



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

**COR 2019 001113**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

*Section 67 of the Coroners Act 2008*

Findings of:	Coroner Despot
Deceased:	FM
Date of birth:	12 December 1978
Date of death:	2 March 2019
Cause of death:	1(a) Sudden unexpected death in epilepsy (SUDEP) in a woman with schizophrenia
Place of death:	52 Williams Street, Lalor, Victoria, 3075
Keywords:	Death in care, Disability care, Natural causes

## INTRODUCTION

1. On 2 March 2019, FM was 40 years old when she passed away. At the time of her death, FM lived at a disability group home in Lalor, operated by the Department of Families, Fairness and Housing<sup>1</sup> (DFFH), with four other residents.
2. FM had a past medical history including epilepsy, intellectual disability, menorrhagia, and schizoaffective disorder (bipolar). She was prescribed aripiprazole, atorvastatin, Ferrograd C, lamotrigine, rabeprazole and topiramate.
3. FM was described as an active woman who enjoyed basketball, football, dancing, singing, listening to music, spending time on her computer, and going out to lunch. FM was able to state her needs clearly and could follow instructions from her carers. She worked one day per week at Aurora Support Services and spent two days per week at the Ivanhoe Diamond Valley Centre for day services.
4. FM's seizures were generally infrequent and were triggered by excitement, cold or hot temperatures, and anxiety. She was required to sleep on an EpiMat and a motion detection mat to alert her carers if she was suffering a seizure whilst sleeping.
5. On 26 January 2019, FM suffered an absence seizure followed by a tonic-clonic (grand mal) seizure while on holiday in New South Wales. She was taken to hospital and discharged later that day. She was reviewed by her neurologist on 30 January 2019, who did not make any changes to her epilepsy management plan.

## THE CORONIAL INVESTIGATION

6. FM'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 is a mandatory report to the Coroner, even if the death appears to have been from natural causes.<sup>2</sup>
7. 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

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<sup>1</sup> Then known as the Department of Health and Human Services (DHHS).

<sup>2</sup> See the definition of "reportable death" in section 4 of the *Coroners Act 2008*, especially section 4(2)(c) and the definition of "person placed in custody or care" in section 3 of the Act.

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of FM's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.
9. This finding draws on the totality of the coronial investigation into the death of FM, 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.<sup>3</sup>

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

### **Circumstances in which the death occurred**

10. On 27 February 2019, Neulactil (periciazine) was added to FM's medication regime to assist with her anxiety. No adverse effects were noted following the introduction of this new medication.
11. On 1 March 2019, FM attended her usual employment at Aurora Support Services. She returned home and attended her weekly friendship group at the Greensborough Anglican Church at about 7.30pm.
12. One of FM's carers drove her to the friendship group and noted that FM was unusually quiet in the car. The carer thought this might have been due to the new medication that FM had been prescribed.
13. FM took a taxi home from her friendship group meeting and arrived at about 10.00pm. The carer noted that FM's behaviour was unusual, she was " *pacing around the house* ". This was unusual for FM, as she usually went to bed quite early. As she was no longer pacing the house at that time, the carer believed that FM had already gone to bed at about 10.30pm. The carer made a note to let her sleep in the next morning due to her late night.

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<sup>3</sup> 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.

14. The next morning, the carer awoke at about 7.00am and proceeded to wake up three other residents at the group home. She provided breakfast to one resident and administered medication to another. The carer did not enter FM's room as she wanted to give her an opportunity to sleep in. The carer also noted that it was forecast to be a hot day, which was one of FM's known epilepsy triggers.
15. A second carer commenced work at about 9.00am and at about 9.20am, they attended FM's room to check on her. When the second carer entered the room, she observed FM lying supine in bed, with her eyes partially open. She was not breathing, had dried blood coming out of her nose and appeared very pale in complexion. The second carer alerted the other carer, who called Triple Zero for assistance.
16. Victoria Police and Ambulance Victoria attended the scene and confirmed that FM had passed away. Resuscitation was not attempted.
17. The carer who was on duty overnight from 1 to 2 March 2019, confirmed that she did not hear any alarms emanating from FM's EpiMat. When police attended the scene following FM's passing, they confirmed that the EpiMat was fitted, plugged in, and switched on. It was later tested and was noted to be in working order with no faults identified.

### **Identity of the deceased**

18. On 2 March 2019, FM, born 12 December 1978, was visually identified by her carer.
19. Identity is not in dispute and requires no further investigation.

