FINDINGS, COMMENTS and RECOMMENDATIONS of Coroner Olivia McTaggart following the holding of an inquest under the *Coroners Act* 1995 into the death of:

DAMIAN MICHAEL CRUMP

A suppression order has been made pursuant to s 57(1)(c) of the *Coroners Act* 1995 by Coroner McTaggart in respect of the persons referred to in these findings as "CW", "KM", "LK", "JT", "HL" and "ZJ"

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Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Damian Michael Crump, with an inquest held at Hobart in Tasmania, make the following findings:

Hearing Dates

15, 16, 17, 18,19, 22, 23, 24 and 25 March 2021, 23 and 24 August 2021, 3 November 2021, final closing submissions received on 1 June 2022.

Representation

Counsel Assisting the Coroner: M Allen and V Dawkins

Counsel for Department of Health and Human Services and Ambulance Tasmania ("the Department"): G Chen

Counsel for the Attorney General for the State of Tasmania: P Turner SC

Counsel for ZJ, Stephen Elliott, Sally Jones, Amanda Hutchinson, Monica Baker, Brett Gibson and Michael McDermott (Ambulance Tasmania paramedics) T Cox

Counsel for Dr M Rybak: C Law

Counsel for Dr C Georgakas: M Wilkins

Counsel for Australian Paramedics Association: E Voulcaris

Counsel for Health and Community Sector Union: H Pill

Introduction

Mr Damian Michael Crump, aged 36 years, was an intensive care paramedic employed by Ambulance Tasmania (AT). He died by suicide on 23 December 2016 by deliberately consuming fatal quantities of drugs which he had taken without authorisation from the AT headquarters drug store in Hobart in the hours before his death. He was discovered deceased in his car in a supermarket car park in Sorell.

His unnatural death was reported pursuant to the provisions of the *Coroners Act* 1995 ("the *Act*"). Pursuant to the provisions of the *Act*, a very comprehensive investigation was

conducted by Sergeant Terrence McCulloch and First Class Constable Erica Franks ("the investigators") in their role as Coroner's Officers under the *Act.*[1]

Following the investigation, I decided that it was desirable to hold a public inquest into the death of Mr Crump.[2]

The investigation and issues identified

During the investigation into Mr Crump's death, the investigators identified and investigated several issues arising out of Mr Crump's employment with AT which they considered relevant to his death.

One significant issue identified in the investigation was the adequacy of AT systems and processes for the access to, and handling of, medication (particularly, potent drugs of addiction) by paramedics.

Another significant issue was the management of Mr Crump in his employment, in light of known facts about his behaviour and mental health. This aspect of the investigation considered policies and/or systems for dealing with the mental health, welfare and discipline of employees, as well as the training provided to their managers around such issues.

Further, Sergeant McCulloch[3] concluded in his investigation that the ability of AT to address many issues was likely restricted by a lack of depth within staff management and staffing versus management ratios. I will refer to this issue in the finding as being an issue related to the "span of control". Sergeant McCulloch formed the view that there was an unacceptably large span of control, particularly in respect of duty managers over paramedics. Because of this issue, he was of the view that AT was unable to implement necessary changes and there was a lack of operational supervision to oversee compliance. Ultimately, he identified a lack of resourcing as a significant contributor to this situation.

From the investigation, I formed a preliminary view that the following matters were relevant and connected to Mr Crump's death:

a) That Mr Crump died of toxicity as a result of ingesting a large quantity of drugs that he improperly removed from the AT drug store, with no other contributory medical cause of death.

[1] Section 16 of the *Act.*
[2] Section 24 (2) of the *Act* allows a coroner discretion to hold an inquest.
[3] The primary investigator whose signature appears on the report.

b) That Mr Crump was able to improperly access dangerous drugs for his own use from AT stores on multiple other occasions before his death.

c) That AT medication was stolen from the Glenorchy and Mornington stations in September 2016, with Mr Crump suggested as a possible suspect by AT in the police investigation.

d) That no other person was found to be responsible for the stolen medication in September 2016.

e) That the improper removal of medication by Mr Crump in the period leading up to his death was not detected or prevented by AT.

f) That AT medication was stolen from AT by two separate AT employees in 2012 and 2014 respectively, in similar circumstances or manner to Mr Crump.

g) That Mr Crump misused prescription medications and used recreational drugs before his death, and this fact was known by others at AT.

h) That Mr Crump had a "suicide plan" involving ending his life by the age of 40 years, which plan was known to AT colleagues.

i) That Mr Crump, whilst being dedicated to his work and highly knowledgeable, was difficult to manage, inappropriate in his dealings, behaviour and communications at times, and did not always follow clinical guidelines.

j) That there was a lack of appropriate management, discipline and welfare support by AT for Mr Crump (and other employees requiring those things), with evidence that AT managers responsible for these areas were insufficient in number and inadequately trained.

Bearing in mind the above matters, it appeared to me prior to inquest that significant, causal or contributing circumstances leading to Mr Crump's death may have been a failure of AT to appropriately manage him and, if necessary, discipline him or terminate his employment. Appropriate management may well have resulted in a different outcome. Similarly, inadequate responses by AT to the two earlier known cases of stealing medication from AT stores may have allowed Mr Crump to more easily access medication, including the fatal quantity of medication stolen before his death. It also appeared that adequate welfare assistance and support by AT for his drug abuse and mental health issues

may have changed the outcome. [4]

Sergeant McCulloch was the first witness to give evidence at the inquest. He spoke articulately and concisely regarding the evidence and his conclusions in the investigation. In his oral testimony, he summarised the various important aspects of his investigation. I set out, following, selected passages from the transcript of Sergeant McCulloch's evidence explaining the issues and his process in considering their relevance to Mr Crump's employment and death.

Firstly, in relation to the span of control issue, Sergeant McCulloch said;

> *"As I went into the investigation, I became increasingly aware of the lack of management of staff. So span of control became a term that was referred to, and span of control basically is manager to worker ratios. It was quite surprising and AT later identified that in a report from 2017 that they'd had issues in regards to span of control. For instance, the recommended span of control is between 10 and 30 people, but five to eight is considered an optimum level to my understanding, your Honour. In that report, AT indicated that their span of control was 180 full-time – sorry, approximately 180 full-time equivalents, around 300 volunteers to one manager. So that span of control seemed to me to be entirely dysfunctional, and that was one of the biggest surprises to me during this investigation, that one person was perhaps considered responsible for such a large number of people, and many of the issues that perhaps have been identified in this investigation are contributable (sic) to that span of control.*[5]

On this subject, he further stated:

> *"….the staff at AT are extremely intelligent people. Many of them hold multiple degrees in all sorts of things, including management. Most of those degrees and qualifications are ones that they choose to obtain themselves. There was a general indication across the board that the managers don't receive adequate training. There's no – there was no systematic management path for them to follow. For instance, an acting manager or someone trying to get experience in the duty manager role would simply shadow that existing manager and try and learn that way. So there was a management course that I'm aware of that some AT members undertook with police. That was, I believe, our inspectors course. But, again, across the board, the managers or the staff, including existing managers, indicated that they didn't receive sufficient training to be able to perform the role that they were expected to perform. And those issues were perhaps, again, exacerbated by the fact that the span of control was so*

[4] This paragraph replicates Ruling Upon Scope, Annexure "A" paragraph 15. The issues set out are not concluded views but reasons for the scope of the inquest.
[5] T 31.

> *bad. In respect to the management, your Honour, there was certainly – again, many of the staff indicated that there seemed to be a lack of accountability for behaviours at AT. I think some of those behaviours indicated in any of the affidavits could well have been dealt with had there been closer supervision and management of staff. I think, again, that lack of accountability may well have been contributable* (sic) *to a lack of management at lower levels. And, again, it was an identified issue in regards to the lack of managers to be able to implement change within the agency*".[6]

Sergeant McCulloch gave evidence that there was a "flat" management structure in respect of the on-road paramedics so that, for example, on any given shift there would be one duty manager for the entire south of the state responsible for vast numbers of staff. He said that there was no "in-between" management, such as the police equivalent of having many Sergeants supervising a smaller number of Constables. He said that, as it stood, it was a full time job for the existing managers to simply ensure that staff were rostered on to work. He said that the ability for the duty managers to be able to do other duties relevantly including medication management, just simply *"fell off the wagon"*.[7]

He added that a further issue exacerbating the situation was the number of Acting Manager positions. Sergeant McCulloch expressed the opinion that, in acting roles lasting for a period of up to three years, the person occupying such a role could not effectively implement change.

Further, Sergeant McCulloch said that his investigation revealed that there were inadequate mental health structures for a professional agency whose members attend the highest number of traumatic incidents. He gave evidence that the mental health supports for AT staff appeared *ad hoc* and relied solely on two avenues – the Critical Incident Stress Management (CISM) teams consisting of part-time volunteers; and secondly, the Employee Assistance Program (EAP) which was available to the whole of state government.

He said that was very limited professional psychology or psychiatry services available and that there was an apparent widespread lack of confidence in the EAP service. Sergeant McCulloch said that the overwhelming view of the many AT staff that he had interviewed (many of whom made affidavits that were tendered at inquest), was that there was insufficient professional support for their mental health and welfare.[8]

Sergeant McCulloch gave evidence that AT's medication management systems were flawed in many ways, indicating that he had mainly investigated the issues that enabled Mr Crump to

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[6] T 31 and T 32
[7] T 33
[8] T 29.

source medication without coming under scrutiny. He gave the following evidence:

> *"AT conducted a two-month audit of their medication management post Crump and that clearly indicated that Damian Crump was diverting specified medications for at least those two months. I then asked AT to conduct a 12-month audit. They graciously did that and the results from that audit are quite surprising and disturbing in respect to what was found to be the case.*
>
> *…….I guess if you look at it, the amount of medication that was unaccounted for was very surprising. I'll just check some figures, your Honour. The report indicated that there were a total of some 568 entries consisting of some 933 ampoules of specified medications that couldn't be verified. So, in short, there was potential that 933 ampoules of specified medications could've been diverted through that 12-month period. That figure is disturbing to me and that it wasn't picked up on earlier than it had been. It's unlikely that …..all 933 ampoules of medication were diverted. There may have been errors in regards to entries and there was some industrial action undertaken where staff, to my belief, didn't fill out some of the required documentation, but I think it would be fair to say that a substantial amount of that medication was diverted, whether by Crump or other staff. That can't fully be established".*[9]

Sergeant McCulloch told the Court that a proper system of medication management should have involved thorough drug audits. He said that such audits did not occur, merely simple "drug counts" undertaken by duty managers. This meant that there was no cross-referencing of records comparing the outgoing drugs with records of their actual administration to patients.

He considered that a better medication management system, with thorough audits, would have been a significant factor in preventing Mr Crump from improperly accessing medication, including the fatal quantity just before his death. He considered that the unacceptable management span of control, creating an unrealistic workload, prevented the required audits taking place. In the investigation, numerous experienced members of AT expressed the view that the organisation was under resourced, a view held by Sergeant McCulloch as indicated above. He concluded that the lack of resourcing directly impacted upon AT's ability to properly manage medication.

Sergeant McCulloch was also of the opinion that AT did not respond adequately or at all to the thefts of medication in 2012 and 2014 after which it had a chance to tighten its practices

[9] T 34.

to prevent diversion of medication.[10] He also commented, relevant to those thefts and those in September 2016 which were investigated by police, that AT did not conduct sufficient additional investigations.

Sergeant McCulloch also identified as part of the investigation that AT did not, in 2016, have in place a regime for alcohol and drug testing, and still did not have such a system at the time of inquest. He was of the view that such a regime within AT would discourage diversion or misappropriation of drugs.[11]

I observed that Sergeant McCulloch's investigation report was subtitled *"That's just Crumpy!"* This phrase, or an equivalent, was included in the affidavits of several AT paramedics to describe the tolerance by the organisation over many years of Mr Crump's unacceptable and idiosyncratic behaviour.[12] Sergeant McCulloch was of the view that AT's lack of action in terms of welfare and discipline created (at least, in part) the situation where Mr Crump was able to remain unchecked and to engage in diversion of medication for a prolonged period before his death.

At the conclusion of his evidence, Sergeant McCulloch thanked Mr Crump's family, friends, colleagues as well as other agencies for the assistance provided by them, stating that such assistance made the process of investigation a far easier one than it might have been.

Sergeant McCulloch acknowledged Mr Crump's passion for his work and his desire to develop, improve and seek positive change within AT. He also referred in evidence to the intelligence, dedication and focus of the members of AT whose work is often performed in traumatic circumstances.[13]

Sergeant McCulloch's opinions were not challenged by other counsel. It is, of course, my role to determine the weight to be given to his opinions. In fact, it was not challenged by most counsel in the inquest that broadly there was inadequate resourcing within AT, deficient auditing and an inability of management to perform many important functions.

The issue taken by counsel for two interested parties,[14] as further discussed, was the relevance of many of the systemic problems identified in the investigation to the circumstances surrounding the death of Mr Crump and to the jurisdiction of the coroner generally.

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[10] T 40.
[11] T 36 - 37
[12] C 56 Affidavit of Michael Fawcett, C64 affidavit of Stephanie Buell, C78 Affidavit of Andrew Porter.
[13] T 46.
[14] Primarily, counsel for AT and the Department of Health, and Counsel for the paramedics.

Role of the coroner

The functions of a coroner are prescribed by the *Coroners Act* 1995. Under the *Act,* a coroner has jurisdiction to investigate any death that occurs in Tasmania and appears to *"have been unexpected, unnatural or violent or to have resulted directly or indirectly from an accident or injury".*[15] The death of Mr Crump by suicide was unnatural in manner and unexpected.

The coroner's role under the *Act* in investigating any reportable death is inquisitorial. A coroner must investigate the death and determine the matters required by section 28(1) of the *Act*. Those matters include the identity of the deceased, how the deceased died, the cause of death, and where and when the person died.

This process requires a coroner to make these findings without apportioning legal or moral blame for the death.[16] The coroner is to make findings of fact about the death from which others may draw conclusions. A coroner does not charge people with criminal offences, or punish or award compensation to anyone, as such functions are for other courts. A coroner conducting an inquest holds an inquiry into a death with the benefit of oral testimony and documentary evidence to make the required findings.

Recommendations and comments

Importantly, the role of the coroner is also critical in identifying matters contributing to or connected with any individual death with a view to making comments and recommendations for the prevention of further deaths. The *Act* sets out in section 28 these important functions as follows:

> *"(2) A coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.*
>
> *(3) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice."*

Throughout the years, coronial recommendations have been instrumental in many changes and developments creating a safer community. A coroner, pursuant to the powers under the *Act,* may make comments and recommendations about matters which have sufficient nexus to a death, even though the matter the subject of the comment of the recommendation

[15] Section 3 – definition of *"reportable death"*.
[16] *R v Tennent; Ex Parte Jager* [2000] TASSC 64.

cannot be necessarily found to be a matter which would, if it had been present, have averted death.[17]

Standard of proof for findings

The standard of proof at an inquest is the civil standard. Therefore, where findings of fact are made, a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, where findings may reflect adversely upon an individual, it is well-settled that the standard applicable is that expressed in *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation against anyone is proved should be approached with a good deal of caution.[18]

Not bound by rules of evidence

The coroner is not bound by the rules of evidence in holding an inquest and may be informed and conduct an inquest in any manner the coroner reasonably thinks fit.[19] To be properly received at an inquest, the evidence must be capable in some way of assisting the coroner to determine the matters under section 28 (1) or, in appropriate circumstances, to assist in making a comment or recommendation. The coroner has significant latitude in receiving evidence, providing the evidence is something more than *"mere supposition, guess or intuitive hypothesis"*.[20] The question of weight to be given to any evidence tendered at an inquest is a question for the coroner after receiving submissions from interested parties.

Procedural fairness

The coronial process, including an inquest, is subject to the requirement to afford procedural fairness.[21] Specifically, section 52 of the *Act* provides that a person with a "sufficient interest" may be represented by a legal practitioner, call and examine or cross-examine witnesses, and make submissions, at an inquest.

Generally, any person (including any legal entity) who might be the subject of an adverse finding or comment will have a sufficient interest. In the context of many coronial inquiries, "adverse comment" may mean criticism of a person or organisation for deficits in procedures or failure to adhere to prescribed standards which may be connected to a death.

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[17] See, for example, *Doomadgee & Anor v Deputy State Coroner Clements & Ors [2005] QSC 357 Hurley v Deputy State Coroner Clements & Ors* [2005] QSC 357 paragraphs[26] to [33]
[18] (1938) 60 CLR 336 (see in particular Dixon J at page 362).
[19] Section 51 of the *Act*.
[20] See *Ruling and reasons* of Coroner Cooper in the *Inquest into the deaths of Craig Nigel Gleeson, Alistair Michael Lucas and Michael George Welsh* dated 1 February 2018, and the authorities referred to therein.
[21] See *Annetts v McCann*, (1990) 170 CLR 596.

The class of persons who have a sufficient interest under section 52 extends to family members.[22] The section allows the coroner some discretion regarding determination of sufficiency of interest. In this case, I determined that it was also appropriate, given the issues and the number of AT employees participating in the inquest, that legal representatives for the two associations appear and question witnesses.

Importantly, however, all parties identified as potentially being subject to adverse comment were provided with full disclosure of the evidence well prior to inquest, and were legally represented. These parties, through their legal representatives, were provided with a full opportunity to examine witnesses, call witnesses and make submissions.

Scope of the inquest

In setting the scope, admitting evidence and conducting an inquest generally, a coroner must bear steadily in mind his or her duty to discharge the obligation imposed by section 28 (1) (b) of the *Act*, being to make findings as to *how* death occurred. *'How'* has been determined to mean *'by what means and in what circumstances',*[23] a phrase involving the application of the ordinary concepts of legal causation.[24] Any coronial inquest necessarily involves a consideration of the circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

In *Conway v Jerram*, the members of the New South Wales Court of Appeal observed that the scope of an inquest is a matter for the coroner to determine using both proper discretion and common sense.[25] Campbell JA referred to *Harmsworth v State Coroner* in which Nathan J discussed the fact that the enquiry must be relevant in the legal sense to the death and that a coroner is not permitted to conduct a "*wide, prolix and indeterminate*" inquest surrounding remote issues.[26]
The judgments of *Re State Coroner; Ex parte Minister for Health*[27] *and R v Doogan; Ex parte Lucas-Smith*[28] also emphasise that the coroner is not authorised within his or her proper limits to undertake a roving enquiry into any possible causal connection, no matter how tenuous, between a particular fact or circumstance and the death of the deceased.

The coroner's function of finding *how death occurred* usually requires the coroner to make an assessment for the purposes of the scope of the inquiry as to the substantial or operating

[22] *Annetts v McCann*, supra.
[23] See *Atkinson v Morrow* [2005] QCA 353.
[24] See *March v E. & M.H. Stramare Pty. Limited and Another [*1990 – 1991] 171 CLR 506.
[25] [2011] NSWCA 319 at [47-48].
[26] *Harmsworth v State Coroner* [1989] VR 989.
[27] [2009] WASCA 165.
[28] [2005] ACTSC 74.

causes of the death. These causes should not be merely part of the background or too remote. The question of causation should be determined by applying common sense to the facts and not resolved by speculative or hypothetical theories.[29]

In *Re the State Coroner; Ex Parte the Minister for Health,* Buss JA stated:[30]

> *"…In my opinion, a construction of s25(1)(b) which entitles and requires the coroner to find, if possible, by what means and in what circumstances the death occurred reflects the public interest which is protected and advanced by a coronial investigation…Also, this construction is consistent with the decision of the Court of Appeal of Queensland in Atkinson on a comparable statutory provision...*
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> *44. The coroner, in finding, if possible 'the cause of death', is not confined or restricted by concepts such as 'direct cause', 'direct manner', 'direct and natural cause', 'proximate cause' or the 'real or effective cause'. Similarly, a coroner is not confined or restricted to a cause that was reasonably foreseeable…*
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> *47. It will be necessary, in each inquest, to delineate those acts, omissions and circumstances which are, at least potentially, to be characterised as causing or a cause of death of the deceased. This is to be undertaken by applying ordinary common sense and experience to the facts of the particular case."*

Additionally, the wide powers given to a coroner under s28(2) to make recommendations *"with respect to ways of preventing further deaths"* also support a broad construction of powers to make findings under s28(1) as to *"how death occurred"* and the *"cause of death"* within the parameters of the authorities, such as those cited above.

It is apparent that the circumstances of death which require examination and causal analysis vary greatly from case to case. Some matters require examination of circumstances which are temporally confined. However, the death of Mr Crump is not such a case. The circumstances extend to those organisational matters as referred to in evidence by Sergeant McCulloch and set out in the introduction.

After receiving the complete documentary investigation file, I determined that the issues to be examined at inquest, pursuant to s 28 of the *Coroners Act 1995* should be as follows:

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[29] See for example: *E & MH March v Stramare Pty Ltd* (1991) 171 CLR 506; *Campbell v The Queen* (1981) WAR 286; *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1; and *Atkinson v Morrow and Anor* [2005] QCA 353.

[30] At [42].

1. The circumstances surrounding the death of Damian Michael Crump to enable findings to be made, if possible, under s 28(1) of the *Coroners Act 1995*.

2. The circumstances of and the response of AT to the reported missing and/or unauthorised taking of morphine and/or other drugs from AT Stations in Southern Tasmania in approximately September 2016.

3. Any established systems and/or policies providing for the storage, security, access and accounting of drugs and associated paraphernalia of drugs held by AT for purposes connected with its authorised functions, both in 2016 and at the time of this Inquest.

4. Any misuse of drugs by Damian Crump, and other employees of AT, as relevant to the circumstances of Mr Crump's death, including any knowledge of and response to such use by AT.

5. The investigation, internal management of and organisational response by AT to the suspected misuse and/or theft of drugs held by AT prior to Mr Crump's death by two other employees.

6. Any established mental health and welfare systems or policies relating to or providing for support to Mr Crump and other employees of AT in 2016. The availability and use of such systems and/or policies at the time of the inquest.

7. The capacity and ability of those occupying relevant supervisory positions in AT either substantively or occasionally, both in 2016 and at the time of inquest with respect to:

    a. Identifying and assisting employees with mental health issues;

    b. Managing the risks, if any, that those issues posed to both patient and staff safety;

    c. The pathways available to managers to deal with those issues;

    d. Assistance available to managers in dealing with employees with mental health issues; and

    e. Any management training provided by AT.

The scope of the inquest, as above, was determined after several case management conferences in which all counsel were heard. Counsel for the Department of Health

maintained her submission that I was not permitted, by the provisions of the *Act*, to examine the issues at points 5, 6 and 7, all relating to organisational issues within AT. She submitted that such examination was tantamount to conducting an investigation into the operations of AT without the necessary connection to the death of Mr Crump as required by the provisions of section 28 of the *Act*.

Ruling on scope 23 December 2020

On 23 December 2020 I delivered a written ruling to finalise the scope of the inquest. I ruled that I was permitted to enquire into organisational issues within AT that appeared to be connected with Mr Crump's death and therefore points 5, 6 and 7 remained as part of the scope.

In the ruling, I determined that the affidavit evidence from witnesses surrounding such issues may well form part of the circumstances of death (that is, *how* death occurred) and therefore the requisite connection had been established. I determined that the evidence indicated that it may well be that significant causal or contributing circumstances leading to Mr Crump's death involved a failure of AT to appropriately manage him and, if necessary, to discipline him or terminate his employment. Appropriate management may well have resulted in a different outcome. Similarly, inadequate responses by AT to the two earlier known cases of stealing medication from AT stores may have allowed Mr Crump to more easily access medication, including the fatal quantity of medication stolen before his death. Further, adequate welfare assistance and support by AT for his drug abuse and mental health issues may have changed the outcome.

The ruling regarding the scope of inquest is annexed and marked 'A'.

Evidence in the investigation

The evidence

The evidence comprised documentary exhibits and oral testimony from witnesses at inquest.

The 164 documentary exhibits are set out in the List of Exhibits annexed to these findings and marked 'B'.

These documentary exhibits comprised evidence in the following general categories;

- Affidavits from Mr Crump's family, friends and colleagues;
- Affidavits confirming identification;
- Affidavits of the forensic pathologist and toxicologist;

- Affidavit of the witness who discovered Mr Crump's vehicle;
- Affidavits of police officers investigating Mr Crump's death;
- Affidavits of AT managers and senior personnel;
- Affidavits and statements of Mr Crump's treating medical professionals;
- Affidavits of Pharmaceutical Services Branch employees;
- Affidavits of two former AT employees who, before Mr Crump's death, were involved in unauthorised removal of medication from AT premises;
- Mr Crump's medical and hospital records;
- AT drug store records;
- Photographs, electronic evidence (including emails, text messages, computer downloads) and other forensic evidence; and
- AT organisational documents, research papers, reviews, policies and procedures.

Of the many witnesses who provided affidavits, statutory declarations, statements or reports in documentary form, 32 witnesses were called to give evidence at inquest. The names and positions of these witnesses is annexed to these findings and marked 'C'.

Under the *Act*, the coroner is empowered to summons witnesses if the coroner reasonably believes they are necessary for the purposes of an inquest.[31] I was satisfied, prior to inquest, that the witnesses to be summonsed were likely to provide oral testimony that could assist me in performing my functions and, in the case of several witnesses, to ensure procedural fairness where adverse comment or criticism may have been contemplated. The proposed witnesses to be called were discussed with all counsel in a series of case management conferences. No counsel for any interested party sought to call any additional witnesses. I am also satisfied that there were no other witnesses who should have given oral testimony who could have assisted substantially with the issues in the inquest.

Further, Sergeant McCulloch's investigation report, amounting to 360 pages, was provided to all interested parties and tendered as an aid to the exhibits with some small agreed redactions. The report particularly contained very useful summaries of the documentary evidence.

Objections to evidence

There were objections from counsel for AT to the admission of large portions of the affidavit evidence, including affidavits that had been tendered in their entirety at the beginning

[31] Section 53 (1) (a) of the *Act*.

of the inquest by counsel assisting with no apparent objection by any other counsel. Unfortunately, the situation surrounding the process of making and resolving objections to affidavit evidence was marred by late notice, lack of specificity in the objections and confusion in communication.

On 3 June 2021, whilst the inquest was part heard, I handed down a written ruling concerning objections to a significant body of affidavit evidence. This ruling is annexed and marked with the letter 'D'. It is unnecessary to include the original attachment of the large volume of affidavit material that accompanied the ruling.

This ruling sets out the history of the issue concerning objections, although the matter deserves some further attention in this finding.

To put the issue of objections in context, there was a significant body of affidavit evidence from 49 individual AT paramedics or former AT paramedics who occupied (or had occupied) a variety of roles within that organisation. Many of those provided evidence concerning interactions with or knowledge of Mr Crump, including his drug use and mental state. Many of the affidavits from these witnesses also covered matters such as their knowledge of medication management processes, mental health and welfare systems, and other systemic issues that were said to have relevance to the matters within the scope of the inquest.

Many of the affidavits were written in a personal style whereby the deponents described in detail their own particular experiences to underpin their reasoning regarding inadequacy of management, welfare systems and disciplinary processes for paramedics. Some of the language used by the deponents was emotive, and relevant material was often intertwined with material of possibly little relevance. Some of the evidence was sensitive in content and portrayed negative judgments of colleagues and superiors within AT. [32]

Nevertheless, across the body of affidavit evidence presented, there were consistent criticisms of the organisation about inadequate medication management, inadequate number of managers (and the consequences thereof) and lack of welfare support for paramedics. [33]

As noted, objections from counsel for AT were made and ruled upon during the inquest in respect of affidavits of witnesses who had presented in court to give oral testimony.

Once the inquest was adjourned after the first nine sitting days, objections were made in respect of large portions of 26 affidavits where the deponents were not called to give oral

[32] This paragraph extracted from Ruling dated 3 June 2021, paragraph 26.
[33] Ibid, paragraph 27.

testimony at inquest or who were due to give evidence when the inquest resumed in August 2021.

The main grounds of objection on the basis of irrelevancy submitted by counsel were as follows:

i. Mr Crump's personality and the deponent's relationship with Mr Crump;

ii. Mr Crump's recreational drug use;

iii. Opinions as to management structures and training of managers;

iv. Opinions as to staffing levels;

v. Speculation about Mr Crump's drug use and theft, behaviour, medical treatment and work relationships, and management or disciplinary action in respect of him by AT;

vi. The welfare system at AT, the deponent's experience with the welfare system and opinion on the efficacy of the welfare system;

vii. Opinions on the need for drug and alcohol testing within AT;

viii. Matters relating to other AT employees, such as mental health issues and AT's response to them

ix. Staff promotion practices and acting roles; and

x. Comparisons between AT and interstate ambulance services in various respects.[34]

In my view, these grounds of objection amounted to a complaint about the scope of the inquest rather than a submission upon whether the evidence was or was not relevant in respect of the existing scope. The scope, in itself, had already been the subject of a written ruling.

Counsel assisting, Mr Allen, made submissions throughout the inquest, in response to the objections, that, with some limited exceptions, the evidence was relevant to the matters being examined at inquest. He also submitted that the matters for examination, listed in the scope, were integrally related to the issue of how Mr Crump, in the context of the organisational structure, culture and deficits, was able to access medication in the months

[34] Ibid paragraph 49.

before his death without sanction or prevention and then to end his life by similar unauthorised use of AT medication.

Mr Allan further submitted that the list of areas of alleged irrelevance lacked context and that the lack of proper management of Mr Crump's inappropriate behaviour at work and his widely known suicidality were very significant circumstances surrounding his death.

In my written ruling of 3 June 2021, consistent with my oral rulings during the inquest, I determined that, for the large part, the affidavit evidence was admissible as being relevant to the scope issues, subject to assessing weight.

The AT witnesses were experienced paramedics, some in management positions and most of whom had knowledge and dealings with Mr Crump. I determined that their opinions on issues such as inadequacies of management and welfare processes, as well as their observations and opinions of Mr Crump's behaviour and management, was evidence within the scope of the inquest.

The evidence in this inquest was voluminous and the process of isolating objections should ideally have been undertaken in a cooperative process between counsel before the inquest, with a preliminary ruling sought if necessary. [35] Because this did not occur, there were delays and confusion relating to the making of and resolving evidentiary objections - a most unfortunate situation in a sensitive inquest.

This highlights the importance of counsel in case management processes identifying, at an early stage, any documentary evidence that is the subject of an objection, in order that a timely ruling may be given before the inquest.

There is often nothing to be gained in occupying the coronial process with lengthy objections to evidence, when the evidence in question might assist the inquiry or, ultimately, be given little weight. As observed by Muir J in *Doomadgee v Clements,* it will normally be inappropriate to seek from a coroner a ruling that one piece of evidence or another is inadmissible or irrelevant as if the coroner were conducting a civil or criminal trial.[36]

Counsel's closing submissions regarding scope and jurisdiction

In written closing submissions following the conclusion of evidence at the inquest, counsel for the Department of Health and counsel for managers Monica Baker and Amanda Hutchinson maintained that numerous proposed findings, comments and recommendations

[35] Ibid, paragraph 27.
[36] *Doomadgee and Anor v Deputy State Coroner Clements and Ors* [2005]QSC 357 at [36]

submitted by counsel assisting in their closing submissions were outside the proper ambit of section 28(1) of the *Act* and thus outside the coronial jurisdiction.[37]

Again, the matters specified in their submissions as being objectionable were essentially the same matters that were the subject of submissions upon scope and in objecting to evidence as referred to above. The essence of the unrelenting complaint was that many of the matters traversed bore little or no connection to the cause and circumstances of Mr Crump's death.[38]

I have stated in my rulings why there is a potential causal connection between the circumstances of Mr Crump's death and the organisational issues specified in the scope. Whilst I do not consider that, for the most part, the contrary submissions have force, I am mindful that they are maintained in respect of many areas of this inquiry and I discuss them further in this finding as appropriate.

Counsel for the Department suggested in her closing submissions, that parts of the documentary and oral evidence in the inquest was directed at inquiring into Mr Crump's death solely for the purpose of enabling comments to be made, submitting: [39]

> *"The comments in Harmsworth and Hallenstein are pertinent to the present case. Much of what was traversed during the hearing of the inquest was not, it is submitted, relevant to making the necessary findings as demanded by section 28(1)(b) and (c) of the Act."*

With respect to counsel, this approach assumes an overly narrow interpretation of the words *"connected to death"* in s 28(3).

In *Thales Australia Limited v The Coroners Court of Victoria,* Beach J affirms the approach in *Doomadgee v Clements,* stating as follows:

> *"Whilst the words "connected with" are capable of describing a spectrum of relationships ranging from direct and immediate to tenuous and remote, I agree with the interpretation given to these words by Muir J in Doomadgee v Clements. In that case, Muir J had to consider s 46 of the Coroners Act 2003 (Qld), which permitted a Coroner to comment on anything "connected with a death". His Honour noted that there was no warrant for reading "connected with" as meaning only "directly connected with". His Honour went on:*

[37] For example, see paragraphs 2 and 3 of Closing Submissions for the Secretary of the Department of Health.
[38] Ibid, paragraph 20.
[39] Submissions of Counsel for the Department of Health, paragraphs 14 – 17

> *"Something connected with a death may be as diverse as the breakdown of a video surveillance system, the reporting of the death, a police investigation into the circumstances surrounding the death, and practices at the police station or watchhouse concerned."*
>
> *Similarly, relevant occupational health and safety standards and protocols at Thales in relation to the work the deceased was doing at the time of his death are, in my view, matters connected with the death within the meaning of s 67(3) and s 72(2) of the Coroners Act."*.[40]

The decision of *Attorney General v Copper Mines of Tasmania Pty Ltd,* in which Blow C J analysed the authorities, makes it plain that the coroner is obliged to take an expansive or inclusive approach towards the scope of an investigation. [41] This proposition is reinforced by the broad powers given to a coroner throughout the *Act* and the functions being remedial in nature. In addition, there is use of the wide expressions "connected with" and "relates to" within the provisions empowering the making of recommendations and comments.[42]

A coroner should steadily bear in mind, however, that there are limits to the jurisdiction, and that much of the evidence properly received as tending to show the existence or non-existence of facts relevant to an issue to be determined, may ultimately be given little or no weight. [43]

Mr Crump's background

General Background

Mr Crump was born in Hobart on 4 September 1980 to parents Mrs Alanah Eva Crump (nee Rogers) and Mr Michael William Crump.[44] He had a younger brother, Mr Cameron Paul Crump, born in 1983. Mr Crump was 36 years old at the time of his death. He was not married or in a significant relationship and did not have children.

Mr Crump grew up in Lindisfarne. He attended Lindisfarne Primary School, Rose Bay High School and Rosny College. Mr Crump worked from the age of 15 years at Coles Eastlands on weekends and sometimes after school. [45] At school, Mr Crump showed an interest in the medical field.[46]

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[40] [2011] VSC 133 at paragraph 75 and 76.
[41] [2019] TASFC 4 at paragraph 39, citing *Priest v West* at [6]
[42] *Doomadgee*, supra at paras [30]-[33]
[43] Blows CJ in *Copper Mines* at [41]
[44] C14 Affidavit – Alanah Eva Crump.
[45] C14 Affidavit – Alanah Eva Crump.
[46] C14, C47A Affidavits – Alanah Eva Crump, Daryl Long.

After completing grade 12, Mr Crump enrolled in a nursing degree at the University of Tasmania. He studied the first two years of that degree in Launceston and the final year in Hobart. He graduated from his Bachelor of Nursing degree in 2001 and enrolled with the Nursing Board of Tasmania. After successfully applying to join AT after graduation, he commenced his training as a paramedic in February 2002 in Hobart. He became a qualified paramedic and later qualified as an intensive care paramedic. An intensive care paramedic (ICP) is a highly skilled paramedic clinician who can perform more complex clinical interventions and administer medication above that of a paramedic. To become an ICP, Mr Crump completed the 12 month ICP course within AT which combined both theory and on road clinical supervision and mentoring. [47]

In the year before his death, Mr Crump also held the position of Acting Clinical Support Officer (CSO) within the Southern Regional Training Unit. CSOs provide clinical skills, instruction and assessment; and also provide on-road clinical skills backup, as required[48].

Mr Crump was continuously employed with AT until his death. He was described by numerous witnesses as highly intelligent, devoted to his work and passionate about acquiring clinical knowledge and sharing it with his colleagues.

Mr Crump lived with his parents in Hobart until he bought his house in Siandra Crescent, Geilston Bay in about 2008.[49] His friend, Mr Daryl Long, lived with him at that house until his death. Mr Crump had a dog named Linc[50].

Daryl Long had been friends with Mr Crump since their school days. Mr Long said in his affidavit *"Growing up and into his twenties, Crumpy was always bright, bubbly, confident and very very smart. There was never any indication in those days that he had any kind of mental health issues. Crumpy was the person that everyone would turn to if they were having trouble of any kind".*[51]

Mr Long further described Mr Crump as being easy to live with and was a person who never complained about anything. He said that Mr Crump had never really spoken to him about having poor mental health until he admitted himself to St Helen's Hospital a few years after he started work with AT. Subsequently, he was more open with Mr Long about being unwell and having depression.[52]

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[47] C159 Affidavit of Neil Kirby, paragraph 10.
[48] Ibid, paragraph 11.
[49] C47 Affidavit – Daryl Long.
[50] C 48 Affidavit – Dean Long, page 2.
[51] C 47A Affidavit of Daryl Long, page 2.
[52] Ibid, page 2.

