IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2015 1118

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

Findings of:	Paresa Antoniadis Spanos, Coroner
Deceased:	Caterina Fratto
Date of birth:	4 February 1970
Date of death:	On or about 7 March 2015
Cause of death:	Hanging
Place of death:	Reservoir, Victoria

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of CATERINA FRATTO without holding an inquest:

find that the identity of the deceased was CATERINA FRATTO

born on 4 February 1970

and that the death occurred on or about 7 March 2015

at 3/22 Banff Street, Reservoir, Victoria, 3073

from:

1 (a) Hanging

Pursuant to section 67(1) of the *Coroners Act 2008*, I make findings with respect to the following circumstances:

Background

1. Caterina 'Cathy' Fratto was a 45-year-old woman who lived alone in Reservoir. She was born to Fiorella and Paul Fratto and had a younger sister, Laura.
2. Ms Fratto had a medical history of anorexia nervosa and depression, which was diagnosed in early adolescence when she first began to engage with mental health services. She was later diagnosed with Bipolar Affective Disorder and Borderline Personality Disorder with Cluster B traits.
3. Ms Fratto was admitted to hospital on a number of occasions and had significant contact with the Crisis Assessment and Treatment Team. In more recent years, Ms Fratto was managed in the private mental health system. Ms Fratto had a history of attempts to end her own life by overdose and episodes of self-harm.

Circumstances immediately proximate to death

4. In July 2014, Ms Fratto was referred to Northern Area Mental Health Service (NAMHS) via the mental health nurse at Darebin Community Health, who was concerned about a deterioration in her mental state. At that time, Ms Fratto was under the care of a private psychiatrist, Dr Tanya Gettinger.
5. Between 15 July 2014 and 28 July 2014, Ms Fratto was an in-patient at the Northern Psychiatric Inpatient Unit (NPU) after community treatment had failed. Initially, Ms Fratto presented with mania without psychotic symptoms, which progressed to what

appeared to be a mixed affective episode that gradually settled with treatment. This was followed by a depressive episode that did not respond to treatment. During this episode of care, her treating consultant psychiatrist was Dr Basanth Kumar Kenchaiah.

6. Treatment was difficult due to poor engagement, negotiating her medication and other psychosocial supports. Ms Fratto's initial discharge plan was for follow up with Dr Gettinger with additional support from the Central Community Team of North Western Mental Health (NWMH). However, in light of her perceived ongoing risks, Ms Fratto was ultimately referred for full care with the NAMHS Central Team on 5 August 2014. Psychiatric care continued in the community with Dr Kenchaiah and other key clinicians.

7. Risk assessments conducted by clinicians identified a number of concerns, which included partial adherence to her medication regime, unilateral dose changes made by Ms Fratto and overdoses of prescribed medications in July and August 2014, which required treatment in an Emergency Department. Other concerns were that Ms Fratto was allegedly a victim of family violence, allowed patients from the in-patient unit to stay at her house (albeit for short periods), excessive spending on herself and others while in a vulnerable state, and experienced significant weight loss in 2015. Dr Kenchaiah discussed and implemented various strategies to manage these risks.

8. In November 2014, Ms Fratto gradually increased her frequency of contact with NAMHS. Ms Fratto's treatment team liaised with her general practitioner (GP) to facilitate a physical health examination and necessary investigations to elucidate a reason for her weight loss.

9. At about the same time, Ms Fratto became depressed in the context of social stressors and relationship difficulties. Fluoxetine was prescribed, but Ms Fratto did not take it.

10. A non-urgent application to appoint an administrator and guardian was completed by psychiatry registrar, Dr Wendy Wong in December 2014 and was still pending at the date of Ms Fratto's death. Her fluoxetine was changed to mirtazapine and diazepam was prescribed for the short term. A referral to the Prevention and Recovery Service

(PARC[1]) was made for short-term residential support and Ms Fratto was due to be admitted on 15 December 2014, but she did not arrive.

11. Ms Fratto was assessed on 16 December 2014 and declined to go to PARC. She indicated that her mood had improved somewhat, and she had increased her dose of quetiapine of her own volition. She did not wish to stay with her mother. Nor would she consider an admission to hospital. Nevertheless, her treating team did not consider that she met the criteria for an involuntary admission to hospital at that time.

12. Over the next few weeks, Ms Fratto continued to have regular contact with her treatment team, which often occurred by telephone because she was often late or did not show up for appointments.

13. By mid-January 2015, Ms Fratto was disclosing thoughts of suicide but refused to entertain any exploration of plans or intent. She was also experiencing increased anxiety, poor concentration and memory loss.

14. Dr Kenchaiah discussed the potential role of electroconvulsive therapy (ECT) with Ms Fratto, who refused to consider it due to a bad experience in the past. Her last appointment with Dr Kenchaiah was on 29 January 2015 but she continued to be reviewed by her new treating team, psychologist Jesse Gates and psychiatric registrar Dr Rachel O'Connor, who took over in February 2015 and appraised Dr Kenchaiah of Ms Fratto's progress.

