IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2008 5014

FINDING INTO DEATH WITHOUT INQUEST

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

I, AUDREY JAMIESON, Coroner having investigated the death of:

WILLIAM ANDREW POSKITT
without holding an inquest:
find that the identity of the deceased was WILLIAM ANDREW POSKITT
born on 20 June 1977
and the death occurred on 9 November 2008
at The Alfred Hospital, Commercial Road, Prahran, Victoria, 3181
from:

1 (a) INJURIES SUSTAINED IN A FALL FROM A HEIGHT
2 PNEUMOCYSTIS CARINII PNEUMONIA

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

BACKGROUND CIRCUMSTANCES:

1. Mr William Poskitt was 31 years of age at the time of his death. He lived at 25 Kelvin Grove Thornbury and was a professional Pricenist. Mr Poskitt studied at the Victorian College of the Arts completing a Bachelor of Music Performance (Honours) and a Masters in Performance. He worked in jazz and the music industry.[1]

[1] In his memory, the University of Melbourne and William Poskitt's parents have established the Will Poskitt Priceno Scholarship.

2. Mr Poskitt was diagnosed with human immunodeficiency virus (HIV) in 2000. He had recently commenced antiretroviral[2] therapy (ART) after using only complementary therapies for many years. Mr Poskitt was wary of mainstream treatments for HIV and was very aware of their effects. On 29 September 2008, Mr Poskitt's General Practitioner, Dr Michael Porter ceased a course of the antibiotic Trimethoprim because Mr Poskitt had developed an allergic reaction in the form of a global allergic rash.

3. On 4 November 2008, Mr Poskitt was admitted to The Alfred for treatment of pneumonia and associated increased shortness of breath, which had not responded to antibiotic therapy commenced two days prior. At The Alfred, Mr Poskitt was diagnosed with Pneumocystis Carninii Pneumonia.[3] The treatment of choice is Trimethoprim.

SURROUNDING CIRCUMSTANCES

4. On Wednesday 5 November 2008, The Alfred medical files record Mr Poskitt as having a labile mood and *difficultly adjusting to the diagnosis of HIV* and requested help from psychiatry. That same night he told nursing staff he was experiencing *dark thoughts* and again requested psychiatric input as an inpatient. Consequently, the treating team (medical, nursing and allied health staff of 2West ward) completed a referral to The Alfred HIV Psychiatry Liaison Service on 5 November 2008. Mr Poskitt did not have a psychiatric history and the Medicare and Pharmaceutical Benefits Scheme reports for the twelve months prior to his death show only four General Practitioner appointments between April and October 2011 and no other providers. The only PBS prescription in that time was for Fluconazole, an antifungal medication. The antiretroviral therapy Mr Poskitt had recently commenced, was provided through The Alfred pharmacy.

5. On the night of Thursday 6 November 2008, Mr Poskitt told nursing staff he was having *racing thoughts*.

6. On 7 November 2008, Mr Poskitt becomes aware he has an AIDS defining illness. He is also given desensitization therapy for Trimethoprim. After he had completed desensitization

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2 Standard antiretroviral therapy (ART) consists of the use of at least three antiretroviral (ARV) drugs to maximally suppress the HIV virus and stop the progression of HIV disease. Huge reductions have been seen in rates of death and suffering when use is made of a potent antiretroviral regimen.

3 Pneumocystis Carninii Pneumonia (jiroveci) is now one of several organisms known to cause life-threatening opportunistic infections in patients with advanced HIV infection. The mainstay of treatment is trimethoprim-sulfamethoxazole (Bactrim, Septra), given intravenously or orally depending on severity.

therapy, the HIV Psychiatry Liaison clinician recorded that Mr Poskitt did not *want psychiatric involvement as he had had a reasonable traumatic morning and was not wanting to engage at this stage.* The clinician also wrote that the HIV Social Worker, Ms Cate Rowe was working with *William and his family.* Some time later that same day, Cate Rowe reviewed the medical file, takes note of the entries by the nursing staff and HIV Psychiatry Liaison and does not see Mr Poskitt because *Pt resting at time of review, so did not disturb him.* That same afternoon a nurse wrote that William Poskitt was *very anxious* and that evening the medical file records William as *talking in an inappropriate manner with nursing staff.* Also on 7 November 2008, the Dietician Ms Julia Price, chose not to disturb William Poskitt for a nutritional assessment because *Pt not wishing to be disturbed as per SW* (Social Worker). This was the second time Ms Price had not completed a planned assessment of William Poskitt, the other being 5 November 2008, when she wrote, *Pt currently with two visitors, therefore not assessed.*

7. On 8 November 2008, Mr Poskitt commenced Trimethoprim. That evening he reported to staff that he was *feeling blue.* At that time, the clinician reportedly assured Mr Poskitt he would have psychiatric input on Monday 10 November 2008.

