IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 005257

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Kieran Joseph McGuinness
Date of birth:	8 January 1985
Date of death:	11 September 2022
Cause of death:	1(a) Sudden unexpected death in epilepsy (SUDEP) in the setting of acquired brain injury with post traumatic epilepsy
Place of death:	4/6 Inverleith Court, St Kilda, Victoria, 3182
Keywords:	Epilepsy, seizure risk, SUDEP, disability support

INTRODUCTION

1. On 11 September 2022, Kieran Joseph McGuinness was 37 years old when he died at home. At the time of his death, Kieran lived alone in St Kilda but received daily support from disability support workers at Dynamic Care Services (**DCS**), a registered provider through the National Disability Insurance Scheme (**NDIS**).

2. Kieran is survived by his parents, Tracy Leeves and Gerard McGuinness, and his sister Laura.

BACKGROUND

3. Kieran's medical history included an acquired brain injury with post-traumatic epilepsy and liver cirrhosis secondary to alcohol misuse. He had also undergone a melanoma excision and a laparoscopic appendicectomy in February 2018.

4. On 1 October 2018, Kieran was admitted to the Intensive Care Unit (**ICU**) of the Royal Melbourne Hospital for treatment of a head injury after he suffered a fall onto concrete from standing height. He underwent an urgent left craniectomy and evacuation of a subdural haematoma. During his admission, Kieran underwent further evacuation of a large subgaleal haematoma, and he remained in the ICU due to ventilator-associated pneumonia, meningoencephalitis and several seizures for which he was commenced on anti-epileptic medication. Kieran was discharged on 22 November 2018 with referrals for outpatient follow-up with the neurosurgical team; however, he failed to attend multiple appointments.[1]

5. The long-term effects of Kieran's injury included difficulties with speech and communication, loss of peripheral vision and memory loss.

6. In 2020, Kieran had a guardian appointed by the Office of the Public Advocate to support his decision-making. During this period, Kieran's father continued to play an active role in arranging his NDIS funding and a support program was implemented.

7. In July 2020, Kieran was admitted to the Alfred Hospital for treatment of a presumed seizure of unknown cause. His risk factors were recorded as excessive alcohol consumption and occasional non-compliance with his prescribed medications.

8. In around February 2021, Kieran was referred to DCS. At the time of the referral, he was funded for medium term accommodation but was instead self-funding a hotel stay. The

[1] Medical records, the Royal Melbourne Hospital.

purpose of the referral was to support Kieran's re-engagement with support services, including for his day-to-day care needs.[2]

9. According to Luisa Di Fabio, director and manager of DCS, Kieran was "*quite independent and capable of most daily tasks but required prompting*", however he also held strong views that he did not require support.[3]

10. After a brief stay in short-term accommodation, the St Kilda apartment was secured for Kieran and DCS commenced providing daily support services at the apartment for nine hours each day from February 2021, funded by the NDIS. In consultation with his care team and treating specialists, it was settled that his day-to-day support would include accompanying him to medical and allied health appointments, observing him take medications, meal preparation and grocery shopping, and cleaning.

11. Throughout their engagement with Kieran, DCS staff filed multiple incident reports in relation to falls and behavioural issues, including an assault on a staff member, and longstanding fluctuating paranoia and perceptual disturbances that were identified during a psychiatric evaluation. Staff also raised concerns with Kieran's treating specialists about his excessive drinking. In the months leading up to his death, staff documented Kieran's worsening memory, non-compliance with prescribed medications, and increased falls.[4]

12. Throughout 2021 and 2022, Kieran's engagement with his treating teams was sporadic and he continued to miss multiple appointments.

13. In January 2022, Kieran underwent a further admission to the Alfred Hospital for treatment of a presumed seizure of unknown cause. He underwent an electroencephalogram, which revealed changes consistent with moderate encephalopathy of an unknown cause, but no other abnormalities relating to his epilepsy. Kieran's anti-epileptic medication doses were increased during this admission.

