IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 000856

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Rory James Van Geleuken
Date of birth:	13 November 1992
Date of death:	13 February 2024
Cause of death:	1a : COMPRESSION OF THE NECK 1b : HANGING
Place of death:	1/33 Southey Street Elwood Victoria 3184
Keywords:	Suicide; Mental health

INTRODUCTION

1. On 13 February 2024, Rory James Van Geleuken was 31 years old when he was found deceased in his home. At the time of his death, Rory lived at 1/33 Southey Street, Elwood, Victoria, 3184 with his partner, Bhavjeet Saxena.

2. Rory was the youngest of two sons born to Martin and Helen Van Geleuken and was raised in Boronia. Rory completed his undergraduate bachelor's degree and master's at the University of Melbourne and was completing a post doctorate degree at RMIT in the lead up to the fatal incident.

3. In 2021, Rory met Bhavjeet and commenced a relationship, the couple moved in together in June 2022.

Relevant history of mental health treatment

4. Rory was first diagnosed with major depressive disorder and generalised anxiety disorder when he was seventeen years old. He has diagnosed with Major Depressive Disorder (**MDD**) in 2010 by Psychiatrist Associate Professor Dr Shashi Varma at Delmont Private Hospital. In 2011 he was admitted to Delmont Hospital for associated symptoms including suicidal ideation.[1]

5. Rory was admitted to the Alfred Hospital in May 2022 following an acute episode of depression and anxiety that resulted in a suicide attempt. Prior to this, he had accessed support for depression and anxiety from four different mental health professionals (psychologists and counsellors) between 2010 and 2017.[2]

6. Rory was prescribed Sertraline shortly after Dr Varma diagnosed MDD. His prescription was altered shortly thereafter to Lexapro due to adverse side effects. In the lead up to the fatal incident Rory was prescribed the following medications under the medical care of his General Practitioner (**GP**): Lexapro; Seroquel and Rizatriptan.[3]

7. In 2022, Rory was further diagnosed by Dr Simone Gindidis with autism spectrum disorder and attention deficit hyperactivity disorder (**ADHD**).[4]

[1] *Coronial Brief*, Dr Simone Gindidis Psychological Report dated 14 December 2022.
[2] Ibid.
[3] Ibid.
[4] Ibid.

8. Between January to April 2023, Rory was seeing Dr Rebecca Adams who treated him for depression and anxiety with Duloxetine and Seroquel. Rory had also been prescribed medicinal cannabis by his treating GP, Dr Tony Helman.[5]

9. Between October to December 2023, Rory was treated by a specialist psychiatrist, Dr Sevagram Umesh Babu. Rory reported distress with uncertainties in his employment, living situation and academic aspirations. Dr Babu treated Rory with Mirtazapine to achieve better control of his anxiety and depressive symptoms and Clonidine to dampen his elevated stress response to sensory overload. During this period, Rory also sought assistance from a psychologist, Mr Matt Cicchini.

10. Rory was seen by his most recent treating GP, Dr Timothy Lucas between December 2023 and 16 January 2024. During these appointments, Rory did reported concerns about the dosage of his Mirtazapine and medicinal cannabis, he had reduced the dosages and reported feeling better. Dr Lucas advised Rory to continue with Clonidine and Quetiapine in the meantime.

THE CORONIAL INVESTIGATION

11. Rory'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.

12. 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.

13. 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.

14. Victoria Police assigned Senior Constable John Chios to be the Coronial Investigator for the investigation of Rory's death. The Coronial Investigator conducted inquiries on my behalf,

[5] *Coronial Brief*, Statement of Dr Tony Helman.

including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

15. This finding draws on the totality of the coronial investigation into the death of Rory James Van Geleuken 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.[6]

16. In considering the issues associated with this finding, I have been mindful of Rory's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

17. On 13 February 2024 at about 9.20 am, Bhavjeet spoke with Rory briefly before heading off to her morning yoga session.[7] Bhavjeet returned around 10.50 am and was unable to locate Rory inside their residential unit.

18. Bhavjeet walked outside to check around the residential unit and saw Rory's feet through the garage entrance attached to the side of the residential unit. Bhavjeet pulled up the garage door and found Rory hanging from an electrical cord, she yelled out for assistance and tried to call 000 emergency services.[8]

19. Rory's landlord and his father were nearby and came to Bhavjeet's assistance. Bhavjeet commenced cardiopulmonary resuscitation (**CPR**) whilst waiting for paramedics to arrive.[9] Emergency services personnel and police arrived shortly but Rory could not be revived and was formally pronounced deceased.[10]

20. Police found no suspicious circumstances.[11]

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[6] 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.

[7] *Coronial Brief*, Statement of Bhavjeet Saxena.

[8] Ibid.

[9] *Coronial Brief*, Statement of Bhavjeet Saxena; Statement of Dimitrios Nakis.

[10] *Coronial Brief*, Statement of Senior Constable John Chios.

[11] Ibid.

Identity of the deceased

21. On 13 February 2024, Rory James Van Geleuken, born 13 November 1992, was visually identified by their partner, Saxena Bhavjeet.

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

Medical cause of death

23. Forensic Pathologist Dr Hans De Boer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 14 February 2024 and provided a written report of his findings dated 15 February 2024.

24. The external examination of the body showed findings in keeping with the reported circumstances. There was evidence of a ligature mark consistent with the submitted ligature and no other remarkable findings.

