



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

Court Reference: COR 2014 4052

**FINDING INTO DEATH WITH INQUEST**

*Form 37 Rule 60(1)*

*Section 67 of the Coroners Act 2008*

Findings of:	<b>JUDGE SARA HINCHEY, STATE CORONER</b>
Deceased:	<b>PATRICIA MARGARET BUSBY</b>
Hearing date:	9 March 2017
Delivered on:	9 March 2017
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Representation:	Nil
Counsel assisting the Coroner:	Jodie Burns, Senior Legal Counsel
Catchwords:	Homicide; no person charged with an indictable offence in respect of a reportable death; mandatory inquest; family violence using a firearm

## TABLE OF CONTENTS

<b>Background</b>	<b>1</b>
<b>The purpose of a coronial investigation</b>	<b>3</b>
<b>Matters in relation to which a finding must, if possible, be made</b>	
- Identity of the deceased pursuant to section 67(1)(a) of the <i>Coroners Act 2008</i>	<b>5</b>
- Medical cause of death pursuant to section 67(1)(b) of the <i>Coroners Act 2008</i>	<b>5</b>
- Circumstances in which the death occurred pursuant to section 67(1)(c) of the <i>Coroners Act 2008</i>	<b>5</b>
<b>Comments pursuant to Section 67(3) of the <i>Coroners Act 2008</i></b>	<b>10</b>
<b>Findings and conclusion</b>	<b>13</b>

## **HER HONOUR:**

### **BACKGROUND**

- 1 Patricia Margaret Busby (**Ms Busby**) was born in Warracknabeal, on 26 March 1973. At the time of her death, Ms Busby was 41 years old, lived in a rented house in Pental Island with her 14 year old daughter and worked as a domestic support worker in the Swan Hill area.
- 2 Ms Busby separated from her first husband (**Mr Busby**), and her daughter's father, in mid-2000. Mr Busby was a citizen of the United States of America (**USA**). Mr and Ms Busby married in the USA and their daughter was born there.
- 3 In the years following her separation and return to Australia, Ms Busby and her daughter moved around frequently, before settling in the Swan Hill area in 2008. Ms Busby maintained a close circle of friends and family, by whom she was warmly regarded and with whom she was in frequent contact.
- 4 Gregory Murray (**Mr Murray**) was born in Kerang on 26 July 1972 and was 42 years old at the time of his death. He lived alone in a house owned by, and located on, his parents' dairy farm in Murrabit. Mr Murray was trained as a fitter and turner. However, for approximately two years before his death he had worked on the property, employed by the family farming business.
- 5 Mr Murray had three children, aged between 9 and 14, to a former spouse (**Mr Murray's former wife**). The children lived with their mother, and her current husband, in nearby Kerang. The relationship between Mr Murray, his former wife and her new husband was tense.<sup>1</sup> Mr Murray's former wife reported that there had been an incident involving family violence prior to her separation from Mr Murray in 2007, when Mr Murray had hit her causing significant bruising and threw one of their daughters across the room. These assaults were not reported to police.
- 6 Following Mr Murray's separation from his former wife, Mr Murray had limited contact with his two daughters who were reported to be reluctant to spend time with him.<sup>2</sup> Until a few months before his death, Mr Murray saw his youngest child, a son, more regularly. However, the frequency of these visits had begun to decrease as Mr Murray's son was not keen to go to

---

<sup>1</sup> Coronial Brief, pp. 44 – 45; 50 – 51; 75.

<sup>2</sup> Coronial Brief, pp. 45; 50 – 51; 57; 75.

the farm and also due to the fact that Mr Murray was often working.<sup>3</sup> Mr Murray's relationship with his children was a source of discontent for him.

