FORM 38

Rule 60(2)

FINDING INTO DEATH WITHOUT INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 4964/09

In the Coroners Court of Victoria at Melbourne

I, KIM PARKINSON, Coroner

having investigated the death of:

Details of deceased:

Surname: SINAPI
First name: ROSA
Address: 9 Penrith Crescent, Bundoora, Victoria 3083

without holding an inquest:

find that the identity of the deceased was ROSA SINAPI
and death occurred on 18th October, 2009

at 9 Penrith Crescent, Bundoora, Victoria 3083

from
1a. RISPERIDONE TOXICITY

Pursuant to Section 67(2) of the **Coroners Act 2008**, an inquest into the death was not held and the deceased was not immediately before the person died, a person placed in custody or care; but there is a public interest to be served in making findings regarding the following circumstances:

1. Ms Rosa Sinapi was born on 30 March 1962 and was 47 years old at the time of her death. She resided at 9 Penrith Crescent, Bundoora, where she boarded with a family friend, Ms Roslyn Gent. The circumstances of Ms Sinapi's death have been the subject of investigation by Victoria Police. Senior Constable Elizabeth Brown of Mill Park Police Station provided a brief to the coroner setting out the investigations undertaken. I have drawn from those investigations in my finding.

2. Ms Sinapi had a history of psychiatric illness including depression and she had been diagnosed as suffering with delusional disorder. She attended General Practitioner, Dr Tacye Todd, who had treated her intermittently for the last 14 years. Dr Todd reported that Ms Sinapi had a past history of several psychotic episodes, depression, hypertension, gastro-oesophageal reflux disease and hyperlipidaemia. She reported that she had cared for Ms Sinapi intermittently during the course of her psychiatric illness and that she had suffered her first psychotic episode in 1996, which settled with anti-psychotic medication. The next event of which Dr Todd is aware occurred in September 2007, when she examined Ms Sinapi at the request of Victoria Police and found her to be paranoid and psychotic on examination. She commenced treatment with the anti-psychotic risperidone and referred her to the Northern Area Mental Health Service.

3. Dr Maxwell Gayner, consultant psychiatrist at the North Western Area Mental Health Service, Darebin Community Mental Health Centre, reports that Ms Sinapi was a patient of his between September 2007 and March 2009. He reports that her formal diagnosis was delusional disorder, with associated depressive mood and that she was not his patient at the time of her death. He reported that during the period of his contact with Ms Sinapi she responded well to treatment with risperidone in combination with the anti depressant, citalopram. He reports that during the course of her treatment she was difficult to engage in treatment.

4. It appears that she was discharged from the care of the Darebin Community Mental Health Service in March 2009, to the follow up care of her General Practitioner. She was prescribed risperidone 4mg at night and citalopram 20mg in the morning. Dr Gayner reports that his only subsequent contact with Ms Sinapi was for a fitness to drive assessment for VicRoads, undertaken on 18 May 2009, on the referral of her GP. He reports that she appeared well on that occasion and did not report any concern about her mental health.

5. On 16 October 2009, she attended her GP, Dr Todd at her clinic. Dr Todd reports that she was apparently in difficulty and that she was requiring of specialist assistance and that it was required immediately. Dr Todd describes that she presented in an agitated state. She stated:

> *"In the course of that consultation, Rosa told me that she was at her wits end and had been kicked out by her housemate for leaving the dishes undone and staying in her room too much. She said she wanted to die, but told me she would not take any action to harm herself, because she lacked the 'guts'. She stated that she would die soon in any case, and that she needs to be cared for in a nursing home. She reported sleeping during the day, but poor sleep at night. She said she was worrying 24 hours a day. She told me she had increased her risperidone from 3mg daily to 3mg twice daily at her own initiative and without medical advice about six weeks previously to settle herself. On examination I found Rosa to be disinhibited, swearing at times during the consultation (which was unusual for her) and agitated."*

6. Although she was coherent, her actions and plans varied during the consultation and the doctor noted that she had some involuntary facial movements of concern, which she considered were attributable to the risperidone medication.

