JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	SARAH HELEN LINTON, DEPUTY STATE CORONER
HEARD	**:**	27 JULY 2021
DELIVERED	**:**	6 AUGUST 2021
FILE NO/S	**:**	CORC 643 of 2019
DECEASED	**:**	MILLS, ALEX CARL

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Sgt Alan Becker assisted the Coroner.
Mr L Geddes (SSO) appeared for the Department of Justice.

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Sarah Helen Linton, Deputy State Coroner, having investigated the death of ***Alex Carl MILLS*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 27 July 2021, find that the identity of the deceased person was* ***Alex Carl MILLS*** *and that death occurred on 16 May 2019 at Fiona Stanley Hospital, 102-118 Murdoch Drive, Murdoch, from sepsis, with osteomyelitis and infective endocarditis in the following circumstances:*

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INTRODUCTION

1. Alex Mills was a patient receiving palliative care at Fiona Stanley Hospital when he died on 16 May 2019. His death was due to sepsis from a bacterial infection that did not respond to antibiotics.

2. Mr Mills was a sentenced prisoner at the time of his death. He had been transferred to the hospital from Casuarina Prison about a week before his death due to his failing health and medical treatment needs, which could not be properly met in a prison setting.

3. As Mr Mills was a prisoner at the time of his death, he was a 'person held in care' under the terms of the *Coroners Act 1996 (WA)* and a coronial inquest into his death is, therefore, mandatory.[1]

4. I held an inquest on 27 July 2021. At the inquest, extensive written material was tendered in relation to the investigations into Mr Mills' death[2] and, of particular relevance in this case, the medical care he received prior to his death. Two witnesses from the Department of Justice were also called to give evidence at the inquest in person.

BACKGROUND

5. Mr Mills was born in New Zealand. He joined the navy at 15 years of age but was discharged due to medical illness when he was 20 years old. He migrated to Australia in 1980.[3]

6. In the 1980's Mr Mills lived in a house with another New Zealander and both men worked together in a car detailing business. It was alleged that both men sexually offended against children who were hired to assist with the business.[4]

7. The offending came to light many years after the offending occurred, when the children had become adults. Mr Mills was eventually convicted after a trial in 2016 of six charges relating to historical sexual offences against the children. The charges were representative of similar uncharged conduct against at least one of the victims.[5]

8. Mr Mills was 76 years old at the time he was sentenced. He was known to suffer from severe rheumatoid arthritis in his hands that had caused his fingers to retract into a 'claw like' position. He was also blind in his right eye due to glaucoma and suffered from atrial fibrillation. He had undergone mitral and tricuspid valve repair in February 2014. Mr Mills was on a number of medications, including a low dose of a steroid medication, prednisolone, for his arthritis.[6]

[1] Section 22(1)(a) *Coroners Act*.
[2] Exhibits 1 and 2.
[3] Exhibit 1, Tab 9.
[4] Exhibit 1, Tab 10.
[5] Exhibit 1, Tab 10.
[6] Exhibit 1, Tab 10.

9. However, there was evidence he was still able to care for himself and there was nothing to suggest he could not be properly cared for in prison, nor that any of his medical conditions would make it harder for him to spend time in custody than if he were in the community.[7]

10. The learned sentencing Judge ultimately imposed a total effective sentence of 5 years' imprisonment, with eligibility for parole. The sentence was backdated to commence on 28 February 2015, when Mr Mills first went into custody. As a result, Mr Mills earliest date that he was eligible to be released on parole was 28 February 2018.[8] He remained in custody until his death in 2019.

