IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005011

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Aileen Mary McLeish
Date of birth:	19 April 1969
Date of death:	8 September 2023
Cause of death:	1a : PULMONARY THROMBOEMBOLISM COMPLICATING LEFT CALF DEEP VENOUS THROMBOSIS 2 : FRONTO-TEMPORAL DEMENTIA
Place of death:	37 Osmond Crescent Wollert Victoria 3750
Keywords:	Death in care; NDIS participant

INTRODUCTION

1. On 8 September 2023, Aileen Mary McLeish was 54 years old when she died after being found unresponsive by staff of the accommodation facility she resided in. At the time of her death, Aileen lived at 37 Osmond Crescent, Wollert, Victoria, 3750 (**Wollert House**)[1] which was an accommodation facility managed by Claro Aged Care and Disability Support.

2. Aileen was the youngest of five siblings and grew up in the West Heidelberg and Westmeadows areas of Victoria before meeting her first partner, Robert Drayton with whom she shared her first son, Daniel Thomson. Shortly after Daniel was born Aileen separated with Robert.[2] Aileen got married to her then husband, Adam McLeish in December 1996 and they had two children together, Declan McLeish and Ethan McLeish. Aileen and Adam remained together until 2006 before separating and Aileen moving out to Kilmore with her three sons.[3]

3. Aileen was employed with CSL Behring as a documentation assistant between the years 2000 to 2018 before she was made redundant after developing schizophrenia and unable to continue working. Aileen started developing hallucinations throughout the period of 2018-2019 and was treated by medical practitioners at Nexus Wallan.[4]

4. After a series of hospitalisations in 2019 and 2020, Aileen was transferred to a 24-hour care facility in Kyneton operated by Co-Ability.[5] Aileen continued to experience deteriorating health issues and developed motor function symptoms affecting gait, slow speech and memory issues. On 24 August 2019 and 7 March 2020, she was formally confirmed to be diagnosed with Parkinsons disease.[6]

5. In April 2022, Aileen was transferred to Wollert House managed by Claro Aged Care and Disability Support facility.[7] At the time of her transfer, Aileen was diagnosed with schizophrenia, early onset dementia and frontal temporal dementia with Parkinsons. The Parkinsons affecting Aileen was progressive with no cure.[8]

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[1] Wollert House was a Specialist Disability Accommoation facility as defined under the *Residential Tenancies Act 1997* (Vic)
[2] *Coronial Brief*, Statement of Tina Sorraghan.
[3] Ibid.
[4] Ibid.
[5] Ibid.
[6] *Coronial Brief*, Medical records provided by Nexus Primary Health (Wallan).
[7] *Coronial Brief*, Statement of Kristylee Simmonds (Claro Aged Care and Disability Services).
[8] Ibid.

6. Aileen was a recipient of National Disability Insurance Scheme (**NDIS**) support package which included covering the costs of supported independent living at Wollert House. Aileen did not have cognitive capacity to use compensatory strategies or call for assistance as her mobility and function deteriorates. Due to her inability to calculate risk, Aileen was an extremely high falls risk and had previously sustained falls that resulted in hospital admission.[9]

THE CORONIAL INVESTIGATION

7. Aileen'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.

8. In this instance, Aileen was a '*person placed in custody or care'* pursuant to the definition in section 4 of the Act, as she was '*a prescribed person or person belonging to a prescribed class of person*' due to her status as an '*SDA resident residing in an SDA enrolled dwelling.'*[10]

9. 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.

10. 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.

11. Victoria Police assigned Senior Constable Luke Ferguson to be the Coronial Investigator for the investigation of Aileen's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

[9] NDIS Commission report dated 3 June 2024.
[10] 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.

12. This finding draws on the totality of the coronial investigation into the death of Aileen Mary McLeish 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.[11]

13. In considering the issues associated with this finding, I have been mindful of Aileen's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

14. On 7 September 2023 at around 11.00 pm, Care worker 1 was rostered on night shift to supervise the residents at 37 Osmond Crescent, Wollert, which included Aileen. Aileen was reported to be sleeping in her bed and no issues were noted that evening.[12]

15. The following day on 8 September 2023 at 5.30 am, Care worker 1 found Aileen in her bedroom on the floor. Care worker 1 reported that he asked Aileen if she was ok and she responded "Yes." Care worker 1 then asked if she was in pain to which she responded "No." [13] Care worker 1 proceeded to cover her with a blanket and leave her on the floor as she was classed as a "two persons assist" client which required two people to move in the event of a fall.[14]

16. Care worker 1 reported that he checked on Aileen again two more subsequent times between 5.30 am and 5.40 am that morning. Care worker 1 noted that he stood at the front door of Aileen's bedroom and called to her each time he checked on her and that she responded "Yes" both times.[15]

17. At 6.00 am the same morning, Care worker 2 checked in for his day shift and was informed by Care worker 1 about Aileen's circumstances.[16] Care worker 2 checked on Aileen and found

