JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	11 JUNE 2024
DELIVERED	**:**	9 AUGUST 2024
FILE NO/S	**:**	CORC 464 of 2022
DECEASED	**:**	WOODS, LINDSAY

Catchwords:

Nil

Legislation:

Criminal Law (Mentally Impaired Accused) Act 1996 (WA)
Coroners Act 1996 (WA)

Counsel Appearing:

Mr W Stops appeared to assist the coroner.

Sergeant C Martin assisted the coroner.

Ms I Darch (State Solicitor's Office) appeared on behalf of the Office of the Public Advocate, and the North Metropolitan Health Service.

Ms O Roberts (Aboriginal Legal Service WA Inc.) appeared on behalf of members of Lindsay's family.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Lindsay WOODS*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 11 June 2024, find that the identity of the deceased person was* ***Lindsay WOODS*** *and that death occurred on 19 February 2022 at Sir Charles Gairdner Hospital, Hospital Avenue, Nedlands, from metastatic high-grade neuroendocrine carcinoma, treated palliatively in the following circumstances:*

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INTRODUCTION

1. Lindsay Woods (Lindsay)[1,2] died on 19 February 2022 at Sir Charles Gairdner Hospital (SCGH) from metastatic high-grade neuroendocrine carcinoma. He was 48 years of age.[3,4,5,6,7,8,9,10,11,12,13] At the time of his death, Lindsay was accommodated at the Frankland Centre, and he was subject to a custody order made under the *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) made on 8 June 2020.[14,15]

2. As Lindsay was not a "*person held in care*" pursuant to the *Coroners Act 1996* (WA) (the Coroners Act), an inquest into his death was not mandatory.[16] Nevertheless, in view of the circumstances of his being placed on an Order, it was appropriate for his death to be investigated. I held an inquest into Lindsay's death at Perth on 11 June 2024. The inquest focused on the care, treatment and supervision provided to Lindsay while he was the subject of the Order, as well as the circumstances of his death.

3. The documentary evidence adduced at the inquest comprised three volumes and included expert reports, Lindsay's medical notes and other documents relating to his management. The following witnesses gave evidence at the inquest:

a. Dr Rachel Griffiths (Consultant psychiatrist, Frankland Centre);[17] and

b. Dr Samantha Bowyer (Medical oncologist, SCGH).[18]

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[1] Through their counsel Ms Roberts, Mr Woods' family asked that Mr Woods be referred to as "*Lindsay*" in this finding
[2] ts 11.06.24 (Roberts), p42
[3] Exhibit 1, Vol. 1, Tab 7, Report - Sen. Const. J Lewis (16.04.23)
[4] Exhibit 1, Vol. 1, Tab 1, Death in Hospital Form (19.02.22)
[5] Exhibit 1, Vol. 1, Tab 2, P100 - Report of Death (16.04.23)
[6] Exhibit 1, Vol. 1, Tab 3, P98 - Mortuary Admission Form
[7] Exhibit 1, Vol. 1, Tab 4, P92 - Identification of Deceased Person (22.02.22)
[8] Exhibit 1, Vol. 1, Tab 4, Affidavit - Sen. Const. B Hockey (22.02.22)
[9] Exhibit 1, Vol. 1, Tab 4, Affidavit - Sen. Const. K Asher (22.02.22)
[10] Exhibit 1, Vol. 1, Tab 4, Coronial Identification Report (21.02.22)
[11] Exhibit 1, Vol. 1, Tab 5.1, Supplementary Post Mortem Report (22.09.22)
[12] Exhibit 1, Vol. 1, Tab 5.2, Post Mortem Report (02.03.22)
[13] Exhibit 1, Vol. 1, Tab 6, Toxicology Report (24.08.22)
[14] Part 5, *Criminal Law (Mentally Impaired Accused) Act 1996* (WA)
[15] Exhibit 1, Vol. 1, Tab 15.1, Report - Office of the Public Advocate (29.05.24), p1
[16] Sections 3, 22(1)(a) & 25(3), *Coroners Act 1996* (WA)
[17] Exhibit 1, Vol. 1, Tab 16, Report - Dr R Griffiths (04.06.24) and ts 11.06.24 (Griffiths), pp5-26
[18] Exhibit 1, Vol. 1, Tab 14, Report - Dr L Oh & Dr S Bowyer (28.02.22) and ts 11.06.24 (Bowyer), pp26-34

LINDSAY

Background[19,20,21]

4. Lindsay was born on 7 January 1974. As a child, he lived at the Swan Valley Noongar Community in Lockridge (the Community), which was closed by the State Government in 2003. While at the Community it is likely Lindsay was exposed to "*violence, substance use, and unstable family relationships*", and he was made a ward of the State when he was about 12 years of age.

