IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005179

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Caine David Knight
Date of birth:	23 July 1997
Date of death:	16 September 2023
Cause of death:	Cardiomegaly in a man with Prader-Willi syndrome
Place of death:	72 Millawa Avenue St Albans, Victoria
Keywords:	In care – Natural causes

INTRODUCTION

1. On 16 September 2023, Caine David Knight was 26 years old when he passed away at home. At the time of his death, Caine lived in a residential care facility in St Albans, Victoria, managed by Yooralla.

BACKGROUND

2. Caine's medical history included Prader-Willi syndrome, intellectual disability, obesity hypoventilation syndrome, hypertension, tachycardia, fluid retention, epilepsy, and anxiety. His medications included quetiapine, cetirizine, metformin, escitalopram, esomeprazole, frusemide, HCT, loperamide, salbutamol, melatonin, metoprolol, semaglutide (Ozempic), spironolactone, testosterone, topiramate, and daily vitamins D and B12.

3. Despite high doses of diuretics, Caine continued to gain weight due to fluid retention and required fluid restrictions. Caine also had a Respiratory Management Plan to support staff in his oxygen therapy.

4. Caine regularly exhibited challenging behaviours, such as wandering, damaging property or becoming verbally aggressive towards staff and other residents. These behaviours were often triggered by boredom, overwhelming demands, or any experience of resistance to his preferences and needs. Caine's Behaviour Support Plan assisted staff in de-escalating any behaviours of concern and they were generally able to intervene or redirect him. Although he required verbal prompting, Caine was fully ambulant and did not require any physical assistance to mobilise.

5. Throughout 2022, Caine required multiple admissions to Sunshine Hospital for type 2 respiratory failure. Following a three-month admission from July to October 2022, he was discharged with a BiPAP[1] machine and home oxygen for hypoxia management. In the first half of 2023, Caine presented to the emergency department (**ED**) of Sunshine Hospital for respiratory distress on four occasions.

[1] Biphasic positive airway pressure.

6. On 10 August 2023, Caine was shopping with a carer when he became overwhelmed and stressed and sat on the ground. He denied shortness of breath or chest pain but was found to have reduced oxygen saturation and fluctuating blood pressure. Caine was transferred by ambulance to Sunshine Hospital, where he underwent a brief period of observation and supplemental oxygen before discharge.

7. On 14 August 2023, Caine presented to Sunshine Hospital ED with sharp/stabbing chest pain and exertional breathlessness. His carer advised that they believed Caine needed more occupational therapy input and perhaps a wheelchair or walking frame for increased breathlessness while walking.

8. Caine was reviewed via telehealth the following day by clinicians at the Western Health Cardiology Clinic, who diagnosed Caine with clinical right heart failure secondary to obesity hyperventilation syndrome. They considered cardiac magnetic resonance imaging (**MRI**) or right heart catheterisation, however given the likely need for anaesthetics/sedation and Caine's weight and risk of acute respiratory failure, it was considered appropriate to manage him expectantly with diuretics and oxygen via non-invasive ventilation if required. He was discharged for follow-up with his treating GP.

9. On 12 September 2023, Caine was supported by carers to see a movie at HOYTS Watergardens. After the movie, Caine sat on a couch in the hallway of the theatre and appeared to experience a small seizure before falling asleep. Staff at the shopping centre contacted emergency services and Ambulance Victoria paramedics arrived a short time later. Responding paramedics took Caine's blood pressure and observed him for approximately 40 minutes, after which they considered his vitals were normal and advised he could go home.

10. Caine returned home at approximately 10.40pm and had missed his dinner time medication. After liaising with the on-call nurse and Poisons Control Centre, staff administered Caine's dinner time and bedtime medication together.

11. In the days that followed, Caine slept well and used his BiPAP as needed. He enjoyed playing his Nintendo Switch and generally appeared in good spirits.

