
JURISDICTION : CORONER'S COURT OF WESTERN AUSTRALIA
ACT : CORONERS ACT 1996
CORONER : MICHAEL ANDREW GLIDDON JENKIN, ACTING
DEPUTY STATE CORONER
HEARD : 25 - 27 FEBRUARY 2026
DELIVERED : 26 MARCH 2026
FILE NO/S : CORC 2302 of 2024
DECEASED : KEALY, BRIAN JOHN

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)

Prisons Act 1981 (WA)

Counsel Appearing:

Mr D McDonald appeared to assist the coroner.

Mr E Heywood and Mr A Gibson (State Solicitor's Office) appeared on behalf of Department of Justice.

Mr M Williams (instructed by Panetta McGrath) appeared on behalf of Dr M-J Flavel.

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

*I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of **Brian John KEALY** with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 25 - 27 February 2026, find that the identity of the deceased person was **Brian John KEALY** and that death occurred on 2 August 2024 at Hakea Prison, 1170 Nicholson Road, Canning Vale, from ligature compression of the neck (hanging) in the following circumstances:*

Table of Contents

INTRODUCTION	3
BRIAN	4
<i>Background and medical history</i>	4
<i>Offending and prison history</i>	4
<i>Circumstances of last incarceration</i>	5
<i>Receival and management at Hakea</i>	6
MANAGEMENT OF BRIAN'S MENTAL HEALTH ISSUES	15
<i>Dr Hanratty's assessment</i>	15
<i>PHS and PMH involvement</i>	19
<i>Dr Flavel's reviews</i>	21
<i>Brian's requests for olanzapine</i>	22
<i>Fragmentation of mental health care at Hakea</i>	24
EVENTS LEADING TO BRIAN'S DEATH	26
<i>Observations and lunch</i>	27
<i>Brian is found</i>	28
CAUSE AND MANNER OF DEATH	29
LESSONS LEARNED WORKSHOP	30
<i>Overview</i>	30
<i>Lessons learned</i>	30
QUALITY OF SUPERVISION, TREATMENT AND CARE	32
<i>Overview</i>	32
<i>Quality of physical health treatment and care</i>	32
<i>Quality of supervision</i>	33
<i>Quality of mental health treatment and care</i>	33
RECOMMENDATIONS	35
<i>Recommendation No. 1</i>	35
<i>Recommendation No. 2</i>	35
<i>Recommendation No. 3</i>	36
<i>Recommendation No. 4</i>	36
<i>Recommendation No. 5</i>	36
CONCLUSION	39

INTRODUCTION

1. Mr Brian John Kealy (Brian)¹ died at Hakea Prison (Hakea) on 2 August 2024 from ligature compression of the neck. At the time of his death, Brian was on remand at Hakea and therefore in the custody of the Chief Executive Officer (Director General) of the Department of Justice (the Department). As a result, immediately before his death Brian was a “*person held in care*” within the meaning of the *Coroners Act 1996* (WA) and his death was a “*reportable death*”.^{2,3,4,5,6,7,8}
2. In such circumstances, a coronial inquest is mandatory and where (as here) the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.⁹
3. Brian’s sister (Ms Judkins) and a family friend (Ms Scully) attended the inquest I conducted into Brian’s death in Perth on 25 - 27 February 2026. The documentary evidence comprised one volume and the following witnesses gave evidence:
 - a. Ms A Thorpe, Prison officer, Hakea;¹⁰
 - b. Ms L Cairnes, Prison counsellor, Hakea;¹¹
 - c. Dr M-J Flavel, Senior Medical Practitioner, Hakea;¹²
 - d. Dr A Brett, Independent Consultant Forensic Psychiatrist;¹³
 - e. Ms C McLeod, Psychological Health Services, DOJ;¹⁴
 - f. Mr A Beck, Deputy Commissioner, Offender Services, DOJ;¹⁵
 - g. Mr D Brampton, Deputy Commissioner, Operational Support, DOJ;¹⁶
 - h. Ms T Palmer, Senior Review Officer, DOJ;¹⁷ and
 - i. Dr H Harris, Director Medical Services, DOJ.¹⁸

¹ At the request of his sister, the deceased was referred to as “Brian” at the inquest and in this finding.

² Section 16, *Prisons Act 1981* (WA) & sections 3, 22(1)(a) and 25(3), *Coroners Act 1996* (WA)

³ Exhibit 1, Vol 1, Tab 1, P100 - Report of Death (02.08.24)

⁴ Exhibit 1, Vol 1, Tab 2, P98 - Mortuary Admission Form (02.08.24)

⁵ Exhibit 1, Vol 1, Tab 3, P92 - Identification of Deceased Person by Visual Means (05.08.24)

⁶ Exhibit 1, Vol 1, Tab 4, Life Extinct Certification (02.08.24)

⁷ Exhibit 1, Vol 1, Tab 5, Supplementary Post Mortem Report (27.08.24)

⁸ Exhibit 1, Vol 1, Tab 27, Death in Custody Review (08.01.26)

⁹ Sections 3, 22(1)(a) and 25(3), *Coroners Act 1996* (WA)

¹⁰ Exhibit 1, Vol 1, Tab 27.45, Statement - Ms A Thorpe (07.10.25) & ts 25.02.26 (McLeod), pp9-24

¹¹ Exhibit 1, Vol 1, Tab 21, PHS ARMS File Notes (06.07.24 - 27.07.24) & ts 25.02.26 (Cairnes), pp24-53

¹² Exhibit 1, Vol 1, Tab 29, Statement - Dr M-J Flavel (16.02.26) & ts 25.02.26 (Flavel), pp53-97

¹³ Exhibit 1, Vol 1, Tab 25, Report - Dr A Brett (12.11.25) and ts 25.02.26 (Brett), pp97-110

¹⁴ ts 25.02.26 (McLeod), pp110-132

¹⁵ ts 26.02.26 (Beck), pp136-150

¹⁶ Exhibit 1, Vol 1, Tab 28, Lessons Learned Report (11.12.25) & ts 26.02.26 (Brampton), pp150-164

¹⁷ Exhibit 1, Vol 1, Tab 27, Death in Custody Review (08.01.26) & ts 26.02.26 (Palmer), pp164-171

BRIAN

Background and medical history^{19,20,21,22,23,24,25,26,27}

4. Brian was born in Perth on 5 October 1981 and had two older siblings. He was a qualified electrician and had worked in that industry for about a year. It appears Brian spent most of his adult life with no fixed abode, and when his parents died he received what was described as “*a substantial inheritance*”.²⁸ Brian was not in a relationship at the time of his death and had no known children.
5. Brian’s medical history included psoriasis, pityriasis rosea (a common, non-contagious skin rash), gastro-oesophageal reflux disease, high cholesterol, severe social anxiety, cluster-B personality disorder, and anti-social personality disorder.
6. Brian also had a history of polysubstance use (including alcohol and methylamphetamine) and he had been admitted to psychiatric facilities on several occasions in relation to drug-induced psychosis, and/or ongoing depression and anxiety.

Offending and prison history^{29,30,31,32,33}

7. Brian had an extensive criminal history with 132 convictions for offences including armed robbery, stealing, drug and traffic offences, and breaches of various court orders. Brian was imprisoned on 15 occasions between 2004 and 2024, and at the time of his death he had been charged with a number of serious offences.

¹⁸ Exhibit 1, Vol 1, Tab 31, Health Services Review (20.02.26) & ts 26.02.26 (Harris), pp171-200

¹⁹ Exhibit 1, Vol 1, Tab 8, Report - Coronial Investigator Ms L Jackson (28.08.125), pp5 & 17-27

²⁰ Exhibit 1, Vol 1, Tab 10, Report - Dr I Assumption (06.05.08), pp1-12

²¹ Exhibit 1, Vol 1, Tab 11, Medical records - Fremantle Hospital (02.01.24 - 01.02.24)

²² Exhibit 1, Vol 1, Tab 12, Report - Dr D Hanratty (23.04.24), pp1-12

²³ Exhibit 1, Vol 1, Tab 13, Medical records - Royal Perth Hospital (15.07.24)

²⁴ Exhibit 1, Vol 1, Tab 14, EcHO Medical Records (02.02.24 - 02.08.24)

²⁵ Exhibit 1, Vol 1, Tab 27, Death in Custody Review (08.01.26), pp4-7 & 9-32

²⁶ Exhibit 1, Vol 1, Tab 31, Health Services Review (20.02.26)

²⁷ Exhibit 1, Vol 1, Tab 25, Report - Dr A Brett (12.11.25), pp10-13

²⁸ Exhibit 1, Vol 1, Tab 12, Report - Dr D Hanratty (23.04.24), para 92, p12

²⁹ Exhibit 1, Vol 1, Tab 8, Report - Coronial Investigator Ms L Jackson (28.08.125), p12

³⁰ Exhibit 1, Vol 1, Tab 18, ARMS Reception Intake Assessment (01.02.24), pp1-2

³¹ Exhibit 1, Vol 1, Tab 12, Report - Dr D Hanratty (23.04.24), pp5-11

³² Exhibit 1, Vol 1, Tab 27, Death in Custody Review (08.01.26), p9

³³ Exhibit 1, Vol 1, Tab 27.2, History for Court - Criminal and Traffic (compiled 06.05.25)

Circumstances of last incarceration^{34,35,36,37,38}

8. On 14 November 2023, Brian was released on home-detention bail and ordered to reside at the Linkt Rehabilitation Centre (Linkt) in relation to charges of: attempted aggravated robbery, being armed in a way that may cause fear, possession of methylamphetamine, threats to kill, aggravated assault occasioning bodily harm, and wilfully and unlawfully damaging or destroying monitoring equipment.
9. On 2 January 2024 Mr Kealy self-presented to the outpatient clinic at Fremantle Hospital (Alma Street) for a review of his medications. Amongst other things, he told staff that his olanzapine was making him feel “groggy”. Brian agreed for his dose of olanzapine to be reduced from 10mg to 5mg and he also requested diazepam. Brian’s request for diazepam was refused and his consultant psychiatrist noted no perceptual disturbance or formal thought disorder.
10. When Brian returned to Alma Street on 29 January 2024, he was again seen by a consultant psychiatrist. Brian said although his olanzapine was making him “depressed” he wasn’t willing to stop it as he was worried he would not be able to sleep. Brian also reported feeling agitated and anxious, and asked to be prescribed diazepam or Xanax. These requests were refused, and the consultant psychiatrist again noted no psychosis or thoughts of self-harm.
11. Later that day, Brian removed his home detention bracelet and absconded from Linkt. On 31 January 2024, Brian was arrested by police at a motel in Rivervale and charged with various offences. On 1 February 2024, Brian appeared in the Magistrates Court held at Perth. He was remanded in custody and transferred to Hakea Prison (Hakea).

