MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Rod Chandler, Coroner, having investigated the death of Shanelle Jean Webb

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Shanelle Jean Webb;
b) Ms Webb was born in Hobart on 25 September 1994 and was aged 22 years;
c) Ms Webb died on either 22 or 23 August 2017 at Seven Mile Beach; and
d) The cause of Ms Webb's death was Sudden Unexpected Death in Epilepsy (SUDEP).

Background

From an early age Ms Webb suffered from multiple health issues. She had a cognitive disability which delayed her development so that her mental age was estimated to be around 10 years. She was a long term sufferer of epilepsy and had also been diagnosed with schizophrenia. Ms Webb's principal carer was her mother, Merchelle Webb, who resided at Campbell Town.

Ms Webb's disabilities entitled her to assistance from the National Disability Insurance Scheme (NDIS) and this included funding for two nights per week respite care. This care was provided by Oak Possability, a provider of support for persons receiving funding from NDIS. It had a facility at Seven Mile Beach (SMB) which had the capacity to provide overnight accommodation for five clients. Since May 2015, Ms Webb had utilised this facility most weeks for the two nights of respite.

Circumstances Surrounding the Death

In early August 2017 Ms Webb acquired an ear infection. Her mother reports that when ill her daughter could sometimes *"have very bad moods, refuse to eat and become difficult to manage."* She therefore chose to care for her at home and not allow her to go to SMB. However, after around three weeks, Ms Webb had largely recovered and her mother agreed that she could resume her respite stays at SMB beginning on Monday 21 August. Ms Webb spent that morning at a day-support facility at Moonah which was her usual practice. After lunch she was collected by Ms Emily Triffit, a disability support worker with Oak Possability, and driven to SMB where she spent the night. The next morning Ms Triffit took Ms Webb back to the day-support facility where she stayed until

around 2.50pm when Ms Triffit again collected her and drove her back to SMB. Later that afternoon Ms Webb asked if she could be taken for a drive. Ms Triffit agreed and they travelled together to the Hobart airport where they watched several planes land and take-off. They then returned to SMB arriving shortly before 5.00pm. At this time Ms Webb appeared well although she made complaint of a stomach ache and a headache. Ms Triffit gave Ms Webb her medications and then started to prepare her evening meal. Ms Webb began watching a movie on the television. Shortly after she telephoned her mother which was her daily practice. Of the phone call Mrs Webb reports: *"She told me about her day programme. To me she sounded happy. She didn't sound sick or complain about her health as she sometimes did."*

After she had eaten her meal, Ms Webb had a shower. She then asked Ms Triffit to put on a movie in her bedroom. It was about 7.00pm when Ms Triffit reports: *"I put the movie on and Shanelle got into bed and said goodnight and asked me to close her door, which she always does. This was the last time I spoke with her."*

The next morning Ms Webb had not appeared by 7.15am which was unusual. Ms Triffit went to her room and found her lying on her stomach on her bed. She was unable to wake her and called for an ambulance after first calling her manager. It was apparent to the ambulance paramedics that Ms Webb was deceased.

Post-Mortem Examination

This was carried out by State Forensic Pathologist, Dr Christopher Lawrence. His report includes these comments:

> *"There is biting of the tongue which would be consistent with a seizure….."*
>
> *"Toxicology reveals a high olanzapine and lamotrigine level which are in the toxic range but these are probably artificially elevated by post-mortem decomposition."*

In Dr Lawrence's opinion the cause of Ms Webb's death was Sudden Unexpected Death in Epilepsy (SUDEP).

Investigation

This has been informed by:

1. A Police Report of Death for the Coroner.
2. An affidavit from Mrs Merchelle Webb.
3. An affidavit from Ms Emily Triffit.
4. Consideration of Ms Webb's records at Oatlands Surgery.
5. Consideration of Ms Webb's records at Oak Possability.
6. A report from the Chief Executive Officer of Oak Possability.

I am satisfied from the investigation of the following:

- That Ms Triffit was the only carer working at SMB on the night of Ms Webb's death. She was working a sleepover shift meaning that she was permitted to sleep on the premises. However, she was available to be woken if a client required assistance.

- Oak Possability's model of care provided for sleepover shifts only at night. Because it did not provide 'awake or active overnight shifts' it did not accept any client who required overnight monitoring.

- That Ms Webb's medical condition and her care and supervision needs had been discussed with her family by Oak Possability and an Individual Support Profile and Plan was prepared and signed by the parties in July 2015. It shows epilepsy as a known illness. Under the heading 'Routines' it shows that Ms Webb *"Usually goes to bed between 6 and 8pm."* and *"sleeps well."* The document does not cite detail of any required overnight supervision. There is a question 'Health and Safety Action Plan Required?' which is answered 'No.'

- That there was an incident on one occasion where Oak Possability suspected that Ms Webb may have had an overnight seizure when she woke a staff member on the sleepover shift to report that she had bitten her tongue. Oak Possability says that there was a phone conversation with Mrs Webb that morning when she confirmed that night seizures did *"sometimes happen."*

- That staff did not make any check of Ms Webb during the night of 22/23 August.

- That there is not any evidence to suggest that Ms Webb was over-medicated during her 2 day stay at SMB. It leads me to conclude that the elevated levels of olanzapine and lamotrigine found in her blood were not reflective of the true levels and were attributable to post-mortem decomposition as opined by Dr Lawrence.

Findings, Comments and Recommendations

The evidence strongly indicates that Ms Webb did experience a night-time epileptic seizure during her stay at SMB and I therefore accept Dr Lawrence's opinion upon the cause of her death. However, the evidence does not permit me to make a precise finding upon the time and date of death. It only enables me to find that Ms Webb died at an unknown time after 7.00pm on 22 August 2017 and before 7.15am the following day.

An issue raised by Ms Webb's unfortunate death is whether the non-provision of night-time monitoring by Oak Possability was appropriate in the light of Ms Webb's history of epilepsy. In hindsight it does seem to me that it would have been prudent for Oak Possability, at least after it became aware that Ms Webb did suffer night-time seizures, for it to review her night-time monitoring requirements, and determine, in collaboration with the family whether any change was necessary.

The circumstances of Ms Webb's death are not such as to require me to make any further comments or make recommendations pursuant to Section 28 of the *Coroners Act 1995*.

I convey my sincere condolences to Ms Webb's family and loved ones.

Dated: 5 December 2018 at Hobart in the State of Tasmania.

Rod Chandler
Coroner