THE CORONIAL INVESTIGATION

12. Caine's death was reported to the coroner as it 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. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes. Caine was a person in care at the time of his death and was a Specialist Disability Accommodation (**SDA**) resident living in an SDA dwelling pursuant to Regulation 7 of the *Coroners Regulations 2019*. However, an inquest was not required to be held pursuant to section 52(3A) of the Act given that Caine's death was from natural causes.

13. 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.

14. 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.

15. This finding draws on the totality of the coronial investigation into Caine's death, including information obtained from his medical records and the National Disability Insurance Agency. 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.[2]

[2] 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.

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

Circumstances in which the death occurred

16. On 16 September 2023, Caine enjoyed a McDonald's Happy Meal in the common area and was administered his medication before he returned to bed at around 2.30pm. He slept until getting up for dinner at approximately 8.30pm, when he sat on the couch to chat with staff before asking for his medication. After his medication was administered, Caine asked staff to prepare his bed and BiPAP machine.

17. As he was walked back to his bedroom, staff observed Caine to lean on the wall before suddenly collapsing to the floor. Staff asked him if he was okay but he did not respond and did not appear to be breathing. They did not observe any obvious signs of injury. Staff immediately contacted emergency services and commenced cardiopulmonary resuscitation (**CPR**). Ambulance Victoria arrived a short time later but were unable to revive Caine and pronounced him deceased at 9.05pm.

Identity of the deceased

18. On 16 September 2023, Caine David Knight, born 23 July 1997, was visually identified by his carer, Robert Kemboi.

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

Medical cause of death

20. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine conducted an autopsy on 21 September 2023 and provided a written report of his findings dated 31 October 2023.

21. Dr Burke reviewed a post-mortem computed tomography (**CT**) scan, which revealed an enlarged heart with small pleural effusion. There were no acute changes within the head, nor any evidence of injuries that could have caused or contributed to death.

22. The post-mortem examination revealed cardiomegaly (an enlarged heart weighing 740 grams) with right ventricular hypertrophy. Dr Burke did not observe any evidence of underlying coronary artery disease or valve disease.

23. Dr Burke commented that obese individuals may develop an enlarged heart, which carries of a risk of sudden cardiac death from cardiac arrhythmia. He noted that individuals with Prader-Willi syndrome have a relatively high mortality rate, often associated with obesity and subsequent cardiovascular risk.

24. Toxicological analysis of post-mortem samples identified the presence of citalopram, quetiapine, topiramate, metoprolol, metformin, frusemide and hydrochlorothiazide, consistent with Caine's prescribed medications.

25. Dr Burke provided an opinion that the medical cause of death was *1(a) Cardiomegaly in a man with Prader-Willi syndrome*. Dr Burke advised that the death was due to natural causes.

26. I accept Dr Burke's opinion.

FINDINGS AND CONCLUSION

27. Pursuant to section 67(1) of the Act, I make the following findings:

    a) the identity of the deceased was Caine David Knight, born 23 July 1997;

    b) the death occurred on 16 September 2023 at 72 Millawa Avenue St Albans Victoria, from cardiomegaly in a man with Prader-Willi syndrome; and

    c) the death occurred in the circumstances described above.

28. As noted above, Caine's death was reportable by virtue of section 4(2)(c) of the Act because, immediately before his death, he was a person placed in care as defined in section 3 of the Act. Section 52 of the Act requires an inquest to be held, except in circumstances where someone is deemed to have died from natural causes. In the circumstances, I am satisfied that Caine died from natural causes and that no further investigation is required. Accordingly, I exercise my discretion under section 52(3A) of the Act not to hold an inquest into his death.

I convey my sincere condolences to Caine's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Michael Knight, Senior Next of Kin

Michelle Hamilton, Senior Next of Kin

Yooralla

Senior Constable Brad Douglas, Coronial Investigator

Signature:

Coroner David Ryan

Date: 05 June 2025

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.