³⁴ Exhibit 1, Vol 1, Tab 8, Report - Coronial Investigator Ms L Jackson (28.08.125), pp19-23

³⁵ Exhibit 1, Vol 1, Tab 11, Medical Records - Fremantle Hospital Report (02.01.24 - 02.02.24)

³⁶ Exhibit 1, Vol 1, Tab 12, Report - Dr D Hanratty (23.04.24)

³⁷ Exhibit 1, Vol 1, Tab 27, Death in Custody Review (08.01.26), p9

³⁸ Exhibit 1, Vol 1, Tab 27.2, History for Court - Criminal and Traffic (compiled 06.05.25)

Receival and management at Hakea^{39,40,41,42,43,44,45,46,47,48}

12. From previous inquests I have conducted, I am aware that the At-Risk Management System (ARMS) is the Department's primary suicide prevention strategy and aims to provide staff with clear guidelines to assist with the identification and management of prisoners at risk of self-harm and/or suicide.
13. When a prisoner is received at a prison, an experienced prison officer (reception officer), conducts a formal assessment designed to identify any presenting risk factors. Within 24 hours of arriving at a prison, the prisoner's physical health needs are assessed by a nurse.
14. When it is deemed necessary to manage a prisoner on ARMS, an interim management plan is developed and the prisoner is managed with observations at either high, moderate or low levels. ARMS observation levels were previously: high (one or 2-hourly), moderate (6-hourly) and low (12-hourly), but in mid-2016, ARMS observation levels were changed to: high (one-hourly), moderate (2-hourly) and low (4-hourly).
15. When Brian was received at Hakea he underwent an ARMS assessment during which he was asked a series of questions to determine his risk level. At the conclusion of the assessment, the reception officer made the following entry in Brian's Reception Intake Assessment:

(Brian) did not present as a risk of self-harm or suicide in my interview. There were No statements, or any ideation made referring to Self-Harm at the time of interview. (Brian) was cooperative and answered all questions during my interview. (Brian) had made good eye contact and was very focused and had clear plans for his future. Nil recommendations or concern relating to self-harm at the time of my interview.⁴⁹

³⁹ Exhibit 1, Vol 1, Tab 14, ECHO Medical Records (02.02.24 - 02.08.24)

⁴⁰ ARMS Manual (1998) & ARMS Manual (2019)

⁴¹ Exhibit 1, Vol 1, Tab 25, Report - Dr A Brett (12.11.25)

⁴² Exhibit 1, Vol 1, Tabs 27, Death in Custody Review (08.01.26), pp9-32

⁴³ Exhibit 1, Vol 1, Tabs 27.1-27.55, Death in Custody Review Attachments (08.01.26)

⁴⁴ Exhibit 1, Vol 1, Tab 31, Health Services Review (20.02.26)

⁴⁵ Exhibit 1, Vol 1, Tabs 27.45, Statement - Ms A Thorpe (07.10.25) & ts 25.02.26 (Thorpe), pp9-24

⁴⁶ ARMS Manual (1998) & ARMS Manual (2019)

⁴⁷ ts 26.02.26 (Palmer), pp164-171

⁴⁸ ARMS Manual (1998) & ARMS Manual (2019)

⁴⁹ Exhibit 1, Vol 1, Tab 18, ARMS Reception Intake Assessment (01.02.24), p7

16. While Brian was incarcerated at Hakea, he was managed on ARMS on a number of occasions and he was reviewed regularly by prison counsellors who conducted self-harm risk assessments. Prison counselling notes show that Brian regularly made disclosures in relation to thoughts and plans to self-harm, often in the context of requests to have his dose of olanzapine re-instated (after it had been ceased), or to be moved or to remain in a particular cell or unit within the prison. Brian also regularly sought help from the mental health team to re-instate his olanzapine medication after it had been ceased.^{50,51}
17. Key events in Brian’s management following his reception at Hakea on 1 February 2024 may be summarised as follows:
- a. **3 February 2024:** prison officers found Brian standing at the ablution grille in a distressed state. Brian said he had tried to hang himself and he was placed on “high” ARMS and taken to a fully ligature-minimised cell in the Multi-Purpose Unit.^{52,53}
 - b. **7 - 8 February 2024:** during an ARMS risk assessment Brian said he had “*unbearable anxiety*” and requested olanzapine. It was noted that a previous higher dosage of olanzapine had been helpful and this was prescribed on 8 February 2024.⁵⁴
 - c. **9 February 2024:** following an ARMS risk assessment Brian “*denied risk to self*” and he was placed on moderate ARMS.⁵⁵
 - d. **12 February 2024:** following an ARMS risk assessment Brian again denied risk to himself and he was removed from ARMS.⁵⁶
 - e. **19 February 2024:** Brian was seen by a prison medical officer (PMO), who noted he was anxious with a congruent “affect”, unimpaired cognition, and he did not appear to be experiencing delusions or hallucinations. The PMO ceased Brian’s olanzapine once his current script expired.⁵⁷

⁵⁰ Exhibit 1, Vol 1, Tab 14, EcHO Medical Records (02.02.24 - 02.08.24)

⁵¹ Exhibit 1, Vol 1, Tabs 18, 20, 21 & 27.11 - 27.42, ARMS Assessments, PRAG Minutes & PHS Counselling notes

⁵² Exhibit 1, Vol 1, Tab 27, Death in Custody Review (08.01.26), p12

⁵³ Exhibit 1, Vol 1, Tab 27.11, ARMS Interim Management Plan (03.02.24)

⁵⁴ Exhibit 1, Vol 1, Tab 25, Report - Dr A Brett (12.11.25), p2

⁵⁵ Exhibit 1, Vol 1, Tab 25, Report - Dr A Brett (12.11.25), p2

⁵⁶ Exhibit 1, Vol 1, Tab 25, Report - Dr A Brett (12.11.25), p3

⁵⁷ Exhibit 1, Vol 1, Tab 14, EcHO Medical Records (02.02.24 - 02.08.24), pp58-61

- f. **12 March 2024:** Brian walked out of an ARMS risk assessment saying he was not being listened to. He was placed on high ARMS.⁵⁸
- g. **13 - 17 March 2024:** Brian underwent daily ARMS risk assessments and variously threatened to go on a hunger strike, and hang himself. On 17 March 2024, Brian was placed on moderate ARMS and follow up from the mental health team was recommended “*given the concern of possible development of chronic psychosis*”.⁵⁹
- h. **20 March 2024:** Brian presented with “*ongoing bad anxiety, panic attacks and claustrophobia*”. He was assessed by a PMO (Dr Luna) who requested approval to restart Brian’s olanzapine dose on an “*off-label*” basis, noting that Brian was not displaying overt delusion or hallucinations. Dr Luna’s request was approved by Director, Medical Services the following day.^{60,61}
- i. **12 April 2024:** during an ARMS review, a prison counsellor noted that Brian appeared stable and was laughing and joking. Brian confirmed he was back on olanzapine and that he believed it had started to work. Brian was removed from ARMS but approved for a single cell on the basis of his mental health.^{62,63}
- j. **23 April 2024:** Brian underwent a fitness to stand trial assessment by a court-appointment consultant forensic psychiatrist (Dr Hanratty). Dr Hanratty expressed the opinion that Brian was not fit to stand trial.⁶⁴
- k. **16 May 2024:** a senior PMO (Dr Flavel) assessed Brian and ceased his olanzapine dose noting: “*There is no evident affective disturbance or psychotic illness the presentation is more ASPD⁶⁵ with drug seeking behaviour and I have concerns about misappropriation*”.^{66,67}

⁵⁸ Exhibit 1, Vol 1, Tab 25, Report - Dr A Brett (12.11.25), p3

⁵⁹ Exhibit 1, Vol 1, Tab 25, Report - Dr A Brett (12.11.25), p3

⁶⁰ Exhibit 1, Vol 1, Tab 14, EcHO Medical Records (02.02.24 - 02.08.24), p40

⁶¹ Exhibit 1, Vol 1, Tab 25, Report - Dr A Brett (12.11.25), p3

⁶² Exhibit 1, Vol 1, Tab 14, EcHO Medical Records (02.02.24 - 02.08.24), p36

⁶³ Exhibit 1, Vol 1, Tab 25, Report - Dr A Brett (12.11.25), p3

⁶⁴ Exhibit 1, Vol 1, Tab 12, Report - Dr D Hanratty (15.05.24)

⁶⁵ Anti-social personality disorder which Brian was diagnosed with on 20 March 2024

⁶⁶ Exhibit 1, Vol 1, Tab 14, EcHO Medical Records (16.05.24), p33

1. **17 May 2024:** Brian remained on low ARMS, and a Prisoner Risk Assessment Group (PRAG) meeting noted:

Current ARMS placement: Brian was placed on LOW ARMS on the 16.05.2024 due to the mental health team are concerned due to a medication adjustment. (Brian) may be at risk of self-harm.

Presentation: Brian answered all questions but displayed some level of frustration regarding his current placement, which was evident through his body language and tone of voice. Brian recounted the discussion with the psychiatrist yesterday⁶⁸ reporting he did not appreciate it being implied that he was manipulating the system to get medication. He expressed concerns about his ability to cope should he be taken off the olanzapine.⁶⁹

- m. **6 June 2024:** was due to see Dr Flavel but did not attend his appointment. The EcHO notes record Dr Flavel's recommendation as: "[M]edics highly encouraged to not prescribe given absence of mental illness and no clear indication for medication aside from secondary gain".^{70,71}
- n. **2, 3, 9 & 25 July 2024:** during phone calls to his sister (Ms Judkins) on these dates, Brian expressed his concerns about being taken off olanzapine. Brian appeared distressed and asked his sister to make a complaint through the Administration of Complaints Compliments or Suggestions (ACCESS) and to contact his lawyer to let them know he had been taken off his medication and was suicidal.^{72,73,74}
- o. **5 July 2024:** Brian handed a peer support prisoner a makeshift ligature made from a towel. When spoken to by a Senior Officer, Brian said he felt unwell and was hearing voices. Brian was placed on high ARMS and moved to a safe cell in Crisis Care Unit (CCU).⁷⁵

⁶⁷ See also: Exhibit 1, Vol 1, Tab 29, Statement - Dr M-J Flavel (16.02.26) & ts 25.02.24 (Flavel), pp53-97

⁶⁸ This is an erroneous reference to Brian's review by Dr Flavel who was not a psychiatrist at that time

⁶⁹ Exhibit 1, Vol 1, Tab 27.29, ARMS Prisoner Risk Assessment Group Minutes (17.05.24)

⁷⁰ Exhibit 1, Vol 1, Tab 14, EcHO Medical Records (06.06.24), p28

⁷¹ Exhibit 1, Vol 1, Tab 25, Report - Dr A Brett (12.11.25), p5

⁷² Exhibit 1, Vol 1, Tab 27.51, PTS Call Log (01.02.24 - 02.08.24)

⁷³ Exhibit 1, Vol 1, Tab 27.52, Audio recordings of Calls (02.07.24 & 09.07.24)

⁷⁴ Exhibit 1, Vol 1, Tab 22, Transcript of Call - Ms A Judkins & Brian

⁷⁵ Exhibit 1, Vol 1, Tab 28, Lessons Learned Report (11.12.25), p6

- p. **6 - 7 July 2024:** remained in a safe cell and his diagnoses were recorded as cluster B personality disorder, and antisocial personality. Brian self-reported depression, anxiety, psychosis, tension headaches, nightmares and insomnia. Brian also described a severe decline in his mental health and said: “*he wanted to die if he was denied the medication he was on before*”. The PRAG Minutes on 7 July 2024 recommended Brian remain on high ARMS, noting:

Brian continues to make statements about suicide and self-harm in protest regarding his cessation of olanzapine, He said when medication is suddenly stopped, he experiences changes in his mental health to the point where he becomes suicidal and sees no point in living. A review by (mental health) would be beneficial given his ongoing debate about medication. He is a heavy (methylamphetamine) user in the community and olanzapine is often prescribed for people whose mental health is affected by (methylamphetamine) use in the community. He reports that Alma Street Clinic was prescribing this to him.^{76,77}

- q. **9 July 2024:** Ms Judkins wrote a powerful letter to Hakea raising concerns about Brian’s medical care in the following terms:

Brian has rung me numerous times in despair saying that he is not getting any medical attention for his schizophrenia. I am writing out of desperation to please get proper medical attention for (Brian). (Brian) first rang me on 2 July in agony saying that Hakea Prison had withdrawn his medication.

