IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 4344

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Philip Charles Arnott

Delivered On:	14 July 2026
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing Date:	14 July 2026
Findings of:	Coroner Paul Lawrie
Representation:	no appearance
Assisting the Coroner:	Ms Olivia Vella, Coroners Court of Victoria
Keywords:	In care; Specialist Disability Accommodation; SDA; Risperidone toxicity

INTRODUCTION

1. On 8 August 2023, Philip Charles Arnott was 70 years old when he died at the Gandarra Palliative Care Unit at the Queen Elizabeth Centre (Grampians Health) in Ballarat, Victoria.

2. At the time of his death, Mr Arnott resided in Delacombe, Victoria, at a Specialist Disability Accommodation (**SDA**) dwelling enrolled under the National Disability Insurance Scheme (**NDIS**). The SDA was operated by West End Support Services, a registered NDIS provider. Mr Arnott received funded daily independent living support through the NDIS.

CORONIAL INVESTIGATION AND INQUEST

3. 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.

4. 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.

5. Pursuant to section 4(2)(c) of the *Coroners Act 2008* (Vic) (**the Act**), the death of a person who immediately before their death was 'a person placed in custody or care', falls within the definition of a reportable death. A person in Victoria who is an SDA resident[1] residing in an SDA enrolled dwelling'[2] is a person 'in care' within the meaning of the Act.[3] The

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[1] 'SDA resident' means a person with a disability – (a) who receives, or is eligible to receive, funded daily independent living support; and (b) who is residing, or proposes to reside, in an SDA dwelling under an SDA residency agreement or residential rental agreement, *Residential Tenancies Act 1997* – s.3(1).

[2] *Residential Tenancies Act 1997* – s.3(1) (definition of 'SDA enrolled dwelling').

[3] *Coroners Regulations 2019* – r.7(1)(d).

death of a person in care is a mandatory report to the coroner, regardless of the apparent cause of death.

6. I am satisfied Mr Arnott was an SDA resident residing in an SDA enrolled dwelling and therefore he was a person 'in care' for the purposes of the Act. Accordingly, pursuant to section 52(2)(b) of the Act, an inquest is mandatory where the apparent cause of death is not wholly attributable to natural causes.

7. I determined that the inquest should proceed in a summary manner as the evidence may be regarded as complete and uncontentious, and it is appropriate for the evidence to be admitted in a summary form without the need to examine witnesses. This took place on 14 July 2026.

8. First Constable (**FC**) Jack Clarke of Victoria Police acted as the Coronial Investigator for the investigation of Mr Arnott's death. FC Clarke conducted inquiries on my behalf, including taking statements from treating medical practitioners, clinicians and care support workers, and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of Philip Charles Arnott 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.[4]

PERSONAL BACKGROUND

10. Mr Arnott was one of nine children. He was born in Horsham, Victoria, and spent most of his life in the Ballarat area. His brother described him as "*very sporty*". He enjoyed many sports including football, cricket, pool and tennis. He also enjoyed playing the pokies and Tattslotto.

[4] 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.

11. Mr Arnott suffered a football injury when he was about 13 years old. His family explained that this appeared to be the beginning of his mental illness, including schizophrenia.

12. In his later life, Mr Arnott was also diagnosed with heart failure,[5] hypothyroidism, gastro-oesophageal reflux disease and chronic obstructive pulmonary disease. He was prescribed 12 mg paliperidone to control his symptoms of schizophrenia. This dose was commenced in 2015 and continued until the time of his death.

13. In the 12 months prior to his death, Mr Arnott had five inpatient admissions to Grampians Health for both physical and mental health problems. According to his carer, he had numerous falls or instances where he lowered himself to the ground, expressing a fear that he was going to fall. He did not suffer any major injuries from these incidents.

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

Circumstances in which the death occurred

14. On 31 July 2023, Mr Arnott was at home, having a shower with the assistance of his carers. He collapsed from standing height and hit his head on a bench in the shower. He remained conscious, however complained of feeling dizzy and was unable to stand up on his own. Staff assisted him up off the floor and into a seated position and called Triple Zero due to his altered conscious state.

