IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 003764

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner David Ryan
Deceased:	Neville Ernest Mills
Date of birth:	1 March 1955
Date of death:	15 July 2021
Cause of death:	1(a) Ruptured abdominal aortic aneurysm
Place of death:	Bacchus Marsh and Melton Regional Hospital, 29-35 Grant Street, Bacchus Marsh, Victoria, 3340
Keywords:	Aortic aneurysm, emergency department, access block

INTRODUCTION

1. On 15 July 2021, Neville Ernest Mills was 66 years old when he passed away at hospital in Bacchus Marsh. At the time of his death, Mr Mills lived in Melton West with his daughter, Sarah-Jayne and her partner. He is survived by his three children.

THE CORONIAL INVESTIGATION

2. Mr Mills' death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. This finding draws on the totality of the coronial investigation into the death of Mr Mills including evidence obtained from Western Health. While I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

6. In the evening on 14 July 2021, Mr Mills complained to Sarah-Jayne that he was experiencing pain in his lower left side which had commenced at around 6.30pm. The pain increased and Sarah-Jayne contacted emergency services at around 9.30pm. Ambulance Victoria

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

paramedics arrived at around 10.00pm and observed that Mr Mills' vital signs and the results of an electrocardiogram (**ECG**) were normal. Mr Mills and Sarah-Jayne advised the paramedics that he usually had high blood pressure, which was consistent with his medical history of hypertension and high cholesterol. The paramedics determined that Mr Mills ought to be transported to hospital for further treatment.[2]

7. Mr Mills arrived at the Emergency Department (**ED**) of Sunshine Hospital at 10.29pm. At triage, he was reported to be comfortable and he declined pain relief, although the medical records disclose that he was given 400mg of ibuprofen at 10.39pm. His vital signs were again recorded as normal, and he was allocated a triage urgency code of 4 according to the Australasian Triage Scale (**ATS**)[3] as he did not require ongoing parenteral analgesia and had normal vital signs. Within 10 minutes of arrival, Mr Mills was transferred to the waiting room of the ED as all of the treatment cubicles were full at that stage.[4]

8. Sarah-Jayne stated that she received a call from a staff member at the Sunshine Hospital at around 4.50am on 15 July 2021 advising that her father could be picked up. She collected him at 5.24am and Mr Mills told her that he had not seen a doctor and that his "*symptoms didn't seem severe enough*".[5]

9. The medical records from the Sunshine Hospital record that Mr Mills decided to leave the ED of his own accord without being assessed by a doctor at 4.52am. In a statement provided to the Court, the Director of the Sunshine ED, Dr Gary Ayton observed that "*Mr Mills presumably called his daughter to pick him up before medical assessment and there are no notes recorded that he discussed this with the nursing staff at triage*".[6] Given Sarah-Jayne's recollection, I find that it is more likely that Mr Mills requested that a staff member contact his daughter to request that she pick him up.

10. Sarah-Jayne drove her father home and he rested until around 1.00pm. Mr Mills was still in considerable pain so at around 1.30pm, Sarah-Jayne drove him to the Bacchus March and

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[2] Statement of Sarah-Jayne Mills dated 24 July 2021; Statement of Dr Gary Ayton dated 29 March 2022.
[3] Clinical tool used to establish maximum waiting time for medical assessment and treatment of a patient. Category 4 is a potentially serious condition, which should be seen within 60 minutes.
[4] Statement of Dr Gary Ayton dated 29 March 2022.
[5] Statement of Sarah-Jayne Mills dated 24 July 2021.
[6] Statement of Dr Gary Ayton dated 29 March 2022.

Melton Regional Hospital where he presented at 2.07pm. He was observed to be afebrile with a tender abdomen and "*not stressed by pain*", with a suspected diagnosis of renal colic.[7]

11. A computed tomography (**CT**) scan was performed and at around 5.07pm, while the medical staff were awaiting the results, they contacted Sarah-Jayne and advised her that her father's kidneys were not functioning normally and that they considered he needed to be transferred to a bigger hospital for further treatment. Shortly afterwards, Mr Mills suffered a sudden onset of severe pain in his left side and collapsed in traumatic circumstances which was witnessed by Sarah-Jayne. At the same time, the results of the CT scan became available and confirmed that Mr Mills had suffered an abdominal aortic aneurysm. An ambulance was called and cardiopulmonary resuscitation (**CPR**) was performed for 40 minutes, but Mr Mills was unable to be revived and he was declared deceased at 6.11pm.[8]

Identity of the deceased

12. On 15 July 2021, Neville Ernest Mills, born 1 March 1955, was visually identified by his son, Laurie Smith-Mills.

13. Identity is not in dispute and requires no further investigation.

Medical cause of death

14. Forensic Pathologist Dr Sarah Parsons from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 16 July 2021 and provided a written report of her findings dated 20 July 2021.

15. A CT scan confirmed a ruptured abdominal aortic aneurysm and coronary artery calcification.

16. Toxicological analysis of ante-mortem samples identified the presence of drugs consistent with the provision of emergency treatment in hospital.

17. Dr Parsons provided an opinion that the medical cause of death was 1 (a) Ruptured abdominal aortic aneurysm.

18. I accept Dr Parsons's opinion.

[7] Statement of Sarah-Jayne Mills dated 24 July 2021; E-Medical Deposition, Sunshine & Melton Regional Hospital, dated 15 July 2021.

[8] E-Medical Deposition, Sunshine & Melton Regional Hospital, dated 15 July 2021.

