IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2007 3964

FINDING INTO DEATH WITH INQUEST[1]

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

Inquest into the Death of: IGNAC LECEK

Hearing Dates:	4 October 2010 – 8 October 2010 29 November 2010 – 1 December 2010
Appearances:	• Mr A. Burns on behalf of The GEO Group Australia Pty Ltd and Pacific Shores Health • Mr P. Halley on behalf of Dr. Anthony McCarthy • Mr P. McCaffrey on behalf of the Chief Commissioner of Police • Mr R. Gipp on behalf of Senior Constable Grant Polglase • Ms E. Rice on behalf of the Lecek family (from 8 October 2010)
Counsel Assisting the Coroner:	Ms Fiona Ellis instructed by Ms Sarah Manly, Solicitor
Findings of:	AUDREY JAMIESON, CORONER
Delivered on:	29 May 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank 3006

[1] The Finding does not purport to refer to all aspects of the evidence obtained in the course of the Investigation. The material relied upon included statements and documents tendered in evidence together with the Transcript of proceedings and submissions of legal representatives/Counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

I, AUDREY JAMIESON, Coroner having investigated the death of IGNAC LECEK

AND having held an inquest in relation to this death on 4 – 8 October 2010 and

29 November 2010 - 1 December 2010

at Melbourne

find that the identity of the deceased was IGNAC LECEK

born on 23 July 1939

and the death occurred on 4 October 2007

at St. Vincent's Hospital, Fitzroy 3065

from:

1(a) ISCHAEMIC SMALL AND LARGE INTESTINE COMPLICATING CARDIOGENIC SHOCK IN THE SETTING OF ISCHAEMIC HEART DISEASE

in the following summary of circumstances:

1. On 4 October 2010, a mandatory inquest under section 52(2)(b) of the *Coroners Act 2008* (Vic) (the Act)[2] began into the death of Mr Ignac Lecek, because immediately before death, Mr Lecek was "a person placed in custody" as it is defined in the Act, in that prior to his death, Mr Lecek was in legal custody and was being detained at the Melbourne Custody Centre.

2. On 2 October 2007, Mr Lecek was taken into custody in Bendigo and detained in the Bendigo Police cells. On 3 October 2007, Mr Lecek was transferred to the Melbourne Custody Centre and on 4 October 2007, Mr Lecek was located collapsed in his cell. He was transferred to St. Vincent's Hospital but died later that day. Mr Lecek had been complaining of feeling ill since approximately 9.50pm on 2 October 2007 and on 3 October 2007, he was experiencing vomiting and diarrhoea. He was assessed by a number of custodial nurses, but was not reviewed by a doctor until he was transferred to St. Vincent's Hospital.

[2] See below discussion under the heading "Jurisdiction" for further explanation.

BACKGROUND CIRCUMSTANCES

3. Mr Ignac Lecek was 68 years of age at the time of his death. He lived in Elmore, Victoria. According to his son Robert Lecek, Mr Lecek came from a close and loving family.

Medical History

4. Mr Lecek had a history of hypertension and gout. He had been a patient of General Practitioner Dr Adel Asaid at the Elmore Medical Practice since approximately 2000. The Elmore Medical Practice records, amongst other things, reflect that:

    a. in 2001 Mr Lecek had a laparoscopic cholecysetcomy which was complicated by a duodenal perforation requiring emergency laparotomy and oversew;

    b. in February 2002 Mr Lecek was reviewed by General Surgeon Mr Barling, whose opinion was that Mr Lecek was recovering well although suffering from a number of unrelated conditions including carpal tunnel syndrome.

    c. in June 2003 Mr Lecek was again reviewed by Mr Barling, who from an abdominal point of view, regarded Mr Lecek, as "settling down quite nicely." Mr Lecek however reported some pain in the epigastrium and a gastroscopy was organised;

    d. following the gastroscopy Mr Lecek was diagnosed by Registrar to Mr Barling, Dr Ischia, as suffering from gastritis;

    e. in July 2007 Mr Lecek was reviewed by Dr B. Lai at Bendigo Hospital on referral from Dr Asaid in relation to a complaint of *pruiitis ani*. Mr Lecek was noted to have "no altered bowel actions, [no] PR bleeding, PR discharge or constipation. He has had no recent change in diet or increased intake of spicy food, however he drinks two bottles of wine per day on most days."[3]

SURROUNDING CIRCUMSTANCES

Bendigo Police Station

5. On 2 October 2007, at approximately 5.40pm Mr Lecek arrived at the custodial watch house, Bendigo Police Station (BPS) subsequent to being remanded in custody for sentence. He was searched by police members and spoken to by the Watch House Keeper, Senior Constable (SC)

[3] Statement and attachments from Dr Adel Asaid dated 2 February 2010 – Inquest Brief (IB) @ pp70-85.

Grant Polglase, who asked Mr Lecek questions about his identity and whether he had any welfare concerns. He was then placed alone in cell F1.

6. At approximately 7.39pm, SC Polglase returned to Mr Lecek's cell and observed he had not eaten his meal. SC Polglase spoke to Mr Lecek about not eating his meal, but Mr Lecek did not raise any health issues.

7. At 9.50pm, SC Polglase again attended the watch house. On this occasion, Mr Lecek asked for toilet paper and water and complained of feeling ill and tight in the stomach. There was a discussion between them about requesting the attendance of a doctor and SC Polglase told Mr Lecek that he would organise for the doctor to attend at the watch house in the morning.[4]

8. SC Daniel Valentine and SC Jason Smith worked the night shift at the BPS commencing at 10.00pm. Neither officer observed anything about Mr Lecek's behaviour to indicate any concerns about his health.[5] Prior to lock down, Mr Lecek was observed to use the toilet but otherwise appeared to sleep overnight.[6] The officers observed Mr Lecek's cell via the watch house monitors from time to time during the night and did not notice him moving around.[7]

9. On 3 October 2007, SC Polglase commenced his shift at the watch house at 6.00am. At approximately 7.22am, Mr Lecek requested to see a doctor as he had been experiencing vomiting and diarrhoea.

10. At approximately 7.26am, SC Polglase rang the custodial medical officer Dr Anthony McCarthy (CMO Dr McCarthy), on his mobile telephone and left a message for him to attend the police station.[8] At approximately 9:51am, SC Polglase contacted the doctor's surgery and left a message with the staff that the doctor was required[9] at BPS.

11. At approximately 10.28am, SC Polglase contacted the Victoria Police Custodial Medicine Unit in Melbourne and spoke to the on call custodial nurse, Registered Nurse Samuel Hindle (RN Hindle) about Mr Lecek's complaints of feeling unwell. After asking SC Polglase a number of questions about Mr Lecek's symptoms, RN Hindle advised that only clear fluids were to be

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[4] Exhibit 1 – Statement of Grant Polglase dated 24 November 2011.
[5] Exhibit 6 – Statement of Daniel Valentine dated 5 October 2007.
[6] Exhibit 7 – Statement of Jason Smith dated 5 October 2007.
[7] Transcript of proceedings (T) @ p68.
[8] Exhibit 1 – Statement of Grant Polglase dated 24 November 2011.
[9] *Ibid.*

taken and that SC Polglase should monitor Mr Lecek until reviewed by a custodial medical officer. [10]

12. SC Polglase conveyed the advice given to him by RN Hindle to Mr Lecek and told him that he would see a doctor at Melbourne Custody Centre (MCC) if the custodial medical officer did not arrive at BPS before he left.

