MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Dallas Brooks Shrimpton

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that:

a) The identity of the deceased is Dallas Brooks Shrimpton;
b) Mr Shrimpton died from carbon monoxide inhalation as a result of an action taken by himself with the intention of ending his life;
c) The cause of death was carbon monoxide asphyxia; and
d) Mr Shrimpton died between 19 and 20 December 2017 at West Takone, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Shrimpton's death. The evidence includes:

- The Police Report of Death;
- Life extinct and identification affidavits;
- An opinion of the forensic pathologist who conducted the autopsy upon Mr Shrimpton;
- Affidavit of a forensic scientist regarding toxicological results from testing Mr Shrimpton's post-mortem blood;
- Affidavit of Kathryn Delbridge, long-term friend and provider of care to Mr Shrimpton;
- Affidavit of Emma Delbridge, Mr Shrimpton's former partner;
- Affidavit of Wendy Lynch, Mr Shrimpton's sister;
- Affidavit of Tarquin Dick, friend of Mr Shrimpton;
- Affidavits of five police officers involved in the missing person search and / or attending the scene of Mr Shrimpton's death;
- Affidavit and scene photographs of a specialist forensics officer;
- Tasmanian Health Service records for Mr Shrimpton;
- Records of Wynyard Medical Centre, where Mr Shrimpton was a patient;
- Tasmanian Health Service Root Cause Analysis document and information regarding response to internal recommendations specified in that document; and

- Affidavit of Dr Thomas Haskell, who assessed Mr Shrimpton's mental health on 17 December 2017 at the Royal Hobart Hospital.

Background

Mr Dallas Brooks Shrimpton was born on 12 July 1963, the youngest of five siblings. He was aged 54 years at the time of his death. He was not married and did not have any children. He had been a refrigeration mechanic during his working life, although he had stopped working in 2012 due to sustaining an injury. He was a disability pensioner at the time of his death.

Mr Shrimpton's father passed away when he was very young and, when he was 16 years of age, his mother died. He then moved to Victoria to live with his sister, Wendy Lynch. Mr Shrimpton was a gifted athlete in his youth but he started to use illicit drugs. Ms Lynch asked him to leave her home due to the issues that his drug use was causing. Mr Shrimpton then moved to Western Australia to live with his brother, Norman Shrimpton (now deceased) and began using heroin on a regular basis. He later moved to Sydney and continued his drug use. It is clear that his mental health was very poor from this early stage of his life. He attempted suicide in Sydney by gassing himself in a car, but was saved by a passing pedestrian.

There is little evidence in the investigation about much of Mr Shrimpton's adult life before 2009. It appears that he was engaged in employment as a refrigeration mechanic and was treated with methadone whilst living in Queensland in an attempt to overcome his addiction to heroin. In 2009, whilst in Queensland, Mr Shrimpton formed a relationship with Emma Delbridge ("Emma"). Later that year, he made a suicide attempt by overdosing on heroin. On that occasion he was revived by paramedics and taken to hospital.

In 2011 Mr Shrimpton returned to Tasmania with Emma. They both commenced to live with Emma's mother, Kathryn Delbridge, at 189 Pinner Road in West Takone. In 2015 the relationship ended, with Emma moving to South Australia, but Mr Shrimpton remained living at Mrs Delbridge's residence until the time of his death. In 2017 Mr Shrimpton received a compensation payment as a result of injuring his shoulder in 2012 and being no longer able to work.

Mr Shrimpton's Health and Treatment

The evidence in the investigation discloses that Mr Shrimpton had an extensive history of substance abuse, alcoholism and mental health issues (including suicide attempts). Mrs Delbridge, in her affidavit, stated that Mr Shrimpton's alcohol consumption increased to very

concerning levels from 2015 onwards. She stated that his drinking further escalated after receiving his compensation payment as he was able to buy more beer. She stated that he would consume about two 30-can cartons of beer in three days. Mr Shrimpton was under the care of general practitioners at the Wynyard Medical Centre. The records from that practice state that, at the time of his death, he was suffering from alcohol dependence, depression and pain from his right shoulder dislocation.

In her affidavit, Mrs Delbridge describes Mr Shrimpton, whilst intoxicated, being involved in several serious incidents shortly before his death. These included hitting his head on concrete on 28 October 2017 requiring hospitalisation. Mrs Delbridge then arranged with Mr Shrimpton's general practitioner to have him admitted to rehabilitation for alcohol abuse and the overuse of his pain medication. On 21 November Mr Shrimpton underwent an assessment by Alcohol and Drugs Services and was advised that detoxification at an inpatient facility in Hobart was required.