7. Dr Todd's description of the process of attempting to obtain the assistance is as follows:

"I was very concerned for Rosa and felt that she needed specialist psychiatric care. Rosa also wanted specialist help. She told me that she would be returning to her previous address, which was in the catchment area of Darebin Community Mental Health and wanted to see the mental health team she was already familiar with, so I initially contacted Darebin . However, the person I spoke to was adamant that Rosa could not be seen by them, unless she had actually physically moved her things to an address within their catchment area.

They advised me that Rosa fell under the care of the North East Mental Health Service, so I telephoned them, but was redirected by them back to Darebin after a lengthy process of checking geographical boundaries against street names.

When I spoke again to Darebin, they went back to check their map and found that the Whittlesea Community Mental Health Service was responsible for Rosa. I telephoned Whittlesea but their intake worker was busy. Rosa was upset that she would have to be cared for in Whittlesea, stating that she didn't even know how to get there. She told me I should have lied about her address so that she could have been seen at Darebin. I told her she would be contacted by me or the intake worker to tell her what would happen next, but I did not know how long it would take the intake worker to return my cal l. I also asked Rosa to stop taking her risperidone twice daily and to take only one tablet per day until she was reviewed by the psychiatrist, as I was concerned by the side effects she was havi ng. Rosa left my surgery, agreeing to return to see me the following week. She made an appointment to do so on her way out. No medication was prescribed for Rosa on that day and she did not ask for any prescription.

After Rosa had left, the intake worker from Whittlesea Branch of the Northern Mental Health Service rang me back and we discussed the case. She told me she would organise an appointment for Rosa and contact her on her mobile phone. I faxed a referral letter and copy of Rosa's discharge summary from Darebin Mental Health to Whittlesea immediately."

8. North Western Mental Health Service, of which the Darebin Community Mental Health Centre is a part, was where Ms Sinapi had previously attended Dr Gayner and Case worker, Mr David Chisholm. Dr Gayner describes the process of Dr Todd's referral process as follows:

"Five months later on 16th October 2009, Ms Sinapi's general practitioner sought further help from the psychiatric service for her. By this time Ms Sinapi had relocated to Bundoora and Dr Todd consequently contacted the Whittlesea Community Mental Health Servic,e advising of her concerns about a deterioration in Ms Sinapi's mental health, Dr Todd found Ms Sinapi to be not actively suicidal, but nevertheless in need of immediate assessment. A triage worker at Whittlesea Community Mental Health centre accepted the referral from Dr Todd and initially tried to arrange assessment by the primary mental health team. When told there would be a three week delay the triage worker arranged for an assessment to be performed by a doctor and case manager at the Centre on 22 October."

9. Attempts to contact Ms Sinapi after she left the doctors surgery on 16 October 2009, were unsuccessful. The Whittlesea Community Mental Health Centre reported that a message was left on her telephone answering machine on that day and subsequently on 19 October 2009.

10. On 18 October 2009, at approximately 4.00pm, Ms Gent and her friend, Mr Gotts returned home after shopping. Shortly afterwards, they located Ms Sinapi unresponsive in her bedroom. Mr Gotts commenced resuscitation under instruction from 000 operators. Ambulance and fire brigade attended, however Ms Sinapi was deceased.

11. Police attended and located prescription medication in the bedroom. These included risperidone, citalopram, felodur, panamax and an over the counter allergy medication, Telfast. The risperidone blister packages, which contain 60 tablets, were empty. There were no signs of forced entry or interference with the premises. Police reported no suspicious circumstances.

12. An autopsy was conducted by Dr Melissa Baker, Forensic Pathologist with the Victorian Institute of Forensic Medicine. Dr Baker reported:

"The cause of death was risperidone toxicity. Toxicological analysis of blood revealed a markedly elevated level of risperidone of 1240ng/mL. Hydroxyrisperidone, a metabolite of risperidone was detected at a comparatively much lower level of 36ng/mL, which is consistent with acute ingestion of a large dose of risperidone . Therapeutic post mortem concentrations of risperidone range up to approximately 100 ng/mL. The level detected in this case is more than ten times that. Toxic effects upon the cardiovascular system such as hypotension and an ability to cause arrhythmias due to prolongation of the QT interval, seizures, respiratory depression and development of neuroleptic malignant syndrome. Toxicological analysis of blood also revealed the presence of citalopram, an anti-depressant medication, at a concentration consistent with therapeutic use. Paracetamol was detected at a concentration of 62 mg/L, which is above the quoted therapeutic range. A trace of temazepam was also detected."

