PE1667/C
Mrs Judith Gilliland submission of 29 August 2017

When a young man dies of hypothermia in the Lammermuir Hills, one week after being given a pass from hospital one would assume that questions would be asked as to why this happened.

No questions were asked. There was silence. Nothing from the police, the procurator fiscal, the doctors.

We, the parents of that young man, had to ask the questions.

The Hospital Board, when approached, conducted an inquiry in private and told us that there had been no fault on its part.

We eventually approached the Procurator Fiscal (PF) who was quite perturbed by what we had to say and began proceedings towards a FAI (fatal accident inquiry).

Our case was taken from him and transferred to another office and to a different PF. There was no further move towards a FAI although we requested one. Witnesses would have been called who could have helped answer our questions as to what had gone wrong.

We were never allowed to see the PF's report but he did apply for an Independent Psychiatric Report of which we were allowed a copy.

Fifteen months earlier our son had been diagnosed with Schizophrenia quite suddenly and unjustly and medicated against his will, while on a three day detention order in hospital. He had to be held down to be injected. He described this as inhumane and wrote a letter of complaint to the Mental Welfare Commission who did not respond.

Once the diagnosis was made and the medication enforced, without any communication with his parents, (Joseph was living at home at the time), it was almost impossible to contest it. I was told I had "no insight" because I disagreed with the diagnosis and tribunals were ineffective although they are considered to be safeguards.

However, when we received a copy of the report from the Independent Psychiatrist we found that he, too, was not satisfied with the diagnosis.

He writes "There were no other clear symptoms of schizophrenia and he (Joseph) would not have satisfied ICD (International Classification of Diseases) 10 or DSM (Diagnostic and Statistical Manual) IV criteria for this diagnosis. Social withdrawal, apathy and avoidance are often associated with schizophrenia but they are not pathognomonic of the illness." He described Joseph as suffering from "worries" and as someone who "had lost their way in life and was desperately struggling to find some meaning - hence Joseph's preoccupation with reading the Bible and the Koran".

The diagnosis of schizophrenia caused distress to Joseph and to all his family and when, in October 2009, he found himself in hospital again, because of misunderstandings, and in a hospital he did not know, he must have despaired.

The very next day he “negotiated" (the independent psychiatrist’s word) a pass from which he did not return. When I read the hospital notes some long time afterwards, (only obtainable through FOI), I discovered that Joseph had not slept well and had been given substantial medication to calm him. The notes indicated that the staff were concerned because Joseph was not eating and the doctor on duty had said that he was in hospital "informally" but "detainable if he decides to go" as he "might be a risk to himself'.

Furthermore, the day before, Joseph called me to say he had concerns whereupon I had rung the hospital and was promised that the doctors would call me. They never did and the next thing we knew, notified by the police, not the hospital, was that Joseph had gone missing.

In our quest for information and understanding of the suffering we have undergone we have applied to at least five authorities for help but have been met with a wall of bureaucracy.

The only apology was for "lack of communication" but, since the psychiatrist apologised for that, all was considered well.

I hope things have changed for the better since Joseph died.