



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 001347

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner Ingrid Giles
Deceased:	Michelle Anne Leiper
Date of birth:	10 October 1965
Date of death:	08 March 2025
Cause of death:	1a: ASPIRATION PNEUMOMIA AND UROSEPSIS COMPLICATING ALZHEIMER'S DEMENTIA IN SETTING OF DOWN SYNDROME (TRISOMY 21)
Place of death:	Angliss Hospital 39 Albert Street Upper Ferntree Gully Victoria 3156
Keywords:	In Care, specialist disability accommodation, SDA, disability, natural causes

INTRODUCTION

1. On 8 March 2025, Michelle Anne Leiper¹ was 59 years old when she died at Angliss Hospital. At the time of her death, Michelle had been living in Specialist Disability Accommodation (SDA) in Boronia, Victoria. She was receiving Supported Independent Living (SIL) services through Scope Disability Services (Scope).
2. Michelle was a talented swimmer. In 1996, she won a silver medal in a swimming event at the Atlanta Paralympics. She was also a talented dancer and had been part of a tap-dancing troupe, dancing in live performances and television programs.
3. Michelle's medical history included down syndrome, epilepsy, dysphagia, asthma, anxiety, recurrent Urinary Tract Infections, hypothyroidism and hyponatremia.
4. In 2014, Michelle began to experience cognitive decline and in January 2015, she was diagnosed with Alzheimer's disease. Prior to this diagnosis, Michelle had largely lived independently, including for a number of years, working at a business which specialised in employing people with intellectual disabilities. After the diagnosis, Michelle experienced functional decline and began requiring the use of the wheelchair for mobility. She moved into a residential aged care facility and in August 2017, into an SDA-enrolled dwelling, first in Lysterfield and then Boronia. Scope staff assisted Michelle with all daily tasks.
5. In the two years prior to her death, Michelle's health deteriorated and she became largely bedbound. Her admissions to hospital became more frequent due to recurrent aspiration pneumonia, respiratory issues, increased seizures and pulmonary embolism.
6. On 13 February 2024, Michelle was admitted to Box Hill Hospital with a principal diagnosis of aspiration pneumonia. During this admission, further to discussion with Michelle's family and GP, Michelle's goals of care were amended to focus on maximising comfort and alleviating symptoms, rather than life-prolonging therapy.
7. Michelle was discharged on 19 February 2024 and referred to Eastern Palliative Care Ltd (EPC) for community palliative care support. On 23 July 2024, Michelle was discharged by EPC following assessment that she had remained stable over some months. On 21 January 2025, Michelle attended an appointment with her GP for a medication review. In this appointment, her GP referred Michelle back to EPC for palliative care.

¹ Referred to throughout my finding as 'Michelle' unless more formality is required.

THE CORONIAL INVESTIGATION

8. Michelle's death fell within the definition of a reportable death in the *Coroners Act 2008* (the Act) as she was a 'person placed in custody or care' within the meaning of the Act, as a person in Victoria who was an 'SDA resident residing in an SDA enrolled dwelling' immediately prior to her death.
9. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort, and is reflected in the definition of a 'person placed in custody or care' in section 3(1) of the Act, read in conjunction with Regulation 7 of the *Coroners Regulations 2019*.
10. 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.
11. 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.
12. There is a requirement under section 52(2)(b) of the Act to hold an Inquest into the death of a person who was in custody or care immediately prior to passing, though pursuant to section 52(3A) of the Act, the coroner is not required to hold an Inquest if the coroner considers the death was due to natural causes. I exercise my discretion under this provision not to hold an Inquest in the present case on the basis that Michelle's passing was due to natural causes and there are no further issues I have identified that require the hearing of *viva voce* evidence.
13. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Michelle's death. The Coronial Investigator conducted inquiries on the Court's behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.
14. This finding draws on the totality of the coronial investigation into the death of Michelle Anne Leiper 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.²

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

Circumstances in which the death occurred

15. On 15 February 2025, Michelle was found unresponsive by Scope staff in her bed with a superficial graze on her forehead. Emergency services were contacted and Cardiopulmonary Resuscitation (**CPR**) was performed until paramedics attended. Michelle was admitted to Angliss Hospital overnight with the principal diagnosis of epilepsy. She was discharged with the plan to contact EPC for advice if Michelle experienced further deterioration.
16. On 18 February 2025, Scope staff located Michelle limp and unresponsive in her wheelchair. Emergency services were contacted and Michelle was taken to Angliss Hospital. Her oral intake during admission was limited and Michelle's health continued to deteriorate.
17. On 28 February 2025, the hospital had a discussion with Michelle's brother regarding her ongoing deterioration. In light of her minimal oral intake, deteriorating health and care plan, Michelle was transferred to the palliative care unit on 4 March 2025 and placed on end-of-life care. At 7:51pm on 8 March 2025, Michelle died peacefully in hospital.

Identity of the deceased

18. On 24 March 2025, Michelle Anne Leiper, born 10 October 1965, was identified via DNA comparison.
19. Identity is not in dispute and requires no further investigation.

Medical cause of death

20. On 12 March 2025, Senior Forensic Pathologist Dr Matthew Lynch (**Dr Lynch**) from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination and reviewed a post-mortem computed tomography (**CT**) scan and other relevant materials. He provided a written report of his findings dated 17 March 2025.

² 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.

21. His findings were consistent with Michelle's medical history.
22. Dr Lynch provided an opinion that the medical cause of death was '*1(a) aspiration pneumonia and urosepsis complicating Alzheimer's dementia in setting of Down syndrome (Trisomy 21).*'
23. I accept Dr Lynch's opinion.

FINDINGS AND CONCLUSION

24. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
 - a) the identity of the deceased was Michelle Anne Leiper, born 10 October 1965;
 - b) the death occurred on 8 March 2025 at Angliss Hospital, 39 Albert Street, Upper Ferntree Gully, Victoria, from *1(a) aspiration pneumonia and urosepsis complicating Alzheimer's dementia in setting of Down syndrome (Trisomy 21)*; and
 - c) the death occurred in the circumstances described above.
25. Taking into account all available information, I am satisfied that Michelle died from natural causes, in the setting of multiple health conditions.
26. I am satisfied that Michelle's death was not caused, or contributed to, by any issue in relation to the care and management provided by Scope or its staff, or Eastern Health clinicians, including by EPC. In this regard, Michelle's brother recalled that he "*always found the Scope staff to be very professional.*"
27. The factual matrix of Michelle's death does not, therefore, support a conclusion that Michelle being 'in care' at the time of her death – according to the Act – had a causal relationship with her death. In such circumstances, I have not identified any opportunities for prevention.

I convey my sincere condolences to Michelle's family for their loss and note their reflections and memories of Michelle, including that she was happy and outgoing in nature.

ORDERS AND DIRECTIONS

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:

Thomas Leiper and Ethel Leiper, Senior Next of Kin

Scope (Aust) Ltd

Leading Senior Constable Mikael Hamalainen, Coronial Investigator

Signature:



Coroner Ingrid Giles

Date: 16 March 2026

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.
