

PE1494/X

10 February 2014

Andrew Howlett
Assistant Clerk
Public Petitions Committee
Scottish Parliament
Edinburgh
EH99 1SP

Dear Mr Howlett,

Please accept the enclosed submission in support of Mr W. Hunter Watson's petition to the Scottish Parliament, PE01494.

Yours sincerely,

Judith Gilliland

Mr Andrew Howlett
Public Petitions Committee
Scottish Parliament

I have read material which has appeared online, on the PEO 1494 website or in my Emails, with regard to the Mental Health (Care and Treatment) (Scotland) Act 2003.

It seems that authoritative bodies such as the Law Society of Scotland, NHS Scotland, the Scottish Government (letter from Alex Neil) etc, who have made submissions to the Public Petitions Committee, consider that the 2003 Act is adequate to ensure the wellbeing and uphold the human rights of individuals suffering mental health problems. (These problems may be of an emotional or spiritual nature but there seems little provision for troubles of this kind).

I quote N.H.S. Scotland. "When it came into force (the Act) in 2005 it was heralded for having an innovative new principles-based framework at its core. Underlying each decision medical professionals make is a set of principles which they must have regard to. These include taking into account present and past wishes of the patient, the views of carers and guardians, using the least restrictive alternative and the importance of providing maximum benefit to the patient."

These are fine words, which many people, including our son, who have experienced the trauma of treatment in a mental health hospital, would dismiss with contempt. Indeed they have done so. Unfortunately our son is not able to do so. He is dead.

The assumption seems to be that every psychiatrist will have regard to these principles and mistakes will never be made. This is not so.

I have learnt, from what happened to our son, that consultant psychiatrists, even if they are "careless" in their regard to these "set principles", have absolute authority when deciding whether or not a person is of "unsound mind."

Should a psychiatrist err, there are "safeguards" we are told. The psychiatrist's decision must be approved by an MHO appointed by the local authority. If that "safeguard" fails free advocacy service is available to enable a patient to arrange a tribunal to hear his case.

The Law Society of Scotland claims that the above "set of principles" and the further "safeguards" would suggest that the 2003 Act is compatible with ECHR and that "any ECHR violations are likely to be related to the implementation of the 2003 Act". What they are saying is that mistakes can be made. Mistakes were made in our son's case.

Because this submission must be brief, I can only touch on some of the abuse our son suffered as a patient. I will concentrate first on his admission to hospital in August 2008.

On 29th August 2008 he declared his intention of undertaking an eight day fast for religious reasons. He was living at home in Scotland at the time. The Community Practice Nurse (CPN) contacted an out of hours GP and an MHO. They all spoke to my son but we don't know what they said. The privacy rule was very much adhered to at that time. There was much confusion with regard to this rule. Some staff did not understand how it worked and others used it as an excuse not to pass on information.

Much of what we know about our son's treatment we have only discovered after nearly four and a half years' searching for information. After his death we found a letter which he had written to the Mental Welfare Commission complaining about his treatment on the night of 29th and subsequently. (The letter was never answered-more of that later).

He describes how the GP was offensive with regard to his religious beliefs and how the CPN dismissed the authority of the Bible as "stories from a long time ago". ECHR compliant? His letter reports that, after speaking to him, the MHO considered that he, (our son), "had made a rational and informed decision" about the fast. The MHO was overruled and our son sent to hospital on a 72 hour emergency detention. The "safeguard" had failed. The fast could have been supervised at home.

On the 31st August our son was interviewed in hospital by the consultant (RMO). He says that "following a heated discussion he (the RMO) chose to section me for 28 days not the original 3". And he considered that the reasons for the detention were quite wrong. When I read the detention certificate which we only saw very recently, having asked for a copy from the MWC, I agree with my son.

He says he was told this detention order was open to "constant review" but that when he sought a review he was told he needed to see the consultant who had gone on holiday. He goes on to describe how on the 8th September 2008 he was told by a representative from the advocacy service that his "case would take a week to get going". He says he was "frustrated and distressed by my (his) circumstances" and tried to leave the hospital.

He says his attempt to flee the hospital "resulted in me being returned to hospital voluntarily in a member of staff's car and man-handled and forcefully injected. This was a highly distressful experience and the effects are still with me. At all times I was able to explain my case but no-one was listening". He goes on, "I believe the whole process is against my basic and personal freedoms, that I have no psychiatric illness whatsoever and that the whole process has been a very real injustice".

After he tried to leave and one can understand why he did so, he was suddenly diagnosed with schizophrenia and given involuntary intramuscular injections of Risperidone. The diagnosis was proved to be a misdiagnosis in an independent report after our son's death.