[2] Statement of Luisa Di Fabio dated 5 July 2023.
[3] Statement of Luisa Di Fabio dated 5 July 2023.
[4] Statement of Luisa Di Fabio dated 5 July 2023.

THE CORONIAL INVESTIGATION

14. Kieran'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.

15. 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.

16. 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.

17. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Kieran's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as DCS staff and the forensic pathologist. Records were also obtained from DCS, Ambulance Victoria and the Royal Melbourne Hospital and correspondence was received from Kieran's father.

18. This finding draws on the totality of the coronial investigation into Kieran's death including evidence contained in the coronial brief. While 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.[5]

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

Circumstances in which the death occurred

19. At approximately 8.00am on 9 September 2022, DCS carer Kumar Tamang arrived at Kieran's home. In his statement to police, Mr Tamang advised that despite his objection, Kieran was drinking alcohol throughout his visit and believed he had already been drinking by the time

[5] 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.

he arrived that morning. When Mr Tamang completed his shift at around 1.00pm, he observed that Kieran was in bed sleeping.[6]

20. On the morning of 10 September 2022, DCS carer Adamo Ruffilli arrived at Kieran's apartment and observed him awake in his room. Mr Ruffilli asked Kieran to take his morning medications and he did so. In his initial statement to police, Mr Ruffilli advised that Kieran remained in his room drinking alcohol for most of the day.[7] He later clarified that he did not in fact observe Kieran drinking alcohol that day but he was aware that he kept alcohol in his bedroom. Mr Ruffilli recalled that aside from leaving his bedroom to eat or go to the bathroom, Kieran remained in bed for most of the day.[8]

21. At approximately 8.44am, Mr Tamang missed a call from Kieran but when he returned the call, Kieran did not answer.[9]

22. At approximately 3.00pm, Mr Ruffilli was in the living room when he heard a noise in the hallway. He went to investigate and encountered Kieran. The sequence of events as described by Mr Ruffilli in a DCS incident report and in subsequent statements to police are, at times, inconsistent; however, I consider these inconsistencies likely originated from an imperfect recollection, rather than any carelessness or dishonesty on the part of Mr Ruffilli.

23. Mr Ruffilli noted in the incident report that he found Kieran in the hallway, conscious but having fallen and "*wobbling upright against the wall*" in what Mr Ruffilli described as a "*drunken state*". He further noted that he only "*presumed*" Kieran was intoxicated as he and other carers had previously found him on the floor in such a state. Mr Ruffilli reported that Kieran then tried to lay on his stomach but Mr Ruffilli helped him roll onto his back, slightly on his side, and placed a pillow underneath his head.[10]

24. In his first statement to police, however, Mr Ruffilli advised that at around 3.00pm, he found Kieran already lying face down on the carpeted hallway floor, wearing a backpack and with vomit beside him. Having formed the view that he had passed out from drinking alcohol, Mr Ruffilli cleaned the vomit and then that he placed a pillow beneath Kieran's head.[11]

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6 Statement of Kumar Tamang dated 11 September 2022.
7 Statement of Adamo Ruffilli dated 11 September 2022.
8 Statement of Adamo Ruffilli dated 7 March 2023.
9 Statement of Kumar Tamang dated 11 September 2022.
10 Dynamic Care Services incident report completed by Adamo Ruffilli dated 10 September 2022.
11 Statement of Adamo Ruffilli dated 11 September 2022.

