IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 001163

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Audrey Jamieson
Deceased:	Charles Frederick Norton
Date of birth:	01 March 1932
Date of death:	On or about 28 February 2020
Cause of death:	1(a) ISCHAEMIC HEART DISEASE IN THE SETTING OF IMMERSION
Place of death:	320 Point Cook Road, Point Cook, Victoria, 3030
Keywords:	Immersion in body of water precipitated by ischaemic heart disease, elderly, retirement village

INTRODUCTION

1. On 28 February 2020, Charles Frederick Norton was 87 years old when he was found, deceased, lying prone in a canal which flowed through the retirement village where he lived.

2. At the time of his death, Mr Norton was a widower and lived by himself at the Point Cook Retirement Village (PCRV), Point Cook, since March 2009.[1]

3. Mr Norton's partner, Jean Evans, lived in a neighbouring unit within the PCRV precinct.[2]

Background

4. Mr Norton was born in Liverpool, England, on 1 March 1932. A merchant seaman by trade, Mr Norton relocated to Australia in 1960, settling in Melbourne.

5. Before moving to the PCRV, Mr Norton lived in Laverton with his family-- his wife, Alma Norton, and their two sons, Kirk Norton (Kirk) and Craig Norton (Craig). Alma passed away in 2009. The evidence indicates that Mr Norton moved to the PCRV around the time of his wife's death.

6. Craig described his father as a 'kind man' who, during his wife's lifetime, was 'a very caring husband'. Craig recounted further that Mr Norton was also 'an excellent father' to him and his brother.[3]

7. According to Ms Evans, she and Mr Norton met in 2011 and became friends 'almost straight away' and, sometime during 2012, they 'became partners'. Ms Evans described her partner as 'a total gentleman' and, as a couple, they were together 'all the time', from walking their dogs to sharing meals to going on holidays, enjoying 'cruises together'.[4]

8. Ms Evans stated further that Mr Norton 'liked a drink' but when 'he drank, he wasn't a nasty drunk, he would still be pleasant and good company'.[5]

9. According to Craig, his father led an active lifestyle and was 'quite a fit man' who played soccer until he was about 55 [years old]' and who had given up smoking approximately 30

[1] Coronial Brief of Evidence [CB], statement of Craig Norton.
[2] CB, statement of Jean Evans.
[3] CB, statement of Craig Norton.
[4] CB, statement of Jean Evans.
[5] Ibid

years earlier. Craig did not know his father to be 'a big drinker' but became aware that Mr Norton 'drank a bit more when he [went to live] at the village'.

Mr Norton's health concerns

10. Although Craig did not know that his father had 'any health issues', he became concerned after his father had suffered a fall outside the club at the PCRV. According to Craig, on 11 October 2018, Mr Norton had been drinking and then fell, breaking his wrist and sustaining injuries to his face. About six months before his death, Mr Norton suffered another fall and amidst the family's growing concerns about Mr Norton's physical abilities, Craig took his father's car keys away from him because he 'was worried that his driving was getting bad'.[6]

11. Around the same time, Ms Evans also noticed a decline in Mr Norton's physical abilities. According to Ms Evans, about nine months before Mr Norton's death, she noticed that he was losing weight and that 'things got a bit hard' for her partner after he 'had a few falls that took their toll'.[7]

12. During the week before his death, Mr Norton called Ms Evans at 'about 6.45 am' on the 'Saturday before he died' to report to her that his 'arms were not working'. Mr Norton then asked Ms Evans to come to his unit to assist him to dress himself and when she arrived there to assist him, he complained 'about a pain in his side'. Mr Norton was then conveyed to Werribee Mercy Hospital (WMH) by ambulance where he was treated and discharged at approximately 3.30 pm on the same day. It is unclear what transpired at the WMH or what diagnosis was made there, if any.

13. On 24 February 2020, Mr Norton appeared to be disorientated and reported what Ms Evans described as 'strange things' happening to him. According to Ms Evans, Mr Norton told her that he 'was being kidnapped'. Concerned about the state of her partner's mental health, Ms Evans contacted one of his sons and arrangements were made for Mr Norton to consult his doctor (GP)[8].