Mr Long's brother, Mr Dean Long, was also a good friend of Mr Crump. Dean Long described Mr Crump as a "happy kind of guy" but with an underlying scepticism in his views. He recounted in his affidavit Mr Crump's enjoyment of his aquarium, movies, cars and building Lego. He also described Mr Crump as using ecstasy recreationally and said that Mr Crump was often the person who would obtain the substance for others. [53]

Daryl Long also said that Mr Crump used "ecstasy or acid" to go out but did not recall that he would use "speed or ice" and did not see him injecting himself with drugs.[54]

Mr Crump struggled with his sexuality, and told only his closest friends that he was homosexual but generally would not talk openly about it. He did not disclose his sexuality to his mother although she was aware of his struggle with it and was very supportive and loving.[55] He informed others that he thought he would not have a significant relationship.[56] Mr Crump had a difficult relationship with his father, who had strong views about homosexuality.[57]

Mrs Crump described her son's long-standing issues with depression and recounted his history of being given different diagnoses, medication and treatments over many years. [58]

Daryl Long described that, in the last six months of Mr Crump's life, he noticed a "remarkable decline" in everything he did.[59] Mr Long's observations in this regard correspond with a large amount of other evidence in the investigation, as will be discussed. Mr Long said that, during this time, Mr Crump had days of being withdrawn and would not come out of his bedroom. Mr Long said in his affidavit that he offered to talk to Mr Crump if he needed to but that he declined the offers. [60]

Mr Long said that Mr Crump's good friends and AT colleagues, JT and Ms Monica Baker, told Mr Long on the phone that they were worried about his mental health. Mr Long said that Ms Baker and Mr Crump "basically spoke on the phone every night" with Ms Baker trying to help him.[61]

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[53] C 48 Affidavit – Dean Long, page 2.
[54] C 47A Affidavit of Daryl Long pages 2 and 3.
[55] C 14 Affidavit of Alanah Crump, page 3.
[56] C47, C36 Affidavits – Daryl Long, Monica Baker.
[57] C20 Affidavit – JT.
[58] C 14 Affidavit of Alanah Crump, page 3
[59] See 47A Affidavit of Daryl Long, page 2.
[60] Ibid, page 3.
[61] Ibid, page 3.

Health

Mr Crump was diagnosed with depression in his early twenties, although records indicated that he had suffered depression since age 14 years.[62] Dr Marzena Rybak, a psychiatrist who had treated Mr Crump, formed the opinion that he suffered episodic major depressive disorder, first occurring at the age of 15 years, then at 18 years and then again at 24 years.[63] Mr Crump attended the Bayfield Medical Centre, which later became the Clarence GP Super Clinic, from 2001 to 2016.

On 7 November 2008, Dr Alice Frampton (at the Bayfield Medical Centre) referred Mr Crump to psychiatrist, Dr Stephanie Auchincloss.[64] Dr Auchincloss saw Mr Crump on three occasions between 2008 and April 2012. Subsequently, Mr Crump did not attend a follow-up appointment with her because she had declined to prescribe him medication at the maximum dosage.[65]

Mr Crump subsequently attended the Lindisfarne Clinic and saw general practitioner, Dr Mariusz Rybak, from 3 September 2012 to 16 June 2015. It was then that Mr Crump was referred to psychiatrist Dr Marzena Rybak[66] for an initial assessment, which occurred on 28 May 2013.[67] Noting the sibling relationship between Dr Mariusz Rybak and Dr Marzena Rybak, from this point I refer to Dr Marzena Rybak as "Dr Rybak". There is little further reference to Dr Mariusz Rybak in this finding.

Dr Rybak treated Mr Crump until 11 June 2015. Initially, her assessment was that he was profoundly biologically depressed, with symptoms including exhaustion, lack of motivation, severe anxiety and anhedonia. She outlined in her affidavit the numerous medications he had been prescribed, including that he had been taking double doses of one medication (fluoxetine) contrary to his general practitioner's advice.[68]

Dr Rybak organised for Mr Crump to be hospitalised for a lengthy inpatient admission at St Helens Private Hospital on 10 June 2013. Between that date and 30 July 2013 Mr Crump underwent 12 sessions of electroconvulsive therapy (ECT). He also completed 20 sessions of transcranial magnetic stimulation (TMS).[69] His medication was also adjusted.

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[62] C11 – Medical Records: The Lindisfarne Clinic – Letter 27/9/13 Dr Timothy Begbie to Dr Mariusz Rybak, 32.
[63] C11 – Medical Records The Lindisfarne Clinic – Letter Dr Marzena Rybak 5 June 2013, 33.
[64] C12 – Medical Records Clarence GP Super Clinic – 'Visit 15'.
[65] C 162 – Affidavit Dr Ian Sale, page 2.
[66] Sister of Mariusz Rybak – C162 affidavit of Dr Ian Sale, page 1.
[67] C11 – Medical Records The Lindisfarne Clinic – Letter Dr Marzena Rybak 5 June 2013, 33.
[68] C 161 Affidavit Dr Marzena Rybak, page 2.
[69] C161 Affidavit Dr Marzena Rybak pages 2 and 3.

Mr Crump improved significantly after his hospital treatment, although as his illness relapsed and his mood became low, he underwent further medication adjustment and ECT under Dr Rybak throughout 2014. He also requested that Dr Rybak prescribe him ketamine, a highly addictive drug which was, at that stage, only an experimental treatment for depressive illness. She did not prescribe him that medication. [70]

Medical records indicate that Mr Crump was prescribed numerous medications for his depressive illness over a lengthy period of time. These included sertraline, escitalopram, duloxetine, desvenlafaxine, mirtazapine, amitriptyline, aripiprazole, alprazolam and lithium.

In February 2016 Mr Crump reduced his lithium dose without medical advice and had requested Kalma (alprazolam) tablets from Dr Frampton by taking into an appointment an expired bottle with the sticker removed.[71] Alprazolam is a potentially addictive benzodiazepine prescribed to relieve anxiety. Dr Frampton noted that Mr Crump was sweaty and agitated and she was concerned that he may be exhibiting medication side effects or drug withdrawal. Mr Crump also, inappropriately, made reference to Dr Rybak in very coarse terms, conveying that she was liberal in prescribing alprazolam. After this consultation, Dr Frampton made a notification to PSB under Section 59B of the *Poisons Act* 1971, that Mr Crump was exhibiting drug seeking behaviour.[72]

On 26 May 2016, Dr Frampton saw Mr Crump for renewal of his standard prescriptions and described the unusual consultation in her affidavit. She stated that Mr Crump hesitated to roll up his sleeve for a routine blood pressure check, and when he did, he randomly spoke of ambulance patients who were tolerant to opioids. Dr Frampton was surprised at Mr Crump's behaviour. She did not see any evidence of intravenous drug use but described Mr Crump as being "dismissive" when she asked him why he had hesitated to expose his arm.

On 28 May 2016, Mr Crump wrote a letter to Dr Frampton providing 'feedback' which is indicates his perspective on medication and his perceived knowledge at the time.[73] The letter in part sought to explain his attitude to not rolling up his sleeves at the consultation.[74]

The letter was lengthy and rambling and written to convey his disappointment in Dr Frampton apparently questioning whether he used drugs illicitly. He wrote in a patronising, intellectually superior tone, replete with his own medical opinions concerning treatment of his condition. He was critical of many of his treating health practitioners (with the exception

[70] Ibid, pages 3 and 4.
[71] C12 – Medical Records Clarence GP Super Clinic – 'Document 7.RTF'
[72] C12 – Medical Records Clarence GP Super Clinic- 'Document 7 Page 140164_52.JPG' and 'Visit 27'.
[73] C12 – Medical Records Clarence GP Super Clinic - 'Document 8 Page 140165_67.JPG'.
[74] C12 – Medical Records Clarence GP Super Clinic – 'Visit 28'.

of Dr Rybak) and complained about their lack of trust in him managing the doses of his medication himself. By that letter, he ended the doctor/patient relationship with Dr Frampton.

On 1 August 2016, Mr Crump attended a new practice, the Rosny Park Family Practice, and saw Dr Columbine Mullins. This was his final consultation with a doctor before his death.[75]

On that date, Mr Crump discussed with Dr Mullins his history of depression and she prescribed only his standard prescriptions for lithium carbonate (250mg twice daily), and sertraline (100mg daily) and made arrangements for the appropriate blood and urine tests. The notes of this consultation are unremarkable, with Mr Crump telling Dr Mullins that he was "much better" on his current medication regime and that his mood was good. [76]

Mr Crump did not consult with Dr Rybak or any other psychiatrist throughout 2016. He did not attend a scheduled appointment with Dr Rybak in April 2016, later telling Dr Frampton that he would be wasting her (Dr Rybak's) time. [77] He was not seeing other mental health professionals and had not presented to any hospital. He did not attend for the blood or urine tests ordered by Dr Mullins at his last appointment.[78]

In summary, Mr Crump suffered from major depressive disorder and anxiety. He did not attribute his condition to effects of his work at AT in consultations with his medical professionals. To the contrary, he expressed that he gained purpose and motivation from his work. It is possible that stressors from his work may have contributed to his symptoms at times but the evidence overwhelmingly suggests that his long standing and severe mental health symptoms had been present since his teenage years.

It is clear that his symptoms severely affected his happiness, well-being and ability to function socially and in intimate relationships. As will be further discussed, multiple incidents of his problematic behaviour at work over the time of his employment were driven by his mental health issues. His symptoms were not resolved by the medication prescribed and the many ECT treatments he had undergone.

Additionally, Mr Crump was unwilling to attend many referrals for psychological therapy. If he had done so, he may have been able to deal with issues surrounding his sexuality which clearly exacerbated his symptoms. Sadly, even to Dr Rybak, he maintained that he was

[75] C 10 Medical Records Rosny Park Medical Practice.
[76] C10 – Medical Records Rosny Park Family Practice, 1.
[77] C 160, Affidavit of Dr Alice Frampton, page 2.
[78] Ibid, there are no pathology results on the medical file.

heterosexual and that his inability to form a long-term relationship was solely due to his illness. [79]

He openly rejected conservative treatments, was focused on chemical solutions for his condition, and promoted self-medicating by adjusting his own doses.[80] Unfortunately, Mr Crump's arrogant attitude that he was better able to treat himself than the majority of his own health professionals, did not help resolve his condition. His use of illicit substances had turned from "party" drugs to dangerous drugs of addiction in about the last 12 months of his life. His treating practitioners were conscious of his drug-seeking behaviour, manifesting in requests for addictive prescription medication. They were also aware of his non-compliance with prescribed doses.

In early 2016, Dr Frampton became concerned about his use of addictive illicit drugs. She notified Dr Rybak of the matter but Mr Crump chose not to attend her appointment. Dr Rybak had accepted Mr Crump's assertions that he did not use illicit drugs and, until the notification from Dr Frampton, did not have any reason to suspect otherwise.

Thus, Mr Crump was able to hide his illicit drug use during 2016 from his doctors. When suspicions arose, he changed general practitioners, stopped seeing his psychiatrist, and did not undergo the necessary blood and urine tests to monitor his medication. I have no doubt that these were measures taken to avoid detection of his increasingly heavy addiction. Indeed, he also successfully hid his addiction from many others, as will be discussed.

Although several of his AT colleagues were aware that Mr Crump expressed the desire to end his life by the age of 40 years, this statement of intention was never made to his doctors.

Mrs Crump told Constable Sophie Langdale on 23 December 2016 that her son had attempted suicide before Christmas two or three years before his death by tying a plastic bag over his head. Mrs Crump did not mention this in her later affidavit but, with the detailed description given by Constable Langdale, I accept that Mr Crump made this attempt to end his life. [81] Again, it appears that none of Mr Crump's treating doctors were aware of this significant incident because he did not tell any of them.

Even during his lowest of moods, he denied to his doctors that he had suicidal thoughts. [82]

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[79] C 161 Affidavit Dr Rybak, page 5.
[80] C 12 Medical Records Clarence GP Super Clinic - 'Document 8 Page 140165_67.JPG'.
[81] C 24, Affidavit of Constable Sophie Langdale and Subject Report, page 15 – summary of discussion between Constable Sophie Langdale and Mrs Crump.
[82] For, example C 161, Affidavit Dr Rybak page 5.

Dr Rybak said in her affidavit that, during her contacts with Mr Crump, suicidality was never an issue. She said that even when he felt the lowest and required ECT treatment, he never gave any indication of having suicidal thoughts. She was not aware that he had ever made suicide attempts or exhibited self-harming behaviour.[83] She reinforced in evidence that Mr Crump categorically denied suicidal intentions when she asked him, and had never self-harmed or attempted suicide to her knowledge.[84]

Similarly, he denied suicidal ideation or plan to Dr Frampton, simply stating that he thought about death sometimes.

It would seem from the evidence as a whole, however, that Mr Crump suffered from chronic suicidal ideation and intentionally did not disclose those thoughts to his doctors, possibly because of concern that he may be prevented from continuing in his work.

The medical treatment provided to Mr Crump was of a high standard but was limited in significant respects by Mr Crump's own unwillingness to disclose critical matters to his doctors and refusal to accept a range of treatment options that could have helped him.

Mr Crump's employment

Mr Crump was considered by AT colleagues to be an excellent clinician, with high level clinical knowledge and to have a good manner with patients.[85] He was described as a passionate individual who greatly enjoyed the paramedic role.[86] He was prolific in researching and writing papers on clinical matters and sharing them with other staff to improve the level of knowledge and treatment provided to patients. For this purpose, Mr Crump set up a Facebook Group nicknamed 'The Crump Academy of Fine Learning'. [87] It seems that Mr Crump also used this platform to share his articles and instigate discussion about new medical procedures that were not part of AT's existing Clinical Practice Guidelines.[88]

Numerous colleagues considered that Mr Crump was, at times, inappropriate in his comments and behaviours at work. It certainly was the case that Mr Crump displayed unacceptable behaviour at work and this important topic is dealt with below.

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[83] C 161 page 5
[84] T3 page 11
[85] C59, C35, C42, C17 Affidavits – Matthew Robert Aiton, Peta Hooper, Bess Rowena Swinton, Stephen Elliott.
86 C18 Affidavit – Brett Gibson.
87 C36, C58 Affidavits – Monica Baker, Simon Geard.
[88] C 58 – Affidavit of Simon Geard, page 1.

Many of his colleagues were also aware that he suffered a mental illness, or assumed he suffered a mental illness. They attributed his marked vacillations in mood and behaviour whilst at work to his illness.

His personnel file contained information relating to his employment with AT, some of which is set out in the following paragraphs.

In October 2006 AT investigated a case where Mr Crump had, without authority to do so, provided Schedule 8 medication (morphine) to a patient suffering a high level of pain. After detailed consideration of the case, it was found that the circumstances rendered the matter not warranting prosecution or other action.[89]

In May 2009, Mr Crump had his AT driver's authority suspended due to driving through a school zone at high speed. Acting Superintendent Peter Morgan sent a letter to Mr Crump's psychiatrist, Dr Stephanie Auchincloss, indicating concern about his behaviour and medication. Dr Auchincloss subsequently cleared Mr Crump to work and the Chief Executive reinstated his authority to drive.

In 2010 Mr Crump had two performance meetings regarding his failure to complete paper work and using inappropriate language to a patient.[90]

Mr Crump received letters of appreciation in 2011, 2012, 2013, 2014, and 2015 regarding contact from patients.[91]

Mr Crump was recruited into the Regional Training Unit as an Acting Clinical Support Officer in around 2011.[92] In 2015 the role of a CSO was changed to incorporate the training of Volunteer Ambulance Officers. Consequently, Mr Crump moved out of this role, as he was concerned about public speaking to trainee groups.[93]

From early 2016, Mr Crump returned to his original role of being an on-road intensive care paramedic, the position he held at the time of his death.[94]

(i) AT structure and key personnel

[89] C13A AT Personnel Record 1.
[90] C13A-D – AT Personnel Records.
[91] C13A, C13B – AT Personnel record 1 and 2.
[92] C18 and C70 Affidavits – Brett Gibson, Peter Hampton.
[93] C18 Affidavit – Brett Gibson.
[94] C18 Brett Gibson

Ambulance Tasmania, formerly known as the Tasmanian Ambulance Service, provides ambulance services in this state. The service is established by the *Ambulance Service Act* 1982 and it operates within the Department of Health.

In 2016, at the time of Mr Crump's death, AT was divided into seven distinct sections with a Chief Executive (CE) heading the organisation. It supported an operational paramedic workforce, including managers and clinical support and education staff of 322 personnel. This number increased to 454 personnel over the following five years.[95]

In 2016, the seven sections of AT comprised: Emergency and Medical Services North, South and North-West, Aeromedical and Retrieval, Medical Services, State Communications and Operational Support Services. Because the organisational structure relates to many issues in this enquiry, attached to these findings and marked 'E' is a chart depicting the overall structure of AT in 2016. [96]

Attached and marked 'F' is another chart specifically relating to the composition of Emergency and Medical Services, being applicable to this inquest. It will be observed from the chart that, for the Southern Region, there were approximately 84 paramedics, together with 24 Branch Station Officers, 254 Volunteer Ambulance Services officers and 6 Patient Transport Officers. For the total of these personnel, two full-time duty managers were employed. The duty managers themselves reported to one full-time Operations Manager who, in turn, reported to one full-time Regional Manager. [97]

It is to be noted that changes to the AT structure since Mr Crump's death have been implemented to improve the organisational governance by providing frontline staff with greater levels of management support and to separate and better define the area of clinical oversight from operational oversight. Amongst numerous changes to the structure, two important roles were created - the Director of Operations and the Director of Clinical Services. Additionally, the number of duty managers was increased by two positions in 2020.[98]

For ease of reference, below I set out a number of the AT personnel who are referred to in this finding and a brief description of their position and role within the organisation.

Dominic Morgan: Chief Executive of AT from 2009 until March 2016.

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[95] C 159 Affidavit of Neil Kirby, page 1.
[96] C 158 Affidavit of Dale Webster, page 10.
[97] Ibid, page 10.
[98] C158, Affidavit of Dale Webster, Deputy Secretary, Community, Mental Health and Wellbeing, Department of Health, pages 1 and 2, and Annexure A (Ambulance Tasmania Organisational Chart 2021)

Paul Templar: Acting Chief Executive from March 2016 to November 2016. He passed away in 2020.

Neil Kirby: Chief Executive from November 2016 until February 2020, when he relinquished the position due to ill-health. Matthew Eastham then took over as Acting Chief Executive until February 2021.

Joseph Acker: Interim Chief Executive from February 2021 before being appointed as Chief Executive of AT from July 2021.[99] Mr Acker resigned in early 2023, with Jordan Emery now occupying the role.

Con Georgakas: Since 2015, and at the time of the inquest, Dr Georgakas held the position of Director of Medical Services, involving clinical governance. [100] He had responsibility for the AT Medication Management Policy. He did not manage operational paramedics apart from the clinical services team. He did not know Mr Crump and did not have any interactions with him. Dr Georgakas was also responsible for being in charge of a large policy development project to improve medication management following Mr Crump's death.[101]

Craig Westlake: Regional Manager Southern Region at the time of Mr Crump's death. He commenced employment with AT in 2013 and is a qualified intensive care paramedic.

Brett Gibson: Clinical Support Manager at the time of Mr Crump's death. He commenced employment with AT in 1995 and is a qualified intensive care paramedic.

Monica Baker: Southern Region Duty Manager for since 2010 and was Acting Operations Manager Southern Region at the time of Mr Crump's death. She is a qualified intensive care paramedic and, since about 2003, had been close friends with Mr Crump.

Peter Berry: Southern Duty Manager at all material times, with knowledge of Mr Crump. Mr Berry was a qualified intensive care paramedic and had been an AT employee since 1978.

Kim Fazackerley: Acting Duty Manager Southern Region at the time of Mr Crump's death. She has been employed with AT as a paramedic from 2011, after working for the Queensland Ambulance Service as an advanced care paramedic. She knew Mr Crump as a

[99] The dates relating to the tenure of the respective Chief Executives and Acting Chief Executives are taken from C 159 – Affidavit Neil Kirby, page 15. I have not checked them against other records and they may be approximate only.
[100] Dr Georgakas is an Emergency Medicine specialist.
[101] C 95 Affidavit of Dr Con Georgakas.

colleague. She found him stealing Schedule 8 drugs from the AT Hobart drug store before his death.

(ii) Terms and acronyms used in this finding

CE refers to the Chief Executive of AT.

ICP refers to an intensive care paramedic.

SRLS refers to the Safety Reporting and Learning System at AT. This is the electronic platform used by staff of AT for documenting and reporting a particular issue, including incidents involving risk, safety concerns or hazards. Once a report is generated, the manager directly above the reporting person must investigate the report, communicate with the reporting person and come to a resolution.[102]

Schedule 8 medications/specified medications/dangerous drugs are terms used interchangeably in this finding to refer to those drugs held by AT which are governed by strict legislative and/ or storage controls or which have a high potential for misuse. Morphine is one such substance.

AT drug store/drug store refers to the room in AT's headquarters in Melville Street Hobart containing AT's stock of medication, including safes containing Schedule 8 medications.

PSB refers to Pharmaceutical Services Branch, part of the Department of Health. PSB administers the Tasmanian legislation which provides for the possession, supply, and use of medicines and poisons. PSB was involved in providing advice and assistance to AT with issues surrounding its medication management.

Circumstances surrounding death

Circumstances before death

Mr Crump's mental state, behaviour and drug-seeking deteriorated approximately 6 to 12 months before his death. I have covered this already from the perspective of his medical treatment.

I now set out below a brief timeline of the critical events occurring in the months before Mr Crump's death, several of which represented opportunities on the part of AT to recognise that he had a serious problem; and that intervention by AT was required. These events must

[102] T 143 – evidence of Kim Fazackerley.

be looked at in light of his known mental health condition, unpredictable and unacceptable workplace behaviours, and his intention expressed to colleagues that he would end his life before he reached the age of 40 years.[103]

Approximately four months prior to his death, a friend and colleague, JT, saw a detailed "suicide plan" on Mr Crump's phone which involved him ingesting morphine, midazolam and amiodarone and also using a plastic bag or rope. Mr Crump had told her about the plan on his phone and made her promise not to tell anyone about it. It was when Mr Crump went out of the room that JT was able to find it on his phone. [104]

JT explained in her affidavit: *"Had I told anyone at work it was likely they would have taken him off road and that would have probably caused more issues for him with his mental health, and pushed him over the edge to suicide. I did not mention the conversation to anyone at AT management".*[105]

In late September 2016, Mr Crump's name was mentioned by Ms Monica Baker, Acting Operations Manager, in a statutory declaration to police regarding a complaint of missing medication in suspicious circumstances from the AT branch stations in Mornington and Glenorchy. He was named because he was discovered to have accessed the Glenorchy station by swipe card on 24 September 2016 when he was on leave and not rostered to work. [106] In total, AT reported that six ampoules of morphine were missing from Mornington together with one ampoule of midazolam; and that three ampoules of morphine were missing from Glenorchy together with one of fentanyl.[107]

On about 2 October 2016 there were text message exchanges between Mr Crump and JT concerning Mr Crump indicating that he had sourced a drug (Kapanol, according to JT) and had injected it intravenously after making a solution. Mr Crump stated that upon increasing the quantity, he had got to a state where he could not walk without falling and that he was *"off his face".*[108]

On 16 November 2016, one of Mr Crump's colleagues observed that his behaviour was very concerning whilst at a job at Vaucluse Gardens aged care facility. He was shaking, sweating and swearing and was unable to assist the patient. He agreed to go home. The incident was reported to managers Brett Gibson and Kim Fazackerley.[109]

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[103] C20 Affidavit – JT, page 19; T107 Kim Fazackerley.
[104] C20 Affidavit – JT.
[105] C 20 Affidavit – JT, page 4.
[106] C 26 page 49/50 – Statutory declaration of Monica Baker.
[107] C26 page 49- Statutory declaration of Monica Baker.
[108] C 20 – JT – page 13 – text message Annexure.
[109] C60 Affidavit – Emily Byers, p 2; C 42 Affidavit of Bess Swinton.

On 14 December 2016, nine days before Mr Crump's suicide, an incident occurred involving Mr Crump behaving inappropriately whilst at a job near Bushy Park. He became angry and frustrated after the ambulance in which he was travelling left the road and became bogged in a ditch. Once mobile again, he was requested by manager Ms Amanda Hutchinson to return to headquarters. Instead, he abused Ms Hutchinson and drove the ambulance to another station. The incident was reported to manager Peter Berry and Mr Crump was stood down for a shift. [110]

Immediate Circumstances of Death

(i) The facts

On 23 December 2016, Acting Duty Manager Ms Kim Fazackerley was working from the Hobart headquarters of AT in Melville Street. At approximately 4.45pm, she was walking up to the communications office through the garage. At this point she saw Mr Crump, who was then on recreation leave, attempting to swipe into the building. She asked him why he was there and he informed her that he had left his hard drive at the station.

Ms Fazackerley became suspicious because of her knowledge of his possible involvement in the drug thefts reported in September 2016 and consequently went immediately up to the communications office and looked at the CCTV camera into the drug store. There, she saw Mr Crump opening the morphine and midazolam safe.[111]

Ms Fazackerley then went to the drug store and confronted Mr Crump about his actions. He handed over to her 8 ampoules of morphine in two separate batches. She asked him to come to the office and instructed him to not leave and if he did, she would have no choice but to call the police. Mr Crump told her *"if you call police you'll kill me."* She said that she could help him and asked him to go to her office. Mr Crump replied that it was too late and that he could not be helped. During the conversation, he said he was going to go home and kill himself. She said that Mr Crump looked blank and defeated. [112]

Ms Fazackerley tried to call managers Mr Brett Gibson and Mr Craig Westlake for assistance, but both calls went unanswered.

A short time later, her phone rang and she walked no more than two metres away from Mr Crump to answer the call, which was from Mr Westlake. While she was talking to Mr Westlake, Mr Crump stated that he would sit outside that door and "have a smoke".

[110] C72 Affidavit – Amanda Hutchinson.
[111] C15 Affidavit – Kim Fazackerley.
[112] Cease 15 Affidavit – Kim Fazackerley, pages 3 and 4.

The phone call lasted for about 30 seconds and when it had ended, she discovered that Mr Crump had left. Ms Fazackerley then went outside to see if she could see where he had gone. She was unable to locate him. It is likely at this time he had returned to the drug store.

Mr Gibson also returned Ms Fazackerley's call and indicated that he would come to headquarters. Ms Fazackerley then called police.

During this process, Ms Baker was notified of the situation by Mr Westlake and then had a discussion with Ms Fazackerley about what had occurred. Ms Baker then made calls to those AT colleagues close to Mr Crump, including JT, who may have been in contact with him. [113]

JT described in her affidavit receiving a call from Ms Baker at this time enquiring as to the whereabouts of Mr Crump. In her affidavit, JT stated;

> *"She said that he was missing and I asked what she meant and for how long he had been missing, she said for about half an hour from work. I asked how that could mean that was missing and she said that he had been caught stealing morphine at which stage I said oh fuck, that's part of his suicide plan. Monica asked what I meant and I told her that I had seen the suicide plan on his phone and she asked what the rest of it was and I told her to go and check the midazolam and amiodarone. She asked someone to go and check the safe and came back to me that that was missing as well. She told me how much was missing, it was a huge amount and could have killed an elephant with that amount."*[114]

When Mr Gibson arrived at headquarters, they went to the drug store and found 45 additional morphine ampoules missing, indicating that Mr Crump had returned to the drug store and taken them.

After being informed of Mr Crump's suicide plan by JT, Mr Gibson and Ms Fazackerley also checked the amiodarone and midazolam stores. In total, 40 x 5mg ampoules of midazolam, 45 x 10mg ampoules of morphine and 42 x 150mg ampules of amiodarone were identified as missing.[115]

Tasmania Police officers conducted a search for Mr Crump once his disappearance was reported. Police officers attended Mr Crump's address, his mother's address and the headquarters of AT.

After a photograph of Mr Crump, his car and its registration plate was released to the media, police received a phone call from a member of the public, Mr Jack Steele, who

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[113] C 36 Affidavit Monica Baker, page 46.
[114] C 20 page 4
[115] C22 Affidavit – Sergeant Timothy McLean Etheridge.

advised that he had seen Mr Crump's vehicle parked in the Woolworths car park at Sorell near the petrol station at approximately 9.00pm that evening. [116]

Police officers attended and located Mr Crump deceased in his car. He was in the driver's seat with a drip attached to his arm and a rope around his neck.[117] A handwritten note was located in the vehicle providing instructions relating to Mr Crump's finances and dog.[118]

A full autopsy upon Mr Crump's body was conducted by forensic pathologist, Dr Donald Ritchey. Dr Ritchey also had regard to the toxicological analysis of Mr Crump's post-mortem blood sample by Forensic Science Service Tasmania, which reported the presence of the following substances in his blood:

- Morphine (a narcotic analgesic and central nervous system depressant obtained from opium) 6mg/L - within the reported fatal range;
- Lignocaine (used to produce local anaesthesia) 19mg/L - within the reported fatal range;
- Midazolam (a benzodiazepine used in a hospital environment) 0.4mg/L - at a therapeutic level; and
- Sertraline (an antidepressant agent) 0.7mg/L - at a greater than therapeutic level.[119]

In his report, Dr Ritchey concluded as follows:

> *"The cause of death of this 36-year-old man, Damian Michael Crump, was mixed prescription drug toxicity (morphine, lignocaine, midazolam). Significant contributing factors were depression and intravenous drug abuse.*
>
> *Mr Crump's body was found deceased in the driver's seat of his car with a rope ligature around the neck tied in a hangman's noose and secured over the back of the driver's seat. An intravenous bag of normal saline was hanging from the rear view mirror attached to plastic tubing and a cannula inserted into the posterior left hand.*
>
> *The autopsy revealed a normally developed obese (obesity defined as a body mass index of greater than or equal to 30 kg/m²) adult man with a rope ligature tied in a hangman's noose around the neck. There were no conjunctival or peri-orbital petechiae and there were no*

[116] C26 Affidavit – Jack Gary Steele.
[117] C27 Affidavit – Constable Douglas James McKinlay.
[118] C28 Affidavit – Senior Constable Jeremy Paul Williams.
[119] C5 – Post Mortem Report of Forensic Pathologist, Dr Donald Ritchey, page 8; C6 Toxicology report.

observable injuries of the neck internally suggesting that asphyxia was an unlikely mechanism of death.

An intravenous catheter was secured with tape on the posterior left hand. Tubing connected [sic] to an empty reservoir of normal saline. Toxicology testing of samples obtained at autopsy revealed markedly elevated concentrations of morphine and lignocaine (a local anaesthetic) in addition the therapeutic concentration of midazolam (a benzodiazepine class drug use in anaesthesia).

Microscopic sections of lung revealed widespread crystalline debris and foreign body giant cell reaction to the crystalline debris. This pattern of lung pathology is highly suggestive of chronic intravenous drug use particularly the injection of crushed tablets. The pattern may also be seen with the injection of 'cutting agents 'added to illicit street drugs. There was no hepatitis by microscopic criteria of liver sections".[120]

I accept the opinion of Dr Ritchey. Specifically, I find that Mr Crump died directly because of the toxicity produced by the drugs that he had stolen from the AT drug store only hours earlier. I find that, in addition to the three drugs appearing on the toxicology analysis, Mr Crump also ingested amiodarone, which was apparent from the scene. At the time of the toxicology results, amiodarone was not part of the Forensic Science Service Tasmania routine drug screen. [121] This medication also contributed to his death.

I find that asphyxiation as a result of the rope noose did not contribute in any significant way of death.

I find that he took the action of ending his life in the manner specified in his pre-prepared suicide plan. There is no evidence that he went home between stealing the drugs at AT and driving to Sorell. It is most likely that he kept the required rope and other equipment his car, previously telling a friend and AT colleague that he had a "go kit" for the purpose of suicide. [122]

Mr Crump's home in Siandra Crescent was later searched by police officers and large quantities of prescription and illicit drugs were located. These included a snaplock bag of MDMA crystals (ecstasy) and a snaplock bag containing MDA and MDEA tablets (illicit psychoactive stimulants). The drugs found in the house which appeared to have been misappropriated from AT were fentanyl, ondansetron, midazolam, morphine, Ketalar

[120] C5 Post- mortem report, pages 8 and 9.
[121] Expanded drug screening, including for amiodarone, commenced in September 2017.
[122] C 54 Affidavit ZJ, page 7.

(ketamine) and Narcan (naloxone). Empty vials and packaging were also located in the search.

Mr Crump's housemate, Mr Long, said that recently before Mr Crump's death, he had observed needles in the house, particularly on the window ledge where Mr Crump would sit. When Mr Long raised the issue, Mr Crump said that he used the needles for "removing fat cells from his dog". I consider this to be an unlikely explanation. [123]

Upon all of the evidence, it is plain that for at least several months before his death, Mr Crump was heavily addicted to injecting illicit drugs. These were sourced from his own contacts, as well as the morphine and other drugs that he was stealing from AT.

The damaged state of Mr Crump's lungs seen at autopsy reinforces that, for some time, he had engaged in the dangerous practice of intravenously injecting crushed pills. I have no doubt that Mr Crump, with his clinical knowledge, would have understood that the insoluble binding agents in the pills are likely to cause serious vascular and pulmonary damage.

(ii) Could Mr Crump's removal of the fatal quantity of drugs been prevented?

In her oral evidence, Mrs Crump was critical of a perceived failure to stop her son from returning to the drug store after Ms Fazackerley had initially caught him stealing medications.

Mrs Crump said:

> *"You know, in my eyes, that was a preventable – it should never have happened. You know, if there'd been things in place – I mean, if I'm – I'm a teacher. If I have a little fellow doing the wrong thing and I need to get the principal or something. I don't say, "You just stand there in the corridor or by the wall. I'll be back with the principal in a minute". Do you think that kid's going to be there when you get back? No way. Yeah, I mean, you take them with you. You don't leave them. And if that had happened, Damian would still be with us".*[124]

In dealing with this criticism, Ms Fazackerley's oral evidence about what occurred in these moments is significant, in particular the context in which she encountered Mr Crump on 23 December. As dealt with further on, Ms Fazackerley had every reason to believe that Mr Crump was responsible for the theft of medications from the Glenorchy Ambulance Station in September 2016.[125] Therefore, when she found Mr Crump accessing the Ambulance Station while on recreational leave this day, she recalled:[126]

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[123] C 47 Affidavit Daryl Long, page 1.
[124] T56, p20.
[125] C15 – Affidavit – Kim Fazackerley, p 2 & oral evidence T110, pp 1-25, T111: 19 – 112: 6.
[126] T113: 37-45.

> *"Yeah, so when I – when I saw him there and I – I let him in because he – you know he was at the door and he told me he was there to collect a hard drive, and we had a bit of a laugh and joke and you know then he – it was – I walked past him and it was sort of like, all that information just sort of hit me like a bit of a bombshell, like oh my God I think he's – this is why he's probably here. So I went back looking for him, where I thought he might have gone, and I couldn't find him. So, I knew that there was a drug – CCTV camera, so I went to the State Operation Centre to watch that camera."*

In her oral evidence, Ms Fazackerley explained in detail the moments after she had confronted Mr Crump, and how he admitted what he had done by surrendering the medication in his possession. I agree with Counsel Assisting's submission that the following minutes were extremely difficult and tense for Ms Fazackerley, who was desperately attempting to obtain some assistance by trying to contact relevant managers. It was during that very brief time that Mr Crump took the opportunity to move out of her sight.

Ms Fazackerley's narrated in her oral testimony how the distressing situation unfolded:

> *"I just – I was trying to encourage him to come down to the office – I knew if I could get him to the office then you know I could – he would be secure, I could shut the door and have a conversation outside that door knowing that he was in there because you know I didn't want to have conversations with managers around him, you know. I'd been trying to ring people, there was no one answering their phone on the way down to the drug room. I tried to ring a few people while I was with him at the door. He just kept saying he wanted to go home. He was – and he did say that he – oh yeah he said to me "Please don't ring police if you ring the police you'll kill me", and I said to him "Right now I just need to get you safe, mate, we need to get you down to the office, I'm concerned for your welfare". He talked about wanting to kill himself. Then he just said "I just want to go home" and I said to him "I can't let you go home you know I can't let you go home". We continued to have that conversation, it was probably a few minutes, I guess, and then that's when my phone rang and I said to him, "I need to take this phone call" and I turned my back on him and walked towards, I guess up the – towards up the other end of the garage, because I didn't want him to hear my conversation. I recall him saying something like "I'm going out for a smoke" and I think said "I'll come straight out". I literally had a thirty second to a minute maybe conversation with Craig Westlake, spun around and he's gone".*[127]

[127] T116: 28 – T117: 5.

It is clear that Ms Fazackerley was trying to ensure that she could keep Mr Crump at the station because she appreciated the immediate and extreme risk to Mr Crump's safety if he were to leave with the drugs.

I agree with Counsel Assisting that Ms Fazackerley had little chance of keeping Mr Crump at the station. It would have been obvious to him that this was what she was trying to do, and that she would need help from others. There is nothing else that Ms Fazackerley could have reasonably done to try and detain Mr Crump in these circumstances, and his decision to leave could not have been prevented.

As I discuss below, Mr Crump had determined to end his life at that point and he was intent upon not being prevented from doing so.

I was impressed with Ms Fazackerley's evidence at inquest and fully accept her account of the incident, which was corroborated by the CCTV footage.

