



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 001710

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Richard John Norton
Date of birth:	6 January 1950
Date of death:	30 March 2025
Cause of death:	1(a): Complications of an out of hospital cardiac arrest 1(b): Anaphylaxis 2: Asthma, hypertrophic cardiomyopathy.
Place of death:	The Alfred Hospital 55 Commercial Road Melbourne Victoria
Keywords:	Peptides – anaphylaxis – unapproved therapeutic goods – prescription medication

INTRODUCTION

1. On 30 March 2025, Richard John Norton was 75 years old when he passed away at the Alfred Hospital. At the time of his death, Richard lived in South Melbourne with his wife, Judy Norton.

BACKGROUND

2. Richard was a very experienced martial artist. He had also been involved in the film and television industry as an actor, stuntman and instructor.
3. Richard's medical history included asthma, bilateral shoulder reconstructions and osteoarthritis. He had been prescribed medication by his treating medical practitioners including anastrozole, finasteride, loratadine, metformin, somatropin, testosterone and Genotropin.
4. On 11 March 2025, Richard attended medical practitioner Dr Jerzy Muchnicki and advised that he was interested in peptide therapy. He disclosed to Dr Muchnicki that he had been previously prescribed peptides¹ by another practitioner which had been effective in treating symptoms relating to fatigue, reduced physical recovery, shoulder pain and loss of lean muscle mass. Dr Muchnicki stated that he reviewed Richard's medical history and discussed in detail what was involved with peptide therapy, including the experimental nature of the treatment. They also discussed the potential risks and the lack of other alternative treatment options currently approved by the Therapeutic Goods Administration (TGA). Dr Muchnicki also arranged a series of blood tests "*to confirm baseline health parameters and assess for any contraindications or underlying conditions that may influence treatment decisions*".
5. On 15 March 2025, Richard consulted with Dr Muchnicki and they discussed his blood test results and Richard also signed an *Informed Consent Form for Peptide Therapy* which outlined the treatment he would be receiving and the benefits and the risks. One of the risks identified for the peptide CJC1295 & Ipamorelin was anaphylaxis.
6. On 19 March 2025, after arranging further blood tests and a computed tomography (CT) artery calcium score, Dr Muchnicki considered that it was clinically indicated for Richard to commence peptide therapy. Specifically, he prescribed CJC1295 & Ipamorelin 2000mcg solution, with a subcutaneous injection of 0.1ml in the evening on Monday to Friday. Dr

¹ BPC157 & Thymosin B4; CJC1295 & Ipamorelin; TB-500.

Muchnicki stated that he obtained the medication from a licensed compounding pharmacy in Queensland, which was then forwarded to Richard.

7. Dr Muchnicki stated that:

“Peptide therapy was prescribed as an adjunctive, non-surgical option after consideration of prior treatments and patient preference, absence of identified contraindications on assessment and emerging but limited literature suggesting potential benefit in musculoskeletal healing pain and modulation.”

8. He acknowledged that *“the treatment is recognised as experimental and prescribed off-label, but it is done so under close clinical supervision, with ongoing monitoring and consideration of individual patient needs and responses”*.
9. On 25 March 2025, Richard consulted with Dr Muchnicki and reported that he was feeling good and the peptide therapy was improving his symptoms.
10. On 28 March 2025 at around 4.00pm, Richard consulted with a nurse at Dr Muchnicki’s clinic. He advised that he had dropped and broken a vial of CJC1295 & Ipamorelin and requested a replacement. The nurse spoke with Dr Muchnicki over the phone who authorised the replacement. Richard reported that he was experiencing better sleep, reduced pain and increased exercise capacity with no side effects. He also disclosed to the nurse that he had been administering double the prescribed dose of CJC1295 & Ipamorelin. The nurse advised Richard that from the following week he ought to only administer the prescribed dose. Further, Dr Muchnicki prescribed two additional peptides, BPC157 & Thymosin B4 and TB-500 with the intent to further improve function and reduce pain.