- 7 In December 2012, Mr Murray and Ms Busby were introduced by a mutual friend. An intimate relationship commenced immediately and continued over the following years. The couple did not live together and maintained their respective residences, although they frequently spent evenings and weekends at each other's house. Ms Busby's daughter would often join her mother in visiting and staying overnight at Mr Murray's property on the farm. Their friends and family were all aware of their relationship and they were regarded as a couple.
- 8 In May 2014, Mr Murray and Ms Busby separated for approximately two months. Evidence suggests that the separation was Ms Busby's decision, and that the impetus for her decision was that Mr Murray was too obsessive and controlling. Ms Busby is reported to have wanted her independence.<sup>4</sup> The evidence also indicates that Mr Murray struggled to accept the separation and was resolved to reunite with Ms Busby.<sup>5</sup> There is no evidence, however, that Mr Murray used physical violence or made threats to harm either himself, Ms Busby or others at this or at any other point in the relationship.
- 9 After a period of approximately two months, the relationship between Ms Busby and Mr Murray recommenced. Mobile phone records indicate that Ms Busby, whatever her reservations about the relationship, was proactive and clear in expressing her desire to reunite with Mr Murray.<sup>6</sup> Mobile phone records further confirm that the relationship appeared to have resumed on good terms. In the weeks preceding Ms Busby and Mr Murray's deaths, they organised a weekend away together and had made a September booking at a boutique bed and breakfast for this purpose.<sup>7</sup>
- 10 On 11 July 2014, *en route* from his house to Pental Island to visit Ms Busby, Mr Murray was stopped by a police officer and 'breath tested'. Mr Murray's test revealed that he had a blood alcohol concentration of 0.102% and he was charged with exceeding the prescribed concentration of alcohol in his blood while driving a motor vehicle. Mr Murray was very concerned about the impact that losing his driver's licence would have on his work and broader life. He was also fearful that, given his prior convictions for the same offence, he may be sentenced to a period of imprisonment.

---

<sup>3</sup> Coronial Brief, p. 45.

<sup>4</sup> Coronial Brief, pp. 86; 89 – 90.

<sup>5</sup> Coronial Brief, pp. 86; 90.

<sup>6</sup> Coronial Brief, Exhibit 2.

<sup>7</sup> Coronial Brief, Exhibit 1.

- 11 Mr Murray's level of concern was such that the police officer involved, with Mr Murray's consent, made a formal referral for him to a counselling service.<sup>8</sup> Mr Murray did not take up this offer when he was later contacted by the relevant community organisation. However, he took other steps to obtain legal advice and character references, via the assistance of the Northern District Community Health Service, in preparation for his court date.
- 12 Mr Murray also made arrangements with his family and Ms Busby to ensure he would be able to get to the shops and visit his children without his licence.<sup>9</sup>
- 13 On 19 July 2014, Mr Murray disclosed to a friend, while drinking alcohol, that he was feeling down having lost his licence and that he was thinking of hurting himself. In a later conversation with the same friend, Mr Murray's mood appeared much improved.
- 14 There is no known evidence that Mr Murray had suicidal ideation or had made homicidal threats preceding him killing Ms Busby and himself.
- 15 At the time of Mr Murray's death, the 'drink driving' charge had not been dealt with by the Court. However, the evidence reveals that Mr Murray was keen to resolve the matter as it was a source of stress and anxiety for him.

## **THE PURPOSE OF A CORONIAL INVESTIGATION**

- 16 Ms Busby's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as her death occurred in Victoria, and was violent, unexpected and not from natural causes.<sup>10</sup>
- 17 The jurisdiction of the Coroners Court of Victoria is inquisitorial<sup>11</sup>. 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.
- 18 It is not the role of the coroner to lay or apportion blame, but to establish the facts.<sup>12</sup> It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

---

<sup>8</sup> Coronial Brief, pp. 104 – 105.

<sup>9</sup> Coronial Brief, p. 106.

<sup>10</sup> Section 4 *Coroners Act 2008*.

<sup>11</sup> Section 89(4) *Coroners Act 2008*.

<sup>12</sup> *Keown v Khan* (1999) 1 VR 69.