I find that Ms Fazackerley acted in a clear and decisive manner throughout the incident. She quickly identified Mr Crump's intentions in entering the station on this day, when she might have accepted without question his "innocent" explanation. Her approach to Mr Crump was necessarily firm and her actions as Duty Manager were commendable. She was also fair and reasonable in her dealings with Mr Crump as a colleague.

(iii) Mr Crump's intention in removing the second quantity of drugs

I am satisfied that Mr Crump, in initially removing 8 ampoules of morphine, intended to use that substance for his personal use as he had been doing for some months. He was not, at that stage, contemplating suicide.

The question arises as to whether the large quantity of drugs taken by Mr Crump whilst Ms Fazackerley was on the phone were removed deliberately with the intention of using them to end his life.

The drug store footage captures Mr Crump entering, purposefully removing the drugs and quickly leaving. At that time, I have no doubt that the consequences of being detected had struck him, the most significant of which was that his career as a paramedic would be lost. This thought process was reflected in his words to Ms Fazackerley "*if you ring the police, you'll kill me."* He was contemplating suicide at this point.

In the investigation, I received a helpful independent opinion from Dr Ian Sale, psychiatrist, in relation to a number of issues surrounding Mr Crump's mental illness. He opined in his

report that the discovery of his theft of opiates was *"the immediate cause of him to implement his plan"*. [128]

In his oral evidence at inquest, Dr Sale reinforced this view, stating:

> *"I think he would've been devastated, because it's obvious from the stuff I've been reading and these various statements by colleagues and, I think, Dr Frampton and a couple of others that the job was his life. This was a man who, in retrospect, is somewhat psychologically fragile for some time and that one of the things that kept him together was his job. Being discovered to have pilfered S8 drugs, dangerous drugs, would probably have meant – and he would've realised this – the end of his career, the end of his access to this important vocation for him".*[129]

JT was of the view that Mr Crump, having been detected stealing drugs from AT, would have seen the incident as the end of his career and would not have seen any other way to deal with the situation.[130] Once she had been told that he had taken the substances referred to in his suicide plan, she considered that there would only be *"an hour or two to find him"*.[131] She was, unfortunately, correct in this assessment.

I am satisfied that after Ms Fazackerley confronted him, Mr Crump's longstanding suicide plan crystallised. He then returned to the drug store and stole a vastly greater quantity of drugs to give immediate effect to this plan.

Events connected with death

I now deal in more detail under various headings with what I consider to be the significant matters that may have been connected causally to the circumstances of Mr Crump's suicide.

These matters are dealt with under the following headings:

- Mr Crump's behaviour at work;
- Mr Crump's suicide plan and suicidality;
- The theft of medication in September 2016;
- Continuing medication theft by Mr Crump; and
- Ambulance incident of 14 December 2016.

[128] C162 – Report Dr Ian Sale, p 6.
[129] T2 50: 35-45.
[130] C 20 page 4
[131] ibid

This investigation focused significantly upon the adequacy of the response by AT to these matters involving Mr Crump. Did inadequate responses by AT contribute to his suicide? Alternatively, were there at least significant opportunities for AT to have prevented his death?

Each of the above issues must be discussed with consideration of the knowledge and actions of AT through its personnel. In the context of this investigation, such consideration necessarily leads to an examination of systemic issues within the organisation, being an underlying cause of the inadequacy in response.

I have been reluctant, in such circumstances, to be critical of the actions or omissions of AT employees operating within such an environment. I have, however, found it necessary to make critical comment concerning some of Ms Baker's actions and omissions in light of her knowledge of relevant matters, her close friendship with, and supervision of Mr Crump over a lengthy period of time. Even so, I fully recognise that Ms Baker, also, was impacted by the culture of the organisation and inability to fulfil the duties of her supervisory role.

I have concluded that there were plain opportunities for AT as an organisation to take action to deal appropriately with Mr Crump's diversion of medication and behavioural issues, and that it should have done so.

As set out earlier in this finding, Counsel for the Department and Counsel for Ms Baker submitted that much of what was considered during the course of the inquest, including most of the following topics, did not bear any causal connection to Mr Crump's death and was not relevant to making the necessary findings under section 28(1)(c) of the *Act.*

Counsel for the Department, Ms Chen, submitted that Mr Crump's mental illness was unrelated to his employment with AT and that his role as a paramedic, in fact, served to *"fortify him against the tumult of his condition".*[132] She further submitted that AT knew of his mental health condition but respected his right to keep his health status private. She submitted that his mental illness did not affect his capacity for work and that JT was the only person in whom Mr Crump confided regarding any "meaningful possibility" of suicide and JT did not pass on that information. Further, she submitted that Mr Crump did not disclose his drug addiction to anyone and his AT colleagues did not suspect that he had an illicit drug habit.[133]

[132] Closing admissions, Department of Health, paragraphs 73.
[133] Ibid, paragraphs 76 to 79.

Thus, Ms Chen submitted that there was no issues in the AT organisation that could be causally connected to Mr Crump's death. In the final paragraph of her closing submissions, she encapsulated the position of AT and the Department:

> *"In this case the nexus to the employer was established by way of [Mr] Crump's unlawful activity in stealing drugs that belonged to the employer. He gained access to the drugs only by breaching the trust placed in him. He did not die as a result of any inherent risk or hazard at his workplace - he died as a result of an intentional act of suicide after having been apprehended stealing drugs from his employer."*

It is certainly the case that Mr Crump brought about his own death intentionally and that he engaged in serious misconduct whilst occupying a position of trust. It is also the case that Mr Crump was covert in his activities and selective as to those with whom he chose to share information.

However, I do not accept the submission that, as coroner performing my functions under the *Act,* I am not entitled to consider the organisational circumstances which permitted him to engage in a lengthy course of stealing dangerous drugs from AT (including those causing his death) whilst still working as an intensive care paramedic.

Ultimately, Mr Crump's course of conduct culminated in his detection and suicide. It is not to the point to say that he would have ended his life before he was 40 years of age in any event. He may not have done so, or he may have done so in other circumstances unrelated to serious issues associated with his workplace.

Mr Crump's behavior at work

Many AT witnesses provided evidence of Mr Crump's erratic, inappropriate behaviour and emotionally labile moods whilst at work. Over many years, but particularly in the months before his death, his behaviour was tolerated, even accepted, with colleagues often attributing it to him simply being *"Crumpy".*

From the large body of evidence on this topic, I set out some examples of Mr Crump's workplace behaviour to highlight the nature of the issue.

- Mr Crump had extreme highs and lows in his behavior, vacillating in mood between manic and introverted. [134]For that reason, Mr Berry considered that he suffered bipolar disorder. He said that Mr Crump required management when

[134] C35 Affidavit Peta Hooper.

he was both high and low. When he was low, he was "difficult" and hard to manage. [135]

- One of his colleagues, Stephen Elliott, described an incident involving Mr Crump, stating *"I had never come so close to throwing anyone out of the ambulance I was working in other than Crumpy. It was all about his behavior."* Mr Elliott considered that, in the workplace, Mr Crump *"just stepped over boundaries and didn't act like a grown up for a grown up job". [136]*
- Many witnesses described Mr Crump's negative approach to matters and that he regularly vocalized frustration and anger with the AT structure and lack of support for training and development. He was also impolitic in his comments about the organisation. [137]
- His interpersonal dealings were often highly inappropriate. One of his colleagues described Mr Crump constantly saying things that were *"off the charts inappropriate"* but he would say them in such a way that everyone would laugh.[138] Another said that he appeared to have *"no filter".* [139] It seems that his comments would cause nervousness in his colleagues because of what he might be saying about them behind their backs.[140] Similarly, his unpredictable reactions caused difficulty and discomfort for those who were required to deal with him. [141]
- Mr Crump was critical of, and had difficulty with, those individuals who he judged as struggling with their clinical ability and who did not demonstrate the same degree of passion or interest to achieve the same clinical expertise as him.[142] For example, he would call some of the staff *'dumb fucking arseholes'*, saying that they should not be at AT.[143]
- Mr Crump was not respectful and did not adhere to proper boundaries in making requests of his managers. For example, he would approach Mr Berry to demand a change of roster in order to avoid working with those colleagues he did not respect.[144] In November 2016, he called Ms Baker at work saying that he needed some ondansetron, an anti-emetic medication (to stop nausea). Ms Baker told him that he knew she could not take it from work for him, although

[135] C40 Peter Berry p4 and page 5.
[136] C17 p2 Stephen Elliott
[137] For example, see C17 Stephen Elliott p2; and C36 Monica Baker.
[138] C35 Peta Hooper p3
[139] C82 Affidavit of Patricia Magrovramakis, page 1.
[140] C35 Peta Hooper p3
[141] C 64, page 2; C82 Affidavit of Patricia Makrogamvrakis, page 1.
[142] C18 Brett Gibson p2
[143] C 40 Peter Berry P5
[144] Ibid.

he expected her to do so. Mr Crump then called her "a bitch" and hung up.[145] Another colleague said that Mr Crump would make derogatory posters about management on his computer and show colleagues.[146]

- Mr Crump had a reputation as a "cowboy" with clinical practice because he frequently ignored AT guidelines in doing what he thought best for the patient.[147] For example, he often administered medication outside the Clinical Practice Guideline, giving a patient a much larger dose of pain medication than specified. He would then falsify the patient's weight on the documentation to justify the larger dose.[148]

Mr Crump's unacceptable workplace behaviour also manifested in his written communications.[149] Again, examples of his communications show the extent to which he was allowed to conduct himself without consequence.

He used his AT email to write to colleagues in a manner that was inappropriate and not conducive to workplace cohesion. In evidence, for example, was an email sent by Mr Crump to the HSR South group (AT Health and Safety Representatives) copying in the whole southern region workforce. In the email, Mr Crump was rude and accused the group members of being '*weak as piss!!!*'[150]

In early 2016, Paul Templar became Acting Chief Executive of AT following Mr Dominic Morgan leaving for a similar position in New South Wales Ambulance. Mr Templar said that he knew little about Mr Crump, although was aware that he was held in high regard clinically. Mr Templar had heard him spoken about as being a "*difficult customer to manage, he had his own way of doing things and too bad if you didn't like it*".[151]

Mr Templar recounted in his affidavit that Mr Crump sent a group email in relation to AT running a campaign on the back of ambulances concerning violence against staff. Mr Crump had sent an email in reply and Mr Templar was concerned about its contents.

The email was dated 5 February 2016 and was sent to several AT staff.[152] In the email, Mr Crump called the campaign a '*self-indulgent crusade*' and vigorously objected to driving an ambulance with stickers on it. Mr Templar said in his affidavit *"I was told at the time not to*

[145] C36 Monica Baker
[146] C35 Peta Hooper p3
[147] C36 Monica Baker
[148] C 35 Affidavit Peter Hooper, page 2.
[149] C138.
[150] C138; Simon Geard C58; C82 Patricia p2
[151] C 76 Paul Templar p 1
[152] C138 P1

worry about the behaviour, "That's just Crumpy". Based on advice I did not personally intervene to address the behaviour. I was advised that the matter was dealt with by managers at the time".[153] There is no evidence that the matter was taken any further.

In February 2016 there were a series of emails between Mr Crump and Dr Konrad Blackman. Dr Blackman was a staff specialist in the Emergency Department of the Royal Hobart Hospital who was appointed to provide clinical advice to paramedics.[154] Mr Crump was advised to contact Dr Blackman in relation to sedation of a patient. Mr Crump forwarded the concern onward to Dr Blackman. Dr Blackman replied with a number of questions for consideration to which Mr Crump wrote a one word email to Dr Blackman stating '*Whatever*'.[155]

Dr Blackman, in reply, expressed to Mr Crump that his response was extremely unprofessional and said that if he did not behave more appropriately he may be unable to work with him to address the questions of concern.[156] Mr Crump sent a reply, apologising to Dr Blackman.

On 5 October 2016, Ms Baker emailed Mr Crump in formal terms relating to a rostering issue. Mr Crump's reply was unprofessional and sarcastic, stating that the rostering would be "*a fulfilling addition to my already content and meaningful existence*'; and further stating '*I do find it somewhat unpalatable that you write your correspondence in a tone that suggests that we have never met? (what in the actual fuck is that about?)*".[157]

Whilst Ms Baker was his friend, she was also his manager. Such correspondence to his manager on his work email on any view should not have been tolerated.

By that stage, however, I am satisfied that Ms Baker had serious concerns about Mr Crump's mental health and was attempting to help him maintain stability.

On 6 October 2016, being the following day, Mr Crump wrote to Ms Baker on his work email, referring to a film he had watched called 'Bridegroom' and stating that it would help her understand why he was dying and had no future. In the email, he further instructed her to *'tell no one'* and *'never speak of it again'.*[158]

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[153] C 76 Paul Templar
[154] Dr Blackman is listed in the email as a staff specialist in Aero Medical and Medical Retrieval Division Ambulance Tasmania.
[155] C138
[156] C138
[157] C36 Baker p42 of 50
[158] C36 baker p 44 of 50

If Mr Crump had a normal level of insight, he would not have put Ms Baker in the position of demanding that she tell no other person about his suicidal intentions.

At 12.34pm on Friday 23 December 2016 Mr Crump replied to a Christmas email sent by the new Chief Executive of AT, Neil Kirby, to all staff.[159] In the email to Mr Kirby, Mr Crump introduced himself and said that he was "*thrilled*" to see that AT was intending to improve education and training as that had been severely lacking; and, in fact, clinical development had been "*openly blocked*" and replaced with other workplace matters. He concluded by stating the following:

> "*Anyway, I'm probably not even supposed to write directly, I promise I won't make a habit of it. Dominic's regime was a low quality dictatorship, everyone knows that, but no one would ever dare speak up about it. Believe what lower level people tell you about it, even if they sound like conspiracy theorists, it's all true. I only mention this because the result of it is extremely poor morale, so it may take you a while to acquire any trust from the staff.*
>
> *I'd be drawn and quartered for writing to the previous CEO like this, but we have heard good things about you and your new priorities look exciting.*
>
> *Cheers, have a good Christmas*".[160]

This email was sent by Mr Crump to Mr Kirby four hours before Mr Crump entered the Medication Store room to unlawfully access AT medications. There is no indication in that email of a fatalistic view. To the contrary, it indicates that he was fully engaged in his work with AT.

The act of a paramedic writing to a new Chief Executive in this manner and tone, including being openly derogatory in relation to his predecessor, was highly improper. This email required appropriate action to be taken at a management level. I doubt that that would have occurred.

The evidence as a whole indicates that Mr Crump was a person who did not respect authority, who operated outside guidelines, was intolerant of many colleagues, was unpredictable in mood, and did not observe politeness in communication. In his early years, his preparedness to speed in an ambulance through a school zone and to administer narcotic substances without permission were, in hindsight, indicators of such traits.

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[159] C159Affidavit of Neil Kirby; C138 emails
[160] C138

Colleagues tended to "manage" his behaviour and tolerate it. This may have been because he was intelligent, humorous and dedicated to his work. It also seems that some colleagues were wary of his moods and did not wish to provoke him. Concern for his precarious mental health was also a reason given by many for accepting his behaviour, with his suicide plan known amongst a sector of his colleagues. Finally, it is clear that most of his colleagues assumed, without knowing more, that behaviour was driven by his depression and therefore he had limited control over it.

Mr Crump's suicide plan and suicidality

It was well known amongst a number of AT employees that Mr Crump intended to suicide by the age of 40 years and had a specific plan to effect his own death.

Ms Fazackerley said in evidence in respect to being told by several people about the suicide plan:

> *"Yeah, so again, that was something that was spoken about, not by him but by others that knew him and that were close to him, and they all said that you know that he had a suicide plan that he would suicide before he was forty. He didn't want to turn forty. There was – there was comments around that he – that he kept a noose in the back of his car and that if he – that if he couldn't overdose himself he would hang himself. Yeah".* [161]

Ms Fazackerley expressed her sadness at this situation but appeared to accept that it was likely true. She was asked by Counsel Assisting about her response as an Acting Duty Manager but indicated that due to a *"siloed approach to management"* for this type of welfare issue, she felt that it would be dealt with *"up the chain"* at the Operations Manager and Regional Manager level and that considerable information did not filter to her level.

Ms Fazackerley said that, as Acting Duty Manager, she was told if Mr Crump was not at work for rostering purposes but she would not be made aware of the reasons or the nature of any issues. However, she stated that Ms Baker was worried about Mr Crump because she knew of his suicide plan and had shared emails written by him referring to it.[162]

Emma Thornley, intensive care paramedic with AT, was close friends with Mr Crump. She said that she had known for many years about his mental health problems and would assist him in researching matters to do with his treatment. She said in her affidavit that in 2013 and following, she had many conversations with Mr Crump. [163]

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[161] T 108.
[162] T108.
[163] C 55,p4

Mr Crump had previously told Ms Thornley that he did not wish to try TMS and ECT treatments, as was recommended, because he did not consider they were likely to work. He told her that if they did not work he guessed that he would have to "end it". [164] This, of course, did not eventuate and it appeared that, at least temporarily, Mr Crump gained some relief from these treatments.

It was during his conversations with Ms Thornley that he told her about his suicide plan. In evidence, she said the following:

> *"Did he tell you what that plan involved?.....Yep. He said that – he said he would set up an IV line and he would use a few things to knock him out so he wasn't aware of anything, like midazolam and fentanyl, morphine. Numb-ers, he'd call them, "I'd use some numb-ers and then I'd – " and the next bit actually surprised me a bit because I hadn't thought of it and it actually was very clever. He said, "I'd use something cardiotoxic." He said, "I'd just use lignocaine and amiodarone in large amounts because that's cardiotoxic so even if they get to you and they try and do pushies and blowies no amount of time that they buy you will work because there ain't anything that will reverse the cardiotoxicity from a massive overdose of that." And I was like, "Oh, yeah, that's actually – yep."*
>
> *Now, at any stage from that point on did you tell anyone at Ambulance Tasmania management about that plan?.....No, because they would have acted in a punitive way and – I believe – and probably stopped him from doing his job and that was the one thing that he was still – that still made him feel a sense of self-worth and self-pride". [165]*

JT also described in her affidavit that, as a close friend, she talked a lot to Mr Crump. She said that she was aware of him having chronic major depression since his teens. She said that his mental health was deteriorating in the last years of his life. She described him being in a particularly bad way in the 12 months before his death.

I have already referred to the suicide plan on Mr Crump's phone, but some further detail is warranted.

Approximately four months prior to his death, Mr Crump told JT that he had a suicide plan on his phone but she would not be able to find it. JT said that when he was out of the room and had left his phone on the kitchen bench, she looked to try and find the plan.[166]

JT stated in her affidavit;

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[164] T231 and C 55 page 4
[165] T231
[166] C 20 Affidavit – JT, page 3

> *"……. He said that he was going to take morphine, midazolam and amiodarone. I can't remember if he had the quantities written down. He said that he would also use a plastic bag over his head or a rope to make sure that his airway was compromised. He had a list of things what [sic] he would need, there was the drugs, the IV fluids, the giving set, cannulas, rope or plastic bag. There was probably a bit more but I cannot remember exactly what.*
>
> *The plan did not say where he was going to get these drugs and items from but I knew that it would be by getting it from work, there isn't anywhere else you could get it from".*[167]

JT said that she did not think that Mr Crump would execute the plan in the near future. She discussed it with her partner and took into consideration that Mr Crump was, she believed, receiving treatment from medical professionals. She also considered the fact he had sworn her to secrecy. JT, like Ms Thornley, said that if she had told anyone at work, AT would likely have taken him off the road which may have pushed him over the edge to suicide. She therefore did not mention the suicide plan on his phone to anyone in AT management.[168]

Having her own mental health issues, JT said that she did not wish to put him at risk and therefore made a deliberate decision not to interact with him a great deal in the last two or three months before his death.[169]

Ms Baker said that she was aware that Mr Crump had severe major depressive disorder and looked after him at work with his "ebbs and flows" as well as during his extended period of hospitalisation for his mental health treatments. She painted a picture of Mr Crump being significantly mood disordered, who had had a plan formulated since adolescence that he would not live past forty. Ms Baker said that it was something that Mr Crump *"kept saying for years".*[170] It is apparent that Ms Baker treated Mr Crump's plan seriously and said in her affidavit that she thought that she had time to *"help him through that stage".* [171]

There is no question that Ms Baker provided Mr Crump with unwavering support throughout her friendship and work relationship with him. Her intense support and serious concern for his condition was not conducive to managing him in an objective and dispassionate manner. No other manager at AT shared the role of supporting him and there was no organisational strategy to monitor his behaviour and performance. Equally, Ms Baker did not openly share with management her knowledge of and concern for Mr Crump's safety.

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[167] C20 Affidavit – JT, page 3 – 4
[168] Ibid page 4
[169] Ibid page 3
[170] C36 page 6
[171] Ibid.

It appears that the lines between friendship, support and supervision became even more difficult for Ms Baker to negotiate as Mr Crump's behaviour and mood deteriorated in the months before his death.

Ms Baker said that in the last year of Mr Crump's life he had become unkempt, was not washing and did not appear to care about his appearance.[172] She described him as tormented and needing a lot of rest to deal with his issues.[173] She said that due to his mental health issues, she felt responsible for his welfare as his manager and as a friend. [174] Her vigilance towards his safety clearly increased towards the end of 2016, likely after the drug thefts from Mornington and Glenorchy stations.

Mr Crump's email to Ms Baker of 6 October 2016 relating to his death must have also contributed to her sense of foreboding about his intention of suicide. I do not find that she was aware of Mr Crump stealing drugs from the drug store at AT headquarters.

Ms Baker must have been suspicious, based upon her long friendship with him, that increased drug use was at least part of the reason for Mr Crump's decline.

Ms Baker was aware that Mr Crump used recreational drugs. She explained a text message from Mr Crump which stated *"get me some Endone"* as silly banter. She said that she would *"shut him down"* so that he would not continue such messages.[175]

Some other of Mr Crump's AT colleagues were aware of his recreational drug use. Some of the evidence, for example, was as follows:

- Mr Crump spoke to fellow AT employee, Nicholas Ward, about using "acid" and substances to keep him awake whilst writing assignments;[176]
- He explained to fellow paramedic, Peta Hooper, that it was acceptable to take large quantities of medication to assist sleep, including "harder medication";
- Mr Crump told colleague Simon Geard, ICP, that he used cocaine, ecstasy and marijuana;
- ZJ said that Mr Crump told her that he used illicit drugs and had sent a photo of some MDMA (ecstasy) and mentioned going out on the *"pingas"*. She was also aware he was using a lot of over-the-counter panadeine to help him sleep and that he had injected Kapanol once; [177] and

[172] C36 page 6
[173] Ibid page 7
[174] Ibid page 6
[175] Ibid page 7.
[176] C 66
[177] C 54 page 4

- Mr Crump spoke candidly to Ms Thornley about his illicit drug use, although she said that she did not wish to engage with him on the topic.

It is fair to say that Mr Crump's propensity to misuse medication and to use illicit drugs socially was a reasonably well known fact amongst his closer colleagues. It also appears that other colleagues suspected it but did not have direct knowledge.[178] However, that drug use was not conveyed to his colleagues accompanied by suicidal statements – rather, that he enjoyed using drugs socially and was prone to experimenting with the effects of medication.

Mr Berry said that it was common amongst some AT staff to wonder *when* he was going to die by suicide, not *if* he was going to do so. Mr Berry said he had a good relationship with Mr Crump and would encourage him to seek help when it was obvious he was struggling. However, nothing formal was provided by AT to manage his mental health. He believed that Ms Baker may have helped him seek assistance but he did not know what that involved. Mr Berry said that Mr Crump was resistant to help and not responsive to direct talk about his health issues.[179]

Similarly, Ms Hooper stated in her affidavit *"I think a lot of us knew that Crumpy was going to do it one day, commit suicide".*[180]

ZJ said that Mr Crump told her that he had a *"go kit"* that he would use to kill himself, maintaining that he would not live past the age of 40. She said that he did not expand on the issue and did not tell her what was in the kit.[181]

In summary, it was well-known amongst members of AT, including duty managers, that Mr Crump either had a specific plan to end his life or in general that he did not intend to live beyond the age of 40.[182] It is quite feasible that higher levels of managers had heard of his intention.

Mr Crump's suicidal intentions were accepted without the matter being escalated to a formal welfare strategy on the part of AT. Several matters are likely to have contributed to inaction - the lack of adequate welfare systems; the assumption that he was being treated by his own private health professionals; the length of time over which he had expressed his intention; and the consequences for Mr Crump's career if the issue was reported; and, in Ms Baker's case, a belief that she was able to manage the risk herself when, rationally, that could never have been the case.

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[178] For example, Stephen Elliott C 17
[179] C 40
[180] C 35, page 3.
[181] C 54 page 6
[182] Kim Fazackerley, Monica Baker

Theft of medication in September 2016

At inquest, the occurrence of the thefts of medication from the Mornington and Glenorchy stations was examined with particular focus on AT's knowledge about the involvement, or suspected involvement, of Mr Crump. Also explored was the requirement for AT to internally investigate the thefts separately to the police investigation.

At the outset, I should say that regardless of the knowledge or suspicion of various persons within AT about Mr Crump's involvement, I find that Mr Crump was in fact the person responsible for the thefts. In making that finding and the findings following, I have the benefit of hindsight and a considerable quantity of evidence not available at the time, including Mr Crump's now-known continuing theft of medication from AT.

(i) The policy background

In September 2016, a Medication Management Policy, effective from 17 February 2014,[183] applied within AT across the state. The policy set out the requirements of AT for the management of medications. It was also stated to apply to the supply, handling, storage, disposal, record keeping and audit requirements for medication utilised within AT, as required by the *Poisons Act* 1971 and *Poisons Regulations* 2008.[184]

Relevantly, the policy provided for the safety and security of Specified Medications, being Schedule 8 substances, such as morphine, fentanyl and ketamine together with some restricted substances such as midazolam and methoxyflurane.[185]

The policy provided that Specified Medications are either stored in individual safes to be accessed when AT employees are replacing medications; or within Specified Medications Kits (SMK) that are housed in a SMK safe for daily use by ambulance crews.

The policy also dealt with the recording of medication in "Medications Registers", these being the documentation process used to record the movement and storage of all medications held in a station medication store. There is a separate Medications Register for Specified Medications as well as General Medications.[186]

Relevantly, the policy set out the following requirements, which I summarise:[187]

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[183] C103.
[184] C103 – Medication Management Policy, p 2.
[185] "Restricted substances" are defined under the *Poisons Act* 1971 to mean a substance that is, for the time being, specified in Schedule 4 to the Poisons List;
[186] Defined in the policy at page 3 as meaning all drugs other than Specified Medications used by AT Clinicians.
[187] Largely using the same words as the policy but omitting headings.

1. That the Regional Manager is responsible for overseeing the storage and security of all medications within their region.[188]

2. That the Duty Manager must maintain stock levels for medications stored on station.

3. That the Operations Manager or Duty Manager is required to conduct regular medication stock and register audits of all stations. These are to occur at least once every three months. This audit should be reconciled with the appropriate Medications Register and recorded as "Audit" in green pen.[189]

4. The Medication Registers and all entries within the Registers must comply with the Poisons regulations and with AT policy.

5. At the commencement of a shift a clinician must, in the presence of a second clinician (where available) conduct a check of the stock of Specified Medications Kits ("SMK") in the safe and make a record in the register, ensuring the number of kits in the safe must match the records.[190]

6. At the commencement of a shift, a clinician is to select an SMK to use for the shift and confirm the SMK is sealed and the tag number matches the tag number on the relevant SMK Register. The clinician must also open the kit, check the contents and sign out the SMK or use on the shift using a prescribed set of procedures. If any discrepancies are found, the duty manager must be immediately notified.[191]

7. At the completion of the shift the crew signing off must secure their SMK by selecting the next numbered security tag from the stock roll and placing it on the SMK.

8. Specific procedures in the policy apply to documentation of Specified Medications, including procedures for correcting an error in the register.[192]

9. If there is a discrepancy with any Medications Register, the employee discovering the discrepancy must immediately report and record the incident by:

[188] C103 – Medication Management Policy, p 6.
[189] C103 – Medication Management Policy, p 7.
[190] C103 – page 8-Medication Management Policy
[191] ibid, page 8
[192] C103 – Medication Management Policy page 10

i. Making an entry into the appropriate Medications Register in red.

ii. Immediately notifying the Duty Manager.

iii. Submitting an EIMS notification.

iv. The Duty Manager will notify the Operations Manager at the earliest convenience.

10. On receiving a report as above, the Operations Manager will:

i. Notify their Regional Manager and follow up with an Issues Brief and completion of the relevant sections of the EIMS report.

ii. Commence appropriate investigative procedures, and complete the EIMS report with details of all activities undertaken to account for the discrepancy. If theft is considered, the Operations Manager will organise for referral of the incident to Tasmanian [sic] Police, and a police reference number must also be included in the EIMS report.[193]

11. The Duty Manager is responsible for recording discrepancies in medication and notifying the Operations Manager.

12. The Operations Manager is to conduct three-monthly reconciliation audits of all medications.

13. The Operations Manager is to conduct investigations regarding discrepancies, suspected theft, unusual patterns of breakages and other irregular usages of medication in AT.

14. The Regional Manager is responsible for overseeing the storage and security of all medications.

15. The Chief Executive Officer is responsible for ensuring that AT personnel comply with their responsibilities as defined within the *Poisons Act* 1971 and *Regulations* 2008.[194]

[193] C103 – Medication Management Policy page 10
[194] C 103 – Medication Management Policy, p 14.

16. Under the heading "Audit", there is a requirement for monthly audits of stock, three- monthly reconciliation audits and random audits of VACIS/PCR[195] reports against the Medications Register, and all discrepancies and breakages must be recorded in the EIMS system.[196]

17. Audits must be presented to the Director of Emergency and Medical Services, with 100% compliance expected.

(ii) Police investigation

On 25 September 2016 Detective Senior Constable Danny Jackson received a telephone call from Mr Berry outlining a number of concerns relating to missing drugs, including morphine, from SMKs.[197] The drugs were purportedly missing from the Mornington Branch Station. [198]

Detective Jackson attended AT headquarters the next day where it was confirmed that there were discrepancies surrounding paramedics signing in and out the SMKs and inconsistences relating to the auditing of the contents when they were starting and finishing their shift. He was informed that staff are expected to check the kits every day by breaking the individual security tag and inspecting the contents. However, they sometimes did not break the tag, would keep the same tag on the pouch and write "tag intact". This led to delay in discovering what appeared to be thefts of drugs.

In his affidavit, Mr Berry outlined various inadequacies in the management and security of medications, stating that human error and mistakes were reasonably common and were not detected promptly. [199] He gave evidence at inquest that, over and above the usual errors, there were features of this incident that suggested theft, as there were missing broken morphine ampoules within a pack containing an apparently incorrect tag.[200] The concerns were reported to Detective Jackson relating to incidents beginning around 15 September 2016.[201]

On 28 September 2016 Detective Jackson was contacted by Ms Baker about further thefts of drugs from the Mornington and Glenorchy stations respectively.

On the same date, Detective Senior Constable Tami Nelsen was briefed about the thefts. She met with Ms Baker and Stephen Riley (Acting Duty Manager) the following day, being 29

[195] ATs electronic patient records.
[196] C103 – medication Management policy page 15
[197] C38 Affidavit – Detective Senior Constable Danny Jackson.
[198] T 974/975 – P Berry.
[199] C 40 Affidavit Peter Berry, page 6
[200] T975
[201] C38 Affidavit – Detective Senior Constable Danny Jackson.

September 2016.[202] By that time, Ms Baker as Operations Manager had undertaken some investigations and was able to provide Detective Nelsen with information.

In her statutory declaration, Detective Nelsen stated;

> *"I asked Baker if they had any information to suggest that the matter was an internal staff member related stealing and she stated that she believed it must have been a staff member as members of the public do not have access to the areas where the medications were stored. I further asked if there was anyone that they had suspicions about. Baker informed me that she was a friend of Damian Crump's and whilst she did not suspect that he would steal medication she did hold some concerns about his mental health.*
>
> *Baker stated that Crump was an Intensive Care Paramedic for Ambulance Tasmania and was aware that he was medicated for severe depression and that some other colleagues of Crump's had described his behaviour to her on the 29 August 2016 as erratic. She further informed me that Crump had been on annual leave for 3-4 weeks and that a different colleague (name not provided) mentioned to her that a few weeks prior he had stated he wanted to flip his car. Baker stated to me that years prior Crump had told her and other friends that he would be gone by the time he was 40 years of age. Baker told me that she suspected that Crump was homosexual but that he had never "come out". Baker further stated she had no direct reason to suspect Crump involved in stealing medication".* [203]

Ms Baker also told Detective Nelsen that the ambulance stations did not have closed circuit television (CCTV) which may have assisted with identifying the offender.

I accept Detective Nelsen's account of the discussion with Ms Baker on 29 September 2016.

On 4 October 2016, Detective Nelsen attended AT and spoke further to Ms Baker. At that time Ms Baker advised that, upon further checking of the swipe card records, she identified that Mr Crump had accessed Glenorchy station on 24 September 2016 whilst on annual leave and this was an evening when medication went missing. At this time, Ms Baker made a statutory declaration for the police investigation.

Significantly, Ms Baker stated in the statutory declaration, referring to Mr Crump *"This is the only person who has accessed the station when they have not been rostered to work. I have not spoken to Damian about this matter".*[204]

Ms Baker goes on to say in her declaration:

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[202] C39 Affidavit – Detective Senior Constable Tami Nelsen, p 1.
[203] C39 Affidavit – Detective Senior Constable Tami Nelsen, p 1 and 2.
[204] C36 Affidavit – Monica Baker (Affidavit dated 4/10/2016, pp 2-3).

> *"To access the room where the restricted medication pouches are kept at the Ambulance stations a person would need to use their swipe card access card to enter the station or use an air key which is in most of the ambulances. Once inside access to the room is via a pin code (generic for all ambulance officers to use). This is not recorded to show times accessed. There is a key pad on a safe which is again generic for all ambulance officers to use. A register is signed indicating who has signed the pouch in and out, the pouch number, includes tags/seals number and medications present in the kit.*
>
> *Initial indications are that the offender/s are members of staff from Ambulance Tasmania as they have known the pin access code to enter the room and the safe".*[205]

In relation to Mr Crump as a potential suspect, Ms Baker told Detective Nelsen that it was not unusual for off-duty staff to call into their work place whilst on leave.[206] Neither Ms Baker nor any other AT employee named any other paramedic or AT staff member who may be involved in assisting the police investigation.

Detective Nelsen submitted a Call Charge Record (CCR) request on 7 October 2016 for Mr Crump's mobile telephone number which indicated that the telephone had not been used around the time or in the vicinity of the locations where the offences were alleged to have been committed.

After this, Detective Nelsen advised Ms Baker as follows: (a) that the CCR results had not provided any further avenues of enquiry; (b) that Mr Crump had not been identified as a suspect; and (c) that without any further information, the matter would be filed (by which I take to mean cease to be actively investigated).[207]

Mr Crump was not spoken to or formally interviewed as part of any enquiry, either by Tasmania Police or AT.

On 18 April 2017 Detective Nelsen swore a comprehensive affidavit regarding this complaint made at the request of Sergeant McCulloch. She compiled the affidavit in order to fully expand upon the details of her investigation. This enabled Sergeant McCulloch to review that investigation to determine whether the investigation was sufficiently thorough and whether Mr Crump should have properly been questioned as a suspect.

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[205] C36 Affidavit - Monica Baker (Affidavit dated 4/10/2016, p 3).
[206] C39 Affidavit – Detective Senior Constable Tami Nelsen, p 2.
[207] C39 Affidavit – Detective Senior Constable Tami Nelsen, pp 2-3.

Sergeant McCulloch gave evidence that, at the time, the police investigation was carried out as best as it could be based upon the information provided. He also indicated that the investigation was reviewed by the Inspector in charge of Drug Investigation Services. [208]

Sergeant McCulloch concluded that, based upon the information in the possession of Tasmania Police, its investigation could not be criticised.

Counsel Assisting, on the other hand, submitted that Tasmania Police should have considered Mr Crump a suspect and taken steps to interview him. They submitted that this was the case because of the following matters:

- Mr Crump was a member of a group, albeit a large group, of AT employees based in Southern Tasmania, one or more of whom were likely to have committed the crimes;
- His swipe card was known to have accessed the Glenorchy Station on a date coinciding with the theft of drugs from that station;
- He was not rostered to work on this date; and
- He was on recreational leave.

I would add to the above points by noting that Ms Baker had also advised Detective Nelsen on 29 September 2016 that Mr Crump's colleagues had recently witnessed him engaging in "erratic" behaviour. As previously described, Ms Baker further advised that Mr Crump had recently told one particular colleague that he wanted to *"flip his car"*. Ms Baker also told Detective Nelsen that Mr Crump had a plan to be *"gone"* by the time he was 40 years of age.[209]

I tend to agree with Counsel Assisting that police investigators might properly have approached Mr Crump with the information they already held in order to obtain an explanation for the obvious anomaly - why his card was used to access the Glenorchy station on a day when drugs were stolen and when he had no obvious reason to be there.

It may have been that Mr Crump could have explained himself satisfactorily, but whatever he said may have been able to be further verified. This, in turn, may have led to Mr Crump's records of accessing other stations being checked. Alternatively, Mr Crump may have declined to provide any information, as would have been his entitlement.

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[208] T 34 and 35
[209] C39 Affidavit – Detective Senior Constable Tami Nelsen, pp 1-2.

