QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION:	**Inquest into the death of Jye Conrad PERRY (a Child)**
TITLE OF COURT:	**Coroner's Court**
JURISDICTION:	Rockhampton
FILE NO(s):	Cor 88/02
DELIVERED ON:	16 November 2005
DELIVERED AT:	Rockhampton
HEARING DATE(s):	16/11/2004, 4/4/05, 29-30/8/05.
FINDINGS OF:	A M Hennessy, Coroner
CATCHWORDS:	**CORONERS: Inquest, Mental Health forensic patient, Person of Special Notification – flagging of files, integrated information system – medical and Mental Health, consequences of breach of Limited Community Treatment conditions, confidentiality and proper disclosure to carers/family.**

REPRESENTATION:

Counsel Assisting:	Mr William Isdale, Crown Law
Family of Jye Perry:	Bernadine Wilkinson (mother) and Steven Perry (father) in person
Director of Mental Health: Rockhampton District Mental Health Service:	Mr John Tate, Crown Law Mr Kevin Parrott, Crown Law
Qld Nurses Union:	Mr Gavan Rebetzke, Roberts and Kane
Dr Talat Choudhry:	Mr G O'Driscoll, Counsel

Judgment Category Classification:
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TRANSCRIPT OF PROCEEDINGS

CORONERS COURT

HENNESSY, Coroner

No 88 of 2002

IN THE MATTER OF AN INQUEST INTO THE
CAUSE AND CIRCUMSTANCES SURROUNDING
THE DEATH OF JYE CONRAD PERRY

ROCKHAMPTON

..DATE 16/11/2005

CONTINUED FROM 30/08/2005

..DAY 7

FINDINGS

CORONER: I will now proceed to deliver my findings and make recommendations in relation to this matter which I note under the previous Coroner's Act.

On the 26th of December 2002 Psychologist Garner and Nurse Hyam were working as the Acute Care Team at the Accident and Emergency Section of Rockhampton Hospital when Ms Natalia Perry presented.

Nurse Hyam was familiar with Ms Perry's case and advised Ms Garner that she was a forensic patient and was being case managed by the Rockhampton Mental Health Service. During the interviews the two women conducted with Ms Perry, she was fatuous in affect but was organised in her thinking. She told the women that she had been at Great Keppel Island for a brief holiday, had unprotected sex during her stay and had jumped off a ferry on the return journey as she did not wish to leave the fellow she had taken up with on the island.

The ferry was at the time at least a kilometre from shore and had to turn around to retrieve Ms Perry from the water. She was returned to the island and the police investigated the matter but took no action. The gentleman friend of Ms Perry thought that she needed some assistance and took her to the hospital.

Ms Perry told Ms Garner and Nurse Hyam that she had not taken her medication for some time but that she wanted to recommence her treatment. She reported previously hearing an argument between Jesus and the devil but did not appear to be hearing voices at the time of the interview. The women were trying to encourage Ms Perry to be compliant with her medication regime and to return to the treatment plan.

It is noted that the focus of many treating practitioners is to foster a therapeutic alliance with patients to encourage mutual respect which is more conducive to the patient complying with treatment. Ms Perry was referred to Dr Choudhry for assessment. Ms Garner did not expect

that Ms Perry would be admitted to hospital as the general approach was that if a person was prepared to consent to treatment, then admission was not necessarily appropriate.

Dr Choudhry reported that Ms Perry was most concerned about the possibility of unwanted pregnancy and advised that she wished to resume her treatment. He found that she was well-oriented in time and place, was not impulsive at the time, despite her previous and recent impulsive behaviour in jumping off the ferry. She was responsive, calm and patient. She was not exhibiting psychotic symptoms, despite the report of previous delusions and was willing to comply with her treatment plan, despite her admitting that she had not taken her medication for some time.

Dr Choudhry had volume three of Ms Perry's file and determined from the file that she was a known schizophrenic but he did not have access to the information that she was a forensic patient, a person of special notification, or that she had previously killed a child.

Dr Choudhry further stated that in Ms Perry's situation, mental status can be variable from day-to-day, hour to hour. Her chart indicated that she had been stable for some time. Dr Choudhry had spent a significant period of time with Ms Perry and seems to have conducted a thorough assessment of her and I was most impressed by him as a witness.