- 19 The term “cause of death” refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.
- 20 For coronial purposes, the 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.
- 21 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 ‘prevention’ role.
- 22 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
  - (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.
- 23 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*.<sup>13</sup> 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.
- 24 Section 52(2) of the Act provides that it is mandatory for a coroner to hold an inquest into a death if the death or cause of death occurred in Victoria and a coroner suspects the death was as a result of homicide (and no person or persons have been charged with an indictable offence in respect of the death), or the deceased was immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.
- 25 While Ms Busby’s identity was not in dispute and she was not a person placed in “*custody or care*” as defined by section 3 of the Act, her death is considered to be a homicide. Therefore, it

---

<sup>13</sup> (1938) 60 CLR 336.

is mandatory to conduct an inquest into the circumstances of her death as no person or persons have been charged with an indictable offence in respect of 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 *Coroners Act 2008***

26 The Deceased's identity was confirmed by dental record comparison.

27 Identity is not in dispute in this matter and therefore required no further investigation.

### **Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008***

28 On 11 August 2014, Dr Jacqueline Lee (**Dr Lee**), a Forensic Pathologist, practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Ms Busby's body. Dr Lee provided a written report, dated 27 May 2015, which concluded that a reasonable cause of death was '*gunshot wound to the head*'

29 Dr Lee's report contained the following comments:

*"The autopsy revealed a shotgun wound to the right side of the head and blunt impact injuries to the left side of the face, top of the left shoulder and limbs. Glass fragments were found on the neck and chest. The mechanism of death may be a combination of neurogenic shock as a consequence of skull fractures and blood loss as a consequence of vascular injury... Swelling associated with bruises to the face is a likely indication that the injuries occurred prior to the shotgun wound. Although the body is found on the floor with the left side of the face on the floor, the swelling is localised to the areas of injury. An additional post-mortem component of the swelling may not be excluded."*<sup>14</sup>

30 Toxicological analysis of Ms Busby's post mortem blood detected 0.22g/100mL of alcohol and a post mortem vitreous humour sample taken identified 0.25g/100mL of alcohol. No other common drugs or poisons were detected and Dr Lee stated that the presence of alcohol in Ms Busby's system did not cause or contribute to her death.<sup>15</sup>

### **Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008***

31 On Friday 8 August 2014, Ms Busby travelled by car to spend the weekend with Mr Murray at his house in Murrabit. Evidence reveals that Mr Murray, who had been working on the farm until 6.00pm, was keen to get home and see her.<sup>16</sup>

---

<sup>14</sup> Coronial Brief, pp. 201 – 202.

<sup>15</sup> Coronial Brief, pp. 201 – 202.

<sup>16</sup> Coronial Brief, p. 76.

- 32 On Saturday 9 August 2014, Ms Busby and Mr Murray travelled together to the nearby town of Barham for lunch. Around this time, Ms Busby exchanged affectionate texts with her daughter, who was staying with a friend for the weekend.<sup>17</sup>
- 33 Before they left, Ms Busby also sent a text message to a mutual friend, of hers and Mr Murray's. The text message stated "*Just off to Barham to have lunch then back to Greg's to get on it!!!! I LOVE beer:-)*".<sup>18</sup>
- 34 CCTV footage from the Barham Hotel revealed nothing out of the ordinary in relation to Mr Murray and Ms Busby's behaviour. The Licensee of the Hotel, who served them, observed the couple to be happy and holding hands. During the lunch, Ms Busby had two light pots of beer and Mr Murray had two stubbies of beer.<sup>19</sup>
- 35 While still in Barham, Mr Murray spoke, via telephone, to the same mutual friend that Ms Busby had previously texted. They discussed what they had been up to that day. Mr Murray was noted to be good spirits. Mr Murray made a joke about visiting his friend in Mildura on a V-Line bus, given that he did not have his licence. Mr Murray ended the conversation with "*it's all good here mate.*"<sup>20</sup>
- 36 After returning to Mr Murray's home, Ms Busby, at 1.42pm, spoke to her brother in Western Australia for approximately 15 minutes. They talked mostly about things which were happening in Ms Busby's brother's life. Ms Busby's brother's evidence is that "*everything seemed quite normal and there didn't appear to be anything wrong or upsetting Patricia.*"<sup>21</sup> Ms Busby's brother later followed up his telephone call with his sister with a text message containing pictures of furniture that he had purchased and a drinking glass. At 8.01pm, Ms Busby responded, by text. Nothing in that text message caused her brother any concern.<sup>22</sup>
- 37 Shortly thereafter, at approximately 8.04 pm, Ms Busby left two separate voice messages for two friends, in which she stated that she was listening to music. Ms Busby's tone suggested that she was in good spirits,<sup>23</sup> although somewhat alcohol affected. There was no indication that anything was wrong.<sup>24</sup> There was a hiatus of a couple of hours where no further texts or telephone calls are recorded as having been made or received.