25. The post-mortem CT scans evidenced bilateral lung consolidation with air bronchograms.

26. Toxicological analysis of post-mortem samples identified the presence of cannabidiol,[12] doxylamine[13] (~0.06 mg/L) and delta-9-tetrahydrocannabinol[14] (~3 ng/mL). The concentrations of substances detected did not impact the cause of death.

27. Dr De Boer provided an opinion that the medical cause of death was 1(a) compression of the neck secondary to 1(b) hanging and I accept his opinion.

FAMILY CONCERNS

28. In her statement to the court dated 16 July 2024, Bhavjeet expressed the following concerns:[15]

    a) How difficult it was to find mental health practitioners who would treat adult patients with both autism and ADHD symptoms;

[12] Cannabidiol (CBD) is a cannabinoid indicated, as adjunctive treatment in combination with clobazam or valproate, in Lennox-Gastaut or Dravet syndrome. Nabiximols, a combination product of delta-9-tetrahydrocannabinol and CBD, is indicated as second-line therapy for spasticity in multiple sclerosis.

[13] Doxylamine is an antihistamine agent and sleep-inducing agent (Baselt, 2017). It acts by competitively inhibiting the binding of histamine to central and peripheral histamine H1-receptors.

[14] Delta-9-tetrahydrocannabinol (THC) is the active form of cannabis (marijuana). The strength of cannabis usually varies from 2-4% but can exceed 10%.

[15] *Coronial Brief*, Statement of Bhavjeet Saxena.

b) Mental health practitioners would not prescribe an alternative medication despite Mirtazapine not reportedly working well for Rory; and

c) Resistance to prescribing medication for Rory's ADHD due to his unemployment.

29. Whilst I appreciate the time taken to detail these concerns, the role of the coroner is limited. I am only empowered to examine matters that are proximate and causative, or contributory, to a death. Coroners do not investigate circumstances that have occurred after the death that have not contributed to a person's death. The limitations on this jurisdiction sometimes lead to the result that concerns raised by families are not able to be investigated because they are not sufficiently connected with the cause and circumstances of their loved one's death.

30. After reviewing the circumstances, I am satisfied that the relevant mental health practitioners provided a reasonable and appropriate level of care to Rory.

FINDINGS AND CONCLUSION

31. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the Briginshaw gloss or explications.[16] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

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

a) the identity of the deceased was Rory James Van Geleuken, born 13 November 1992;

b) the death occurred on 13 February 2024 at 1/33 Southey Street, Elwood, Victoria, 3184, from 1(a) compression of the neck secondary to 1(b) hanging ; and

c) the death occurred in the circumstances described above.

[16] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

33. Having considered all of the circumstances, I am satisfied that Rory intentionally took his own life. It is often difficult to determine what may have precipitated a person's decision to end their own life. There are sometimes issues known only to the deceased person. It is possible that Rory was struggling with the pressures of his post-doctorate studies and seeking employment more than he let on to family or friends. I find that his death could not have been reasonably foreseen, and no one bears responsibility for this tragedy.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death:

34. The frustrations with the mental health care system voiced by Rory's loved ones are well founded. In 2019, the Royal Commission into Victoria's Mental Health System (**the Royal Commission**) was established after the Victorian Government recognised that the system was failing to support people living with mental illness or psychological distress, families, carers and supports, as well as those working in the system.

35. On 2 March 2021, the Royal Commission's final report was tabled in Parliament and includes 65 recommendations which the Victorian Government has committed to implementing over the following 10 years.[17]

36. The Royal Commission's final report relevantly highlighted that:

"Many people cannot access suitable services, and even when they can, services are difficult to navigate and often do not meet their needs. People are told they are not 'sick enough' to access specialist services... Families, carers and supporters feel ignored by the system. Suicide continues to have a profound impact across communities."[18]

37. I note that several recommendations of the Royal Commission identified the need to ensure:

a) that mental health and wellbeing services provide appropriate 'needs identification and initial support' functions;[19]

b) the establishment of a Suicide Prevention and Response Office reporting to the Chief Officer for Mental Health and Wellbeing with a focus on supporting a system-based

[17] *Royal Commission into Victoria's Mental Health System* (Final Report, March 2021), available online at: https://www.vic.gov.au/royal-commission-victorias-mental-health-system-final-report
[18] *Royal Commission into Victoria's Mental Health System* (Final Report, March 2021), vol 1, 12.
[19] Ibid, Recommendation 7.

approach to suicide prevention and response efforts. The Suicide Prevention and Response Office would work with people with lived experience of suicidal behaviour, family members and carers, and people with lived experience of bereavement by suicide to co-produce, implement and monitor a new suicide prevention and response strategy for Victoria;[20] and

c) the establishment of a new statewide specialist service built on the foundations established by the Victorian Dual Diagnosis Initiative to primary consultation to people living with mental illness and substance use or addiction who have complex support needs.[21]

38. I am hopeful that the recommendations made by the Royal Commission and subsequent actions planned and taken by the mental health system will be able to assist others in similar situations who are experiencing significant distress, thereby avoiding similar occurrences in the future.

I convey my sincere condolences to Rory's family 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:

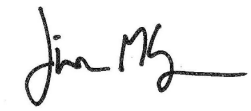
Bhavjeet Saxena, Senior Next of Kin

Penelope Corns and Doris Melara Escobar, Avant Legal

Senior Constable John Chios, Coronial Investigator

[20] Ibid, Recommendation 28.
[21] Ibid, Recommendation 36.

Signature:



Coroner Simon McGregor

Date: 02 May 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.