I rang Hakea on 2 July 2024 to confirm Brian had recently been diagnosed with schizophrenia by a Court appointed psychiatrist but that Brian was telling me that he was not getting any treatment. I was told Brian needed to request medical assistance via the 'pink slip'.

I told Brian to do this on Wednesday 3 July. Today 9 July Brian rang me again to tell me he still has not received appropriate medical assistance and instead been placed on suicide watch.

⁷⁶ Exhibit 1, Vol 1, Tab 27.32, ARMS Prisoner Risk Assessment Group Minutes (07.07.24)

⁷⁷ Exhibit 1, Vol 1, Tab 25, Report - Dr A Brett (12.11.25), pp5-6

Brian tells me he does NOT WANT TO COMMIT SUICIDE - he simply wants the medication.

Can you please take urgent action to get Brian the appropriate medical treatment he needs. He is in agony. He has been diagnosed with schizophrenia by a Court appointed psychiatrist and there is no humane reason to not give him the medication he needs.⁷⁸ [Original Emphasis]

- r. **9 - 12 July 2024:** Brian remained on high ARMS in a safe cell. He said he was “*thinking of nothing but suicide with a plan*” and “*would cut his throat with a razor*”. Brian also said he had a noose in his cell and “*described feeling not believed and victimised*” and as having “*feelings of helplessness and hopelessness*”. On 12 July 2024, Brian was seen by a PMO (Dr Omotoso) who prescribed prazosin for poor sleep and noted Brian had “*anxiety disorder and likely PTSD*”;^{79,80,81}
- s. **13 July 2024:** during an ARMS risk assessment, Brian handed over a ligature after threatening self-harm. Brian presented in what was described as a “*psychotic manner*” and said he was constantly fearful and was “*seeing demons and talking to the devil*”. The assessment was terminated when he began “*growling*” in an intimidating manner and he remained on high ARMS in a safe cell.^{82,83,84}
- t. **15 July 2024:** during a transfer from Hakea to the Perth Magistrates Court, Brian experienced what appeared to be seizure activity. As he was being offloaded, Brian self-harmed by banging his head against the vehicle and was transferred to Royal Perth Hospital.

An entry in Brian’s ECHO records the following interaction between the Hakea mental health team and RPH: “*Hi Team, This morning, I received a call from RPH Dr. Gaeth regarding (Brian) who ended up at the ED. It seems that (Brian) went to court and complained about seizures and auditory hallucinations...*”

⁷⁸ Exhibit 1, Vol 1, Tab 23.1, Letter - Ms A Judkins to Hakea (09.07.24)

⁷⁹ Exhibit 1, Vol 1, Tab 14, ECHO Medical Records (12.06.24), p20

⁸⁰ Exhibit 1, Vol 1, Tab 25, Report - Dr A Brett (12.11.25), pp5-6

⁸¹ Exhibit 1, Vol 1, Tab 27.32, ARMS Prisoner Risk Assessment Group Minutes (09.07.24 - 12.07.24)

⁸² Exhibit 1, Vol 1, Tab 14, ECHO Medical Records (13.07.24), p19

⁸³ Exhibit 1, Vol 1, Tab 21, PHS ARMS File Note - Ms L Cairnes (13.07.24)

⁸⁴ Exhibit 1, Vol 1, Tab 25, Report - Dr A Brett (12.11.25), pp6-7

*(Brian) informed the medical team there that olanzapine helped settle him down, and Dr. Gaeth mentioned that olanzapine had a settling effect. I informed them about the (Mental Health team) decision, stating that there is no indication for psychotropic medication, but the team could recommend it on the discharge summary if they wish, and they agreed.*⁸⁵

- u. **16 July 2024:** after Brian had repeatedly banged his head on the wall and toilet of his safe cell in Unit 6, he was transferred to the CCU and he remained on high ARMS. Brian's next court appearance was adjourned to 30 July 2024 on the basis that further information about "his serious mental health illness" had been requested.^{86,87,88,89}
- v. **17 July 2024:** the PRAG meeting held on this day noted information from Dr Flavel that Brian had "*No evidence of psychosis or affective disorder that warrants psychotropic medication*". Dr Flavel also noted that Brian's antisocial personality disorder was characterised by "*his drug seeking behaviour*" with threats of self-harm if his needs were not met. A "*structured and consistent*" behaviour management plan was recommended: "*in response to (Brian's) manipulative, conditional suicidal behaviour*" to provide adequate risk response to:
- [P]erceived distress through environmental changes, ensuring limitation of access to psychotropics that are prescribed only when indicated noting that suicidal ideation is not a clinical indication for psychotropics.^{90,91}
- w. **18 July 2024:** an ARMS risk assessment by Ms Cairnes was unable to determine Brian's risk level. Brian was wearing anti-ligature clothing and was ambivalent about his risk level. He also described being "*confused and angry about why he is not being supported by medical and mental health*". Ms Cairnes suggested a less restrictive regime may help Brian become more settled and also recommended "*a medication review*" to assist with "*anxiety and emotional regulation*".^{92,93,94}

⁸⁵ Exhibit 1, Vol 1, Tab 14, EcHO Medical Records (15.07.24), p17

⁸⁶ Exhibit 1, Vol 1, Tab 14, EcHO Medical Records (15.07.24), p16

⁸⁷ Exhibit 1, Vol 1, Tab 21, PHS ARMS File Note - Ms N Hampton (16.07.24)

⁸⁸ Exhibit 1, Vol 1, Tab 25, Report - Dr A Brett (12.11.25), p7

⁸⁹ Exhibit 1, Vol 1, Tab 28, Lessons Learned Report (11.12.25), p6

⁹⁰ Exhibit 1, Vol 1, Tab 27.36, ARMS Prisoner Risk Assessment Group Minutes (17.07.24)

⁹¹ See also: Exhibit 1, Vol 1, Tab 25, Report - Dr A Brett (12.11.25), p7

⁹² Exhibit 1, Vol 1, Tab 21, PHS ARMS File Note - Ms L Cairnes (18.07.24) and ts 25.02.26 (Cairnes), pp38-39

⁹³ Exhibit 1, Vol 1, Tab 25, Report - Dr A Brett (12.11.25), p7

- x. **19 July 2024:** the Deputy Superintendent of Hakea (Mr Smith) responded to Ms Judkins' letter of 9 July 2024 in the following terms:

Re Access to Medication: Thank you for your letter and raising your concerns regarding your Brother's Medication. Although I cannot divulge any specific medical conditions or/and treatment, I would like to assure you that the Prison has a very competent array of health professionals, including Drs, Nurses (Primary and Mental Health) as well as Psychological Health Services managing and reviewing all prisoners regularly. Please be confident and assured Brian is being treated in consultation with all these services, with his health and wellbeing, being their primary objective.⁹⁵

- y. **20 July 2024:** Brian was reviewed by a mental health nurse for a medication review. The nurse was unable to illicit any evidence of psychotic symptoms, and although Brian said he had experienced "*bad thoughts*" he refused to elaborate and terminated the appointment early. Ms Cairnes conducted an ARMS risk assessment and noted she had requested information about Brian's medication regime. Brian had said he did not know what he was being prescribed, and Ms Cairnes' view was that information about his medication regime "*would also assist with PHS case management*".^{96,97,98}

At the inquest she said this about her attempts to get information about Brian's medication regime:

I just...tried to do a bit of research on Echo...as I didn't want to make a mistake, and misinterpret what was on the system (and) I just asked mental health what medication (Brian) was on, just so that I knew where we were at with his treatment, and I was told that that was not my job to inquire about.⁹⁹

I will say more about this kind of disconnect when I comment on the fragmentation of mental health and psychological care at Hakea later in this finding.

⁹⁴ Exhibit 1, Vol 1, Tab 27.36, ARMS Prisoner Risk Assessment Group Minutes (18.07.24)

⁹⁵ Exhibit 1, Vol 1, Tab 23.2, Letter - Dep. Supt. Hakea to Ms A Judkins (19.07.24)

⁹⁶ Exhibit 1, Vol 1, Tab 14, EcHO Medical Records (02.02.24 - 02.08.24), p14

⁹⁷ Exhibit 1, Vol 1, Tab 14, EcHO Medical Records (02.02.24 - 02.08.24), p14

⁹⁸ Exhibit 1, Vol 1, Tab 14, EcHO Medical Records (02.02.24 - 02.08.24), p14

⁹⁹ ts 25.02.26 (Cairnes), p37 and see also: ts 25.02.26 (Cairnes), pp46-47 & 51-53

- z. **23 July 2024:** Brian was referred to Dr Flavel “*in the context of ongoing opinion dispute between service providers particularly in terms of PRAG/Risk management*”. During a review that lasted about one hour, Dr Flavel was unable to illicit any psychotic symptoms which would have required olanzapine, and Brian did not express any thoughts of harm to himself or others.^{100,101} In his review of Brian’s care, Dr Brett said this about Dr Flavel’s review:

