CORONERS COURT OF SOUTH AUSTRALIA

INQUEST INTO THE DEATH OF JOHN DOUGLAS KENNEDY

[2025] SACC 26

Inquest Findings of her Honour Deputy State Coroner Kereru

20 October 2025

CORONIAL INQUEST

Examination of the cause and circumstances of the death of John Kennedy who died in April 2020 after experiencing cardiac failure. The Inquest examined the circumstances which led to a delay in dispatching an ambulance to Mr Kennedy.

Held:

1. John Douglas Kennedy, aged 65 years of Mount Barker, died at the Mount Barker District Soldiers Memorial Hospital on 16 April 2020 as a result of ischaemic heart disease on a background of hypertension.

2. Circumstances of death as set out in these findings.

Recommendations made.

Counsel Assisting: MR D EVANS

Interested Party: SA AMBULANCE SERVICE
Counsel: MR W AMBROSE - Solicitor: CROWN SOLICITOR

Witness: MS T LYNCH, MR K MACDONALD, MR D WILSON, MR S BAULDERSTONE, MS S LINN & MS C GRIFFITHS
Counsel: MR W AMBROSE - Solicitor: CROWN SOLICITOR

Witness: DR E HEINZLE
Counsel: MR S PLUMMER - Solicitor: WALLMANS LAWYERS

Hearing Date/s: 03/02/2025-06/02/2025, 13/03/2025 & 07/04/2025

Inquest No: 01/2025 File No/s: 1070/2021

INQUEST INTO THE DEATH OF JOHN DOUGLAS KENNEDY [2025] SACC 26

Introduction

1 John Douglas Kennedy was 65 years old when he died at the Mount Barker District Soldiers Memorial Hospital (Mount Barker Hospital) on 16 April 2020.

2 At the time of his death Mr Kennedy was living with his wife, Mrs Dianne Kennedy, in their Mount Barker home. They had one adult daughter who lived nearby.

3 Mr Kennedy's past medical history was of high blood pressure, for which he was prescribed atenolol[1] and Dapa-Tabs. A recent blood test revealed elevated cholesterol, but Mr Kennedy had not been medicated for this condition.

4 On 15 April 2020, Mr Kennedy told his wife he thought he might have COVID as he had experienced a heaviness on his chest ('*like a brick on his chest*')[2] during the night. The pain had passed after he took some Rennies.[3] Mrs Kennedy stated in her affidavit that, following this isolated complaint, they spent a normal day together and went to bed on the evening of 15 April 2020. Everything appeared to be fine.[4]

5 Just after midnight on the morning of 16 April 2020, Mrs Kennedy awoke to find her husband sitting on the edge of their bed. She noticed that he was wearing his jeans and assumed that he had already been up and about. Their bedroom light was on. Her husband was breathing heavily in and out. Mrs Kennedy asked him what was wrong and he told her that he had severe chest pains and to ring an ambulance, otherwise he would '*have to go himself*' (presumably to hospital). Mr Kennedy told his wife not to panic.[5]

6 Mrs Kennedy contacted triple zero at 00:19:22 on 16 April 2020 seeking urgent assistance for her husband. An ambulance did not arrive until 00:43. By that time, or shortly thereafter, Mr Kennedy was in cardiac arrest. Cardiopulmonary resuscitation (CPR) efforts commenced at 00:52, and the ECG monitor was connected at 00:54. Mr Kennedy was taken to the Mount Barker Hospital under CPR and MedStar was called. Unfortunately, despite prolonged efforts, Mr Kennedy was pronounced life extinct at 2:08am. A death certificate was signed.

7 The Inquest explored the reason for the delay of the ambulance, the cause of Mr Kennedy's death, and whether his death could have been prevented had the ambulance arrived earlier.

Delay to the coronial investigation into Mr Kennedy's death

8 With the signing of a death certificate, Mr Kennedy's death was not reported to the State Coroner. It was only when Mr Kennedy's family wrote to the Coroners Court to raise their concerns about the delay in the ambulance arriving, that a report of death was

---

[1] Antihypertensive tablets under the brand name Noten
[2] Exhibit C2, paragraph 5
[3] Antacid tablets
[4] Exhibit C2, paragraph 5
[5] Exhibit C2, paragraph 6

received. This was on 25 March 2021, almost a year after his death and at a time after his remains had been cremated. The family were operating under the reasonable belief that Mr Kennedy's death had been reported to the State Coroner.

9 This meant that a coronial investigation into Mr Kennedy's death did not begin in a conventional way.[6] A further consequence of not reporting Mr Kennedy's death was that it not only delayed the coronial investigation, but limited its scope, particularly with respect to a precise cause of death and the issue of preventability. This was because an autopsy was not performed. Had this occurred, it is probable that Mr Kennedy's heart would have been examined to determine the level of coronary artery disease, the affected coronary vessels and the level of resultant damage to Mr Kennedy's heart. This investigation may also have revealed the timing of a myocardial infarction, with an examination of the histological samples of any thrombus found.

10 The death certificate was signed by Dr Erich S Heinzle at the Mount Barker Hospital on 16 April 2020 in the early hours of the morning. The certified cause of death was '*Myocardial Infarction (1 Day), Ischaemic Heart Disease (Years) and Hypertension (Years)*'. The certificate form clearly instructed that it is not to be issued '*if the State Coroner or a police officer is required to be notified of the death under the Coroners Act 2003*'.[7]

11 Pursuant to section 28 of the *Coroners Act 2003*, the following obligation exists:

> 'Section 28—
>
> (1) **A person must, immediately after becoming aware of a death that is or may be a reportable death, notify the State Coroner** or (except in the case of a death in custody) a police officer of the death, unless the person believes on reasonable grounds that the death has already been reported, or that the State Coroner is otherwise aware of the death. [8]
>
> Section 3—
>
> (2) A reportable death means the State death (other than a State death to which subsection (2) or (2a) applies) of a person— (a) by **unexpected**, unnatural, **unusual**, violent or **unknown** cause;' [9]

12 The circumstances as they are detailed below, support a finding that Mr Kennedy's death met the criteria under the Coroners Act to be reported.

13 Dr Heinzle was summonsed to give evidence about his decision-making on the morning of Mr Kennedy's death. He also provided an affidavit.[10] Dr Heinzle is a specialist general practitioner and a fellow of the Royal Australian College of General Practitioners. He holds a Master of Public Health, a Bachelor of Science in Mathematics and a Graduate Diploma in Occupational Health and Safety Management. At the time of Mr Kennedy's

---

[6] If Mr Kennedy's death had been reported to the State Coroner all powers of investigation under the *Coroners Act 2003 were available to be exercised immediately concerning his death*
[7] Exhibit C8, page 1
[8] Emphasis added
[9] Emphasis added
[10] Exhibit C24

presentation, Dr Heinzle was contracted to provide services to the Mount Barker Hospital Emergency Department through Summit Health.[11]

14 Dr Heinzle had some memory of the morning of 16 April 2020 and Mr Kennedy, but was unable to recall whether he was notified that Mr Kennedy was on his way to the hospital before he arrived. Assisted by the clinical records, Dr Heinzle agreed that Mr Kennedy arrived at 1:55am on 16 April 2020 in cardiac arrest and MedStar had been contacted and were on their way. Dr Heinzle assisted the paramedics, and then the MedStar team, in the attempt to resuscitate Mr Kennedy. This was unsuccessful, despite their best efforts.[12]

15 It is important to note that the evidence of Dr Heinzle was ancillary to the issues explored during the Inquest. The Inquest focused on the delay in the ambulance from the call made by Mrs Kennedy to the arrival of the paramedics at the Kennedy residence. The concern of the delay was the reason the report was received in March 2021 as described above.

16 The delay in the provision of emergency response to Mr Kennedy in the early hours of the morning, in my opinion, met the criteria that Mr Kennedy's death was unusual. As was ultimately discovered, SA Ambulance officers who attended to Mr Kennedy in cardiac arrest, shared this view by submitting their own concerns by way of an internal statement and a Safety Learning System (SLS) report about the delay.

17 Dr Heinzle explained that he was not aware of the issue concerning a delayed ambulance at the time Mr Kennedy presented to the Mount Barker Hospital. I have accepted Dr Heinzle's evidence, and in doing so accept that he would have had no basis to consider Mr Kennedy's death to be unusual.

