CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into death of Sebastian Nicholas Pelle**
Citation:	**[2019] ACTCD 10**
Decision Date:	22 August 2019
Before:	**Coroner Boss**
Decision:	See [2], [17]
Catchwords:	**CORONIAL LAW** – cause and manner of death – epileptic patient complaining of headaches – discharge from hospital without brain scan – inappropriate medical treatment
Legislation Cited:	*Coroners Act 1997* (ACT)
File Number:	CD 181 of 2016

CORONER BOSS:

1. The death of Sebastian Nicholas Pelle, a 20 year old man at the date of his death, was reported to the ACT Coroner on 26 July 2016, in accordance with section 13(1)(e) of the *Coroners Act 1997*, as no doctor provided a death certificate as to the cause of Mr Pelle's death.

2. Having considered the police report, post-mortem examination report and an expert review of Mr Pelle's hospital treatment prior to his death, I now make the following formal findings:

   (a) Sebastian Nicholas Pelle died on 26 July 2016 at 37 Elliot Place, Campbell in the Australian Capital Territory;

   (b) The manner and cause of death of Mr Pelle are sufficiently disclosed and therefore a hearing is unnecessary;

   (c) The manner and cause of Mr Pelle's death is sudden unexplained death in epilepsy (SUDEP). A right frontal lobe epidermal cyst is a significant condition contributing to Mr Pelle's death but not related to the disease or condition causing death; and

   (d) Pursuant to section 52(4)(a)(i) of the *Coroners Act 1997*, no matter of public safety is found to arise in connection with this inquest.

Facts

3. Mr Pelle lived with his parents in Canberra. He was a generally fit and well young man.

4. On 3 April 2015 Mr Pelle saw a dentist. A gum swelling on his right side, indicative of infective process, was identified although no dental abscess was observed.

5. In August 2015 Mr Pelle started to complain of headaches. On 8 November 2015 Mr Pelle had a seizure and became unconscious. He was taken to The Canberra Hospital (TCH) by ambulance, where he underwent emergency surgery to remove a lesion on his frontal lobe 50x20x19 mm in size. An examination of the cyst found that it was benign, but Mr Pelle was recommended to have regular screening tests to check on possible regrowth of the cyst and prescribed a short course of anticonvulsant medication. The first few screening tests returned negative results.

6. On New Years Day in 2016 Mr Pelle suffered another seizure while in Sydney and he was admitted to St Vincent's Hospital. Mr Pelle was released with instructions to continue taking his anticonvulsant medication. A subsequent MRI on 7 April 2016 showed no further growth of the lesion.

7. On 24 July 2016 Mr Pelle complained to family of a 'bad headache' but said he did not wish to go to hospital.

8. On the morning of 25 July 2016 Mr Pelle commenced work at IGA O'Connor. After being at work for about an hour he complained that the pain in his head was unbearable. He called his mother and agreed to go to TCH. While at TCH Mr Pelle had some blood tests, and intravenous analgesia was given, but no scans of Mr Pelle's head were done. Mr Pelle was discharged home the same day with advice that if the headaches persisted to return to hospital, and he was given a prescription for Panadeine Forte. He went immediately to bed. At about 10pm Mr Pelle was seen by his father watching a movie in bed and complained to his father of a headache.

9. Mr Pelle was discovered deceased partially lying off the bed by his mother at 7am the following morning, 26 July 2016.

10. A post-mortem examination of Mr Pelle was directed. Associate Professor Jain opined that Mr Pelle died from epilepsy, with a right frontal lobe epidermal cyst as a significant condition contributing to Mr Pelle's death but not related to the disease or condition causing death. Mr Pelle had bitten his tongue and there were petechial haemorrhages on the visceral pleura and pericardium, strongly suggestive of death occurring in the context of a seizure. The only substances found in Mr Pelle's system were Codeine, Doxylamine and Chlorpromazine, none of which contributed to his death.

11. In all the circumstances I consider that the cause of Mr Pelle's death is best given as sudden unexplained death in epilepsy (SUDEP).

Matters of Public Safety

12. I am also required by section 52(4)(a) of the *Coroners Act 1997* to state whether a matter of public safety is found to arise in connection with the inquest, and if I find such a matter, to comment upon it.

13. Coroner Campbell directed that an expert review of the treatment of Mr Pelle at TCH on the day prior to his death occur. That review was undertaken by Dr Ross Mellick, a Consultant Neurologist. With the benefit of hindsight, Dr Mellick considered that the source of infection causing Mr Pelle's cystic lesion could have been the dental pathology identified on 3 April 2015.

14. Dr Mellick concluded that Mr Pelle should have had other investigations performed at TCH on 25 July 2016; further, the clinical features with Mr Pelle's patient history

would have and should have justified a hospital admission. He said that it was not possible at the time of the assessment to have determined that Mr Pelle would have died the following day; however, a scan may have identified other information and pointed towards admission, which might have avoided a fatal outcome the following day. Additionally, Dr Mellick stated that if Mr Pelle had been in hospital it is possible that an immediate response to the occurrence of a seizure may have enabled resuscitation which might have saved him. He stated that the failure to perform a non-contrast CT scan was outside the bounds of accepted medical practice, indeed it was wrong management.

15. However, in the circumstances I am not satisfied that the failures outlined by Dr Mellick amount to a matter of public safety. Certainly Mr Pelle did not receive appropriate treatment during his visit to TCH on 25 July 2016, but this does not necessarily demonstrate a systemic or fundamental flaw in the processes or practices of TCH. I do however consider that a referral to the Medical Board, via the Australian Health Practitioners Regulatory Agency in respect of Mr Pelle's treating doctors is appropriate.

Considerations

16. In all the circumstances, in my view there is no benefit in holding a public hearing in relation to Mr Pelle's death. I believe I have all the evidence which exists, or is likely to exist, and which could possibly bear on the decisions I must make.

17. I direct that a referral be made to the Australian Health Practitioners Regulatory Agency in respect of the doctors involved in treating Mr Pelle at TCH on 25 July 2016. I authorise the provision to AHPRA, and to TCH, of the autopsy report, the police report and Dr Mellick's report in relation to Mr Pelle. Mr Pelle's family are supportive of the courses of action I intend to take.

18. I direct that these findings be published in due course on the Coroner's Court website. I also direct that any response to my recommendations that I receive will also be published on the Court website.

19. I extend my condolences to Mr Pelle's family and friends.

CORONER BOSS