(Dr Flavel) noted: “*[I]n terms of psychopathy checklist he has superficial charm, grandiose self-worth, pathological lying, manipulative behaviour, shallow affect, lack of empathy, parasitic lifestyle, poor behavioural controls, early behaviour problems, lack of long term goals, poor boredom tolerance, many short term intimate relationships (for which he hates anyone who ‘cuts’ him), revocation of conditional release, irresponsibility*”. (Dr Flavel) was concerned about Brian’s level of sociopathy. She stated that he was a chronic risk of self-harm. She believed he used violence to enforce his desired outcome. The plan was for the disposition to be “*per custodial*”. She provided a medication rationalisation. She ceased his prazosin, stating it was not indicated. She switched him from paroxetine to escitalopram; it was not clear why this occurred. His amitriptyline was to be weaned off.¹⁰²

- aa. **24 - 27 July 2024:** was received daily ARMS risk assessments and he remained on high ARMS. He remained suicidal and variously presented with self-loathing and guilt and said: “*the devil was inside him*”. On 27 July 2024, Brian’s mental state appeared to have improved and he was reduced to moderate ARMS.^{103,104}
- bb. **30 - 31 July 2024:** during a call with Ms Judkins Brian confirmed he wanted to see her the following day. He seemed to have low mood, and he cut the call short. Brian’s demeanour during this call was in contrast to previous calls when he had appeared to be in an agitated state. Departmental records show that on 31 July 2024, Brian had a successful visit from Ms Judkins.^{105,106,107}

¹⁰⁰ Exhibit 1, Vol 1, Tab 14, ECHO Medical Records (23.07.24), pp10-12

¹⁰¹ Exhibit 1, Vol 1, Tab 29, Statement - Dr M-J Flavel (16.02.26), p16 & ts 25.02.24 (Flavel), pp53-97

¹⁰² Exhibit 1, Vol 1, Tab 25, Report - Dr A Brett (12.11.25), p8

¹⁰³ Exhibit 1, Vol 1, Tabs 27.37 & 27.38, ARMS Prisoner Risk Assessment Group Minutes (24.07.24 - 26.07.24)

¹⁰⁴ Exhibit 1, Vol 1, Tab 25, Report - Dr A Brett (12.11.25), p9 and see also: ts 25.02.24 (Cairnes), pp40-43

¹⁰⁵ Exhibit 1, Vol 1, Tab 28, Lessons Learned Report (11.12.25), p7

18. During his incarceration at Hakea, Brian was briefly employed as a kitchen hand but was otherwise not employed in any prisoner jobs. Brian did not send or receive any mail, but he regularly used the Prisoner Telephone system to make calls to his sister and a male person.^{108,109,110}
19. Whilst at Hakea, Brian committed three prison offences (two offences of disobeying a lawful order of a prison officer, and one offence of behaving in a threatening manner towards prison officers), and lost gratuities for a total of five days. During his incarceration, Brian was not subject to any drug and alcohol tests, and there are no records that the cells he was accommodated in were ever searched.^{111,112}

MANAGEMENT OF BRIAN'S MENTAL HEALTH ISSUES^{113,114,115}

*Dr Hanratty's assessment*¹¹⁶

20. As noted on 23 April 2024, Brian underwent a two hour video-link “*fitness to stand trial*” assessment with Dr Hanratty, who also spoke with Brian’s sister and lawyer to obtain collateral information. Dr Hanratty found Brian demonstrated disordered thought, incongruent affect, inappropriate laughter, command auditory hallucinations, and thoughts of the devil interfering in his life and encouraging him to kill himself. Brian confirmed he was taking olanzapine, which he said had reduced his thoughts of self-harm.
21. At the conclusion of his assessment, Dr Hanratty expressed the opinion that Brian was unfit to stand trial but that he would likely become fit in three to six months with “*assertive treatment*”. Dr Hanratty also expressed the opinion that Brian was experiencing a primary psychotic illness, with the most likely diagnoses being schizophrenia or schizoaffective disorder.

¹⁰⁶ Exhibit 1, Vol 1, Tab 27.51, PTS Call Log (01.02.24 - 02.08.24)

¹⁰⁷ Exhibit 1, Vol 1, Tab 27.40, Visit History - Offender (01.02.24 - 02.08.24)

¹⁰⁸ Exhibit 1, Vol 1, Tab 27.54, Work History - Offender (01.02.24 - 02.08.24)

¹⁰⁹ Exhibit 1, Vol 1, Tab 27.50, Prisoner Mail - Offender (01.02.24 - 02.08.24)

¹¹⁰ Exhibit 1, Vol 1, Tab 27.51, Prisoner Telephone System Log (01.02.24 - 02.08.24)

¹¹¹ Exhibit 1, Vol 1, Tab 27.48, Charge history - Prisoner (01.02.24 - 02.08.24)

¹¹² Exhibit 1, Vol 1, Tab 27.55, Substance use tests results - Prisoner (01.02.24 - 02.08.24)

¹¹³ Exhibit 1, Vol 1, Tab 31, Health Services Review (20.02.26) & ts 26.02.26 (Harris), pp171-200

¹¹⁴ Exhibit 1, Vol 1, Tab 25, Report - Dr A Brett (12.11.25), p17 & ts 25.02.24 (Brett), pp97-110

¹¹⁵ Exhibit 1, Vol 1, Tabs 18, 20, 21 & 27.11 - 27.42, ARMS Assessments, PRAG Minutes & PHS Counselling notes

¹¹⁶ Exhibit 1, Vol 1, Tab 12, Report - Dr D Hanratty (15.05.24)

22. After his assessment, Dr Hanratty prepared a comprehensive report for the court in which he dealt with the circumstances of Brian's most recent charges, Brian's background (including his psychiatric and medical history), and his opinion about Brian's likely diagnoses and whether he was fit to stand trial for the criminal offences he had been charged with.
23. Although Dr Hanratty's report was not provided to Hakea, on 16 May 2024, he sent the following email to Dr Wynn Owen (who was then the Acting Head, State Forensic Mental Health Service):

Hi Peter and nursing colleagues, Re: Name: Brian John KEALY, Date of Birth: 05 October 1981 I hope you are all well. **I assessed (Brian) and wrote a report for the court and said that in my opinion, he is unfit to stand trial and that he needs assertive treatment.** He is in Hakea Prison. Could you please pass this on to the psychiatrist covering Hakea Prison? Please let me know if you would like to discuss further.¹¹⁷ [Emphasis added]

24. At 8.05 am on 16 May 2024, Dr Wynn Owen forwarded Dr Hanratty's email to Mr Winston [Nurse Unit Manager, Prison Mental Health team at Hakea (PMH team)]. At 8.48 am the same day, Mr Winston forwarded Dr Hanratty's email to the PMH team at Hakea, and to Dr Flavel (who was employed as a senior PMO at Hakea at the time).^{118,119,120}
25. As I noted earlier in this finding, Dr Flavel reviewed Brian on 16 May 2024. In preparation for her review Dr Flavel had sent the following email to Dr Hanratty (with whom she had previously worked):

Hi Donal, What a blast from the past, we worked together when I first moved to Melbourne. I can see you made a recommendation and a court report, unfortunately I do not have access to this. Would you kindly forward a copy, as I am due to see him today.^{121,122}

¹¹⁷ Exhibit 1, Vol 1, Tab 30.2, Email - Dr D Hanratty to Dr P Wynn Owen & Others (3.14 am, 16.05.24)

¹¹⁸ Exhibit 1, Vol 1, Tab 30.2, Email - Dr P Wynn Owen to Mr N Winston (8.05 am, 16.05.24)

¹¹⁹ Exhibit 1, Vol 1, Tab 30.2, Email - Mr N Winston to Hakea PMH team and Dr MJ Flavel (8.48 am, 16.05.24)

¹²⁰ Exhibit 1, Vol 1, Tab 30.2, Email - Dr D Hanratty to Dr P Wynn Owen & Others (3.14 am, 16.05.24)

¹²¹ Exhibit 1, Vol 1, Tab 30.1, Email - Dr MJ Flavel to Dr D Hanratty (3.56 am, 16.05.24)

¹²² See also: ts 25.02.26 (Flavel), pp59-61

26. Dr Hanratty responded to Dr Flavel's email as follows:

Hi MJ, Hope you are doing well! The court is very particular when it comes to sharing reports, I cc'd in the people who are able to release the report. Colleen, could you please let our colleagues in Hakea know when they might be able to get the report? Many thanks for your help.¹²³

27. Dr Hanratty's email to Dr Flavel was copied to several people, including Ms Colleen Tonkin, who was an Administrative Assistant with the Forensic Psychological Intervention Team based in Perth. Ms Tonkin is presumably the "Colleen" referred to by Dr Hanratty in his email, and on 17 May 2024, she sent Dr Flavel an email which said: "*Good afternoon Dr Flavel, The report will be available on Content Manager following Mr Kealy's court appearance on Monday (20/05)*".¹²⁴
28. Content Manager is a database the Department uses to store various documents, and Dr Flavel had been given access to the database when she started working at Hakea. However, although Dr Flavel had been given access to Content Manager, in order to access Dr Hanratty's report, she also required a "link" to the document, which she had not been given.^{125,126}
29. In her evidence at the inquest, Dr Flavel said that she had driven to the Department's Health Services office where she spoke with Dr Fontana (the then Director, Medical Services). Dr Flavel says Dr Fontana told her that problems with accessing documents on Content Manager were common and that she wouldn't be able to access Dr Hanratty's report.¹²⁷
30. There were clearly other steps Dr Flavel could have taken to obtain Dr Hanratty's report including emailing or calling Ms Tonkin, and/or Dr Hanratty, and at the inquest, Dr Flavel conceded it was open to her to have contacted Ms Tonkin.¹²⁸

¹²³ Exhibit 1, Vol 1, Tab 30.1, Email - Dr D Hanratty to Dr MJ Flavel (3.31 pm, 16.05.24)

¹²⁴ Exhibit 1, Vol 1, Tab 30.1, Email - Ms C Tonkin to Dr MJ Flavel (3.24 pm, 17.05.24)

¹²⁵ Exhibit 1, Vol 1, Tab 29, Statement - Dr M-J Flavel (16.02.26) & ts 25.02.24 (Flavel), pp91-92 & 96-97

¹²⁶ ts 26.02.24 (Harris), pp196-197

¹²⁷ ts 25.02.24 (Flavel), pp91-92 & 96-97

¹²⁸ ts 25.02.24 (Flavel), pp71-72, 91-92 & 96-97

31. Nevertheless, the fact remains that the Department had possession of a comprehensive report relating to the clinical care of a prisoner which it did not make readily available to Dr Flavel.
32. Dr Hanratty was not Brian's treating psychiatrist, but his report contains valuable information about Brian's mental health history and possible diagnoses. Dr Hanratty also made these observations about what happened to Brian's mental state when he was taken off olanzapine:

(Brian) had had his antipsychotic medications discontinued numerous times in prison over the past twelve months. **The evidence suggests he deteriorated in his mental state after each of these trialled reductions or cessations of his antipsychotic medication.** He has promptly requested increases in his antipsychotic dose when it has been reduced, and he has frequently asked for it to be reinstated when it was discontinued. This suggests that if (Brian) were to be reviewed by a psychiatrist in prison and if he were to be prescribed an increased dose of antipsychotic, he would likely accept it.¹²⁹ [Emphasis added]

33. As for the lack of clarity concerning Brian's possible diagnoses and recommendations for Brian's ongoing care, Dr Hanratty noted:

In my opinion, the ongoing lack of clarity regarding (Brian's) diagnosis has probably perpetuated his cycle of incarceration, homelessness and reincarceration, in the context of substance use and an untreated or at times a sub-optimally treated primary psychotic illness. In my opinion, he may be a suitable candidate for the START Court from a clinical perspective, particularly if he were to continue to accept his antipsychotic medication and seek out psychiatric support in the way that he has done over recent months.