5. Lindsay had an extensive criminal record, and by the time of his admission to the Frankland Centre, he had accumulated 101 convictions for offences including assaulting a public officer, disorderly behaviour, stealing, robbery whilst armed, burglary, and traffic offences.

6. Lindsay served several terms of imprisonment, and on 25 April 2019, he was charged with grievous bodily harm after allegedly stabbing "*another homeless man in the chest who was living at the same squat in Highgate in the context of significant paranoia*".[22]

7. In June 2020, in the District Court of Western Australia, Lindsay was found unfit to stand trial in relation to the charge due to his mental health issues, and he was placed on a custody order (the Order) under the *Criminal Law (Mentally Impaired Accused) Act 1996* (WA).

8. The effect of the Order was to dismiss the grievous bodily harm charge without deciding guilt, and to require Lindsay to remain in custody for an indefinite period, until released by an order of the Governor. The Mentally Impaired Accused Review Board (the Board) subsequently determined that Lindsay was to be detained at the Frankland Centre, where he could receive ongoing treatment for his mental illness.

[19] Exhibit 1, Vol. 1, Tab 15.1, Report - Office of the Public Advocate (29.05.24), pp1-2
[20] Exhibit 1, Vol. 1, Tab 17, Court Outcomes History - Criminal and Traffic
[21] Exhibit 1, Vol. 1, Tab 16, Report - Dr R Griffiths (04.06.24), pp2-3
[22] Exhibit 1, Vol. 1, Tab 12, Discharge Summary - State Forensic Mental Health Service (19.02.22), p1

Medical history[23,24,25,26]

9. Lindsay's medical history included ischaemic heart disease, and poorly controlled type-2 diabetes. In 1991, he sustained a significant head injury after the stolen car he was travelling in crashed while being pursued by police. Lindsay was subsequently diagnosed with chronic paranoid schizophrenia, antisocial personality disorder, and polysubstance abuse disorder. Later Lindsay's diagnosis was amended to "*organic psychosis*", indicating a mental illness caused by his acquired brain injury. Lindsay also had cognitive deficits (frontal lobe impairment) secondary to his head injury.

10. Lindsay had a long history of polysubstance use including solvents, alcohol, cannabis, and methylamphetamine, and a documented history of "*self-harm and auditory hallucinations to kill*". Lindsay had numerous admissions to psychiatric facilities, with his first to Graylands Hospital (Graylands) in 1991 following his head injury. Between 2005 and 2022, Lindsay had 13 inpatient admissions, including a three year admission to Graylands from 2006 until 2009.

11. Although Lindsay was managed in the community on a series of Community Treatment Orders, his chaotic lifestyle and homelessness made his management challenging, and he "*often could not be found to receive his treatment*".

12. Psychiatric reports in 2019 and 2020 described Lindsay's chronic paranoid schizophrenia as "*severe and treatment resistant*", and it was noted he had been trialled on various antipsychotic medications, including depot injections.

13. During most of his admission to the Frankland Centre Lindsay was treated with clozapine (regarded as the gold standard for treatment resistant schizophrenia). Although Lindsay appeared to respond well to this medication, "*his symptoms did not completely resolve*".

[23] Exhibit 1, Vol. 1, Tab 10, Patient medical records - Derbarl Yerrigan Health Service
[24] Exhibit 1, Vol. 1, Tab 12, Discharge Summary - State Forensic Mental Health Service (19.02.22)
[25] Exhibit 1, Vol. 1, Tab 15.1, Report - Office of the Public Advocate (29.05.24), p2
[26] Exhibit 1, Vol. 1, Tab 16, Report - Dr R Griffiths (04.06.24), pp2-3 and ts 11.06.24 (Griffiths), pp6-8

MANAGEMENT AT FRANKLAND CENTRE

General issues[27,28,29]

14. After Lindsay was placed on the Order he was admitted to the Frankland Centre on 8 June 2020, where he remained until his death. The Frankland Centre is the only secure forensic mental health facility in Western Australia, and provides clinical care for persons in custody. When it opened in 1993, the Frankland Centre had 30 beds at a time when the prison population in Western Australia was about 2,000.[30,31]

