IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 5779

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	Caitlin English, Acting State Coroner
Deceased:	Tre Leigh Lawson
Date of birth:	16 September 1996
Date of death:	15 November 2017
Cause of death:	I(a) Hanging
Place of death:	1 Patterson Avenue, Mildura, Victoria

INTRODUCTION

1. Tre Leigh Lawson was a 21-year-old Barkindji and Latji Latji man who was living in temporary accommodation with his aunt, Dina Mitchell (**Ms Mitchell**), at the time of his death. Tre is survived by his parents, Anthony Mitchell and Samantha Lawson.

2. Tre grew up and spent most of his life in Menindee, with his sister, father and paternal grandmother. He had many lifelong connections and friendships with the people of Menindee. Tre was raised by his paternal grandmother Brenda Mitchell and his father and step-mother, Karen Wilson and they were his legal custodians as a child.

3. Tre spent many happy years and maintained strong family and community links with Menindee. He spent most of his life doing what he loved, working on the land, hunting, fishing and camping, in and around Menindee.

4. Tre was found deceased in the backyard of Ms Mitchell's home on Patterson avenue in Mildura on 15 November 2017.

THE PURPOSE OF A CORONIAL INVESTIGATION

5. Tre's death was reported to the Coroner as it was unnatural and unexpected and so fell within the definition of a reportable death in the *Coroners Act 2008.*

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. The Coroner's Investigator prepared a coronial brief in this matter. The brief includes statements from witnesses, including family members, the forensic pathologist who examined Tre, clinical services and investigating officers.

8. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established to the standard of proof of the balance of probabilities.[1]

[1] This is subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

IDENTITY

9. On 15 November 2017 Ms Dina Mitchell visually identified her nephew Tre Lawson, born 16 September 1996.

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

BACKGROUND

11. In approximately 2016, Tre formed an intimate relationship with Ms Shakira Smith (**Ms Smith**). The couple were living together in a unit on San Mateo Avenue in Mildura with Ms Smith's one-year old son from another relationship.

12. Tre and Ms Smith's had a tumultuous relationship with infrequent occurrences of family violence. There were at least three reported family violence incidents between the couple that involved Police intervention.

13. The first incident of family violence occurred on 24 April 2017 following an altercation between Tre and Ms Smith at their home.[2] Police attended this incident and applied for a Family Violence Intervention Order (**FVIO**) to protect Ms Smith from Tre. Tre was also charged with criminal damage and was released on bail with conditions to appear at the Mildura Magistrates Court on 7 June 2017.[3]

14. On 1 May 2017, a final FVIO was granted with limited conditions allowing Tre and Ms Smith to continue residing with each other.[4]

15. The second incident of family violence occurred on 14 May 2017, this incident involved Police attending Ms Smith's home due to a report of Tre attempting self-harm by wrapping a wire around his neck and threatening suicide.[5] An earlier incident on the same day involved Tre physically assaulting Ms Smith in public before both parties returned home and Ms Smith was taken to her mother's home for her safety.[6]

16. Tre was arrested by Police members and taken to the Mildura Base Hospital for a mental health evaluation. He was assessed by mental health clinicians who formed the view that

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[2] *Coronial Brief,* Statement of Shakira Smith dated 15 February 2018, 1
[3] *Coronial Brief,* Victoria Police LEAP records for incident number ,170139315 10
[4] Ibid
[5] *Coronial Brief,* Victoria Police LEAP records for incident number 170162282, 9
[6] Ibid

Tre's self-harm attempt was a '*situational crisis and imminent risk to self was low*'.[7] Tre was released within 24 hours to Police custody. Tre was then charged with property damage, threats, assault, contravention of the FVIO in effect at the time and breach of bail conditions arising from the 24 April 2017 incident.[8]

17. On the following day, 15 May 2017, a Magistrate from the Mildura Magistrates Court varied the FVIO in place at the time to a full conditions order preventing any contact between Tre and Ms Smith.[9] In relation to the criminal charges arising from the incident the day before, Tre was found guilty and was sentenced to comply with a good behaviour bond and signed an undertaking to engage with Mildura or Broken Hill Mental Health to receive treatment.[10] Tre never attended either service for mental health treatment.