14. On 26 February 2020, after Mr Norton returned from his consultation with his GP, Ms Evans learned that her partner had 'said some odd things' at the [doctor's surgery] while he was there. Arrangements were then made for Mr Norton to attend the United Wellbeing Centre

[6] CB, statement of Craig Norton.
[7] CB, statement of Jean Evans.
[8] Ibid. The date is inferred from the context in which the statement is written. It is not clear from the evidence which one of Mr Norton's sons, Ms Evans had contacted about his disorientated state.

(UWC) in Werribee, a respite centre, 'where he would get more care'. The evidence indicates that, at this stage, Mr Norton's health was in such rapid decline that his family thought that he needed specialised care.[9]

15. According to Ms Evans, on 27 February 2020, when she was in the process of conveying Mr Norton to the UWC, he was 'unsteady on his feet'. Upon their return from the UWC later that day, as indicated by the evidence, Mr Norton 'was talking strange', telling Ms Evans 'that his bed was missing' when, in fact, his bed was not missing.[10]

Medical management

16. Mr Norton attended the Laverton Medical Centre (LMC) for day-to-day treatment.

17. According to Dr Patrick Gilbourne of the LMC, Mr Norton was diagnosed with the following medical conditions:[11]

    i. Carpal tunnel release;[12]
    ii. Diabetes, type 2;[13]
    iii. Gout;[14]
    iv. Hypercholesterolaemia;[15]
    v. Hypertension;[16] and
    vi. Aortic stenosis.[17]

18. To manage his ongoing health concerns, Mr Norton was prescribed the following medication:

    i. Cartia tablets 100 mg;[18]
    ii. Gastrogel suspension 500mL;[19]
    iii. Endep tablets 10 mg;[20]
    iv. Eutroxsig tablets 50 mcg;[21]

[9] Ibid.
[10] Ibid.
[11] CB, statement of Dr Gilbourne dated 13 November 2020. According to Dr Gilbourne, Mr Norton was allergic to penicillin.
[12] Procedure performed to cut through the ligament in the wrist that is pressing down on the carpal tunnel.
[13] A chronic condition that affects the manner in which the body processes blood sugar.
[14] A form of arthritis affecting the joints.
[15] High amounts of cholesterol in the blood
[16] High blood pressure
[17] Narrowing of the valve in the large blood vessel branching off the heart.
[18] Low dose aspirin that helps to prevent blood clotting and reduces the risk of heart attack and stroke in patients with blood vessel disorders.
[19] Antacid
[20] Indicated for the treatment of mood related problems such as depression.
[21] Indicated for the management of demonstrated thyroid hormone deficiency

v. Allosig tablets 300 mg;[22]

vi. Nexium tablets 20 mg;[23]

vii. Diaformin tablets 500 mg;[24]

viii. Simvar tablets 40 mg;[25]

ix. Diamicron 60 mg;[26]

19. Dr Gilbourne noted that Mr Norton's 'history of hurting himself' by falling, resulted from his alcohol addiction which he found 'very difficult to control'. Dr Gilbourne stated further that Mr Norton 'was very resistant to any form of advice' to reduce his alcohol consumption. The evidence indicates that Dr Gilbourne had ongoing concerns about Mr Norton's alcohol-related injuries and consultations with the clinicians at the LMC.

20. On 26 February 2020, when Mr Norton attended the LMC and reported that he was having 'visual hallucinations' because he was 'withdrawing from alcohol', Dr Gilbourne advised him 'to cut down dramatically or cease alcohol consumption' because it had a detrimental effect on his health.[27]

21. Dr Gilbourne maintained that Mr Norton's 'main issue over the last number of months of his life was excessive alcohol consumption and repetitive falling' which resulted from his excessive consumption of alcohol.

THE CORONIAL INVESTIGATION

22. Mr Norton'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.

23. 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

[22] Indicated for the treatment of high levels hyperuricaemia (high levels of uric acid in the blood) associated with gout.
[23] Indicated for the treatment of acid reflux and/or ulcers.
[24] Indicated for the treatment Type 2 Diabetes Mellitus.
[25] Indicated for the treatment of hypercholesterolaemia
[26] Indicated for the treatment of Type 2 Diabetes Mellitus.
[27] CB, statement of Dr Gilbourne. The evidence that Mr Norton had hallucinations when he was withdrawing from alcohol is corroborated by the evidence of Ms Evans who stated that Mr Norton did not drink alcohol from the Monday before his death because they 'had removed all the alcohol from his unit'. Subsequently, as per VIFM Toxicology Report, *infra*, alcohol was not detected in Mr Norton's biological samples retained at autopsy which confirms that Mr Norton's symptoms may have been brought about by his withdrawal from alcohol.

