IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2021 006480

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

INQUEST INTO THE DEATH OF WENDY ANN McCABE

Findings of:	Coroner Audrey Jamieson
Delivered On:	12 November 2025
Delivered At:	65 Kavanagh Street Southbank, Victoria, 3006
Hearing Dates:	12 November 2025
Assisting the Coroner:	Samantha Brown, Principal Inhouse Solicitor
Representation:	Rachel Ellyard of counsel on behalf of the Chief Commissioner of Police Andrew Imrie of counsel on behalf of nine separately represented Victoria Police members
Catchwords	Death in police custody, Knox, self-harm/suicide risk warnings, demeanour, risk assessment and management in police custody, Victoria Police Manual policy changes

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SUMMARY

1. Wendy Ann McCabe was 40 years old when she died on 3 December 2021 at Box Hill Hospital in Box Hill, Victoria, of hypoxic ischaemic encephalopathy secondary to ligature compression of the neck.

2. Ms McCabe was arrested in Boronia on the morning of 2 December 2021 and was lodged in the cells at Knox Police Station (**Knox**) at 12.19pm pending a bail/remand hearing later that day.

3. Just before 8pm, Ms McCabe was found unresponsive in the "female cell" at Knox with a ligature around her neck fashioned from a Victoria Police-issued blanket.

4. Prior to being found unresponsive at 7.58pm, police members' last direct contact with her was one hour and 26 minutes earlier, at 6.32pm, when they provided Ms McCabe with a cup of tea.

THE CORONIAL JURISDICTION

5. Ms McCabe's death falls within the definition of a *'reportable death'*[1] in section 4 of the *Coroners Act 2008* (**the Act**), satisfying both section 4(2)(a) of the Act which includes (relevantly) a death that appears to be unexpected or to have resulted from an accident or injury, and section 4(2)(c) which captures deaths where a person immediately before death was a person placed 'in custody or care.' From the time of her arrest in Boronia and throughout her detention at Knox Police station, Ms McCabe was 'in the custody of a police officer' and remained so at the time of her death.[2]

6. The Coroners Court of Victoria is an inquisitorial jurisdiction.[3] Coroners independently investigate reportable deaths to ascertain, if possible, the identity of the deceased person,

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[1] The term is exhaustively defined in section 4 of the Act *2008*. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act). Some deaths fall within the definition irrespective of the section 4(2)(a) characterisation of the 'type of death' and turn solely on the status of the deceased immediately before they died – section 4(2)(c) to (f) inclusive.

[2] See the definition of a 'person placed in custody or care' in section 3 of the Act.
[3] Section 89(4) *Coroners Act* 2008.

the cause of death and the circumstances in which death occurred.[4] The *cause* of death refers to the *medical* cause or mechanism of death. For coronial purposes, the *circumstances* in which death occurred refers to the surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[5]

7. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by Coroners, generally referred to as the 'prevention' role.[6] Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[7] These are effectively the vehicles by which the prevention role may be advanced.[8]

8. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.

9. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[9] In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw*.[10] These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

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[4] Section 67(1) of the *Coroners Act 2008*. All references which follow are to the provisions of this Act, unless otherwise stipulated.

[5] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[6] The "prevention" role is explicitly articulated in the Preamble and Purposes of the Act.

[7] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[8] See also sections 73(1) and 72(5) of the Act which requires publication of Coronial Findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a Coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[9] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.

[10] (1938) 60 CLR 336.

- the nature and consequence of the facts to be proved;
- the seriousness of any allegations made;
- the inherent unlikelihood of the occurrence alleged;
- the gravity of the consequences flowing from an adverse finding; and
- if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

10. The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

Mandatory inquest

11. Ms McCabe's status as a *person placed in custody or care*[11] at the time of her death meant that an inquest was mandatory under section 52(2)(b) of the Act.

12. At the conclusion of my investigation, I was satisfied that I could discharge my obligations pursuant to s67 of the Act and make findings about the deceased's identity, the cause of death and the circumstances in which death occurred without the need to call witnesses. This was because no evidentiary conflicts or discrepancies were identified that would justify calling witnesses. Accordingly, the matter was listed for Summary Inquest only.

Sources of Evidence

13. This Finding draws on the totality of the material the product of the coronial investigation into Ms McCabe's death. That is, the court records maintained during the coronial investigation, the Coronial Brief prepared by Detective Leading Senior Constable (**DLSC**) Justin Tippett and further material sought and obtained by the Court, and the submissions made on behalf of Victoria Police and individual police members who interacted with or had responsibility for Ms McCabe's safe management at Knox.

[11] As this phrase is defined in section 3 of the Act.

14. In writing this Finding, I do not purport to summarise all the evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. The absence of reference to any particular aspect of the evidence does not infer that it has not been considered.

BACKGROUND

Personal History

15. Ms McCabe was born in Lewisham, England, to parents Keith Payne and Heather Fields-McCabe. Mr Payne had two older daughters from another relationship and Ms Fields-McCabe had two sons and a daughter after Ms McCabe with a different partner.[12]

16. Shortly after Mr Payne's death, when Ms McCabe was about ten years old, she moved with her mother and younger siblings to Australia, settling in Melbourne's inner-city suburbs.[13]

17. According to Ms McCabe's partner, Brett Swift, Ms McCabe's mother 'struggled with alcohol and drugs' when her children were young.[14] There were periods when Ms McCabe cared for her younger siblings, and other times when all the children were placed separately in foster care.[15] Mr Swift considered that Ms McCabe 'never knew what family was about, as she never had that herself growing up.'[16]

18. Ms McCabe had four children though none were in her care at the time of her death.[17] Her two eldest children live in New Zealand; her two younger children had been placed permanently with other carers, though Ms McCabe continued to have periodic contact with the youngest child.[18]

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[12] CB, page 56.

[13] CB, page 56.

[14] CB, page 56.

[15] CB, page 56.

[16] CB, page 57.

[17] CB, page 57.

[18] Statement of John Daniliuc dated 17 February 2022.

19. Mr Swift described Ms McCabe as 'a firecracker': she was outspoken, strong-willed and the 'life of the party.'[19] Although she 'struggled to get her life together,' she 'always tried' and 'loved her kids more than anything.'[20]

20. Ms McCabe's medical history included asthma, illicit drug use (involving heroin and methylamphetamine), alcohol dependence, bilateral carpal tunnel syndrome, depression and anxiety.[21] Dr Sze Wong of the Boronia Mall Clinic had been Ms McCabe's general practitioner since 2014. Dr Wong saw Ms McCabe monthly to renew prescriptions (in person prior to the Covid-19 pandemic).[22] At the time of her death, Ms McCabe was prescribed 20ml methadone daily as pharmacotherapy, 15mg diazepam twice per day for anxiety, 150mg pregabalin for wrist pain; she had been prescribed 20mg fluoxetine daily for depression but unilaterally ceased using it in June 2021.[23] Ms McCabe collected diazepam and methadone doses weekly from a pharmacy in Croydon.[24]

21. At the time of her death, Ms McCabe was living alone in Ringwood in public housing.

Contacts with Police, Hospitals, Courts and Corrections Victoria after May 2021

22. Ms McCabe's contact with Victoria Police and the criminal justice system commenced when she was an adolescent and continued with little abatement thereafter.[25] Most but not all her offending involved dishonesty and illicit drugs rather than the threat or use of violence.[26] Ms McCabe had been sentenced to virtually every available penalty and was last sentenced to a term of imprisonment (time served) in August 2018.[27]

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[19] CB, page 57.

[20] CB, page 57.

[21] CB, 59.

[22] CB, pages 59-60. Telehealth consultations commenced in about March 2020.

[23] CB, page 59.

[24] CB, pages 59-60. Dr Wong frequently checked Safe Scripts when renewing Ms McCabe's diazepam prescription to ensure that no other doctors were providing concurrent prescriptions.

[25] CB, pages 491-532.

[26] CB, pages 491-532.

[27] CB, page 255.

23. Over the course of 2021, Ms McCabe encountered police members numerous times. Most interactions were 'checks'[28] by police members and Protective Service Officers of Ms McCabe while she was in public places such as train stations.

May 2021

24. Around 3.20pm on 12 May 2021, a police member exercised his power under the *Mental Health Act* 2014 (**MHA**) to apprehend Ms McCabe for mental health assessment.[29] Police had responded to the report that a woman had activated the emergency button and leapt from a moving train between East Camberwell and Canterbury stations. Ms McCabe was located at a residential address adjacent to the railway line[30] and was 'heavily intoxicated,' 'verbally abusive' and 'incoherent' but confirmed she jumped from the train intending to harm herself.[31]

25. Ms McCabe was transported to Maroondah Hospital by ambulance in restraints[32] and with a police escort.[33] Police members remained with Ms McCabe until her care was formally transferred to clinicians[34] through completion of a Mental Disorder Transfer Form (**MDTF**)[35] and later updated her LEAP Person Warning Flags.[36] When reviewed by a clinician, Ms McCabe was 'obviously drug/alcohol affected' and denied any suicidal ideation (and that she'd been on a train track).[37] She was systemically well, oriented to time and place but emotionally labile, intermittently tearful, co-operative and

[28] Understood to be 'name checks' where a person is stopped and asked their name so police can ascertain information from law enforcement databases such as warnings/flags, outstanding warrants or criminal matters.

[29] CB, page 65. Section 351 of the *Mental Health Act* 2014 authorized a member of police to apprehend a person for mental health assessment if satisfied that the person appears to have a mental illness and because of the person's apparent mental illness, the person needs to be apprehended to prevent serios and imminent harm to the person or to another person.

[30] A 'burglary' was reported not long after the earlier 'welfare check' job in the vicinity of the railway line: CB, page 65.

[31] CB, page 65.

[32] CB, page 540.

[33] CB, page 65.

[34] CB, page 537. The ambulance arrived at the hospital around 5.45pm and police left Ms McCabe around 8.15pm.

[35] The MDTF appears at CB, page 527. The MDTF records the details of the incident and copies are retained by Victoria Police and the receiving designated mental health service (hospital).

[36] Similar text to the content of the MDTF was added to Ms McCabe's LEAP Person Warnings relating to: "Mental Disorder" and "Suicide/Self Injury": CB, pages 469-472.

[37] Ms McCabe's Eastern Health medical record (EMR), page 7.

forthcoming, then shouting and aggressive.[38] She refused blood tests and a phone call to her mother (at Ms McCabe's request) 'escalated' her behaviour when she was encouraged by her mother to remain, cooperate and seek help.[39]

26. Restraints were removed and Ms McCabe was provided food and drink and an opportunity to walk around the emergency department (**ED**), which all occurred without incident.[40] Given Ms McCabe's denial of suicidality, the clinical plan was to not intervene if she chose to leave.[41] Ms McCabe left the ED sometime before 10pm and before psychiatric review.[42]

June 2021

27. On 24 June 2021, Ms McCabe appeared at Ringwood Magistrates Court where she was sentenced to complete a 12-month Community Corrections Order (**CCO**).[43] The conditions of the CCO required Ms McCabe to report within two days to commence supervision by Ringwood Community Corrections Services (**CCS**); undergo assessment and treatment for drug dependency and mental health issues; attend offending behaviour programs as directed; and, not commit any further offences.[44]

July 2021

28. In the early hours of 1 July 2021, Ms McCabe was sent by taxi to the ED by Safe Steps[45] for 'a risk assessment.'[46] She was assessed by a psychiatric nurse who obtained collateral

[38] Ms McCabe's Eastern Health medical record (EMR), page 7.

[39] Ms McCabe's Eastern Health medical record (EMR), page 7. Collateral information from Ms McCabe's mother included that Ms McCabe lived alone in Ringwood in 'poor' conditions and that she used heroin and ice intravenously as well as taking 'whatever' pills she 'can get hold of'. Ms McCabe's mother told clinician she could 'no longer offer Wendy help.'

[40] Ms McCabe's Eastern Health medical record (EMR), page 7.

[41] Ms McCabe's Eastern Health medical record (EMR), page 7.

[42] Ms McCabe's Eastern Health medical record (EMR), page 6 and CPF, page 84.

[43] CB, page 491. The CCO was imposed for dishonesty, assault, making threats and bail offences.

[44] CB, pages 254-255.

[45] Safe Steps provides Victoria's only statewide, 24-hour family and domestic violence crisis support service.

[46] Ms McCabe's Eastern Health medical record (CPF), page 73.

information from Safe Steps which Ms McCabe had contacted after an episode of 'community violence.'[47]

29. On assessment, Ms McCabe did not appear substance-affected, was initially irritable but was easily engaged during interview and 'generally appropriate' in social manner.[48] She was irritated that a Safe Steps worker 'felt she needed a risk assessment' and claimed she had 'never felt suicidal in [her] life.'[49] She denied psychiatric symptoms, family violence from her partner, and thoughts of deliberate self-harm.[50] Ms McCabe spoke of 'wanting to change her life' and planning 'with her Corrections Officer' to engage in drug and alcohol rehabilitation.[51] Overall, Ms McCabe's risks were assessed as 'low'.[52] She was provided with refreshment in the ED before being seen safely into another taxi provided by Safe Steps.[53]

30. Ms McCabe failed to attend CCS within two days and failed to attend another induction appointment arranged via text message though she did contact the office by phone on that date. During the call, Ms McCabe was reportedly 'substance-affected,' and 'fixated' on obtaining a new mobile phone through a support worker; she 'became impatient and abruptly' ended the call.[54] She called back the next day[55] and a further induction appointment was scheduled.[56]

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[47] Ms McCabe's Eastern Health medical record (CPF), page 73.

[48] Ms McCabe's Eastern Health medical record (CPF), page 73.

[49] Ms McCabe's Eastern Health medical record (CPF), page 73.

[50] Ms McCabe's Eastern Health medical record (CPF), page 73.

[51] Ms McCabe's Eastern Health medical record (CPF), page 73.

[52] Ms McCabe's Eastern Health medical record (CPF), page 74.

[53] Ms McCabe's Eastern Health medical record (CPF), page 75. Safe Steps' plan was for Ms McCabe to go from the ED to the police station to report the incident of community violence. There is no record that Ms McCabe reported a crime to police on this date.

[54] CB, page 533.

[55] During which Ms McCabe was 'experiencing issues with her mobile phone': CB. Page 533.

[56] CB, page 533.

31. In the early hours of 5 July 2021, Ms McCabe presented to the ED 'very drug affected' (though denying consumption of drugs).[57] She remained for a few hours and then left after being provided a cup of coffee.[58]

32. Later the same day, Ms McCabe attended CCS 'substance-affected' and was partially inducted onto the CCO.[59]

33. On 12 July 2021, Ms McCabe attended an appointment with CCS. She 'again presented as substance-affected and engaged in erratic, paranoid behaviours.'[60] Due to her presentation, a planned drug treatment assessment was re-scheduled; she was given a taxi voucher for the journey home and CCS requested police perform a welfare check. According to her CCS Case Manager, two hours after leaving CCS, Ms McCabe presented to the Ringwood Police Station with a police member reporting Ms McCabe was 'intoxicated and unable to walk in a straight line ... [or] put a sentence together'.[61] She was arrested and issued with a penalty notice upon release from the cells.[62]

34. Ms McCabe was due to attend CCS again on 19 July 2021. However, a social worker at Royal Melbourne Hospital (**RMH**) telephoned CCS to explain that Ms McCabe had been the victim of an assault by unidentified individuals the day before and had been treated at RMH.[63] The CCS appointment was rescheduled to 26 July 2021, but Ms McCabe did not attend.[64]

35. On 27 July 2021, Ms McCabe presented to the ED complaining of knee and shoulder pain after being 'hit by [a] car' four days earlier.[65] After being triaged as a low acuity patient, vital observations were recorded and Ms McCabe was provided first aid while she waited.[66] Sometime later, Ms McCabe 'woke suddenly' and was 'extremely

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[57] Ms McCabe's Eastern Health medical record (EMR), page 83.

[58] Ms McCabe's Eastern Health medical record (EMR), page 83.

[59] CB, page 533.

[60] CB, page 533.

[61] CB, page 534.

[62] CB, 534.

[63] CB, page 534.

[64] CB, page 534.

[65] CB, page 560.

[66] CB, page 560.

aggressive' toward staff.[67] She was asked to calm down and told she would be asked to leave if she did not: Ms McCabe became 'more aggressive.'[68] Ms McCabe only left the ED after staff had called Triple Zero for police assistance.[69]

August 2021

36. Ms McCabe was informed by letter that her next appointment with CCS was on 2 August 2021. Concerned for her welfare when she did not attend, CCS contacted Ms McCabe's usual pharmacy where a staff member confirmed she had attended an hour earlier to collect methadone. Given her 'poor compliance and risk management concerns,' Ms McCabe's CCO was 'placed into contravention.'[70]

37. On 28 August 2021, a charge of contravention of CCO was served on Ms McCabe by a police member.[71]

38. Around 10pm on 29 August 2021, police were called to a hotel in Wantirna South following a report of a sexual assault.[72] On arrival, police found Ms McCabe 'crying uncontrollably, placing her hands on her face and having difficulty speaking.'[73] Ms McCabe disclosed that she had been sexually assaulted.[74] She also disclosed that she had 'used' methadone and consumed alcohol that night.[75] Police members observed that Ms McCabe was unsteady on her feet, and her speech was slurred and considered her to be alcohol and drug affected.[76]

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[67] Ms McCabe's Eastern Health medical record (EMR), page 82.

[68] Ms McCabe's Eastern Health medical record (EMR), page 82.

[69] Ms McCabe's Eastern Health medical record (EMR), page 82.

[70] CB, page 534.

[71] CB, page 536.

[72] CB, page 67. The call to Triple Zero was made by a hotel staff member.

[73] CB, page 67.

[74] CB, page 67.

[75] CB, page 68.

[76] CB, page 68.

39. A man approached one of the police members to report he had been assaulted by Ms McCabe after inviting her to his hotel room.[77] The man and Ms McCabe were separated, and specialist sexual offence investigators (**SOCIT**) notified.[78]

40. Ms McCabe was taken to the ED by ambulance, arriving just after midnight on 30 August 2021.[79] She had told paramedics, and reiterated to ED clinicians, that she had been raped and punched/slapped to the left side of her face.[80] She declined to change into a hospital gown and was observed to be drowsy.[81] Ms McCabe slept for much of the following three hours while awaiting medical review but was easily roused and compliant with nursing observations.[82]

41. Around 4.45am Ms McCabe was awake and verbally abusive, demanding a 'forensic examination' and preparing to leave.[83] Following the managing nurse's intervention, she was persuaded to remain.[84] A nurse called the 'Emergency Crisis Centre' on Ms McCabe's behalf but she did not want to engage with a support worker; similarly, Ms McCabe declined to speak to a SOCIT, who had called the hospital to 'take her report,' because she was tired.[85] Ms McCabe slept for the next hour or so.

42. At about 7.30am, a friend of Ms McCabe, "Groz", called the ED.[86] Groz raised concerns 're: suicidal ideation + detox' with the nurse, spoke to Ms McCabe directly and left her contact number.[87] The nurse handed over Groz's concerns to the incoming nurse, who in turn, informed the ED doctor who had not yet examined Ms McCabe.[88]

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[77] CB, page 68.

[78] CB, page 68.

[79] CB, page 563.

[80] Ms McCabe's Eastern Health medical record (CPF), page 69; and (EMR), page 81.

[81] Ms McCabe's Eastern Health medical record (EMR), page 81.

[82] Ms McCabe's Eastern Health medical record (EMR), page 80.

[83] Ms McCabe's Eastern Health medical record (EMR), page 80.

[84] Ms McCabe was 'advised of a lack of service in MH [Maroondah Hospital] at the moment' though it is not clear if this note refers to the unavailability of forensic examination or counselling by ECASA (Eastern Centre Against Sexual Assault), as ECASA was also unavailable at the time of Ms McCabe's presentation: Ms McCabe's Eastern Health medical record (EMR), pages 80 and 81.

[85] Ms McCabe's Eastern Health medical record (EMR), page 80.

[86] Ms McCabe's Eastern Health medical record (EMR), page 79.

[87] Ms McCabe's Eastern Health medical record (EMR), page 79.

[88] Ms McCabe's Eastern Health medical record (EMR), page 79.

