IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 004845

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sarah Gebert
Deceased:	Aaron Matthew Forte
Date of birth:	21 October 1998
Date of death:	31 August 2023
Cause of death:	1a: Sudden unexpected death in epilepsy
Place of death:	9 Scaevola Road Craigieburn Victoria
Keywords:	*In-care; SUDEP; Natural Causes*

INTRODUCTION

1. On 31 August 2023, Aaron Matthew Forte was 24 years old when he was unexpectedly discovered deceased at home.

2. At the time of his death, Aaron lived in Craigieburn in specialist disability accommodation (**SDA**) operated by Melbourne Disability Services (**MDS**).

THE CORONIAL INVESTIGATION

3. Aaron's death was reportable by virtue of section 4(2)(c) of the *Coroners Act 2008* (Vic) (**the Act**) because, immediately before his death, he was an SDA resident residing in an SDA enrolled dwelling.[1] 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.

4. 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.

5. 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.

6. Victoria Police assigned Senior Constable Grace Fryer to be the Coronial Investigator for the investigation of Aaron's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of Aaron Matthew Forte 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

[1] Reg. 7 *Coroners Regulations 2019* (Vic); see also s. 3(1) *Coroners Act 2008* (Vic)

narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

BACKGROUND

8. Aaron was the third child to parents Dennis and Tracey Forte. He had two older siblings, Justin and Rebecca. At birth, Aaron was diagnosed with Jacob's XXY Syndrome, a rare genetic syndrome where a male has an extra Y chromosome. Subsequently, Aaron was expected to experience enhanced physical development and learning difficulties throughout his life.

9. He was first raised in the Chiltern area where Aaron and his siblings would play for hours in the neighbouring state forest. Around the time Aaron started primary school the family moved to Wodonga. Shortly after moving to Wodonga, Aaron experienced his first seizure and was later diagnosed with epilepsy.

10. He was well-liked amongst his peers however as he progressed further into high school the gap between he and his peers grew more prominent and his friendship circle reduced. Aaron completed year 11 at school which made his family extremely proud.

11. Aaron was passionate about Australian Rules Football and played for local clubs in Wodonga. After he moved to Melbourne, he continued to play football in Whittlesea. Aaron also enjoyed fishing, particularly with his father.

12. Aaron attended General Practitioner (**GP**) Dr Ali Mohtaji of the Northland Medical Centre in Preston since January 2021. His medical history included epilepsy characterised by tonic clonic and myoclonus seizures, Jacob's XXY Syndrome, intellectual disability, schizophrenia, depression, and illicit drug use. His epilepsy was managed by neurologist Dr John Archer. Dr Mohtaji reported that Aaron intermittently had seizures that would result in hospitalisation.

13. Since 2020, Aaron attended the Northern Hospital Emergency Department (**ED**) on four occasions following seizures. His final presentation was on 28 June 2023 following a seven-minute-long tonic clonic seizure. At the time his epilepsy medications were lamotrigine 200 mg twice daily, zonisamide 200 mg in the morning and 300mg at night, and clobazam 5mg twice daily.

[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.

14. He was discharged the following day with a plan to increase the dose of clobazam to 10mg twice daily and for follow-up in the Northern Health epilepsy clinic. He underwent an electroencephalogram scan on 2 August 2023 although was not seen in the Northern Health epilepsy clinic prior to his death.[3]

15. In March 2023, Aaron moved to the MDS from another care facility. He received 24-hour care with one-on-one support, occupational therapy, behavioural support and support coordination. During his stay at MDS Aaron maintained regular contact with family. His father, Dennis said that Aaron's time spent at MDS was a "*very positive time*" for him and that Aaron was truly happy at MDS.

16. At the time of his death, Aaron was subject to a Community Corrections Order (**CCO**) which commenced on 24 July 2023 and was due to expire on 23 January 2025. He was managed by Coolaroo Community Correctional Services and as part of his CCO had completed alcohol and other drug counselling. The evidence suggests he was abstinent from drugs at the time of his death.

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

Circumstances in which the death occurred

17. On 31 August 2023, MDS staff conducted a shift change at 6.00am. At this time Aaron was observed in his bed and was heard snoring by staff members.

18. He was next observed at 7.00am when his disability care worker (**DCW**) entered his room. By this time Aaron was lying on his side on the floor and was still audibly snoring. The DCW could also see that his stomach was moving as he breathed. She noticed Aaron's bed was wet and believed Aaron had positioned himself on the floor to avoid sleeping on the wet mattress. It was not unusual for Aaron to urinate in bed.

19. The DCW stated that she believed Aaron was wearing his seizure monitor at this time however clarified he would wear it under his clothes therefore *"couldn't really see if he was wearing it or not*".[4]

20. At around 8.00am, the DCW returned to Aaron's room and discovered him lying face down on the floor, unresponsive and cold to the touch. She rolled him onto his back, commenced

[3] Statement of Associate Professor Douglas Crompton dated 15 October 2024.
[4] Statement of the DSW dated 3 July 2024.

cardiopulmonary resuscitation (**CPR**) and alerted their colleagues to contacted emergency services.