---

<sup>17</sup> Coronial Brief, Exhibit 2.

<sup>18</sup> Coronial Brief, p. 91.

<sup>19</sup> Coronial Brief, p. 93.

<sup>20</sup> Coronial Brief, p. 91.

<sup>21</sup> Coronial Brief, p. 80.

<sup>22</sup> Coronial Brief, p. 81.

<sup>23</sup> Coronial Brief, p. 86.

<sup>24</sup> Coronial Brief, p. 82.



38 Just after 10.00pm, Ms Busby telephoned her brother again. Due to Ms Busby's brother leaving his mobile phone in his motor vehicle, he missed the call. The message that Ms Busby left was as follows:

*"I can't believe he said there's something wrong with me, he said I'm not right in the head."*<sup>25</sup>

39 In this message, Ms Busby sounded very intoxicated.<sup>26</sup> Ms Busby's brother did not hear the message until after 2.00am and given the hour he decided not to call his sister back. There is no evidence to indicate that Ms Busby used her mobile phone to message or speak to anyone after she left the message for her brother.

40 Telephone records relevant to Mr Murray's phone indicate that he did not make any phone calls or send any text messages during the evening.<sup>27</sup>

41 There are no reported sightings of Ms Busby or Mr Murray after they left the Barham Hotel. However, not long after 11.00pm, Mr Murray arrived alone at his former wife's house in Kerang. On arrival he rang the doorbell. Mr Murray's former wife and her husband were in bed. Mr Murray's former wife went to the door, stepped outside and stood between the security and the glass front doors to speak to Mr Murray.<sup>28</sup>

42 Mr Murray indicated that he needed to talk and that he particularly needed to talk to his former wife's new husband outside. Mr Murray said that he had done something and when questioned about this, he replied that he had lost his licence for 'drink driving'. Mr Murray's former wife reports that she felt uncomfortable about the situation and stepped back into her house. It was her impression that Mr Murray appeared desperate and agitated. Mr Murray's former wife would not let her husband go outside to speak to Mr Murray.<sup>29</sup>

43 Mr Murray was told that if he did not leave, the Victoria Police would be called to take him away from the premises.<sup>30</sup> Mr Murray's former wife shut the front door, and then immediately Mr Murray fired two shotgun blasts through the door, shattering the glass. Mr Murray's former wife, who was hit by pellets in the chest, neck and hand, ran with her daughters and their friend through the back door. Her husband, who had been hit by pellets in the chest, went to follow,

---

<sup>25</sup> Coronial Brief, p. 80.

<sup>26</sup> Coronial Brief, p. 79.

<sup>27</sup> Coronial Brief, Exhibit 1.

<sup>28</sup> Coronial Brief, p. 46.

<sup>29</sup> Coronial Brief, pp. 46 – 47; 52; 57 – 59.

<sup>30</sup> Coronial Brief, pp. 47; 52 – 53; 59.

but hearing Mr Murray forcing his way in and concerned for the other children still asleep in the house, he turned instead to confront Mr Murray and wrestled with him for the shotgun.<sup>31</sup>

