IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 4561

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of JOSEPH VITALE

Delivered On:	11 OCTOBER 2018
Delivered At:	THE CORONERS COURT OF VICTORIA 65 KAVANAGH STREET, SOUTHBANK
Hearing Date:	12 SEPTEMBER 2018
Findings of:	CORONER PHILLIP BYRNE
Attendees:	MS ELISA TYMMS & MS LOTTA LILJA OF THE JUSTICE ASSURANCE AND REVIEW OFFICE MS MEREDITH WILLIAMSON OF JUSTICE HEALTH
Counsel Assisting the Coroner	MS STEFANIE TODOROV, COURT LEGAL OFFICER

I, PHILLIP BYRNE, Coroner, having investigated the death of Joseph Vitale
AND having held an inquest in relation to this death on Wednesday 12 September 2018
at The Coroners Court of Victoria
find that the identity of the deceased was Joseph Vitale
born on 2 December 1985
and the death occurred 10 September 2017
at Port Phillip Prison
from:

(a) Unascertained

in the following circumstances:

BACKGROUND

1. Joseph Vitale, 31 years of age at the time of his death, was in custody at Port Phillip Prison. His sentence was due to expire on 13 November 2017 when it was proposed that he be deported to New Zealand. Mr. Vitale wished to remain in Australia and proposed to appeal the decision that he be deported.

CURCUMSTANCES SURROUNDING DEATH

2. At 7.30am on 10 September 2017 a corrections officer conducted what is known as a "pre-let-out trap count" at Mr. Vitale's cell. It is stated Mr. Vitale raised a hand in acknowledgement.

3. At 9am Mr. Vitale's cell was unlocked and his cellmate exited. Mr. Vitale remained in the lower bunk. At approximately 9.10am having been advised Mr. Vitale had a scheduled appointment with the Opioid Substitution Therapy Program a corrections officer made a public address announcement in the unit requesting Mr. Vitale keep the appointment. As there was no response a second announcement was made. Further reminders of the scheduled appointment were made by way of the cell intercom. Again, there was no response. Finally, a correction officer attended at the cell and shortly thereafter observed that Mr. Vitale was unresponsive without a pulse.

4. A code Black (death or serious medical event) was called at 9.44am. A corrections officer immediately commenced CPR until medical staff attended within minutes and took over CPR including enlisting a defibrillator. Ambulance paramedics who had been summoned arrived at the scene shortly after 10am. In spite of full resuscitation measures Mr. Vitale remained unresponsive. At 10.30am CPR was ceased as futile and Mr. Vitale was declared deceased. Shortly after 11am, following established protocols, members of Victoria Police attended including a member from Wyndham Criminal Investigation Unit. Again, following established protocols investigating a police member examined Mr. Vitale body; no signs of injury were observed.

CORONIAL INVESTIGATION

5. Mr. Vitale's unexpected death was reported to the coroner. Having considered the circumstances, having conferred with a forensic pathologist and being advised the family did not object to autopsy, I directed a full autopsy and ancillary tests.

6. An autopsy was performed at VIFM by Forensic Pathology Registrar Dr. Melanie Baker. Professor Noel Woodford Director of VIFM reviewed Dr. Baker's findings. In spite of

exhaustive autopsy and extensive ancillary tests the precise cause of Mr. Vitale death could not be determined. It remains therefore

a) Unascertained.

7. At their request, prior to post mortem examination, I took the unusual step of authorising family members undertake their own examination/inspection of the body of Mr. Vitale.

MANDATORY INQUEST

8. Section 52 of the Coroners Act 2008 mandates that an inquest must be held where the deceased person was, immediately before death, an inmate in prison. However, as a result of a relatively recent amendment to the Act, section 52 (3A) provides that if the Coroner considers the death was due to natural causes then a formal inquest need not be held.

9. In this particular case as the forensic pathologist was unable to determine the precise cause of death, which remains "unascertained", I am unable to invoke section 52 (3A) which means I am required to proceed to inquest.