8. At approximately 10.32pm, nursing staff heard banging from a room and followed appropriate procedures by calling a Code Grey. At the time, Mr Poskitt's bedroom door was closed and the lights off. Multiple staff members and two security guards attended to investigate Mr Poskitt's bedroom. When they gained entry they discovered that Mr Poskitt had punched at least two holes in the plastered walls, broken the window in his bedroom, and had jumped off the landing from the 7th floor. He was located on the ground and resuscitation attempts commenced at the scene by The Alfred medical emergency response team and Intensive Care Unit (ICU) staff. He was transferred to the Emergency Department for ongoing resuscitation attempts but died at 12.17am on 9 November 2008.

INVESTIGATION

Medical investigation

9. A post-mortem examination was conducted at the Victorian Institute of Forensic Medicine (VIFM) by Forensic Pathologist Dr Noel Woodford who determined the cause of death as '1(a) Injuries sustained in a fall from height'. Pneumocystis Carninii Pneumonia' was identified by Dr Woodford as a contributing factor. Trimethoprim and nevirapine - an anti-

viral drug - were identified in a toxicological analysis of a specimen of serum obtained on 8 November 2008.

William Poskitt's mental state

10. Mr Poskitt did not have a formal or informal mental state assessment completed during his four-day admission to The Alfred. The following outlines the events of concern.

Identification of mental health issues

11. Mr Poskitt formally asked staff for psychiatric input whilst an inpatient at least three times, on 5, 6 and 8 November 2008. The nursing staff recorded in the medical file symptoms of changed mental state from 5 November 2008 and on all four days of Mr Poskitt's admission. These reports are supported by records of insomnia and hallucinations made by Dr Barber, and the HIV Physiotherapist, Mr/Ms Weerakkody. Mr Poskitt's family told the nursing and medical staff they were concerned about William's mental state on 6, 7 and 8 November 2008.

Accessing a psychiatric assessment

12. The treating team completed the written referral for Mr Poskitt to the HIV Psychiatry Liaison Service on 5 November 2008. This referral was discussed with the Psychiatric Registrar (name unknown) and a decision reached to refer him to the HIV Social Worker in the first instance, who *have counselling expertise and are able to provide support with adjustment to the impact of HIV on a person's life.* There is no record of this discussion or decision in the clinical file, only in the statement of Dr Mark Jeanes, Psychiatrist at the Victorian HIV Mental Health Service (VHMHS).

13. Dr Jennifer Hoy, Professor Director of HIV Medicine, Infectious Diseases Unit states Mr Poskitt refused to see the HIV Dietician, the HIV Physiotherapist, the HIV Social Worker and the HIV Psychiatric Liaison clinician on 7 November 2008. The medical file reveals the HIV Physiotherapist did see William Poskitt, but William did not want actual hands-on physiotherapy, the HIV Social Worker did not attempt to see him, neither did the HIV Dietician. The HIV Psychiatry Liaison clinician attended the ward and spoke with Mr Poskitt in the passageway. The clinician records in the file that nursing staff are to make contact with the clinician should Mr Poskitt change his mind and a pager number is provided. Directions to contact the Psychiatric Registrar over the weekend if needed, is also recorded. The Social

Worker, Cate Rowe does not attempt to see Mr Poskitt but does read his file and states she will liaise with the medical team that day. There is no evidence in the files if this took place or the outcome. On the same day, it appears Mr Poskitt had three reviews by medical staff, all of whom he saw.

14. On 8 November 2008 when Mr Poskitt again asks for psychiatric input, he is informed both the HIV Social Worker and HIV Psychiatry Liaison Service will have *ongoing involvement* from Monday 10 November 2008.

Impact of Prednisolone

15. Dr Mark Jeanes states that Mr Poskitt had symptoms of a changed mental state prior to commencing Predisolone[4] 40mgs twice daily from 5 November 2008, a mid to high dose range. It is unclear, if Dr Jeanes is suggesting the symptomatology and outcome was not the result of the Prednisolone or if the presence of Mr Poskitt's psychiatric symptoms should have resulted in some other action by the treating team.