THE CORONIAL INVESTIGATION

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

13. 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.
14. Section 8 of the Act provides that a coroner should liaise with other investigative authorities, official bodies or statutory officers to avoid unnecessary duplication of investigations and to expedite the investigation of deaths.
15. This finding draws on the totality of the coronial investigation into Richard's death, including information obtained from his medical records, statements from treating medical practitioners and evidence obtained from the Australian Health Practitioner Regulation Agency (**AHPRA**) and the TGA. While 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.²

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

Circumstances in which the death occurred

16. On 28 March 2025 at around 9.00pm, Richard injected a dose of CJC1295 & Ipamorelin. Judy reported that he had also administered a dose in the morning. Judy recalled that after administering the second dose, Richard complained of feeling hot and flushed and then collapsed and became unresponsive. She contacted her General Practitioner who in turn contacted emergency services at 9.10pm. Judy also commenced cardiopulmonary resuscitation (**CPR**). Ambulance Victoria arrived at around 9.22pm and paramedics observed that Richard was experiencing cardiac arrest. Return of spontaneous circulation was achieved at 9.55pm and Richard was intubated and transported to the Alfred Hospital for further treatment.
17. At hospital, Richard's tryptase and troponin levels were noted to be elevated. Clinicians assessed that Richard had likely suffered a cardiac arrest secondary to anaphylaxis from the

² 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.

peptide injection. He subsequently developed ischaemic bowel and was deemed not suitable for medical intervention. He passed away on 30 March 2025 at 10.17am.

18. Judy disclosed to medical staff that Richard had been injecting peptides twice a day for muscle growth and healing. It was recorded that Richard had been experiencing reactions since his first injection – *“initially local redness and swelling, and subsequently whole of body flushing for the last few days”*. It was recorded that when Richard administered the injection in the morning on 28 March 2025, *“he had whole of body flushing, chest tightness, and shortness of breath”* which subsided after he used his Ventolin.³
19. After Richard passed away, Victoria Police attended his house and Judy provided them with a number of medication containers, including an unsealed pouch containing a vial of CJC1295 & Ipamorelin and a sealed pouch containing an unused vial of BPC157 & Thymosin B4.⁴ No vials of TB-500 were located at the scene.

Identity of the deceased

20. On 30 March 2025, Richard John Norton, born 6 January 1950, was visually identified by his wife, Judy Norton.
21. Identity is not in dispute and requires no further investigation.

Medical cause of death

22. Forensic Pathologist Dr Daniel Hussey from the Victorian Institute of Forensic Medicine performed an autopsy on 3 April 2025 and provided a written report of his findings dated 18 September 2025.
23. Dr Hussey noted that Richard suffered a cardiac arrest at home following self- administration of recently commenced peptide therapy. He stated that death resulted from hypoxic ischaemic encephalopathy, ischaemic bowel and myocardial ischaemia which occurred as a result of cardiac arrest.
24. Dr Hussey explained that peptides are small proteins which can be produced synthetically or endogenously. Injections of some types of peptides are increasingly being used in sports performance to increase healing and muscle growth. However, they are not approved by the

³ Alfred Health medical records, p 174.1

⁴ The pouches were labelled with the logo of Dr Muchnicki’s clinic, Dermal Clinicians.

TGA or any global regulatory authority for human use. They are mostly considered experimental in humans. The toxicology is largely unknown, but they have potential side effects including carcinogenicity, endocrine and cardiovascular effects.