It is impossible to know whether further information regarding Ms Perry may have made any difference to Dr Choudhry's decision to return her to the community rather than admitting her, but it seems very unlikely, given her expressed willingness to comply with treatment and the prevailing treatment focus.

Following Dr Choudhry's assessment, Ms Garner and Nurse Hyam drove Ms Perry home. Ms Garner gave evidence that a young child was present at the house when they arrived. An offer was made to speak to the family which Ms Perry refused. Shortly after being taken home, Ms

Perry stabbed and killed her three year old nephew in the setting of an apparent exacerbation of her psychotic illness.

Jane Hutchins, a nurse with the Indigenous Mental Health team at the Rockhampton Mental Health Unit, had been working with Ms Perry for some time. She gave evidence that she had visited Ms Perry at her home on many occasions over an extended period of time.

On some occasions, there were young children also in the home. Ms Hutchins gave evidence that the children related well with Ms Perry. There were a number of changes in Ms Perry's mental state over the period of time but she was always cooperative and presented well. She did not like to be alone but otherwise seemed to cope with life.

Ms Hutchins gave evidence that the fact of children being in the house did not necessitate any risk assessment. It was not considered to be a hazard because it was assumed that Ms Perry was not considered a risk when she was returned to the community. Her psychosis was considered to be under control. Ms Hutchins stated that the staff were not informed that Ms Perry posed any risk to children. Further, the staff who had taken Ms Perry home did not know whether she had recommenced her medication at that time.

Ms Hutchins confirmed that it was Ms Perry's responsibility as part of her being in the community to take her medication. Ms Hutchins had spoken with Ms Perry's father and sister on a couple of occasions about her treatment but there was no regular communication with the family. It was occasional at best.

There was no specific discussion with family members to monitor the taking of medication in any way. The drug that Ms Perry was taking, Risperidol, was a daily dosage drug and it was estimated that the dose was suitable for a 24 hour period with the person becoming free of the effect of the drug within about four to five days, according to Dr Choudhry.

On her report of being off medication for some time, it was probable that Ms Perry was drug free as at the 26th of December.

In the Director of Mental Health's submission to the Coroner in this matter, the key principle of treatment of mental health patients was stated to be "the need to balance the rights of individuals to optimal care provided in the least restrictive setting".

It was also a stated policy of providing a higher level of oversight of care of persons with special notification and for treatment to take into account past harm caused by the patient, public sensitivity and community safety.

Ms Perry had a diagnosis of chronic schizophrenia and was at the time of the incident a forensic patient by order of the Mental Health Court and was classified as a person of special notification.

Ms Perry was the subject of this order after being arrested for the murder of her young child. She was removed from the criminal justice system by the Mental Health Court.

Dr Kingswell gave evidence that:

> "The forensic order will generally remove somebody from the criminal justice system to the care of Health with the expectation that Health will manage that person's health needs and to the greatest extent possible, prevent further offending."

(page 340 of the transcript)

Following a period of time as an in-patient, the Mental Health Review Tribunal determined that Ms Perry be released on limited community treatment or LCT.

The LCT allows the patient to be released into the community to continue with treatment which is usually subject to certain conditions tailored to the circumstances of the particular person. Conditions can relate to residence during treatment, attending appointments for care, use of alcohol and drugs, taking of medications, et cetera. The release would usually be a slow and gradual process with persons charged with murder in order to gradually test the person's ability to comply with leave conditions.

Consequences of failure to comply with conditions could include a return to hospital to have the taking of medication supervised or the use of alternate forms of medication or daily visits by Mental Health staff to supervise medication.

At the present, a review of the LCT's is tending towards clear decision trees being set down for dealing with failures to comply with treatment conditions. A consistent approach and clear direction adopted across the State and even within one Mental Health unit would be beneficial for treating doctors and patients alike.

An additional level of review is now provided by the LCT committee which reviews documentation and recommendations to be provided and made by the treatment team to the Mental Health Review Tribunal for the six monthly review of all persons on LCT's.