25. Mr Ruffilli appeared to have a clear recollection that he did not observe any injuries to Kieran and he "*didn't consider him to have had a seizure or a medical episode at the time*". Kieran then took a sip of water that Mr Ruffilli offered to him and indicated with a nod and thumbs up gesture that he was okay. Mr Ruffilli contacted Mr Tamang and they agreed that he should leave Kieran on the floor to allow him to sober up as it was against DCS policy to physically lift him. According to Mr Ruffilli, they were previously instructed by their employer that whenever staff encounter Kieran "*drunk on the floor in his bedroom or somewhere else*", they should "*give him time and space for him to sober up again*". Mr Ruffilli continued to monitor Kieran until the end of his shift.[12]

26. Mr Ruffilli advised police that prior to departing at approximately 5.00pm, he observed Kieran on the floor in the same position, and that his eyes were open and not moving. He recalled that Kieran was breathing at this time as his chest was moving up and down.[13] In the DCS incident report, Mr Ruffilli added that prior to leaving, he asked Kieran if it was okay to leave, to which Kieran reportedly responded with a thumbs up gesture.[14]

27. At approximately 8.10am on 11 September 2022, Mr Tamang arrived at Kieran's apartment. As he entered the hallway, he observed Kieran face down on a pillow on the floor. He tried to rouse him but Kieran remained unresponsive. Mr Tamang initially formed the view that Kieran had passed out from drinking, as he also recalled it was "*very common to find him passed out in random places in the apartment*".[15]

28. After noticing traces of blood near Kieran's mouth and on the pillow, Mr Tamang contacted emergency services before separately contacting Mr Ruffilli and Ms Di Fabio.[16] Ambulance Victoria paramedics arrived at approximately 8.29am but were unable to find signs of life and pronounced Kieran deceased at 8.50am.[17]

[12] Dynamic Care Services incident report completed by Adamo Ruffilli dated 10 September 2022; Statement of Adamo Ruffilli dated 7 March 2023.
[13] Statement of Adamo Ruffilli dated 7 March 2023.
[14] Dynamic Care Services incident report completed by Adamo Ruffilli dated 10 September 2022.
[15] Statement of Kumar Tamang dated 11 September 2022.
[16] Statement of Kumar Tamang dated 11 September 2022; Statement of Luisa Di Fabio dated 5 July 2023.
[17] Ambulance Victoria Patient Care Record dated 11 September 2022.

29. Victoria Police arrived at approximately 9.10am and inspected the home. Police located seven weekly medication planners containing multiple medications prescribed to Kieran and divided into schedules for morning, lunch, dinner and night. Police also located several empty cans of alcohol in a bathroom cabinet, and a partially empty bag of cask wine inside a wardrobe in the bedroom.

Identity of the deceased

30. On 11 September 2022, Kieran Joseph McGuinness, born 8 January 1985, was visually identified by Luisa Di Fabio.

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

Medical cause of death

32. Forensic Pathology Registrar Dr Michael Duffy, supervised by Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine, performed an autopsy on 19 September 2022 and provided a written report of his findings dated 20 January 2023.

33. On external examination, Dr Duffy observed minor abrasions and bruising to the extremities suggestive of recent falls, however he did not consider these to have caused or contributed to the death.

34. At autopsy, Dr Duffy identified natural disease in the form of advanced liver cirrhosis from presumed excessive alcohol use. He commented that the absence of any metabolic derangements suggested that the death was caused by the advanced liver disease.

35. Dr Duffy reviewed the results of a neuropathological examination, which revealed evidence of earlier brain injury and areas of bleeding associated with softening or loss of brain tissue, but no other acute brain injury that would have caused or contributed to the death.

36. Toxicological analysis of post-mortem samples identified the presence of levetiracetam, topiramate, olanzapine and lacosamide, at levels consistent with therapeutic use. No alcohol or illicit drugs were detected.

37. In the absence of any acute brain injuries, significant natural disease, or adverse toxicological results, Dr Duffy considered it reasonable to attribute Kieran's death to sudden unexpected death in epilepsy (**SUDEP**).

