IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 003872

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Dimitra Dubrow
Deceased:	Geoffrey Rhys Maddern-Wellington
Date of birth:	10 September 1947
Date of death:	Unknown date
Cause of death:	Unascertained
Place of death:	Unknown
Keywords:	Missing person-suspected death

INTRODUCTION

1. At some stage on or after 12 December 2022, Geoffrey Rhys Maddern-Wellington (hereafter referred to as Rhys as he preferred to be called), was 75 years old when he went missing. At the time of his disappearance, Rhys resided in Paynesville.

2. Rhys is survived by his nephew, Mr Bryn Maddern-Wellington. Rhys' brother, Bryn's father, Mr Hugh Maddern-Wellington recently passed away. Although there were no formal statements from family provided in the coronial brief, Hugh had advised the Coronial Admissions & Enquiries Team on 25 February 2025 that his brother was a Vietnam Veteran, an engineer, and *'knew how to live off the land.'*.

3. Rhys's medical history included type 2 diabetes mellitus, non-ST elevation myocardial infarction, anxiety disorder and panic attacks, and a provisional diagnosis of obsessive-compulsive disorder.

4. In 2021, Rhys attended Psychotherapist Patricia Clancy for two appointments. Ms Clancy noted in her letter to Rhys's General Practitioner Dr Nazanin Bahrami, that she considered that he:

> *'appears to have little insight into his mental health issues. It is my concern that he has a longstanding mental health issue, it has been difficult to confirm the latter as he is guarded and avoided providing a history of his childhood, any previous history of mental health issues, any education or career history and did not believe it was relevant to his current situation.'*

Ms Clancy noted that Rhys's mood was labile during the consultations and he presented as angry, tearful and laughing. She considered that Rhys did not present a risk of harm to himself or others but presented with *'delusions of persecution focusing on how unfairly treated he has been. It is difficult to move the topic or discussion away from his focus on feeling bullied or persecuted.'* Rhys declined to attend any further appointments.

5. On 8 July 2022, Rhys attended the Capstone Medical Centre for a routine review with Dr Stephen Omnifolaji. It was noted that he had poorly controlled blood glucose levels and was '*cooperative enough to discuss preventative health, including a bowel cancer screening kit.'*

6. On 30 August 2022 at a further review, Dr Omnifolaji noted that Rhys presented *'in an acute, severe state of psychological distress…He was highly defensive, agitated and preoccupied*

with external interpersonal grievances.' Rhys brought a letter with him that indicated his immediate suspension from a local family history social group due to behaviour that made other members "uncomfortable." Dr Omnifolaji noted that Rhys was entirely resistant to clinical advice, uncooperative with therapeutic suggestions and defensive when confronted with evidence of medication non-compliance.

7. Dr Omnifolaji provided Rhys immediate general emotional support, de-escalation strategies, and anti-anxiety pharmacotherapy to break the panic cycle, however, Rhys *'aggressively rejected all medical advice, options and support.'* Dr Omnifolaji noted that there was no further communication or correspondence by Rhys with the clinic.

THE CORONIAL INVESTIGATION

8. Rhys'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. Under section 3 of the Act, death includes suspected death.

9. 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.

10. 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.

11. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Rhys's death. The Coronial Investigator, First Constable Lucas Krstic **(F/C Krstic)**, conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

12. This finding draws on the totality of the coronial investigation into the death of Geoffrey Rhys Maddern-Wellington 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]

13. The coronial investigation of a suspected death differs significantly from most other coronial investigations which commence with the discovery of a deceased person's body or remains. The focus in those cases is on identification of the body or remains, a forensic pathologist's examination and advice to the coroner about the medical cause of death and, where possible, the circumstances in which the death occurred.