13. At approximately 12.00pm, Mr Lecek told SC Polglase that he was still feeling ill. SC Polglase gave Mr Lecek a plastic bag and water for his transfer to MCC. At 12.12pm, Mr Lecek was taken from his cell at BPS for transfer to MCC. He had not yet seen the custodial medical officer.

14. Mr Lecek was transported to MCC by GSL Victorian Prisoner Service (GSL) in a VicPol Brawler, MBS 146. SC Polglase advised Mr Brian Merry, Escort Officer (EO Merry) of Mr Lecek's complaints of vomiting and diarrhoea and that he had not yet seen the Custodial Medical Officer. EO Merry observed Mr Lecek to be "gaunt, thin and grey" and that he "didn't look well."[11] The journey to Melbourne took approximately two and a half hours. At Malmsbury the Escort Officers[12] stopped their transport vehicle and checked on Mr Lecek's welfare. EO Merry observed Mr Lecek on the vehicle's CCTV monitor throughout the course of the journey. Mr Lecek appeared unwell and vomited twice.[13]

Melbourne Custody Centre[14]

15. On arrival at the MCC, EO Merry informed the person he believed to be in charge at the time, Custody Officer "Chris" (CO Chris Lewis) that Mr Lecek had been complaining of diarrhoea and vomiting and suggested to CO Chris that "he should seek some medical attention for him as soon as possible".[15] CO Michael Breese, Shift Supervisor (CO Breese) was also present in the Reception area when Mr Lecek arrived at the MCC.

16. At approximately 2.50pm, Mr Lecek was lodged at the MCC. He arrived without any paperwork reporting that he had a medical condition, that the custodial nurse had been contacted

[10] Exhinit 9 – Statement of Samuel Hindle dated 19 December 2007.
[11] Exhibit 35 – Statement of Brain Merry dated 18 November 2010.
[12] EO Merry and EO Dino Brunato was driving the transport vehicle.
[13] Exhibit 35 – Statement of Brain Merry, above n 11.
[14] At the time of Mr Lecek's death GEO Australia Group Pty Ltd managed the Melbourne Custody Centre. On 28 March 2010, G4S assumed responsibility for the day-to-day running of The Melbourne Custody Centre on behalf of Victoria Police.
[15] Exhibit 35 – Statement of Brain Merry, above n 11.

about this medical condition or that he needed to see a doctor. He had a sick bag and water bottle in his possession and told CO Breese that he was feeling a bit queasy but was okay now.[16] Mr Lecek was placed in the holding cell and subsequently searched before being taken to see the custody nurse for a routine admission assessment.

17. At approximately 3.30pm, Mr Lecek was assessed by the custodial nurse, Registered Nurse Sarah Walsh (CRN Walsh) in the presence of CO Breese. CRN Walsh undertook routine observations and obtained a history from Mr Lecek noting that he was a chronic alcoholic, suffered from gout and hypertension for which he was prescribed "progout" and Coversyl respectively. He had not brought any of his medication with him. Mr Lecek complained to CRN Walsh of feeling cold and she noted that he looked cold. She was otherwise not concerned about Mr Lecek as all his observations were within normal limits.[17] CRN Walsh recommended that Mr Lecek receive his prescription medication and because she believed that Mr Lecek was withdrawing from alcohol, she also recommended that he commence the MCC's standard alcohol withdrawal regime of diazepam and thiamine. CRN Walsh placed Mr Lecek on hourly observations[18] to be undertaken by COs because he had multiple medical problems, was withdrawing from alcohol[19] and because he was elderly.[20] CRN Walsh assessed Mr Lecek's serious medical condition as high risk.[21]

18. Mr Lecek shared cell 24 with Mr Stephen Lambert who described Mr Lecek as looking "pretty fucked" and as "walking really slow and bent over."[22] Mr Lambert said that Mr Lecek was vomiting, not eating. Mr Lambert made up Mr Lecek's bed for him because he was unwell. Overnight, Mr Lambert buzzed the custodial officers on two occasions and informed them that Mr Lecek had vomited multiple times. A custodial officer responded by providing Mr Lecek with a *throw up* bag which, according to Mr Lambert, Mr Lecek emptied about three times during the night.[23]

19. On 4 October 2007, Mr Lecek told Mr Lambert that he felt too sick to have a shower and that he could not move.[24] According to Mr Lambert, the COs threatened to take Mr Lecek's bedding

[16] Exhibit 13 – Statement of Michael Breese dated 10 October 2007.
[17] Exhibit 16 – Statement of Sarah Walsh dated 24 October 2007.
[18] Exhibit 18 - 'Risk Assessment Plan' completed by CRN Walsh.
[19] Exhibit 21 - 'Alcohol Withdrawal Scale' completed by CRN Walsh.
[20] Exhibit 16 – Statement of Sarah Walsh, above n 17.
[21] Inquest Brief (IB) @ p24.
[22] Exhibit 30 - Statement of Stephen Lambert dated 5 October 2007.
[23] *Ibid.*
[24] *Ibid.*

away if he did not have a shower. At 7.37am Mr Lecek got up from his bed and was escorted from the cell by CO Paul Regulski. He returned to his cell at approximately 8.00am.[25] According to Mr Lambert, Mr Lecek was still vomiting.[26]

20. At approximately 8.00am, custodial nurse, RN Christopher Woolven (CRN Woolven) administered Mr Lecek's medication. CRN Woolven noted that Mr Lecek looked unwell and had a dusky tinge and was lethargic which he attributed to Mr Lecek being a withdrawing alcoholic.[27] CRN Woolven did not ask Mr Lecek how he was feeling.[28] CRN Woolven checked Mr Lecek's file and put him down for review by the nurse clinic later in the morning.

21. At 9.00am, CO Jeffrey Williams (CO Williams) checked on Mr Lecek as a part of his duties on the High Risk Assessment Team (HRAT).[29]

22. At approximately 1.10pm, CO Williams returned to cell 24 in response to a request to undertake a HRAT check. From the observation window in the cell door, CO Williams could see Mr Lecek lying on his stomach on his bed with his head to the side. Mr Lecek did not respond to CO Williams' questions and he was not moving. CO Williams called for assistance from CO Lewis as he wanted to enter the cell to check on Mr Lecek.[30] On entering cell 24, CO Williams said that Mr Lecek was grumbling and that he could not understand what Mr Lecek was saying to him. He said that Mr Lecek seemed tired and his skin was blotchy with a blue tinge. CO Williams left cell 24 and reported to CRN Woolven that Mr Lecek did not look well. CRN Woolven requested that the CO escort Mr Lecek to the clinic to see him. CO Williams returned to collect Mr Lecek requesting assistance from CO Dave Ebert (CO Ebert). Shortly after entering cell 24, Shift Manager CO Breese also entered the cell. The COs tried to help Mr Lecek to stand up from his bed but they were unable to move him. CO Williams requested CRN Woolven to attend at cell 24.[31] On attending the cell, CRN Woolven observed that Mr Lecek was only semi-conscious and unable to respond to his commands. His limbs were cold and flaccid.[32] CRN Woolven returned to the clinic to collect oxygen for administration and a pulse oximeter to measure Mr Lecek's oxygen saturation levels. CRN Woolven returned and

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[25] Exhibit 40 – DVD of CCTV footage.
[26] Exhibit 30 - Statement of Stephen Lambert, above n 22.
[27] IB @ pp34-35 – (Statement of Christopher Woolven dated 19 December 2007).
[28] T @ p536.
[29] Exhibit 25 - Statement of Jeffrey Williams dated 9 October 2007.
[30] *Ibid.*
[31] *Ibid.*
[32] Exhibit 43 - Statement of Christopher Woolven dated 19 December 2007.

