IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 5227

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the Coroners Act 2008

Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Deceased:	**NANCY MAY BUDGE**, born 3 March 1933
Delivered on:	11 September 2017
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	11 September 2017
Counsel assisting the Coroner:	Leading Senior Constable Sonia Reed

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HER HONOUR:

BACKGROUND

1. Mrs Nancy May Budge was 83 years old and resided with her husband, Mr Roy Budge (**Mr Budge**) in Rosebud prior to her death. Mr and Mrs Budge were married for 63 years until their deaths on 3 November 2016. Mrs Budge is survived by her three children Kay, Mark and Jeffrey.

2. Mr and Mrs Budge were retired dairy farmers who previously ran a dairy farm in the Wallan area, and later switched from dairy farming to beef cattle farming. Retiring in their early 50s, Mr and Mrs Budge moved to the Mornington Peninsula. They moved to their home in Rosebud in 2013.

3. Mrs Budge had a familial history of ischaemic heart disease, with her father dying aged 54 years and her mother dying aged 93 years as a result of ischaemic heart disease.[1] Mrs Budge had a medical history of atrial fibrillation, chronic obstructive pulmonary disorder, hyperlipidaemia, left shoulder osteoarthritis, left ventricular failure, hypertension, and ischaemic heart disease. In 2000, she received an aortic valve replacement.[2]

4. In the five years prior to her death, Mrs Budge's health deteriorated further. In 2011 an echocardiogram revealed Mrs Budge had left ventricular hypertrophy, and left ventricular eccentric hypertrophy. In 2011 she received a further aortic valve replacement and a mitral valve replacement. Unfortunately, the prosthetic aortic valve began to fail. A further valve replacement procedure was considered, but it was thought that Mrs Budge would not survive a further procedure. In 2014, Mrs Budge had a pacemaker inserted. In 2016 she was diagnosed with congestive cardiac failure.[3]

5. Mrs Budge was admitted to The Bays Hospital on two occasions proximate to her death, namely 10-20 October 2016, and 22-31 October 2016. Mrs Budge presented with exacerbation of her heart failure and infective exacerbation of her chronic obstructive pulmonary disease. Mrs Budge made a good recovery in hospital, and sought a second opinion regarding further cardiac surgery from cardiologist Dr Teperman. Mrs Budge did not display signs or symptoms of depression during either admission at The Bays Hospital in

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[1] Coronial brief, health summary of Mrs Nancy Budge, dated 5 January 2017, 100.
[2] *Ibid*, 101.
[3] Above n 1, 101.

October 2016.[4] According to Mr Mark Budge, Mrs Budge was told by doctors that there was not much more they could do to help her in relation to further treatment of her medical conditions.[5]

6. Mr Budge also experienced significant health issues in the years proximate to his death, with diagnoses of throat and bowel cancer. Chemotherapy treatment for cancer further affected Mr Budge's health.[6] Mr Budge found it difficult to watch Mrs Budge's health decline, noting to a neighbour that it was hard for him to watch Mrs Budge sitting in her chair in the night time not being able to breathe and there being nothing he could do to help her.[7]

7. Mrs Budge had previously told her son Mr Jeffrey Budge that if doctors could not do anything to help her, she "*would take matters into her own hands and get dad's gun and shoot herself because she was not going to live like this.*"[8] Further, Mr Budge told Mr Jeffrey Budge that "*if he had to shoot [Mrs Budge] then he would have to make sure it was a good shot.*"[9] Mr Jeffrey Budge did not believe that Mr and Mrs Budge were serious regarding these statements, but he was aware that they did not want to go on suffering as they were.

8. On 2 November 2016, Mark, Kay and Jeff Budge attended Mr and Mrs Budge's home to check on them. During this visit to the family home Mrs Budge looked "*like she was on her last legs*", and Mark thought to himself that Mrs Budge did not look like she would live much longer.[10] The family had a cup of coffee together and chatted, with Kay noting that everything seemed fine and Mr and Mrs Budge seemed in good spirits.[11]

9. At 8:30p.m., Mrs Budge's granddaughter Melanie called Mrs Budge to advise that her mother Kay had some issues with her home phone and for Mrs Budge to call Kay's mobile or Melanie directly if she needed anything. Mrs Budge sounded short of breath on the phone, which Melanie reported was normal for her.[12]