14. Absent a body or remains, the coronial investigation focuses on the last sighting of the person suspected to be deceased; any subsequent contact with family, friends or authorities; and any evidence of proof of life since the last sighting. In such cases, the coronial investigation must first endeavour to establish, on the balance of probabilities, whether the person suspected to be deceased – is deceased. Such proof of death often relies on the absence of evidence that the person is alive, such as physical searches for the person; a lack of contact with known friends, family or colleagues; a lack of banking or like activities; and the lack of an "electronic footprint" that is usually evident with innumerable modern everyday activities. It also relies on other circumstantial evidence such as the prevailing environmental conditions and the individual attributes of the person suspected to be deceased, including their state of health.

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

Circumstances in which the disappearance occurred

15. At lunchtime on 12 December 2022, witness Mr Michael Carstairs took his dog for a run on the Corduroy Track in Toorloo Arm. He observed an orange 2012 Subaru XV parked in an unusual spot and again observed the same vehicle in the same location on 13 and 16 December 2022. Michael considered this to be strange and reported it to police.

16. Police attended and identified that the vehicle belonged to Rhys. The vehicle was locked but did not appear to have been tampered with. A search of the surrounding area provided no evidence of Rhys.

[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.

17. Police made enquiries with Rhys's neighbours who indicated they had not seen him for between one to two weeks. One neighbour said they noticed that his car was missing from his driveway on 17 December 2022. Letters in Rhys's mailbox dated back to 5 December 2022 and a search of his home did not reveal any further information regarding his potential whereabouts. A check of local hospitals did not reveal any admissions. There was no answer on Rhys's mobile and phone triangulation provided no value.

18. From 18 December 2022, extensive large-scale patrols and searches were conducted of the area nearby to where the vehicle was located. Searches involved Victoria Police Search and Rescue Unit, Victoria Police Canine Unit, Victoria Police Airwing, local Victoria Police Uniform members, and SES. The search covered a nearby cave system, paths, gullies and neighbouring residences. Doorknocks were conducted in the surrounding area for any information with no results.

19. F/C Krstic stated that on 20 December 2022, survival expert Dr Luckin provided expert advice that Rhys was unlikely to be found alive due to the weather conditions, medical conditions, and the terrain.

FURTHER POLICE INVESTIGATION

20. On 8 and 9 April 2023, Victoria Police enlisted the services of a Cadaver Dog Unit from New South Wales Police. Extensive searches of the area with the dogs were of no value.

21. Police also reviewed phone records that indicated that Rhys last made a phone call on 1 December 2022 to the West Gippsland Endoscopy Centre. Enquiries with financial institutions did not yield any results regarding recent transactions.

22. F/C Krstic noted that extensive media coverage has also failed to locate any positive sightings of Rhys. Since mid-December 2022, there have been no indications that Rhys has been active within the community.

23. On 23 December 2023, the search for Rhys was called off and police investigators consider that he is deceased.

FINDINGS AND CONCLUSION

24. Rhys went missing at the age of 75. Today he would be 79 years old, and I am satisfied that he is deceased. Further, I am satisfied that there are no further avenues of investigation reasonably open at this stage to elicit further evidence about the cause and circumstances of his death.

25. The evidence does not enable me to be satisfied as to the exact circumstances or cause of Rhys's death. I am satisfied that at some stage on or after 12 December 2022; Rhys attended the Corduroy Track in his vehicle. Beyond that, his movements are not known, and it is possible that he became lost or injured, succumbed to exposure to the elements, or took his own life. There is no evidence to indicate that any third party was involved in Rhys's death.

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

    a) the identity of the deceased was Geoffrey Rhys Btb: Maddern-Wellington, born 10 September 1947;

    b) the death occurred on an unknown date from unascertained causes; and

    c) the death occurred in the circumstances described above.

27. I convey my sincere condolences to Rhys's family and friends for their loss.

Pursuant to section 73(1A) 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:

Bryn Maddern-Wellington, Senior Next of Kin

First Constable Lucas Krstic, Coronial Investigator

Signature:





Coroner Dimitra Dubrow

Date: 08 November 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.