IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 1560

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the ***Coroners Act 2008***

Amended pursuant to Section 76 of the Coroners Act 2008 on 12 April 2021[1]

Findings of:	Darren J Bracken, Coroner
Deceased:	Christopher Douglas Ritson
Date of birth:	13 February 1998
Date of death:	21 March 2020
Cause of death:	1(a) Hypoxic ischaemic encephalopathy complicating hanging
Place of death:	Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria 3128

[1] This document is an amended version of the Finding Without Inquest into the death of Christopher Douglas Ritson dated 23 February 2021. Corrections to paragraphs 16 and 31 have been made pursuant to Section 76 of the *Coroners Act 2008* (Vic).

INTRODUCTION

1. Christopher Douglas Ritson was twenty-two years old when he died on 21 March 2020 at Box Hill Hospital from hypoxic ischaemic encephalopathy on the background of hanging. At the time of his death, Mr Ritson lived with his family at 23 Banksia Court, Heathmont. He is survived by his father, Andrew Ritson (**Mr A Ritson**), mother, Marian Sims (**Ms Sims**) and his brother Robert.

2. Mr Ritson was described as "*hard working, kind, funny, polite, good looking, observant of things around him and the beauty in nature and many other wonderful things.*"[2]

3. Mr Ritson's medical history included severe alcohol dependence and polysubstance abuse specifically ICE and cannabis usage associated with mental health problems including, depression, social phobia and anxiety disorder. He was prescribed diazepam.[3]

4. In her statement to the coronial investigator (**CI**), Ms Sims said that her son, "*seemed to have a problem with drinking from about 14 to 15 years old onwards.*" Ms Sims elaborated:

   > "*I think at about this time he was also smoking marijuana regularly, although not at our home and not with our permission as well as taking other drugs, Xanax, Ketamine, and using Nangs*[4]".

5. In 2017, Mr Ritson, lost his learners licence as a consequence of drink driving. According to Ms Sims her son "*did some garden landscaping and labouring work with a friend*" whom she believed introduced Mr Ritson to "*ice*". That same year, Mr Ritson obtained a metal fabrication apprenticeship at a factory in Heathmont. Ms Sims said that her son seemed "*good at times although drinking, substance abuse and maintaining a poor friendship group was an ongoing problem.*"

6. Mr Ritson's general practitioner, Dr Josephine Kavanagh of Maroondah Alcohol and Drug Addiction Residential Rehabilitation Program in Ringwood, provided a statement to the coronial investigator (**CI**) in which she advised that she saw Mr Ritson on a regular basis between 12 March 2018 and 28 September 2019.

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[2] Statement of Marian Sims dated 3 September 2020; Coronial Brief.
[3] Diazepam is used to treat anxiety, alcohol withdrawal and seizures.
[4] Nangs is a slang terms for nitrous oxide.

Dr Kavanagh said that during this time, "*Chris did undertake counselling and attended Alcoholics Anonymous and Narcotics Anonymous, but was not consistent. Many lapses occurred, as well as period of improvement.*"[5]

7. Ms Sims said that her son "*successfully completed a week of detox at Windana*[6] *in Dandenong in September 2019.*" In October 2019, his employment was terminated due to drug issues.

8. On or about 20 December 2019, police were called when Mr Ritson behaved aggressively towards a neighbour. Police issued an intervention order (**IVO**) against Mr Ritson. At the police station, Mr Ritson expressed suicidal ideation. He was detained under *s351 of the Mental Health Act 2014* (Vic) and police took him to the Maroondah Hospital emergency department.

9. Consultant psychiatrist, Dr Jonathan Starke at Maroondah Hospital, who was not Mr Ritson's treating physician, provided a statement to the CI. Dr Starke noted that following a psychiatric assessment, Mr Ritson was discharged with a "*plan for a referral to Alcohol and Drugs Services*".[7] He was provided with the mental health triage (**the MHT**) contact details and encouraged to make phone contact if required.

10. On 30 December 2019 at 3.09pm, a Centrelink social worker, contacted the MHT when Mr Ritson reported that the previous evening, whilst under the influence of alcohol he rolled his car and Mr Ritson was unsure if he had attempted suicide. The MHT clinician spoke directly with Mr Ritson who reported that he was no longer living with his parents because of an IVO (referred to in paragraph 10), but he denied "*current suicidal ideation*". It was noted that:

> "*An ongoing risk for misadventure linked with substance use was noted, as was a possible risk of violence to others-Christopher reported that the previous night he had been expelled from a hospital because of being verbally abusive to staff. Protective factors included his girlfriend and friends who were assisting with accommodation, as well as his AOD counsellor* [sic]."
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> "*The plan made at the time was for Christopher to ring the telephonic triage number if he felt his mental health was deteriorating, or to attend the nearest ED.*"

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[5] Statement of Dr Josephine Kavanagh undated; Coronial Brief.
[6] Windana Drug and Alcohol Recovery Centre.
[7] Statement of Dr Jonathan Starke undated; Coronial Brief.