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

24. 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.

25. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Norton's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

26. This finding draws on the totality of the coronial investigation into the death of Charles Frederick Norton 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.[28]

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

Circumstances in which the death occurred

27. After returning from the UWC on 27 February 2020, Ms Evans took a pasta dish to Mr Norton which she had prepared for his dinner. According to Ms Evans, her partner had his dinner at his own unit. Later that evening, at approximately 6.30 pm, when she went back to Mr Norton's unit, Ms Evans found him in bed. The evidence indicates that Ms Evans went back to Mr Norton's unit that evening to check on him. The evidence indicates further that this was the last time that Ms Evans or anyone else had seen Mr Norton.

28. On 28 February 2020, when Ms Evans went to Mr Norton's unit 'to check on him', she found Mr Norton's son, Kirk, there but there was no sign of Mr Norton himself. Ms Evans stated that they thought that Mr Norton was in the bathroom and when Kirk asked her to 'go and check on him', she discovered that he was not in the bathroom.

[28] 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.

29. Ms Evans then went driving around the PCRV grounds to see if she could find Mr Norton. When she could not find him, Ms Evans enquired from the 'village nurse' whether she had seen Mr Norton. According to Ms Evans, the nurse did not see Mr Norton on that day.

30. After Ms Evans had made her way back to Mr Norton's unit to wait for him there, both she and Kirk made a few calls to other people who they thought may have heard from or seen Mr Norton. Neither Kirk nor Ms Evans were successful in finding Mr Norton, however. Kirk then took the decision to alert the police because they 'were worried' about Mr Norton.

31. On the same day, Terri Turner, a PCRV resident and her friend, Kathy Mackendrick who was visiting her, went for a walk on the PCRV grounds.[29]

32. According to Ms Mackendrick, as they crossed the 'bridge (. . .) over the stream', her love of plants and flowing water drew her attention to the plants near the water's edge and when she ventured nearer to bridge's parapet to 'have a closer look at the plants near to the wall', she noticed an 'object which [she] thought was a large ball'. When Ms Mackendrick pointed out the object to her friend, Ms Turner identified the object as a 'human body' and alerted the PCRV Office to their discovery.[30]

33. At approximately 2.15 pm, Senior Constable (SC) Neil Purkiss of the Werribee Police Station arrived at the PCRV. According to SC Purkiss, when he arrived at the scene, his colleagues, First Constables (FC) Phoebe Riggs and Shana Famularo were already there and when the location of the "human body" was pointed out to him, he observed a 'body in the water' which was 'face down with his head under water'.[31] (sic)

34. Shortly afterwards, members of Victoria Police Search and Rescue Unit (SRU) arrived at the scene. Those SRU members then waded into the water and brought the 'body to the bank'. Arrangements were then made to convey the body to the Victorian Institute of Forensic Medicine (VIFM).

[29] CB, statement of Kathy Mackendrick. Although Ms Mackendrick refers to the date as 27 February 2020, the weight of the available evidence more accurately reflects 28 February 2020 as the date on which she had made her discovery in the canal.
[30] Ibid
[31] CB, statement of SC Neil Purkiss who subsequently assumed the role of my Coroner's Investigator.

Identity of the deceased

35. On 28 February 2020, Charles Frederick Norton, born 01 March 1932, was visually identified by a Point Cook Retirement Village employee, Robert Thomson, who signed a formal Statement of Identification.

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

Medical cause of death

37. Forensic Pathologist (FP) Dr Yeliena Baber of the VIFM conducted an autopsy on 4 March 2020.

38. Prior to conducting the autopsy upon the body of Charles Frederick Norton, Dr Baber reviewed the scene photographs, a post-mortem computed tomography (CT) scan and the Police Report of Death, Form 83.

39. After she had conducted the autopsy upon the body of Charles Frederick Norton, Dr Baber reviewed the post-mortem toxicology results and Mr Norton's medical records held on file at the LMC.

40. Dr Baber provided a written report (MER) of her findings dated 16 September 2020.

41. The post-mortem examination revealed that Mr Norton's coronary arteries and his aortic valve were 'calcified' with narrowing of both coronary ostia and all major branches of the anterior aorta. Dr Baber commented that there 'are no specific signs' consistent with a death by drowning and postulated that a medical event may have precipitated Mr Norton's 'fall into the water'.

