IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 002875

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Jacqui Hawkins, Deputy State Coroner
Deceased:	Jaymii Leslie Mott (Green)
Date of birth:	4 January 1991
Date of death:	5 June 2019
Cause of death:	1(a) Diffuse hypoxic cerebral injury 1(b) Prolonged downtime following neck compression due to self suspension
Place of death:	The Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004
Keywords:	MILDURA; ABORIGINAL; SUICIDE; ACCESS TO MENTAL HEALTH SERVICES; ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM; MALLEE DISTRICT ABORIGINAL SERVICES

INTRODUCTION

1. Jaymii Leslie Mott (Green) was 28 years old when he passed on 5 June 2019. At the time of his passing, Jaymii lived at home with his partner Tenarah Higgins, and their daughter, Amiyrah. Jaymii was of Aboriginal descent.

2. Jaymii had a history of mental health issues, alcohol and drug use. In the year prior to his passing he spent three months in custody after being found guilty of an assault in Mildura.

THE CORONIAL INVESTIGATION

3. Jaymii's passing was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

4. 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.

5. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

6. Victoria Police assigned Leading Senior Constable Brenton Lewin to be the Coroner's Investigator for the investigation of Jaymii's passing. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

7. Upon receipt of the coronial brief and concerns regarding a heightened number of suicides among the Aboriginal population in Mildura, the Coroner's Prevention Unit (**CPU**) conducted an investigation.[1] The CPU reviewed the coronial briefs of evidence for seven passings to

[1] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner.

establish commonalities, and whether availability (or lack of) services at all contributed to the passings.

8. There was consensus among all parties and organisations consulted in the investigation that persons living in Mildura are significantly affected by several stressors including: high rates of crime, unemployment, family violence, low socioeconomic status, geographic isolation (which can impede access to health and other services), lack of available housing and accommodations support, and lack of access to availability of mental health services. Significantly, all parties and organisations identified substance misuse as the most prevalent stressor in the Mildura area, indicating that this is compounded by there being no drug and alcohol rehabilitation or detoxification facilities in Mildura.

9. The findings of the CPU, and how they relate to Jaymii's passing are discussed in more detail below.

10. This finding draws on the totality of the coronial investigation into the passing of Jaymii including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

IDENTITY OF THE DECEASED

11. On 5 June 2019, Jaymii Leslie Mott (Green), born 4 January 1991, was visually identified by his mother, Rebecca Green, who signed a formal statement of identification to this effect.

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

MEDICAL CAUSE OF DEATH

13. On 7 June 2019, Dr Yeliena Baber, Forensic Pathologist from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination. Dr Baber also considered the Victorian Police Report of Death Form 83 and the post-mortem computed tomography (**CT**) scan and provided a written report of her findings.

The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[2] 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.

14. The post-mortem examination showed findings in keeping with the clinical history. Examination of the post-mortem CT scan showed cerebral oedema but nothing else of note.

15. Routine toxicological analysis of post and ante-mortem samples identified the presence of morphine,[3] paracetamol,[4] venlafaxine (and desmethylvenlafaxine),[5] lignocaine,[6] Delta-9-tetrahydrocannabinol,[7] levetiracetam,[8] and laudanosine.[9] It was noted that a number of these drugs were likely administered by emergency and hospital staff.

16. Dr Baber provided an opinion that the medical cause of death was 1 (a) diffuse hypoxic cerebral injury and 1 (b) prolonged downtime following neck compression due to self-suspension.

17. I accept Dr Baber's opinion.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

18. On the evening of 31 May 2019, Jaymii's partner Ms Higgins picked him up from work. They had an argument on the way home and Jaymii got out of the car and decided to walk home. They exchanged a number of texts in which Ms Higgins threatened suicide. She stated she was *"over the abuse and putting up with him"*. Jaymii replied and said that he would see her *"on the other side"*.

19. Ms Higgins arrived home and went inside to speak with her mother. Her mother said that Jaymii was outside in the shed. Ms Higgins walked outside to the shed and found Jaymii hanging from an electrical cord.