43. Around 8.30am, an ED doctor reviewed Ms McCabe. The physical examination was limited by Ms McCabe's unwillingness to remove her clothing and revealed no obvious significant injury and was otherwise unremarkable.[89] Ms McCabe denied thoughts of self-harm and suicide and was 'keen to go home.'[90] Sexual health counselling, drug/alcohol and mental health counselling services were offered and declined but Ms McCabe accepted contact details for these services, and that of the psychiatric triage service.[91]

44. With Ms McCabe's consent, the ED doctor called Groz (who reiterated her concerns) to explain the plan to discharge Ms McCabe home as she was 'unwilling to engage with services … [and] there [was] currently nothing for [clinicians] to hold [her] against her will.'[92] Ms McCabe was discharged, with a bus fare, shortly thereafter.[93]

45. Following her initial disclosure of sexual assault, Ms McCabe was unwilling to engage with SOCIT.[94] No-one was charged, and the investigation was closed in early November 2021.[95]

<u>September 2021</u>

46. Just before 3pm on 17 September 2021, a member of the public called an ambulance for Ms McCabe who was lying on the street 'asleep' near a shopping centre in Croydon.[96] An open alcohol container was on the ground nearby and bystanders reported Ms McCabe was often 'intoxicated in the area.'[97] Paramedics assessed her as 'very much under the influence of something … struggling to stay awake and slurring her words' notwithstanding Ms McCabe's denial of ingesting anything but her medications as

[89] CB, page 561.

[90] CB, pages 561-562.

[91] CB, page 562.

[92] CB, page 562.

[93] CB, page 562.

[94] CB, page 197.

[95] CB, page 197.

[96] Ms McCabe's Eastern Health medical record (CPF), page 60.

[97] Ms McCabe's Eastern Health medical record (CPF), page 60.

prescribed.[98] As she was non-compliant and verbally abusive, the police were called to attend; Ms McCabe was persuaded to present to hospital by ambulance.[99]

47. Ms McCabe was asleep on the ambulance trolley when first examined in the ED at 5.30pm. She initially refused examination but allowed blood to be drawn and went 'straight back to sleep'.[100] Two hours later, Ms McCabe remained 'drowsy but rousable' when a further attempt was made to examine her.[101] 'Simple intoxication' was diagnosed with a plan to observe her until she was safe to be discharged.[102]

48. Ms McCabe was reviewed by ED doctors twice on the morning of 18 September 2021, the latter occurring around 9am when she was 'alert' and 'stable while walking.'[103] She was discharged; the discharging doctor noting 'suspected intentional overdose of alcohol, pregabalin, diazepam and methadone.'[104]

October 2021

49. In early October 2021,[105] the Boronia Mall Clinic receptionist received a call from Ms McCabe to schedule a telehealth appointment with Dr Wong. Ms McCabe was 'upset and sobbing' and disclosed that 'her partner' was 'being physical towards her' and she believed he was keeping her under surveillance.[106] The receptionist encouraged Ms McCabe to leave the relationship and discuss her concerns with Dr Wong. Ms McCabe told the receptionist she could not leave the partner because they had a child together and ended the call before making an appointment saying that she would call back.[107]

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[98] Ms McCabe's Eastern Health medical record (CPF), page 60.

[99] Ms McCabe's Eastern Health medical record (CPF), page 60. Paramedics considered Ms McCabe to be 'too intoxicated' to be left alone where she was and to be lodged in police cells. She was described as 'more abusive than threatening' towards paramedics and police: Ms McCabe's Eastern Health medical record (CPF), page 63.

[100] Ms McCabe's Eastern Health medical record (EMR), page 86.

[101] Ms McCabe's Eastern Health medical record (EMR), page 86.

[102] Ms McCabe's Eastern Health medical record (EMR), page 86. Ms McCabe's blood alcohol level was equivalent to a breath alcohol level of > 0.2% (four times the legal limit for driving).

[103] Ms McCabe's Eastern Health medical record (EMR), page 92.

[104] Ms McCabe's Eastern Health medical record (EMR), page 92.

[105] The relevant date is believed to be either the 5th or 6th of October 2021 based on the witness' work schedule: CB page 62.

[106] CB, page 63.

[107] CB, page 63.

50. On 14 October 2021, a charge of contravention of CCO was listed at Ringwood Magistrates' Court. When Ms McCabe failed to attend court, the matter was adjourned to a date in January 2022.[108]

November 2021

51. Around midday on 23 November 2021, police were called to assist paramedics responding to the report of a drowsy/unresponsive woman who had become agitated and abusive.[109] Paramedics had found Ms McCabe about 20 minutes earlier lying on top of her bags near a football oval in Lilydale, responsive to painful stimuli but unable to sit up independently and unwilling or unable to answer questions.[110] There was no sign of alcohol use but prescribed medications including methadone were located in her bags. Part of a dose of naloxone[111] was administered by syringe before Ms McCabe 'woke up' and paramedics 'retreated'.[112]

52. Ms McCabe was 'fully alert' within about five minutes, swore at paramedics and 'staggered off' with her belongings. Paramedics continued to observe her from a distance and saw her stumble down an embankment (and continue to move around) but due to the 'risk of aggression' did not approach Ms McCabe and requested police.[113]

53. When police members arrived,[114] Ms McCabe was 'lying face down' at the bottom of the embankment 'quite close to the water' in a creek, apparently unresponsive and unaware of the police presence.[115] A 'LEAP check'[116] revealed 'a pattern of incidents' of public intoxication 'sometimes associated with … mental health' and 'flags for suicide and self-harm.'[117] In consultation with his colleague and supervising sergeant, a police

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[108] CB, page 536.

[109] CB, page 70.

[110] Ms McCabe's Eastern Health medical record (CPF), page 52.

[111] Naloxone is a medication that rapidly reverses (or reduces the effects of) opioid overdose which may be administered intranasally, intravenously or intramuscularly.

[112] Ms McCabe's Eastern Health medical record (CPF), page 57.

[113] Ms McCabe's Eastern Health medical record (CPF), page 57.

[114] One of whom had performed a 'welfare check' on Ms McCabe earlier in the day when she was 'more lucid': Ms McCabe's Eastern Health medical record (EMR), page 84 and CB, page 70.

[115] CB, page 71.

[116] LEAP is the 'Law Enforcement Assistance Program' a database used by Victoria Police.

[117] CB, page 71.

member exercised his power under the MHA to apprehend Ms McCabe for mental health assessment.[118] Two police members approached Ms McCabe and, each taking hold of one arm, 'pulled her up' the embankment towards the ambulance.[119] She became 'a bit verbally aggressive towards [them] and struggled a bit' but was 'still out of it.'[120] Once on the stretcher, Ms McCabe was placed in restraints by paramedics and transported to the ED with a police escort.[121] The MDTF was signed by an ED clinician accepting responsibility for Ms McCabe's care at 2.25pm.[122] Police later updated Ms McCabe's LEAP Person Warning Flag relating to 'violence.'[123]

54. On initial assessment in the ED around 3pm, Ms McCabe was found to have overdosed on methadone and/or benzodiazepine with 'intent unclear at this point.'[124] The plan was for her to remain in restraints and under observation until 'safe and lucid.'[125]

55. A couple of hours later, Ms McCabe was 'becoming more alert and less agreeable' denying use of 'drugs' and telling the ED doctor it was 'bullshit' that she had Covid-19 notwithstanding return of a positive rapid test result.[126] Although she did not want to remain in the ED, she was unable to stay awake long enough to leave. Once she was able to mobilise safely, however, the doctor considered there was 'no reason' to keep her against her will.[127]

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[118] CB, page 71. The member acknowledged that at the time he decided to use s351 MHA Ms McCabe was unresponsive and had not made any threats to self-harm or suicide. Nonetheless, based on her 'history of using drugs to assist her mental health' and her inability to 'make safe and rational decisions' at the time of attendance, it was necessary to apprehend her 'for her own safety and to ensure [police] had fulfilled [their] duty of care responsibilities.'

[119] CB, page 71.

[120] CB, page 71.

[121] CB, page 71-72. Accompanying police transferred care to ED clinicians shortly after arrival: CB, page 566.

[122] CB, page 566.

[123] CB, pages 465-466. The text of the Person Warning Flag for "violence" related to Ms McCabe's alleged verbal abuse towards paramedics. It recorded that she 'indulges in heavy drug use' to manage her 'history of mental health' and on this particular date there were 'concerns re welfare / safety.'

[124] Ms McCabe's Eastern Health medical record (EMR), page 85.

[125] Ms McCabe's Eastern Health medical record (EMR), page 85.

[126] Ms McCabe's Eastern Health medical record (EMR), page 92.

[127] Ms McCabe's Eastern Health medical record (EMR), page 92. The basis for the conclusion that Ms McCabe did not meet the criteria for compulsory psychiatric treatment under the MHA is unclear from the notes and/or is not documented.

56. Ms McCabe remained in the ED intermittently sleeping, accepting refreshment and complying with nursing observations.[128] At 3am on 24 November 2021, she was reviewed again by a doctor who found her alert, able to mobilise safely and keen to go home.[129] Ms McCabe 'became more aggressive' when asked to wait for the results of a second coronavirus test and as there was 'no mental health reason for the presentation,' she was not prevented from leaving the ED at 3.15am.[130]

57. Just after midnight on 26 November 2021, police responded to the report of a woman standing in traffic on Victoria Road in Lilydale 'purposefully going in front of vehicles.'[131] When police members arrived, they found Ms McCabe on the footpath. Police considered her to be drug or alcohol affected because her speech was slurred. Ms McCabe confirmed her identity and denied attempting to collide with vehicles, claiming to have only been crossing the road. She asked for directions, which the police members provided before returning to the police station given Ms McCabe 'did not state any suicidal ideations' and required no other assistance.[132]

CIRCUMSTANCES IN WHICH DEATH OCCURRED

58. According to her friend Philip Cream, Ms McCabe spent 1 December 2021 with friends in Croydon and Ringwood looking for the girlfriend of another friend, Brian Prentagast. Ms McCabe was drinking wine 'all day' and in Mr Cream's estimation 'seemed a little bit off' in that she was 'quieter than usual'.[133]

59. Around 9am on Thursday 2 December 2021, police members responded to the report of a burglary at a residence under construction in Tulip Crescent, Boronia. The report was made by an electrician working at the property development site who saw a man and a woman 'walk from the garage' of one of the units.[134]

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[128] Ms McCabe's Eastern Health medical record (EMR), pages 70-73.

[129] Ms McCabe's Eastern Health medical record (EMR), page 91.

[130] Ms McCabe's Eastern Health medical record (EMR), page 91.

[131] CB, page 74.

[132] CB, page 74.

[133] CB, page 80. Mr Cream also commented that he 'thought Wendy was suicidal.' Ms McCabe 'never said or did anything' explicit but that she was suicidal was his 'gut feel.'

[134] CB, page 225.

60. As police members approached the address, they saw a pair who 'matched the description' of the alleged offenders.[135] On request, the pair identified themselves as Brian Prentagast and Wendy McCabe. The electrician had observed police speaking to Mr Prentagast and Ms McCabe and via phone confirmed they were the people he had seen at the unit around 8.30am and whom he believed had damaged its fixtures and stolen a toilet roll holder.[136]

61. Mr Prentagast and Ms McCabe were arrested, and arrangements made for them to be transported separately to Boronia Police Station (**Boronia**) for processing.[137] At about 9.15am Ms McCabe, whose wrists had been handcuffed in front of her body by First Constable (**1C**) Peter Creek, was placed in the custody pod of the Knox divisional van and monitored via CCTV while in transit to Boronia.[138]

Boronia Police Station

62. The divisional van arrived at Boronia at 9.25am but was not permitted to enter the sallyport because Mr Prentagast was being processed there with a plan that he be remanded in custody and the only cell would therefore be occupied.[139] The transporting members were directed to wait for further instructions. The delay was explained to Ms McCabe via intercom, and she was permitted to alight from the custody pod while waiting.[140]

63. The Boronia Section Sergeant 'checked' Ms McCabe on LEAP and formed the view that she 'was also to be remanded.'[141] In accordance with usual practice, he called Knox, the closest police station to Boronia to ascertain if there was capacity to process Ms McCabe at Knox.[142] Sergeant (**Sgt**) Rebecca Phillips, the Custody Sergeant and Bail Decision

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[135] CB, page 86.

[136] CB, pages 86 and 225.

[137] CB, pages 86-87.

[138] CB, page 90.

[139] CB, page 92.

[140] CB, page 91.

[141] CB, page 92.

[142] CB, pages 92-93. In the usual course, if an accused person was arrested in the Knox Police Service Area it is likely they would be taken to a Police Station in the Knox PSA, relative to where the arrest occurred and that had the ability to accept the accused. There would be occasions when this may not occur, for example if the closest Police Station was at capacity and other stations in the PSA could not accommodate an accused person may be transported to Ringwood or another station for processing, given police obligations under section 464A

Maker (**BDM**) for the morning shift at Knox, confirmed there was capacity to process Ms McCabe.[143]

64. At around 10am, the Boronia Section Sergeant directed the Knox divisional van members to transport Ms McCabe to Knox. She was monitored via CCTV in transit and arrived at Knox at about 10.35am.[144]

Knox Police Station

65. At 10.38am, Ms McCabe, who appeared somewhat unsteady on her feet, was escorted to the Charge Counter at Knox.[145] She was entered onto the Attendance Register at 10.40am, with the 'Arrival Check' noting an existing minor injury,[146] that Ms McCabe was not affected by alcohol or drugs nor mental incapacity, and that Sgt Phillips had authorised a 'full search.'[147]

66. BDM Sgt Phillips spoke with Ms McCabe at the Charge Counter. The interaction was 'pleasant,' and Ms McCabe provided 'coherent' responses to questions about her physical and mental health and 'Indigenous Status.'[148] Sgt Phillips then assisted Ms McCabe to remove some items of jewellery which were, with other items, entered onto a 'Prisoner's Property Sheet.'[149]

(4) of the *Crimes Act* 1958 (which requires an accused person to be released unconditionally, on bail or be brought before a Magistrate within a 'reasonable time').

[143] CB, pages 92 and 94.

[144] CB, page 91.

[145] Exhibit 33.

[146] Bruise and a scratch on the left leg: CB, page 456.

[147] CB, page 456. A 'full search' may involve the removal and examination of all clothing and the visual examination of the person but generally will not include contact with the person's body. There must be 'reasonable grounds' to conduct a search. A detained person may be searched at the direction of an Officer in Charge who has reasonable ground to believe the search is necessary for the security/good order or a police goal or for the safety of any person: VPM – *Search of a person*.

[148] CB, page 94. Police are required to ask if a person in care or custody identifies as being of Aboriginal or Torres Strait Islander descent, from which an obligation to notify the Victorian Aboriginal Legal Service flows if the person does identify as Aboriginal. The phrase 'Indigenous status' is that used in the Attendance Module to prompt the inquiry (Sgt Phillips did not use that phrase). Ms McCabe stated that she did not identify as Aboriginal.

[149] CB, pages 94-95 and 445-446.

67. In her 'Initial Supervisor's Check' on the Attendance Register, Sgt Phillips noted among other matters that Ms McCabe reported mental health 'issues but could not disclose any diagnosed disorders. Requires methadone.'[150]

Search

68. Ms McCabe was escorted to the "female" cell by Senior Constable (**SC**) Holly Bawden and Constable 1[151] and a full search was conducted. SC Bawden observed that Ms McCabe appeared 'slightly'[152] substance affected – 'she wasn't steady on her feet, swaying back and forth and her [pupils] appeared fully dilated.'[153] At one stage, Ms McCabe appeared confused but did not elaborate when asked the reason by the member.[154] SC Bawden's impression was that Ms McCabe was 'a little absent minded.'[155]

69. At 11.05am, Ms McCabe was entered onto the Custody Register.[156] Sgt Phillips made a note to reflect her authorisation of a full search in anticipation of Ms McCabe being lodged in a cell after interview pending a bail/remand application.[157]

Interview

70. Around the same time, and at the direction of morning shift Section Sergeant Sgt Jarrod Ross, Ms McCabe was escorted to an interview room.[158] She remained there with Constable 1 awaiting the arrival of the interviewing member, SC Michael West of Boronia.[159] According to Constable 1 there was 'minimal general conversation' during the approximately 15-minute wait.[160]

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[150] CB, 456.

[151] This police member has been deidentified and is referred to as "Constable 1" hereafter.

[152] CB, page 97.

[153] CB, page 96.

[154] CB, page 96.

[155] CB, page 97.

[156] CB, page 458.

[157] CB, page 458.

[158] CB, page 96.

[159] CB, pages 101 and 99.

[160] CB, page 101.

71. Between 11.15am and 11.45am, Ms McCabe participated in an audio-visually recorded interview conducted by SC West and corroborated by Constable 1.[161]

72. For much of the interview, Ms McCabe appeared subdued:[162] she remained quite still in her chair[163] and responded quietly to the questions posed.[164] She provided an account (denying the substantive allegations)[165] and sought clarification of the evidence put to her.[166] Her demeanour changed when SC West informed her that she would be charged with burglary, theft and criminal damage.[167] Ms McCabe turned in her chair to face away from the police members,[168] bending at the waist and hunching over,[169] before standing and walking to the wall. She turned and walked back to her chair but remained standing to remonstrate with SC West.[170] She paced, her body language suggestive of disbelief, until the interview concluded.[171]

Fingerprints

73. After the interview, Ms McCabe was seated outside the interview room, and behind Constable 1, while the police member prepared the digital fingerprinting machine. At 11.50am CCTV footage depicts Ms McCabe hit the back of her head into the wall behind her with what appears to be intentional, significant force.[172] It is not clear that Constable 1 observed Ms McCabe's action[173] but she 'heard a bang' and immediately turned to face

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[161] CB pages 297-322. Ms McCabe declined to speak to a legal representative before the interview commenced.

[162] Exhibit 6, particularly the first ~26 minutes of the recording. The quality of the recording is quite poor, with low light conditions.

[163] Ms McCabe was comparatively animated when highlighting perceived inconsistencies in the evidence presented by the interviewing member. See for instance, Exhibit 6 at file positions ~7:30-7:41 and ~12:14-12:21 and ~23:28-52.

[164] See generally, Exhibit 6.

[165] Ms McCabe also provides an explanation for the prescription medications located during a search of her possessions, including the details of her prescribing doctor and dispensing pharmacy: CB, pages 313-315.

[166] For instance, CB, pages 316-319.

[167] Exhibit 6, file position ~28:26 and following.

[168] And the camera.

[169] Exhibit 6, file position ~28:26

[170] CB, page 320.

[171] Exhibit 6, file position ~28:43-30:56.

[172] Exhibit 33, file position 35:32-35:35.

[173] Constable 1 was standing not quite side-on to Ms McCabe but facing the fingerprint machine which suggests that if she saw anything it would only have been in her peripheral vision.

her.[174] By then, Ms McCabe was leaning forward in the chair with her elbows on her knees and face in her hands.[175]

74. CCTV footage shows that Constable 1 placed a gloved hand on Ms McCabe's shoulder and leaned over in an apparent effort to make eye contact.[176] The women remained in that posture for ten seconds, after which Ms McCabe sat up and appeared to wipe her eyes.[177] For a further 25 seconds or so, Constable 1's hand remained on Ms McCabe's shoulder and they appear to be conversing.[178] According to Constable 1, she asked Ms McCabe why she had hit her head and Ms McCabe responded that she had not meant to do so.[179] At 11.51am, Ms McCabe moved her chair away from the wall at Constable 1's request.[180] Though they spoke no more about it, Constable 1 gave Ms McCabe several tissues with which she wiped her face.[181]

75. Ink fingerprints were ultimately taken after which Constable 1 and SC West escorted Ms McCabe to the Charge Counter after she had washed her hands.[182]

76. While at the Charge Counter (or at some other time during their interaction), Constable 1 witnessed a 'short outburst' by Ms McCabe in which she said words to the effect, 'Fuck this world.'[183] Constable 1 recalled that Ms McCabe 'straight away … corrected herself' and said something to the effect that 'the world was a beautiful place.'[184]

Lodged in Cell 1 and provided a "standard blanket"

77. At about this time, BDM Sgt Phillips was involved in the bail/remand hearing of another detainee conducted via WebEx.[185] To assist, Sgt Ross and Constable 1 escorted Ms

[174] CB, page 101.

[175] Exhibit 33, file position 35:36.

[176] Exhibit 33, file position 35:36.

[177] Exhibit 33, file position 35:56.

[178] Exhibit 33, file position 35:56-36:16.

[179] CB, page 101.

[180] CB, page 101 and Exhibit 33, file position 36:16.

[181] CB, page 101 and Exhibit 33, file position 37:10.

[182] CB, pages 101 and 99-100.

[183] CB, page 102.

[184] CB, page 102.