INITIAL HEALTH CARE IN PRISON

11. Mr Mills was first seen in the prison medical clinic on 5 March 2015. He underwent a routine health assessment and his complex past medical history was noted. He was seen by a doctor the following day and it was noted they were awaiting information from his community GP to ensure he remained on his regular medication regime.[9]

12. On 11 March 2015 Mr Mills developed a sore right eye. It was known he had pre-existing visual loss in his right eye. He was referred to the Royal Perth Hospital (RPH) eye clinic, where he was prescribed eye drops for his glaucoma. Later in the year he was reviewed by an optometrist and diagnosed with a cataract. In late January 2016 a note was made that he had been receiving the wrong eye drops for three weeks. This was immediately corrected and no adverse effects were detected in relation to the error.[10]

13. During his four years in custody, Mr Mills received yearly flu vaccinations and regular blood tests and blood pressure checks and comprehensive medical reviews. He also continued to see an ophthalmologist and had audiology testing and dental work. Early in his sentence it was noted his blood pressure was poorly controlled, and it was concluded that it was difficult to control as a result of his long-term steroid use.[11]

14. Mr Mills was followed up in the Fiona Stanley Hospital (FSH) Cardiology Outpatient Clinic twice in 2017 regarding his known valvular heart disease. He was not seen at the first appointment in June 2017 as his transport was over an hour late. He was successfully reviewed on 8 August 2017. He had experienced some dizzy spells, so he underwent Holter monitoring in October 2017 to investigate it, and underwent further review at the FSH Cardiology Clinic on 21 November 2017. This resulted in a change of medication and a rheumatology referral to review his long-term steroid use.[12]

[7] Exhibit 1, Tab 10, p. 947.
[8] Exhibit 1, Tab 10.
[9] Exhibit 2, Tab 31.
[10] Exhibit 2, Tab 31.
[11] Exhibit 2, Tab 31.
[12] Exhibit 2, Tab 31.

15. He began to experience severe shoulder pain in early 2018, and told health staff he had previously been advised to have surgery but had refused. He was now interested in pursuing surgical treatment for the problem. The shoulder pain was felt to be consistent with severe osteoarthritis. An x-ray was ordered and he was referred to orthopaedics. He had a shoulder x-ray at Fiona Stanley Hospital on 8 March 2018 and the orthopaedics referral was followed up.[13]

16. Mr Mills also suffered from some ulcers on his legs intermittently from 2016 onwards. In May 2018, he had developed an ulcer on his right foot. The ulcer was dressed regularly and a swab grew the bacteria *Staphylococcus aureus*. He was prescribed an antibiotic. [14]

17. On 28 June 2018 Mr Mills was added to the terminally ill module stage 3 in the prison health system due to his multiple health issues and risk of an acute terminal event.[15]

EVENTS IN AUGUST AND SEPTEMBER 2018

18. On 8 August 2018 Mr Mills presented to a nurse complaining of a large, painful bruise on the right side of his body that extended from his scapula to his waist. He denied any traumatic cause. He was sent to Armadale Hospital Emergency Department for review.[16]

19. Mr Mills was reviewed at the hospital and noted to have a mass over the right postero-lateral chest well, which was enlarging. Blood tests showed anaemia and a raised white cell count. A chest wall ultrasound reported a large, complex haematoma on the right posterolateral chest wall. It was felt that the haematoma was most likely secondary to minor trauma and anticoagulant use. He was discharged with advice to have repeat blood tests in two to three days and to continue on his anticoagulant, despite the bleeding, as he was at high risk of a stroke if he stopped taking it.[17]

20. He was reviewed by a prison doctor on 9 August 2018 and it was noted he was to be reviewed immediately if the bruise was increasing in size or other bleeding occurred.[18] The bruising was noted by a nurse to have extended the next day and he reported red stools, so Mr Mills was returned to Armadale Hospital ED on 10 August 2018. The hospital tried to discharge him back again that day, but the clinical nurse manager refused as there were reduced services at Karnet Prison over the weekend and it would not be safe. He was admitted under the surgical team and given intravenous fluids, a proton pump inhibitor to manage gastrointestinal bleedings and his steroid and anticoagulants were stopped. CT abdomen and pelvis were normal and he was monitored overnight. He had no further bleeding, so he was discharged back to prison on 11 August 2018 with advice to restart his steroid and withhold his

[13] Exhibit 2, Tab 31.
[14] Exhibit 2, Tab 31.
[15] Exhibit 2, Tab 31.
[16] Exhibit 2, Tab 31.
[17] Exhibit 2, Tab 31.
[18] Exhibit 2, Tab 31.

anticoagulants for a week.[19] Mr Mills was referred for a colonoscopy, which revealed colonic polyps and haemorrhoids.[20]