- 44 A neighbour, having heard the argument and subsequent gunshots, assisted with restraining Mr Murray and pushed him to the ground. Despite this, Mr Murray then ran to his motor vehicle, parked on the other side of the road, and fled, abandoning the shotgun in the process.<sup>32</sup>
- 45 Emergency services were called at approximately 11.30pm. Police and ambulance officers subsequently attended. The scene was secured and witnesses were interviewed and Mr Murray's identity was ascertained. Police officers also ascertained that a possible address, being his parents' address in Salau Road, Murrabit West, would be where they could locate Mr Murray.
- 46 Police officers located a double barrel 'Crucelegui' shotgun on the front lawn with a loaded cartridge in the chamber of both the left and right barrels,<sup>33</sup> indicating that it had been reloaded after the shots were fired through the front door.
- 47 At approximately 1.00am, Mr Murray's motor vehicle was located approximately 500 metres from the Murrabit address. The keys were in the ignition and there was still petrol in the tank.<sup>34</sup> Fifty nine loaded shotgun cartridges and one fired shotgun cartridge were located in the motor vehicle.<sup>35</sup> This was secured as a second crime scene.
- 48 Police officers made further inquiries to inform their risk assessment for an arrest plan. It was ascertained that Mr Murray's father, of the same address, had three firearms licensed to him. Mr Murray's father confirmed that two of these firearms, both shotguns, were missing from his gun cabinet.<sup>36</sup>
- 49 Aware that Mr Murray may have another shotgun, and unable to raise him on his mobile phone, the police officers formulated a plan to approach his residence on the Murrabit farm. The plan was executed at approximately 4.15am.<sup>37</sup>
- 50 After entering the premises, Ms Busby was found deceased on the floor in the main bedroom with a wound to the side and back of her head. There was blood staining on the floor, roof and

---

<sup>31</sup> Coronial Brief, pp. 53 – 54.

<sup>32</sup> Coronial Brief, pp. 54; 63.

<sup>33</sup> Coronial Brief, p. 155.

<sup>34</sup> Coronial Brief, p. 118.

<sup>35</sup> Coronial Brief, pp. 147 – 149.

<sup>36</sup> Coronial Brief, pp. 119, 128.

<sup>37</sup> Coronial Brief, pp. 113; 119; 128 – 129.

walls of this bedroom.<sup>38</sup> In the bathroom, blood staining was observed on the vanity basin and on a blue coloured face washer.<sup>39</sup> An upper glass panel on the rear door of the house was found smashed with a large amount of glass fragments located on the exterior step, suggesting an impact from the inside out.<sup>40</sup>

- 51 Police officers also located Mr Murray deceased, sitting in the driver's seat of Ms Busby's motor vehicle, parked in the carport at the rear of the house. Mr Murray had head injuries which appeared to be consistent with a shotgun blast. The keys were still in the ignition, the engine was running and the headlights were on.<sup>41</sup> Ms Busby's mobile phone was located on the passenger seat. Mr Murray was holding a single barrel shotgun between his legs, with the barrel facing up. A fired cartridge case was located in the chamber of this shotgun.<sup>42</sup> Six intact, unspent shotgun cartridges and one fired cartridge were later located in clothing he was wearing.<sup>43</sup>
- 52 A search of the area located a further fired shot gun cartridge on Salau Road between where Mr Murray's vehicle was located and his house.<sup>44</sup>
- 53 Four fired shot gun cartridges were located; one in Mr Murray's abandoned utility; one beside Salau Road between his motor vehicle and home; one in the clothing Mr Murray was wearing, and one in the barrel of the shotgun that was found between Mr Murray's legs. On the available evidence, at least four shots had been fired: the shot which killed Ms Busby, the two shots fired into the front door of Mr Murray's former wife's house and the shot which killed Mr Murray.
- 54 The four fired cartridges were examined by Leading Senior Constable Pringle from Victoria Police Ballistics Unit who determined that three of the cartridges had all being fired from the double barrel 'Crucelegui' shotgun. This is the shotgun that Mr Murray had abandoned at his former wife's house.
- 55 The fourth cartridge located in the single barrel shotgun found with Mr Murray had been fired from that gun.<sup>45</sup>

---

<sup>38</sup> Coronial Brief, p. 148.

<sup>39</sup> Coronial Brief, p. 148.

<sup>40</sup> Coronial Brief, p. 148.

<sup>41</sup> Coronial Brief, pp. 119 – 120.

<sup>42</sup> Coronial Brief, p. 155.

<sup>43</sup> Coronial Brief, p. 177.

<sup>44</sup> Coronial Brief, p. 121.

<sup>45</sup> Coronial Brief, pp. 155 – 156; 169 – 170.

