Having read the submissions of various authorities to the Public Petitions Committee with regard to Petition PEO1494 I have been impressed by their almost consistent assertion that the Mental Health (Care and Treatment) (Scotland) Act 2003 is, if not absolutely perfect in all respects, an adequate vehicle to ensure the mental wellbeing and uphold the human rights of individuals in Scotland suffering mental health problems. Therefore it is considered compliant with the European Court of Human Rights, ECHR.

"Psychiatrists are regulated by the General Medical Council and abide by the standards laid out in Good Medical Practice. These standards are upheld through Clinical Governance by Health Boards, regular appraisal of individual performance and more recently revalidation by the General Medical Council. As psychiatrists we strive to uphold excellent standards and to provide the best treatment in the interests of patients and their families." Dr Alex Cook, Royal College of Psychiatrists in Scotland.

“When a person is made subject to a Short Term Detention Certificate (STDC), the patient or the patient’s named person may apply to the Tribunal under section 56 of the 2003 Act for revocation of the STDC. The Scottish Tribunals Service (STS) which provides administrative support to the Tribunal, has a Key Performance Indicator (KPI) requiring it to schedule a hearing within 5 days of receipt of application.” Mental Health Tribunal for Scotland.

The Mental Health Tribunal also states that the ECHR “has held that the term ‘a person of unsound mind’...cannot be taken to permit the detention of someone simply because his/her views or behaviour deviate from established norms.”

“The 2003 Act contains various “safeguards” to protect patients. Patients can have a Named Person/Welfare Attorney/Guardian to look after their interests; recourse to the Mental Health Tribunal, the Mental Welfare Commission (MWC), free access to independent advocacy services and a Mental Health Officer, MHO who must give consent before certain orders can be granted.” Kirsty McGrath Head of Protection of Rights and Mental Health Unit

When we read medical notes, accessible only after our son’s death, we were appalled by the low standard of the consultant psychiatrist’s records. They contained contradictions, assumptions, inconsistencies and much misinformation. Correct, honest record keeping is an essential ingredient of “Good Medical Practice” and the “excellent standards” necessary to “provide the best treatment in the interests of patients and their families.”
Our son was admitted to hospital on 29th August 2008. He had declared his intention to fast for 8 days. The CPN, Community Practice Nurse, called an out of hours GP we did not know, and an MHO, to our house in Scotland where our son lived with us. The GP and CPN offended our son by their attitude to his religious views. He wrote in a letter to the MWC dated 3rd Sept, that “The MHO, when he arrived, was much more aware and listened to what I had to say. He said it was very hard to section someone who was clearly in a rational state of mind.” But the MHO was overruled by other medical staff.

(We found an undated letter which refers to the 8th Sept. I think it was a rough copy of a further letter which he meant to send since he had had no reply from the MWC. The MWC sent me a copy of the letter which was sent. It is dated 3rd Sept 2008).

On Sunday Aug.31st our son had a “heated discussion” with the consultant, who put him on a STDC. He was angry that his religious reasons for fasting, described as “self-starvation”, were dismissed. Thoughts our son had had, some months back, about low flying aircraft (we lived near Molesworth when he was small) and had not been considered a problem by the consultant, were now used as an excuse for the STDC. Because he refused medication in hospital he was said to “lack insight” into his “illness.” In a letter to the GP about our son’s admission to hospital the consultant wrote “Neither the duty doctor nor the MHO could find hard evidence of mental disorder.”

Our son was seen at 9.30 a.m. on 31st Aug. By 10.30 a.m. the MHO, a different one, had granted the STDC. The consultant wrote on the form that it had been impracticable to call us. His reason, “I phoned the home number and left a message for Mr G. to call back.” Yet three days may elapse between the examination of a patient and granting a SDTC.

On 1st Sept our son saw a representative from the advocacy service who suggested he should pursue his case through a solicitor but that it would take “a week or so” to get the case going. Our son writes, “in distress and sorrow I tried leaving the ward, thinking that if the police came for me there would be a legal means I could pursue.” He writes, “This ended with me voluntarily getting into a member of staff’s car and returning to the hospital. After a struggle, when medication was mentioned, I ended up being forcibly injected against my will ‘to relieve my distress.’” Least restrictive?

The consultant describes this incident as follows, “he was brought back to the ward and was “given” (no mention of a struggle or forced injection) IM Haloperidol and IM Lorazepam because of his ‘agitation and distress’’. The irony of this “compassion” for his “distress” is that it caused greater distress as our son says in his letter.

The consultant wrote, in his letter to the GP that, by the 8th Sept, (our son) “was much improved, played chess with other patients and was sleeping well at night.” The consultant goes on, “I reviewed him on the 8th Sept. I explained to him, on that date, that we would be starting regular IM Risperidal Consta. He was given 25mgs of Risperidal on that day”. In the undated letter our son says he was forcefully injected on the 8th Sept.
By the 12th Sept he was “much brighter”. Perhaps it was because his Tribunal was to be held on the 18th. On the 18th he was “more tense, more perplexed and more angry about the whole detention process.” His Tribunal had been postponed to the 25th September.

