimed at strengthening inter-agency working, which to our knowledge have been implemented. Many of the Report's findings are in line with our own, but the additional work of this Inquiry has identified issues, which could not be covered by the terms of reference of a Part 8 Review as follows:

1. The evidence we received from the Perinatal Psychiatrists interviewed during the course of our Inquiry indicated that post-natal relapse with a history of severe depression was of sufficient likelihood, between 30% and 50%, that services should act as though relapse would occur.

2. The onset and nature of Daksha's illness could have been predicted from her relapse signature (we have adopted this term which is in growing use and is persuasive – meaning the collection of warning signs which precedes a relapse), had this been identified.

3. The realistic fear of stigma by Daksha and her treating professionals was a much greater driving force for actions, or lack of them, than previously allowed.

4. The relationship between treating doctors and doctors in treatment requires significant attention.

5. Freya was never viewed by Health and Social Care services as a citizen in her own right except by the Health Visitor, but as an appendage of her mother.

A Coroners Inquest was held beginning on December 3rd 2001 and concluding on December 5th 2001. This Inquest concluded "stab wounds to the neck and inhalation of fire fumes and burns" caused the death of Freya Emson. The verdict was unlawful killing. It also concluded that Daksha acted of her own free will unaided, being neither forced nor coerced. The verdict was that "she killed herself while the balance of her mind was disturbed".

The Department of Health decided an Independent Inquiry under Health Service Guidelines (Appendix 7.3) was required and North East London Strategic Health Authority and the London Borough of Newham commissioned this Inquiry, including in its remit some of the issues arising from the Part 8 Review. The Inquiry Panel commenced work in January 2002.

The Inquiry Panel has met with witnesses to fact, professional witnesses, expert witnesses and read evidence from other witnesses as well as numerous national policy guidance documents. It engaged in discussion with the Royal College of Psychiatrists and the National Institute For Mental Health England with a view to achieving the maximum effect on those issues which most contributed to the tragedy: -

- Stigma of mental illness
- Being a doctor and a patient
- Inadequacies in perinatal mental health services
- Being a child of a parent with mental illness
- Inadequacies in NHS Occupational Health Services

In evaluating the response of Health and Social Care services to the needs of Daksha Emson and her family in the period leading to the tragic outcome, the Panel has attempted to place them in their proper structural (financial and staffing resources, professional and governmental policies and training), cultural (professional knowledge, attitudes and values) and biographical (personal attitudes, values and behaviour) contexts. In doing so we have taken evidence of fact from family, friends and professionals and knowledge from experts. We have carefully weighed the

evidence and produced what we believe to be reasoned conclusions based on our extensive collective knowledge and experience in many relevant fields of service. We have not seen ourselves as undertaking research or as producing a scholarly academic treatise. Nonetheless we believe we have produced an appropriately wide-ranging analysis of the structural, cultural and personal variables that influenced the services that intervened in the lives of Daksha Emson and her family.

In the main we concluded that the sources of the deficiencies that we identify, were located in the structural context and have directed our recommendations there. Much of the extremely helpful information in the Report has come from our many witnesses but the responsibility for what we made of it lies with the Panel alone.

Recommendations

1. Stigma

The NHS Executive, in the person of the Chief Executive together with Chief Medical Officer and the National Director for Mental Health, should take the lead in directing management action to reduce drastically the stigma of mental illness amongst the 1.25 million employees in the NHS. To achieve this they should:

1. Issue an anti-discriminatory code of practice binding on NHS employers

2. Support this by a programme of compulsory anti-stigma training for all senior clinical staff and senior managers to be fully introduced by the end of 2004.

We believe stigma is a particular problem for doctors and senior managers with mental illness; especially because doctors and senior managers are perceived as prejudiced against staff with mental illness. Therefore:

3. The Chief Medical Officer should lead a group involving the General Medical Council (GMC), British Medical Association (BMA), Academy of Royal Colleges, the Institute of Health Service Management and the NHS Confederation to address this issue.

4. The Royal College of Psychiatrists continues to have a particular role and responsibility to eliminate stigma towards mental illness within its membership and should take the appropriate action.

2. Doctor-to-Doctor Treatment and Care

The Director of the National Institute For Mental Health England should convene the Sick Doctors Group and in conjunction with the BMA, the GMC, Royal Colleges and the Postgraduate Medical Deaneries:

1. Produce, rapidly, a protocol for doctor-to-doctor consultations.

2. Make recommendations on the nature and structure of services for doctors with physical or psychological illnesses.

3. Perinatal Mental Health

The Department of Health and all Strategic Health Authorities should insist that:

1. Existing guidance from the Royal College of Psychiatrists is followed to ensure comprehensive provision of perinatal mental health services (in many areas costed plans already exist which are not expensive – but the will and the commitment are lacking).

2. The National Specialist Commissioning Group at the Department of Health rapidly produce guidance on the commissioning of perinatal mental health services.

3. Work on the maternal mental health section of the National Service Framework for Children's Services is not further delayed by the internal reorganisation of the Department of Health.

4. The National Institute For Mental Health England and the National Institute for Clinical Excellence take responsibility for ensuring all disciplines involved in the post-natal care of mothers with a history of mental illness are up to date with advice on good practice.

The Royal College of Psychiatrists is responsible for the provision of continuing education and should ensure that all psychiatrists are educated in this area and that it forms part of Continuing Professional Development.

4. Children of Patients

1. The Department of Health through the National Institute For Mental Health England and Strategic Health Authorities and the National Care Standards Agency through the agency of Local Authority Social Services Area Child Protection Committees, should ensure that mental health services to patients with children are child sensitive and 'child protection proofed'. Ensuring that National Service Frameworks for Mental Health and Children are implemented in these two respects should meet this requirement.

2. Area Child Protection Committees should issue guidance to their local mental health services, provide training for their staff and should ensure that services are adequately resourced to fulfil this function comprehensively.

3. Mental Health Trusts should not wait for their local Area Child Protection Committees but should make proposals for 'child protection proofing' their services with Social Services Departments immediately.

5. Occupational Health Services

The Department of Health needs to strengthen the effectiveness of Occupational Health Services in the NHS by taking responsibility for setting standards, monitoring quality in the provision of these services and checking NHS organisations:

1. Resource staff in these departments to take appropriate responsibility for the care and support of staff and act as a supportive interface between their clinical needs and their employers.

2. Recognise through appropriate expertise that 50% of the disabilities in employees are psychological and psychiatric in nature (Appendix 7.4) and some of those employees are in very mobile posts.

In addition:

3. The Department of Health should examine whether there are advantages to Occupational Health Services being provided across the NHS by Primary Care Trusts.

4. The Modernisation Agency needs to train managers to supervise and support staff with psychological and psychiatric needs and help to create a climate through codes of practice and staff training in which employees with a range of needs can seek support without fear of the consequences of stigma.

Contents

Foreword

This tragedy deserves the attention of all those in the NHS, the medical profession, medical education and social care who could have organised things differently, and thereby might have saved the life of this young doctor and her baby and others like her.

We have structured the Report in a way that we hope is helpful to the reader. The executive summary, conclusions and recommendations contain the essential findings and messages of the report. However, 'Daksha's Story' the heart of the Report, is both a unique and poignant account of one woman's life and death, and a story repeated in the lives of some other women patients. The Key Issues Papers explain in more detail the reasons behind many of our conclusions and recommendations, and are based on our understanding of contemporary policy and practice.

We have restricted ourselves to recommendations on five key issues arising from the conclusions that attracted our most serious concern; these recommendations are directed to structures, cultures and systems in Health and Social Care. All of our other conclusions deserve study because they carry implications for changes in policy, values or practice.

We are aware that in the last few years Independent Inquiry Panels have increasingly become regarded as unfortunate necessities that often achieve virtually nothing, produce little new learning, are often perceived as unfair and have alienated professionals. It is true to say that some have been actually destructive in their overall effect. We have sought to find the underlying reasons behind the tragic events that occurred and to draw out any lessons from them.

The purpose of this Inquiry

Using the ideas set out in an article in the British Medical Journal (Appendix 7.5) we have set out below the dual premise on which this Inquiry Report is founded:

- The facts of this case are substantially agreed. Whilst there are differences of emphasis and opinion, a full account of Daksha's life has been drafted from evidence given and records received with some areas of conjecture where people have been unwilling to attend.

- There is such substantial learning to be taken from this case that it is of real concern that similar cases have been dealt with on the basis of a Part 8 Review under the Children Act 1989 alone. The structure and timing of those reviews simply does not allow for a full exploration of the issues and rarely fully addresses the adult mental health learning. Similarly, mental health inquiries often overlook child health issues.

Our primary lessons are set out in the ten Key Issues Papers and the five recommendations.

We believe attending the Panel has proved a beneficial experience for a number of witnesses.

"If the NHS cannot look after a psychiatrist with manic depression what hope is there for anyone else?" is an understandable reaction from the general public. Our Inquiry demonstrates that much of the knowledge that was lacking in those caring for Daksha was already available in the NHS but not brought to their attention or integrated into practice. We have not found anyone who did not show good faith and act competently within the knowledge they held at the time.

Our recommendations are designed to promulgate knowledge with the active support of the Royal College of Psychiatrists, the National Institute for Mental Health England, the Department of Health and others. We believe the public should feel reassured that such concerns have been, and are being addressed.

Deficiencies in the professional practice and culture of psychiatry, the culture of the NHS, Social Care and Occupational Health Services, are laid at the door of the policy makers and those responsible for policy implementation.

The Panel recognises that not all deaths in mental health services are preventable. Some patients are too determined to end their lives and some do so despite all the competent efforts of professionals and services because professionals are not infallible and because competent people can make mistakes. This was not one of those cases. More could and should have been expected of the systems of Health and Social Care to prevent these tragic events.

This case may well provide important leverage for changes to some professional practices and processes.

This Inquiry is therefore potentially exceptional in that it is not driven by the normal imperatives on Inquiries but confronts the question:

> If virtually everybody did virtually everything according to the appropriate custom and practice of their profession and context, how was it that two people died?

Outcome of This Inquiry

In the British Medical Journal article (Appendix 7.5) the authors note:

> "Many Inquiry reports highlight similar sorts of failures suggesting that lessons are not always learnt"

And

> "Often these failures are organisational and cultural and the necessary changes are not likely to happen simply because they are prescribed in a report."

It is the Panel's experience as recipients, participants and members of these Inquiries that these observations ring true. We have sought, therefore to engage with the relevant decision and policy makers directly, and to look beyond the staff who get it tragically wrong into the organisational culture of secrecy and taboo around mental illness, professional racism and other cultural characteristics of the NHS. Policy makers owe it to the staff of the NHS and their patients to bring about change by thoroughly implementing our recommendations.

Daksha's Story

A short account of her life based on records and the testimony of her husband, family, friends and work colleagues

Daksha was born on 21st April 1966 in Tanzania; her parents Pravin and Nirmala Patel were 17 or 18 at the time of her birth. Approximately two years later she had a younger brother Mjrudang, and two years after that she had another brother Davendra. In the late 1960s Tanzania was politically unstable, and along with many people of Indian origin the Patels had to flee the country - in their case returning to India.[1]

The family lived in India in Rajkot, Gujarat their city of origin for around five years before coming to England when Daksha was nine in 1974.[2]

Daksha's parents bought and developed a grocer's business in Newham, a borough with a considerable South Indian population, and the family lived in a small two-bedroomed flat above the shop. Her parents had one bedroom, the two boys had the second bedroom and Daksha slept on a bed in the living room.[3] Apparently, at the first school she attended Daksha was very unhappy. She suffered derision from her peers, even though they were of Indian origin, because she could not speak English[4].

From 1977 to 1984 Daksha attended the Plashet Girls' Comprehensive School, Plashet Grove, where she seems to have had a number of friends. Her GP described her as socially active at school where the Indian community was considerable.[5] Although English had not been her first language before the age of nine, she achieved eight A Grades at 'O' Level and then Grade A at 'AO' level maths and statistics. In 1984 she achieved three A Grades at 'A' Level in chemistry, biology and maths.[6]

At some time in this period, it appears that Mr Pravin Patel's parents came to live with the family. In the late 1970s and early 1980s Mr and Mrs Patel were running a shop together for very long hours, had three teenage children, lived in a tiny flat and accommodated two elderly parents. All three children went on to achieve outstanding academic records.