25. Dr Hussey found evidence of anaphylaxis at autopsy. Anaphylaxis is a severe life-threatening allergic reaction that results from degranulation of mast cells in the soft tissues, especially in the airways and gastrointestinal system. It occurs when the immune system reacts inappropriately to a substance to which the individual has previously been exposed. Symptoms include airway swelling, facial flushing, low blood pressure and vomiting. Death can result from either asphyxia or clinical shock due to profoundly low blood pressure with resultant circulatory collapse and cardiac arrest.
26. Noting the temporal relationship between Richard's commencement of peptide therapy and the allergic symptoms in the lead up to his collapse, Dr Hussey favoured the peptide injections as a possible cause for his anaphylaxis.
27. Hypertrophic cardiomyopathy⁵ was also found at autopsy which increases the risk of lethal heart arrhythmias and cardiac arrest. Dr Hussey stated that it could have contributed to death in the setting of anaphylaxis.
28. Dr Hussey also considered that induced airway swelling from Richard's asthma could have contributed to death in the setting of anaphylaxis.
29. Toxicological analysis of ante-mortem samples identified the presence of midazolam, laudanosine, amiodarone, metformin and atropine, consistent with the provision of emergency medical treatment. Detection of the specific peptides administered by Richard was not possible as part of the post-mortem toxicological testing process.
30. Dr Hussey provided an opinion that the medical cause of death was *1(a) Complications of an out of hospital cardiac arrest; 1(b) Anaphylaxis; 2 Asthma, hypertrophic cardiomyopathy.*
31. I accept Dr Hussey's opinion.

⁵ Hypertrophic cardiomyopathy is a disease of the heart muscle that results in enlarged heart muscle cells, dysfunction of the heart muscle and fibrosis.

AHPRA INVESTIGATION

32. AHPRA is the national regulation agency that provides administrative support to a number of national boards, including the Medical Board of Australia (MBA) under the Health Practitioner Regulation National Law. One of their purposes is to ensure that Australia's health practitioners are suitably trained, qualified and safe to practise.
33. AHPRA received a notification raising concerns about Richard's treatment by Dr Muchnicki. The MBA conducted an investigation which included obtaining an independent expert report from Clinical Professor Alistair Vickery. He is a very experienced medical practitioner with a speciality qualification in clinical general practice, medical education, clinical governance and academic research.
34. Professor Vickery stated that CJC1295/Ipamorelin is a peptide which is deemed experimental, with no therapeutically approved uses in Australia or quality evidence-based research studies on its safety, efficacy or benefits. He stated that the likely adverse effects associated with CJC1295/Ipamorelin include nerve or muscle or joint pain, oedema, carpal tunnel syndrome and numbness or tingling of the skin, headaches, increased glucose levels, heart disease, diabetes and in rare cases allergic reaction including anaphylaxis.
35. Professor Vickery stated that there is insufficient evidence that CJC1295/Ipamorelin is safe, effective or beneficial for human use.
36. Taking into account Dr Muchnicki's training and experience, and the history and written consent obtained from Richard (including his prior use of peptides without adverse effects and the reported improvements experienced by him), Professor Vickery considered that the clinical care provided by Dr Muchnicki was at a standard reasonably expected. However, he considered that the contemporaneous notes taken by Dr Muchnicki which recorded his consultations with Richard were sparse, inadequate and perfunctory and were substantially below the standard reasonably expected. He also found that, given the known risk of misuse of CJC1295/Ipamorelin, Dr Muchnicki ought to have directly contacted Richard to obtain an accurate history and risk assessment before re-prescribing the medication on 28 March 2025. He considered that Dr Muchnicki's performance as a medical practitioner was below the standard expected in regards to this issue.
37. In the course of the MBA's investigation, Dr Muchnicki acknowledged Professor Vickery's criticisms in relation to his practice, accepted accountability for his actions and apologised for

his errors in judgment and lapses in record keeping, and expressed sorrow for the impact on Richard and his family. He stated that he had reflected on the circumstances and was committed to improving his practice and professional standards. Further, he had engaged an educator to provide one-on-one education in clinical record keeping and management. Dr Muchnicki advised the MBA that he will no longer prescribe peptides and will refrain from doing so unless supported by robust clinical evidence, such that the ongoing risk they present has been mitigated.