The thefts of drugs of addiction by an AT staff member are, of course, very serious matters. However, Detective Nelsen considered that she was unable to advance the investigation after obtaining Mr Crump's phone records.

Whilst Glenorchy and Mornington stations did not have CCTV, this existed in the drug store at Hobart headquarters. If investigators had been told of this fact, it is possible that they may have viewed footage and identified Mr Crump stealing medication.

I do not suggest that Ms Baker or any other AT staff member deliberately withheld that information from investigators. However, AT might have been more vigilant in considering available evidence that could materially assist in identifying an offender who had already entered two other AT stations. The reality is that police rely heavily upon complainant organisations (such as AT) to provide relevant information, including concerning their systems, to assist the investigation.

I did not require Detective Nelsen to give oral evidence. There was no application from Counsel for Ms Baker or Counsel for the Department to have her appear at the inquest. As such, her evidence is unchallenged and represents a detailed account of how the police investigation unfolded.

I conclude that the decision by Tasmania Police to cease active investigation on the matter without speaking to Mr Crump was, in the circumstances, reasonable.

(iii) Should AT have conducted its own investigation?

The Medication Management Policy provisions summarised above make it plain that the responsibility to investigate discrepancies in medication is the responsibility of the Operations Manager - Ms Baker at the time. It is not the intent of the policy that AT should refrain from internally investigating such incidents where police have also been involved.

The timing of *when* any internal investigation is to take place may need to be considered with respect to any police action.

At the point where Tasmania Police advised AT that the matter would be filed, AT was no longer constrained in any way about what action it could properly take in response to these thefts.

A properly functioning organisation would have immediately proceeded to conduct its own thorough investigation, knowing with a reasonable degree of certainty that an unidentified criminal offender was amongst its employees.

Dr Con Georgakas, Director of Medical Services for AT, said that where there was an apparent diversion of medication that it was incumbent on AT through its operational managers to perform its own full investigation; and this should occur independently of and concurrently with police, for purposes including identifying compliance with policy, any management or supervision concerns, and any training or disciplinary issues.[210]

Dr Georgakas agreed that it was not necessary to wait for the results of an investigation in order to act protectively in respect of a staff member, indicating that it was a matter of balancing risks before making a recommendation of that type, including suspending a paramedic's authority to practice while the investigation is undertaken.[211]

The Regional Manager, Mr Westlake, gave evidence about AT's failure to conduct an investigation into the September 2016 medication thefts. Mr Westlake gave honest and articulate evidence and I found him to be a very helpful witness.

Mr Westlake said that he was advised of the discrepancies at the time by way of an email, although he was never told that Mr Crump may have been a suspect.[212] He said that this fact should have been briefed up to his level, and he would have advised the Chief Executive. He gave evidence that he did, in fact, brief the Chief Executive. However, the evidence is that the briefing concerned the thefts generally, the fact that police were investigating and that no one had been identified as responsible. [213]

Both former Chief Executives also agreed in their evidence that they would have expected to be notified of the possible identity of a person who may be responsible for the purpose of investigating disciplinary action.[214]

Mr Westlake accepted that an investigation was required by AT under the terms of the policy and independent of any action taken by police. Such an investigation was necessary not just because the policy required it, but to properly manage issues such as the welfare of the person involved (or possibly involved), to manage the obvious risks to the person's colleagues, members of the public and any patients that the person may have been caring for.[215]

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[210] T908: 25 – T909:15-25.
[211] T922: 9-14.
[212] T344: 35-45.
[213] T345: 1-12. So Also evidence of Neil Kirby T2 149.
[214] T2 84: 8-16 (Dominic Morgan) & T2 149: 21 - 25 (Neil Kirby). Also T349 (Craig Westlake)
[215] T346-348.

Again, both former Chief Executives in their evidence agreed that there were other very serious organisational issues of concern beyond the issue of criminal charges that justified an investigation by AT independent of the police.[216] This is plainly the case.

It is difficult to understand why AT did not undertake a full internal investigation, as is expected as a matter of course from any large organisation where an event occurs which presents a significant safety or other risk.

In stark comparison, AT investigated and dealt with Mr Crump's inappropriate administration of morphine in 2006 by way of forming an investigation team, obtaining (*inter alia)* expert pharmaceutical and medical evidence, and seeking a formal explanation from Mr Crump. The final detailed investigation report made considered factual findings and recommendations.[217]

When asked if he thought enough had been done by AT to investigate, Mr Westlake replied: *"In the balance[sic] of hindsight, no."*[218] In explaining why he held this view, Mr Westlake said he could not say what he would do differently because this occurred *"in a context of – at the time, it was one crisis after another after another after another"*. He did not consider that *"anything was done properly."*[219]

Unfortunately, Mr Westlake's comments about the organisation regard are borne out by the evidence in this investigation.

Mr Westlake was asked if his view included the management of this incident and he replied:

> *"Including these – this incident and any other incident that was[sic] probably happened at the time. It was just completely overwhelming. And in the midst of all of this stuff, you're still trying to keep an ambulance service operational and functioning, and it was literally – it was, you know, 10-hour days at work and working at home at night time. It was just non-stop. So, look, I've racked my brain over and over again. I know in hindsight, you know, in a perfect world what you would do. What I would do at the time, I just don't know."*[220]

The evidence indicates that the Regional Manager and Chief Executive of AT did not even contemplate conducting an investigation into the thefts in light of the fact that police had not identified a suspect. The overwhelming pressures and competing demands in the organisation are apparent from Mr Westlake's evidence.

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[216] T2 86: 26- 42 (Dominic Morgan) & T2 152: 4 - 24 (Neil Kirby).
[217] C 13 A, AT personnel records, page 5 and onwards.
[218] T348: 21-2.
[219] T348: 24-32.
[220] T348: 34-42.

As Acting Operations Manager, Ms Baker had the responsibility to investigate the thefts of September 2016. There was conflict in several areas between her evidence and other AT colleagues regarding her belief concerning Mr Crump as a suspect as well as the extent to which she disclosed her belief to others on a formal and informal basis.

I do not accept the submissions of Counsel for Ms Baker that the extent of Ms Baker's knowledge of Mr Crump's involvement in the theft of drugs from the Glenorchy station is immaterial to the circumstances of Mr Crump's death.

If Ms Baker did not provide the requisite degree of assistance to police and if she did not progress an internal AT investigation as her role required, this meant that a major opportunity to stop Mr Crump's activities was lost.

Because he was able to continue his misappropriation of drugs from his workplace, his addiction, mental health issues and suicidality were able to escalate until he was apprehended. Even at that point, he was still able to gain access to large quantity of drugs to effect his suicide.

Because the issue is material to Mr Crump's death, the process of fact-finding may require evidentiary conflict to be resolved. Further, the necessary fact-finding is not a case of impermissibly making moral judgements, as Counsel for Ms Baker submitted. If Ms Baker did not acquit her role in material respects connected to Mr Crump's death, then findings surrounding that issue are required.

In this case, the findings necessarily involve a consideration of Ms Baker's credibility and the issue of whether she was irreconcilably conflicted with respect to investigating Mr Crump for stealing drugs from AT.

In these circumstances, I consider the submission of Counsel for Ms Baker that Counsel Assisting were unfairly singling out or biased against Ms Baker to be without any merit whatsoever.

In her affidavit of 28 September 2018, Ms Baker explained her role and actions relating to the drug thefts, stating that she named Mr Crump as *"a suspect"* in relation to them.

She said that when she spoke to the detectives, she believed she had done what she needed to do and her actions were in accordance with the policy. She did not consider that she was protecting Mr Crump in any way.[221]

[221] C 36 page 5.

She said in her affidavit:

> *"Sometime after this (the missing medication report to police), I had a conversation with Damien[sic] about the situation with the drugs going missing at[sic] station and that I had had a pretty ordinary day as I had to call the Police and provide a statement, he went quiet but said nothing more about the matter . After that conversation they didn't go missing in the same manner".*[222]

Ms Baker must have concluded after this discussion with Mr Crump that he was responsible for the thefts at Glenorchy station. I can only take that meaning from her words. At inquest, however, she testified that Mr Crump's silence in the conversation did not cause her to be suspicious. Her answers to questions about this matter contained hyperbole and were not logical or helpful.[223] I do not accept her evidence on this point.

Her state of mind about Mr Crump's responsibility is also borne out in statements made to Ms Fazackerley and Jo Blowfield, administration manager at the Hobart station.

At inquest, Ms Fazackerley gave evidence, consistent with her affidavit,[224] that Ms Baker had told her shortly after the thefts had been reported that she *knew* that Mr Crump was responsible.[225] Ms Fazackerley also referred to a conversation she had with Ms Blowfield, who said that Ms Baker had also told her that Mr Crump *was the person responsible* for the thefts.[226]

In her affidavit, Ms Blowfield provided her direct account of this interaction with Ms Baker:

> *"The only real conversation I had with anyone surrounding the missing medication was with the Operations Manager Monica Baker. It was either the day of or within days of a police [officer] coming to Ambulance Tasmania to take statement from Monica about the missing medication. That conversation took place in Monica's office. She said to me that she knew who was stealing the drugs, I asked who and she told me to guess. I said a couple of names to her which she said were wrong. She then told me it was someone I liked, that always makes me laugh and I immediately said Damian (Damian Crump) and Monica nodded her head*". [227]

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[222] C 36 page 5
[223] T 726
[224] C15 – Affidavit of Kim Fazackerley, p 2.
[225] T110: 1-30.
[226] C15 – Affidavit of Kim Fazackerley, p 7.
[227] C67 – Affidavit of Joanne Blowfield, p.1.

At inquest, Ms Baker testified that she did not recall the conversation with Ms Blowfield about Mr Crump's involvement, although accepted that it may have occurred. [228] Similarly, she said that *if* she had told Ms Fazackerley, then it would only have been in relation to the Glenorchy thefts because of her suspicion. [229]

I accept Ms Fazackerley's credible evidence and Ms Blowfield's unchallenged evidence, that Ms Baker told both of them on separate occasions, shortly after the thefts, that Mr Crump was responsible. I find that she did so because she believed that Mr Crump *was* responsible.

Ms Baker gave evidence, inconsistent with the above statements, that the first time she suspected Mr Crump for these thefts was when she received a call from Mr Westlake on the 23 December.[230] I do not accept her evidence in this regard, particularly in light of the evidence of Ms Fazackerley and Ms Blowfield. Ms Baker was fully aware of the possible significance of Mr Crump's swipe access to the Glenorchy Station whilst on leave combined with his erratic behaviour and poor mental health. She appeared to acknowledge this fact in evidence and indicated that, in response to the risk, she put in place checks to make sure he was okay and she rang him regularly.[231]

Ms Baker gave evidence at the inquest in respect of her involvement in investigating the thefts. She indicated that she took over the investigation of the reported thefts at Glenorchy from Mr Berry.[232] She said that, in investigating, *"we used the medication management policy as our guide"*.[233] Her involvement included, amongst other things, contacting police and making a statement.[234]

Ms Baker agreed that, in investigating and reporting to police, it was definitely a point of concern for her that Mr Crump's swipe entry was anomalous. [235] It is clear from her evidence that from the outset she did not consider any other person to have been responsible apart from Mr Crump. [236]

Ms Baker was at pains in her evidence to highlight that Mr Crump had always expressed disapproval about misappropriation of medication and that he never displayed the physical signs of having used any opiate or similar. She also said that he would routinely be at his shift early to check his vehicle and was doing his job appropriately. She commented *"he'd*

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[228] T732: 7-15.
[229] T730: 34-37.
[230] T722: 41-43.
[231] T723: 26-34.
[232] T655: 26-29.
[233] T655: 37-39.
[234] T656: 8-10.
[235] T657: 1-20.
[236] T658: 19-22.

sometimes be a bit cheeky and we'd have to – I'd have to bring him up – pull him in line a bit, but that was, sort of, his – his character.[237] Ms Baker, it appears, was so accustomed to unacceptable behaviour on Mr Crump's part that she had limited ability to respond objectively. Ms Baker gave significant weight to Mr Crump's statements concerning misappropriation of medication but did not appear to consider the significance of his improper requests to her for medication.

Ms Baker said that she did not believe that she was protecting Mr Crump and, in fact, said *"I would not protect him"* and was *"probably…harder on him than I would've been on anyone else because, like, you know, I mean, his – his job was his life".*[238] This statement does not make logical sense. However, it does demonstrate exactly the issue faced by Ms Baker - understanding that her role required managing him appropriately; but, as his friend, wanting to ensure that he remained in his work, with the loss of his job potentially catastrophic for him.

Ms Baker said she did not think there was anything else that needed to be done in respect of the thefts, apart from reporting to police, as she explained in the following passage:

> *"I was checking on him. I had a very good relationship with him I thought and, you know, I contacted him quite regularly because of his underlying mental illness and also the fact that we were friends. But as far as – I – I know that he would not – he – he had been offered by me numerous times psychological support. I knew he was being treated by a psychiatrist because he told me. We had documentation from her when he returned back from work after being treated in hospital to make sure that he was okay and fit to do the job. He refused to have any psychological support because he wasn't a fan of psychologists after he went to one many, many years ago and he told them he thought that he might be gay and they said, "Don't be silly. You're not gay." So as far as CBT, you know, cognitive behavioural therapy, all sorts of things, therapies, to provide support for him, he wouldn't have utilised or he would've actually been quite anti".*[239]

Mr Crump was certainly able to perpetuate the view held universally by his colleagues that he was under regular care of a psychiatrist who was monitoring his treatment and medication. As earlier discussed, he had stopped seeing his general practitioner early 2016 and he had last consulted with his psychiatrist in mid-2015. Mr Crump was even able to persuade Ms Baker that he was under adequate treatment.

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[237] T659: 4-20.
[238] T661: 18-27.
[239] T663: 10-25.

In cross-examination, Ms Baker denied feeling any conflict between her role as Mr Crump's manager, and their friendship.[240] In respect of any perception of a concern about how she treated Mr Crump, she said that she had a professional relationship at work with him most of the time and that she had never been spoken to by any superior to the effect that she was managing him inappropriately.[241] I cannot accept that Ms Baker did not feel conflicted. For many years, she had been in the position of having to induce modification in his unacceptable professional behaviour whilst at the same time being involved closely with him socially. In the latter regard, she had invited Mr Crump to her home for Christmas Day 2016.

Counsel Assisting, Mr Allen, asked Ms Baker about potential conflict concerning the investigation in the passage as follows:

> *"[Mr Allen] Now well, to be clear, what I'm asking you is, for someone who was close friends with Damian Crump, who knew of the critical importance of his job to him, to his identity, to his health, to be in charge of an investigation that had him identified as a suspect, you would have seen obvious conflict in those two positions – if you do your investigation properly and identify him, it will have the effect, very likely, of causing him to lose the very thing he loves - ……[Ms Baker]You sound like you don't - well –*
>
> *[Mr Allen]- that's the question I'm asking you?……[Ms Baker] Ultimately Craig Westlake has carriage of that sort of decision in the region. Whether he chose to read the SLRS or listen to me, was up to him, okay. I mean I – I did everything that I could do and no, I do my job properly, and I know, because I go to drug addicts all the time, I see what happens when people take drugs, but I know that they can get rehabilitated as well. So you know, no, my main thing was that he is alive and well, not the fact that whether – I mean yes, I know he would have worried about his job but that's – I'm the parent in the role here that needs to basically make a decision and say 'no, we need to do something about it', and I – I just like, other than those strange sort of things that's the – people can say what they want. People know that I do things – the majority of people know that I do things the right way and I would not have done that. I never did let Damian push me into doing anything that wasn't appropriate".*[242]

Ms Baker disputed Mr Westlake's claim that he was never told that Mr Crump was a suspect. She gave evidence that she *"would have told him",* possibly in one of their regular, weekly meetings.[243] It was apparent, however, that she had no actual recall of such a discussion.

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[240] T696: 18-31.
[241] T698: 24-41.
[242] T733 – 734.
[243] T722

Ms Baker was also questioned about whether she named Mr Crump as a suspect in the SRLS reports endorsed by her. The relevant reports were tendered in evidence and did not contain any mention of Mr Crump.[244] Ms Baker partially conceded that this was the case, stating *"- he (Mr Westlake) might be right about that because Damian's name wasn't on that-… If he didn't go through the appendages, yes".*[245] I was not referred to evidence of any appendages or what they contained.

In a somewhat contradictory statement, Ms Baker agreed that the SRLS reports did not contain Mr Crump's name because she did not wish to pre-empt the police investigation. [246] I can safely conclude that, if there were other documents containing Mr Crump's name, they were not brought to Mr Westlake's attention. He could no doubt have asked for Ms Baker's police statement and the swipe card records, although he was relying upon Ms Baker to handle the matter. The lack of an assertive approach to the matter by the Regional Manager was, in itself, problematic.

I found Ms Baker's evidence to be confusing and inconsistent on this point. If she had clearly communicated to Mr Westlake that she suspected or believed that Mr Crump may be responsible, I have no doubt that Mr Westlake would have taken the matter further, including with the Chief Executive. I find that she did not advise Mr Westlake of her belief. She certainly did not advise Mr Westlake of her discussion with Mr Crump about the thefts.

I am satisfied, for the reasons given, that Ms Baker suspected that Mr Crump was responsible for the thefts once his swipe entry had been identified; and that this suspicion was elevated to an actual belief once she had spoken to Mr Crump about the matter.

Ms Baker agreed that the investigation of these thefts was limited to the police complaint and was not directed towards any sort of systemic or welfare issues that might have been of concern to AT.[247] This fact is confirmed on the SRLS reports which simply indicate that a police investigation is ongoing. She also conceded in hindsight that someone should have been tasked separately to manage the investigation,[248] later acknowledging that the risks were huge.[249]

[244] C104, C105 and C106 – Safety Event Management Forms.
[245] T722
[246] T722
[247] T718: 29-43.
[248] T720: 21.
[249] T721: 4.

Ms Baker agreed that, in hindsight, on the information available regarding Mr Crump's swipe card she should have acted to prevent his access to medication stores, although she said she was unaware at the time that this was possible.[250] She later added:

> *"But in hindsight now, would I – I probably just would have turned off his swipe for a couple – not told him and then – and then if I hadn't heard anything from the police maybe we would have had to take it into our own hands".* [251]

Mr Westlake gave evidence that AT had the ability to cut the access to any drug store of any person suspected of being involved in theft and acknowledged that such early action was protective and not contingent on any actual finding or proof of responsibility.[252]

I agree with the submission of Counsel Assisting that Ms Baker's evidence at inquest conveyed that she believed that her decision-making was unaffected by her close friendship with Mr Crump.

Counsel for Ms Baker submitted that she was not required to do any more than she did, which included advising police of Mr Crump's potentially anomalous swipe access. This submission would have had some force if Ms Baker did not hold the belief that Mr Crump was responsible. Once she actually formed a belief, as stated to Ms Fazackerley and Ms Blowfield, she needed to immediately and honestly convey that belief to police investigators. As it stood, Detective Nelsen had been advised by Ms Baker that she did not suspect Mr Crump and that it was not unusual for off-duty staff to call into their workplace whilst on leave. [253] An investigator is likely to be influenced, or even misled, in the investigation by information and views from a senior manager of the complainant organisation.

Ms Baker was untenably conflicted in her role as a senior manager tasked with investigating the thefts. She appeared not to appreciate the fact that her close friendship with him made it imperative that she step aside from the investigation. Consistent with the proper performance of her duties as a senior manager, she should have declared her conflict to the Regional Manager, Mr Westlake, and told him of her belief that Mr Crump was responsible.

Regardless, she should also have honestly reported her belief to Tasmania Police, including; his tendency to use recreational drugs, misuse medication, that he offered no explanation when she spoke to him, and that no further drugs had been stolen (to her knowledge) after this conversation. This may well have prompted an investigation in which Mr Crump was

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[250] T724: 1-41.
[251] T726: 7-10.
[252] T346: 28 – 347: 13.
[253] C 39 Affidavit of Detective Nelsen, page 2

interviewed as a suspect, with interim measures taken to ensure he was denied access to drugs held by AT.

Having been critical of Ms Baker, it is important to note that senior managers at AT over a number of years let Ms Baker take on the responsibility of managing Mr Crump's behaviour and welfare, knowing that his mental illness manifested in his workplace behaviour and that Ms Baker was his close friend. The conflicted situation was able to become entrenched because AT had no adequate oversight.

I add that Ms Baker's motivation to help Mr Crump was well-intentioned. However, she believed that Mr Crump as her friend was honest with her but he was not in several critical respects.[254] There were no effective checks and balances in their professional relationship. In the organisation as it then was, the level of management input required to both support Mr Crump and modify his behaviour simply did not exist.

The difficulty of Ms Baker being both a friend and manager of Mr Crump was recognised by various AT employees in the evidence provided in the investigation. These comments included that whilst Ms Baker provided him support and had a caring personality she need further assistance to manage his difficult behaviour; that she became confused between her role as that of a manager and friend;[255] and that she and Mr Crump had a love-hate relationship.[256]

It is to be noted that other AT managers were aware of Mr Crump's swipe access to Glenorchy whilst he was on leave. These were Mr Riley and Mr Gibson.

Mr Gibson, who had been Acting Operations Manager, returned to his other managerial position shortly after the commencement of the investigation and Ms Baker then took up that position with responsibility for the investigation under the AT policy.[257]

Mr Riley, Acting Duty Manager, assisted in the initial phases of the investigation. He may not have formed any view about whether Mr Crump's entry was suspicious at that time and concluded his role as Acting Duty Manager in mid-October 2016, when he returned to his role as ICP stationed at Triabunna. He did not, and was not required to, have any further

[254] Mr Crump did not tell Ms Baker that he was addicted to intravenous opioids, was stealing Schedule 8 medications from AT and that he was under appropriate psychiatric treatment.
[255] Jaeger C79
[256] Jaeger C79 and Berry C40
[257] T618

involvement.[258] It seems that at a later time he formed a view that Mr Crump was likely responsible.[259]

Mr Berry was also Duty Manager during the period of the thefts and had started investigating the Mornington thefts before he went on a period of leave. Subsequently, Ms Baker took carriage of the whole investigation as Operations Manager. For the period of his involvement, Mr Berry had not heard Mr Crump's name as a suspect and did not recall Ms Baker mentioning Mr Crump in this context. [260]

I do not consider that Mr Gibson, Mr Riley or Mr Berry in the circumstances were obliged to follow up the investigation when it had clearly been handed over to Ms Baker. None of them held a positive belief that Mr Crump ought to be considered a suspect and had no duty to provide additional information.

Mr Westlake as Regional Manager had an overarching responsibility to ensure a prompt internal investigation by AT despite not being told that Mr Crump may be responsible. I have dealt with this issue above.

The Chief Executive was ultimately responsible for ensuring the Medication Management Policy was operating effectively and that a proper investigation occurred. He had been briefed about the thefts. However, the briefing did not include information that anyone (in particular, Mr Crump) had been identified as a suspect.

As submitted by Counsel Assisting, if proper drug auditing was taking place at the time under the existing Medication Management Policy there was a likelihood of AT identifying Mr Crump as the person who was diverting drugs, and to effectively deal with all of the issues arising, including those relating directly to Mr Crump's mental health and wellbeing.

I have previously referred to the fact that, in 2016, drug counts took place at AT instead of more thorough audits. Mr Westlake described the audits as being a process to account for the use of every ampoule; whereas drug counts simply asked the question*, "How many have been used, how many have been signed out and how many do we need to order*"?

Mr Westlake gave evidence that the audit process did not occur.[261] He admitted that as the Regional Manager at the time that he did not require auditing to be done. He said that, in hindsight, he probably should have done, but added: *"...whether you had the capacity to do it is*

[258] C 37 Affidavit of Stephen Riley, page 2.
[259] C15 Kim Fazackerley, page 3.
[260] T993.
[261] T354: 28-33.

another question".[262] He described the practice of auditing at that time as *"absolutely largely a reactive one".*[263]

Mr Westlake said that the new policy required an *"audit back to the case record every use of a S8 and some S4 drugs, and a hospital – a copy of the patient care record is left in the drug room with the drug register and they are cross-checked every day".*[264]

I conclude that if a proper investigation of the theft of AT medication by Mr Crump in September 2016 had taken place, it may well have changed the trajectory of Mr Crump's life and the manner in which his death occurred less than three months later.

It is, of course, possible that Mr Crump would have ended his life after allegations were put to him in a properly supported investigative process. Alternatively, he may have taken the opportunity to obtain much needed treatment for his mental illness and drug addiction.

Regardless, AT had a responsibility to its employees, including Mr Crump, to (a) ensure that there was a robust process of audit to account for the dangerous drugs it possessed as part of its authorised functions, and (b) to conduct a proper investigation where anomalies or discrepancies are reported or identified.

These things did not happen. Because they did not happen, the activities of Mr Crump in diverting serious drugs of addiction continued unabated until the unfortunate events of 23 December 2016.

Continuing medication theft by Mr Crump

Mr Crump was stealing narcotic medication from the AT drug store before he stole the medication from the Glenorchy and Mornington stations in September 2016. He continued doing so, undetected and with a high level of frequency, until his death.

As I have just mentioned, a properly resourced and well-functioning organisation would have used the September 2016 thefts from the Mornington and Glenorchy stations to trigger a thorough audit of medication. This is particularly the case because the Schedule 8 substances in the individual SMKs held at the various stations were restocked from the drug store at AT headquarters. The fact that auditing was not undertaken meant that Mr Crump was able to continue stealing drugs from the drugs store in AT headquarters.

[262] T354: 40-41.
[263] T358: 1-2.
[264] T352: 40-42.

Ms Fazackerley helpfully described in her affidavit the drug store access procedures and how undetected theft of drugs could occur.

She said that the Schedule 8 stock in the drug store was used by the paramedics for restocking their medication pouches[265] used on a shift and which are kept in the individual ambulance stations.

When restocking a medication pouch, a paramedic is required to swipe into the drug store, gain access to the safe using a common pin code and record in the drug register book all case details - including case number, patient name, dose given and amount replaced. This entry requires two signatures as a safety measure, one from the administering officer and another from a witness.

Ms Fazackerley stated that if an AT employee wanted to steal Schedule 8 drugs, they could take the following steps: enter the drug store, select the drugs they wanted, make an entry into the drug register using false patient details and a false case number, and leave with the drugs.

She said that in 2016 time there was no checking of these details against actual case details from other records, such as patient records made by the AT paramedics. This process would be undertaken in a proper medication audit but these were not taking place. She said that the only way someone could have been caught would be if they took drugs but did not actually sign them out. This would show an incorrect drug count.[266]

Ms Fazackerley described in her affidavit how, two days following Mr Crump's death, she discovered the extent of the thefts from the drug store;

> *"On Christmas Day, when I was back at work, I went to the drug store and got the morphine drug register book. I took it back to my office and started looking back through it and started to see a clear pattern of Crumpy's entries, I could tell that they were false entries. There was a distinct pattern to them, the majority of his sign outs were three ampules. This never happens because the maximum dose is 20 mg (2 ampules) for a paramedic and [sic] ICP can give more but it is very rare. The majority of sign outs are 1 ampule, occasionally there are 2, but there are rarely, if ever, are (sic) three ampules given. I grabbed Leah Geard, a CSO, to come and help me because I knew we were going to have to get all of the drug registers.*

[265] I assume the term is used interchangeably with SMK.
[266] C 15 – Affidavit of Kim Fazackerley, page 6

> *I photocopied that whole morphine book and started with highlighting all of the entries that were 3 ampules. I went back over it again and highlighted the entries that were consistent with his handwriting and the pattern that we had picked up".*[267]

It became apparent to Ms Fazackerley that a pattern of other anomalies was associated with the fraudulent entries in the Medication Register for morphine. One of these included not recording the date in a second, required field. Another was the use of unusual names, as well as names of AT employees and volunteers who were unlikely to be utilising the drug store on the dates or in the pairings indicated.[268]

Ms Fazackerley then immediately proceeded to conduct her own audit of the medications in the drug store. She found the same pattern for the other Schedule 8 Medication Registers. She assessed that, in all, there were a *"few hundred"* ampoules that could not be accounted for and had obviously been stolen. She said that this diversion appeared to have occurred over the past *"couple of years",* although it had escalated in the last three months.[269]

Ms Fazackerley then immediately notified the Chief Executive, Mr Kirby, of her findings and met with him. Mr Kirby had only just commenced his tenure in that position. He asked Ms Fazackerley to take the drug books out of circulation and replace them with a new series of books. The following day, he took possession of the drug books from Ms Fazackerley for further investigation. By this time, the coronial investigation had commenced.

As the investigation progressed, CCTV from the drug store was interrogated. Only one month of footage was available due to the capacity of the AT drives at the time.

CCTV footage for this limited period depicts 19 occasions of Mr Crump entering the store and making entries in the drug registers. On each occasion he is seen accessing Schedule 8 medications, the majority of which appear to have been placed in his trouser pockets. The footage depicts Mr Crump in both AT uniform and plain clothes. [270]

Given that Mr Crump was plainly captured on CCTV on multiple occasions in the three weeks before his death, the CCTV would have almost certainly shown a similar pattern in the months prior to December 2016. It was not checked routinely before being overwritten but the audit results speak for themselves.

Apart from Mr Crump's increasingly erratic and unacceptable behaviour at work, there were few clues to his colleagues regarding his unlawful activities. Leaving aside the possibility of Mr

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[267] C15 – Affidavit of Kim Fazackerley, p 7
[268] C15 – Affidavit of Kim Fazackerley, p 7
[269]. C15 – Affidavit of Kim Fazackerley, p 7
[270] C 141

Crump being a suspect in the branch station thefts in September 2016, no one suspected that he was stealing drugs from the headquarters drug store. Ms Baker believed that Mr Crump was responsible for stealing from the Glenorchy, and likely Mornington, stations but did not suspect that he was stealing from the drug store.

Following Mr Crump's death, at least two of Mr Crump's colleagues recounted particular incidents which, only in hindsight, they considered suspicious.

A newly graduated paramedic, Bess Swinton, saw Mr Crump in the drug room one day in plain clothes which she considered unusual. At that time, she was not familiar with the requirements around Clinical Support Officers[271] being in the drug store alone. She recounted that he was in one of his over-exuberant moods and told her that the medication was for his *"dogs glands"* and that was the reason for taking items from the drug store.

Ms Swinton said that Mr Crump was looking in the basket draws on the non-Schedule 8 side of the room and may have been holding medications in his hands.[272] It was only when she found out about his death that she raised this incident and expressed upset to Ms Fazackerley that she had not appreciated what he is doing.

I make no criticism at all of Ms Swinton. At the time, Mr Crump was a respected mentor to her and it is apparent that she gained great benefit from his teaching. I have no doubt that Mr Crump was convincing in his explanation, being accustomed to the use of deception. She could not have expected that his actions were unlawful at the time.

A further concerning incident occurring on 30 November 2016 came to the attention of HL, another less experienced paramedic, where Mr Crump had forged her signature to sign out fentanyl, a Schedule 8 medication.

In her affidavit, HL said that, on that date, she had been working with Mr Crump on a day shift at Mornington and had used fentanyl to treat a patient from a crash. She said that Mr Crump later in the shift went to headquarters to re-stock the vehicle (with medication for the SMK) whilst she stayed with the patient in the ramped ambulance.

In her affidavit, HL said:

> *"The next day on 1 December 2016 I was in the drugstore and noticed that my name had been written and my signature had been forged in the register for the case from the day before; this caused me immense panic. I can't recall if the number of ampoules matched the*

[271] Mr Crump's role earlier in 2016.
[272] C 42, Affidavit of Bess Swinton, page 2.

actual number we used that day. I spoke to Monica very soon after when I saw her in the garage, about the situation with the entry in the register. I asked her what I should do and suggested I fill in an SRLS report. She told me I didn't need to do that and she would talk to Crumpy. About the same time another member came in and she went off with them.

I then decided to write Peter Berry and[sic] email about it. He responded and asked who I was with at the time. I told him Crumpy and he said he would sort it out when back at work. I have copies of the emails and have attached them. He asked me to confirm what the medication was and I told him it was fentanyl and it was for [sic] patient.

I later had a conversation with Peter Berry in the office and he said he would talk to Crumpy and that I didn't need to submit a SRLS report".[273]

HL said that she later received a *"messenger"* message from Mr Crump apologising to her. HL's evidence accords with the message extracted from Mr Crump's mobile phone on 7 December 2016 reading: *"Hi. Spoke to Berry today. Sorry about that fentanyl thing, sometimes I do it to save time that's all. It's all good".*[274]

Mr Berry did not deal with this report by HL in evidence, although I can safely conclude that Mr Berry was aware of it and that he spoke to Mr Crump informally and without initiating formal disciplinary process.

It is fair to say that this was yet another example of exceptionally serious concerns relating to Mr Crump's behaviour not being properly dealt with. Ms Baker was also aware of this matter and, in combination with her concerns regarding Mr Crump in respect of the September thefts, should have appreciated the high degree of risk in Mr Crump's behaviour.

Forging a signature in relation to a Schedule 8 medication safety process is exceptionally serious. Doing so undermines necessary safety protections. Apart from lawfulness and safety matters, for Mr Crump to place his colleague in such a position was irresponsible and unfair.

Additionally to Ms Fazackerley's audit, a formal audit occurred for the coronial investigation at the request of Sergeant McCulloch. This audit covered the 12-month period from 26 December 2015 to the 26 December 2016. This audit was undertaken by a senior policy officer and an intensive care paramedic, and was validated by AT manager, Michael McDermott. I have no reason to doubt the accuracy or thoroughness of this audit.

[273] C 65, Affidavit of HL, page 3
[274] C 137, page 102, Mobile phone examination.

The audit report, dated 16 January 2019, formed part of the evidence at inquest.[275] It concluded that a total of 568 drug register entries, comprising 933 ampoules of specified medications, could not be verified on their face and therefore, 933 ampoules could potentially have been diverted.

The report further concluded that 201 entries comprising 452 ampoules of specified medications were found to be false entries. Of these, 49 ampoules were attributed to Mr Crump's theft on the evening of his death. The report noted that, between 10 May 2016 and 21 July 2016 AT staff undertook industrial action during which some staff refused to complete associated paperwork. This affected the accuracy of the audit, and there was likely a greater quantity of drugs misappropriated.

The false entries were identified due to the following primary reasons: fake employee numbers were recorded on the entry and there was not a supporting case sheet able to be located; quantities in the medication book were manually changed and the case sheets supported the original entry; duplicate entries; case sheets did not support the quantities supported in the medication book; case numbers recorded existed but with different patients with no record of medication use.[276]

Mr Westlake, regional manager, responded to these findings by saying:

> *"I'm horrified by it. Absolutely horrified by it. At no time was I ever alerted that there was that information that either was available or should have been made available. But I think that comes back to your earlier question that, in all likelihood, there was no auditing".*[277]

He went on to provide an insight into why the required depth of auditing did not occur, indicating that he accepted a level of responsibility as regional manager, as well as the issue being the responsibility of the operations manager. He told the inquest:

> *"I mean, we were all doing each other's jobs. Again, if I may paint a – this context of this leadership – the two duty managers, they were – there was only ever one on at any one time. They worked a four on, four off roster. They worked only during the days and were on call overnight. So they were on for 96 hours straight. They were responsible for making sure the fleet is ready and available; they were responsible for the rosters; they were responsible for staff welfare; they were responsible for any supplies. They were responsible for so many things. The operations manager, you know, had all of those people. They were dealing with the day to day human resource issues, complaints – both customer complaints. They were*

[275] C117 Medication Record Book Audit – Summary of Findings.
[276] C117 – Medication Record Book Audit – Summary of Findings.
[277] T356: 29-33.

> *dealing with, you know, budgetary or ordering, all of those things. As a regional manager, most of my day was filled up with things like ministerial responses, were filled up with dealing with complex complaints, were filled up with staffing matters. I was the investigator, the adjudicator, the – all of those things and all of the time you were feeling conflicted. You were constantly putting one thing on the side to start on the next crisis that hit your desk. This went on for years".*[278]

Mr Westlake gave articulate and frank evidence to the court. During his evidence, he became emotional at recalling how the conflict he experienced as described in this passage created by the inability to fulfil all of the duties which were part of his role.

In his evidence, Mr Kirby agreed that the subsequent audit highlighted significant deficiencies in relation to the medication management process.[279]

Every day that a thorough audit did not occur allowed Mr Crump a further opportunity to remain undetected.

The evidence allows me to conclude that the managers were aware of the need to perform thorough audits of medications in accordance with the policy. However, they simply did not have the capacity to do so and their higher managers did not insist on this occurring. This was due to the overwhelming workload of the managers and the need to ensure that, as a primary function of the organisation, the ambulances were on the road and responding to calls.

Work incidents in November and December 2016

An ICP colleague and friend of Mr Crump, Ms Emily Byers, said in her affidavit that she was wary of him being up and down in his mood and behaviour and knew he was mentally unwell.

Ms Byers described working with Mr Crump at a time in late October or early November 2016 and noticed that he was sweating, shaking and swearing a lot at a job at Vaucluse Gardens. She said that she tried to *"talk him around"* to going home and was extremely concerned about his behaviour. He was eventually persuaded to leave the job and to return to the station and see Ms Fazackerley.