[185] CB, page 103 and Exhibit 33.

McCabe to the "female cell," via the indoor exercise area adjacent to it where she removed her shoes before entering Cell 1 at 12.19pm.[186] Sgt Ross offered Ms McCabe a mattress, a blanket and refreshment; she accepted the offer of a blanket.[187]

78. Sgt Ross went to a secure room where blankets are stored. He took a blanket from the top of a pile, shook it out to ensure he had picked up only one,[188] and returned to Cell 1. He did not examine the blanket to ascertain if it was worn or damaged.[189]

79. At 12.21pm Sgt Ross (accompanied by Constable 1)[190] provided Ms McCabe with a "standard" blanket and then secured the cell door.[191] Sgt Ross updated the Custody Register to reflect that Ms McCabe had been lodged in a cell awaiting remand paperwork and a hearing time, that she was given a blanket and all appeared correct.[192]

80. Cell 1 is approximately rectangular, with two walls significantly shorter than the others. In the middle of one long wall is the cell door into which is set a narrow horizontal window at approximately head height. High on the opposing (long) cell wall is a window. Along one short wall (bearing the numeral "1") and the long "window" wall is a bench/bed. A toilet and sink are fitted on the remaining short wall. The CCTV camera is situated high, near the corner of the "window" and "toilet" walls.[193]

81. The blanket Sgt Ross gave Ms McCabe was light-coloured and lightweight with an open weave.[194] Much of the blanket appears to have been slightly ribbed, except for sections at the top and bottom which were flat; its edges were hemmed.[195]

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[186] Exhibit 33, file position 1:01:15.

[187] CB, pages 103-104.

[188] CB, page 104

[189] CB, page 104.

[190] This was Constable 1's last involvement with Ms McCabe.

[191] Exhibit 33, file position ~1:03:03.

[192] CB, page 458.

[193] Exhibit 33, file position 1:01:15.

[194] Exhibit 12, photograph 1.

[195] Exhibit 12, photographs 1-6.

82. Ms McCabe placed the blanket on the bench/bed along the short wall, far from the "window" wall, where she was standing.[196] She paced unsteadily,[197] intermittently holding her head in her hands and wiping her face with tissues for about two minutes before focussing, for the following five minutes, on wall "1" and running her hands over it.[198]

83. By the time Sgt Ross (accompanied by Sgt Latham) entered Cell 1 at 12.29pm to ascertain whether Ms McCabe had damaged a wall, she had traversed the length of the bench/bed (and partway back), dragging the blanket underfoot.[199] Sgt Ross observed no damage to the wall and when asked what she had been doing, Ms McCabe denied doing anything.[200] The police members left.[201]

84. Ms McCabe remained in the cell undisturbed between 12.30pm and 2.15pm.[202]

85. Ms McCabe paced the bench/bed gesturing with open arms towards wall "1" for about a minute before standing beneath the window and banging her head and hands against the wall beneath it.[203] She stamped her foot (head bowed against the "window" wall)[204] for several seconds before pacing to the corner (near wall "1") and bending at the waist, with her hands on her knees.[205] When she stood, she adjusted her ponytail before kneeling down with her forehead to the bench/bed.[206] She moved to wall "1" and then adopted a similar posture.[207] A couple of minutes later, Ms McCabe slumped onto her side with her head in her hands.[208]

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[196] Exhibit 33, file position ~1:03:13

[197] And somewhat precariously along the bench/bed given her unsteady gait.

[198] Exhibit 33, file position ~1:05:00-1:10:55.

[199] Exhibit 33, file position ~1:11:06.

[200] CB, page 105. There is no entry in the Custody Register reflecting this entry to Ms McCabe's cell or what prompted it.

[201] Exhibit 33, file position ~1:11:50.

[202] CB, page 592.

[203] Exhibit 33, file position ~1:12:50.

[204] Exhibit 33, file position ~1:13:01.

[205] Exhibit 33, file position ~1:13:31.

[206] Exhibit 33, file position ~1:13:54-1:15:04.

[207] Exhibit 33, file position ~1:16:22.

[208] Exhibit 33, file position ~1:18:34. It appears that Ms McCabe may be crying.

86. For the following 57 minutes, Ms McCabe remained still, lying on the blanket on her side, facing into the room (and the camera) with her head in her hands.[209] At 1.33pm, she repositioned slightly.[210]

87. Thirty-one minutes later (at 2.04pm), Ms McCabe raised her head briefly[211] before slumping down, with her head over the edge of the bed/bench for the following six minutes. At about 2.10pm she raised her upper body so that she was leaning on her forehead and elbows[212] for about two minutes, then appears to wipe her face[213] before slumping down again.[214] She remained roughly in this posture until the cell door was opened just before 2.15pm.[215]

Change of Shift 2-3pm

88. Just before 2pm, Section Sergeant Sgt Ross provided a verbal handover to the incoming Section Sergeant for the afternoon shift, A/Sgt Rhett Rattray. A/Sgt Rattray was told there were three men and a woman in custody at various stages of being processed and there had been 'no issues.'[216]

89. Afternoon Custody Sergeant and BDM Sgt Timothy Mithen received a handover in advance of his shift start time of 2pm.[217] From this handover he understood that there were four people in custody and that the Detainee Risk Assessment (**DRA**) relating to

[209] Exhibit 33, from file position ~1:18:33.

[210] Exhibit 33, file position ~2:15:01.

[211] Exhibit 33, file position ~2:46:10

[212] Exhibit 33, file position ~2:52:45.

[213] Exhibit 33, file position ~2:54:11.

[214] Exhibit 33, file position ~2:54.19.

[215] Exhibit 33, file position ~2:56:51.

[216] CB, page 112.

[217] There is a discrepancy in statements of Sgt Phillips and Sgt Mithen about the handover at change of shift: Sgt Phillips states that she handed over to Sgt Mithen while he states he received handover from Sgt Mark Preston.

Ms McCabe had not yet been completed.[218] Sgt Mithen directed that the DRA be 'put on.'[219]

90. The Watch House members for the afternoon shift were First Constable (**1C**) Jodie Holmes, 1C Melyssa Johnston and C/ Edward Dalton.[220] It is unclear what, if any, specific handover the afternoon Watch House members received from the outgoing members except that the morning shift had been busy and there were people in custody.[221] The 'Prisoner Board'[222] recorded who was in custody, the reason/charge and the Informant's Call Sign.[223]

91. In accordance with his usual practice, BDM Sgt Mithen nominated one of the Watch House members, 1C Johnston, to assist him to manage people in custody although the other Watch House members would assist when required.[224]

Detainee Risk Assessment

92. Between about 2.15pm and 2.24pm,[225] C/ Ellie Smith was accompanied by Senior Constable 1[226] to Cell 1 to obtain information from Ms McCabe so her DRA could be completed; at Knox in 2021, the DRA was initially filled out in hardcopy.[227] One component of the DRA contained 25 questions to elicit information from the detainee

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[218] CB, page 135. I note that Sgt Phillips' account of the content of her handover to Sgt Mithen is consistent with Sgt Mithen's account of the information he received in handover. The only additions in Sgt Philips' account was that Ms McCabe was awaiting a WebEx hearing (information available on the Custody Register) and an observation that Ms McCabe had been 'no trouble at all:' CB, page 95.

[219] CB, page 135. Sgt Mithen does not say to whom he provided this direction. C/ Dalton states that C/ Holmes was tasked, and that he and C/ Johnston asked Ms McCabe the DRA questions on C/ Holmes' behalf. C/ Holmes appears to have entered the DRA data into the electronic DRA on LEAP.

[220] They commenced between 2pm and 3pm: C/ Holmes had commenced shift at midday but commenced watch house duties at about 1.30pm; C/ Johnston commenced shift around 2.30pm, ahead of her 3pm start time; and C/ Dalton commenced at 3pm.

[221] CB, pages 126.

[222] The Prisoner Board is a whiteboard positioned on the wall between the Section Sergeant's Office and the Custody Counter in the Watch House.

[223] Photograph #10. The entry in relation to Ms McCabe read (later in the afternoon shift): Female Cell – McCabe, Wendy – DRA – Complete – Remand App: EBO307 [Boronia 307] : BURG [burglary].

[224] CB, page 135.

[225] The Watch House members attended twice in this period (2.15-2.17pm and 2.18-2.24pm) as on the first occasion they brought with them a Covid-19 questionnaire rather than the DRA. Exhibit 33, file position ~2:56:51-3:06:45.

[226] This police member has been deidentified and will be referred to as "Senior Constable 1."

[227] CB, pages 449-453 (hardcopy DRA).

about their medical and mental health risks to inform their safe management while in police custody.[228] The remaining six sections of the DRA did not require any further input from the person in custody.[229]

93. C/ Smith had never completed a DRA and so the SC assisted her.[230] C/ Smith asked Ms McCabe 'every question on the form' but she was 'being very difficult' and would not answer some questions and was 'argumentative' when asked others.[231] According to C/ Smith she was 'directed by [the SC] to skip 1 or 2 questions' when Ms McCabe refused to answer them.[232]

94. Ms McCabe did respond to questions about her mental health[233] with the following recorded:

Mental health issues current / past?	Yes	Bipolar
History of self harm current / past?	Yes	
Are you depressed or suicidal?	Yes	
Are you thinking about harming yourself now?	No[234]	

95. After recording Ms McCabe's responses on the hardcopy DRA, C/ Smith returned to the Watch House and as it was near the end of her shift, she 'gave a handover' to 1C Holmes who would 'upload the information'[235] onto the Custody Register (that is, complete the

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[228] In 2021, three questions related to Covid-19 exposure; one each relating to dependent children and pets; questions about the possession of prohibited articles, separation from other detainees, emergency contacts, and whether the person had been in custody before. The remaining questions related to physical health/injury; existing medical conditions (including diabetes, allergies, and the need for a special diet), medications, alcohol and drug use/withdrawal and mental health (including previous history and current self-harm and suicide ideation), though there is a final inquiry 'anything else to bring to my attention?'

[229] Detainee LEAP Check; Identification of specified categories of risk; application of the Medical Checklist/'Coma Scale'; Risk Assessment; Determination of the Level of Observation Required; and the Frequency of Observations. DRAs are also reviewed by the BDM/Custody Sergeant (though it appears this may only occur after the electronic DRA is completed).

[230] CB, page 107.

[231] CB, page 107.

[232] CB, page 107. While every question in the questionnaire section of the hardcopy DRA is completed there are two distinct handwriting styles evident and two pens were used (one in blue ink, which I take to be that of C/ Smith and the other in black ink which may have been recorded by C/ Johnston though it is not clear). There are asteria near the mental health, medication and emergency contact questions on the DRA in black ink.

[233] CB, page 108.

[234] CB, page 450.

[235] CB, page 108.

electronic DRA). The section of the DRA requiring Ms McCabe's responses was the only part of the document completed by C/ Smith.

96. Ms McCabe remained in Cell 1 undisturbed between 2.24pm and 3.26pm.[236] CCTV footage depicts Ms McCabe initially sitting upright on the bench/bed (she had been semi-recumbent when speaking to C/ Smith) before slumping face down then wiping her face with her hands and curling up on her right side.[237] She appears largely motionless for about 30 minutes before levering herself up on one elbow, head bowed with the blanket held to her face.[238] She remained in a similar pose until just before the door of Cell 1 was opened.

97. At 3.26pm, 1C Johnston (accompanied by C/ Dalton) entered Cell 1 with paperwork.[239] Ms McCabe sat upright, wiping her face with her hands. 1C Johnston appears to ask questions and write down Ms McCabe's responses.[240] Ms McCabe's gaze is averted, her head in one hand for much of the interaction, though she does occasionally look at 1C Johnston.[241] C/ Dalton characterised Ms McCabe's presentation as 'refusing to look at us … engaging with us up to appoint and then … mumbling and no longer interested.'[242]

98. For the final two minutes of this interaction, Ms McCabe was positioned on her side and elbows with her face tucked between her shoulders (1C Johnston's view was of the top of Ms McCabe's head).[243] She remained like that until just before the Watch House members returned seven minutes later (at 3.38pm) bearing a mattress and cup. Ms McCabe sat up and wiped her face.[244]

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[236] CB, page 592.

[237] Exhibit 33, form file position ~3:06:45.

[238] Exhibit 33, file position ~3:50:43.

[239] Exhibit 33, file position ~4:08:17. I have inferred that the paperwork was the hard copy DRA given the presence of more than one writing style (see note 230 above).

[240] CB, page 141.

[241] Exhibit 33, file position ~4:09:47. At about this time, Ms McCabe appears distressed.

[242] CB, page 121. In his statement, C/ Dalton observed that Ms McCabe 'withheld information about her next of kin by mumbling and not wanting to engage any further … [she was asked to repeat her answers but] bowed her head and refused to look at either of us, looking down at her feet … [she was] engaging with us to a point and then … would drift off … mumbling and no longer interested.'

[243] Exhibit 33, file position ~4:11:30-4:13:39.

[244] Exhibit 33, file position ~4:20:31.

99. C/ Dalton placed the mattress on the bench/bed under the window while 1C Johnston put the cup down in front of Ms McCabe, who had levered herself onto one elbow.[245] 1C Johnston and Ms McCabe appear to converse briefly before the members once again left Cell 1. 1C Johnston made an entry on the Custody Register at 3.41pm (the first of the afternoon shift) reflecting the purposes of the contact with Ms McCabe.[246]

100. 1C Johnston perceived that Ms McCabe was 'always fairly groggy and slow moving/talking' whenever members entered her cell.[247]

101. Ms McCabe remained in Cell 1 undisturbed between 3.38pm and 4.20pm. Shortly after the police members left, Ms McCabe laid on her side and remained in that position, virtually motionless, until the cell door was opened again.[248]

102. At some point between 3.20pm (and 6.30pm when BDM Sgt Mithen approved it) Ms McCabe's electronic DRA (**e-DRA**) was completed by 1C Holmes.[249] Ms McCabe's responses to questions about her mental health were recorded in the eDRA as follows:

Mental health issues current / past?	Yes	Bipolar
History of self harm current / past?	Yes	Type – NA When – Long time ago[250]
Are you depressed or suicidal?	Yes	Depressed
Are you thinking about harming yourself now?	No[251]	

103. Other information recorded on the e-DRA included that Ms McCabe had:

Not tested positive to Covid-19
No injuries, physical injuries or allergies
Not seen a doctor or presented to hospital for treatment recently
Been prescribed methadone and Valium[252] by Dr Wong
Last used 'ice'[253] on 1/12/21 and was a daily user of ice and alcohol (cider)[254]

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[245] Exhibit 33, file position ~4:21:11.

[246] CB, pages 4598-459.

[247] CB, page 144.

[248] Exhibit 33, file position ~4:21:20-5:02:40.

[249] CB, page 460-463.

[250] The origin of the information about when previous self-harm occurred is unclear (it does not appear on the hardcopy DRA).

[251] CB, pages 460-461.

[252] Valium is a brand name under which the drug diazepam is sold.

[253] Ice is a colloquial name for the illicit drug methylamphetamine.

[254] CB, pages 460-461.

104. The drug use and alcohol consumption questions on the DRA[255] are accompanied by a prompt to 'consider withdrawal – Notify CHAL,' Victoria Police's Custodial Health Advice Line.[256] There is no evidence to suggest CHAL was consulted about Ms McCabe.

105. Ms McCabe's known LEAP 'Warnings/Risks' (suicide, mental disorder, custody; drug use, violent)[257] and E*Justice 'Custody Risks' (S4, T3 and E4)[258] and associated 'Risks/Recommended Actions' auto-populated into the Custody Register and eDRA.[259]

106. Ms McCabe's E*Justice 'Risk/Recommended Actions' were, relevantly, as follows:[260]

Placement 3	10/11/2014	Presents as vulnerable in custodial environment
Security 4	15/6/2015	History of low-level escape risk
Suicide/Self-harm 4	25/9/2008	Previous history or risk of suicide or self-harm[261]

107. 1C Holmes checked Ms McCabe's LEAP and other Victoria Police records.[262] She entered the following values by way of assessment and management of Ms McCabe's risks while in custody at Knox:

Coma Scale Assessment on Entering Custody[263]	4
Observation & Welfare Requirements on Entering Custody Observation Level[264]	Level 3

[255] Both the hardcopy and eDRA.

[256] CB, page 461 (and page 450).

[257] To read the narrative connected to each warning or risk, a police member must open the LEAP record: Statement of Inspector Donna Mitchell, Custody Operations Branch of Victoria Police, undated (received 2 May 2025, 'Mitchell Statement'), paragraph 52.

[258] The S, T and E-risks are part of the E*Justice risk rating system used by Victoria Police, Courts and Corrections Victoria to capture risk assessments and recommended actions. S = suicide/self-harm T = placement and E = security; a numeric scale (1-4) of severity of risk where 1 is the highest risk and 4 the lowest (T-ratings have only three levels, 1-3). The 'risks and recommended actions' screen

[259] Statement of Inspector Donna Mitchell, Custody Operations Branch of Victoria Police, undated (received 2 May 2025, 'Mitchell Statement'), paragraph 51.

[260] CB, page 458.

[261] CB, page 458.

[262] CB, page 462.

[263] The Coma Scale assessment is part of the 'Medical Checklist' which 'applies to all people in the care or custody of police at all times.' It uses a scale (1-5) to assess the person's best verbal response (where 5 = oriented and 1 = nil response) and guide the police response to that presentation, including guidance for people presenting as disturbed/depressed or suicidal, having significant injuries or illness or otherwise requiring medical attention or medication (such as to seek medical advice or call an ambulance). The descriptor and guidance corresponding to a Coma Scale Score of 4 are, respectively, 'confused, unable to state name, date, place, etc' and 'consider obtaining medical advice. Monitor regularly for signs of deterioration': CB, page 462.

[264] There are four levels of observations specified (in the hardcopy DRA and policy) ranging from Level 4 – General Observation (minimum 4-hourly physical checks) to Level 1 – High Risk (where the person should not remain in police custody due to an 'immediate risk' of suicide or self-harm or a serious medical

Observation Frequency[265] 30 minutes[266]

108. At 4.20pm, 1C Holmes and C/ Dalton entered Cell 1 to provide Ms McCabe with a meal.[267] She sat up immediately to eat it.[268] After gathering the packaging and placing it by the cell door, Ms McCabe covered the mattress with the blanket and then sat on it with a cup of liquid.[269] She appears to over-balance and spill the liquid on herself, retrieving a used napkin to dry her legs and mop up the liquid from the floor.[270] She returns to sit on the mattress where her movements captured on CCTV are suggestive of distress: variously placing a hand over her face, throwing her back against the wall behind her and then remonstrating with herself (verbally and with gestures).[271] She drew part of the blanket over her legs and shoulder (facing away from the CCTV camera).[272]

109. At about 4.55pm, Ms McCabe placed the cup to one side and manoeuvred herself into the centre of the mattress and sat with her back against the "window" wall, covering her head with the blanket.[273] She remained in that position for approximately five minutes. 1C Johnston had observed on the CCTV monitor that Ms McCabe's head was covered and asked Watch House members to ask her to remove the blanket from her head.[274]

110. At 5.01pm, 1C Holmes (with A/Sgt Rattray)[275] entered Cell 1. While she collected meal packaging from the cell,[276] 1C Holmes directed Ms McCabe to not cover her head with

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condition/symptoms requiring immediate treatment). The Level 3 – Intermittent Observation descriptor states: This is the minimum acceptable level for detainees affected by alcohol or drugs, or who have been assessed by a medical practitioner as presenting with physical or mental health risks: Detainees to be physically checked at least every 30 minutes, or more regularly if directed by the medical practitioner; CCTV can be used in addition to physical checks; The detainee is to be actively engaged during every physical check: CB, page 462.

[265] The Observation Frequency guidance (in the hardcopy DRA) provides scope, for instance, to enable a custody staff member to assess a detainee's Observation Level as Level 4 but specify that physical observations occur more frequency than four-hourly.

[266] CB, page 462.

[267] CB, page 592 and Exhibit 33, file position ~5:02:40.

[268] Exhibit 33, file position ~5.02:42-5:34:20.

[269] Exhibit 33, file position ~5:33:26.

[270] Exhibit 33, file position ~5:34:20.

[271] Exhibit 33, file position ~5:34:20-5:36:09.

[272] Exhibit 33, file position ~5:36:23.

[273] Exhibit 33, file position ~5:37:28.

[274] CB, page 142.