18 In his evidence Dr Heinzle did address whether Mr Kennedy's cause of death was unusual. He explained that Mr Kennedy had suffered a relatively straightforward myocardial infarction, he had a history of hypertension (a risk factor for heart disease), he was male and was 65 years old. To Dr Heinzle, '*this was not an unusual mode of death for someone with [Mr Kennedy's] underlying risk factors and was certainly not suspicious or malicious*'.[13]

19 In relation to whether it was an unexpected cause, Dr Heinzle was asked how he reconciled the Kennedy family's distress upon their learning of his death, with his death being expected, he explained his understanding in his oral evidence:

> 'I would distinguish between unexpected to those around the patient at the time of death, with unexpected in the eyes of a medical examiner or practitioner, treating the patient. No-one usually knows the exact time of someone's passing, but it can be anticipated or expected based on premorbid conditions or circumstances, in which case it is not unexpected to the medical practitioner, even though a relative or a stander-by might consider it unexpected. From my perspective he was at elevated cardiac risk, which made a myocardial infarction a quite foreseeable mode of death. In that sense it was not unexpected that he might present with that as a cause of death.' [14]

---

[11] Exhibit C24, paragraph 4
[12] Exhibit C24, paragraphs 11-15
[13] Exhibit C24, paragraph 18
[14] Transcript, page 439

20 In his affidavit, Dr Heinzle went on to extrapolate that given the history (as he understood it to be) of chest pain spanning two consecutive nights and his symptoms suggestive of established heart failure (frothy sputum reported by SA Ambulance), Mr Kennedy's death was unlikely to have been prevented with or without a delay from the ambulance. This evidence was given with the knowledge of the delay which he learnt of later. He explained:

> 'Mr Kennedy appears to have undergone a fairly routine course of medical management for his ventricular fibrillation, and the die was likely cast by whatever underlying heart disease he had, which progressed over the preceding twenty-four hours or so and culminated in his collapse.'[15]

21 While I accept that Dr Heinzle was entitled to form a belief as to a reasonable cause of death based on his experience as a senior medical practitioner, that was a separate consideration to whether Mr Kennedy's death was a reportable one. In fact, other than where a death occurs as a result of an unknown cause, a doctor is required to form a view about the cause of all deaths they report.[16]

22 Dr Heinzle was aware that Mr Kennedy had presented in an Emergency Department, in cardiac arrest (in ventricular fibrillation) with a very recent history of chest pain and had previously been prescribed the antihypertensive medication, Noten. Dr Heinzle made it clear that he did not consider this presentation to be from either an unexpected or unknown cause. I have formed the view that, irrespective of his knowledge or otherwise of the delay, Mr Kennedy's death also met the criteria for both an unexpected and unknown cause.

23 With respect to '*unexpected cause*', Mr Kennedy had suffered an out-of-hospital cardiac arrest and arrived at the hospital under active resuscitation with MedStar involvement. These attempts continued for over an hour and a half in total, which Dr Heinzle noted were quite extended and exceptional efforts to restore cardiac output.[17] Efforts of this magnitude would be highly unlikely if the cause of death was an expected one.

24 With respect to '*unknown cause*', Dr Heinzle was not Mr Kennedy's treating doctor. Beyond chest pain and blood pressure medication, very little clinical information was known to Dr Heinzle about Mr Kennedy. While chest pain and the particular cardiac arrest rhythm recorded on the ECG was suggestive of a cardiac cause, Dr Heinzle did not know at that time how long Mr Kennedy had been suffering from hypertension, nor did he know how long (if ever) he had been diagnosed with ischaemic heart disease, as he himself deposed to in his affidavit ('*whatever underlying heart disease he had*'[18]). This was at odds with the declaration Mr Kennedy had ischaemic heart disease for years in the death certificate. Dr Heinzle even considered an alternative cause, as evidenced in his consideration of a possible pulmonary embolus which could have resulted in the same presentation.[19]

25 A submission made on behalf of Dr Heinzle was that he made an informed, honest and reasonable decision based on a thorough consideration of the facts. Further, that there

---

[15] Exhibit, C24, paragraph 23
[16] Section 28(2)(b) of the Coroners Act 2003
[17] Exhibit C24, paragraph 24
[18] Exhibit C24, paragraph 23
[19] Transcript, pages 431 and 454; Exhibit C8, paragraph 5

was no evidence before the Court of any different opinions; and if there were, the decision in the circumstances could only be one upon which reasonable minds might differ.[20] On this reasoning, it must then follow that reasonable minds may differ as to the cause of death. In which case there cannot be actual knowledge as to the cause, only a belief.

26 Dr Heinzle was an earnest and straightforward witness who gave evidence honestly. He appeared to have considered the issue of reportability very carefully by the time he came to give evidence. He was able to explain his process of reasoning in detail.

27 I find that Dr Heinzle had turned his mind to the question of reportability and genuinely believed he was not required to report Mr Kennedy's death to the State Coroner.

28 I find that in taking that approach, Dr Heinzle was operating under a belief rather than knowledge as to the cause of death. Belief is something short of knowledge. Dr Heinzle made his own diagnosis of ischaemic heart disease based on the outcome he had witnessed, without having performed any cardiac examinations or ever having spoken to Mr Kennedy. Dr Heinzle took comfort from statistical probabilities associated with Mr Kennedy's demographics, however in the end statistics do nothing to convert a belief to knowledge. The difficulty with Dr Heinzle's approach is that the law requires a doctor signing a death certificate to reach a degree of certainty, akin to knowledge, before doing so. Not only is an unknown cause a specific limb of reportability, but this requirement is also made clear by the obligation that a death be reported whether it is or *may be* reportable. Where there is something short of knowledge, then the law sets out procedures which enable the State Coroner to determine the precise cause of death if that can be achieved. Entering a cause of death on a death certificate on the basis of a belief has the effect of inhibiting the State Coroner from using those procedures to try and reach a state of knowledge of the actual cause.

29 While I accept Dr Heinzle's evidence that he only became aware of the ambulance delay in the period after Mr Kennedy's death, the circumstances in which Mr Kennedy was received into his care gave rise to consideration of whether the death was, or may have been, reportable.

30 I find that the circumstances which presented to Dr Heinzle on the night meant that Dr Heinzle should have reported Mr Kennedy's death to the State Coroner rather than signing a death certificate. That is, a previously unknown patient arriving in cardiac arrest with no known cardiac history and only one or potentially two days of chest pain, must lead to the conclusion that his cause of death is at least unknown, but also *may be* unexpected.

31 I wish to make it clear that I do not suggest in any way that Dr Heinzle did not make a report to the State Coroner in order to frustrate any proper process, to prevent coronial investigation or achieve anything other than what he thought was appropriate at the time. That is, this was a carefully considered decision made incorrectly but in good faith.

32 Of course as I have observed, once reported as unknown or unexpected, the revelation of the ambulance delay also made Mr Kennedy's death unusual in that it occurred without prompt emergency assistance as is the usual course in the lead up to that cause.

---

[20] Written submissions of counsel for Dr Erich Heinzle, paragraph 6.4

Cause of death

33 The delay in the coronial investigation has not prevented me from arriving at a finding on the balance of probabilities in relation to Mr Kennedy's cause of death.

34 The circumstances leading up to his collapse are classic symptoms of myocardial infarction, as described in oral evidence by expert cardiologist, Professor William Heddle.[21] This remains so even in the absence of an ECG trace recording the elevation in the ST Wave, or some other abnormality. Further, and as correctly identified by Dr Heinzle, the end stage arrythmia (ventricular fibrillation)[22] recorded on the cardiac monitor, once connected after the arrival of the paramedics, is typically seen in a cardiac related episode.

35 I was additionally informed by a pathology review conducted by Dr Erin O'Connor of Forensic Science SA (FSSA).[23] Dr O'Connor's findings were discussed with senior forensic pathologist Professor Roger Byard (also of FSSA) and a report was completed on 12 July 2022. A pathology review is a review of relevant medical history and case notes, including ambulance Patient Clinical Records (PCR). This review is usually conducted in lieu of an autopsy after a person has died in hospital following treatment which is extensively documented. In this instance it was conducted because Mr Kennedy had died on 16 April 2020, a death certificate was signed, and he was cremated. As detailed above, this was because Mr Kennedy's death was not reported to the State Coroner.

36 The pathology review stated:

> 'On the balance of probability, the most likely cause of death given the symptoms prior to cardiac arrest and the cardiac arrest rhythm, is ischaemic heart disease, likely an acute myocardial infarction. There does not appear to be any other preceding symptoms other than the chest pain the night prior to his death.' [24]

37 Based on the clinical information known and the past medical history, the physiological circumstances which led to Mr Kennedy's death were ischaemic heart disease (damage to the heart muscle caused by lack of oxygenated blood flow) which created circumstances of electrical instability in the heart which, in turn, triggered the fatal arrythmia when there was a blockage of blood flow from one or more of the coronary arteries, likely from a build-up of plaque. Hypertension was the underlying comorbid condition.

38 Dr Heinzle's certified cause was '*myocardial infarction (1 day) due to ischaemic heart disease (years) on a background of hypertension (years)*'. The difficulty with this cause of death was that Dr Heinzle had based his assessment of the presumed long-standing ischaemic heart disease as having caused the myocardial infarction. A history of ischaemic heart disease was not known to Dr Heinzle,[25] or to anyone. This condition had

---

[21] Transcript, pages 273-274
[22] A life-threatening arrhythmia where the heart's lower chambers (ventricles) quiver instead of pumping blood, leading to cardiac arrest and death without immediate treatment
[23] Exhibit C1a
[24] Exhibit C1a, page 2
[25] Transcript, pages 457-458

not been diagnosed in Mr Kennedy's lifetime. Dr Heinzle himself conceded that the years long history of ischaemic heart disease was a '*reasonable guess*'.[26]

39 I am satisfied on balance that Mr Kennedy's cause of death was ischaemic heart disease on a background of hypertension. I so find.

Definition of relevant terms

40 There are several SA Ambulance Service (SAAS) terms used throughout the Finding that require clarification. For the sake of accuracy and understanding, these terms are defined below.

- Priority 1 - This signifies that a triple zero dispatch involves an immediate life-threatening emergency, such as cardiac or respiratory arrest, requiring an immediate, life-saving intervention.
- Priority 2 - This signifies that a triple zero dispatch is an urgent, but not immediately life-threatening, emergency that requires a quick response.
- Priority 3 - This signifies that a triple zero dispatch is for a non-urgent incident that does not require lights and sirens for transport.
- Crib Break - This is also known as a rest break or tea break, and is a short, paid break for employees to eat a meal while remaining available for duty. Unlike standard meal breaks, employees may be required to stay on-site and can be called back to work in emergencies.
- 10D02 (10Delta02) - This is a particular 'determinant' used in SA Ambulance systems to categorise the nature of taskings, made up of component parts. The digit 10 signifies the category of chest pain or non-traumatic chest discomfort. Delta indicates that this is the most serious set of circumstances within the category. The digits 02 signify the key component of the presentation; in the example of 10Delta, 02 indicates that the patient has difficulty speaking between breaths.