56 Both shotguns were tested and were found to have effective safety mechanisms and to operate by the normal method of applying pressure to the trigger.<sup>46</sup>

### COMMENTS PURSUANT TO SECTION 67(3) OF THE *CORONERS ACT 2008*

57 For the purposes of the *Family Violence Protection Act 2008*, the relationship between Ms Busby and Mr Murray was one that fell within the definition of ‘family member’ as they had an intimate personal relationship. I am satisfied, on the available evidence, that Mr Murray killed Ms Busby and then took his own life. Moreover, the actions of Mr Murray shooting Ms Busby and causing her death constituted ‘family violence’.

58 The unexpected, unnatural and violent death of a person is a devastating event. Violence perpetrated by a person within the family unit is particularly shocking, given that it is expected to be a place of trust, safety and protection.

59 After reviewing the evidence in this matter, I requested that the Coroners Prevention Unit (CPU)<sup>47</sup> examine the circumstances of Ms Busby’s death as part of the Victorian Systemic Review of Family Violence Deaths (VSRFVD).<sup>48</sup>

60 The CPU identified the presence of known risk factors for family violence, including:

(a) recent instability in his relationship with Ms Busby, leading to discussions in relation to her desire to have more independence, a brief period of separation, and then reconciliation; and

(b) problematic alcohol use.

61 In the inquest of Ms Kelly Ann Thompson, Judge Ian Gray, State Coroner (as he then was) commissioned a report from Professor James Ogloff, Director of the Centre for Forensic Behavioural Science, about, *inter alia*, risk factors of intimate partner violence and intimate partner homicide.

62 Professor Ogloff, in his report, dated 25 August 2015, summarised current international evidence regarding the general risk factors that have been found to pertain to an increased risk

---

<sup>46</sup> Coronial Brief, p. 157.

<sup>47</sup> The Coroners Prevention Unit is a specialist service for coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety.

<sup>48</sup> The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition, the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focussed recommendations aimed at reducing the incidence of family violence in the Victorian community.

for repeating intimate partner violence. Referencing a number of studies, Professor Ogloff stated:

*“Research has identified a number of factors that have been shown to be associated with a higher risk of intimate partner violence (“IPV”). Such factors include: history of physical aggression in an intimate relationship, emotional or verbal abuse, high levels of anger/hostility, history of child abuse, mental health and disorders, substance abuse, and financial distress amongst others. Demographically, IPV is a heterogenic occurrence and is present in all groups; however, socio economic status has been indicated to weakly predict IPV. Age and ethnicity have been shown to somewhat predict IPV, but it should be noted that no demographic group holds great predictive accuracy. Psychological adjustment difficulties and behavioural history are the more accurate predictors of IPV.”<sup>49</sup>*

63 With respect to the risk factors associated with intimate partner homicide, Professor Ogloff reported:

*“Data on intimate partner homicide (“IPH”) are normally collected through friends/family of the victims or archival records after the victims has been killed. As such, the information available is often limited.*

*At the outset it is important to differentiate information that pertains to characteristics of IPH from risk factors per se. The information in this section, which describes the characteristics of IPH (perpetrators, victims and situation), is based upon known perpetrators/victims/situations. The characteristics are not necessarily risk factors. Risk factors are characteristics which serve to differentiate IPH perpetrators and situations from those who do not commit IPH in the relevant cohort in the broader population.....*

*It may be tempting to think that combining characteristics of known IPH may help establish a risk assessment instrument since the number of people who share the characteristics reduces as new characteristics are added. For example, unemployed men who are stalking their ex partners is a smaller group than all unemployed male partners. While this is true, the difficulty with IPH is its heterogeneous nature. Indeed, some male partner who kill their female partners are employed and many did not stalk their victim before killing them. Thus even combining known risk factors does not move us very far along the goal of developing an accurate risk measure for IPH.*

*While identifying and understanding characteristics of IPH is a critical first step in ultimately identifying possible risk factors, the risk factors will only be valid when they serve to validly differentiate a partner at risk of death or serious physical harm from other forms of IPV or no IPV whatsoever.”<sup>50</sup>*

64 In light of Professor Ogloff’s comments, it is important to be cautious about describing any particular matter as being a contributing factor to a family violence death or a factor which increased its likelihood or foreseeability.

---

<sup>49</sup> Report of Professor James Ogloff, 25 August 2015, [16].

