IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 006212

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Mark Fava
Date of birth:	16 March 1977
Date of death:	8 November 2023
Cause of death:	Coronary artery disease
Place of death:	Port Phillip Prison 451 Dohertys Road Truganina Victoria
Keywords:	In custody – natural causes

INTRODUCTION

1. On 8 November 2023, Mark Fava was 46 years old when he passed away at Port Phillip Prison (**PPP**). PPP is operated by staff from G4S Custodial Services Pty Ltd (**G4S**) and medical services to prisoners at PPP are provided by St Vincent's Custodial Health Service (**SVCHS)**.

BACKGROUND

2. In around 2011, Mr Fava had his right leg amputated below the knee as a result of an accident.

3. On 10 October 2023, Mr Fava was remanded in custody at the Melbourne Assessment Prison relating to charges of burglary, theft and committing an indictable offence while on bail. On 16 October 2023, he was transferred to PPP where he was ultimately placed in the Sirius West unit. While in custody, Mr Fava complained of ongoing nerve pain relating to his amputation for which he was prescribed amitriptyline.

THE CORONIAL INVESTIGATION

4. Mr Fava's death constitutes a "*reportable death*" under sections 4(1)(b) and 4(2)(c) of the *Coroners Act 2008* (**the Act**), as his death occurred in Victoria and immediately before his death, he was a person placed in custody or care. However, an inquest was not required to be held pursuant to section 52(3A) of the Act given that Mr Fava's death was from natural causes.

5. 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.

6. 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.

7. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Mr Fava'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.

8. This finding draws on the totality of the coronial investigation into Mr Fava's death including evidence contained in the coronial brief and the JARO report (see below). While 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]

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

Circumstances in which the death occurred

9. On 8 November 2023 at 7.56am, Mr Fava was located unresponsive by custodial staff while lying supine on his bed in his cell. A Code Black[2] was activated at 7.58am and an ambulance was called. Health staff attended the cell at 8.00am and commenced cardiopulmonary resuscitation (**CPR**).

10. At 8.01am, Tactical Operations Group (**TOG**)[3] officers arrived and assisted to move Mr Fava to the floor where CPR and defibrillation attempts were continued. Ambulance Victoria arrived at 8.14am. At 8.21am, paramedics directed that CPR be ceased and Mr Fava was pronounced deceased.

11. Victoria Police attended the scene and did not identify any suspicious circumstances.

Identity of the deceased

12. On 16 November 2023, Mark Fava, born 16 March 1977, was identified via fingerprint identification.

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

Medical cause of death

14. Senior Forensic Pathologist Dr Philip Burke from the Victorian Institute of Forensic Medicine performed an autopsy on 15 November 2023 and provided a written report of his findings dated 4 December 2023.

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

[2] A Code Black is a medical alarm which signifies a serious medical incident requiring urgent assistance.

[3] Specialist correctional officers with responsibilities for responding to prison incidents and escorting prisoners around the prison.

15. Dr Burke did not identify any evidence of injury which would have contributed or led to death. He noted that there was significant heart disease which was consistent with causing sudden death due to sudden cardiac arrhythmia.

16. Toxicological analysis of post-mortem samples identified the presence of amitriptyline.[4]

17. Dr Burke provided an opinion that the medical cause of death was *1(a) Coronary artery disease* and that the death was due to natural causes.

18. I accept Dr Burke's opinion.

OTHER INVESTIGATIONS

19. Section 7 of the Act requires the coroner to liaise with other investigative authorities and to not unnecessarily duplicate inquiries and investigations.

20. Mr Fava's death was reviewed by the Justice Assurance and Review Office (**JARO**) which is part of the Department of Justice & Community Safety and reported to the Secretary to the Department, who is responsible for the monitoring of all correctional services to achieve the safe custody and welfare of prisoners.[5]

21. JARO prepared a report containing its findings and recommendations which it produced to the Court on 29 November 2024. The review was conducted in collaboration with Justice Health.[6]

22. In summary, JARO made the following relevant findings:

    a) The healthcare provided to Mr Fava in custody was well managed and consistent with policy requirements and the Justice Health Quality Framework; and

    b) The overall custodial management provided to Mr Fava was appropriate.

23. JARO noted that the response of health staff to Mr Fava's death was in accordance with current policy and procedure but noted that CPR was continued until the arrival of Ambulance Victoria paramedics, notwithstanding that no signs of life were observed to be evident and rigor mortis was present. JARO highlighted the vicarious trauma risk posed by continued

[4] Amitriptyline is an antidepressant indicated for major depression, panic disorder, neuropathic pain and enuresis.
[5] Section 7 of the *Corrections Act 1986*.
[6] Justice Health is a part of the Department of Justice and Community Safety and has responsibility for the delivery of health services to Victoria's prisoners.

resuscitation attempts in individuals who have clinical signs of death, which also risks causing post-mortem injury.

24. JARO identified a number of minor opportunities for improvement where the response of custodial officers to Mr Fava's death was inconsistent with established incident response procedures, specifically:

    a) Custodial staff not providing Mr Fava with immediate first aid after finding him unresponsive in his cell;

    b) Several staff failing to activate their Body Worn Cameras; and

    c) Tabards not being worn by the Unit Supervisor and Field Commander.

25. JARO noted that a formal staff instruction was issued to custodial staff by G4S on 11 January 2024 to ensure they were aware that CPR is to be commenced as soon as possible, once safe to do so.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Mark Fava, born 16 March 1977;

    b) the death occurred on 8 November 2023 at Port Phillip Prison, 451 Dohertys Road, Truganina, Victoria, from coronary artery disease; and

    c) the death occurred in the circumstances described above.

27. As noted above, Mr Fava's death was reportable by virtue of sections 4(1)(b) and 4(2)(c) of the Act because, immediately before his death, he was a person placed in custody as defined in section 3 of the Act. Section 52 of the Act requires an inquest to be held, except in circumstances where someone is deemed to have died from natural causes. In the circumstances, I am satisfied that Mr Fava died from natural causes and that no further investigation is required. Accordingly, I exercise my discretion under section 52(3A) of the Act not to hold an inquest into his death.

I convey my sincere condolences to Mr Fava'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:

Teresa Reiss, Senior Next of Kin

Department of Justice and Community Safety, c/o Victorian Government Solicitor's Office

Justice Assurance and Review Office

G4S Custodial Services Pty Ltd, c/o Gilchrist Connell

Alfred Health

Senior Constable Justin Hollander, Coronial Investigator

Signature:

Coroner David Ryan

Date: 19 February 2025

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.