IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 005124

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	Quang Vinh Truong
Date of birth:	22 May 1984
Date of death:	30 August 2024
Cause of death:	1a : Unascertained
Place of death:	31 Milroy Street Brighton East Victoria 3187
Keywords:	In care, SDA resident, Lennox-Gastaut Syndrome, natural causes death

INTRODUCTION

1. On 30 August 2024, Quang Vinh Truong **(Mr Truong)** was 40 years old when he died at his supported living residence in Brighton. He is survived by his mother, Mai Pham.

2. Mr Truong's medical history included Lennox-Gastaut Syndrome (a complex, rare and severe form of epilepsy), partial trisomy 15 and intellectual disability. At the age of 13, Mr Truong moved into Specialist Disability Accommodation **(SDA)** at 31 Milroy Street, Brighton as he required full time care. He received supported independent living services from St John of God Accord and remained at this residence until his death.

THE CORONIAL INVESTIGATION

3. Mr Truong's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**).[1] 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. In this instance, Mr Truong was a *"person placed in custody or care"* pursuant to the definition in section 4 of the Act, as he was "*a prescribed person or a person belonging to a prescribed class of person"* due to his status as an *"SDA resident residing in an SDA enrolled dwelling."*[2]

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. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Mr Truong's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of Quang Vinh Truong 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] Section 4(1), 4(2)(c) of the Act.
[2] Pursuant to Reg 7(1)(d) of the Coroners Regulations 2019, a *"prescribed person or a prescribed class of person"* includes a person in Victoria who is an *"SDA resident residing in an SDA enrolled dwelling"*, as defined in Reg 5.

narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[3]

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

Circumstances in which the death occurred

7. On 29 August 2024, Mr Truong participated in several appointments and routine activities throughout the day. He had dinner as usual and watched television with his co-residents before retiring to bed at 8pm. At 10pm, he was checked on by a staff member and was noted to be asleep.

8. At 6.50am on 30 August 2024, a care worker entered Mr Truong's room to get him ready for the day. He was located lying in a position which was consistent with signs of having had a seizure.

9. Staff commenced first aid and contacted emergency services. Sadly, Mr Truong could not be assisted and he was declared deceased.

Identity of the deceased

10. On 5 September 2024, Quang Vinh Truong, born 22 May 1984, was identified at the Victorian Institute of Forensic Medicine **(VIFM)** via a Statement of Identification and circumstantial evidence.

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

Medical cause of death

12. Forensic Pathologist Dr Hans de Boer from the VIFM conducted an external examination on 2 September 2024 and provided a written report of his findings dated 2 October 2024.

13. The post-mortem examination and CT scan were consistent with the reported circumstances.

14. Toxicological analysis of post-mortem blood demonstrated the anti-convulsant medications clobazam, levetiracetam, valproic acid, perampanel, and lamotrigine. Cannabidiol was also

[3] 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.

detected. Dr de Boer noted that the concentrations of these substances were all within normal range, and they are therefore unlikely to be of direct relevance for the cause of death.

15. Vitreous humour biochemistry was within normal post-mortem limits. In absence of an autopsy examination, issues of medicolegal significance or family health significance might remain unresolved.

16. Dr de Boer noted that 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 neuro-respiratory pathways. Sudden and Unexpected Death in Epilepsy (SUDEP) can be considered as a sole cause of death in certain circumstances that include the absence of a competing cause of death and does not require evidence of a seizure immediately before death. Various classifications have been proposed for sudden death in persons with epilepsy. The criteria for Definite SUDEP (sudden death in epilepsy) require a *"sudden, unexpected, witnessed or unwitnessed, non-traumatic and non-drowning death, occurring in benign circumstances, in an individual with epilepsy, with or without evidence for a seizure and excluding documented status epilepticus (seizure duration ≥ 30 min or seizures without recovery in between), in which postmortem examination does not reveal a cause of death".* Under the unified classification proposed by Nashef et al. (2012, Epilepsia 53(2):227-233), this death would fall under the category of "Probable SUDEP" because the death fits the criteria for SUDEP, with the exception of an autopsy.

17. Dr de Boer provided an opinion that the medical cause of death was 1(a) Unascertained. However, he further noted that in the absence of evidence of an unnatural cause or contribution to death, the death was due to natural causes.

18. I accept Dr de Boer's opinion.

FINDINGS AND CONCLUSION

19. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Quang Vinh Truong, born 22 May 1984;

    b) his death occurred on 30 August 2024 at 31 Milroy Street Brighton East Victoria 3187, from an unascertained cause; and

    c) his death occurred in the circumstances described above.

20. I note that section 52 of the Act requires that an inquest be held, except in circumstances where the death was due to natural causes. Having considered the evidence and the medical report from Dr de Boer, I am satisfied that Mr Truong died from natural causes, and I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death

I convey my sincere condolences to Mr Truong's family, carers and loved ones 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:

Mai Pham, Senior Next of Kin

Leading Senior Constable Greg Downing, Coronial Investigator

Signature:

Coroner Kate Despot

Date: 14 May 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.