Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 52/12

I, Barry Paul King, Coroner, having investigated the death of ***Luke Isaac Forkin*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth,*** *on* ***25 February 2014****, find that the identity of the deceased person was* ***Luke Isaac Forkin*** *and that death occurred on* ***30 November 2010*** *at* ***33A Snowbird Gardens, Joondalup,*** *from* ***ligature compression of the neck*** *in the following circumstances:*

Counsel Appearing:

Ms M. Smith assisting the Coroner
Ms R Hartley (State Solicitors Office) appearing on behalf of the Health Department of WA

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INTRODUCTION

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)**.

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*.

3. Section 22 (1)(a) of the *Coroners Act 1996* provides that a coroner who has jurisdiction to investigate a death must hold an inquest if the death appears to be a Western Australian death and the deceased was immediately before death a person held in care.

4. An inquest to inquire into the death of the deceased was therefore mandatory.

5. Under s.25 (3) of the *Coroners Act 1996*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

6. The death of the deceased was investigated together with the death of nine other persons who immediately before death had been persons held in care as involuntary patients at Graylands under the *Mental Health Act 1996*.

7. A joint inquest commenced before Coroner D.H. 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.

8. On 20, 21 and 22 March 2013 and 16 April 2013 evidence specific to the deceased was adduced.

9. On subsequent hearing days, evidence relevant to the other deceased persons and general evidence about Graylands was provided to the Court. The hearings were completed on 22 April 2013.
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10. Coroner Mulligan became unable to make findings under s.25 of the *Coroners Act 1996* so I was directed by Acting State Coroner Evelyn Vicker to investigate the deaths.

11. To remove any doubt of my power to make findings under s.25, on 25 February 2014 I held another inquest into the death of the deceased. The evidence adduced in that inquest was that which had been obtained by Coroner Mulligan, including exhibits, materials and transcripts of audio recordings of the inquests. Interested parties who were present at the inquests before Coroner Mulligan were invited to make fresh or further submissions. All of the parties indicated their agreement with the appropriateness of the procedure I had adopted.

12. I should note that there was a 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 a bearing on any or some of the deaths and to allow the coroner to comment on the quality of supervision, treatment and care of the deceased patients. For example, evidence of the condition of the buildings at Graylands containing wards was provided in order to allow the Court to investigate whether the physical environment of the wards would have been more therapeutic had the buildings been refurbished.

13. That general evidence was useful in providing an overview of the context in which the deceased persons were treated for their mental illnesses; however, in my view many of the issues the subject of that evidence were not sufficiently connected with all the respective deaths for me to comment on those issues under s.25

(2) or (3) of the *Coroners Act 1996* generally as if they did.

14. 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 the deceased, I have addressed them in the respective findings.

THE DECEASED

15. 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 mother's first relationship. The deceased's father was her second partner. The deceased's younger siblings were from her third partner, from whom he took his surname.

16. The deceased's biological father was in prison for a serious offence at the time the deceased was born. His mother had met her third partner, a cray boat fisherman who became the deceased's step-father.

17. The deceased was a normal, caring child when he was young. His mother described him as a great child. He and his family lived in Exmouth when the deceased was 11 to 14 years old. He had a close relationship with his mother and step-father at that time.

18. The family moved to Perth and the deceased became a loner and had trouble fitting in at school. He truanted regularly and was eventually expelled from school in Year 8 for fighting.

[1] Most of the following information is from Ex 1, Vol 3 Tab 1, p107-111

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.
20. In 2002, the deceased suffered a gunshot wound to the abdomen when his step-father accidently shot him with a handgun during unrest between groups in the street where the deceased's family lived.[2] The deceased lost a third of his pancreas and kidney, and two of his vertebrae were fractured in the accident. The deceased received the Disability Support Pension from that time and apparently received a substantial compensation payment because of the injury.[3]

21. As well as using amphetamines, the deceased also used cannabis every day and he used heroin, LSD and ecstasy intermittently. It is not clear whether he also abused alcohol.

22. By 2005 the deceased had been using amphetamines every day for five years, though had stopped using cannabis after abusing it daily for seven years. He had been leading an itinerant lifestyle and had a growing criminal history but had not yet been sentenced to detention or imprisonment.