On 31st August the consultant, giving his reasons for the detention order, writes that our son "refuses to take medication on an outpatient basis". There was no reason for him to take medication. He had simply stated that he wanted to undertake an eight day fast and his reasons had been accepted by the MHO. Our son's views and wishes were ignored. The consultant describes his fast as "self-starvation". He also writes on 31st, "he is likely to deteriorate physically and mentally if he continues to starve himself". This proved inaccurate after a few days when our son accepted bread and fruit I took into the hospital.

The psychiatrist writes that our son "has no insight". "He does not believe that he has a mental illness".(I was said to have no insight when I doubted the diagnosis of schizophrenia) Our son's written comment on the psychiatrist's reason for saying he was mentally ill showed more insight into the psychiatrist's lack of insight than vice versa.

The consultant examined our son at 9.30 a.m. on 31st August. By 10.30 a.m. the certificate of detention had been approved by the MHO - a different MHO from the one who had seen our son at home - and granted. The consultant, when filling in the section to explain why it had been "impracticable" to "consult" our son's "named person" writes, "I phoned the home number and left a message for Mr G. to phone me back". The information on the certificate states that three days may elapse between the examination of the patient and the granting of an order. There was time to wait for my husband to phone back. We were not told about the detention order nor "consulted" as to our "views". This was contrary to the "set-principles" a psychiatrist must "have regard to".

I have read in the submission, with regard to PEO1494, sent in by the Scottish Commission for Human Rights that "to be in compliance with the ECHR, the confinement of a person of unsound mind must comply with the requirements laid down in the Winterwerp v. the Netherlands, namely:

- it must have been reliably established, through objective medical expertise, that the patient has a true mental disorder;
- the mental disorder must be of a kind or degree warranting compulsory confinement;
- the validity of continued confinement depends upon the persistence of such a disorder.

I hope that my account of the carelessness with which our son was detained and misdiagnosed shows that none of the above requirements were complied with.

When he was given intramuscular injections with the use of force the legitimate purposes for this were not complied with - see section 243 (3) (a)(b)(c) (d)(i)(ii) -of the 2003 Act Once the "label" of schizophrenia had been attached to my son it was deemed legitimate to force medication on him when he had the misfortune to be hospitalised a further time.

The last time he was admitted to hospital was in October 2009, because of bad practice and misunderstandings.(Psychiatrists don't always follow the "standards laid out in Good Medical Practice" as Dr Alastair Cook of the Royal College of psychiatrists claims). Although showing no symptoms of schizophrenia according to the hospital notes, our son

was still given Risperidone orally and other medication, twice orally and twice by intramuscular injection. This was in spite of his having called me to complain about the Risperidone whereupon I had immediately called the hospital to express his concerns and mine. I was told the consultant (the same one) would call me about our concerns but he never did. Our views were ignored. Less than 24 hours after admission the consultant, without informing or consulting us, gave our son a 2 hour pass. He never returned to hospital and was found dead in the Lammermuirs a week later. He was twenty seven.

The consultant's treatment was not compatible with the 2003 Act, he did not "consult" with his patient's carers (he might have saved his patient's life if he had) and he made, "unreliably", a distressing diagnosis which no-one had the power to dispute.

The "safeguards" proved ineffective. The first MHO was overruled, the second simply agreed with the consultant and it proved very difficult to arrange a tribunal "speedily" as is claimed in the Act. Our son was forcefully medicated before he had time to appeal. The MWC failed too. After his death we were told that the person who should have answered our son's poignant and articulate letter had been on sick leave and nobody else had picked it up. We received an apology.

When I attended a tribunal, arranged by our son, in February 2009 the consultant did not attend, (a junior doctor took his place who knew little about the case), our son did not attend and was not made to, although he was in hospital at the time. Yet the panel are supposed to assess the "capacity" of the patient before making a judgement.

After our son's death every authority we complained to (N.H.S.Loithian, the COPFS, the MWC, the GMC, the Ombudsman) claimed that there had been no failings. Until it is accepted that a psychiatrist can make mistakes and is penalised for his errors, patients will suffer and the 2003 Act will remain incompatible with ECHR.

Alex Neil, Cabinet Secretary for Health and Wellbeing says that Mr Watson (PEO1494) has "provided no relevant 'case law' to support his viewpoint that the short-term detention provisions are incompatible with ECHR legislation". Mr Neil continues "The Scottish Government is not aware of a 'human rights case' relevant to the 2003 Act short detention provisions". There may be no case law because it is complicated and expensive to "go to law" even in one's own country and it may be that cases against psychiatrists have never been successful. Going to the European Court would be an even more difficult, daunting and expensive prospect. We have had no success in putting our case to the authorities named above. With respect we feel there has been a lack of probity in their investigation of our case. The individual is powerless against the bureaucratic machine.

"As for you, say what you can; my false o'erweighs your true." Angelo to Isabella

Measure for Measure.

Mrs J. Gilliland