DEVELOPMENT OF INFECTION – OCTOBER 2018

21. On 26 October 2018 Mr Mills was reviewed by a Prison Medical Officer with complaints of a red, hot, tender left foot. He claimed the pain had improved to some degree after taking anti-inflammatories. He pointed to the joint of the big toe as the main site of his pain. The doctor felt the diagnoses was most likely gout, rather than cellulitis (an infection of the skin). He prescribed colchicine, a treatment for gout, and further anti-inflammatories. There appears to have been little improvement in the following days. On 28 October 2018 Mr Mills requested to go to hospital as his entire lower left leg, from the knee down, was now hot and swollen. He was sent to Armadale Hospital ED that day.[21]

22. Mr Mills was admitted to Armadale Hospital on 28 October 2018. Tests were suggestive of infection. He was diagnosed with left, lower limb cellulitis and commenced on intravenous antibiotics. He underwent CT and MRI scans of the left foot, which showed no definite osteomyelitis (infection in a bone) or septic arthritis, and blood cultures were negative. Mr Mills was discharged back to the Casuarina Infirmary on 7 November 2018 on an oral antibiotic.[22]

23. Mr Mills had regular nursing reviews at the Casuarina Infirmary and saw a doctor on 12 November 2018, who cleared him to return to Karnet Prison, which was his preference. He returned to Karnet on 19 November 2018.[23]

24. On 28 November 2018 Mr Mills' legs were swollen and red again. He was reviewed by a doctor and he was prescribed a further course of clindamycin and blood tests were ordered. His blood tests continued to show a raised white cell count and CRP.[24]

25. On 12 December 2018 Mr Mills self-presented to the health centre feeling unwell and requesting antibiotics. He had an e-consult with a doctor and was diagnosed with a respiratory tract infection and prescribed antibiotics. At review two days later, he said he was nearly completely well following the antibiotics course. His Vitamin D and iron levels were noted to be low and bloods were to be ordered once he was completely well.[25]

26. In late December 2018 there were some concerns about Mr Mills' medication regime and effect on his blood pressure and heart, which resulted in some medication changes.[26]

[19] Exhibit 2, Tab 31.
[20] Exhibit 2, Tab 31.
[21] Exhibit 2, Tab 31.
[22] Exhibit 2, Tab 31.
[23] Exhibit 2, Tab 31.
[24] Exhibit 2, Tab 31.
[25] Exhibit 2, Tab 31.
[26] Exhibit 2, Tab 31.

MEDICAL DETERIORATION – 2019

27. Other than his ongoing shoulder pain issues, for which Mr Mills received pain medication while on a wait list for surgery, Mr Mills' health conditions appeared to have settled in January 2019, although he remained on the terminally ill register. He had a discussion with a nurse about arranging a 'not for resuscitation' order and the relevant policy was explained to him. [27]

28. On 11 February 2019 Mr Mills presented to a prison nurse with a complaint of right flank pain, which he said had started after he was hit by a door that was caught by the wind. The nurse recorded no signs of bruising or inflammation but did note some tenderness. His observations were normal, apart from a raised temperature, but he indicated he had not opened his bowels for a few days. He was given laxatives and analgesia. He appeared to have improved the next day, but two days later, on 13 February 2019, Mr Mills' right flank was noted to be swollen, pink and warm to the touch. He complained of constant discomfort, so he was transferred to Armadale Hospital for review.[28]

29. At the hospital, blood tests showed a raised CRP, raised white cell count and anaemia. A CT scan confirmed a right abdominal wall haematoma in the setting of a non-displaced fracture of the posterolateral right 11th rib. Mr Mills was administered IV antibiotics and admitted to the general medical ward. He was discharged back to prison after two days, with advice to withhold his anticoagulants until 17 February 2019. On his return from hospital, a nurse noted he appeared frail and still had a large area of cellulitis on the right side of his abdomen.[29]

30. On 27 February 2019, Mr Mills complained of intermittent dizziness. His observations were normal and he was reassured, but his case was also referred to a doctor for review. It was noted on 28 February 2019 he required a comprehensive medical review.[30]