On 12 December, Mrs Delbridge drove Mr Shrimpton into Burnie to board the scheduled Redline bus to the Inpatient Withdrawal Unit ("IPWU") in Hobart. However, Mr Shrimpton was involved in an altercation with another male on the bus and was removed from the bus in Launceston for his behaviour. Police officers transported him to safe accommodation but, due to his concerning behaviour, he was then taken to the Emergency Department ("ED") of the Launceston General Hospital ("LGH"). He left there without waiting to be seen.

The following day, 13 December, Mr Shrimpton consumed a large quantity of alcohol (at least a bottle of vodka, possibly with medication) in Launceston to the point of suffering a decreased conscious state. He was again conveyed by ambulance to the LGH ED. He remained sedated in hospital overnight.

On 14 December Mrs Delbridge collected Mr Shrimpton from the LGH and drove him to Hobart to the IPWU. Mrs Delbridge stated in her affidavit that Mr Shrimpton appeared worried about being admitted to rehabilitation but was hopeful that it would help him. Mr Shrimpton was admitted formally to the IPWU at about 3.00pm that afternoon. The records from that facility relating to Mr Shrimpton describe him as having "severe alcohol dependence" and recorded that he consumed 45 standard drinks per day. It was also noted that he used prescription medication and opioids to excess and that he suffered depression with previous suicide attempts using high lethality methods. The records also indicate that he experienced witnessed alcohol withdrawal seizures during the first evening of his admission. In his initial

assessment at the IPWU, the psychiatrist recorded that Mr Shrimpton appeared to be significantly disturbed and had a chronic, high suicide risk.

The following day, being 15 December, Mr Shrimpton was monitored, medicated and assessed. By about 8.25pm Mr Shrimpton was expressing a desire to leave the facility. He then discharged himself from the IPWU at 9.35pm against medical advice. His participation was voluntary and therefore there were no grounds to lawfully detain him. I infer that, in allowing him to do so, the medical staff assessed him as having capacity to make that choice. There is no reason upon the evidence to consider that he did not have the ability to make this decision, even if it was not in his best interests.

The evidence indicates that, over the next 24 hours after leaving the IPWU, Mr Shrimpton consumed alcohol, including in a hotel in Hobart. On 16 December at about 8.00pm he was found walking in the street by police, intoxicated, and expressing suicidal ideation. He was taken by police officers to the ED of the Royal Hobart Hospital ("RHH") arriving there at about 8.30pm. At 9.18pm, within the allocated time for his initial triage category, he was reviewed by a Psychiatric Emergency Nurse (PEN). Whilst the notes from his presentation at the RHH are not entirely adequate, it is clear that he told the PEN that he did not want to die and was happy to wait to be seen. The nurse explained that there were no cubicles available for him. The normal process should have been to have Mr Shrimpton settled into an appropriate and private space for monitoring. However, the records indicate that the following sequence of events occurred.

Just after midnight on 17 December Mr Shrimpton, who had left the internal area of the ED to go outside into the forecourt of the RHH, placed his belt around his neck apparently commencing a suicide attempt. When he was discovered, he told the nurse that he was sick of waiting and sick of living but did not want to die either. He further said that he wanted to get some "good heroin" and die that way. An involuntary protective custody order was immediately made in respect of Mr Shrimpton, and it appears that this may have been followed by an Assessment Order under the *Mental Health Act* 2013 but this is unclear. In any event, he remained in the ED and the staff treated him through the evening.

Between 3.20am and 7.51am Mr Shrimpton was observed by nursing staff to veer between agitation, sleep and requesting cigarettes and medication.

At about 8.00am, Mr Shrimpton underwent a formal mental health assessment by Dr Thomas Haskell. Dr Haskell also provided a report for the investigation. He said in his report that, upon examination of Mr Shrimpton at that time, he was reassured that Mr Shrimpton was stable, did not have significant acute medical illness, and there was no evidence of hallucinations or clouded thinking. However, in recognition of his potential suicide risk, Dr Haskell said he felt that Mr Shrimpton should have a further assessment by the specialist psychiatry team. At that time Mr Shrimpton told him that he was willing to stay in the ED for this review. Dr Haskell, in my view, appropriately assessed Mr Shrimpton as having capacity to give informed consent regarding medical decisions and therefore Mr Shrimpton remained in the ED as a voluntary patient and free to leave at any stage.

A very short time later, at about 9.20am, Mr Shrimpton was seen by a specialist psychiatry clinician. By this time, Mrs Delbridge, who had driven to Hobart to support Mr Shrimpton, was present at the assessment. There are detailed notes of the assessment, with the clinician concluding that Mr Shrimpton had no pervasive mood disorder or psychosis that warranted further care at the RHH. Mr Shrimpton said that he wanted to go home and Mrs Delbridge indicated to the clinician that she would provide a high level of support. At that stage Mr Shrimpton denied suicidality, accepted that he was an alcoholic and said that he would see his general practitioner the following day. Mrs Delbridge also requested that the Crisis Assessment and Treatment Team ("CATT") follow-up at their home for Mr Shrimpton. Mr Shrimpton was therefore discharged. Again, there were no grounds in my view to detain Mr Shrimpton involuntarily at that stage, even though he had a limited insight into his issues.