20. Ms Higgins and her mother cut Jaymii down and contacted emergency services. They started CPR before Ambulance Victoria arrived. Paramedics were able to resuscitate Jaymii though he did not regain consciousness. He was taken to Mildura Base Hospital and then transferred to the Alfred Hospital.

21. He was assessed by medical staff and believed to have suffered a diffuse hypoxic brain injury which was considered to be unsurviveable. Following a consultation with Jaymii's family the decision was made to withdraw active treatment. He passed at about 7:30pm on 5 June 2019.

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[3] Narcotic analgesic used for the treatment of moderate to severe pain.
[4] Analgesic drug.
[5] An antidepressant.
[6] Local anaesthetic administered to patients prior to surgery or during resuscitation attempts.
[7] Cannabis.
[8] Antiepileptic used for the control of partial onset seizures.
[9] The metabolite of atracurium, a non-depolarising neuromuscular blocker, used for general anaesthesia.

CPU INVESTIGATION INTO SUICIDES IN MILDURA

22. In July 2019, Murray Primary Health Network (**Murray PHN**) contacted the Coroners Court of Victoria to convey concern about a perceived increased frequency of suicides that had occurred in the Mildura Local Government Area between May and June 2019. Following this, the CPU were requested to identify suspected suicides which had occurred in Mildura and determine whether this purported elevated frequency of suicides had occurred.

Analysis of suspected suicides

23. The CPU used the Victorian Suicide Register (**VSR**) to conduct a retrospective case series examination of suspected suicides where the location of the fatal incident or the location of the deceased's usual residence was in Mildura. The CPU identified seven suspected suicides that had occurred in Mildura between May and June 2019, being the highest frequency of suspected suicides to occur in a two-month period in Mildura over the 10-year period examined.

24. This retrospective examination showed that between May and June 2019, Mildura experienced an elevated frequency of suspected suicides. This met the Centre for Disease Control and Prevention's definition of a suicide cluster.[10]

25. This review did not uncover any known personal links between the people who suicided, however, there was evidence of several stressors that recurred across multiple passings. These stressors included: substance misuse, diagnoses and suspected mental ill health, experience of abuse as both victim and perpetrator, and in some cases, consequent involvement with the criminal justice system, and recent or threatened separation from and/or conflict with partner. Further analysis of the VSR also showed that, compared to other regional Victorian local government areas, Mildura had the highest average annual suicide rate per 100,000 residents across the period 2010-2019, with a rate of 35.5 suicides per 100,000 Mildura residents.

Meetings and submissions

26. Given this elevated frequency of suicides, staff from the CPU and Koori Engagement Unit at the Court were invited to meet with several organisations and community members from the Mildura area. The aim of these meetings was to obtain informed input regarding the

[10] *"A group of suicides or acts of deliberate self-harm that occur closer together in space and time than would normally be expected on the basis of statistical prediction and/or community expectation* (Centres for Disease Control, 1994).

vulnerabilities of Mildura residents, with the aim of assisting to make prevention focused recommendations in these matters.

27. Court representatives visited Mildura on 22 and 23 August 2019 and met with representatives from the Aboriginal Health Unit at the Mildura Base Hospital, Mallee District Aboriginal Services, Mildura Justice Services Centre, Mildura Magistrates Court and Murray PHN as well as community members in attendance at the Sunraysia Mallee Prevention Awareness and Support Network Community Proposal Meeting run by Murray PHN. All participants were invited to openly discuss vulnerabilities faced by the Mildura community, including barriers to accessing health and other services in the region. I would like to acknowledge and thank all the parties and organisations who engaged with the Court as part of this investigation.

28. Additionally, I received a submission from Murray PHN detailing their response to this elevated suicide frequency. On behalf of the Victorian Government, Murray PHN leads implementation of the Mildura Place Based Suicide Prevention Trial (2017-2022). The Mildura trial takes a systems approach to community suicide prevention and incorporates postvention and community response planning within its remit.