31. On 4 March 2019, Mr Mills was reviewed by a nurse as he appeared unwell during the medication round. He complained of groin pain and feeling generally unwell. He was noted to look 'unwell' and he had lost weight. His observations were taken and showed a high temperature and rapid heart rate. His left lower leg was also noted to be hot and red. He was sent to Armadale Hospital for medical review.[31]

32. Mr Mills was found on admission to be anaemic with a raised white cell count, CRP and creatinine. A chest x-ray and head CT were reported to be normal. However, blood cultures grew MRSA (Methicillin-resistant *Staphylococcus aureus*). He was diagnosed with bacteraemia (bacteria in the blood stream) and acute kidney injury. He was started on IV antibiotics. Raised inflammatory markers pointed to infective endocarditis (an infection of the heart valves or endocardium) but an echocardiogram showed no evidence of this. Repeat blood cultures several days later still grew

[27] Exhibit 2, Tab 31.
[28] Exhibit 2, Tab 31.
[29] Exhibit 2, Tab 31.
[30] Exhibit 2, Tab 31.
[31] Exhibit 1, Tab 21.

MRSA so, on the advice of an infectious disease consultant, the antibiotics were changed.[32]

33. A CT scan of the abdomen and pelvis showed a small collection in the anterior pelvis related to the pubic symphysis, but no obvious bony destruction to suggest florid osteomyelitis.[33]

34. Mr Mills complained of a swollen elbow, which was thought to possibly be the source of the MRSA infection. However, aspiration of fluid from the elbow showed no bacteria and instead detected crystals consistent with pseudogout.[34]

35. On 8 March 2019 an echocardiogram performed at RPH showed no evidence of infective endocarditis. Blood cultures on 13 March 2019 still grew *Staph areus*, so his antibiotic was changed again.[35]

36. Blood cultures were finally negative on 15 March 2019 and Mr Mills was eventually discharged back to prison on 19 March 2019 with advice to continue with his IV antibiotics for six weeks. Mr Mills returned to the Casuarina Prison Infirmary as he was too unwell to go to Karnet. He was noted to have a diagnosis of MRSA bacteraemia, most likely from pelvic abscess. He was administered his antibiotics and had weekly blood tests. His white cell count remained elevated, despite the antibiotics, but he reported feeling well. Mr Mills had regular nursing and medical reviews and weekly blood tests to monitor his progress. It was noted on 8 April 2019 that he needed a wheelchair for long distances but was otherwise managing quite well in the infirmary.[36]

37. From 9 April 2019 Mr Mills received twice daily nursing reviews. He remained stable and was generally independent in his care. On 17 April 2019 Mr Mills was reviewed by a doctor and he appeared to be improving. He indicated he was keen to return to Karnet Prison when possible.[37]

38. Mr Mills was reviewed in the Armadale Hospital Infectious Diseases Clinic on 18 April 2019. It was noted that the source of the bacteraemia was suspected to be from his skin. His recent blood tests still showed a raised white cell count and he complained of ongoing back ache, so a CT scan was requested. The CT scan showed a decrease in the size of the pelvic collection but a new finding of osteomyelitis of the symphysis pubis. The prison was informed to recommence an antibiotic for a further one to two months and to refer him to rheumatology. Mr Mills received the antibiotics as prescribed and the referral was completed.[38]

[32] Exhibit 1, Tab 21; Exhibit 2, Tab 31.
[33] Exhibit 1, Tab 21; Exhibit 2, Tab 31.
[34] Exhibit 1, Tab 21.
[35] Exhibit 1, Tab 21.
[36] Exhibit 2, Tab 31.
[37] Exhibit 2, Tab 31.
[38] Exhibit 1, Tab 18; Exhibit 2, Tab 31.