In 1984 Daksha went to the Royal London Hospital Medical School to begin studies to become a doctor; she was the first pupil from her school ever to enter medical school. Shortly after the beginning of her second year in November 1985 she made a very serious suicide attempt, taking

1 Testimony from Davendra Patel
2 Davendra Patel ibid cit
3 Davendra Patel ibid cit
4 Testimony from David Emson
5 Letter from Dr Sohi to Dr Rosen 8/11/85
6 Daksha Emson's Curriculum Vitae

forty aspirin and ninety-six paracetamol. Her mother discovered her some six hours after she had taken the overdose; fortunately Daksha had vomited in her sleep and suffered no physical damage as a result of this overdose. Daksha was diagnosed as suffering from depression and initially treated as an outpatient under the supervision of her GP Dr Sohi. In January 1986 Daksha was admitted to Guy's Hospital and treated as an inpatient for four months; during this time she received electro-convulsive therapy.[7]

The clinical judgment about this depression was that it was caused by Daksha's isolation during her first year at medical school. This isolation was itself reinforced by her living at home and by her familial restrictions - no parties, no smoking, no drinking, and no boyfriends. It is possible that this was to a significant degree, self-imposed though the notes record conflict with her parents.[8] There were other Asians in her year but they had relaxed these restrictions for themselves. It was at this time that she was persuaded to tell her parents about the sexual abuse she had experienced when she was eight; this was recorded in her discharge summary.[9]

Daksha was discharged as an in-patient on 11th April 1986 and remained as a day patient until 24th September 1986. During her attendance as a day patient her mood became elated and her behaviour overactive and disinhibited. When she was discharged Daksha was put on lithium carbonate and her diagnosis was changed to bipolar affective disorder.

Daksha restarted medical school in the autumn of 1986 but in December 1986 she had a recurrence of her illness. She was admitted to Guy's Hospital on December 17th where she remained until her discharge on 19th January 1987.

In May 1987 Daksha and her mother went to visit her family in Rajkot in the Gujarati province of India. Daksha wrote a glowing account of what a good time she was having and how much better she felt. In that account she suggested she should come off all medication but was persuaded by her psychiatrist Dr Rosen, to continue to take lithium carbonate as a safety net, even though she wrote, "but now I am even beginning to doubt I need that".[10,11]

In August 1987 Dr Rosen wrote to the Dean of the Royal London Hospital Medical School, recommending that Daksha start back on her course in the autumn of that year. In his letter he acknowledged his difficulty in determining the extent to which her depression was caused by a recurrent illness process or by the result of an extremely stressful home environment. He stated he was cautiously optimistic and that Daksha "is far more insightful about her condition".

She recommenced her medical studies in autumn 1987 and, in that first term won the David Reeve Prize in embryology. At the end of the academic year in June 1988 she won the Buxton

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7 Case notes from the York Clinic at Guy's Hospital
8 Discharge summary 11.4.86 Dr Wolfson
9 Discharge summary 11/4/86 Dr Wolfson
10 Letter from Daksha Emson dated 4.5.87
11 Case notes York Clinic Guy's Hospital

Prize in combined anatomy, biochemistry and physiology and the Howard Prize in pharmacology. Unfortunately on 28th August 1988 she was readmitted to Guy's Hospital with hypomanic relapse; however at the end of the next academic year she achieved first place in all her exams. In the discharge summary at the end of that short admission (she was discharged on 23rd September 1988), the Registrar noted that Daksha herself had noticed that in the period three to four weeks ahead of the episode, she suffered from poor concentration and had difficulty sleeping. She had also noticed that she tended to relapse at that time of the year: August/September. A pattern began to be identified in Daksha's relapse into her depressive illnesses. In addition to the symptoms identified above she would minimise and try to hide her depressed feelings from her doctor, and begin to develop suicidal ideation and paranoid ideas.

Daksha was again admitted to the York Clinic at Guy's Hospital on 23rd January 1989 and discharged on 10th March 1989, on that occasion being seriously depressed. Her depression was described to us as losing her 'bubbliness' – she would go to bed and stay there. She used to stop cleaning herself; she always wore contact lenses and they always became a problem when she had depression because she failed to clean them. When she became hypomanic she was unbearably bubbly, would spend money, was generous to everybody and had no insight. She did not have insight when she was 'going high' but anyone around her would have recognised it[12]. During this admission Daksha received a course of electro-convulsive therapy but then started to become manic. With further treatment including electro-convulsive therapy, her mood stabilized. Despite this admission Daksha completed that year's medical studies, winning the Floyer Prize for history taking in December 1989. Following the exams she went to India for three months; however she was readmitted to Guy's Hospital on 2nd August 1989 with depression, and was discharged on 25th October 1989.

Daksha then undertook her first clinical year as a Pre-Registration House Officer. During this time she experienced a 'high' episode for which she was treated on an outpatient basis. An exchange of correspondence between the Postgraduate Dean and Dr Rosen elicited a very clear and positive view from Dr Rosen that Daksha should be encouraged to continue in her career in medicine.[13]

Between 21st January 1991 and 27th February 1991 Daksha wrote regularly to Dr Rosen. She then went on a two-month elective to Cork in Ireland. This was possibly the first time that she had been living away from her parents or family members since the start of her medical education in 1985.

During this elective her supervising tutor was Dr Tina Quinlan the Senior Lecturer in Psychiatry; Dr Quinlan shared a house on the hospital site with a number of junior doctors and other staff; it seemed that Daksha lived nearby. Very shortly after Daksha's arrival and in Dr Quinlan's presence she met David Emson; it was love at first sight. David Emson was a radiographer, a

12 Testimony of close friend Julia Lambourne
13 Case notes York Clinic Guy's Hospital

Yorkshire man of Scandinavian origin. Daksha had a number of long discussions with Dr Quinlan about this relationship and about the difficulties that she would have conceiving and bearing a child given her illness, and about her real love for David.[14] The couple themselves anticipated opposition from Daksha's parents, as it had always been made clear to Daksha by her parents that they expected her to have a traditional Indian marriage[15]. They continued to court after Daksha returned to London, David seeking a job to be near her.

In August 1992 Daksha started a job as a House Physician on the 'firm' of Dr Barnes at the Royal London Hospital.

Daksha and David persevered with their courtship and in 1992 were married in a registry office. They also had a Hindu wedding ceremony.[16]

David never felt accepted by the family and indeed in cultural terms, he would have been seen as 'not good enough' for Daksha. This reservation seems to have been present throughout their relationship.

Daksha completed her House Officer jobs between August 1993 and January 1995 and became a Senior House Officer on rotation in psychiatry. She also gained Part One of the Member of the Royal College of Psychiatrists (MRCPsych) at the first attempt.

Daksha was concerned about the stigma of mental illness; she mentioned it to her best friend several times. The friend reports that 'she worried about confidentiality, the reason she worried was that she felt that there was one Consultant in particular who was difficult to her because he was against female psychiatrists. She observed: "if he was like that with females what would he be like with a bipolar female?" This was the sort of prejudice and attitude that she was up against and she said: "It puts me off being honest and saying that I've got a bipolar illness". She said: "I'm going to have to make this decision whether I'm being honest about my illness." In her heart of hearts she wanted to be able to be honest and say "This is what I've got, take me as I am."' [17]

'She was worried: she didn't feel that people were judged in the same light. As soon as they knew you had a psychiatric illness she felt that there was a stigma attached to it. She always said she wished she could tell her employers about her illness. She reasoned that if she were not successful it would be attributed to her mental illness. She would have to carry that with her and it would affect her career significantly. It would also have implications for other people with mental illness. She believed that in psychiatry the stigma was even worse: she felt surrounded by it'.[18]

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14 Testimony from Dr Tina Quinlan
15 Testimony from David Emson
16 Testimony from David Emson, Davendra Patel, Steve Williams and others
17 Testimony from Julia Lambourne
18 Testimony from Julia Lambourne

She only told one individual directly as a person in an 'employer' capacity Dr Liz Parker, the Training Programme Director for her rotational scheme, in 1998.[19]

From February 1995 to July 1997 Daksha was a registrar in the Registrar Training Scheme at Guy's Hospital University Medical and Dental School, during this rotation she gained her MRCPsych Part Two at the first attempt. In June 1997 she had a viral illness followed by post-viral depression that was treated by Dr Rosen with a small increase in Prozac.[20]

From August 1997 until her death she was a member of the University Medical and Dental School Specialist Registrar Rotation.[21] When Daksha was admitted to the rotation scheme she underwent an Occupational Health assessment in which she acknowledged bipolar affective disorder. The Occupational Health Service sought advice from Dr Rosen - Dr Rosen responded in such terms that they did not pursue the questions of any risk to her patients, or any needs she might have for support.[22] The staff at the Bracton Centre her penultimate place of work, did not know of her illness. Neither did the Deanery responsible for her education have any knowledge of her illness[23] but this is quite normal.[24] One of her training consultants learned she was on lithium carbonate, only after their professional relationship had ended.[25]

At least one of her Consultant supervisors describes Daksha as having had the most extraordinary presence in a room, as capable of empathising with everyone and as an exceptional clinician.[26] Another colleague who admired Daksha had nonetheless felt at the time that Daksha was not protecting herself sufficiently from what could be incessant demands from patients, fearing that she would not be able to maintain the level of work without undue strain;[27] this colleague was not aware of Daksha's mental health condition. During the time when Daksha was working but still on lithium carbonate, according to her husband she would return home from work completely exhausted.[28] [29]

From 1992 to 1999 David Emson was working as a radiographer part time and studying part time for a degree. Subsequently he studied for a Masters in Ecology, and in order to earn money he was undertaking on-call and agency work.[30]

In June 1999 Dr Rosen wrote to Dr Ivinson, Daksha's new GP, saying that he was leaving his post at the end of July 1999 and would no longer be able to care for Daksha. With Dr Rosen's

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19 Letter from Dr Parker 23/5/03
20 Case notes from York Clinic Guy's Hospital
21 Daksha Emson's Curriculum Vitae
22 Case notes from York Clinic Guy's Hospital
23 Testimony of Dr B Hicks
24 Conversation with Professor Peter Hill, Chair of the Conference of Postgraduate Deans
25 Testimony from Dr O'Neill-Byrne
26 Testimony from Dr O'Neill-Byrne
27 Testimony from Dr D Brook
28 Testimony from David Emson
29 However this might also be accounted for by the normal mood swings of Bipolar Affective Disorder which would mean low grade depressions might regularly occur – Prof Goodwin
30 Testimony from Steve Williams Community Psychiatric Nurse and friend of David and Daksha

support Daksha had stopped her lithium carbonate in February 1999, as she wanted to become pregnant. He did not say so in his letter but it is thought that she also stopped her Prozac. In May 1999 she miscarried at approximately two months whilst on holiday in Greece. Daksha was reported to have coped well with the miscarriage and to have remained psychiatrically stable. Dr Rosen commented that: "Daksha would like to stay off lithium and have another go at conception and I think after 15 years this is justified especially as she has been very well for most of that time. Fortunately she has excellent insight into her condition and will certainly consult you if she relapses. In that situation I think there ought to be careful discussion about her continuing follow-up and I would certainly recommend she is seen by a psychiatrist at her nearest teaching hospital". This was the final discharge from Dr Rosen.

At some time in early 1999 Daksha had changed her GP practice from Dr Sohi with whom she had been throughout her entire illness, to Dr Sandra Ivinson.[31]

In July 1999 she had a further miscarriage – treated at St. Bartholomew's Hospital; so that in all she had two miscarriages involving three foetuses. [32] [33] [34]

As a result of a referral from Dr Ivinson, Daksha met with Dr Bhandari, the local consultant psychiatrist, on 10th September 1999. Dr Ivinson did not refer Daksha because of concerns that she was becoming ill but as a precaution because she was attempting to become pregnant. Dr Bhandari was a local psychiatrist and that was Daksha's preference, which may have been influenced by the fact that the local teaching hospital was where she was employed. Apparently Daksha had called in to see Dr Bhandari without an appointment. Dr Bhandari had become a consultant in July of that year; he was approximately the same age and had similar training to Daksha. Initially there was a question in Dr Bhandari's mind whether this was a consultation or the opportunity for a future patient to meet her future consultant, if she should need him. It is fairly certain that Daksha significantly understated the serious nature of her previous illness, which Dr Bhandari took on trust from a colleague and did not pursue by obtaining the medical records. After the meeting in September 1999 they did not meet again until May 2000.

