IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2014 / 2123

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: JOHN WILFRED KNIGHT

Delivered On:	20 January 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank MELBOURNE
Hearing Dates:	20 January 2015
Findings of:	PHILLIP BYRNE
Representation:	
Counsel Assisting the Coroner	Mr Marc Fisken, Coroner's Solicitor

I, PHILLIP BYRNE, Coroner, having investigated the death of JOHN WILFRED KNIGHT

AND having held an inquest in relation to this death on 16 June 2015
at MELBOURNE
find that the identity of the deceased was JOHN WILFRED KNIGHT
born on 16 July 1942
and the death occurred on 27 April 2014
at Monash Health, Biala Assessment Unit, 400 Warrigal Road, Cheltenham
from:

1 (a) SEPSIS

1 (b) BRONCHOPNEUMONIA AND SACRAL ULCER

in the following circumstances:

1. Mr John Knight, 71 years of age at the time of his death, previously resided at 8 Dromana Avenue, Bentleigh East, with his wife of some 50 years Mrs Dawn Knight.

2. Mr Knight migrated to Australia from Wales in 2011 following the migration to this country of two of his children.

3. Mrs Knight had noticed a gradual change in her husband's personality, cognition and behaviour over a number of years. In 2012, Mr Knight was diagnosed with likely frontal temporal dementia. He was initially prescribed sertraline which resulted in some improvement. However, soon after his condition significantly worsened resulting in his admission to the psycho-geriatric unit at Kingston Hospital, the Biala Assessment Unit. Mr Knight died in the facility, in palliation, some five months after admission.

4. The death was reported to the Coroner as Mr Knight was an involuntary patient at Biala. Having regard to the circumstance and taking into account the family's position regarding post-mortem examination, I directed an autopsy be performed at Victorian Institute of Forensic Medicine (VIFM).

5. Having commenced an investigation into the death of Mr Knight, I directed the Coronial Investigator to provide a Brief of Evidence. The Brief of Evidence was received at the Court on 5 January 2015. The Brief of Evidence contained statements from Senior Forensic Pathologist Doctor Michael Burke, Mrs Dawn Knight, Consultant Psychiatrist Professor Daniel O'Connor, Division one nurse Ms Zoe Jobson and Constables Jake Samuel and Brendan Rees.

6. Doctor Burke of VIFM who undertook the directed autopsy advised the cause of death was:

1 (a) SEPSIS

1 (b) BRONCHOPNEUMONIA AND SACRAL ULCER

7. In her comprehensive statement, Mrs Knight relates details of her husband's progressively deteriorating condition; it makes for desperately sad reading and demonstrates what an insidious, debilitating disease dementia is. It was with interest I noted a comment made by Professor O'Connor in his statement to the Court, referring to Mrs Knight's family he said:

> *"They were unfailingly kind and coped bravely with Mr Knight's lengthy and traumatic mental and physical decline."*

8. Being an involuntary patient in the Biala Assessment Unit at the time of his death meant that the Coroners Act 2008 mandated that the coronial investigation be finalised by inquest. I determined, having considered the statements and other material contained in the Coronial Brief of Evidence, to conclude the matter by way of "Summary Inquest"; that is to finalise the matter "on the papers" without hearing viva voce evidence from witnesses. This decision was communicated to Adviceline Injury Lawyers who had advised they represented the family's interest in relation to potential Common Law claims. Adviceline Injury Lawyers indicated family proposed to commission their own expert opinion.

9. In early May 2015, a copy of an expert opinion by Doctor Paul Champion de Crespigny, consultant physician and nephrologist, was provided to the Court by the family's lawyers. In an accompanying letter dated 5 May 2015 the lawyers submitted, on the basis of Doctor Champion de Crespigny's report, that a full Inquest was warranted claiming a "public interest" perspective.

10. I carefully examined Doctor Champion de Crespigny's report and reviewed the entire file. I concluded the matter did not require use of the full forensic judicial process and in a memorandum dated 18 May 2015, a copy of which was provided to Adviceline Injury Lawyers, explained the bases upon which I still proposed to conclude the matter by way of a "Summary Inquest."

11. The matter was listed for Summary Inquest at the Coroners Court of Victoria on 16 June 2015.

12. At that hearing Mrs Sarah Litsas, Mr Knight's daughter, appeared together with two supporters; the family were not legally represented. Mr John Snowdon, general counsel for Monash Health appeared on behalf of Monash Health and its staff.

13. At the hearing, Mrs Litsas re-iterated, indeed levelled even more strident criticism of the performance of those managing her father in the period leading to his death. Mrs Litsas focused particularly on a sacral ulcer, the existence of which was apparently not communicated to either Mrs Litsas or Mr Knight's wife Mrs Dawn Knight. When this issue was raised I indicated the existence of the sacral ulcer was not my focus as it did not appear to be a causal factor in Mr Knight's death, but a "background circumstance."