39. On 3 May 2019 Mr Mills was seen for review by a doctor regarding his fitness to return to Karnet Prison, as he was still keen for the transfer. He was deemed fit to return to Karnet.[39]

40. However, two days later, on 5 May 2019, Mr Mills complained of back pain and was unsteady on his feet. All his observations were normal at that time, but he remained in bed and that evening he passed blood in his urine and protein was noted. A urine sample eventually grew *Enterobacter aerogenes*. He was reviewed by a Prison Medical Officer the next day and complained of bilateral loin pain. He was diagnosed with a urinary tract infection and started on another antibiotic.[40]

LAST HOSPITAL ADMISSION

41. Mr Mills deteriorated overnight and on 7 May 2019 he developed nausea and began vomiting. He was taken by ambulance to FSH for assessment.[41]

42. The impression of Mr Mills was of septic shock. He was admitted to intensive care and administered intravenous fluids, antibiotics and a medication to support his blood pressure. An abdominal CT scan showed a progression of his osteomyelitis and a new vertebra compression fracture. An echocardiogram showed vegetations on the mitral valve of the heart, consistent with a diagnosis of infective endocarditis. Bone scans confirmed osteomyelitis of the pubic bone and blood cultures grew *Staph areus*.[42]

43. A doctor requested that approval be given for all restraints to be removed, given Mr Mills' ongoing care requirements. Approval was eventually given several days later.[43]

44. Mr Mills was reviewed by the Infectious Diseases Specialist, who considered his prognosis was very poor. He was also reviewed by the cardiothoracic surgeon who deemed him unsuitable for surgery. Mr Mills was transferred to the General Ward once he was weaned off blood pressure support, and made 'not for resuscitation'.[44]

45. At 11.55 pm on 14 May 2019 Mr Mills had an increased respiratory rate and heart rate. A Medical Emergency Team (MET) call was made. An ECG showed fast atrial fibrillation and a chest x-ray showed multiple pulmonary infiltrates. He was given diuretics and morphine and diagnosed with multiorgan failure. After further discussions and another review by cardiothoracics, it was decided he would not be for further MET calls in view of his frailty and poor prognosis. Active treatment was ceased.[45]

[39] Exhibit 2, Tab 31.
[40] Exhibit 2, Tab 31.
[41] Exhibit 1, Tab 12; Exhibit 2, Tab 31.
[42] Exhibit 1, Tab 13.
[43] Exhibit 1, Tab 19 and Tab 20.
[44] Exhibit 2, Tab 31.
[45] Exhibit 1, Tab 13.

46. A doctor notified the Superintendent of Casuarina Prison on 15 May 2019 that Mr Mills' death was likely imminent and it was requested that his next of kin, also a prisoner at Casuarina Prison, be notified and a visit arranged.[46] The visit appears to have been facilitated that afternoon.[47] Mr Mills was kept comfortable until he died on 16 May 2019.[48] The Prison Superintendent and WA Police were notified of the death, so appropriate processes and investigation could commence.

CAUSE AND MANNER OF DEATH

47. Forensic Pathologists Dr Cooke and Dr Ong performed a post mortem examination on 20 May 2019. They found changes of recent medical care and ageing and evidence of past surgery to the heart. The heart valves showed apparent infection (infective endocarditis) and part of the pubic bone was softened, consistent with the history of osteomyelitis. There were secondary changes of sepsis in the heart and lungs and microbiology testing showed the presence of bacterial organisms, including *Staph areus*, all possibly associated with significant sepsis.[49]

48. Toxicology analysis showed the presence of medications consistent with Mr Mills' recent medical care.[50]

49. At the conclusion of all investigations, the forensic pathologists expressed the opinion the cause of death was sepsis, with osteomyelitis and infective endocarditis. They expressed the opinion the death was due to natural causes.[51]

50. I accept and adopt the opinions of Dr Cooke and Dr Ong as to the cause and manner of death.[52]

COMMENTS ON TREATMENT, SUPERVISION AND CARE

51. Mr Mills had a number of significant pre-existing health conditions when he was first admitted to prison as an elderly man. He was referred to multiple specialists. There was some difficulty in ensuring he attended all of his external appointments, due to issues with transport being unavailable at times. Dr Joy Rowland, the Director of Medical Services for the Department of Justice, gave evidence that the transport issues were due to problems with the transport contractor at that time. However, she noted most of the appointments impacted for Mr Mills were eye appointments, and he ultimately had good control of his eye issue, so the cancelled appointments didn't affect the outcome in this case.[53]

[46] Exhibit 1, Tab 15.
[47] Exhibit 1, Tab 11.
[48] Exhibit 1, Tab 13.
[49] Exhibit 1, Tab 6A.
[50] Exhibit 1, Tab 6A and Tab 8.
[51] Exhibit 1, Tab 6A.
[52] Exhibit 1, Tab 6A.
[53] T 12 - 13.