A letter from Dr Bhandari to Dr Ivinson, in which he pressed Dr Ivinson to send him a copy of Dr Rosen's discharge letter, recorded the consultation. He noted that it was a very good sign that, despite being off medication for seven months, Daksha had remained free from a relapse of her bipolar affective disorder.[35]

By 1st November 1999 Daksha was again pregnant and was sent to the Early Pregnancy Assessment Unit at St. Bartholomew's Hospital.

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[31] GP notes
[32] GP notes
[33] Testimony from David Emson
[34] The maternity notes record 29/5/99
[35] Testimony from Dr Bhandari and GP notes

Daksha was working at the Bracton Centre and her consultant supervisor was Dr Paul Wolfson, who by coincidence had been the Senior House Officer on the ward when Daksha was an inpatient in 1986. Daksha did not discuss her illness with Dr Wolfson, and having taken advice he did not raise it with her.[36]

Daksha's father became seriously ill and appeared to be dying. She visited him regularly and she seemed to cope with this well.[37]

Sometime in March or April 2000 David and Daksha's father had a serious disagreement in the garden of the marital home. As a result David refused to allow Mr Patel into the house. This resulted in considerable strain between the two households and Daksha becoming relatively isolated.

The pregnancy proceeded relatively straightforwardly to full term. In deference to her illness and her status as a doctor she was seen regularly at the hospital by the consultant, Dr Kollipara. David attended these consultations but did not speak and was described as being withdrawn.[38] Following a further consultation in May 2000 the Community Psychiatric Nurse made a home visit, having been asked by Dr Bhandari to visit without processing it through the full clinical team in order to maintain clinical confidentiality as Daksha was a doctor. This meant that the Community Mental Health Team was unaware of the case; it was also not registered on the Team database.

Freya was born on 4th July 2000 by caesarean section. Daksha's main visitor during the birth was her husband, which is very unusual in Indian births where large numbers of family members normally congregate and fuss over the new mother. Freya and Daksha were discharged home on 7th July 2000 and went to the marital home as opposed to her birth family home. In Gujarati culture Daksha would have been expected to go and stay with her parents for two to three weeks following the birth so that she could receive the loving support and care of her own mother.[39] The naming of the baby is also a very important event,[40] and it is not clear how much the extended family played a significant part in this process. However her mother did visit regularly every two or three days and took her food.

The Health Visitor discussed Daksha's psychiatric history with her and it was noted that she was in contact with both the Community Psychiatric Nurse and a Psychiatrist. David was also aware of whom to contact if he had concerns about Daksha. The Community Midwife visited and in due course, the Health Visitor attended. They noted the support that she was receiving and recommended that she attended the Health Visitor Clinic weekly.[41]

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36 Letter from Dr Wolfson and case notes
37 Letter from Dr Wolfson
38 Testimony from Dr Kollipara
39 Testimony from Davendra Patel
40 Testimony from Dr Rachel Dwyer
41 Part 8 Review

Throughout July and August 2000 Daksha and Freya lived the normal lives of a mother and her newborn baby: they attended clinic appointments and received home visits. All professionals concerned reported the unmitigated pleasure that Daksha took in her new baby, and the way the two were successfully bonding.[42]

Daksha was still quite isolated; her mother continued to visit fairly frequently, often driven to the house by her husband.[43] Relations between her and David were sometimes strained.[44]

On 14th September 2000 the Community Psychiatric Nurse visited Daksha in response to a telephone call from her. She had not been sleeping well over the previous week, i.e. from 7th September. The Community Psychiatric Nurse suggested that she should have a break from the baby, go out with her husband and also try relaxation exercises, tapes, mother and baby group, and other post-natal supports. They discussed the prospect of counselling for Daksha and David. The Community Psychiatric Nurse offered to see her weekly until a counsellor was available but explained that before the counselling could be arranged, it would have to be discussed with the Community Psychiatric Nurse's manager and a case opened formally with the Community Mental Health Team. Daksha agreed to a referral to a counsellor and agreed that the Community Psychiatric Nurse could discuss the appropriate counsellor with Dr Bhandari. She also agreed that the Community Psychiatric Nurse could make an appointment for her to see Dr Bhandari.

On 18th September 2000 Daksha telephoned the Community Psychiatric Nurse to say that she had changed her mind and did not want counselling nor did she want any further visits - her husband was not happy with either of these arrangements. She would however, see Dr Bhandari about cancelling her appointment with the Community Psychiatric Nurse, but couldn't make the appointment arranged for 19th September at 3.30p.m.

On 19th September 2000 the Community Psychiatric Nurse visited Daksha at home and observed her happily breastfeeding. Daksha had a possibility of a job-share Consultant post at Bexley with Dr Kiki O'Neil-Byrne. However, Daksha was very anxious about the Advisory Appointment Committee.[45] She did not see the need to continue to see the Community Psychiatric Nurse despite the Nurse's reassurance about the confidential nature of their relationship. She was still not sleeping well, which she said she would discuss with Dr Bhandari. The Community Psychiatric Nurse subsequently phoned Dr Bhandari who agreed to phone Daksha at home.[46] On 20th September 2000 the Community Psychiatric Nurse telephoned Daksha to say that Dr Bhandari was unable to speak to her and asked Daksha to phone him via his secretary.

On 25th September 2000 at the Health Visitor Clinic there was the first discussion of weaning;

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42 Part 8 Review, GP notes
43 Testimony from David Emson
44 Testimony from David Emson
45 Testimony from Dr O'Neil-Byrne and David Emson
46 Part 8 Review

Daksha was to return to the Clinic in four weeks.[47] Also on 25th September Dr Bhandari both received a copy of Dr Rosen's letter and saw Daksha; he determined in the consultation that Daksha was not depressed.[48]

On 26th September 2000 the Health Visitor discussed Daksha at her Child Protection Supervision meeting. It was agreed to remove Freya from the concern list, as Daksha did not fit the criteria and there were no parenting concerns. Until then the Health Visitor caring for Daksha had been covering a vacant post; a permanent Health Visitor had been appointed and Daksha's notes were to be transferred to the new worker. David recounted that during that week he had on several occasions pressed Daksha to give up breastfeeding and go back on medication, which was the main reason for her appointment with Dr Bhandari. He stated that his prime concern was that she had been breastfeeding for almost three months rather than any subconscious worries about her condition.[49]

On Thursday 5th October 2000 Dr Bhandari again saw Daksha. She recounted a number of the stresses from which she was currently suffering. She had opted to manage without medication in order to continue breastfeeding, as breastfeeding was so important to her. She had become depressed; she and Dr Bhandari discussed which would be the best anti-depressant for her to take. They eventually decided on Setraline 50mg once a day. This was the drug that Daksha had decided was best for her in discussion with David the night before.[50] Dr Bhandari suggested that she should go back on lithium carbonate and should consider weaning the baby, but acceded to her proposal. Dr Bhandari sent a letter to the GP informing her of this decision.

On Friday 6th October 2000 Daksha and David were due to go out for the evening to a concert to which they had both been looking forward. Daksha's sister-in-law Preeti had agreed to babysit. Late on Thursday afternoon Daksha said that she had changed her mind and did not want to go to the concert but that David should go without her.[51]

On Saturday 7th October 2000 following the usual regime, Daksha woke promptly because Freya was not allowed to cry. Freya slept in a cot beside Daksha who would feed her and bring her into bed. On that morning Daksha and David argued about who should go to Tesco to buy some groceries but mainly to buy milk for Freya so that Daksha could stop breastfeeding. Daksha then went shopping around 8.30/9.00a.m. After her return there was apparently a telephone call from her mother suggesting that she and Preeti should visit, but Daksha declined. It is possible that on this trip Daksha bought the accelerant that she used to ignite the fire on Monday afternoon, as well as the milk substitute to feed Freya.[52]

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47 Part 8 Review
48 Testimony from Dr Bhandari and GP notes
49 Part 8 Review
50 Testimony from David Emson
51 Testimony from Davendra Patel
52 Coroner's Inquest

On the Sunday she was not her normal self but seemed a little tired and a little low. David sent Daksha to bed to sleep, which she had not done before during the day.

On the Sunday evening she acknowledged that she felt a little bit tired and a little bit low and David suggested that she should call Dr Bhandari on his mobile phone.

During the Saturday or the Sunday Daksha wrote in a notepad. David thought she was writing to a friend: although she initially asked him to read it, she withdrew it and he did not see what she had written. They had an exchange in which they agreed to try to see Dr Bhandari on the following Tuesday and possibly get an anti-depressant for David.[53]

On Monday 9th October 2000 Daksha was up first as usual possibly not having slept too well, David waking around 6.45/7.00a.m. David needed to leave the house at 7.30a.m. as he had to give a barium session at 8.30a.m. As David was putting his lunch into his rucksack Daksha said "Dave are there bad forces at work against us?" and he replied "No my love there isn't." She asked "Dave does God still love us"? David said, "My love, of course God still loves us". He went on to say "I am here to protect you, I am here to protect Freya, there is no force on this earth that will get past me to get to you two, that is my duty, that is something I want." He then left for work.

At 11.30 that Monday morning Daksha's mother came to the door of the house having been dropped off by her husband. There was no answer and looking through the letterbox, she could see no sign of life. Her mother assumed that Daksha had perhaps gone to the clinic.

At some point on Monday Daksha wrote a suicide note, she took Freya's life and caused both stab wounds and very serious burns to herself. Following this she lay on the floor until around 5.45p.m. when David returned and discovered her. He dialled 999 and the ambulance service arrived and took her immediately to the Accident and Emergency Department at the Royal London Hospital. They treated her for her wounds and burns and transferred her to the burns unit at Chelmsford on Tuesday 10th October. She remained there without regaining the ability to communicate until her death on 27th October 2000.

[53] Coroner's Inquest

Conclusions

The Panel reached the following conclusions:

The Deaths

1. The deaths of Daksha and Freya should be regarded as an extended suicide[54], rather than a suicide and infanticide, or a suicide following a homicide (Appendix 7.6).

2. Daksha's extended suicide was:

    a. Predisposed by bipolar affective disorder
    b. Precipitated primarily by the biological consequence of giving birth and the absence of any protection through medication
    c. Influenced by psychosocial stresses impossible to assess precisely.

3. All clinical staff acted in good faith in accordance with their common professional practices.

Stigma

1. Daksha did what she could to keep well and to acknowledge and accept treatment for her illness. On the whole all involved in her treatment appeared to be influenced by the fear of discrimination against her because of her mental illness.

2. Daksha was afraid of being stigmatised if others knew of her illness. Every one of our witnesses from the NHS regarded this as a significant problem and took different steps to protect themselves and their patients from it. Her fear would seem well justified, as the NHS was considered by a senior expert in health employment, with experience of both the private sector and the NHS, to be far worse than the private sector for stigmatising mental illness in its employees.

3. The Royal College of Psychiatrists has campaigned widely (for instance the 'Changing Minds' campaign) against stigma amongst the general public but accepts it has done very little to eradicate stigma by its own members, or to support its members who are the object of that stigma. The fear of stigma has predisposed services to fail to provide a quality of service that may have saved Daksha's life.

[54] By extended suicide is meant a suicide where the mother regards her baby as an indivisible part of herself and both die

The Effect of Being a Doctor

1. There are particular difficulties presented in doctor-to-doctor relationships, and Daksha's second Responsible Medical Officer was not well served by the lack of appropriate structures and guidelines for managing doctor-to-doctor consultations.

2. Many patients (and especially doctors) minimise their illnesses, particularly when well and during pregnancy (Appendix 7.7), and therefore dependence on their account alone is inadequate.

Perinatal Mental Health

1. Following a birth where the mother has a history of severe depression, the risk of relapse is best viewed as though it were inevitable; preparedness to intervene in the relapse is the key to care planning. As the relapse is very likely to follow the 'relapse signature' (the pattern of development in the previous illness or relapse) this then should be the focus of inter-agency and carer monitoring. It is the key to supporting the mother in the anxiety and unpleasantness of a relapse and the disruption to bonding with her child. It gives a much better chance of protecting them from the much lower risk but more serious consequences of suicide and harm.