38. The MBA found that Dr Muchnicki's practice "*is or may be unsatisfactory*" in the following respects:

- a) Dr Muchnicki authorised an additional supply of CJC1295/Ipamorelin on the basis that the patient reported inadvertently breaking the prescribed bottle. However, he did so without consulting the record of a practice nurse, which documented that the patient had reported dosing the medication incorrectly, and without directly contacting the patient to confirm appropriate use or to assess for potential misuse or adverse effects. This represents a departure from the expected standard and a missed opportunity to provide additional counselling on safe use, prior to the fatal outcome experienced by the patient; and
- b) Patient records lacked adequate detail and failed to record the particulars of the consultations and assessments that occurred, as reported by Dr Muchnicki. This represents a departure from the *Medical Board of Australia - Good medical practice: a code of conduct for doctors in Australia*.

39. In the course of its decision dated 16 July 2026, the MBA stated that it does not endorse the prescribing of peptide therapies. However, after noting the report of Professor Vickery and Dr Muchnicki's acknowledgements, concessions and intentions, the MBA determined that regulatory action was not warranted in relation to the clinical care provided to Richard by Dr Muchnicki. Although, the MBA did determine to:

- a) Caution Dr Muchnicki to reinforce the need for ongoing vigilance and adequate risk assessment before issuing a replacement prescription; and
- b) Impose conditions on Dr Muchnicki's registration requiring him to undertake one-on-one education in relation to clinical record keeping and management in order to build on the education that he has already undertaken as well as undergoing an audit of his

record keeping following completion of the education to satisfy the MBA that the education has resulted in change to his practice.

THERAPEUTIC GOODS ADMINISTRATION

40. The Court obtained a statement from the TGA dated 18 September 2026.
41. The TGA administers the *Therapeutic Goods Act 1989* (Cth) which provides, among other things, a national system of control relating to the quality, safety, efficacy and timely availability of therapeutic goods in Australia.
42. The TGA explained that, generally, therapeutic goods must be included in the Australian Register of Therapeutic Goods (**ARTG**) before they can be manufactured, supplied in, or exported to Australia. Therapeutic goods that are not included in the ARTG are described as “unapproved” and have not been evaluated by the TGA for quality, safety or efficacy.
43. The peptides CJC1295 & Ipamorelin, BPC157 & Thymosin B4 and TB-500 are not listed in the ARTG and are therefore unapproved therapeutic goods. Various pathways exist to enable Australian-registered health practitioners (including medical practitioners) to access unapproved goods, including the Authorised Prescriber Scheme and the Personal Importation Scheme. Generally, health practitioners are expected to have trialled or considered treatment options that are included in the ARTG and are available for supply in Australia prior to considering accessing unapproved therapeutic goods.
44. CJC1295 & Ipamorelin, BPC157 & Thymosin B4 and TB-500 and many other peptides are classified as prescription-only medicines in Schedule 4 of the Poisons Standard.⁶ This standard has been incorporated into Victorian law by the *Drugs, Poisons and Controlled Substances Act 1981*.
45. The TGA has received six reports of anaphylaxis or hypersensitivity in patients using CJC1295 & Ipamorelin, BPC157 or Thymosin B4 and TB-500, including three cases of anaphylaxis in patients using CJC1295 & Ipamorelin (not including Richard’s case).

⁶ *Therapeutic Goods (Poisons Standard – June 2006) Instrument 2026* (Cth). This standard is administered by the TGA and is intended to promote uniform scheduling of substances throughout Australia.

GUIDANCE FOR PRACTITIONERS

46. AHPRA has stated that it has been concerned that growing consumer demand for certain medicines (including some peptides), coupled with undue commercial influence, has led some practitioners to depart from established professional standards. To respond to that concern, they recently published in September 2026 new guidance for practitioners when prescribing off-label,⁷ unapproved or compounded medicines.⁸ The guidance notes that:

“Prescribing of off-label, unapproved or compounded medicines can play an important role in providing safe, effective and patient-centred care. These medicines may help meet specialised patient needs, provide treatment options for those not eligible for clinical trial, or support access when another medicine is unavailable or in short supply”.⁹

47. The guidance provides that off-label, unapproved or compounded medicines should only be prescribed when there is sufficient evidence, a clear indication or when other treatments have not worked or are inappropriate for the patient.