Ms Byers said that usually if Mr Crump was having a bad day he could still manage to treat a patient but she was not confident that he would have been capable of doing so on that

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[278] T358-359
[279] T2: 147: 16 - 20.

occasion. She said that she did not suspect that his behaviour was attributable to drugs at that time. She told managers Ms Fazackerley and Mr Gibson and expressed her serious concern about Mr Crump. She hoped that the incident would be dealt with further by management but she did not believe that occurred.[280]

Ms Fazackerley dealt with this incident in her affidavit, stating that she became concerned for Mr Crump's welfare, as she thought he may have been going home to self-harm. She rang Mr Riley and asked if, in relation to the drugs that had previously been stolen, it was likely that Mr Crump had stolen them to stockpile with the intention of self-harm. Mr Riley told her that he was of the belief that it was Mr Crump who had stolen the drugs and that she should be concerned for his welfare. She began calling Mr Crump but was unable to reach him. She spoke to Mr Gibson, Clinical Support Manager, and told him what had happened. Mr Gibson told her that he had seen Mr Crump a lot worse but continued to call him. Eventually, they were able to contact Mr Crump and Ms Fazackerley said that that was the end of the matter.[281]

Another ICP, Ms Leah Geard, described in her affidavit that on 16 November 2016, she arrived at a bariatric job in Glenorchy but Mr Crump was not there as he should have been. When she called him he told her that she could do the job. Ms Geard assumed that something was wrong with him and she called other staff to assist her with the job.

Mr Crump then returned to the job and Ms Geard explained he was no longer needed. She said that he remained at the scene smoking, which was unprofessional and out of character for him. She said in her affidavit as follows:

> *"After that job I went to my managers, Monica Baker, Craig Westlake and Kim Fazackerley. I can't recall if I saw them together or separately and told them that something had to be done about Damian. I told them that I thought his behaviour was out of character and I was concerned about him."*[282]

Ms Geard did not see evidence of any action being taken in respect of the situation and believed that Ms Baker was too close to Mr Crump which made it difficult for her to manage the situation.

Ms Geard did not give evidence and the contents of her affidavit were not challenged. It appears that the event described by Ms Geard on 16 November 2016 is not the same

[280] C60 Emily Byers
[281] C15 Affidavit Kim Fazackerley.
[282] C61 Page 2

incident as that at Vaucluse Gardens reported by Ms Byers.[283] I have no reason to doubt Ms Geard's account.

It is highly likely that he was under the influence of drugs at the time of this incident. I particularly note that he was communicating drug-seeking behaviour to his friend and colleague, ZJ, seeking Valium only four days before this incident.[284]

Formal disciplinary and welfare action was immediately required by AT in response to these very serious incidents where Mr Crump's behaviour placed patient safety in jeopardy; moreover, where he was thought to be at risk of suicide by drugs stolen from AT. It was completely unacceptable that he was allowed to continue working without action being taken.

Ms Patricia Makrogamvrakis, paramedic, said that towards the end, Mr Crump did not listen to or respect managers. She said that on 6 December 2016, she observed him at work behaving unusually. She said that he was jittery, wouldn't stand still, was not making conversation and talking nonsensically. She said that this was the last time she saw him.[285]

An incident involving Mr Crump occurring on 14 December 2016 further illustrated Mr Crump's obvious unfitness for his work. The detail of this incident is set out more fully in the affidavit of Ms Stephanie Buell.[286]

Ms Buell outlined in her affidavit that she and Mr Crump attended a job in the New Norfolk area. She was aware that Mr Crump was mildly elevated at the commencement of the job and became increasingly frustrated as the crew had trouble locating the address. This culminated in him backing the ambulance into a ditch from which they were unable to drive out. As Mr Crump attempted to dig them out of the ditch, he became more and more frustrated. He was sweating, swearing and becoming noticeably stressed.

Ms Buell said that Ms Amanda Hutchinson, Duty Manager State Operations Centre, spoke on the phone to Mr Crump at the scene after being advised that the ambulance could not transport the patient. Ms Buell heard Mr Crump being abusive to Ms Hutchinson and said he may have called her a '*bitch*' or similar.

After the ambulance was successfully removed from the ditch, they drove the patient and his mother to hospital with Mr Crump being '*mildly rude*' to the patient and their mother.

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[283] Bess Swinton was also at the Vaucluse Gardens incident.
[284] ZJ C54 p7.
[285] C82 Affidavit of Patricia Makrogamvrakis, page 2.
[286] C64 Affidavit – Stephanie Buell, pp 4-5.

After the incident Ms Buell spoke to Ms Thornley and conveyed to her that Mr Crump had *"completely lost it"* and was acting as if he was having a severe psychological crisis, withdrawing from drugs or under the influence of alcohol.[287]

Ms Hutchinson confirmed the details of the incident in her evidence at inquest and said that she was concerned about the welfare of the patient in this incident. She said that Mr Crump's behaviour seemed *"irrational and manic"* and was completely inappropriate and out of character in terms of her previous experiences with him. [288]

Ms Hutchinson determined as a result of Mr Crump's abusive behaviour towards her to require him to return to Hobart headquarters after leaving the hospital. However, Mr Crump ignored this directive, drove past headquarters and headed back to the Bridgewater station.

Mr Berry, the Duty Manager on this day, told the inquest that he became aware that there had been an interaction between Mr Crump and Ms Hutchinson, and had received a complaint from her about Mr Crump's language to her during their conversation.

Mr Berry said he travelled out to Bridgewater to see Mr Crump about this incident because *"it sounded like he needed a break out of it and to go home at the time".*[289] It is apparent that Mr Berry was forced to travel to Bridgewater because Mr Crump did not, as instructed, drive the ambulance back to Hobart headquarters.

On speaking with Mr Crump, Mr Berry found him *"not agitated, but he was upset about it in ways".*[290] Mr Berry was asked in evidence about his approach to managing this situation and said:

> "*… and we talked about it, and the outcome at that time was that I suggested he go home, take the rest of the shift off, and a day or two when things had settled, ring Amanda and apologise for the way he'd spoken to her, which he did. I recall the – I can't remember how many days post it was, but it wasn't that long*".[291]

I agree with counsel assisting's submission that Mr Berry's oral evidence about this incident gave the impression that he did not regard this as a particularly significant or memorable event.

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[287] C55 Thornley
[288] C72 Affidavit Amanda Hutchinson, page 2.
[289] T974: 13-14.
[290] T974: 24-29.
[291] T974

It was also a very concerning event for Ms Buell, who said that when she later spoke with Ms Thornley about her concerns, they both decided to speak to Ms Baker. Ms Buell said that she was *"concerned about the seriousness of it and the impact it could have on Crumpy"*.[292] Significantly, she indicated that Ms Baker's response was to say *"I'll take care of it, I've been looking after this boy for years."* Ms Buell felt that there was a lack of concern for *"the potential implications on Crumpy's mental state"* as well as the effect on her personally.[293]

Ms Thornley's evidence was similar. She said that when Ms Buell told her what had happened, she *"dragged"* Ms Buell to Ms Baker's office where they explained to her what happened. [294]

Ms Thornley described Ms Baker's response:

> "*And I know Monica's had a really long friendship with Damian but she was in that – she was duty manager and that's what I was telling her, as a duty manager. And she said in a really singsong voice and she was shuffling papers around and she said, "I know, I know about all of this already. Of course. Everyone does." Like – and she was just maybe trying to make light of it. And I made another attempt to let her know how concerned I was, that I thought there was something really wrong and she made the comment, something like, "I've known this boy for years. I know how to look after him. I've got it under control*".[295]

In her affidavit, Ms Baker did not indicate that she was involved in management of Mr Crump in respect of this incident. However, she recalled the occurrence of the incident and that Mr Berry sent him home after it had occurred.[296]

In her oral evidence, Ms Baker was asked about her recollection of this incident. She initially seemed to accept that this meeting could have taken place, although she said she did not recall it.[297] She later categorically denied both that any meeting about this incident (if it occurred at all) involved Ms Thornley and denied that she said *"I've been looking after this boy for years."* She was less sure about whether any meeting had occurred with Ms Buell.

I cannot understand how Ms Baker could not recall her involvement in the reporting of this incident on 14 December 2016, only two weeks before Mr Crump's death. This is especially the case when it involved the significant step of Mr Crump actually being stood down from a shift, albeit only for a short period. Ms Baker specifically denied making the comment *"I have*

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[292] C64 – Affidavit - Stephanie Buell, p 5.
[293] C64 – Affidavit - Stephanie Buell, p 5.
[294] C55 – Affidavit – Emma Kate Thornley, pp 15-16 & T230-231.
[295] T231
[296] C36 p 4 Monica Baker
[297] T716, pp 4- 15.

been looking after this boy for years" giving the reason that Mr Crump had not spoken to Ms Thornley for years.

I have no hesitation in accepting the account of Ms Buell both in respect of the incident, although I think it was a more dramatic event than her 2018 affidavit conveyed. I also accept her account of notification to Ms Baker.

Both the account of Ms Buell and Ms Thornley are consistent and I find that Ms Baker knew about the incident and could have initiated action at that time. Mr Berry could also have done so. Standing Mr Crump down for a single shift was an inadequate response to the seriousness of the matter and the attendant risks.

Both Dr Sale and Dr Rybak provided opinions regarding the concerning nature of this incident and the response that should have taken place.

Dr Ian Sale, in his report and oral evidence cites this event as being significant in terms of an opportunity to intervene. [298]

Dr Sale told the inquest:

> *"When, I looked through the material, I had to see if there were any opportunities where I would've imagined that concerns would've been apparent to the management level of Ambulance Tasmania, and this was a particular incident, I believe, that would've – well, did rise to management level. So theoretically, there was a chance there that management might've stepped in and done something differently, but – that's pretty speculative, but it was at least an opportunity, because they knew that there was a problem where he failed to manage an incident that was potentially critically important. There was no way of knowing, I think at the early stages, how serious the patient was to whom they were travelling."*

In her oral evidence, Dr Rybak said she agreed with Dr Sale's opinion about the significance of this event:

> "*…because if – if the colleagues – you see, we all, in professional positions, we all kind of watch our colleagues, and if the colleagues are not fulfilling their professional roles, or they're failing in some way or another, we should – we all have a duty to kind of approach the colleague and say, "Hang on, you're not quite right. What – let's do something about it. Let's either talk to the boss or talk to your doctor or do something." So, yeah. I agree with Dr Sale that something should have been done. That's a bit out of character for the patient, and even*

[298] C162 – Medical Report – Dr Ian Sale, p 6. T2 43: 11-38.

seeing Mr Crump like that in my interactions with him. So he obviously wasn't well for some reason".[299]

Both Dr Sale and Dr Rybak were firm in their view that this episode should have been managed by AT and that it represented an important opportunity to change the course of events. What followed this incident was a rapid downward spiral to his death.

I accept their opinions. It could not have been clearer that Mr Crump was unable to fulfil his critically important professional obligations, did not follow directions of his superiors in AT, was unable to interact appropriately with his colleagues and was a risk to himself. It should also have been well within the contemplation of AT management that his behaviour may have been exacerbated by the consumption of illicit drugs.

The fact that Mr Crump was able to remain in his work after the incident of 14 December 2016 as an intensive care paramedic was a gross failure of the organisation as a whole.

Comments

The following areas require comment, being connected to Mr Crump's death for the reasons I have already outlined.

Span of control and management issues

(i) Inadequate manager to staff ratios

As I outlined at the commencement of these findings, the investigation led by Sergeant McCulloch gathered a great deal of evidence regarding the insufficient numbers of managers within AT and the consequences flowing from this issue. The main consequence relevant to this inquest, of course, was that inadequate management contributed to the issues identified in respect of Mr Crump before his death.

I fully accept Sergeant McCulloch's conclusion that such was the level of management failures with respect to Mr Crump before his death, it is difficult to be overly critical of individuals in AT, especially those at the Duty Manager level. They were required to operate with little training and support in a system that had not been conducive to sound and efficient decision-making for a long while.

Sergeant McCulloch thought that Duty Managers could perhaps have made stronger complaints about their overwhelming workload and inability to complete their designated duties. I do not necessarily agree that this is the case. This unsatisfactory situation was well

[299] T2 p29.

known to AT. The Duty Managers were loyal and dedicated AT staff members who had little choice but to perform their duties in a chronically under-supported and under-resourced organisational environment.

I have made critical comments about AT failing to deal with Mr Crump's behaviour in numerous respects. These failings necessarily occurred through the agency of AT management personnel. However, apart from the specific comments relating to Ms Baker, I consider that personal criticism is unwarranted in light of the many organisational deficits impacting their ability to fulfil their functions.

In May 2017, the Department of Health and Human Services published the *"Review of Ambulance Tasmania Clinical and Operational Service Final Report May 2017".*[300]

The main purpose of the Review was to identify reforms to increase the efficiency of AT and to reduce demand on emergency services. The Review stated that, over the previous seven years, the use of ambulance services had grown 14 times faster than the Tasmanian population; and that, left unchecked, such growth would have significant resourcing implications.[301]

The following passage from the Review is particularly relevant to this inquest:

> *"In term [sic] of operational support, the review identified significant concerns with regard to the current operational structure, and the ability to support operational resources.*
>
> *For example, there are currently around 138 FTE in Emergency and Medical Services in the South and around 300 volunteers reporting to a single Duty Manager. This manager is responsible for professional development and management of all of these paid and volunteer staff. This is a very large span of control and impedes the ability of Ambulance Tasmania to provide effective support and supervision.*
>
> *Identifying a solution to providing adequate supervision and line management to paid and volunteer staff in Ambulance Tasmania is beyond the scope of this review. It should, however, be considered further as a priority".*[302]

In regards to the above conclusion, the Review recommended as follows:

> ***"Recommendation #17** – That AT reviews its organisational structure, particularly in relation to frontline tactical and clinical management, to include greater depth and shared*

[300] C 152.
[301] Ibid, page 4.
[302] Ibid, page 39.

> *accountability for operational coordination, clinical governance and professional development of operational staff".*[303]

Additionally, the Review identified that there was a limited capacity for AT to sustain its corporate support capabilities, stating "*There are widespread single-person dependencies, which represent a significant and ongoing organisational risk for Ambulance Tasmania".*[304]

The review discussed the merits of the Department of Health and Human Services consolidating its support functions into single, whole of agency support units. A recommendation was made that this issue be considered further as a priority.[305]

The conclusion from the Review that management problems arose from the very large span of control was consistent with the evidence received at inquest from many experienced and knowledgeable AT staff members. It is not an understatement to say that many of their affidavits portrayed the experience of an almost intolerable level of workplace stress.

Dr Morgan, former Chief Executive, discussed the extreme challenges faced by Duty Managers:

> *"I think that you'll find in any national ambulance service, this level of operational manager is a very difficult one for any individual to negotiate. The reason being is there's - obviously you – you are taking on a lot of responsibility for your direct workforce and you all – and making the operation happen and then you've got a lot of expectation from senior management and the executive coming down and there is a lot of difficulty for those individuals in these really challenging operational leadership roles. Now, having said that, in most other jurisdictions, in my experience, the span of control or the number of individuals that any given manager would have supervised tends to be a lot smaller than within Ambulance Tasmania".*[306]

Mr Berry gave the following evidence:

> *"Monica (Baker) and I – she understood how the role worked because Monica and I were the two duty managers for southern region and we worked four days on, four days off opposite each other. We had the responsibility for those 21 stations. So if you draw a line from Coles Bay across to Strathgordon, anything below that was ours. We had the operational staff. We had another 200 volunteer staff to manage. We had a fleet of 35 plus vehicles we had to care for. I was doing the rostering off the side of my desk for the years –*

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[303] Ibid.
[304] Ibid, page 40.
[305] Ibid.
[306] T2 73-74: 36-3.

> *28 of the years that I was there. The volume of work – our staff group just became so much that we just couldn't manage all that we were doing".*[307]

Ms Baker also commented in her affidavit upon the *"massive growth"* of AT and that management has not *"kept pace"*. She said that she was unable to conduct Professional Development Agreements (which I take to mean performance assessments) with the staff due to workload.[308]

Ms Fazackerley stated the span of control for a duty manager was: *"If you include the volunteers, well over 200 on a day to day basis".*[309]

In in her questioning of Mr Westlake, Counsel for the Department suggested to him that the ratio of duty manager to staff was in fact 1 to 54.[310] Mr Westlake indicated that that figure may be correct, but it was still insufficient for managers to do the job. It appears that the lower figure of 54 may relate to the number of personnel on active shifts at any one time as opposed to the full paramedic and VAO workforce.

Mr Westlake said that when he worked in South Australia, he was accustomed to the ratio of managers to staff being 1 to 10.

The organisational diagram contained in Mr Webster's affidavit indicates that there were two Duty Managers who were responsible for 60 Paramedics, 24 relief paramedics, 254 VAOs, 18 Branch Station Officers and 6 relief Branch Station Officers, and 6 Patient Transport Officers.[311]

I cannot fully resolve the issue of the number of staff requiring Duty Manager supervision without receiving more evidence, although the 2017 Review by the Department of Health and Human Services itself suggests the number of staff to one manager is extremely high.[312]

Like Mr Westlake, other AT witnesses provided oral evidence that the span of control in AT was significantly higher than other ambulance services around Australia which they had worked.[313]

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[307] T984 19-24.
[308] C 36, page 9.
[309] T140 8.
[310] T443.
[311] C158 Affidavit of Dale Webster – Annex B.
[312] C152, page 39 stop
[313] See C80: Affidavit of Michael McDermott (ACT), C78: Affidavit of Andrew Porter (South Australia), T560: 8-19 (Victoria).

The position of Operations Manager was also affected by the workload issue. As already noted, Mr Westlake described how he felt in crisis *"for years"* with the pressure of work.[314] Michael McDermott, ICP and Manager State-wide Services for AT, also described in his affidavit the unsustainable workload of the Operations Manager, who had no other colleague at that level to perform the functions of that position. [315]

Mr Han-Wei Lee, paramedic and former Intensive Care Nurse, was in an Acting Management role in AT State Headquarters at the time of Mr Crump's death and he had no relevant involvement with Mr Crump. And, at the time of swearing his affidavit for the Coronial investigation, he had been part of the Senior Leadership Team at AT (comprising higher level managers) for three years.

Mr Lee described *"front line management"* not having the ability to provide effective supervision and to look after the well-being of staff and volunteers. He said that managers were *"saturated"* with simply keeping the wheels of the ambulances moving out the front door. He cited an example of the ambulance fleet being out of registration for a two-week period, likely due to the manager of that area being swamped with excessive duties.

Mr Lee commented that managers were also not trained to provide pathways to direct staff to the appropriate care provider for mental health and welfare assistance.[316]

In his very helpful evidence at inquest, Mr Lee testified that there was no clear pathway for managers to respond when an employee appeared to be acting inappropriately. He said that even initiating a performance management plan at that time would have been difficult due to a lack of available human resources support.[317]

Mr Lee said that he had worked for large and small hospitals and ambulance services in his career but he had never worked in a place with so few managers and support staff. He commented that he was *"amazed"* that AT could maintain service delivery, let alone ensure sound process, management and governance.[318]

The benefits to be gained by reducing the span of control are obviously significant.

Dr Morgan stated that:

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[314] T358-359: 38-10.
[315] C 80, page 4.
[316] C 73, page 3
[317] T578
[318] C 73, page 2

> *"….it's my observation that first responders and particularly paramedics really lean heavily to their supervisors to help them make sense of the complex and chaotic environment within which paramedicine is practiced. You can imagine when you've got not a[sic] 10 but 20 and very difficult spans of control and you're taking on board a lot of the emotional challenges of some of the people who you're responsible to care for, it can be quite overwhelming to that manager in themselves and we now do management well checks with psychologists in New South Wales so that we can make sure that our frontline managers are coping, as well as our current line staff because it's not just about the trauma you experience from attending first responder events, it's also about the vicarious trauma that our frontline operational supervisors take on board when managing very large spans of control... But I think that most ambulance services these days are very much focused on reducing spans of control for their managers".*[319]

The ability to manage Mr Crump was obviously affected by the issue described. To manage his behaviour and personality required a carefully considered and consistent approach to his welfare and discipline. The time taken to develop a strategy and to implement it would have been considerable. All Duty Managers and the Operations Manager would need to endorse the strategy and help put it into effect. This was simply beyond the capacity of the organisation at the time.

The lack of necessary management of Mr Crump was obvious to other AT paramedics, who commented about the issue in their affidavits.[320] The fact that he was able to escape accountability created a real sense of unfairness in some of his colleagues.

If there had been a lower span of control and greater management oversight within the organisation, Mr Crump's inappropriate behaviours, and the reasons for them, would likely have been identified. Adequate training of his managers, which did not occur, was also necessary.

With a strategy in place founded on correct facts, necessary welfare and intervention measures could confidently proceed. The culture of AT at the time did not support such a process. Again, the poor culture was largely attributable to the lack of management oversight. Managers simply could not implement change, including adequately dealing with the time-consuming process of managing unacceptable behaviour by staff members or assisting with their mental health issues as they impacted upon their work.

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[319] T2 75: 14-37.
[320] For example, Patricia Makrogamvrakis C82 p2;

Together with span of control issues and lack of managers, was the fact that there was a high proportion of "acting" positions in AT management at the time surrounding Mr Crump's death. Further, the "acting" management positions were for a duration of up to 3 years.

This issue was not ventilated to any significant degree at inquest. It is possible that budget cuts, retirements and placing substantive positions on hold pending the Departments Review may have contributed to this situation.[321]

The only comment I make in this finding, is that those in acting positions are less likely to be able to implement change and are less likely to be trained. It is simply common sense that multiple acting positions is not conducive to stability, consistency and progressive leadership within an organisation. This is especially the case where those placed into acting positions are faced with an enormous workload. This issue must have compounded the management issues in 2016 to which I have referred above.

(ii) SRLS as a reporting system

The Safety Reporting and Learning System, being the electronic platform used by staff of AT for documenting and reporting issues. As discussed previously, the Mornington and Glenorchy station thefts in September 2016 were reported in this system.

Mr Westlake described the SRLS as the organisation's *"incident and complaints management system"* stating that it was used for staff to report a wide variety of matters. This fact made resolution of a large volume of individual reports a *"completely overwhelming"* task.[322]

He described having the SRLS cases open *"for months"* before he was satisfied he could close them; and even when he closed them, he would often not be satisfied that justice had been done. He said that the SRLS did not meet the expectations of staff who reported or wished to report a matter. There was evidence from AT staff that SRLS reports were not read or that the issues were not dealt with, and closed in the system prematurely.

The SRLS was not effective to resolve issues or complaints in a timely manner, and therefore staff members were reluctant to use it to report incidents. In the case of the forged signature by Mr Crump, AT employees were actually discouraged from entering the matter into this system.

If this system had been functioning effectively and the concerning incidents involving Mr Crump had been reported into it, rather than informally to managers, this may have resulted

[321] C75 Affidavit of Peter Morgan, page 9.
[322] T360

in a more objective and thorough consideration of the issues. It may also have highlighted to senior management the regularity with which his behaviour was placing others at risk and suggested worsening mental health issues and drug use.

(iii) *The Bus* as a means of management

Prior to 2014, an informal system of management called *"The Bus"* had been developed by some members of AT management.

Ms Thornley explained *The Bus* in some detail in her affidavit. Her evidence was unchallenged and mostly corroborated by other witnesses.[323]

Ms Thornley said that an AT employee was put on *The Bus* if he or she upset management or did not conform to the path AT prescribed. She was aware that *The Bus* was so named because it was the metaphorical bus that would drive an employee out of AT.

She said that she was told at one stage that she had been placed on *The Bus.* Acting Duty Managers advised her at one stage that they had been provided with a list of people who were on *The Bus* and who were to be treated more harshly than others in an attempt to have them leave AT.

Relevantly to Mr Crump, Ms Thornley said:

> *"Damian was acutely aware that you were either, like – he was acutely aware that staff get treated differently, that there's no merit-based process and that there's often a decision made on someone's progress or, you know, their return to work or something and it doesn't appear to follow any process. Like, it's just random, and he was very aware of it and he had also seen how I'd been treated and another couple of people close to him, and we knew about – we'd found out about this system called "the bus" where if managers thought you were being difficult or hard to manage, you'd be put on the bus which was the bus to drive you out of the Ambulance Service. And so there was a co-ordinated attempt by management to be aware that you were on the bus and to make sure that your life was difficult".* [324]

Mr Berry, who admitted to being one of the managers involved in the formation of the metaphorical bus, gave the following evidence at inquest:

> *"[Mr Berry] It was a – in-office joke between myself and my then regional manager, two people.*

[323] C 55 Affidavit Emma Thornley, page 3.
[324] T220: 5-15.

> *[Counsel] And – Who was the regional manager, sorry? [Mr Berry]He's retired now. It was Andrew O'Brien at the time. It was – it was a way of – I don't know in your workplace whether you vent or want to say something without saying something to anybody else. Andrew and I talked about if we ever started our own private ambulance firm who would we employ from work? Right? And there were some people that we would employ and some people that we wouldn't. So, it was – that's all it was. It was a standing joke between Andrew and I. Now, at some point one of the acting duty managers picked up on that and took it outside of the office room".*[325]

Mr Westlake, as he commenced his position as Regional Manager, became aware of *The Bus* and gave evidence as follows:

> *"When I moved here there was a metaphorical bus. Absolutely there was a metaphorical bus. It wasn't a widespread thing. I just remember within the first few days hearing, "Oh, this person, you know, they'd be put on the bus, you know," because I met with a number of staff which were reported to me as quite problematic. I gave them an opportunity in the first few days of being here of telling me their stories. I recall, you know, within the first short period of time of having to say to people, "From this point forward there is no bus. There is no such thing, it doesn't exist." You know, you can't treat people like that. Now, the managers at the time would definitely deny that there was any such thing. But my observations would suggest there absolutely was".*[326]

Mr Westlake was asked by counsel assisting at inquest whether, from the perspective of an employee on *The Bus* that employee would think that they were being treated in a way that they may reasonably perceive as being bullying, harassing, intimidating, marginalising and *"all of those types of words".* Mr Westlake agreed that that was the case.[327]

Thus, presence of *The Bus* developed as a management technique which at least several managers considered a viable pathway to deal with risks or disciplinary issues. Of course, such a construct was unfair, lacked transparency and induced significant angst in AT employees.

In my view, *The Bus* was only able to become an entrenched technique for behaviour modification because of the lack of sufficient leadership and clear pathways for formal disciplinary and welfare processes.

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[325] T989: 5-24.
[326] T372: 17.
[327] T373.

Even after the dissolution of *The Bus* prior to 2014, there remained a lack of formal procedures for disciplinary action in respect of AT employees and a culture of reluctance of reporting inappropriate behaviour.[328]

I am satisfied that Mr Crump was able to "get away with" his behaviour partly because there remained a reluctance on the part of colleagues to report it due to fear of repercussions and a likely lack of action. [329]

Welfare of AT employees

The scope of the investigation included consideration of any established mental health and welfare systems or policies relating to or providing for support to Mr Crump and other employees of AT in 2016 and the availability of such systems at the time of the inquest.

There was a large body of the documentary evidence concerning this aspect of the scope and Sergeant McCulloch's report summarised the evidence in detail. I received this evidence, as I indicated at the beginning of this finding, on the basis that adequate welfare assistance and support by AT for his drug abuse and mental health issues may have changed the outcome for Mr Crump.

In one sense, this statement is true. There were no mandatory processes in place whereby AT could compel an operational paramedic to undergo independent psychological assessment in order to ascertain the extent to which any welfare assistance should be provided.

However, I am satisfied that Mr Crump did not and would never have availed himself of AT's welfare support services existing at the time. In the last year of his life, offers of assistance were declined, with Mr Crump inducing the belief in his managers that he was receiving regular private psychiatric treatment. This was not an honest statement of fact on his part and yet, quite understandably, his managers accepted that this was the case. [330]

Moreover, Mr Crump falsified a medical certificate which he presented to AT in December 2016, just prior to his death. He did this by forging Dr Rybak's signature on the certificate and falsifying the date. He had not seen Dr Rybak for a period of 18 months.[331]

The evidence discloses that AT employees believed that mental health support for paramedics in 2016 contained gaps which were not met by the existing services – these

[328] See for example: C57 – Affidavit of Charles Wendell-Smith.
[329] C 64 Affidavit of Stephanie Buell, page 2 and 3.
[330] T443 2-7 Evidence of Craig Westlake.
[331] T2, pages 11- 12.

being the Employee Assistance Program (EAP) and the Critical Incident Stress Management (CISM).

EAP is a confidential professional support service designed to provide short-term assistance for work-related and personal issues that may be affecting performance and wellbeing at home and in the workplace. EAP offers a limited number of consultations which may include provision of immediate assistance or support with identifying options for longer term support. The EAP system was offered by private providers but attracted some criticism from AT employees in relation to the quality of the service and the perceived lack of confidentiality.

CISM is a program run jointly between all emergency services and is an incident triggered response team service, whereby contact by a CISM team member is made with personnel involved in a stressful incident. It appears from the evidence that this service is generally effective for assisting with mental health and welfare in the immediate aftermath of a "critical incident". However, I make no further comment upon its operation.

For the reasons given these services could not, by their nature, address Mr Crump's issues. He did not find his work stressful and he would not engage with voluntary services.

Nevertheless, it is appropriate to briefly summarise the very positive developments undertaken by AT in this area as they impact beneficially on the whole AT workforce.

The Peer Support Program was implemented by AT after Mr Crump's death. [332]

Peer Support Officers are AT employees or volunteers. They provide voluntary assistance to their colleagues by offering emotional and practical support and appropriate referral to specialists during times when their colleagues are experiencing stressful events either at work or in their personal life.

Inspector Matthew Richman, Director of Well-being Support for the Department of Police, Fire and Emergency Management (DPFEM) and Ambulance Tasmania, gave evidence at inquest on welfare developments in AT.

Inspector Richman explained that additional funding has been received by DPFEM and his department, and *"they are looking to revamp some of the critical incident stress management processes to examine issues of cumulative matters".*[333] He also gave evidence about *MyPulse* as a voluntary mental health and physical screening tool designed for early intervention. He noted

[332] C128
[333] T524.

that the number of Wellbeing Support Officers have increased since Mr Crump's death from one to five and will shortly increase to nine.

In May 2018, AT also appointed a permanent Human Resource (HR) Consultant Mental Health and Wellbeing, this position being responsible for overseeing the peer support officers.[334] Their statement of duties for the position includes the research, development and implementation of the Ambulance Tasmania's mental health and wellbeing strategy. They are also responsible for coordination the Peer Support program.[335]

Mr Kirby noted that "the Ambulance Tasmania Mental Health and Wellbeing Strategy is currently being developed".[336]

The developments initiated by AT in this area are significant and positive.

I observe, however, that the welfare and support options rely upon willingness and honesty of those seeking the services. Unfortunately, this was not Mr Crump. [337]

For his own reasons, he did not disclose his sexuality (apart from to a few); he hid his drug addiction; and he induced in his colleagues and managers the false belief that he was being treated privately.

Several AT witnesses considered that mandated psychological assessments for employees should occur at regular intervals.[338] This would likely involve a baseline assessment upon entry into AT and mapping throughout their employment. Ms Baker, in particular, considered that such a mandatory system of psychological assessment may have been particularly instructive in relation to Mr Crump's downward psychological trajectory.[339]

Medication security

(i) Background to medication management policies

Dr Morgan was the Chief Executive of AT from 2009 until December 2015. Dr Morgan provided a written statement for the inquest in which he outlined that, upon his appointment, he took responsibility for implementing the recommendations from two recent reviews.[340]

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[334] C159. Affidavit of Neil Kirby at [83].
[335] C129.
[336] C159. Affidavit of Neil Kirby at [87].
[337] T226-227: 25-8.
[338] For example, Han-Wei Lee, Bess Swinton
[339] T669-670
[340] C 88 A, statement of Dominic Morgan, paragraph 6

He said that, at the time of his appointment, AT was the lowest funded State ambulance service *per capita* in Australia.[341] However, he said that the Tasmanian Government had committed to fund the recommendations of the reviews by providing a large injection of recurrent funding over a period of four years and that this commitment to fund the required reform was the primary reason for him accepting the appointment.

Dr Morgan said that the funding commitment, though, was substantially offset by budget cuts in the aftermath of the global financial crisis in 2011. Further, budget cuts were required to be made in every following year of his tenure.[342]

As a result, Dr Morgan was required to dismantle a number of organisational improvements only a short time after their introduction. These included dismantling executive, clinical and management support positions, which impacted upon AT's ability to progress reform.

He described how he introduced extensive reforms, including trying to ameliorate the flat leadership structure by adding an operations manager in each region and introducing meetings of the Senior Leadership Team for the purpose of implementing reforms.

He said that by the conclusion of 2015 the recommendations from the original reviews were all complete, as well as Dr Morgan himself undertaking two workforce reviews in 2010 and 2014/2015 resulting in a 20-year plan for AT ambulance staffing and infrastructure.[343]

Importantly, Dr Morgan described the process by which he developed the AT Medication Management Policy ("MMP"), noting that the *Poisons Act* 1971 did not provide specific regulation in relation to the management of drugs of dependence in the out-of-hospital environment.

He said that the MMP, first published in 2014, was a large undertaking and represented a significant body work. He detailed that there was consultation with the Chief Pharmacist over a period of a year and the Chief Pharmacist ultimately endorsed the MMP. He also detailed an associated statewide system of safe upgrades and introduced CCTV surveillance in accordance with a security schedule agreed with the Chief Pharmacist.

Dr Morgan commented that the development of the MMP required a sizeable investment relative to the funds available.

Dr Morgan emphasised that the issue of medication diversion, addiction and theft must be dealt with using various defences; these being regulatory requirements, governance

[341] ibid, paragraph 8, citing the Productivity Commission Annual Report on Government Services 2008.
[342] Ibid paragraph 11
[343] C 88 A statement of Dominic Morgan, paragraphs 25 and 26

framework (policy and procedures), training and education, documentation requirements and physical security (safes and CCTV), cross checking by two officers (if possible), auditing by managers and ensuring a positive workplace culture.

There was some focus in the investigation upon the previous drug thefts by former paramedics, CW and KM in 2012 and 2014. However, I do not now consider it necessary to discuss the details of the thefts. I am satisfied on the basis of the unchallenged evidence that Dr Morgan was putting in place a new MMP and other measures prior to 2014 within the confines of resourcing. He was also putting in place a number of drug security measures. The MMP was approved to be effective from 17 February 2014.

In 2015, Dr Georgakas became Director of Medical Services for AT in 2015 and assumed responsibility for the MMP. His view was that the policy was satisfactory having been peer-reviewed, based on the Victorian Ambulance Service template, met the objectives required and met statutory requirements.

As part of the Senior Leadership Team (in another Division at that time), he endorsed the policy. This policy applied at the time of Mr Crump's death. It outlined the requirements of AT for the management of medications; set out the requirements for handling storage disposal and audit; and to ensure AT staff manage medication is in a manner consistent with the law, best practice and patient safety.

Counsel for Dr Georgakas submitted that the policy was adequate but the issues associated with Mr Crump's theft related to the enforcement of the policy at an operational level, and these were not within his sphere of responsibility

Relevantly, the policy required regular audits and these did not occur. In his affidavit, Dr Georgakas emphasised that his sphere of direct control was in governance and not in operational matters. He stated that he did not have management of operational staff employed by AT other than the clinical services team.[344]

I accept the evidence of Dr Georgakas. His role might properly have allowed him some scope to query with the operations team whether the policy was effective and being complied with in all respects. However, there is no evidence that he was required to do so and I accept that the issues surrounding compliance with the policy were not, for all intents and purposes, the responsibility of Dr Georgakas.

[344] C 95, page 2

Immediately following the death of Mr Crump, Dr Georgakas issued a "*service update"* to all staff, requiring double swipe access on the drug store at the Hobart headquarters.[345] This meant that the drug store could still be accessed by a staff member with only one swipe card but that, as a matter of procedure, two cards were required. The purpose of this requirement was to enforce the change that two AT staff must be present when the store was being accessed. Further, the fact of the "double swipe" could be audited against the electronic records created.[346]

Mr Westlake in his evidence described that following its implementation there were checks to ensure compliance with this directive.[347] In addition to requiring a double swipe of two different cards to access the drug store, Mr Westlake also recalled that the pin codes to the medication safes were changed.[348]

Dr Georgakas explained that he chaired a medication management review that commenced shortly after Mr Crump's death. That review was delivered in December 2017 and made a large number of recommendations for changes within AT.[349]

In respect of the system of accountability under the 2014 policy, Dr Georgakas said *"Look, I think just reading this policy and what became apparent in our review that followed Damian Crump's death is that there was no clear direction as to what an audit should look like".*[350]

He indicated that what he thought was happening, and how it appeared the policy was being interpreted by the various management levels was *"a numbers audit to make sure the numbers added up".* He said that what did not occur was making the link to patient care records so that it could be confirmed that medication reportedly given to a patient was actually given.[351]

Dr Georgakas said in his affidavit that *"since 2016 a great deal of work, but not enough due to financial and other constraints has been undertaken".* This includes the development of the following policy and suite of procedures to support improved medication management procedures in AT. These have been endorsed by the Secretary and Chief Pharmacist, and comprise:

- A new medication management policy;
- A medication disposal procedure;
- A medication document management procedure;

[345] T876: 32-44.
[346] T922: 16-27.
[347] T350: 15-40
[348] T353: 20-32.
[349] C115 AT Medication Management Review Final Report Dec 2017.
[350] T903: 27-32.
[351] T905: 25-35.