21. Ambulance Victoria paramedics and Fire Rescue Victoria (**FRV**) members arrived minutes later and continued resuscitation. Despite all efforts, Aaron was unable to be revived and at 9.20am was verified deceased at the scene.

Identity of the deceased

22. On 31 August 2023, Aaron Matthew Forte, born 21 October 1998, was visually identified by his carer, Damien Owen, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

24. Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 4 September 2023 and provided a written report of her findings dated 8 January 2024.

25. The autopsy showed a left frontal tongue bruise which may be the result of recent seizure activity. There was otherwise no evidence of any injuries which could have caused or contributed to death.

26. Neuropathological examination of the brain identified no overt epileptogenic focus. Dr Fronczek advised this is not an unusual finding in death from a seizure disorder.

27. Toxicological analysis of post-mortem samples detected clobazam, risperidone and its metabolite, fluoxetine and its metabolite, zonisamide, and lamotrigine. No alcohol or any non-prescription substances were detected. Dr Fronczek stated that the detected substances were at non-toxic concentrations and did not consider them contributory to death.

28. Dr Fronczek provided an opinion that the medical cause of death was "*1(a) sudden unexpected death in epilepsy*" and considered the death was due to *natural causes*.

29. Regarding the formulation of the cause of death, Dr Fronczek stated:

*The cause of death is sudden unexpected death in epilepsy (**SUDEP**). It is well recognised that epilepsy predisposes an individual to a higher risk of sudden death, and it is thought that this is mediated through neuro-cardiac and/or neurorespiratory pathways.*

This death would fall under the category of "Definite SUDEP" because the criteria for SUDEP are satisfied, and there is no competing cause of death.

30. I accept Dr Fronczek's opinion.

CPU REVIEW

31. As part of my investigation, I obtained advice from the Coroners Prevention Unit (**CPU**) about the clinical management and care provided to Aaron and whether there were any opportunities to prevent his death.

32. The CPU is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing, and research experience to evaluate the clinical management and care provided to the deceased by reviewing the medical records, and any particular concerns which have been raised.

33. As part of their review, the CPU were assisted by the coronial brief, a statement from Associate Professor Douglas Crompton, Head of Neurology at Northern Health, Aaron's resident file from MDS, and the medical records from Northern Health and the Northland Medical Clinic.

34. The CPU advised that SUDEP is the sudden, unexpected death of someone with epilepsy who is otherwise healthy. It is unclear what the underlying mechanism is, but thought to be from problems with breathing, heart rhythm or brain function. SUDEP most often occurs at night/during sleep. There may or may not be signs that a person has had a seizure prior to death. Tonic-clonic seizures increase the risk of SUDEP. The best prevention method is to improve seizure control.

35. Aaron wore a seizure monitor and the DCW believed he was wearing it on the morning of his death. Regarding the efficacy of such monitors, the CPU advised that although they are useful at alerting people that someone is having a tonic-clonic event, there is no evidence to support that seizure monitors can guarantee safety.

36. The CPU identified that there was an improvement in Aaron's overall seizure control after his admissions to the Northern Hospital and changes to his medications in May and June 2023. The CPU noted that Aaron was not seen in the Northern Hospital Outpatient Neurology Clinic.

37. The CPU provided an opinion that the care provided by MDS in Craigieburn was appropriate. The staff had a comprehensive care plan including what steps to take if Aaron had a prolonged seizure, provided appropriate supervision (including hourly checks overnight) and conducted meetings regarding his care. Moreover, the fact that staff administered his anti-epileptic drugs ensured good adherence and therefore good seizure control.

38. The CPU did not consider there were any prevention opportunities in Aaron's case.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Aaron Matthew Forte, born 21 October 1998;

    b) the death occurred on 31 August 2023 at 9 Scaevola Road Craigieburn Victoria, from "*1(a) sudden unexpected death in epilepsy*"; and

    c) the death occurred in the circumstances described above.

40. Without the benefit of hindsight, the decision by the DCW to leave Aaron resting on floor when last observed alive at 7.00am on 31 August 2023 was a reasonable decision in the circumstances and there is no information to suggest that the outcome would have altered if a different course had been undertaken.

41. Further, I am satisfied that the care Aaron received proximate to his death was appropriate and that his death was not preventable.

42. Aaron'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 by virtue of his residency with MDS in Craigieburn. Section 52 of the Act requires an inquest to be held, except in circumstances where the death was due to natural causes. I am satisfied that Aaron died from natural causes and that no further investigation is required.

I convey my sincere condolences to Aaron'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:

Dennis Forte, senior next of kin

Tracey Forte, senior next of kin

Northern Health

Melbourne Disability Services

NDIS Quality and Safeguards Commission

Senior Constable Grace Fryer, Victoria Police, Coronial Investigator

Signature:

Coroner Sarah Gebert

Date: 14 March 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.