11. In or about January 2020, Mr Ritson returned to the family home in Heathmont.

12. After a four-month absence, Mr Ritson saw Dr Kavanagh again on 6 February 2020, when he reported major relapses, including heavy use of ICE, leading to episodes of psychosis and paranoia with suicidal thoughts. Dr Kavanagh recommended that Mr Ritson "*attend immediate residential detoxification and long-term rehabilitation*", but he refused.

13. Mr Ritson saw Dr Kavanagh again and for the last time on 13 February 2020. Dr Kavanagh reported that "*the situation was basically unchanged.*" Dr Kavanagh elaborated:

> "*I rang Windana Residential Rehabilitation Centre which would accept Chris as soon as possible if Chris was willing – this was the obstacle.*"

14. In his statement to the CI, Mr A Ritson said that around the middle of February 2020 his son spent two nights at the Melbourne Custody Centre following an incident with security guards. Mr A Ritson elaborated:

> "*Christopher then went into rehabilitation at Windana and basically stayed there for two weeks...After returning from rehabilitation, Christopher did not look well, and I believe that this was the time he started having suicidal ideation.*"

15. In his statement to the CI, Dr Starke referred to a clinician from MHT having attended Mr Ritson's home on 6 March 2020 at about 8.29pm. The clinician "*had attended with police and ambulance to the family home after Christopher's father had called 000 with concerns that Christopher was suicidal and appeared more agitated than at previous times.*" The summary of the assessment indicated that Mr Ritson appeared to be in crisis with a high risk for suicide attempt and a moderate risk for misadventure, but that he had support from his family, and he appeared to be help seeking. The plan was for a voluntary admission to the psychiatric unit.

16. That same evening at about 9.34pm, Mr Ritson was transported to Maroondah Hospital ED via ambulance. On 7 March 2020 at 2.00am,[8] the clinician went to review Mr Ritson, who was noted by ED staff to be with his mother in the ED waiting room, but neither Mr Ritson nor his mother could be found both apparently having left without being seen.

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[8] Time of review amended to 2.00am pursuant to section 76 of the *Coroners Act 2008* (Vic).

17. Dr Starke advised that the "*plan was that mental health triage would follow up with Christopher later on the 7/3/2020.*" Dr Starke elaborated:

> "*On 7/3/2020 at 19h20 a mental health clinician made telephonic contact with Christopher to follow up in relation to the events from earlier in the day. Christopher answered his phone, stating that he had gotten tired of waiting and decided to go home to sleep. He indicated that nothing had changed for him, and quickly became irritable when the clinician posed further questions. He stated that he did not want to come back to ED, indicating that he was at home with his parents. The clinician informed Christopher that they would attempt to make contact with his parents, and Christopher subsequently terminated the call. The clinician attempted phone contact with both of Christopher's parents, but neither of them answered. Voice messages were left and text messages were sent to both numbers requested [sic] return contact with triage. The subsequent plan was to wait for further contact from Christopher or his parents and that triage would not initiate further contact.*"

18. According to Dr Starke, a clinical review was performed by an independent clinician on 12 March 2020 with "*no change to the original plan*".

19. In her statement to the police, Ms Sims said:

> "*To be honest over the last few weeks of Chris' life I was scared for my safety as well as Andrew's and Rob's. Chris talked about jumping in front of a train and Andrew and I tried to get him to stay home and not go out. We were scared every time he left the house, that he would hurt himself or someone else.*"

THE CORONIAL INVESTIGATION

20. Mr Ritson's death was reported to the Coroner and fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

21. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

22. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

23. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Ritson's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family treating clinicians and other police – and submitted a coronial brief of evidence.

24. This finding draws on the totality of the coronial investigation into the death of Mr Ritson, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities. [9]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

25. On the evening of 17 March 2020, Mr Ritson and his family had dinner at their house in Heathmont. Ms Sims said that her son *"started scratching his inner forearm with the dinner knife. I told him to stop and was short with him."* She described Mr Ritson's behaviour as *"difficult"* and said that he asked for money to buy heroin with which to kill himself.

