Royal Commission into Victoria's Mental Health System Submission

From: [redacted]
To: Royal Commission Victoria Mental Health System (DPC) <contact@rcvmhs.vic.gov.au>
Date: Tue, 09 Jul 2019 15:51:24 +1000

Dear Phil / others

As advised I received confirmation of my submission below.

I answered question 64 with the details of my nephew, [redacted] suicide on [redacted] 2018.

[redacted]

Thank You
[redacted]

Q64. Is there anything else you would like to share with the Royal Commission?

My submission relates to my nephew [redacted], who died on the [redacted] 2018 on the [redacted] Road in a single vehicular accident that collided with a tree. The Coroner's report is imminent.

[redacted] was working as a [redacted] from early –mid 2017 until his death.

In late 2017, [redacted] sustained a work place injury to his knee while rushing [redacted].

[redacted] was reportedly initially concerned about reporting this as it could impact on his job prospects at the [redacted] or future employment.

As the condition worsened [redacted] was unable to work and sought treatment. Anti depressants had bene prescribed by a GP.

[redacted] reportedly made several attempts to lodge a claim, including the week prior to his death, with his manager [redacted]. The WorkCover claim was not completed after meeting with his manager.

[redacted] was being supported by his friend and colleague, [redacted].

In the weeks prior to [redacted] death, [redacted] presented to both the [redacted] departments with physical symptoms that were causing him distress, and could be interpreted as catastrophising.

At this stage, I am concerned that [redacted] mental health deterioration was not identified, especially during his presentations to [redacted] Hospital.

On Friday the [redacted], the night before [redacted]'s death, [redacted] presented at the [redacted] Hospital Emergency department.

[redacted] was assessed and an appointment was made to a clinic for admission the following day.

His crisis had been identified. [redacted]'s colleague and friend, [redacted] has reported that while [redacted] was at the hospital, Hs manager, [redacted], advised [redacted] to no longer have anything to do with [redacted] personally and professionally. [redacted] and her family had been [redacted]'s support at this time.

[redacted] was allowed to leave the emergency department on his own recognisance, with no support.

The following day [redacted] was deceased.

Many questions arise from [redacted]'s death.

1. Why was [redacted] allowed to leave the hospital on his own, without support, when he had voluntarily presented seeking support in a crisis?
2. Why was [redacted]'s presentations at Victorian Public Hospitals, in the preceding two weeks not viewed as a person in crisis?
3. What ability does Victorian Public Hospitals have to identify Mental Health conditions and respond to people in crisis to prevent suicide?
4. In particular to [redacted]'s workplace, what role did his workplace injury, failure of the department to support reporting of injuries, timely medical treatment, and income support during recovery impact on [redacted]'s impending crisis?
5. What are the results of any internal review and what recommendations have been made and implemented?
6. If the [redacted] Emergency department could not support [redacted], was this personal and could [redacted] have been ostracised [redacted]?
7. If not, and they cannot provide life saving care to one of their own, what confidence can the general public have when self presenting to hospital?

And Finally,

8. Will [redacted] be another statistic or can his death result in improvements to care in [redacted], that he strived so hard to bring to his profession ?

[redacted]

[redacted]

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