



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 000949

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

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| Findings of: | Coroner Paul Lawrie |
| Deceased: | Gerald Francis Ridsdale |
| Date of birth: | 20/05/1934 |
| Date of death: | 18/02/2025 |
| Cause of death: | ISCHAEMIC AND VALVULAR HEART DISEASE |
| Place of death: | Port Phillip Prison 451 Dohertys Road, Truganina Victoria 3029 |
| Keywords: | In custody, natural causes |

INTRODUCTION

1. On 18 February 2025, Gerald Francis Ridsdale was 90 years old when he died following a period of palliative care at Port Phillip Prison, 451 Dohertys Road, Truganina, Victoria.
2. Gerald Ridsdale was born in St Arnaud, Victoria on 20 May 1934 and grew up in the Ballarat region. In 1961 he was ordained as a priest in the Catholic Church.
3. Between 1961 and 1990 he held some 16 different appointments at various parishes while exploiting his position as a priest to repeatedly sexually abuse many young children.
4. At the time of his death, Gerald Ridsdale was an inmate at Port Phillip Prison having been sentenced on multiple occasions to lengthy periods of imprisonment. He was first imprisoned in August 1993 and remained in prison from 1994 following sentencing for further offences on 14 October 1994. He received further sentences of imprisonment in 2006, 2014, 2017, 2020 and 2022.
5. The offences to which he pleaded guilty involved more than 70 children.

THE CORONIAL INVESTIGATION

6. Gerald Ridsdale's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as he was a 'person placed in custody or care' within the meaning of the Act. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death. Moreover, the coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.
7. First Constable Sam Philpott acted as the coronial investigator, to conducted inquiries on my behalf and compiled a coronial brief of evidence.
8. This finding draws on the totality of the coronial investigation into the death of Gerald Francis Ridsdale 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.¹

¹ 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

9. In November 2022, Gerald Ridsdale was transferred to the St John's sub-acute medical unit at Port Phillip Prison, where he remained until his death. His medical care was provided by St Vincent's Correctional Health Service.²
10. He had multiple diagnoses including ischaemic heart disease, aortic sclerosis, congestive cardiac failure, hypertension, asthma, and severe osteoarthritis. As well as care to manage these conditions, he received regular physiotherapy and occupational therapy.
11. Gerald Ridsdale's health progressively worsened and in December 2024 his clinical team discontinued active treatment to focus on optimal pain control and comfort care. This step accorded with his decision not to be actively treated if his quality of life was poor.
12. He continued to be visited by his sister every month with the last visit taking place in early February 2025.
13. On 25 January 2025, a continuous subcutaneous infusion through a syringe driver was commenced for management of severe pain.
14. By early February 2025, he was noted to be slowly deteriorating, although he was still eating, and pain was apparently under control.
15. On 15 February 2025, it was noted that his oral intake had drastically reduced, and he had deteriorated significantly over the preceding few days.
16. By 17 February 2025 his oral intake had stopped altogether, and he was observed to be extremely drowsy and non-verbal.
17. Gerald Ridsdale died at 9.41am on 18 February 2025. He was pronounced deceased by the medical officer at that time.

Identity of the deceased

18. On 18 February 2025, Gerald Francis Ridsdale, born 20 May 1934, was visually identified by a staff member, Belinda Geelhuizen.

² As part of St Vincent's Hospital (Melbourne) Limited.

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

Medical cause of death

20. Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine conducted an examination on 19 February 2025 and provided a written report of his findings dated 25 March 2025.

21. The findings of the post-mortem examination (including CT scan) were in keeping with the clinical history.

22. Toxicological analysis of postmortem samples was unremarkable.

23. Dr Lynch provided an opinion that the medical cause of death was 1(a) ISCHAEMIC AND VALVULAR HEART DISEASE, and that the death was due to natural causes.

24. I accept Dr Lynch's opinion.

FINDINGS AND CONCLUSION

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

- a) the identity of the deceased was Gerald Francis Ridsdale, born 20/05/1934;
- b) the death occurred on 18 February 2025 at Port Phillip Prison, 451 Dohertys Road, Truganina, Victoria, from ISCHAEMIC AND VALVULAR HEART DISEASE; and
- c) the death occurred in the circumstances described above.

26. There is no evidence to suggest that the medical care provided to Gerald Ridsdale was anything other than appropriate.

27. Having considered all the available evidence, I find that Gerald Ridsdale's death was due to natural causes and that no further investigation is required. Accordingly, I have exercised my discretion under section 52(3A) of the Act to finalise the investigation of Gerald Ridsdale's death without holding an inquest.

I thank the Coronial Investigator and those assisting for their work in this investigation.

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:

Carmel Densley, Senior Next of Kin

Secretary, Department of Justice and Community Safety

St Vincent's Correctional Health Service

First Constable Sam Philpott, Coronial Investigator

Signature:



Coroner Paul Lawrie

Date: 11 March 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.
