IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 001108

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Therese McCarthy
Deceased:	Ashley John Bryant
Date of birth:	3 September 1977
Date of death:	26 February 2025
Cause of death:	1(a) Metastatic adenocarcinoma of the gastroesophageal junction
Place of death:	Queen Elizabeth Centre 102 Ascot Street South, Ballarat Central, Victoria
Keywords:	Death in Custody; Natural Causes; Supervision Order

INTRODUCTION

1. On 26 February 2025, Ashley John Bryant was 47 years old when he died in the Gandarra Palliative Care Unit (**Gandarra**) at the Grampians Health Queen Elizabeth Centre.

2. At the time of his death, Ashley was subject to a renewed post-sentence supervision order under the *Serious Offenders Act 2018* (Vic). As part of the supervision order, Ashley resided in Corella Place—a residential facility managed by Corrections Victoria. Corella Place provides accommodation for people who have been convicted of serious sex offences and post-sentence have been placed on a supervision order as they require high levels of supervision in a supported setting.

3. Ashley had a difficult childhood. His father passed away when he was around four years old and he subsequently lived with his mother who suffered from paranoid schizophrenia. According to Ashley's brother, Bradley, as a child, Ashley was exposed to doomsday scenarios by his mother. Ashley was an insular person but would be outgoing when he had the opportunity to socialise.[1]

4. As an adult, Ashley remained mostly private but would regularly join Bradley to watch bands. Ashley's main interests often involved computers.

5. Ashley spent time incarcerated on and off between 2008 and 2023 for possessing child abuse material and failing to comply with a supervision order and reporting obligations.

6. Ashley's medical history included ethanol misuse disorder, liver cirrhosis, and dyslipidaemia. In April 2024, his health was reviewed by a doctor from Grampians Health after he reported several months of weight loss, abdominal distension, and dysphagia. Ashley was subsequently diagnosed with metastatic gastroesophageal junction cancer in May 2024 which is an incurable cancer. He was commenced on first line palliative chemotherapy and immunotherapy.[2]

7. After four cycles of treatment, in July 2024, a computed tomography (**CT**) scan showed progressive disease. Ashley was then switched to second line palliative chemotherapy. In January 2025, it was confirmed that treatment had been ineffective and his disease had

[1] Coronial Brief, Statement of Bradley Bryant.
[2] Coronial Brief, Statement of Dr Lee Na Teo.

progressed. Given his poor response to treatment, active medical intervention was ceased, and his medical team focused on quality of life and pain management.

THE CORONIAL INVESTIGATION

8. Ashley's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as immediately before his death he was *'a person placed in custody or care'* within the meaning of the Act.

9. Deaths in custody are reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of prisoners or those serving under state-imposed supervision orders, and the level of power and control exercised by those who care for them. Moreover, the coroner is required to investigate the death, and publish their findings, even if the death appears to have been from natural causes.

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 Ashley's death. The Coronial Investigator conducted inquiries on behalf of the Court, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

13. In July 2025, I assumed carriage of the investigation into Ashley's death upon the retirement of then Coroner John Olle for the purpose of finalising the investigation and making findings.

14. This finding draws on the totality of the coronial investigation into the death of Ashley John Bryant 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.[3]

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

Circumstances in which the death occurred

15. On 11 February 2025, Ashley was admitted to Gandarra at the Queen Elizabeth Centre for end-of-life care and comfort measures.

16. During his palliative care admission, Ashley gradually deteriorated, becoming bed bound and less responsive. He passed away on 26 February 2025.[4]

Identity of the deceased

17. On 25 February 2025, Ashley John Bryant, born 3 September 1977, was visually identified by Corrections Victoria employee, Ian Wilson.

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

Medical cause of death

19. Forensic Pathologist Associate Professor (**A/Prof**) Sarah Parsons from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 27 February 2025 and provided a written report of her findings dated 5 March 2025.

20. The post-mortem examination was consistent with the reported circumstances. The post-mortem CT scan revealed ascites, infiltration in the mesentery, and a thickened stomach wall.

21. Toxicological analysis was not indicated and was therefore not performed.

22. A/Prof Parsons provided an opinion that the medical cause of death was *"1(a) Metastatic adenocarcinoma of the gastroesophageal junction"*.

23. I accept A/Prof Parsons' opinion.

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[3] 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.

[4] Coronial Brief, Grampians Health Discharge Summary dated 4 March 2025.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Ashley John Bryant, born 3 September 1977;

    b) the death occurred on 26 February 2025 at the Queen Elizabeth Centre, 102 Ascot Street South, Ballarat Central, Victoria, from *metastatic adenocarcinoma of the gastroesophageal junction*; and

    c) the death occurred in the circumstances described above.

25. Having considered all the available evidence, I find that Ashley's 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 his death and to finalise the investigation of Ashley's death in chambers.

I convey my sincere condolences to Ashley'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:

Bradley Bryant, Senior Next of Kin

Senior Constable Jack Clarke, Coronial Investigator

Signature:

Coroner Therese McCarthy

Date: 25 August 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.