Q1. Who was the deceased?

Question:

Who was the deceased?

Answer:

Based on the provided context, the deceased was a man born in Western Australia in 1982 into a blended family. He had a complex family history including a biological father in prison and multiple partners of his mother. He experienced difficulties fitting in socially, struggled with drug use (amphetamines, cannabis, heroin, LSD, ecstasy), and had a criminal history involving drug-related offenses and burglary. He suffered a serious injury in 2002 resulting in a gunshot wound and subsequent reliance on the Disability Support Pension.

Source 1:

\* text: "THE DECEASED\n15. The deceased was born in Western Australia on 23 October 1982 into a blended family . 1 He was the second of his mother's four children from three relationships. His elder sibling Jason; with whom he had a close bond, was from his mothers first relationship The deceaseds father was her second partner. The deceaseds younger siblings..."

\* page: 4

\* document: data/Forkin-finding-2014.pdf

Source 2:

\* text: "THE DECEASED\n- 19 The deceased began to use drugs, including amphetamines and cannabis, when he was 14 years old. He worked on farms and as a pearl diver and deck hand. He last worked when he was 18 or 19. At about that time he was convicted of several drug-related offences as well as for burglary, presumably connected to fund his use of drugs.\n- 2..."

\* page: 5

\* document: data/Forkin-finding-2014.pdf

Source 3:

\* text: "THE DECEASED\n- 22\_ 2005 the deceased had been using amphetamines every for five years, though had stopped using cannabis after abusing it daily for seven years. He had been leading an itinerant lifestyle and had growing criminal history but had not been sentenced to detention or imprisonment. By day yet"

\* page: 5

\* document: data/Forkin-finding-2014.pdf

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Ask your question (type q to quit):

Q2. When did the death occur?

Answer:

The death occurred at approximately 12.00am or 1.00am on 30 November 2010.

Source 1:

\* text: "EVENTS LEADING TO THE DEATH\n62. The next morning Mr and Ms Ward left for work at 6.30am. did not see the deceased and assumed that he was still in bed asleep. left the front door unlocked. They They\n30 Ex 1, Vol 2, Tab 51\n31 ts 49-52\n32 ts 54~55\n33 ts 53\n34 ts 55\n35 Ts 55, Ex 1, Vol 1, Tab 10 p.2\n- 63\_ Mr Ward and his wife returned home from work ..."

\* page: 13

\* document: data/Forkin-finding-2014.pdf

Source 2:

\* text: "THE DECEASED\n- 19 The deceased began to use drugs, including amphetamines and cannabis, when he was 14 years old. He worked on farms and as a pearl diver and deck hand. He last worked when he was 18 or 19. At about that time he was convicted of several drug-related offences as well as for burglary, presumably connected to fund his use of drugs.\n- 2..."

\* page: 5

\* document: data/Forkin-finding-2014.pdf

Source 3:

\* text: "EVENTS LEADING TO THE DEATH\n58. When the deceased left Graylands on 29 Noember 2010, he went to the house of a friend, Nathan Ward, who lived with his wife in Joondalup. The deceased and Mr Ward had known each other for about eight years after the deceaseds brother Jason had introduced them.31\n59. The deceased arrived at the Wards house unexpectedl..."

\* page: 13

\* document: data/Forkin-finding-2014.pdf

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Ask your question (type q to quit):

Question:3

Where did the death occur?

Answer:

The death occurred at the house of Nathan Ward in Joondalup.

Source 1:

\* text: "EVENTS LEADING TO THE DEATH\n62. The next morning Mr and Ms Ward left for work at 6.30am. did not see the deceased and assumed that he was still in bed asleep. left the front door unlocked. They They\n30 Ex 1, Vol 2, Tab 51\n31 ts 49-52\n32 ts 54~55\n33 ts 53\n34 ts 55\n35 Ts 55, Ex 1, Vol 1, Tab 10 p.2\n- 63\_ Mr Ward and his wife returned home from work ..."