[275] I note that 1C Johnston's Custody Register note suggests C/ Dalton accompanied 1C Holmes, however, 1C Holmes' statement (and that of A/Sgt Rattray) suggests the accompanying member was A/Sgt Rattray.

[276] CB, page 593.

the blanket and warned her that the blanket would be removed from the cell if she refused.[277] Ms McCabe was slow to remove the blanket from her face[278] but did so and asked when she would be permitted to speak to a lawyer.[279] She was told an opportunity to do so would be provided soon.[280]

111. 1C Johnston recorded in the Custody Register that Ms McCabe had been 'checked' and asked to 'stop putting the blanket over her head' and that all appeared correct.[281]

112. Ms McCabe remained in the cell undisturbed between 5.01pm and 5.44pm.[282]

113. After the police members left, Ms McCabe repositioned herself on the mattress, curled on her right side facing the "window" wall with the long edge of the blanket (folded lengthwise) across her body.[283] CCTV footage shows that Ms McCabe covered her face with her hands and appears to rock herself, before adjusting the blanket so that her face is covered by it though the top of her head (which is closest to the CCTV camera) remains visible.[284] She uncovered her face a minute later, and then lashed out at the wall, striking it with one hand.[285] She again covered her face with her hands, and then the blanket.[286]

114. Just before 5.07pm, Ms McCabe punched herself repeatedly to the head and does so again, with apparently more force, about 30 seconds later.[287] She then covered her face with her hands. She sat up[288] with her head in her hands and then adjusted her ponytail. While doing so, Ms McCabe kicks the "window" wall with the sole of her foot with

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[277] CB, page 127.

[278] Exhibit 33, file position ~5:44:03.

[279] CB, page 113.

[280] CB, pages 113-114.

[281] CB, page 459. This Custody Register entry was timed '17.01'. Ms McCabe does not place the blanket over her head again until ~6.58pm: Exhibit 33, file position 7:40:42.

[282] CB, page 593; Exhibit 33, file position ~6:27:22.

[283] Exhibit 33, file position ~5:45:10.

[284] Exhibit 33, file position ~5:46:07.

[285] Exhibit 33, file position ~5:47:07; 5:47:16.

[286] Exhibit 33, file position ~5:47:45; 5:48:18.

[287] Exhibit 33, file position ~5:48:56-5:59:41.

[288] Exhibit 33, file position ~5:49:52.

apparent force.[289] Next, she forcefully struck herself to the head again.[290] Ms McCabe put her head in her hands and rocked back and forth[291] for a couple of minutes, intermittently wiping her face with her hands.[292]

115. At 5.12pm, Ms McCabe moved the mattress (while still sitting on it) along the bench/bed to the corner (of wall "1" and the "window" wall).[293] She sat, facing the corner, with her head in her hands. She spent some minutes manipulating the hem of her skirt before repositioning the blanket over her shoulders, sitting once again with her head in her hands, rocking, for more than five minutes.[294]

116. Between about 5.26pm and 5.44pm, Ms McCabe appears occupied by something (she appears to be manipulating something with her hands). Her body effectively screens her activities from the CCTV camera.[295] She is slow to break off from her activity when police members open the door of Cell 1 at 5.44pm.[296]

Bail/remand brief

117. The bail/remand brief in relation to Ms McCabe was prepared by 1C Creek at Boronia.[297] He did not commence its compilation until after Mr Prentagast had been processed and recalled presenting it for authorisation by Boronia BDM A/Sgt Joshua Webber around 5pm.[298] A/Sgt Webber refused to grant Ms McCabe bail and determined that she should be brought before a magistrate where police would seek her remand in custody.[299] 1C Creek recalled emailing the bail/remand brief to the Melbourne Magistrates' Court for filing at about 5.25pm.[300]

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[289] Exhibit 33, file position ~5:50:56 (just before 5.09pm).

[290] Exhibit 33, file position ~5:51:09.

[291] Exhibit 33, file position ~5:51:45.

[292] Exhibit 33, file position ~5:53:54.

[293] Exhibit 33, file position ~5:54:29.

[294] Exhibit 33, file position ~6:00:49-6:08:45.

[295] Exhibit 33, file position ~6:08:45-6:26:08.

[296] Exhibit 33, file position ~6:26:08.

[297] CB, pages 199-296.

[298] CB, page 87.

[299] CB, pages 110 and 215.

[300] CB, page 87. A copy of the brief was provided to Melbourne Prosecutions at the same time.

Phone Calls

118. Around 5.45pm, Ms McCabe was escorted by First Constables Johnston and Holmes to the Charge Counter to use the landline phone.[301]

119. The first call was to Nicholas Jane, a lawyer employed by Stary Norton Halphen,[302] the firm that had provided Ms McCabe with legal representation in the past. Ms McCabe spoke to Mr Jane for approximately three minutes[303] with the lawyer recalling she sounded 'a bit scattered, as she was rambling a bit about getting out of custody and the allegations were "bullshit".'[304] He provided legal advice.[305] Although he perceived Ms McCabe to be 'agitated about being in custody, she did not demonstrate any overt distress or suicidal ideation.'[306] He had 'no impression of her being particularly depressed or at risk of any self-harm.'[307]

120. At 5.52pm, Ms McCabe attempted to call her friend "Groz"[308] but the number she provided was incorrect.[309] As the correct number was stored in Ms McCabe's mobile phone, police members retrieved it from her property and charged it so the number could be found.[310]

121. The second call, which had been transferred from the Watch House, was from Katrina Hartman, a Victoria Legal Aid (**VLA**) Duty Lawyer at the Bail and Remand Court

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[301] Exhibit 33, file position ~6:27:22.

[302] Exhibit 33, file position ~6:28:35 (5.46pm).

[303] Exhibit 33, file position ~6:31:23-6:33:49 (5.49-5.51pm).

[304] Affidavit of Nicholas Jane dated 14 July 2022.

[305] Mr Jane appears to have been under the impression that at the time he spoke to Ms McCabe she had yet to be interviewed (he considered advice about how Ms McCabe should respond during interview to be the most 'pressing' issue); He was surprised by the dearth of information the Custody Officer was able to provide about the circumstances of Ms McCabe's arrest. Mr Jane advised Ms McCabe that she would be presented to the BaRC where a Victoria Legal Aid lawyer would assist her and if her case was not reached, she would be remanded overnight, and his firm could assist her the next day: Affidavit of Nicholas Jane dated 14 July 2022.

[306] Affidavit of Nicholas Jane dated 14 July 2022.

[307] Affidavit of Nicholas Jane dated 14 July 2022.

[308] Although recorded in police documentation as "Gross" [CB, page 448], it seems likely (and I have assumed) that Ms McCabe was trying to contact the same friend she contacted when at the ED (whose name was recorded in Eastern Health documentation as "Groz").

[309] Exhibit 33, file position ~6:34:49:16-40 (5.52pm).

[310] CB, page 127.

(**BaRC**).[311] Ms Hartman spoke to Ms McCabe for approximately 24 minutes[312] having reviewed the remand paperwork filed by 1C Creek.[313] During their conversation, Ms Hartman provided legal advice about the pending charges, Ms McCabe's prospects for bail and BaRC processes.[314] Ms McCabe instructed that she wished to make a self-represented application for bail.[315]

122. Ms Hartman recalled that Ms McCabe 'did not express suicidal ideations' during their call but had informed her of 'severe depression,' previous mental health diagnoses and current prescribed medications, and had asked to be seen by the 'custody nurse' about medications.[316] The lawyer recorded this information as 'custody management issues' for the benefit of the presiding magistrate when she informed the BaRC that Ms McCabe would make an in-person bail application.[317]

123. After concluding the call with the VLA lawyer, a police member asked Ms McCabe to identify the number for "Groz" on her phone.[318] Ms McCabe did so, and the member dialled the number for her on the landline.[319] Ms McCabe left a voicemail and tried to reach her friend another two times. She left a further voicemail on the third call around 6.20pm stating that she was at Knox and asking "Groz" to call her back.[320]

124. At 6.20pm, Ms McCabe was escorted to Cell 1 by First Constables Johnston and Holmes.[321]

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[311] CB, page 142 and Exhibit 33, file position ~6:35:59 (5.53pm).

[312] Exhibit 33, file position ~6:34:16-6:58:44 (5.52pm-6.16pm).

[313] CB, page 132.

[314] CB, page 132.

[315] CB, page 132.

[316] CB, page 336.

[317] CB, page 132. Ms Hartman was advised by the BaRC Registrar at 8.12pm that Ms McCabe had been found unresponsive in her cell: CB, page 337. She later spoke to a police member at Knox who provided information about Ms McCabe, her attempted suicide and guarded prognosis: CB, page 133.

[318] 1C Holmes was the member manipulating Ms McCabe's phone and 'didn't want her to see a message on her phone that I had seen from "Phil" that said, "call Phill asap, Jess has passed." I don't know if [Ms McCabe] saw it or not, but she was getting annoyed that I was looking at her phone': CB, page 127.

[319] Exhibit 33, file position ~6:59:20.

[320] Exhibit 33, file position ~6:59:20-7:02:19 (6.17pm-6.20pm).

[321] Exhibit 33, file position ~7:03:15.

125. Ms McCabe remained in the cell undisturbed between 6.20pm and 6.32pm.[322]

126. Ms McCabe sat on the mattress facing wall "1," shook the blanket and then ran its hem through her hands before covering her shoulders with it.[323] She engaged in some activity (which is obscured by her position in relation to the CCTV camera) for about three minutes, before laying down facing the "window" wall covered by the blanket.[324]

127. About three minutes later, Ms McCabe sat up with her head in her hands before striking herself to the head with apparent force several times.[325] She struck herself again repeatedly at 6.27pm.[326]

128. Around 6.32pm, Ms McCabe walked over to the cell door and placed her head to it before looking through the glass panel and then returning to sit on the mattress with her head in her hands.[327] Moments later, a police member entered Cell 1 to give Ms McCabe a cup.[328] The Custody Register reflects that Ms McCabe was provided tea.[329]

129. Between 6.30pm and 7pm, 1C Holmes 'glanced' at the CCTV monitor, observing Ms McCabe sitting on the bench/bed with a blanket around her shoulders facing away from the camera.[330] Given the brevity of the observation, and because she was unconcerned by what she saw,[331] she did not record it in the Custody Register.

130. 1C Johnston also recalled 'glancing' at the CCTV monitor 'on a few different occasions.'[332] Ms McCabe 'just looked like she was sleeping' which she considered was in keeping with her posture for 'the majority of [the member's] shift' except when she

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[322] Exhibit 33.

[323] Exhibit 33, file position ~7:04:07.

[324] Exhibit 33, file position ~7:05:37.

[325] Exhibit 33, file position ~7:08:17.

[326] Exhibit 33, file position ~7:09:28.

[327] Exhibit 33, file position ~7:14:43.

[328] Exhibit 33, file position ~7:15:10.

[329] CB, page 459.

[330] CB, page 128.

[331] 1C Holmes recalled that Ms McCabe had been sitting in that position 'off and on so it didn't worry' her: CB, page 128.

[332] CB, page 143.

entered Cell 1 or escorted Ms McCabe to make phone calls.[333] 1C Johnston did not record her observations on the Custody Register due to the pressure of other duties.[334]

Events immediately proximate to death

131. Ms McCabe remained in Cell 1 undisturbed between 6.33pm and 7.58pm.[335]

132. CCTV footage shows that Ms McCabe drank some of the tea before sitting on the blanket and mattress, facing wall "1". Her head was in her hands before and after she struck herself on the thigh with apparent force.[336] A short time later, she lay on her back on the mattress with the blanket, lengthwise, covering her body.[337] She repositioned to face the "window" wall and then returned to lay on her back covered by the blanket; there is near constant movement evident beneath the blanket.[338]

133. At 6.46pm, CCTV footage shows Ms McCabe sitting up facing wall "1", her back covered by the blanket.[339] She appears to be engaged in an activity (involving frequent repositioning) for much of the following ten or so minutes.[340] At 6.52pm and 6.58pm she appears to pass part of the blanket over her head, with her head covered by the blanket for a period of approximately five seconds at 6.58pm.[341] For more than a minute around 6.52pm, and again at around 7.03pm, Ms McCabe appears to place tension on the blanket.[342] On the second occasion, Ms McCabe reclined without placing her head on the mattress with her knees up; the blanket appears bunched or knotted near her throat.[343]

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[333] CB, page 143.

[334] CB, page 144.

[335] Exhibit 33.

[336] Exhibit 33, file position ~7:20:07.

[337] Exhibit 33, file position ~7:23:28.

[338] Exhibit 33, file position ~7:23:28-7:25:56.

[339] Exhibit 33, file position ~7:29:13.

[340] Exhibit 33, file position ~7:26:02-7:40:47.

[341] Exhibit 33, file position ~7:26:02-7:40:47.

[342] Exhibit 33, file position from ~7:35:15; ~7:44:52.

[343] Exhibit 33, file position ~7:44:52-7:45:52. This unusual blanket configuration is captured by the CCTV camera for about 40 seconds.

134. At 7.04pm and for much of the following seven or so minutes,[344] Ms McCabe sat close to and facing wall "1", repositioning herself and the blanket frequently.[345]

135. From about 7.11pm until she collapsed two minutes later, Ms McCabe appears to be sitting facing the wall, with the blanket under her and over her shoulders.[346]

136. Following her collapse at 7.13pm, Ms McCabe was on her back with knees up and the blanket beneath her body and covering only her left shoulder and knee.[347] She remained in that position, and motionless after 7.16pm, until police members entered Cell 1 at 7.58pm.[348]

137. At round 7.40pm, BDM Sgt Mithen received a call from the Registry of the BaRC confirming Ms McCabe's bail/remand hearing was listed at 8pm via WebEx.[349]

138. At 7.56pm, 1C Johnston made an entry on the Custody Register in anticipation of transferring Ms McCabe from Cell 1 to participate in a bail/remand hearing remotely via audio-visual link to the BaRC.[350]

139. At 7.58pm, Sgt Mithen and 1C Johnston entered Cell 1 where they found Ms McCabe lying on her back. Sgt Mithen thought she was asleep and so told her it was time for her hearing.[351] When Ms McCabe did not respond, he approached and observed that she was 'tied up in' the blanket with part of it 'tied tightly around her neck.'[352] Sgt Mithen tried to loosen the blanket and rouse Ms McCabe but she was unresponsive. He directed 1C Johnston to activate the duress alarm.[353]

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[344] Exhibit 33, file position ~7:46:28-~7:54:11.

[345] There is an approximately four-minute period during which her movements are suggestive of placing the blanket under tension: Exhibit 33, between file positions ~7:50:24 and~7:54:11.

[346] Exhibit 33, file position ~7:54:09~7:56:00.

[347] Exhibit 33, file position 7:56:11.

[348] Exhibit 33.

[349] CB, page 136.

[350] CB, page 459.

[351] CB, page 137.

[352] CB, page 137.

[353] CB, page 137.

140. 1C Johnston activated the duress alarm before leaving Cell 1 to summon assistance and request that an ambulance be called.[354] An ambulance was requested at 7.59pm.[355]

141. Several police members responded to the call for assistance. Scissors were used to remove the blanket from Ms McCabe's neck and the mattress moved from beneath her before chest compressions were commenced at 8.01pm.[356] A defibrillator was used to analyse Ms McCabe's cardiac output[357] from 8.02pm.[358]

142. Police members continued chest compressions until Ambulance Victoria paramedics arrived at Ms McCabe's side at 8.08pm.[359] Paramedics found Ms McCabe to be cyanotic, unconscious with dilated pupils, and pulseless.[360] A minute later, Ms McCabe was moved from Cell 1 to the adjacent indoor exercise yard to facilitate paramedic management.[361]

143. A Mobile Intensive Care Ambulance (**MICA**) paramedic arrived a short time later. Ms McCabe remained unresponsive without respirations and cardiac rhythm.[362] The MICA paramedic asked police members to establish Ms McCabe's likely "downtime."[363]

144. While police members reviewed CCTV footage of Cell 1, paramedics continued to treat Ms McCabe with cardio-pulmonary resuscitation (**CPR**), intubation and ventilation, and intravenous adrenaline. These and other interventions produced a return of spontaneous circulation at 8.46pm.[364] Ms McCabe continued to be mechanically ventilated en route to the ED of Box Hill Hospital.[365]

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[354] CB, page 145.

[355] CB, pages 145 and 584.

[356] Exhibit 33, file position 8:43:35.

[357] Ms McCabe was asystolic (no cardiac rhythm nor pulseless electrical activity): CB, page 586.

[358] Exhibit 33, file position 8:44:45.

[359] Exhibit 33, file position 8:51:00. Around this time, Sgt Mithen alerted the BaRC to the emergency situation involving Ms McCabe: CB. Page 137.

[360] CB, page 576.

[361] Exhibit 33, file position 8:52:02.

[362] CB, page 158.

[363] CB, pages 158 and 137-138. 'Downtime' refers to the interval between when the patient was last observed to be alive and when they were found in cardiac arrest and is an important factor in determining the likelihood of survival and neurological recovery.

[364] CB, pages 158 and 581.

[365] CB, page 158.

145. Police members' review of CCTV footage revealed that Ms McCabe had 'wrapped part of a blanket around her neck at approximately 7.13pm.'[366]

Transfer to Box Hill Hospital

146. Ms McCabe arrived at the ED around 9.45pm.[367] Her initial examination revealed a Glasgow Coma Score of 3, breathing and circulation supported by ventilation and adrenalin infusion respectively and soft tissue bruising and swelling over the neck.[368] Ms McCabe's prognosis was assessed as poor given the long downtime and fixed/dilated pupils since paramedic arrival.[369] Computerised Tomography (**CT**) imaging of Ms McCabe's brain demonstrated significant brain injury.[370]

147. Ms McCabe's condition deteriorated with worsening hypoxia and hypotension despite maximal interventions, until her death at 2.21am on 3 December 2021.[371]

IDENTITY OF THE DECEASED

148. Wendy Ann McCabe, born 6 September 1981, late of an address in Ringwood, was visually identified by her mother.[372]

149. Identity was not in dispute and required no further investigation.

MEDICAL CAUSE OF DEATH

150. On 6 December 2021, Forensic Pathologist Dr Joanna Glengarry of the Victorian Institute of Forensic Medicine (**VIFM**) reviewed the circumstances of Ms McCabe's death as reported by police to the coroner, CCTV footage from Knox Cell 1, post-mortem CT scans of the whole body,[373] and performed an autopsy.

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[366] CB, pages 117 and 152.

[367] CB, page 159.

[368] CB, page 586. A Glasgow Coma Score of 3 is indicative of 'deep coma' (noting that Ms McCabe was sedated).

[369] CB, page 586.

[370] CB, page 587.

[371] CB, page 589.

[372] Statement of Identification dated 3 December 2021.

[373] Dr Glengarry also reviewed the Medical Deposition prepared by clinicians at Box Hill Hospital, Ms McCabe's Eastern Health medical records, results of PCR testing performed at Box Hill Hospital and the

151. Dr Glengarry provided a written report of her findings dated 17 February 2022.[374] Among her anatomical findings were shallow unsloping ligature marks over the left and right anterior neck together with sequalae of neck compression including facial petechiae and hypoxic ischaemic encephalopathy;[375] there was a right parietal subgaleal bruise[376] (and various insignificant bruises and abrasions over the body);[377] natural disease including mild to moderate coronary artery atherosclerosis,[378] hepatic steatosis,[379] chronic bronchial asthma, SARS-CoV-2 positive (without histological evidence of Covid-19 lung disease);[380] and anterior rib and sternal fractures consistent with CPR.[381]

152. Toxicological analysis of ante- and post-mortem samples detected methadone[382] and its metabolite; methylamphetamine and amphetamine;[383] pregabalin;[384] diazepam[385] and

request from Victoria Police for an immediate autopsy and the results of toxicology and microbiology testing: CB, page 171. Dr Glengarry also examined the proposed ligature: CB, page 176.

[374] CB, pages 169-185.

[375] CB, page 172.

[376] The 'right parietal' is the area of the right side of the skull above the temporal bone (which extends over the ear) and between the frontal and occipital (back of the skull); 'subgaleal' refers to a specific anatomical space on the scalp, located between a fibrous layer (the galea aponeurotica) and the membrane covering the bone (periosteum) of the cranium.

[377] Small abrasions and/or bruises were identified on Ms McCabe's face, torso, right arm and both legs: CB, pages 175-176.

[378] Atherosclerosis is the thickening or hardening of the arteries caused by a buildup of plaque in the inner lining of an artery.

