[redacted]

On the 10th of June 2000, my husband made a very serious attempt at ending his life. He overdosed with insulin, drove to an isolated area where he cut his wrist and lost consciousness before being able to shot himself with the loaded gun. He was found after an intensive search, collapse beside his truck at the bottom of a hidden gully.

He was taken to the local bush nurse, stabilised and at his own doctors request was to be flown to the psych ward in Traralgon for the psych help his doctor who knew his background felt he needed. He was unable to be transported by helimed because of regulations of transporting psych patients and instead was taken by road ambulance to the nearest hospital which was Bairnsdale. At Bairnsdale a Triage referral was faxed to Gippsland psychiatric services and Peter was not accepted for services. Peter was accessed by 2 psych nurses the next day at Bairnsdale and was again not accepted for services.

I asked the coroner to investigate this case and she writes, " I consider that Mr Sidebottoms management by the staff at the Bairnsdale community mental health services was excellent." She also states" I have assessed the evidence in this case having the advantage of conducting many inquests and reviewing expert opinions in similar cases" Yet no expert was call upon in this case and in fact she didn't call Peters own doctor or the treating doctor or the Bush nurse or the local minister etc. I felt the inquest was a white wash. Can you imagine the mayhem it would cause if these "many similar cases" were investigated fully and honestly. The fact that the coroner admits there are many similar cases says to me that the system isn't working and that the powers to be are not taking mental illness treatment seriously or treating it as a human right.

It's all well and good to say it's best for the consumer to be treated in the community and by the consumers own doctor, but for this to have any chance to work you must ensure the right hand knows what the left hand is doing and that all parties involved know exactly what each other is doing and that each have the appropriate skills. The fact that it was felt that my having an affair was why Peter wasn't able to cope is all the more reason he should have been taken seriously after his suicide attempt in June which if psych services had have

listen to me (Peters carer) or if they had contacted his doctor, they would have noted this was indeed his second serious suicide attempt. Even if they didn't believe me- the so call main problem, why didn't they ask Peter if what I told them was true and what were the circumstances leading up to the first suicide attempt and what if any treatment he had after that attempt.

There are no notes in their records of the phone call I had with Steven Bradley on the 11th of June 2000, and he was never asked about our conversation. If need be I could name a witness who waited with me for hours while I repeatedly phoned to speak to a psych nurse, and who was with me during the conversation. I do not know this person's currant address as we have not spoken for over 4 years, but I'm sure I could track them down if need be. They say that Peter was coping well and was happy etc before I told him of my short-term affair. This is absolutely not true, as I and others have stated in some of the enclosed documents. If I had understood depression earlier I would have understood this is why Peter had changed, why he was so negative, cynical, sad etc and why he was pushing me away and things would have been different, but the truth is I honestly thought he didn't love me. I remember feeling overwhelming sadness and so alone.
I was doing all I could possibly do for him and he stopped loving me. I knew I was needed, by more than just Peter, but there was a part of me that needed to be wanted. We were had so many things we had dealt with and were still going through so much.

Now I know it is not uncommon for people with depression to push away the very people they need to help them get through. While I knew Peter loved me I could deal with whatever had to be dealt with and whatever was to come, but then slowly everything started falling apart. As for Peters assaulting me and burning down the house with all our memories, it was not fair play on his behalf and it is something I didn't deserve, but I can't be angry with him. I know from the hospital notes (which I didn't know existed until 5 min before the coroners inquest) he had planned to do this on the 10th of June but decided to only attempt suicide instead.

I don't blame any one person for Peters death, but for the life of me I cannot understand why people want to run for cover instead of wanting to find out how and why Peter was not given the help he needed and where the system failed, to try to ensure it doesn't happen again. At one stage I thought I will sue the bastards, not for money but to put the issues in the public arena, but then I knew I would need more strength than I had to do that and I haven't any faith in the justice system and it would cost more money than I have.