26. At about 11.00pm Ms Sims went to her bedroom and fell asleep. At approximately 11.20pm Mr A Ritson found his son hanging from the balcony with a rope tied around his neck. Mr A Ritson cut the rope and placed his son on the ground; he was unresponsive and not breathing. Mr A Ritson then alerted his wife.

27. Emergency services were called. Ambulance Victoria (**AV**) paramedics arrived at approximately 11.25pm. CPR was commenced by paramedics and they inserted an endotracheal tube into the trachea after return of spontaneous circulation. Mr Ritson was transported via ambulance to the Box Hill Hospital emergency department.

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[9] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

28. Shortly afterward, Victoria police arrived and examined the scene. On the balcony, police observed a knife with what appeared to be blood on the blade. Police located a homemade bong[10] and an empty wine bottle on the table. A 'suicide note' read:

> *"I love you all I wish it didn't come to this but I see no other way this in no way your fault you are the best parents I could wish for I just don't deserve you I love you all- Chris"*

29. Police did not identify any suspicious circumstances.

30. On arrival at the hospital on 18 March 2020 at 12.41pm Mr Ritson was admitted into the intensive care unit. Two multidisciplinary team meetings with Mr Ritson's family was held on 18 and 19 March 2020 with an ICU specialist regarding Mr Ritson's poor prognosis

31. Mr Ritson died on 21 March at 9.46am.[11] Mr Ritson's family generously consented to organ/tissue donation.

32. During the course of the investigation, Dr Starke said:

> *"The 5-day delay in clinical review being performed on this final episode of care is far longer than the target review period, which is 24hrs. The available clinical record does not make clear the reason for the delay in this episode of care being reviewed, but it may represent a systemic failure at that time. Since this, standardising and tightening up the clinical review process is a key focus for the team involved, and this important oversight function is now routinely completed within the desired 24- hour timeframe."*

Identity of the deceased

33. On 19 March 2020, the deceased was identified by Ms Sims as her son, Christopher Douglas Ritson, born 13 February 1998.

34. Identity is not in dispute and requires no further investigation.

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[10] A bong is a filtration device generally used for smoking cannabis, tabaco, or other herbal substances.
[11] Time of review amended to 9.46am pursuant to section 76 of the *Coroners Act 2008* (Vic).

Medical cause of death

35. Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine **(VIFM)**, conducted an external examination on 23 March 2020 and provided a written report of his finding dated 24 March 2020.

36. Dr Lynch further commented that the external examination showed a ligature mark about the neck. The findings were consistent with the history.

37. Toxicological analysis of post-mortem samples identified the presence diazepam and its metabolites nordiazepam, and temazepam;[12] morphine;[13] midazolam; metabolite 7-aminoclonazepam;[14] fluoxetine[15] and its metabolite norfluoxetine; levetiracetam;[16] laudanosine[17] and paracetamol (all consistent with medical care provided to Mr Ritson in the intensive care unit).

38. In his report Dr Lynch opined that the medical cause of death was '*1(a) Hypoxic ischaemic encephalopathy complicating hanging*'.

39. I accept Dr Lynch's opinion.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

40. A finding of suicide is of great moment and can impact upon the memories of a deceased person held and treasured by those who knew and loved them. It can reverberate through generations of a family. Such a finding should only be made based on compelling evidence and not from inexact proofs, indefinite testimony or indirect inferences.

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[12] Temazepam is a sedative/hypnotic drug of the benzodiazepine class.

[13] Morphine is a narcotic analgesic used for the treatment of moderate to severe pain.

[14] Clonazepam is a nitrobenzodiazepine clinically used for treatment of seizures. As a benzodiazepine derivative it binds the benzodiazepine site on the GABA receptor potentiating the neuroinhibitory effects of GABA. Clonazepam may not be detected post-mortem due to bacterial conversion of the parent nitrobenzodiazepine to its 7-amino metabolite.

[15] Fluoxetine is a selective-serotonin reuptake inhibitor (SSRI). Fluoxetine is clinically indicated for major depression, obsessive compulsive disorder and premenstrual dysphoric disorder. The anti-depressant efficacy of SSRIs is delayed by a few weeks, suggesting neuroadaptive changes may be required for their clinical effect. Trade names include Fluotex, Lovan, Proztet and Zactin. Fluoxetine hydrochloride is available in 2 mg tablets or capsules for oral administration. Typical adult oral doses are 20 mg per day, with a maximum of 80 mg daily. Chronic daily oral doses of 20-60 mg administered to 24 patients led to an average steady-state serum fluoxetine and norfluoxetine (desmethylfluoxetine) concentration of 0.109 mg/L (range 0.025-0.473) and 0.130 mg/L (range 0.018-0.466), respectively. In another study, the steady state plasma fluoxetine concentration was on average 3.6-fold higher in poor CYP2D6 metabolisers compared to extensive metabolisers.