[379] Hepatic steatosis or 'fatty liver disease,' is a condition where excess fat builds up in the liver. It's a common liver condition, especially in Western countries, and can be caused by various factors, including alcohol abuse, obesity, and certain medical conditions.

[380] CB, page 172. Dr Glengarry interpreted acute bronchitis and early, patchy bronchopneumonia (given the evidence of aspiration of gastric contents due to reduced consciousness) as a complication of ischaemic encephalopathy rather than a sign of Covid-19, especially given the pattern was inconsistent with that seen in Covid-19: CB, page 173.

[381] CB, page 172. Dr Glengarry also noted that an intercostal drain had been inserted into the left side of Ms McCabe's chest.

[382] Methadone is a synthetic opioid and MNDA receptor agonist as potent as morphine as an analgesic with noticeable sedative effects with repeated administration due to its accumulation in plasma; methadone is used to treat opioid dependence and severe pain.

[383] Amphetamine is the term used to describe central nervous system stimulants structurally related to dexamphetamine. Methlyamphetamine (known as speed or ice) is a strong stimulant which acts like the neurotransmitter noradrenaline and the hormone adrenaline. Amphetamine is also a metabolite of methylamphetamine.

[384] Pregabalin is a gabapentim analogue used clinically for the treatment of seizures and neuropathic pain.

[385] Diazepam is a benzodiazepine derivative used to treat anxiety and seizures.

clonazepam[386] and their metabolites; the metabolite of nitrazepam;[387] fentanyl[388] and midazolam[389] – medications administered during resuscitation – were only found in post-mortem samples.[390]

153. Dr Glengarry also examined the proposed ligature, namely, a beige 'Princes Laundry Service' woven blanket of approximate dimensions 185x230 centimetres.[391] She observed that the hem of the short edge of one end appeared to have been torn away from the weave of the blanket and the loose hem had been cut with a sharp edge at one point.[392] Dr Glengarry commented that although it was not possible to completely reconstruct the ligature from the blanket provided, in her opinion, one hem had been fashioned as a ligature and used to compress the neck.[393]

154. The autopsy showed that death resulted from hypoxic ischaemic encephalopathy, which is brain death due to deprivation of oxygen and nutrients, most commonly caused by loss of blood supply to the brain. The forensic pathologist observed that in this case, given the evidence of ligature bruising to the neck, it had occurred as a complication of the effects of neck compression.[394]

155. Dr Glengarry opined that the cause of Ms McCabe's death was hypoxic ischaemic encephalopathy due to ligature compression of the neck.[395]

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[386] Clonazepam is a nitrobenzodiazepine used to treat seizures.

[387] Nitrazepam is a sedative (hypnotic) drug of the benzodiazepine class.

[388] Fentanyl is a synthetic opioid with 50-100 times the potency of morphine, rapid onset and short duration of action.

[389] Midazolam is an antiepileptic, sedative-hypnotic and anaesthetic induction agent used as a preoperative medication.

[390] CB 184 and 339-353.

[391] CB, page 176.

[392] CB, page 176.

[393] CB, page 173.

[394] CB, page 172.

[395] CB, page 172.

THE CORONIAL INVESTIGATION & INVESTIGATIONS BY OTHER ENTITIES

156. Upon Ms McCabe's death, a coronial investigation was commenced by DLSC Justin Tippett of the Homicide Squad with oversight by Detective Sergeant Frank Marino of Victoria Police's Professional Standards Command.[396]

157. On 15 December 2021, a directions hearing was held in accordance with Practice Direction 5 of 2020,[397] which among other matters fixed a date by which DLSC Tippett was to file the coronial brief of evidence.

158. Following receipt of the coronial brief in April 2022, further investigations were undertaken at my direction.

159. In January 2023, I was informed that WorkSafe had initiated an investigation into the circumstances of Ms McCabe's death.[398]

160. In March 2023, the Court received a copy of the report prepared by Superintendent Simon Humphrey of his Operational Safety Critical Incident Review (**OSCIR**). Victoria Police undertakes reviews of certain critical incidents[399] to ascertain the adequacy of and compliance with its policies and guidance, and the appropriateness of police members' actions, police practices and culture.[400]

161. I held a directions hearing in May 2023[401] to ascertain, among other things, the status of the WorkSafe investigation and whether I might proceed to inquest given the Court's usual practice that coronial investigations follow any criminal investigation (and/or prosecution) connected with the death.

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[396] Coronial brief, CB 190.

[397] Practice Direction 5 of 2020 requires a public hearing to be held within 28 days of any death reported to the Coroner for which an inquest will be mandatory pursuant to s52 of the Act.

[398] Correspondence from WorkSafe's Senior Investigator to the Court dated 16 January 2023.

[399] Critical incidents are defined in Victoria Police Manual – Death or serios injury/illness involving police.

[400] Each critical incident will have its own 'scope of evaluation' but will focus on these types of organisational issues.

[401] Transcript of directions hearing held on 30 May 2023.

162. At that directions hearing, Victoria Police confirmed that it had informed WorkSafe of the 'notifiable incident'[402] on 5 January 2023.[403] I was told that WorkSafe's investigation was well-progressed but not concluded and following it, a legal team within WorkSafe would consider any appropriate charges.[404] WorkSafe's best estimate was that its decision about prosecution would 'probably' be made by the end of 2023.[405]

163. The coronial investigation into Ms McCabe's death was held in abeyance between June 2023 and January 2025, the Court having been advised in December 2024 that WorkSafe had concluded its inquiries and no prosecution would be initiated.[406]

164. In January 2025, I sought information from the Chief Commissioner of Victoria Police (**CCP**) about any changes to custody arrangements at Knox (including any arising from recommendations made in the OSCIR) and Victoria Police Manual (**VPM**) policy/guidance relating to safe management of people in police care or custody since 2021.[407] As the CCP's response was delayed, a mention hearing was held on 4 April 2025[408] with the response ultimately being filed on 2 May 2025.

165. Thereafter, I afforded those police members involved in Ms McCabe's management on 2 December 2021 an opportunity to make submissions about the potential for adverse

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[402] The 'incident' was the death of a person (Ms McCabe) at a workplace (Knox Police Station). Section 38 of the Occupational Health and Safety Act 2004 requires an 'employer' to notify the WorkSafe Authority of an 'incident' and provide a written record of the incident within 48 hours. These legislative requirements form part of the Victoria Police Manual (VPM) and VPM Procedures and Guidelines (VPMG): VPM – OHS Incident management and VPMG – Investigation of workplace incidents. The VPM/G provides that a 'police commander' [the 'member responsible for managing police resources and the police response at the incident site'] is responsible for ensuring that WorkSafe is notified of certain incidents including incidents involving death or serious injury at a place of work. In 2021 there was an informal process by which WorkSafe notifications were monitored, however, these were prompted by the report of an incident using Victoria Police (internal reporting) systems, 'HR Assist' and/or 'Incident Fact Sheet' (IFS) system pursuant to VPM requirements in paragraph 3 of the VPM – OHS Incident management and VPM – Deceased persons, respectively. I was advised that Victoria Police intended for the informal monitoring process (of liaison between Victoria Police's OHS Unit and the 'Work Unit' about WorkSafe notification) to be formalised within the VPM – OHS Incident Management: Correspondence from VGSO (on behalf of the Chief Commissioner of Victoria Police) to the Court dated 7 September 2023.

[403] Transcript of directions hearing held on 30 May 2023, page 4.

[404] Transcript of directions hearing held on 30 May 2023, pages 6-7.

[405] Transcript of directions hearing held on 30 May 2023, page 7.

[406] Correspondence from WorkSafe to the Court dated 4 December 2024.

[407] Victoria Police had also been invited to respond to the potential for adverse findings.

[408] Transcript of mention hearing held on 4 April 2025.

findings to be made about their conduct based on the available evidence. Submissions were received on 6 and 11 June 2025.

FOCUS OF THE CORONIAL INVESTIGATION

166. The focus of my investigation into Ms McCabe's death was on her management while in police custody on 2 December 2021, particularly while she was accommodated at the detention facilities at Knox.

Knox and its detention facilities

167. Knox, situated on the Burwood Highway in Wantirna South opposite a large shopping centre, is the only 24-hour police station in the Eastern Region of Victoria Police's service area.[409] In addition to police members assigned to the police station, Knox houses various support and specialist units and all members draw their equipment from the Knox Watch House.[410]

168. In 2021, the detention facilities at Knox were classified as a 'Police Holding Room' pursuant to the *Register of Detention Facilities*.[411] This designation limits the period for which a person in custody may be detained and has implications for the number and type of staff tasked to ensure their safe management.[412] That is, custody management at Knox is undertaken by sworn police members performing watch house and reception duties[413]

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[409] The Knox Police Service Area (PSA) is located 25 km east of the Melbourne CBD, covering an area of 114 square kilometres with an estimated population of 161,000. The area is predominantly residential, with some commercial and industrial areas covering the suburbs of Bayswater, Boronia, The Basin, Wantirna, Wantirna South, Ferntree Gully, Upper Ferntree Gully, Knoxfield, Lysterfield, Scoresby and Rowville. Police Stations within the Knox PSA include Knox, Boronia and Rowville.

[410] At Knox, the 'Watch House' is an area of the police station bounded on one side by the public counter (which is adjacent to the foyer) and on another by the 'Charge Counter' which is adjacent to the custody suite/detention facilities. Among the duties of members performing watch house duties is the issue of equipment.

[411] AM-02-02 (Statement of Acting Superintendent Gerry Cartwright dated 20 January 2023). Although ordinarily used as a Police Holding Room, Knox's detention facilities meet the standards of a Gazetted Police Gaol and so may be used as such if the cells at Ringwood Police Station are unavailable and Victoria Police's Business Continuity Plan is activated.

[412] Victoria Police Manual Policy (VPMP) – *Persons in police care or custody*: CB, pages 377-387.

[413] The Operational Safety Committee Incident Review (OSCIR) following Ms McCabe's death dated 8 February 2023 provides the following insight into the range of tasks members may undertake when rostered to perform duties in the Watch House/Custody area: issuing equipment, answering phone calls and responding to counter enquiries, managing/processing people (searches, fingerprinting) at the police station for interview or otherwise in custody, conducting bail hearings via WebEx and preparing bail documentation, facilitating communications between people in custody and their legal representatives and facilitating visits with detainees.

(not Police Custody Officers)[414] under the supervision of a Custody Sergeant (the BDM Sergeant)[415] referred to in policies as the 'custody supervisor.'[416]

169. Knox detention facilities comprise of four cells and a holding cell[417] with a nominal capacity of 13 beds.[418] One of the cells is designated a "female" cell[419] – Cell 1 – and is located furthest from the Watch House and separate from the three "male" cells.[420] Each cell is equipped with a single CCTV camera which may be monitored on screens located in the Section Sergeant's Office, at the Charge Counter and in the Watch House Reception.[421] There is some evidence that the size and quality of the view/images shown on these CCTV screens was considered suboptimal by Knox members.[422]

170. For operational (that is, safety) reasons, two police members are required to escort a person in custody (between locations within the police station or during a bail hearing via WebEx) or when interacting face-to-face with them (such as when entering a cell to perform a welfare check or provide refreshment).[423]

171. According to the OSCIR, the Knox 'custody facility was appropriately and adequately staffed and supervised'[424] while Ms McCabe was present. As noted above, the members performing watch house and reception duties at Knox on 2 December 2021 considered it to be busy, particularly in the afternoon.[425]

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[414] Police Custody Officers are public servants authorized under s200D of the *Victoria Police Act* 2013 whose legislative authority is (broadly) limited to the performance of duties in respect of people lawfully detained in a 'gazetted police gaol' (rather than a police holding room) pursuant to the *Corrections Act* 1986.

[415] Mitchell Statement, paragraph 11.

[416] See for instance, VPM *Persons in police care or custody*, section 4.2-4.3, CB page 383-384.

[417] CB, page 354.

[418] AM-02-02 (Statement of Acting Superintendent Gerry Cartwright dated 20 January 2023).

[419] Victoria Police Manual Guideline (VPMG) – *Safe management of person in police care or custody* states that where possible, female detainees must be separated from male detainees: CB, pages 378-430; 407.

[420] CB, page 354.

[421] CB, page 366, and see generally, Exhibit 33 (Knox CCTV Compilation).

[422] See for instance, CB, pages 112, 117 and 126. I note that the OSCIR dated 8 February 2023 referred to 'advocacy for some time' at Knox for improvements to the CCTV system but that any inadequacy of the system was not considered 'contributory'.

[423] CB, pages 410 (VPMG *Safe management of persons in police care or custody*) and 356 (*Standard Operating Procedures – Knox Police Station*).

[424] OSCIR dated 8 February 2023.

[425] See for instance, CB pages 113, 121, 126, 136, 140 and 143. The OSCIR dated 8 February 2023 also noted high operational demands.

Policy, practice and expectations for the safe management of people in custody in 2021

172. In December 2021, four documents set out the minimum mandatory requirements and best practice guidance for the safe management of people in police care or custody: VPM Policy Rules *Persons in police care or custody*;[426] VPM Guidelines *Safe management of persons in police care or custody*;[427] VPM Procedures and Guidelines *Attendance and custody modules*;[428] and *Standard Operating Procedures Station – Knox Police Station*.[429]

173. Accompanying and investigating police members, custody staff and the custody supervisor have specific responsibilities for the 'safety, security and wellbeing' of a person in their care or custody.[430] Each person in care or custody must be treated as an individual, having regard to their specific risks and needs; decisions about how a person is to be managed must balance their welfare, dignity and human rights against any risk to their (and others') safety and security.[431]

174. The Medical Checklist must be used to assess each person in care or custody and be re-applied whenever care or custody is transferred to another member. If the person experiences a medical episode, displays behaviour that indicates a previously undocumented or unknown mental health condition, or experiences 'trauma to the head … including self-inflicted trauma' the Medical Checklist must be reapplied.[432]

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[426] CB, pages 377-387. VPM Policy Rules contain mandatory requirements where non-compliance or departure from their terms may result in management or disciplinary action.

[427] CB, page 388-431: VPM Guidelines support the interpretation and application of rules and responsibilities and are not mandatory requirements on their own. Where 'rules and responsibilities' state that employees 'must have regard to' Procedures and Guidelines, they 'must be used to help make decisions in support of the rules.'

[428] CB, pages 432-444: VPM Procedures and Guidelines have a similar function and status as VPM Guidelines.

[429] CB, pages 355-376: These Local Standard Operating Procedures constitute a 'lawful instruction' for the purpose of s125(1)(i) of the *Victoria Police Act* 2013 and were not to replicate, replace or be inconsistent with the VPM or legislation.

[430] VPM Policy Rules *Persons in police care or custody*, sections 3 and 4. These include application of the Medical Checklist (and its reapplication as soon as practicable upon becoming aware of a change or presentation, behaviour or circumstance) and that they retain responsibility until care or custody is transferred to another person (pursuant to the Policy Rules) and to communicate 'risks or safety concerns' (pursuant to the Policy Guideline): VPM Policy Guideline *Persons in police care or custody*, section 4.6.

[431] VPM Policy Rules *Persons in police care or custody*, section 1, CB page 378.

[432] VPM Policy Guideline *Persons in police care or custody*, section 2.1, CB page 391-392.

175. A person 'entering custody' is subject to an initial assessment and Initial Supervisor Check and a search. Risks or concerns may be identified by the supervisor or by those who conduct the search or those who interview the person.[433] The expectation is that police members 'will report to custodial staff and/or record' in the Attendance and Custody Registers 'any behaviours or matters of concern' that come to their attention when a person is in custody.[434]

176. The CHAL should be contacted for help if a person in custody 'appears to be presenting with mental health' or medical issues.[435]

177. The DRA is a process linked to the Custody Register and a DRA was required to be completed for persons "lodged" in a detention facility[436] or held in custody for more than four hours.[437]

178. The purpose of the DRA is to assess any risks faced or presented by the detainee to inform how those risks should be managed and so 'the expectation was that a DRA would be completed as soon as possible.'[438] There was 'no written policy on how soon the DRA was to be completed' but the 'practice was that it should be done within an hour.'[439] The DRA came into effect once it was submitted to the custody supervisor for approval.[440] It

[433] Mitchell Statement, paragraph 14.

[434] Mitchell Statement, paragraph 14 and VPM Policy Guideline *Persons in police care or custody*, section 4.6.

[435] Mitchell Statement, paragraph 14.

[436] VPM Guidelines *Attendance and custody modules*, section 2, CB, page 347. I note that the term 'lodged' was not defined in any of the relevant policies. However, a person in police custody at a police station was regarded as 'lodged' when a DRA had been completed and the person entered onto the Custody Register and/or placed in a cell: Mitchell Statement, paragraph 21.

[437] Mitchell Statement, paragraph 23 and VPM Policy Guideline *Persons in police care or custody*, section 3.

[438] Mitchell Statement, paragraph 23.

[439] Mitchell Statement, paragraph 13. The 'within an hour' advice from the Custody Management Division of Victoria Police was applicable irrespective of whether the DRA was completed electronically (e-DRA) or as a hard copy and 'uploaded' to the Custody Register.

[440] Mitchell Statement, paragraph 27. According to Inspector Mitchell, applicable policy in 2021 did not require that the DRA to be approved by a supervisor notwithstanding that it was the custody supervisor's responsibility to determine how to detain the person. However, I note 'custody supervisors' were 'required to conduct a Detainee Risk Assessment' of each person in care/custody by virtue of VPMG *Safe management of person in police care or custody*, sections 4.4 and 5.2.

is understood that following completion/approval[441] of a DRA it is transmitted to Victoria Police's Custodial Health Service for review.

179. To the extent that a person was "in custody" for any period of time before completion of the DRA, custody staff had access to notes made on the Attendance and/or Custody Registers, any relevant flags on LEAP, their own observations of the person via CCTV and in person and any information provided in verbal handovers or discussions within the custody management team.[442]

180. Information (including the initial information and the Initial Supervisor Check) is recorded on the Attendance and Custody Registers, with specific guidance provided as to what, where and by whom events and observations should be documented.[443]

181. To ensure 'continuity of supervision' there should always be at least one custody staff member present in the vicinity of the detention facility. If a custody staff member needs to 'leave the area,' they should handover their duties to another custody staff member.[444]

182. If custody responsibilities are transferred, 'comprehensive briefings' should be given addressing the 'status, risks and welfare of each detainee' and handovers should be recorded on the Custody Register.[445]

183. The custody supervisor has 'overall responsibility for ensuring the appropriate management and care'[446] of people in custody during their shift and is responsible for ensuring that 'relevant information about a detainee is communicated to and understood by other custody staff members.'[447]

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[441] It's not clear from the available materials whether the custody supervisor's approval of a DRA was required *before* it was submitted to the CHS.

[442] Mitchell Statement, paragraph 19.

[443] VPMG *Attendance and custody modules*, sections 1, 2.1-2.8, 2.10 and 2.11, CB pages 432-441 and 442-443.

[444] VPMG *Safe management of person in police care or custody*, section 8.1, CB page 409.

[445] VPMG *Attendance and custody modules*, section 8.1, CB pages 409-410 and Mitchell Statement, paragraph 20.

[446] VPMP *Persons in police care or custody*, section 4.3, CB page 384.

[447] Mitchell Statement, paragraph 20.

184. Custody staff are responsible for undertaking the day-to-day tasks required to ensure the care and welfare of people in detention facilities.[448]

Risk/assessment

185. Medical, welfare and risk assessments are central to safe management of people in police care or custody.[449] As noted above, the Medical Checklist, LEAP flags and other warnings and intelligence, the CHAL, the DRA, observation/engagement and communication/recording are the mechanisms designed to support decision-making about appropriate responses or actions.

186. Risk assessment is a continuous and ongoing requirement for the duration of a person's period in police care or custody.[450] Guidance outlines a process of hazard identification,[451] assessment of previous and current risks, implementation of risk controls (including recording and communication of management plans), continual monitoring, and review of risk assessment.[452] This process informs ongoing management and care requirements, including the appropriate level and frequency of observation.

187. The 'period following an interview' is noted in the guidance as a time when people in custody are 'at higher risk of suicide or self-harm.'[453] Members and staff are to advise their supervisor 'if they notice any change in the person's behaviour *that may alter the risk assessment* and require the person to be more closely monitored' (emphasis added).[454]

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[448] VPMP *Persons in police care or custody*, section 4.3, CB page 384

[449] 'Management principles' emphasise: the person's safety, health and welfare; their individuality having regard to their specific risks and needs; continual monitoring and assessment and prompt response to identified medical and safety risks; balancing the person's welfare, dignity and human rights against any risk to their safety and security (and that of others) when determining how they are managed; and communication of all relevant risks to and by members and staff with responsibilities: VPMP *Persons in police care or custody*, section 1.1, CB, pages 378-379.