He ran away to London to his brother’s house on 22nd of September. That was the day appointed for his next IM injection and he had been told that the RMO and MHO would be applying for a section 63 CTO on 25th September. He is now called “absconder”.

The consultant reports in a letter to the GP, dated 14th Oct 2008, that our son is in London at his brother’s house. He writes “I have made it very clear to (our son) and his family that in my opinion he suffers from schizophrenia. I think that he would benefit from being on regular antipsychotic medication. However it must be emphasised that this diagnosis is still somewhat tentative in that he has only ever described one specific psychotic symptom (a delusional memory) that his body was affected by a low flying aircraft many years ago. All the rest of his behaviour can certainly be described as odd and idiosyncratic (because he was reading the Bible and the Koran? The ECHR warns against such judgements) but it’s clearly not psychotic. There has never been any evidence that he suffers from hallucinations. He does not appear to have any other paranoid thinking or any other form of delusional thinking.” He concludes, “If he returns to Scotland, I would certainly be keen to establish him on antipsychotic medication once again but I do not feel that we can be actively pursuing him at this point.”

Please note that we obtained medical notes and letters only after our son’s death. When I had expressed doubts about the diagnosis of schizophrenia I was told that I had “no insight”. Our GP had diagnosed depression but then agreed with the consultant, even after receiving the above letter. I was vilified to some extent and “my views” ignored.

An independent psychiatric wrote a report after our son’s death in which he claimed there was no evidence to support the diagnosis. All authorities we have since complained to, including the COPFS, who commissioned the report, have ignored his finding.

The MHO is not a “safeguard”. The first one who came to our house was honest but he was overruled. The second MHO, in hospital, agreed with the RMO and granted a short term detention certificate within an hour. The third MHO agreed with everything the RMO said, kept inaccurate and misleading records, and interfered when it was not in her remit. I complained but was just told “she is very professional”.

The MWC, in our experience is not a safeguard. Our son wrote to the MWC for help. His letter was articulate, described events and his distress. It was never answered, we discovered after our son’s death, because the person responsible had been on sick leave.

The Tribunal system is not a “safeguard”. KPI requires that a tribunal be scheduled “within 5 days of the receipt of application”. However the time required to present an “application” is lengthy. It took from the 1st Sept 2008 to 25th Sept. 2008 to arrange our son’s tribunal. First a solicitor has to be found, then he has to interview the patient and various other people have to be consulted and supply reports, (RMO, MHO etc.). An
independent psychiatrist has to be found to examine the patient and make a report. In our case a psychiatrist agreed to do this, then declined and another had to be found. However, the 2003 Act empowers the consultant to force medication on the patient before he/she can appeal. The frustration must be unbearable.

Kirsty McGrath has written, with regard to Tribunals, that S318 of the 2003 Act creates an offence of knowingly making a false entry or statement in any “relevant document”.

The RMO and MHO both made false statements in hospital and tribunal reports. Whether “knowingly” or simply carelessly we do not know, but carelessness is not acceptable. The RMO claimed he had known our son for several years. He only met him in person in Sept. 2007. He and the MHO accuse our son of “sleeping rough”. We know this was untrue. The solicitor notes that our son denies this accusation. The MHO reports that our son was bullied at primary school, that we took him out of school and “home educated”. Their accusations appeared to be an attempt to suggest that he was isolated and odd. He actually had a glowing report at primary school, “an intelligent, athletic, popular and caring” boy. The independent psychiatrist noted this in his report after our son’s death.

In the report of a tribunal held on 10th Feb.2009, which my husband and I attended, it was noted “Both parents also expressed clear objections to what they stated were factual inaccuracies in the previous decision, 25th Sept. 2008. But nothing was changed.

Our son went to hospital for the last time on Oct 8th 2009 because of misunderstandings and bad practice on the part of the police and the (same) consultant. Our son called home to express concerns about his treatment, the re-introduction of medication, and I informed the hospital of his call and our concerns. I was promised that the consultant would call me back. He is supposed to “consult” the views of carers. He ignored us. The next day, less than 24 hours later, our son was given a 2 hour unescorted pass. We were not informed or “consulted”. He died of hypothermia in the hills eight days later.

We learnt from the hospital notes, acquired through FOI, that no symptoms of schizophrenia had been evident on his admission to hospital but our son had still been given medication. Was he forced? We don’t know. When he left the hospital he would have known that, if he returned home or to hospital he would be put on a STDC and forced to take medication which he did not want and for which there was no justification.

“Excellent standards” and the “best treatment in the interest of patients and their families”.

Our son was misdiagnosed, heid down and forcibly injected and is dead.

The Health Board, the COPFS, the MWC and the SPSO found “no failings”.

Mrs Judith Gilliland