attempted to take Mr Lecek's observations but was unable to detect any blood pressure, pulse or oxygen saturation levels. He requested that an ambulance be called.[33]

Ambulance transfer

23. At 1.22pm, a Mobile Intensive Care Ambulance (MICA) was dispatched for MCC for a "male unconscious".[34] The single responder MICA paramedic, Damien Dambrosi (MICA paramedic Dambrosi) was backed up by an ambulance paramedic unit. Both units were responding on a Code 1 representing a Time Critical assessment and the activation of both lights and sirens. MICA paramedic Dambrosi arrived at MCC at 1.26pm and was at Mr Lecek's side at 1.31pm.[35] He noted that Mr Lecek appeared extremely unwell with mottled skin and an altered conscious state. He had no detectable radial pulses and no recordable blood pressure and did not verbally respond to MICA paramedic Dambrosi's questions other than to be seen to rubbing his abdomen.[36] From the history provided to MICA paramedic Dambrosi by MCC staff, he considered a diagnosis of dissecting abdominal aortic aneurysm. He inserted an intravenous cannula and commenced intravenous fluids before arranging urgent transfer to St. Vincent's Hospital (SVH). The ambulance departed the MCC at 1.42pm also on a Code 1, Time Critical assessment with the activation of both lights and sirens and arrived at SVH Accident & Emergency (A&E) at 1.47pm.

St. Vincent's Hospital

24. At approximately 2.00pm, the on-call vascular surgeon Mr Mark Westcott was made aware of Mr Lecek's arrival at SVH A&E by Dr Toby Cohen, Surgical Registrar who told him that Mr Lecek's history was one of a 68 year old man with back and abdominal pain and collapse with vascular risk factors. The diagnosis was of a possible ruptured aortic aneurysm. Due to Mr Lecek's hemodynamic instability he was taken directly to the operating theatre. On his arrival in the operating theatre, Mr Westcott noted Mr Lecek to be markedly cyanotic and peripherally shut down. He performed a targeted ultrasound scan of the abdomen to assess for the presence of an aneurysm but none was identified. Mr Westcott proceeded to aortic angiography to confirm that there was no vascular catastrophe occurring. Before plans for possible exploratory surgery could be advanced, Mr Lecek suffered a cardio-respiratory arrest. He was intubated at

[33] *Ibid.*
[34] IB @ pp40-43 – (Statement of Damien Dambrosi [undated]).
[35] *Ibid.*
[36] *Ibid.*

2.55pm and chest compressions commenced at 3.00pm. Despite resuscitation efforts Mr Lecek did not respond and he was declared deceased at 3.20pm.[37]

INVESTIGATION

Identification

25. The identity of Ignac Lecek was without dispute and required no additional investigation.

Forensic Medical Investigation

26. On 8 October 2007, Dr. Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM) performed an autopsy on the body of Ignac Lecek. Dr. Lynch reported that at autopsy there was evidence of marked bowel ischaemia and significant coronary artery atherosclerosis and myocardial fibrosis involving anterior, posterior and septal walls of the left ventricle. Post mortem toxicological analysis of antemortem specimens obtained from St. Vincent's Hospital detected diazepam, levels of which Dr. Lynch stated were consistent with therapeutic administration. Dr Lynch ascribed the cause of Mr Lecek's death to ischaemic bowel (involving both the small and large intestines) which has occurred as a complication of cardiogenic shock in the setting of ischaemic heart disease.

Police Investigation

27. Detective Sergeant Greg Baker (DS Baker) from Melbourne Crime Investigation Unit (CIU) undertook the investigation and compilation of the Inquest Brief on my behalf.

JURISDICTION

28. At the time of Mr Lecek's death, the *Coroners Act 1985* (Vic) (the old Act) applied. From 1 November 2009, the *Coroners Act 2008* (Vic) (the new Act) has applied to the finalisation of investigations into deaths that occurred prior to the new Act commencement.[38]

29. In the preamble to the new Act, the role of the coronial system in Victoria is stated to involve the independent investigation of deaths for finding the causes of those deaths and to contribute to the reduction of the number of preventable deaths and the promotion of public health and safety and the administration of justice. Reference to preventable deaths and public health and safety is found in other sections of the new Act.[39]

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[37] Exhibit 31 – Statement of Dr Mark Wescott dated 17 January 2008.
[38] Section 119 and Schedule 1 - *Coroners Act 2008*.
[39] See for example, sections 67(3) and 72 (1) & (2).

30. Section 67 of the new Act describes the ambit of the Coroner's Findings in relation to a death investigation. A Coroner is required to find, if possible, the identity of the deceased, the cause of death and, and in some cases, the circumstances in which the death occurred.[40] The 'cause of death' generally relates to the *medical cause of death* and the 'circumstances' relates to the *context* in which the death occurred.

31. A Coroner may also comment on any matter connected with the death, including matters relating to public health and safety and the administration of justice.[41] A Coroner may also report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with a death, which the Coroner has investigated including recommendations relating to public health and safety or the administration of justice.[42]

Standard of proof

32. The standard of proof for coronial findings of fact is the civil standard, being on the balance of probabilities as expounded in *Briginshaw.*[43] Coroners should not therefore make adverse comment about or findings against individuals unless the evidence provides a comfortable satisfaction that their departure from the prevailing standards of their profession has caused or contributed to the death under investigation.

INQUEST

Direction hearings were held on 9 February 2010 and 9 March 2010. The Inquest was held from 4 October 2010 to 8 October 2010 and 29 November 2010 to 1 December 2010.

33. The following issues were identified as requiring further exploration:

    a. the cause of death;

[40] Section 67(1).
[41] Section 67(3).
[42] Section 72(1) & (2).
[43] *Briginshaw v Briginshaw* (1938) 60 CLR 336 @ pp362-363. "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences..." (per Dixon J).

b. whether the care, observation and treatment of Mr Lecek whilst lodged at the BPS was responsive to his medical condition, complaint and/or request(s) for medical assessment and/or treatment;

c. does the failure of a medical practitioner (the custodial medical officer) in not attending to Mr Lecek whilst lodged in the BPS represent the loss of an early opportunity to possibly diagnose and, treat Mr Lecek's condition, thereby possibly averting the ultimate outcome;

d. was the response of the on-call custodial nurse appropriate in the absence of attending on Mr Lecek; is there an expectation that the on-call custodial nurse will attend on sick prisoners and if so, in what circumstances and what is the role of the custodial nurse to report to the custodial medical officer and/or a custodial centre;

e. the relevance (if any) the fact that Mr Lecek was in the custody of BPS and/or MCC had upon the delivery of medical treatment, nursing care and overall care and management;

f. was there sufficient information conveyed by BPS to MCC to enable the custody centre to adequately appreciate Mr Lecek's current medical condition and need/request for medical assessment;

g. were the hourly observations of Mr Lecek conducted at the MCC adequate to enable identification of a change in his condition; and

h. whether there are identifiable failures in communication that are relevant to the circumstances surrounding Mr Lecek's death (and if so what possible recommendations could follow).