42. Toxicological analysis of post-mortem blood samples retained at autopsy detected Doxylamine concentrated at ~0.02 mg/L.[32]

43. The toxicological analysis did not identify the presence of any alcohol or any other common drugs or poisons.

[32] CB, Toxicology Report of Lachlan Arentz, VIFM Forensic Toxicologist dated 23 March 2020. Doxylamine is an antihistamine medication indicated for the treatment of seasonal allergies and insomnia.

44. Dr Baber provided an opinion that the medical cause of death was 1 (a) ISCHAEMIC HEART DISEASE IN THE SETTING OF IMMERSION.[33]

THE FAMILY'S CONCERNS

45. On 31 March 2020, Mr Norton's daughter-in-law, Dearne Norton (Dearne) sent an email to the Court to draw my attention to 'the circumstances in which Charles was found deceased'.[34]

46. According to Dearne, she was 'troubled by the fact that the canal (. . .) does not have any type of safety railing and that the retaining wall is a sharp drop into the water'. (sic) Dearne was concerned that if anyone fell into the canal 'there does not seem to be any access out' (sic) and felt that the lack of a physical barricade to the canal 'needs to be looked at further to ensure no other family has to endure the trauma of [losing] a loved one in this way again'.

47. On 1 June 2020, Mr Norton's son, Craig, sent an email to the Court to 'provide further insight into possible contributing factors' which may be connected to his 'Fathers untimely death'.[35] (sic)

48. According to Craig, the canal running through the centre of the PCRV, in which his father 'was found immersed' was 'poorly barricaded' and 'would not have provided adequate protection for an elderly person', like Mr Norton, 'who may stumble or be unsure on their feet'. (sic)

49. To place his email in context, Craig provided photographs and a video of the PCRV environs, to illustrate that if an elderly person were to 'fall in, there is NIL way of getting out'.

50. I have perused the family's concerns and it appears that both Dearne and Craig have concerns which relate to the same issue, namely that the lack physical barriers along the canal which flows through the PCRV precinct would appear to present a risk to the 'elderly' who live there.

51. In considering the family's concerns and by taking into account the factual matrix within which the death occurred and opinion of the FP in her MER, that the medical cause of death was ischaemic heart disease in the setting of immersion, I determined that the family's concerns were valid. That Mr Norton's body was found in an unsecured canal which flowed

[33] CB, Medical Examiner's Report of Dr Yeliena Baber.
[34] Court File, email from Dearne Norton to the Court.
[35] Court File, email from Craig Norton to the Court.

through the grounds of the retirement village where other elderly people lived, that canal, in my view, would present an ongoing risk to public health and safety.

52. Consequently, invoking my prevention role as articulated in the Preamble and Purpose of the Act, I determined further that I would advance my investigation into Mr Norton's death by interrogating the family's concerns.

FURTHER INVESTIGATIONS

53. On 5 November 2020, I Directed my Coroner's Investigator (CI), SC Neil Purkiss, to compile a Directed Brief of Evidence. I specifically requested SC Purkiss to procure evidence with regard to:

i. Mr Norton's background including his personal and/or social circumstances;
ii. How long Mr Norton had been a resident at the PCRV;
iii. Mr Norton's medical and mental health history including diagnoses and concomitant prescription medication to treat any diagnosed conditions;
iv. Details of the safety features, or lack thereof, along the canal which flows through the PCRV precinct; and
v. All details of any prior incidents associated with or related to the canal where the safety of any resident was compromised.

54. On 14 January 2021, SC Purkiss delivered the Coronial Brief of Evidence (CB) for my perusal. The CB contained the following:

i. A statement from Ms Mackendrick, the witness who discovered Mr Norton's body;
ii. A statement from Mr Norton's son, Craig;
iii. A statement from Mr Norton's partner, Ms Evans;
iv. A statement from Mr Norton's GP, Dr Gilbourne of the LMC; and
v. A statement from my Coroner's Investigator, SC Neil Purkiss.

55. In addition to these statements, the CB was replete with the photographs of the canal, a map of the PCRV supplied by their Management, an internet-generated version of the map of the

PCRV, sourced from Google Maps and a PCRV Safety Audit Report (SAR), dated 29 March 2019.[36]

56. In reviewing the CB, I noted that the banks of the canal were not secured by a physical barrier, as depicted in the photographs of the scene, confirming the observations made by the family which prompted their concerns about the circumstances in which Mr Norton's death had occurred.