FAMILY CONCERNS

19. On 24 July 2021, Sarah-Jayne wrote to the Court expressing concern, frustration and distress at the lack of treatment received by her father after he presented to the Sunshine Hospital. She also sent an email dated 1 September 2022 after reviewing the statements obtained from Western Health.

REVIEW OF CARE

20. In response to Sarah-Jayne's concerns, the Court requested statements from Western Health in relation to the care and treatment provided to Mr Mills upon his presentation to the Sunshine Hospital on 14 July 2021. As identified above, the medical records disclosed that, after having waited for over 6 hours, Mr Mills decided to leave the ED of his own accord without being assessed by a doctor.

21. Dr Ayton considered that Mr Mills' presenting problem on arrival to the Sunshine ED suggested "*renal colic as the most common cause however, ruptured aortic aneurysm is a recognised, although much less common cause of this presentation*". Dr Ayton considered that it was likely that Mr Mills' diagnosis of abdominal aortic aneurysm would have been made much earlier if he had been medically assessed at the Sunshine ED as it is likely that a CT scan would have been performed. Dr Ayton expressed the opinion that it would be unreasonable to expect a triage nurse to escalate Mr Mills' case as a possible of abdominal aortic aneurysm given that "*his pain had improved, he had normal vital signs, and his presentation could be reasonably attributable to the much more frequent and generally non-life threatening condition of renal colic*".[9]

22. Dr Ayton stated that Mr Mills' case highlighted a recognised clinical issue in most EDs where "*access block*"[10]and resultant over-crowding in the ED, combined with comparatively reduced levels of overnight staff results in long wait times. When Mr Mills presented to Sunshine Hospital, there were over 90 adult patients in the ED with an adult cubicle capacity of under 50. Over 45 adults were waiting to see a doctor, 25 of whom had been allocated a higher triage category than Mr Mills. There were 8 patients yet to be off-loaded from ambulances and the ED streaming processes were further compromised by requirements to

[9] Statement of Dr Gary Ayton dated 29 March 2022.

[10] Access block is the situation where patients who have been assessed in the emergency department and require admission to a hospital bed are delayed from leaving the emergency department for more than eight hours due to lack of inpatient capacity.

manage suspected and known Covid-19 patients. Further, there were 4 Medical Officers/Registrars on duty to manage the adult patients.

23. On 14 July 2021, the average time that it took patients in the Sunshine ED to get into a treatment space was 5.75 hours. A further 10 patients either left the ED before being seen or were discharged home without gaining access to a treatment space. The average length of stay for these 10 patients was 10.95 hours. The number of patients that were seen by a doctor within the ATS recommended time was 9%.[11]

24. Dr Ayton noted that the delay in patients being able to see a doctor at the Sunshine ED is being addressed in a number of ways including the following:

    a) The introduction of a Rapid Assessment and Discharge Medical Inpatient Unit and other inpatient measures to attempt to reduce access block;

    b) The expansion of the ED to increase cubicle capacity and staffing levels, especially overnight; and

    c) New processes to contact high risk patients who decide to leave without being seen by a doctor.[12]

FINDINGS AND CONCLUSION

25. Mr Mills' death may have been prevented if he had been able to be seen earlier by a doctor when he presented to the ED at Sunshine Hospital on 14 July 2021. It may also have been prevented if he had have remained at the ED until he was seen by a doctor. However, it is understandable in the circumstances that Mr Mills left, given he had waited over 6 hours and he may have been minimising his pain.

26. I do not consider that this case warrants any adverse comment in relation to any of the ED staff at the Sunshine Hospital as the problem of access block is a widespread systemic issue which delays the transfer of patients from the ED to inpatient wards with a corresponding reduction in the treatment space and staff capacity to treat newly presented patients. It is clear that EDs across Victoria are experiencing significant overload which causes increased delay in the treatment of patients and significant stress to staff.

[11] Statement of Dr Gary Ayton dated 9 June 2022.
[12] Statement of Dr Gary Ayton dated 29 March 2022.

27. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Neville Ernest Mills, born 1 March 1955;

    b) the death occurred on 15 July 2021 at Bacchus Marsh and Melton Regional Hospital, 29-35 Grant Street, Bacchus Marsh, Victoria, 3340, from a ruptured abdominal aortic aneurysm; and

    c) the death occurred in the circumstances described above.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

28. The Australian College for Emergency Medicine has identified access block as the most serious issue facing health systems in Australia. It considers that the problem is symptomatic of a health system in crisis – a relative lack of hospital inpatient bed capacity compared to demand, which cannot be solved solely by ED based interventions. It a requires multifactorial, evidence-based sustainable solutions, primarily related to increasing capacity throughout the public health system through investments in hospital infrastructure, clinical workforce and efficiencies in patient care.[13]
29. The problem of access block cannot be effectively addressed by hospitals in the absence of a comprehensive funding and resource response from government. I note that the Victorian government announced in the recent budget that it had made accommodation for up to 7000 new health workers and a $12 billion pledge to help repair the State's stretched health and emergency system.

I convey my sincere condolences to Mr Smith's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

[13] Australian College of Emergency Medicine, Position Statement on Access Block dated March 2021.

I direct that a copy of this finding be provided to the following:

Sarah-Jayne Mills, Senior Next of Kin

Douglas Mills, Deceased's brother

Laura Pascoe, Western Health

Senior Constable Jason Allison, Coroner's Investigator

Signature:

Coroner David Ryan

Date : 27 September 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.