

IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

**COR 2024 005422**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Desmond Alick Budge
Date of birth:	2 May 1961
Date of death:	13 September 2024
Cause of death:	1(a) Aspiration pneumonia in a man with trisomy 21, Alzheimer's dementia and other medical co-morbidities
Place of death:	Northeast Health 35 Green St Wangaratta, Victoria 3677
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

## INTRODUCTION

1. On 13 September 2024, Desmond Alick Budge (**Mr Budge**) was 63 years old when he died at Northeast Health Wangaratta following an aspiration event.
2. At the time of his death, Mr Budge was a National Disability Insurance Scheme (**NDIS**) participant. He received funding for a Specialist Disability Accommodation (**SDA**) enrolled dwelling<sup>1</sup> operated by Kirinari Community Services where he resided with four other residents. Mr Budge had a current approved NDIS plan that started on 19 July 2024 and was due to be reassessed within 12 months. The plan included attendance at day programs at Yooralla twice per week and one on one support on a Thursday each week to access community and other activities that Mr Budge identified.
3. Mr Budge had a brother that he saw irregularly due to his brother's age. He attended church most Sunday with a friend, and they regularly had lunch together after church.

## THE CORONIAL INVESTIGATION

4. Mr Budge's death fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**) as he was a 'person placed in custody or care' within the meaning of the Act, as a person receiving funding for Supported Independent Living (**SIL**) and residing in an SDA enrolled dwelling immediately prior to his death. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.
5. 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

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<sup>1</sup> SDA enrolled dwelling is defined under the *Residential Tenancies Act 1997* (Vic). The definition, as applicable at the time of Mr Budge's death, is a permanent dwelling that provides long-term accommodation for one or more SDA residents, that is enrolled as an SDA dwelling under relevant NDIS (Specialist Disability Accommodation) Rules in force at the relevant time. An SDA resident means a person who is an NDIS participant funded to reside in an SDA enrolled dwelling, or who receives continuity of supports under the Commonwealth Continuity of Support Program in respect of specialist disability services for older people (from 1 July 2021, the Disability Support for Older Australians program). The definition of SDA resident was amended on 1 July 2024 pursuant to the *Disability and Social Services Regulation Amendment Act 2023* to extend to include persons who are residing, or propose to reside, in an SDA dwelling under an SDA residency agreement or residential rental agreement.

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

6. 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.
7. This finding draws on the totality of the coronial investigation into the death of Desmond Alick Budge, including information from the National Disability Insurance Agency (NDIA) and, the Pathologists report prepared by Dr Judith Fronczek of the Victorian Institute of Forensic Medicine (VIFM) 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.<sup>2</sup>

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

### **Circumstances in which the death occurred**

8. Mr Budge's medical history included trisomy 21 (Downs Syndrome), advanced Alzheimer's dementia, asthma, osteoarthritis and testicular cancer.
9. On 8 September 2024 he presented to Northeastern Health Wangaratta with hypoxia and tachypnoea. He was started on antibiotics and non-invasive ventilation. His condition deteriorated over the next few days and it was decided that he would be transitioned to end of life care. He sadly passed away on 13 September 2024.

### **Identity of the deceased**

10. On 13 September 2024, Desmond Alick Budge, born 2 May 1961, was visually identified by his nephew Gary Budge.
11. Identity is not in dispute and requires no further investigation.

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<sup>2</sup> 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.

## **Medical cause of death**

12. On 16 September 2024, Specialist Forensic Pathologist Dr Judith Fronczek from the Victoria Institute of Forensic Medicine conducted an external examination of the deceased and provided a written report of her findings dated 9 December 2024.

13. Dr Fronczek provided an opinion that the medical cause of death was:

1a: ASPIRATION PNEUMONIA IN A MAN WITH TRISOMY 21, ALZHEIMER'S DEMENTIA AND OTHER MEDICAL CO-MORBIDITIES

Dr Fronczek provided an opinion that the cause of death was due to natural causes.

14. I accept Dr Fronczek's opinion and am satisfied that the death was due to natural causes.

## **FINDINGS AND CONCLUSION**

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

- a) the identity of the deceased was Desmond Alick Budge , born 2 May 1961;
- b) the death occurred on 13 September 2024 at Northeast Health Wangaratta in Victoria from Aspiration pneumonia in a man with trisomy 21, Alzheimer's dementia and other medical co-morbidities; and
- c) the death occurred in the circumstances described above.

16. The available evidence does not support a finding that there was any want of clinical management or care on the part of the SIL provider, or clinical staff at Northeast Health Wangaratta, that caused or contributed to Mr Budge's death.

17. Having considered all the available evidence, I find that Mr Budge'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 Mr Budge's death in chambers.

I convey my sincere condolences to Mr Budge's family, friends and carers 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:

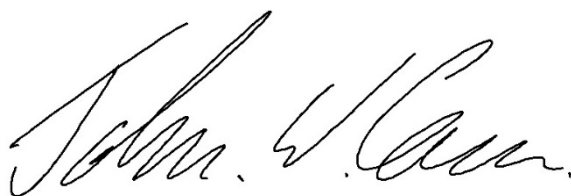
Ronald Lindsay Budge, Senior Next of Kin

Senior Constable Matthew Simmonds, Coronial Investigator

Kirinari Community Services

North East Health

Signature:



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Judge John Cain  
State Coroner  
Date: 12 May 2025

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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.

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