\* page: 13

\* document: data/Forkin-finding-2014.pdf

Source 2:

\* text: "CAUSE AND MANNER OF DEATH\n66. On 2 December 2010 Chief Forensic Pathologist Dr C T Cooke carried out a post mortem examination of the deceased. He found a ligature-type marking to the skin of the neck and internal neck injury with fracture of the main throat cartilage, but no other injuries. There was congestion of the lungs consistent with asphyxi..."

\* page: 14

\* document: data/Forkin-finding-2014.pdf

Source 3:

\* text: "EVENTS LEADING TO THE DEATH\n58. When the deceased left Graylands on 29 Noember 2010, he went to the house of a friend, Nathan Ward, who lived with his wife in Joondalup. The deceased and Mr Ward had known each other for about eight years after the deceaseds brother Jason had introduced them.31\n59. The deceased arrived at the Wards house unexpectedl..."

\* page: 13

\* document: data/Forkin-finding-2014.pdf

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Ask your question (type q to quit):

Question: 4

What was the cause of death?

Answer:

Ligature compression of the neck (hanging) due to asphyxiation.

Source 1:

\* text: "CAUSE AND MANNER OF DEATH\n66. On 2 December 2010 Chief Forensic Pathologist Dr C T Cooke carried out a post mortem examination of the deceased. He found a ligature-type marking to the skin of the neck and internal neck injury with fracture of the main throat cartilage, but no other injuries. There was congestion of the lungs consistent with asphyxi..."

\* page: 14

\* document: data/Forkin-finding-2014.pdf

Source 2:

\* text: "EVENTS LEADING TO THE DEATH\n62. The next morning Mr and Ms Ward left for work at 6.30am. did not see the deceased and assumed that he was still in bed asleep. left the front door unlocked. They They\n30 Ex 1, Vol 2, Tab 51\n31 ts 49-52\n32 ts 54~55\n33 ts 53\n34 ts 55\n35 Ts 55, Ex 1, Vol 1, Tab 10 p.2\n- 63\_ Mr Ward and his wife returned home from work ..."

\* page: 13

\* document: data/Forkin-finding-2014.pdf

Source 3:

\* text: "INTRODUCTION\n- (2) or (3) of the Coroners Act 1996 generally as if they did.\n14. I have therefore not addressed those general issues separately from a consideration of each death. Rather, where I have come to the view that the issues were connected with the death or were potentially relevant to the quality of the supervision, treatment and care of..."

\* page: 4

\* document: data/Forkin-finding-2014.pdf

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Ask your question (type q to quit):

Question: 5

Who was the presiding coroner?

Answer:

Ms R Hartley

Source 1:

\* text: "Counsel Appearing:\nMs M. Smith assisting the Coroner Ms R Hartley (State Solicitors Office) appearing on behalf of the Health Department of WA"

\* page: 1

\* document: data/Forkin-finding-2014.pdf

Source 2:

\* text: "INTRODUCTION\n- (2) or (3) of the Coroners Act 1996 generally as if they did.\n14. I have therefore not addressed those general issues separately from a consideration of each death. Rather, where I have come to the view that the issues were connected with the death or were potentially relevant to the quality of the supervision, treatment and care of..."

\* page: 4

\* document: data/Forkin-finding-2014.pdf

Source 3:

\* text: "Coroners Act 1996 [Section 26(1)]\nWestern"

\* page: 1

\* document: data/Forkin-finding-2014.pdf

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Ask your question (type q to quit):

Question: 6

What were the circumstances leading to the death?

Answer:

The deceased was found hanging by his neck with an electrical cord tied to a rafter through an open manhole in the ceiling. Mr. Ward returned home, found the body, called 000, cut the cord, and applied chest compressions until paramedics arrived. The paramedics were unable to revive him. A post-mortem examination revealed a ligature-type marking on the neck and internal neck injury with fracture of the main throat cartilage, consistent with asphyxiation due to neck compression. Toxicology analysis showed the use of various drugs, including amphetamines, cannabis, heroin, LSD, and ecstasy, within the 24 hours prior to death.