14. Before turning to address the issues of medical management of Mr Knight, I believe it is incumbent upon me, particularly at a hearing where unrepresented laypeople are involved, to include in my finding aspects of the law which impact upon the exercise of my powers under the Coroners Act 2008.

15. Often parties leave with an unfulfilled expectation if strong denouncement/criticism is not made of a party they see as contributing to the death. It must be understood that it is not my role to lay or apportion blame, fault or culpability, but to seek to elucidate the facts surrounding the death in question. While what is generally referred to as an "adverse finding" is made as a matter of law it has, in my view, to be couched in more subtle terms.

16. Often the implied attribution of fault is lost on the lay party who expected more direct strident denouncement of the party against whom the adverse finding is made.

17. Keown v Kahn (1999) 1VR69 a decision of the Victorian Court of Appeal represents a landmark judgement which, in my opinion, provided much needed guidance to Victorian (and other) coroners. His Honour Mr Justice Callaway adopting a statement contained in the report of the Brodrick Committee (UK) Report said:

> *"In future the function of an inquest should be simply to seek out and record as many of the facts concerning the death as public interest required, without deducing from those facts any determination or blame."*

18. Again quoting the Broderick Committee (UK) Report, His Honour noted:

> *"In many cases, perhaps the majority, the facts themselves will demonstrate quite clearly whether anyone bears any responsibility for the death; there is*

a difference between a form of proceeding which affords to others the opportunity to judge an issue and one which appears to judge the issue itself."

19. So while not laying or apportioning blame a Coroner should endeavour to establish the CAUSE, or CAUSES, of a death; the distinction is fine but real. As Callaway J.A. described it in Keown v Kahn (1999) 1VR69 @ 76:

> *"In determining whether an act or omission is a cause or merely one of the background circumstances, that is to say a non-causal condition, it will sometimes be necessary to consider whether the act departed from a norm or standard or the omission was in breach of a recognised duty, but that is the only sense in which para. (e) mandates an inquiry into culpability. Adopting the principal recommendation of the Norris Report, Parliament expressly prohibited any statement that a person is or may be guilty of an offence. The reasons for that prohibition apply, with even greater force, to a finding of moral responsibility or some other form of blame: the proceeding is inquisitorial; the conclusion would be more indeterminate than a conclusion about legal responsibility; and there would be no prospect of a trial at which the person blamed might ultimately be vindicated by an acquittal."*

20. The Broderick Committee Report was a review undertaken in the UK into their coronial system. I have found the dichotomy between finding cause of death on one hand and finding or apportioning fault, blame or culpability on the other difficult to articulate. Quite recently, in a judgement of the New Zealand Court of Appeal I saw as good an explanation of the conundrum as I have seen. In the Coroners Court v Susan Newton & Fairfax New Zealand Ltd (a judgement delivered 30th November 2005) reference is made to Laws of New Zealand, Coroner's. At paragraph 28 under the heading of "blame", the following statement appears:

> *"It is no part of the coroner's function to apportion blame for the death. The coroner must however be able to go beyond the mere cause of death if the coroner is to serve a useful social function, and must establish so far as is possible, the circumstances of the death. The implicit attribution of blame may be unavoidable in order for the coroner to ascertain or explain how the death occurred in the wider events that were the real cause."*

21. In his judgement in Keown v Kahn (1999) 1VR69 @ 75, Callaway J.A. referred to the Norris Report upon which the 1985 Coroners Act was largely founded and observed in relation to whether the action of the police was an act of self defence:

> *"A coroner is not concerned with questions of law of that kind. Instead the coroner is to find the facts from which others may, if necessary, draw legal conclusions."*

22. Importantly in the context of this case His Honour, on the next page, continued:

> *"It follows that a person who kills necessarily contributes to the cause of death and that is none the less true where the killing is in lawful self defence. A coroner is not concerned with the latter question but will ordinarily set out the relevant facts in the course of finding how death occurred and the cause of death. The facts will then speak for themselves, leaving readers of the record of investigation to make up their own minds about lawful self defence or any similar issue."*

23. In the same case His Honour Mr Justice Ormiston observed:

> *"The findings of coroners ought to eschew use of language which connotes legal conclusions as opposed to factual findings."*

24. Once the facts are elucidated the parties (and others) can do with them what they will. I have heard contended that if there is no determination of criminal or civil liability what is the point of the exercise. That contention is, in my view, not only cynical, but ill founded.

