IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2017 5436**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**PHILLIP BYRNE, CORONER**
Deceased:	**TIMOTHY SHANE NORTON**
Date of birth:	**10 SEPTEMBER 1971**
Date of death:	**25 OCTOBER 2017**
Cause of death:	**I (a) COMPLICATIONS OF STAGE 4 COLORECTAL CANCER IN A MAN WITH MULTIPLE MEDICAL COMORBIDITIES**
Place of death:	**2 HENNESSY STREET, CHADSTONE, VICTORIA, 3148**

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

I, PHILLIP BYRNE, Coroner, having investigated the death of TIMOTHY SHANE NORTON without holding an inquest:
find that the identity of the deceased was TIMOTHY SHANE NORTON
born on 25 September 1971
and the death occurred on 25 October 2017
at 2 Hennessy Street, Chadstone, Victoria, 3148

from:

1 (a) COMPLICATIONS OF STAGE 4 COLORECTAL CANCER IN A MAN WITH MULTIPLE MEDICAL COMORBIDITIES

Pursuant to section 67(1) of the Coroners Act 2008 I make findings with respect to the following circumstances:

BACKGROUND

1. Timothy Shane Norton, 46 years of age at the time of his death, resided at a Department of Health and Human Services (**DHHS**) shared home at 2 Hennessy Street, Chadstone. He had resided there with three other residents for some ten years. Mr Norton had a severe intellectual disability. He suffered cerebral palsy, epilepsy and chronic constipation, and was unable to communicate verbally. Mr Norton's sisters, Ms Kerry Ann Norton and Ms Kym McGrane, were appointed his guardians following the death of Mr Norton's mother in 2016.

CIRCUMSTANCES SURROUNDING DEATH

2. Mr Norton suffered chronic constipation over several years. On 5 June 2017, Mr Norton was admitted to Monash Medical Centre where the following day he underwent a colonoscopy which revealed stage 4 bowel cancer. Further investigations demonstrated lesions on his liver. The situation was discussed with colorectal surgeons and oncology clinicians. It was concluded Mr Norton was not suitable for surgery or chemotherapy. On 14 August 2017, Mr Norton's

sisters and his general practitioner (**GP**), Dr Darshika Herath, agreed upon a Not for Resuscitation directive. He was placed in palliative care. Mr Norton was supported at the Hennessy Street home by staff and the Eastern Palliative Care service. Mr Norton passed away at the home in the presence of family and staff on 25 October 2017.

REPORT TO THE CORONER

3. Mr Norton's death was reported to the coroner on the basis that he was "in care" at the time of his death. Having considered the circumstances, and having conferred with a forensic pathologist, I directed an external only post mortem examination. Subsequently, I received a report under the hand of Forensic Pathologist Dr Victoria Francis of the Victorian Institute of Forensic Medicine (VIFM) who confirmed Mr Norton's death was due to:

> *1 (a) complications of stage 4 colorectal cancer in a man with multiple medical comorbidities.*

FURTHER INVESTIGATION

4. I asked my registrar to seek a directed coronial brief of evidence. In April 2018, a short directed brief was lodged with the Court. The principal statement in the brief was provided by Mr Norton's GP, Dr Darshika Herath of the Hanover Street Medical Centre. In his statement, Dr Herath wrote:

> *"Timothy was cared for by very dedicated staff and I was updated by the staff of Hennessy Street on a regular basis regarding the patient's condition."*

5. I was subsequently advised that the Disability Services Commissioner (**DSC**), after being advised of Mr Norton's death, under their charter, initiated their investigation into the provision of disability services. Following an established protocol, I determined to leave my investigation in abeyance until DSC concluded its investigation.

6. In February 2019, I received from DSC an investigation report to which is attached a caveat as to disclosure of the content of the report.

7. The investigation report is comprehensive, covering various aspects of the care/management of Mr Norton. The DSC investigation concluded that several aspects of Mr Norton's care/management were sub-optimal. From my coronial perspective, all but one of the conclusions reached by the DSC reviewers could not, in my view, reasonably be considered causal or contributory factors in Mr Norton's death. In relation to the issue of the delay in his carers arranging a faecal occult blood test as advised by his GP, even if the test did not

occur, and there seems to be some controversy surrounding the issue, while not taking issue with the DSC finding, I am not comfortably satisfied it was a causal factor in Mr Norton's death. In his statement, Dr Herath, stating that the Eastern Health Palliative team advised him of Mr Norton's death, opined Mr Norton's passing was 'caused by the natural and expected progression of his terminal condition.'

8. In any event the fact is a Notice to Take Action was issued by the DSC.

CONCLUSION

9. Section 7 of the *Coroners Act 2008* provides that a coroner should liaise with other investigative statutory officers to avoid unnecessary duplication of investigations. Based on the thorough investigation undertaken by the DSC, in accordance with section 7, I propose no further investigations and finalise my investigation by way of Finding Without Inquest.

FINDING

10. I formally find Timothy Shane Norton died on 25 October 2017 at 2 Hennessy Street, Chadstone, due to:

    1 (a) complications of stage 4 colorectal cancer in a man with multiple medical comorbidities.

11. Pursuant to section 73 (1) (B) of the Coroners Act 2008, I order that this Finding be published on the Coroners Court of Victoria website

DISTRIBUTION OF THE FINDING

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

    Mrs Kym McGrane, Senior Next of Kin; and

    Constable Laura Oriti, Reporting Officer, Victoria Police

Signature:

PHILLIP BYRNE
CORONER

Date: 28 February 2019