18. Despite a full conditions FVIO in effect from 15 May 2017, Tre and Ms Smith continued to see each other and communicate until the fatal incident. Tre started to reside with Ms Mitchell from 15 May 2017 until his death.

19. The last incident of family violence occurred on 15 October 2017 and involved an altercation between Tre and Ms Smith at their home. Tre had physically assaulted Ms Smith and Ms Smith reported the incident to Police later that day. Tre was arrested by Police in the afternoon of 15 October 2017 and remanded in Police custody until a hearing at the Mildura Magistrates Court the next day.

20. On 16 October 2017, at the Mildura Magistrates Court, Tre was found guilty of assault and contravening a FVIO, he was convicted and subject to a Community Corrections Order (**CCO**) for 15 months requiring him to complete unpaid community work, supervision by Community Correctional Services Mildura (**CCS Mildura**) and attend a Men's Behavioural Change program.

21. Tre's friends and family confirm that he had issues with substance abuse and was a daily marijuana user.[11] Ms Smith reported that the incidents of family violence usually occurred when Tre was intoxicated and was unable to manage his mental health issues.[12]

22. The available evidence provided to the Court suggests that prior to the fatal incident, Tre had not sought mental health treatment from any service.

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[7] *Coronial Brief*, Letter from Dr Slobodan Curcic dated 14 August 2018
[8] *Coronial Brief*, Victoria Police LEAP records for incident number 170162282, 9
[9] *Coronial Brief*, Family Violence Intervention Order dated 15 May 2017 with case number H11119545
[10] *Coronial Brief*, Victoria Police Criminal History Outcomes for Tre Lawson, 2
[11] *Coronial Brief*, Statement of Dina Mitchell dated 8 February 2018, 2
[12] *Coronial Brief*, Statement of Shakira Smith dated 15 February 2018, 3 and 5

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

23. On 15 November 2017 at approximately 1:00am, Tre was home with his aunt, Ms Mitchell and her husband, Mr Greg Lawson.[13] Tre was observed to be using his uncle's mobile phone to call Ms Smith. Family members reported that Tre was observed to be agitated and upset by the telephone call with Ms Smith.[14]

24. Ms Smith confirms that she was arguing with Tre via text messages and over the telephone until approximately 2.30am and went to sleep around this time.[15] Ms Smith confirms that whilst she was asleep, Tre continued to send text messages to her until 5:05am.[16]

25. At approximately 4:30am, Tre called his paternal grandfather and told his grandfather that he was stressed about everything going on in his life including his community service requirements that prevented him from leaving the area to escape from Ms Smith.[17]

26. On the same day at approximately 8:20am, one of Ms Mitchell's children found Tre in the backyard of the house and called out to another family out of concern for Tre. Ms Mitchell's brother was at home and came out to the backyard and found Tre lying facedown with a hose tied around a tree branch.[18]

27. Ms Mitchell contacted emergency services and they arrived at the Patterson avenue address at 8.37am. Paramedics confirmed that Tre was deceased upon arrival.[19]

CAUSE OF DEATH

28. On 16 November 2017, Dr Malcolm Dodd, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination upon Tre's body and provided a written report, dated 23 November 2017. In that report, Dr Dodd concluded that a reasonable cause of death was 'I(a) Hanging'.

29. Dr Glengarry commented that external examination of Tre's left forearm evidenced fresh self-inflicted superficial incised injury and trauma to the left forearm.

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[13] *Coronial Brief,* Statement of Dina Mitchell dated 8 February 2018, 2
[14] *Coronial Brief,* Statement of Dina Mitchell dated 8 February 2018,
[15] *Coronial Brief,* Statement of Shakira Smith dated 15 February 2018, 4
[16] *Coronial Brief,* Statement of Dina Mitchell dated 8 February 2018, 4
[17] *Coronial Brief,* Statement of Dina Mitchell dated 8 February 2018, 4
[18] Ibid, 3
[19] *Coronial Brief,* Statement of First Constable Megan Allen dated 7 March 2018, 1

30. Toxicological analysis of the post mortem samples taken from Tre identified the presence of Methylamphetamine[20], Amphetamine[21] and Delta-9-tetrahydrocannabinol[22] (an active component of cannabis).