In my opinion, if he were to receive assertive treatment it is likely he would become fit to stand trial in the next three to six months. I have notified the Frankland Centre and the prison mental health team at Hakea Prison that in my opinion, (Brian) is unfit to stand trial and that in my opinion, he needs assertive treatment.¹³⁰ [Emphasis added]

¹²⁹ Exhibit 1, Vol 1, Tab 12, Report - Dr D Hanratty (23.04.24), paras 115-116, p18

¹³⁰ Exhibit 1, Vol 1, Tab 12, Report - Dr D Hanratty (23.04.24), paras 115-117, p18

34. Whilst it is by no means certain that Dr Flavel’s assessment and management of Brian would have been any different if she had been able to review the contents of Dr Hanratty’s report beforehand, the Department’s failure to provide her with ready access to this document is **deeply regrettable**.
35. I will deal with Dr Flavel’s two reviews of Brian later in this finding. For now it is enough to say that any suggestion that Dr Hanratty was Brian’s treating psychiatrist, or that he had any ongoing responsibility for Brian’s care is nonsense.¹³¹
36. Instead, Dr Hanratty was engaged to provide a specialist opinion about whether Brian was fit to stand trial in relation to the criminal charges against him. Once Dr Hanratty had discharged that obligation, his therapeutic relationship with Brian (such as it was) came to an end.
37. Further, the assertion that Dr Hanratty gave any direction about Brian’s care, either in his report or in his emails on 16 May 2024 is simply wrong, as even the most cursory reading of these documents would have demonstrated.^{132,133}
38. Taken at its highest, Dr Hanratty’s report (and his email on 16 May 2024 at 3.14 am), contained recommendations that Brian should receive “*assertive treatment*”. Regardless of what Dr Hanratty may have meant by his use of this, it is patently obvious that on its face, “*assertive treatment*” cannot be understood as a direction that Brian should be prescribed olanzapine, or indeed any other particular medication.^{134,135}

PHS and PMH involvement^{136,137,138}

39. The evidence before me makes it clear that Brian was regularly seen by PHS counsellors, and that he was also reviewed by PMH clinicians on a number of occasions.

¹³¹ See: ts 25.02.24 (Brett), pp103-104

¹³² Exhibit 1, Vol 1, Tab 30.1, Emails - Dr D Hanratty (3.14 am & 3.31 pm, 16.05.24)

¹³³ Exhibit 1, Vol 1, Tab 12, Report - Dr D Hanratty (23.04.24)

¹³⁴ Exhibit 1, Vol 1, Tab 30.1, Emails - Dr D Hanratty (3.14 am & 3.31 pm, 16.05.24)

¹³⁵ Exhibit 1, Vol 1, Tab 12, Report - Dr D Hanratty (23.04.24)

¹³⁶ Exhibit 1, Vol 1, Tabs 18, 20, 21 & 27.11 - 27.42, ARMS Assessments, PRAG Minutes & PHS Counselling notes

¹³⁷ Exhibit 1, Vol 1, Tab 14, EcHO Medical Records (02.02.24 - 02.08.24)

¹³⁸ Exhibit 1, Vol 1, Tab 31, Health Services Review (20.02.26), pp39-60 and see also: ts 25.02.26 (McLeod), pp113-116

40. However Brian's care was delivered in a fragmented manner, and there were no regular multidisciplinary team meetings at which his management was discussed. As I have pointed out, there was a difference of opinion between PHS and PMH about the basis for Brian's repeated requests for olanzapine, and his self-reports about suicidality when his olanzapine dose was ceased and not reinstated.
41. On one hand, the PMH took the view that Brian was not exhibiting psychotic symptoms that would justify him being prescribed olanzapine. Further, Brian's requests for olanzapine were regarded as evidence of his drug seeking and manipulative behaviour, and to be symptomatic of his antisocial personality disorder.¹³⁹
42. On the other hand, PHS regarded Brian's requests for olanzapine as a legitimate attempt by him to deal with his deteriorating mental health. Due to the fragmented approach to prisoner care at Hakea, there was limited consultation between the PHS and PMH teams and their respective opinions appeared to become more entrenched.¹⁴⁰
43. Although I am satisfied that PHS and PMH clinicians did their best to provide care to Brian, he was not provided with effective multidisciplinary care for a number of systemic issues. These issues include the fact that PHS and PMH at Hakea are not co-located and do not appear to have ready access to each other's counselling and medical notes. Further, at the relevant time PHS and PMH rarely attended multidisciplinary team meetings, and the prison muster at Hakea meant that PHS and PMH clinicians shoulder an intolerable caseload.¹⁴¹
44. During various risk assessments when he was on ARMS, Brian consistently expressed thoughts and plans of self-harm to PHS counsellors, and he repeatedly asked PMH staff to re-instate his olanzapine prescription. Had a multidisciplinary approach been in place at Hakea at the relevant time, these issues could have been dealt with in an holistic manner. Instead, as a result of treatment "silos" Brian's care was never effectively managed.

¹³⁹ See for example: ts 25.02.26 (Flavel), pp61-73

¹⁴⁰ See for example: ts 25.02.26 (Cairnes), pp29-31, 36-38 & 45-47

¹⁴¹ ts 25.02.26 (Flavel), pp57-58; ts 25.02.26 (Brett), pp106-107 and ts 25.02.26 (McLeod), pp117-118

*Dr Flavel's reviews*¹⁴²

45. Dr Flavel was employed at Hakea as a senior prison medical officer, to cover the absence on long-service leave of consultant psychiatrist, Dr Smith. It is important to point out that although Dr Flavel was a senior psychiatric registrar (who would later become a consultant psychiatrist), she was **not** employed in that capacity.
46. Although Dr Flavel's designation when she made entries in the Department's electronic health record (EcHO) came up as "*psychiatric registrar*" this was a limitation in the EcHo system, and not something Dr Flavel was responsible for. Dr Flavel's evidence was that she always made it clear to clinicians and custodial staff at Hakea that she was not a psychiatrist and that instead, she was a senior prison medical officer.
47. Dr Flavel's evidence on this point is consistent with several email chains, in which Dr Flavel's position title appears as "*Prison Medical Officer - Psychiatry*" in her signature block.¹⁴³ Further, in her evidence at the inquest, Ms McLeod said that although she had initially made the erroneous assumption that Dr Flavel was a psychiatrist, she had come to understand that this was not the case.¹⁴⁴
48. The fact that the Department was obliged to backfill Dr Smith's position with a medical practitioner who was not a consultant psychiatrist neatly illustrates the broader issue facing the Department. The recruitment of clinical staff in general, and consultant psychiatrists in particular is problematic for various reasons, not the least of which is the perception that the Department's employment conditions are inferior.
49. The Department has approximately 3.0 full time equivalent positions (FTE) available to employ psychiatrists to service the entirety of the prison system in Western Australia. Whilst this number is pitiable, only 0.4 FTE (i.e.: 2 days per week) are substantively filled. Despite two recent recruitment drives, neither attracted a single applicant.¹⁴⁵

¹⁴² Exhibit 1, Vol 1, Tab 29, Statement - Dr M-J Flavel (16.02.26) & ts 25.02.26 (Flavel), pp53-97

¹⁴³ See for example: Exhibit 1, Vol 1, Tab 30.1, Email - Dr MJ Flavel to Dr D Hanratty (3.56 am, 16.05.24)

¹⁴⁴ ts 25.02.24 (McLeod), p119

¹⁴⁵ Exhibit 1, Vol 1, Tab 31, Health Services Review- Report: Dr K Smith (12.09.25), p21

50. In any case, the short point is that at the relevant time, Dr Flavel was **not** a consultant psychiatrist and she did not hold herself out to be one.¹⁴⁶
51. Dr Flavel first reviewed Brian on 16 May 2024 to assess his need for antipsychotic medication. During her assessment, Dr Flavel could not illicit any appreciable thought disorder or psychotic symptoms that would warrant antipsychotic treatment.^{147,148}
52. When Dr Flavel told Brian she was unable to prescribe him olanzapine as it was not required, Brian stood over her in an intimidating manner and said words to the effect of: *“You’re telling me I don’t need medication, that you’re not going to give me olanzapine...this is not over”*. Dr Flavel informed Brian that the appointment was at an end and directed him to leave, which he did.^{149,150}
53. On 23 July 2024 Dr Flavel reviewed Brian for *“diagnostic clarification”* and this time her review lasted about one hour. Although Dr Flavel was able to obtain some history from Brian, she was unable to illicit any psychotic symptoms which would require olanzapine, and Brian did not express any thoughts of harm to himself or others.^{151,152}

Brian’s requests for olanzapine^{153,154,155}

54. The evidence before me shows that Brian had been managed on relatively low doses of olanzapine at various times. As I have noted, on both occasions Dr Flavel reviewed Brian, he did not appear to demonstrate any psychotic symptoms which in her view would justify the re-prescription of the anti-psychotic Brian was requesting, olanzapine.

