IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2025 004302

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	Heather Joy Harris
Date of birth:	26 September 1963
Date of death:	25 July 2025
Cause of death:	1(a) Unascertained (natural causes)
Place of death:	3 Koomba Street, White Hills, Victoria
Key words:	In care, supported disability accommodation, unascertained, natural causes

INTRODUCTION

1. On 25 July 2025, Heather Joy Harris was 61 years old when she was found deceased in her home. At the time, Ms Harris lived at a supported disability accommodation (**SDA**) run by Possability, in White Hills.

2. At the age of two, Ms Harris' parents raised concerns about her development, as she was non-verbal, and not crawling or walking. She was later diagnosed with an intellectual disability.

3. Ms Harris was homeschooled until the age of 16, when she attended a special development school. At about this time, she received funding for her care and spent two days a week at a care facility.

4. When Ms Harris completed her schooling at 18 years of age, she was mostly non-verbal and spoke with a minimal vocabulary. She was later diagnosed with autism spectrum disorder, a speech disorder, anxiety, and depression.

5. Ms Harris' medical history also included hypothyroidism, hyperlipidaemia, osteoarthritis, hearing loss, osteopenia, dyspnoea, and aortic regurgitation.

6. Until the age of 28, Ms Harris resided with her parents, she then received full-time care through the National Disability Insurance Scheme (NDIS). Ms Harris resided in several care facilities until she moved into her SDA in White Hills, seven years before her death.

7. At her SDA, Ms Harris preferred having a routine and knowing what activities she had coming up. Ms Harris enjoyed swimming, water aerobics, dance class, trips to Castlemaine, resident meetings, going out for lunch, and visiting her parents. Due to her anxiety, Ms Harris could become agitated towards co-residents, care staff, or people in the community, if there was any disruption to her routine.

8. Due to her hypothyroidism and medications, Ms Harris had a history of gaining and losing weight. As a result, she followed a healthy diet and was weighed with all other residents on the first day of each month.

9. Ms Harris also received care from a general practitioner (**GP**), dentist, psychiatrist, podiatrist, cardiologist, occupational therapist, and underwent eye examinations, and hearing tests.

10. Ms Harris' GP did not observe an apparent decline in her health, other than an increase in shortness of breath on exertion. In 2022, she was reviewed by Bendigo Health and found to have no significant valvular dysfunction.

11. On 29 January 2025, Ms Harris' GP referred Ms Harris to a cardiologist. The cardiologist did not report any concerns with Ms Harris' cardiovascular system, as a stress test showed no evidence of inducible ischaemia, and her left ventricular systolic function was normal on an echocardiogram without severe valvular pathology.

THE CORONIAL INVESTIGATION

12. Ms Harris' death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Generally, reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury. However, if a person satisfies the definition of a person placed in care immediately before death, the death is reportable even if it appears to have been from natural causes.[1]

13. 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.

14. 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.

15. The Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Ms Harris' 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.

16. This finding draws on the totality of the coronial investigation into Ms Harris' death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only

[1] See the definition of "reportable death" in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of "person placed in custody or care" in section 3 of the Act.

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

Identity of the deceased

17. On 25 July 2025, Heather Joy Harris, born 26 September 1963, was visually identified by her carer, Dianne Bottriell, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

19. Forensic Pathologist, Dr Joanne Ho, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 28 July 2025 and provided a written report of her findings dated 31 July 2025.

20. The post-mortem examination and computed tomography (CT) scan were consistent with the clinical history.

21. Dr Ho identified bilateral anterolateral rib fractures, likely due to cardiopulmonary resuscitation. There was no evidence of other injuries that could have caused or contributed to death.

22. Dr Ho also noted Ms Harris' height of 147 centimetres and body weight of 81 kilograms equates to a body mass index of 37.5, which is considered in the obese category.

23. Routine toxicological analysis of post-mortem samples detected sertraline,[3] and clozapine,[4] but no alcohol or other commonly encountered drugs or poisons.

24. Dr Ho provided an opinion that the medical cause of death was *"1(a) Unascertained (natural causes)"*.

---

[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.

[3] Sertraline is an anti-depressant drug for use in cases of major depression.

[4] Clozapine is a second-generation (atypical) antipsychotic drug effective for treating the positive and negative symptoms of schizophrenia.

25. I accept Dr Ho's opinion.

Circumstances in which the death occurred

26. On 25 July 2025, Ms Harris did not go to her usual activities, as she displayed influenza symptoms. As another resident was also experiencing influenza symptoms, staff decided to keep all residents at the SDA. Ms Harris did not like missing out on her activities, but staff reported that she seemed content to do other things at the home.

27. Dinner was served at about 5.00pm. Ms Harris was quiet at dinner and did not eat as much as she usually did. After she finished eating, she brushed her teeth and went to her room. Although it was unusual behaviour, Ms Harris' carer, Dianne Bottriell, considered that it may have been because Ms Harris was not feeling well.

28. At 5.30pm, Ms Bottriell went to the office to complete her evening paperwork. Ms Bottriell was in the office for about 25 minutes and did not hear Ms Harris go to the bathroom, as she usually would. So, Ms Bottriell went to check on Ms Harris.

29. At about 5.55pm, Ms Bottriell knocked on Ms Harris' door. Usually Ms Harris would wake – as she was a light sleeper – but she did not. Ms Bottriell entered the room and found Ms Harris laying on her side, unresponsive. Ms Harris was pale in colour, but warm to the touch. Ms Bottriell turned on the light and attempted to rouse Ms Harris, but Ms Harris was not breathing, and her lips were blue.

30. Ms Bottriell contacted emergency services and was instructed to move Ms Harris onto the floor and commence cardiopulmonary resuscitation (C**PR**). Ms Bottriell completed three cycles of 30 compressions with no breaths.

31. Fire Rescue Victoria and Ambulance Victoria Paramedics arrived a short time later and took over CPR with a defibrillator.

32. Despite treatment, Ms Harris was declared deceased at 6.05pm.

33. Victoria Police found no evidence to suggest the circumstances of Ms Harris' death were suspicious.

FINDINGS AND CONCLUSION

34. Pursuant to section 67(1) of the Act I make the following findings:

(a) the identity of the deceased was Heather Joy Harris, born 26 September 1963;

(b) the death occurred on 25 July 2025 at 3 Koomba Street, White Hills, Victoria;

(c) the cause of Ms Harris' death was unascertained (natural causes);

(d) immediately before death, Ms Harris' was a *"person placed in custody or care"* as defined in section 4 of the Act; and

(e) the death occurred in the circumstances described above.

35. I convey my sincere condolences to Ms Harris' family, friends and carers for their loss.

PUBLICATION

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.

DISTRIBUTION

I direct that a copy of this finding be provided to the following:

Patricia and Hugh Harris, senior next of kin

Leading Senior Constable Todd Deason, Victoria Police, Coronial Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 29 June 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.