***Viva voce* evidence at Inquest**

34. *Viva voce* evidence was obtained from the following witnesses:

a. Senior Constable Grant Polglase, BPS;

b. Senior Constable Daniel Valentine, BPS;

c. Senior Constable Jason Smith, BPS;

d. RN Samuel Hindle, Victoria Police Custodial Medicine Centre;

e. Dr. Anthony McCarthy, Custodial Medical Officer;

f. Michael Breese, Custody Officer, MCC;

g. RN Sarah Walsh, Custodial Nurse, MCC;

h. Jeffrey Williams, Custody Officer, MCC;

i. Paul Reguliski, Custody Officer, MCC;

j. Dr. Matthew Lynch, Forensic Pathologist, VIFM;

k. Stephen Lambert, fellow prisoner at the MCC;

l. Dr. Mark Westcott, St. Vincent's Hospital;

m. Dr. Angela Sungaila, Independent Expert Opinion;

n. Dr. John Quinn, Independent Expert Opinion;

o. Brian Merry, Escort Officer;

p. Chris Lewis, Custody Officer MCC;[44]

q. Timothy Luckman, Operations Manager, MCC;

r. John Morrell, Department of Justice;

s. Detective Sergeant Gregory Baker, Coroner's Investigator;

t. Acting Senior Sergeant Anthony Kekich; and

u. RN Christopher Woolven, Custodial Nurse, MCC.

35. At the conclusion of the evidence, I heard submissions from Counsel Assisting and Counsel appearing on behalf of the Interested Parties. I have had regard to these submissions in making my Findings.

[44] At the time of giving evidence at the Inquest, Chris Lewis was no longer a CO but a Constable with Victoria Police. For consistency I have referred to him throughout the Finding as "CO Lewis".

Medical attention at BPS

36. On 2 October 2007, following SC Polglase's discussion with Mr Lecek about his complaint of feeling ill and tight in his stomach, it was agreed to wait until the next morning to contact a doctor to attend BPS.

37. On 3 October Mr Lecek complained of vomiting and diarrhoea and requested to see a doctor. SC Polglase attempted to contact the CMO, Dr McCarthy on two occasions, the first being at 7.26am and the second at approximately 9.51am. His reasons for contacting Dr McCarthy at these times were not because he held the view that Mr Lecek required urgent medical attention, but rather that he was hoping to arrange for Dr McCarthy to attend the cells before going to his surgery. [45] In his evidence, SC Polglase said that Mr Lecek did not "come across really sick" and that he was aware that there was a bit of a "gastro outbreak at the time."[46] SC Polglase said that if there had been any perceived urgency to Mr Lecek's presentation, either an ambulance would be called or the prisoner would have been transferred by police car to hospital. There is no ability at BPS to contact an alternate medical practitioner to the CMO.[47]

38. CMO Dr McCarthy stated that his employment contract with the Custodial Medical Unit of Victoria Police is to provide services that are requested in a reasonable type of way. He said:

> *"If detainees are seriously unwell and clearly require urgent treatment that either an ambulance is called or they are taken to hospital. There is really no facility to treat seriously unwell people in the police cells".*[48]

39. Dr McCarthy said that there was nothing communicated to him that indicated any urgency for a review of the prisoner and that he had intended to attend the cells during his lunch break.

40. Dr Westcott gave evidence and Dr Sungaila agreed[49] that a medical practitioner informed of a prisoner suffering from diarrhoea or vomiting would not attribute any urgency to the request to review that person.[50] Both doctors Westcott and Sungaila gave evidence that it would be reasonable for a medical practitioner in such circumstances to delay consultation for a few hours.

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[45] T @ p21.
[46] *Ibid.*
[47] T @ p27.
[48] T @ p125.
[49] T @ p356.
[50] T @ p328.

41. Doctors Sungaila and Westcott further gave evidence that it was reasonable for a lay person such as a police officer not to appreciate the potentially serious significance of symptoms such as vomiting and diarrhoea in an elderly person.[51]

42. According to Dr Quinn it is was "less than ideal"[52] that Mr Lecek was transferred from the BPS to the MCC on 3 October 2007 given that he continued to be unwell and had requested but had not yet been reviewed by a medical practitioner. In addition, the fact that the custodial nurse contacted by SC Polglase was in Melbourne and not in a position to examine Mr Lecek, "emphasises the fact that some medically trained person needed to see Mr Lecek in Bendigo before he went anywhere."[53] Dr Sungaila also stated that Mr Lecek ought to have been reviewed by a medical practitioner "sooner rather than later"[54] that is, prior to transfer. According to Mr Westcott and Dr Sungaila, if Mr Lecek had been reviewed by a medical practitioner whilst at the BPS, then it is likely that that doctor would have been able to detect indicators of illness either by way of examination or investigations. If such medical intervention had been afforded to Mr Lecek prior to his departure from BPS, Mr Westcott said that he thought it "highly likely his outcome would have been better".[55]

Observations of Mr Lecek at MCC

43. In her evidence, CRN Walsh said that there was nothing about the matters noted by her on Mr Lecek's presentation that warranted him being seen by a medical officer and nor did he require his observations to be performed by a person with nursing or medical qualifications. With the benefit of hindsight, however, CRN Walsh accepted that whilst it was impractical for nurses to carry out the observations of prisoners because of the number of prisoners requiring observations compared with the single nurse on duty, she did say that such observations were better performed by staff who had training and an understanding of what relevant signs and/or symptoms to look for.

44. CRN Walsh had no formal training or qualifications in the area of assessing persons withdrawing from substances however she had seven years practical experience as a nurse performing such assessments in the custodial setting at reception. In CRN Walsh's opinion, Mr

[51] T@ p333 (Westcott), p356 (Sungalia)
[52] Exhibit 34 – Statement of Dr John Quinn dated 1 February 2010
[53] T @ p393.
[54] T @ p358.
[55] T @ p319.

Lecek fell within the category of withdrawing from substance, as had many of the prisoners that she had assessed over the years.

45. Mr Lecek's recent history of feeling unwell was not know to CRN Walsh when he arrived at MCC, however according to Mr Westcott, it was the history recorded by CRN Walsh at the MCC reception that necessitated medical assessment.[56] In particular, Mr Lecek's age, history of hypertension and alcohol withdrawal, together with his vital observations on arrival at MCC; that should have prompted the instigation of a medical assessment. According to Mr Westcott, significantly it was alcohol withdrawal in a person with Mr Lecek's known co-morbidities that required nursing monitoring or observation and/or medication in its' own right.[57] He said:

> *A 68 year old man withdrawing from alcohol of quite a high level, that taken alone is a man at increased risk of other intercurrent illnesses developing.*[58]

46. In relation to Mr Lecek's vital signs as recorded by CRN Walsh, Mr Westcott said that the blood pressure of 130/100 was unusual to see in a man with known hypertension. He said this was evidence of diastolic hypertension while the systolic blood pressure did not show hypertension. He said this would have "flummoxed" him and he would have repeated the blood pressure.[59] In addition, Mr Lecek's temperature was below the normal range, and Mr Westcott would regard this as hypothermia.[60] Mr Westcott considered it could also be consistent with ischemia of the bowel[61] and could be seen as signifying possible illness.[62] According to Mr Westcott, the fact that he was only wearing a T shirt in the Reception area was not relevant in terms of his temperature.[63]

47. According to Dr Sungaila's evidence, if BPS had provided CRN Walsh with Mr Lecek's history, it may have changed her perspective of Mr Lecek's health status.