52. Dr Rowland gave evidence that this issue has largely resolved since that time, with a new contractor engaged that has more flexibility, and transport is not so often an issue now for prisoners as it was then.[54]

53. There were also issues with Mr Mills' referral to rheumatology being sent but no appointment being made. Dr Rowland noted that it is unknown whether his management may have altered if he had been reviewed, but she observed that he had been symptomatically controlled on a low dose of prednisolone for many years in the community, so it was unlikely he would have been weaned off that dose and tried on a newer drug at his age.[55]

54. Dr Rowland also noted that the health summary suggested the seriousness of Mr Mills' clinical deterioration in May 2019 could have been detected a day or two earlier and resulted in a transfer to hospital at a slightly earlier stage than actually occurred. However, she acknowledged that a number of nurses and doctors were involved in his care at that stage and none of them were alarmed by his clinical presentation, so it may be that he did not look as unwell as he later proved to be. Alternatively, he may have had only a mild infection, that escalated rapidly. Given he then spent a further nine days in hospital and his infection did not respond to intensive and prolonged treatment, Dr Rowland expressed the opinion that earlier transfer was unlikely to have change the trajectory and ultimate outcome of Mr Mills' illness, in any event. However, She noted that early recognition of serious infection is clinically valuable in most cases, and the Department has since introduced standardised charges and care plans for the Infirmary at Casuarina that will prompt recognition of a deteriorating patient, as well as implementing education sessions for both nursing and medical staff on sepsis and clinical deterioration of a patient.[56]

55. I am satisfied that Mr Mill received medical care comparable, or better, to what he could have received in the community. It appears that everything possible was done to manage his persistent infections, but he eventually succumbed. However, I commend the Department, and particularly Health Services, for scrutinising his care closely with a view to improving health services for other prisoners. I note that evidence was given that the Department is moving forward with a plan to build a new, larger infirmary at Casuarina, which will be staffed with a better staffing mix of nurses and doctors, including specialists nurses in aged and infirm patients and better medical officer ratios, which will no doubt improve the care options for patients with complex health issues like Mr Mills when it is complete.

56. One issues which arose in the Department's overall review of Mr Mills' supervision, treatment and care, was a failure to refer Mr Mills for consideration of release on the Royal Prerogative of Mercy. This was required under the relevant Department Policy,[57] but at the time there was an issue with staffing in the Sentence Management Unit, which meant that there was no staff member responsible for completing this

[54] T 13.
[55] T 20.
[56] T 15 – 18; Exhibit 2, Tab 31, pp. 24 – 26.
[57] Policy Directive 8: Prisoners with a Terminal Medical Condition.

task.[58] It is unlikely that a briefing note to the Minister would have altered the outcome in this case, as release on a RPOM is extremely rare and takes a significant period of time. Noting the nature of Mr Mills' offending, his lack of community support given he was extradited from interstate, his significant health issues and his rapid deterioration, I am satisfied that it was extremely unlikely Mr Mills would have been considered eligible for early release.

57. However, it is important that this process is initiated, and I am reassured by Ms Toni Palmer, the Senior Review Officer for the Department's Death in Custody Review Team, that all potential terminally ill prisoner cases were reviewed in 2020 and a staff member has since commenced in the Sentencing Management Unit with this specific task allocated to their role.

CONCLUSION

58. Mr Mills was a prisoner who was received into custody with a complex medical history and experienced a number of severe acute illnesses once in custody, including several episodes of infection requiring hospitalisation. The infection progressed to osteomyelitis and then to systemic infection, from which he did not recover. He died in hospital, where he received all possible available medical care, but he was made palliative very shortly before his death when it became clear there were no more treatment options available.

S H Linton
Deputy State Coroner
6 August 2021

[58] Exhibit 2, Tab 1, pp. 16 – 21.