25. A most comprehensive statement was provided to the Court by Professor Daniel O'Connor; Clinical Head of the Monash Health Aged Persons' Mental Health Service and Professor of Old Age Psychiatry at Monash University. Professor O'Connor was Mr Knight's consultant psychiatrist during his admission to the Biala aged psychiatry inpatient unit at the Kingston Centre. His statement relates the course of treatment, particularly the medication regime provided to Mr Knight during his admission from 28 November 2013 until his death on 27 April 2014. In very broad terms, Mr Knight suffered from a debilitating dementia which impacted on his cognition, personality and behaviour as his condition progressively deteriorated. Again broad terms, Mr Knight's condition posed significant challenges to those seeking to care for and manage him.

26. Rather than endeavouring to encapsulate Professor O'Connor's explanation as to the various treatments provided, I include in this Finding several excerpts from his comprehensive statement:

> *"At the time of admission, Mr Knight was taking an antipsychotic medication, Olanzipine 5mg twice daily, and an antidepressant medication, Sertraline 100mg daily. To this we added a small dose of benzodiazepine, Oxazepam 7.5mg three times daily. These doses of medication are standard in our unit.*
>
> *The dose was increased over the next week to 15mg three times daily in an attempt to reduce Mr Knight's almost ceaseless pacing, intrusion into co-patients' rooms, irritability and resistiveness to nursing help with personal activities of daily living. We also stopped the antidepressant medication given his apparently elevated mood, pressured speech and motor over-activity.*
>
> *In early December we concluded that Oxazepam was not helping greatly. In its place, we prescribed a mood stabiliser, Sodium Valproate, in gradually increasing doses up to 600mg twice daily. From this time on, the disinhibited and physically aggressive behaviours became increasingly problematic, to the point where four or five nurses were required to assist with showering and toileting. Mr Knight was also more confused and his speech was mostly incoherent. We suspected that Olanzapine was contributing to this problem and so it was withdrawn. When it became clear that the Sodium Valproate was not helping, it was withdrawn too.*
>
> *By late December, it seemed that withdrawal from the Olanzapine was responsible for a rapid escalation in levels of physical aggression and so it was re-instated at a dose of 5mg twice daily.*
>
> *Levels of aggression continued to escalate and so the dose of Olanzapine was increased to 5mg three times daily. In the last week of December it was*

ceased and replaced with another antipsychotic, Quetiapine, in gradually increasing doses up to 100mg twice daily (a relatively low dose). This did not prove helpful and so we replaced Mr Knight's regular doses of Oxazepam with Clonazepam, another benzodiazepine with a longer duration of action, in doses gradually increasing over a period of two months to 5mg per day (a relatively high dose).

Mr Knight's mood was now low and angry and, at his family's request, we re-instated Sertraline, the antidepressant that we had stopped at the time of admission to hospital. His wife and daughter recalled that Sertraline had lifted his mood when first prescribed and another trial of up to 100mg daily seemed warranted. Unfortunately, it led to an increase in levels of agitation and aggression and was later withdrawn.

Mr Knight's physical health was monitored constantly by our nursing and medical staff (one of the doctors was an advanced trainee in geriatric medicine).

In late February we started treatment with Cyproterone Acetate, a medication that reduces levels of testosterone and can be helpful in reducing levels of aggression in older men with dementia. It did not prove helpful in Mr Knight's case and we stopped in two weeks later.

After a series of falls it was clear that we needed to find an alternative to benzodiazepines. We therefore started treatment in early March with another mood stabiliser, Carbamazepine, in doses up 400mg twice daily. To our great relief, it proved very helpful indeed. Mr Knight was more relaxed, less aggressive and more accepting of help from the nurses. This made it possible to reduce the dose of Clonazepam to 1mg daily.

When Mr Knight developed a macular rash on his face and scalp in late March, his wife and daughter attributed it to psoriasis, a skin condition that

he had had previously. We applied symptomatic treatments but the rash became steadily worse, extending over most of his body. It became clear in early April that the rash was a type of epidermal necrolysis, a rare side-effect of Carbamazepine that resulted eventually in extensive, confluent areas of purple, exudative dermatitis. We were left with no choice, therefore, but to reduce the dose of Carbamazepine from 10 April onwards (stopping it abruptly might have provoked epileptic seizures).

The aggressive behaviours escalated thereafter and so we attempted treatment with Haloperidol up to 1mg three times daily. Haloperidol is a first generation antipsychotic that we use very occasionally because of its availability in oral and intramuscular formulations. It helped to some extent and the skin rash also improved, leading to discussions with the family about a transfer to our psychogeriatric nursing home for continuing care.

We withdrew the Haloperidol on 19 April, at the request of Mr Knight's family who were naturally concerned about possible adverse effects.

Mr Knight's health deteriorated abruptly from 21 April, with drowsiness, an inability to eat and drink and fever. It appeared that he was developing a secondary systemic infection secondary to the skin rash.