FINDINGS AND CONCLUSION

48. I am satisfied that Richard’s death was triggered by his injection of the peptide CJC1295/Ipamorelin. Richard had been taking amounts of the medication in excess of the dose prescribed by his medical practitioner. The injection caused an anaphylactic reaction which in turn led to cardiac arrest.
49. Pursuant to section 67(1) of the Act, I make the following findings:
- a) the identity of the deceased was Richard John Norton, born 6 January 1950;
 - b) the death occurred on 30 March 2025 at the Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, from complications of an out of hospital cardiac arrest, anaphylaxis and asthma and hypertrophic cardiomyopathy as contributing factors; and
 - c) the death occurred in the circumstances described above.

⁷ Off-label refers to the use of medicine, which is included in the ARTG, for a purpose that or in a manner that differs from that stated in its TGA-approved product information.

⁸ Compounded medicines are preparations, mixtures or alterations of ingredients made by a pharmacist or doctor for a specific patient when commercially available products are unsuitable or unavailable. Compounded medicines are unapproved medicines and have not been assessed by the TGA for safety, quality and efficacy prior to supply.

⁹ <https://www.ahpra.gov.au/Resources/Prescribing-off-label-unapproved-or-compounded-medicines#>

COMMENTS

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

50. Peptides such as CJC1295/Ipamorelin are prescribed as poisons under Schedule 4 of the Commonwealth Poisons Standard administered by the TGA and incorporated into Victorian law by the *Drugs, Poisons and Controlled Substances Act 1981*. They can only be legally obtained with a prescription from a medical practitioner. Drugs included in Schedule 4 are generally intended for recognised therapeutic use.
51. Peptides are deemed experimental, with no therapeutically approved uses in Australia. There is insufficient evidence that CJC1295/Ipamorelin is safe, effective or beneficial for human use. Peptide therapy is not endorsed by the MBA. Further, peptides such as CJC1295 & Ipamorelin, BPC157 & Thymosin B4 and TB-500 have not been evaluated by the TGA for quality, safety and efficacy.
52. Given the likely risks associated with peptides such as CJC1295/Ipamorelin, including anaphylaxis, and the lack of evidence as to their therapeutic benefits, I am not satisfied that it is appropriate for them to be available to be prescribed by medical practitioners. It is not clear to me how their safe use can be clinically indicated given the acknowledged uncertainties as to their therapeutic benefit and their risks (as yet not fully known) to the safety of patients. Accordingly, I am not satisfied that they are appropriately included in Schedule 4 of the Poisons Standard.
53. In the circumstances, I am of the view that it would be appropriate and in the public interest for the TGA to review the use of peptides such as CJC1295/Ipamorelin and consider whether further restrictions ought to be imposed, such as them being classified under Schedule 10 of the Poisons Standard. Schedule 10 is titled *Substances of such danger to health as to warrant prohibition of supply and use*. Such a classification could be formulated to ban the use of peptides such as CJC1295/Ipamorelin for human use subject to specific exceptions, such as clinical trials or other experimental use. This would enable further research to continue in relation to their use, as it may be that in time specific therapeutic uses will be identified which justify the associated risks.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendation:

1. That the Therapeutic Goods Administration review the therapeutic benefits and safety risks of peptides such as CJC1295/Ipamorelin and consider whether further restrictions ought to be imposed on their use, such as them being classified under Schedule 10 of the *Therapeutic Goods (Poisons Standard – June 2006) Instrument 2026* (Cth).

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

Pursuant to section 73(1A) 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:

Judy Norton, Senior Next of Kin

Dr Jerzy Muchnicki

Dr Peter Lewis

Alfred Health

Australian Health Practitioner Regulation Agency

Therapeutic Goods Administration

Constable Tao Soerono, Coronial Investigator

Signature:



Coroner David Ryan

Date: 28 October 2026



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.
