IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 001520

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge Liberty Sanger, State Coroner
Deceased:	Kirsten Meredith Scott
Date of birth:	27 October 1973
Date of death:	21 March 2025
Cause of death:	1a: Asthma in the setting of WHO class III obesity and Huntington's disease
Place of death:	8 Boxer Drive Wyndham Vale Victoria 3024
Keywords:	In care, natural causes

INTRODUCTION

1. On 21 March 2025, Ms Kirsten Meredith Scott (**Kirsten**) was 51 years old when she died at home. At the time of her death, Kirsten lived in Wyndham Vale, Victoria.

2. Kirsten resided in supported accommodation which was enrolled under the National Disability Insurance Scheme (**NDIS)**. She received 24-hour support for personal care, domestic assistance, medication administration, community access, and asthma and oxygen management.

3. Kirsten's medical history included Huntington's disease, bipolar disorder, type 2 diabetes, and sleep aponea.

4. Kirsten is survived by her son Lachlan and her brother Justin.

THE CORONIAL INVESTIGATION

5. Kirsten'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.
6. Kirsten was a person in care at the time of her death as she was a Specialist Disability Accommodation (**SDA)** resident living in an SDA dwelling pursuant to Regulation 7 of the *Coroners Regulations 2019.* However, an inquest is not required as Kirsten's death was due to natural causes.

7. 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.

8. This finding draws on the totality of the coronial investigation into the death of Kirsten Meredith Scott. 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.[1]

9. Coroner Kate Despot initially had carriage of the investigation into Kirsten's death. In October 2026, I assumed carriage of the investigation for the purposes of conducting additional investigative steps, finalising the investigation and making findings.

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

Circumstances in which the death occurred

10. In the early hours of 21 March 2025, Kirsten was outside smoking a cigarette. She went back to her room to lie down for a few minutes before coming out of her room and asking her support worker for a coffee. She went back outside to have a cigarette.

11. Kirsten then came back inside and complained of breathing difficulties and asked her support worker for her Ventolin 'puffer'. Kirsten used the puffer, became drowsy and fell backwards. The support worker caught Kirsten and lowered her to the ground and contacted emergency services.

12. Kirsten tried to get back up and walk around, but fell over again, being caught by the support worker and lowered to the ground. She was breathing heavily.

13. After a few minutes, Kirsten stopped breathing. The support worker called emergency services again, and the call taker guided them through cardiopulmonary resuscitation (**CPR)**. The support worker continued CPR until Ambulance Victoria paramedics arrived.

14. AV paramedics continued CPR, however Kirsten was unable to be revived and was sadly declared deceased at 1.12am.

Identity of the deceased

15. On 21 March 2025, Kirsten Meredith Scott, born 27 October 1973, was visually identified by her carer.

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

[1] 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.

Medical cause of death

17. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 24 March 2025 and provided a written report of his findings dated 2 December 2025.

18. The autopsy revealed significant natural disease in the form of hyperexpanded oedematous lungs with mucus plugging. There were changes in the brain in keeping with Huntington's disease, as well as evidence of WHO class III obesity which is associated with significant cardiovascular morbidity and mortality.

19. Toxicological analysis of post-mortem samples identified the presence of desmethylvenlafaxine[2], quetiapine[3], risperidone[4] and its metabolite, zopiclone[5] and metformin.[6]

20. Dr Lynch provided an opinion that the medical cause of death was 1(a) asthma in the setting of WHO class III obesity and Huntington's disease. He opined that the death was due to natural causes.

21. I accept Dr Lynch's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased is Kirsten Meredith Scott, born 27 October 1973;

    b) her death occurred on 21 March 2025 at 8 Boxer Drive,Wyndham Vale, Victoria 3024, from 1(a) asthma in the setting of WHO class III obesity and Huntington's disease; and

    c) her death occurred in the circumstances described above.

23. Having considered all the available evidence, I am satisfied that Kirsten's death was due to natural causes and no further investigation is required. As such, I have exercised my discretion pursuant to section 52(3A) of the Act not to hold an inquest into Kirsten's death.

[2] Metabolite of antidepressant venlafaxine
[3] Medication used to treat bipolar disorder and depression
[4] Antipsychotic medication
[5] Sleeping medication used for short-term treatment of severe insomnia
[6] Medication used to manage type 2 diabetes

I convey my sincere condolences to Kirsten's family, loved ones and carers for their loss.

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:

Lachlan Vandy, Senior Next of Kin

Mercy Health

Senior Constable Mohamed Elhouli, Coronial Investigator

Signature:





Judge Liberty Sanger, State Coroner

Date: 03 November 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.