Following discussion with his wife, we chose not to transfer Mr Knight to a general hospital for intensive medical treatment. It was clear that his life was coming to an end and we therefore adopted a palliative approach, focussing on relieving distress and promoting comfort.

Because of Mr Knight's immobility and exudative dermatitis, he developed a sacral pressure area despite assiduous nursing attention to appropriate mattresses and bed coverings, regular turns and subcutaneous fluids. The ulcer progressed rapidly and became very large indeed."

27. As stated earlier in this Finding, the family commissioned their own expert opinion from Doctor Paul Champion de Crespigny. Doctor Champion de Crespigny was requested to assess the efficacy of the treatment provided to Mr Knight as well as making some general observations about treatment. Doctor Champion de Crespigny responded to seven (7) specific questions put to him by lawyers for the family. Again, lest something be lost in the translation, rather than endeavouring to encapsulate his opinions, I propose to include in this Finding several excerpts from his report. I re-iterate I do not propose to focus on the fact the existence of a sacral ulcer was apparently not sufficiently communicated to the family, save to say Doctor Champion de Crespigny opined that the development of the ulcer could not practically have been avoided.

28. I accept, and I do not believe it is contentious, that bronchopneumonia was central to the cause of Mr Knight's death. Again I do not think it is contentious that it is likely he developed bronchopneumonia as a result of sedation which was unfortunately required to deal with Mr Knight's aggressive behaviours. As Doctor Champion de Crespigny observed, Mr Knight's health progressively declined so that he became progressively more "de-conditional", ultimately requiring sedation with haloperidol. He further observed that heavy sedation is associated with, among other things, chest infections; a well known potential complication.

29. Doctor Champion de Crespigny was invited to comment upon whether those treating Mr Knight should have considered at an earlier stage that Carbamazepine could have been the cause of his rash. Doctor Champion de Crespigny indicated that he believed the treating doctor "ought not have considered at an earlier stage" that Carbamazepine could have been the cause of the rash. He did suggest however that the earlier cessation of Carbamazepine may well have resulted in a less severe rash which would have been less likely to have spread body wide. When asked a critical question:

> *"Do you agree with the proposition that the delay in the cessation of medication likely allowed the secondary infection to develop?"*

Doctor Champion de Crespigny responded:

> *"In my opinion I do not agree with the proposition that the delay in cessation of the medication likely allowed the secondary infections to develop."*

And added that the "primary event" was on balance bronchopneumonia, not an infection related to the deceased's skin condition. I viewed that issue critical because it goes to a causal factor in the death which has been the principal focus of my investigation, not a "background circumstance" to utilise the dichotomy alluded to by Justice Callaway in Keown v Khan.

30. Doctor Champion de Crespigny was also asked:

> *"Do you consider that it was appropriate not to treat the infections more aggressively?"*

I include his response to the question in full because it includes significant considerations:

> *"In my opinion it was appropriate not to treat the infections more aggressively.*
>
> *The deceased had been in hospital for more than four months at the time he became infected. He was suffering a progressive decline in his mental state and on the basis of the information provided, at the age of 71 years, it is most unlikely he would ever have been able to return home. In my opinion, from the information provided, it would appear that the deceased was likely to require substantial sedation for the rest of his life. On the basis of this information, after discussions were held with the family, I would consider it was appropriate not to treat the infections more aggressively."(my emphasis)*

I include one final observation made by Doctor Champion de Crespigny; primarily because it is an observation with which I concur. He wrote:

> *"The medical staff also clearly document the family's support of the deceased and also the treating clinician's difficulties finding appropriate medication and also ensuring a safe working environment. Once the deceased developed bronchopneumonia, even with optimal medical care, given his requirement for heavy sedation, it is unlikely he could have recovered. With the benefit of hindsight, transfer to an acute public hospital and most probably with the resultant admission to Intensive Care on or about 21 April 2014, would most probably have made no significant difference to the overall outcome."*

31. When one considers the totality of Doctor Champion de Crespigny's expert opinion, I think it is fair to say while he suggests aspects of medical management may not have been optimal medical practice, he is not particularly critical of the overall medical management of Mr Knight and acknowledges the particular difficulties/challenges faced by the treating team.

32. Having carefully considered the available material, I conclude the weight of evidence does not support the contention that the medical management of Mr Knight was significantly deficient. I am satisfied on the evidence that the medical/clinical management of Mr Knight, while in some respects perhaps sub-optimal, was reasonable and appropriate in the trying circumstances that prevailed.

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

Mrs Dawn Knight

Ms Susan Van Dyk, Monash Health

Constable Brendan Rees, Moorabbin Police Station

Signature:

PHILLIP BYRNE
CORONER
Date: **30 June 2015**