IN THE CORONERS COURT OF THE NORTHERN TERRITORY

Rel No: D0031/2026

Police No: 26 16921

CORONERS FINDINGS

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

I, Elisabeth Armitage, Coroner, having investigated the death of **an 80 year old Caucasian male** and without holding an inquest, find that he was born on **12 April 1945** and that his **death occurred on 7 February 2026, at Royal Darwin Hospital in the Northern Territory.**

Introduction

According to St John, 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 4 February 2026.

This elderly patient fell at home and waited on the floor for an ambulance for over 6 hours. It is the opinion of the forensic pathologist who reviewed his medical records that this 'long lie' caused by ambulance delay contributed to his death. St John NT does not contest that conclusion.

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:	**Hospital / aspiration pneumonia on a background of a fall (with head strike) and a long lie**
2	Other significant conditions contributing to death but not related to the condition causing death:	**Chronic obstructive pulmonary disease, diabetes mellitus (type 2), osteoporosis and recurrent falls**

In the absence of a post-mortem:

- This was the death of 80 -year-old male with multiple co-morbidities who had an unwitnessed fall with head strike, long lie and aspiration.
- The deceased was admitted to hospital with scalp lacerations and aspiration pneumonitis. The deceased subsequently developed a hospital acquired pneumonia. Death occurred on 7 February 2026.

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

- The deceased, due his advanced age, frailty and multiple co-morbidities, had an increased risk of falls. The fall resulted in scalp lacerations, an aspiration event and a long lie. This then resulted in a clinical course which was characterised by aspiration pneumonia, hospital acquired pneumonia and death. Hence the clinical consensus was that the fall and the complications thereof (scalp lacerations, long lie and subsequent aspiration) contributed to the death.

Background

The deceased was born and raised in England and emigrated to Australia in 1967. He worked in Queensland, New South Wales and Victoria before moving to the Northern Territory, where he continued working in labouring and gardening positions. Later he secured employment with the Commonwealth Government, in the Department of Aboriginal Affairs. He remained in public service employment until his retirement in 2000. He was married. The couple were together for 55 years and had three children.

Circumstances

At around 8am on 4 February 2026, he experienced a collapse when his right leg gave way in the bathroom of the family home. He made his way to the lounge room with the assistance of his four-wheel walker. Once seated, he asked his wife to get his medication from the bedroom.

While his wife was in the bedroom, she heard him call out, and she then heard a loud impact noise from the lounge area. She found him lying on the floor with a bleeding laceration on the head. His wife and son attempted to assist him up from the floor, however, due to the significant pain he said was in, they were unable to move him safely.

Family contacted emergency services at 8.12am. Over the next 6 ¼ hours they waited for an ambulance. St John Ambulance rang for updates on his condition. St John paramedics finally arrived at 2.22pm and he was transferred to Royal Darwin Hospital (RDH), arriving at 3.31pm.

On arrival at ED, he was found to have scalp lacerations, scalp bogginess, and tenderness to the neck. Clinical assessment also indicated that he appeared to have aspirated. Imaging studies excluded acute head or spinal skeletal trauma. There was radiological evidence consistent with aspiration pneumonitis. His condition subsequently deteriorated, with progressive respiratory compromise, and he later developed a hospital-acquired pneumonia.

Despite medical management, his condition continued to decline, and he passed away at 3.50pm on 7 February 2026.

His death was reported to the Coroner on 18 February 2026.

His care at hospital

His wife said that the care he received at the hospital was ‘above and beyond’. She said the nursing staff were very compassionate and ensured that he was not in any pain or discomfort.

St John Ambulance delay

The couple waited 6 ¼ hours for the ambulance, and his wife wondered if this long wait contributed in any way to his death. He lay on the tiles in the loungeroom for that entire time after the fall and was in pain. He did not lose consciousness. He did not eat and had only small sips of water. He could not be moved. His wife said that when the ambulance did come, it took five people (three ambulance people and two sons) to get him onto the stretcher. His wife wondered whether an ambulance may have arrived more quickly if she said he was unconscious.

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.

The assigned job number to this case was A26011307. The job was coded as a Priority 2 (P2) which is a 'serious incident' with a 30 minute target response time.

St John NT were down one emergency crew. Attendance was delayed because every available emergency unit was already committed to higher-priority cases classified as Priority 0 (P0) 'imminent threat to life' and Priority 1 (P1) 'critical condition'. The higher-acuity incidents took priority and occupied the responding crews.

In addition, one crew remained at RDH for approximately 1.5 hours following a complex case. During that time they completed patient hand-over, crew de-briefing, cleaning and restocking, completion of clinical documentation and staff welfare checks. Although Car 16 was available for dispatch it was not an additional emergency ambulance. It was the Shift Supervisors vehicle, is not capable of transporting patients, and St John advised that 'there was no requirement for immediate response by the shift supervisor'.

Accordingly, St John NT advises 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 resources.

The forensic pathologist who carefully reviewed his medical records considered that the 'long lie' of over 6 hours caused by the ambulance delay contributed to this man's death.

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.

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.

These changes remain subject to consultation, workforce availability and final implementation decisions and should not be understood as having removed the underlying capacity risk.

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.

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, the relevant circumstances concerning the death and I do not consider that the holding of an inquest would elicit any information additional to that disclosed in the investigation to date. 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.