At 3.57pm the CATT received the referral from the RHH and resolved to discuss his situation the following day, on 18 December.

Circumstances Surrounding Death

Upon returning home, Mr Shrimpton attended an appointment with his general practitioner at 11.00am on Monday 18 December. The general practitioner recorded that he had no suicidal ideation and a plan was made for him to reduce alcohol consumption and return on Wednesday 20 December. Instead, Mr Shrimpton attended the surgery again in the afternoon of 18 December asking for morphine, abused reception staff in front of patients in the waiting room and then left the surgery. Mrs Delbridge, who witnessed the incident as she was in the waiting room for her own appointment, went to look for Mr Shrimpton. She found him at a local hotel and then drove him home.

Later on in the evening at 12.20am (by now, Tuesday 19 December), Mrs Delbridge was woken as a result of Mr Shrimpton having a behavioural episode and tipping over the wardrobe in his bedroom. Mrs Delbridge followed him outside and saw that he had a pipe running from the exhaust pipe of her father's car into the front passenger side window. Mrs Delbridge called 000 for assistance and tried to pull the pipe off the exhaust but it had been firmly secured with duct tape. She was also unable to take the other end of the pipe out of the window. Mr Shrimpton was sitting in the car and would not give Mrs Delbridge the keys. Before she was able to stop him, he drove away in the car with the pipe still attached in the same places.

After seeing Mr Shrimpton drive away, Mrs Delbridge called 000 again for assistance. She saw in the house that there was a half-empty carton of beer and empty pain medication boxes for the medications he had only been prescribed earlier that day.

Police immediately implemented missing persons procedures, and Mrs Delbridge and her father drove around the area to look for Mr Shrimpton. In her affidavit, Mrs Delbridge stated that there were many forestry roads in the area and "hundreds" of places he could have gone.

Mrs Delbridge finally located Mr Shrimpton at approximately 4.30pm on Wednesday 20 December 2017. He was sitting deceased in his vehicle on a Forestry Tasmania track running off Farquhars Road, West Takone. His vehicle was parked around a slight bend about 500 metres from Farquhars Road.

Mrs Delbridge opened the driver's door of the vehicle but did not touch Mr Shrimpton; she then phoned police a short time later when she returned to mobile phone range.

Police arrived on scene and located Mr Shrimpton sitting in the driver's seat of the vehicle. The ignition was still on but the vehicle was not running. The vehicle was unlocked and it had a black pipe taped to the exhaust tailpipe and routed to the side of the vehicle and into the front left hand passenger window. That window was wound up most of the way, and the gap at the top around the pipe was sealed with a pillow and a jumper.

The attending officers saw that Mr Shrimpton had an open beer bottle sitting on the seat between his legs. There were four other unopened beer bottles on the passenger seat along with cigarettes, a mobile phone and other personal property. Also located on the passenger seat was a note written by Mr Shrimpton apologising to those close to him and stating that he did not wish to die but was also not keen on living.

Paramedics had also arrived on scene along with attending police officers. Paramedics determined that Mr Shrimpton was deceased.

CIB and forensics officers examined and photographed the scene. Attending officers and detectives determined that there were no suspicious circumstances indicating that any other person was involved in Mr Shrimpton's death. Upon all of the evidence, I am satisfied that Mr Shrimpton drove to the location in which he was found after leaving the house the morning before, and intentionally ended his life by carbon monoxide asphyxiation using the exhaust gases from the vehicle.

Toxicological testing of Mr Shrimpton's blood after his death revealed the presence of moderate levels of alcohol and antidepressant medications.

Comments and Recommendations

I am satisfied, having conducted a thorough investigation, that Mr Shrimpton's death could not have been reasonably prevented. It has taken a great deal of consideration to reach this conclusion. Upon receiving the investigation file, it appeared that there may well have been issues or deficits associated with Mr Shrimpton's treatment in the week before his death that may have been causally related to his death. The potential issues I identified include:

- An apparent lack of information sharing between the LGH, the IPWU, and the RHH in relation to Mr Shrimpton's presentation and symptoms in each of these facilities which may have assisted the other facilities in understanding his condition;

- Reasons for a significantly different suicide risk assessment by clinicians at the IPWU and the RHH - and therefore consideration of whether a further order under the *Mental Health Act* 2013 for involuntary treatment should have been made at the RHH; and

- The apparent lack of timely treatment of Mr Shrimpton in the RHH ED over a period of three and a half hours after being seen by the PEN; whether there were deficits in his supervision whilst waiting; and the lack of an available cubicle – all of which may have contributed to Mr Shrimpton going outside and placing his belt around his neck preparatory to suicide.