THE DECEASED'S MENTAL HEALTH

23. On 4 May 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 May 2005 when he was discharged with a principal diagnosis of psychotic symptoms of schizophrenia and drug withdrawal.

[2] ts 29; Ex 1, Vol 1, Tab 42
[3] ts 31; Ex 1, Vol 1, Tab 9

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 drug use and IV amphetamine use'.

25. On 21 June 2006, the deceased was admitted into Broome Health Service after asking for assistance from police at Sandfire. He was suffering from ongoing paranoid psychotic episodes exacerbated by substance abuse. He was transferred to Graylands on 22 June 2006 where he was admitted into a secure ward as an involuntary patient and treated with olanzapine. He had no suicidal ideation.

26. On 27 June 2006 after the deceased's symptoms had settled, he was transferred to an open ward. The next day he left the ward without authorisation and did not return. The deceased's status was changed to voluntary on 28 June 2006 and he was formally discharged on 3 July 2006 with a final diagnosis of amphetamine-induced psychosis.

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 a partner ended and the lease on the house he shared with his partner expired, so he could not find accommodation. He had resumed intravenous amphetamine use after not using amphetamines for a year.

28. He was admitted to Graylands as an involuntary patient, placed in a secure ward and treated with oral olanzapine. He soon showed no formal thought disorder, delusions or perceptual disturbances and was no longer suicidal. He was uncooperative but not psychotic.[5]

[4] Ex 1, Vol 3, Tab 1, p2
[5] Ex 1, Vol 3, Tab 1 p. 3

29. After three days the deceased was transferred into a secure ward and within three hours he again left the hospital without authorisation. His status was later changed to voluntary, and he was a discharged with a final diagnosis of polysubstance abuse, acute mood and behavioural disturbance due to drug use, and antisocial personality traits.[6]

30. According to Dr E L Walker, who had been the deceased's doctor since he was born, the deceased had attempted suicide by hanging on 27 January 2008, but there is no record available to me to indicate that staff at Graylands were aware of that incident.

31. In late November 2008, the deceased's brother Jason died of a heroin drug overdose. The deceased and his mother believed that Jason had committed suicide, but their belief appears to have been misconceived.[7] Jason's death affected the deceased badly.[8] He apparently left the Perth metropolitan area for some time.

32. In April 2010 the deceased was convicted of aggravated robbery and sentenced to imprisonment for 24 months suspended for 18 months.[9]

33. On 5 July 2010 the deceased attended an appointment at Community Justice and told the officer that he was going to kill himself with a heroin overdose when he received his pension on 7 July 2010 or would hang himself. He was taken to the emergency department at Sir Charles Gairdner Hospital where he was assessed and transferred to Graylands on the same day.[10]

34. At Graylands the deceased said that he had suicidal and violent thoughts, that he heard voices telling him to

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[6] Ex 1, Vol 3, Tab 1 p. 2-3
[7] Coroner's Court 1172/08
[8] ts 31
[9] Ex 1, Vol 1, Tab 41

[10] Ex 1, Vol 3, Tab 2, p 144-150, 151

harm himself and others, that he had a microchip in his chest and that he was receiving TV and radio messages.[11]

35. The next day the deceased was made an involuntary patient for two days and transferred to an open ward with a requirement of observations every 30 minutes for absconding but with unescorted 30 minute ground access. He displayed no psychotic features by the afternoon of 7 July 2010.[12]

36. That afternoon he left the ward contrary to advice from a nurse. The next day he was placed on daily leave and, given that the treating psychiatrist considered that the deceased had no overtly treatable mental illness, on 12 July 2010 he was discharged outright.[13]

37. The timing of the following events is difficult to ascertain from the available evidence, but it seems that the deceased's mother received a phone call from a woman with whom the deceased had been staying shortly after Jason's death. The woman said that the deceased was back in Perth and that he was suicidal. The deceased's mother went to the deceased's unit in Dianella where she found him and took him back to her home to stay with her.[14]

38. However, it seems that the deceased told an assessing clinician at Graylands that he had damaged his unit before that time and had been ejected by Homeswest.[15] Two weeks later he told the Graylands welfare officer that associates of his had trashed the unit after gaining access with the keys kept in the letterbox.

