IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 003795

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: STUART ALAN RONNING

Delivered On:	11 July 2013
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne Victoria
Hearing Date:	17 April 2013
Findings of:	CORONER K. M. W. PARKINSON
Representation:	Mr Robert McClosky of Counsel instructed by Ms Jan Moffat Donaldson Trumble Solicitors for North Western Mental Health Services;
Police Coronial Support Unit Assisting the Coroner	Acting Sergeant Kelly Ramsay

I, K. M. W. PARKINSON, Coroner having investigated the death of **STUART ALLEN RONNING**

AND having held an inquest in relation to this death on 17 APRIL 2013

AT MELBOURNE

find that the identity of the deceased was **STUART ALLEN RONNING**

born on 14 December 1968

and that the death occurred on or about 1 October 2010

at: The Shankland Reserve, Roxbourgh Park. 3049

from:

1 (a) HANGING

in the following circumstances:

1. An inquest was held into the death of Mr Stuart Alan Ronning on 17 April 2013. The following witnesses gave evidence in the proceedings: Mr Jim Kesselschmidt and Ms Lynnette Wade, Registered Psychiatric Nurses; Mr Tibor Janos, Division 2 Registered Nurse; Mr Michael Bruce, Manager of Emergency Crisis Assessment Team ('ECAT') Royal Melbourne Hospital.

BACKGROUND AND CIRCUMSTANCES

2. Mr Stuart Ronning was a 41-year-old man. He was employed in the manufacturing industry. Mr Ronning had a significant history of alcohol dependency and mental health issues.

3. He had reported depressive symptoms since 2004 and had been diagnosed with recurrent depressive disorder with alcohol abuse. Mr Ronning had experienced admissions to in patient facilities in 2004 and 2009 after attempts to take his own life by hanging. His mental health decline was frequently associated with excessive alcohol consumption.

4. Mr Ronning generally avoided ongoing treatment. After discharge from admission to outpatient services in 2009, he was referred by the North West Area Mental Health Service ('NWAMHS') to drug and alcohol services and to a private psychiatrist for ongoing intensive therapy. The psychiatrist diagnosed personality disorder with narcissistic features. Dr Thomas Fong, Consultant Psychiatrist with NWAMHS noted that it was not suggested that Mr

Ronning suffered from a major Axis I psychiatric disorder that would benefit from case management and that his risk of self-harm was chronic, intermittent, and exacerbated by poor attendance on any further out patient service and ceased taking medication.

5. On 30 September 2010, Mr Ronning had been consuming alcohol at home. He became involved in a verbal argument and Mr Ronning left the house. At approximately 12.30 am on 1 October, 2010 he was reported by a railway station staff member to police after he was observed at the Glenroy Railway station with a rope tied in a noose to a tree, by which he was intending to hang himself. Police detained Mr Ronning pursuant to s10 of the *Mental Health Act 2008* and transported him to the Royal Melbourne Hospital.

6. He was under the influence of alcohol and severely intoxicated. Mr Ronning was assessed by a registered psychiatric nurse, Mr Jim Kesselschmidt as requiring Category 2 Special Nursing. This involves supervision by involving visual contact by nursing staff at all times. Mr Kesselschmidt stated that as there had been no assessment and the effects of alcohol continued to affect mood, Mr Ronning remained at risk of self harm and hence the need for special nursing supervision and for him to remain in hospital. It was noted that Mr Ronning had a prior history of self harm attempts and a history of minimising his symptoms.

7. It was necessary for him to remain in the emergency department until the effects of the alcohol had abated, he had been monitored for possible side affects or adverse reaction and a comprehensive psychiatric assessment could be made.

8. He was assessed by Dr Ashbolt who noted that Mr Ronning was to remain at the hospital for this purpose, to enable drug and alcohol clinicians to see him the following day and after which assessment of his mental state and ongoing care needs would be made. Dr Ashbolt noted that whilst Mr Ronning was a 'voluntary patient' in the event that he attempted to leave the hospital his status was to be altered immediately to 'involuntary'. The consequence of this alteration of status would be that he could be detained and restrained from leaving the facility.