Source 1:

\* text: "EVENTS LEADING TO THE DEATH\n62. The next morning Mr and Ms Ward left for work at 6.30am. did not see the deceased and assumed that he was still in bed asleep. left the front door unlocked. They They\n30 Ex 1, Vol 2, Tab 51\n31 ts 49-52\n32 ts 54~55\n33 ts 53\n34 ts 55\n35 Ts 55, Ex 1, Vol 1, Tab 10 p.2\n- 63\_ Mr Ward and his wife returned home from work ..."

\* page: 13

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Source 2:

\* text: "CAUSE AND MANNER OF DEATH\n66. On 2 December 2010 Chief Forensic Pathologist Dr C T Cooke carried out a post mortem examination of the deceased. He found a ligature-type marking to the skin of the neck and internal neck injury with fracture of the main throat cartilage, but no other injuries. There was congestion of the lungs consistent with asphyxi..."

\* page: 14

\* document: data/Forkin-finding-2014.pdf

Source 3:

\* text: "THE DECEASED\n- 19 The deceased began to use drugs, including amphetamines and cannabis, when he was 14 years old. He worked on farms and as a pearl diver and deck hand. He last worked when he was 18 or 19. At about that time he was convicted of several drug-related offences as well as for burglary, presumably connected to fund his use of drugs.\n- 2..."

\* page: 5

\* document: data/Forkin-finding-2014.pdf

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Ask your question (type q to quit):

Question:7

What relevant medical or mental health history did the deceased have?

Answer:

Based on the provided context, the deceased had the following relevant medical and mental health history:

\* \*\*Schizophrenia:\*\* Initially diagnosed with psychotic symptoms of schizophrenia in 2005.

\* \*\*Amphetamine-Induced Psychosis:\*\* Diagnosed with amphetamine-induced psychosis in 2006.

\* \*\*Substance Abuse:\*\* A history of intravenous amphetamine use, leading to multiple admissions and diagnoses. This was a recurring issue, with a year-long period of abstinence followed by a resumption of use.

\* \*\*Suicidal Behavior:\*\* Demonstrated suicidal behavior, including attempting self-harm with petrol and a car, and previous suicidal ideation.

\* \*\*Paranoid Psychotic Episodes:\*\* Experienced ongoing paranoid psychotic episodes, often exacerbated by substance abuse.

\* \*\*Psychotic Symptoms:\*\* Experienced psychotic symptoms including delusions and perceptual disturbances.

Source 1:

\* text: "THE DECEASEDS MENTAL HEALTH\n- 23\_ On 4 2005 the deceased presented at the Joondalup Health Campus emergency department complaining of suicidal self-harm and auditory hallucinations. He was admitted into the Joondalup Mental Health Unit until 16 2005 when he was discharged with a principal diagnosis of psychotic symptoms of schizophrenia and drug wi..."

\* page: 5

\* document: data/Forkin-finding-2014.pdf

Source 2:

\* text: "THE DECEASEDS MENTAL HEALTH\n- 24 . Two days later the deceased was again admitted into the Joondalup Mental Health Unit after using amphetamines. He was discharged with a diagnosis of 'psychosis secondary to use and IV amphetamine use drug\n25. On 21 June 2006, the deceased was admitted into Broome Health Service after asking for assistance from pol..."

\* page: 6

\* document: data/Forkin-finding-2014.pdf

Source 3:

\* text: "THE DECEASEDS MENTAL HEALTH\n- 27 . On 4 November 2007 the deceased was referred to Graylands from the emergency department of Joondalup Health Campus following suicidal behaviour. 4 He had apparently poured petrol on himself and his car, intending to kill himself. Three weeks previously, his relationship with partner ended and the lease on the hous..."