15. Between February and March 2015, Ms Fratto was attending twice weekly appointments with NAMHS.

16. On 10 February 2015, Ms Fratto was reviewed by her GP, Dr Prabhjot Khanna. She reported that she was taking quetiapine, lamotrigine and mirtazapine, which had been prescribed by her psychiatry team.

17. During her first appointment with Mr Gates, Ms Fratto presented in a depressed state and exhibited chronic suicidal ideation. Ms Fratto expressed a negative self-image about herself and the future. Notwithstanding her chronic suicidal ideation, in the month that Mr Gates treated Ms Fratto, she expressed that she wanted to live because

[1] PARC is a supported residential facility for adults with mental health problems who are becoming unwell or are in the early stages of recovery from an acute illness. PARC sits between adult psychiatric inpatient units and intensive community support in a client's usual place of residence.

she knew the impact her death would have on her mother, Fiorella Fratto, who was a committed and involved caregiver.

18. On 24 February 2015, Ms Fratto arrived late for a medical review. Her identified issues at that time were diminishing body weight, no improvement in her depressive symptoms, insomnia, inappetence, feelings or worthlessness and unworthiness, poor concentration and low mood. Her risk of suicide was documented as low to moderate, with noted chronic suicidal ideation. A formal risk assessment was not included in Ms Fratto's medical records.

19. Ms Fratto's presentation had not improved three days later when she saw Mr Gates.

20. On 3 March 2015, Fiorella Fratto telephoned Mr Gates and informed him that on 1 March 2015, her daughter had overdosed but that she had not taken enough medication to warrant follow up in hospital. Mrs Fratto also said that she had taken control of her daughter's medications.

21. The same day, Mr Gates reviewed Ms Fratto who expressed a wish to die through overdose but said that her plans had been foiled by her mother taking control of her medications. She also described vague ideas of jumping in front of a car but was afraid to do so because she might be unsuccessful, and because of the impact on the driver. Ms Fratto refused the offer of a referral to PARC and NPU but guaranteed her safety until their next appointment on 6 March 2015. Ms Fratto indicated that she was happy to keep two appointments a week and to see Dr Kenchaiah for their next appointment on 10 March 2015.

22. At her next appointment with Mr Gates on 6 March 2015, Ms Fratto expressed a wish to die, but she did not report any intent or plan. Indeed, Mr Gates commented that she was more engaged than usual and responsive to suggestions about involving her family in treatment.

23. At a recovery review meeting on the same day, Mr Gates subsequently discussed Ms Fratto and presented information concerning the deterioration in her mental state and his concerns. The meeting was chaired by Dr Kenchaiah, with several other NAMHS community mental health team clinicians present. It was not felt to be appropriate to admit Ms Fratto to a psychiatric facility unless she was agreeable to PARC. Dr Kenchaiah did not consider that Ms Fratto met the criteria for a compulsory admission

to a mental health facility. Accordingly, the plan was to document Ms Fratto's ongoing risk, while trying to develop her motivation for a PARC admission and possible family consultation. Dr Kenchaiah was due to review Ms Fratto himself four days later.

24. That evening, Ms Fratto had dinner at her parent's house and took her medication. However, shortly afterwards, she said that she wanted to go home but would not say why.

25. On the morning of 7 March 2015, Mrs Fratto could not raise her daughter on the telephone. Concerned, she drove to Ms Fratto's house and let herself in using her spare key. She found the bed unmade, which indicated that Ms Fratto had slept the night before. The back door was unlocked, and when Ms Fiorella entered the backyard, she found her daughter hanging from the porch.

26. Emergency services were called and Ambulance Victoria paramedics responded a short time later. On their assessment Ms Fratto was deceased and they did not render active treatment.

Medical cause of death

27. On 10 March 2015, Senior Forensic Pathologist Malcolm Dodd, from the Victorian Institute of Forensic Medicine, performed an external examination on the body of Ms Fratto and reviewed the circumstances of the death as reported by Police to the Coroner and the post mortem computed tomography scans (PMCT) of the whole body.

28. Having done so Dr Dodd advised that PMCT did not show any evidence of significant naturally occurring disease and that his findings on external examination were consistent with the reported facts.

29. Routine toxicological analysis of post-mortem samples was undertaken and detected therapeutic levels of mirtazapine and quetiapine and a low level of diazepam and its metabolite nordiazepam. No alcohol or illicit drugs were detected.

30. Dr Dodd advised that it would be reasonable to attribute Ms Fratto's death to *hanging,* without the need for autopsy.

Coroners Prevention Unit

31. In light of the circumstances in which Ms Fratto died, I asked a Mental Health Investigator (MHI) at the Coroners Court for an opinion about the clinical management and care provided to Ms Fratto in the period immediately preceding her death.