38. SUDEP is used to describe the sudden and unexpected death of a patient with a history of epilepsy, whether witnessed or unwitnessed, where there may or may not be evidence of a seizure and excluding documented status epilepticus; there is no evidence of trauma or circumstances of drowning; and there is no toxicologic or anatomic cause of death identified. While the precise mechanism of death in epilepsy is unknown, hypoventilation and/or cardiac arrhythmias occurring during or shortly after a seizure are thought to be such a mechanism.

39. Dr Duffy ultimately provided an opinion that the medical cause of death was 1(a) Sudden unexpected death in epilepsy (SUDEP) in the setting of acquired brain injury with post traumatic epilepsy.

40. I accept Dr Duffy's opinion.

FAMILY CONCERNS

41. During the course of the investigation, Mr McGuinness expressed concerns to the Court regarding the care Kieran received through DCS. In particular, Mr McGuinness was critical of Mr Ruffilli's response to finding Kieran in the hallway on 10 September 2022.

REVIEW OF CARE

42. Mr Tamang and Mr Ruffilli confirmed in their respective statements to police that they were aware of Kieran's history of epilepsy.

43. Ms Di Fabio further advised that Kieran's Client Care Plan was readily available to staff as it was contained in the sign-in-book they were required to complete at the commencement of each shift. The care plan outlined Kieran's living situation, challenging behaviours, and day-to-day tasks for staff, as well as his risk of seizure-related falls.[18]

44. Ms Di Fabio referred to Kieran's Seizure Management Plan prepared by his treating team with the Alfred Health Epilepsy Clinic and noted that DCS staff were trained to follow this plan if they suspected a seizure. She noted that her policy for DCS staff was to request an ambulance in the event of any fall with head strike, but that a routine follow-up medical appointment would suffice for a client that did not suffer any visible injuries.[19]

[18] Statement of Luisa Di Fabio dated 5 July 2023.
[19] Statement of Luisa Di Fabio dated 5 July 2023.

45. The Alfred Health Seizure Management Plan dated 23 July 2020 sets out several scenarios in which an ambulance should be contacted for Kieran, including if he was to hit his head, if staff held any concerns regarding his airway ("*blue lips/breathing difficulty*"), if he has a seizure that lasts longer than five minutes, or "*If Kieran takes a significant amount of time to recover from the seizure (e.g. is drowsy and less responsive*").

46. Kieran's epilepsy management plan dated 25 May 2022, prepared by his treating team at Alfred Health, also stipulated that an ambulance should be called if he was observed to have a seizure for longer than 5 minutes (a sign of which is noted to include unresponsiveness), or if he remained unconscious.

47. Notwithstanding Kieran's known seizure risk and hospitalisation from January 2022 for seizures, his carer did not consider the possibility on 10 September 2022 that he was suffering a prolonged seizure.

48. Nevertheless, I acknowledge the difficulty for DCS staff in distinguishing between a presentation due to acute intoxication as compared to a seizure, and that staff considered that Kieran's presentation was not dissimilar to previous occasions when he had been intoxicated.

49. While I am unable to conclude that an earlier emergency response would have materially altered the outcome, I am satisfied that there was an opportunity for staff to have escalated Kieran's care from the time he was found on the hallway floor.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Kieran Joseph McGuinness, born 8 January 1985;

    b) the death occurred on 11 September 2022 at 4/6 Inverleith Court, St Kilda, Victoria, from sudden unexpected death in epilepsy (SUDEP) in the setting of acquired brain injury with post traumatic epilepsy; and

    c) the death occurred in the circumstances described above.

RECOMMENDATIONS

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

(i) That Dynamic Care Services provide training to staff on epilepsy and seizure management, with a particular emphasis on the circumstances in which it is necessary to call an ambulance.

I convey my sincere condolences to Kieran'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:

Gerard McGuinness, Senior Next of Kin

Tracy Leeves, Senior Next of Kin

National Disability Insurance Scheme Quality and Safeguards Commission

Senior Constable Somar Sara, Coroner's Investigator

Signature:

Coroner David Ryan

Date : 16 January 2024

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.