57. Noting further that the PCRV's most recent SAR, *vis-a-vis* Mr Norton's death, pre-dated his death, I turned to consider whether the SAR of 29 March 2019 considered the risk, actual or potential, which the unsecured banks of the canal posed to public health and safety. In my view, given the nature of the establishment, the PCRV being a residential village for the elderly, the non-existence of a physical barrier along the canal posed a risk to the PCRV residents.

58. The SAR was compiled by Eastman Lynch, an occupational health and safety (OHS) consulting firm, specialising in advising and supporting businesses to comply with their OHS legal obligations.

59. Upon closer scrutiny of the SAR, I noted that the ambit of the safety audit conducted by Senior Consultant, Danny Lynch, on 28 March 2019 was to inspect the facilities of the PCRV including the Community Centre, the apartments, the pool and gym, the roadways and garden areas, the walking paths, the resident's workshop and *all* (my emphasis) other areas.

60. In evaluating and analysing the risks to which the residents may be exposed, Eastman Lynch reviewed the PCRV's manual handling, emergency procedures, trip and *fall hazards* (my emphasis), electrical safety, general housekeeping and traffic management. According to the SAR, these were the focal points of the audit, as required by the PCRV, 'due to the risk they present being a major source of injuries in retirement villages'.[37]

61. In a "tick-box" format, the SAR specifically addressed the following areas with scores allotted, expressed as a percentage:

    i. Housekeeping, Slips and Trips and Falls—99%;

[36] CB, The SAR is titled "Safety Audit Recommendations Report" and appears to have been commissioned by the PCRV 'Village Manager', Kerry Rentsch, on behalf of the PCRV. Ms Rentsch is the nominated 'Client'. Although the SAR is dated 28 March 2019, the evidence indicates that the audit was conducted on that date and the written report was made available on 29 March 2019.

[37] CB, Eastman Lynch SAR

ii. Staff welfare, amenities and hygiene—100%;
iii. [Personal protective equipment] PPE—97%;
iv. Chemical safety—96%;
v. Accessing heights—100%;
vi. Emergency response—99%;
vii. Equipment maintenance—98%;
viii. Vehicle safety—100%;
ix. Traffic management—99%;
x. Swimming pool safety—100%;
xi. Gymnasium safety—100%;
xii. Electrical—99%;
xiii. Public areas—100%;
xiv. Manual handling and ergonomics—100%;
xv. Documentary recording—100%;

62. As part of the 2019 audit, Eastman Lynch had to consider whether the PCRV had either 'rectified' hazards identified in previous reports or put 'plans in place' to rectify hazards identified in the previous audit reports. In this regard, the 2019 SAR refers to a '2014 Audit and Compliance Completion Rating' in which the PCRV scored 99%. The evidence indicates that the PCRV commissioned safety audits to be conducted at five-yearly intervals.

63. Having scrutinised the SAR, it did not appear to me that the risk posed by the canal had been properly considered. In this regard the SAR is devoid of any reference to the inherent risks associated with a body of water in the nature of the canal which flowed through the PCRV precinct. Under the rubric "Public Areas", for which a score of 100% was allotted, the SAR document directed Eastman Lynch to consider and report on the following points only:

i. Are the car parks easy to access and safe for vehicles and pedestrians?;
ii. Are building walls protected by bollards where car spaces are close by (could be contacted if accelerator is pressed instead of brake)?; and
iii. Have all large or potentially dangerous trees been inspected in the last 12 months and has the required maintenance been carried out?;

64. Having reviewed the evidence available to me at this stage of my investigation, I was not satisfied that the PCRV safety audit considered the "Public Areas" of their precinct in its entirety. The evidence indicates that the safety audit conducted by Eastman Lynch did not

properly consider '*fall hazards*' around the canal and, moreover, the safety audit did not explore the associated risks in '*all* other areas' of the PCRV precinct as expressed in the SAR.

65. Consequently, given that the PCRV had commissioned Eastman Lynch to conduct the safety audit, I determined that it would be appropriate to address this oversight with the facility directly to advance my investigation into Mr Norton's death.