- A medical infrastructure procedure;
- A medication possession and storage procedure;
- A medication Stock maintenance order and Transfer procedure;
- A site compliance inspection procedure;
- A Specified medication kit audit procedure;
- A specified medication register procedure; and
- A Specified Medication Safe Register Audit Procedure.[352]

Dr Georgakas said that the implementation of these policies was done without any extra resourcing. He also acknowledged the assistance provided by the Pharmaceutical Service Branch (PSB) of the Department of Health.[353]

Two of the pharmacists involved also gave evidence of their involvement with the oversight of the implementation of the recommendations coming from the medication management review. Ms Monica Steiner said that she considered there were significant delays from AT over the project's progression, which had the impact of PSB providing increasing support.[354]

When asked why she thought that was the case, she said that she did not consider that AT made it their top priority and that *"they had a lot of other things on their plate to tackle".*[355]

At the time of completing her affidavit in July 2020, Ms Steiner said that, in her opinion, lack of progress in the medication management review continues to be a significant organisational safety risk to the department, AT staff and members of the public.[356]

Ms Steiner explained that had had been involved in training sessions with AT staff who she found were not well aware of some legislative requirements that related to their role, and considered that further training in this area was needed because *"every authorised health professional must know their requirements under the legislation".*[357]

Ms Steiner also commented that medication management is not an area that she thought paramedics would be expected to have a good knowledge of, which is why the training is needed.[358]

Mr Martin Neumeyer was the other pharmacist who gave evidence on this matter. He largely agreed with Ms Steiner, saying that delays in the medication management project

[352] C95 – Affidavit – Dr Con Georgakas, p 5.
[353] C95 – Affidavit of Dr Con Georgakas, p 5.
[354] T571: 1-15.
[355] T580: 30-36.
[356] C85 – Affidavit of Monica Steiner, p 3. See also T572: 7-19.
[357] T574:20-37 & T576: 28-39.
[358] T577: 1-17.

were largely due to insufficient resources being directed to it, and the scope of the project being much larger than first thought.[359]

Dr Georgakas explained how AT had commissioned an independent review of the medication management project by KP Health.[360] A copy of the report was provided as an annexure to Dr Georgakas' affidavit.[361]

The report is extremely comprehensive, although the Executive Summary provided makes the following key points:[362]

- Since project establishment, progress towards implementing the recommendations of the review has been slow, with only a proportion of the review recommendations implemented.
- The Medication Management Project is a very large, complex and multi-faceted reform program that includes a number of sub-projects within it. The 97 recommendation of the Medication Management Review, consists of 127 component parts.
- Broadly, the 127 component parts (or recommendations) fit within three distinct categories, which can be described as:
    - Strengthening the chain of custody of medications
    - Developing a systems approach to support quality use of medicines
    - Enhancing medication security, audit capacity, and document efficiency via technology
- The scope of the project was derived from the amalgamation of recommendations across three individual medication review types that included a peer review, internal investigation and a gap analysis. This resulted in a very large project scope that lacked overarching definition and focus. Further, some of the recommendations were not scoped correctly for the community setting, and as such, lack relevance to practice and are difficult to implement.
- Collectively the recommendations represent a very broad-reaching medication governance reform agenda, together with a significant infrastructure project and a multi-component eHealth project. The implementation time frame of two years, originally anticipated for this project, was unrealistic. Even with

[359] T590: 10-38.
[360] C95 – Affidavit of Dr Con Georgakas, p 5 & T922: 33 – T923: 3.
[361] C95 – Affidavit of Dr Con Georgakas, Annexure "K".
[362] C95 – Affidavit of Dr Con Georgakas, Annexure "K" KPH Report, pp 5-6.

appropriate resourcing, it would be reasonable to expect a project of this size and complexity would require up to five years to implement and evaluate.

- In recognition of the broad scope of the project, and its reliance on support and expertise from areas outside of Ambulance Tasmania, the Project would have benefitted from additional expertise and advice to the Steering Committee and support for the working group/project team in relevant areas including: infrastructure, project management, finance, information management and technology, and quality use of medicines.
- Success of the Medication Management Project has been significantly undermined by a lack of project resources. The single greatest barrier to progress for this project has been failure to secure adequate funding for a project team at the commencement of the project and throughout the duration of the project.
- A project of this size requires a multi-member project team with central and regional implementation arms. The very modest request for human resources, infrastructure and capital resources, and ongoing maintenance for this project, reflect a lack of understanding of the size and complexity of the undertaking. The inability to secure even these modest levels of funding suggests that the legal, clinical and safety risks associated with not implementing the recommendations have not been articulated effectively to decision makers.

In terms of findings, at the time of its publication in December 2020, the authors of the report concluded that:[363]

- Despite the significant financial limitations and issues of scope associated with the project there has been substantial progress towards implementation of the recommendations of the Medication Management Review.
- Evidence of achievement against each of the recommendations for the project as a whole demonstrates that:
    - 24% of recommendations have been implemented
    - 49% of recommendations have been partially implemented
    - 25% of recommendations have not been implemented (although 44% of these recommendations do have evidence of preparation in anticipation of implementation)
    - 2% of recommendations are no longer relevant.

[363]C95 – Affidavit of Dr Con Georgakis, Annexure "K" KPH Report, pp 7-9.

- Whilst only one quarter of the recommendations have been fully implemented, evidence of implementation, partial implementation or preparation towards implementation was identified for 84% of the recommendations.

The report goes on to provide further detail regarding the implementation of the recommendations against the three sub-categories.[364]

In his evidence, Dr Georgakas commented that it did not surprise him that the length of time required to implement the recommendations was much longer than forecast.[365] He indicated however that AT had advocated for additional resources for the project at the time.[366]

Produced to the inquest during the hearing was an affidavit, sworn 18 March 2021, of the Deputy Secretary, Community Health and Wellbeing, Mr Dale Webster.

Mr Webster addressed the further progress of these recommendations and other changes in AT.

In respect of the Medication Management Review, Mr Webster also responded to the findings of the KP Health Report said:[367]

1. The Department is in the process of appointing a Project director to lead the delivery of the recommendations of the KP Health Report.

2. The person will initially:

    i. Develop an implementation plan for the outstanding actions;

    ii. Do a business impact analysis which will determine operational impact; and

    iii. Develop a business case if there is a need for additional resourcing to implement the policy and procedures and to ensure ongoing compliance.

3. The Department has also prioritised additional infrastructure works to increase the security of medication rooms in Ambulance Tasmania.

[364] C95 – Affidavit of Dr Con Georgakis, Annexure "K" KPH Report, pp 7-9
[365] T924: 1-5.
[366] T924: 7-9.
[367] C158 – Affidavit of Deputy Secretary Dale Webster, pp 3-4.

4. Work has commenced on a $2.7 Million upgrade to the security systems which will follow the approach in the KP Health Report.

5. The planned expenditure was $1 Million in the 2020-21 financial year. Additional investment to ensure all existing stations are upgraded to the same security standard will be allocated from the 2021-22 financial year.

6. In addition, 8 new stations are planned to be built over the next 5 years, with the standing functional design briefs to include the new security specifications to be applied to all future station builds as part of the construction contracts. Detailed planning, including the increased security specification is currently underway for new stations at Glenorchy and Burnie.

In addition, and amongst other matters, Mr Webster made the following comments:[368]

1. He has worked with the Chief Executive of Ambulance Tasmania to implement changes to the management structure, including the creation of two senior management roles, being the Director of Operations and the Director of Clinical Services.

2. In addition, there were two further Duty Manager positions created in 2020.

3. The Emergency Operations Centre created for COVID 19 will be an ongoing function in AT.

4. A process called Secondary Triage was introduced in the State Operations Centre by which lower priority patients are reassessed and where possible transferred to alternative more appropriate health services.

Whilst it is significant that there has been progress towards the implementation of these recommendations, it is important as identified by Mr Webster that sufficient resources are directed not just to their continued implementation, but on a practical level, that those responsible for the day to day operation of these policies have the capacity to perform these functions as part of their normal duties.

There was a significant body of evidence at the inquest from experienced paramedics to the effect that there was no time to perform, or at least properly perform some of the critical functions required by policies, perhaps most notably that of drug auditing.[369]

[368] C158 – Affidavit of Deputy Secretary Dale Webster, pp 1-3.
[369] See, e.g. T946: 9 - 20 (Peter Morgan); T983:10 – T984: 10 (Peter Berry).

In terms of further improvements, Dr Georgakas indicated that they had recommended the implementation of a system of access to drug stores that requires the entering of a PIN unique to each officer, in conjunction with their electronic swipe card.[370]

In addition, Dr Georgakas indicated that ideally there should be CCTV in each drug room as well as each narcotic safe, electronic drug registers with all of this linked to an electronic rostering system[371] providing for greater control over access when staff are not rostered to work.

In his oral evidence Dr Georgakas also mentioned audible alarms of drug store doors.[372] He ideally supported a two-person authentication system, but raised practical issues such as the requirement for paramedics to work alone in remote areas and urban stations, and the significant cost attached to achieving this standard.[373]

The evidence received at inquest allows me to find that AT has gone to significant efforts to improve security of medications since the MMP developed in 2014. These efforts have not only highlighted the critical importance of medication management but have, through dedicated work of a number of AT staff, been successful in improving medication safety and security. AT's efforts have taken longer than envisaged but weres considerably constrained by a lack of dedicated resourcing for the task.

I note from the more recent AT *Culture Improvement Action Plan* that AT has progressed a major upgrade of medication management infrastructure to install new medication safes at all paramedic stations to include card swipes, personal identification codes (PIN), and closed-circuit-television (CCTV) in the medication rooms. This project was on track to be completed at the end of 2022.[374]

Drug and Alcohol testing

In early 2016, AT issued a draft Alcohol and Other Drugs Policy. The draft policy was provided to HACSU[375] for response. The letter to Mr Templar in response dated 18 February 2016 was annexed to Mr Jacobson's affidavit for the inquest and provided clear comments on particular areas of concern and disagreement regarding the policy.[376]

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[370] C95 – Affidavit of Dr Con Georgakas, p 6. See also T885: 22-40.
[371] C95 – Affidavit of Dr Con Georgakas, pp 6-7. See also T886:1-7.
[372] T887:10-22.
[373] C95 – Affidavit of Dr Con Georgakas, p 7.
[374] C164, page 16.
[375] The Health and Community Services Union – a Registered Organisation covering AT employees.
[376] C 93, the author of the letter being Chris Kennedy, Industrial Officer.

Mr Jacobson stated in his original report for the investigation that HACSU members supported a drug testing process. He stated, however, that there were reservations about the punitive nature of the policy provided.

Mr Jacobson said in his report:

> *"We believe that any policy should be starting from a health improvement welfare point of view in the first instance. This interim policy had no test for impairment, nor any tolerances to a positive test. It wasn't clear who would conduct testing. It appeared not to be randomised, event triggered or suspicion of, and we had concerns about it being a targeted weapon to "get an individual employee".*[377]

In his oral testimony, Mr Jacobson reiterated general support for alcohol and drug testing but said that the draft policy did not have any measures contained in it that went to social or medical factors associated with alcohol or drug consumption.[378]

Mr Templar, in his affidavit, said that he attempted to implement drug and alcohol testing, but further stated:

> *"Last time we tried the union objected to it. It was not going anywhere as I was told there was a need for legislation reform in the act [sic]. I think it's a serious failing that there is no drug and alcohol testing for staff. I volunteer at Don River Railway, the manager came in and random breath tested me recently. It's a safety issue and has to be complied with. It needs policy and procedures behind it".*[379]

There is no evidence of a widespread culture of drug misuse within AT, nor is drug theft from AT stores or stations a common event.

However, Mr Crump's case shows the difficulty of detecting in a timely way those employees who may be affected by drugs whilst working in the absence of a system of testing.[380]

Former paramedic, LK, gave evidence at inquest and provided a detailed affidavit. She commenced work with AT in 2009 and was addicted to "ice" (methamphetamine) between about 2012 and 2014. She said that her managers and colleagues were not aware of the issue, despite the obvious physical indications upon her body and an increase in sick days. She stated in her affidavit that she did not believe she should have been allowed to continue working.

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[377] C 87, p4
[378] T2 782
[379] C 76 p 6
[380] For example, affidavit of Paul Templar C 76 p6

She said that in about December 2013 she crashed her vehicle whilst off-duty and was charged with drink-driving. Shortly after that incident, she was arrested and charged for possession of ice and driving with illicit drugs in her system. Her managers at AT discovered this information and she then disclosed that she had been using illicit drugs for at least two years. Following a further period of investigation, LK was given the option of resigning, which she took, I infer, at about the end of 2014.

LK said in her affidavit and in her credible oral testimony that mandatory drug testing was required at AT, a matter that she broached with her managers at the time of her resignation.[381] She said in evidence that random drug testing system would have detected her use as drugs would have been present in her system on every occasion she was tested.

LK said that her current employment involves conducting on-site drug testing for employees in numerous companies around Tasmania. She said that random drug testing would identify where a person has a drug problem and also prevent people from taking drugs because their employment been jeopardy.[382]

The case of LK's heavy illicit drug is illustrative of the safety outcomes to be gained by random alcohol and drug testing. I am grateful that LK provided such frank evidence, which benefited the inquest.

Whilst I accept that this matter requires consultation and careful consideration to balance several issues, it should nevertheless be implemented without delay. This is particularly so in the context of the overwhelming evidence given at inquest that, in principle, such a policy enhances safety and is desirable for the benefit of employees and the organisation as a whole.

Ms Thornley provided a considered response to the issue of random drug testing and emphasised that a policy that achieves appropriate balance between safety, health and welfare and punitive measures would be the ideal model. She described having knowledge and experience of how well resourced policies are essential. She emphasised the degree of education, training and awareness involved in a successful policy would be considerable and that a poorly resourced and poorly constructed model could have negative ramifications.[383]

There was abundant support from other witnesses for such a policy from paramedics and managers on the basis that paramedics are exposed to significant trauma, have access to

[381] C45 p7
[382] T192
[383] T238

drugs, are driving ambulances at high speed, working without sleep at times and are dealing with patients' lives and making drug calculations for patients.[384]

Dr Georgakas said in evidence:

> *"…..that would be my desire that we do have an alcohol and drug protocol or policy that we can enact as soon as practical. My understanding is that our – the draft protocol that I put forward was effectively utilising the Ambulance Victoria drug and alcohol protocol at the time. So I understand it's been improved and revised since those days. And I would hope that we can revisit alcohol and drug testing within Ambulance Tasmania, possibility utilising Ambulance Victoria's updated protocol as a base to provide us the framework of our own policy".*[385]

He went on to say that the alcohol and drug policy should focus upon a supportive culture within AT- that is, one focussing supporting the paramedics, but also protecting the patients and staff.

It was not within the scope of this inquest to consider the most desirable model for a drug and alcohol testing regime. However, many work places have implemented such a regime, achieving appropriate balances between safety, welfare and discipline. This matter should be progressed as a priority.

Resilience Scan and Culture Improvement Action Plan July 2022

Mr Joseph Acker, then Chief Executive of AT, swore an affidavit for the coronial investigation on 26 October 2021.

Mr Acker stated in his affidavit that AT had contracted an organisation called Frontline Mind to conduct a *"resilience scan"* survey to identify the culture of the organisation.

He said that the results had been collected at the time of making his affidavit with three themes identified, being: *"1) leadership, 2) communication, and, 3) inconsistency in decision-making".* Mr Acker said that the AT Executive Committee had identified a number of initiatives to address these issues to begin in October 2021. There were further plans to engage with staff which were intended to identify additional opportunities to improve culture.[386]

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[384] for example, JT T310, ZJ T185, Kim Fazackerley T136, S Elliott T479
[385] T924
[386] C 163, Affidavit Joseph Acker, page 9

I have recently located on the AT website a document entitled AT *"Culture Improvement Action Plan"* dated July 2022. It appears that this was published as a discrete news article on the website on 12 August 2022.[387] The plan endorsed by The Premier (also Minister for Health) and the Secretary, Department of Health.

The plan was underpinned by a "Resilience Scan", based upon obtaining from 323 AT staff their views on the organisation. It is obvious that the process of obtaining such views, and holding workshops and consultation sessions was a significant one. The analysis contained in the plan is highly relevant to the inquest and the organisational circumstances surrounding Mr Crump's death.

In the plan, under the heading *"Background",* is the following passage:

> *"In March 2021, a Coronial inquest into the 2016 death by suicide of an Ambulance Tasmania paramedics raised several very concerning issues regarding an unhealthy organisational culture, poor leadership, inadequate mental health and well-being support, and ineffective medication management procedure.*
>
> *Over several weeks of testimony at the Coronial inquest, current and former Ambulance Tasmania staff reported their experiences of being bullied, harassed, subjected to sexually inappropriate behaviour, and not being supported by supervisors and managers when issues were raised. Evidence was provided to the Coroner of medication management infrastructure and procedures that did not meet acceptable standards, an absence of a peer support program, and supervisors and managers who were over tasked and not prepared to support the mental health and well-being of their staff."*

This summary is accurate.

I located this 48-page document only by chance when considering my findings. It would seem that the report, or at least a version of it, was available in late 2021. Even if it had not been fully completed until July 2022, the process of closing submissions had only just finished. [388]

It would have been far more helpful if an additional affidavit had been provided to me, with the report, explaining the results, recommendations and action taken as a result of this process- especially since the contents could well affect any recommendations to be made in the coronial investigation. Indeed, taking this approach would be a genuine indicator of an increasingly mature and open organisation.

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[387] C164

[388] The inquest was awaiting submissions from Counsel for the Attorney General, (received on 1 June 2022)

The report concluded that it is *"very clear from the results of the Resilience Scan that staff at Ambulance Tasmania are feeling very negative about the organisation, and it is critical that well considered actions be implemented as quickly as possible."*[389]

The plan sets out 73 actions for completion before the end of 2022. These are categorised into 7 focus areas: clinical support and standards, workplace values, leadership accountability, building capacity, systems and processes, communication, operations and health, safety and well-being.

Many of the proposed actions are relevant to this inquest. As an example, actions concerning the following matters are proposed:

- Improving leadership and management roles, including by training, education and reviews;
- Developing and implementing high-quality feedback mechanisms for employees;
- Strengthening Performance Development Agreements between staff and their managers;
- Improvement to SRLS processes and accountabilities of supervisors to action SRLS reports more quickly and to report outcomes; and
- A review of all AT policies, procedures, guidelines and work instructions.

The entrenched cultural issues identified in the *Culture Improvement Action Plan accord* with those described almost universally by the witnesses at inquest.

It is commendable that AT has widely consulted its employees and has openly recognised long-standing issues in the organisation that require remediation. All efforts should be made to complete the specified actions.

Co-operation of AT investigation and at inquest

Overall, the degree of cooperation and assistance in the inquest process from AT as an organisation, as opposed to particular individuals, was markedly poor.

I have referred already to the submissions from AT, through counsel for the Department, throughout inquest that I was not entitled to have regard to evidence of AT systems and processes that I considered to be connected to Mr Crump's death. These submissions continued after a formal ruling on the scope and then a formal ruling concerning evidentiary objections to the same effect.

[389]C164 Culture Improvement Action Plan, Page 11

Notwithstanding the detailed nature of the affidavits and breadth of the areas covered in them, those paramedics were, and are, dedicated to their important work; but disillusioned with the culture of the organisation. Their intelligent and detailed observations were made, I thought, in the hope that AT might effect change for the betterment of all staff, patients and those impacted by the organisation.

The fact that AT objected the entirety of many affidavits and very large portions of many others, was unhelpful to the process and those witnesses, particularly when much of their evidence gave me overall insight as to important matters which related to Mr Crump's work environment.

There was also a lack of pro-active steps by AT to place before the inquest evidence from the current and former Chief Executives.

On 5 October 2018 Mr Kirby was requested in writing to address particular questions to assist the inquest. It appears that, due to Mr Kirby's ill health, the response was not forthcoming. From the time Mr Kirby was served a summons for the inquest in January 2021 there followed discussions between a legal advisor in the Department of Health regarding whether Mr Kirby would be able to give evidence. It was plain that, most unfortunately, Mr Kirby had significant health issues.[390] In September 2020, Mr Kirby had returned to work with the Department of Health on a return to work plan. I was satisfied that he was able to provide some evidence in an appropriate setting.

Mr Kirby's informative affidavit, together with 29 annexures, was duly provided on 6 April 2021, although only after the inquest had commenced and had nine days of evidence. Ideally, it should have been filed well before the commencement of the inquest. [391]

As part of the inquest, a view was conducted at AT headquarters on 25 March 2021 which included a tour of the drug store led by senior AT officers, including the new Chief Executive, Mr Acker. I attended the view, as did counsel for the interested parties. The view was, primarily, for the purpose of understanding the evidence about Mr Crump's movements on the night in question, the layout of relevant parts of the premises and the procedures around the drug store (from which Mr Crump was stealing). A "Points of View" list was circulated by counsel assisting to other counsel and it contained 7 listed points for viewing.[392]

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[390] Including suffering a stroke in February 2020 and undergoing open-heart surgery in July 2020.
[391] C 159, affidavit of Neil Kirby.
[392] 1. Walk to Ambulance Tasmania State Headquarters, 1 Melville Street, Hobart.
2. View street access door where Mr Crump entered the garage.
3. Walk through garage to the communications/ duty manager's office.
4. View CCTV of drug store from communications/duty manager's office.

It came to my attention following the view that in June 2020, AT had had installed a large bulk drugs safe (the "DS3 safe") in the headquarters premises. The purpose of the DS3 safe was to store drugs which could then be used to restock the smaller safes in the drug store. This was installed due to the need for storage of a larger number of doses of medications. Prior to 2020, AT did not have bulk storage of narcotics on-site as the storage function was managed by the Royal Hobart Hospital pharmacy, with orders being placed by AT as needed. [393] The fact that this drug safe was now installed at AT headquarters meant that additional medication safety measures and procedures were likely required. For example, questions would arise regarding the access to the safe, the availability of CCTV et cetera, which did not arise at the time of Mr Crump's employment.

Furthermore, it came to my attention following the view that the safe was apparently non-compliant with legislative requirements for the storage of Schedule 8 drugs, a fact later confirmed by Mr Acker his affidavit. [394] The issue came to light following a series of emails forwarded to the Coronial Division bringing my attention to the matter. The information received indicated that an order for a new, compliant level 4 safe was instigated by senior AT employees the day before the view (and likely in anticipation of it) with the order being completed on the day of the view.

At the view on 25 March 2021, the DS3 safe was not shown to me or other counsel, nor was the new process for re-stocking the Schedule 8 medications in the drug store mentioned. AT management did not refer to the safe or its non-compliance at that time or after the view.

Counsel assisting submitted that it was known by AT that the inquest, as part of its scope, was considering any current AT systems for the storage, security, access and accounting of drugs and associated paraphernalia of drugs held by AT for purposes connected with its authorised functions. They submitted that, with respect to Mr Acker, it was disappointing that in view of the clear scope of this enquiry the evidence regarding the existence of, and issues with, this safe was not volunteered to the inquest.

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5. Walk to drug store.
6. View, accompanied by a clinician,
    - Swipe card access to drug store;
    - Locations of S8 safes;
    - Location of S8 drug register;
    - Amiodarone storage area.
7. Walk back to the street access door.

[393] C163, Affidavit of Joseph Acker, pages 4 and 6
[394] Likely contrary to the requirements of the Secretary imposed under Rule 29 of the *Poisons Regulations* 2018; also See 163, Affidavit of Joseph Acker, page 5.

As a result of the issue of the safe coming to my attention, I requested further investigation, culminating in Mr Acker providing a detailed explanation in affidavit form.

Mr Acker stated in his affidavit that the DS3 safe was known to be non-compliant at the time of the view, indicating that its use exceeded the stocking limitations required under the regulations. He stated, however that the non-compliance issues did not affect the safety or security of the medications, with these safe weighing approximately 328 kg, being bolted to the floor and located behind two locked doors. [395]

I accept Mr Acker's statement in his affidavit that there was no intention, at least on his part, to avoid showing me the safe at the view. It is quite correct that counsel and I were shown the points of view as itemised in the document and I understand the submission that these points could be taken as defining the extent of the view.

However, if there had been a genuine willingness to assist me in my functions in determining the current state of medication security and to openly highlight any current issues, such an approach could only result in a proper and careful ventilation of the issue rather than creating the appearance of secrecy and wishing to avoid scrutiny.

I do not find in any way that Mr Acker was deceitful and take into account that his tenure had just commenced. He was still gaining knowledge of importance parts of AT operations and, in fact, had not been involved in the preparation of the inquest.

Thus, there is force in the submission of counsel assisting;

> *"A more open and helpful approach in the context of the issues being examined at the Inquest would have been for Mr Acker (or a delegate) to explain at a time prior to the Inquest but no later than at the view the known issue with the DS3 safe, what was being done about it and invite the Coroner to inspect the room containing the safe. Of course it could also have been explained that the operation of this safe was not in use when Mr Crump was alive, but had come in subsequently. Open disclosure of these facts in this way would have been demonstrative of an organisation committed to fixing known issues, rather than simply giving the appearance of doing so".*[396]

Counsel for the Department submitted that I had no "relevant power" to consider matters related to the DS3 safe. I reject such submission as propounding an overly narrow approach to the coroner's power to comment.

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[395] C163, Affidavit of Joseph Acker, page 6.
[396] Counsel assisting closing submissions paragraph 94.

I have already set out an apposite passage in *Doomadgee*[397] directly on point regarding a coroner's power to comment on a diverse range of matters, including issues surrounding the reporting and investigation of a death.[398] It could not possibly be said that a coroner is prohibited from making comments concerning a potential lack of candour by an interested party during a view which was directly to issues of safety and within the scope of the inquest.

This unhelpful closing submission from AT, through its counsel, again demonstrates a lack of appreciation of the breadth of the jurisdiction under the *Act*, including the public benefit of the coronial process.

Conclusion

Mr Crump ended his life following a lengthy course of stealing dangerous drugs from AT, his employer. He was a highly intelligent Intensive Care Paramedic who loved his work and enthusiastically imparted his clinical knowledge to many of his colleagues.

Unfortunately, he suffered long-standing mental illness and unresolved psychological issues. His poor mental health was unrelated to his work at AT. Nevertheless, his practices and behaviour at work regularly exceeded appropriate boundaries and, in the weeks before his death, alarmingly so.

He was never adequately called to account for his behaviour by AT management, the spoken and unspoken view being *"That's just Crumpy!"* Further, it was known amongst his colleagues and some managers of his longstanding intention to die by suicide before the age of 40 years. This was not taken further as a welfare issue, despite his deteriorating mental state.

The coronial investigation highlighted severe resourcing deficits in the organisation, inadequate management of staff and a culture of tolerating unacceptable behaviour. These factors substantially contributed to Mr Crump's behaviour and welfare not being dealt with and his drug thefts remaining undetected. He was therefore able to remain working as an operational Intensive Care Paramedic.

His manager and close friend took it upon herself to look after him, knowing of his mental illness and believing that he was honest with her. He was, however, dishonest about his medical treatment and his drug addiction. He treated her and other managers disrespectfully at times and was generally disrespectful of authority within the workplace. She became conflicted in her managerial role when she was required to report her belief that he had

[397] *Doomadgee v Deputy State Coroner Clements*[2005] QSC 357
[398] See also Ruling in *Xu and Davies*, 3 May 2023.

been stealing AT medication to police, and to initiate an internal investigation. There were no processes in AT to ensure that an internal investigation was progressed at all, and therefore Mr Crump was not formally identified as being responsible.

Numerous other opportunities existed for AT to properly deal with his behaviour and actions, including the serious ambulance incident nine days before his death. Appropriate intervention may have uncovered his addiction and thefts at that time.

Because of the unfeasibly large workload of AT managers and their lack of adequate training, there was no proper auditing of medication and there were no pathways to deal with Mr Crump's behaviour or welfare. He was therefore able to remain at work and able to keep stealing Schedule 8 medications from the drug store.

The considerable work completed by AT in improving medication management is to be commended.

Resourcing has also been committed and comprehensive strategies developed in other critical areas of management and welfare.

AT has taken very significant steps to change the culture of the organisation in the years between Mr Crump's death and today.

This change is ongoing, and remains heavily reliant upon sound planning and resourcing. It must be continued if AT is to overcome the cultural and systemic issues that have been highlighted in this investigation.

Formal findings required by section 28(1) of the *Coroners Act* 1995:

a) The identity of the deceased Damian Michael Crump, date of birth 4 September 1980.[399]

b) Mr Crump intentionally ended his own life by ingesting fatal quantities of drugs that he stole from the AT drug store in Hobart in the hours before his death; and the circumstances surrounding his death have been fully set out in these findings.[400]

c) Mr Crump died as a result of combined morphine, lignocaine amiodarone and midazolam toxicity.[401]

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[399] C3 – Identification Affidavit & C14 - Affidavit of Alanah Eva Crump.
[400] *Coroners Act 1995*, s 28(1)(b).
[401] C5 – Post Mortem Report of Forensic Pathologist, Dr Donald Ritchey.

d) Mr Crump died between about 7.00pm on Friday 23 December 2016 and 2.00am on Saturday 24 December 2016 at Sorell in Tasmania.[402]

Recommendations

1. I **recommend** that Ambulance Tasmania implement random drug and alcohol testing for all employees as a matter of priority.

2. I **recommend** that Ambulance Tasmania implement any remaining recommendations from the December 2020 *KP Health Medication Management Outcome Assessment* as a matter of priority.

3. I **recommend** that Ambulance Tasmania conduct regular reviews of the operation of its policies relating to the management, storage, safekeeping, handling and accountability of drugs to ensure that the policies are effective and contemporary.

4. I **recommend** that Ambulance Tasmania provide regular training for all staff and managers regarding their obligations in respect of each policy relating to the management, storage, safekeeping, handling and accountability of drugs held by Ambulance Tasmania; and implement and maintain robust systems of accountability that ensure a high degree of compliance.

5. I **recommend** that Ambulance Tasmania implement a system of regular mandatory psychological assessments for its employees in order to identify mental health and psychological issues, and any changes, over the whole period of their employment with Ambulance Tasmania.

6. I **recommend** that Ambulance Tasmania continue to make efforts to reduce the span of control for duty managers and other managers.

7. I **recommend** that Ambulance Tasmania regularly review the ability of front line managers to undertake their duties of supervision adequately.

8. I **recommend** that Ambulance Tasmania provides regular training for all managers in managing staff generally and in responding to mental health issues.

[402] See especially: C15 - Affidavit of Kim Maree Fazackerley; C26 - Affidavit Jack Gary Steele; C27 - Affidavit of Constable Douglas James McKinlay; C28 - Affidavit of Senior Constable Jeremy Paul Williams. See also the other evidence generally.

9. I **recommend** that Ambulance Tasmania provides training for managers who are required to conduct or oversee investigations under a policy; this training to include knowledge of the policy, basic investigation skills, reporting requirements in SRLS or other electronic platform and identifying and managing conflicts of interest.

10. I **recommend** that Ambulance Tasmania complete any outstanding action items, of the 73 actions to which it has committed, from the *Culture Improvement Action Plan July 2022.*

11. I **recommend** that Ambulance Tasmania publish on its website a report setting out the progress of the 73 action items from the *Culture Improvement Action Plan July 2022*, indicating whether they have been completed or otherwise, providing details of those items that have not been completed, and providing a timeframe for their completion.

12. I **recommend** that Ambulance Tasmania complete and publish on its website updates at appropriate intervals of the *Culture Improvement Action Plan*, with the aim of promoting confidence and transparency.

13. I **recommend** that Ambulance Tasmania develop processes to provide timely assistance, where required, in a coronial investigation, including providing the coroner with relevant material to address matters pertaining to the scope of the inquest.

Acknowledgements

I acknowledge the work of Sergeant Terence McCulloch, investigating officer, together with Constable Erica Franks, who investigated the death of Mr Crump in a manner that has contributed to positive change in the organisation of Ambulance Tasmania.

I am also grateful for the very competent assistance provided by Counsel Assisting, Mr Allen and Ms Dawkins.

I particularly acknowledge the participation of Mrs Crump in this lengthy but important process.

I convey my condolences to her and all of Mr Crump's family members, as well as his friends and his colleagues.

Dated: 5 July 2023 at Hobart in the State of Tasmania

Olivia McTaggart
Coroner

ANNEXURES

'A'

Inquest into the death of Damian Michael Crump

Ruling No.1

1. Damian Michael Crump, an intensive care paramedic employed by Ambulance Tasmania ("AT"), died on or about 23 December 2016. His death was reported pursuant to the provisions of the *Coroners Act* 1995 ("the Act") and, as Coroner conducting the investigation, I have decided that a public inquest should be held into Mr Crump's death.

2. The evidence in the investigation strongly indicates that Mr Crump intentionally ended his own life by ingesting a fatal combination of drugs which he obtained without authorisation in the hours before his death from the Ambulance Tasmania drug store in Hobart.

3. The investigation into Mr Crump's death has been lengthy and thorough, and has involved a consideration of numerous issues which may be considered relevant to the circumstances of his death. These issues included, but were not limited to, Mr Crump's known mental health conditions and prescription drug abuse, adequacy of his management, supervision and welfare requirements by AT and his ability to access drugs and the drug store without authorisation.

4. After several case management conferences pursuant to rule 22 of the *Coroners Rules* 2006, held in court, at which interested parties were in attendance, counsel assisting proposed that the inquest should examine the following matters ("the Draft Scope") pursuant to section 28 of the Act:

    1) The circumstances surrounding the death of Damian Michael Crump to enable findings to be made, if possible, under section 28(1) of the Act;

    2) The circumstances of, and the response of Ambulance Tasmania to, the reported missing and/or unauthorised taking of morphine and/or other drugs from Ambulance Tasmania Stations in Southern Tasmania in approximately September 2016;

    3) Any established systems and/or policies providing for the storage, security, access and accounting of drugs and associated paraphernalia of drugs held by

Ambulance Tasmania for purposes connected with its authorised functions, both in 2016 and at the time of this inquest;

4) Any misuse of drugs by Mr Crump, and other employees of Ambulance Tasmania, as relevant to the circumstances of Mr Crump's death, including any knowledge of and response to such use by Ambulance Tasmania;

5) The investigation, internal management of, and organisational response by Ambulance Tasmania to the suspected misuse and/or theft of drugs held by Ambulance Tasmania prior to Mr Crump's death by two other employees;

6) Any established mental health and welfare systems or policies relating to or providing for support to Mr Crump and other employees of Ambulance Tasmania in 2016. The availability and use of such systems and/or policies at the time of this inquest; and

7) The capacity and ability of those occupying relevant supervisory positions in Ambulance Tasmania either substantively or occasionally, both in 2016 and at the time of inquest with respect to:

   i. Identifying and assisting employees with mental health issues;

   ii. Managing the risks, if any, that those issues posed to both patient and staff safety;

   iii. The pathways available to managers to deal with those issues;

   iv. Assistance available to managers in dealing with employees with mental health issues; and

   v. Any management training provided by Ambulance Tasmania.

5. This ruling will finalise the scope of the inquest. In particular, I address the written submissions of Counsel for the State of Tasmania (representing AT).

6. Counsel for AT, Ms Chen, takes issue with paragraph 4 of the Draft Scope so far as it relates to employees of AT other than Mr Crump. She also submits that I ought not to examine the matters in points 5, 6 and 7 of the Draft Scope. Ms Chen submits that these issues proposed to be traversed at inquest are not relevant to making the necessary findings as demanded by section 28 (1)(b) and (c) of the Act. She submits, citing authorities, that the examination of the issues at points 5, 6 and

7 are tantamount to conducting an investigation into the operations of AT without the necessary connection to the death of Mr Crump as required by the provisions of section 28 of the Act.

7. Ms Chen submitted that the State does not challenge:

   a) That Mr Crump died in his vehicle at the location stated in the Police Report of Death;

   b) That the cause of Mr Crump's death was mixed prescription drug toxicity;

   c) That Mr Crump stole from AT at least some of the drugs that caused his death; and

   d) That, had the drugs stolen by Mr Crump been better secured by AT, he would not have been able to steal them.

8. She submitted that the Act is directed towards discovering the cause of death and not concerned with the broad circumstances surrounding it.

9. I observe initially that the obligation to find, pursuant to section 28 of the Act, *"how death occurred"* refers not only to the manner of death (in the case of Mr Crump likely by ingesting prescription substances) but the circumstances surrounding the occurrence of the death.[403] It will be a matter for the Coroner to determine and investigate those matters that should properly be considered to be relevant, or potentially relevant, circumstances surrounding the death. Notions of common sense must be applied to consider any significant causal role of such circumstances in the death.

10. In *Liam Mead - Ruling on Evidence* dated 2 August 2019, Coroner Stanton discussed the authorities concerning the proper scope of an investigation into the circumstances of a death and the associated functions of making comments and recommendations.

11. At paragraph 16, His Honour stated:

> *"It is well established that an inquest ought not be held solely to enable comments or recommendations to be made. The power to make such comments and recommendations*

[403] *Re The State Coroner; ex parte Minister for Health* (2009) 38 WAR 553 per Buss JA at [42].

is not free standing. The coroner has no power to conduct a roving commission of inquiry into any matter connected with the death.

Indeed, the power to comment and make recommendations is subordinate and incidental to the power to make findings relating to how deaths occurred and their causes. The powers to comment and make recommendations arise as a consequence of the prime function to make findings about how death occurred and the cause of death: Harmsworth v State Coroner [1989] VR 989 per Nathan J at 996. But once the inquest is held, although the limits on the power to comment are not easily defined, it is wide so long as it is connected with the death: Commissioner of Police v Hallenstein [1996] 2 VR 1 per Hedigan J at 7. Similarly recommendations must be made with respect to ways to prevent further deaths whenever appropriate. The reference to "further deaths" requires that the recommendations arise out of, or have some connection to, the findings in respect of this death. In Attorney General v Copper Mines of Tasmania Pty Ltd above, Blow CJ said that the duty to investigate the circumstances leading up to the death includes doing so with a view to making recommendations with respect to ways of preventing further deaths and other appropriate matters: at [45]."

