



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign King at Adelaide in the State of South Australia, on the 2nd day of December 2022 and the 30th day of June 2023, by the Coroner's Court of the said State, constituted of David Richard Latimer Whittle, State Coroner, into the death of Shane Michael Doran.

The said Court finds that Shane Michael Doran aged 54 years, late of 103 West Street, Brompton, South Australia died at Brompton, South Australia on or about the 1st day of September 2020 as a result of hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction, reason for inquest and cause of death

- 1.1. Shane Michael Doran was born on 11 June 1966. He died on or about 1 September 2020. He was 54 years old.
- 1.2. An inquest into Mr Doran's death was mandatory, pursuant to section 21(1)(a) of the Coroners Act 2003, as Mr Doran was on home detention bail at the time of his death. This renders Mr Doran's death a death in custody as defined by section 3 of the Coroners Act 2003.
- 1.3. Dr Stephen Wills of Forensic Science South Australia performed a post mortem examination on Mr Doran by way of an external examination and a CT scan. In his report Dr Wills stated the cause of death as hanging,¹ and I so find.

¹ Exhibit C2

2. Background

- 2.1. Ms Maryanne Noon provided background information regarding Mr Doran.² They met in 1988 whilst working as croupiers at the Adelaide Casino and were long-term partners, although they did not always live together.
- 2.2. Mr Doran was born in Murray Bridge and attended Marryatville Primary School and Norwood High School. His parents were Robert and Pam. He was the middle of three children, his siblings being Craig and Rebecca.
- 2.3. Mr Doran had two half-sisters, Marcia and Jennifer, who are children of Mr Doran's father and his later partner Rosalie.
- 2.4. Mr Doran's brother Craig died of leukaemia in 2010 and his mother Pam died from cancer the following year.
- 2.5. In 2012 Mr Doran's sister Rebecca was murdered by her partner Stephen Casey, leaving behind their son Alex. Mr Doran supported his nephew and, according to Ms Noon, was like a father to him. Ms Noon believes that Mr Doran's significant relationships were with herself and his nephew Alex.
- 2.6. Mr Doran's father Robert passed away in 2018.

3. Medical history

- 3.1. In 2018 Mr Doran attended the Royal Adelaide Hospital complaining of a headache. He was diagnosed with an aneurysm of the internal carotid artery. A diverting stent was inserted on 1 February 2018. Mr Doran was also prescribed medication for hypertension. There is no record of Mr Doran ever being diagnosed with any mental health illness, although Ms Noon believes that he may have suffered from an undiagnosed mental illness.³

4. Circumstances leading to the death of Mr Doran

- 4.1. Mr Doran was arrested on 18 May 2020 for alleged offences against Ms Noon. Ms Noon made a report to police on 16 May 2020, but police were unable to locate

² Exhibit C8

³ Exhibit C8

Mr Doran, who handed himself in to police on 18 May 2020. The allegations are set out briefly Ms Noon's statement and in the SAPOL investigating officer's report.⁴

- 4.2. Mr Doran was in police custody overnight on 18 May 2020. For the first two hours of his incarceration Mr Doran was subject to observations every 15 minutes. No concerns were noted on the records and observations then commenced hourly. A risk assessment was conducted by the custody officer, Mr Moriarty, at 1:12pm. The notes indicate that Mr Doran advised Mr Moriarty that he was not suffering from mental health problems or depression and that he had never tried to harm himself.
- 4.3. Mr Doran remained in police custody until 19 May 2020, when he appeared in court and was remanded into the custody of the Department for Correctional Services, whereupon he was then transferred to the Adelaide Remand Centre. He was initially assessed by a registered nurse, Ms Amanda Chambers, of the South Australian Prison Health Service.⁵ The notes made by Ms Chambers indicate that her assessment took about 20 minutes to complete, and it included a mental state examination. She noted that Mr Doran was calm and cooperative, and that she had no concerns in relation to his cognition, his affect, his perception or his behaviour. She assessed him to be at low risk of suicide.
- 4.4. Mr Doran was also interviewed by Baden Watson on 19 May 2020. Mr Watson completed a prisoner stress screening form.⁶ Mr Doran specifically denied suicidal thoughts past or present.
- 4.5. On 2 June 2020 Mr Doran was transferred to the Yatala Labour Prison. He was housed in E Division. He was subject to daily observations. The observation forms completed indicate that Mr Doran appeared to be adapting well to life in prison, that he was mixing well with other prisoners, and that he did not appear to be withdrawn or upset.
- 4.6. On 21 July 2020 Mr Doran was granted home detention bail with electronic monitoring. It appears that he was released on 22 July 2020 at 10:30am.
- 4.7. Mr Doran's home detention bail address was 103 West Street in Brompton. This residence was a shared accommodation complex with detached units at the rear of the address. Mr Doran's supervision conditions required him to report once a week to a