Subsequent investigations

66. On 2 December 2021, I Directed my Coroner's Investigator to obtain a statement from a suitably qualified member of the PCRV's management team to address the following issues:

    i. Has a safety audit been conducted since Mr Norton's death? And
    ii. If so, did the most recent audit assess the safety of the canal, the bridges across the canal and the surrounding pathways.

67. On 8 December 2021, Mr Peter Quinn in his capacity as the PCRV's Chief Operating Officer (COO) responded to my request for further information.

68. According to Mr Quinn, the PCRV had undertaken OHS reviews prior to Mr Norton's death and continued to do so after Mr Norton's death. The most recent OHS safety audit was conducted by Eastman Lynch on 25 October 2021. Mr Quinn submitted a copy of the SAR dated 25 October 2021 for my perusal.

69. Mr Quinn informed me further that the PCRV had undertaken 'its own inspection [of the PCRV precinct] in February 2021' and 'determined to install railings on the two bridges and three landings as well as [on the] sections of the pathway (. . .) to further enhance safety in key areas along the edge of the canal'. Mr Quinn submitted photographs of the newly erected barriers to secure the banks of the canal for my perusal.

70. In the context my prevention role and having considered the probative value of the October 2021 SAR in conjunction with the evidence relating to the PCRV's 'own inspection', I determined that this evidence would enhance the evidence already before me. Consequently,

I incorporated Mr Quinn's statement and the attachments thereto into my Coronial Brief of Evidence.[38]

71. Having reviewed the body of evidence as it was now before me, taking into account the family's concerns in relation to Mr Norton's death, I determined that the available evidence would enable me to discharge my statutory obligations and make pertinent findings in this matter. Consequently, I considered my investigation into Mr Norton's death to be complete.

COMMENTS

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

Mr Norton's death

1. The medical cause of Mr Norton's death, as ascribed by Dr Baber, does not appear to be consistent with the circumstances in which his body was found. The evidence in this regard appears to be contradictory.

2. Mr Norton was found deceased, prone and with his head submerged, in the canal which flowed through the PCRV, where he lived. The medical cause of Mr Norton's death, however, could not be reconciled with a death by drowning. Simply put, the FP did not find compelling evidence to support a conclusion that Mr Norton's death was caused by drowning. The evidence, therefore, indicates that Mr Norton's death was precipitated by an event, distinct from the circumstances in which his body was found.

3. Mr Norton's GP, Dr Gilbourne of the LMC where Mr Norton had been a patient for at least 'a number of months' leading to his death, listed 'aortic stenosis' as one of Mr Norton's medical conditions.[39]

4. At autopsy, the FP, Dr Baber, noted that the aorta and major arteries showed 'Severe complicated atherosclerosis throughout with narrowing of all major ostia'.[40] Subsequent histological testing conducted at the VIFM 'confirmed the macroscopic findings and revealed changes suspicious of amyloid deposition in the heart'.[41]

[38] CB, statement of Peter Quinn
[39] Paragraph 17, *supra*.
[40] CB, MER of Dr Baber
[41] Ibid. Amyloid deposits in the heart causes 'stiff heart syndrome'

5. Although it appears that Mr Norton's family were unaware of the nature or severity of his medical conditions, the weight of the available evidence supports a conclusion that Mr Norton's existing medical conditions were of a complex nature. The evidence indicates further that Mr Norton's cardiac health was significantly compromised.

6. In support of her autopsy findings, Dr Baber postulated four sequences in which the death may have occurred as follows:
   i. A fatal cardiac event followed by a fall into the water and no drowning;
   ii. A cardiac event followed by a fall into the water and subsequent drowning;
   iii. An accidental fall into the water and drowning without contribution from ischaemic heart disease; and
   iv. An accidental fall into the water with subsequent terminal cardiac event and no drowning.

7. Dr Baber was unable to determine which one of these sequences most accurately described the circumstances in which the death occurred.

8. In my jurisdiction, it is incumbent upon me to make findings of identity, the cause of death and the circumstances in which the death occurred, if possible, guided by the evidence and by the applicable standard of proof, *on the balance of probabilities*.[42] The rationale for making findings in relation to the circumstances in which a death has occurred, is ensconced in the restorative and preventative role which investigating coroners are bound to fulfil, as articulated in the Preamble and Purpose of the Act.

9. Without the advantage of an eyewitness account to establish how Mr Norton's body came to be found in the canal, I am left to consider the body of available evidence to enable me to make pertinent findings. In the absence of direct evidence, I sought to infer the circumstances in which Mr Norton's death occurred from the evidence before me. I considered the available evidence, mindful that any inference I sought to draw had to be reasonable in the circumstances and further, that the inference I sought to draw had to be the only reasonable inference in the circumstances.

