IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 001895

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner John Olle
Deceased:	Shannon Troy Calvert
Date of birth:	3 March 1971
Date of death:	7 April 2022
Cause of death:	1(a) aspiration pneumonia in a man with severe scoliosis 1(b) cerebral palsy
Place of death:	Dandenong Hospital 135 David Street, Dandenong, Victoria, 3175
Keywords:	Natural causes death in care, history of aspiration pneumonia

INTRODUCTION

1. On 7 April 2022, Shannon Troy Calvert was 51 years old when he died at Dandenong Hospital. At the time of his death, Shannon lived at an independent living facility located at 9 Leigh Court, Doveton, Victoria, 3177.

THE CORONIAL INVESTIGATION

2. Shannon'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. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

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. Victoria Police assigned Senior Constable James to be the Coroner's Investigator for the investigation of Shannon'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.

6. This finding draws on the totality of the coronial investigation into the death of Shannon Troy Calvert 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.[1]

[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

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

Circumstances in which the death occurred

7. Shannon was in National Disability Insurance Scheme (**NDIS**) care for his cerebral palsy, physical disability scoliosis and intellectual disabilities. Shannon was permanently in a wheelchair. Shannon required full care, requiring assistance with showering and personal care, including meal assistance and a modified diet. Shannon could drink independently but always had to be monitored whilst drinking. Shannon also had a history of aspiration pneumonia.

8. On 28 March 2022, Shannon was taken to Dandenong Hospital with concerns of drowsiness; he was noted to be hypothermic on admission.

9. Investigations for the source of the infection were sent, with unremarkable findings on routine blood tests, blood cultures and urine tests. He had an aspiration episode during the admission and developed severe aspiration pneumonia with a possible element of hospital-acquired pneumonia.

10. Shannon was kept nil by mouth and continued as such following assessment by speech pathology, given the high risk of aspirating, even on his own secretions. After two days with no oral intake, a nasogastric tube was placed under fluoroscopy guidance and appeared to be in the correct position radiologically. However, Shannon continued to aspirate, and nasogastric feeds were ceased after minimal intake. He continued to deteriorate and sadly died on 7 April 2022.

Identity of the deceased

11. On 7 April 2022, Shannon Troy Calvert, born 3 March 1971, was visually identified by his mother, Elaine Calvert.

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

Medical cause of death

13. Forensic Pathologist Dr Baber from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 8 April 2022 and provided a written report of her findings dated 2 May 2022. Dr Baber also reviewed the Victoria Police Report of Death (**Form 83**), the

evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

medical deposition from Dandenong Hospital, the post-mortem computed tomography (**CT**) scan and the VIFM contact log.

14. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

15. Dr Baber provided an opinion that the medical cause of death was 1 (a) Aspiration pneumonia in a man with severe scoliosis and 1 (b) cerebral palsy.

16. I accept and adopt Dr Baber's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Shannon Troy Calvert, born 3 March 1971;

    b) the death occurred on 7 April 2022 at Dandenong Hospital 135 David Street, Dandenong, Victoria, 3175, from aspiration pneumonia in a man with severe scoliosis and cerebral palsy; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Shannon's family 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:

Elaine Calvert, Senior Next of Kin

Kate Macdermid, Monash Health

Senior Constable James, Coroner's Investigator

Signature:

Coroner John Olle

Date : 9 August 2023

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.