39. Either way, over the months during which he stayed with his mother, the deceased's mental health issues

[11] Ex 1, Vol 3, Tab 2, p153, 159
[12] Ex 1, Vol 3, Tab 2, p171
[13] Ex 1, Vol 3, Tab 2, p171-172
[14] ts 36
[15] Ex 1, Vol 1, Tab 28; Ex 1, Vol 3, Tab 2 p28

became worse. He threatened and attacked his mother on more than one occasion.[16]

40. On 22 October 2010, the deceased allegedly attacked a stranger after a music concert at the Burswood Dome, head-butting him and kicking him in the head. The victim ran off and alerted police, who apprehended the deceased and obtained his details. The deceased displayed paranoia and further spontaneous violence later that night. He was charged by prosecution notice on 2 December 2010.[17]

THE DECEASED'S LAST ADMISSION TO GRAYLANDS

41. On 5 November 2010 the deceased became agitated when trying to fix a car in the car-park of his mother's home. He behaved strangely: storming up and down the car-park and swearing loudly before going inside and hiding in the shower. When his mother found him in the shower and tried to offer him support, he chased her out of the house and smashed up the inside of her home.[18]

42. The deceased's mother managed to get into her car and drive away. She went to a shop and called police who took the deceased to Sir Charles Gardner Hospital where he was assessed before being transferred to Graylands.[19]

43. On arrival at Graylands the deceased was admitted to a closed ward with a provisional diagnosis of psychotic disorder, possibly secondary to substance abuse, with an additional diagnosis of personality disorder.[20] In the ward he was drug-seeking for days, sometimes polite and other times aggressive and demanding.

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[16] ts 34
[17] Ex 1, Vol 2, Tab 57
[18] ts 36
[19] Ex 1, Vol 2, Tab 53
[20] Ex 1, Vol 3, Tab 2, p8

44. On 8 and 10 November 2010 the deceased's mother rang Graylands to express her fear for her life if the deceased were released. Over the next week or so, she obtained a violence restraining order against the deceased.[21]

45. On 10 November 2010 the deceased was granted 30 minute escorted ground access twice a day. The next day he was on an escorted ground access when he absconded by pretending to use the toilet in a ward urgently and then eluding the nurse escorting him. With the help of a colleague, the nurse saw the deceased walking to the nearby train station and managed to persuade him to return to Graylands.

46. By 18 November 2010 the deceased settled and became more cooperative. His medical doctor, Dr F Rosell, allowed him 30 minute escorted ground access twice a day with orders that he be declared AWOL immediately if he absconded.

47. The next day, the welfare officer at Graylands spoke to the deceased about the possibility of him returning to his unit after discharge. She had arranged with Homeswest for that to occur and the deceased was keen to return. That day he pleaded with Dr Rosell to be moved from the secure ward.[22]

48. On 20 November 2010 the deceased went out on escorted ground access without any problems and was settled, but the next afternoon he was particularly agitated and demanding, with aggressive and threatening behaviour. However, no overt psychotic symptoms were observed. By that evening he was appropriate and pleasant, interacting well with staff and fellow patients.

49. On 23 November 2010 the deceased presented well when reviewed by his treating psychiatrist, Dr R Iyyalol, and Dr Rosell. They transferred him to an open ward

[21] Ex 1, Vol 1, Tab 56
[22] Ex 1, Vol 3, Tab 2, p51-52

due to lack of beds in the closed wards. He utilised unescorted ground access for 30 minutes without incident. Dr Iyyalol would have discharged the deceased that day if there were a place for the deceased to go.[23]

50. 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 Dome on 22 October 2010. Given that the deceased was on a suspended sentence of imprisonment at the time of the alleged offence, it appears to me that there was a real possibility that he would be sentenced to imprisonment.[24] It would be reasonable to assume that the deceased would have been aware of that.