[42] Section 67(1) of the *Coroners Act 2008 (Vic).*

10. In this regard, the evidence of Ms Evans and the medical evidence of Dr Gilbourne in conjunction with the MER of Dr Baber was particularly insightful. Immediately prior to his death, Mr Norton was confused, he experienced physical weakness and he appeared to be hallucinating. In the months prior to his death Mr Norton was diagnosed with a significant heart condition which was confirmed by Dr Baber at autopsy. The autopsy findings could not confirm that Mr Norton's death was by drowning. According to Dr Baber, Mr Norton's lungs were 'Normal in configuration and fully inflated' which was not consistent with 'signs seen in "classical" drowning' cases.

11. I have considered all the evidence. In my view, given Mr Norton's recent bout of ill health, immediately prior to his death, the weight of the available evidence supports a conclusion that his death was precipitated by a medical event. The available evidence does not enable me, however, to determine when that medical event occurred. I am, therefore, unable to determine whether Mr Norton's medical event occurred before or after he came to be in the water of the canal.

12. Similarly, the weight of the available evidence does not a support a conclusion that the absence of a barricade to secure the banks of the canal at the time of Mr Norton's death, presented an opportunity lost for Mr Norton and I am, therefore, unable to determine whether Mr Norton's death was preventable in the circumstances.

13. I do, however, acknowledge that the lack of a barricade at the time of Mr Norton's death may have been the source of the distress that his family suffered when it had been brought to their knowledge that his body was discovered in the water of the canal. Had there been a barricade in place at the time, the possibility exists that Mr Norton would not have entered the water and remained on the adjacent pathway when he died.

14. On the other hand, given the nature of the PCRV, a facility established to cater for the needs of elderly residents, the weight of available evidence supports a conclusion that the unsecured canal posed an ongoing and undue risk to public health and safety in general.

Restorative and preventative measures

15. I have considered the evidence of Mr Quinn, the facility's COO, who provided a report replete with a photographic representation of the restorative and preventative measures taken by the

PCRV after Mr Norton's death. The photographs depict the newly secured banks of the canal which flows through the PCRV precinct, with barricades installed to prevent residents from accidentally falling into the canal. I commend the proactive measures taken by the PCRV and I consider their measures to have been taken in the interests of public health and safety and with the aim of preventing harm to members of the public in similar circumstances.

16. Having acknowledged the restorative and preventative measures adopted by the PCRV, I consider any recommendations in this regard to be inappropriate and to no purpose.

17. I now make pertinent Findings in this matter.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Charles Frederick Norton, born 01 March 1932;

   b) the death occurred on or about 28 February 2020 at the Point Cook Retirement Village, 320 Point Cook Road, Point Cook, Victoria, 3030; and

   c) I accept and adopt the medical cause of death as ascribed by Dr Baber and I find that Charles Frederick Norton died from ischaemic heart disease in the setting of immersion.

2. The available evidence does not enable me to make a definitive finding about the circumstances proximate to Charles Fredrick Norton's death and I am unable to make a definitive finding about how Charles Frederick Norton's body came to be found in the water of the canal which flowed through the Point Cook Retirement Village.

3. Similarly, the weight of the available evidence does not enable me to find that Charles Fredrick Norton's death was consistent with a death by drowning and I am unable to find that his immersion in the water of the canal contributed to Charles Frederick Norton's death.

4. While it remains unknown how his body came to be found in the water of the canal, the available evidence does not support a finding that Charles Frederick Norton was alive when the chain of events occurred which led to his body being found in the water of the canal.

5. AND FURTHER, the weight of the available evidence supports a finding that Charles Frederik Norton had suffered the agonal event which contributed to his death either before or after the events which led to his body being found in the water and I find that Charles Frederick Norton's death was precipitated by a medical event.

I convey my sincere condolences to Mr Norton's family for their loss.

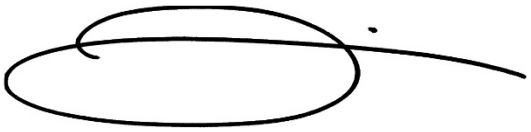
Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Craig Norton

Senior Constable Neil Purkiss, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 20 December 2022

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.