⁴ Exhibit C11

⁵ Exhibit C17

⁶ Exhibit C18

Community Corrections officer. On 24 July 2020 Mr Doran attended his initial appointment with his Community Corrections officer, Mr Daniel Mannix.⁷

- 4.8. During an appointment on 31 July 2020, Mr Mannix recommended that Mr Doran organise a mental health care plan through his general practitioner, to assist him to negotiate his time on home detention bail. Mr Mannix stated in his affidavit that this was his standard practice and that it was not a topic that was raised by Mr Doran.
- 4.9. On 3 August 2020 Mr Doran attended the Hindmarsh General Practice and saw Dr Marr who referred him to a psychologist, Nicole Viscione. However, Dr Marr advised Mr Doran that he did not qualify for a mental health care plan as he did not have an existing mental health issue. Mr Mannix then spoke with Dr Marr over the telephone about the necessity for a mental health care plan for Mr Doran. However, Dr Marr remained of the view that Mr Doran did not qualify for such a plan.
- 4.10. Mr Mannix advised Mr Doran to attend a different practitioner at the Hindmarsh Bowden Health Group, so he then saw Dr Nicholas Hayes on 14 August 2020. Dr Hayes completed a mental health care plan for Mr Doran and provided a copy of that plan to Mrs Viscione, the psychologist, with the effect that sessions with her could be bulk-billed. Mr Doran confirmed with Mr Mannix that he had scheduled an appointment to see Mrs Viscione on 8 September 2020.
- 4.11. On 1 September 2020, Mr Mannix directed Mr Doran to attend the Adelaide Community Corrections Centre at 10am for the purpose of a drug urinalysis check, as provided for by his bail conditions. Mr Doran did not attend the appointment. Mr Mannix was concerned, as Mr Doran had always been compliant with his reporting conditions and he was always on time. Four attempts were made to contact Mr Doran by telephone. When this was unsuccessful Mr Mannix requested that a welfare check be done.
- 4.12. At 12:20pm that day Michael Atkinson, an intensive compliance officer of the Department for Correctional Services, attended Mr Doran's address.⁸ Mr Atkinson gained access to Mr Doran's room and found him lying against the wall with an

⁷ Exhibit C6

⁸ Exhibit C5

extension cord wrapped around his neck, clearly deceased. An ambulance was called and Mr Doran was declared life extinct at 1pm. Police also attended.

- 4.13. Handwritten notes were located, including a note addressed to Ms Noon, a note addressed to Mr Doran's nephew Alex, and a note addressed to coroner or investigator. There was also a document found entitled '*Last will of Shane Michael Doran*' which is signed. The signature on the bottom of that document appears consistent with the signature on the bail agreement. In particular the notes to Ms Noon and his nephew indicate that Mr Doran was remorseful in relation to the alleged assault on Ms Noon. In a note addressed to coroner or investigator Mr Doran states this:

'I have never thought of harming myself just this has got a little bit too much.'

- 4.14. I find that Mr Doran was the author of the notes found, and that they are demonstrative of his intention to end his life.