2. The Royal College of Psychiatrists guidelines on perinatal mental illness (Appendix 7.8) should have been communicated to all professionals and adhered to by them. This responsibility lies in four different places: The Royal College of Psychiatrists which should be an effective communicator; the individual clinician who has a responsibility to be up to date; the employer responsible for the professional practice of employees; and Commissioners of mental health services to specify quality standards.

3. If all the professional staff had all the up-to-date information on relapse effectively conveyed to them, Daksha's extended suicide could probably have been prevented by an appropriate inter-agency response.

4. Daksha's death was the culmination of a relapse of her illness, the course of which was similar to a previous pattern of relapse easily identifiable from her case notes.

5. A fully informed risk assessment on Daksha should have been made in the knowledge set out in the Confidential Enquiries into Maternal Deaths (Appendix 7.9) that:

   i) Suicide is the leading cause of maternal death
   ii) The majority of these women die by violent means as opposed to overdosing or more usual means of female suicide
   iii) The suicides were typically socially advantaged
   iv) Half of those dying had a previous psychiatric history

   Specific risk factors for Daksha included:

   i) Her psychiatric history opened with serious and life-threatening overdose
   ii) She was a psychiatrist
   iii) She was post-partum
   iv) She had bipolar affective disorder
   v) She was an Indian woman

6. The incidence of severe mental illness and suicide is reduced during pregnancy (Appendix 7.10). However for the sub-group of patients with an established affective disorder there is a significantly increased risk of relapse. This may have led to confusion.

7. Women who suffer from a recurrence of a severe mental illness are at particular risk of suicide (Appendix 7.9). The provision of adequate safeguards for mothers and their children in the post-natal period requires generalists (general Psychiatrists and Consultant Obstetricians) to have greater knowledge of the risks; and specialists (Perinatal Psychiatrists) who can manage the high risk cases and advise others on their management.

8. Had Daksha lived in Hackney rather than Newham she would have had access to a perinatal psychiatrist. There is good reason to believe that if this service had been available to her, Daksha's chances of being alive today would have been much greater. This is an example of a most invidious form of postcode lottery that is not peculiar to this Strategic Health Authority.

9. Every antenatal service should benefit from the advice of a perinatal mental health unit and every mental health service should have some sessions of a perinatal psychiatrist attached.

10. Being a good mother by breastfeeding Freya, as Daksha saw it, took such precedence over the need for treatment of her mental illness that she put her mental health at risk. There is a great deal of ignorance about breastfeeding and bipolar affective disorder on the part of professionals and conflicting views by expert witnesses about whether it is safe to breastfeed in conjunction with a mood stabiliser such as lithium carbonate.

Services to Patient and Family

1. The Part 8 Review conducted by the Area Child Protection Committee into Freya's death (Appendix 7.1) concluded that 'it was unlikely that the mother's suicide and the child's filicide could have been fully anticipated and prevented'. For the reasons given in this report this Inquiry comes to a different conclusion. There are a number of issues suggesting there was a significant risk of recurrence of the illness following the birth; had that risk been assessed and the appropriate action taken these tragic events might have been averted.

2. Services were not sufficiently child-centred. Where mental health services are treating patients who are parents they need to be more oriented towards the children involved. As some of those children may be facing risk of significant harm from their ill parents, the service needs to be child protection 'proofed' by the Area Child Protection Committee. Too often mental health professionals tend to focus on the needs and rights of parents rather than focus on the lawful rights of children as well as those of their parents.

3. Community Mental Health Teams should more readily consult local child protection services, should have a child care worker in the team and should be equipped with a protocol to contribute to every Care Programme Approach assessment of a patient with children.

4. Daksha became increasingly isolated because of conflict between her family and her husband. This caused her a great deal of stress and reduced the opportunities for accessing family support. The family network of husband and extended maternal family was essential to any plan to protect Daksha and Freya. No attempt was made by professionals to contact them, or involve them in the service responses to mother and child.

5. Daksha's treatment was never formalised in a Care Plan using the Care Programme Approach. The fact that she had carers in her husband and extended family was never explored with her. None of them was interviewed by the providing services. As a consequence their possible entitlements and needs under the Carers (Recognition and Services) Act 1995 were never assessed.

Occupational Health Services

Occupational Health Services exist to support employees in continuing employment but Occupational Health Services played no part in Daksha's care and support and indeed were not resourced to do so. An efficiently operating Occupational Health Service could have supported her to access a full range of services to meet her individual needs and put an appropriate work schedule in place.

Racism and Ethnicity

1. Daksha had shown enormous resilience in overcoming many difficulties and traumas in her life. Her resilience was as a result of who she was – an Indian woman. As an Indian woman clearly brought up within a traditional Indian Hindu family, it is reasonable to assume that she would have been brought up within the context of the usual norms, values, traditions and belief systems, which she carried with her throughout her life. Nevertheless it is clear from the evidence presented, that Daksha faced difficulties in managing the competing and conflicting demands of her inherent culture and the one in which she found herself.

2. The life and death of Daksha and Freya Emson should be viewed as being influenced by multiple layers of context. Daksha was brought up in an Indian immigrant family and in a society where the experience of racism is pervasive though often subtle both in the personal and professional worlds. The impact of this cannot be underestimated. However well-meaning all professionals in her care were, at no point were issues of culture and racism considered meaningfully, and she was seemingly treated in a 'colour blind, culture blind way.'

3. The key to any successful and effective intervention in service provision must be based upon a comprehensive assessment that takes into account a person's history, values, traditions, norms, cultural and religious belief systems, language and familial background.

4. Because Daksha presented as an intelligent, articulate professional married to a white man, her cultural and religious context was ignored. Had she been an uneducated Indian woman married traditionally, culture and religion may have been at the forefront of any assessment and decision making process. It is crucial that all professionals are trained to ask, explore and take account of the importance and significance of every individual's familial, cultural and religious background when undertaking any assessment and intervention.

5. As an Indian female professional working in the NHS Daksha would have experienced discrimination in different ways for example, institutional racism and the sexism of a white male-dominated, patriarchal organisation and profession (psychiatry). This would have been an additional burden for her and potentially a barrier to her career progression.

Professional Practice

1. It is essential that thorough histories are taken from patients during the initial consultation and in all cases that strenuous efforts are made to obtain previous documented histories. In this case it would have been helpful if the retiring consultant and the consultant taking over her care had spoken to each other.

2. During a hospital admission Daksha said she was sexually abused in childhood and if this was so, it was likely to have represented a continuing psychosocial stress and more support could have been provided.

3. The professional training of Health Visitors seems deficient, both in respect of their knowledge of mental illness and of the risks of post-natal relapse.

4. The General Practitioner and Primary Care Team responsible for Daksha's care had the single most accessible source of Daksha's patient history, through the hospital discharge summaries and the occasional update letters from her Consultant Psychiatrist. However, neither GP viewed it as their role to use the information to brief either the Obstetrician or the new Consultant Psychiatrist. This was a lost opportunity and reflects the ambiguity in expectations of GPs by both themselves and others, in the inter-agency network of services to patients and to each other.

Key Issues Paper One

The Impact of Stigma

Stigmatisation of mental illness by the medical profession including psychiatrists, and its associated impact on medical confidentiality, had an important influence on Daksha's view of herself, her illness (Appendix 7.11), her treatment by care givers (see below) and in the deaths of both her and her child.

There is an invidious interrelationship between stigma and medical confidentiality in the way that it affects the psychiatric treatment of patients who are also senior health care professionals. Because of stigma towards mental illness within the profession, the possession of knowledge about it by others in powerful positions is believed to seriously impair progress in a career. As confidentiality is believed to be poor within the health service, both patients and those treating senior professionals do everything to maintain secrecy and anonymity even where the 'need to know' is required to protect the patient's welfare and that of others.

Professional Context

The Royal College of Psychiatrists' Council Report CR91 acknowledges that stigma towards mental illness persists within the psychiatric profession, both with regard to patients and to colleagues who have experienced illness. Doctors are terrified that in addition to all the risks they run in common with other citizens, they will also jeopardise their chances of better jobs through promotion should their illness become known to senior colleagues. This stigma continues despite the campaigns conducted by the Royal College of Psychiatrists. In Daksha's case, she may have been further concerned about the multiple jeopardy she faced given her gender and race.

Present Practice

The evidence suggesting that Daksha and her treating physicians feared her stigmatisation is as follows:

- Daksha was not placed on Care Programme Approach when the scheme was introduced.
- Daksha did not make her condition and previous history of illness known to most of her colleagues.
- Her consultant, in his transfer letter, diminished the seriousness of her history, concentrating on her 'good' points, creating an unduly optimistic assessment of her health.
- Her local Consultant Psychiatrist did not make a written assessment of her needs.
- He did not register her with his service nor place her on the appropriate level of the Care Programme Approach.
- He did not discuss her openly with his colleagues in his Community Mental Health Team, as Daksha feared the loss of her anonymity.
- There was inadequate communication with the Primary Care Team, and an informal supervisory arrangement was set up with a Community Psychiatric Nurse, which was not adequate in the circumstances.

All of these deficiencies in arrangements are common in mental health services where they are influenced by the fear of stigma that would undermine the career interests of those in senior positions.

Conclusion

There is widespread mistrust of NHS confidentiality by senior health professionals. Stigma and the fear of stigma because of the failure of confidentiality, was the unacknowledged presence that haunted Daksha's work, life and her treatment. The NHS as both the employer and the treatment agency was complicit through neglect in the sequence of events culminating in this tragedy.

Despite its recent support for campaigns the NHS could do a great deal more work around de-stigmatising employment of mentally ill people in senior positions. The Royal College of Psychiatrists has made little attempt to address this issue amongst its members. It is a shameful indictment of two such responsible bodies that the Panel is unable to find evidence beyond one recently issued leaflet of significant action to address this issue. See recommendations.

Key Issues Paper Two

Doctor-to-Doctor Consultations

When doctors are asked to see a doctor they are faced with a variety of considerations such as the context in which a consultation is taking place, the suitability of the match between doctor and "patient", the limits of confidentiality and anonymity, the lines of responsibility, and the relationship with other medical or psychological services including General Practitioners and Occupational Health. This is equally true for consultations in both hospital and general practice. Should there be dedicated services for doctors seeking help for a specific condition, and what is the relationship then of those services to generic services? All the doctors we asked in the course of this Inquiry said they would not put a doctor on Care Programme Approach for the reasons given below.

Context

At Daksha's initial consultation with her local Consultant Psychiatrist there was a lack of clarity as to whether she was a patient or a potential patient. There were a number of assumptions about her 'expertness' and likely insight. Her husband was not involved in her care as he might have been. She was not 'put through the books', to protect her anonymity.

Although Daksha was in contact with Obstetric Services, General Practice and Psychiatry, it was her psychiatric illness which dominated the events and influenced the eventual outcome. Doctors, especially female doctors and especially psychiatrists, are known to have higher rates of depression and suicide than the general population (Appendix 7.12). Patients living with bipolar affective disorder have a 10% lifetime risk of suicide (Appendix 7.13).

Present Practice

A large number of doctor-to-doctor consultations are carried out on an informal basis, the "patient" seeking advice from a colleague often without reference to the General Practitioner. Self-medication, particularly of psychotropic medication, is commonplace. There are a number of specific services for sick doctors. Within this plethora of provision there exists a 'grey market' for the treatment of doctors, particularly those with psychological/psychiatric problems in which for a variety of reasons, the doctors may end up being treated less effectively than if they were 'ordinary' patients.

Present Policy

There is no national policy for the treatment of doctors but there is recognition of the need. The document 'Supporting Doctors Protecting Patients' (1999) is predominantly centred on protecting patients. The Nuffield Hospital Report (1994) advocates the establishment of services based on regional Post-Graduate Deaneries; the implementation of their recommendation has been patchy. The Royal College of Psychiatrists has set up a working group under the chairmanship of Professor John Gunn to look at services for doctors in need of psychological/psychiatric treatment. It is currently collecting information. The London Post-Graduate Deanery has recently produced a report of Deanery-based services. The General Medical Council is currently more concerned with revalidation and fitness to practice than with providing support services for doctors.

Conclusion

Inevitably Daksha was seen first and foremost as a doctor, a psychiatrist and a colleague leading to an underestimate of the level of risk indicated by her personal history, the nature of her enduring mental illness and her current circumstances.

Services are needed which would have seen her first as a patient. This may translate into a strong argument for discreet services for doctors; however there are circumstances where these need to be integrated into local services. An integrated response would best be managed through a modification of the Care Programme Approach; it is therefore important that the relevant bodies address this issue. See recommendations.