15. In 2024 the Frankland Centre still has only 30 beds, whereas the prison population is upwards of 6,500. Clearly access to beds at the Frankland Centre is an ongoing issue, and although a new secure forensic mental health facility with increased capacity is planned, there is no firm indication of when this facility will actually open, and when the new beds will become available.[32,33]

16. On 26 November 2020, the State Administrative Tribunal appointed the Public Advocate as Lindsay's limited guardian for a period of five years. The limited guardian's role was to make treatment decisions for Lindsay; to seek legal advice and representation in respect of Board hearings he was involved in; and to investigate options for Lindsay's future accommodation and services.

17. The Public Advocate successfully applied for funding from the National Disability Insurance Scheme (NDIS) to enable Lindsay to achieve his health and community access goals. Although the application for NDIS funding was successful, it was subsequently determined that the allocated grant was insufficient to enable Lindsay to achieve his goals. For that reason, an application for additional funds was made, and the review process in relation to that application was ongoing at the time of Lindsay's death.

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[27] Exhibit 1, Vol. 1, Tab 12, Discharge Summary - State Forensic Mental Health Service (19.02.22)
[28] Exhibit 1, Vol. 1, Tab 15.1, Report - Office of the Public Advocate (29.05.24), pp1-4
[29] Exhibit 1, Vol. 1, Tab 15.2, Order - State Administrative Tribunal (26.11.20)
[30] ts 11.06.24 (Griffiths), pp13-14
[31] See: Australia Prisoners 1993 at: www.aic.gov.au/sites/default/files/2020-07/npc1993.pdf
[32] See: https://www.wa.gov.au/system/files/2023-10/department-of-justice-annual-report-2022-2023.pdf
[33] ts 11.06.24 (Griffiths), pp13-14

Management of medical issues[34,35]

18. During his admission at the Frankland Centre, Lindsay received his antipsychotic medication regularly, and he was regarded as "*mentally stable most of the time*". On 26 May 2021, Lindsay's clozapine was ceased after had an electrocardiogram (ECG), which was found to be abnormal.

19. However, Lindsay was under the care of a clozapine cardiologist, and his clozapine medication dose was resumed on 27 July 2021, when his mental state deteriorated. Following a review, it was considered that the benefits Lindsay received from his clozapine treatment outweighed any potential cardiac risks.[36]

20. In my view the decision to reinstate Lindsay's clozapine dose after his mental state deteriorated was reasonable, especially when considered in a broader context. As Lindsay's consultant psychiatrist (Dr Griffiths) pointed out in her report:

> Without clozapine we would have been unable to progress with Lindsay's community reintegration because he was too much of a risk to others. Obtaining eventual freedom was very important to Lindsay.[37]

21. Lindsay received weekly medical reviews, and was regularly seen by a GP, a cardiologist, and by his psychiatrist, Dr Griffiths. Lindsay declined to discuss his early history, and was described as "*quiet and reserved*". Nevertheless, he sought medical help when "*he had something to discuss*". He also followed rules, and was "*pleasant towards staff and peers*". Lindsay was also described as being very focussed on eventually being released from custody, and at the inquest, Dr Griffiths noted that "*the plan was that we were going to start to formulate a discharge plan for him, probably in about three years*".[38]

[34] Exhibit 1, Vol. 1, Tab 16, Report - Dr R Griffiths (04.06.24), pp3-7 and ts 11.06.24 (Griffiths), pp10-26
[35] Exhibit 1, Vol. 1, Tab 12, Discharge Summary - State Forensic Mental Health Service (19.02.22)
[36] ts 11.06.24 (Griffiths), pp8-10
[37] Exhibit 1, Vol. 1, Tab 16, Report - Dr R Griffiths (04.06.24), p4
[38] ts 11.06.24 (Griffiths), p4

22. When asked, Lindsay would usually describe his mood as "*OK*", although his outward display of emotions was documented as "*blunted*". Lindsay was known to become irritable if his needs were not immediately met, and his speech was slurred due to his refusal to wear dentures. Lindsay would often write "*nonsensical letters in code*", and occasionally disclosed delusional beliefs (e.g.: that he could use satellites to contact space about government issues). However, Lindsay "*could easily engage in reality-based conversations*", and he had some insight into his mental illness, and the need for treatment.

