



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 002259

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner Simon McGregor
Deceased:	Jacqueline Stott
Date of birth:	12 October 1964
Date of death:	26 April 2025
Cause of death:	1a : ASPIRATION PNEUMONIA IN THE SETTING OF ADVANCED HUNTINGTON'S DISEASE
Place of death:	203/154 Pigdons Road Highton Victoria 3216
Keywords:	SDA resident; Death in care

INTRODUCTION

1. On 26 April 2025, Jacqueline Stott was 60 years old when she died in hospital. At the time of her death, Jacqueline lived in Specialist Disability Accommodation (SDA) at 203/154 Pigdons Road, Highton, Victoria, 3216 operated by InLife Disability support provider.
2. Jacqueline was diagnosed with Huntington's Disease in 2008 and had a recent admission to St John of God Hospital in Geelong from 26 March 2025 until 24 April 2025.
3. Jacqueline was transferred and admitted to Barwon Health Community Palliative Care on 24 April 2025 and discharged the following day on 25 April 2025 to her SDA enrolled dwelling for end of life care.

THE CORONIAL INVESTIGATION

4. Jacqueline'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.
5. Because Jacqueline was a Specialist Disability Accommodation (SDA) resident residing in an SDA enrolled dwelling¹ at the time of her death, her passing was determined to be 'in care' and, as such, is subject to a mandatory further investigation, pursuant to section 52(3A) of the Act. These findings are the result of that investigation.
6. 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.
7. 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.
8. Victoria Police assigned Senior Constable Jakob Reed to be the Coronal Investigator for the investigation of Jacqueline's death. The Coronal Investigator conducted inquiries on my

¹ See Regulation 7(1)(d) of the Coroners Regulations 2019.

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. This finding draws on the totality of the coronial investigation into the death of Jacqueline Stott 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
10. In considering the issues associated with this finding, I have been mindful of Jacqueline’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

11. On 25 April 2025, a community nurse from Barwon Health visited Jacqueline at her SDA accommodation at around 11:05 am and Jacqueline was observed to be comfortable but unresponsive. She was treated with a Continuous Subcutaneous Infusion (CSCI) and this was replenished with buprenorphine patch changes and oxygen therapy applied for comfort.
12. On 26 April 2025 at 8:15 am, Jacqueline’s InLife carers noted that she appeared to have passed away and her death was confirmed by a community nurse from Barwon Health at 8:37 am.

Identity of the deceased

13. On 28 April 2025, Jacqueline Stott, born 12 October 1964, was visually identified by their husband, Michael Stott.
14. Identity is not in dispute and requires no further investigation.

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.

Medical cause of death

15. Forensic Pathologist Dr Joanne Ho from the Victorian Institute of Forensic Medicine (VIFM) conducted an external examination on 30 April 2025 and provided a written report of her findings dated 2 May 2025.
16. The post-mortem examination and CT scan were consistent with the reported clinical history. Dr Ho noted that aspiration pneumonia is a lung infection that occurs when fluids, food or substances are accidentally inhaled into the lungs and that Jacqueline's death was due to natural causes.
17. Dr Ho provided an opinion that the medical cause of death was 1(a) ASPIRATION PNEUMONIA IN THE SETTING OF ADVANCED HUNTINGTON'S DISEASE, and I accept her opinion.

FINDINGS AND CONCLUSION

18. 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.³ 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.
19. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
 - a) the identity of the deceased was Jacqueline Stott, born 12 October 1964;
 - b) the death occurred on 26 April 2025 at 203/154 Pigdons Road Highton Victoria 3216, from 1(a) ASPIRATION PNEUMONIA IN THE SETTING OF ADVANCED HUNTINGTON'S DISEASE; and
 - c) the death occurred in the circumstances described above.

³ *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...'

20. Having considered all of the circumstances, I am satisfied that Jacqueline's care was reasonable and appropriate at all material times.

21. As Jacqueline was residing in Specialist Disability Accommodation at the time of her passing, her death is considered to be 'in care' as defined by section 3 of the Act and subject to a mandatory inquest unless exceptions applied.⁴ I am satisfied by the available evidence that Jacqueline's death was due to natural causes and pursuant to section 52(3A) of the Act, have therefore determined not to hold an inquest.

I convey my sincere condolences to Jacqueline's family 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:

Michael Stott, Senior Next of Kin

Lorraine Judd, Barwon Health

Emma Hay, St John of God Hospital

Senior Constable Jakob Reed, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 03 March 2026

⁴ Section 52(2) of the Act.

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.
