IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 1743

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: ROBERT KEITH KNIGHT

Delivered On:	5 November 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank, VIC 3006
Hearing Dates:	5 November 2015
Findings of:	JOHN OLLE, CORONER
Coroner's Solicitor	Kate Hamilton

I, JOHN OLLE, Coroner having investigated the death of ROBERT KEITH KNIGHT

AND having held an inquest in relation to this death on 5 November 2015
at Melbourne
find that the identity of the deceased was ROBERT KEITH KNIGHT
born on 24 May 1950
and the death occurred on 23 April 2013
at Royal Melbourne Hospital, 300 Grattan Street, Parkville VIC 3050
from:

1 (a) HEAD INJURIES SUSTAINED IN FALL FROM HEIGHT

in the following circumstances:

1. At approximately 7.55pm on 23 April 2013 Mr Knight jumped from the top tier of the Deakin A Side Unit at the Metropolitan Remand Centre. He unfortunately sustained fatal injuries due to the fall and died approximately two hours later at the Royal Melbourne Hospital.

SUMMARY INQUEST

2. Mr Knight was born on 24 May 1950 and was 62 years old at the time of his death. The Coroners Court was provided a report by the Office of Correctional Services Review at the Department of Justice, a statement by Corrections Victoria at the Department of Justice, and a coronial brief by Victoria Police, comprising statements obtained from witnesses, treating clinicians and investigating officers. I have drawn on all of this material as to the factual matters in this finding.

3. At inquest, a summary was read into evidence by Coroner's Solicitor, Kate Hamilton. I am satisfied that the summary accurately reflects the evidence.

4. Mr Knight was, immediately before death, a person placed in the legal custody of the Secretary to the Department of Justice, and Mr Knight's death was not due to natural causes. Consequently, this matter is a mandatory inquest.[1] Mr Knight was received into custody on 26 October 2012 and was on remand, listed to appear in court on 24 April 2013.[2]

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[1] See *Coroners Act 2008* (Vic) s 52(2)(b); *Coroners Act 2008* (Vic) s 3, definition of 'person placed in custody of care'; *Coroners Act 2008* (Vic) s 3A.

[2] Department of Justice Office of Correctional Services Review into the death of Mr Robert Knight on 23 April 2013, 12.

5. On 26 October 2012, during assessment at Melbourne Assessment Prison, medical records document that Mr Knight had no indicators of psychiatric risk including no distress or discussion of self-harm, no suicide attempt in the previous two years and no psychiatric history.[3] His suicide and self-harm risk rating and psychiatric risk rating were recorded as 'nil'.[4] Mr Knight requested protection due to the nature of his offences. At this time, he was classified as low-risk with no follow-up required.

6. On 5 November 2012 Mr Knight was transferred to the Metropolitan Remand Centre ('MRC'). Despite Mr Knight denying prior suicide attempts or current plans to self-harm, he was referred for a risk review. On 6 November 2012 a Modified Risk Management Plan was conducted and documented no suicidal or self-harming ideations or plans. It was determined unnecessary to observe or review him further. MRC continued to conduct regular assessments of Mr Knight's wellbeing after each court appearance on 6, 16, 23 and 29 November 2012, 20 December 2012, 4 February 2013, 4 March 2013 and 3 April 2013. The assessments explored whether any concerns had emerged from attending court, if Mr Knight could guarantee his personal safety and if a referral was required to another service. On each occasion, Mr Knight guaranteed his personal safety and raised no concerns.[5]

7. On 29 November 2012 the conditions of Mr Knight's supervision order were reviewed and further temporary conditions were imposed. Mr Knight was given a curfew, was unable to leave his residence alone, had to comply with electronic or other monitoring by the Adult Parole Board, and was not permitted to access technology. These conditions would have remained in place until February 2013, however Mr Knight was refused bail and remained at MRC.

8. On 21 December 2012 Mr Knight was referred for an 'at risk' assessment after outgoing mail was intercepted in which he stated hopelessness and a desire to end his life.[6] Following assessment with Justice Health, Mr Knight was classified into the highest risk category, 'S1',[7] and was placed in a "Muirhead"[8] observation cell in a canvas gown on 15 minute observations.

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[3] Metropolitan Remand Centre Reception Assessment, 1.

[4] Metropolitan Remand Centre Interim Risk Management Plan, dated 26 October 2012.

[5] Medical Records, Justice Health, 132-133.

[6] Ibid 139.

[7] The suicide risk rating scale utilised by Justice Health are; S1 'Immediate risk of suicide/self-harm', S2 'Significant risk of suicide/self-harm', S3 'Potential risk of suicide/self-harm', and S4 'History of suicide or self-harm actions'.

[8] Isolation and observation cells aimed at reducing access to means to self-harm/suicide.

Mr Knight's risk was reviewed daily and he was documented as being angry and disgruntled about residing in a safe cell[9]. On 23 December 2012 Mr Knight's risk was rated as 'S2' and his observations were reduced to 30 minute intervals. On 24 December 2012 Mr Knight's risk was rated as 'S3' and observations were reduced to 60 minute intervals. On 25 December 2012 Mr Knight was deemed low risk ('S4'), and returned to standard custody with no observations.