16. The MIMS[5] Prednisolone Full Product Information states:

> *Neurological. Adverse neurological effects have included headache, vertigo, insomnia, restlessness and increased motor activity, ischaemic neuropathy, EEG abnormalities and seizures. Large doses can cause behavioural and personality changes ranging from nervousness, euphoria or mood swings, to psychotic episodes which can include both manic and depressive states, paranoid states and acute toxic psychoses.*
> *It is no longer believed that previous psychiatric problems predispose to behavioural disturbances during therapy with glucocorticoids. Conversely, the absence of a history of psychiatric illness is no guarantee against the occurrence of psychosis during hormonal therapy.*

Documentation

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4 Steriod based medication with string anti-inflammatory actions

5 Accessed 28 November 2008 at: https://www-mimsonline-com-au.ezproxy-f.deakin.edu.au/Search/FullPI.aspx?ModuleName=Product%20Info&searchKeyword=prednisolone&PreviousPage=~/Search/QuickSearch.aspx&SearchType=&ID=28310001_2

17. Prima facie the documentation in the clinical record appeared quite detailed, but following review of the statements obtained in the course of the investigation it would now appear that there are many omissions. There is a lack of detail of the decision making of the treating team regarding the assessment of Mr Poskitt's mental state. There are omissions of instances of behaviour and statements such as those by Ms Amy Buxton-Rella in her statement regarding Mr Poskitt's declaration on the night of 6 November 2008 of having slept with people who were HIV positive with the intent of contracting the illness. This information is not in the medical file and there is no way of validating the claim or of assessing if Mr Poskitt was voicing a disordered and *dark* thought that caused him stress and that he had sought help for.

18. Another omission in the records is the family concerns reported to staff. For example, on the 8 November when Mr Don Poskitt (William's father), spoke to the nursing staff about his concern that his son would discharge himself from hospital. There are other inaccuracies, for example, on 8 November 2008, Nurse Elder states Mr Poskitt asked for two Temazepam tablets, because *one did not work*, and she had told him he was prescribed only one Temazepam 10mg tablet. The medication chart clearly states 10-20mgs, with a maximum of 30mgs in 24 hours, prescribed by Dr Barber on 5 November 2008.

Lack of staff knowledge of events

19. According to Mr Don Poskitt and Mr Philip Bucknell (William's partner), on 7 November 2008 William became aware he was no longer just HIV positive, but he also had an AIDS defining illness. The family and Philip Bucknell, report William became increasingly anxious and bizarre and he asked for his house keys so he could check himself out of the hospital. Over the next 24 hours, William initially withdrew, and then he sent text messages to close friends who came to visit him. He told Philip Bucknell he could not sleep. The night shift clinical file note (name indecipherable) made on the night of 7-8 November 2008 states *settled overnight. Obs stable. Nil complaints offered.*

20. When his friends arrived, Philip Bucknell and another friend helped William into a wheel chair to take him to the park. Mr Philip Bucknell and William spent some time alone in the park. Mr Philip Bucknell describes the time as *I recall he was quite philosophical and was saying some bizarre things about what happens when you die.* When joined by friends and his parents, the conversation reportedly became *quite emotional. I remember everyone was trying*

to support and encourage William that his condition could still be managed. The family and William returned to the hospital room and more friends arrived.

21. The medical file suggests the staff were unaware of the events, although it was the day Mr Don Poskitt told the staff his son was at risk of discharging himself and he was very concerned for his son's mental state and this information is not in the file. Instead, the notes made by nursing staff (name indecipherable) state:

    Pt independent and self-caring with ADL's. Vital signs stable. Meds as charted. Gone off ward with friends. Nil other issues.

22. Dr Jennifer Hoy, states Mr Poskitt was well enough to go to the cafeteria on 8 November 2008 with friends, but due to tiredness, he spent the afternoon in bed. William spent a great deal of the afternoon in the park with family and friends and was described by nursing staff as *very anxious.* It also says, he was not agitated or distressed and the staff were not concerned about his mental state. However, the nursing notes clearly state he was *feeling blue* and that he was asking for a psychiatric assessment.

PROCEDURE:

23. On 8 August 2012, a Mention Hearing was held. The purpose of the mention was to advise Alfred Health that the investigation had identified some matters that required comment, some of which could be adverse to The Alfred. In the circumstances, I provided the Alfred Health an opportunity to be heard on these matters including the option of proceeding to Inquest.

24. Mr Taffe appeared on behalf of The Alfred. There was no application to provide further material/submissions or for an Inquest to be held.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

1. The referral to the HIV Psychiatric Liaison Service following Mr Poskitt initially reported racing thoughts and insomnia was appropriate. However, what is not clear is how this referral did not result in any assessment of his mental state.

2. From the investigation, there appears to be a culture of delegating responsibility to other clinicians involved in Mr Poskitt's care, to the point where an assessment of his mental state did not take place.

