IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 006352

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Dimitra Dubrow
Deceased:	Dean Andrew Broughton
Date of birth:	6 September 1994
Date of death:	16 November 2023
Cause of death:	1(a) Sudden Unexpected Death in Epilepsy (SUDEP)
Place of death:	6 Clifton Circuit Tarneit Victoria 3029
Keywords:	Death in care, natural causes, epilepsy, SUDEP, Specialist Disability Accommodation

INTRODUCTION

1. Dean Andrew Broughton was 29 years old when he was found deceased at home by a care worker. At the time of his death, Dean lived in an assisted living facility run by Gellibrand Support Services to support his independence.

THE CORONIAL INVESTIGATION

2. Dean'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. Dean was a person in care for the purposes of the Act and *Coroners Regulations 2019* because of his living arrangements.

3. 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.

4. 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.

5. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Dean's death. The Coroner's Investigator conducted inquiries on behalf of Coroner Lorenz (as she then was), who had carriage of this investigation at the time, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of Dean Andrew Broughton 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.[1]

BACKGROUND

7. Dean was diagnosed with hyperekplexia at birth and subsequently diagnosed with global developmental, autism, and speech impairment. Dean required specialised care in the context of these diagnoses and was also prescribed anti-epileptic medications. At around aged 10, Dean's seizure activity stabilised, and he no longer required anti-epileptic medications.

8. In 2012, Dean required hospitalisation following possible unwitnessed seizure activity. Dean had further confirmed seizure in the emergency department was recommenced on anti-epileptic medication.

9. At a review soon after discharge, Dean's neurologist was satisfied that the seizure activity was in the context of head trauma and increased startle reflexes. As such, he did not require ongoing medication, and the anti-epileptic medication was ceased. The neurologist provided an opinion in a letter to Dean's GP that if Dean had unprovoked seizures in the future, then it would be appropriate to recommence medication.

10. In 2021, Dean moved into the assisted living facility and his health remained stable. His younger brother, who also had intellectual disability, lived at the same facility. Dean was nonverbal but was able to communicate through other means including through his iPad. He would videocall his family every day and generally carried a joyful demeanour.

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

Circumstances in which the death occurred

11. In March 2023, Dean had an episode of loss of consciousness while eating dinner at home in the assisting living facility. On-site care staff performed CPR and Dean was admitted to hospital. It was not clear if Dean had a chocking episode or if he had a seizure.

12. Dean was reviewed by his neurologist, who noted that Dean had been seizure free for at least twelve years with no medication and agreed that it was unclear if Dean had a seizure or a

[1] 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.

choking episode. In discussion with Dean's mother, the plan was agreed that medication was not required for the time being unless new definite seizures occur. If a similar episode were to occur, the neurologist recommended ambulance be contacted as had occurred after the previous incident.

13. Dean had two further episodes of possible seizure activity on 18 August and 14 October 2023. Dean presented to hospital following the episode on 18 August 2023 and ambulance arranged an emergency department telehealth consultation following the episode on 14 October 2023. Dean was referred by his GP to his neurologist following both episodes and for an expedited appointment for review following the 14 October 2023 episode which was scheduled to take place in early January 2024..

14. However, on 16 November 2023, a care worker went to check on Dean and found him laying down on his bed, face first wearing the same clothes as the day prior and appeared to be deceased. The worker called Triple Zero and paramedics from Ambulance Victoria arrived soon after.

15. Unfortunately, Dean was deceased and could not be revived.

Identity of the deceased

16. On 16 November 2023, Dean Andrew Broughton, born 6 September 1994, was visually identified by his father, who completed a statement of identification.

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

Medical cause of death

18. Forensic Pathologist Dr Michael Duffy from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 20 November 2023 and provided a written report of the findings.

19. The autopsy showed mild coronary artery disease.

20. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any other commons drugs or poisons.

21. Based on the medical records available to VIFM at the time, Dr Duffy explained that Sudden Unexpected Death in Epilepsy (**SUDEP**) was not an appropriate cause of death as there was

no definite diagnosis of epilepsy, only hyperekplexia and possible seizures in the months prior to death.

22. The precise mechanism of death in SUDEP is unclear but thought to be related to physiological changes associated with epilepsy and is a very rare complication of epilepsy.

23. As such, Dr Duffy initially provided an opinion that the medical cause of death was *1(a) undetermined*.

24. Upon later review of the subsequently obtained medical records, and in discussion with Dean's parents, Dr Duffy was satisfied that Dean was diagnosed with epilepsy and issued an amended report dated 24 July 2024.

25. Dr Duffy provided a revised opinion that the medical cause of death was *1(a) Sudden Unexpected Death in Epilepsy (SUDEP)* and that the death was from natural causes.

COMMENTS

Pursuant to section 67(3) of the Act I make the following comments:

1. Unfortunately, Dean passed away before he could have further review with his neurologist and further investigations. However, I am not prepared to find that Dean's death was preventable if he had been reviewed earlier.

2. Firstly, anti-epileptic medications, and all medications, carry their own risks and may not have been prescribed, particularly in the context of Dean's specific and rather atypical epilepsy.

3. Secondly, there is still so much unknown about SUDEP and while medications can reduce the risk of SUDEP it does not eliminate the risk entirely.

4. Nonetheless, I consider it to be in the public interest to highlight this apparent delay in accessing specialist neurological care. This is not a criticism of any of the care and treatment Dean received, but instead an observation about the healthcare system generally.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Dean Andrew Broughton, born 6 September 1994;

b) the death occurred on 16 November 2023 at 6 Clifton Circuit Tarneit Victoria 3029, from *Sudden Unexpected Death in Epilepsy (SUDEP)*; and

c) the death occurred in the circumstances described above.

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

Pursuant to section 73(1B) of the Act, this finding is to be published on the Court's website in accordance with the rules.

Pursuant to section 49(2) of the Act, I direct the Registrar of Births, Deaths and Marriages to amend the cause of death to the following: "1(a) Sudden Unexpected Death in Epilepsy (SUDEP)"

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

Russell & Joanne Broughton, Senior Next of Kin

Signature:

Coroner Dimitra Dubrow

Date : 18 November 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.