15. When paramedics arrived, Mr Arnott had a rapidly declining conscious state with low blood pressure, and a heart rate of 50 bpm. He was also hypothermic (temperature of 30.1°C). Paramedics conveyed him to Ballarat Base Hospital.

16. Clinicians thought Mr Arnott's presentation on this occasion was similar to his previous presentation (from 28 May to 20 July 2023), where the working diagnosis was functional decline and cold sepsis. Clinicians ordered computed tomography (CT) brain and neck scans; however, these were not performed and it is unclear why this is so. In the emergency

[5] Heart failure with preserved ejection fraction.

department, Mr Arnott received antibiotics, multiple fluid boluses of normal saline and metaraminol and noradrenaline.

17. Mr Arnott was admitted to a general medicine ward. Clinicians noted his presentation was similar to previous presentations, with no clear source or aetiology. Following discussions with Mr Arnott's family, he was transitioned to end of life care. On 1 August 2023, he was moved to the Gandarra Palliative Care Unit where he passed away on 8 August 2023.

Identity of the deceased

18. On 8 August 2023, Philip Charles Arnott, born 20 May 1953, was visually identified by his carer, Gary Jew.

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

Medical cause of death

20. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine conducted an autopsy on 14 August 2023 and provided a written report of his findings dated 1 November 2023.

21. The post-mortem CT scan showed increased lung markings. However, there was no evidence of intracranial haemorrhage, and the cervical spine was unremarkable.

22. The post-mortem examination showed bronchopneumonia in multiple lung fields, acute pancreatitis and an enlarged heart with relatively mild coronary artery disease. There was no evidence of adrenal gland atrophy or infiltration as a cause of unexplained hypotension.

23. The post-mortem examination showed no evidence of any injury which would have contributed or led to death.

24. Toxicological analysis of post-mortem samples did not identify any alcohol. There was a raised acetone level, reflecting a fasting state. There was no hyperglycaemia, which excluded the likelihood of diabetic ketoacidosis. The analysis also showed a raised urea concentration of 30 mmol/L, which indicated a degree of renal impairment.

25. Toxicological analysis also detected hydroxyrisperidone (Paliperidone) at approximately 120 ng/mL, however Dr Burke explained that therapeutic levels of this drug are approximately 20 ng/mL. Mr Arnott was on a dose of 12 mg at night. Excess risperidone in the blood may result in hypotension, muscle spasms, lethargy, coma, tachycardia, sweating and fever. Dr Burke opined that at least some of Mr Arnott's symptoms could be explained by the toxic effects of risperidone.

26. Dr Burke provided an opinion that the medical cause of death was *1(a) Multiple organ failure* secondary to *1(b) Bronchopneumonia and acute pancreatitis in a man with hypertensive heart disease and probable risperidone toxicity.*

27. I accept Dr Burke's opinion save that I determine it is appropriate to include schizophrenia as a contributing factor, for reasons detailed below. Accordingly, I find that the cause of death is:

    1(a) Multiple organ failure
    1(b) Bronchopneumonia and acute pancreatitis in a man with hypertensive heart disease and probable risperidone toxicity
    2. Schizophrenia

FURTHER INVESTIGATIONS AND CPU REVIEW

28. In light of Dr Burke's findings of probable risperidone toxicity, I referred this case to the Coroners Prevention Unit (**CPU**)[6] for an independent review of the medical treatment Mr Arnott received from Grampians Health in the period shortly before his death. The Court also gathered a statement and records from Grampians Health.

[6] The CPU was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

Paliperidone (9-hydroxyrisperidone)

29. Paliperidone is an antipsychotic agent used for the treatment of schizophrenia and schizoaffective disorders. It is available as an extended-release tablet or injection. Paliperidone is the active metabolite of risperidone.

30. As noted above, Mr Arnott was prescribed 12 mg daily, which is the maximum dose suggested by the manufacturer. He was on this dose from 2015 and appeared to tolerate it well for most of that time. However, he did experience some refractory mental health symptoms requiring inpatient admissions and additional medications at times.