> *...without the benefit of knowing the symptoms and the fact that he had been sick for the entire night, she may be excused for thinking that – relying on her observations entirely and going to the extent of arranging hourly observations later. With the*

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[56] T @ p315.
[57] T @ p341.
[58] T @ pp314-315.
[59] T @ pp313, 338.
[60] T @ p313.
[61] T @ p338.
[62] T @ p339.
[63] *Ibid.*

wisdom of hindsight clearly it was inadequate and clearly she should have arranged a medical assessment. [64]

48. However, Dr Sungaila in evidence agreed that even if the absence of any communication from BPS to MCC, there were enough indices from CRN Walsh's own assessment to have prompted her to ensure that a medical assessment took place or, in the alternative, ongoing medical observations were undertaken until the state of Mr Lecek's alcohol withdrawal or any other illness could be monitored or assessed.[65]

49. CRN Woolven understood that Mr Lecek was to have hourly observations was because of his hypertension. Furthermore, the frequency of observations was no more or less than any other prisoner received and the observations were to be carried out by custodial officers. When CRN Woolven saw Mr Lecek at 8.00am on 4 October to administer his medication, he noted that Mr Lecek was exhibiting mild signs and symptoms consistent with withdrawing from alcohol. He described Mr Lecek as "having a dusky tinge" by which he meant that Mr Lecek had a florid nose with nearby broken capillaries. Despite Mr Lecek's relatively benign state, CRN Woolven accessed Mr Lecek's medical file, "because of his appearance". In his evidence however, CRN Woolven sought to clarify the reason for accessing the medical file as being to ascertain the cause of Mr Lecek's known hypertension. CRN Woolven did not take a further set of observations, increase the frequency of Mr Lecek's observations or give specific direction to the custodial staff in relation to Mr Lecek, as his own concern for him was not elevated.

50. The type of observations conducted by the custodial staff were to the effect of asking – "are you all right?" and were inadequate in the circumstances of Mr Lecek's case according to Dr Sungaila.[66] Dr Sungaila said that this type of inquiry by way of observation would have no positive benefit and may in fact elicit an inaccurate response from the prisoner, which in turn may "delay treatment or an assessment or an awareness of the illness that is progressing".[67]

51. Contrary to the evidence of CO Williams[68] and CRN Woolven[69] about vomiting and diarrhoea frequently being seen in persons experiencing alcohol withdrawal, Mr Westcott stated that he would not regard vomiting and diarrhoea as the standard sign of alcohol withdrawal. Rather, he

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[64] T @ p365.
[65] T @ p366.
[66] T @ p361.
[67] T @ p362.
[68] T @ p202.
[69] IB @ pp34-35 – (Statement of Christopher Woolven, above n 32), T @ pp534-535.

said that these symptoms represent pathology rather than alcohol withdrawal, signalling that the gut "simply is not working".[70]

52. CRN Woolven's description of Mr Lecek on the morning of 4 October 2007 and that of EO Merry's on the day before, during the transportation of Mr Lecek, is difficult to reconcile. It is unlikely from all the evidence of Mr Lecek's appearance and behaviour that his presentation to CRN Woolven was somewhat better than how he had appeared to EO Merry the previous day. CCTV footage on Mr Lecek in his cell over the period between 3 and 4 October 2007 shows him repeatedly vomiting and/or dry retching. He also frequently used the toilet during that period. The physical description of Mr Lecek by CRN Woolven and that of Mr Lecek's cell mate, Mr Lambert is also difficult to reconcile. Similarly, the physical description of Mr Lecek by CRN Woolven is difficult to reconcile with the images of Mr Lecek on the CCTV footage and with both Mr Westcott's or Dr Quinn's commentary about Mr Lecek's appearance on the CCTV footage.

Cause of death

53. At the time of preparing his report,[71] Dr Lynch had available to him both the Police Report of Death for the Coroner (Form 83) and the medical practitioner's deposition. It was only during his *viva voce* evidence that Dr Lynch learnt that the St Vincent's Hospital records also contain biochemistry results consistent with an acute myocardial infarction. Nevertheless Dr Lynch did not seek to alter the cause of death he ascribed in his report.[72] He gave evidence that the cause of death could be narrowed down but in his opinion, ischemic heart disease catches both acute and chronic ischemic changes.

54. According to Dr Lynch, there are at least two possible scenarios that led to Mr Lecek's death. One begins with cardiogenic shock leading to acute ischemia of the bowel and the other, an inadequate blood flow combined with a blockage to the blood vessels causing ineffective flow to the all tissues.[73] He was unable however to distinguish between these two scenarios.[74] In his evidence Dr Lynch said that he was able to demonstrate during the autopsy that:

> *... a bowel that shows ischemic damage as a result of under perfusion, so it wasn't*

[70] T @ p317.
[71] Exhibit 28 – Autopsy Report of Dr Matthew Lynch dated 6 October 2010.
[72] T @ pp272, 273.
[73] T @ p258.
[74] T @ pp 259 - 260.

getting enough blood. And the reason it wasn't getting enough blood could be that either related to (sic) a generalised under perfusion of tissues, such as in shock, and in this case cardiogenic shock, or as a result of some kind of inadequate blood flow combined, combined with blockage to the blood vessels to the bowel. [75]

55. Dr Lynch was unable to say whether the ischemic change in the bowel was recent or otherwise, whether it was related to Mr Lecek's complaints of abdominal pain in the days before death[76] and he could not exclude the possibility that Mr Lecek was suffering coincidentally from a gastro intestinal disorder causing vomiting and diarrhoea as distinct from the ischemic bowel.

56. Mr Westcott's evidence also touched on Mr Lecek's cause of death. As the Vascular Surgeon who treated Mr Lecek upon his arrival at St Vincent's Hospital on 4 October 2007, Mr Westcott said that in the setting of dehydration, Mr Lecek was vulnerable to an acute myocardial event due to his underlying vascular disease evidenced by the findings of ischemic heart disease and diseased mesenteries. Mr Westcott said that gross dehydration depicted in Mr Lecek's elevated haemoglobin[77] and creatinine levels,[78] with or in the absence of an acute myocardial infarct, led to Mr Lecek becoming hypotensive, which in turn led to cardiogenic shock from underperfusion of his vital organs. Mr Westcott said that Mr Lecek's high haemoglobin reflects quite severe volume depletion, "and hence an increase in blood viscosity and a tendency towards thrombosis."[79] Mr Westcott said that his creatinine level,[80] in the absence of a history of renal impairment, would have occurred over a period of days and not hours and was probably the result of Mr Lecek's vomiting and diarrhoea.[81] Mr Lecek's gross dehydration was inextricable from his demise in that it resulted in hypoperfusion of the bowel and worsening of the cardiogenic shock.[82]

57. According to Mr Westcott, Mr Lecek's Troponin I level of 12.7 mcg/L as depicted in the biochemistry results of his admission blood tests, indicated that the acute myocardial event was

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[75] T @ p251.
[76] T @ pp251, 252.
[77] T @ p304.
[78] T @ p309.
[79] T @ p306.
[80] Biochemistry and haematology results from bloods drawn in the ED demonstrated a creatinine level of 441 micromol/L and Hb of 215g/L - (Exhibit 31 – Statement of Mark Westcott dated 17 January 2008).
[81] T @ p309.
[82] T @ p307.

most likely to have occurred six to 12 hours before his collapse at the MCC.[83] He said that cardiogenic shock eventuates because of a:

> *..vicious cycle of some pump failure occurring resulting in the ischemia to the bowel which has led to abdominal pain, the vomiting, the diarrhoea, fluid depletion, dehydration, then a failure of the heart to function properly due to the volume depletion and a worsening of the ischaemia, so a re-entering cycle, a vicious positive feedback cycle that's led to worsening myocardial function and worsening bowel perfusion in ischaemia.*[84]

Whether or not there were sufficient signs and/or symptoms which, if detected earlier, may have led to a different outcome.