51. Early that afternoon the deceased was found on the floor of the ward apparently experiencing a mild seizure. An emergency team was summoned and the deceased was conveyed to Sir Charles Gairdner Hospital by ambulance. There he was examined but no neurological deficit was found and nothing untoward was noted elsewhere. He was transferred back to Graylands that afternoon and was placed in the closed Smith Ward.[25]

52. On the next day, the welfare officer at Graylands made arrangements with the deceased to pay for cleaning and repairs of his unit by Homewest as a condition of him returning to it. The deceased indicated that he still wanted to move back into it.

53. On 25 November 2010 the treating team, including Dr Iyyalol and Dr Rosell, determined to keep the deceased's status as involuntary for a further two weeks due to his pending court appearance and the risk he

[23] ts 121
[24] ts 126
[25] Ex 1, Vol 3, Tab 2, p.56-58

posed to his mother.[26] After that, he would be discharged.

54. The deceased was granted 30 minute escorted ground access twice a day. Over the next few days he was mostly settled on the ward and utilised his escorted ground access without any problems. Dr Iyyalol was considering discharging him.

55. On 29 November 2010 the deceased was seen by Dr Iyyalol and Dr Rosell. He was settled, cooperative and polite. He denied hearing voices or receiving messages from TV and radio and denied suicidal or homicidal ideation.[27] He was aware that he had to go to court that week. He promised not to have drugs and to behave and follow directions. Dr Iyyalol did not consider him to be a threat to his mother.[28] He and Dr Rosell decided to allow the deceased unescorted ground access for 60 minutes twice a day.

56. The deceased had utilised escorted ground access between 10.00am and 11.00am that morning. He was then allowed unescorted ground access between 12.00pm and 1.00pm without incident. The deceased was again allowed unescorted ground access again at 2.00pm.[29]

57. Shortly after 3.00pm on 29 November 2010 the shifts at Smith Ward changed over from morning shift to evening shift. At about 3.45pm staff at the ward discovered that the deceased had not returned from the unescorted ground access. A search of the grounds and surrounding areas was then conducted without success. At 5.45pm Dr Rosell was contacted; he instructed that the deceased be declared AWOL, which occurred. Police and the Mental Health Emergency

[26] ts 131, Ex 1, Vol 3, Tab 2, p.59
[27] Ex 1, Vol 3, Tab 2, p.62
[28] Ex 1, Vol 2, Tab 48, para 53
[29] Ex 1, Vol 3, Tab 2, p.62

Response Line were notified that the deceased had absconded, as was the deceased's mother.[30]

EVENTS LEADING TO THE DEATH

58. 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 deceased's brother Jason had introduced them.[31]

59. The deceased arrived at the Ward's house unexpectedly at about 7.00pm on 29 November 2010. He told Mr Ward that he had absconded from Graylands and asked him if he could stay for a few days, to which Mr Ward agreed.[32]

60. The deceased appeared to Mr Ward to be his normal self except that he was pacing around a lot.[33] He mentioned that he had a court date but did not seem to be too concerned about it.[34] The deceased did not do or say anything which made Mr Ward think that he was going to harm himself.

61. That evening the deceased and Mr Ward smoked some cannabis and talked until about 9.00pm when the deceased went to bed in the spare room. At about 12.00am or 1.00am Mr Ward saw the deceased in the hallway walking back to his bedroom, but did not speak with him.[35]

62. The next morning Mr and Ms Ward left for work at 6.30am. They did not see the deceased and assumed that he was still in bed asleep. They left the front door unlocked.

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[30] Ex 1, Vol 2, Tab 51
[31] ts 49-52
[32] ts 54-55
[33] ts 53
[34] ts 55
[35] Ts 55, Ex 1, Vol 1, Tab 10 p.2

63. Mr Ward and his wife returned home from work at about 4.00pm and noticed that the front door was locked. Mr Ward entered the house first and saw the deceased hanging by his neck with an electrical cord tied to a rafter through an open manhole in the ceiling.[36]

64. Mr Ward called 000 and was provided with advice by the operator. He cut the electrical cord and applied chest compressions to the deceased until ambulance paramedics arrived.