12. With respect, I agree that His Honour has set out the proper approach to the Coroner's power to comment and make recommendations.

13. It is not appropriate or necessary to deal in detail with the evidence in this comprehensive investigation. However, applying the above principles, I am clearly satisfied that the Draft Scope is appropriately formulated in order to examine and determine the material circumstances surrounding Mr Crump's death and the matters potentially connected with the death which may be appropriate for comments and recommendations.

14. In this investigation, there is evidence from witnesses regarding matters that, upon the evidence as it stands, may well form part of the circumstances of death (that is, how death occurred). These matters include the following:

    a) The fact that Mr Crump suffered serious mental health issues known to AT employees and management, including expressing suicidal plans;

    b) That Mr Crump abused prescription medication before his death;

    c) That AT medication was reported missing in September 2016, with Mr Crump suspected as being one of those responsible;

    d) That AT medication was stolen from AT stores by two separate

AT employees in 2012 and 2014 respectively, in similar circumstances or manner to Mr Crump; and

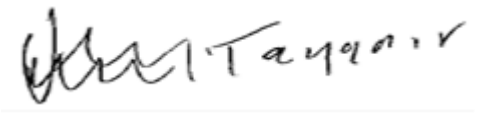
e) That there was a lack of appropriate management, discipline and welfare support by AT for Mr Crump (and other employees requiring those), with evidence that AT managers responsible for these areas were insufficient in number and inadequately trained.

15. It may well be that significant, causal or contributing circumstances leading to Mr Crump's death involve a failure of AT to appropriately manage him and, if necessary, discipline him or terminate his employment. Appropriate management may well have resulted in a different outcome. Similarly, inadequate responses by AT to the two earlier known cases of stealing medication from AT stores may have allowed Mr Crump to more easily access medication, including the fatal quantity of medication stolen before his death. Further, adequate welfare assistance and support by AT for his drug abuse and mental health issues may have changed the outcome.

16. In examining the circumstances of how death occurred, it will be appropriate (subject, of course, to relevance of any particular evidence) to explore the nature of any such deficits or inadequacies with a view to accurately commenting upon them and/or making recommendations to prevent similar deaths in accordance with the provisions of section 28(2) and (3). Upon the evidence as it now stands, the matters set out at points 4-7 of the Draft Scope are likely to be connected to Mr Crump's death and may also reveal systemic issues within AT appropriate for such comment and recommendations.

17. For these reasons, the Draft Scope in its entirety, as set out above, properly identifies the areas for examination at inquest.

Dated 23 December 2020 in Hobart in the State of Tasmania



Olivia McTaggart
Coroner

'B'

LIST OF EXHIBITS

Record of investigation into the death of

Damian Michael Crump

Tab No.	TYPE OF EXHIBIT	NAME OF WITNESS
C1	REPORT OF DEATH	CONSTABLE DOUG MCKINLAY Tasmania Police
C2	LIFE EXTINCT AFFIDAVIT	DR M ROGERS Royal Hobart Hospital
C3	AFFIDAVIT OF IDENTIFICATION	CONSTABLE JEREMY WILLIAMS Tasmania Police
C4	AFFIDAVIT OF IDENTIFICATION	ANTHONY CORDWELL Mortuary ambulance officer
C5	POST MORTEM REPORT	DR DONALD MACGILLIVRAY RITCHEY Forensic pathologist
C6	TOXICOLOGY REPORT	MIRIAM CONNOR Forensic scientist
C7	FSST CERTIFICATE OF ANALYSIS	CLAIRE FULTON Forensic scientist
C8	NOT USED	
C9	MEDICAL RECORDS OF DAMIAN CRUMP	CITY DOCTORS
C10	MEDICAL RECORDS OF DAMIAN CRUMP	ROSNY PARK FAMILY PRACTICE
C11	MEDICAL RECORDS OF DAMIAN CRUMP	THE LINDISFARNE CLINIC
C12	MEDICAL RECORDS OF DAMIAN CRUMP	CLARENCE GP SUPER CLINIC
C13A C13B C13C C13D	AMBULANCE TASMANIA PERSONNEL RECORDS OF DAMIAN CRUMP	AMBULANCE TASMANIA
C14	AFFIDAVIT 15/3/17	ALANAH CRUMP

		Mother of Damian Crump
C15	**AFFIDAVIT 19/3/17**	**KIM FAZACKERLEY** **Ambulance Tasmania**
C15A	**WALK THROUGH VIDEOS**	**KIM FAZACKERLEY** **Ambulance Tasmania**
C16	**AFFIDAVIT 4/9/18**	**LEE KUSKOPF** **Ambulance Tasmania**
C17	**AFFIDAVIT 24/9/18**	**STEPHEN ELLIOTT** **Ambulance Tasmania**
C18	**AFFIDAVIT 5/11/18**	**BRETT GIBSON** **Ambulance Tasmania**
C19	**AFFIDAVIT 7/11/18**	**CRAIG WESTLAKE** **Ambulance Tasmania**
C20	**AFFIDAVIT 4/12/18 & PHOTOGRAPHS OF TEXT MESSAGES BETWEEN DAMIAN CRUMP AND JT**	**JT** **Ambulance Tasmania**
C20A	**EMPLOYEE RECORDS AND CORRESPONDENCE**	**JT** **Ambulance Tasmania**
C21.	**AFFIDAVIT 27/1/17**	**CONSTABLE MARC DANIELETTO** **Tasmania Police**
C22.	**AFFIDAVIT 1/2/17**	**SERGEANT TIMOTHY ETHERIDGE** **Tasmania Police**
C23.	**AFFIDAVIT 2/2/17**	**INSPECTOR IAN EDMONDS** **Tasmania Police**
C24.	**AFFIDAVIT 4/3/17**	**CONSTABLE SOPHIE LANGDALE** **Tasmania Police**
C25.	**AFFIDAVIT 28/1/17**	**CONSTABLE ALISHA ESAM** **Tasmania Police**
C26.	**AFFIDAVIT 24/12/16**	**JACK STEELE** **Witness at scene of death**
C27.	**AFFIDAVIT 17/2/17**	**CONSTABLE DOUGLAS MCKINLAY** **Tasmania Police**
C28.	**AFFIDAVIT 24/1/17**	**SENIOR CONSTABLE JEREMY WILLIAMS** **Tasmania Police**
C29.	**AFFIDAVIT 24/1/17**	**SENIOR CONSTABLE JUSTIN CASWELL** **Tasmania Police**

C30.	**AFFIDAVIT 24/1/17**	**CONSTABLE JAMIE HARRISS** **Tasmania Police**
C31.	**AFFIDAVIT 16/1/17**	**DETECTIVE CONSTABLE CRAIG FRY** **Tasmania Police**
C31A	**AFFIDAVIT 4/4/19**	**DETECTIVE CONSTABLE CRAIG FRY** **Tasmania Police**
C32.	**AFFIDAVIT 6/1/17**	**DETECTIVE SENIOR CONSTABLE NICHOLAS BOWDEN** **Tasmania Police**
C33.	**AFFIDAVIT 6/3/17**	**DETECTIVE CONSTABLE ADAM HUNTER** **Tasmania Police**
C34.	**AFFIDAVIT 31/3/17**	**SENIOR CONSTABLE PAUL HYLAND** **Tasmania Police**
C34A	**AFFIDAVIT 19/4/17**	**SENIOR CONSTABLE PAUL HYLAND** **Tasmania Police**
C35.	**AFFIDAVIT 31/8/18**	**PETA HOOPER** **Ambulance Tasmania**
C36.	**AFFIDAVIT 28/9/18, STATUTORY DECLARATION 23/12/16 & 4/10/16 AND ATTACHMENTS**	**MONICA BAKER** **Ambulance Tasmania**
C36A	**RESEARCH PAPER**	**MONICA BAKER** **Ambulance Tasmania**
C37.	**AFFIDAVIT 23/8/18**	**STEPHEN RILEY** **Ambulance Tasmania**
C38.	**AFFIDAVIT 19/5/17**	**DETECTIVE SENIOR CONSTABLE DANNY JACKSON** **Tasmania Police**
C39.	**AFFIDAVIT 18/4/2017 AND APPENDICES A-J**	**DETECTIVE SENIOR CONSTABLE TAMI NELSEN** **Tasmania Police**
C40.	**AFFIDAVIT 21/8/18**	**PETER BERRY** **Former Ambulance Tasmania Employee**
C41.	**AFFIDAVIT 6/8/18**	**BRIANNE GOSS** **Ambulance Tasmania**

C42.	**AFFIDAVIT 19/10/18**	**BESS SWINTON** **Ambulance Tasmania**
C43.	**AFFIDAVIT 3/10/19**	**KM** **Former Ambulance Tasmania Employee**
C44.	**AFFIDAVIT 4/7/18**	**URSULA MATTHEWS** **Former Ambulance Tasmania Employee**
C45.	**AFFIDAVIT 15/10/18**	**LK** **Former Ambulance Tasmania Employee**
C46.	**DOCUMENTATION RELATING TO CW INCLUDING;** • **Tasmania Police Subject Report** • **Facts for the Prosecutor** • **Various Email Correspondence Between Coroner's Office and Department of Health** • **Various Correspondence from Ambulance Tasmania to CW** • **Notice of Disqualification and Granting of Restricted License** • **Various documents from DHHS employees Regarding CW's Alleged Breaches of the State Service Code of Conduct Including** • **File Note** • **Various Examiner News Articles**	**CW** **Former Ambulance Tasmania Employee**
C46A	**AFFIDAVIT 5/3/21**	**CW** **Former Ambulance Tasmania Employee**
C47.	**AFFIDAVITS 24/12/2016**	**DARYL LONG** **Housemate**
C47A	**AFFIDAVIT 6/7/18**	**DARYL LONG** **Housemate**
C48.	**AFFIDAVIT 5/7/18**	**DEAN LONG** **Friend**
C49.	**AFFIDAVIT 4/7/18**	**DAYNE COLEMAN** **Friend**
C50	**AFFIDAVIT 10/7/18**	**BENJAMIN CORMIE** **Friend**
C51	**AFFIDAVIT 14/7/18**	**DAMIEN NEWMAN** **Friend**
C52	**AFFIDAVIT 10/8/18**	**ELLEN BURKE** **Friend**
C53	**AFFIDAVIT 6/7/18**	**DAVID TAYLOR**

		Friend
C54	**AFFIDAVIT 25/9/18** **Together with additional documents regarding electronic communications**	**ZJ** **Ambulance Tasmania**
C55	**AFFIDAVIT 1/4/19**	**EMMA-KATE THORNLEY** **Ambulance Tasmania**
C56.	**AFFIDAVIT 30/8/18**	**MICHAEL FAWCETT** **Ambulance Tasmania**
C57.	**AFFIDAVIT 20/9/18**	**CHARLES WENDELL-SMITH** **Ambulance Tasmania**
C58.	**AFFIDAVIT 28/9/18**	**SIMON GEARD** **Ambulance Tasmania**
C59.	**AFFIDAVIT 1/8/18**	**MATHEW AITON** **Ambulance Tasmania**
C60.	**AFFIDAVIT 16/7/18**	**EMILY BYERS** **Ambulance Tasmania**
C61.	**AFFIDAVIT 13/7/18**	**LEAH GEARD** **Ambulance Tasmania**
C62.	**AFFIDAVIT 14/8/18**	**JOHN (JACK) INGLIS** **Ambulance Tasmania**
C63.	**AFFIDAVIT 20/9/18**	**LAUREN HEPHER** **Ambulance Tasmania**
C64.	**AFFIDAVIT 2/8/18**	**STEPHANIE BUELL** **Ambulance Tasmania**
C65.	**AFFIDAVIT 17/2/21**	**HL** **Former Ambulance Tasmania Employee & Current Registered Nurse**
C66.	**AFFIDAVIT 24/8/18**	**NICHOLAS WARD** **Former Ambulance Tasmania Employee**
C67.	**AFFIDAVIT 24/7/18**	**JOANNE BLOWFIELD** **Ambulance Tasmania**
C68.	**AFFIDAVIT 27/7/18**	**MATTHEW PROBIN** **Ambulance Tasmania**
C69.	**AFFIDAVIT 15/10/19**	**ANDREW SUMMERS** **Ambulance Tasmania**
C70.	**AFFIDAVIT 12/10/18**	**PETER HAMPTON** **Ambulance Tasmania**
C71.	**AFFIDAVIT 2/8/18**	**NICHOLAS COLLINS**

		Ambulance Tasmania
C72.	**AFFIDAVIT 3/10/18**	**AMANDA HUTCHINSON** **Ambulance Tasmania**
C73.	**AFFIDAVIT 11/12/18**	**HAN-WEI LEE** **Ambulance Tasmania**
C74.	**AFFIDAVIT 23/7/18 AND STATEMENT OF DUTIES, DUTY MANAGER - COMMUNICATIONS**	**SCOTT FYFE** **Ambulance Tasmania**
C75.	**AFFIDAVIT 4/2/19**	**PETER MORGAN** **Retired from Ambulance Tasmania**
C76.	**AFFIDAVIT 5/10/18**	**PAUL TEMPLAR** **Retired from Ambulance Tasmania**
C77.	**AFFIDAVIT 8/8/18**	**SIMONE HAIGH** **Ambulance Tasmania**
C78.	**AFFIDAVIT 13/8/19**	**ANDREW PORTER** **Ambulance Tasmania**
C79.	**AFFIDAVIT 12/12/18**	**GAVIN JAEGER** **Former Ambulance Tasmania Employee**
C80.	**AFFIDAVIT 11/12/18**	**MICHAEL McDERMOTT** **Ambulance Tasmania**
C81.	**AFFIDAVIT 24/10/18**	**BENJAMIN GREEN** **Ambulance Tasmania**
C82.	**AFFIDAVITS 17/1/19** **Annexures to affidavit:** **A1 - Timeline** **A2 - Statement 12/7/15** **B – Statement 20/6/unknown year** **C - Email Correspondence with Handwritten Notes** **D - Doctors Certificate** **E - Email Correspondence,** **F - Meeting Notes 14/8/15** **G - Report and Responses.**	**PATRICIA MAKROGAMVRAKIS** **Ambulance Tasmania**
C83.	**AFFIDAVIT 3/10/18 AND EAP AWARENESS PRESENTATION, CONVERGE INTERNATIONAL**	**IAN TROTTER** **Department of Health and Human Services (Communities)**
C84.	**AFFIDAVIT 5/9/18**	**SALLY JONES** **Ambulance Tasmania**
C85.	**AFFIDAVIT 3/7/20**	**MONIKA STEINER**

		Pharmaceutical Services Branch, Department of Health
C86.	**AFFIDAVIT 12/11/18**	**CONSTABLE NICHOLAS MONK** **Forensic Services, Tasmania Police**
C87.	**REPORT PART 1 AND 2 10/12/18**	**TIM JACOBSON** **Health and Community Services Union**
C88.	**REPORT 15/11/18**	**DOMINIC MORGAN** **Former Employee of Ambulance Tasmania and Current Employee of NSW Ambulance**
C88A	**AFFIDAVIT 5/8/21**	**DOMINIC MORGAN** **Former Employee of Ambulance Tasmania and Current Employee of NSW Ambulance**
C89.	**LETTER FROM PSB 9/7/20**	**CHOI-LIN BATTEN** **Pharmaceutical Services Branch, Department of Health**
C90.	**AFFIDAVIT 1/3/21** **Attachments to affidavit:** **Critical Incident Stress Management Report's involving Damian Crump: 16/2/15, 21/6/15, 12/7/16, 16/12/16, 9/1/12, 24/4/07, 27/04/12, 21/6/12, 17/9/09, 10/12/05, 28/2/03.**	**MATTHEW PETER RICHMAN** **Wellbeing Support, Department of Police, Fire and Emergency Management**
C91.	**AFFIDAVIT 14/10/19**	**SERGEANT TERRENCE MCCULLOCH** **Tasmania Police**
C92.	**AFFIDAVIT 9/7/20**	**MARTIN NEUMEYER** **Pharmaceutical Services Branch, Department of Health**
C93.	**AFFIDAVIT 2/02/2021**	**TIM JACOBSON** **Health and Community Services Union**
C94.	**AFFIDAVIT 25/1/2021** **Attachments to affidavit:** **1 – Email** **2 - Photo of Medicine Pouch** **3 - Specified Medications Kit Sign Out/In Register December 2020** **4 - Ambulance Tasmania Medication Management Policy - January 2020** **5 – Letter - July 2017** **6 - Australian Paramedics Association DRAFT minutes - February 2017**	**PATRICIA MAKROGAMVRAKIS** **Australian Paramedics Association Tasmania**

	7 - APA Agenda November 2013, Australian Paramedics Association Minutes - January 2018 **8 – Email** **9 – Email** **10 – Email** **11 – APA Agenda - November 2013** **12 - SLT Meeting - November 2013** **13 - Australian Paramedics Association Meeting Agenda - June 2015** **14 - SLT Meeting - April 2014** **15 - Australian Paramedics Association Agenda - September 2015** **16 - Training Session Flyer** **17 – Continuing Professional Development Program 2016** **18 - Health & Wellbeing, Participant Resource, Continuing Professional Development Program 2016** **19 – Email** **20 – Email** **21 – Email** **22 - APA Meeting minutes - November 2013** **23 – Email** **24 - Australian Paramedics Association DRAFT Minutes - October 2016** **25 – Email** **26 - Transition to Senior Roles – Trial Program - November 2016.**	
C95.	**AFFIDAVIT 1/3/21** **Annexures to affidavit:** **A - Ambulance Tasmania Medication Management Policy – 2 January 2020** **B - Medication Disposal Procedure – 2 January 2020** **C - Medication Document Management Procedure – 2 January 2020** **D - Medication Infrastructure Procedure – 15 April 2020** **E - Medication Possession and Storage Procedure - 2 January 2020** **F - Medication Stock Maintenance, Order and Transfer Procedure – 2 January 2020** **G - Site Compliance Inspection Procedure – 2 January 2020** **H - Specified Medication Kit Register Audit Procedure – 2 January 2020**	**DR CON GEORGAKAS** **Ambulance Tasmania**

	I – Specified Medication Register Procedure – 2 January 2020 **J - Specified Medication Safe Register Audit Procedure – 2 January 2020** **K - KPH medication management project outcome assessment prepared for Ambulance Tasmania December 2020**	
C96.	**MEDICAL REPORTS**	**DR MARZENA RYBAK** **St Helens Private Hospital**
C97.	**MEDICAL RECORDS**	**ROSNY PARK FAMILY PRACTICE**
C98.	**MEDICAL RECORDS**	**CHEMIST WAREHOUSE LINDISFARNE**
C99.	**MEDICAL RECORDS**	**CITY DOCTORS**
C100.	**MEDICAL RECORDS**	**THE LINDISFARNE CLINIC**
C101.	**GENERAL PRACTITIONER MEDICAL RECORDS 2001 – 2016 PART 1 & 2**	**VARIOUS**
C102.	**EMPLOYMENT RECORDS OF DAMIAN CRUMP**	**AMBULANCE TASMANIA**
C103.	**MEDICATION MANAGEMENT POLICY - 17 February 2014**	**DEPARTMENT OF HEALTH & HUMAN SERVICES**
C104.	**SAFETY EVENT MANAGEMENT FORM 36547**	**SUBMITTED BY STEVE HICKIE**
C105.	**SAFETY EVENT MANAGEMENT FORM 36870**	**SUBMITTED BY PETA HOOPER**
C106.	**SAFETY EVENT MANAGEMENT FORM 36930**	**SUBMITTED BY RICHARD BUGG**
C107.	**SAFETY EVENT MANAGEMENT FORM 37052**	**SUBMITTED BY STEPHEN RILEY**
C108.	**SAFETY EVENT MANAGEMENT FORM 37151**	**SUBMITTED BY RICHARD HANSLOW**
C109.	**SAFETY EVENT MANAGEMENT FORM 38318**	**SUBMITTED BY DARYL PENDREY**
C110.	**SAFETY EVENT MANAGEMENT FORM 38390**	**SUBMITTED BY LAUREN HEPHER**
C111.	**MEDICATION MANAGEMENT REVIEW MINUTE TO SECRETARY**	**DEPARTMENT OF HEALTH & HUMAN SERVICES**
C112.	**SPECIFIED MEDICATION MANAGEMENT INVESTIGATION SOUTHERN REGION 3/11/16-26/12/16**	**AMBULANCE TASMANIA**

C113.	**SPECIFIED MEDICATION MANAGEMENT INVESTIGATION NORTHERN REGION 1/1/17-28/2/17**	**AMBULANCE TASMANIA**
C114.	**SPECIFIED MEDICATION MANAGEMENT INVESTIGATION NORTHWEST REGION 1/1/17-28/2/17**	**AMBULANCE TASMANIA**
C115.	**AMBULANCE TASMANIA MEDICATION MANAGEMENT REVIEW FINAL REPORT - DEC 2017** **AMBULANCE TASMANIA MEDICATION MANAGEMENT REVIEW INTERIM REPORT – JAN 2017** **MEDICAL SERVICES SPECIFIED MEDICATION MANAGMENT INVESTIGATION 2017 SUMMARY OF RECOMMENDATIONS**	**AMBULANCE TASMANIA**
C116.	**INTERIM SPECIFIED MEDICATION AUDIT PROCEDURE – 9 March 2017**	**AMBULANCE TASMANIA**
C117.	**12 MONTH – MEDICATION RECORD BOOK AUDIT – SUMMARY OF FINDINGS 26/12/15 – 26/12/16**	**DEPARTMENT OF HEALTH & HUMAN SERVICES**
C118.	**AMBULANCE SERVICE ACT 1982**	
C119.	**STATE SERVICE ACT 2000**	
C120.	**AMBULANCE TASMANIA 2010-2013 BUSINESS PLAN – ACTION PLAN RESULTS**	**AMBULANCE TASMANIA**
C121.	**AMBULANCE TASMANIA BUSINESS PLAN 2013-2016**	**AMBULANCE TASMANIA**
C122.	**AMBULANCE TASMANIA CLINICAL GOVERNANCE FRAMEWORK 2012**	**AMBULANCE TASMANIA**
C123.	**AMBULANCE TASMANIA COMMUNICATIONS REFORM PLAN 2015**	**AMBULANCE TASMANIA**
C124.	**STAFF CONTACT DURING EXTENDED ABSENCE PROCEDURE - 25 APRIL 2012**	**AMBULANCE TASMANIA**
C125.	**HEALTH AND WELLBEING PARTICIPANT RESOURCE & FACILITATOR GUIDE - CONTINUING PROFESSIONAL DEVELOPMENT PROGRAM 2016, CRITICAL INCIDENT STRESS MANAGEMENT FOR THE TASMANIAN EMERGENCY SERVICES – REVISED AUG 2013, CONVERGE**	**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

	INTERNATIONAL – THE CASE OR USING EAP	
C126.	**EMPLOYEE ASSISTANCE PROGRAM & RELATED SUPPORT SERVICES, UTILISATION REPORT - DEPARTMENT OF HEALTH AND HUMAN SERVICES, AMBULANCE TASMANIA - APRIL 2017 – JUNE 2017**	**LANA SCHWARTZ** **Converge International**
C127.	**REVIEW OF AMBULANCE TASMANIA CLINICAL & OPERATIONAL SERVICE FINAL REPORT MAY 2017**	**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
C128.	**PEER SUPPORT OFFICER CHARTER OF RESPONSIBILITIES - 23 JUNE 2017**	**AMBULANCE TASMANIA**
C129.	**STATEMENT OF DUTIES – HR CONSULTANT – MENTAL HEALTH AND WELLBEING**	**DEPARTMENT OF HEALTH AND HUMAN SERVICES AND TASMANIA HEALTH SERVICE**
C130.	**HEALTH AND WELLBEING STRATEGY – A RESILIENT WORKFORCE AND HEALTHY WORKPLACE**	**THE COUNCIL OF AMBULANCE AUTHORITIES INC., AMBULANCE NEW ZEALAND, NATIONAL COUNCIL OF AMBULANCE UNIONS.**
C131.	**MENTAL HEALTH AND WELLBEING STRATEGY 2016-19**	**AMBULANCE VICTORIA**
C132.	**SPAN OF CONTROL REPORTS** **"Span of control and the significance for public sector managers' job demands: A multilevel study" as published in the Economic and Industrial Democracy Journal** **"Span of control in teamwork and organization structure" as published in Montenegrin Journal of Economics**	**VARIOUS**
C133.	**OPERATION TONE: SPECIAL REPORT CONCERNING DRUG USE AND ASSOCIATED CORRUPT CONDUCT INVOLVING AMBULANCE VICTORIA PARAMEDICS - SEPTEMBER 2017**	**INDEPENDENT BROAD-BASED ANTI-CORRUPTION COMMISSION VICTORIA**
C134.	**STATEMENT OF DUTIES – DUTY MANAGER - COMMUNICATIONS**	**DEPARTMENT OF HEALTH AND HUMAN SERVICES AND TASMANIAN HEALTH SERVICE**
C135.	**EXAMINATION OF COMPUTER**	**TASMANIA POLICE**
C136.	**HANDWRITTEN NOTES, PERSONAL AND FINANCIAL INFORMATION AND LAST WILL AND TESTAMENT**	**DAMIAN MICHAEL CRUMP**

C137.	**PHONE EXAMINATION**	**TASMANIA POLICE**
C138.	**VARIOUS EMAIL CORRESPONDENCE SENT BY DAMIAN MICHAEL CRUMP FROM AMBULANCE TASMANIA EMAIL**	**DAMIAN MICHAEL CRUMP**
C139.	**NOT USED**	
C140.	**SPECIAL MEDICATION KIT OPENING - VIDEO**	**SERGEANT TERRENCE MCCULLOCH** **Tasmania Police**
C141.	**CCTV OF AMBULANCE TASMANIA, HOBART DRUG ROOM**	**TASMANIA POLICE**
C142.	**PHOTOS OF SCENE AND DECEASED**	**TASMANIA POLICE**
C143.	**PHOTOS OF ITEMS IN VEHICLE**	**TASMANIA POLICE**
C144.	**PHOTOS OF RESIDENCE**	**TASMANIA POLICE**
C145.	**PHOTOS OF ADDITIONAL DRUGS IN VEHICLE**	**TASMANIA POLICE**
C146.	**PHOTOS OF AMBULANCE TASMANIA STORE ROOMS**	**TASMANIA POLICE**
C147.	**THE SENATE – THE PEOPLE BEHIND 000: MENTAL HEALTH OF OUR FIRST RESPONDERS - FEBRUARY 2019**	**EDUCATION AND EMPLOYMENT REFERENCES COMMITTEE**
C148.	**REVIEW OF AMBULANCE TASMANIA CLINICAL AND OPERATIONAL SERVICES – DISCUSSION STARTER**	**AMBULANCE TASMANIA**
C149.	**TASMANIAN AMBULANCE SERVICE THE IMPACT OF EXPANDED SCOPE OF CARE BY PARAMEDICS ON EMERGENCY HEALTHCARE DEMAND: A LITERATURE REVIEW - JANUARY 2017**	**FACULTY OF HEALTH, QUEENSLAND UNIVERSITY OF TECHNOLOGY**
C150.	**ANALYSIS OF TASMANIAN HEALTH SERVICES AMBULANCE CLIENTS PREPARED FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, TASMANIA - MARCH 2017**	**PREPARED BY KP HEALTH**
C151.	**AMBULANCE TASMANIA REVIEW: PROJECT REVIEW AND CLOSURE REPORT - 2 MARCH 2018**	**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
C152.	**REVIEW OF AMBULANCE TASMANIA CLINICAL AND OPERATIONAL SERVICE – FINAL REPORT**	**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

C153.	**CHANGE PROPOSAL – AMBULANCE TASMANIA – AT SOUTH - 12 JULY 2017**	**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
C154.	**SERVICE UPDATE – AMBULANCE TASMANIA ORGANISATIONAL STRUCTURE REVIEW No. 11-2017**	**AMBULANCE TASMANIA**
C155.	**DRAFT AMBULANCE TASMANIA ORGANISATION STRUCTURE REVIEW**	**MATHEW HEALEY (COMMUNITIES TASMANIA)**
C156.	**EVENT HISTORY REPORT 1/10/2016-4/1/2017**	**AMBULANCE TASMANIA**
C157.	**AFFIDAVIT 11/3/2021**	**ANNETTE HUMPHREY** **Ambulance Tasmania**
C158.	**AFFIDAVIT 18/3/21** **Annexures to affidavit:** **A - Ambulance Tasmania Organisational Chart 2021** **B - Ambulance Tasmania Interim Organisational Structure 2016** **C - Statement of Duties – Director Clinical Services** **D - Medication management project outcome assessment – KPH – December 20202**	**DALE EDWARD WEBSTER** **Community, Mental Health and Wellbeing**
C159.	**AFFIDAVIT 1/4/21** **ANNEXURES NK1 TO NK29** **NK1 – Email from Damian Crump** **NK2 – Event History Report 4/1/2017 – 1/10/2016** **NK3 - Application for leave forms and time sheets Damian Crump** **NK4 – Statement from Ambulance Tasmania notifying staff** **NK5 – Medical services update no: 13-2016, Interim medication management procedure amendment** **NK6 – Safety Event Management Form 16/9/16** **NK7 – Safety Event Management Form 23/9/16** **NK8 – Safety Event Management Form 23/9/16** **NK9 – Safety Event Management Form 26/9/16** **NK10 – Medication Management Policy 17/2/14** **NK11 – Ambulance Tasmania Medication Management Policy 2/1/20** **NK12 – Medication Document Management Procedure 2/1/20** **NK13 – Medication Possession and Storage Procedure 2/1/20** **NK 14 – Medication Disposal Procedure 2/1/20**	**NEIL KIRBY** **Ambulance Tasmania**

	NK15 – Site Compliance Inspection Procedure 2/1/20 **NK16 – Specified Medication Kit Register Audit Procedure 2/1/20** **NK17 – Specified Medication Safe Register Audit Procedure 2/1/20** **NK18 – Medication Stock Maintenance, order and Transfer Procedure 2/1/20** **NK19 – Specified Medication Register Procedure 2/1/20** **NK20 – Ambulance Tasmania Clinical Work Instruction, Diazepam – Storage, Disposal & Recording Requirements 7/10/20** **NK21 – Medical Services Update No: 01-2020, Medication Management Policies and Procedures** **NK22 – Medical Services Division, Specified Medication Management Investigation, Southern Region 3/11/16 – 26/12/16** **NK23 – Ambulance Tasmania Medication Management Review, Final Report, December 2017** **NK24 – Documentation regarding KM** **NK25 – Documentation regarding CW** **NK26 – Documentation regarding JT** **NK27 – Documentation regarding LK** **NK28 – Tasmanian Emergency Services CISM Program** **NK29 – Ambulance Tasmania's Mental Health and Wellbeing Program Development and the Peer Support Program Training 2020**	
C160.	**AFFIDAVIT 16/4/21**	**DR ALICE FRAMPTON** **Glebe Hill Medical Practice**
C161.	**AFFIDAVIT 27/4/21**	**DR MARZENA RYBAK** **St Helens Private Hospital**
C162.	**AFFIDAVIT 31/05/21 AND ARTICLE** **Suicide Risk In Patients with Major Depressive Disorder**	**DR IAN SALE** **Forensic and Medico legal Psychiatry**
C163.	**AFFIDAVIT 26/10/2021** **Annexures to affidavit:** **A – Schedule 8 Order Book** **B – South Region CMI PR* Level 4 Drug Safe** **C – Request for Tour of Hobart Station and "points of view"** **D – Tasmanian Poisons Regulations (Excerpts)** **E – Ambulance Tasmania Medication Management Policy and Procedure Documents**	**MR JOSEPH ACKER** **Ambulance Tasmania**

	F – Old and New Drug Kits for Ambulance Use **G – Station security & CCTV Proof of Concept Sites**	

'C'

WITNESS LIST

In the inquest into the death of

Damian Michael Crump

1.	**Sergeant Terrence McCulloch**	**Investigating Officer, Tasmania Police**
2.	**Alanah Crump**	**Mother of Damian Crump**
3.	**Daryl Long**	**Housemate of Damian Crump**
4.	**KM**	**Former Ambulance Tasmania Employee**
5.	**CW**	**Former Ambulance Tasmania Employee**
6.	**Kim Fazackerley**	**Ambulance Tasmania**
7.	**ZJ**	**Ambulance Tasmania**
8.	**LK**	**Former Ambulance Tasmania Employee**
9.	**Emma-Kate Thonley**	**Ambulance Tasmania**
10.	**JT**	**Ambulance Tasmania**
11.	**Craig Westlake**	**Ambulance Tasmania**
12.	**Stephen Elliott**	**Ambulance Tasmania**
13.	**Sally Jones**	**Ambulance Tasmania**
14.	**Michael McDermott**	**Ambulance Tasmania**
15.	**Matthew Richman**	**Wellbeing Support, Department of Police, Fire and Emergency Management**
16.	**Han-wei Lee**	**Ambulance Tasmania**
17.	**Monika Steiner**	**Pharmaceutical Services Branch, Department of Health**

18.	**Martin Neumeyer**	**Pharmaceutical Services Branch, Department of Health**
19.	**Brett Gibson**	**Ambulance Tasmania**
20.	**Monica Baker**	**Ambulance Tasmania**
21.	**Timothy Jacobson**	**Health and Community Services Union**
22.	**Amanda Hutchinson**	**Ambulance Tasmania**
23.	**Patricia Makrogamvrakis**	**Ambulance Tasmania**
24.	**Andrew Porter**	**Ambulance Tasmania**
25.	**Dr Con Georgakas**	**Ambulance Tasmania**
26.	**Peter Morgan**	**Retired from Ambulance Tasmania**
27.	**Peter Berry**	**Former Ambulance Tasmania Employee**
28.	**Dr Marzena Rybak**	**St Helens Private Hospital**
29.	**Dr Alice Frampton**	**Glebe Hill Medical Practice**
30.	**Dr Ian Sale**	**Forensic and Medico Legal Psychiatry**
31.	**Dr Dominic Morgan**	**Former Employee of Ambulance Tasmania**
32.	**Neil Kirby**	**Ambulance Tasmania**

'D'

Inquest into the death of Damian Michael Crump

Ruling No.2

Counsel

Counsel Assisting the Coroner: M Allen and V Dawkins

Counsel for the Secretary of Department of Health and Human Services and Ambulance Tasmania: G Chen

Counsel for the Attorney General for the State of Tasmania: P Turner

Counsel for the Director of Medical Services of Ambulance Tasmania, Dr C Georgakas: M Wilkins

Counsel for Ambulance Tasmania Employees, ZJ, Stephen Elliott, Sally Jones, Amanda Hutchinson, Monica Baker, Brett Gibson and Michael McDermott: T Cox

Counsel for the Australian Paramedics Association: E Voulcaris

Counsel for the Health and Community Services Union Tasmania: H Pill

Counsel for Dr D Morgan: B Bradley

Introduction

1. This Ruling addresses objections made by Counsel for Ambulance Tasmania ("AT"), Ms Chen, to substantial portions of the affidavit evidence of 26 witnesses. Ms Chen submits that the portions of evidence which she has identified in the affidavits are irrelevant to the issues being examined and fall outside the scope of matters which are permitted to be examined under section 28 of the *Coroners Act* 1995 ("the Act").

2. Damian Michael Crump was an intensive care paramedic with AT and died on or about 23 December 2016. The evidence in the investigation indicates that Mr Crump intentionally ended his own life using a fatal combination of drugs which he took from the AT drug store in Hobart without authorisation in the hours before his death.

3. The investigation into Mr Crump's death involved a consideration of several issues which were considered relevant to the circumstances of Mr Crump's death. These

issues included, but were not limited to, Mr Crump's known mental health conditions, his alleged unauthorised taking of AT medication three months before his death, the adequacy of his management and supervision by AT and his ability to access drugs intended for administration to patients in the course of his employment.

4. His death is the subject of a public inquest, with nine hearing days having already been completed between 15 March and 25 March 2021, and 27 witnesses giving oral testimony during that time.

5. By a written ruling dated 23 December 2020, addressing submissions by counsel for AT that the scope exceeded the coroner's jurisdiction under the Act, I determined that matters appropriate for consideration at inquest ("the scope") were as follows:

    1) The circumstances surrounding the death of Damian Michael Crump to enable findings to be made, if possible, under s28 (1) of the *Coroners Act 1995*;

    2) The circumstances of and the response of AT to the reported missing and/or unauthorised taking of morphine and/or other drugs from AT Stations in Southern Tasmania in approximately September 2016;

    3) Any established systems and/or policies providing for the storage, security, access and accounting of drugs and associated paraphernalia of drugs held by AT for purposes connected with its authorised functions, both in 2016 and at the time of this inquest;

    4) Any misuse of drugs by Damian Crump, and other employees of AT, as relevant to the circumstances of Mr Crump's death, including any knowledge of and response to such use by Ambulance Tasmania;

    5) The investigation, internal management of and organisational response by AT to the suspected misuse and/or theft of drugs held by AT prior to Mr Crump's death by two other employees;

    6) Any established mental health and welfare systems or policies relating to or providing for support to Mr Crump and other employees of AT in 2016. The availability and use of such systems and/or policies at the time of this Inquest; and

7) The capacity and ability of those occupying relevant supervisory positions in AT either substantively or occasionally, both in 2016 and at the time of inquest with respect to:

   i. Identifying and assisting employees with mental health issues;

   ii. Managing the risks, if any, that those issues posed to both patient and staff safety;

   iii. The pathways available to managers to deal with those issues;

   iv. Assistance available to managers in dealing with employees with mental health issues; and

   v. Any management training provided by AT.