[450] VPMP *Persons in police care or custody*, section 1.1.

[451] 'Hazard Identification' includes guidance to check the recorded information about the detainee on LEAP and in the Attendance/Custody Register, including current risks, recommended actions, observation level and management plan. Police members/staff are to assess the current condition of the detainee – by observation, and active engagement and assess them in terms of the Medical Checklist, the risk of self-harm, the risk of harming others (including members/staff) and security risks. Medical advice to aid risk assessment should be sought 'if required,' CB page 402.

[452] VPMG *Safe management of person in police care or custody*, section 5.2, CB page 402.

[453] VPMG *Safe management of person in police care or custody*, section 4.6, CB page 400.

[454] VPMG *Safe management of person in police care or custody*, section 4.6, CB page 400.

188. Guidance on 'how to detain the person' emphasises consideration of a range of factors including the person in custody's physical condition, age, demeanour and 'indication … [they] may harm themselves or others,' and any other relevant factors (E*justice and LEAP flags) as well as the station facilities and presence of other police to assist with management.[455] Unsurprisingly, the focus is the person's current circumstances. There is no guidance to assist decision-makers to integrate and weight information about and from a person in custody that may be open to interpretation, conflict with other information, or that is historic, recent or current.

189. I was informed that Victoria Police:

> does not issue prescriptive guidance on how to integrate and weight [the] different types of information when making an assessment (which is done by referring to relevant VPMs and the narrow criteria provided by the Coma Score). [This is because] it is not possible to be prescriptive when the range of potential factors is so broad and where detainee behaviour can have many potential explanations.
>
> Police members are trained to make decisions in the course of their duties and to do so in a manner which takes into account applicable law, policy and the 'Scrutiny, Ethical, Lawful and Fair' test. When conducting a DRA and making decisions about the frequency of observations, or about any risks which a detainee might pose to themselves, police are expected to make decisions based on the above factors, individual circumstances, rapport, member's experience, supervisor's experience, familiarity with or knowledge of other people being held in the facility at the same time, local practice, environment, resourcing and other relevant factors and to subsequently document their decision appropriately. …
>
> Police members have to make efficient decisions in the best interests of the prisoner based on all of the above factors as well as how the prisoner is behaving and what they disclose to police members at the time. Whilst warning flags and LEAP information should always be considered, if a detainee is presenting in a manner which is different to those flags and LEAP information, the police member cannot always resolve that conflict and they cannot ignore the presentation of the detainee because it is inconsistent with past presentations.[456]

Risks and Recommended Actions

190. The Victoria Police Custody and Operations Logistics intranet site provides access to 'Risks and Recommended Actions – Guidance Notes' and a 'Risks and Recommended Actions Matrix' which recommend (rather than mandate) actions to safely manage people in police custody.[457] The risk categories align with the E*Justice risks and ratings. Relevantly, the recommended actions linked to a S4 (suicide) rating include 'only issue

[455] VPMG *Safe management of person in police care or custody*, section 5.3, CB page 403.

[456] Mitchell Statement, paragraphs 65-68.

[457] OSCIR dated 8 February 2023, page 20.

suicide resistant blanket; place in a shared cell; review required for each new reception.'[458]

191. In relation to blankets, the VPM guidance stated that they should be provided to people in custody 'as needed' and that 'high risk' detainees 'may' be provided with suicide resistant blankets.[459]

Levels of Observation and conducting checks

192. The DRA informs (among other things) appropriate observation levels and so the frequency and manner of check conducted on the person in custody.[460] There are four observation levels, each associated with a descriptor and linked to a minimum frequency and manner of check. Level 4 (General) observations set the minimum acceptable level of observation (physical checks at least every four hours).[461] In contrast, if Level 1 (High Risk) observations are required, there is an expectation that the detainee will not remain in custody due to a serious medical condition/symptoms requiring immediate treatment or an 'immediate risk of suicide or self-harm.'[462] In the interim, the person is to be constantly monitored via CCTV cameras and 'actively engaged during physical checks' at least every 30 minutes (that is, the same observation requirements as Level 2).[463]

193. The minimum frequency and manner of physical checks required for Level 3 (Intermittent) and Level 2 (Constant) observations are the same, but Level 2 observations require constant monitoring via CCTV in addition to physical checks.[464] Although not clear-cut,[465] the chief difference between these levels of observation is the circumstances of their apparent intended use: Level 3 observations appear directed to detainees '*affected* by alcohol or drugs' while Level 2 observations are directed to detainees whose 'risk

[458] OSCIR dated 8 February 2023, page 20.

[459] VPMG *Safe management of person in police care or custody*, section 8.6, CB page 417.

[460] VPMG *Safe management of person in police care or custody*, section 8.3, CB page 411. Though I note Inspector Mitchell's expectation that 'everything' is taken into account: Mitchell Statement, paragraph 59.

[461] VPMG *Safe management of person in police care or custody*, section 8.3, CB page 412.

[462] VPMG *Safe management of person in police care or custody*, section 8.3, CB page 412.

[463] VPMG *Safe management of person in police care or custody*, section 8.3, CB page 412.

[464] VPMG *Safe management of person in police care or custody*, section 8.3, CB page 412.

[465] That is, in addition to Level 3 being the minimum acceptable level of observation for detainees affected by alcohol or drugs, it is also applicable to detainees 'assessed by a medical practitioner as presenting with physical or mental health 'risks.'

assessment indicates a *likelihood of self-harm'* (emphasis added).[466] Indeed, in addition to requirements about manner and frequency of observation, the Level 2 descriptor mirrors most of the Recommended Actions applicable to detainees with a S4 rating.[467]

194. 'Checks' must be conducted in accordance with the relevant observation level and recorded in the Custody Register, including 'the detainee's behaviour/condition,' with 'any changes' to be reported to supervisor 'immediately.'[468] Physical checks – observation of the person in custody in the detention facility as opposed to via CCTV cameras – are required but these need not involve interaction or engagement and response unless required by the relevant observation level.

195. CCTV can be used in addition to physical checks to monitor the detainee's health and wellbeing.[469]

196. The benefit of continuity in checks – that is, the same person performs sequential checks where possible – to inform evaluation of changes to the detainee's condition and risks is emphasised.[470]

197. The guidance on observation/checks includes a warning (to be 'taken into consideration') that detainees may be more vulnerable in circumstances, including relevantly, after interview, after charge, when attending court and upon refusal of bail.[471]

Context, Concessions and Submissions

198. Inspector Mitchell, on behalf of Victoria Police, and some members involved in Ms McCabe's management at Knox on 2 December 2021 made concessions about non-compliance with policy, guidelines or Recommended Actions and shortcomings in her management while in custody.

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[466] VPMG *Safe management of person in police care or custody*, section 8.3, CB page 412.

[467] VPMG *Safe management of person in police care or custody*, section 8.3, CB page 412. That is, the guidance includes that any items that the person could use to harm themselves is removed; they are lodged with another person where possible/appropriate; and a point of divergence from the S4 Recommended Action but overlap with the Level 1 descriptor (if in terms of less immediacy), consideration of referral for assessment under the *Mental Health Act* 2014 and removal from police custody.

[468] VPMG *Safe management of person in police care or custody*, section 8.3, CB page 411.

[469] VPMG *Safe management of person in police care or custody*, section 8.3, CB page 411.

[470] VPMG *Safe management of person in police care or custody*, section 8.3, CB page 412.

[471] VPMG *Safe management of person in police care or custody*, section 8.3, CB page 413.

Documentation/Handovers

199. Inspector Mitchell acknowledged that notes of observations made during the full search were not adequate, but stated it was unclear whether better notes would have affected risk assessment.[472]

200. She considered that notes made on the Attendance Register during BDM Sgt Phillip's Initial Supervisor Check were 'limited' but 'above the minimum required.'[473] My own view is that while certain hazards or risks were identified, no risk assessment (if performed) nor management plan was recorded.[474]

201. Inspector Mitchell did not otherwise comment on the quality of the notations on Ms McCabe's Attendance/Custody Registers. My observations are that generally, entries were few, brief and tended to be task-oriented rather than containing 'meaningful information about the detainee's condition' as required by the VPM guidance.[475] However, I note that the example of "meaningful information" provided in the VPM is unlikely to enable anything meaningful to be gleaned about a detainee save their level of apparent consciousness/alertness.[476]

202. Inspector Mitchell observed that there was no record of nor evidence that Constable 1 handed over to custody staff her observations of Ms McCabe[477] on 2 December 2021.[478] While she acknowledged it was information that 'could' have been passed on to custodial staff, in circumstances where Ms McCabe was later questioned by them and denied any suicidal ideation, she considered it unclear that handing over the information would have made 'any difference in the outcome.'[479] Inspector Mitchell observed Ms McCabe's

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[472] Mitchell Statement, paragraph 31.

[473] Mitchell Statement, paragraph 29.

[474] As required by VPMG *Attendance and custody modules* section 1.4 (and 1.7), CB, page 434 (and 435-436).

[475] VPMG *Safe management of persons in police care or custody* section 8.3, CB page 413.

[476] The example included is: 'detainee awake, reading, spoken to, offered drink, drink refused,' VPMG *Safe management of persons in police care or custody* section 8.3, CB page 413.

[477] That is, the member's characterization of Ms McCabe as erratic, the possible/apparent intentional head strike before fingerprinting and short outburst "Fuck this world" at potentially some other time.

[478] Mitchell Statement, paragraph 32. The only reference to the observations made by the member appears in her statement for the coronial investigation.

[479] Mitchell Statement, paragraph 34.

further contextual comments[480] may have diminished the significance of her head strike/"outburst" in Constable 1's mind but that she (Inspector Mitchell) 'would not anticipate [the behaviour] would ring alarm bells at the time.'[481]

203. Inspector Mitchell observed that 'with hindsight' Ms McCabe striking her head can be seen as a 'potential indicator of an intention to self-harm,' but commented that because it is a 'very common behaviour … it might not have appeared significant' at the time.[482]

204. My reading of the applicable VPM guideline is that the "outburst" likely constituted an 'incident' – of self-harm – requiring documentation as an Observation in the Custody Register, report to custody staff and/or a sub-officer, and 'as soon as possible' reassessment of the Risks and Recommended Actions relating to the person in custody.[483]

205. I will return to the issue of handovers below.

Issuing a "standard blanket" and the S4 rating

206. Victoria Police conceded that Ms McCabe should have been issued with a suicide-resistant blanket in circumstances where she had a S4 rating although this was not a mandatory requirement at the time.[484] However, in Inspector Mitchell's view, it was not unreasonable for Ms McCabe to have been given a "standard" blanket in circumstances where the DRA had not been completed and where Ms McCabe was 'not presenting with any signs of distress or self-harm.'[485]

207. For his part, though Sgt Ross acknowledged that the Recommended Action resulting from a S4 rating was 'not followed,' he submitted that this did not amount to insufficient compliance with policy or guidance.[486] He confirmed that, mindful of Ms McCabe's 'basic human rights,' he offered her a blanket for comfort/warmth because it was often

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[480] That the "world was a beautiful place".

[481] Mitchell Statement, paragraph 33. Indeed, Constable 1 stated that she interpreted the 'outburst' as Ms McCabe's frustration at being in police custody and considered that their subsequent conversation was 'relatively positive:' CB, page 102.

[482] Mitchell Statement, paragraph 16.

[483] VPMG *Attendance and custody modules* section 2.7, CB, page 439.

[484] Mitchell Statement, paragraph 94.

[485] Mitchell Statement, paragraph 37. Inspector Mitchell acknowledged that the Professional Standards Command had found that Ms McCabe should not have been given a "standard" blanket.

[486] Submission on behalf of Sgt Ross, paragraph 17.

cold in the cells.[487] His usual practice 'irrespective of the circumstances' was to provide a suicide-resistant blanket if one was available and appears to have inferred from the type of blanket Ms McCabe was given that no suicide-resistant blanket was available.[488]

208. Sgt Ross does not recall speaking to morning BDM Sgt Phillips, reviewing the Custody Register or being warned by any other member that a "standard" blanket should not be issued[489] before providing one to Ms McCabe. To that point, his involvement with Ms McCabe was limited to escorting her to Cell 1 after fingerprinting. Despite this, Sgt Ross volunteered that S4 ratings are 'very common and can't be removed' and 'often indicate suicide risks that are old' and while they are 'one factor' to consider, it is 'most important to assess the person's demeanour and responses while they are in custody which is a more reliable indicator of any current welfare issues.'[490]

209. At no stage in any of his interactions with Ms McCabe (escorting her, offering a blanket and involvement in a check 10 minutes later) did he observe anything in her demeanour or responses that caused him to consider she had "suicidal tendencies"[491] or was at risk of self-harm or suicide.'[492] Further, at the time the "standard" blanket was issued, Ms McCabe had been in police custody for nearly two and a half hours and 'no concerns had been raised about her welfare.'[493]

210. Sgt Ross noted on the Custody Register he had given Ms McCabe a blanket and accepts that the S4 rating would have been visible when he did so but cannot recall if he looked

[487] Submission on behalf of Sgt Ross, paragraph 9.

[488] Submission on behalf of Sgt Ross, paragraph 8. The near-contemporaneous account provided in his first statement contains nothing about the availability or otherwise of suicide-resistant blankets though there is some evidence that the supply of these blankets was limited in 2021.

[489] Submission on behalf of Sgt Ross, paragraph 8 and CB, page 104.

[490] Submission on behalf of Sgt Ross, paragraph 11.

[491] This phrase is used in the Standard Operating Procedures – Knox Police Station in the context of guidance about issuing suicide-resistant blankets to people with 'self-injury or suicidal tendencies:' CB, page 363.

[492] Submission on behalf of Sgt Ross, paragraphs 11, 13 and 14.

[493] Submission on behalf of Sgt Ross, paragraph 11.

at it or considered it at the time.[494] Nonetheless, for the reasons outlined above, he submitted there was no reason to remove the "standard" blanket.[495]

211. Notwithstanding her acknowledgement of her supervisory responsibilities in relation to Ms McCabe's custody management, BDM Sgt Phillips submitted that no adverse comment relating to Sgt Ross' provision of a blanket to Ms McCabe was applicable to her because she was unaware of it.[496] She was unable to recall when she became aware Ms McCabe had been given a blanket, or if she observed Sgt Ross' entry on the Custody Register.[497]

212. Further, although conceding that the S4 rating would have been visible on the Custody Register when she made notations, BDM Sgt Phillips does not recall whether she observed it at that time.[498] That said, it was her expectation that if a suicide-resistant blanket was available, one would have been provided to Ms McCabe based on her S4 rating.[499]

213. Like Sgt Ross, BDM Sgt Phillips did not assess Ms McCabe as presenting with 'any welfare concerns' based on her own (single) interaction and the absence of any concerns reported by other members.[500] She too opined that the person's 'presentation while they are in custody' was a 'more reliable indicator' of welfare issues than the 'common' S4 rating.[501] BDM Sgt Phillips (like Sgt Ross) considered that the assessment that Ms McCabe did not demonstrate "suicidal tendencies" or a likelihood of self-harm was 'consistent with the DRA' completed after her shift.[502] She further noted that the DRA

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[494] Submission on behalf of Sgt Ross, paragraph 10. S/Sgt Ross' submission is qualified by the phrase, 'assuming the S4 warning flag was on the custody module at that time' which appears at odds with Inspector Mitchell's evidence that the custody risk rating preload automatically.

[495] Submission on behalf of Sgt Ross, paragraph 15.

[496] Submission on behalf of Sgt Phillips, paragraph 9.

[497] Submission on behalf of Sgt Phillips, paragraph 14.

[498] Submission on behalf of Sgt Phillips, paragraph 13.

[499] Submission on behalf of Sgt Phillips, paragraph 15. Sgt Phillips accepted that if a suicide-resistant blanket was available on 2 December 2021, that she did not ensure the Recommended Action was followed: Submission on behalf of Sgt Phillips, paragraph 19.

[500] Submission on behalf of Sgt Phillips, paragraph 16.

[501] Submission on behalf of Sgt Phillips, paragraph 17.

[502] Submission on behalf of Sgt Phillips, paragraph 16 and Submission on behalf of S/Sgt Ross, paragraph 11.

indicated Ms McCabe had 'no current suicidal ideation and her previous self-harm was a "long time ago" and not related to being in police custody.'[503]

Delayed DRA

214. Inspector Mitchell conceded that notwithstanding the absence of explicit policy concerning the timeframe for completion of the DRA, that Ms McCabe's DRA was not completed until she had been in custody for several hours was not consistent with Victoria Police expectations.[504] BDM Sgt Phillips made a concession in similar terms[505] noting both the operational context on 2 December 2021 and that since Ms McCabe's death she is 'hypervigilant' about completing DRAs 'as soon as a person enters into custody' and communicating custody management requirements to custody staff.[506]

215. Several members were involved in the creation and approval of the DRA. Notably, the members who elicited information from Ms McCabe for the DRA were not involved in its risk/assessment component[507] and the member who determined her Coma Score and level and frequency of observation had not interacted with Ms McCabe before doing so,[508] nor was she specifically tasked to perform custody management duties.[509] Although commendable as a demonstration of teamwork and no doubt necessary when operational demands are high, this approach somewhat undercuts the benefits of continuity of supervision/management of people in custody[510] requiring even greater emphasis on communication and handover to minimise loss of pertinent information.

216. The only account of 1C Holmes' DRA risk/assessment was provided in the submissions made on her behalf. At this time, in 2025, she could not recall the extent to which self-

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[503] Submission on behalf of Sgt Phillips, paragraph 17.

[504] Mitchell Statement, paragraph 13. Ms Mcabe was placed on the Attendance Register at 10.43am and on the Custody Register at 11.06am (when it was noted police would see her remand in custody) and placed in a cell at 12.19pm. Members commenced the hardcopy DRA at 2.15pm and it was completed (in hardcopy) at 3.38pm. The e-DRA was commenced at 3.20pm and approved by the BDM Sergeant at 6.30pm.

[505] Submission on behalf of BDM Sergeant Phillips, paragraphs 7 and 21.

[506] Submission on behalf of BDM Sergeant Phillips, paragraph 27.

[507] Submission on behalf of SC Johnston, paragraph 10.

[508] Though she likely observed Ms McCabe via CCTV monitor while performing watch house duties, noting that the size and quality of the image allowed her to 'vaguely' see people in custody but 'not in detail:' CB, page 126.

[509] Submission on behalf of SC Holmes, paragraph 6.

[510] VPMG *Safe management of persons in police care or custody*, section 8.1, CB page 409.

harm risk was considered nor what was taken into account but that she 'would have conducted a LEAP check.'[511] It is unclear what her "LEAP check" involved or what 1C Holmes gleaned from it. That said, the LEAP warnings (alone) referred to:

24/11/21	Violent: history of mental health reports and heavy drug use (to manage mental health); concerns about welfare/safety (unresponsive in a river); abusive to AV;
16/5/21	Mental Disorder: relating to the incident below which occurred on 12/5/21;
14/5/21	Suicide/self-injury: Ms McCabe jumped from a moving train because she wanted to hurt herself;

in addition to other documented incidents of apparently intentional or reckless self-harm involving alcohol or drugs and attempts to collide with trains and cars in 2016, 2017 and 2020.[512]

217. Inspector Mitchell observed that Ms McCabe's LEAP flags regarding suicide risks were not related to past attempts at suicide or self-harm in a custodial environment or using methods which might be available in custody.[513] Therefore, she asserted – and I note with some alarm – that while those LEAP flags should be 'considered, based on their context, they would have been assessed as not specifically relevant to Ms McCabe's level of risk in custody.'[514]

218. There is no account of the reason for Ms McCabe's Coma Scale score (which Inspector Mitchell considered inconsistent with Ms McCabe's presentation and potentially an error).[515] I note that there is no requirement to record the rationale for either the Coma Scale score nor the level and frequency of observations: the former is considered self-evident from the short descriptors on the scale and the latter implicit from a global assessment of the Medical Checklist/Coma Scale score, DRA and LEAP, with both – unfathomably – considered to 'not allow for personal interpretation or subjectivity.'[516] In my view, this suggestion (made principally in Inspector Mitchell's statement)

[511] Submission on behalf of SC Holmes, paragraphs 7 and 8.

[512] See CB pages 457-458.

[513] Mitchell Statement, paragraph 30.