58. From 2 October 2007, Mr Lecek complained of abdominal tightness after he was placed in the cells at BPS. The extent of this "tightness" is difficult to discern. Dr Lynch said that tightness could be the same as discomfort which in itself is not dissimilar to abdominal pain.[85] Dr Lynch noted that the original report of the circumstances surrounding Mr Lecek's death as depicted in the Police Report of Death for the Coroner (Form 83) definitely refers to "abdominal pain".[86] Dr Sungalia agreed with this proposition.[87] There is an absence of CCTV footage from the BPS[88] but the CCTV footage of Mr Lecek's cell at MCC provided clear and cogent evidence that he was repeatedly vomiting and suffering from diarrhoea.

59. Mr Westcott had an opportunity to view some of this CCTV footage and read the transcript of the same, and agreed that the footage depicted Mr Lecek frequently vomiting and dry retching as well as frequently going to the toilet. In the viewed CCTV footage, Mr Westcott said that Mr Lecek appeared to be "in a terrible state".[89] He said that he believed there were "more than 20 documented episodes of retching or vomiting" which "were entirely consistent with the degree of gross volume depletion and dehydration seen at the time of presentation"[90] at St. Vincent's Hospital.

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[83] T @ p303.
[84] T @ p305.
[85] T @ p261.
[86] T @ p261.
[87] T @ p357.
[88] CCTV footage from BPS was inadvertently overwritten.
[89] T @ p318.
[90] T @ p318.

60. According to Mr Westcott the critical window of opportunity to change the outcome for Mr Lecek, was in the 24 hours before his death, which equates with the approximate time of his admission to MCC at approximately 3.00pm on 3 October 2007. Within those 24 hours and in particular, in the six hours prior to admission at St. Vincent's Hospital, is the likely timeframe of the onset of the acute myocardial infarction evidenced by the Troponin I level and the absence of acute myocardial infarction at autopsy. If Mr Lecek's deteriorating condition had been noted and treated within the 24 hours, excluding the last six hours, Mr Westcott considered Mr Lecek's chances of survival as 'highly likely to be very good",[91] but only possible[92] to remote[93] at or after that six hour mark prior to his presentation at hospital.

61. Dr Quinn opined that if Mr Lecek had received medical intervention after 2 October and before his admission to St Vincent's Hospital, it would have made a difference, in particular if medical attention had been received 24 hours prior to admission, then he would have had a likely chance of survival. He said the earlier the medical assessment, the greater the chance of his survival. Dr Quinn opined that while Mr Lecek's care in custody could have been more assiduous, "it may not have made any difference to the eventual outcome except in a temporal one."[94]

Systems of Communication

i) Communication between the BPS and GSL

62. SC Polglase gave evidence that he informed the transport staff about Mr Lecek's complaint in the expectation that they would continue to keep an eye on him during transport and on-communicate the issues to staff at the MCC.[95] EO Merry corroborated the evidence of SC Polglase that he did receive an overview about Mr Lecek from the watch housekeeper at the BPS. EO Merry also stated that he did make frequent observations of Mr Lecek during the trip to MCC and then on-communicated to the MCC staff that "the prisoner was complaining of diarrhoea and vomiting"[96] and that "he should seek some medical attention for him as soon as possible".[97]

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[91] T @ p320.
[92] T @ p321.
[93] T @ p335.
[94] Exhibit 34 – Expert Opinion Report of Dr John Quinn, above n 52.
[95] T @ pp31-32.
[96] Exhibit 35 – Statement of Brian Merry, above n 11.
[97] *Ibid.*

63. The evidence of CO Breese, who was acting in the role of shift supervisor at the MCC on 3 October 2007, was that he had no recollection of any conversation with transport staff about Mr Lecek on his reception into the MCC. He quite categorically said:

> *I was told nothing about the prisoner, you know, whether there wasn't any concerns or there was, I was told nothing.*[98]

64. Conversely, CO Lewis, said that the GSL Prisoner Transport arrived at MCC at approximately 1.30pm with Mr Lecek from the BPS, and that he had a conversation with the driver[99] of the truck who informed him that Lecek was not feeling well. CO Lewis stated that Mr Lecek

> *..had possession of a sick bag and was asked if he was ok and needed anything to which he replied "No".*[100]

65. In his evidence, CO Lewis said that he could not remember the exact wording EO Merry used about Mr Lecek's condition apart from that Mr Lecek was feeling unwell.[101] CO Lewis said he did not pass this information onto the shift supervisor or the CRN as the information was not indicative of anything serious. He said there was not a requirement to do so "unless it was serious enough",[102] but because Mr Lecek "walked in and he spoke to us and he sat down and he said he didn't need anything",[103] CO Lewis said he did not need to pass the information from the transport driver, EO Merry, on and that Mr Lecek would see the nurse "pretty much straight away after he'd been lodged."[104] CO Lewis was working on the reception counter at the time of Mr Lecek's arrival at MCC, and acknowledged that he had access to information through the computer system that may have been entered by police officers at a police station, but that he did not access this information in this instance.[105]

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[98] T @ p133.
[99] PO Lewis recognised Mr Merry as the driver when he was present in Court – T @ p441.
[100] Exhibit 36 – Statement of Chris Lewis dated 19 November 2011.
[101] T @ p442.
[102] T @ pp445, 450-451.
[103] *Ibid.*
[104] T @ p450.
[105] T @ p443.

*ii) Interface between the Thin Blue Line (BPS) and E*Justice*[106]

66. SC Polglase gave evidence that he made entries on the computer module, the Thin Blue Line, at BPS. The computer system enables SC Polglase to view the observations of other officers who made entries over the course of Mr Lecek's incarceration in the cells. SC Polglase also said that any custody centre including MCC can access the observations entered into the Thin Blue Line at any police station.[107]

67. The information that was available on the Thin Blue Line and accessible to CN Walsh and CO Breese included:

    a. Mr Lecek had complained of feeling ill and tight in the stomach on 2 October;

    b. Mr Lecek had requested to see a doctor on 3 October;

    c. a doctor had twice been contacted on 3 October;

    d. advice had been sought from a custodial nurse; and

    e. Mr Lecek had not been seen by a doctor prior to transfer (although this fact would have also been known by reason that Mr Lecek arrived at MCC without a "pink form").

68. In her evidence, CRN Walsh said that she was not aware that she could view observations recorded on the Thin Blue Line via the E*Justice system.[108]. She said that normally, any concerns for a prisoner coming into the MCC would be conveyed to her through:

    ..the shift manager who would have spoken to the transport drivers or occasionally we would get a phone call from the custodial nurse.[109]

69. CRN Walsh said that she had not received any formal training in relation to either the Thin Blue Line or E*Justice.[110] CRN Walsh had however accessed the system before 3 October 2007, having been informed by a colleague, that the system might assist in providing a prisoner's

[106] "The E*Justice application was developed to track an individual from attendance and custody at a police station, through any court proceedings, through any custodial or non-custodial penalty to discharge from the system." – Exhibit 38 – Statement of John Morrell dated 16 November 2010.
[107] T @ p31.
[108] T @ pp171, 486, 488.
[109] T @ p171.
[110] T @ pp486-487

history of psychiatric illness.[111] CRN Walsh said she was unaware that the computer system held any observations recorded by police officers who had had the care and custody of the prisoner prior to their arrival at the MCC.[112]

