IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 007279

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Sharon Maree Harris
Date of birth:	14 October 1962
Date of death:	14 October 2025
Cause of death:	1a : ASPIRATION PNEUMONIA IN A WOMAN WITH SEIZURE DISORDER, DOWN SYNDROME, DEMENTIA AND NORMAL PRESSURE HYDROCEPHALUS
Place of death:	Colac Area Health 2-28 Connor Street Colac Victoria 3250
Keywords:	In care, natural causes

INTRODUCTION

1. On 14 October 2025, Sharon Maree Harris was 63 years old when she died at her Specialist Disability Accommodation (**SDA**) in Colac.

THE CORONIAL INVESTIGATION

2. Sharon'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.

3. As with Sharon, the death of a person in care is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

4. 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.

5. 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.

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

Circumstances in which the death occurred

6. Sharon had a medical history that included Down Syndrome, seizure disorder, dementia, normal pressure hydrocephalus, recurrent aspiration pneumonia, hyperthyroidism and intellectual disability. She resided in an SDA facility in Colac.

7. In the three months prior to her death Sharon had been experiencing seizures and she had been in functional decline for four weeks.

8. On 1 October 2025, Sharon presented as confused and she refused food.

9. On 2 October 2025, Sharon was transferred from her home to urgent care after being found by carers with slow and laboured breathing in a post ictal state. CPR was performed and whilst this led to an improvement in her breathing, she became hypotensive and bradycardic. A CT scan of her brain revealed worsening of her hydrocephalus.

10. Sharon had a further seizure that night and her oxygen saturations remained low. Sharon was subsequently palliated, and she passed away on 14 October 2025.

Identity of the deceased

11. On 14 October 2025, Sharon Maree Harris, born 14 October 1962, was visually identified by one of her long-term carers, Tracey Hegedus.

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

Medical cause of death

13. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 16 October 2025 and provided a written report of his findings.

14. The post-mortem examination revealed bilateral lung consolidation, hydrocephalus and coronary artery calcification.

15. Dr Young provided an opinion that the medical cause of death was 1(a) ASPIRATION PNEUMONIA IN A WOMAN WITH SEIZURE DISORDER, DOWN SYNDROME, DEMENTIA AND NORMAL PRESSURE HYDROCEPHALUS.

16. I accept Dr Young's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Sharon Maree Harris, born 14 October 1962;

    b) the death occurred on 14 October 2025 at Colac Area Health 2-28 Connor Street Colac Victoria 3250, from 1(a) ASPIRATION PNEUMONIA IN A WOMAN WITH SEIZURE DISORDER, DOWN SYNDROME, DEMENTIA AND NORMAL PRESSURE HYDROCEPHALUS; and

c) the death occurred in the circumstances described above.

I extend my sincere condolences to Sharon's family for their loss.

Pursuant to section 73(1B), this finding is to 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:

Richard Harris, Senior Next of Kin

Signature:

Coroner Leveasque Peterson

Date: 15 January 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.