23. Other than one incident of aggression in 2020, Lindsay "*displayed good behaviour*" at the Frankland Centre, and "*was making good progress towards community reintegration*". Lindsay had been granted escorted grounds, and community access by the Board and he was said to enjoy visits to the swimming pool, shops, and fast-food outlets. During the time he was at the Frankland Centre, Lindsay did not receive any visits from friends or family members.[39]

24. In relation to contacting Lindsay's next of kin, a cousin was identified early in his admission to the Frankland Centre, but that person did not wish to have contact with Lindsay. Thereafter, for most of Lindsay's admission, Aboriginal Liaison Officers (ALO), who can typically assist in locating a person's family, were unavailable at the Frankland Centre.

25. At the inquest Dr Griffiths conceded that this aspect of Lindsay's care (and the care of other Aboriginal patients at the Frankland Centre) was "*very lacking at the time*". However, Dr Griffiths also confirmed that in about October 2021, ALOs from Graylands began assisting at the Frankland Centre, and conduct cultural groups and provide "*a very good service*". These ALOs were also instrumental in locating Lindsay's family, who were then able to visit him at Sir Charles Gairdner Hospital (SCGH) in the period shortly before his death.[40]

[39] ts 11.06.24 (Griffiths), pp10-11
[40] ts 11.06.24 (Griffiths), pp10-13

26. Key aspects of Lindsay's medical management at the Frankland Centre from 2021 until his death may be summarised as follows:[41]

a. *December 2021 - January 2022*: Lindsay had complained of not opening his bowels regularly, which Dr Griffiths noted was "*a common problem for patients on clozapine*". Lindsay also experienced two episodes of nocturnal faecal incontinence, and a series of abdominal x-rays supported the view that his constipation was related to his medication.

b. *10 January 2022*: Lindsay was found to have low blood pressure, but when reviewed, he denied pain in his chest or abdomen, and he underwent an ECG which was normal.

c. *20 January 2022*: Lindsay was found to be grimacing and he complained of back pain. When he was reviewed by the psychiatric registrar it was noted that an abdominal x-ray Lindsay had undergone the day before had shown "*significant L5-S1 facet joint arthritis*". Lindsay was given analgesia, and further investigations into the cause of his back pain were planned.

   I note that there is no evidence in Lindsay's medical records that he had complained of back pain in the months preceding this incident.[42,43,44]

d. *21 January 2022*: Lindsay complained of not being able to get out of bed, and told staff "*I'm crippled, my back, I can't move*". Lindsay's blood pressure was low and a Code Blue medical emergency was activated, and he was taken to SCGH by ambulance.

27. After Lindsay was transferred to SCGH, Dr Griffiths was not involved with his day-to-day care. However, Dr Griffiths received regular updates on his progress from the Frankland Centre nursing staff who escorted Lindsay, and supervised him "*24-hours per day while he was at SCGH*".[45]

[41] Exhibit 1, Vol. 1, Tab 16, Report - Dr R Griffiths (04.06.24), pp5-6
[42] ts 11.06.24 (Griffiths), pp15-16
[43] Exhibit 1, Vol. 2, Tab 1, Medical Records - Frankland Centre (Volume 10, B0654820)
[44] Exhibit 1, Vol. 3, Tabs 1 & 2, Medical Records - Frankland Centre (Volumes 13 & 14, B0654820)
[45] ts 11.06.24 (Griffiths), pp16-17

Management at SCGH and death[46,47,48,49]

28. After he was admitted to SCGH, Lindsay underwent CT scans of his abdomen and pelvis, and a PET scan. He also had an ultrasound guided biopsy of his right cervical lymph nodes, and was subsequently diagnosed with metastatic high-grade neuroendocrine carcinoma.

29. At the inquest, Dr Bowyer (consultant medical oncologist), said this about metastatic high-grade neuroendocrine carcinoma:

> They can arise from multiple primary sites. They tend to be aggressive in their behaviour. And in this case, we needed further staging, which was done in sequential order as we gathered more information, to identify the primary site. The primary site on the PET scan appeared to be a sinonasal neuroendocrine tumour, and that had disseminated and moved to different organs within the lymph nodes, the lungs and the bones.[50]

30. On 10 February 2022, Dr Oh (oncology registrar) reviewed Lindsay, but when she attempted to discuss his diagnosis and treatment options, Lindsay declined to engage with her. Lindsay told Dr Oh "*he did not want treatment as he wished to die*", and even though Dr Oh explained he might experience pain as the cancer progressed, Lindsay insisted "*he would rather die and not have active treatment*".[51]

31. In her report, Dr Oh (with whom Dr Bowyer agreed) suggested ongoing psychiatry input to assess Lindsay's capacity, and a palliative care review to address management of his symptoms, including his ongoing pain. When Dr Bowyer attempted to review Lindsay on 14 February 2022, he was difficult to rouse, and ward staff noted he had been spending increasing amounts of time in bed.