Persons on forensic orders may also be categorised as Persons of Special Notification (PSN) as in this case if they have been charged with a serious offence. Once identified as such, the person's chart is now flagged. Treatment plans for persons of special notification are subject to monthly review by a psychiatrist and weekly by case workers.

It has been said that there is a continual and close follow-up of persons of special notification and a higher level of support, as opposed to other patients where intervention would usually

decrease over time. Reports are required to be submitted to the director of Mental Health by an authorised psychiatrist in relation to persons of special notification.

Flags on charts in relation to forensic order patients are essential to draw the treating officer's attention to the relevant aspects of the patient's classification and other information on the forensic patient summary sheet. Dr Rofe described the information in the file:

> "There are several summary sheets that can quickly alert the Mental Health Act clinician as to the seriousness of the patient presenting and indices such as the date of the index offence, the index offence, circumstances relating to it, mental state at the time of offending, significant systematology at the time of the offence, stresses - environmental or relationship - at the time of the offence, issues of substance use or misuse, static risk factors and other information relevant to the offending behaviour".

It is obvious that this information could be crucial to treatment decisions being made in relation to the patient. The flag also needs to be very prominent and in a position where it is ensured that it cannot be obscured from view. Each volume of a multi-volume file needs to be marked with the flag and contain the background information.

It is also essential that the practice is uniform around the State to provide consistency in the event of patients and Mental Health staff moving between regions.

Following this tragic incident, Queensland Health conducted a review into the care of Ms Perry. That review and the review of sentinel events, deaths in Queensland in 2002 to 2003 involving people with serious mental illness including suicides and murders, have led to a number of initiatives to improve the quality of care provided, particularly to forensic patients.

The review was presented to the Director-General on the 9th of March 2005 with nine key recommendations, one of which relates specifically to the improvement and standardisation of processes for the management of persons on forensic orders and persons of special notification.

A further recommendation related to the provision of training for emergency department staff to ensure appropriate assessment of mentally ill persons presenting to the department. It would seem appropriate, then, that the information systems of the Emergency Department and the Mental Health unit be complimentary and sufficient to allow access for staff to both the person's Mental Health records and health records.

Treatment plans now include risk management or action plans that outline the response to the failure to comply with treatment or LCT conditions. Persons of special notification who are pregnant or have dependent children are subject to risk assessment and management strategies to ensure the safety of those children. It would seem sensible that this be extended to persons residing with children, especially where the index offence related to children.

Forensic liaison officers have also been introduced into the Mental Health service. Dr Kingswell's evidence suggested that the duties of the position could be better identified and standardised to provide more effectiveness from the position.

It would seem that if the officers are in a unique position to be a conduit of information regarding patients in their district, particular secure patients and those in the criminal justice system, forensic liaison officers have intimate working knowledge of all clinical aspects of patients on forensic orders or persons of special notification and it's said that these workers are easily accessible to any member of staff.

Since this incident, staff undergo training and risk assessment and management of forensic patients. At present when a forensic patient is being treated in Accident and Emergency, the registrar is required to consult with a consultant psychiatrist in relation to the patient. In-service training and orientation for new staff has been improved and upgraded. Medical staff are tested for competency in understanding of the Act before being authorised.

There are weekly administrative audits of case management and auditing of forensic treatment plans. Risk assessment is built into plans and auditing procedures. A state-wide clinical risk assessment and management training project has also been commenced. There has been an improvement and standardisation of processes of management of forensic patients and persons of special notification, I have been told.

An issue in this matter arises from the failure of staff delivering Ms Perry to her father's home to discuss that day with the family members living with her - primarily her father and brother - of her change in circumstances. An offer was made by the staff dropping Ms Perry home to talk to her family but she declined the invitation. The staff took the view that it would be a breach of Ms Perry's confidence to then speak with the family. It must be said that the staff did not consider that there was anything extraordinary in the behaviour of Ms Perry and relied on Dr Choudhry's assessment that she was not at the time psychotic.

Section 62 of the Health Services Act provides for confidentiality to be maintained in relation to health issues for any person. There are a number of situations in which it is permitted for a health professional to disclose information regarding the health of another to other persons.