\* page: 6

\* document: data/Forkin-finding-2014.pdf

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Ask your question (type q to quit):

Question:8

Who testified or assisted in the inquest? (eg, doctors, police, witnesses)

Answer:

Based on the provided text, the following individuals testified or assisted in the inquest:

\* \*\*Ms M. Smith:\*\* Assisting the Coroner.

\* \*\*Ms R Hartley:\*\* Appearing on behalf of the Health Department of WA (State Solicitors Office).

\* \*\*Witnesses:\*\* The text mentions evidence was provided by “witnesses” relating to the deaths.

Source 1:

\* text: "INTRODUCTION\n- A joint inquest commenced before Coroner DH. Mulligan in the Perth Coroner's Court on 27 August 2012. Evidence was provided relating to the deaths of two of the other nine deceased persons. The inquest was then adjourned until it recommenced on 11 March 2013 when evidence relevant to another deceased person was adduced.\n- 8 On 20, 21..."

\* page: 2

\* document: data/Forkin-finding-2014.pdf

Source 2:

\* text: "INTRODUCTION\n12. I should note that there was great deal of evidence adduced at the inquest that was related to general or systemic issues pertinent to Graylands. That evidence was adduced to investigate whether those issues had bearing on any or some of the deaths and to allow the coroner to comment on the quality of supervision; treatment and car..."

\* page: 3

\* document: data/Forkin-finding-2014.pdf

Source 3:

\* text: "Counsel Appearing:\nMs M. Smith assisting the Coroner Ms R Hartley (State Solicitors Office) appearing on behalf of the Health Department of WA"

\* page: 1

\* document: data/Forkin-finding-2014.pdf

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Ask your question (type q to quit):

Question: 9

Was the deceased considered a “person held in care” under the Coroners Act?

Answer:

Yes, the deceased, Luke Isaac Forkin, was considered a “person held in care” under the Coroners Act 1996. The text states: “As the deceased was an involuntary patient under the Mental Health Act 1996 at the time of his death, he was a ‘person held in care’ under section 3 of the Coroners Act 1996.”

Source 1:

\* text: "INTRODUCTION\n- 1 Luke Isaac Forkin (the deceased) died on 30 November 2010 when he hanged himself while he was absent without leave from Graylands Hospital (Graylands).\n- 2 As the deceased was an involuntary patient under the Mental Health Act 1996 at the time of his death, he was a 'person held in care' under section 3 of the Coroners Act 1996.\n- ..."

\* page: 2

\* document: data/Forkin-finding-2014.pdf

Source 2:

\* text: "INTRODUCTION\n- (2) or (3) of the Coroners Act 1996 generally as if they did.\n14. I have therefore not addressed those general issues separately from a consideration of each death. Rather, where I have come to the view that the issues were connected with the death or were potentially relevant to the quality of the supervision, treatment and care of..."

\* page: 4

\* document: data/Forkin-finding-2014.pdf

Source 3:

\* text: "Coroners Act 1996 [Section 26(1)]\nWestern"

\* page: 1

\* document: data/Forkin-finding-2014.pdf

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Ask your question (type q to quit):

Question:10

Was there evidence of any substance or drug in the body? Summarise the toxicology findings?

Answer:

Yes, there was evidence of multiple substances and drugs in the body.

\*\*Summary of Toxicology Findings:\*\*

The toxicology analysis revealed:

\* Therapeutic and sub-therapeutic levels of prescription medicines.

\* A low level of tetrahydrocannabinol (THC), indicating cannabis use within 24 hours.

\* Evidence of use of amphetamines, cannabis, heroin, LSD, and ecstasy intermittently.

\* Unclear evidence of alcohol abuse.

Source 1:

\* text: "CAUSE AND MANNER OF DEATH\n66. On 2 December 2010 Chief Forensic Pathologist Dr C T Cooke carried out a post mortem examination of the deceased. He found a ligature-type marking to the skin of the neck and internal neck injury with fracture of the main throat cartilage, but no other injuries. There was congestion of the lungs consistent with asphyxi..."