As I said before, it's not about blame it's about the truth. How is it a man can attempt suicide as Peter did, then have his own doctors' request for his treatment ignored. What happened to the doctor's request, did it not get passed and was ignored, did the bush nurse not pass it on to the ambulance or is it out of her hands once the ambulance takes over. And is it then up to the ambulance to pass on the request. Did someone forget to do the paper work? or was the request somehow watered down. On admission to hospital after such a serious event why weren't questions asked from the admitting doctor, in this case Dr Worboys, to get Peters medical history and some background of his mental state. Should the bush nurse have phoned the hospital or should someone in the hospital have contacted her. Was it a busy night and this was overlooked? or was it because it was a long weekend and they were short staffed.

In the notes of the Bairnsdale regional health service, under presenting history, "o/d atrapidinsulin?? 2 pens.....found by police with gun-has no recollection of events....."
Peter was not found by police. How can it be that after such a serious event people are taking the word of the patient who has no recollection of the event? How is it that if someone has a life threatening physical injury or illness, our society rightly expects and demands that every possible appropriate treatment is available to them to try to ensure a full recovery. And yet people with self inflicted life-threatening injuries and mental illnesses are treated as not being worthy of the same consideration and help.

Why is it ok to accept the judgement of an inappropriately trained doctor or a psych nurse for appropriate treatment for a person with a mental illness, but it is not ok to accept the judgement of a highly trained nurse or inappropriately trained doctor for a physical illness?
Why wasn't Peter seen by at the very least a psychologist and more appropriately a psychiatrist? How can it be that a person at the receiving end of a fax or phone call can make a critical judgement about someone with so little knowledge of the patients history or the circumstances that led to a referral.

After Peters death and after I started to ask questions, it is my understanding that all staff working for Gippsland psychiatric services were required to undergo Applied Suicide Intervention Skills Training. I myself undertook this training which was over a 2 day duration, I was shocked and sickened to hear at this training that up until 2001 there had never been any such training required for staff specifically for suicide and suicide intervention.
Not surprisingly any questions I have asked since regarding this matter, have fallen on deaf ears.

After the coroner's inquest, I was told by 2 very reliable people that Diane Coxon, mentioned in the coroners report, had agued with Steven Bradley over his actions regarding Peter on the 14th of June. I have not been able to confirm this, as I don't know how to contact Diane.

As people were searching for Peter I was going to walk around on the back track of our property to see if Peter was there. Senior Constable Ian Nankivell wouldn't allow me to go around there in case Peter was there and may harm me again. I wanted someone to take a look but it was seen as being unnecessary. As it turned out this was where Peter was found. I felt guilt at not insisting I had a look as I had wanted to and that in doing so I may have been able to save Peter. I didn't say anything to anyone about this, as it wasn't going to change what happened.

A few weeks later when I went to the police station to pick up the items Peter had on him, Ian told me he hadn't been able sleeping well since Peter died. He said he kept remembering me wanting to see if Peter had driven on the track. He said he had checked it out and felt that there was no way a car could have been able to drive passed the parked truck. He told me how sorry he was and that he felt some guilt. Had he mentioned to me at the time the reason for his decision, I would have told him, the truck wasn't parked there when we arrived and I had got Nigel to park it there so the CFA truck could get close to the house, but I didn't know the reason for the decision.

When I explained this to him he was somewhat relieved, and we agreed there was a cock up but there was no one person was to blame. I can guarantee that if Ian or I are ever in a similar situation we will make sure we double check. I now hold Ian Nankivell in high esteem, not because he is human and unwittingly made a mistake, but because he was honest. I only wish there people like Ian in the mental health system.

I am more than willing to discuss any aspects of this case if there is a real chance for real change in our very broken mental health system.

With kind regards and courage in your endeavour to openly and honestly inquire into mental health in Australia.

Sue Sidebottom.

Please find enclosed documents in relation to Peter Sidebottoms treatment from the Victorian regional mental health system.