Evidence at Inquest

41 The documentary evidence at Inquest comprised 41 exhibits.

42 In addition to the documentary evidence, oral evidence was heard from:

- Tina Lynch, Emergency Operation Centre Dispatcher, SA Ambulance
- Kym MacDonald, Emergency Operation Centre Team Leader, SA Ambulance
- Dean Wilson, Paramedic, SA Ambulance
- Scott Baulderstone, Intensive Care Paramedic, SA Ambulance
- Susan Linn, Intensive Care Paramedic, SA Ambulance
- Dr Erich Heinzle, Specialist General Practitioner, formerly of Mount Barker Hospital
- Professor William Heddle, Cardiologist

[26] Transcript, page 458

Hindsight bias

43 I warn myself concerning a vital consideration in the assessment of the evidence and any potential criticisms of witnesses in this Inquest, namely hindsight bias.

44 A description of 'hindsight bias' is given in the Australasian Coroners Manual, namely:

> 'The tendency after the event to assume that events are more predictable or foreseeable than they really were. What is clear in hindsight is rarely as clear before the fact. If it were, there would be far fewer mistakes made. It is an obvious point, but one that nonetheless bears repeating, particularly when Coroners are considering assigning blame or making adverse comments that might damage a person's reputation …
>
> Hindsight, of course, is a very useful tool for learning lessons from an unfortunate event. It is not useful for understanding how the involved people comprehended the situation as it developed. The distinction needs to be understood and rigorously applied.'

45 As stated, I am very mindful of this warning when considering the evidence in this Inquest.

Briginshaw v Briginshaw

46 Some of the findings that I have made are adverse to witnesses that gave evidence during the Inquest. In coming to these conclusions, I have been mindful of the need to satisfy myself that such findings should only be made based on the relevant evidence presented as being reliable and compelling. In doing so, I have applied the principles expressed by the High Court of Australia in '*Briginshaw v Briginshaw*'.[27] I also refer to the recent Supreme Court of South Australia analysis of the Briginshaw case in an appeal case of '*SJ Berry Pty Ltd v McEntee*'.[28]

Mr Kennedy

47 In an affidavit provided to the Court, Mrs Kennedy remembered her husband of 40 years as growing up in Naracoorte with a large family and moving to Adelaide in his high school years due to his father's ill health. Mr and Mrs Kennedy married in 1981 and they had a daughter, Kristen, in 1982.

48 Mr Kennedy was an art teacher at a local Mount Gambier high school for a period of time before moving overseas on exchange and then returning to teach in Adelaide. The family then moved to Mount Barker and Mr Kennedy retired from teaching. He turned his attention to other endeavours, driving a community bus, operating a signing business and engaging in further study to become a real estate agent. Mr Kennedy entered that profession and ran his own business.[29]

49 It was evident from the affidavit of his wife, and his daughter's letters of concern to the State Coroner, that Mr Kennedy was a much-loved member of his family.

---

[27] (1938) 60 CLR 336 in particular Dixon J at 362, 'Briginshaw'
[28] (2022) 142 SASR 31
[29] Exhibit C2

Circumstances leading up to death

50 As touched on above, Mr Kennedy had complained of a heaviness in his chest on the morning of 15 April 2020, which he reported to have experienced over the preceding night. He attributed the pain to the possibility of having contracted COVID-19. There was no suggestion that Mr Kennedy had turned his mind to the possibility that he was, or might have been, suffering an acute coronary event. Mr Kennedy did not complain of any other symptoms throughout the day. From Mrs Kennedy's perspective, it was a normal day and evening with the couple retiring to bed at the end of the day, as was their usual routine. It was shortly after midnight on 16 April 2020 that Mrs Kennedy was awoken to her husband sitting on their bed and breathing heavily. He complained of severe chest pain. Mr Kennedy instructed his wife to call triple zero and not to panic.

51 Mrs Kennedy rang triple zero at 12:19am. She spoke to call-taker Ms Courtney Griffiths. This call was recorded, and the audio recording was played a number of times in Court.[30] A transcript was also prepared and tendered in evidence.[31] This call lasted 5 minutes and 53 seconds. It was reported by Mrs Kennedy in the call that her husband was having difficulty speaking between breaths, that his colour was pale and he felt clammy. Towards the end of the call Mrs Kennedy conveyed to Ms Griffiths that her husband was feeling faint and was experiencing dizziness. Mr Kennedy could be heard quietly at times in the background.

52 Ms Griffiths gave oral evidence at the Inquest and explained in some detail the process in which a triple zero call is received and how the information entered into the system then generates a code which is given a priority in terms of the ambulance response time. Ms Griffiths' oral evidence was guided with reference to the Event Chronology that was generated on the night for Mr Kennedy's tasking. A portion of the Event Chronology is extracted below:

> '0: 2020-04-16 00:20:54: •• LOI search completed at 16/04/20 00:20:54
> 0: 2020-04-16 00:20:54: ** CLI DATA 3213222
> 1: 2020-04-16 00:20:54: Problem: WOKEN UP WITH CHEST PAIN
> 2: 2020-04-16 00:20:54: Patient Number: 1
> 3: 2020-04-16 00:20:54: 65-year-old, Male, Conscious, Breathing.
> 4: 2020-04-16 00:20:54: Dispatch CAD Code: 10D02' [32]

53 Ms Griffiths explained that '*WOKEN UP WITH CHEST PAIN*' was entered by her as 'free text' at 00:20:54. With the information of '*DIFFICULTY SPEAKING BETWEEN BREATHS*' being chosen by her in a drop-down box, the system interpreted the information and then chose the determinant code 10D02. Ms Griffiths explained that this particular code was designed to inform those viewing the system of the level of seriousness. This information was displayed by the computer software to the SA Ambulance dispatcher while Ms Griffiths remained on the phone with Mrs Kennedy.

54 The dispatcher, Ms Tina Lynch, viewed the tasking at 00:21:00. This meant that it took six seconds for the job to be coded and given a priority and for the dispatcher to view it.

---

[30] Exhibit C6
[31] Exhibit C6a
[32] Exhibit C10

Ms Lynch's role was to locate a nearby resource and to task it to Mr Kennedy's address within the target timeframe for a Priority 2 being 16 minutes from call receipt to ambulance arrival. Ms Lynch gave oral evidence at the Inquest. She told the Court that she was an experienced dispatcher, having undertaken two years as a metropolitan dispatcher. She then moved to the role of regional dispatcher, which she described as a more challenging role.[33]

55 While remaining on the phone with Mrs Kennedy, Ms Griffiths recorded further information from Mrs Kennedy about her husband's condition. This was displayed in the Event Chronology as extracted below:

> '5: 2020-04-16 00:20:54: Determinant Level: DIFFICULTY SPEAKING BETWEEN BREATHS
> 6: 2020-04-16 00:20:54: --: He is completely alert (responding appropriately).
> 7: 2020-04-16 00:20:54: --: He is not breathing normally.
> 8: 2020-04-16 00:20:54: --: He has difficulty speaking between breaths.
> 0: 2020-04-16 00:21:00: ** Event A003026660 was viewed at: 16/04/20 00:21:00
> 1: 2020-04-16 00:21:00: •• by: 3813 on terminal: saasdisp09
> 0: 2020-04-16 00:21:43: --: He is changing colour.
> 1: 2020-04-16 00:21:43: --: His colour change is pale.
> 2: 2020-04-16 00:21:43: --: He is clammy.
> 3: 2020-04-16 00:21:43: --: He has not had a heart attack or angina (heart pains) before.
> 4: 2020-04-16 00:21:43: --: He took some drugs (medications) in the past 12hrs.
> 5: 2020-04-16 00:21:43: --: He took a prescribed medication in the past 12 hrs: REGULAR MEDICATION'

56 This information was available to Ms Lynch while it was being recorded on the system by Ms Griffiths as she spoke with Mrs Kennedy. Ms Griffiths was required to end her call with Mrs Kennedy at 00:25:20 as there were other urgent calls that required attention. Ms Griffiths reassured Mrs Kennedy that:

> 'we have an ambulance coming out to you, lights and sirens okay' and
> 'there's an ambulance organised, we are coming to you lights and sirens there' and
> 'help has been arranged' [34]

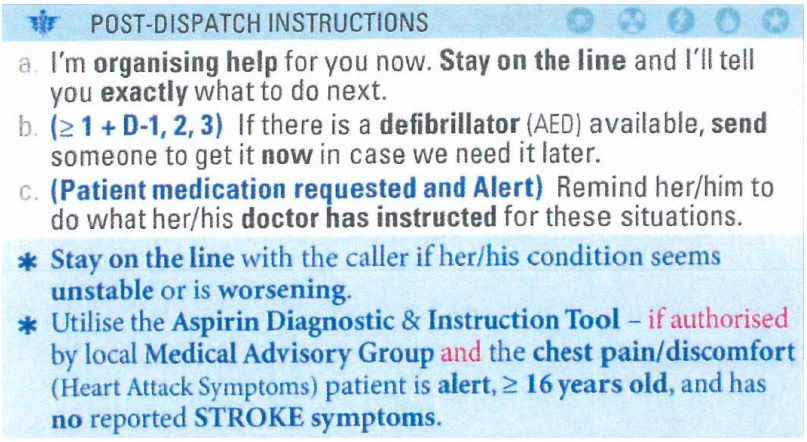
57 These comments were the subject of cross-examination during the Inquest as at no time during the duration of the call had an ambulance been dispatched. In fact, it would be another four minutes following the end of the call before an ambulance was on its way to Mr Kennedy.

