IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2023 003142

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	Mark Andrew Spillane
Date of birth:	11 April 1965
Date of death:	10 June 2023
Cause of death:	1(a) Septic shock secondary to intraabdominal collections as sequelae of osteomyelitis/discitis in a man with Trisomy 21
Place of death:	University Hospital Geelong, 272-322 Ryrie Street, Geelong, Victoria
Key words:	Septic shock, osteomyelitis, discitis, Trisomy 21, in care, SDA resident, palliative care

INTRODUCTION

1. On 10 June 2023, Mark Andrew Spillane was 58 years old when he died in hospital. At the time, Ms Spillane lived in Leopold.

2. Mr Spillane was born with Trisomy 21 (Down syndrome) and was received into state care at a young age. Mr Spillane had previously resided in Specialist Disability Accommodation in Marshall, which was managed by Scope. His medical history also included diagnoses of dysphagia, osteoarthritis, congenital heart lesions, paraumbilical hernia, Graves' disease, reflux, and iron deficiency.

3. In October 2022, Mr Spillane was admitted to hospital with a serious chest infection. Despite recovering from the infection, Mr Spillane's overall physical health had deteriorated. He thereafter received additional diagnoses of early onset dementia and Atlanto-occipital axial instability of the spine. He could no longer walk independently, required a wheelchair to mobilise at all times, and generally required a higher level of assistance with the activities or daily life.

4. Given his accommodation in Marshall was no longer suitable for his increased support needs, an application was made to the Victorian Civil and Administrative Tribunal (**VCAT**) and the Office of the Public Advocate was appointed as Mr Spillane's guardian for the purposes of making accommodation and medical decisions on Mr Spillane's behalf.

5. Following his discharge from hospital on 19 April 2023, Ms Spillane lived in Specialist Disability Accommodation in Leopold, also managed by Scope.

6. According to Lisa Evans, Chief Operating Officer of Scope, Mr Spillane was non-verbal, and staff relied on his facial expressions and body language to ascertain whether he was in pain.

7. Over the following weeks, Mr Spillane attended routine medical and allied health appointments and assessments during which blood tests were ordered.

THE CORONIAL INVESTIGATION

8. Mr Spillane's 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. Generally, reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or

injury. However, if a person satisfies the definition of a person placed in care immediately before death, the death is reportable even if it appears to have been from natural causes.[1]

9. 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.

10. 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.

11. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Spillane's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

12. This finding draws on the totality of the coronial investigation into Mr Spillane's death, including evidence contained in the coronial brief. Whilst 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.[2]

[1] See the definition of *"reportable death"* in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of *"person placed in custody or care"* in section 3 of the Act. Regulation 7(1)(d) of the Coroners Regulations 2019 provides that a person placed in custody or care now includes *"a person in Victoria who is an SDA resident residing in an SDA enrolled dwelling".* 'SDA resident' has the same meaning as in the *Residential Tenancies Act 1997* (Vic) and captures a person who is an SDA recipient (that is, an NDIS participant who is funded to reside in an SDA enrolled dwelling). 'SDA enrolled dwelling' also has the same meaning as in the *Residential Tenancies Act 1997* and is defined as a: *"long term accommodation for one or more SDA resident and enrolled as an SDA dwelling under the National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016 of the Commonwealth as in force from time to time or under other rules made under the National Disability Insurance Scheme Act 2013 of the Commonwealth."*

[2] 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.

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

Identity of the deceased

13. On 11 June 2023, Mark Andrew Spillane, born 11 April 1965, was visually identified by his support worker, Cassie Walters, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

15. Forensic Pathologist, Dr Joanne Ho, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 13 June 2023 and provided a written report of her findings dated 29 June 2023.

16. The post-mortem examination was consistent with the reported circumstances.

17. A post-mortem CT scan showed no intracranial haemorrhage or skull fracture. There were retroperitoneal collections and drains in situ, anasarca, bilateral pleural effusions, and increased lung markings. There were also L1, L2, and L5 disc degenerative type changes.

18. Dr Ho provided an opinion that the medical cause of death was *"1(a) Septic shock secondary to intraabdominal collections as sequelae of osteomyelitis/discitis in a man with Trisomy 21"*. Dr Ho noted the death was due to natural causes.

19. I accept Dr Ho's opinion.

Circumstances in which the death occurred

20. On 27 May 2023, Mr Spillane had an x-ray of his feet, which detected a possible bone infection. A CT scan of his foot was requested. Over the following days, medical staff tended to Mr Spillane's foot.

21. On 6 June 2023, Mr Spillane's general practitioner advised that Mr Spillane should be taken to hospital as recent blood test results had identified anaemia (haemoglobin of 57).

22. Mr Spillane was transported by ambulance to University Hospital Geelong where he presented with intra-abdominal collections. A CT abdomen scan showed large bilateral psoas and retroperitoneal collections and L5/S1 osteomyelitis with moderate pre-sacral collections. It was felt that the large abscess was secondary to osteomyelitis/discitis.

23. He was commenced on antibiotics and underwent drainage of the collections which drained large amounts of purulent fluid. Analysis of the drained fluid revealed serious infection and Mr Spillane's prognosis was considered to be poor. It was determined that further surgery would not be in Mr Spillane's best interests. He was continued intravenous antibiotics. However, during his admission Mr Spillane became increasingly distressed by the intravenous cannulas and they had to be removed.

24. Given his limited improvement, Mr Spillane was transitioned to palliative care and kept comfortable until he passed away at 10.30pm on 10 June 2023.

FINDINGS AND CONCLUSION

25. Pursuant to section 67(1) of the Act I make the following findings:

    (a) the identity of the deceased was Mark Andrew Spillane, born 11 April 1965;

    (b) the death occurred on 10 June 2023 at University Hospital Geelong, 272-322 Ryrie Street, Geelong, Victoria;

    (c) the cause of Mr Spillane's death was septic shock secondary to intraabdominal collections as sequelae of osteomyelitis/discitis in a man with Trisomy 21; and

    (d) the death occurred in the circumstances described above.

26. The available evidence does not support a finding that there was any want of clinical management or care on the part of the staff of SCOPE and the clinical staff at University Hospital Geelong that caused or contributed to Mr Spillane's death.

I convey my sincere condolences to Mr Spillane's carers and friends for their loss.

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

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

Public Advocate, guardian

Barwon Health

Senior Constable Matthew Brock, Victoria Police, Coroner's Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 11 April 2024

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.