Key Issues Paper Three

Perinatal Mental Health

The Confidential Inquiry into Maternal Deaths makes clear that in the post-natal period a very few mothers and their children may be at high risk. The knowledge and skills of the antenatal, primary care and mental health staff responsible for the perinatal care of a mother with a bipolar affective disorder did not take account of this.

Context

Evidence indicates that 10% of women giving birth experience some post-natal depression. Women with a history of bipolar disorder have a 30-50% chance of relapse in the post-natal period and the women who relapse into depression will do so in the same pattern as their previous illness or relapse.

The risk of serious mental illness in pregnancy is reduced so many health professionals rightly saw pregnancy as protective. They did not recognise there is a sub-group with a history of severe depressive illness in which the opposite is true post-partum (Appendix 7.8).

Present Practice

This suggests that:

- Many general psychiatrists are poorly informed about the degree of risk in the post-natal period to a patient with a history of bipolar disorder.

- Many antenatal services are not very skilful at identifying the high-risk patients among the pregnant mothers coming through their services. Almost all simply note post-natal depression on the case notes and do not obtain the previous psychiatric case papers where they exist.

The Community Practitioners and Health Visitors Association made it clear that their members were not effectively trained to address the needs of patients with pre-existing mental illness. The Association was not conversant with the document “Why Mothers Die”, (Appendix 7.14).

Local Practice

The position in the East London boroughs of Tower Hamlets, The City, Hackney and Newham was not significantly different to many parts of the country. An enthusiastic Consultant Psychiatrist had created a service virtually out of nothing – this had become a tertiary service for inpatients from a large catchments population. It also provided a secondary service and an advice service to certain areas e.g. Hackney, but not Newham. In this case the tertiary inpatient service (which was available) was not needed but the secondary outpatient service was and this was not available to her Consultant.

Present Position

The Department of Health report Women's Mental Health: Into the Mainstream published in January 2003, the National Service Framework For Mental Health (Appendix 7.15) and the Royal College of Psychiatrists' report (Appendix 7.8) all draw attention to the risks to mothers in the post-natal period.

The Royal College of Psychiatrists, in its Council Report CR 88 April 2000: Perinatal Mental Health Services [Appendix 7.16) addresses all these concerns. Although written in 1996 it was not published until 2000 because of the anticipated changes in the NHS. The Report's authors Oates et al, describe the structure of services, the proper interventions, including the reinstatement of medication and the need for specialisation of services. Oates et al, argue it is essential to have specialist perinatal psychiatrists to treat the 2% of women who suffer from psychosis and the most severe forms of post-natal depression and to provide consultation and liaison services. The National Specialist Commissioning Group is currently deliberating on this issue and must take account of the findings of this Independent Inquiry Report.

The National Institute for Clinical Excellence is currently considering maternity services and could significantly improve care by effectively disseminating this well established knowledge.

Conclusion

The relevant knowledge about the high risk to mothers like Daksha has been known since the mid 1990s. The necessary policies based on the above knowledge already exist but remain to be implemented and the knowledge remains to be disseminated. The level of need and the resources required to meet them have been calculated. All that is required is higher prioritisation and implementation. See recommendation.

Key Issues Paper Four

Parental Mental Illness and Children's Welfare

Mental health problems in a parent or carer do not necessarily have an adverse impact on a child but it is always essential to assess the implications of their illness for any children involved in the family. Mental health services tend to focus on the need of adult patients and tend to ignore the needs of their children. This is inevitable given the present primacy of the patient, the orientation of professionals and the structure of funding.

Even where there are concerns about risk of significant harm to the child there may be reluctance by doctors to invoke child protection procedures because of perceived stigma to their patient. The term 'child protection' causes a most unhelpful reaction amongst health professionals.

Context

It is estimated that 30% of mentally ill adults have dependent children and that 4% of all parents with dependent children have mental health problems (Appendix 7.17). Parental mental health problems have been identified as one of the key sources of stress that may make the difficult task of parenting even harder (Appendix 7.18).

Recent figures on the Sheffield Child Protection Register show that 28% of all the children registered have at least one parent with a mental health problem. Oates (1997) found psychiatric diagnoses in 40% of children of patients with affective disorders. At the most extreme, parental mental health problems have been identified as a clear factor in a significant number (33%) of child deaths.

Another reason for mental health workers to take note of the needs and demands of the children in a family is in order to assess the impact that these may have on the mental health of the parents themselves. An adult, who may be capable of maintaining a stable lifestyle and adhering to treatment programmes if living without children, may find that the specific difficulties presented by caring for children make this almost impossible.

Present Practice

The practice in this case and some of the expert evidence offered suggests that mental health services do not take a holistic approach to the families of patients in treatment, or include in their Care Programme Approach assessments of the possible impact of the parent's illness on the welfare of their children.

In Newham following this incident the Social Services Department and East London and The City Mental Health Trust agreed to the creation of children's workers in each Community Mental Health Team, to ensure that the needs of the children of adults with mental illness were considered. This is an intelligent attempt to address the problem. However, other models of closer working might be effective.

Present Position

Department of Health guidance 'Working Together' supporting the implementation of the Children Act 1989 and the National Service Framework for Mental Health (Appendix 7.19) make it clear that mental health services have a responsibility to address the needs of the children of their patients. This should be done in conjunction with children's agencies by sharing information and contributing to a common assessment. The assessment should be compiled using the 'Framework for the Assessment of Children in Need and their Families' (Department of Health 2000). In addition, the assessment should be informed by practice guidance provided through the local Area Child Protection Committee. The assessment should systematically cover the child's health, education, emotional and behavioural development, identity, social presentation, self-care skills, and family and social relationships.

Conclusion

Mental health services need to be made more child aware. Children should never be left at risk of significant harm from their parents because of indecision about sharing or reluctance to share information. Research and experience have shown repeatedly that keeping children safe from harm and ensuring that their needs are met requires professionals and others to communicate properly, involve each other and work together.

Key Issues Paper Five

Culture

Throughout Daksha's contact with services, no professional undertook an assessment that took full account of the fact that she was a woman of Indian culture living in England with a set of values, beliefs, norms and traditions that had an impact on her situation.

A number of questions could have been asked. How did her cultural context affect this tragedy? Was mental illness more stigmatized because of her background? Were there particular family issues because she came from a different culture to her partner? Was child sexual abuse more hidden because of her culture? Was she stigmatized or discriminated against because of who she was? Did she find herself in a situation with conflicting cultural demands and competing loyalties? Did service providers take account of her religious, cultural and familial issues during assessment or management?

Context

All young people have to deal with their parents' value systems, norms and mores that they might have to conform to, abandon, reject or reach an accommodation with. For children of parents who might have migrated to the UK from developing countries the choices can often appear starker. The choice can be seen as being between aspirations and expectations based on the primacy of the family and the community as opposed to those based on the primacy of the individual. All this should be seen against a background of discrimination in society. Children can often have difficulty with this even as young adults as can the parents. The parents in addition, being acutely aware of their minority position in society and wishing to hold on to that which has given them strength and solace and their lives meaning, believe like all parents that they know best.

Rapid changes including for example cultural changes and transitions from urban to rural, and illiterate to literate can make it very difficult to understand and accept a cultural context in the UK where benefits to the individual and the value of individual happiness and fulfilment supercedes the value of the family and community. Thus shame can come to have a profound meaning. For example the impact of one person's actions or say, mental health difficulties, can call into question not only the status, value and honour of the individual concerned but, by implication, the whole family's honour, seriously undermining its standing within the community. On the other hand young people are very heavily influenced by peer pressure and the broader society that they live in. Whilst there are instances of young people being assaulted and even murdered or forcibly married (feeding the widespread stereotypes), the large majority of young people and their families come to some compromise and perhaps some accommodation.

Present Situation

Daksha came from a traditional Hindu family although it is not clear to what extent her family accommodated to society around them. When she went to medical school Daksha elected not to have boyfriends or to socialize unlike some of her peers. Later she formed a relationship with a white man who was not a doctor; this was clearly a difficult situation for all parties. Some accommodation was perhaps arrived at resulting in her having a Hindu wedding as well as a formal registry wedding. This suggests that Daksha's cultural and religious context was important to her and perhaps what she was faced with was reaching a position where she was comfortable with the two important parts of her life. There were clearly ongoing tensions between the family and her husband that may have been a mixture of interpersonal as well as cultural and religious issues. Daksha attempted to resolve these conflicts and continued to see her parents and family and to mediate between the different parties.

Daksha wanted to make her marriage work. Although a falling out of this kind can happen in any family from any background, in this case the cost was the loss of the closeness and support that she would expect to receive from her family of origin for the sake of the new nuclear unit that was being created. The implications of this loss meant it reduced her ability to access important cultural and religious support at a significant time in her life, i.e. at the birth of her child and in the period following childbirth.

Conclusion

The difficulties Daksha faced in successfully negotiating the cultural divide in these relationships, and the lack of shared understanding by all the professionals involved, resulted in her family of origin not being available to provide a comprehensive support network at a time when it was essential for her continued well being. Daksha's isolation was also perhaps attributable to being in a mixed race marriage where such cultural divides and tensions could not be safely and comfortably acknowledged and discussed. There is no evidence that any of the services dealt with cultural or religious issues or were sensitive to the cultural and religious divide in the relationships.

Key Issues Paper Six

Impact of Racism on Professionals in the NHS

The Panel questioned whether and to what extent, racism contributed to Daksha's self-perception, world-view and her management of her professional life. We also questioned whether racism contributed to some extent to this tragedy.

Context

Racism exists in the NHS as it does in society; whilst it may be overt as in racial abuse between patients it is usually covert. The experience of many black doctors is, that in order to be seen to be as good as their peers, they have to work much harder and to excel. Subtle racism may be experienced by many as marginalisation and in not being offered the same opportunities as their peers. This is difficult to challenge and those who do challenge the system may find themselves being labelled the problem and isolated rather than being supported as victims. The outcome is that people either opt out of the system or stay and learn how to survive. Often this process is not articulated, but the behaviour suggests that the game has been understood and a decision made as to how the game will be played.

The black doctor is not viewed as a doctor who happens to be black, but as a black person who happens to be a doctor; this can carry negative cultural assumptions such as having an extended family, an arranged marriage and cultural conflicts. Racism causes a person's background and culture to be incorporated negatively into a view of their professional competence in a way that would never be considered in a white middle-class person.

In 'Breaking the Circles of Fear' (2002), one of the striking findings was that professionals feared talking about issues of race and culture in a safe and honest manner.

Present Situation

Daksha came to this country not being able to speak English and experienced considerable difficulties on entering school. These difficulties may have been due to racism. Despite this Daksha managed to excel at her comprehensive school and enter Medical School. In her first years at Medical School, unlike others of her Asian peer group she elected not to socialize. Daksha showed enormous resilience in persisting on a course that was difficult enough without the added effects of bipolar affective disorder.

When she became ill Daksha opted to discuss her illness with only very few people, knowing that mental illness was so stigmatising that it would produce multiple jeopardy.

We were offered no evidence that Daksha discussed racism with her family, with her partner, with her doctors or in the work place.

Conclusion

There is recent legislation to ensure that all are treated appropriately: The Race Relations (Amendment Act) 2002. Major changes in institutional culture as well as individual behaviours need to take place in order to ensure that all professionals may be confident that they will be judged on skills and competence and not on the basis of their ethnic origin. The specific duties of the Race Relations (Amendment Act) are the vehicle for organisations to ensure that these issues are addressed at all levels.

It is a legal requirement that staff be trained on the general duty under the Race Relations (Amendment Act) 2000 to promote race equality and good race relations and to eliminate unlawful racial discrimination.

Key Issues Paper Seven

The Role of Occupational Health Services

Daksha was not properly assessed by her employer for any risks to herself or her patients or, for any ongoing support that might be necessary to avoid those risks to ensure her success as an employee. The Occupational Health Service should take this responsibility on behalf of the employer, in this case Guy's and St Thomas's NHS Trust.

Policy Context

The Department of Health regards occupational health as the responsibility of individual NHS employers. Whilst highly prescriptive in relation to other human resources or clinical performance matters, the Department of Health does not have a national policy lead on occupational health and does not monitor the quality of provision on offer.