[46] Exhibit 1, Vol. 1, Tab 16, Report - Dr R Griffiths (04.06.24), pp6-7
[47] Exhibit 1, Vol. 1, Tab 14, Report - Dr L Oh & Dr S Bowyer (28.02.22) and ts 11.06.24 (Bowyer), pp26-34
[48] Exhibit 1, Vol. 1, Tab 15.1, Report - Office of the Public Advocate (29.05.24), pp5-6
[49] Exhibit 1, Vol. 1, Tab 13, SCGH Medical Records (21.01.22 - 19.02.22)
[50] ts 11.06.24 (Bowyer), pp27-28
[51] Exhibit 1, Vol. 1, Tab 14, Report - Dr L Oh & Dr S Bowyer (28.02.22), p2

32. In her report Dr Oh noted that Lindsay's treating team had been advised that:

> [H]igh grade neuroendocrine tumours are usually highly aggressive cancers with a median survival of 12 months even with optimal treatment. The risks of systemic treatment is high including the risk of septic death. Although (Lindsay) does not have the capacity to make a decision regarding his treatment, we did not feel systemic treatment would be in his best interest. This is because even in an optimal scenario, treatment is likely to only prolong life in terms of months and not necessarily his quality of life.[52]

33. On 14 February 2022, Lindsay's delegated guardian was advised of his diagnosis, and that he was not a candidate for chemotherapy. On 16 February 2022, after discussions between the palliative care physician at SCGH, and Lindsay's delegated guardian, approval was given for Lindsay to be treated palliatively.

34. Lindsay was kept comfortable, but his condition deteriorated and he was declared deceased at 5.00 pm on 19 February 2022.[53]

[52] Exhibit 1, Vol. 1, Tab 14, Report - Dr L Oh & Dr S Bowyer(28.02.22), p3
[53] Exhibit 1, Vol. 1, Tab 1, Death in Hospital Form (19.02.22)

CAUSE AND MANNER OF DEATH[54,55]

35. A forensic pathologist (Dr Junckerstorff) conducted an external post mortem examination of Lindsay's body on 2 March 2022 and reviewed CT scans and Lindsay's hospital medical notes.

36. Dr Junckerstorff noted that post mortem CT scans showed enlarged lymph nodes in Lindsay's neck and chest, along with coronary artery calcification, and right lower lobe lung consolidation.

37. Toxicological analysis found various medications in Lindsay's system that were consistent with his recent medical care. Alcohol, cannabinoids and other common drugs were not detected.[56]

38. At the conclusion of his external post mortem examination, Dr Junckerstorff expressed the opinion that the cause of Lindsay's death was "*metastatic high-grade neuroendocrine carcinoma, treated palliatively*". Dr Junckerstorff also said that in his opinion, Lindsay's death was "*consistent with natural causes*".[57]

39. I accept and adopt Dr Junckerstorff's conclusion as my finding in relation to the cause of Lindsay's death, and I find that death occurred by way of natural causes.

[54] Exhibit 1, Vol. 1, Tab 5.1, Supplementary Post Mortem Report (22.09.22)
[55] Exhibit 1, Vol. 1, Tab 5.2, Post Mortem Report (02.03.22)
[56] Exhibit 1, Vol. 1, Tab 6, Toxicology Report (24.08.22)
[57] Exhibit 1, Vol. 1, Tab 5.1, Supplementary Post Mortem Report (22.09.22), p1

QUALITY OF CARE

Comments on standard of Lindsay's supervision, treatment and care

40. On the basis of the available evidence, I am satisfied that the supervision Lindsay received while he was the subject of the Order was of a good standard. Lindsay was in receipt of the Disability Pension, and an application for NDIS funding (to provide a support worker) had successfully been made on his behalf. Efforts were underway to slowly reintegrate Lindsay back into the community, and the supervised grounds and community access that he was granted by the Board were an important part of that long-term goal.