32. The MHIs are part of the Coroners Prevention Unit (CPU), established in 2008 to strengthen the prevention role of the Coroner. The CPU assists Coroners to formulate prevention recommendations and comments and monitors and evaluates their effectiveness once made. MHIs are practicing mental health clinicians independent of the health professionals or institutions involved. They assist coronial by evaluating the clinical management and care provided and identifying areas of improvement so that similar deaths may be avoided in the future.

33. Following a review of Ms Fratto's medical record, the MHI did not consider that her depression was improving with treatment. On 3 March 2015, Ms Fratto again voiced her wish to die and said that her thoughts of suicide were growing stronger. She also expressed that she had not taken enough medication to die on previous occasions.

34. The MHI commented that a thorough and well documented risk assessment and management plan that is regularly reviewed and updated is necessary for the effective management of a person's suicide risk. They noted that a formal general risk assessment tool was completed on 12 December 2014 by the community mental health psychiatric registrar, which recorded several static and dynamic suicide risk factors. At that time, Ms Fratto was not expressing suicidal ideas. That appeared to the last formal risk assessment conducted.

35. With respect to the conversations between Mr Gates and Dr Kenchaiah, the MHI did not see evidence of a clinical escalation process being applied, nor any documentation of a clinical review meeting that occurred between 3 and 6 March 2015.

36. The MHI considered that the appropriateness of continuing to manage Ms Fratto in the community without referral for acute clinical supports to contain risk was questionable. A response was accordingly sought from NAMHS as to why Ms Fratto was not referred to a mental health facility for treatment as an involuntary patient.

37. Dr Kurt Wendelborn, Director of Clinical Services noted that the objectives of the *Mental Health Act* 2014 are to provide for assessment and treatment in the least restrictive way possible to enable persons to make or participate in decisions about their assessment, treatment and recovery.

38. Dr Wendelborn commented that Ms Fratto's treating team considered that her relatively poor responses to more restrictive treatments including admission to hospital and ECT and the chronic nature of her suicidal thoughts in the context of an absence of immediate intent, militated against involuntary treatment. It was also clinically inappropriate because of Ms Fratto's apparent capacity to consider and weigh the various therapeutic options available to her and the fact that both she and her mother were of the view that admission to hospital or a 'step up' facility like PARC were unlikely to help. Instead, intensive community input in the form of frequent reviews, telephone contact and support were preferred.

39. With respect to the clinical discussion about Ms Fratto on 6 March 2015 and the lack of documentation, Dr Wendelborn conceded that it was a significant oversight and had since been addressed.

40. The MHI concluded that the treatment plan on 6 March 2015 was appropriate. They also commented that although the clinical management of Ms Fratto appeared appropriate in the context of the available information at that time, they remained concerned that no risk assessment was documented on 6 March 2015. The MHI considered that it would have been prudent to create one considering the identified deterioration in Ms Fratto's mental state and concerns raised by Mr Gates at the clinical meeting earlier that day.

41. According to the NAMHS procedures and guidelines, a Community Risk Assessment and Plan form should have been completed in response to Ms Fratto's deterioration. However, the last Community Risk Assessment was completed on 12 December 2014.

Findings

42. I find that Caterina Fratto late of Reservoir, Victoria, died at home on or about 7 March 2015 from *hanging*. The available evidence, including the lethality of means chosen, supports a finding that Ms Fratto intentionally took her own life.

43. While the evidence does not support a finding that there was any want of clinical management or care on the part of NAMHS staff that caused or contributed to Ms Fratto's death, I have made some comments below reinforcing the need for improved documentation by clinicians and mental health services in the interests of improved patient safety.

Comment

Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comments in connection with the death:

44. The importance of providing patient care in accordance with recognised mental health frameworks is an integral aspect of ensuring patient safety and preventing adverse outcomes.

45. The *Department of Health: Working with the Suicidal Person Clinical Practice Guidelines for Emergency Departments and Mental Health Services* recognises that careful and detailed documentation is especially important in the active, crisis-oriented assessment and management of persons who are suicidal.

46. These guidelines make particular reference to the need for regular documented risk assessments with treatment decisions being based on the documented risks and evidence of consultation that supports the treatment plan. Mental health services should ensure that their policies and procedures reflect such guidelines and that all clinicians are cognizant of the importance of adhering to these policies and procedures.

Publication of finding

Pursuant to section 73(1A) of the Act, I order that this finding and comments by published on the Internet in accordance with the rules.

Distribution of finding

I direct that a copy of this finding be provided to the following:

The family of Caterina Fratto

Dr Neil Coventry, Office of the Chief Psychiatrist

North Western Mental Health Service c/o Ms Jan Moffatt, Grindal + Patrick

Mr Peter Kelly, Melbourne Health

Signature:

PARESA ANTONIADIS SPANOS

Coroner

Date: 30 July 2019

CC: Manager, Coroners Prevention Unit