IN THE CORONERS COURT OF THE NORTHERN TERRITORY

Rel No: D0008/2026

Police No: 26 5388

CORONERS FINDINGS

*Section 34 of the **Coroners Act 1993***

I, Elisabeth Armitage, Coroner, having investigated the death of **a 75 year old female** and without holding an inquest, find that she was born on **28 June 1950** and that her **death occurred on 16 January 2026, at Royal Darwin Hospital in the Northern Territory.**

Introduction

According to St John NT, demand growth for ambulance services in the Northern Territory has significantly outpaced funding. As demand has increased response rates have become slower due to insufficient staffing levels to manage demand.[1] These findings describe one experience of ambulance delay on 9 January 2026.

This elderly patient fell at her aged care home and waited for an ambulance response for close to 1 ½ hours. It was the opinion of the forensic pathologist who reviewed her medical records that the ambulance delay **did not** contribute to her death.

Following an operational review St John NT advised that this delay was not caused by incorrect prioritisation, but by concurrent emergency demand and the absence of an immediately available, clinically appropriate ambulance resource.

Cause of death

1(a)	Disease or condition leading directly to death:	**Acute subdural haematoma**
1(b)	Morbid conditions giving rise to the above cause:	**Blunt force head trauma**
1(c)		**Reported fall**
1(d)		**Anticoagulant therapy, frailty**

[1] St John Media Release 29 March 2026 "Ambulance service at critical response level".

Following a careful review of all medical records the forensic pathologist was of the opinion that the head injury suffered in the fall was unsurvivable. Her rapid clinical deterioration was consistent with the severity of her head injury and the delayed ambulance response did not contribute to her death.

Background

The deceased was born in and grew up with her large family in the Philippines. She married and moved to Australia. She had a son in 1983. When her husband passed away she did not remarry but was supported by her many friends and her son when he grew up.

On 6 January 2025 she had a fall and suffered a head strike. There were concerns about memory impairment and decline in mobility. She was admitted to Royal Darwin Hospital (RDH) and was discharged on 14 January 2025.

On 15 January 2025, she was re-admitted as she was unable to mobilise at home. The treating team requested further allied health input as it was unsafe for her to be discharged home again due to her mobility and cognition issues. On 16 January 2025, she was transferred to the Aged Care Unit in Palmerston Regional Hospital (PRH) for ongoing assessment and rehabilitation. Hospital based care continued and confusion, memory issues, cognitive impairment and a shuffling gait were all documented.

On 11 July 2025, she was discharged from PRH to out of hospital care at Carpentaria. On 30 July 2025, she was reviewed by a Geriatrician who noted that she was walking with a 4 x wheel walker, there were no recent falls, and she was independent with activities of daily living (ADLs). On 7 August 2025, she was reviewed by the Neurosurgery team who documented some confusion and loss of hearing.

On 18 November 2025, she was admitted to a nursing home as it was not safe for her to live at home. She was under Public Guardianship for medical matters.

Circumstances

On 9 January 2026, at approximately 16:45pm she was standing and reading a newspaper in the lounge area of her nursing home when she had a witnessed fall with head strike. She was lying supine and she was dizzy. She suffered slight bleeding and a lump to the left posterior of her head. It was reported that she did not lose consciousness. She was moved to a nursing station for close monitoring. Her son was notified of the incident and he requested that his mother be sent to hospital.

Staff contacted 000 at 17:05pm. Several further calls were made between staff and St John Ambulance to monitor her condition and seek updates on the ambulance response. A critical response unit arrived first at 18:33pm, followed by the emergency crew at 18:59pm. She was then transported to hospital, arriving at the emergency department at 19:19pm.

She underwent a CT Brain which demonstrated a large acute right subdural haematoma with significant mass effect leading to midline shift of 19mm. The brain injury was deemed unsurvivable by the neurosurgery team. At 22:15pm she was admitted to the Intensive Care Unit for organ support pending family discussions. On 10 January 2026, the treating team extubated her at 20:35 hours and she was transitioned to end of life care for transfer to palliative care. On 11 January 2026, she was admitted to the Palliative Care Unit and given comfort care.

On 16 January 2026, at 3:40am she passed away with her son by her side.

St John NT – Review

Her son raised concerns about the delay in responding to her fall. The Coroner's Office made enquiries with St John NT regarding the prioritization of the emergency calls and the reasons for any delay in ambulance dispatch.

In response, St John NT conducted a comprehensive review of the incident, including the call records, event chronology, Medical Priority Dispatch System (MPDS) quality assurance reviews, and ambulance resource availability at the relevant time.

On 13 July 2026, St John provided a response which set out the following chronology of events.

At 17:05pm nursing home staff contacted 000. The call was triaged as a 'Priority 2', requiring an emergency ambulance response within 30 minutes.

At 17:45pm, St John NT attempted to contact the nursing home to obtain an update on the patient, but was placed on hold for over 4 minutes. The call was disconnected so that contact could be re-established, however the St John dispatcher was subsequently required to respond to another incoming 000 call.

At 17:47pm, nursing home staff made a further 000 call reporting reduced responsiveness and the case was upgraded to 'Priority 1', requiring an ambulance response within 15 minutes.

At 17:59pm, a further call-back identified ongoing deterioration, but the call was discontinued as another dispatcher was already actively triaging the case through the 5.47pm 000 call.

At 18:24pm, St John NT again attempted to contact the nursing home but was placed on hold for more than 3 minutes and disconnected to remain available for incoming emergency calls.

At 18:24pm, nursing home staff made a further 000 call. The case remained a Priority 1.

At 18:29pm the first clinically appropriate available resource, a Critical Response Unit staffed by an Intensive Care Paramedic, was dispatched. The Critical Response Unit arrived at 18:33pm, and a transporting emergency ambulance crew was subsequently dispatched and arrived at the facility at 18:59pm.

At 19:15pm the ambulance departed the nursing home and transported her to RDH, arriving at the emergency department at 19:19pm.

St John NT advised that the delay in dispatch was attributable to the level of concurrent emergency demand and the absence of an immediately available, clinically appropriate, ambulance crew.

St John NT advised that when the patient's condition deteriorated and the case was upgraded to Priority 1, approximately five other Priority 1 incidents were also pending an emergency ambulance response. The Critical Response Unit was therefore dispatched as soon as it became available as the first clinically appropriate response. A transporting emergency ambulance was also allocated when an appropriate crew became available. The review found that the initial Priority 2 classification and subsequent upgrade to Priority 1 were consistent with MPDS and St John NT procedures.

St John NT advised that the delay was not attributable to an incorrect priority allocation but arose from concurrent higher-acuity demand and the limited availability of appropriate ambulance resource.

ST John NT were afforded an opportunity to consider a draft of these and two other findings and were invited to provide any further evidence or response

By letter dated 31 August 2026 St John advised as follows:

> Thank you for the opportunity to provide further information in relation to the draft findings concerning these three matters.
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> St John NT acknowledges the seriousness of the forensic pathology findings. In D31/2026, the forensic pathologist concluded that a "long lie" of more than six hours contributed to the patient's death. In D35/2026, the forensic pathologist similarly concluded that a long lie of approximately five hours was a contributing factor in death. In D08/2026, the forensic pathologist concluded that the approximately 1½-hour ambulance delay did not contribute to death because the underlying head injury was unsurvivable.
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> St John NT does not seek to contest those conclusions.
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> Our operational reviews identified that the delays were not caused by incorrect prioritisation, but by concurrent emergency demand and the absence of an immediately available, clinically appropriate ambulance resource. This is consistent with the circumstances recorded in the draft findings.
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> The broader context for these delays is set out in the independent **ORH Demand Causation Analysis**, commissioned by St John NT in 2026. That analysis found that ambulance demand across the Northern Territory increased by **37.7 per cent between 2020 and 2025 and by 61.1 per cent since 2015**. It also found that demand growth has substantially exceeded population growth and that the Northern Territory has the highest ambulance demand rate per capita of any Australian ambulance service.
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> This pressure is routinely evident operationally. St John NT regularly experiences periods of **OPCAP Red and OPCAP White**, representing severe pressure on ambulance availability. These periods and the associated operational risks are routinely reported to the Department of Health through weekly reporting.
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> Following these incidents, the Northern Territory Government provided an additional **$10 million investment** in ambulance services. St John NT is working to apply that investment to improve operational resilience and better align available resources with periods of highest demand. However, the additional investment does not address the full service-capacity gap identified through current demand and utilisation analysis, particularly in Darwin.
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> Within the current funding envelope, St John NT has developed an operational change proposal intended to make the best use of the additional investment available. The proposal includes additional peak-demand ambulance resources, a second Critical Response Unit trial, a low-acuity response capability and dedicated secondary triage clinicians. These measures are intended to improve ambulance availability during peak demand and provide additional clinical options where a conventional emergency ambulance is not immediately available.
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> These changes remain subject to consultation, workforce availability and final implementation decisions and should not be understood as having removed the underlying capacity risk.
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> St John NT has not operated under a long-term ambulance services contract with the Northern Territory Government since 2022. Instead, the service has relied on a series of short-term extensions and funding arrangements, at times providing certainty for only three months. This has created significant operational uncertainty and constrained St John NT's ability to undertake long-term workforce planning, recruit and retain staff, invest in additional service capability and plan the future capacity of a critical emergency service.
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> St John NT is currently working with the Northern Territory Government toward a new long-term service agreement, which is anticipated to be finalised by December 2026. In support of those negotiations, St John NT has developed a broader five-year service delivery model setting

out the additional capability considered necessary to better respond to current and projected demand.

Subject to Government agreement and funding, the model would progressively increase emergency ambulance capacity in Darwin and Alice Springs and strengthen secondary clinical triage, Extended Care Paramedic response, lower-acuity transport and Emergency Communications Centre capability.

As part of this work, St John NT is also exploring additional education and clinical guidance to support decision-making for older adults, particularly those who have fallen or are experiencing prolonged waits. Current medical advice is that automatic escalation based on age alone may create significant over-triage without necessarily improving outcomes. St John NT is seeking the supporting evidence for that advice.

Accordingly, our focus is on strengthening clinicians' index of suspicion, clinical judgement and recognition of risk, supported by secondary triage, clinical advice and dispatch oversight. This is particularly relevant where risk changes during a prolonged wait and further clinical reassessment may be required.

The broader future-state capabilities described above are not currently commissioned and remain subject to Northern Territory Government agreement and funding.

Until the required additional capacity is agreed, funded and implemented, the underlying risk identified in these matters remains. Where emergency demand exceeds the number of immediately available, clinically appropriate ambulance resources, patients may continue to experience delayed responses despite correct prioritisation and escalation processes.

The findings in D31/2026 and D35/2026 demonstrate that prolonged ambulance delay can itself become a source of clinical harm, particularly for older and frail patients following a fall.

St John NT is taking steps within its current resources to strengthen clinical oversight and make better use of available capacity. However, materially reducing the underlying system risk will require additional funded capacity and service capability.

St John NT will continue to work with the Department of Health to address that risk.

Decision not to hold an inquest

Under section 16(1) of the *Coroners Act 1993* I decided not to hold an inquest because the investigations into the death disclosed the time, place and cause of death and the relevant circumstances concerning the death. I do not consider that the holding of an inquest would elicit any information additional to that disclosed in the investigation to date and the circumstances do not require a mandatory inquest because:

- The deceased was not, immediately before death, a person held in care or custody; and
- The death was not caused or contributed to by injuries sustained while the deceased was held in custody; and
- The identity of the deceased is known.