5. Coronial investigation

- 5.1. At the time of his death Mr Doran was under the supervision of Mr Mannix. To his credit Mr Mannix encouraged Mr Doran to seek mental health support in the absence of any indication to Mr Mannix that Mr Doran was struggling with his mental health. Mr Doran clearly took that advice on notice and made an initial appointment with Dr Marr. When Dr Marr declined to provide the mental health care plan, Mr Mannix advocated on Mr Doran's behalf and encouraged him to see a different general practitioner.
- 5.2. It is clear from the events that followed that at some stage Mr Doran developed a suicidal intent which was not known to Mr Mannix. The notes relating to Mr Doran's appointments with general practitioners on 14 and 18 August 2020 indicate that on 14 August 2020 Mr Doran stated he had no depression or anxiety, no low moods, he felt as if he was coping well, and he had no suicidal ideation or thoughts of self-harm.⁹ On 18 August 2020 he reported feeling anxious, but again stated that he had no delusions, no hallucinations, no suicidal thoughts or attempts, and no issues with substance abuse.

⁹ Exhibit C15

- 5.3. In summary, there is no evidence that Mr Doran disclosed any issues regarding his mental health to his general practitioner in August 2020, despite being encouraged to do so. It may be that at this stage Mr Doran was in fact coping well as he said, and that his mental state declined after 18 August 2020.
- 5.4. The DCS offender case notes after 18 August 2020 indicate that Mr Doran attended two further face-to-face appointments with Mr Mannix, one on 21 August 2020 and another on 28 August 2020. At both appointments Mr Doran confirmed his upcoming psychology appointment with Mrs Viscione and did not report any issues or concerns relating to his state of mind.
- 5.5. On 1 September 2020 Mr Mannix spoke with Mr Doran on the telephone. He authorised a pass-out for Mr Doran to attend a medical appointment the following day. It was during that call that Mr Mannix directed Mr Doran to attend Community Corrections for urinalysis the following day. However, Mr Doran was found deceased on 2 September 2020.
- 5.6. I note that the Department for Correctional Services undertook a review of the supervision of Mr Doran following his death. The post-incident analysis did not find any fault with the supervision of Mr Doran.¹⁰ However, it is noted in the review that Mr Mannix has reflected upon the incident, stating that it has increased his awareness of the fact that people may present well superficially when in fact they are not.
- 5.7. This observation is consistent with the views expressed by Ms Noon. Ms Noon stated that she believes Mr Doran could manipulate mental health assessments and that if he did have a mental health assessment it would appear that he was fine. Ms Noon expressed concern in her statement that if Mr Doran had sought mental health treatment, or had such treatment forced upon him, things may have been different. However, I note that Mr Doran did in fact have an appointment to receive mental health treatment. With hindsight it might be said that the need for that appointment was urgent, but there was nothing to justify that conclusion at the time and it was not and could not have been apparent to Mr Mannix.
- 5.8. Ms Noon also expressed the view that the urinalysis appointment may have prompted Mr Doran's suicide. There was no suggestion of any drugs or alcohol in the system of

¹⁰ Exhibit C11

Mr Doran at the time of his death. However, Ms Noon was of the view that he may have been concerned that the sample would be interfered with and that he would be reincarcerated. If this was a factor, it is not something that Mr Mannix ought to have anticipated.

- 5.9. It is clear from Mr Mannix's statement that he was unaware of particular details of the alleged offending for which Mr Doran was on bail.¹¹ However, Mr Mannix stated that knowledge of these details would not have caused him to change the approach he took to monitoring Mr Doran other than possibly conducting more frequent welfare checks on him.

6. Conclusions

- 6.1. I find that at the time of his death Mr Doran was in the lawful custody of the Department for Correctional Services.
- 6.2. I find that sufficient and appropriate steps were taken by the Department for Correctional Services and by South Australia Police to adequately supervise Mr Doran whilst he was in their custody. Whilst Mr Doran must have developed suicidal ideation at some stage, the lack of any outward signs made it difficult, if not impossible, for those charged with his care to take preventative action.
- 6.3. I have no recommendations to make in this matter.

Key Words: Death in Custody; Home Detention; Suicide

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 30th day of June, 2023.

State Coroner

¹¹ Exhibit C6a