31. I accept Dr Dodd's opinion as to the cause of death.

Intent

32. I find that Tre, in a substance affected state, intentionally ended his own life.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

33. Research from the World Health Organisation indicates that relationship conflict and discord can cause situational psychological stress and is associated with increased risk of suicide. [23] Researchers have noted that depression, substance use disorders and antisocial behaviours are relatively common and most people suffering from them may not display suicidal behaviour.[24]

34. Tre's last altercation with Ms Smith on 15 October 2017 before his death involved violent outbursts and Tre physically assaulting Ms Smith. Research into family violence suggests that '*men who died from suicide most often perpetrated abuse against a partner or family member'*.[25] Furthermore, research statistics evidence the fact that, '*perpetrators had commonly done [committed intimate partner violence] so in the prior 6 weeks'* before suicide.

Management of Tre's Community Corrections Order

35. Tre attended the Mildura Magistrates Court on 16 October 2017 due to his offending behaviour with Ms Smith the day before. A court assessor from CCS Mildura conducted a

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[20] Methylamphetamine is a strong stimulant drug that acts like the neurotransmitter noradrenaline and the hormone adrenaline, it is known as "speed" or "ice".

[21] Amphetamines is a collective word to describe central nervous system stimulants structurally related to dexamphetamine.

[22] Delta-9-tetrahydrocannabinol is the active form of cannabis (Marijuana). It is normally inhaled through cigarettes smoked in a similar fashion to tobacco or inhaled through a water pipe. Persons under the influence of cannabis will experience impaired cognition.

[23] World Health Organisation, *Preventing Suicide: a global imperative* (2014) available online at: http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/; Kposowa AJ, *Divorce and suicide risk.* Journal of Epidemiol Community Health (2003).

[24] World Health Organisation, *Preventing Suicide: a global imperative* (2014) available online at: http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/).

[25] Michael B MacIsaac, Lyndal Bugeja, Tracey Weiland, Jeremy Dwyer, Kav Selvakumar and George A Jelinek, *Prevalence and Characteristics of Interpersonal Violence in People Dying from Suicide in Victoria, Australia*, Asia Pacific Journal of Public Health (2018).

pre-sentence assessment of Tre to determine his suitability to undertake a CCO. At this time, the court assessor was provided with a copy of the assessment request, a copy of Tre's criminal history and a summary of the charges he was brought to court for on 16 October 2017.

36. The criminal history provided to the court assessor indicated that on 15 May 2017, Tre was required to attend a mental health service in Mildura or Broken Hill to receive treatment as directed. The summary of the charges arising from the events on 15 October 2017 also provided relevant information to the court assessor as to the nature of family violence events that brought Tre to court.

37. The court assessor however did not recommend to the presiding Magistrate that any conditions for mental health treatment be imposed on any CCO that Tre would be subject to. This is despite contrary information available to the court assessor indicating that Tre was required to attend a mental health service in Mildura or Broken Hill to receive treatment as directed in a prior criminal hearing in May 2017. Had further enquiries been made by the court assessor with Police prosecution members or Victoria Police, this would have disclosed pertinent information regarding Tre's prior self-harm attempt on 14 May 2017. This was a missed opportunity for intervention in the death of Tre.

38. In 2017, the Mental Health Advice and Response Service was introduced under the Forensic Mental Health Implementation Plan managed by the Department of Justice and Community Safety. The purpose of the Mental Health Advice and Response Service is to provide clinical mental health advice, within the court, to improve the suitability of mental health interventions and referrals for individual's appearing before the court.

39. Data from the Australian Bureau of Statistics relating to suicides across Australia between 2001 and 2010 suggests that the '*overall rate of suicide for Aboriginal and Torres Strait Islander peoples was twice that of non-Indigenous people, with a rate ratio of 2.0 for males and 1.9 for females.*'[26] Furthermore, '*suicide rates for Aboriginal and Torres Strait Islander females aged 15-19 years were 5.9 times higher than those for non-Indigenous females in this age group.*'[27] However, it is important to note that:

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[26] Australian Bureau of Statistics, *Aboriginal and Torres Strait Islander Suicide Deaths*, http://www.abs.gov.au/ausstats/abs@.nsf/Products/3309.0~2010~Chapter~Aboriginal+and+Torres+Strait+Islander+suicide+deaths?OpenDocument

[27] Australian Bureau of Statistics, *Aboriginal and Torres Strait Islander Suicide Deaths*, http://www.abs.gov.au/ausstats/abs@.nsf/Products/3309.0~2010~Chapter~Aboriginal+and+Torres+Strait+Islander+suicide+deaths?OpenDocument.

