IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 000969

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Benjamin Goossens
Date of birth:	15/01/1971
Date of death:	18/02/2025
Cause of death:	GLIOBLASTOMA
Place of death:	Austin Hospital 145 Studley Road, Heidelberg Victoria 3084
Keywords:	In custody, natural causes

INTRODUCTION

1. On 18 February 2025, Benjamin Goossens was 54 years old when he died from glioblastoma following a period of palliative care at the Austin Hospital, 145 Studley Road, Heidelberg, Victoria 3084.

2. At the time of his death, Mr Goossens was in custody subject to a Custodial Supervision Order which had been in place since 1997 and was next due for review in March 2027. He was confined as a patient at the Thomas Embling Hospital in Fairfield until he entered the Palliative Care Unit at the Austin Hospital on 12 February 2025.

3. From approximately 1987, Mr Goossens suffered episodes of psychosis marked by auditory hallucinations, delusional ideation, and violent behaviour. His psychosis was apparently linked to the use of cannabis and psilocybin mushrooms.

4. On 18 January 1997, in the midst of a psychotic episode, he assaulted and killed his mother at her home.

5. On 12 June 1997, before the Supreme Court of Victoria, Mr Goossens was found not guilty of murder by reason of mental impairment. He was placed on a Custodial Supervision Order with a nominal term of 25 years. At a hearing on 2 March 2022, the Custodial Supervision Order was extended, with the next review due after five years.

THE CORONIAL INVESTIGATION

6. Benjamin Goossens' death fell within the definition of a reportable death in the *Coroners Act 2008* (**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. 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. Sergeant Carl Sartori 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 Benjamin Goossens 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]

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

Clinical summary at Thomas Embling Hospital

9. The Victorian Institute of Forensic Mental Health (**Forensicare**) provides inpatient services at Thomas Embling Hospital in Fairfield, Victoria. This is a secure forensic mental health facility.

10. Whilst at Thomas Embling Hospital, Mr Goossens was diagnosed with Type II diabetes mellitus, dyslipidaemia, obesity, and mild Vitamin D deficiency. He had a psychiatric diagnosis of treatment resistant schizophrenia, associated with cognitive impairment.

Circumstances in which the death occurred

11. In 2010 Mr Goossens was found to have a Grade 2 frontal glioma which was initially managed with ongoing surveillance and serial MRI[2] scans. By 2021 the disease had progressed to a Grade 4 frontotemporal glioblastoma which required debulking surgery. He underwent this surgery on 12 December 2021 at St Vincent's Hospital. This improved his focal neurological symptoms, but pathological testing of the tumour demonstrated transformation to a high-grade or aggressive glioblastoma. After a follow-up at St Vincent's Hospital on 21 December 2021, the prognosis was a life expectancy of 12 months without additional treatment[3]. Moreover, treatment was only expected to extend the prognosis by two months. He remained under the care of an oncologist from 2021 until his death.

12. In February 2024, an MRI scan showed the growth of a new lesion in Mr Goossens' brain and his physical health began to decline. He developed dysarthric speech, swallowing difficulties, increasing right-sided hemiparesis, and impaired mobility.

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[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.

[2] Magnetic Resonance Imaging

[3] Based upon an average for patients with this form of tumour.

13. By 12 February 2025, Mr Goossens' physical health had deteriorated to the point where a decision was made to transfer him to the Austin Hospital in Heidelberg for palliative care. He died at 11.00pm on 18 February 2025.

Identity of the deceased

14. On 25 February 2025, Coroner Ryan determined the identity of the deceased (based upon fingerprint and other evidence) as Benjamin Goossens, born 15 January 1971.

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

Medical cause of death

16. Associate Professor Sarah Parsons, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an examination on 20 February 2025 and provided a written report of her findings dated 5 March 2025.

17. The post-mortem examination (including CT scan) revealed features in keeping with the known clinical history, and no significant unexpected features.

18. Toxicological analysis was not indicated and thus not performed.

19. Associate Professor Parsons provided an opinion that the medical cause of death was "1(a) GLIOBLASTOMA", and that the death was due to natural causes.

20. I accept the opinion of Associate Professor Parsons.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Benjamin Goossens, born 15 January 1971;

    b) the death occurred on 18 February 2025 at the Austin Hospital, 145 Studley Road, Heidelberg, Victoria 3084 from GLIOBLASTOMA; and

    c) the death occurred in the circumstances described above.

22. Mr Goossens' death was expected and not preventable. There is no evidence to suggest that the medical care provided to him was anything other than appropriate.

23. Having considered all the available evidence, I find that Benjamin Goossens' 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 Benjamin Goossens' 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:

Heather Kelly, Senior Next of Kin

Victorian Institute of Forensic Mental Health (Forensicare)

Secretary, Department of Justice and Community Safety

Austin Health

Sgt Carl Sartori, Coronial Investigator

Signature:

Coroner Paul Lawrie

Date: 02 December 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.