Present Practice

- Daksha saw The Occupational Health Service as 'the enemy' and those professionals who gave evidence understood her attitude. Not to be lied to for fear of dismissal, these departments are widely mistrusted by those who have not used them and many of those who have.

- The Panel heard evidence to suggest that 50% of those attending Occupational Health Services have psychiatric or psychological problems but these departments do not offer specialist psychiatric advice with very few exceptions.

- Doctors cost over £500,000 to train yet no special account is taken of the need to safeguard this asset. It compares very unfavourably with the care given to comparably costly pieces of equipment.

- Specialist Registrars are particularly disadvantaged by a system that can see their employer change once a year or even more.

- At present, Occupational Health Services in the NHS do not have a mission or a responsibility to help to support individuals in their jobs; services are there solely to advise an employer on employment matters.

- According to a national expert on bipolar affective disorder, the current best advice to people suffering from bipolar affective disorder is to inform their manager or, failing that, someone in the workplace they trust. If they are depressed they may be a danger to themselves; if manic they may become a danger to others and may not know it. Occupational Health Services are not equipped or mandated to play a role in dealing with this.

Present Provision

Occupational Health Services are patchy in coverage: fewer than 50% of Trusts have such departments in house; some Occupational Health Services are provided to Trusts under contract from other Trusts. Services are variable in staffing; most have an Occupational Health Nurse. Their role is primarily to screen out ill people from employment and to advise the employer on working practices and directives to protect the organisation from risks from or caused by employees.

Many Trusts have only a skeletal Occupational Health Service and even the best do not compete with many in the private sector. There is little incentive for Trusts to develop these services, which are seen as diverting resources away from patient care and national targets (such as waiting lists) on which they will be judged.

Conclusion

The position of the Department of Health in relation to Occupational Health Services is indefensible.

Unless these services are properly resourced and centrally prioritised the taxpayer will lose millions in opportunity costs from lost staff and patients will be at increased risk. The admirable commitment of the government to keep in employment citizens who have experienced mental illness will be merely fine words. See recommendation.

Key Issues Paper Eight

Patients' History and Medical Records

It is believed by the staff involved in her care and interviewed in the course of this Inquiry, that Daksha would have been treated differently if the full seriousness of her earlier illness - a major suicide attempt, five hospitalisations, and three courses of electro-convulsive therapy - had been known. This could have been achieved by obtaining her previous medical records.

In a new case or where it is difficult to obtain the previous case records, clinicians assess a patient's needs by interview and exploration of background and context in a process usually described as history taking. In this case history taking (from an expert), together with the referral letter from the GP and the referral letter from the consultant to the GP, was the sole source of history.

A comprehensive history is recognised as essential to diagnosis and effective treatment. However, some clinicians make a virtue of a 'clean slate' assessment, preferring to make their assessment uninfluenced by a previous clinical view. The rights of patients to be aware of all the information written about them is seen as inhibiting what they record by many psychiatrists. Some patients, for example adolescents, may prefer to be given a fresh start avoiding what they regard as an unhelpful 'label'. Without the distance of a formal doctor–patient relationship the consultant may regard it as being discourteous to send for records. For all these reasons it is not automatic to obtain previous clinical notes.

Practice in This Case

1. Patients in general and pregnant women in particular, tend to minimise the seriousness of their illness both because in pregnancy they often feel very well and because they fear that others will regard their baby as being at risk.

2. The doctor-to-doctor relationship undoubtedly influences practice.

3. General Psychiatrists can experience delay in obtaining the previous records.

4. In this case there was no difficulty in obtaining records from Guy's Hospital.

5. There may have been other records kept by the consultant at Guy's Hospital and not included in the medical records.

6. The most accessible previous records were held by the GP in the form of discharge summaries, but the GP did not regard it as her responsibility to pass them on to a new consultant.

Present Position

The Department of Health's position is that the previous case records should always be obtained and taken fully into account, whilst recognising that they are not always easy to access.

The Royal College of Psychiatrists acknowledges the legitimacy of a 'clean slate' assessment, but this assessment must then be compared with the previous history and the best clinical course decided from them both. Present concern centres around the fact that although the introduction of a system of electronic records will make transfer of history more efficient, patients' rights will need to be taken into account. The Department of Health informed us that more responsibility for records policy would pass to professional bodies over the next ten years.

Conclusion

Policy in respect of obtaining the previous clinical record is clear from the Department of Health but different in the Royal College of Psychiatrists. This will feel ambiguous in practice and will militate against the interests of patients as it did in this case.

Every professional witness was strongly of the opinion that accessing and studying previous records is essential. The Royal College of Psychiatrists should address the matter urgently.

Key Issues Paper Nine

Carers

The Panel considered the following questions in respect of the involvement of Daksha's husband and family in her treatment and care.

Did the services involved with Daksha and her family have sufficient regard to whether her husband and extended family were acting as her carers? Did they consider whether they had needs arising from Daksha's illness?

Apart from the first few years when Daksha was a patient when her parents were interviewed, no mental health professional engaged Daksha's husband or family in her treatment or as carers for her psychiatric illness. The one exception is that Daksha and her husband jointly attended the antenatal clinics and the GP. The lack of engagement by the care team was a serious deficiency in the post-natal period but it may have reflected ambiguity in their perception of her role as a patient, ambivalence on her part towards involving others and the underlying failure to realise the risk of relapse. It is clear that Daksha and her daughter could not have been competently protected without involving at least her husband in a supervisory and caring role.

The Carers Recognition and Services Act 1995 (Appendix 7.21) emphasises the entitlement of carers to have their own needs assessed and to receive support from services in their own right. The guidance is clear that services cannot breach confidentiality by discussing the patient with the carer without the patient's permission and preferably in their presence. It also appears to assume that someone who lives with a patient or who is related to a patient and provides help is a carer, because by definition a patient receiving treatment is in need.

We have no evidence that Daksha ever refused the involvement of her husband or her family in her care. The treating professionals probably viewed it as 'not the done thing' as it would imply that she was not competent to manage her own treatment alone. When the Community Psychiatric Nurse tried to support Daksha through involving her husband and treating them as a couple, this was refused because they did not think couple counselling would help.

In the post-natal period Daksha needed to be cared for in the sense that she needed to be the focus of a care plan involving her close supervision by her relatives in the event of a relapse. Her husband and her family if they were to be involved needed the support of mental health and primary care professionals. This would have enabled them to understand not just depression and mania, which Daksha had talked to David about extensively, but also psychosis – of which he was completely unaware. They needed to know what to look out for and what to do if a relapse started. They would have needed the support of regular contact by professionals to encourage them to both maintain the close supervision and to discuss any difficulties in maintaining the arrangements perhaps for as long a period as a year.

Conclusion

Guidelines on the management of bipolar affective disorder and carers are urgently needed; these should be developed perhaps with the help of the Manic Depression Fellowship.

There was no indication that the services involved had incorporated Daksha's carers into their thinking either as people who may have their own needs or as a resource to the patient.

Key Issues Paper Ten

Inter-professional and Inter-agency Communication and Co-ordination

The failure of professionals to communicate effectively and to co-ordinate care appropriately, contributed to the adverse outcome in this case. Some of these failures can be traced back to the root causes outlined in the Key Issues Papers on Stigma, Doctor-to-Doctor Consultation and Perinatal Mental Health.

Daksha was not placed on the Care Programme Approach when it was introduced in 1991, and on transfer was judged not to meet the criteria as she was not on medication and was not experiencing symptoms.

The GP as the head of the Primary Care Team, had the single best source of information about Daksha's past history, her relapse signature and the risk of relapse but did not pass this information on to either the ante-natal services or to her Consultant Psychiatrist.

The Consultant Psychiatrist in his role of Responsible Medical Officer, was considered to be the person responsible for organising her post-natal support, but did not view her as at high risk of relapse and decided to support her informally outside the normal system of care.

Current Good Practice

Under the current guidance for the Care Programme Approach it may have been appropriate to place Daksha on the enhanced level of care. Daksha was a complex patient with a long history of mental illness, including a history of suicide attempts, treatment with electro-convulsive therapy, maintained in the long term by mood stabilisers and anti-depressants, recently withdrawing from medication because of a desire to become pregnant, and whose care was being transferred to another service.

Using a model of an Ideal Care Pathway developed by the Inquiry Panel for a complex patient for whom anonymity is not a concern, the current care team writes to the GP and to the new Secondary Care Team and, on occasion, the Consultant Psychiatrist also communicates directly by telephone with the Consultant Psychiatrist of the Secondary Care Team. The new team, having received the referral, arranges to see the patient and decides on the Care Plan and communicates this to the GP. The new team will see the patient and will decide whether the patient needs to be in secondary care or not. If not, they will transfer the care to the GP. If the patient needs to be in secondary care the team will determine the appropriate level of the Care Programme Approach. If the person is on simple Care Programme Approach to begin with, she will be placed on enhanced Care Programme Approach on becoming pregnant. She will also be discussed again in the Secondary Care Team when more team members become involved,

including a Social Worker for engagement of the partner and the extended family. As the pregnancy progresses, the patient's mental health is closely monitored in liaison with the Obstetricians and Psychiatric Liaison Service. Monitoring of her mental health state occurs frequently around the time of the birth and immediately after the birth. Following delivery and discharge from the Obstetrics Department, the Health Visitor and the rest of the Primary Care Team replace the Obstetrics Services.

With the agreement of the patient, their partner and extended family continue to be involved in discussions of both mother and child's needs with continuous close monitoring. Their own needs as carers for support and information are assessed. The GP is kept constantly informed of progress and any changes to medication and other care plans.

Actual Practice in This Case

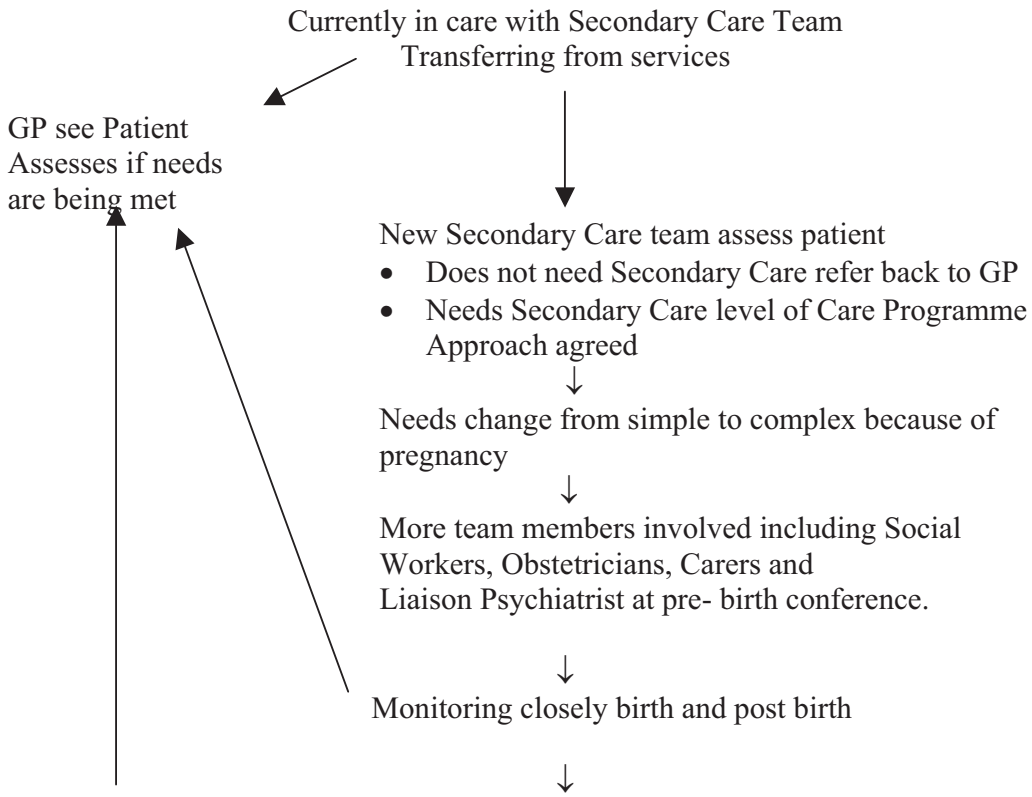
Daksha, because she was relatively well, was discharged with advice from the original care team to the General Practitioner. After a period of months and only as a precaution did the GP refer her to a Consultant Psychiatrist and Secondary Care Team but Daksha was seen without an appointment and without the benefit of all the previous history being documented. Because of the stigma of mental illness and because there were no documented previous notes, risks were not assessed appropriately; Daksha did not become part of the care system in a formal way and a Care Plan was not generated in the normal way.