As would be apparent from my findings, I am satisfied that Mr Shrimpton, at all relevant times, was able to use and weigh information and make his own decisions in respect of his treatment. Although he lacked insight, he suffered no delusions and was able to understand medical advice.

This being the case, there was nothing that could have compelled staff at the LGH, IPWU and RHH to have treated him involuntarily (apart from during those brief orders discussed). Further, I am satisfied that he received appropriate, professional treatment at each facility. As noted by Dr Haskell, suicide risk varies from assessment to assessment, and I do not make any finding that either assessment was incorrect. The assessments, particularly at the RHH, could have been enhanced by access to records or communication with other THS facilities.

In relation to Mr Shrimpton's wait at the RHH ED, he was triaged appropriately and within the allotted time; however, I am in no doubt that his need to wait for several hours (and hence his action of leaving the ED) was an incident of the endemic lack of staffing and bed availability in the RHH ED. I cannot criticise anyone working at the relevant time for this unsatisfactory situation.

I am also satisfied that CATT follow-up for Mr Shrimpton was properly and promptly arranged. The CATT undertook a review of Mr Shrimpton's case on 18 December, spoke to Mr Shrimpton's general practitioner on 19 December and developed a plan to assist Mr Shrimpton.

After considering these issues, I do not consider that anything more could have been done to prevent Mr Shrimpton's death. He chose not to remain at the IPWU and voluntarily left the RHH with excellent support from Mrs Delbridge and his general practitioner.

I conclude, therefore, that any issues with treatment are not causally connected to Mr Shrimpton's death. However, given that I have made comment, it is appropriate to acknowledge the conclusions of the Root Cause Analysis ("RCA") conducted by the Tasmanian Health Service in respect of its interactions with, and treatment of, Mr Shrimpton in the days before his death. The report sets out the chronology of Mr Shrimpton's treatment from the period he was assessed for detoxification on 29 October 2017 until his death. The investigating team compiling the report came to the following conclusions:

- Mr Shrimpton was assessed in the IPWU by a consultant psychiatrist on the morning of his discharge as he was presenting with suicidal ideation. The assessment concluded that whilst there was some level of suicidal ideation, a transfer to the RHH would not have been useful especially in consideration of the significant bed block in both the ED and the Department of Psychiatry;

- Transport of clients from the north/north-west to Hobart to access the IPWU has been a problem for many years. Catching a Redline bus from these two regions is inadequate;

- Investigation into the reported interaction between Mr Shrimpton and an Alcohol and Drug Services staff member which may have contributed to his early discharge against medical advice has been addressed through appropriate human resources processes;

- The RCA process highlights the ongoing communication issues between departments. At no time during Mr Shrimpton's admission to the RHH ED was there any contact between the IPWU and RHH, despite the fact that those organisations share common electronic patient systems which would show that Mr Shrimpton was a patient of the IPWU. This highlights a gap in providing informed care;

- IPWU admissions and discharges are generally planned, however, when a patient discharges against medical advice there is no appropriate and timely process to notify other health services. A DMR (Digital Medical Record) form that could be completed by nursing staff in the first instance may perhaps address this issue and be visible to other THS health services should the patient present;

- The DMR notes of Mr Shrimpton's RHH admission are unclear in parts and there was no documentation of Mr Shrimpton being released from the protective custody order - this was concerning as Mr Shrimpton had attempted suicide whilst in attendance at the RHH; and

- The *Alcohol Drug Dependency Act* 1968 needs to be reviewed and/or revoked as it is out-dated, not evidence-based and the facility and staffing are not fit for purpose.

The above conclusions specified in the RCA report appear sound. In the conclusion to the report, the reviewing panel sets out a plan for progressing each of the above recommendations. I have now received advice that most of these matters have been resolved or are being progressed. In particular, the *Alcohol and Drug Dependency Act* is currently before Parliament for repeal; a variety of transport options for north/north-western patients scheduled to enter the IPWU are now fully funded; Alcohol and Drug Services, state-wide, has now transitioned to the DMR, with the DMR also planned for implementation in the IPWU (thereby allowing other THS entities to see relevant patient information to inform treatment decisions).

I commend the THS for its thorough review of issues relevant to Mr Shrimpton's treatment shortly before his death and its continuing efforts to remedy those matters.

Mr Shrimpton, unfortunately, suffered severe alcohol and drug dependency with chronic suicidal ideation, conditions that he could not overcome. Despite support, he was not able to engage in the treatment offered to him and he succumbed to his wish to end his life.

The circumstances of Mr Shrimpton's death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I extend my appreciation to Constable Thomas Donnellan, investigating officer, and Ms Libby Newman, forensic nurse, for their assistance in this case.

I convey my sincere condolences to the family and loved ones of Mr Shrimpton.

Dated: 30 June 2020 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner