CORONERS COURT OF SOUTH AUSTRALIA

INQUEST INTO THE DEATH OF EMMA LOUISE O'HALLORAN

[2025] SACC 17

Inquest Findings of her Honour Deputy State Coroner Kereru

11 June 2025

CORONIAL INQUEST

Examination of the cause and circumstances of the death of a 48-year-old woman who drove to a regional area and took a deliberate overdose of medication. She was located by police after a significant search effort and detained under the *Mental Health Act 2009*. Following a delay in ambulance attendance she was taken to the Kapunda Hospital where she died. The Inquest explored an issue with the communications between SAPOL and the SA Ambulance Service once she had been found which delayed the arrival of paramedics.

Held:

1. Emma Louise O'Halloran, aged 48 years of Hackham, died at Kapunda Hospital on 20 May 2020 as a result of multiple drug toxicity consisting of flecainide, lorazepam and diazepam.

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

No recommendations made.

Counsel Assisting: MR D EVANS
Hearing Date/s: 29/02/2024
Inquest No: 02/2024 **File No/s: 0989/2020**

This judgment contains discussion of suicide and may be distressing to some people

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INQUEST INTO THE DEATH OF EMMA LOUISE O'HALLORAN [2025] SACC 17

Introduction, cause of death and reason for Inquest

1 Emma Louise O'Halloran died on 20 May 2020 at the Kapunda Hospital. She had been brought to the hospital by SA Ambulance (SAAS) from a remote area following an overdose of prescription medication. She was 48 years old.

2 A post-mortem examination was carried out by Dr Stephen Wills, a forensic pathologist at Forensic Science SA. In his report, Dr Wills gave the cause of death as '*multiple drug toxicity, consisting of flecainide, lorazepam and diazepam*'.[1] I so find.

3 Ms O'Halloran was considered to be in custody at the time of her death. SAPOL officers who were first on the scene considered Ms O'Halloran to be detainable under section 57(1)(c) of the *Mental Health Act* 2009, effectively exercising that power of detention. Because of this, Ms O'Halloran's death was a death in custody within the meaning of that expression in the *Coroners Act* 2003, and this Inquest was held as required by section 21(1)(a) of that Act.

Background

4 Ms O'Halloran was born in Adelaide and adopted as an infant, before reconnecting with her birth parents as an adult. She had a rebellious childhood and moved out of home in her teenage years. At 21 years of age Ms O'Halloran and her partner had a daughter, Alexandra. While in this relationship she began using illicit substances,[2] and there was a self-harm incident related to her substance use around this time.

5 Following her separation from Alexandra's father, Ms O'Halloran commenced a new relationship with Stephen Savenkoff. They had three sons together, each diagnosed with autism with varying degrees of impact, and other conditions. Initially the family lived in Murray Bridge before moving to a farm in Meningie. Here they kept various animals, but largely used the farm for the agistment of cattle. Together, Ms O'Halloran and Mr Savenkoff managed the daily challenges of the children and the farm. Ms O'Halloran was described by her birth mother, Ms Barbara Pedruco, as dedicated to her sons, continually looking for new therapies and ensuring they received opportunities in life.[3]

6 Initially this was a stabilising time in Ms O'Halloran's life. However, there were signs in the years leading up to her death that Ms O'Halloran's mental health was fragile at times and her relationship with Mr Savenkoff was acrimonious. In September 2012, Ms O'Halloran left the farm telling her family that she wanted to '*end it all*', and that she was not coming back. She was reported missing, but returned later that day.[4] In 2018, Ms O'Halloran reported to her doctor that her '*home life was shit*'.[5]

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[1] Exhibit C3a
[2] Exhibit C1a
[3] Exhibit C5, paragraph 14
[4] Exhibit C49b, page 46
[5] Exhibit C49b, page 38

7 Following a knee replacement, Ms O'Halloran's friend, Carol Catanzariti, observed some behavioural and lifestyle changes.[6] Ms O'Halloran was spending more time away from the farm with her brother, and she had resumed smoking and drinking.[7]

8 Ms Victoria Buckeridge was Ms O'Halloran's biological sister. She observed that the relationship between Ms O'Halloran and Mr Savenkoff had become progressively worse over time. They argued a lot and, most significantly, there was a difference of opinion about whether it was appropriate to use medication for the three boys which limited their violent outbursts.

9 In late February or early March 2020, Ms O'Halloran moved in to live with her adult daughter. This was around the time her relationship with Mr Savenkoff ended. She stayed with Alexandra for about six weeks. During this time her daughter observed that she lacked the energy to do things that she had previously enjoyed,[8] although she continued to speak to her sons on the phone each morning and night.[9] Ms O'Halloran then moved from her daughter's home to live with Ms Pedruco at Gawler. COVID-19 restrictions then followed which limited the amount of in-person interaction Ms O'Halloran had with her daughter. They also had a disagreement which strained the relationship.[10]

10 A longstanding friend of Ms O'Halloran, Donna Lewis, saw her on 18 May 2020. Ms O'Halloran told her she was anxious and '*just was not feeling right*'.[11] Ms Lewis discussed with Ms O'Halloran the option of going back on antidepressants, but Ms O'Halloran refused. Ms O'Halloran did in fact see her general practitioner that day and was prescribed lorazepam and diazepam.

11 A few days prior to her death, Ms O'Halloran returned to stay at the farm. The situation deteriorated and reportedly ended with Mr Savenkoff throwing bricks at her car as she drove away.[12]

12 Throughout the morning of 20 May 2020, Ms O'Halloran used her mobile phone to conduct several searches on the internet. The phrases that she searched were:

- Concerta risperidone overdose
- Risperidone overdose
- Carbon monoxide poisoning
- Carbon monoxide poisoning from car
- What happens with carbon monoxide from car poisoning[13]

SAPOL later found the medication risperidone in Ms O'Halloran's bedroom at Ms Pedruco's house.[14] It had been prescribed to Ms O'Halloran's son.

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[6] Exhibit C18
[7] Exhibit C18
[8] Exhibit C1a, paragraph 35
[9] Exhibit C1a, paragraph 107; Exhibit C18, paragraph 8
[10] Exhibit C1a, paragraph 43
[11] Exhibit C19
[12] Exhibit C6, paragraph 21
[13] Exhibit C49b, page 66
[14] Exhibit C40

13 From the information obtained from Ms O'Halloran's mobile phone it was apparent that she had been contemplating suicide. She was dealing with several personal issues. This manifested in a clear intention on the morning of 20 May 2020.

Ms O'Halloran's relevant medical history

14 Ms O'Halloran had ongoing issues with her knees which led her to have gastric bypass surgery in early 2019 as a preliminary step to allow for knee surgeries to safely occur. In her last 18 months of life, Ms O'Halloran lost approximately 80 kilograms of body weight. She had a total replacement of her left knee on 9 January 2020, followed by two minor surgeries in February and March 2020.

15 Ms O'Halloran's general practitioner, Dr Deborah Kerrigan, had previously prescribed sertraline and venlafaxine for depression, but Ms O'Halloran found that neither helped her and she ceased using them.[15] Dr Kerrigan prescribed lorazepam to deal with Ms O'Halloran's anxiety. Dr Kerrigan said that she had offered referrals to a psychologist and a psychiatrist, but Ms O'Halloran had refused.[16] She reported that she had previously seen a psychiatrist once in 2018 and did not wish to visit again.

16 Dr Kerrigan said that Ms O'Halloran had a recorded history of anxiety and depression dating back to 2017. She reported symptoms of self-worthlessness and difficulty coping. Dr Kerrigan said that, at the time of her death, Ms O'Halloran was suffering ongoing depression associated with her relationship and the care of her three sons.[17] While she had recently reported that she had moved out of her home and felt burnt out, she had never indicated any intention to self-harm.[18] Dr Kerrigan asked Ms O'Halloran whether she wished to see a psychologist following her departure from the family home and Ms O'Halloran again refused.

17 Relevantly, Ms O'Halloran was prescribed a medication named flecainide at the dose of 50mg in 2020.[19] This was following a presentation to the Lyell McEwin Hospital for symptoms of dizziness and a slow pulse. Following examination she was discharged, but the following morning she presented to the Ashford Hospital by ambulance and was assessed by cardiologist, Dr Fahd Chahadi. Dr Chahadi diagnosed Ms O'Halloran with ventricular bigeminy, a common heart rhythm abnormality. She was first prescribed a beta blocker which was changed to flecainide.[20] Following her hospital admission, Ms O'Halloran saw Dr Chahadi for a follow-up appointment on 15 May 2020. Ms O'Halloran spoke of her relationship breakdown and the compounding difficulties of children who had disabilities. Notwithstanding the discussion of these issues, Dr Chahadi did not consider her to have any outward signs of depression and there were no indications of self-harm.[21] I note here that Ms O'Halloran was seeing Dr Chahadi for his specialist cardiology services, not for a mental health assessment. He provided Ms O'Halloran with a further prescription for flecainide with instructions to take a maximum of two per day.

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[15] Exhibit C16
[16] Exhibit C16, paragraph 13
[17] Exhibit C16, paragraph 9
[18] Exhibit C16, paragraph 17
[19] Exhibit C17, paragraph 15; Exhibit C49R; Exhibit C49K
[20] Flecainide works by blocking sodium channels in the heart, slowing down the electrical signals that cause heartbeats
[21] Exhibit C17, paragraphs 20-21

The circumstances leading to Ms O'Halloran's death

18 On 20 May 2020, Ms Pedruco observed that Ms O'Halloran had woken up with a depressed mood. Ms Pedruco travelled to Adelaide to visit her son, however contacted Ms O'Halloran upon arrival to check on her. Ms O'Halloran told her that she had just filled a prescription and was going for a drive. CCTV footage and pharmacy records revealed that Ms O'Halloran filled prescriptions for 50 tablets of lorazepam, 50 tablets of diazepam and 60 tablets of flecainide at about midday.[22] The footage showed her interacting with pharmacy staff and smiling.[23] After leaving the chemist she was seen heading in the direction of Bunnings. At around this time Ms O'Halloran used her mobile phone to search the internet with the question '*does carbon monoxide poisoning hurt*'.[24] Records showed that she contacted and spoke to Mr Savenkoff.

19 Mr Savenkoff called emergency services just after 1pm. He informed them that he had spoken to Ms O'Halloran about 45 minutes earlier, with her reporting that she was intending to take pills and gas herself in her car. He had been unable to contact her since the call ended. He reported that he had told her that the tubing would melt, and she had responded '*well that's no good then*'.[25]

20 An 'event' was created in SAPOL's computer aided dispatch system (SACAD); a digital system for managing the dispatching of police officers to incidents across the State. The event was initially managed by the Hills Fleurieu and Barossa dispatcher, Senior Constable Cathryn Fearn.[26] SAPOL patrols were dispatched over radio. A phone triangulation commenced in respect of Ms O'Halloran's phone, and it returned a result that it was in the vicinity of Black Springs, a town south of Burra and east of Clare. At 1:37pm, Ms O'Halloran sent identical text messages to her mother, brother and sister which said, '*I'm sorry and I love you all*'.[27]

21 Brevet Sergeant Michael Fidock was on duty and heard the dispatch broadcast. He phoned Ms O'Halloran's mobile and spoke to her. He was not able to obtain information about her location. He spoke with other police officers and then called her back to ask her to use her phone to locate herself on a map. She was not able to do so. She mentioned that she had had a '*crash*'.[28]

22 In the meantime, Ms Pedruco received a call from Mr Savenkoff. He informed her that Ms O'Halloran said she was down a country road, had alcohol and was going to take all her pills. Over the next couple of hours Ms O'Halloran spoke to members of her family over several calls. In affidavits tendered to the Court, these family members described Ms O'Halloran as incoherent, slurring her words and crying.[29] She told Mr Savenkoff that she had taken an entire bottle of Valium.[30] Ms O'Halloran's daughter and Ms Buckeridge tried to assist her to find her location on Google maps, but neither was successful. Mr Savenkoff contacted police six times with updates.

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[22] Exhibit C14
[23] Exhibit C49a, paragraphs 42-44
[24] Exhibit C49b, paragraphs 45-46
[25] Exhibit C42
[26] Exhibit C45, paragraphs 8-45
[27] Exhibit C49b, page 67
[28] Exhibit C24
[29] Exhibit C6, page 5
[30] Exhibit C43

23 The search for Ms O'Halloran had called in officers from two local service areas. As a result, at 2:37pm, a second event was created in SACAD and linked to the first.[31] All the text remarks that had been entered into SACAD until that point were carried over from the first event to the second. The location of the new event was recorded as the Barrier Highway at Black Springs. The event was assigned for management by the Murray Mallee, Limestone Coast and Yorke Mid North dispatcher, Senior Constable Simon Steer.

24 Ms O'Halloran's brother, Vincent Pedruco, had possession of Ms O'Halloran's iPad, which was linked to her phone. He was able to use that to track her location and advise Mr Savenkoff who rang SAPOL at 2:58pm and provided the address. Ms Pedruco also contacted police with the information. The phone's location was Prior Road at Marrabel, about 30 kilometres south of Black Springs. At 2:59pm both SACAD events were updated with a text remark noting that the location had been reported. However, the formal location of the events were not updated.[32] The triangulation was repeated at 3:03pm and this time showed the location of Marrabel. At about 3:18pm, police radio records revealed the following interaction:

'Brevet Sergeant Fidock	Given the fact that she's stated she's had a 201[33], I think we probably need to get ambos rolling, even though we don't have a location yet.
Operator	No. That's fine. Obviously they're going to want to know where to go, and I don't know where to send them.
Brevet Sergeant Fidock	If you send them to Marrabel at this stage I think. Looks like we'll be definitely in that area somewhere. I think once we get all three of us police there, we'll be in a better position to start searching.
Operator	Roger. I'll definitely let them know and get them rocking and rolling. Thanks. Patrols - Just standby while I try and get this organised.' [34]

25 At 3:21pm, Senior Constable Simon Steer created an InterCAD job. InterCAD is a system which provides an interface between the digital dispatch systems for SAPOL, SAAS and the Metropolitan Fire Service. The result was that SAPOL systems notified SAAS of the incident at 3:21pm through InterCAD. The event comments up to that point were then visible to SAAS, although only 4000 characters were shared.[35] Senior Constable Steer shared the following remark with SAAS:

> 'CAN I JUST MAKE YOU AWARE OF A CHECK WELFARE THAT MAY NOW HAVE TURNED ITO [sic] A CRASH SOMEWHERE IN THE AREA OF MARRABEL – WE HAVE 3 PATROLS LOOKING FOR THE FEMALE – SHE STATES SHE HAS TAKEN A LOAD OF VALIUM AND ALSO BEEN INVOLVED IN A MVC' [36]

26 SAAS opened an event on their system but did not dispatch an ambulance as Ms O'Halloran had not yet been located.[37] The records revealed that SAAS

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[31] Exhibit C45, paragraph 43
[32] Exhibit C45, paragraphs 38-39; paragraph 45
[33] Code for vehicle collision
[34] Exhibit C28; Exhibit C36 MFO1a
[35] Exhibit C45, paragraphs 50, 55
[36] Exhibit C45, paragraph 54
[37] Exhibit C21

acknowledged the InterCAD message and indicated they would wait to be informed of the location. Senior Constable Steer then announced on the radio:

> 'And those patrols on the Black Springs job. SAAS are aware. Obviously, they're just waiting for a proper location. But they're aware.'

Senior Constable Steer then made enquiries about PolAir assisting in the search.

27 Senior Constable Andrew Dredge was on duty at Freeling. He saw the location provided by Ms O'Halloran's brother and had local knowledge of that area. He drove to the location, arriving at about 3:40pm, finding Ms O'Halloran in her car near the intersection of Prior and Roehr Roads. He advised SAPOL Communications. The first SACAD event was updated with an entry that Ms O'Halloran had been found.[38] Senior Constable Dredge remained on the Hills Fleurieu and Barossa channel briefly. He spoke to Senior Constable Fearn who confirmed the location with Senior Constable Dredge, asked for further observations and said, '*We'll get SAAS rolling to you*'.[39] Senior Constable Dredge was then referred to Senior Constable Steer's channel. Senior Constable Steer made an announcement of the location to the other officers searching. He said:

> 'I'm just getting all the details from that job and trying to link them altogether and then I'll get SAAS rolling to that location.' [40]

28 From that point on police officers at the scene and in the vicinity believed that an ambulance had been tasked to attend.

29 At 3:40pm Senior Constable Fearn updated the first event's formal location to Prior Road at Marrabel and transferred the event to Senior Constable Steer. No event comments from this event were shared with SAAS via InterCAD.[41] Senior Constable Steer took over management of both SACAD events and closed the first, merging it into the second.[42] This resulted in the entire 'event remarks' of the first event being duplicated into the second event,[43] thereby creating an additional five pages of text[44] being added to the event all at once.[45] This overwhelmed the system and resulted in a break in the InterCAD link for this event. There was no warning or notification of the failure of the link.

30 At 3:44 pm Senior Constable Steer updated the event entry for the now combined event intending to notify SAAS that Ms O'Halloran had been located, writing '*FEMALE IS PRIOR RD- ROEHR*'.[46] He received no response. At 3:46pm, he provided further updates intended for SAAS that there had possibly been a crash and that it was believed Ms O'Halloran had taken medication. He provided a phone number for Senior Constable Dredge. He received no response. Senior Constable Steer assumed that these messages would have been delivered through InterCAD and then dealt with other taskings, messages and outstanding issues regarding other tasks.[47] He stated that it was not unusual

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[38] Exhibit C45, paragraph 40
[39] Exhibit C27, Attachment 1, page 11
[40] Exhibit C28, page 7
[41] Exhibit C45, paragraph 50 and Annexure A pages 7-8
[42] Exhibit C45, paragraph 39
[43] Exhibit C45, paragraph 60
[44] When printed
[45] Exhibit C45, Annexure B
[46] Exhibit C45, Annexure B
[47] Exhibit C28, paragraph 27

to be dealing with the dispatch and coordination of over 120 patrols on an afternoon shift.[48] The area covered by his station included the entirety of Murray Bridge, Port Pirie and Mount Gambier as well as other smaller bases. Subsequent analysis of the actual workload at the time of this incident revealed that Senior Constable Steer was managing more than 70 patrols and dealing with 40 events every five minutes between 2pm and 7:30pm.[49]

31 Chief Inspector Scott Collins was the State Response Manager at the time, with statewide management of SAPOL resources and the monitoring of police-related events at the time. He reviewed the Communication Centre's activities for 20 May 2020. He explained that country areas are serviced by a single dispatch officer unless specific times of demand call for a dual dispatch arrangement. Further, there is an overflow dispatcher with whom at any point in time the workload of a country dispatch officer can be split.[50] Chief Inspector Collins stated that training on the Communication Centre Dispatch Standard Operating Procedure (SOP) mandated a phone call to other agencies if they had not responded in a timely fashion to information provided through InterCAD.[51] He explained that the SOP dictates, '*All dispatchers have a responsibility to ensure InterCAD events are read as soon as possible*'.[52]

32 When Senior Constable Dredge arrived at the accident scene he observed the front bumper of Ms O'Halloran's car to be detached and on the opposite side of the road to the car. The airbags had been deployed.[53] Ms O'Halloran had a small graze to her chin consistent with the deployment of the airbags.[54] Ms O'Halloran was holding a can of premixed vodka in her left hand and at least six small white round tablets in her right. Senior Constable Dredge knocked the tablets out of her hand and poured out the can of drink. He observed Ms O'Halloran to be drowsy.[55] She asked whether she was going to be arrested, and Senior Constable Dredge reassured her that she was not. He told her, '*we're just waiting for an ambulance to check on you and make sure you're ok*'.[56] She asked whether she would be taken to the '*Nutter Department at the Royal Adelaide*'.[57]

33 Senior Constable Dredge enquired about the graze on Ms O'Halloran's chin, and she indicated towards the airbag.[58] Senior Constable Dredge mentioned the bumper bar to Ms O'Halloran, and she got out of the car walking towards the bumper. He observed her to be unsteady on her feet, almost falling, but being caught by Senior Constable Dredge. He helped her up and led her back to the car. He then collected the bumper bar and placed it in the back seat of the car.

34 Senior Constable Dredge removed the following from Ms O'Halloran's car:

- An empty bottle of 50 tablets of 5mg diazepam, dispensed on 20 May 2020

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[48] Exhibit C28, paragraph 6
[49] Exhibit C45, Annexure F; Exhibit C45a, paragraph 63
[50] Exhibit C44, paragraph 6
[51] Exhibit C44, paragraph 8
[52] Exhibit C44, paragraph 9
[53] Exhibit C23, pages 2-3
[54] Exhibit C23, page 6
[55] Exhibit C35, paragraph 3
[56] Exhibit C49d, page 4; Exhibit C35, Annexure A, pages 5 and 10
[57] Exhibit C49d, page 4
[58] Exhibit C35, page 4

- An empty bottle of 50 tablets of 1mg lorazepam, dispensed on 20 May 2020
- Two boxes of 60 tablets of 50mg flecainide, one dispensed on 20 May 2020 with 27 remaining, the other dispensed at an earlier date and empty [59]

35 Later examination of the car found 13 small white pills in the driver's side footwell, another on the driver's seat and four on the passenger seat.[60] There were two cans of premixed vodka (one unopened) in the car and two empty cans on the roadside.

36 Shortly after 4pm, Brevet Sergeants Fidock and Haines arrived at the scene. While waiting for the ambulance Ms O'Halloran's car was moved off the road for safety.[61] Ms O'Halloran then sat in the passenger seat and applied makeup from cosmetics that were in the car and then packed them up.[62] Brevet Sergeant Fidock described Ms O'Halloran as '*vague, like fatigued as if she was on, you know, clearly on something, but, but friendly*'.[63] At one point she opened the boot of the car and showed the officers that she had a length of flexible ducting and duct tape, still in its packaging.[64] She remained unsteady on her feet.[65] She stated that she had planned to use it to redirect the exhaust gases into the car to kill herself.

37 During this time Ms O'Halloran spoke to Ms Pedruco on a police officer's phone, as her phone battery was flat. She told Ms Pedruco that she had crashed her car, and they spoke about going to hospital.

38 Senior Constable Dredge stated that they requested ambulance attendance on a '*couple of occasions*'. When interviewed, he said that he considered taking her to the hospital in the police vehicle, but did not think it was appropriate and thought that the ambulance would arrive soon.[66] At 4:24pm the officers with Ms O'Halloran asked for an update on the arrival of an ambulance by inputting text into SACAD via the terminal in the police vehicle.[67] As there had been no ETA entered by SAAS onto the event in the dispatch system, Senior Constable Kurt Edwards at the SAPOL Communications Centre rang SAAS by phone. This marked the first occasion on which SAAS became aware that Ms O'Halloran had been located.

39 At 4:33pm SAAS responded via InterCAD with '*CALL FROM SAPOL COMMS @1632 UPDATING LOCATION*'. The SAAS event priority was changed to P2 which required a 'lights and siren' response. Two minutes later a page was sent to the Kapunda crew. There was no acknowledgment, and a second page was sent at 4:36pm. At 4:38pm, the SAAS Coordinator phoned the Kapunda Station and received no response. At 4:39pm, the SAAS Coordinator phoned one of the crew members on their personal phone number. He received an engaged tone. At 4:43pm, the SAAS Coordinator used the radio network to contact the Kapunda crew who acknowledged the communication and were advised of the tasking. At 4:45pm, they acknowledged the event on their device. There was therefore an 11-minute delay between the tasking and the acknowledgment. A SAAS

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[59] Exhibit C23, page 4
[60] Exhibit C33, page 5; Exhibit C46, paragraph 15
[61] Exhibit C36, page 6
[62] Exhibit C35, page 4
[63] Exhibit C36, page 14
[64] Exhibit C33, page 6; Exhibit C36, page 5
[65] Exhibit C3, page 14
[66] Exhibit C35, Annexure STO1A pages 15 and 17
[67] Exhibit C45, paragraph 63

dispatcher recorded in the InterCAD comments at 4:45pm '*MULTI PAGER FAILURES TODAY*'.[68]

40 Paramedic Tracy Callanan was on duty at Kapunda. She expressed her surprise to hear that there had been an emergency callout as her pager had not gone off in accordance with protocol.[69] She recalled that this had also occurred earlier in the same shift.

41 Just before 5pm, police with Ms O'Halloran at Marrabel saw that she appeared to lose consciousness and was unable to be roused. She was observed to be breathing but was struggling. Another request for an ambulance was made and the SACAD event remarks were updated. SAAS updated in response that they were five minutes away. The officers kept Ms O'Halloran in the car given the cold temperatures outside. Bureau of Meteorology records from the nearest weather station, Nuriootpa, recorded an air temperature of 12.8°C at the time with a 28 kilometre per hour wind.[70]

42 The ambulance departed Kapunda station and travelled to the intersection of Prior and Roehr Roads at Marrabel, arriving at 5:09pm. Ms O'Halloran was in the front passenger seat. She was blue, unconscious and had no radial pulse. Her respiratory rate was low, and she was breathing with poor effort. Given the cold and windy conditions, and the amount of dust in the air, Ms Callanan made a clinical decision to commence Ms O'Halloran's treatment in the car.

43 Ms O'Halloran was bagged and masked[71] and then removed from the car and placed onto a stretcher which was loaded into the ambulance. Senior Constable Dredge drove the ambulance towards the Kapunda Hospital, which was 23 kilometres away.[72] This allowed both SAAS members to focus on Ms O'Halloran. They had to stop during the trip as Ms O'Halloran went into ventricular tachycardia. A defibrillator was used to deliver an electric shock at 5:28pm but was not effective. Brevet Sergeant Haines got into the back of the ambulance and assisted with CPR under Ms Callanan's direction.[73] Further shocks and CPR were continued as the ambulance resumed its route.

44 They stopped a second time to onboard an experienced paramedic from another ambulance to take over from Brevet Sergeant Haines. Fifteen minutes later they again stopped for another experienced officer to board the ambulance. The journey was slow due to a combination of weather conditions consisting of heavy rain and wind, and the need to keep the ambulance stable for treatment to continue. They arrived at Kapunda Hospital at 6:08pm. By this time there had been a total of four shocks and 3mg of adrenaline administered.

45 As the ambulance made its way to Kapunda, so too did MedSTAR officers, including Associate Professor Hooper, a senior medical retrieval consultant. Their journey was by road due to the inclement weather, described by Associate Professor Hooper as '*atrocious and punishing*'.[74] They arrived at Kapunda Hospital at 6:11pm.

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[68] Exhibit C45, Annexure B, page 13
[69] Exhibit C7, paragraph 8
[70] Exhibit C49s, pages 2 and 8
[71] A process of providing a high level of oxygen
[72] Exhibit C49b, page 57
[73] Exhibit C24, paragraph 20
[74] Exhibit C12, paragraph 14

46 Upon arrival at the hospital, Ms O'Halloran had a momentary return of spontaneous circulation and a palpable radial pulse, however it was not sustained. She was occasionally attempting to breathe on her own. Doctors administered medication to try to reverse the effects of the flecainide. Intermittent brief improvements in heart rhythm were observed. After more than 90 minutes of CPR, and a further four shots of adrenalin and other medications, Ms O'Halloran's blood gas results indicated a worsening of her condition. Alternative treatments were considered, but were not viable, and CPR was ceased. Ms O'Halloran was pronounced life extinct at 7:08pm.

Was Ms O'Halloran's death preventable?

47 In the opinion of Associate Professor Hooper, Ms O'Halloran's blood gases on admission to hospital were acceptable, which was a sign that effective CPR had been commenced in a timely manner.[75] Associate Professor Hooper opined that if it was not for the catastrophic cardiac toxicity from the flecainide overdose, her condition would have been potentially reversible. He explained that he was shown Ms O'Halloran's heart rate rhythm strip at the time of cardiac arrest by the intensive care paramedic. It revealed a specific type of abnormal heart rhythm often associated with drug toxicity, 'Torsades de pointes'. Associate Professor Hooper explained:

> '… from the information available to me, I was able to ascertain the patient had consumed between 50-70, 50mg flecainide tablets. In my opinion at the time, this amount is way beyond a lethal dose.' [76]

48 Dr Chahadi agreed with this opinion. He stated that while flecainide was one of the safest anti-arrhythmic medications available when taken in therapeutic doses, 500mg taken at once would be a fatal overdose that no outpatient medical intervention could prevent.[77] Given that there were thirty-three 50mg tablets missing from the quantity dispensed on 20 May 2020, potentially minus the 18 found in the car, it appeared that Ms O'Halloran had ingested at least 750mg. However, she may have consumed a greater quantity from earlier prescription. Dr Chahadi indicated that treatment for a potentially fatal dose of flecainide would include aggressive electrolyte replacement and an infusion of hypertonic sodium bicarbonate. Ms O'Halloran received this treatment at the Kapunda Hospital.[78]

49 Analysis of a post-mortem blood sample returned a result for flecainide at 8.7mg/L, a concentration within the range reported in previous fatalities attributed to that drug, albeit towards the lower end of that fatal range. The sedative drug lorazepam was found at 0.3mg/L, a concentration consistent with levels reported in previous deaths. The sedative drug diazepam was detected at 0.56mg/L, a therapeutic level, with its metabolite also found. Other drugs consistent with the medical intervention were identified. There was no alcohol detected.

50 Based on the ingestion of a fatal level of flecainide, and in combination with an overdose of other drugs, I find that Ms O'Halloran's death was not preventable. This was notwithstanding the delay experienced with the arrival of SAAS.

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[75] Exhibit C12, paragraph 20
[76] Exhibit C12, paragraph 19
[77] Exhibit C17, paragraph 28
[78] Exhibit C13

Conclusions

Detention

51 When interviewed, Senior Constable Dredge said that if Ms O'Halloran had tried to leave, he would have detained her until her physical and mental health was assessed.[79] He said that he had also formed the impression that she had probably been driving under the influence, but that he was more concerned about her mental health status.[80] Brevet Sergeant Fidock said that while at the scene they had treated it as a '*section 56 or 57 depending on what SAAS were going to do*'.[81] When interviewed he said that Ms O'Halloran was essentially detained as they would not have let her go anywhere if she had asked.[82] By the time police arrived, Ms O'Halloran had presented ample circumstances of concern about her mental health which necessitated a detention for the purposes of assessment by medical officers.

52 Ms O'Halloran was therefore in the lawful custody of police leading up to her death. The care and concern shown by the officers who responded to and remained with Ms O'Halloran until SAAS arrived, was commendable.

SAAS delays

53 There were two issues that require consideration relating to the response of SAAS.

54 SAAS records revealed that there were no updates to SAAS between the initial event creation at 3:21pm and 4:32pm, when SAAS received the phone call from SAPOL advising that Ms O'Halloran had been found and her location. That was 48 minutes after she had been located. Senior Sergeant Neil Anderson, the SACAD Coordinator, stated that the comments entered into the event which recorded Ms O'Halloran's location were not shared with SAAS '*…due to the complexity and duplication of extensive event remarks, the process that sends this information failed to complete*'.[83] This was likely due to the 4000 character limit on the InterCAD system which was exceeded when the first event was merged into the second, duplicating all text up until that point.[84] Senior Sergeant Anderson said that the incident identified a:

> '…training gap in relation to operators following up with other agencies when they provide them with an update, particularly where that updated [sic] is expected to be actioned, such as an event location change or request for attendance.'

He explained that this has never been formally included in training documentation.

55 Senior Sergeant Tracey Brett, the Communications Group Training and Planning Coordinator, provided an update to the Court. She advised that on 4 August 2020 an email was sent to all Communications Centre staff advising of the issue with duplicated text and advising dispatchers to ensure a confirmation that information sent through InterCAD had been received.[85] The email was sent by Senior Sergeant Anderson. In

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[79] Exhibit C35, Annexure STO1A, page 19
[80] Exhibit C35, Annexure STO1A, page 23
[81] Exhibit C36, page 6
[82] Exhibit C36, page 6
[83] Exhibit C45, paragraph 71
[84] Exhibit C49b, page 62
[85] Exhibit C59, paragraph 14

addition, she provided an extract of the Standard Operating Procedure which refers to this requirement.

56 The SAPOL investigating officer, Senior Constable Dredge, made a recommendation for a review to be conducted in relation to the Communication Centre's workload and processes. Chief Inspector Collins indicated that those reviews were conducted.

57 The second issue was the delay in SAAS dispatching an ambulance once they received notification that Ms O'Halloran had been located.

58 The SAAS Dispatch Team Leader caused a review to be conducted on 21 May 2020. A technician sent to the Kapunda Station found that the National Broadband Network line had been disconnected from the modem. Once this was rectified, the phone services to the station were restored.[86] It remains unknown how this came to be disconnected. A sign has since been placed near the modem warning that the cabling must not be disconnected.[87]

59 The pager system used by paramedics is operated through the South Australian Government Radio Network. The technician found that the signal strength for the radio network at the station was low outside and poor inside. Since this incident, the pagers have been replaced with newer versions which are more sensitive to paging activity, with improvement noted.[88] There has been a protocol change which requires the on-duty crew to take a handheld radio from the ambulance into the station with them and leave it turned on. They are required to leave the garage door open with the alarm on the terminal inside the ambulance turned to maximum volume. SAAS have actioned plans to install a paging amplifier at the Kapunda Station. This will activate lights and sirens within the station when a pager alert is received. SAAS have introduced a text-to-mobile-phone procedure for Kapunda that sends a text message to the on-duty paramedic at their personal number when a pager alert is activated. There is then a protocol for a follow-up call if there is no response within three to four minutes. Since the implementation of these measures, there have been no reports of pager failure at the Kapunda Station.[89] SAAS has made a request to the SA Government Radio Network to add another tower at Wild Dog Hill to increase the paging coverage at Kapunda, as the local tower has no paging ability and Kapunda relies on a tower further away for paging signals.

60 I consider that the action taken by SAAS to address both issues above are appropriate and sufficient.

61 It was certainly undesirable that the breakdown in the InterCAD and paging systems saw a cumulative delay in expert medical assistance for Ms O'Halloran. This did not however alter the tragic outcome for Ms O'Halloran.

62 I once again acknowledge the excellent police work involved in finding and supporting Ms O'Halloran until the arrival of SAAS. I further acknowledge the valiant efforts of both police and SAAS officers in retrieving Ms O'Halloran to the Kapunda Hospital in challenging weather conditions. Once at the Kapunda Hospital, the treatment which

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[86] Exhibit C21, paragraph 13
[87] Exhibit C21a, paragraph 5
[88] Exhibit C21a, paragraphs 6-7
[89] Exhibit C21, paragraph 9

Dr Chahadi said was required to reverse the toxic effect of flecainide was administered but unable to prevent her death. Dr Chahadi stated that flecainide is absorbed into the bloodstream quickly and causes malignant arrhythmia, or total cardiovascular collapse. As I have outlined above, it was unlikely that Ms O'Halloran's death would have been prevented if the InterCAD and SAAS systems (notification and dispatch) worked as they should have. This position is supported by the opinion of Associate Professor Hooper, who expressed the view that Ms O'Halloran's situation might have been reversable if it were not for her catastrophic cardiac toxicity from flecainide.

Recommendations

63 I make no recommendations in this matter.

Keywords: *Death in Custody; Police; SAAS; Drug Overdose*