9. After change of shift, Senior Registered Psychiatric Nurse Ms Lynette Wade took over the oversight of the psychiatric care of Mr Ronning and he was nurse specialled in the emergency department by Division 2 Nurse Mr Tibor Janos.

10. Mr Ronning was located in Emergency Department Cubicle 28 and another patient for whom Mr Janos was also responsible was located in Cubicle 27. During the course of the night Mr Ronning remained apparently asleep and there were no difficulties with his management and no indications that he was intending to leave the hospital. Mr Janos took hourly vital observations and continued to visually observe the patient during the shift.

11. At approximately 11.15am on 1 October 2011, Mr Janos briefly attended to another patient and he returned to find Mr Ronning in the last stages of dressing himself and preparing to leave the hospital. Mr Janos attempted to convince Mr Ronning to stay however he was determined to leave and became hostile and aggressive. Mr Janos called a Code Grey in order to activate a security response. Dr Choong, Emergency Department medical officer in charge, also attended. They followed Mr Ronning out of the cubicle area. The cubicle was located near to the door to the ambulance entrance bay.

12. Security staff attended the Code Grey, however Mr Ronning took advantage of an opportunity to exit from the ambulance entry door as ambulance officers were entering with an emergency patient. The door does not automatically open from the inside so would usually be secure against a patient leaving, unfortunately however on this occasion there was a coincidence of timing at the point at which Mr Ronning had decided to make his escape.

13. Security staff attempted to intervene, however Mr Janos states that Mr Ronning increased his pace to a sprint and was able to avoid them whilst on the hospital property. He made his way to the street and the staff lost sight of him.

14. The hospital records note that police were advised of Mr Ronning's absconding (and I use the word absconding loosely as he was not an involuntary patient) at approximately 11.29am. This advice was apparently made by notification to 000.

15. It is clear that there was no follow up documentation provided to police as to Mr Ronning's absence. This may be because his status was now uncertain, having left as an voluntary patient, and not yet having been made involuntary, despite this being the intention of the treating doctor as indicated in the medical records.

16. Mr Bruce stated that it is usual practice for follow up documentation to be provided to police from the inpatient psychiatric service however Mr Bruce's evidence was that this protocol is not followed by the Emergency Department. Ms Wade notified the North Western Area Mental Health Service. It does not appear that his status was altered to 'involuntary' for the purposes of apprehension or follow up by police.

17. No contact was made by the hospital with Mr Ronning's partner, Ms Korinis from the time of his admission to the emergency department or after he left the facility. Ms Korinis was not aware that Mr Ronning had left the hospital until police attended to advise her of his death.

18. The evidence is that Mr Ronning was text messaging Ms Korinis shortly before he left the hospital. She stated that he was asking to come home and that she advised him that he should stay in the hospital to get help and that they needed to take a break. Another message at around 11.30am may be understood to be indicating his intention to take his own life.

19. Ms Korinis was not in contact with hospital staff and had not been contacted by the hospital at Mr Ronning's admission so was not in a position to liaise with any hospital staff member as to these messages. Ms Korinis called Mr Ronning's estranged wife, Ms Sandra Ronning who was often able to intervene and calm him when he was upset. Ms Ronning attempted on a number of occasions to call Mr Ronning however he did not answer her calls.

20. Mr Bruce's evidence was that it is usual that next of kin are contacted when a patient is admitted and that there appeared to have been an oversight on this occasion.

21. At approximately 5pm on 1 October, 2011 Mr Ronning was located by a number of people hanging from a tree in the Shankland Reserve at Roxburgh Park. He was unresponsive. Witnesses removed him from the tree and commenced CPR. Ambulance paramedics attended however Mr Ronning was unable to be resuscitated.