58 Ms Griffiths described the language that was used when speaking to callers in emergencies. This was prompted during the call by the computer, but there existed a backup document colloquially referred to as the 'flip book', to use in case of a system outage. This was tendered to the Court.[35]

---

[33] Transcript, page 14
[34] Exhibit C6a
[35] Exhibit, C10a, *Extract of Emergency Dispatch protocol guide for chest pain, chest discomfort non-traumatic*

59 This document guided certain language to be conveyed to callers as follows:



POST-DISPATCH INSTRUCTIONS

a. I'm **organising help** for you now. **Stay on the line** and I'll tell you **exactly** what to do next.

b. **(≥ 1 + D-1, 2, 3)** If there is a **defibrillator** (AED) available, **send** someone to get it **now** in case we need it later.

c. **(Patient medication requested and Alert)** Remind her/him to do what her/his **doctor has instructed** for these situations.

* **Stay on the line** with the caller if her/his condition seems **unstable** or is **worsening**.
* Utilise the **Aspirin Diagnostic & Instruction Tool** – if authorised by local **Medical Advisory Group** and the **chest pain/discomfort** (Heart Attack Symptoms) patient is **alert, ≥ 16 years old**, and has **no** reported **STROKE symptoms**.

60 The language used about what was happening was important as it potentially impacted an opportunity for Mrs Kennedy, or her daughter (when she arrived), to drive Mr Kennedy to hospital, rather than waiting for the ambulance which in reality had not been dispatched. This possibility was raised in the affidavit of Mr Kennedy's daughter (Ms Kristen De Gilio) who explained:

> 'At that point I knew that we were only up the road from the Mount Barker Hospital Emergency Department and I could have put dad in the car and got him there within 3 minutes maximum.
>
> I can't remember which one of us rang the ambulance service but I think it was me. I was questioning where they were and how far away they were. The operator was feeding me words like, 'lights and sirens are flashing'.' [36]

61 If they had been informed that an ambulance was still in the process of being requested rather than '*we are coming to you lights and sirens*', they could have made their own decisions. Mrs Kennedy described the guilt she felt following her husband's death for not having made the decision to take him to the hospital in her own vehicle. She stated:

> 'We have felt a lot of guilt dealing with that because we could have taken him but we were told by the operator that the ambulance was on its way.' [37]

62 Ms De Gilio shared that sentiment:

> 'My biggest emotion is anger because they should have been there much quicker and the fact that what they communicated with us over the phone and what I have read from the documents we got from SAAS is incorrect. They weren't anywhere near coming to us when we were told lights and sirens are on. I could have moved my Dad to the car and driven him to the hospital had I known the ambulance was not on its way and was going to take so long to get to us.' [38]

63 Ms Griffiths was asked if she agreed that the language she had used to calm Mrs Kennedy on the morning of 16 April 2020 could have falsely reassured Mrs Kennedy that an ambulance was already on its way. To her credit, Ms Griffiths candidly agreed that her

---

[36] Exhibit C3, page 2
[37] Exhibit C2, paragraph 12
[38] Exhibit C3, paragraph 11

language implied that an ambulance was on its way, when it had not in fact been dispatched at that time. She accepted that this could have been misleading to Mrs Kennedy.[39] Perhaps if she had not been required to end the call due to high demand she would have actively chased up where the ambulance was. It was evident that Ms Griffiths had a genuine concern for Mr Kennedy's wellbeing, as was captured in a further recorded conversation with a nurse at the Mount Barker Hospital. I will detail that below.

64 The Court heard evidence from a number of witnesses that at this particular time the Adelaide Hills area was experiencing a high demand for emergency response and was under-resourced by SA Ambulance. There were three separate crews in the Adelaide Hills at this time; one in Mount Barker, one in Stirling and one at Woodside. When these crews were busy with taskings it was not uncommon to have crews tasked from the metropolitan areas which required extended travel time.[40] The evidence at Inquest established that this has since been addressed with the provision of a greater number of ambulance crews permanently stationed in the hills and witnesses described the additional resourcing as having a positive effect.

65 However, resourcing was not the issue that impacted on the delay for Mr Kennedy. As will be outlined below, there was an ambulance on a 'crib break' which had no tasking during the relevant time period. This was ultimately the ambulance that was tasked to attend at Mr Kennedy's home, but only after a delay of almost 10 minutes. I will return to this topic later in the Finding.

The two crews

66 The Court heard there were two ambulance crews in the Adelaide Hills area that morning. The first was 181 Barker. This was staffed by Intensive Care Paramedic Dean Wilson and Paramedic Adam Banasiak. At the time of the first call from Mrs Kennedy they were at the Mount Barker Hospital, having conveyed a patient there. This was an approximate six-minute drive from the Kennedy residence. The second crew was 181 Stirling, staffed by Intensive Care Paramedic Susan Linn and Paramedic Scott Baulderstone. They were at the Stirling station on a crib break from 00:20 to 00:25. Following that they remained at the station without a tasking. The Stirling station was approximately 14 minutes from the Kennedy residence.[41]

67 At 00:21:46, Ms Lynch radioed the closest crew, being Barker 181. The following exchange took place:

> '00:21:46 - Ms Lynch asked - '***any chance you would be able to clear a P2 in Mount Barker***'.[42]
>
> 00:22:14 - Mr Banasiak radioed back to Ms Lynch stating - '***we'll be a few minutes***'.[43]
>
> 00:22:21 - Ms Lynch responded stating - '***Thanks Barker 181, it will be yours if you can clear***'.' [44]

---

[39] Transcript, page 344
[40] Transcript, page 71
[41] Exhibit C9, page 2
[42] Exhibit C6a, page 6
[43] Exhibit C6a, page 7, emphasis added
[44] Exhibit C6a, page 8, emphasis added

68 After this exchange there was no communication between the Barker crew and Ms Lynch for seven minutes. During her oral evidence Ms Lynch was questioned about her exchange with Mr Banasiak in the context of an urgent tasking. In her evidence-in-chief, Ms Lynch explained that she was expecting the Barker crew to be unloading their current patient, making up a new stretcher and getting in their ambulance and calling her to say they had cleared and were ready to attend Mr Kennedy's house. Her expectation was that it would take between three to four minutes for this to occur.[45] In cross-examination, Ms Lynch was asked whether she should have asked for a more specific timeframe.

> 'Q. My question is when [Mr Banasiak] said 'We'll be a few minutes', you should have asked for more information about exactly how long that meant.
>
> A. I can see what you're saying, but to me, I've asked him and he's given me that. And I was happy with that at the time. But I can see that you're saying definitively how long - what is a few minutes? Is it three, is it five, is it seven?
>
> Q. And do you agree that the task of dispatching ambulances in urgent and emergency situations is something where time is critical.
>
> A. Yes.
>
> Q. Your job involves dealing with critical timeframes every day.
>
> A. Absolutely.
>
> Q. And particularly in these cases, P1s and P2s, the quicker you can get a resource, the better.
>
> A. Yes.
>
> Q. And so, when somebody tells you 'We'll be a few minutes', you should really dig into that further, shouldn't you, to find out exactly what they mean so that then you can assess what other resources you may have at your disposal.
>
> A. Yes, my assessment on the few minutes though is that he's also working while he's doing that. And my thought process behind this is he knows it's there, there's things that they'll be going through to clear and tidy up so that they can go to the next job. I wouldn't necessarily talk a lot on the radio to them because I'm expecting them to be doing their things they need to get onto the next job.'[46]

69 Further, Ms Lynch was asked whether her statement 'it will be yours if you can clear' meant that she thought she had assigned the job or was waiting to be informed that they had accepted it. She explained:

> 'Q. And you say 'It will be yours if you can clear'.
>
> A. Yes.
>
> Q. Do you accept that that is not a black-and-white statement.
>
> A. In reading it, it doesn't appear like that, but that is just how I normally speak with the crews. It's just normal, sort of, language that I use. I've told them it's theirs if they can clear. They've already said they can clear in a couple of minutes. And then they've followed it up with the phone call that says there's this other job going on, and that's that timeframe.

---

[45] Transcript, page 34
[46] Transcript, page 45

> Q. So, at the time that you said this on p.8, 'It will be yours if you can clear', would you expect that Mr Wilson would have understood that the job was his.
>
> A. Yes.
>
> Q. It's assigned to him.
>
> A. Verbally assigned, yes, I've told them it's their job. They've said they can do it, I've said 'It's yours'.
>
> Q. So, you said 'verbally assign', by that do you mean it wasn't assigned on the computer system.
>
> A. It hasn't - yeah, it hasn't set their pagers off or anything like that.
>
> Q. But you intended by this and you would expect him to understand that nobody else was going to be assigned to this case.
>
> A. Yes.'[47]

70 Ms Lynch was asked whether she had made a conscious decision to wait for the Barker crew to be clear as the Stirling crew were on a crib break at this time. She explained that with a Priority 1 or 2, she would interrupt a crib break and dispatch that crew straight away in accordance with the 2019 Tactical Deployment Plan.[48] Ms Lynch testified that she had never decided against tasking a crew to a Priority 1 or Priority 2 emergency because they were on their crib break.[49] I accept that the crib break had no role in the decision making process.

