IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 001522

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Virginia Catherine Harris
Date of birth:	5 July 1964
Date of death:	21 March 2023
Cause of death:	1a: Non-operative management of ruptured oesophagus (palliated) 2: Epilepsy, intellectual disability, scoliosis
Place of death:	University Hospital Geelong Bellerine Street Geelong Victoria 3220

INTRODUCTION

1. On 21 March 2025, Virginia Catherine Harris was 60 years old when she died at University Hospital Geelong. She was affectionately known to her family as Ginny.

2. At the time of her death, Virginia resided at Karingal St Laurence, a Specialist Disability Accommodation (**SDA**) dwelling enrolled under the National Disability Insurance Scheme (**NDIS**). Virginia received funded daily independent living support due to her diagnoses of epilepsy and intellectual disability, which was provided by disability service provider GenU.

3. Virginia suffered from a lack of oxygen at birth, leading to a diagnosis of epilepsy. According to her parents she experienced horrible seizures for the first 13 years of life. After this, with the availability of more advanced medication, she became *"in control of her life … more alert, more alive."*

4. Virginia was a bright student who was very personable and had a great group of friends. She attended primary school and then boarding school at Yooralla in Balwyn, before leaving at around the age of 14. She then studied at Box Hill TAFE but unfortunately had to withdraw due to her epilepsy.

5. Virginia had lived at her Karingal residence for around 30 years. According to her parents Robin and Helen, she lived a great life there; *"the daily social interaction and supportive services were just magical."*

6. Virginia had a close relationship with her parents who kept in regular contact and visited often. She enjoyed seeing her family, listening to music, playing boardgames and supporting the Geelong Football Club.

THE CORONIAL INVESTIGATION

7. Virginia's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as she was a 'person placed in custody or care' within the meaning of the Act, as a person with disability who received funded daily independent living support and resided in an SDA enrolled dwelling immediately prior to her death.[1] This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The

[1] This class of person is prescribed as a 'person placed in custody or care' under the *Coroners Regulations 2019* (Vic), r 7(1)(d).

coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

8. 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.

9. 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.

10. This finding draws on the totality of the coronial investigation into the death of Virginia Catherine Harris including evidence contained in the coronial brief and information from the National Disability Insurance Agency (**NDIA**) and the NDIS Quality and Safeguards Commission. 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

11. Virginia's general practitioner Dr Joseph Virgona was called to see her on 18 March 2025 as she was presenting with lower abdominal pain. He noted mild tenderness in her lower abdomen.

12. Dr Virgona re-examined Virginia later that evening and noted she had improved significantly and had no abdominal tenderness.

13. At around midnight on 20 March 2025, Virginia's carers called an ambulance as she was in pain and distress. She was found to be tachycardic, tachypnoeic and hypoxic. She was

[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.

conveyed to University Hospital Geelong, where she was found to have an oesophageal perforation.

14. After discussion with Virginia's parents, it was decided that she was for non-operative management, and later that day her care was stepped down to palliative measures.

15. Virginia died at 2:38am on 21 March 2025, in the presence of her parents.

Identity of the deceased

16. On 21 March 2025, Virginia Catherine Harris, born 5 July 1964, was visually identified by her father, Robin Harris, who completed a Statement of Identification.

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

Medical cause of death

18. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of Virginia Harris on 24 March 2025. Dr Baber considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan and E-Medical Deposition Form from University Hospital Geelong and provided a written report of her findings dated 25 March 2025.

19. The external examination was in keeping with the clinical history. The post mortem CT scan showed hyperostosis with unremarkable brain, pneumomediastinum, bilateral increased lung markings, fatty liver and scoliosis.

20. Dr Baber provided an opinion that the death was due to natural causes and ascribed the medical cause of death as 1(a) NON-OPERATIVE MANAGEMENT OF RUPTURED OESOPHAGUS (PALLIATED), 2 EPILEPSY, INTELLECTUAL DISABILITY, SCOLIOSIS.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Virginia Catherine Harris, born 5 July 1964;

   b) the death occurred on 21 March 2025 at University Hospital Geelong, Bellerine Street, Geelong, Victoria 3220;

c) I accept and adopt the medical cause of death ascribed by Dr Yeliena Baber and I find at Virginia Catherine Harris, a woman with epilepsy, intellectual disability and scoliosis died from non-operative management of a ruptured oesophagus;

2. AND, the available evidence does not support a finding that there was any want of clinical management or care on the part of the disability service provider, or clinical staff at University Hospital Geelong, that caused or contributed to Virginia Catherine Harris' death.

3. Having considered all the available evidence, I find that Virginia Catherine Harris' death was from natural causes and that no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into her death and to finalise the investigation in chambers.

I convey my sincere condolences to Virginia's family, friends 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.

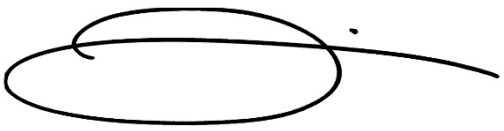
I direct that a copy of this finding be provided to the following:

Mr Robin Harris & Mrs Helen Harris, Senior Next of Kin

Barwon Health

Senior Constable Matthew Richards, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 28 November 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.