70. Mr John Morrell, Manager, Application Management, Knowledge Information and Technology Services, Department of Justice, was asked to examine whether MCC staff were able to access observation notes entered by BPS staff. Mr Morrell confirmed that an analysis of the audit logs showed that MCC staff were able to access observation notes entered by BPS staff.[113] He also said that there was evidence that MCC staff had accessed Mr Lecek's details over 3 to 4 October 2007, but there was no evidence that either CRN Walsh or CO Breese had accessed Mr Lecek's custody overview or his observation data in the same period.[114]

iii) Communication to the custodial nurses

71. SC Polglase contacted the custodial registered nurse, CRN Hindle at the Custodial Medical Centre in Melbourne for advice. He was of the view that the CRN would arrange for Mr Lecek to be reviewed by a medical officer. CRN Hindle gave evidence that the system does not necessarily work like that[115] and he did not make contact with the MCC because he was not aware that Mr Lecek was to be transferred.[116]

72. CRN Walsh gave evidence that if she was to receive an update about an incoming prisoner's medical condition, it would likely be received from the facility that the prisoner was coming from and more likely to occur if the prisoner was coming from a facility where a registered nurse was employed. In other words, direct communication about a prisoner's medical condition in CRN Walsh's experience, occurred between custodial facilities rather than police cells.[117]

Observations undertaken by Custodial Officers

73. CO Williams gave evidence about of the ability of custodial officers to conduct observations without specific direction from medical or nursing staff and stated that he would prefer if the

[111] T @ p488.
[112] T @ pp488-489.
[113] Exhibit 38 – Statement of John Morrell, above n 106.
[114] *Ibid.*
[115] T @ pp 89-90.
[116] T @ p88.
[117] T @ pp172-173.

nurses carried out the observations themselves.[118] He said that custodial officers are not medically trained and any judgement about what they observed in a prisoner required medical training.[119]

74. CRN Walsh was not critical of the system that required custodial officers to perform the hourly observations and felt that a safeguard existed whereby the custodial officers report any adverse response to the question "are you all right?" to the nurse. She did, however, accept that custodial officers were not trained in identifying those matters that may attract the interest of nursing staff. CRN Walsh herself had no formal training or qualifications in the area of assessing people withdrawing from substances.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

1. The circumstances of Mr Lecek's death highlights the dangers of making assumptions about the "health" of prisoners only being associated with abuse of substances and/or withdrawal from the same rather than assuming a prisoner's baseline to be that of good health.

2. Over exposure to substances abusing/withdrawing prisoners in conjunction with the seeming repetition of processing prisoners coming into the MCC appears to have resulted in a laissez-faire approach to maintaining effective lines of communication in general and to the nursing assessment of Mr Lecek at reception specifically.

3. SC Polglase tried to seek medical attention for Mr Lecek, however with the benefit of hindsight, should have sent him to hospital when he could not achieve what he considered necessary at the time that is, an examination of Mr Lecek by the CMO and/or achieve the assistance Mr Lecek was asking for.

4. RN Hindle did not follow-up with a telephone call to the MCC on either Mr Lecek's condition upon arrival to the MCC or to relay the advice sought from him prior to Mr Lecek's transport. EO Merry told CO Lewis at the MCC of his concerns during the transportation of Mr Lecek from Bendigo but CO Lewis did not pass this information on. The "system" places too much reliance on the prisoner advising each and every one of the professionals involved in his processing of his feelings of ill health. Not one staff member at the MCC, including CRN

[118] T @ p202.
[119] *Ibid.*

Walsh, made any enquiries with either E*Justice or the BPS despite some of Mr Lecek's observations, in which he was depicted as "gaunt", "thin", "elderly", "grey" and "cold" and despite his cellmate attempting to tell the custody officers that Mr Lecek was not well.

5. The "nursing" approach to prisoner Mr Lecek did not accord with the standard of nursing care expected to be provided in the community – there was no follow-up of vital signs, no documentation of Mr Lecek's skin colour, no documentation of phone orders for medication and the administration of benzodiazepines or for the basis of the very cursory diagnosis of alcohol withdrawal, made by an individual not formally trained in this area.

6. The "system" of communication between custodial centres lacked structure and certainty and in this case, failed Mr Lecek.

FINDINGS

1. I find that the identity of the deceased is Ignac Lecek.

2. I accept and adopt the medical cause of death as identified by Dr. Matthew Lynch and find that Ignac Lecek died from ischaemic small and large intestine complicating cardiogenic shock in the setting of ischaemic heart disease.

3. I find that the failure to have Mr Lecek seen by a medical practitioner in the Bendigo Police Station prior to his transportation to Melbourne Custody Centre may have influenced the outcome. However, I accept the submissions of Counsel Assisting that the responsibility associated with any such failure and loss of opportunity to instigate timely and appropriate medical care to Mr Lecek does not lay with individuals. At the Bendigo Police Station, the loss of opportunity to instigate timely and appropriate medical care rests with the system in place, which, as reflected by Mr Lecek's case, did not support the non-medically trained police officer to explore anything other than limited options to provide medical attention to him. At that time, Mr Lecek did not fit into the emergency end of the spectrum that necessitated direct transfer to hospital, which left Senior Constable Polglase to make the decision on whether to facilitate the scheduled transfer to Melbourne Custody Centre when for all intents and purposes from Senior Constable Polglase assessment, Mr Lecek did not "come across really sick". Senior Constable Polglase explored advice from the custodial nurse, which I consider was an appropriate course of action for him to adopt in the circumstances. The system in place at the time did not empower Senior Constable Polglase to seek out an alternative medical practitioner to attend the Bendigo Police Station. Save for sending Mr Lecek directly to hospital, Senior Constable Polglase

explored all the options that the system afforded him. Accordingly, I make no adverse finding against Senior Constable Polglase or any other police officer at the Bendigo Police Station.

4. Similarly, I make no adverse finding against custodial medical officer Dr McCarthy, who is not a full-time custodial medical officer for the Bendigo Police Station but must accommodate requests to attend to prisoners whilst running and attending to his own private practise patients. I accept that he intended to attend the Bendigo Police Station in his lunchtime on 3 October 2007, and accept that he did not personally have information available to him that would have alerted him that his attendance might have been required earlier in the day.

5. AND I find that Senior Constable Polglase did communicate to the GSL Victorian Prisoner Service Transport driver, Escort Officer Merry, his knowledge and observations of Mr Lecek's unwellness whilst in the Bendigo Police Station.

6. I find that at the time of Mr Lecek's lodgement at the Melbourne Custody Centre, Escort Officer Merry communicated to the Reception Custody Officer his observations of Mr Lecek during transportation from the Bendigo Police Station to the Melbourne Custody Centre and I accept his evidence that he also communicated his opinion that Mr Lecek needed medical attention.

7. I find that the information about Mr Lecek's period of unwellness from his time at the Bendigo Police Station and during his transportation to the Melbourne Custody Centre was not communicated to the shift supervisor Custody Officer Breese or to the custodial nurse, Registered Nurse Walsh. At the outset of his lodgement at the Melbourne Custody Centre, this was an opportunity lost to the Melbourne Custody Centre staff to be better informed of Mr Lecek's immediate and relevant medical history. The opportunity to inform the Melbourne Custody Centre staff of Mr Lecek's immediate and relevant medical history was further lost because no Melbourne Custody Centre staff member accessed the specific computer module set up to enhance communication between custodial centres, including police cells. Had the observations entered at the Bendigo Police Station been accessed by relevant Melbourne Custody Centre staff they would have been informed that Mr Lecek had requested to see a doctor, and that despite attempts to secure a medical assessment, this had not been achieved before he left the Bendigo Police Station.