13. Ms Sinapi left no note indicating that she was intending to take her own life. Family and friends state that they believe her actions were most likely as a result of a cry for help, not an intentional act. Ms Sinapi was reported by mental health clinicians to have denied suicidal ideation throughout the course of her illness on the basis of her religious belief.

14. Whilst I cannot, on the evidence, entirely exclude the possibility that her actions in taking an overdose of her medication were a 'cry for help', the quantity of prescription medication which she ingested, is consistent with a serious attempt to self harm.

15. Having considered all of the available evidence, I am satisfied that no further investigation is required. I am satisfied that there were no suspicious circumstances. The evidence does not entitle a conclusion that any person or party caused or contributed to the death.

16. I find that Ms Sinapi took her own life and to the extent that she deliberately ingested the overdose of prescription medication, risperidone, her death was intentional. I find that Ms Rosa Sinapi died on 18 October 2009, as a result of risperidone toxicity.

COMMENTS:
Pursuant to Section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

1. There are some aspects of this case, which are appropriate for comment. Whatever may have been the referral processes, it appears that the General Practitioner experienced difficulty in locating an immediate response mental health assessment and treatment option for Ms Sinapi.

2. This criteria for determining whether a person receives treatment from a service, relying as it does, not on their history of receiving service, or indeed absent any factors relating to the convenience of the patient, but rather map driven geographical boundaries, mitigates against the provision of quality care and may be a disincentive to mental health patients to engage with services.

3. In this case Ms Sinapi, expressed her desire to attend a service she had previously attended with clinicians with whom she was familiar. She expressed reluctance to attend at a 'new' location. It would seem apparent that some consistency of service provision for a mental health patient would be a useful treatment tool and may have engaged Ms Sinapi in the process, although no conclusion may be reasonably drawn that it would have prevented the death.

4. Mental health patients are not infrequently transient or homeless, often as a result of behaviours arising from their mental illness. In this case, a referral issue arose because of Ms Sinapi's residential address change. For the mental health service provision to be dependant upon residential address would, given these factors, seem to be counter-intuitive.

5. It was acknowledged in the statement of North Western Area Mental Health, that the GP was seeking immediate assessment. Notwithstanding this, there was no immediate clinical team available to see Ms Sinapi and it was proposed that assessment would take place 6 days later on 22 October 2009. Whilst this no doubt arises as a result of the resources available to public mental health facilities and clinicians, the intervention of a GP in referring a person for "immediate assessment" would suggest that the matter requires of more urgent assistance than 6 days into the future.

RECOMMENDATIONS:

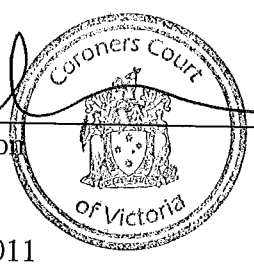
Pursuant to Section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. That the Secretary, Department of Health, review mental health service practices in relation to the patient's residential address being the determinant of the location of care. In particular in relation to patients with prior attendance history at an area mental health service

2. That the Secretary, Department of Health, review the manner in which referrals by General Practitioners to Public Mental Health Services are made and prioritised or triaged, to ensure that GP's as frontline mental health service providers, have access to appropriate levels of support and assistance when making referrals.

3. I direct that a copy of these findings be provided to the interested parties: The Honourable Mr David Davis, MLC Minister for Health (Victoria); The Secretary, Department of Health (Victoria); The Executive Officer, North West Mental Health Service; The Office of the Chief Psychiatrist, Dr Ruth Vine; The Royal Australian College of General Practitioners and Dr Tacye Todd.

Signature:



Kim M W Parkinson
Coroner

13th September, 2011