FORENSIC PATHOLOGIST EXAMINATION AND EVIDENCE

22. An examination was undertaken by Dr Paul Bedford, Forensic Pathologist with Victorian Institute of Forensic Medicine, who provided a report to the Coroner. Dr Bedford noted a ligature furrow above the thyroid cartilage consistent with the ligature collected at the

scene. No unusual injuries were noted as a result of the external examination or the CT scan.

23. Toxicology results identified a post mortem ethanol (blood alcohol) level of 0.27g/100mL. This is a significant blood alcohol reading, in excess of five times the legal limit for driving a motor vehicle, and consistent with the levels of alcohol Mr Ronning was known to consume.

24. Dr Bedford reported that a reasonable medical cause of death was: 1(a) Hanging.

25. Police reported that there were no suspicious circumstances.

FACTORS CAUSING AND CONTRIBUTING TO DEATH

26. I am satisfied having regard to Mr Ronning's prior psychiatric history, including a long-standing history of suicidal ideation and the circumstances in which Mr Ronning was located, that there were no suspicious circumstances and that Mr Ronning intentionally took his own life by hanging.

27. I am satisfied that the clinical management was reasonable and appropriate within the limitations of the facilities available. It is relevant to note that there was good clinical reason for Mr Ronning to be admitted and to remain in the emergency department.

28. He required medical monitoring and notwithstanding he also required mental health care and assessment, there was no other more secure area available which would also enable the requisite medical monitoring.

29. I am satisfied that his death was not likely to have been prevented even had Mr Ronning been made an involuntary patient prior to leaving the hospital, as there was unlikely to have been any change in his management or location for treatment.

30. There was no early indication that Mr Ronning was likely to leave the hospital or was reluctant to stay in the emergency department. In view of the text messages being sent by Mr Ronning, it is possible that had communication been established between the next of kin or other family member, earlier advice of his intention to leave and his evinced suicidal ideation may have been obtained by the emergency department. However, the circumstances and

timing of his leaving in a short space of opportunity may still have prevented any effective intervention.

31. The manner in which he left was via unexpected access to the ambulance door. Unfortunately, the security personnel were unable to intervene to prevent the absconding. This has been explained as being because the patient once outside of hospital premises security staff do not have authority to physically detain and that the matter is referred to police. In any event, it appears that in this case Mr Ronning was able to successfully avoid the security officers.

32. Mr Ronning was found at a public park and not at his home. He did not text or telephone Ms Korinis or Ms Ronning, or advise of his location after he left the hospital. It is therefore unlikely that notification by the hospital to Ms Korinis or to Ms Ronning of his absconding would have resulted in an opportunity being afforded her to intervene to prevent the death.

33. It appears that upon leaving the hospital he has consumed significant quantities of alcohol, which resulted in a tragic replaying of the circumstances, other than the location, for which he was admitted to hospital on 29 September – 1 October 2010.

34. I find that Mr Stuart Ronning died on 1 October 2010 and that he intentionally took his own life.

COMMENTS

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

35. A review of policies and procedures and the available bed facilities occurred following the death of Mr Ronning and a recommendation made that a dedicated area be developed associated with the emergency department but located separately, which would accommodate the monitoring and security needs of patients who required short term monitoring and assessment for both medical and mental health issues. Mr Bruce stated that this was known as the High Observation Low Stimulus ('HOLS') proposal and would be located in an area which was more secure than the Emergency Department and whilst not locked would be more

difficult for patients to exit. Mr Bruce stated that the funds for this proposal were not forthcoming; however, the hospital was still committed to the proposal.

36. The provision of these beds appears to address the complexity of caring for a patient with co-morbidity of mental health and alcohol or drug issues, where further assessment is required before decisions are able to be made as to ongoing treatment requirements.

RECOMMENDATIONS

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

1. That arrangements be made for the introduction in accordance with the Royal Melbourne Hospital internal review 'HOLS' recommendation, of more securely located emergency department beds which will accommodate the monitoring and security needs of mental health patients who require short term monitoring and assessment for both medical and mental health issues.

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

The family of Mr Ronning;
The interested parties;
The Investigating Member

Signature:

CORONER K. M. W. PARKINSON
Date: 11 July 2013