It seems to me that the sections may not prohibit the disclosure of certain information in this type of situation but the Mental Health professionals who gave evidence at the Inquest seem to believe that the section was interpreted much more narrowly in this regard. That doubt should be removed.

Mr Steven Perry, the father of the deceased child, Jye, who lived in the house at the time, stated that if someone had told the family of the unusual events of the days that Ms Perry had been absent from her home preceding the event, that the family would have been aware that all was not well with her.

The family knew Ms Perry better than anyone else and were well aware of the fluctuations in her condition from time to time. As it was, she seemed okay to them but they were not aware that she had not been taking her medication for some time and they were unsuspecting regarding any resulting instability.

The family were generally relying on the fact that she had been released into the community and they felt from that action that nothing would happen again in the future. They had not been given any advice of what to expect or warning signs to look out for, said Mr Perry.

It would seem that those providing care for persons under treatment should have the right to be informed of information necessary to carry out their carer's role and for the protection of others in the household. Medical staff need to be "advocates for the person's well being, not necessarily their wishes", in Dr Kingswell's words.

It may be considered that to rely on the wishes of a person who may not necessarily be stable to know what is in their best interests or in the interests of others is a risky undertaking. There is obviously a need to balance the rights of the person under treatment and the carer's need to know.

Information should only be shared with people who have a clear responsibility to provide care and support for the person. In order to protect the person's rights, an intervention to discuss matters with family or carers without consent should be an action of last resort. One resolution to the confidentiality question, apart from amending the section, may be to include a condition in the LCT to allow staff to share information with key people in certain situations.

If treating practitioners were to take into account past harm caused by the patient, public sensitivity and community safety in this case, they have failed. There was no risk assessment of Ms Perry in relation to her access to children in unsupervised conditions. Assessment of home arrangements and other occupants of the house is needed, especially in these circumstances.

Risk management of Ms Perry's treatment was not what it could have been and there would seem to have been insufficient monitoring of her medication compliance and attendance at appointments over a period of time.

In relation to the findings themselves, I formally find that the deceased child was Jye Conrad Perry, born on the 2nd of February 1999 and that he died on the 26th of December 2002. I find that Jye died as a result of fatal stab wounds to the heart at the hands of his aunt, Natalia Perry, in his father's home during an apparent exacerbation of Ms Perry's mental illness diagnosed as schizophrenia.

There are some recommendations that I would make with a view to this particular situation or similar situations, not resulting in injury to any person in the future:

1. That Queensland Health progress as soon as possible a Mental Health information system that interfaces with the Emergency Department information system to allow sufficient access for staff to both a person's mental health records and health records, particularly the person's status under the Mental Health Act, any flags in relation to treatment plans and conditions in order to allow for appropriate and effective treatment of the person's presenting issue, based on accurate and complete medical and psychiatric information;

2. That Queensland Health ensure that a state-wide uniform practice be adopted for forensic patient files to be flagged, drawing attention to a forensic patient's summary sheet. That such flags be situated prominently and in a position where it is ensured that they cannot be obscured from view in each volume of the patient's file;

3. I support and encourage the continuation of the improvement and standardisation of processes of management of forensic patients and persons of special notification, in particular, the development of clear decision trees for dealing with failures of patients to comply with treatment conditions in LCT's;

4. That the risk assessment and management strategies to ensure the safety of the children presently in place for persons of special notification who are pregnant or who have dependent children be extended to cases where children reside with the person receiving treatment, whether full time or part time, particularly where the event resulting in the forensic order involved an injury to a child;

5. That Queensland Health review and implement changes to the present confidentiality provisions to ensure that confidentiality of the person receiving treatment is balanced with the rights of the public to protection against the risk of harm, including the persons who have responsibility to care for and support the person under treatment and other members of the household. In particular, that there be sufficient provision in the Health Services Act to provide for Mental Health staff sharing information regarding the patient with key people in certain circumstances; and

6. It would assist Coronial inquiries for the Queensland Police Service to have direct access to medical staff for the purposes of taking statements or obtaining

information for the purpose of such inquiry and in order to avoid hindrance of or delay to such investigations.