6. In formulating the scope of the inquest as above, I had regard to voluminous and largely consistent evidence from witnesses, including many experienced paramedics and AT managers, regarding the following matters:

   a) The fact that Mr Crump suffered long-term and serious mental health issues known to some AT employees, including members of management;

   b) The fact that he had expressed suicidal ideation and a suicide plan to fellow AT colleagues;

   c) Knowledge by AT employees that Mr Crump used illicit substances and excessive quantities of medication;

   d) That AT medication was reported missing in September 2016, with Mr Crump suspected by an AT manager as being responsible;

   e) That AT medication was stolen by two separate AT employees in 2012 and 2014, in similar circumstances to Mr Crump;

   f) That there were deficiencies in procedures for storage, security and access to medication on AT premises;

   g) That Mr Crump exhibited increasingly inappropriate and disrespectful behaviour whilst at work, particularly in the 12 months before his death; and

   h) That there was lack of appropriate/adequate management, discipline and welfare support available for Mr Crump (and other employees requiring such support)

with evidence that there were insufficient managers and that managers were poorly trained or not trained to address the issues relevant to Mr Crump leading up to his death.

Ambulance Tasmania Objections

7. Attached to this ruling and marked "A" are copies of the 26 affidavits the subject of objections by counsel for AT. The portions highlighted by counsel for AT represent the passages to which objection is made. At the conclusion of each affidavit, counsel has provided a list of reasons why the highlighted portions are irrelevant and therefore inadmissible. The highlighted portions, together with the respective lists of reasons for inadmissibility on the basis of irrelevance, were provided to counsel assisting and all other counsel in the inquest on 12 May 2021.

8. The 26 affidavits subject to objections had already been tendered by counsel assisting and given exhibit numbers on 15 March 2021, the first day of the inquest, with no objection raised by any counsel other than Ms Chen. In respect of Ms Chen's objections, for the reasons discussed below I did not appreciate that she intended to object to the admissibility of the contents. Further, no other counsel, apart from counsel assisting, were aware of proposed objections by AT.

9. Therefore, once I had appreciated that objections were intended to be made I listed the matter, (which had been adjourned prior to hearing the final witnesses), to hear submissions upon the following issues:

    a) Whether there exists a power or discretion to allow the withdrawal or excising of evidence already tendered; and

    b) To hear substantive submissions with a view to ruling upon the disputed evidence.

10. It is necessary to set out some background to the issue generally of objections to affidavits by AT in this inquest to inform the current issue and explain the reasons for previous rulings.

Background

11. On or about 6 August 2020 counsel for AT and all other counsel, received a USB drive from the Coronial Division containing disclosure of the investigation evidence proposed to be tendered at inquest. The only documents not included were the affidavit of Emma-Kate Thornley which was provided to parties on 22 January 2021, the affidavit of HL, provided to parties on 22 February 2021 and the affidavit of Annette Humphrey, provided to parties on 12 March 2021.

12. On 18 September 2020 my Court Clerk sent to all counsel, including counsel for AT, a copy of the witness list, containing the names of witnesses who had provided affidavits in the investigation and who I proposed to call to give oral evidence at inquest.

13. Case management conferences were held pursuant to rule 22 of the *Coroners Rules* 2006*,* on 17 July, 24 September and 29 October 2020 and 9 March 2021 respectively. Apart from issues taken by counsel for AT regarding the proposed scope of inquest (resulting in my written ruling), she did not outline objections to specific witnesses or their evidence at all at any of those case management conferences.

14. By rule 22, it is expressly the purpose of a case management conference for persons with a sufficient interest in an investigation to attend for the purpose of facilitating the conduct of the investigation[404] and for identification of any issues that any person attending the conference expects to arise in the investigation.[405] At no stage did counsel for AT raise that there would or may be objections to the affidavits. It should have been apparent that the process of hearing all counsel and ruling upon extensive objections would necessarily be a time consuming process that would likely cause significant delays in the witness schedule. As such, it should have been raised in a case management conference and dealt with before the commencement of the inquest.

15. On 10 March 2021, all counsel were emailed a confirmed and completed inquest schedule, the named witnesses on such schedule not departing from the witness list forwarded to counsel almost 6 months previously.

16. On Thursday 11 March 2021, two working days before the commencement of the inquest, Ms Chen wrote to counsel assisting, Mr Allen, regarding proposed objections to the affidavit evidence proposed to be tendered at the inquest. The content of the letter is set out in full as follows;

> *"The Secretary/Ambulance Tasmania intends to object to some of the evidence that is proposed to be tendered at the inquest.*
>
> *The principal focus of the Secretary/Ambulance Tasmania's objections will be relevance.*
>
> *The voluminous material gathered by Sergeant McCulloch appears in many instances to go well beyond the scope of the inquest. This is not surprising, given that the scope was finalised after Sergeant McCulloch's investigation.*

[404] Rule 22 (1)
[405] Rule 22 (5) (a)

Rather than delay the progress of the inquest and interrupt the witness schedule, it is proposed that I set out the Secretary/Ambulance Tasmania's objections to the particular witnesses' affidavits at the start of their evidence. Her Honour can then make a ruling and the evidence from that witness can then proceed with minimal interruption.

I can indicate that of the proposed witnesses to be called at the inquest, it is only Tim Jacobson whose evidence will be objected to in its entirety. It will be submitted that Mr Jacobson's evidence is irrelevant and should not be admitted. Significant portions of the affidavits of Sergeant McCulloch, Emma Kate Thornley, Patricia Makrogamvrakis and Andrew Porter will also be objected to.

As to the balance of the affidavits prepared by Sergeant McCulloch that you propose tendering, but about which witness testimony will not be given at the inquest, it would seem more time efficient for the Secretary/Ambulance Tasmania to raise their objections in final submissions to the Coroner. The balance material is significant and, in our submission, is comprised of substantial amounts of irrelevant material. (My emphasis)

I would be grateful if you would consider the above, and confer with her Honour and advise if the proposed course is acceptable.

Feel free to call me if you would like to further discuss the matter."

17. On the same date, Mr Allen forwarded to me by email the above correspondence and indicated that he had no difficulty with the course proposed. By return, I indicated that I was content with the proposal.

18. Despite the passage in Ms Chen's letter set out in bold above clearly indicating that she proposed to make evidentiary objections in final submissions, I incorrectly interpreted the proposal to mean that submissions regarding the *weight* that should attach to the subject evidence would be made in final submissions. This course would be the usual and appropriate way to deal with affidavits in coronial inquests where counsel submits that little weight should be given to portions of evidence for various reasons. Mr Allen, unfortunately, also did not properly appreciate what Ms Chen was proposing in her correspondence.

19. Where actual objection is made to the *admissibility* of affidavit evidence such that it is submitted that it should be removed from consideration at inquest, the ruling would routinely be made before the formal tender of the affidavit in question. In such a

situation, the evidence over which objection is made would be identified with particularity and all counsel would require an opportunity to consider and be heard upon the portions of objected evidence.

20. In this case, no counsel other than counsel assisting were aware of the proposal that Ms Chen intended to object to significant portions of affidavit evidence from numerous affidavits and intended to leave the objections until final submissions. It goes without saying that dealing with evidentiary objections in this manner leaves the evidence, including that given orally, in an uncertain state and has the potential to prejudice the interests of other parties. The consequence of making objections after hearing all of the oral evidence and having tendered the documentary evidence is that all other parties would need to be heard upon the objections and might well, depending upon any ruling, make application to call further witnesses. It could also result in the court occupying time hearing oral evidence that is ultimately deemed irrelevant and thus inadmissible.

21. Before the commencement of the inquest, there were no further reasons provided for the objections on the grounds of irrelevance and no notice of the objectionable portions were provided. No further correspondence concerning evidentiary objections was received before the start of the inquest.

22. At the commencement of the inquest on Monday,15 March 2021, Mr Allen and Ms Dawkins tendered the documentary exhibits, including numerous affidavits of AT paramedics or former paramedics not proposed to be called to give oral testimony. I set out the following relevant passage from the transcript:

> *"Your Honour, the witnesses to be called to give evidence at this inquest include Sergeant McCulloch. He'll give evidence shortly this morning. Following Sergeant McCulloch will be Mr Crump's mother, Alanah and his housemate Daryl Long. There will be, over the course of the next two weeks, a number of serving and former paramedics, some of whom are also close friends of Mr Crump. Those people will all speak to the critical issues in this inquiry. The inquest will also hear from several either current or former senior members of Ambulance Tasmania to deal most relevantly with the management issues that fall out of this investigation. A schedule of witnesses has been published to the parties and I understand also been made available to the media this morning. Now, at this point, your Honour, I propose to tender the affidavits and exhibits not to be – for the witnesses not to be called at the inquest:*
>
> *HER HONOUR: Right.*

MS DAWKINS: Your Honour, I tender the following exhibits: C1, report of death, Constable Doug McKinlay.

EXHIBIT #C01 – REPORT OF DEATH, CONSTABLE DOUG McKINLAY – TAKEN IN

MS DAWKINS: C2, life extinct affidavit, Dr Ann Rogers.

EXHIBIT #C02 – LIFE EXTINCT AFFIDAVIT, DR ANN ROGERS – TAKEN IN

MS DAWKINS: C3, affidavit of identification, Constable Jeremy Williams.

EXHIBIT #C03 – AFFIDAVIT OF IDENTIFICATION, CONSTABLE JEREMY WILLIAMS – TAKEN IN

MS DAWKINS: C4, affidavit of identification Anthony Cordwell.

EXHIBIT #C04 – AFFIDAVIT OF IDENTIFICATION, ANTHONY CORDWELL – TAKEN IN

HER HONOUR: Can you just stop there, Ms Dawkins, just for a minute so I can follow you on – counsel, I will assume of course that there's no objection unless anyone wishes to raise objections. I'm not sure what the best process for that might be. Whether any exhibits are objected to as a whole or whether there's issues relating to weight of some of the matters. Ms Chen?

MS CHEN: Your Honour, counsel assisting and I had some discussions about this last week.

HER HONOUR: Yes.

MS CHEN: The position that we agreed to and obviously subject to how you would like to deal with it, your Honour, is that we don't propose to make any objection at this point in relation to those affidavits that are going in now. We will address issues –

HER HONOUR: Yes.

MS CHEN: – that we consider relevant in closing submissions.

HER HONOUR: Yes.

MS CHEN: Any objections as to contents of affidavits of witnesses who will be called, it's been suggested that we will outline what our objections are to the affidavits at the start of their evidence.

HER HONOUR: Yes. No, that's –

MS CHEN: Otherwise we hope not to interrupt the flow of the evidence.

HER HONOUR: Thanks, Ms Chen, I think that's appropriate and I think submissions relating to the weight of some of the untendered material are going to be no doubt made by various counsel. So that's certainly a matter for submissions, I think that's a sensible way to deal with it."

23. This passage reinforces my continued and erroneous view that the affidavits of the deponents not called to give oral testimony (referred to inaccurately by me as "untendered material") would be marked as evidentiary exhibits without objection and subject to submissions as to weight to be made at the conclusion of the inquest. I accept that Ms Chen did refer to having discussions with counsel assisting the previous week and that she qualified her assent to the tenders by indicating that she did not have any objection to the tenders *"at this point".*

24. In hindsight, the use of such expression might have prompted me to request elaboration on that matter. However, neither Ms Chen nor Mr Allen took the opportunity to ventilate in open court and in the presence of all other counsel the issue that had been the subject of discussions. Therefore, the belief of all other counsel as a result of this exchange was that the affidavits were tendered without objection and subject to submissions regarding weight.

Objections to affidavits of witnesses called at inquest

25. Once the inquest commenced, I assented to the proposal of counsel for AT to outline objections to the affidavits where the deponents were called at the commencement of their oral testimony at inquest. That evidence not having been delineated, however, I was not aware that the objections were extensive and would require detailed submissions and consideration. Because of the continuing lack of specificity regarding the objections, this issue became unnecessarily difficult throughout the inquest.

26. There was a significant body of affidavit evidence from the 49 AT individual or former AT paramedics in a variety of roles within that organisation. Many of those provided evidence concerning interactions with or knowledge of Mr Crump, including his drug use and mental state. Most of the affidavits from these witnesses also covered matters such as their knowledge of medication management processes, mental health and welfare systems, and other systemic issues that were said to have relevance to the matters within the scope of the inquest. Many of the affidavits were written in a personal style and described their own experiences to demonstrate their view of, for example, inadequacy of management, welfare systems and disciplinary processes for paramedics. Some of the language used by the deponents was emotive and relevant

material was often intertwined with material of possibly little relevance. Some of the evidence was sensitive in content and portrayed negative judgments of colleagues and superiors within AT.

27. Nevertheless, upon the body of affidavit evidence presented, there were consistent criticisms of the organisation - most relating to inadequate medication management, inadequate number of managers (and the consequences thereof), lack of welfare support for paramedics. The affidavits were mostly lengthy and the process of isolating objections should ideally have been undertaken in a cooperative process between counsel before the inquest.

28. On the first day of the inquest, Sergeant Terrence McCulloch, the investigating officer, gave evidence about his investigation and, specifically, addressed each item of the scope. He provided his opinion on those items with reference to the evidence, having been involved in this complex investigation over several years. The counsel for AT did not object to his affidavit or oral evidence nor did she cross-examine him. In general terms, Sergeant McCulloch expressed the view that there were organisational deficits in Ambulance Tasmania with respect of each item listed in the scope – medication management, mental health and welfare systems, lack of training of managers and insufficient number of managers to deal with issues such as medication management, disciplinary processes and well-being. He expressed the opinion that such apparent deficits at the time of Mr Crump's death were an integral part of the organisational circumstances in which Mr Crump worked, and which enabled him to continue to be employed without checks on his inappropriate behaviour in the workplace, without adequate mental health assistance, as well as allowing him ease of access to medications. Also, two former paramedics, CW and KM were called, and their affidavits were tendered without objection from counsel for AT. Both had unlawfully taken medication from AT for personal use, and both described what they considered to be contributing organisational issues – including poor medication management processes and lack of an appropriate mental health approach. KM stated that he supported random alcohol and drug testing in the context of the issue of medication diversion.

29. On the second day, Kim Fazackerley, (paramedic and colleague of Mr Crump), ZJ (current duty manager and colleague of Mr Crump) and LK (former paramedic) gave evidence. The affidavits of these witnesses were tendered without objection from counsel for AT. The witnesses proceeded to give oral evidence, largely in line with their affidavits. Counsel for AT did not cross-examine any of these three witnesses. Their evidence concerned not only their knowledge of Mr Crump but their

observations and opinions on such matters as: the ability of AT to detect drug use in paramedics, securely store medications, manage mental health issues and poor employee behaviour and the inability of managers to assist employees due to overwhelming workload and other issues. The evidence of these witnesses in these respects was directly within the items contained in the scope.

30. On the subsequent days, counsel for AT objected on the basis of relevance to either large tracts of affidavit evidence or the entirety of affidavits of the further AT paramedic or former paramedic witnesses called at inquest. Difficulties arose particularly in relation to the failure to specify the portions of objected evidence of paramedic Emma-Kate Thornley, who gave lengthy oral evidence on the third day of the inquest. In order to proceed with the witness schedule, I delayed the ruling upon the objections to her affidavit until later in the inquest. Further delays and inconvenience to scheduled witnesses occurred in hearing and ruling upon extensive objections in respect to the affidavits of JT, Stephen Elliott, Sally Lee Jones and Michael McDermott who presented to give evidence on the fourth and fifth day of the inquest.

31. Before the commencement of the sixth day of the inquest, counsel for AT objected to significant portions (which she had, by now, marked upon copies) of the affidavit evidence of paramedic witnesses scheduled to give evidence at inquest – these were Han-Wei Lee, Brett Gibson, Peter Berry, Peter Morgan, Monica Baker and Amanda Hutchinson. Further, she advised that she would object to the receipt of the *entire* affidavits of Andrew Porter, Scott Fyfe, Tim Jacobson (union representative) and Patricia Makrogamvrakis. She also indicated that the entirety of Ms Thornley's affidavit was objected to.

32. Accompanying her objections at this time, counsel for AT announced a list of areas which she submitted were contained in affidavit material and were not admissible on the basis of relevance – these were:

> "*Ambulance Tasmania recruitment practices, its HR system, short-term employment contracts, its resourcing, its promotion selections and practices, its approaches to alternative duties, its return to work programs, its workers compensation practices, the SLRS system, descriptions of interstate ambulance services in comparison with Tasmania's, the stockpiling of non-schedule 8 drugs at branch stations, the interface between the (indistinct word) system and the CAD system, opinions of witnesses as to management structures, opinions of staff members as to staffing levels, opinions of staff as to management and training, opinions as to the CISM and EAP systems, matters relating to industrial actions, industrial disputes and industrial issues, the strategic planning of Ambulance Tasmania,*

criticisms of staff acting – or occupying acting positions for periods that witnesses deem unacceptable".[406]

33. She submitted that Mr Crump breached the law by unauthorised access to AT medication, a situation he knew he was prohibited from doing. He suffered a long term mental illness that was not caused or exacerbated by his work. His work, she submitted, was his "panacea" and his "happy place", and it reinvigorated him. He was not troubled by shift work and did not suffer undue trauma as a result of his attendance on patients in the course of his work. He was under treatment by a private psychiatrist. [407] In such circumstances, Ms Chen submitted that the above issues were irrelevant.

34. In respect of her specified objections to the 10 further affidavits, counsel for AT submitted that the inquest was *now* delving into a general enquiry into AT's operations and had proceeded beyond those matters required to be addressed under section 28 of the Act. She submitted that *"the court can't pull itself up by its own bootstraps by creating a scope that goes beyond the power of that which is granted to it under the Act".*[408] If the submission was that the scope of the inquest had expanded at a particular point during the inquest, the submission is incorrect. At the risk of repetition, full disclosure had been provided seven months previously, the scope of the inquest had been defined for four months, no new affidavit evidence of significance had been introduced and the witnesses giving oral testimony largely adhered to their affidavit evidence with little or no challenge by counsel for AT.

35. The submissions of counsel for AT, in my view, amounted to a complaint about the scope of the inquest rather than a submission upon whether the evidence was or was not relevant in respect of the existing scope, which was the subject of a written ruling.

36. Mr Allen made submissions throughout the inquest, in response to the objections, that, with some limited exceptions, the evidence was relevant to the matters being examined at inquest. He also submitted that the matters for examination, listed in the scope, were integrally related to the issue of how Mr Crump, in the context of the organisational structure, culture and deficits, was able to access medication in the months before his death without sanction or prevention and then to end his life by similar unauthorised use of AT medication. He submitted that the list of areas of alleged irrelevance announced by Ms Chen lacked context and that the lack of proper

[406] Transcript 542
[407] Transcript 543
[408] Transcript 543

management of Mr Crump's inappropriate behaviour at work and his widely known suicidality were very significant circumstances surrounding his death.

37. Although comprehensive analysis of the evidence is not warranted in this ruling, I particularly note the fact that Mr Crump had communicated to numerous colleagues, including managers, that he would not live beyond the age of 40 years as he would end his life. The evidence also discloses that about a week before his death he was stood down from his shift by a manager after behaving in an "irrational and manic" way at a job, behaving abusively to his manager on the radio and telephone and then ignoring a directive to return to Hobart headquarters in the ambulance. There is also evidence of an incident in November 2016 where he was seen at work sweating, shaking and swearing, which was reported to management. There is also ample evidence of his inappropriate behaviour and communications towards management and colleagues, with a general attitude by AT of *"it's just Crumpy"*. There was a large body of evidence that there was no ability of management to deal with Mr Crump's behaviour or possible need for welfare support. This was significantly due to an overwhelming workload and lack of training of the managers.

38. Ultimately, I ruled upon AT's objections in respect of the affidavits, with the large majority of the objections being overruled on the basis that the evidence in question was capable of bearing upon the issues in dispute for the reasons submitted by Mr Allen. I gave the following reasons;

> *"In accordance with the authorities, what will be, for the purpose of that section, circumstances or matters that go to how his death occurred or those which may be connected or causally related to death will vary in each case. In this case, it is inescapable the organisational circumstances in which Mr Crump was carrying out his employment and apparent deficits therein; his management, his mental health, medication storage are directly relevant on the evidence as to how he was able to access the fatal quantity of drugs from his employer.*
>
> *Detection of and strategies to assist his severe mental health disorder and how his behaviour should have been managed well prior to death are highly relevant issues to that ultimate outcome and are considered to be part of circumstances to be examined in relation to his death. Put simply, in this case, and not all cases, but in this case, the organisational situation relevant to Mr Crump cannot be divorced from the circumstances of his death. That does not mean that I – to put colloquially, it is my job and it is certainly not to hold a free ranging, broad inquiry, but, in this situation, the circumstances are as such under s21B. (sic)*

Again, in accordance with the authorities, once such matters are within scope, the coroner must look at ways to prevent the death or similar deaths, I should say, which means – which necessarily means inquiring into those systems and then being mandated to make recommendations, if appropriate. So, at the risk of repetition, there must be an ability for the coroner to inform him or herself on these relevant matters as the coroner sees fit. I am conscious that this is now day eight of the inquest. I am conscious that the affidavits are lengthy. I am conscious – very conscious of the way in which the deponents of the affidavits have, in some cases, expressed themselves.

However, in respect of today's witnesses, their evidence is capable of assisting me and I now overrule the objections and take all – or will take all affidavits in in their entirety and, again, of course, bearing in mind that – that's the appropriate course but, bearing in mind of course, that then there will be arguments as to the issues of weight and certainly in relation to how counsel examine – particularly counsel assisting, that we'll (sic) also bear out those issues that are to be treated with a greater weight than others. [409]

39. It was not until about 23 April 2021 when conferring with Mr Allen, (and after the inquest had adjourned pending the final two days' witnesses on 18 and 19 May 2021) that I appreciated that, in respect of the numerous affidavits that had been tendered in evidence at the commencement of the inquest, that counsel for AT expected to deal with objections in closing submissions.

40. For the reasons discussed above, I was of the view that such a course should not occur. It is obvious to say that the parties have based their representation of their clients upon the evidence admitted without apparent objection. Not only would such a course have taken counsel by surprise but may have resulted in prejudice and reopening of the evidence, depending upon the nature of any material excluded. I therefore re-listed the inquest for the purpose of resolving the issue of the evidentiary objections. At the listing on 13 May 2021, Ms Chen maintained that her objections could be reserved for final submissions. As the objections to these affidavits had not been specified, I made a direction that she provide the objections to all other counsel for their consideration.

41. Once those objections had been provided, it was clear that the objections were extensive and based upon similar grounds as those during the inquest. I was not prepared to continue to hear oral evidence until this issue was resolved. I therefore vacated the dates for the final witnesses and set the matter down for the hearing of

[409] Transcript 756 and 757.

submissions upon the legal position of excluding evidence once tendered, and secondly, for resolving the substantive objections. Those submissions occurred on 19 May 2021.

Whether there exists a power or discretion, and if so its nature, to allow the coroner to exclude evidence once admitted?

42. I can deal with this issue briefly. I was provided with detailed, high-quality submissions on behalf of AT, under the hand of Mr Turner SC and Mr Jehne, on 17 May 2021. I am grateful for the analysis of the authorities contained in them. I also received helpful submissions from Mr Wilkins, counsel for Dr Georgakas on 18 May 2021.

43. With the benefit of those submissions, I accept that I have power to either exclude or disregard evidence that has previously been tendered, notwithstanding some difference in approach contained in the cited authorities. In this jurisdiction, section 51 of the Act (that a coroner holding an inquest is not bound by the rules of evidence and may be informed and conduct an inquest in any manner the coroner reasonably thinks fit) provides the power to re-visit tendered affidavits to rule upon objections based upon relevance. I therefore fully accept that, despite the formal tendering of the affidavits, I have the power to rule upon whether parts of their contents should be excluded from consideration and it is fair to do so in the circumstances. No other counsel in the inquest submitted that I did not have the power and should not embark on hearing the substantive objections as a priority.

Ruling on the objections to evidence in respect of the 26 affidavits of deponents not called to give oral testimony

44. After hearing submissions from counsel for all interested parties, on the annexed copies of the affidavits I have marked, using a red line to the left side of the text, the passages of evidence which should be excluded from consideration at inquest. The principles upon which I have proceeded in respect of such rulings are as follows:

    a) As coroner investigating, I am not bound by the rules of evidence and may be informed and conduct the inquest in any manner that I see fit.[410] This provision gives the coroner considerable latitude as to the manner in which an inquest is conducted, broad scope to shape and direct an investigation and to remove inhibitions on the collection and consideration of material which may assist in this task.[411]

[410] Section 51.
[411] *Priest v West* [2012] VSCA 327.

b) The governing principle is whether the evidence is relevant, meaning that the evidence should logically bear upon a matter within the defined scope of the inquest which, in turn, is formulated to be within the coroner's functions for inquiry under section 28 of the Act.[412] Hearsay and opinion are permissible, if the relevance test is satisfied, because the rules of evidence are relaxed.

c) Even bearing in mind the considerable latitude given to a coroner, if the objected evidence is irrelevant, I must exclude or disregard it.

d) Evidence that is ruled relevant may nevertheless have low probative value and may ultimately be shown to have little or no weight. This will be a matter for assessment at the time of findings after submissions from all counsel.

45. In respect of the objections on the basis of relevance, counsel for AT relied only upon the lists of alleged areas of irrelevance annexed to each affidavit and made no additional submissions, except to submit that the issue of alcohol and drug testing in respect of AT employees is not properly a concern of the coroner but a matter for government policy.

46. Counsel assisting, Mr Allen and Ms Dawkins, made oral submissions in court addressing the objections within each affidavit and relied generally upon Mr Allen's previous submissions at page 544-548 of the transcript (summarised earlier in this ruling) to the effect that the evidence was relevant to the issues and deficits in AT concerning medication management, management and disciplinary processes and mental health support - all of which were contributors to the circumstances surrounding Mr Crump's death.

47. I have already provided a ruling above, largely accepting Mr Allen's submissions. Because the current objections cover the same issues and are objected to the same reasons, I overrule AT's objections for the large part. The objected portions almost invariably fall well within the scope of inquiry. It will be noted that I have disregarded some passages of evidence that are unhelpful in elucidating issues or because, whilst a degree of relevance may be seen, the extensive personal nature of the material is unnecessary. If these passages were not subject to formal objections, they would be given little weight.

[412] See, for example, *Connelly v. P and O Resorts Pty Ltd T/A Cradle Mount Lodge* [1996] TASSC 132 and Freckleton and Ranson – Death Investigation and the Coroner's Inquest, page 573.

48. Because counsel for AT provided an itemised list in respect of each affidavit containing areas of alleged irrelevance, it is appropriate to provide some general reasons why I consider the evidence to be relevant:

    a) The objections to the totality of the four affidavits of Mr Crump's long term non-AT friends (Dean Long, Dayne Coleman, Benjamin Cormie and David Taylor) was on the basis that the following areas covered by the affidavits were irrelevant:

        i. Their relationship with Mr Crump;

        ii. Mr Crump's interests and hobbies and their perception of his attitude and temperament;

        iii. Their observations of his illicit drug use, sexuality and mental health;

        iv. Their observations about Mr Crump's attitude to his work at AT; and

        v. Various incidents and text messages between the witness and Mr Crump.

49. I rule the affidavits admissible in their entirety. They are clearly capable of assisting me in respect of Mr Crump's mental health, his concerns about his sexuality and its relationship to his suicidality, his propensity to take drugs and his knowledge of medication. Their relationship with him, including their narratives about incidents of contact or messages with him provide me with the ability to determine how well they knew him, and thus the reliability of their evidence, as well as his mental state, drug use, character and behaviour generally.

    b) The objections to the passages of affidavits from 22 AT paramedics or former AT paramedics included the following grounds of alleged irrelevancy:

        i. Mr Crump's personality and their relationship with Mr Crump;

        ii. Mr Crump's recreational drug use;

        iii. Opinions as to management structures and training of managers;

        iv. Opinions as to staffing levels;

        v. Speculation about Mr Crump's drug use and theft, behaviour, medical treatment and work relationships, and management or disciplinary action in respect of him by AT;

vi. The welfare system at AT, the deponent's experience with the welfare system and opinion on the efficacy of the welfare system;

vii. Opinions on the need for drug and alcohol testing at AT;

viii. Matters relating to other AT employees, such as mental health issues and AT response to them;

ix. Staff promotion practices and acting roles; and

x. Comparisons between AT and interstate ambulance services in various respects.

50. Without exception, the deponents of the affidavits have knowledge of the organisation, and are experienced paramedics, with some in management positions. They are well placed to provide facts and opinions on matters such as the above. The deponents often support their opinions with examples or incidents that may not in themselves be of prime relevance or focus, and may be formulated in a narrative punctuated by hyperbole and strong criticisms of Ambulance Tasmania. Nevertheless, the examples demonstrate how the deponent has formed such a view and are relevant in evaluating the cogency and credibility of the evidence.

51. The deponents' comments on each of their experiences with mental health and welfare systems at AT both before Mr Crump's death and subsequently are matters that can or may well assist with scope item 6. As indicated above, some of the deponents had experience in management roles and comment upon their ability and capacity to manage employees with mental health issues – this evidence coming within scope item 7. Some deponents perform comparative exercises between different ambulance services, but only as relevant to their personal experiences and to inform their comments on any matters they raise with respect to organisational deficits in AT.

52. The majority of the deponents have personal knowledge of Mr Crump. Seven of the deponents explicitly state they are friends of Mr Crump. Thirteen of the other deponents indicate that they knew Mr Crump and had varying degrees of contact with him about personal matters. Only one deponent did not know Mr Crump.

53. Thus, the majority of these deponents make comments on their knowledge and interactions with him. It is true to say that often their evidence is interlaced with opinions of him and in many cases, they explicitly indicate that they *do not* know something about him. Sometimes, the opinions are more in the nature of informed

speculation based upon some known facts. Each adds a colour to Mr Crump's interactions with his colleagues at AT, and adds to the coherence of their evidence. It also provides context to what Mr Crump would disclose to different members of AT about matters including his conflict in his sexuality, mental health and drug use, which, as indicated above, are relevant matters and within scope.

54. Their comments provide information about Mr Crump's known behaviour in the workplace and how he was managed, particularly in the 12 months prior to his death. The deponents often provided apparently informed opinions on the reasons for an absence of effective management at AT. In this regard, much of the evidence highlights the issue of lack of managers to provide effective management or discipline, lack of manager training and the plethora of acting manager positions. A lack of an adequate or transparent system for promotions and management appointments was also described by many deponents as being linked to ineffective management of paramedics. It is in the context of such organisational issues that Mr Crump's behaviour appeared to be tolerated and accepted.

55. In relation to counsel for AT's objection to the affidavit evidence of numerous AT paramedics regarding the desirability for random alcohol and drug testing, the evidence is relevant. Mr Crump's drug abuse may well have been detected if it had been in place. The fact that such a measure is almost universally supported by AT employees, whose need for safety in the workplace is a paramount consideration, is an important evidence. There is no rational prohibition upon consideration of this issue within the scope of this inquest.

56. I make the following final points:

    a) Ms Ali, counsel for Monica Baker, Mr Crump's manager before his death, submitted that a single paragraph in each of the affidavits of Leah Geard and HL should be excluded from evidence. These paragraphs were not the subject of an objection by AT and Ms Baker's counsel was present at the commencement of the inquest when the affidavits were tendered. HL and Ms Geard were not requested by Ms Baker's counsel for cross examination. The statement by Ms Geard relates to Ms Baker's knowledge of Mr Crump's suicidality and her response to the issue. The statement by HL relates to her discussion with Ms Baker shortly before Mr Crump's death, when she allegedly told Ms Baker that she suspected Mr Crump had forged her signature in the drug register the previous day. Both paragraphs are clearly relevant to the issues at inquest and will not be excluded.

b) Notwithstanding this ruling, once the evidence has been completed, counsel still have the opportunity to make submissions regarding the weight to be given to any particular evidence, and it is incumbent upon me as coroner to ensure that findings are based upon reliable and cogent evidence.

c) This ruling is to be taken as my written reasons in respect of all other objections to affidavit evidence by AT where the makers gave evidence at the inquest.

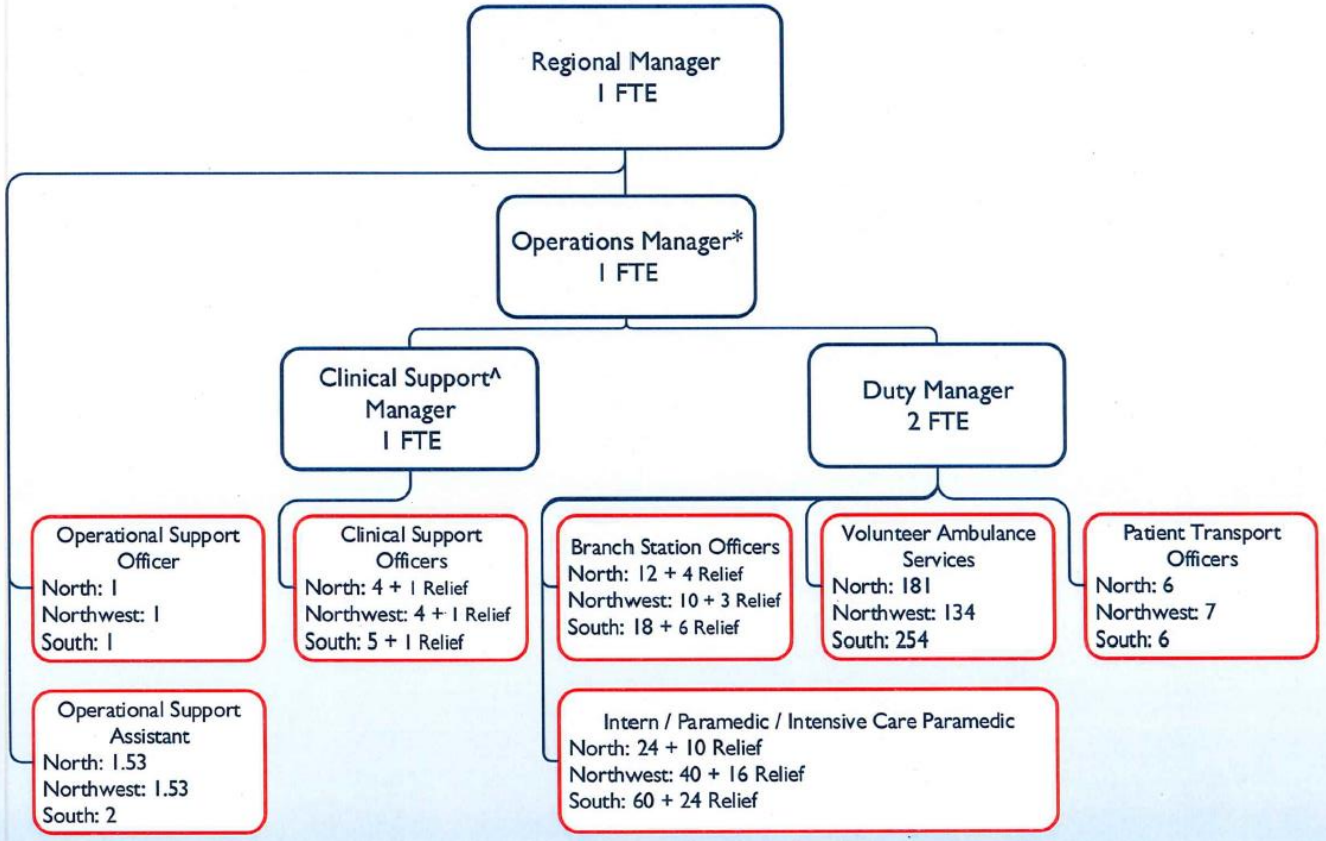
Dated 3 June 2021 in Hobart in the State of Tasmania

Olivia McTaggart
Coroner

'E'

Ambulance Tasmania
Chief Executive Officer
Office of the CEO
Aero-medical and Retrieval
Medical Consult Service
Medical Retrieval Service
Paramedic Retrieval Services
AT Clinical Nurse Services
Retrieval Strategy
Medical Services
Education and Professional Development
Statewide Services
Ambulance Service Medical Officers
Emergency & Medical Services North
Paramedic Services
Volunteer Ambulance Services
Non Emergency Patient Transport
Regional Training Unit
Emergency & Medical Services South
Paramedic Services
Volunteer Ambulance Services
Non Emergency Patient Transport
Regional Training Unit
Emergency & Medical Services North West
Paramedic Services
Volunteer Ambulance Services
Non Emergency Patient Transport
Regional Training Unit
State Communications
Communications Reform
Call Taking
Dispatch
Patient Transport Coordination
Quality Support
Operational Support Services
People and Culture
Strategic Business
Capability and Development
Technical Services
Version 1.0 / 23 February 2016

Emergency and Medical Services
North, Northwest & South



Key Notes

*Operations Manager is to be abolished by attrition and replaced by additional 1.0 FTE Duty Manager in each region.

^Clinical Support Manager will report to the Operations Manager where there is one. Otherwise to the Regional Manager

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