65. Ambulance paramedics arrived within minutes, but the deceased showed no signs of life. One of the paramedics completed a Life Extinct Form at 4.10pm.[37]

CAUSE AND MANNER OF DEATH

66. 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 asphyxiation due to neck compression.[38]

67. A toxicology analysis showed therapeutic and sub-therapeutic levels of prescription medicines and a low level of tetrahydrocannabinol, indicating the use of cannabis within 24 hours.[39]

68. Dr Cooke concluded that the cause of death was ligature compression of the neck (hanging), and I so find.

69. I find that the manner of death was suicide.

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[36] Ex 1, Vol 1, Tab 10
[37] Ex 1, Vol 1, Tab 40
[38] Ex 1, Vol 1, Tab 6
[39] Ex 1, Vol 1, Tab 8

QUALITY OF SUPERVISION, TREATMENT AND CARE

70. The following issues deserve comment under this heading:

    a. the standard of treatment and care of the deceased at Graylands;

    b. the suicide risk-assessment of the deceased before granting him unescorted ground access;

    c. the delay in declaring the deceased AWOL after he had absconded from Graylands on the afternoon of 29 November 2010; and

    d. a lack of proper record-keeping of the deceased's ground access.

71. As to the standard of treatment and care of the deceased, it is important to note that the deceased was a difficult patient much of the time. He was aggressive and demanding to nursing staff and other patients, seeking drugs and trying to manipulate the system for his gratification. He was superficially cooperative with medical officers and psychiatrists, but is seems that his polite behaviour was calculated to obtain benefits, especially ground access to enable him to abscond.

72. Notwithstanding the difficulties of dealing with the deceased, the evidence makes clear that staff at Graylands treated him and cared for him reasonably and appropriately, even so far as arranging for his Homeswest accommodation to be made available to him when he was to be discharged.

73. As to the risk assessment of the deceased before he was granted unescorted ground access on 29 November 2010, Dr Rosell was familiar with the deceased and had no qualms about allowing him to have unescorted ground access. At that stage, both he and Dr Iyyalol

considered that the deceased was neither depressed nor elevated in mood, and that he was not psychotic.

74. The nursing staff had informed Dr Rosell that the deceased was no longer belligerent and aggressive to them.

75. Both Dr Rosell and Dr Iyyalol considered the deceased to have been at a low risk of self-harm.

76. In these circumstances, the deceased's treating team were guided by the requirement to apply the least restrictive approach possible in the treatment of the deceased and allowed him to have unescorted ground access.

77. In my view, 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. While there was always the risk that he deceased might abscond, the probability that he would commit suicide appeared low. Had he not been granted access, there would have been legitimate criticisms that his treatment was unreasonably restrictive.

78. Dr Iyyalol stated that it was not possible to make such decisions with respect to the deceased without risk because of the deceased's impulsivity.[40]

79. As to the delay in declaring the deceased AWOL, it is likely that the deceased was granted unescorted ground access at about 2.00pm on 29 November 2010. Because of other exigencies when the shift handover procedure took place at about 3.00pm, the deceased's failure to return to the ward by 3.00pm was not brought to the attention of the incoming ward coordinator until 3.45pm. The search that ensued in accordance with the policy for absconding patients was completed by 5.45pm, at which time the ward co-ordinator informed

[40] Ex 1, Vol 2, Tab 48, para 49

Dr Roswell that the deceased had absconded and he directed that the deceased be declared AWOL.

80. When considered in that light, taking into account in particular the time necessary to carry out a search for the deceased, the effective delay in declaring the deceased AWOL caused by the failure to notify the ward co-ordinator of the deceased's failure to return at 3.00pm was only 45 minutes.

81. Moreover, taking into account the fact that the police actions resulting from the deceased being declared AWOL were ineffective,[41] presumably because police could not have had any inkling of where the deceased was likely to have gone, the delay was ultimately of little or no consequence in any event.

82. Similar considerations are relevant to the fourth issue: the lack of proper record-keeping of the deceased's ground access.

83. The evidence in relation to this issue was that nurses at Graylands are required to make entries on specialised forms each time a patient goes on ground access. While it was clear that the deceased went on escorted ground access once in the morning and unescorted ground access twice in the afternoon on 29 November 2010, the only record made related to the first ground access.

84. It was accepted by the ward co-ordinator responsible for the day shift that the failure to ensure that the records were properly entered was inexplicable and unacceptable. Given the potential importance of those records, his position on the issue was welcome.