[514] Mitchell Statement, paragraph 30.

[515] Mitchell Statement, paragraph 63.

[516] Mitchell Statement, paragraphs 57, 60 and 62.

overlooks the "personal interpretation and subjectivity" intrinsic in any evaluative process even one involving a structured assessment tool.

219. That said, 1C Holmes was 'confident' that she assessed Ms McCabe as requiring Level 3 observation based on her 'reported drug and alcohol *use*' (emphasis added)[517] and not due to a risk of suicide.[518] She did not consider Ms McCabe as having a 'likelihood of self-harm' because, if she had, she would have indicated Level 2 observation on the DRA.[519]

220. 1C Holmes assessed there was 'no indication' Ms McCabe presented with risks of suicide or self-harm.[520] She noted the handover she received when coming on shift (content unspecified),[521] that Ms McCabe had been in custody more than five hours by that time, the Custody Register and the DRA responses indicating no current suicidal ideation and self-harm a long time ago.'[522] 1C Holmes did not assess Ms McCabe as having "suicidal tendencies."[523] Indeed, in her submission, 'other than the S4 rating and other information on LEAP, there was no information to indicate an imminent risk in custody.'[524]

221. When afternoon BDM Sgt Mithen reviewed Ms McCabe's DRA she had been in police custody at Knox about five and a half hours. While he could not (in 2025) recall what he considered when he reviewed the DRA, he considered it showed a 'decrease in any suicide risk relative to the historic S4 rating'[525] due to Ms McCabe's self-reported denial of suicidality and indication that her history of self-harm was dated.[526] Further, he 'would not have assessed Ms McCabe as having "suicidal tendencies".'[527]

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[517] Noting that the short descriptor relevantly includes the phrase 'This is the minimum acceptable level for detainees affected by alcohol or drugs': CB, page 412. I note the responses on Ms McCabe's DRA relating to drugs and alcohol where that she was a daily user of ice and cider and that she had last used ice the previous day.

[518] Submission on behalf of SC Holmes, paragraph 8.

[519] Submission on behalf of SC Holmes, paragraph 9.

[520] Submission on behalf of C/ Holmes, paragraph 9.

[521] In either C/ Holmes' statement or the submissions filed on her behalf.

[522] Submissions on behalf of C/ Holmes, paragraph 9.

[523] Submissions on behalf of C/ Holmes, paragraph 13.

[524] Submissions on behalf of C/ Holmes, paragraph 9.

[525] Submissions on behalf of BDM Sgt Mithen, paragraph 19.

[526] Submissions on behalf of BDM Sgt Mithen, paragraph 16.

[527] Submissions on behalf of BDM Sgt Mithen, paragraph 20.

222. The DRA completed by 1C Holmes set Level 3 (Intermittent) observation and an observation frequency of 30 minutes, when Ms McCabe was required to be physically checked, roused and actively engaged. It is unclear when the e-DRA was completed (sometime between 3.41pm when all necessary information had been obtained from Ms McCabe and 6.30pm when BDM Sgt Mithen approved it). I note Inspector Mitchell's advice that the DRA came into effect when submitted for approval (not when approved).

223. There is no evidence 1C Holmes alerted 1C Johnston or BDM Sergeant Mithen that Ms McCabe's e-DRA had been completed nor that 30-minutely observations were required as a result. Granted, this information must have been available on the Custody Register but seeing it there required an opportunity to do so. 1C Johnston (no one else) made entries on Ms McCabe's Custody Register at 3.41pm, 4.20pm, 4.52pm, 5.01pm and 5.56pm and so it is possible she saw the e-DRA (but made no mention of having done so in her statement or the submission filed on her behalf).[528]

Retention of the "standard" blanket

224. Neither 1C Johnston, 1C Holmes nor BDM Sgt Mithen turned their mind to whether Ms McCabe had been issued with the 'correct' blanket.[529] BDM Sgt Mithen explained that custody management decisions are the product of continuing risk assessments in response to evolving circumstances such that where circumstances do not relevantly change, management decisions remain the same.[530] In his view, therefore, the type of blanket issued to Ms McCabe should have been considered by the members on the previous shift and, in the absence of any circumstances necessitating reconsideration of that decision, it would not be revisited (and was not as no such circumstances arose).[531]

225. The blanket (if not the type) was brought to mind just before 5pm when 1C Johnston observed Ms McCabe via CCTV covering her head with it. Although it was 'common' for detainees to cover their heads (to block the light), they were not permitted to do so

[528] CB, pages 458-459.

[529] Submissions on behalf of BDM Sgt Mithen, paragraphs 15 and 23; Submissions on behalf of 1C Holmes, paragraph 12; Submissions on behalf of 1C Johnston, paragraph 10, who perhaps was not even aware that suicide-resistant blankets were available at Knox at the time.

[530] Submissions on behalf of BDM Sgt Mithen, paragraph 13.

[531] Submissions on behalf of BDM Sgt Mithen, paragraphs 13-14.

because it prevented custody staff from making clear observations.[532] According to BDM Sgt Mithen, a detainee covering their head did not indicate any additional risk of self-harm or suicide.[533] Nonetheless, it is self-evident that the reason clear observations are needed is to monitor the detainee's safety and wellbeing.

226. As 1C Johnston and BDM Sgt Mithen were involved in a WebEx hearing with another detainee at that time, she asked colleagues to attend Cell 1 and speak to Ms McCabe.[534] 1C Holmes, accompanied by A/Sgt Rattray, did so promptly. According to A/Sgt Rattray, 1C Holmes asked Ms McCabe to remove the blanket from her head 'a couple of times' before she complied.[535] In accordance with her usual practice, 1C Holmes warned Ms McCabe that if she continued to cover her head the blanket would be removed, rather than removing it immediately.[536] Neither she nor A/Sgt Rattray apprehended from this interaction that Ms McCabe was 'at risk of suicide.'[537] This was A/Sgt Rattray's first involvement with Ms McCabe: he had not looked at the Custody Register[538] but was aware she had been in custody several hours and had been arrested for offences, not for being drunk, and as such, had no concerns that she was intoxicated to the point of being in danger.[539]

227. It is fair to say that by 5pm, A/Sgt Rattray was aware that operational demands were such that he as the shift's Section Sergeant was required to assist a Watch House duty member to undertake a custody task as neither of the designated custody members (nor the other Watch House member) were available. Indeed, 'with greater experience and with the benefit of hindsight,' he acknowledged that, given the demands of the shift, he 'could have been more proactive' in identifying whether other duties were preventing BDM Sgt

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[532] Submissions on behalf of 1C Holmes, paragraph 14; see also Submissions on behalf of BDM Sgt Mithen, paragraph 21 and Submissions on behalf of 1C Johnston, paragraph 10.1.

[533] Submissions on behalf of BDM Sgt Mithen, paragraph 21.

[534] A/Sgt Rattray suggests the BDM Sgt Mithen provided a direction to this effect (rather than a request from 1C Johnston): CB, page 113.

[535] CB, page 113.

[536] Submissions on behalf of 1C Holmes, paragraph 14.

[537] Submissions on behalf of 1C Holmes, paragraph 14; Submission on behalf of A/Sgt Rattray, paragraph 10 and 11.

[538] Submission on behalf of A/Sgt Rattray, paragraph 9: he was not rostered to be responsible for custody management duties.

[539] CB, page 113.

Mithen and the members under his supervision from undertaking custody tasks (including checks).[540]

Contact with lawyers/attempt to contact friend

228. By about 5.45pm, the WebEx hearing with which 1C Johnston and BDM Sgt Mithen had been occupied since about 4pm had concluded. 1C Johnston and 1C Holmes escorted Ms McCabe to the Charge Counter so that she could use the phone.

229. 1C Holmes characterised Ms McCabe as 'a little bit agitated' during the first phone call, which she attributed to her own presence within earshot.[541] 1C Johnston also recalled Ms McCabe's agitation and that at one point she 'had a go' at 1C Holmes.[542] 1C Holmes explained her presence (for safety) to which Ms McCabe replied, 'I don't assault cops,' after which 1C Holmes moved her access card and a pen out of Ms McCabe's reach because she 'wasn't sure what she was capable of.'[543]

230. After the first phone call, Ms McCabe 'seemed annoyed at what she was told.'[544]

231. Neither police member offered observations (in their statements or submissions) about Ms McCabe for the remainder of the 35-minute period they spent with her at the Charge Counter, save that she thanked the members more than once for letting her attempt to call her friend.[545] The relevant Custody Register entry records 'Female taken from cell to call solicitor and friend/relative.'[546]

232. In the twelve minutes between Ms McCabe's return to Cell 1 and members' return with a cup of tea for her (during which she had struck her head repeatedly), First Constables Johnston and Holmes had performed a welfare check on another detainee and prepared and delivered refreshment to him. According to 1C Holmes, at this time Ms McCabe 'had

[540] Submission on behalf of A/Sgt Rattray, paragraph 14.

[541] CB, page 127.

[542] CB, page 142.

[543] CB, page 127.

[544] CB, page 127.

[545] CB, page 127.

[546] CB, page 459.

relaxed' since the earlier interaction.[547] The Custody Register note of this final observation of Ms McCabe, made at 6.33pm, read 'provided tea to female.'[548]

No physical checks for one hour and 26 minutes between (6.33pm – 7.56pm)

233. Around 6.30pm, BDM Sgt Mithen approved Ms McCabe's e-DRA without amendment. Although the e-DRA had taken effect earlier, approval of the plan to manage Ms McCabe's safety and wellbeing by at least 30-minutely physical observation with active engagement provided a further opportunity to ensure members, particularly those performing Watch House and custody duties, were aware of it. Approval also allowed the custody supervisor an opportunity to consider tasking to ensure the plan was implemented notwithstanding competing operational demands.

234. BDM Sgt Mithen could not recall (in 2025 nor did he mention in his statement made in 2021) what, if anything, he relayed to Watch House members (including 1C Johnston the member he had assigned to assist with custody management) about Ms McCabe's custody risks and frequency of observations. His usual practice was to do so and to 'constantly' view CCTV monitors depicting the cells.[549] Although he could not recall 'specifics,' after 5pm he 'saw nothing that caused him concern' but noted the size and quality of the images displayed on CCTV monitors did not enable 'clear details' to be observed and conceded that CCTV checks are no substitute for physical checks.[550]

235. The principal Watch House Keeper (C/ Dalton) continued to manage counter enquiries. He could not recall (in 2025 nor did he mention in his statement made in 2021) whether he had been told of the frequency of observations Ms McCabe required, but confirmed communication of such information was customary.[551]

236. 1C Holmes returned to the Watch House where she prepared (unrelated) paperwork and provided some assistance to 1C Johnston (and was permitted to leave Knox to obtain a meal around 7.45pm).[552] She had determined the frequency of Ms McCabe's

[547] CB, page 128.

[548] CB, page 459.

[549] Submission on behalf of BDM Sgt Mithen, paragraph 25.

[550] Submission on behalf of BDM Sgt Mithen, paragraph 28.

[551] Submission on behalf of C/ Dalton, paragraph 10.

[552] CB, page 127.

observations and so knew what was required (unless and until it was altered by BDM Sgt Mithen and any change of plan communicated). When she looked at CCTV footage of Ms McCabe's cell between 6.30pm and 7pm, Ms McCabe was sitting up with her back to the camera and blanket around her shoulders, which 1C Holmes did not consider 'out of the ordinary.'[553]

237. Neither in her statement nor in submissions did 1C Johnston refer specifically to knowing the observation frequency Ms McCabe required (before or) after the e-DRA was approved. After the Custody Register entry she made at 6.33pm, 1C Johnston commenced a task directed by BDM Sgt Mithen, to prepare bail documents for the detainee whose WebEx hearing they had attended.

238. 1C Johnston recalled that at that time there were 'heaps of people' at the Watch House counter, so many that A/Sgt Rattray went to assist.[554] She tried to complete the bail documents quickly because she had heard via police radio (and alerted BDM Sgt Mithen) that a Knox unit was inbound with another person to lodge in the cells. Her progress was interrupted, however, by the detainee to which the bail documents related activating the duress alarm twice. Each time she and another member (first 1C Holmes, then BDM Sgt Mithen) responded to the duress alarm to find that the detainee merely wanted to know when he would be released.[555]

239. 1C Johnston 'glanced'[556] at a CCTV monitor and observed that Ms McCabe appeared to be sleeping.

240. By about 7.35pm the detainee had been released from custody. 1C Johnston and BDM Sgt Mithen escorted him from the custody area while 1C Holmes met the incoming Knox unit at the sallyport. Within about six minutes, 1C Johnston had commenced the Attendance Register for the new reception, BDM Sgt Mithen had recorded his Initial

[553] Submission on behalf of 1C Holmes, paragraph 18. She also noted that the quality of the images on CCTV monitors were 'small and of poor quality' and did not permit clear details to be seen.

[554] CB, page 143.

[555] CB, page 143.

[556] CB, page 143. The timing of these glances is unclear from her statement; in submissions, the glances are characterized as 'regularly observing Ms McCabe': Submissions on behalf of 1C Johnston, paragraph 13.

Supervisor Check and the suspect had been escorted (by the Knox unit members) to an interview room.[557]

241. Around the same time, the custody staff learned that Ms McCabe's bail/remand hearing was scheduled for 8pm and so set up (the computer) for it at the Charge Counter.

242. At 7.56pm, 1C Johnston made a notation on Ms McCabe's Custody Register in anticipation of transferring her from Cell 1 for her WebEx hearing.

243. No physical observations of Ms McCabe occurred after the e-DRA was approved. At least two physical observations were required in the period between 6.32pm (when tea was delivered) and 7.58pm (when members entered Cell 1 to escort Ms McCabe for her bail/remand hearing).

244. Victoria Police conceded that there was a failure to conduct in-person checks on Ms McCabe at the frequency which had been determined as appropriate for her.[558] The absence of checks meant that when Ms McCabe did begin her attempt at suicide 'which was just after 7pm, it was not identified.'[559] It was accepted that checks at the appropriate intervals would have reduced Ms McCabe's opportunity to attempt suicide but would not necessarily have prevented the suicide. Inspector Mitchell noted:[560]

    a. That notwithstanding that police stations are expected to be 'flexible and responsive to fluctuating demand,' there were significant work pressures on the police members working in the custody area which she considered 'well above the usual expectations on a police station like Knox;'

    b. That competing operational demands are relevant to how closely or frequently members watched CCTV monitors;

[557] CB, pages 136 (Mithen) and 144 (Johnston).

[558] Mitchell Statement, paragraph 93.

[559] Mitchell Statement, paragraph 95.

[560] Although she had read the OSCIR (which includes a CCTV chronology of Cell 1) and the Autopsy Report (which contains information about what the CCTV depicts), Inspector Mitchell had not viewed the portion of the CCTV footage which depicts Ms McCabe's asphyxiation.

c. A police member who looked briefly at CCTV footage during the '15 minutes' prior to Ms McCabe's collapse, during which she was not facing the camera, may not necessarily have appreciated the significance of what was occurring;

d. Ms McCabe was correctly told to remove the blanket from her head around 5pm and while this was a missed opportunity to remove the blanket from the cell, it is understandable that members thought that she would comply with the direction. With hindsight, Ms McCabe's action, in placing the blanket over her head, at 6.58pm was 'suspicious' and should have been investigated if observed;

e. An in-person welfare check should have been conducted within a few minutes of that time and, if done, would likely have identified Ms McCabe's actions or at least disturbed them;

f. Given that Ms McCabe's asphyxiation occurred within 15 minutes, she may well have been able to make and complete an attempted suicide between checks.[561]

245. BDM Sgt Mithen and 1C Johnston conceded that insufficient physical checks were conducted between 'completion' of the e-DRA and when Ms McCabe was found unresponsive, and that this represented non-compliance with relevant policy requirements.[562] BDM Sgt Mithen accepted a failure to supervise members performing custody duties.[563]

246. BDM Sgt Mithen and First Constables Johnston and Holmes acknowledged that the failure to conduct checks was 'serious' but submitted that establishing a contribution to Ms McCabe's death required careful consideration.[564] The submissions on their behalf highlighted that:

a. Ms McCabe appeared to have the blanket around her neck at 7.02.30pm, with the ligature fashioned at some point earlier, most likely at 6.58pm;

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[561] Mitchell Statement, paragraphs 98-102.

[562] Submissions on behalf of BDM Mithen, paragraph 24; Submissions on behalf of 1C Johnston, paragraph 11.

[563] Submissions on behalf of BDM Mithen, paragraph 36.

[564] Submissions on behalf of BDM Mithen, paragraph 29; Submissions on behalf of 1C Johnston, paragraph 14; Submissions on behalf of 1C Holmes, paragraph 19.

b. The attempt that caused Ms McCabe to asphyxiate commenced sometime between 7.04pm and 7.14pm;

c. No 'firm conclusions' can be made from the available evidence about what Ms McCabe is doing at any time, what her decision-making was, how far advanced any attempt was or how the circumstances would have presented themselves had custodial staff attended;

d. A check around 7pm 'would have disturbed the preparatory steps' to Ms McCabe's suicide attempt but due to operational demands, 'it is almost certain' that it would have been conducted through the cell door assuming she responded and engaged. As such, though she would have been disturbed, 'it is less likely that her actions would have been identified' than had members entered the cell;

e. Based on the CCTV footage, prior to falling backwards Ms McCabe appeared to be sitting innocuously with the blanket around her shoulders, she went to considerable effort to disguise her suicide attempt, which 'took less than 15 minutes to complete' and was not readily identifiable as such without the benefit of hindsight;

f. Even if checks had occurred around 7pm and 7.30pm, although the later of these 'would certainly' have resulted in Ms McCabe's crisis being discovered earlier, it is not possible to find that that would have made 'any difference to the ultimate outcome;'

g. Checks at these times does not allow for a finding that Ms McCabe's death would have been prevented but if a check had occurred at approximately 7.03pm 'and not earlier,' the failure to do so was a 'missed opportunity to disrupt [her] inchoate suicide attempt which *may* have enabled it to have been identified and prevented.'[565]

[565] Submissions on behalf of BDM Mithen, paragraphs 30-35; Submissions on behalf of 1C Johnston, paragraphs 15-21; Submissions on behalf of 1C Holmes, paragraphs 20-26.

Assessment of Ms McCabe's management in custody

247. I do not doubt that the safe management of people in police care or custody is challenging, nor that the operational demands at Knox on 2 December 2021 complicated discharge of members' responsibilities for Ms McCabe's safety and wellbeing on that date.

248. The VPM and local guidance on the safe management of people in police custody in place in 2021 provided a suitable framework emphasising hazard and risk identification; continuous risk assessment and informed decision-making; implementation of risk controls including monitoring tailored to the detainee's risks and needs; and communication and documentation of pertinent information among those responsible for the detainee.

249. Several interrelated aspects of police members' approach to Ms McCabe's management jeopardised its effectiveness. Members (and Inspector Mitchell) evinced complacency about behaviours "common" among detainees, complacency about the "common" S4 E*justice rating (and the more recent LEAP mental disorder and suicide/self-harm warnings) and confidence in the predictive "reliability" of demeanour. It appears that "common" behaviours and alerts were undervalued and impressions of demeanour, predominantly gleaned from transactional interactions, were overvalued in members' assessment of Ms McCabe's risks. How information was valued, in turn, influenced what was handed over and recorded.

250. It may be that head strikes, verbal "outbursts," visual signs of distress[566] and S4 ratings are common among people in police care or custody but they were particular to Ms McCabe as an individual in police custody on 2 December 2021. It may be that uncommon presentations might appear more significant or concerning to police members but this approach strips "common" presentations of their context which, in part, is the peculiarly stressful situation of being (in Ms McCabe's case)[567] in custody. Devaluing "common" behaviours in the risk calculus is likely to skew assessment of the demeanour

[566] Several members saw or must have seen that Ms McCabe was upset/needed tissues or to wipe her face at various points while in custody at Knox but no member mentioned them in statements.

[567] The (immediate) context of Ms McCabe's presentation was that of an accused person, in police custody facing serious charges and police opposition to a grant of bail and the prospect of remaining in custody for some time. The broader context included her history of vulnerability in custody, an S4 rating, and a range of other concerns arising from her personal circumstances (the details of which police may be unaware).

of the person in custody in a way liable to undercut vigilance about their vulnerability and risks.

