Question and correct answers:  
1. Who was the deceased?  
The deceased was Luke Isaac Forkin, born in Western Australia on 23 October 1982 (page 4)

2. When did the death occur?  
The death occurred on 30 November 2010 (page 1)

3. Where did the death occur?  
The death occurred at 33A Snowbird Gardens, Joondalup, Western Australia (page 1)

4. What was the cause of death?  
The cause of death was ligature compression of the neck (hanging) (page 14).

5. Who was the presiding coroner?  
The presiding coroner was Barry Paul King (page 1).

6. What were the circumstances leading to the death?  
Mr. Forkin, an involuntary patient at Graylands Hospital, absconded from the hospital on 29 November 2010 during unescorted ground access. He went to stay at a friend’s house in Joondalup, where he was found the next day hanging by an electrical cord tied to a roof rafter (pages 13–14)

7. What relevant medical or mental health history did the deceased have?  
He had a history of drug abuse (amphetamines, cannabis, heroin), psychotic episodes, suicidal behavior, and antisocial personality traits. Diagnoses included amphetamine-induced psychosis and polysubstance abuse. He had also previously attempted suicide by hanging in 2008 (pages 5–8)

8. Who testified or assisted in the inquest?  
Those who assisted or gave evidence included Dr. R. Iyyalol and Dr. F. Rosell (treating psychiatrists), Dr. N. Gibson (Chief Psychiatrist), Nathan Ward (friend who discovered the body), paramedics and police officers, Dr. C. T. Cooke (Chief Forensic Pathologist), Ms. M. Smith (assisting the Coroner), and Ms. R. Hartley (State Solicitor’s Office, for the Department of Health) (pages 1, 15–19)

9. Was the deceased considered a “person held in care” under the Coroners Act?  
Yes. He was an involuntary patient under the Mental Health Act 1996 and therefore a “person held in care” as defined by section 3 of the Coroners Act 1996 (page 2).

10. Was there evidence of any substance or drug in the body? Summarise the toxicology findings.  
Yes. Toxicology results showed therapeutic and sub-therapeutic levels of prescription drugs and low levels of tetrahydrocannabinol (THC), indicating recent cannabis use within 24 hours before death (page 14).

11. Summarize the coroner’s findings in 2-3 sentences.  
The coroner found that Luke Forkin committed suicide by hanging while absent without leave from Graylands Hospital. The care, treatment, and supervision were reasonable and appropriate, and the decision to grant unescorted ground access was justified by his apparent stability (pages 20–21).

12. Did the coroner make recommendations for future prevention? If yes, what were they?  
Yes. The coroner noted that Dr. Nathan Gibson (Chief Psychiatrist) had initiated development of a Mental Health Act orientation and training program for all consultant psychiatrists to clarify the legal requirements for detaining and treating patients with personality disorders (page 20).

13. Differentiate between the immediate cause of death and contributing factors.

* Immediate cause: Ligature compression of the neck (hanging) (page 14).
* Contributing factors: Substance abuse, personality disorder, pending court case, strained relationship with his mother, and recent absconding from psychiatric care (pages 9–13, 20)

14. Did the coroner evaluate the adequacy of supervision, treatment, or care provided? Explain the conclusion.  
Yes. The coroner concluded that Graylands Hospital staff provided reasonable and appropriate treatment and supervision. Although there were minor issues with record-keeping and a 45-minute delay in declaring him AWOL, these were not contributory to the death. Staff acted under the “least restrictive” principle of care (pages 15–17).

15. Does this case highlight any broader patterns or lessons relevant to public safety or institutional care?  
Yes. The case highlights the complex challenges in managing patients with personality and substance-use disorders and the need for clearer guidance under the Mental Health Act. It also emphasized system improvements in record-keeping, risk assessment, and staff training, which were implemented after the inquest (pages 18–20)