[16] Levetiracetam is an antiepileptic used for the control of partial onset seizures.

[17] Atracurium (neuro-blocker) is highly unstable, *in vitro,* thus laudanosine is used as a toxicological marker for atracurium exposure.

41. It is often difficult to determine what may have precipitated a person's decision to end their life. The decision is sometimes influenced by issues known only to the deceased person. I am unable to state with any certainty, the reason or reasons for Mr Ritson choosing to take his own life. However, there is significant evidence that Mr Ritson struggled for many years with alcohol and drug dependency, the source of much friction with his family and cause of unemployment.

42. I note Dr Starke's concern that the 5 days between 7 March 2020, when Mr Ritson was taken by ambulance to the Maroondah Hospital and 12 March 2020 when a clinical review was conducted on Mr Ritson was far longer than the 24 hours it should have been and when conducted was inadequate in as much as, at least, it did not explain the delay. I note that on 7 March 2020, Mr Ritson left the hospital without having been seen in circumstances when he had been brought to the hospital by ambulance. The only follow up was by telephone later in the day and when Mr Ritson apparently somewhat abruptly hung-up the telephone. No immediate follow-up was undertaken. Given Mr Ritson's then immediate history of mental health difficulties; that no immediate face-to-face follow up occurred is, at the very least, disappointing and, on one view, simply inadequate. That 5 days then elapsed before Mr Ritson was assessed given his immediate mental health state also seems inadequate.

43. How Mr Ritson's state of mind could be said to have been adequately assessed over the telephone on 7 March 2020 is unclear to me. I am conscious of how busy hospital emergency departments are, but one prematurely ended telephone call, bearing in mind Mr Ritson's immediate history may be seen as inadequate. The 24-hour period within which clinical review ought to have occurred to which Dr Starke refers seems eminently practical and appropriate both generally and particularly in Mr Ritson's circumstances.

44. I am unable to say whether the lacuna to which Dr Starke referred was a cause of Mr Ritson acting to end his life as he did 10 days after the telephone call and 5 days after the clinical review.

45. I am satisfied, having considered all of the available evidence, that on 17 March 2020 Mr Ritson, in a state of emotional distress, acted intentionally to take his own life and subsequently died as a result of hypoxic ischaemic encephalopathy on the background of hanging.

FINDINGS AND CONCLUSION

46. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    (a) the identity of the deceased was Christopher Douglas Ritson, born on 13 February 1998;

    (b) the death occurred on 21 March 2020 at Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria 3128 from hypoxic ischaemic encephalopathy complicating hanging; and

    (c) the death occurred in the circumstances set out in paragraphs 25-31 above.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

1. I recommend that Maroondah Hospital clearly assess the utility of mental health assessments being undertaken by telephone, vis-à-vis face-to-face, and limit the use of such contact to circumstances when contact by telephone has been identified to be adequate.

2. Further I recommend that Maroondah Hospital investigate whether in this case the period of time that elapsed between 7 March and 12 March 2020 was a result of the systemic failure to which Dr Starke referred and if that is found to be the case that it take the steps necessary to prevent a repetition of that systematic failure. I also recommend that if such an investigation does not reveal a systemic failure that the reasons identified for the 5 day delay between 7 and 12 March 2020 be clearly and practically addressed by the hospital so as to ensure that such a delay does not occur again.

Pursuant to section 73(1) of the *Coroners Act 2008* (Vic). I order that this Finding be published on the internet.

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

Mr Andrew Ritson and Ms Marian Sims, Senior Next of Kin;

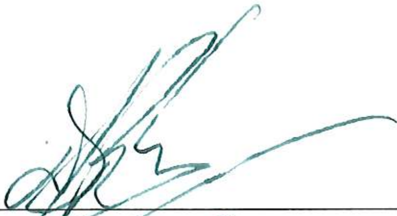
Adj Prof David Plunkett, CEO Eastern Health;

Dr Yvette Kozielski, Medico-Legal Officer, Eastern Health;

Ms Jessica Buzzini, Donatelife Victoria; and

First Constable Anh Do, Victoria Police, Coroner's Investigator.

Signature:



DARREN J BRACKEN

CORONER

Date: 23 February 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.