251. The way Ms McCabe appeared to the police members who dealt with her at Knox on 2 December 2021 was evidently central to their assessment of her risks; demeanour was considered (especially by the most experienced members) to be the "most reliable" indicator of current welfare concerns. Their assessment of her presentation was arguably made based on brief transactional interactions,[568] assumptions about the significance of "common" behaviours and alerts (even if the latter had been known at the relevant time)[569] and – inevitably – an incomplete picture of Ms McCabe's presentation across her time in custody.

252. Ms McCabe had exhibited signs of distress and/or self-harm (during interview and intermittently throughout the periods she spent alone in Cell 1 both before and after the DRA was completed) but these were either not observed, not interpreted as distress or self-harm, or not handed over. I do not suggest that any Knox member knew or ought to have known everything now known about Ms McCabe's behaviour while in custody, nor do I suggest that with a more complete picture of her demeanour that they ought to have predicted the action she ultimately took.

253. Indeed, demeanour is not a good indicator of suicidality or self-harming intent (nor is denial of suicidal ideation). Any number of coronial findings attest to the "predictable unpredictability" of suicide and the inability of mental health professionals and close family or friends to anticipate the act of suicide. Police members/staff cannot be expected to possess greater predictive powers.

254. Confidence that demeanour *is* a reliable indicator of current welfare concerns (or risk of self-harm or suicide) should be discouraged. Of course, demeanour cannot be disregarded but belief in its predictive or reassuring potential is misplaced and is likely to undermine the value of LEAP warnings and E*Justice ratings. Submissions by members to the effect

[568] For instance, formulaic questions and answers of the Initial Supervisor Check, during interview and when administering the DRA and offers of a blanket, mattress or of refreshment. Several members assessed demeanour from a single interaction.

[569] It is unclear whether some members had – or had accessed –information about Ms McCabe before (or after) interacting with her beyond knowing she had been arrested for criminal offences.

that Ms McCabe "demonstrated no indication of suicidal tendencies" save for the "dated" S4 rating are illustrative.

255. By definition, the effectiveness of such warnings should not wholly depend on the person in custody displaying the same concerns that led to creation of the warning. In my view, such alerts should be heeded, given due weight, even allowed to colour witnessed demeanour.

256. Completion of the DRA was delayed and precisely how (or why) the member made the assessment she did, cannot now be reconstructed. That said, the DRA was reviewed and endorsed by the custody supervisor. He approved the plan to manage Ms McCabe's risks in custody by Level 3 (Intermittent) observation, that is, by physical checks involving engagement with Ms McCabe conducted at a minimum frequency of 30 minutes. The custody supervisor had overall responsibility for Ms McCabe's management and responsibility to assign tasks and ensure they were completed.

257. Notwithstanding that Knox experienced operational pressures in excess of usual expectations on the afternoon of 2 December 2021, this cannot be a complete or satisfactory explanation for the absence of any physical check on Ms McCabe for nearly an hour and a half.

258. I accept that competing operational demands are relevant to how closely or frequently members viewed CCTV monitors, and also, that the available image (or Ms McCabe's position in relation to the camera) may not have facilitated easy identification of Ms McCabe's actions prior to her collapse. I can also accept that operational demands might have resulted in a physical check conducted by a single member through the cell door (though no other check appears to have been conducted in this manner that – busy – day).

259. Physical checks – at least two – were required and none occurred between 6.32pm and 7.58pm.

Victoria Police Professional Standards Command Disciplinary Action

260. Following investigation by Professional Standards Command, complaints were established against BDM Sgts Phillips and Mithen, S/Sgt Ross and 1C Johnston. The subjects of the established complaints were failure, in her role as Custody Sergeant, to complete the DRA (BDM Sgt Phillips); failing to ensure Ms McCabe was provided a

suicide-resistant blanket (BDM Sgts Phillips and Mithen and Sgt Ross); and failing to provide care to Ms McCabe by not ensuring 30-minutely checks were conducted (BDM Sgt Mithen and 1C Johnston).[570]

Changes to Victoria Police policies and practices to enhance safe management

261. The classification of the Knox detention facility remains unchanged (though terminology changed in January 2025 from 'holding room' to 'Category B' detention facility) and so custody management continues to be undertaken by sworn police members under the supervision of the Custody Sergeant not Police Custody Officers.

262. However the following changes have occurred at Knox and more broadly across Victoria Police:

    a. in March 2022, in line with a recommendation of the OSCIR, CCTV was upgraded at Knox to improve 'picture quality and [provide] a wider view;[571]

    b. installation of a 'large screen' in the Sergeants' muster room at Knox to show CCTV footage from the cells;[572]

    c. the use of a whiteboard in the Watch House at Knox which lists the people in custody, their arrival time, cell location, reason for holding and warning flags;[573]

    d. the removal of cloth and wool blankets from use in police detention facilities and their replacement with suicide-resistant blankets statewide in 2023;[574]

    e. enhancement of the (electronic) Custody Register to include an alert when observation and physical checks are due;[575]

    f. replacement in January 2025, following a review by Victoria Police's Custody Capability Unit (**CCU**), of VPMs relating to the safe management of people in

[570] Mitchell Statement, paragraphs 99-92.

[571] Mitchell Statement, paragraph 9.1.

[572] Mitchell Statement, paragraph 9.5.

[573] Mitchell Statement, paragraph 9.3.

[574] Mitchell Statement, paragraph 9.2 and 81.

[575] Mitchell Statement, paragraph 9.4.

police care or custody. The new policies do not change 'the substance of the Chief Commissioner's expectations'[576] for management of people in police care or custody. Rather, they 'aim to provide consistent information'[577] about 'key policy changes'[578] and the accountabilities and responsibilities of sworn and unsworn police in relation people in police care or custody.[579]

g. a 'mandatory training requirement'[580] to support the newly introduced policies and practice guides and compliance (with training) tracked by the CCU;[581]

h. activity and communication strategies to support the workforce to implement the new policies, practice guides and training.[582]

'Key' VPM Policy Changes

263. The CCU's review of three custody-related policies in force in 2021 resulted in their consolidation and replacement by two new policies: VPM *Management of people in police care or custody* (**VPM On Management**) and VPM *Attendance and Custody Modules* (**VPM On Modules**). According to Inspector Mitchell, these policies 'address a significant number' of recommendations from coronial inquests and the Royal Commission into Aboriginal Deaths in Custody and OSCIRs, reflect 'best practice' and reinforce Victoria Police's obligations under the *Charter of Human Rights and Responsibilities Act* 2006.[583]

264. An effect of the consolidation is the elevation of much of what was formerly best practice guidance to policy, a departure from which may result in management or disciplinary action. This may, in turn, reinforce among police members and staff the importance of

[576] Mitchell Statement, paragraph 12.

[577] Mitchell Statement, paragraph 74.

[578] Mitchell Statement, paragraph 76.

[579] Mitchell Statement, paragraph 77.

[580] The mandatory training requirement is applicable to police members up to and including the rank of Inspector, Police Service Officers, and Police Custody Officers: Mitchell Statement, paragraph 77.

[581] Mitchell Statement, paragraphs 77 and 79.

[582] Mitchell Statement, paragraph 89; such as creation of an intranet hub for custody staff overseen by the CCU; targeted emails to custody staff who have a specific role, interest or need to know specific information; information packages sent to police stations (including Knox) highlighting key policy changes; alignment of foundational training with new policies; and, a quarterly Custody Management Newsletter.

[583] Mitchell Statement, paragraph 73.

their role in the safe management of people in police care or custody. It is not insignificant that the VPM On Management is so detailed that it runs to 69 pages.[584]

265. Nine 'practice guides' were developed to provide 'additional context and support' to assist police members and staff to comply with the new VPMs. Relevantly, among these Victoria Police Practice Guides (**VPPG**s) are the VPPG *Custody risks and recommended actions* (**VPPG Risks**) and VPPG *People in police care or custody at risk of suicide or self-harm* (**VPPG SASH**).

266. It is evident that attention has been devoted to clarifying or establishing definitions in the new policies (and VPPGs). Although 'person in custody,' 'lodging in detention facilities' and 'detainee' are each now defined,[585] among many other terms, a range of phrases relating to mental health and behaviour are not. For instance, none of the following are defined: "risk of suicide or self-harm,"[586] "self-harm," "self-inflicted trauma" (and how this differs, if it does, from self-harm), "likelihood of self-harm or suicide"[587] (and how this differs, if it does, from being "at risk" and/or presenting with historic or recent risks of these types) and "imminent risk of suicide or self-harm" (and how this differs, if it does, to the test for the exercise of police mental health powers).[588] Given the significance of these phrases to appropriate management responses, clear and consistent understanding among members and staff may be of benefit to them and the people in their care or custody.

267. The VPPG Risks and VPPG SASH are detailed. The VPPG Risks emphasises the value of the assignment of appropriate risk ratings to inform a detainee's safe management in custody. However, while pre-existing risk ratings automatically populate the attendance and custody modules, and some ratings (including the S-rating) may be changed (in consultation with CHAL and the custody supervisor) it is not clear what "new

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[584] The VPM On Modules comprises of 17 pages and, together, the VPPGs a further 67 pages.

[585] VPM *Management of people in police care or custody*, Definitions.

[586] Including "is at risk …" "at risk …" and "poses a risk of suicide or self-harm;" "displaying self-harming or suicidal behaviour" and "acts of self-harm", "has self-harmed or is actively self-harming": VPM *Management of people in police care or custody*, sections 20, 29, 41, 26

[587] VPM *Management of people in police care or custody*, section 48.3.

[588] VPM *Management of people in police care or custody*, section 48.3. Including how this differs, if it does, to the test applicable to an exercise by police of the power to take a person into care and control pursuant to s232 of the *Mental Health and Wellbeing Act* 2022, which contains a similar test ("imminent and serious harm").

information" should prompt a review/change of a rating.[589] Specifically, it is unclear whether "new" information includes police intelligence (such as LEAP warnings) arising between episodes in custody or only that arising during an episode "in custody," or both.

268. The VPPG SASH contains useful guidance (including prompts) about how to elicit information about a person in police care or custody's "risk of" self-harm or suicide.[590] However, while members and custody staff are directed to obtain CHAL advice about previous and current behaviours and management of people identified as "at risk" there is little in the VPPG SASH to assist them to differentiate between (that is, assess) potential risks probabilistically.

269. Three types of DRA now exist: a 'New Custody DRA' (equivalent to the DRA applicable in 2021), a 'Custody Transfer DRA' and a 'Revised Post Custody Incident DRA.'[591] A DRA applicable to the circumstances of the person in custody must be completed and an updated DRA submitted if circumstances change.

270. There remains no greater time-specificity about the completion of DRAs,[592] however, the VPM On Management requires that people are not placed in a cell 'until the relevant risks, management requirements and considerations for the individual have been assessed.[593] Further, the requirements of the Arrival and Initial Supervisor checks relating to the Attendance Register have been enhanced to include documentation of a risk assessment.[594]

271. Changes in observation levels and frequencies have been introduced. There remain four levels of observation (labels have changed but the descriptors are broadly the same) but the minimum acceptable level of observation for anyone in custody is an "in-person

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[589] The VPPG Risks does not define 'new information' while the VPPG SASH states that 'any identified risk or suicide or self-harm must' prompt 'review of the 'S' risk rating (and be escalated to CHAL and be recorded on the applicable module): VPPG Risk, Overview and VPPG SASH, section 1.2.

[590] VPPG SASH, section 1.2.

[591] VPM *Management of people in police care or custody*, section 17. Among the 'change in circumstances' after which a 'Revised Post Custody Incident DRA' must be completed are a 'significant change in behaviour' and 'trauma to the head' since arriving in custody.

[592] That is (a New Custody) DRA must be completed, relevantly, when the person 'is lodged' (generally occurs when a person *has been charged* and is to be presented before a BDM/magistrate and involves placement in a detention facility, including the creation of a DRA) or 'held at a police facility for more than four hours': VPM *Management of people in police care or custody*, Definitions (emphasis added).

[593] VPM *Management of people in police care or custody*, section 41.

[594] VPM *Attendance and Custody modules*, sections 1.2-1.4.

check" at least every hour.[595] There remain three methods by which an "in-person" check may be conducted: an observation check through the flap or window in the cell door (including observing breathing); a verbal check involving conversation with the person to 'assess both their state of mind and their general health' (a 'thumbs up' may satisfy this form of check); or a cell check involving entry by two or more members of staff to 'determine that the person is well and breathing.'[596]

272. The VPM On Modules expands, with specificity, the kinds of information relevant to the safety, security health and wellbeing of a person in custody that must be recorded on the Attendance and Custody modules. For instance, if a person appears affected by alcohol or drugs, their best verbal response must be assessed using the Coma Scale tool and recorded at least every 30 minutes.[597] Documentation of handovers between incoming custody members/staff and supervisors is also required,[598] including an additional 'formal supervisor handover' procedure 'using the Custody module.'[599] While 'comprehensive verbal handovers' must address the 'status, risks and wellbeing of each person in police custody' and 'all relevant information' must be communicated and understanding confirmed by 'relevant staff during the shift' (and upon transfer of custody responsibilities),[600] there is no specific mention of the level and frequency of observation or other management measures required to address risks.[601] Further, it is unclear from either the VPM On Modules or the VPM On Management that the *substance* of handovers must be recorded.

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[595] Anyone who is not assessed at a higher level: VPM *Management of people in police care or custody*, section 48.3. Level 2 observation (now known as 'high risk observation') – that for those with 'a likelihood of self-harm or suicide (or someone assessed by a health professional as presenting with significant physical/mental health risks) – requires a minimum of 15-minutely in-person checks.

[596] VPM *Management of people in police care or custody*, section 48.3 (I have noted the expanded guidance about the purpose of each type of check).

[597] VPM *Attendance and Custody modules*, sections 1.5 and 3.4.

[598] VPM *Management of people in police care or custody*, section 47.2 and 47.4; VPM *Attendance and Custody modules*, sections 1.5 and 2.10.

[599] VPM *Management of people in police care or custody*, section 47.3 and VPM *Attendance and Custody modules*, section 2.10.

[600] VPM *Management of people in police care or custody*, section 47.2.

[601] See for instance, the exemplar of a "detailed and meaningful" custody supervisor handover which reads, 'detainee compliant, had meal, received visit from family, has asthma but Ventolin not requested:' VPM *Attendance and Custody modules*, section 2.10: the example in the 'section'

FINDINGS

Having investigated the death of Wendy Ann McCabe, and having held an inquest in relation to her death on 12 November 2025 at Melbourne, I make the following findings, pursuant to section 67(1) of the Coroners Act:

1. The identity of the deceased is Wendy Ann McCabe, born 6 September 1981.

2. Wendy McCabe died at Box Hill Hospital in Box Hill, Victoria on 3 December 2021.

3. I accept and adopt the medical cause of death ascribed by Forensic Pathologist Dr Glengarry and find that Wendy McCabe died of hypoxic ischaemic encephalopathy due to ligature compression of the neck.

4. Wendy McCabe's death occurred in the circumstances described above in paragraphs 58-145.

5. Further, I find that Victoria Police and its members (particularly the Custody Supervisor and the member tasked with custody duties during the afternoon shift) were responsible for Ms McCabe's safety and wellbeing while she was in their custody at Knox on 2 December 2021.

6. I also find that Ms McCabe's vulnerability in custody and her risk of suicide or self-harm were flagged in LEAP and E*Justice warnings and so were known to the members with responsibility for her at Knox (at least by the member who completed the e-DRA and the afternoon shift Custody Supervisor who reviewed it).

7. I find that completion of Ms McCabe's DRA was delayed.

8. While it is unclear whether any alternative to provision of a "standard" blanket was available on 2 December 2021, I find that Ms McCabe was given a "standard" blanket in circumstances where her risk rating, Victoria Police Manual and local operating guidance indicated a suicide-resistant blanket was recommended.

9. I find that by issuing a "standard" blanket and permitting Ms McCabe to retain it thereafter, Knox members provided Ms McCabe with a means by which she might harm herself.

10. From approximately 6.30pm, the assessment of the Custody Supervisor was, and I find, that (Level 3) 30-minutely physical observation of and engagement with Ms McCabe was required to safely manage her risks while in police custody.

11. I find that no physical checks of Ms McCabe were conducted for one hour and 26 minutes between approximately 6.32pm and 7.58pm.

12. I further find that the afternoon shift Custody Supervisor (BDM) failed to ensure custody staff undertook the tasks required to ensure Ms McCabe's health, safety and welfare between 6.32pm and 7.58pm as required by the Victoria Police Manual. It is unclear whether this failure arose due to inadequate handover to custody and Watch House members of observation requirements, insufficient or unclear tasking, insufficient responsiveness to competing operational demands, or some combination of these and/or other factors.

13. I find that the failure to conduct (Level 3) physical checks at the frequency determined to be necessary provided Ms McCabe with the opportunity to engage in life-threatening, self-injurious behaviour and contributed to her death.

14. Based on her subsequent actions, I find that Ms McCabe had devised a plan to harm herself using the "standard" blanket by 6.52pm at the latest.

15. Ms McCabe trialled or attempted to harm herself twice before the occasion that was ultimately fatally injurious; I find that these attempts occurred around 6.58pm and 7.03pm.

16. Although Ms McCabe positioned herself to mask her activities from the in-cell camera, I find that any (Level 3) physical check conducted approximately 30 minutes after the last (at 6.32pm) was likely to have disrupted her self-injurious activities.

17. I find that Ms McCabe asphyxiated using the "standard" blanket as a ligature between approximately 7.11pm and 7.13pm (or 7.16pm at the latest).

18. I find that for 45 minutes, between her collapse at 7.13pm and 7.58pm when members entered Cell 1, Ms McCabe's body remained in an awkward position, and motionless after 7.16pm.

19. I also find that any (Level 3) physical check conducted approximately 60 minutes after the last check at 6.32pm was likely to have identified that Ms McCabe had harmed herself and was unresponsive, which in turn, would have enabled CPR to have been commenced approximately 30 minutes earlier. However, I am unable to ascertain whether, or the extent to which, Ms McCabe's clinical course might have been different if efforts to revive her were initiated sooner.

20. Given the means she employed, I am satisfied and find that Wendy McCabe intended to take her own life.

21. However, given the cumulation of failures and delays identified above, I find that Wendy McCabe's death could have been prevented.

RECOMMENDATIONS

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

1. With the aim of promoting public health and safety and preventing like deaths, I recommend that Victoria Police (and/or the Officer In Charge at Knox) consider inclusion on the "whiteboard" in the Knox Watch House of the level and frequency of observation required for each person in a detention facility/cell (notwithstanding the new alerts on the custody module) to ensure this information to readily available.

2. In the interests of preventing like deaths, I further recommend that Victoria Police consider the need to amend relevant VPMs or VPPGs and/or provide specific training to members and staff performing custody duties concerning:

    a. Definition of key phrases relating to mental health and behaviour including:

        i. "risk of suicide or self-harm"

        ii. "self-harm"

        iii. "self-inflicted trauma" (and how this differs, if it does, from self-harm),

iv. "likelihood of self-harm or suicide"[602] (and how this differs, if it does, from being "at risk" and/or presenting with historic or recent risks of these types);

v. "imminent risk of suicide or self-harm" (and how this differs, if it does, to the test for the exercise of police mental health powers);

vi. the type(s) of "new information" that should prompt a review/change of an 'S' (self-harm or suicide) rating; and

b. lowering the threshold for seeking CHAL advice about 'S' risks, particularly in the context of "new information;"

c. the unreliability of demeanour and denial of suicidal ideation as predictors of an individual's risk and/or likelihood of self-harm or suicide;

d. assessment of potential risks probabilistically; and

e. recording the substance of handovers.

ORDERS

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

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

a. Ms McCabe's family;

b. Chief Commissioner of Victoria Police;

c. Sergeant Tim Mithen;

d. Senior Constable Melyssa Johnston;

e. Acting Senior Sergeant Rebecca Phillips;

[602] VPM *Management of people in police care or custody*, section 48.3.

f. Senior Sergeant Jarrod Ross;

g. Senior Constable Jodie Holmes;

h. Senior Constable Edward Dalton;

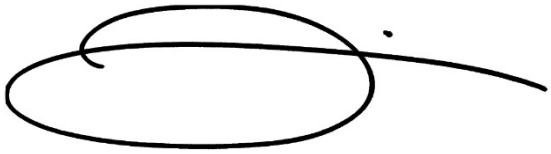
i. Leading Senior Constable Rhett Rattray;

j. Senior Constable Ellie Smith;

k. Senior Sergeant Vin Butera;

l. Coroner's Investigator, Detective Leading Senior Constable Justin Tippett.

Signature:



AUDREY JAMIESON
CORONER
Date: 12 November 2025