85. Systemic issues related to the delay in commencing the AWOL procedure and to the failure to document ground access have been addressed by Graylands since the inquests before Mr Mulligan.

[41] Ex 1, Vol 1, Tabs 38, 39

86. The last of the issues identified above is the legality of keeping the deceased in Graylands as an involuntary patient after his psychotic symptoms had ceased. This issue arose because of Dr Iyyalol's evidence.

87. Dr Iyyalol said that on 23 November 2010 he was considering releasing the deceased in a few days and that he was not concerned for the deceased's safety, but that he was concerned about the deceased as a threat to his mother.[42] On 24 November 2010 the deceased's treating team were informed about the deceased's pending court appearance. The team decided to keep the deceased in Graylands for two more weeks because of concern for his mother's safety and in order to support him through the court appearance given that he had expressed self-harm ideation previously and the appearance could be a very stressful time for him.[43]

88. Dr Iyyalol said that the decision to keep the deceased in Graylands was based on his threat to others rather than on his mental health or psychiatric illness. He said that if the deceased went before the Mental Health Review Board, he would have been released because he did not have a treatable mental illness.[44]

89. He said that, rather than suffering from a treatable mental illness, the deceased suffered from a personality disorder which could not be treated. As a result, Dr Iyyalol considered that the deceased could not have been detained in Graylands under the *Mental Health Act 1996*, but the deceased was a risk to others, and that was the focus of the system.[45]

90. Dr Iyyalol agreed that what he was saying was that on 29 November 2010 the deceased had no mental illness that required treatment and consequently could not have been appropriately held as an involuntary patient.

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[42] ts 126-127
[43] 125-126
[44] ts 129
[45] ts 131

91. This issue was addressed by Dr N Gibson, the Chief Psychiatrist, in evidence adduced on 22 April 2013. In contrast to Dr Iyyalol, Dr Gibson's expressed the view that personality disorders are treatable mental illnesses in accordance with the *Mental Health Act 1996* depending on the individual patient's circumstances. He says that there are international guidelines on the treatment of antisocial personality disorder, but that there is not a lot of research evidence on the best treatment, and the definitions and diagnoses of the disorders are not absolutely robust.

92. As I understand him, Dr Gibson said that the evolution of personality disorders has been much more fluid over the years, so an application of the *Mental Health Act 1996* to personality disorders would not be based on criteria that would remain consistent.

93. It is clear from the discussion above that views of experienced psychiatrists may differ as to the application of the *Mental Health Act 1996* to patients with personality disorders who are a risk to themselves or others.

94. While some difference of opinion might be expected over such a complex topic, putting clinicians such as Dr Iyyalol in the position where, in order to provide their patients with the supervision, care and treatment they consider necessary, they believe that they must act in a way they understand to be contrary to the requirements of the *Mental Health Act 1996* is undesirable from the clinicians' perspective. Dr Iyyalol said that 'it should not be that way, in my opinion.'[46]

95. I agree with him that clinicians should not be placed in such a conflicted position. However, the cause may be seen as a function of what the clinicians understand rather than as a consequence of the operation of the *Mental Health Act 1996*. The ready solution would

[46] ts 127

appear to be the provision to clinicians of education with respect to the requirements of that Act.

96. To that end, counsel for Graylands, Ms Hartley, informed the inquest in closing submissions that Dr Gibson had undertaken the development of a *Mental Health Act* orientation and training package that was to be rolled out in September and October of 2013 for all consultant psychiatrists.

CONCLUSION

97. I am satisfied that on 29 November 2010 the deceased absconded from Graylands and went to the house of friends in Joondalup where, after his friends had left the house the next day to go to work, he committed suicide by hanging.

98. While it appears likely that the particular stressors affecting the deceased at the time of his suicide were a pending court appearance which was likely to result in imprisonment and the destruction of his relationship with his mother, any conclusion in relation to this aspect of his death would involve a mixture of assumption and speculation.

99. It does seem clear that the deceased suffered from a personality disorder and substance abuse issues which together affected him so adversely as to require involuntary admissions in Graylands. I am satisfied that the care and treatment he received there was reasonable and appropriate.

B P King
Coroner
11 April 2014