



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

**COR 2025 003176**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

*Section 67 of the Coroners Act 2008*

Findings of: AUDREY JAMIESON, Coroner

Deceased: Michael Patrick Doran

Date of birth: 11 August 1968

Date of death: 8 June 2025

Cause of death: 1a: Influenza B in a man with epilepsy, Down syndrome and Alzheimer's dementia

Place of death: Northern Hospital Epping  
185 Cooper Street  
Epping Victoria 3076

## INTRODUCTION

1. On 8 June 2025, Michael Patrick Doran was 56 years old when he died at the Northern Hospital of natural causes.
2. At the time of his death, Michael resided at a Specialist Disability Accommodation (SDA) dwelling enrolled under the National Disability Insurance Scheme (NDIS). Michael received funded daily independent living support due to his diagnoses of Down syndrome, intellectual disability and Alzheimer's dementia, which was provided by disability service provider, Life Without Barriers.

## Background

3. Michael was born with Down syndrome resulting in moderately severe intellectual impairment. Doctors advised Michael's parents that they did not expect him to live past the age of 20. He was non-verbal and required assistance for all activities of daily living.
4. From the age of seven, Michael attended Milparinka Development School two days a week. When he turned 17, he began living at the Kingsbury Training Centre, a full-time care facility.
5. After three years living at the Kingsbury Training Centre, Michael moved to his SDA in Mill Park, where he lived until his death. He enjoyed living there and was close with another resident, Toby.
6. Michael's medical history included Alzheimer's dementia first diagnosed in 2017, epilepsy, gout, chronic conjunctivitis and depression.
7. In April 2024, Michael was referred to the Banksia Palliative Care service following repeated presentations to the Northern Hospital with agitation, head banging and a declining cognitive and physical state. It was decided that no further medical intervention would improve his quality of life and his care would be palliative in nature.

## THE CORONIAL INVESTIGATION

8. Michael's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as she was a 'person placed in custody or care' within the meaning of the Act, as a person with disability who received funded daily independent living support and resided in an

SDA enrolled dwelling immediately prior to his death.<sup>1</sup> This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

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. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Michael's death. The Coronial 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 the death of Michael Patrick Doran 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.<sup>2</sup>

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<sup>1</sup> This class of person is prescribed as a 'person placed in custody or care' under the *Coroners Regulations 2019* (Vic), r 7(1)(d).

<sup>2</sup> 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**

### **Circumstances in which the death occurred**

13. On 5 June 2025, Michael was admitted to the Northern Hospital Neurology Unit after experiencing two seizures in the context of Influenza B.
14. Michael's condition continued to deteriorate and in the early hours of 7 June 2025 the decision was made to transition him to end of life care.
15. Michael died at 4:06pm on 8 June 2025.

### **Identity of the deceased**

16. On 9 June 2025, Michael Patrick Doran, born 11 August 1968, was visually identified by his carer, George A-Thommana, who completed a Statement of Identification.
17. Identity is not in dispute and requires no further investigation.

### **Medical cause of death**

18. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (VIFM) conducted an external examination of the body of Michael Doran on 11 June 2025. Dr Young reviewed the Victoria Police Report of Death (Form 83), post mortem computed tomography (CT) scan and E-Medical Deposition Form and medical records from Northern Health and provided a written report of his findings dated 9 July 2025.
19. The external examination showed no unexpected signs of trauma. The post mortem CT scan showed increased markings in the lungs and dilated ventricles in the brain.
20. Dr Young provided an opinion that the death was due to natural causes and ascribed the medical cause of death as 1(a) INFLUENZA B IN A MAN WITH EPILEPSY, DOWN SYNDROME AND ALZHEIMER'S DEMENTIA.

## **FINDINGS AND CONCLUSION**

1. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
  - a) the identity of the deceased was Michael Patrick Doran, born 11 August 1968;

- b) the death occurred on 8 June 2025 at Northern Hospital, 185 Cooper Street, Epping, Victoria 3076;
  - c) I accept and adopt the medical cause of death ascribed by Dr Gregory Young and I find that Michael Patrick Doran, a man with epilepsy, Down syndrome and Alzheimer's dementia died from influenza B;
2. The available evidence does not support a finding that there was any want of clinical management or care on the part of the disability service provider, or clinical staff, that caused or contributed to Michael Patrick Doran's death.
  3. Having considered all the available evidence, I find that Michael Patrick Doran's death was from natural causes and that no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death and to finalise the investigation in chambers.

I convey my sincere condolences to Michael'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:

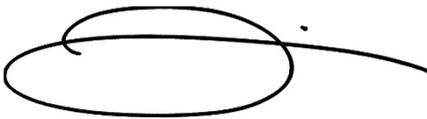
State Trustees

Life Without Barriers

Northern Health

Senior Constable Jack Miller, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 26 February 2026



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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.

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