



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION



Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Duncan Fairley, Coroner, having investigated the death of Samuel Anthony Plummer

Find, pursuant to section 28(1) of the Coroners Act 1995, that:

- a) The identity of the deceased is Samuel Anthony Plummer;
- b) Mr Plummer died in the circumstances set out below;
- c) Mr Plummer died as a result of sudden unexpected death in a person with epilepsy (SUDEP);
- d) Mr Plummer died on 5 August 2016 at 2 Torquay Street, Latrobe in Tasmania;
- e) Mr Plummer was born in Hobart on 29 August 1981 and was aged 34 years; and
- f) Mr Plummer was a single man and was in receipt of a disability support benefit as at the date of his death.

Background:

Samuel Anthony Plummer was born in Hobart, Tasmania on 29 August 1981, the eldest child of Anthony and Kristina Plummer. Mr Plummer was born with hydrocephalus, a congenital defect which involves the accumulation of excess cerebrospinal fluid in the brain. He was eventually diagnosed as suffering from autism, epilepsy and an intellectual disability. As a result of his conditions Mr Plummer required significant levels of care throughout his life. In about 2001 Mr Plummer commenced residing in an assisted living home situated at 2 Torquay Street, Latrobe.

A review of the available medical records, together with information provided by Mr Plummer's mother, indicates that he suffered from a number of chronic medical conditions and was under the ongoing care of a General Practitioner, Consultant Psychiatrist and Neurologist. At the time of his death Mr Plummer was prescribed a range of medications including sodium valproate and lamotrigine to assist in the control

of his epileptic symptoms. Kristina Plummer advised coronial investigators that while her son suffered regular seizures from a young age his last major incident occurred during July 2015. It is of note, however, that Mr Plummer's seizure activity varied and it was not uncommon for a number of months to pass between events. During a major seizure event Mrs Plummer confirmed that her son would collapse suddenly, often without warning.

Circumstances Surrounding the Death:

During the evening of Friday 5 August 2016 Mr Plummer was at the Torquay Street residence with his carer. After dinner Mr Plummer retired to his bedroom as was his habit. When a carer followed approximately 45 minutes later Mr Plummer was found unconscious. He was positioned on the floor with his head propped against a wall. There was evidence that he had struck his head against the wall.

Mr Plummer's carer observed that he was not breathing and immediately called for an ambulance. Cardio pulmonary resuscitation was commenced. Ambulance personnel arrived at the address at 7:10pm. Mr Plummer was ventilated and cardiac compressions continued. Adrenaline was administered. Unfortunately, despite all efforts Mr Plummer remained unresponsive and resuscitation attempts were discontinued at 7:35pm. Mr Plummer was declared deceased by attending paramedics.

The circumstances of Mr Plummer's death meant that an investigation pursuant to the *Coroners Act* 1995 was required. Initially, concerns were raised in relation to a possible fault in the electricity supply to parts of the residence, including Mr Plummer's bedroom. During September 2016 Mr Anthony Millhouse (Electricity Standards and Safety) undertook an investigation into the possibility that an electrical fault had caused or contributed to Mr Plummer's death. As part of the investigation Mr Millhouse identified a Heller brand portable electric oil filled column heater in Mr Plummer's bedroom which demonstrated 20mA of current leakage in the earth conductor when tested on the high setting. Statements obtained from care staff revealed that the heater had been set to high by a support worker before Mr Plummer returned to his room on the evening in question. Mr Millhouse confirmed that the current leakage from the heater when on the high setting was sufficient to trip the residual current circuit breaker of the main

electrical switchboard thereby interrupting electricity supply to relevant parts of the residence.

As part of the enquiry an autopsy was performed by Dr Donald Ritchey (Forensic Pathologist) on 8 August 2016. Dr Ritchey was unable to find any sign of significant external trauma nor any overt cause of death. Specifically, Dr Ritchey excluded the presence of thermal/electric burns suggestive of electrocution. During his examination, Dr Ritchey observed small lacerations of the right side of the tongue together with marked contusions of the tongue tip suggestive of peri-mortem tongue biting. Further investigations included toxicological examination which revealed the presence of Mr Plummer's prescribed medications. In his report Dr Ritchey concluded:

“SUDEP is defined as the sudden unexpected non-traumatic non-drowning death of an individual with epilepsy that may be witnessed or unwitnessed in which the post-mortem examination does not reveal an anatomical or toxicological cause for the death. The finding of significant peri-mortem tongue biting strongly suggests a seizure.”

Dr Ritchey expressed the opinion that Mr Plummer died as a result of sudden unexpected death in a person with epilepsy (SUDEP). I accept Dr Ritchey's opinion.

Comments and Recommendations:

In the circumstances there is no need for me to make any further comment or recommendations.

In concluding, I convey my sincere condolences to the family of Mr Plummer.

Dated: 29 November 2017 Launceston Coroner's Court in the State of Tasmania.

Duncan Fairley
Coroner