"...caution should be exercised when undertaking analysis of Aboriginal and Torres Strait Islander deaths and, in particular, trends in Aboriginal and Torres Strait Islander mortality. This is due to data quality issues, including the under identification of Aboriginal and Torres Strait Islander people in deaths data and the uncertainties inherent with estimating and projecting the size and structure of the Aboriginal and Torres Strait Islander population over time."[28]

40. A search of the Victorian Suicide Register, a database of suspected and Coroner-determined suicides, was undertaken by the Coroners Prevention Unit (**CPU**) to identify relevant deaths of indigenous youth in Victoria.[29] The CPU identified that between 2009 and 2015, there were 11 suicides in Victoria of Aboriginal and Torres Strait Islander people aged 25 years or under and the majority of these deaths (7 of 11) occurred in the Mildura region.[30]

41. Due to the connections between Tre's death, drug abuse and history of family violence, I direct that this finding be distributed to the National Drug and Alcohol Research Centre and to the Department of Premier and Cabinet's Family Violence and Service Delivery Reform Unit.

RECOMMENDATIONS

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

    (a) **Recommendation 1** – That the Forensic Mental Health Implementation Plan and corresponding Mental Health Advice and Response Service be expanded to operate in regional areas that have been identified with high rates of indigenous suicide. In particular I recommend the expansion of the program to the Mildura Magistrates Court.[31]

43. The establishment of the Mental Health Advice and Response Service capitalises on valuable opportunities for intervention and breaking the cycle of poor mental health associate with offending. It enables clinical services to intervene early in the criminal justice

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[28] Australian Bureau of Statistics, *Aboriginal and Torres Strait Islander Suicide Deaths*, available online at: http://www.abs.gov.au/ausstats/abs@.nsf/Products/3309.0~2010~Chapter~Aboriginal+and+Torres+Strait+Islander+suicide+deaths?OpenDocument

[29] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety.

[30] Jeremy Dwyer, *Coroners Prevention Unit Aboriginal Youth Suicide Research Memorandum*, dated 5 December 2018, 2-3. It is important to note that the identification of Aboriginal and Torres Strait Islander people among Victorian suicide deceased is challenging. When a person had died, only secondary sources are available like medical, legal and other documents. These secondary sources are an inadequate substitute for what people can tell the Court about who they are and how they identify themselves.

[31] I advised the Chief Magistrate, Judge Lauritsen of my intention to make this recommendation by cover of letter dated 23 July 2019.

process by identifying where individuals charged with an offence and appearing before the court have a mental illness.

44. The Mental Health Advice and Response Service further provides timely advice and linkage of offenders with relevant treatment providers. This service is not currently provided at the Mildura Magistrates Court but is available at 13 locations across Victoria. In light of the recent statistics on Aboriginal youth suicide rates in Mildura, there is considerable value in exploring the expansion of the Mental Health Advice and Response Service to regional Victorian areas like Mildura.

FINDINGS AND CONCLUSION

45. Having investigated the death, without holding an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that Tre Leigh Lawson, born 16 September 1997, died on 15 November 2017 at 1 Patterson Avenue, Mildura, Victoria, from I(a) Hanging in the circumstances described above.

46. I convey my sincere condolences to Tre's family for their loss.

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

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

Mr Anthony Mitchell, senior next of kin.

Mrs Samantha Lawson, senior next of kin.

Constable Megan Allen, Victoria Police, Coroner's Investigator

His Honour Judge Peter Lauritsen, Chief Magistrate, Magistrates' Court of Victoria.

Her Honour Jelena Popovic, Deputy Chief Magistrate, Magistrates' Court of Victoria.

Department of Justice and Community Safety – Corrections Victoria.

Department of Premier and Cabinet Family Violence and Service Delivery Reform Unit.

National Drug and Alcohol Research Centre, University of New South Wales.

Signature:

CAITLIN ENGLISH

ACTING STATE CORONER

Date: 7 October 2019