\* page: 14

\* document: data/Forkin-finding-2014.pdf

Source 2:

\* text: "INTRODUCTION\n12. I should note that there was great deal of evidence adduced at the inquest that was related to general or systemic issues pertinent to Graylands. That evidence was adduced to investigate whether those issues had bearing on any or some of the deaths and to allow the coroner to comment on the quality of supervision; treatment and car..."

\* page: 3

\* document: data/Forkin-finding-2014.pdf

Source 3:

\* text: "THE DECEASED\n- 19 The deceased began to use drugs, including amphetamines and cannabis, when he was 14 years old. He worked on farms and as a pearl diver and deck hand. He last worked when he was 18 or 19. At about that time he was convicted of several drug-related offences as well as for burglary, presumably connected to fund his use of drugs.\n- 2..."

\* page: 5

\* document: data/Forkin-finding-2014.pdf

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Ask your question (type q to quit):

Question:11

Summarize the coroner’s findings in 2-3 sentences.

Answer:

The coroner addressed general issues relating to Graylands Hospital’s systemic problems, primarily focusing on whether they impacted the care of the deceased patients. However, he didn’t separately examine these broader issues, instead incorporating them into his findings concerning each individual death when they were relevant to the quality of care. Ultimately, the coroner determined many of the systemic issues presented weren't sufficiently connected to all deaths to warrant specific comment under section 25 of the Coroners Act.

Source 1:

\* text: "INTRODUCTION\n- (2) or (3) of the Coroners Act 1996 generally as if they did.\n14. I have therefore not addressed those general issues separately from a consideration of each death. Rather, where I have come to the view that the issues were connected with the death or were potentially relevant to the quality of the supervision, treatment and care of..."

\* page: 4

\* document: data/Forkin-finding-2014.pdf

Source 2:

\* text: "INTRODUCTION\n12. I should note that there was great deal of evidence adduced at the inquest that was related to general or systemic issues pertinent to Graylands. That evidence was adduced to investigate whether those issues had bearing on any or some of the deaths and to allow the coroner to comment on the quality of supervision; treatment and car..."

\* page: 3

\* document: data/Forkin-finding-2014.pdf

Source 3:

\* text: "Counsel Appearing:\nMs M. Smith assisting the Coroner Ms R Hartley (State Solicitors Office) appearing on behalf of the Health Department of WA"

\* page: 1

\* document: data/Forkin-finding-2014.pdf

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Ask your question (type q to quit):

Question:12

Did the coroner make recommendations for future prevention? If yes, what were they?

Answer:

Based on the provided text, the coroner did not make specific recommendations for future prevention. The text states: “however, in my view many of the issues the subject of that evidence were not sufficiently connected with all the respective deaths for me comment on those issues under s.25”. This indicates a focus on providing context regarding Graylands, but not on offering recommendations for preventing similar deaths.

Source 1:

\* text: "INTRODUCTION\n- (2) or (3) of the Coroners Act 1996 generally as if they did.\n14. I have therefore not addressed those general issues separately from a consideration of each death. Rather, where I have come to the view that the issues were connected with the death or were potentially relevant to the quality of the supervision, treatment and care of..."

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Source 2:

\* text: "INTRODUCTION\n12. I should note that there was great deal of evidence adduced at the inquest that was related to general or systemic issues pertinent to Graylands. That evidence was adduced to investigate whether those issues had bearing on any or some of the deaths and to allow the coroner to comment on the quality of supervision; treatment and car..."

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\* document: data/Forkin-finding-2014.pdf

Source 3:

\* text: "Counsel Appearing:\nMs M. Smith assisting the Coroner Ms R Hartley (State Solicitors Office) appearing on behalf of the Health Department of WA"

\* page: 1

\* document: data/Forkin-finding-2014.pdf

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Ask your question (type q to quit):

Question: 13

Differentiate between the immediate cause of death and contributing factors (eg, drugs, mental health, environment).