### **Medical cause of death**

20. Forensic Pathologist Dr Linda Iles, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 6 March 2019 and provided a written report of her findings dated 3 June 2019.
21. Dr Iles commented as follows:

*Post mortem examination does not demonstrate an acute pathological process to indicate a specific cause of death. This lady does have a history of two medical conditions (epilepsy and schizophrenia) which have been associated with sudden death for which there are no anatomical findings at post mortem.*

*SUDEP is defined as 'sudden, unexpected, witnessed or unwitnessed, non-traumatic and non-drowning death in patients with epilepsy, with or without evidence for a seizure and excluding documented status epilepticus, in which post mortem examination does not reveal a toxicologic or anatomic cause of death'. The incident of SUDEP varies from 1:1000 per year through to as many as 1:200 per year in those with epilepsy, depending on the community surveyed. The mechanism of death in SUDEP is not clearly established. Hypoventilation and/or cardiac changes occurring during or shortly after a seizure may be such mechanisms, but at the present time the precise mechanism is not known.*

*Other causes of sudden death with a negative autopsy, particularly in young adults, include cardiac arrhythmias. This includes such conditions as long QT syndrome, Brugada syndrome and catecholaminergic polymorphous ventricular tachycardia (CPVT).*

*In addition, those with a history of schizophrenia have an increased incidence of sudden death for which there are no anatomical findings at post mortem. It is unclear if this is related to intrinsic autonomic instability that occurs in schizophrenia, or the effect of antipsychotic medications on the cardiac conduction cycle, or some other mechanism.*

*On the basis of the information available to be at this time, I am of the opinion that this death is due to natural causes.*

22. Toxicological analysis of post-mortem samples identified the presence of lamotrigine, topiramate, aripiprazole, pericyazine (periciazine).
23. Dr Iles provided an opinion that the medical cause of death was 1 (a) sudden unexpected death in epilepsy (SUDEP) in a woman with schizophrenia.
24. I accept Dr Iles' opinion.

## **DISABILITY SERVICES COMMISSIONER INVESTIGATION**

25. Following FM's passing, the Disability Services Commissioner (DSC) completed a review into her death and the care provided to her by the DFFH. The DSC reported two main findings.
26. The DSC noted that whilst FM's epilepsy monitoring equipment was found to be free of faults and was in working order, the group home staff did not routinely check the equipment to

ensure it was in working order. The staff also did not carry out routine maintenance and repair of the equipment, in accordance with the Residential Services Practice Manual (**RSPM**).

27. Additionally, the DSC found that group home staff breached their duty of care by not carrying out a visual check of FM at the end of the sleepover shift in accordance with RSPM requirements.
28. The DSC provided the DFFH with a proposed “Notice to Take Action” with an opportunity to respond. DFFH subsequently confirmed that it had reviewed the DSC’s draft notice and had no further comment.
29. As a result of the subsequent transition to the National Disability Insurance Scheme (**NDIS**) the responsibility for management and oversight of the accommodation where FM lived was transferred from DFFH to Aruma on 18 August 2019.
30. DFFH worked with Aruma to develop and implement a work program to action the requirements in the Notice to Take Action and address the issues identified in the DSC report. The DSC accepted these actions as satisfactory to remedy the issues and notified DFFH of the closure of the case on 23 June 2021.
31. The oversight responsibility for the delivery of disability services at this address now sits with the NDIS Quality and Safeguards Commission.

## **FINDINGS AND CONCLUSION**

32. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
- a) the identity of the deceased is FM, born 12 December 1978;
  - b) the death occurred between 1 and 2 March 2019 at 52 Williams Street, Lalor, Victoria, 3075, from sudden unexpected death in epilepsy (SUDEP) in the context of a woman with schizophrenia; and
  - c) the death occurred in the circumstances described above.
33. Despite the suboptimal aspects of care identified by the DSC, I am unable to conclude that these issues caused or contributed to FM's death.
34. Section 52 of the Act requires an inquest to be held, except in circumstances where the death is deemed of natural causes. In the circumstances, I am further satisfied that FM died from natural causes and her death requires no further investigation. Accordingly, I exercise my discretion under section 52(3A) of the Act to not hold an inquest into FM's death.

I convey my sincere condolences to FM's family and loved ones for their loss.

Pursuant to section 73(1B) of the Act, I order that a de-identified version of 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:

**The parents of FM, Senior Next of Kin**

**Aruma Disability Services**

**Department of Families, Fairness and Housing**

**Disability Services Commissioner**

**NDIS Quality and Safeguards Commission**

**Royal Children's Hospital**

**Acting Sergeant Mark Rogers, Coroner's Investigator**

Signature:



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Coroner Kate Despot

Date : 16 January 2026

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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.

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