¹⁴⁶ ts 25.02.26 (Flavel), pp54-56 and see also: ts 26.02.26 (Harris), pp187-188 & 195-196

¹⁴⁷ Exhibit 1, Vol 1, Tab 14, EcHO Medical Records (02.02.24 - 02.08.24), p32

¹⁴⁸ Exhibit 1, Vol 1, Tab 29, Statement - Dr M-J Flavel (16.02.26), p12

¹⁴⁹ Exhibit 1, Vol 1, Tab 14, EcHO Medical Records (02.02.24 - 02.08.24), p32

¹⁵⁰ Exhibit 1, Vol 1, Tab 29, Statement - Dr M-J Flavel (16.02.26), p12

¹⁵¹ Exhibit 1, Vol 1, Tab 14, EcHO Medical Records (02.02.24 - 02.08.24), p32

¹⁵² Exhibit 1, Vol 1, Tab 29, Statement - Dr M-J Flavel (16.02.26), p16

¹⁵³ Exhibit 1, Vol 1, Tab 14, EcHO Medical Records (02.02.24 - 02.08.24)

¹⁵⁴ Exhibit 1, Vol 1, Tabs 18, 20, 21 & 27.11 - 27.42, ARMS Assessments, PRAG Minutes & PHS Counselling notes

¹⁵⁵ Exhibit 1, Vol 1, Tab 31, Health Services Review- Report: Dr K Smith (12.09.25)

55. However, in his report, Dr Brett said that on balance, he would have continued Brian's dose of olanzapine, and he made the following observations about olanzapine in his report:

Olanzapine is an antipsychotic medication and so could be used with Dr Hanratty's formulation but would be off label with Dr Flavel's. Olanzapine is known as a major tranquilliser and so would have helped agitation and anxiety, even though this was not the main indication for this. Pragmatically, given (Brian's) presentation and his history, on balance, I would have continued it. Olanzapine is not a significant drug of abuse and I do not see the secondary gain apart from reducing his distress. It is commonly used in prison.¹⁵⁶

56. Dr Smith (who was asked by the Department to review Brian's care) made the following comments about olanzapine:

In my experience Olanzapine can be effective for psychotic symptoms at a very low dose, it is a helpful anxiolytic, it promotes sleep and can act as a mild antidepressant.¹⁵⁷

57. Dr Smith also said he thought olanzapine should have been re-prescribed to Brian, and his reasons for that view may be summarised as follows:¹⁵⁸

- a. Brian had experienced drug-induced psychosis and there was "*genuine concern he had residual psychotic features (delusional guilt, communicating with the Devil etc)*";
- b. Olanzapine had been beneficial to (Brian) whenever it was prescribed and he appeared to respond to a fairly low dose and "*apparently he did not seek to escalate the dose*";
- c. It was more likely olanzapine would have to be relied because Brian's likely frontal lobe impairment made it difficult for him to "*show the adaptive distress-tolerance recommended by (Dr Flavel)*"; and
- d. During Brian's most recent previous incarceration, he had been prescribed olanzapine by a consultant psychiatrist, and in that context, "*It would have been more consistent to re authorise Olanzapine*".

¹⁵⁶ Exhibit 1, Vol 1, Tab 25, Report - Dr A Brett (12.11.25), pp16-17 and see also: ts 25.02.26 (Brett), pp97-110

¹⁵⁷ Exhibit 1, Vol 1, Tab 31, Health Services Review- Report: Dr K Smith (12.09.25), p69

¹⁵⁸ Exhibit 1, Vol 1, Tab 31, Health Services Review- Report: Dr K Smith (12.09.25), pp68-69

58. Ultimately, given the clinical complexities in Brian's case, the question of whether he should have been re-prescribed olanzapine is somewhat beside the point. As Dr Smith properly acknowledged in his report (after explaining why he would have re-prescribed olanzapine):

These comments are made retrospectively when it is easy to assume that different management could have effected a different outcome. It was possibly only a matter of time before (Brian) ended his life, by misadventure or otherwise, because his personality structure and pattern of chronic addiction made him incapable of making changes that could lead to recovery.^{159,160}

Fragmentation of mental health care at Hakea

59. I acknowledge that PHS counsellors and members of the PMH team at Hakea are all skilled professionals who face an intolerable workload due to the ever increasing prison muster at Hakea and the vulnerable prisoners who need their care.
60. The high levels of need amongst prisoners at Hakea (many of whom are being detained for the first time) further elevates the importance of effective information sharing, and for clinicians to have ready access to as much relevant information about a prisoner's medical history as is possible.
61. At the inquest, Ms Cairnes and Ms McCleod both confirmed that at the relevant time at Hakea, PHS staff numbers and the ever rising prison muster meant it was not possible for clinicians to do more than perform self-harm risk assessments, and crisis interventions.^{161,162}
62. Further, until recently, therapeutic spaces at Hakea have been difficult to find, and in any case PHS and PMH team staff have no capacity to undertake long-term therapeutic counselling. Further, wait-lists to see a counsellor or mental health clinician can be lengthy.¹⁶³

¹⁵⁹ Exhibit 1, Vol 1, Tab 31, Health Services Review- Report: Dr K Smith (12.09.25), pp68-69

¹⁶⁰ See also 25.02.26 (Flavel), pp85-86 re the unpredictability of suicide especially in a patient with antisocial personality disorder

¹⁶¹ ts 25.02.26 (Cairnes), pp27-28 & 30-31 and ts 26.02.26 (McCleod), pp112-113

¹⁶² See also: ts 26.02.26 (Brampton), pp155-156

¹⁶³ Exhibit 1, Vol 1, Tab 28, Lessons Learned Report (11.12.25), pp12-14

63. Having acknowledged the challenges facing PHS and PMH clinicians at Hakea, I do not wish the following observations to be seen as a reflection on any of these staff, who I acknowledge do their work under very difficult circumstances. Nevertheless, after carefully considering the available evidence I have concluded that, at the time of Brian's death, the mental health and psychological care provided to prisoners at Hakea was fragmented and was therefore of an unacceptable standard.¹⁶⁴
64. During his closing submissions, counsel for the Department (Mr Heywood) conceded that "*the working relationship between PHS and mental health in respect to Brian at Hakea Prison was fragmented which made it difficult for both services to provide care to Brian*". Mr Heywood also made the following remarks (with which I agree) about the fragmentation of PHS and mental health care at Hakea:

We acknowledge that...there were some problems with the treatment and care provided in a general sense by PHS and the mental health team, and there are problems with the fragmentation of the Mental Health and PHS teams at Hakea Prison, arising from poor information sharing, insufficient resources, inadequate infrastructure, insufficient clinical governance, and I think your Honour described it as a...tribal culture likely driven, in...my submission, by the deficiencies to which I have referred.¹⁶⁵

65. I have made a recommendation aimed at improving information sharing between PHS and PMH clinicians, and another aimed at improving the access these clinicians have to medical, psychiatric and/or other reports and information (Information) relevant to a prisoner's care and treatment. I have also made a recommendation directed at improving the delivery of psychological and mental health care at Hakea, which is based on the following observations made by Dr Brett in his report:

I believe that the management of suicidal prisoners should be led by mental health and preferably psychiatry. I believe that the missed opportunities relate to the whole way mental health is managed in the prison setting...

¹⁶⁴ I note Deputy Commissioner Beck's contrary view with which I disagree: ts 26.02.26 (Beck), pp136-142

¹⁶⁵ ts 27.02.26 (Heywood), p217 and see also: ts 25.02.26 (Flavel), p56-57

Dr Hanratty suggested (Brian) may have been suitable for the Start Court. I work at the Start Court and the approach to mental health in that court could be a model for the prison system. It has a multidisciplinary, interagency approach to care. It is easy for each team member to liaise with each other to help formulate the best plan for the individual. It includes peer workers, family support workers, substance use workers and other more mainstream clinicians. They all work together to ensure the best mental health care for the client. This model could be utilised in the prison system, however, would need a significant change to culture and clinical leadership.

I believe that mental health services in prison should be provided by the Health Department, not the Department of Justice.¹⁶⁶
[Emphasis added]

66. In his evidence at the inquest, Dr Brett outlined a number of benefits to the Department of Health (DoH) taking over the management of mental health care in the prison system. These benefits include: better systems; clearer lines of clinical governance; greater access to mental health beds; a larger pool of mental health clinicians (including psychiatrists) to draw from; more effective transfer of, and access to information; reduced bureaucratic “drag” when referring patients to hospitals; increased access to a multidisciplinary, multi-agency services; and more attractive remuneration and benefits.¹⁶⁷
67. Although a representative from the DoH was not called to comment on this issue during the inquest, Dr Brett’s suggestion appeared to receive broad support from the Department’s witnesses that I heard from.^{168,169} I have therefore recommended that the Department liaise with the DoH to determine the feasibility of the DoH assuming responsibility for prisoner health care (including primary, psychiatric, psychological care).

¹⁶⁶ Exhibit 1, Vol 1, Tab 25, Report - Dr A Brett (12.11.25), paras 23-27), p17 and ts 25.02.26 (Brett), pp97-110

¹⁶⁷ ts 25.02.26 (Brett), pp99 & 107-109

¹⁶⁸ ts 25.02.26 (Cairnes), pp48-49 & ts 25.02.26 (McLeod), p121;

¹⁶⁹ ts 25.02.26 (Beck), p142-145 & ts 25.02.26 (Harris), p173-174

EVENTS LEADING TO BRIAN'S DEATH

Observations and lunch

68. At about 9.30 am on 2 August 2024, Brian was visited by a prison chaplain (Mr Pitts) who spoke with him through the observation hatch in his cell door. Brian was on “moderate” ARMS at the time, and although Mr Pitts noted that Brian presented as “*low in mood*” he was willing to engage in conversation and was far less negative than 11 days prior.¹⁷⁰
69. At about 11.10 am, Prison Officer Thorpe (Officer Thorpe) who was the Control Officer for Brian’s wing, opened the observation hatch on Brian’s cell and offered him some lunch, which he accepted. PO Thorpe did not notice anything unusual in her interaction with Brian and continued serving lunch to other prisoners on the wing.¹⁷¹
70. At the inquest, Officer Thorpe agreed that staff shortages and the large number of prisoners on ARMS meant it was sometimes the case that ARMS observations were little more than a “*body check*”. At 11.25 am, Officer Thorpe made an entry in the ARMS supervision log that stated: “*(Brian) was seen by the chaplain, staff state he appears low and doesn’t engage much, declines all his entitlements, accepted lunch*”.^{172,173}
71. At the inquest, Officer Thorpe confirmed that this observation was been made by another officer, but because staff shortages that other officer did not have time to make the entry, and as control officer she had better access to a computer. Whilst Officer Thorpe’s entry of another officer’s ARMS observation is contrary to established procedure, it does not appear to be relevant to Brian’s death.
72. At about 12.54 pm a PHS counsellor (Ms Cairnes) contacted the Senior Officer on Brian’s wing to request that he be brought down for counselling support. This request was refused due to staffing shortages, and Ms Cairnes made the following entry in Brian’s counselling notes:

¹⁷⁰ Exhibit 1, Vol 1, Tab 19, ARMS Offender Supervision Log (02.08.24), pp25-26

¹⁷¹ Exhibit 1, Vol 1, Tab 27.45, Statement - PO A Thorpe (07.10.25) & ts 25.02.26 (Thorpe), pp9-24

¹⁷² Exhibit 1, Vol 1, Tab 19, ARMS Offender Supervision Log (02.08.24), p26

¹⁷³ ts 25.02.26 (Thorpe), pp15-17

PHS called SO in MPU to request to see (Brian) for counselling support as per management plan. SO stated that due to staffing no escort (was) available to escort (Brian) to Official Visits, SO's office in MPU or even a hatch assessment. Consulted with A/Supervisor who said to put in a non-contact note and to try and arrange see Brian over the weekend.¹⁷⁴