9. On 29 March 2013 a hand-written note by Mr Knight was found during a routine random cell search, causing concern regarding suicidality. When questioned by staff, Mr Knight denied any intentions to self-harm.[10] However, due to the note and recent similar incident in December 2012, Mr Knight was placed in a modified single cell with no access to sharps or cords and was placed on 60 minute observations.[11] It is documented that Mr Knight was to remain on a risk alert for '2 or 3 days to ensure close supervision and daily risk assessment'[12] and was returned to standard custody with ceased observations after assessment on 30 March 2013.

10. At approximately 7.45pm[13] on 23 April 2013 Mr Knight walked to the top level of Deakin A Unit at MRC. In the corner near the correctional officers console, Mr Knight climbed the metal handrail, stood on the top rail, steadied himself with his hands on the roof and jumped head first. Mr Knight did not appear to make any effort to block his landing.[14] Mr Knight's presence on the railing was initially observed by other prisoners, who notified correctional officers. Mr Knight ignored commands of correctional officers to get down[15] and nobody was observed near him while he was standing on the rail. Witnesses estimate that there was a five[16] to fifteen[17] second delay between Mr Knight beginning to climb the rail and jumping. The total height from the ground to the top of the handrail was calculated as 3.86 metres.[18]

11. Correctional officers called a 'Code Black' (medical serious/prisoner death) and requested an ambulance[19]. Mr Knight was observed by correctional officers to be bleeding heavily from his

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[9] Medical Records, Justice Health, 18-19.

[10] Medical Records, Justice Health, 131.

[11] Medical Records, Justice Health, 130.

[12] Medical Records, Justice Health, 130.

[13] Witness estimates of time vary from 7:30pm to 8.00pm.

[14] Statement of Daniel Murphy, Coronial brief, 36.

[15] Statement of Benjamin Sutton, Coronial brief, 1; Statement of Lidija Redfearn, Coronial brief, 8.

[16] Statement of Benjamin Murray, Coronial brief, 15.

[17] Statement of Paul West, Coronial brief, 43.

[18] Statement of Detective Senior Constable Chris Jackman, Coronial brief, 53.

[19] Statement by Lidija Redfearn, Coronial brief, 8.

nose, mouth and ears, and was moaning and making gurgling noises. Correctional officers stated that they did not move him due to concern for spinal injuries, but during their observations Mr Knight independently turned his body over so that he was lying on his back. Two psychiatric nurses from MRC responded to the Code Black, as they were the only medical staff. Nursing staff attempted to control Mr Knight's bleeding with bandages and applied oxygen therapy.

12. Ambulance Victoria records indicate that they received a call in relation to Mr Knight at 7.54pm, attended at 8.07pm, followed by MICA paramedics attending at approximately 8.17pm. Mr Knight was unconscious with major trauma to his head and body, and impaired breathing. His condition continued to deteriorate, despite paramedic intervention. At 9.12pm Mr Knight was taken to Royal Melbourne Hospital. A trauma review conducted at 9.30pm determined that Mr Knight had non survivable brain injury. Cardiopulmonary resuscitation was ceased and Mr Knight died at 9.58pm.[20]

13. A police search of Mr Knight's cell revealed that Mr Knight had packed all his belongings in a plastic bag and placed them on his bed. No note was located but Mr Knight had filled in an MRC property dispatch/ donation application outlining who he wished to have his belongings. Subsequent police interviews of prisoners indicated that Mr Knight was observed to walk around the second level 3 or 4 times on the day prior to his death[21] which was described as unusual.[22] There was also evidence that "in the days prior to the 23rd (Mr Knight) didn't seem to be himself, it appeared that all the stress had got to him as he was withdrawn but not openly upset."[23]

POST-MORTEM EXAMINATION AND REPORT

14. A post-mortem examination and report was undertaken by Dr Matthew Lynch, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine. Dr Lynch reported that at autopsy there was evidence of significant head and chest injuries. Natural disease was noted in the form of incompete septal cirrhosis of the liver with features suggestive of chronic hepatitis C infection.

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[20] Royal Melbourne Hospital medical records of Robert Knight, Clinical Progress Notes, dated 23 April 2013.

[21] Statement of Daniel Murphy, Coronial brief, 36.

[22] Statement of Paul West, Coronial brief, 43.

[23] Statement of Nathan Whiley, Coronial brief, 24.

15. Toxicological analysis of post-mortem blood specimens did not detect any ethanol or common drugs or poisons.

16. Dr Lynch reported that the cause of death is head injuries sustained in a fall from a height.

FURTHER INVESTIGATION

17. At my request, the Coroners Prevention Unit[24] reviewed the mental health medical management and care of Mr Knight. I have used this information to assist my finding.