Answer:

Here’s a breakdown differentiating the immediate cause of death from contributing factors, based solely on the provided context:

\*\*Immediate Cause of Death:\*\*

\* \*\*Ligature Compression of the Neck (Hanging):\*\* According to Dr. Cooke’s post-mortem examination, this was the direct cause of death. The report specifically states “ligature-type marking to the skin of the neck and internal neck injury with fracture of the main throat cartilage.”

\*\*Contributing Factors:\*\*

\* \*\*Drugs:\*\* The toxicology report revealed therapeutic and sub-therapeutic levels of prescription medications (olanzapine), a low level of tetrahydrocannabinol (cannabis – used within 24 hours), and a history of use of amphetamines, heroin, LSD, and ecstasy. These substances likely played a significant role in the deceased's state of mind and potentially impaired his judgment.

\* \*\*Mental Health:\*\* The context highlights a critical period of suicidal ideation and behavior. Specifically:

\* \*\*2007 Incident:\*\* He attempted suicide by pouring petrol on himself and his car, indicating a serious and ongoing mental health crisis.

\* \*\*Graylands Admission (2007):\*\* This was triggered by the breakdown of his relationship and housing situation, alongside a return to amphetamine use. While he showed improvement with treatment, the underlying mental health vulnerability remained.

\* \*\*Environmental Factors:\*\* The breakdown of his relationship and loss of accommodation were significant stressors, contributing to his mental distress and potentially precipitating the suicide attempt.

\*\*In summary:\*\* The immediate cause was hanging, but a complex web of factors—drug use, underlying mental health issues, and environmental stressors—likely led to the decision to end his life.

Source 1:

\* text: "CAUSE AND MANNER OF DEATH\n66. On 2 December 2010 Chief Forensic Pathologist Dr C T Cooke carried out a post mortem examination of the deceased. He found a ligature-type marking to the skin of the neck and internal neck injury with fracture of the main throat cartilage, but no other injuries. There was congestion of the lungs consistent with asphyxi..."

\* page: 14

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Source 2:

\* text: "THE DECEASED\n- 19 The deceased began to use drugs, including amphetamines and cannabis, when he was 14 years old. He worked on farms and as a pearl diver and deck hand. He last worked when he was 18 or 19. At about that time he was convicted of several drug-related offences as well as for burglary, presumably connected to fund his use of drugs.\n- 2..."

\* page: 5

\* document: data/Forkin-finding-2014.pdf

Source 3:

\* text: "THE DECEASEDS MENTAL HEALTH\n- 27 . On 4 November 2007 the deceased was referred to Graylands from the emergency department of Joondalup Health Campus following suicidal behaviour. 4 He had apparently poured petrol on himself and his car, intending to kill himself. Three weeks previously, his relationship with partner ended and the lease on the hous..."

\* page: 6

\* document: data/Forkin-finding-2014.pdf

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Ask your question (type q to quit):

Question: 14

Did the coroner evaluate the adequacy of supervision, treatment, or care provided? Explain the conclusion.

Answer:

Yes, the coroner evaluated the adequacy of supervision, treatment, and care.

Here’s the explanation based on the provided context:

The coroner addressed the quality of supervision, treatment, and care through several specific findings and assessments:

\* \*\*Risk Assessment:\*\* The coroner specifically stated, “there is no reasonable basis for any criticism of the risk assessment of the deceased before allowing him unescorted ground access or of the decision to allow him the access.” This indicates a direct evaluation of the risk management practices.

\* \*\*Least Restrictive Approach:\*\* The coroner noted the treating team’s application of the “least restrictive approach possible” and found this appropriate.

\* \*\*Dr. Iyyalol’s Assessment:\*\* The coroner considered Dr. Iyyalol’s opinion regarding the deceased’s impulsivity and how it impacted decision-making, further demonstrating an evaluation of the care provided.

Essentially, the coroner didn’t simply observe; they actively assessed and justified the decisions made regarding the deceased's care.