71 Ms Lynch's explanation for the delay of seven minutes waiting for Barker 181 to clear was two-fold. Firstly, that she was under the impression that Barker 181 was verbally assigned. Secondly, that the morning was busy and time passed quickly in her role.

72 While the language used by both Ms Lynch and Mr Banasiak was objectively vague in its nature, I have accepted Ms Lynch's explanation that this was the language used in her role and that she held a genuine belief that she had tasked the Barker crew to Mr Kennedy. I also accept the plausibility of time passing quickly with the requirement to dispatch multiple vehicles to different tasks at different priority levels, although I do observe that precautions should be taken to guard against allowing an extended time to pass without dispatch.

73 However, Ms Lynch's demeanour in both the radio communications and then while giving oral evidence, revealed a level of detachment. Perhaps most tellingly was her evidence that Mr Kennedy's tasking was just a '*run of the mill chest pain*' event. This was both concerning and at odds with the information recorded in the Event Chronology by Ms Griffiths. It was also inconsistent with the genuine level of concern that Ms Griffiths had for Mr Kennedy. She explained what '*run of the mill chest pain*' meant. She stated:

> 'We do hundreds and hundreds of chest pain dispatches, and there was nothing in this job that alerted me to think this was any more extreme than any other standard chest pain case that we get.' [50]

---

[47] Transcript, page 46
[48] Exhibit C11, page 12
[49] Transcript, page 38
[50] Transcript, page 47

74 Another concerning observation was that the next communication between the dispatcher and Barker 181 was initiated not by Ms Lynch, but by a phone call from Mr Wilson. This occurred at 00:29:16. That was 10 minutes after Mrs Kennedy contacted triple zero and nine minutes after Ms Lynch viewed the event on her screen. All the while, the Stirling crew were at the Stirling station without a tasking. An inescapable question was how much longer Ms Lynch would have waited before either receiving confirmation that Barker 181 was on their way to the Kennedy residence or contacting them to follow up if Mr Wilson had not made contact first.

75 The audio recording of the contact from Mr Wilson revealed that, while dropping a patient at Mount Barker Hospital, Mr Wilson said he had been approached by a doctor to transport a patient in the Emergency Department to the Royal Adelaide Hospital (RAH). In his oral evidence, Mr Wilson explained that contacted Ms Lynch to seek her permission to be tasked to the Mount Barker Hospital patient, knowing that she had previously requested that his crew (Barker 181) be tasked to attend Mr Kennedy.

76 It was the evidence of both Ms Lynch and Mr Wilson that it was the dispatcher who made formal decisions about where the ambulances went. I accept that this was the policy in principle, but for reasons I have detailed below, this did not occur as it should have on the night. The call began at 00:29:16.

'Operator	Regent south, this is Tina
Crew	Hi Tina, Dean here on the Barker track how are you going?
Operator	Good, how are you?
Crew	Good. Um there's a lady here that ah I think was a job from the Stirling [ward] So I've brought in we've got a lady in the resus room, she's in um she's quite crook she's, they just rang up they want someone as soon as possible to transfer her
Operator	Yep
Crew	I know you've got that other two in Barker
Operator	yep
Crew	um one of the doctors was just talking to me I said do you want me to ring and get us to do this one straight away, um cos we're here. um does that work with you? Have you guys got that through yet? That job…
Operator	…no, we haven't got it hang on, I'll just look…
Crew	…okay cos I've just got one of the nurses ringing now….
Operator	…….its alright, I'll just drop Stirling onto the Barker job…..
Operator	….that's cool, um yeah no worries ummm
Crew	…alright we'll get this one here sorted then if you can get that other one
Operator	Yeah that's alright I'll just put Stirling onto the other one that I'd asked you about..
Crew	..mha…
Operator	…and we'll get them heading up that way for that..
Crew	…mhm…
Operator	….and then as soon as I get yours in I'll drop it onto you

Crew	okay they've got a lady here it looks like she's got a systolic [unclear] she is in a separated AF and a
Operator	…… yeah she's kind of in her forties….
Crew	…its almost sort of [unclear]….stage
Crew	…ah no this one's seventy to eighty I think'

77 It is difficult to convey in words the feeling of unease when listening to this communication. The aspects of the call that invoked this reaction included the knowledge that nine minutes had already passed from Mrs Kennedy first contacting triple zero, and that there was no mention of Mr Kennedy (other than reference to '*the other 2 in Barker*'), or the severity of his condition. Ms Lynch, who was aware of the time that Mrs Kennedy's call was initiated and that Mr Kennedy was experiencing a number of concerning symptoms, conveyed no urgency to Mr Wilson. In fact, she appeared more interested in other taskings coming through. While it is accepted that Ms Lynch was not the call-taker and therefore had not heard the distress in Mrs Kennedy's voice during her triple zero call, she had available to her sufficient information to have advocated the urgency of the dispatch on Mr Kennedy's behalf. At the very least, she should have discussed Mr Kennedy's case with Mr Wilson, who at that time knew nothing more than that it was a Priority 2 in the community. That did not occur. Mr Wilson imparted a preference for the tasking he should take and Ms Lynch capitulated. While Mr Wilson and Ms Lynch agreed that Ms Lynch (as the dispatcher) had the ultimate say on where an ambulance was to be tasked, the conversation appeared led by Mr Wilson. Further, the exchange did not contain the expected level of seriousness that the situation objectively required.

78 Ms Lynch was questioned about her level of dispassion by Mr Darren Evans of counsel assisting. The passage of evidence is as follows:

> 'Q. Do you agree that that's quite a casual conversation.
>
> A. Yep.
>
> Q. There's no sense of urgency.
>
> A. I agree it comes across like that, doing the job that we do. If I panicked and got het up and - I wouldn't be able to do my job. There's a certain level of - we receive a lot of jobs, a lot of - do a lot of multitasking at once and it becomes to a certain level that you just - I don't get heightened, I don't get - you know, internally, I might be quite stressed or worried about things, but it doesn't - it's of no benefit to my job to get het up and stressed and demanding and aggressive and things like that with the crews or with my fellow staff. It's just a matter of just working through processes and trying to cover everything as best I can at the time. In talking to him like that, at no point did that delay sending the Stirling crew. The Stirling crew was dispatched on it pretty much at the start of the phone call with him. The chat after it didn't have any impact on the timeframe of that ambulance being dispatched. It's not like I had a casual phone call and then thought 'Now I better get on and find someone else'. Like, it's all happening all at the same time in the background. There's a - it's sort of hard here because the printout of the times of the chronology and the times of the phone call don't cross over; you can't see where the phone call is made to where the dispatch is

> done, but, yes, Stirling was put on that job as soon as - when actually said on the phone 'I'm putting Stirling on it', that is when they were put on the job.' [51]

79 While I accept that at 00:29:58 Ms Lynch did dispatch the Stirling crew and this was done during her conversation with Mr Wilson, I reject the remainder of Ms Lynch's explanation. Her evidence was simply nonsensical when there was no mention of the patient to which the communication related, and the crew (Mr Wilson and partner) were closer in proximity to the Kennedy residence than the Stirling crew. When challenged, Ms Lynch did accept that a sense of urgency can be conveyed without panic, stress or aggression,[52] although I consider this to be an inexorable concession. It is also important to highlight that the patient Mr Wilson called about (I will refer to this patient as Mrs Q), had not yet been received by SA Ambulance for tasking. Ultimately, this patient was allocated a Priority 3 tasking, meaning Mr Kennedy's tasking would have taken precedence over Mrs Q's tasking. I will deal with this issue below.

80 I pause here to note that the heightened risk associated with chest pain taskings over other Priority 2 taskings, was internally addressed by SA Ambulance in response to Mr Kennedy's death among others. This came about as a result of an SLS report initiated by Ms Linn in the wake of Mr Kennedy's death.[53] The recommendation was for a statewide procedural document which was ultimately put into place. The effect of this procedure was to make chest pain taskings the lowest of the Priority 1 cases - a 10 Delta case.[54] The directive was as follows:

> '**Determinant 10 Delta Dispatch Change**
>
> As a result of recent Adverse Events, a number of internal and external reviews have commenced or been completed, most notably a report from the Chief Medical Officer Dr Michael Cusack, and the release of a number of recommendations. SAAS as a result have commenced a broader quality assurance program to look at elements of these recommendations to continue to support improved patient care in the current environment.
>
> In addition, all of the 10 D determinants (01-05) (Chest Pain Protocol) will now be preferentially tasked over other pending Priority 2 events. Staff may notice a number of changes in the dispatching of these events.
>
> As highlighted, further work is underway, including reviewing response plans, demand management as well as reviewing additional determinants with a Delta code that likewise could have the potential to deteriorate due to a delayed response.'

81 This change was implemented some time in 2022 in order to address the issue of chest pain cases sharing priority with all manner of other less-serious cases. I consider that it adequately addresses the complacency that I detected in communications relating to Mr Kennedy's case. I also consider that it is a positive initiative that addresses the often-precarious clinical situation faced by chest pain sufferers waiting for emergency help in the community.

---

[51] Transcript, page 55
[52] Transcript, page 55
[53] Exhibit C17
[54] Exhibit C19

Mrs Q

82 The case notes of Mrs Q reflected that she had been diagnosed with urosepsis and was in rapid atrial fibrillation. The observation chart recorded an elevated heart and respiratory rate and low blood pressure. There can be no disagreement that Mrs Q required a higher level of care than the Mount Barker Hospital was able to facilitate, and that a transfer to a major tertiary hospital was indicated. However, leaving aside formal priority levels for the moment, Mrs Q was in a hospital, in a resuscitation room with a cardiac monitor, and with an on-duty doctor and nurses. A defibrillator was also on-site. In contrast, Mr Kennedy was at home in the community with just his very concerned wife and later his daughter who arrived before the ambulance. As would be expected for an average home in a suburban or regional area, there was no defibrillator at the Kennedy residence. During cross-examination both Ms Lynch and Mr Wilson accepted the disparity at play between the situation of the two patients in the context of prioritising the tasking to Barker crew for Mr Kennedy.[55] However, that did not appear to play a role in their decisions on the night.