[11] 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.
[12] *Coronial Brief*, Statement of Care worker 1 .
[13] Ibid.
[14] Ibid.
[15] Ibid.
[16] *Coronial Brief*, Statement of Care worker 1; Statement of Care worker 2.

her unresponsive in her bedroom lying face down on the floor next to her bed. Care worker 2 could not tell if Aileen was breathing and asked Care worker 1 to call 000 emergency services. Care worker 2 supported Care worker 1 perform compulsory pulmonary resuscitation (CPR) until Ambulance paramedics arrived at 7.00 am and Aileen was declared deceased.[17]

Identity of the deceased

18. On 8 September 2023, Aileen Mary McLeish, born 19 April 1969, was visually identified by their sister, Tina Sorraghan.

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

Medical cause of death

20. Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 13 September 2023 and provided a written report of his findings dated 22 February 2024.

21. The post-mortem examination revealed significant natural disease in the form of left calf deep venous thrombosis with thrombeombolus within the inferior vena cava, pulmonary arteries and lungs. There was also evidence of anterior mediastinal haemorrhage related to attempted resuscitation and significant coronary artery disease with evidence of previous myocardial infarction.

22. Dr Lynch provided an opinion on the risk factors of development of venous thrombosis including anything affecting alterations in blood flow, blood coagulability and vessel wall integrity. Prolonged immobility is considered an operative factor along with malignancy and recent surgery.

23. A further neurological examination was undertaken and this confirmed the diagnosis of frontotemporal dementia with no evidence of lewy body dementia and some chronic small vessel ischaemic change.

24. Toxicological analysis of post-mortem samples identified the presence of nordiazepam (~0.05 mg/L).

[17] Ibid.

25. Dr Lynch provided an opinion that the medical cause of death was 1(a) pulmonary thromboembolism complicating left calf deep venous thrombosis in the setting of 2 fronto-temporal dementia, I accept Dr Lynch's opinion.

NDIS COMMISSION INVESTIGATION

26. On 8 September 2023, the Aileen's death was reported to the NDIS Commission by Claro Disability Services Pty Limited operating as Claro Aged Care and Disability Services. The reportable incident was investigated by an internal Non-Compliance team within the NDIS Commission.

27. The Non-Compliance team undertook an investigation and provided a report to the Court indicating that:[18]

    a) Care worker 1 had failed to follow Aileen's care plan;

    b) Care worker 1 had failed to provide First Aid assistance to Aileen at the point of time expected by Claro Aged Care and Disability Services; and

    c) Care worker 1 failed to follow Claro Aged Care and Disability Services policies and procedures by failing to contact After Hours services for assistance and guidance, failing to provide accurate incident reporting and failing to comply with the Claro Aged Care and Disability Services Code of Conduct.

28. Claro Aged Care and Disability Services conducted an internal investigation into the conduct of the Care worker 1 and identified serious misconduct as indicated above.[19] Claro Aged Care and Disability Services has reportedly taken all necessary steps to safeguard other residents by responding to the incident and allegation and standing down Care worker 1 whilst investigating.[20] Following the conclusion of the investigation, the allegations of misconduct were substantiated and Care worker 1 was terminated from employment.[21]

29. Claro Aged Care and Disability Services in recognition of elevated participant needs at Wollert House, arranged for a Senior Accommodation Manager to take responsibility for the Wollert House in June 2023. Further Claro Aged Care and Disability Services has identified gaps in service delivery and changes and new systems that have been implemented to improve

[18] NDIS Commission report dated 19 November 2024.
[19] Ibid.
[20] Ibid.
[21] Ibid.

the delivering of supports to residents and in this instance, taken appropriate action to mitigate the risk of a reoccurrence of such an event taking place and therefore there are no safeguarding concerns remaining in relation to this matter or the provider.[22]

FINDINGS AND CONCLUSION

30. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the Briginshaw gloss or explications.[23] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

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

    a) the identity of the deceased was Aileen Mary McLeish, born 19 April 1969;

    b) the death occurred on 08 September 2023 at 37 Osmond Crescent, Wollert, Victoria, 3750, from 1(a) pulmonary thromboembolism complicating left calf deep venous thrombosis in the setting of 2 fronto-temporal dementia; and

    c) the death occurred in the circumstances described above.

32. Having considered all of the evidence, I am satisfied that Aileen's care was not reasonable in her final moments and the individual staff member involved has been appropriately identified and reprimanded in the circumstances. I am satisfied that Claro Aged Care and Disability Services has taken all the necessary steps to safeguard other residents at Wollert House since the fatal incident.

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

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[22] Ibid.

[23] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

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:

Declan McLeish, Senior Next of Kin

Daniel Thomson, Son

Richard Fox, Claro Aged Care and Disability Services

National Disability Insurance Scheme Quality and Safeguards Commission

Senior Constable Luke Ferguson, Coronial Investigator

Signature:

Coroner Simon McGregor

Date: 12 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.