41. I accept Dr Griffiths' evidence, and find that the standard of care and treatment Lindsay received at the Frankland Centre was of a very good standard. Lindsay was regularly reviewed by various specialists, and when he complained of severe back pain he was promptly transferred to SCGH where it was confirmed he had an aggressive form of cancer.

42. Nevertheless, I also accept the submission made by Ms Roberts on behalf of Lindsay's family in relation to culturally safe care, namely:

> We would like to make a submission regarding the quality of care that (Lindsay) received, and I note that we don't intend to say that his medical or mental health care was not anything other than…very good. But rather that as an Aboriginal man it would be our submission that he has additional needs…And this is reflected in the Mental Health Act, specifically section 189, which on my understanding would be that that provision applied to (Lindsay) at the time that he was in the Frankland Centre. And that places an obligation on authorised hospitals to provide treatment with Aboriginal and Torres Strait Islander workers, and with significant members of the patient's community including elders. And so it would be our submission that for whatever reason, whether it was because of funding, that the quality…of care he received…was not sufficient, and that there should have been more culturally safe care available to him at the Frankland Centre.[58]

[58] ts 11.06.24 (Roberts), p38

43. I note with approval that the Frankland Centre now has access to ALOs from Graylands. However, in my view it would be appropriate for the Frankland Centre to consider employing ALOs of their own, or at least engaging with a service that provides greater access to ALOs. The benefits of patients having access to ALOs are clear and include cultural input into treatment decisions, family liaison, and the conduct of social and cultural activities for the benefit of Aboriginal patients.

44. In relation to the treatment of Lindsay's cancer at SCGH, I accept the evidence of Dr Bowyer and find that Lindsay received a very good standard of care. I do not consider that Lindsay's cancer could have been detected any earlier than it was. At the inquest, Dr Bowyer pointed out that tumour biology varies between patients, but nevertheless she made this observation about the likely timeframe for Lindsay's cancer:

> It's not predictable. However, the review of the forensic psychiatry report, the limited symptoms until January and then a rapid decline over a four-week window demonstrate that this was a rapidly progressive tumour, and I doubt it will have been there over many years in this advanced stage.[59]

45. In Lindsay's case, the evidence establishes that within two days of him first complaining of relevant symptoms, he was transferred to SCGH where he was diagnosed with metastatic high-grade neuroendocrine carcinoma. Unfortunately, by that time, Lindsay's cancer had progressed to the point where his only viable treatment option was palliative care, which he received until his death.[60]

46. I note that an ALO providing services to the Frankland Centre towards the end of Lindsay's life was able to notify his next of kin, and that family members visited Lindsay at SCGH before he died. Lindsay was also visited by Dr Griffiths, social workers, a welfare officer, and an ALO from the Frankland Centre, as well as by a fellow patient with whom Lindsay was close.[61]

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[59] ts 11.06.24 (Bowyer), pp28-29 and see also: ts 11.06.24 (Bowyer), p31
[60] ts 11.06.24 (Bowyer), pp29-30 & 33-34
[61] Exhibit 1, Vol. 1, Tab 16, Report - Dr R Griffiths (04.06.24), p7

RECOMMENDATION

47. On the basis of the observations I have made in this finding, I make the following recommendation:

> **Recommendation 1**
> In order to enhance the care and treatment provided to Aboriginal patients housed at the Frankland Centre, the North Metropolitan Health Service should consider engaging the services of sufficient numbers of Aboriginal Liaison Officers to service the Frankland Centre.

CONCLUSION

48. Lindsay was 48 years of age when he died on 19 February 2022 at SCGH. I found that the cause of Lindsay's death was metastatic high-grade neuroendocrine carcinoma, and that his death occurred by way of natural causes.

49. After carefully considering the available evidence, I concluded that Lindsay received a very good standard of supervision, treatment and care while he was housed at the Frankland Centre, although his care would have been enhanced by access to an ALO.

50. I also concluded that the medical care and treatment Lindsay received at SCGH in relation to the management of his metastatic high-grade neuroendocrine carcinoma in the period shortly before his death was of a very good standard.

51. An inquest into Lindsay's death was not mandatory because he was not a "*person in care*" under the terms of the Coroners Act. Nevertheless, in my view it would be appropriate to conduct an inquest into the deaths of all persons who, like Lindsay, were subject of a custody order made under the *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) at the time they died.

52. In conclusion, as I did at the inquest, I wish to extend to Lindsay's family, on behalf of the Court, my very sincere condolences for their terrible loss.

MAG Jenkin
Coroner
9 August 2024