Brian is found^{175,176,177,178,179}

73. At about 1.00 pm, Officer Thorpe went to Brian's cell to conduct an ARMS observation. When she open the cell's observation hatch, she saw Brian hanging from the top bunk with a bedsheet around his neck.
74. Contrary to departmental policy, Officer Thorpe was not wearing her prison radio as she had removed it after visiting the toilet and simply forgotten to replace it. As a result, she ran the short distance back to the control room to notify other prison officers, before running back to the cell with them, and unlocking Brian's cell door. Close circuit TV footage from cameras in Brian's wing confirms that it took 17 seconds for Officer Thorpe to run to the control room and back to Brian's cell.¹⁸⁰
75. A "Code red" medical emergency was called on the prison radio and prison officers cut Brian down and started CPR. St John Ambulance paramedics arrived at Hakea at 1.12 pm and took over resuscitation efforts, but Brian could not be revived and he was declared deceased at 1.40 pm on 2 August 2024.^{181,182}
76. Given the short distances involved, I am satisfied that there was no significant delay in responding to Brian after he was found hanging in his cell. At the inquest Officer Thorpe said that following Brian's death she always ensures her prison radio is on her person at all times, and a Deputy Commissioner's Broadcast was issued to all custodial staff to remind them of this requirement.^{183,184,185}

¹⁷⁴ Exhibit 1, Vol 1, Tab 27.42, PHS File Note - Ms L Cairnes (02.08.24) & ts 25.02.24 (Cairnes), pp44-45

¹⁷⁵ Exhibit 1, Vol 1, Tab 8, Report - Coronial Investigator Ms L Jackson (28.08.125), pp1-5 & 11-17

¹⁷⁶ Exhibit 1, Vol 1, Tab 27.45, Statement - Ms A Thorpe (07.10.25) & ts 25.02.26 (Thorpe), pp9-24

¹⁷⁷ Exhibit 1, Vol 1, Tabs 24 & 27.42, Incident Description Reports & Incident Summary report (02.08.24)

¹⁷⁸ Exhibit 1, Vol 1, Tab 27, Death in Custody Review (08.01.26), pp28-31

¹⁷⁹ Exhibit 1, Vol 1, Tab 28, Lessons Learned Report (11.12.25)

¹⁸⁰ Exhibit 1, Vol 1, Tab 27.46, CCTV footage (02.08.24)

¹⁸¹ Exhibit 1, Vol 1, Tab 9.1, SJA Patient Care Record RIV22D2 (02.08.24)

¹⁸² Exhibit 1, Vol 1, Tab 4, Life Extinct Certification (02.08.24)

¹⁸³ Exhibit 1, Vol 1, Tab 27, Death in Custody Review (08.01.26), pp36-37

CAUSE AND MANNER OF DEATH^{186,187,188,189}

77. A forensic pathologist (Dr V Kueppers) conducted a post mortem examination of Brian's body at the State Mortuary on 8 August 2024 and reviewed post mortem CT scans. The examination noted a ligature mark around Brian's neck which was consistent with the ligature that accompanied Brian's body.
78. There was early coronary artery disease, and Brian's lungs were congested and oedematous (a non-specific finding). There was evidence of resuscitation efforts (including anterior rib fractures and laceration of the liver), but no suspicious injuries were noted. Macroscopic (naked eye) examination of Brian's brain showed no significant abnormality.
79. Toxicological analysis detected the antidepressant medication, amitriptyline, in Brian's system along with its metabolite, as well as citalopram. Alcohol and other common drugs were not detected.
80. At the conclusion of her post mortem examination, Dr Kuepper expressed the opinion that the cause of Brian's death was: "*Ligature compression of the neck (hanging)*".¹⁹⁰
81. I accept and respectfully adopt Dr Kuepper's opinion and find Brian died from ligature compression of the neck.
82. Further, on the basis of the available evidence as to the circumstances of Brian's death, I find that death occurred by way of suicide.

¹⁸⁴ Exhibit 1, Vol 1, Tab 27.45, Statement - Ms A Thorpe (07.10.25) & ts 25.02.26 (Thorpe), pp9-24

¹⁸⁵ Exhibit 1, Vol 1, Tab 28, Lessons Learned Report (11.12.25), p19

¹⁸⁶ Exhibit 1, Vol 1, Tab 5, Supplementary Post Mortem Report (27.08.24)

¹⁸⁷ Exhibit 1, Vol 1, Tab 5.1, Post Mortem Report (08.08.24)

¹⁸⁸ Exhibit 1, Vol 1, Tab 6, Toxicological Report - ChemCentre WA (16.08.24)

¹⁸⁹ Exhibit 1, Vol 1, Tab 7, Neuropathology Report (14.08.24)

¹⁹⁰ Exhibit 1, Vol 1, Tab 5, Supplementary Post Mortem Report (27.08.24), p1

LESSONS LEARNED WORKSHOP

Overview

83. Departmental policy requires that following a critical incident, there is an immediate debrief, and later a more in-depth debrief to capture what went well and identify lessons learned.^{191,192} These debriefs are colloquially referred to as “*hot*” and “*cold*” debriefs respectively, which is the terminology I have adopted.
84. In this case, a “*hot*” debrief was conducted at Hakea in the period after Brian had been declared deceased. It appears that the hot debrief was more of a welfare check, and on the evidence before me, it is unclear whether all first responders were present.¹⁹³
85. A “*cold*” debrief in relation to the critical incident at Hakea on 2 August 2024 was not conducted until 14 July 2025, just over 11 months after Brian’s death. This process was therefore not in accordance with the relevant policy, which requires that a “*cold*” debrief be held as soon as possible after the critical incident.¹⁹⁴
86. In my view the Lessons Learned workshop that was conducted was seriously flawed. Not only did it occur months after Brian’s death, of the 19 attendees, only two had had any contact with Brian, and **none** of the first responders attended.¹⁹⁵

*Lessons learned*¹⁹⁶

87. The Lessons Learned workshop identified the following four “*lessons*” with associated actions that may be summarised as follows:
- a. ***Lesson 1 - Staff shortages:*** Infrastructure and human resourcing limitations as well as the increased number of prisoners requiring support from PHS impacted PHS’ ability to engage with (Brian) on 30 July 2024. PSO (Prison Support Officer) services are also impacted by the same resourcing and infrastructure issues.

¹⁹¹ COPP-13.1 Incident Notification

¹⁹² EMF-DIR-022 Operational debriefing

¹⁹³ See for example: Exhibit 1, Vol 1, Tab 27.45, Statement - Ms A Thorpe (07.10.25), p4

¹⁹⁴ EMF-DIR-022 Operational debriefing (30.11.23)

¹⁹⁵ Exhibit 1, Vol 1, Tab 28, Death in Custody: Lessons Learned Report (14.07.25), pp4-6

¹⁹⁶ Exhibit 1, Vol 1, Tab 28, Lessons Learned Report (11.12.25) & ts 26.02.26 (Brampton), pp150-164

- b. **Lesson 1 - Actions:**
- i. Additional therapeutic spaces have been identified at Hakea, meaning there are 16 areas where “*clinical assessments can be conducted in a safe and secure environment*”.
 - ii. Additional PHS counsellors have been requested in the 2026 budget to cope with the increased prison muster, and Hakea will continue to advocate for additional PSO positions.
 - iii. Although PHS counsellors cannot conduct risk assessments through a prisoner’s cell door, counsellors have been asked to have a brief talk with a prisoner where it is safe to do so, confidentiality is not an issue, and there is an understanding that “*this engagement does not allow for or complement a risk assessment or clinical intervention*”.¹⁹⁷
- c. **Lesson 2 - Recording of ARMS observations:** Brian’s final ARMS observation (at 11.26 am) was entered into the supervision log by the control officer rather than the officer who did the observation.
- d. **Lesson 2 - Actions:**
- i. On 11 July 2025, a notice was issued to all staff at Hakea reminding them of “*the critical importance of completing Supervision Log entries on time and ensuring they reflect meaningful engagement with offenders. This reminder also covered how third-party entries should be documented i.e. entered on behalf of Officer ‘A’*”.¹⁹⁸
- e. **Lesson 3 - Review of medical care provided required:** the review was required to understand why he was not provided the same medications in prison he was prescribed in the community and whether there are any opportunities to ensure prisoners are aware of the ways in which they can raise issues regarding the medical care / medications they are being provided.
- f. **Lesson 3 - Actions:**¹⁹⁹
- i. Medical Services conducted a review of Brian’s medical care and medications.²⁰⁰
 - ii. Posters explaining complaint procedures are displayed throughout all prisons, and accurate information will be conveyed to prisoners during the prisoner orientation process.

¹⁹⁷ Exhibit 1, Vol 1, Tab 28, Death in Custody: Lessons Learned Report (14.07.25), pp13-14

¹⁹⁸ Exhibit 1, Vol 1, Tab 28, Death in Custody: Lessons Learned Report (14.07.25), p15

¹⁹⁹ Exhibit 1, Vol 1, Tab 28, Death in Custody: Lessons Learned Report (14.07.25), pp17-18

²⁰⁰ See: Exhibit 1, Vol 1, Tab 31, Health Services Review (20.02.26)

- g. ***Lesson 4 - Radio not worn by first responder:*** the first responding officer was not wearing a radio at the time she found Brian hanging of and was therefore unable to call a “code red” immediately.
- h. ***Lesson 4 - Actions:***²⁰¹
A Deputy Commissioner’s Broadcast was disseminated to all staff reinforcing the fact that the wearing security equipment such as radios is mandatory at all times.

QUALITY OF SUPERVISION, TREATMENT AND CARE

Overview

- 88. In assessing the supervision, treatment and care that Brian received whilst he was incarcerated, I have applied the standard of proof as set out in the High Court’s decision in the case of ***Briginshaw v Briginshaw***²⁰² (Briginshaw case). The Briginshaw case requires a consideration of the nature and gravity of the conduct when deciding whether a finding adverse in nature has been proven on the balance of probabilities.
- 89. I have also been mindful not to insert hindsight bias into my assessment of Brian supervision, treatment and care. Hindsight bias is the tendency, after an event, to assume the event is more predictable or foreseeable than it actually was at the time.²⁰³

Quality of physical health treatment and care

- 90. The Health Services Review completed after Brian’s death (Health Review) makes the following observations about the management of Brian’s physical health:

(Brian) was held in custody at Hakea Prison for 183 days. He was managed well from a medical standpoint, with regular blood tests and reviews, with updates to his treatments.²⁰⁴

- 91. Having carefully considered the available evidence, I am satisfied the treatment and care Brian received in relation to his physical health while he was in custody was of an acceptable standard.