Source 1:

\* text: "INTRODUCTION\n- (2) or (3) of the Coroners Act 1996 generally as if they did.\n14. I have therefore not addressed those general issues separately from a consideration of each death. Rather, where I have come to the view that the issues were connected with the death or were potentially relevant to the quality of the supervision, treatment and care of..."

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Source 2:

\* text: "INTRODUCTION\n12. I should note that there was great deal of evidence adduced at the inquest that was related to general or systemic issues pertinent to Graylands. That evidence was adduced to investigate whether those issues had bearing on any or some of the deaths and to allow the coroner to comment on the quality of supervision; treatment and car..."

\* page: 3

\* document: data/Forkin-finding-2014.pdf

Source 3:

\* text: "QUALITY OF SUPERVISION, TREATMENT AND CARE\n74. The nursing staff had informed Dr Rosell that the deceased was no longer belligerent and aggressive to them.\n75. Both Dr Rosell and Dr Iyyalol considered the deceased to have been at a low risk of self-harm\n76. In these circumstances , the deceaseds treating team were guided by the requirement to..."

\* page: 16

\* document: data/Forkin-finding-2014.pdf

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Ask your question (type q to quit):

Question: 15

Does this case highlight any broader patterns or lessons relevant to public safety or institutional care?

Answer:

Yes, this case highlights several broader patterns and lessons relevant to public safety and institutional care. Here’s a breakdown based on the provided text:

\* \*\*Systemic Issues at Graylands:\*\* The inquest’s focus on “general or systemic issues pertinent to Graylands” reveals a significant problem – a lack of attention to underlying problems within the institution. This suggests a broader issue of inadequate oversight and a failure to address the conditions that contribute to patient distress and potentially, self-harm.

\* \*\*Patient Manipulation & Risk Assessment:\*\* The deceased’s manipulative behavior and attempts to gain unescorted access highlight a critical failure in risk assessment. The institution seemed to prioritize granting access based on the patient’s perceived “polite behavior” rather than a thorough evaluation of the actual risk.

\* \*\*Absconding & Lack of Control:\*\* The patient’s repeated absconding and the delay in declaring him AWOL point to a breakdown in security protocols and a lack of effective monitoring. This raises concerns about the safety of the community and the ability of the institution to manage potentially dangerous individuals.

\* \*\*Record-Keeping Deficiencies:\*\* The inadequate record-keeping of ground access further exacerbates the problem, making it impossible to track the patient’s movements and assess risks accurately.

\*\*Overall:\*\* The case suggests that institutions providing care for individuals with mental illness must proactively address systemic issues, conduct thorough risk assessments, and maintain robust monitoring and record-keeping systems to protect both the patient and the wider public.

Source 1:

\* text: "INTRODUCTION\n12. I should note that there was great deal of evidence adduced at the inquest that was related to general or systemic issues pertinent to Graylands. That evidence was adduced to investigate whether those issues had bearing on any or some of the deaths and to allow the coroner to comment on the quality of supervision; treatment and car..."

\* page: 3

\* document: data/Forkin-finding-2014.pdf

Source 2:

\* text: "THE DECEASED'S LAST ADMISSION TO GRAYLANDS\n- On 24 November 2010 the ward received a phone call from a Department of Corrective Services officer informing staff that the deceased was required to appear in court on 7 December 2010 in relation to a charge of assault occasioning bodily harm. I infer that the charge related to the incident at Burswood ..."

\* page: 11

\* document: data/Forkin-finding-2014.pdf

Source 3:

\* text: "QUALITY OF SUPERVISION, TREATMENT AND CARE\n- 70 The following issues deserve comment under this heading:\n- the standard of treatment and care of the deceased at Graylands;\n- b the suicide risk-assessment of the deceased before granting him unescorted ground access;\n- C the delay in declaring the deceased AWOL after he had absconded from Graylands o..."

\* page: 15

\* document: data/Forkin-finding-2014.pdf

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Ask your question (type q to quit):