When Daksha became pregnant her needs changed. This did not trigger Care Programme Approach documentation because of the lack of confidence in confidentiality and the need to preserve anonymity. There was no liaison between the Obstetrics Service and the Psychiatric Care Team even though the Obstetrician understood the true risk of relapse.

The Obstetrician did not know Daksha was under the care of a Consultant Psychiatrist and seemed confident in Daksha's ability to manage. Although a Community Psychiatric Nurse was involved in Daksha's care after the delivery, no other members of the multidisciplinary team were involved and there was no close monitoring of the situation. There was no liaison with the Health Visitor or any other members of the Primary Care Team. There was no 'closed loop' of care for this patient and her child.

Ideal Care Pathway (devised by the Inquiry Panel)

The model requires modification for individual patients. In Daksha's case she had a long and complex history of mental illness including previous suicide attempts and use of ECT, was maintained on mood stabilizers and anti-depressants and had recently withdrawn from medication because of wish to become pregnant.



Replace Obstetrics with Health Visitor and Carers and discuss both mother and child's needs and monitor

Conclusion

Until the Care Programme Approach system can guarantee the anonymity of those patients who risk being disadvantaged by stigma through disclosure, treating psychiatrists are likely to circumvent the formal system sometimes as in this case to the disadvantage of the patient. The principles of the Ideal Care Pathway offer the opportunity to Community Mental Health Teams to modify the best feature of the Care Programme Approach to create a Care Plan that is in the best interests of the patient and his or her dependents.

Appendix 1

Acknowledgements

The Families and Friends

Our thanks go out to David Emson and the Pravin Patel family for being willing to help us with such generosity.

To the friends and colleagues who were willing to return to sometimes painful memories, we express deep appreciation.

The NHS and Social Services

We have received impressive evidence from a cross-section of consultants, GPs, social workers, nurses and academics. On the basis of this unscientific sample it is clear that the NHS is a service run by people with a high level of commitment, awareness, knowledge, intelligence and humility.

We were often moved by the humanity, which informed the judgments of our witnesses, and saw many of them in tears.

Other Professionals

For particular advice on Race and Ethnicity we would like to thank Dr Nimesha Patel of the Medical Victims of Torture, Professor Kamlesh Patel of Lancashire University and Yasmin Patel of the Bradford Court Service.

Professor Keith Hawton for his telephone advice to Panel members and Sharon Riley, the Assistant Librarian at Ashworth Hospital, who kindly undertook literature searches for us.

North East London Strategic Health Authority

The Strategic Health Authority which commissioned us has been exceptionally supportive both directly with the administrative support and wise contributions of Dulara Khatun and making accessible the considerable insights and experience of Dr Sheila Adam and John Wilkinson (the latter even from New York).

Transcription Service

Our thanks to the efficient and good-humoured help we received from Peter Collins and Fiona Shipley of the Fiona Shipley Transcription Service.

Appendix 2

Panel Members

Lionel Joyce (Chair)

Previously Chief Executive of an NHS Trust
Chair of Turning Point / service user
Management consultant and coach

Dr Rob Hale

Consultant Psychiatrist. Psychoanalyst at the Tavistock and Portman NHS Trust. Formerly Associate Postgraduate Dean and Medical Director of Mednet Service for Doctors in need of psychological help.

Alan Jones

Alan Jones retired in 2001 as an Assistant Chief Inspector in the Social Services Inspectorate of the Department of Health. For 37 years he was a social worker in various capacities primarily in the children's field and had a special interest in child protection.

Dr Parimala Moodley

Consultant Psychiatrist. Honorary Senior Lecturer at South West London & St Georges Mental Health NHS Trust. Chair of the Special Committee on Ethnic Issues of the Royal College of Psychiatrists.

Appendix 3

Independent Inquiry into the Care and Treatment of DE

Terms of Reference

1. To examine all the circumstances surrounding the treatment and care of Daksha Emson, and in particular

   1.1 The quality and scope of her health and social care and any assessment of risk

   1.2 The appropriateness and quality of any assessment, care plan, treatment or supervision provided, having particular regard to

      1.2.1 Her past history
      1.2.2 Her psychiatric diagnosis
      1.2.3 Her assessed health and social care needs, having regard to gender and ethnicity
      1.2.4 Carers' assessment and carers' needs
      1.2.5 The treatment and care of women who have a history of mental health problems, during pregnancy, childbirth and post partum
      1.2.6 The understanding of child protection issues by CMHT and other mental health professionals and the degree to which they are embodied in professional training and practice
      1.2.7 The care, treatment and support of mental health professionals when they have mental health problems and or other personal problems

   1.3 The roles and responsibilities of human resources and occupational health in the support of practising clinicians in health and social care with health or disability needs.

   1.4 The extent to which her and her child's care and treatment corresponded to statutory obligations, relevant guidance from the Department of Health (including the Care Programme Approach HC (90) 23/LASSL (90) 11 and the Discharge Guidance HSG (94) 27 and local operational policies

   1.5 The extent to which her care and treatment plans

      1.5.1 Reflected an assessment of risk for Daksha and her child
      1.5.2 Were effectively drawn up, communicated and monitored
      1.5.3 Were complied with by Daksha Emson

2. To examine the adequacy of the co-ordination, collaboration, communication and organisational understanding between the various agencies involved in the care of Daksha Emson or in the provision of services to her and her child, in particular whether all relevant information was effectively passed between the agencies involved and other relevant agencies, and whether such information as was communicated was acted upon adequately.

3. To examine the adequacy of the communication and collaboration between the statutory agencies and any family or informal carers of Daksha Emson.

4. To conduct the Inquiry according to the process set out in the attached North East Strategic London Health Authority *Procedure for Independent Inquiry*, discussing with the Head of Mental Health at the Authority (as lead commissioner) and agreeing with him or her any proposed departure or variation from the *Procedure*.

5. To prepare an independent report including such recommendations as may be appropriate and useful to the services involved and their commissioners, and presenting it to the Chief Executive of North East London Strategic Health Authority and the Director of Social Services in the London Borough of Newham.

Appendix 4

North East London Strategic Health Authority

Procedure for Independent Inquiry

1. The Inquiry will be held in private.

2. The findings of the Inquiry and any recommendations will be made public.

3. The evidence which is submitted to the Inquiry orally or in writing will not be made public by the Inquiry, except as is disclosed within the body of the Inquiry's final report.

4. Every witness of fact will receive a letter in advance of appearing to give evidence informing them:

   a. Of the terms of reference and the procedures adopted by the Inquiry.

   b. Of the areas and matters to be covered with them.

   c. Requesting them to provide written statements to form the basis of their evidence to the Inquiry.

   d. That when they give oral evidence they may raise any other matter they wish, and which they feel might be relevant to the Inquiry.

   e. That they may bring with them a friend or relative, member of a trades union, lawyer or member of a defence organisation or anyone else they wish to accompany them, with the exception of another Inquiry witness.

   f. That it is the witness who will be asked questions and who will be expected to answer.

   g. Panel members cannot be cross examined.

   h. That their evidence will be recorded and a copy sent to them afterwards for them to sign and amend if necessary.

5. Witnesses of fact will be asked to confirm their evidence is true.

6. Any points of potential criticism will be put to a witness of fact, whether orally when they first give evidence, or in writing at a later time, and they will be given a full opportunity to respond.

7. Written representation may be invited from voluntary or other organisations and other interested parties as to present arrangements for persons in similar circumstances as the present Inquiry and as to any recommendations they may have for the future.

8. These witnesses may be asked to give oral evidence about their views and recommendations.

9. Anyone else who feels they may have something useful to contribute to the Inquiry may make written submissions for the Inquiry's consideration.

10. Findings of fact will be made on the basis of the evidence received by the Inquiry. Comments that appear within the narrative of the Report and any recommendations will be based on those findings.

Appendix 5

List of Witnesses

Witnesses of Fact

David Emson	Husband
Dr Davendra Patel	Brother
Dr Deborah Brooke	Colleague The Bracton Centre Oxleas NHS Trust
Dr James Anderson	Consultant Forensic Psychiatrist The Bracton Centre Oxleas NHS Trust
Dr Kiki O'Neill-Byrne	Educational Supervisor/colleague Oxleas NHS Trust
Dr Tina Quinlan	Friend/Educational Supervisor
Hannana Siddiqui	Southall Black Sisters
Julia Lambourne	Friend
Steve Williams	Friend
Terry Peck	Friend

Professional Witnesses

Ann Morgan	Child Protection Nurse Specialist Newham Primary Care Trust
Caroline Godleman	Joint Head of Community Mental Health Drug and Alcohol Services London Borough of Newham and East London and The City Mental Health Trust
Dr David Abrahamson	Consultant Psychiatrist East London and The City Mental Health Trust
Dr David Rouse	Pathologist
Dr Jan Falkowski	Former Medical Director East London and The City Mental Health Trust
Dr K M Tan	Consultant Pediatrician Newham Primary Care Trust
Dr Kevin Holland-Elliott	Director of Occupational Health King's Healthcare NHS Trust
Dr Kollipara	Consultant Obstetrician Barking, Havering and Redbridge Hospitals NHS Trust
Dr Sadgun Bhandari	Consultant Psychiatrist East London and The City Mental Health Trust

Dr Sandra Ivinson	GP
Dr Sohi	GP
Jackie Cook	Principal Child Protection Officer London Borough of Newham Social Services
John Wilkinson	Assistant Director of Mental Health North East London Strategic Health Authority
Kathryn Hudson	Director of Social Services London Borough of Newham
Dr Sheila Adam	Director of Public Health North East London Strategic Health Authority
Sheila Foley	Chief Executive East London and The City Mental Health Trust

Expert Witnesses

Professor Anthony Sheehan	Director of National Institute For Mental Health England
Dr Brendan Hicks	Director Kent Surrey and Sussex Post-graduate Deanery
Dr Kit Harling	Director NHS Plus Department of Health
Dr Liz McDonald	Consultant Psychiatrist East London and The City Mental Health Trust
Dr Margaret Oates	Consultant and Senior Lecturer in Psychiatry University of Nottingham
Dr Nimisha Patel	Action for Victims of Torture
Dr Rachel Dwyer	Senior Lecturer in Indian Studies School of Oriental and African Studies
Dr Sabah Sadik	National Clinical Assessment Authority
Jan Cubison	Service Coordinator Sheffield Adult Mental Health Services NHS Trust
Mike Calvin	Manic Depression Fellowship
Obi Amadi	Community Practices and Health Visiting Association
Phil Walker	Head of Information Governance Department of Health
Professor Andre Tylee	Professor of Primary Care Mental Health King's College London Fellow The Royal College of General Practitioners
Professor Guy Godwin	Professor of Psychiatry Oxford University
Professor Ian Brockington	Professor of Psychiatry University of Birmingham

Professor Mike Shooter	President Royal College of Psychiatrists
Professor Sir David Goldberg	Professor of Psychiatry Institute of Psychiatry King's College London
Superintendent Andy Smith	Metropolitan Police Chair of Camden and Islington Area Mental Health Committee

Witnesses providing written evidence

Chris Thomas	Guy's and St Thomas's NHS Trust
Dr Elizabeth Parker	Consultant Psychiatrist South London and Maudsley NHS Trust Training Programme Director for Specialist Registrar in Psychiatry
Dr Paul Wolfson	Consultant Psychiatrist Oxleas NHS Trust

Witnesses declining to give evidence

Dr Bernard Rosen	Consultant Psychiatrist (retired) Dr Rosen declined to give evidence despite being approached on more than one occasion. It is for the Strategic Health Authority to decide whether any further action is appropriate.