²⁰¹ Exhibit 1, Vol 1, Tab 28, Death in Custody: Lessons Learned Report (14.07.25), p19

²⁰² (1938) 60 CLR 336, per Dixon J at pp361-362

²⁰³ Dillon H and Hadley M, *The Australasian Coroner’s Manual (2015)*, p10

²⁰⁴ Exhibit 1, Vol 1, Tab 31, Health Services Review (20.02.26), p22

Quality of supervision

92. Following Brian's death, Ms Palmer conducted a review of his custodial management and supervision and expressed the following conclusions:

This review found Mr Kealy's custodial management, supervision and care were generally in accordance with the Department's policy and procedures as listed in **Appendix 1**. Records indicate that the critical incident response was prompt, following Mr Kealy's discovery and relevant death in custody procedures, including notifications and handover to WA Police were followed.²⁰⁵ [Original emphasis]

93. Ms Palmer identified three areas for improvement, namely:

[T]his review found that although the Date of Interest (DOI) was recorded in the Prisoner Risk Assessment Group (PRAG) and Echo notes it was not recorded in the TOMS²⁰⁶ DOI module; The discovery officer was not in possession of her prison issued radio at the time of discovery; and (Brian) was moved from the area where he was declared deceased into his cell.²⁰⁷

94. Having carefully considered the available evidence, I am satisfied that Brian's supervision and general custodial management whilst he was in custody at Hakea was of an acceptable standard.

Quality of mental health treatment and care

95. At the Court's request, Dr Brett (an experienced consultant psychiatrist) conducted an independent assessment of Brian's care. Dr Brett gave evidence at the inquest and in his report, he expressed the following opinion about Brian's care whilst he was incarcerated at Hakea:

I believe that the quality of (Brian's) mental health treatment in his final period of incarceration was poor. This should be viewed in the context of the earlier information about prevalence of mental disorder, resources and prison infrastructure. There was poor coordination and difference in opinion on (Brian's) diagnosis and management, which made management harder.²⁰⁸

²⁰⁵ Exhibit 1, Vol 1, Tab 27, Death in Custody Review (08.01.26), p8 and see also: ts 26.02.26 (Palmer), pp164-171

²⁰⁶ TOMS is the abbreviation for Total Offender Management Solutions the computer system used to manage prisoners

²⁰⁷ Exhibit 1, Vol 1, Tab 27, Death in Custody Review (08.01.26), p8

²⁰⁸ Exhibit 1, Vol 1, Tab 25, Report - Dr A Brett (12.11.25), p17

96. In my view, Brian was appropriately managed on ARMS on various occasions when it was considered that his risk of self-harm was elevated. However, having carefully considered the available evidence, I agree with the views expressed by Dr Brett and I find that the quality of mental health care Brian received was **poor**.
97. I now wish to make some comments about the serious allegation in the Health Review relating to the care Dr Flavel provided to Brian whilst he was incarcerated, namely that Dr Flavel contravened a direction by Dr Hanratty by ceasing Brian's dose of olanzapine.
98. At the inquest, Dr Harris (Director, Medical Services) was unable to point to a direction by Dr Hanratty that Brian be prescribed olanzapine.²⁰⁹ This is hardly surprising, because to put the point bluntly, the evidence before me **does not** disclose any direction by Dr Hanratty. As noted, Dr Hanratty was not Brian's treating psychiatrist and had no role in Brian's ongoing care. Rather, Dr Hanratty had been engaged as an expert to assess Brian's fitness to stand trial.
99. During his closing submissions Mr Heywood conceded that the Department now accepted that Dr Hanratty had not made a direction that Brian should be prescribed olanzapine.²¹⁰ The Department's concession necessarily negates the allegation levelled at Dr Flavell in the Health Service Review and I have therefore disregarded those portions of the Health Services Review that purport to deal with Dr Flavel.²¹¹
100. Although the Department's concession is obviously welcome it came at the end of the inquest, and three days after the Health Services Review was provided late on the day before the inquest started. Given the obviously spurious basis for the allegation against Dr Flavel, it is **appalling** that the allegation was published by the Department in the first place. Further, disclosing an allegation of this nature shortly before the relevant witness is due to give evidence raises serious issues of fairness, and jeopardises the prospects of the inquest proceeding as scheduled.

²⁰⁹ ts 26.02.24 (Harris), pp177-182

²¹⁰ ts 27.02.24 (Heywood), p219

²¹¹ Exhibit 1, Vol 1, Tab 31, Health Services Review (20.02.26), pp10-12, 15-17 & 22

RECOMMENDATIONS

101. In light of the observations I have made in this finding, I make the following recommendations:

Recommendation No. 1

In order to better manage prisoners and thereby enhance security at Hakea Prison, the Department of Justice should, without delay, take all necessary steps to ensure that Psychological Health Services (PHS) and prison mental health clinicians have reciprocal access to prisoner information stored in the EcHO computer system and the PHS module of the Total Offender Management Solutions system respectively.

Recommendation No. 2

The Department of Justice (the Department) should review the delivery of mental health and psychological health services within Hakea Prison in light of the recommendations made by Dr Adam Brett in his report dated 12 November 2025, which reviewed Brian's care.

Specifically, the Department should:

- a. Form a project group with the Department of Health (DoH) to determine the feasibility of DoH assuming responsibility for prisoner health care (including primary, psychiatric, psychological care); and
- b. Whilst the discussions in paragraph (a) above are taking place, the Department should assess the appropriateness of adopting a truly multidisciplinary model of mental and psychological health care at Hakea Prison, led by a psychiatrist who would provide clear clinical governance, to enable clinicians to work collaboratively to develop appropriate management and treatment plans for prisoners requiring care.

Recommendation No. 3

To enhance the treatment and care provided to prisoners at Hakea, the Department of Justice (the Department) should take all necessary steps to ensure that all available medical, psychiatric and/or other reports and information (Information) relevant to a prisoner’s care and treatment are freely available to treating mental health and psychological clinicians. The Department should also identify any legislative, policy or other barriers preventing access to such Information, and take all available steps to remove such barriers.

Recommendation No. 4

The Department of Justice (the Department) should take all reasonable steps to ensure that the provisions of “*EMF-DIR-022 Operational debriefing*” are complied with.

In particular, in relation to critical incidents involving deaths in custody, the Department should ensure that wherever possible, personnel involved in the critical incident participate in immediate and formal debriefs, so that valuable insights from those officers can be captured and incorporated into any “*lessons learned*” process.

The Department should also ensure that lessons learned reports are disseminated to relevant staff, including those involved in the management and conduct of emergency response skills.

Recommendation No. 5

The Department of Justice (the Department) should conduct a review of the number of mental health and psychological health clinicians at Hakea Prison to determine whether these staffing levels are adequate. Meanwhile, the Department should redouble its recruiting efforts to fill currently vacant positions and should review salary and other benefits with a view to attracting appropriately qualified clinicians.

102. At my request, Mr McDonald (Counsel Assisting) forwarded a draft of my recommendations to counsel for the Department, and Dr Flavel by way of an email on 27 February 2026. Feedback (if any) was requested no later than the close of business on 20 March 2026.²¹²
103. By way of an email dated 28 February 2026, Mr Williams (counsel for Dr Flavel) advised that Dr Flavel did “*not wish to make any responsive submissions*” in relation to the recommendations I had made.²¹³
104. By way of an email dated 20 March 2026, Mr Heywood (counsel for the Department) advised that the Department’s response would be delayed.²¹⁴ In an email dated 25 March 2026, Mr Heywood advised that the Department’s response to the recommendations I had proposed was as follows:²¹⁵

- a. *Recommendation 1:* this recommendation is supported, and the Department advised that PHS notes relevant to primary health and mental health “*should be duplicated from the TOMS PHS module to EcHO*” until a solution can be found. The Department also advised that a review of EcHO found it was outdated and needed replacing.

The Department also provided the following information, which appears to confirm the problem with the current “treatment silos” at Hakea and the urgent need to adopt a multi-disciplinary approach to the mental health and psychological care provided to prisoners:

Psychological Health and Wellbeing Services (PHWS) is predominantly an Allied Health Service (Psychological Health, Prisoner Support Services and Disability support) that cares for prisoners with vulnerabilities that would not necessarily be assessed as requiring Mental Health or Primary Health care. The referral pathway is significantly different to that of the other Health services as any member of staff can and does make referrals for prisoners on the TOMS module.²¹⁶

²¹² Email - Mr D McDonald to Mr E Heywood and Mr E Panetta (27.02.26)

²¹³ Email - Mr M Williams to Mr D McDonald (28.02.26)

²¹⁴ Email - Mr E Heywood to Mr D McDonald (20.03.26)

²¹⁵ Email - Mr E Heywood to Mr D McDonald forwarding Department’s response to Recommendations (25.03.26)

²¹⁶ Department’s response to Recommendations (25.03.26), p1

- b. *Recommendation 2:* although this recommendation is supported, the Department suggested a minor amendment which I have adopted.

The Department also advised that following a “*structural review in early 2025*”, PHWS, mental health, and primary health were brought under a single Executive Director and leadership group. The Department also advised that:

In addition, a revised model of care was developed which proposed a multidisciplinary approach to patient care. Full implementation of this model requires additional resources. (The Department) have submitted a budget bid to ERC which includes additional staff for mental health services.²¹⁷

- c. *Recommendation 3:* this recommendation is supported.
- d. *Recommendation 4:* this recommendation is supported.
- e. *Recommendation 5:* this recommendation is supported and the Department also advised that:

Regular recruitment drives are held for mental health nurse positions, and there has been a submission to treasury for additional health service FTE overall, based on the current muster statewide, versus current funding for lower muster in previous years. The pay scale and benefits for mental health nurses are not commensurate with (Department of Health) positions, which does cause issues with attracting applications.²¹⁸

²¹⁷ Department's response to Recommendations (25.03.26), p2

²¹⁸ Department's response to Recommendations (25.03.26), p4

CONCLUSION

105. Brian was 42 years of age when he hanged himself at Hakea on 2 August 2024. Brian was a complex man, whose life had been adversely affected by his polysubstance use and offending behaviour. Nevertheless, Brian was loved by his family, and at the conclusion of the evidence, Ms Judkins made the following remarks about her brother:

I just wanted to say thank you to everyone for taking so much time to tell me what happened. (Brian) was so complex, but he was my brother, and I loved him. And we did all love him at home. Something went wrong when he was young, and we don't know why. We tried to find out, and we never could find out. And he was difficult to communicate (with). He didn't really know why, but, you know, he was loved. I suppose my only other observation is that we seem to have ended up in a place as a society where we don't have...sufficient psychiatric help for people like...my brother before they start on the path of violent crime and hurting innocent people. And so they end up in the prison system, and the prison system is not the right place for them.²¹⁹

106. I concluded the supervision, and the treatment and care Brian received in relation to his physical health was adequate. However, I found the standard of the care and treatment Brian received in relation to his mental health was **poor**. I made five recommendations aimed at improving the psychological and mental health care provided to prisoners at Hakea which I hope will be fully embraced.

107. As I did at the inquest, I wish to again offer Brian's family and friends, on behalf of the Court, my very sincere condolences for your loss.

MAG Jenkin
Acting Deputy State Coroner
26 March 2026

²¹⁹ ts 26.02.26 (Judkins), p201