10. In those circumstances the matter can proceed to either full inquest, or alternatively summary inquest; the latter involving tendering of the investigation material without hearing oral, *viva voce* evidence.

11. In this matter I had my registrar list the matter for 12 September 2018, invite the interested parties and advise it was likely that matter would proceed as a summary inquest. Invited to the hearing were Mr. Vitale's family, the coroner's investigator, solicitors for G4S Custodial Services P/L the operators of Port Phillip Prison, together with representatives of both Justice Assurance and Review Office (JARO) within the Department of Justice & Regulation, and Justice Health the latter two entities had provided to the Court reports in relation their respective reviews of the custodial management and provision of health care provided to Mr. Vitale while in custody.

12. The matter proceeded as an open court summary inquest on 12 September 2018. At the hearing Ms. Stefanie Todorov a legal officer at the court, appeared to assist. No family members attended. Ms. Elisha Tymms and Ms. Lotta Lilja, both of JARO and Ms. Meredith Williamson, from Justice Health attended the hearing. At the hearing I explained the bases upon which I had proceeded to summary inquest.

13. Prior to the hearing I wanted to know whether JARO would want to claim public interest immunity in relation to their comprehensive report to which the Justice Health report was included as Attachment 1. It was likely I would make use of the Summary of Findings in the JARO report. In response to a query made on my behalf by my legal officer Mr. Darren

McGee on the afternoon of 11 September 2018, I was advised that the Department did not seek to claim public interest immunity in relation to the summary of findings in the JARO report.

14. The principal reason I proposed to proceed by way of summary inquest, rather than full inquest, was because my tentative view was that the police investigation established there were no suspicious circumstances, nor third party involvement in Mr. Vitale's death, nor was there any suggestion of intentional self-harm. Furthermore, after exhaustive postmortem examination, the precise cause of Mr. Vitale's death remained undetermined.

15. In broad terms, the JARO and Justice Health reviews concluded, after what appear to be comprehensive thorough, objective, robust investigations, that the management and care provided to Mr. Vitale while he was in custody was in accord with prescribed standards and within the Justice Health Quality Framework 2014.

16. In those circumstances, I considered there were only three issues I needed to further consider and in respect of which I would make formal findings:

    - Did custodial management meet the presented standards?
    - While in custody was Mr. Vitale provided with appropriate care in relation to both his physical and mental health?
    - Upon being located unresponsive was the response in that emergency situation reasonable and appropriate?

17. Although Mr. Vitale's cause of death remains unascertained, and as I have stated there is no evidence that his death was related to intentional self-harm, I have satisfied myself that the management of Mr. Vitale's mental health issues, (schizophrenia and intermittent bouts of depression) were appropriately addressed while he was in custody.

18. I note that one particular aspect of heath management was considered by JARO, to be sub-optimal, in that an incident of suicide ideation on 30 July 2016, although responded to appropriately, was not entered on the Corrections Victoria database. In relation to that matter JARO made a recommendation which, in my view, does not require coronial imprimatur as I am entirely satisfied it was not a causal or contributing factor in his subsequent death. If Mr. Vitale had intentionally taken his own life the matter may well have been different.

FINDING

19. I formally find Joseph Vitale died at Port Phillip Prison on 10 September 2017 due to unascertained causes. I add that I am satisfied there were no suspicious circumstances, nor

third party involvement in his death. I am further satisfied that the correctional management met prescribed requirements and the health care provided to Mr. Vitale, in relation to both physical and mental treatment/care was reasonable and appropriate, and in accordance with relevant expectations.

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

    - Mrs Vai Vitale, Senior Next of Kin;
    - Ms Michelle Gavin, Acting Director, Justice Assurance and Review Office;
    - Mr Scott Swanwick, Justice Health, Department of Justice and Regulation;
    - Ms Ingrid Nunnink, Marsh and Maher Richmond Bennison Lawyers on behalf of G4S Custodial Services; and
    - Sergeant Christopher Black, Coroner's Investigator.

Signature:

PHILLIP BYRNE
CORONER
Date: 11 October 2018