31. The product information for paliperidone advises that dose adjustments should be made for patients with evidence of renal failure. Mr Arnott had normal renal function in January 2023, and evidence of moderate renal function in May 2023, and until his death in August 2023. On 20 January, Mr Arnott's estimated glomerular filtration rate (**eGFR**)[7] was 65 (normal range is more than 60). On 29 May 2023, his eGFR was 26, and remained low until his death. His last recorded eGFR level was 35, on 9 June 2023. The CPU noted that Mr Arnott's treating clinicians documented his renal impairment but did not reduce his dose of paliperidone.

32. The product information for paliperidone describes the potential effects of toxicity to include dyskinesia,[8] extrapyramidal symptoms,[9] neuroleptic malignant syndrome,[10] orthostatic hypotension,[11] somnolence,[12] prolongation of the QT interval on ECG[13] and reduced ability to regulate body temperature. The CPU noted that many of these clinical features were evident from the medical records during Mr Arnott's admissions from May to July 2023, and July 2023 until his death.

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[7] eGFR measures how well the kidneys are filtering blood.
[8] Abnormal mouth and tongue movements.
[9] Parkinsons-like motor features such as muscle stiffness or twitching, slowed walking speed and reduced facial expression.
[10] A rare and life-threatening reaction to the use of almost any kind of neuroleptic (antipsychotic) medication. It causes hypothermia, muscle rigidity, altered mental status and autonomic nervous system dysfunction.
[11] Low blood pressure, especially after a change in posture.
[12] Drowsiness and altered conscious state.
[13] An electrical measure on the ECG where a prolongation is a risk for arrythmias.

33. The CPU explained that blood tests to monitor for risperidone levels are not recommended, as clinical efficacy may not be reflected by attaining a 'therapeutic level' of risperidone. It is generally preferrable to titrate the dosage for clinical effect, while monitoring for side effects.

34. The CPU noted that while Mr Arnott continued to experience refractory metal health symptoms despite a maximum recommended dose, it was also likely that he was experiencing effects of the drug that warranted a dose reduction.

Statement from Grampians Health

35. A statement on behalf of Grampians Health was provided by Dr Rosemarie Eyre, a registrar training in medical management. Although asked to provide a detailed timeline of Mr Arnott's May to July 2023 admission, the statement included only the following:

> *28/05/23-20/7/23 (General Medicine): Functional decline- cold sepsis and acute urinary retention.*

36. Dr Eyre did not refer to acute pancreatitis or risperidone toxicity[14] as possible contributing factors to Mr Arnott's unexplained decline, but stated:

> *The presentation of fluctuating conscious state and hypothermia was attributed to probable cold sepsis complicated by volume depletion.*

37. Dr Eyre explained that Mr Arnott was reviewed by a consultant on seven occasions from 28 May 2023 to 20 July 2023. Four of those seven reviews occurred within the first four days of his admission.

38. The Court also asked whether Grampians Health had performed an internal review into Mr Arnott's death. Dr Eyre explained that a 'line manager' review had been conducted by the mental health team. This review does not appear to have involved the general medicine team and no recommendations were made.

[14] Such information having been provided to Grampians Health in the Autopsy Report of Dr Burke.

39. Grampians Health did not offer a clinical opinion in relation to whether risperidone toxicity and/or pancreatitis could or should have been considered within the differential diagnosis for Mr Arnott. The statement was also silent as to how paliperidone safety is monitored for patients at Grampians Health.

40. The CPU noted that there was no evidence that an appropriate dose reduction of paliperidone was considered during Mr Arnott's final two admissions, despite the documented renal failure and acute tubular necrosis, which indicated the need for a dose reduction. The CPU ultimately opined that it was likely that unrecognised risperidone toxicity contributed to Mr Arnott's condition. I accept this opinion.

Additional comments arising from the CPU review

41. Mr Arnott had a refractory and progressive mental health condition where his prognosis was poor. He had multiple admissions for mental health issues and was reaching the limits of options for antipsychotic medications, thus capping their effectiveness.

42. The CPU was unable to identify a single trigger for the decline of Mr Arnott's health in May 2023, when he presented with fluctuations in his conscious state, body temperature regulation, renal failure and low blood pressure. He subsequently developed complications including bronchopneumonia and multi-organ failure. The CPU explained that it is known that any condition that causes renal failure may lead to inadequate clearance of paliperidone and risperidone toxicity. Conversely, both risperidone toxicity (through hypotension and dehydration) and/or pancreatitis can cause renal failure. Although the trigger cannot be determined, all conditions were present during Mr Arnott's final illness, of which only risperidone toxicity could be considered a prevention opportunity.