3. Dr Mark Jeanes outlines the process the HIV Psychiatric Liaison Service follows if a patient referred by a treating team refuses to have a psychiatric assessment, but Mr Poskitt only refused to have an assessment at that time, because he was tired after his treatment in the morning. The HIV Psychiatric Service clinician did clearly state in the file how and who to contact if Mr Poskitt changed his mind. The process outlined by Dr Jeanes assumes an absence of risk and delegates the assessment of any current or future risk to the treating team, who have already made the referral for a specialist psychiatric assessment.

4. The nursing staff on the Infectious Diseases Unit are then expected to re-refer to the HIV Psychiatric Liaison Service, which did not occur, despite Mr Poskitt requesting to see a psychiatrist and exhibiting changes in behaviour and the concerns expressed by his family over three days. These changes in behaviour are recorded in the clinical file and reportedly communicated during clinical handover between shifts and within the treating team but did not result in a recontact to the HIV Psychiatric Liaison Service. Neither Dr Jeanes nor Dr Hoy, provided information regarding the training and skills the treating team have in assessing the mental state and risk of patients with changes in mental state.

5. Dr Jennifer Hoy states the Clinical Governance Unit at The Alfred reviewed the circumstances of the death and were *unable to identify any preventable measures that could have altered the outcome and were unable to identify any gaps in the provision of care.* It is of concern that a patient, with symptoms of psychological distress in The Alfred can request to see a psychiatrist, a referral is made by the treating team and some four days later, he still does not have a specialist mental health assessment and that this is viewed internally as reasonable.

CONCLUSION

25. It is unknown if an assessment by the HIV Psychiatric Liaison Service or with Social Worker, Ms Cate Rowe, would have changed the outcome because there is no clear picture established of what Mr Poskitt was going through in the days prior to his death. There is no clarification of what the content of his *racing thoughts*, or *dark thoughts,* were because based on available evidence, no one asked him. Yet, it is clear he was distressed enough to have reported the symptoms to staff. There is also no detail of what the *inappropriate manner of communication*

with staff was and whether it is reasonable to have expected the nursing and medical staff to have been proactive in securing a psychiatric assessment rather than informing Mr Poskitt they would arrange it on Monday, 48 hours later.

26. Mr Poskitt's clinicians each made decisions that resulted in each assuming someone else was providing the assessment or counselling service for William and there are at least two occasions when allied health staff did not disturb him based on what another clinician had recorded, rather than finding out for themselves. The reluctance to disturb Mr Poskitt does not appear to have prevented any other staff from providing a high quality and intrusive medical treatment regime. It could also be considered appropriate for the HIV Psychiatric Liaison Service to take responsibility to have returned to or telephoned 2West to attempt to assess Mr Poskitt at a later or alternate time when he was feeling less tired. However, because Mr Poskitt was not ready for the assessment when the clinician arrived, the HIV Psychiatric Liaison Service appears to have considered their role as complete unless a new contact was made. There is no information about the capability of the nursing staff on 2West being able to assess the mental state and associated risk of a patient with HIV/AIDS, who is expressing symptoms of distress.

27. Furthermore, it is not established whether the Prednisolone impacted on Mr Poskitt's mental state but given his reported symptoms and request to see a psychiatrist, a closer monitoring of his mental state was a reasonable expectation.

28. The evidence supports a conclusion that there were enough alerts and requests made by Mr Poskitt and his family to have resulted in a more proactive response from the treating team to his requests to see a psychiatrist.

FINDING

I find that William Andrew Poskitt died from injuries sustained in a fall from a height in circumstances where he intended to take his own life. Contributing to his death but not directly related to the cause was the condition of pneumocystis carinii pneumonia.

AND I am unable to definitively find that William Poskitt's death was preventable however I find that The Alfred missed a number of opportunities to implement preventative measures by not appropriately attending to Mr Poskitt's reported altered mental state.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death of William Poskitt:

1. To improve the safety of patients with HIV/AIDS in the Infectious Diseases Unit at The Alfred hospital, it review the process for the formal follow-up to a referral to the HIV Psychiatric Liaison Service, to establish a clear pathway of accountability for action and communication of outcome.

2. To increase the safety of patients with HIV/AIDS in the Infectious Diseases Unit at The Alfred hospital, the nursing staff on the Infectious Diseases Unit should undertake training in the assessment of patient's mental states and of the out-of-hours referral process to the HIV Psychiatric Liaison Service.

Pursuant to rule 64(3) of the Coroners Court Rules 2009, I order that this Finding be published on the internet.

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

- Mr Don Poskitt
- Mr Bill O'Shea, Alfred Health

Signature:

AUDREY JAMIESON
CORONER
Date: 13 December 2012