8. In the absence of Mr Lecek's immediate and relevant medical history being communicated/discovered, the assessment of him at the Melbourne Custody Centre reception failed to properly consider matters pertinent to his care and management, and although he was

assessed as requiring frequent observations, it was based on the presumption that he was elderly and withdrawing from alcohol. In the absence of knowing his immediate and relevant medical history, no significance was attached to or explored from the vital sign distortions to diastolic blood pressure and temperature. The common occurrence of prisoners withdrawing from alcohol or other substances on admission to the Melbourne Custody Centre effectively "dumbed down" all observations of Mr Lecek to place him in that category or group of prisoners – the observations that were undertaken by non-medically trained Custodial Officers amounted only to "are you alright" and any observations and or complaints of vomiting and diarrhoea merely relegated and written off as relating to his alcohol abuse and withdrawal from the same. In addition, the other most significant consequence flowing from this laissez-faire system was that no arrangements were made for Mr Lecek to be examined by a medical practitioner.

9. I find that the management of Mr Lecek's health and well-being at the Melbourne Custody Centre was of a lesser standard than would have been rendered to Mr Lecek had he been in the community. The opportunities lost to afford Mr Lecek appropriate and timely medical attention resulted from systemic shortcomings and not through the actions or inactions of particular individuals. Each significant individual Custodial Officer and the custodial Registered Nurse did not have any immediate concerns for Mr Lecek's health and wellbeing. Each and every observation of either his skin colour or his gastrointestinal problems could be and were explained by the belief that he was withdrawing from alcohol. There is no evidence that Mr Lecek ever repeated the request made at the Bendigo Police Station to see a doctor after arriving at the Melbourne Custody Centre, which appears to have reinforced to all those individuals who came into contact with him that there was nothing of great moment about his unwellness.

10. I accept the evidence of Vascular Surgeon Mr Westcott that the critical timeframe within which the instigation of medical treatment may have altered the outcome for Mr Lecek was at about the time he was admitted into the Melbourne Custody Centre. For each hour that elapsed thereafter, the chances of medical intervention achieving a different outcome becomes less certain. While only 68 years old, Mr Lecek had not insignificant co-morbidities and post mortem findings depict significant vascular compromise. In all of the circumstances I cannot therefore make a definitive finding that more timely and appropriate access to medical care would have prevented Mr Lecek's death. I do however find that systemic shortcomings denied him that opportunity.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations connected with the death:

Noting in particular that because The GEO Group Australia Pty Ltd is no longer the operators of the Melbourne Custody Centre, it is necessary to direct recommendations to the current operator. However, given that GEO continue to operate another custodial centre in Victoria,[120] I ask that they heed the following recommendations that would have, but for the passage of time, been directed at them.

1. With a view to providing access to additional medical support to regional police stations with custodial facilities and providing support to existing Custodial Medical Officers and preventing like circumstances, I recommend that Victoria Police, if they have not already done so, review its' policy and/or arrangements with regionally based medical practitioners in the position of Custodial Medical Officer with a view to having at least two medical practitioners available for contact by the watch-house keeper/police station.

2. With a view to improving access to medical attention/consultation by prisoners and preventing like circumstances, I recommend that the current operator of the Melbourne Custody Centre, G4S, if they have not already done so, engage a medical practitioner to assist in the admission health assessments and in particular, should include but not be limited to, having a medical practitioner on site to review and prescribe medications to prisoners that have arrived into custody without their own prescription medication, to check vital observations that are not within a normal range and to provide additional input to management strategies for those prisoners suspected or known to be withdrawing from substances.

3. With a view to supporting custodial registered nurses in their role of assessing, monitoring and recommending management strategies of prisoners suffering from or believed to be suffering from withdrawal from substances and preventing like circumstances, I recommend that the current operator of Melbourne Custody Centre, G4S, provide and/or arrange for formal training/professional development for its' custodial registered nurses in the area of drug and alcohol withdrawal.

[120] I understand that the GEO Group Australia Pty Ltd continue to manage Fulham Correctional Centre in Sale, Victoria on behalf of Corrections Victoria.

4. With a view to supporting custodial officers in their role of observing prisoners suffering from or believed to be suffering from withdrawal from substances and supporting custodial officers in making assessments about the welfare of prisoners suffering from or believed to be suffering from withdrawal from substances and preventing like circumstances, I recommend that the current operator of the Melbourne Custody Centre, G4S, provide and/or arrange for formal training/professional development for its' custodial officers in the area of drug and alcohol withdrawal.

5. With a view to improving lines of communication between custodial centres including police cells, and in particular improving communication about the medical/mental health of prisoners moving between custodial centres, including police cells and preventing like circumstances, I recommend that the current operator of the Melbourne Custody Centre, G4S, if they have not already done so, provide training and instruction on accessing, navigating, viewing and entering data about prisoner welfare observations onto relevant computer modules/programs whether that be E*Justice, the Thin Blue Line or their current equivalents/replacements.

6. With a view to improving lines of communication between custodial centres including police cells and in particular improving communication about the medical/mental health of prisoners moving between custodial centres including police cells and with the view of better informing staff at the Melbourne Custody Centre about in-coming prisoners and preventing like circumstances, I recommend that the current operator of the Melbourne Custody Centre, G4S, if they have not already done so, mandate the accessing of computer generated prisoner welfare observations, including known medical information, by the reception custodial officer and the reception custodial nurse.

7. With a view to improving outcomes for prisoners and supporting custodial officers in performing duties consistent with their training and preventing like circumstances, I recommend that the current operator of the Melbourne Custody Centre, G4S, if they have not already done so, implement a system whereby any prisoner assessed by the custodial nurse and/or doctor, as having an altered physical state and /or other concerns regarding their physical wellbeing, have their observations conducted and recorded by a custodial nurse instead of or in addition to, a custodial officer.

8. The CCTV footage from the cells at BPS was inadvertently overwritten despite timely notification to the Bendigo Police Station that Mr Lecek had died in custody. With a view to

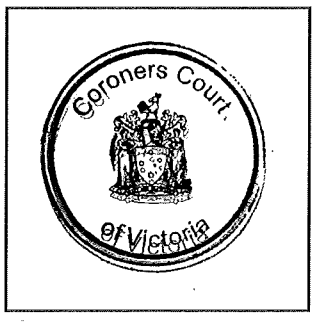
improving the retention of CCTV footage in custodial centres including police cells and preventing like circumstances, I recommend that Victoria Police, if they have not already done so, review its' policies and procedures regarding the retention of the same particularly in light of the notifications of a death in custody.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that this Finding be published on the internet.

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

- Robert Lecek
- Ms Sarah Manly, Russell Kennedy Lawyers
- Victorian Government Solicitors Office (VGSO) for the Chief Commissioner of Police
- G4S Australia and New Zealand
- Monahan & Rowell Lawyers on behalf of Dr. Anthony McCarthy
- Guild Lawyers on behalf of The GEO Group Australia Pty Ltd and Pacific Shores Health
- Lander & Rogers Lawyers on behalf of Senior Constable Polglase
- Maddocks Lawyers on behalf of the Lecek family
- Office of Correctional Services Review
- Justice Health
- The Honourable Martin Pakula, Attorney General of Victoria
- The Honourable Wade Noonan, Minister for Corrections

Signature:



AUDREY JAMIESON
CORONER
Date: **29 May 2015**