83 Following the communication between Mr Wilson and Ms Lynch, an enrolled nurse (EN) by the name of Dayna contacted the SA Ambulance call centre at 00:31:34 to request an ambulance for Mrs Q. Ms Griffiths, who had only recently ended the call with Mrs Kennedy (due to a backlog of other urgent calls), spoke with EN Dayna. A recording of the call from EN Dayna came to light during the evidence of Ms Griffiths, who recalled that she had conveyed the seriousness of Mr Kennedy's situation to EN Dayna at the Mount Barker Hospital. The recording was obtained and then played to Ms Griffiths.[56] Mr Wilson was recalled to give further evidence about the contents of the conversation.

84 It was evident from the audio recording that Ms Griffiths' memory was correct. She was heard acknowledging the tasking for Mrs Q but expressed her unease to EN Dayna at the seriousness of Mr Kennedy's condition, referring to it being a '*very bad case*' and a '*potential unconscious collapse*'. EN Dayna informed Ms Griffiths that the Stirling crew[57] were now tasked for Mr Kennedy and Ms Griffiths made the comment '*oh dear god, they are going to take forever* [to arrive]'.

85 Ms Griffiths asked what priority should be assigned to Mrs Q's tasking and EN Dayna, heard to be instructed by a voice in the background, stated a priority 2 but '*within 30 minutes*'. As was established during the Inquest, a 30-minute response time is akin to a Priority 3, and not a Priority 2. The conversation was:

> 'Operator: Thank you. And what priority do you need this under?
>
> Caller: Priority 2 please, within thirty minutes. We've actually got a crew here, Dean has just spoken to comms.
>
> Operator: Ok, I'm surprised they're not getting that crew out because I know there's a very bad emergency out there at the moment.
>
> Caller: Yeah, I think Woodside's going, I think Woodside's going to that one.
>
> Operator: Oh dear god they're gonna take forever.
>
> Caller: Oh okay, alright.

---

[55] Transcript, page 59 (Lynch), 125 (Wilson)
[56] Exhibit C22 - the recording; Exhibit C22a - transcript of recording
[57] Incorrectly referred to as the Woodside Crew, based around the same distance from Mount Barker as Stirling

> Operator: Yeah, there's, I literally just got off the phone with a very bad case at the moment, umm ...
>
> Caller: Yeah, do you know what it is?
>
> Operator: Um chest pain, possible unconscious collapse ...
>
> Caller: Oh okay.
>
> Operator: Yeah.
>
> Caller: Sure, alright. Well I'll leave it up to you guys to just ...
>
> Operator: Yeah but um, but does this person need to be transferred lights and sirens? ... or?
>
> Caller: Umm, hang on just two seconds ...
> *(Caller speaking to third party)*
> Do you want lights and sirens? ... within thirty?
>
> Caller: Within thirty minutes.
>
> Operator: Within thirty, ok well maybe they can go get that patient [ie Mr Kennedy] and then come back and quickly do this one ... umm, and where are we taking the patient to?' [58]

86 Towards the end of the call, EN Dayna could be heard conveying to Mr Wilson (in the background) that the case in the community was an unconscious collapse. As we know, by that time, the Stirling crew had been dispatched and were on their way to Mr Kennedy. However, as remarked upon by Ms Griffiths, they were geographically further away and would take longer to arrive.

87 Once Ms Griffiths had entered the information for Mrs Q into the system a Priority 3 was allocated. This occurred at approximately 00:35:31 according to the Event Chronology.[59] This meant, as canvassed above, that Mr Kennedy's tasking should have taken priority over Mrs Q's tasking, not just as a matter of common sense, but in accordance with SA Ambulance's own priority allocation policy. Instead, the plan formed in the call between Mr Wilson and Ms Lynch, continued against the now beyond doubt disparity in urgency.

88 Mr Wilson was cross-examined on the system's allocation of a Priority 3 to Mrs Q. His evidence was, having viewed the observation charts and having discussed the matter with the doctor at the Mount Barker Hospital, Mrs Q's matter should have been allocated a Priority 2, given the seriousness of her situation.[60] That is, he disputed the correctness of the prioritisation process. This was his evidence despite being present in the room when a 30-minute response time was requested by EN Dayna when she was speaking with Ms Griffiths. Mr Wilson denied that he was the person to request the 30-minute response time.[61] Irrespective of Mr Wilson's individual assessment of Mrs Q's condition, the fact remained that Mrs Q's transfer was allocated a lower acuity priority level.

89 After being recalled and played the recording of the conversation between Ms Griffiths and EN Dayna, Mr Wilson accepted that he must have known there was a concern, as expressed by Ms Griffiths and relayed to him by EN Dayna. In particular, that there was

---

[58] Exhibit C22a, pages 2-4
[59] Exhibit C13
[60] Transcript, pages 113-114
[61] Transcript, page 376

information available that Mr Kennedy was now an unconscious collapse. Mr Wilson was asked whether he considered contacting SA Ambulance communications to offer to go to the 'unconscious collapse' patient. His response was that '*we don't bid for our cases*'.[62] That evidence was at odds with his call about Mrs Q's tasking.

90 Mr Wilson was an unimpressive and evasive witness, particularly when he spoke about his call with Ms Lynch. He refused to acknowledge the clear and obvious import of what he had done; interfered with the dispatch process.[63] The evidence of this was established by the mere fact that following his call he was assigned to a Priority 3 case notwithstanding being physically closer to a Priority 2 chest pain case (than the other crew on shift) and available for dispatching. Of course, before the call Ms Lynch had determined to send Mr Wilson to Mr Kennedy's case to the extent that she considered him dispatched, albeit not formally in the system. I find that the objective reality is that Mr Wilson's purpose in calling was to alter the ordinary dispatch process.

91 Mr Wilson refused to acknowledge that if he was merely giving information about an upcoming transfer case that he could have done so after accepting Mr Kennedy's case and while travelling to Mr Kennedy's house.[64]

92 Mr Wilson gave evidence that he had no knowledge of the nature of Mr Kennedy's case.[65] After the recording of the call between Ms Lynch and EN Dayna was uncovered, it was obvious that Mr Wilson did in fact have information about Mr Kennedy's case as he was heard being advised about it. Importantly, he heard that it was an 'unconscious collapse' which is extremely serious. He gave evidence about the checking of his pager notwithstanding consistently asserting that he had no memory of the events relating to Mr Kennedy at all. That is, he spoke of feeling concerned about not having been assigned to the case even though he had no memory of any of the events. In light of the content of the call, he then remained reluctant to acknowledge that he had any information about Mr Kennedy's case.[66] I find that Mr Wilson had actual knowledge that Mr Kennedy's case was objectively more serious than Mrs Q's.

93 Mr Wilson gave evidence that he had questioned himself why he had not been assigned to the unconscious patient, a query significant enough that he says he would have checked his pager to see if he had missed being assigned. I find that this evidence was given to distract from the seriousness of what he had done and to reinforce his assertion that he had not intended Ms Lynch to assign him to Mrs Q. Mr Wilson had no plausible explanation for why, notwithstanding having this concern and having earlier been willing to call Ms Lynch, he made no efforts to speak to Ms Lynch again to find out why he was not being sent to deal with the more serious case.[67] I find that Mr Wilson knew exactly why he had not been assigned to Mr Kennedy's case; it was by his design. In his evidence he said that he had not called back asking to be assigned to Mr Kennedy's case because '*we don't bid for our cases*' because it would cause '*chaos*' and that he assumed that

---

[62] Transcript, page 392
[63] Transcript, pages 381, 384 and 389
[64] Transcript, page 387
[65] Transcript, page 364 and 377
[66] Transcript page 377
[67] Transcript page 392

Mr Kennedy's case was '*all in hand*'.[68] Of course that is not an acceptable explanation in light of what he had already done and what he knew at that point.

94 Another difficulty in his evidence was that Mr Wilson had been requested by the doctor at the hospital to convey Mrs Q to Adelaide.[69] The only doctor at the hospital that evening was Dr Heinzle. Dr Heinzle was asked whether he remembered Mr Wilson and the circumstances around him being tasked to Mrs Q's transfer.

> 'Q. Did you speak to the paramedic who was present at hospital about Mrs Q's case.
>
> A. From memory, he wandered into the resus room while we were in there with Mrs Q, and I remember a brief discussion, yes.
>
> Q. And do you remember what the nature of that discussion was.
>
> A. I think he'd just delivered a patient, and he must have seen that there was a job that had been booked, and I think that prompted him to wander in and see whether it would be sensible for him to take Mrs Q.
>
> Q. Do you recall whether that was something that you initially raised with him, or he initially raised with you.
>
> A. I don't recall raising it with him. I think he'd wandered in, having seen the job listed, so it was something that he'd seen as a logical thing. But it's five years ago. I'd struggle to recall with precision the onset of the interaction.
>
> Q. Perhaps if I ask this, do you have a habit or a routine of approaching paramedics and suggesting that they do particular things, take particular cases.
>
> A. No.
>
> Q. Do you generally leave it to the ambulance service to operate their own service.
>
> A. They're quite inscrutable. We roll with it.
>
> Q. And is it therefore likely that on this occasion, you wouldn't have raised the request for this particular paramedic to take this particular case.
>
> A. Well, my job was to simply point out what the patient's needs were and leave it up to SAAS to decide how they were going to schedule their transport. At the end of the day, I would have accepted their decision either way; I have no control over it.' [70]

The above passage of evidence painted a different picture to that described by Mr Wilson in his earlier evidence.[71] In particular Dr Heinzle's assumption that Mr Wilson had seen the job in the system, which of course had not occurred when he contacted Ms Lynch. Dr Heinzle was not challenged on this account.