Appendix 6

Documents Consulted

1. GP Case Notes
2. Case Notes from the York Clinic Guy's and St Thomas's NHS Trust
3. Case Notes from Newham Healthcare NHS Trust
4. Maternity Services Case Notes
5. Health Visitor Case Notes
6. Mental Health and Employment in The NHS Department of Health October 2002
7. Post Graduate Medical Education and Training Medical Education Standards Board Department of Health November 2001
8. For The Record: Managing Records in NHS Trusts and Health Authorities Health Service Circular HSC 1999/053 Department of Health 1999
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Appendix 8

Chronology

21.04.66	Daksha born in Nzaga in Tanzania.
1969	Family moves to India in Rajkot, Gujarat Province, and their city of origin.
1974	Family emigrates to England.
1977	Daksha starts at Plashet Girls School in Forest Gate.
1982	Obtains eight A Grades at 'O' Level and 2 A Grade at AO level.
1984	Leaves Plashet Girls School with three Grade A 'A' Levels in Chemistry, Biology and Maths.
October 1984	Daksha begins medical training at the Royal London Hospital Medical School.
02.11.85	Daksha admitted to Newham General Hospital following a serious suicide attempt by overdose.
08.11.85	Daksha referred to Dr Bernard Rosen Consultant Psychiatrist at Guy's Hospital.
15.11.85	Dr Roy at Newham General Hospital writes to Dr Sohi, Daksha's GP, prescribing Amitriptyline 50mgs and recommending follow up appointment in one week.
18.11.85	Dr Rosen offers Daksha an appointment to see him on 21.11.85.
20.11.85	Dr Rosen writes to Medical Dean at The Royal London Hospital in an attempt to gain clarity over Daksha's wishes around his continued involvement in her care.
25.11.85	Dr Rosen writes to Daksha agreeing to her request for a further appointment offering her time on 28.11.85.
03.12.85	Dr Rosen agrees to consult Royal London Hospital Medical School about Daksha continuing her studies.
17.01.86	Dr Rosen writes to Professor Floyer the Royal London Medical School expressing concern at Daksha depressed mental state and informing him that an admission to Guys Hospital had been arranged for 20.01.86.
20.01.86	Daksha admitted to Guy's Hospital. During admission evidence and materials found indicating Daksha was planning to commit suicide. Daksha informs medical team and her parents that she was sexually abused by a neighbour when she was aged 8.
27.01.86	Medical School write to Dr Rosen informing him that Daksha will need to repeat her second year starting from October 1986.
11.04.86	Daksha discharged from inpatient care and maintained as an outpatient until her discharge on 24.09.86. During this time, her mood was noted to be elated and her behaviour overactive and disinhibited.
02.06.86	The Medical Dean writes to Dr Rosen expressing his view that Daksha was experiencing a manic episode and informing him that Daksha had not made a decision about returning to study.
24.09.86	Daksha discharged from outpatient treatment and prescribed lithium carbonate. Diagnosis changed to bipolar affective disorder.
October 1986	Daksha returned to medical school moving into halls of residence. Daksha experiences a serious relapse within three weeks.

17.12.86	Daksha admitted to Guy's Hospital and treated with electro-convulsive therapy.
19.01.87	Daksha discharged from hospital and referred to local mental health services in the London Borough of Newham.
15.03.87	Daksha and her parents visited by a Gujarati mental health worker with her parents to discuss family situation.
19.06.87	Correspondence between Daksha and Dr Rosen during Daksha's trip to India indicates discussions about Daksha continuing to take medication.
13.08.87	Dr Rosen writes to Dean of the Royal London Medical School recommending that Daksha resume her studies that autumn.
03.09.87	Dean of The Royal London Medical School writes to Dr Rosen agreeing that Daksha should resume her studies.
24.09.87	Dr Rosen writes to the Dean of the Royal London Medical School confirming that Daksha is fit to resume her studies. Daksha wins David Reeve Prize.
June 1988	Daksha wins the Buxton Prize and the Howard Prize.
August 1988	Daksha sends a bizarre card to Dr Rosen.
25.08.88	Dr Rosen writes to Daksha offering an appointment on 31.8.88.
28.08.88	Daksha admitted to Guy's Hospital with a hypomanic episode.
23.09.88	Daksha discharged from hospital. The discharge summary noted the beginnings of a pattern of symptoms prior to relapse including suicidal ideation and paranoia. It was noted that these symptoms tended to begin around August/September.
01.12.88	Dr Rosen writes to Daksha's GP informing him of signs of depression.
17.01.89	Dr Rosen writes to Daksha's GP prescribing an increase in Clomipramine.
23.01.89	Daksha admitted to Guy's Hospital alternating between periods of hypomania and depression. Treated with two courses of electro-convulsive therapy.
10.03.89	Daksha discharged from Guy's Hospital.
25.05.89	Dr Rosen writes to Daksha concerned about her medication and blood level checks.
31.05.89	Daksha writes to Dr Rosen informing him that she feels well and has been collecting her medication from her GP. Daksha also indicates that she will sit exams shortly and will be going to India for three months from the end of June.
02.06.89	Dr Rosen writes to Daksha reminding her of the need to monitor lithium carbonate level in hot climate.
June 1989	Daksha completes her BSc (Hons) in Pharmacology winning the Howard Prize in Pharmacology.
02.08.89	Daksha readmitted Guy's Hospital with depression.
25.10.89	Daksha discharged from hospital. Discharge summary indicates she was feeling depressed before going to India and had been contemplating suicide prior to admission.
December 1989	Daksha wins the Floyer Prize in Patient History Taking.
16.07.90	The Dean of the Royal London Medical School writes to Dr Rosen expressing concern at Daksha ability to undertake Senior House Officer responsibilities given the recurring nature of her illness asking his advice. The Dean agrees that he would not inform Daksha's colleagues of her illness.

19.7.90	Dr Rosen writes to the Dean expressing optimism about the control of Daksha's illness and her developing insight into her pattern of relapse. He confirms that Daksha should continue her course.
1991	Daksha meets David Emson.
1992	Daksha obtained MBBS.
August 1992	Daksha begins work as a House Physician at the Royal London Hospital.
November 1992	Daksha and David Emson were married.
February 1993	Daksha became Senior House Officer at the Royal London Hospital.
August 1993	Daksha joined the United Medical and Dental Schools (U.M.D.S.) Senior House Officer Training Rotation in Psychiatry. Appointed as Senior House Officer in General Adult Psychiatry, Hayes Grove Priory Hospital, Kent.
February 1994	Daksha appointed as Senior House Officer in General Adult Psychiatry, Guy's Hospital London.
11.02.94	Dr Rosen writes to GP reporting Daksha to be well with no recurrence of her hypomanic state or depression.
August 1994	Daksha appointed as Senior House Officer in Old Age Psychiatry, Hither Green Hospital.
January 1995	Daksha awarded Part I of the MRCPsych.
February 1995	Daksha appointed as Registrar in Cognitive-Behavioural Psychotherapy and General Adult Psychiatry, William Harvey Hospital, Ashford, Kent.
August 1995	Daksha appointed Registrar in Child and Adolescent Psychiatry, Bloomfield Clinic, Guy's Hospital, London.
February 1996	Daksha appointed Registrar in Community Psychiatry and Rehabilitation, South Western Hospital, London.
August 1996	Daksha appointed Registrar in Group Psychotherapy, Upton Day Hospital, Bexley Heath, Kent. Gained Part II MRCPsych.
1997	Daksha obtained MSc in Mental Health Studies, University of London.
February 1997	Daksha appointed as Registrar in Forensic Psychiatry, Trevor Gibbens Clinic, Maidstone, Kent.
June 1997	Daksha suffered a viral illness followed by post-viral depression. Dr Rosen prescribes increased level of Prozac.
07.07.97	Dr Rosen writes to GP following Daksha reporting a recurrence of her depression for which an increased level of Prozac is prescribed.
August 1997	Daksha appointed as Specialist Registrar in Neuropsychiatry, St. Thomas' Hospital London.
11.08.97	King's Healthcare NHS Trust Occupational Health Department write to Dr Rosen requesting confirmation of her admissions to hospital following information supplied by Daksha on her Occupational Health questionnaire.
27.08.97	Dr Rosen replies to Occupation Health Department confirming Daksha's history; Occupational Health Department take no further action.
October 1997	Daksha appointed Specialist Registrar in General and Community Psychiatry, North Southwark, London.

1998	Daksha discusses her illness with the rotation scheme Training Programme Director.
October 1998	Daksha appointed as Specialist Registrar in Forensic Psychiatry, Bracton Centre, Bexley Hospital, Kent.
February 1999	Dr Rosen supports Daksha's decision to stop taking lithium carbonate as she was attempting to become pregnant.
01.03.99	Daksha stops taking oral contraceptive pills and lithium carbonate.
22.05.99	Daksha suffers a miscarriage.
02.06.99	Dr Rosen wrote to Daksha's new GP informing him of his intention to leave his post in July 1999.
15.07.99	Daksha suffers a further miscarriage.
10.09.99	Daksha meets her local Consultant Psychiatrist he requests copies of the last discharge summary from the GP noting no relapse in Daksha's mental illness since stopping medication seven months earlier.
01.10.99	Daksha appointed Specialist Registrar in Community and Rehabilitation Psychiatry, Bexley Hospital, Kent. The Consultant Psychiatrist she reported to had treated her during an admission to Guy's Hospital in 1986, neither Daksha or the Consultant discussed her admission or treatment during her appointment.
01.11.99	Daksha becomes pregnant and is referred to the Early Pregnancy Assessment Unit at St. Bartholomew's Hospital.
2000	Consultant Psychiatrist requests a Community Psychiatric Nurse visit Daksha at home from the local Community Mental Health Team. The visit was not processed through the full clinical team and no entry was made on their database.
04.07.00	Freya Emson born.
07.07.00	Daksha and Freya discharged from hospital.
2000	Health Visitor visits Daksha and discusses her psychiatric history noting contact with both the Community Psychiatric Nurse and Consultant Psychiatrist. The Community Midwife visits inviting her to attend the Health Visitor Clinic on a weekly basis.
14.09.00	The Community Psychiatric Nurse visits Daksha in response to a telephone call Daksha had made. The Community Psychiatric Nurse agrees to set up counselling sessions offering weekly meetings until an appointment set up.
18.09.00	Daksha telephoned the Community Psychiatric Nurse to say that she had changed her mind about counselling and did not want any further visits.
19.09.00	The Community Psychiatric Nurse visits Daksha at home and observes her with Freya. Daksha informs the Nurse that she does not see the need for her to make further visits and agrees to discuss sleep problems with her Consultant Psychiatrist.
19.09.00	The Community Psychiatric Nurse telephones the Consultant Psychiatrist, who agrees to telephone Daksha.
20.09.00	The Community Psychiatric Nurse telephones Daksha, asking her to telephone the Consultant Psychiatrist's secretary.
25.09.00	The Consultant Psychiatrist receives a copy of Dr Rosen's discharge letter.
25.09.00	The Consultant Psychiatrist meets with Daksha determining she is not depressed.

26.09.00	Daksha's Health Visitor discusses Daksha at her Child Protection Supervision meeting and agrees Daksha's daughter should be removed from the concern list. Daksha's notes are to be transferred to a permanent Health Visitor.
05.10.00	Daksha and the Consultant Psychiatrist meet to discuss continued breastfeeding and resumption of lithium carbonate. The anti-depressant Setraline 50 mg once a day is prescribed. A letter is sent to the GP containing this advice.
08.10.00	Daksha informs her husband of feeling tired and low; he suggests she telephone her Consultant Psychiatrist.
09.10.00	Daksha and her daughter are understood to have been alone in the house from approximately 7.30am when Daksha's husband left for work. Daksha's mother visited the house at 11.30am but there was no answer at the door. At some point during the day, Daksha wrote a suicide note, stabbed her daughter and set herself and Freya alight. Freya dies as a result of smoke inhalation and burns. Daksha is discovered by her husband and taken to the Accident and Emergency Department at the Royal London Hospital where she is treated for her wounds and burns.
10.10.00	Daksha is transferred to the specialist burns unit at Bloomfield Hospital, Chelmsford.
27.10.00	Daksha dies from her injuries without having regained the ability to communicate.
03.12.01 – whilst the 05.12.01	The Coroner's Inquest at Walthamstow Coroners Court returned a verdict of suicide balance of Daksha's mind was disturbed and the unlawful killing of her daughter.
June 2001	London Borough of Newham Area Child Protection Committee order a Review under Part 8 of the Children's Act 1989.
July 2001	Independent Review into Part 8 Report submitted to London Borough of Newham.
January 2002	Independent Inquiry into the Care and Treatment of Daksha Emson is commissioned by North East London Strategic Health Authority and the London Borough of Newham Social Services.

Notes

Notes

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