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[4] Coronial brief, correspondence of Dr Sam Kaldas, dated 4 January 2017, 63.
[5] Coronial brief, statement of Mark Budge, dated 4 November 2016, 26.
[6] Coronial brief, statement of Jeffrey Budge, dated 4 November 2016, 24.
[7] Coronial brief, statement of Julie Ellis-Jones, dated 14 November 2016, 30.
[8] *Ibid*.
[9] Above n 6.
[10] Above n 5, 5.
[11] Coronial brief, statement of Kay Fitzpatrick, dated 3 November 2016, 15.
[12] Coronial brief, statement of Melanie O'Callaghan, dated 3 November 2016, 19-20.

THE PURPOSE OF A CORONIAL INVESTIGATION

10. Mrs Budge's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was violent, unexpected and not from natural causes.[13]

11. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[14] The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

12. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[15] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

13. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

14. For coronial purposes, the phrase "*circumstances in which death occurred*," refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

15. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

16. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

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[13] Section 4 *Coroners Act 2008.*
[14] Section 89(4) *Coroners Act 2008.*
[15] *Keown v Khan* (1999) 1 VR 69.

(c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

17. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[16] 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 that they caused or contributed to the death.

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

Identity of the Deceased pursuant to section 67(1)(a) of the Act

18. On 14 November 2016, a buccal swab and blood sample were taken from Mr Jeff Budge, a son of Mr and Mrs Budge. DNA comparison identified the deceased to be the mother of Mr Jeff Budge, Nancy May Budge, born 3 March 1933.

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

Medical cause of death pursuant to section 67(1)(b) of the Act

20. On 8 November 2016 Dr Khamis Almazrooei, a Forensic Pathology registrar supervised by Dr Malcolm Dodd at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Mrs Budge's body. Dr Almazrooei provided a written report, dated 7 February 2017, which concluded that Mrs Budge died from a gunshot wound to the head.

21. Dr Almazrooei commented that the examination revealed cardiomegaly, myocardial fibrosis, severe coronary artery atherosclerosis, glomerulosclerosis and renal arteriosclerosis.

22. Toxicological analysis of post mortem specimens taken from Mrs Budge were negative for common drugs or poisons.

23. I accept the cause of death proposed by Dr Almazrooei.

[16] (1938) 60 CLR 336.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the Act

24. On 3 November 2016, Mr and Mrs Budge's neighbour Mr William Donchi observed Mr Budge drive away from his house at approximately 9.45am, and returning a short time later. Mr Donchi observed Mr Budge driving away from the home a further two times, the second time at an unknown time in the mid-morning and the third time at approximately 12.30pm.[17]

25. Enquiries made by Detective Senior Constable Peter Butland indicate that Mr Budge attended the Rosebud branch of the Westpac branch at 11.51am where he withdrew $3,000.[18] The money along with further cash and bills to be paid, was later found in Mrs Budge's handbag left in a kennel at the home of her daughter, Mrs Kay Fitzpatrick.[19]

26. At an unknown time during the day, Mr Budge placed the family's dog in the car and drove to Mrs Fitzpatrick's home at Rosebud. Mr Budge left the dog on the back deck of the house with a plastic bag containing dog food and a note stating "*Look in the kennel Kay*", and placed Mrs Budge's handbag in a kennel at the home.[20]

27. On returning home, Mr and Mrs Budge went out to their car parked in the driveway with an unregistered .22 calibre single action rifle.

28. At approximately 3.30pm Mr Ian Johnson was riding his bike past Mr and Mrs Budge's home on Adams Avenue, when he observed the Budges' car in the driveway with one of the car doors open. On his return to Adams Avenue approximately 45 minutes later, Mr Johnson observed the car door was still open on the Budges' car. Concerned that leaving the car door open would drain the car's battery of power, Mr Johnson stopped and walked up the driveway to see if anyone was there. Mr Johnson found Mr Budge in the driver's seat and Mrs Budge in the front passenger's seat in the car both covered in blood, and a rifle on the ground in the driveway.