95 Mr Wilson vehemently denied any suggestion that he had interfered with the dispatching process by proposing to transfer Mrs Q at the Mount Barker Hospital, where he had just delivered a patient, rather than attending to Mr Kennedy in the community.[72] The evidence as a whole is more consistent with Mr Wilson inserting himself into the

---

[68] Transcript, page 369 and 392
[69] Transcript, page 110, 104, 115, 128-129
[70] Transcript, pages 451-452
[71] Transcript, pages 121, 128-129
[72] Transcript, pages 121 and 123

dispatching process to transfer Mrs Q rather than being approached by the doctor due to the urgency. I find that his involvement in Mrs Q's case was at his instigation.

96 Only Mr Wilson knows why he suggested taking Mrs Q's tasking that evening. There are a number of possibilities, including that it was simply more convenient for him as he was physically at the hospital. I am unable to make a finding about Mr Wilson's motivations, but I find that the consequence of his phone call to Ms Lynch was an interference with the proper tasking process, costing valuable time to Mr Kennedy.

97 Based on the foregoing, there is an uncomfortable conclusion to be drawn that if Mr Wilson had not contacted Ms Lynch requesting to remain at the Mount Barker Hospital, the Stirling crew would have been tasked to the Mount Barker Hospital to transfer Mrs Q. Given the distance between the two locations, the Stirling crew, who had not been allocated a tasking prior to 00:29:00, could have easily reached Mrs Q in the requested 30-minute timeframe. Further, with the Barker crew being available (turned out) from 00:35:29 (as reflected in Mrs Q's Event Chronology), and being six minutes from the Kennedy's residence, their arrival time would have been more in the vicinity of 00:41, at the latest. Without Mr Wilson's intervention that is what would have undoubtedly occurred, with the system determining the priority level and the dispatcher prioritising the higher acuity patient, which was Mr Kennedy. This was certainly Ms Lynch's initial plan before the call from Mr Wilson. This would have seen the Barker crew dispatched to Mr Kennedy (as was the original plan) and the Stirling crew to Mrs Q.

98 I accept that when conveying patients to hospital there may be approaches made to paramedics by clinicians in a busy treatment setting to discuss individual cases. However, a phone call is required to be made to SA Ambulance to formally create a tasking regardless of arrangements between hospital staff and paramedics. This allows the internationally recognised system to allocate an appropriate priority which then sits within the resources available at the time. It must be respected and followed. However, as I have found, this is unfortunately not what occurred on the morning of 16 April 2020.

The Stirling crew and the delay

99 The Stirling crew, paramedics Ms Linn and Mr Baulderstone, gave oral evidence at the Inquest and their statements provided to SA Ambulance were tendered to the Court.[73] They shared the view that the delay may have impacted on the outcome (Mr Kennedy's death). Accordingly, Ms Linn lodged an SLS incident with SA Health after Mr Kennedy's death. This document was tendered to the Court.[74]

100 Ms Linn and Mr Baulderstone were dispatched at 00:29:00. Prior to being dispatched they had travelled to the Stirling station for a crib break. This took place between 00:20 and 00:25. Following the end of the crib break they remained at the base without a tasking. When receiving the tasking to attend on Mr Kennedy, they both immediately noted the delay between the initial call being received and their dispatch, nine minutes later.

101 Ms Linn and Mr Baulderstone described discussing the delay between the call being received and their crew being dispatched while on their way to Mr Kennedy. They had

---

[73] Exhibits C16 and C14 respectively
[74] Exhibit C17

been on a crib break for five minutes of the delay, but both gave evidence that a Priority 2 tasking took precedence over a crib break. In fact, both Ms Linn[75] and Mr Baulderstone shared the view that, notwithstanding the importance of having a break, they would always want to be told of a medical emergency that needed their assistance. Mr Baulderstone emphatically stated:

> 'I would never, ever, ever put my need getting a lunch ahead of saving somebody's life, ever.' [76]

102 Both Ms Linn and Mr Baulderstone described their concern for the wellbeing of the patient to whom they were tasked to attend while en route.[77] This concern was realised when they arrived. Their evidence was consistent that Mr Kennedy's daughter was standing in the front yard of the home in a distressed state.

103 The ambulance PCR recorded the arrival time of the Stirling crew as 00:43.[78] Both paramedics were required to don personal protective equipment (PPE) as it was in the height of the COVID-19 pandemic. They both did so upon alighting the vehicle and estimated that this added perhaps one or two minutes to their usual response time. This was an unavoidable consequence of the pandemic. They then grabbed the equipment and made their way to the front door. Ms Linn remembered that just before she entered the house Mr Kennedy's daughter, who had been on the front lawn initially and then went inside, came out again. In oral evidence she could not remember exactly what was said. However, in her statement (given at a time much closer to the night) she stated:

> '… as I was walking around the ambulance towards the scene the patient's daughter returned and said something to the effect for us to hurry because he had stopped breathing. She was clearly distressed.' [79]

It is difficult to timestamp Ms De Gilio's comment with absolute precision. However, the significance of this evidence was that the family members of Mr Kennedy had identified his cardiac arrest, moments before the paramedics entered the home. Ms Linn said:

> 'I felt it was likely not because of what I saw but of the distress when we arrived. I have a recollection once again of a scream as we arrived. To me, that was at the point where everything changed, say for the family. Everything changed from he needs help to oh my goodness. So, it wasn't so much from what I saw, it was more what I felt and what I heard if that makes sense.' [80]

104 Ms Linn and Mr Baulderstone both described in their evidence that when attending on Mr Kennedy inside the house, it was evident he was in cardiac arrest. They moved him from a room and into the hallway in order to give sufficient space to conduct effective CPR. The commencement of CPR was recorded in the PCR as 00:52.[81] The ECG trace recorded a commencement time of 00:54:14.[82] It is not suggested that Ms Linn and

---

[75] Transcript, page 220
[76] Transcript, page 161 (Baulderstone)
[77] Transcript, pages 187-188 (Linn), 143 (Baulderstone)
[78] Exhibit C15
[79] Exhibit C16 (signed on 6 May 2020)
[80] Transcript, page 215
[81] Exhibit C15
[82] Exhibit C20b

Mr Baulderstone did not undertake every urgent effort to conduct lifesaving medical treatment. They were both impressive witnesses who clearly did their very best to revive Mr Kennedy under difficult circumstances. They were however operating at a handicap, as a result of the nine-minute delay. This timeframe was extremely significant in light of Professor Heddle's expert evidence about whether Mr Kennedy's life could be saved.

Professor William Heddle, cardiologist

105 Professor William Heddle is a senior consultant cardiologist and electrophysiologist, having received his qualification of a Bachelor of Medicine and Surgery from the University of Adelaide in 1972. He received his MD from Flinders University in 1985. He became a Fellow of the Royal Australian College of Physicians in 1980, the Cardiac Society of Australia and New Zealand in 2004 and the Heart Rhythm Society in 2012.

106 Professor Heddle has given evidence extensively in the Coroners Court of South Australia. I consider him to be an expert in his field and have accepted his opinions in their entirety.

107 Professor Heddle explained that when Mr Kennedy was attached to the cardiac monitor, he was identified to be in a rhythm known as ventricular fibrillation. Professor Heddle described this as:

> '… a chaotic rhythm in the ventricle where the heart cells contract in a random way so there's no effective muscle pumping of the heart and blood flow immediately stops.' [83]

108 This is a 'shockable' rhythm for which an automated external defibrillator (AED) can be successful to shock the heart back into normal rhythm. In total, Mr Kennedy received 25 defibrillator shocks before being pronounced life extinct at 2:08am. While this revealed the thorough attempts to resuscitate Mr Kennedy, it was the period of five minutes after he had gone into cardiac arrest that would have seen the best chances of return of spontaneous circulation, according to Professor Heddle. He said:

> 'The five minutes in ventricular fibrillation is the point you start to lose brain function if you have recovery after that. You know, if you get out to 10 minutes, you'll have no recovery to brain function if you have ineffective resuscitation. Under five minutes is the time we think is critical for having had tried effective defibrillation. The other thing, beyond five minutes, your chance of having effective defibrillation goes down. This is in the absence of effective bystander CPR.' [84]

109 Professor Heddle opined that after the period of five minutes,[85] those chances decrease significantly. Due to the nine-minute delay in the Stirling crew being dispatched, with their geographic location being further away from the Kennedy house, the first round of defibrillation fell outside this crucial five-minute timeframe. That was based on the evidence of Professor Heddle who listened to the second triple zero recording between Mrs Kennedy and a call-taker.

110 In the recording, at approximately 00:44, Mrs Kennedy reported that her husband was choking and then snoring.[86] This could also be heard on the audio recording. Professor

---

[83] Transcript, page 264
[84] Transcript, page 280
[85] Transcript, page 264
[86] Exhibit C6a, pages 13-14

Heddle explained that this was likely the time of Mr Kennedy's cardiac arrest. This was further supported by the time the ambulance arrived on scene (00:43), and Ms De Gilio telling Ms Linn, that her father had stopped breathing and to hurry, as well as the paramedics' observations of Mr Kennedy once inside the house. Even with their best efforts, CPR did not commence until 00:52[87] and the earliest defibrillation shock was at around 00:54:14,[88] the latter being approximately 10 minutes after Mr Kennedy suffered a cardiac arrest. The time of the cardiac monitor (for defibrillator shocks to be administered) was precise as it was a time generated by the AED machine.