Evidence of suicidality

18. A letter hand written by Mr Knight, dated 17 December 2012, outlined his reasons for not wanting to live. Within the letter he raised legal matters and the impact that those matters had on the way he lived his life, and he described making a "rational decision to end (his) pain."[25]

19. In a further letter written by Mr Knight, dated 24 March 2013, he again made suicidal ideations and wrote about the impact of his legal matters on the way he lived his life.[26]

Mental health medical care and management

20. Mr Knight had no history of mental health matters, substance use issues, or suicidal or self-harm ideation, planning or intent. This is consistently documented in Mr Knight's Justice Health records for his first period in custody from approximately 1998 to 2008.

21. During his second period in custody MRC staff became aware of Mr Knight's suicidal ideation by chance, when they intercepted a letter and conducted a random cell search. On each occasion they responded to the risk by placing Mr Knight in a safe cell and/or under increased observation. When assessed by medical staff Mr Knight consistently denied current intent, although acknowledged a long-term intent.

22. On 29 March 2013 Mr Knight denied any suicidal or self harm intent and had stated that he had written the letter dated 24 March 2013 as a mental health exercise. The mental health professional who assessed Mr Knight did not fully accept his explanation, as Mr Knight was

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[24] A specialist service for coroners created to strengthen their prevention role and provide them with expert assistance. Hereafter referred to as 'CPU'. The role of the CPU is to assist coroners investigating deaths, particularly deaths which occur in a healthcare setting. The CPU is staffed by healthcare professionals, including practising physicians and nurses, who are independent of the health professionals and institutions under consideration. The CPU professionals draw on their medical, nursing and research experience to evaluate the clinical management and care provided in particular cases by reviewing the brief of evidence, medical records, the autopsy report and any particular concerns which have been raised.

[25] Letter of Robert Knight, Coronial brief, 85.

[26] Letter of Mr Robert Knight, Coronial brief, 87.

unable to provide assurance about his letter. As a consequence, the mental health professional assigned Mr Knight an 'S3' risk rating and he was placed on hourly observations in a standard 'safe' cell[27] with a plan to continue to review him. On 30 March 2013 it was noted that Mr Knight's affect was bright, reactive and polite. He denied any suicide and self harm ideation, intent or plan and Mr Knight referred to his note as a misunderstanding. He informed the mental health professional that he was expecting visits that day and the following day. He made good eye contact and was well dressed and groomed. No formal thought disorder was evident. His speech was normal and he was orientated. No ideas of suicide of self-harm were expressed. Mr Knight was downgraded to an S4 rating, following assessment and confirmation at the Risk Review Team meeting on 30 March 2013. There was no other information which caused staff to believe that Mr Knight was 'at risk' between 30 March 2013 and 23 April 2013, and he was therefore not referred for any further 'at risk' assessments.[28]

23. In a Justice Health review of the adequacy of Mr Knight's mental health management, requested by the Office of Correctional Services Review (OCSR), Justice Health found no issues with their own practice in terms of management, suicide risk rating, or communication between staff.[29] Upon reviewing all the evidence before me, I accept that there were no issues in relation to Mr Knight's mental health medical care and management while in custody.

FINDING

24. I am satisfied, having considered all of the evidence before me, that no further investigation is required.

25. The evidence satisfies me that the medical management and care provided by Justice Health, Ambulance Victoria and the Royal Melbourne Hospital was reasonable and appropriate in the circumstances.

26. I am satisfied that Metropolitan Remand Centre correctional officers responded appropriately and in a timely manner to the incident.

27. I find that Mr Robert Knight died on 23 April 2013 and that the cause of his death is head injuries sustained in a fall from a height.

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[27] A cell without hanging points.

[28] Statement of Acting Commissioner Rod Wise, Corrections Victoria, Department of Justice, dated 30 December 2014.

[29] Department of Justice Office of Correctional Services Review into the death of Mr Robert Knight on 23 April 2013, 3.

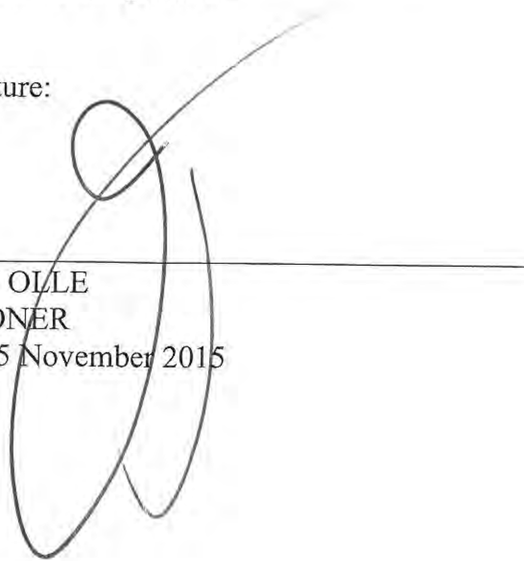
I direct that a copy of this finding be provided to the following:

The family of Robert Knight;

Investigating Member, Victoria Police; and

Interested parties.

Signature:



JOHN OLLE
CORONER
Date: 5 November 2015