43. I accept however that Mr Arnott was resistive to further medical tests and interventions, which made accurate diagnosis difficult.

44. Following a review of Mr Arnott's medical records, the CPU identified several missed opportunities to identify potential risperidone toxicity and reduce his paliperidone dose. I consider that the following opportunities were material:

(a) Mr Arnott's hypotension, hypothermia and altered conscious state reoccurred, despite treatment for sepsis. While alternative diagnoses were considered,[15] risperidone toxicity was not investigated, and a consultant mental health medication review was not arranged.

(b) Possible neuroleptic malignant syndrome was raised and 'cut and paste' repeatedly throughout the medical record, however a medication cause or contribution for Mr Arnott's presentation does not appear to have been considered further. Features of neuroleptic malignant syndrome are also seen in antipsychotic toxicity such as sedation, hypotension and abnormal muscle movements.

CPU recommendation concerning cause of death

45. The CPU suggested that I accept the cause of death as detailed by Dr Burke but also suggested that I add a contributing factor of schizophrenia, given the refractory nature of Mr Arnott's condition and the requirement for high doses of antipsychotic medication, leading to complications.

46. I accept this opinion and amend the cause of death to include schizophrenia as a contributing condition.

Draft recommendation

47. I am satisfied the medical records and the other material provided by Grampians Health demonstrate that there was likely insufficient consideration given to the potential that risperidone toxicity may be a cause of Mr Arnott's clinical decline. Accordingly, the following draft recommendation was communicated to Grampians Health:

(a) That Grampians Health provides ongoing education to all general medicine staff concerning the requirement for review of paliperidone dosage in patients with impaired renal function.

[15] Tests were performed for adrenal insufficiency, non-infective inflammatory conditions and a 'whole body scan'.

Procedural fairness response – Grampians Health

48. As a matter of procedural fairness, the Court wrote to Grampians Health to provide the opportunity to respond to the matters concerning its failure to review and reduce Mr Arnott's dose of paliperidone. Grampians Health were also advised of my intention to make a recommendation in the form detailed above.

49. Grampians Health responded by acknowledging the draft recommendation. It also advised that the service would take steps to implement ongoing education to all general medicine staff concerning the requirement for review of paliperidone dosage in patients with impaired renal function.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Philip Charles Arnott, born 20 May 1953;

    (b) the death occurred on 8 August 2023 at Ballarat Health Service Gandarra Palliative Care, 102 Ascot Street South, Ballarat, Victoria, from multiple organ failure secondary to bronchopneumonia and acute pancreatitis in a man with hypertensive heart disease and probable risperidone toxicity with a contributing factor of schizophrenia; and

    (c) the death occurred in the circumstances described above.

51. Having considered all of the available evidence, I find that Grampians Health did not review Mr Arnott's paliperidone dose in light of his renal impairment. This likely led to risperidone toxicity being a cause for at least some of his clinical presentation and decline. While I cannot determine that Mr Arnott's death was preventable, I am satisfied that the failure to review and reduce his paliperidone dose represented a missed opportunity to determine a potentially reversible cause of at least part of his presentation.

RECOMMENDATIONS

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

That Grampians Health provide ongoing education to all general medicine staff concerning the requirement for review of paliperidone dosage in patients with impaired renal function.

ACKNOWLEDGEMENTS

I convey my sincere condolences to Mr Arnott's family, friends and carers for their loss.

I thank the Coronial Investigator and those assisting for their work in the investigation.

DIRECTIONS

1. Pursuant to section 49(2) of the Act, I direct the Registrar of Births, Deaths and Marriages to amend the cause of death to *1(a) Multiple organ failure 1(b) Bronchopneumonia and acute pancreatitis in a man with hypertensive heart disease and probable risperidone toxicity 2 Schizophrenia.*

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

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

   Dean Arnott, Senior Next of Kin

   Grampians Health

   First Constable Jack Clarke, Coronial Investigator

Signature:

Coroner Paul Lawrie

Date: 14 July 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 inquest. 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.