111 With the Barker crew being available at the latest from 00:35:29 (as reflected in Mrs Q's Event Chronology), the drive to Mr Kennedy's house would have taken, at the most, six minutes. This is based on a Google Maps calculation.[89] Adding to the equation a lights and sirens response, as a Priority 2 would require, this was likely to have been sooner. Allowing for two minutes to alight from the vehicle and adorn PPE, it is conceivable that they would have been inside the house shortly before Mr Kennedy went into cardiac arrest at 00:44 as the evidence as a whole established. With the prompt connection of the AED and knowing that Mr Kennedy was in a shockable rhythm for a period of time, attempts to shock Mr Kennedy's heart into a normal rhythm would have taken place within the crucial five-minute period. This would have provided Mr Kennedy with the best possible chance of survival. This chance was lost as a result of the Mt Barker Crew taking Mrs Q's transfer instead of Mr Kennedy's case.

Preventability

112 In questions posed to Professor Heddle by counsel for the SA Ambulance Service, Mr Ambrose, the pre-morbid condition of Mr Kennedy's heart was an important consideration in relation to the issue of preventability, and that will never be known as an autopsy was not conducted.[90] On the one hand, Mr Kennedy's heart may have been extensively diseased with multiple occluded coronary arteries, requiring open heart surgery. On the other hand, Mr Kennedy may have had just one occluded artery which could have been stented with a minimally invasive procedure. This unknown does impact the ability to assess the preventability of Mr Kennedy's death to a degree.

113 In the absence of the results of an autopsy, there was nevertheless compelling evidence before the Inquest which informed the issue of the preventability of Mr Kennedy's death. I assess the opportunities for prevention as follows.

Before the chest pain

114 Mr Kennedy had not been diagnosed with heart disease of any kind. He had been diagnosed with high blood pressure, which is of course a risk factor for heart disease. Mr Kennedy was prescribed Noten, a common antihypertensive medication. Two years prior to his death, Mr Kennedy had returned an elevated cholesterol level of 6.3 mmol/L.[91] The target range is less than 4.0 mmol/L.

---

[87] Exhibit C15
[88] Exhibit C20b, ECG trace
[89] Exhibit C9, page 1
[90] Transcript, pages 286-288, 504
[91] Exhibit C20a, test undertaken in November 2018

115 Professor Heddle explained that an elevated cholesterol result is a risk factor for acute coronary syndrome, and upon the receipt of this result, an opportunity presented itself for further tests. It is unclear what significance Mr Kennedy attached to this result and that was not a topic explored at the Inquest. However, along with the prescription of statin medication to control cholesterol levels, there is now also a non-invasive test which can illuminate patients at risk of acute coronary events, the CT Calcium scan. This was not readily available in 2020. I will return to this when considering recommendations.

After the chest pain (the brick on the chest)

116 As reported by Mrs Kennedy, on the morning of 15 April 2020 Mr Kennedy complained of experiencing a heaviness in his chest the previous evening. He described it as like a '*brick on his chest*'. He queried whether he might be coming down with the COVID-19 virus. This was at a time when the pandemic was starting to gain momentum in Australia.

117 Professor Heddle opined that had Mr Kennedy acted on this pain in the 18 hours or so following the discomfort, his chances of survival would have been good.[92] The difficulty was that Mr Kennedy did not connect the pain with something as sinister as a heart attack. If he did consider it, he did not articulate that to his wife.

118 While this was an obvious opportunity to have received successful intervention, it was contingent upon Mr Kennedy recognising the symptoms and acting on them. There was no evidence before the Court that he did. There was also a level of fear and uncertainty at the time about the COVID-19 virus and it is entirely plausible that this preoccupied Mr Kennedy's thoughts about the isolated pain he had experienced.

Following the triple zero call

119 Mrs Kennedy contacted triple zero at 00:19:22. In Ms Lynch's mind, Barker 181 were tasked with the case at 00:21:46 subject to clearing. Had Ms Lynch decided not to wait for Barker 181 to clear, the Stirling crew were available. With a lights and sirens response, and a 16-minute distance (at the most), Stirling could have reached the Kennedy residence at or before 00:40. As we now know, this would have been before Mr Kennedy arrested. There were standard emergency treatments that could have been administered for an acute coronary event to improve oxygenated blood flow to Mr Kennedy's heart, thereby potentially preventing his arrest.[93] While I accept Ms Lynch's evidence that she believed Barker 181 had accepted the tasking, this was a missed opportunity.

120 The most compelling opportunity to have prevented Mr Kennedy's death following the triple zero call was if Mr Wilson had not contacted Ms Lynch with the request to be tasked to Mrs Q's case. Had Barker 181 taken the tasking as originally allocated, they would have arrived within the period just before his cardiac arrest. This would have best placed the paramedics to administer preventative treatment (as described above) or shock Mr Kennedy's heart back into a normal sinus rhythm and return spontaneous circulation. Based on the evidence of Professor Heddle, Mr Kennedy's best chance of survival after cardiac arrest was the five minutes immediately following ventricular fibrillation.

121 It is possible that had this occurred, Mr Kennedy's death could have been prevented, in that a return of spontaneous circulation was more likely. However, Mr Kennedy would

---

[92] Transcript, page 273
[93] Transcript, page 180 (Balderstone); page 269 and 278 (Heddle);

then have required emergency transfer to Adelaide in a critically unstable condition. It is difficult to know whether he would have survived this journey as, once again, his pre-morbid cardiac condition is not known.

122 In summary there were clear opportunities to have potentially prevented Mr Kennedy's death. I am unable to elevate it beyond that.

Conclusions

123 The findings I have made are set out in accordance with the issues above. I have come to these conclusions on the basis that I am comfortably satisfied each of them were established on the evidence.

1. Ms Griffiths should not have reassured Mrs Kennedy that an ambulance was '*on its way*' before dispatch had occurred.

2. Ms Lynch should have sought clarification of the specific delay to the availability of the Barker crew so that she could make a sound assessment of the best approach to her dispatch task.

3. Notwithstanding her busy role, Ms Lynch should not have allowed in excess of eight minutes to pass without receiving confirmation that the Barker crew were available.

4. Mr Wilson interfered with the dispatch process. He imparted a preference to be assigned to Mrs Q's case instead of the Priority 2 case (Mr Kennedy's). Mr Wilson should not have intervened in the dispatch process.

5. Ms Lynch should not have entertained Mr Wilson's request to be assigned to Mrs Q's case and should have advised him that he would be assigned to whichever case was most appropriate, particularly when Mrs Q's tasking had not been received.

6. Earlier arrival through either the dispatch of the Barker crew to Mr Kennedy's case, or the immediate dispatch of the Stirling crew, would have seen their arrival at a time before Mr Kennedy's cardiac arrest and his death would have potentially been prevented.

Recommendations

124 Pursuant to section 25(2) of the *Coroners Act 2003* I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

125 A recent advancement in cardiology medicine has seen patients who have an elevated cholesterol level, but are otherwise asymptomatic, be referred for a coronary calcium score. Professor Heddle explained:

> '…I would like to make a comment that I understand that cardiology practice and management of elevated cholesterol has changed over the last five years. And that's relevant because his death occurred in 2022 (sic) and these days if we - I mean, if I see a patient with a cholesterol like that, I'd recommend if they have no symptoms that the patient has what's called a coronary calcium score, which is a rapid CT scan that just looks at the calcium burden. And if it's high, that's a surrogate marker of cholesterol plaque in the heart

> arteries, and if you have this cholesterol, it's a strong indication you need to be treating it. Now that practice was not - I don't think was routine at the time of Mr Kennedy's life and illness.'

126 It is almost always at the general practice level that routine bloods will reveal elevated cholesterol levels, particularly when there are no other symptoms as described by Professor Heddle. A non-invasive CT scan (without contrast) is a simple and efficient way of quantifying the amount of calcium (a component of plaque) in the coronary artery walls.

127 I make the following recommendation directed to the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine:

1) That consideration be given by General Practitioners to routinely referring low to medium risk patients who return elevated cholesterol results, for a CT Calcium score. Particularly those with known family history of coronary artery disease and/or particular lifestyle choices.

128 Taking into account the systemic changes and improvements already implemented, I make the following recommendations directed to the SA Ambulance Service:

1) That paramedics be discouraged from contacting the Operations Centre and advocating for their assignment to particular cases.

2) That dispatchers be reminded of their obligation to assign the most appropriate resource to the most appropriate case, irrespective of any preferences expressed by individual paramedics.

Acknowledgments

129 I wish to acknowledge the excellence of the counsel work of Mr Darren Evans, counsel assisting me.

130 I would like to convey my sincere condolences to the family and loved ones of Mr Kennedy.

131 I acknowledge and understand the guilt Mrs Kennedy has expressed about not choosing to take her husband the short distance to the hospital in their private vehicle. This forms part of the tragic circumstances surrounding Mr Kennedy's death. I feel it is important to reassure Mrs Kennedy and her family that their actions were entirely appropriate given the information they were provided by SA Ambulance Service. I hope that this reassurance provides some comfort to the Kennedy family.

Keywords: Ambulance Delays; Cardiac Arrest