<sup>50</sup> Report of Professor James Ogloff, 25 August 2015, [22] – [25].

- 65 Mr Murray's actions were unforeseen by family and friends. There was no noted change or decline in his mental state. At most, with the benefit of hindsight, his brother reflected that he may have been quieter than usual in the days preceding the death and less focussed on his work.
- 66 While Mr Murray, indicated in a discussion with a friend on 19 July 2014 that he was thinking of hurting himself, there is no available evidence that indicates that he had suicidal or homicidal ideation.
- 67 The available evidence and phone records suggest that Mr Murray had a tendency to be controlling in his relationship with Ms Busby, and that there was degree of tension and negotiation about Ms Busby's desire for her own space, time and independence. However, beyond this, there is no evidence of a prior history of physical family violence between Mr Murray and Ms Busby.
- 68 There is an allegation of family violence, which was not reported to police, by Mr Murray toward his former wife and one of his children several years prior to this incident. The evidence reveals that Mr Murray sought counselling at this time, albeit not directly in relation to his use of family violence.
- 69 Mr Murray's proximate contact with Victoria Police was in relation to 'drink driving'. The police officer involved identified the incident as a potential trigger for psychological distress or crisis and appropriately made a referral to assist Mr Murray's welfare. The agency follow up of that referral was 13 days after the referral was made. It is not clear why it took 13 days to follow up the referral. I have not explored this issue further as I am satisfied that this was not a lost opportunity to prevent the deaths because Mr Murray refused support when contact was eventually made. I note that it was not mandatory for Mr Murray to accept the agency's assistance.
- 70 My investigation has revealed that Mr Murray did not hold a licence or permit under the *Firearms Act 1996* to own or use a firearm. However, Mr Murray's father did. The evidence reveals that the firearms used by Mr Murray were stored in a locked gun cabinet at Mr Murray's father's premises. The firearms and the ammunition were stored separately. The keys to access the firearms and ammunition were hidden against an iron wall in a shed on the Mr Murray's father's farm and that Mr Murray was aware of where the keys were hidden.
- 71 Mr Murray's brother's evidence is that he could not confirm if the gun cabinet was locked or where the keys were located on the day Mr Murray killed Ms Busby. While he could not

confirm definitively whether the gun cabinet was closed on Saturday 9 August 2014 when he finished work at 6.30pm, he thought he would have noticed if it was open. It was his recollection that it was open on the morning of Sunday 10 August 2014, when checked by his father.<sup>51</sup> The available evidence indicates that Mr Murray shot and killed Ms Busby at a time after 10.00 pm on 9 August 2014, with a double barrel 'Crucelegui' shotgun taken from his father's gun cabinet. My investigation has not establish when Mr Murray accessed the 'Crucelegui' shot gun used to kill Ms Busby.

72 I am satisfied that the available evidence does not identify any obvious missed opportunities that could have prevented Ms Busby's death.

73 I am also satisfied, having considered all of the available evidence, that no further investigation is required.

74 There is no evidence of a third party being involved in either Ms Busby or Mr Murray's deaths.

## **FINDINGS AND CONCLUSION**

75 Having investigated the death of Patricia Margaret Busby and having held an Inquest in relation to her death on 9 March 2017, at Melbourne, I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

- (a) that the identity of the deceased was Patricia Margaret Busby, born 26 March 1973; and
- (b) that Patricia Margaret Busby died on or about 9 August 2014, at Murrabit, from a gunshot wound to the head; and
- (c) that the death occurred in the circumstances set out above.

76 I convey my sincerest sympathy to Ms Busby's family and friends.

77 Pursuant to section 73(1) of the *Coroners Act 2008*, I order that this Finding be published on the internet.

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

- (a) Ms Busby's family.
- (b) Sergeant Mal Simpson, Coroner's Investigator.

---

<sup>51</sup> Coronial Brief, p. 77.

- (c) Northern District Community Health Service.
- (d) Mr Peter Lauritsen, Chief Magistrate, Magistrates' Court of Victoria.
- (e) Detective Inspector Michael Hughes, Homicide Squad, Victoria Police.

Signature:



---

**JUDGE SARA HINCHEY**

**STATE CORONER**

Date: 9 March 2017