IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 004923

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner John Olle
Deceased:	Geoffrey David Thorn
Date of birth:	12 July 1961
Date of death:	4 September 2023
Cause of death:	1a : UROSEPSIS
Place of death:	Northern Hospital Epping 185 Cooper Street, Epping, Victoria 3076
Keywords:	'In care' death, natural causes

INTRODUCTION

1. On 4 September 2023, Geoffrey David Thorn was 62 years old when he passed away at Northern Hospital Epping, after a short period of palliative care. At the time of his death, Geoffrey lived at a specialist disability residential care accommodation operated by Aruma Disability Services.

2. Geoffrey liked going for walks, taking bus trips and day placements. He was also regularly visited by his family.

3. Geoffrey had a medical history of intellectual disability, Lennox-Gastaut syndrome[1], cerebral palsy, osteoporosis and recurrent constipation. Though he was minimally verbal and non-ambulant, he used gestures and expressions to communicate with his support workers and ambulate around in a wheelchair.

4. When Geoffrey was seven years old, he was placed at Kew Cottages[2] and he lived there until 2006.

5. Later, Geoffrey moved to a group home on Dredge Street, Reservoir, where he lived until his death. According to his sister, Julie Farrow, Geoffrey thrived at the Dredge Street home – he was always happy and received care that made him feel right at home.

THE CORONIAL INVESTIGATION

6. Geoffrey '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.

7. Section 52(2) of the Act provides that it is mandatory for a coroner to hold an inquest into a death if the death or cause of death occurred in Victoria and a coroner suspect that the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

[1] Lennox-Gastaut syndrome is a severe form of epilepsy. Seizures begin in early childhood, usually before the age of 4 years. Children, adolescents, and adults with Lennox-Gastaut syndrome have multiple types of seizures that vary among individuals.

[2] A government-run accommodation facility for intellectually disabled children.

8. Immediately before his death, Geoffrey was a person placed in care within the meaning of section 4 of the Act, as he was a prescribed class of person[3] due to his status as an "*SDA*[4] *resident residing in an SDA enrolled dwelling*".

9. However, section 52(3A) of the Act provides an exception to the requirement under section 52(2) that the coroner is not required to hold an inquest if the coroner considers the death to have been due to natural causes. Having considered all the evidence in this matter, pursuant to section 52(3A) of the Act, I determined not to hold an inquest into Geoffrey's death.

10. 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.

11. 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.

12. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Geoffrey's 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.

13. This finding draws on the totality of the coronial investigation into the death of Geoffrey David Thorn 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.[5]

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[3] Section 4(2)(j)(i), *Coroners Act 2008 (Vic)*.
[4] Specialist Disability Accommodation.
[5] 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.

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

Circumstances in which the death occurred

14. In the morning of 17 August 2023, care staff called an ambulance due to Geoffrey having a fever and becoming restless. He was then conveyed to Northern Hospital Epping Emergency Department with the company of a support worker.

15. Later, treating clinicians identified a large kidney stone blocking a duct during a computed tomography (**CT**) scan and immediately referred Geoffrey for an emergency surgery at 1.15am on 18 August 2023.

16. Following the surgery, Geoffrey was discharged to the Intensive Care Unit (**ICU**). He remained in the ICU until 21 August 2023 and was transferred to the general ward.

17. In the following days, Geoffrey's condition deteriorated. He developed acute renal failure with worsening hypernatremia and was subsequently diagnosed with urosepsis.

18. In view of Geoffrey's poor prognosis, treating clinicians and his family had a discussion on 30 August 2023 and decided to transition him to comfort care.

19. Geoffrey's condition continued to deteriorate, and he passed away at 3.50am on 4 September 2023.

Identity of the deceased

20. On 4 September 2023, Geoffrey David Thorn, born 12 July 1961, was visually identified by his mother, Beverly Thorn.

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

Medical cause of death

22. Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 6 September 2023 and provided a written report of her findings dated 7 September 2023.

23. The post-mortem examination revealed findings consistent with the reported history.

24. The post-mortem computed tomography (**CT**) scan revealed enhanced lung marking, a fatty liver, prostatic and focal coronary artery calcifications.

25. Routine toxicological analysis was not conducted as it was not indicated.

26. Dr Fronczek provided an opinion that the medical cause of death was 1(a) UROSEPSIS.

27. Dr Fronczek further opined that Geoffrey's death was due to natural causes.

28. I accept Dr Fronczek's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Geoffrey David Thorn, born 12 July 1961;

    b) the death occurred on 4 September 2023 at Northern Hospital Epping, 185 Cooper Street Epping, Victoria 3076, from *urosepsis*; and

    c) the death occurred in the circumstances described above.

30. Having considered the factual matrix within which the death occurred, I am satisfied that the weight of the available evidence does not support a conclusion that a causal nexus existed between the fact that Geoffrey was 'in care' at the time of his death and the medical cause of his death. Consequently, on the evidence available to me, I am unable to find that Geoffrey's status as a person who was 'in care' at the time of his death is connected with or contributed to the medical cause of his death.

31. Further, the weight of the available evidence supports a conclusion that the medical care Geoffrey's received while he was 'in care' at the facility in Reservoir administered by Aruma Disability Services, as well as the medical care (including palliative care) he received from Northen Hospital Epping in the period leading to his death was reasonable in the circumstances. Accordingly, I find that Geoffrey died by natural causes.

I convey my sincere condolences to Geoffrey'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:

Beverley Thorn, Senior Next of Kin

Aruma Disability Services

Leading Senior Constable Emma-lee Maynard, Coronial Investigator

Signature:

Coroner John Olle

Date: 4 July 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.