29. As Mr Johnson got out his mobile telephone to call 000, Mrs Fitzpatrick arrived at the house to visit her parents. Mr Johnson told Mrs Fitzpatrick to call 000.[21]

30. Ambulance Victoria paramedics attended the residence, and declared Mrs Budge deceased at the scene.[22]

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[17] Coronial brief, statement of William Donchi, dated 7 February 2016, 28.
[18] Coronial brief, statement of Detective Senior Constable Peter Butland, dated 13 March 2017, 97.
[19] Coronial brief, statement of Kay Fitzpatrick, dated 4 November 2016, 18.
[20] *Ibid*.
[21] Coronial brief, statement of Ian Johnson dated 3 November 2016, 13.

31. Further investigation by the Chemical Trace Unit at the Victoria Police Forensic Services Centre identified gunshot residue on the hands of both Mr and Mrs Budge. The large number of gunshot residue particles identified on Mrs Budge's right hand palm indicated either that her palm was exposed to the discharge of a firearm at close proximity or that she handled a surface highly contaminated with gunshot residue. Principal Forensic Officer Peter Ross reported that the extremely large number of lead particles detected on Mrs Budge's right palm supported the contention that the particles had been ejected from the muzzle of the firearm when discharged.[23]

32. Mr Ross reported that he was unable conclusively to determine from the particle distributions on Mr and Mrs Budge's hands, whether it was Mr Budge or Mrs Budge who had discharged the firearm.[24]

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

33. The circumstances of Mrs Budge's death illustrates a common theme encountered by Victorian coroners. It is well understood that people who have lived a full, productive and loving life, but who experience an irreversible deterioration in their physical health can develop a determination to end their own lives, often in circumstances of desperation, loneliness and fear.

34. The Coroners Court of Victoria investigates a number of deaths each year in which a person suffering an irreversible decline in physical health, has made the decision to end their own life. Such deaths raise a number of moral and social issues, which fall outside the jurisdiction of the Court.

35. One of the purposes of the *Coroners Act 2008* is to contribute to the reduction of the number of preventable deaths and fires through the findings of the investigation of deaths and fires, and the making of recommendations, by coroners.[25] Further, section 7 of the Act requires that I avoid unnecessary duplication of inquiries and investigations.

36. In 2015, the Parliament of Victoria conducted an Inquiry into End of Life Choices, which produced its Final Report in 2016. This Report contains 49 recommendations, including a recommendation for a legal framework for assisted dying. In December 2016, the Victorian Government responded to this recommendation, advising that it was under review.

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[22] Coronial brief, statement of Brendon Chivers dated 13 November 2016, 22.
[23] Coronial brief, certificate of expert evidence of Mr Peter Ross, dated 1 March 2017, 56.
[24] *Ibid*.
[25] *Coroners Act 2008* (Vic) s 1(c).

37. A Ministerial Advisory Panel was formed, and its work has built upon the recommendations of the Inquiry into End of Life Choices. The Panel has developed a framework to provide access to assisted dying to persons who are at the end of their lives, who are suffering and who wish to choose the time and manner of their deaths. The Panel made 66 recommendations to the Victorian State Government. Victorian Premier Daniel Andrews and the Honourable Jill Hennessy, Minister for Health, have indicated that legislation will be developed and considered by the Victorian Parliament in the second half of 2017.

38. In the context of the purposes of the Act, the current progress of development of a Voluntary Assisted Dying Bill, together with the likelihood that such a bill will be considered by the Victorian Parliament by the end of 2017, it is unnecessary for me to make any further comments or recommendations in this matter.

FINDINGS AND CONCLUSION

39. Having investigated the death of Mrs Budge and having held an Inquest in relation to her death on 11 September 2017, at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

    (a) that the identity of the deceased was Nancy May Budge, born 3 March 1933;

    (b) that Nancy May Budge died on 3 November 2016, at Rosebud, from a gunshot wound to the head; and

    (c) that the death occurred in the circumstances set out above.

40. I convey my sincerest sympathy to Mrs Budge's family and friends.

41. Pursuant to section 73(1) of the Act, I order that this Finding be published on the internet.

42. I direct that a copy of this finding be provided to the following:

(a) Mr Jeffrey Budge, Senior Next of Kin; and

(b) Detective Senior Constable Peter Butland, Coroner's Investigator, Victoria Police.

Signature:

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JUDGE SARA HINCHEY

STATE CORONER

Date: 11 September 2017