29. Immediately after Murray PHN identified that suicides in their region had occurred, the suicide postvention response for the region was activated. Additionally, Murray PHN engaged with Orygen to review the Northern Mallee Suicide Postvention Protocols and conducted a thematic review of the suicides that occurred in Mildura in 2019 to inform ongoing strategic activities for the Mildura Place Based Suicide Prevention Trial and Murray PHN. I would like to further acknowledge and thank Murray PHN for providing a submission to me as part of this investigation.

CPU REVIEW INTO THE CIRCUMSTANCES OF JAYMII'S PASSING

30. Specifically in relation to Jaymii's passing, I requested the CPU investigate the availability (or lack of) services in the Mildura area, with a particular focus on Aboriginal specific mental health care in Mildura.

Jaymii's mental health prior to his passing

31. Jaymii and Ms Higgins moved to Mildura in 2017 in an attempt to remove themselves from the drug scene. Jaymii had a history of anxiety, depression, poor anger management and substance use. He had previously sought treatment for this. Ms Higgins reported family violence

perpetrated by Jaymii in the form of verbal and physical abuse. It does not appear that these issues were reported to police.

32. On 29 June 2018, Jaymii was sentenced to three months imprisonment for an assault. He was released on 1 October 2018 on a community correction order (**CCO**). He was required to complete supervision, treatment, and rehabilitation for alcohol use and offending behaviour programs. Jaymii accessed treatment through Mallee District Aboriginal Services (**MDAS**). He did not participate in an offending behaviour program but was placed in a regional queue. He failed to attend an appointment in relation to this prior to his passing.

33. Jaymii reportedly ran out of medication two weeks prior to his passing. He had not collected his prescription due to work commitments. Ms Higgins advised that Jaymii became more violent towards her in the weeks he was not taking his antidepressant medication.

34. The information suggests Jaymii was inconsistent with his medication, and would sometimes cease against medical advice when he felt well or could not afford the prescription. Text messages between Jaymii and his mother indicate he felt he was becoming angry and violent. She encouraged him to attend his GP, to take his antidepressants and to stop using drugs.

35. On 31 May 2019, Jaymii re-engaged with MDAS and attended an appointment with Dr Mou Rashid Bose, a general practitioner. During this appointment, Jaymii requested a prescription for his usual antidepressant desvenlafaxine. He reported difficulty managing his temper at work and acknowledged that he had started smoking cannabis again. Dr Rashid Bose advised Jaymii to engage in counselling with Alcohol and Other Drugs Service (**AODS**) and the mental health team.

36. Mr Higgins believed the GP had refused to give Jaymii his regular dose of antidepressant. Dr Rashid Bose stated he prescribed Jaymii his regular dose of 50mg desvenlafaxine, but not an increased dose as requested by Jaymii. Dr Rashid Bose believed that Jaymii was in agreement with this plan, but Ms Higgins advised that Jaymii was upset and angry. The records suggest Jaymii was prescribed a higher dose of 100mg in 2016, but was more recently prescribed the lower dose of 50mg. It appears he sometimes increased this without medical advice.

37. Dr Rashid Bose stated his plan was to organise a consultation with a psychiatrist to review Jaymii before making any changes to his dosage. The CPU were of the view that the treatment plan developed by Dr Rashid Bose was reasonable. Any increase in antidepressant prescription

would not have prevented Jaymii's passing as the incident occurred on the same day as the GP visit.

Review of treatment through Mallee District Aboriginal Services

38. Jaymii first engaged with Mallee District Aboriginal Services (**MDAS**) on 21 March 2018 with Dr Dharminder Jit Singh, a GP. Jaymii described symptoms of anxiety and depression and that he was having arguments with his partner. Jaymii advised he had self-ceased his antidepressants and stopped using alcohol and cannabis. He denied any suicidal ideation. The treatment plan was to commence antidepressants (50mg desvenlafaxine) and refer Jaymii to a Dual Diagnosis Worker at MDAS for anxiety and depression, mood regulation and anger, and alcohol and cannabis use. It was noted that a referral to a psychiatrist may be required. A Dual Diagnosis Worker met with Jaymii. He requested help with mood management and a desire to create more stability in his life.

39. Jaymii attended further counselling appointments throughout 2018. He was noted to be compliant with medication and reported improvements in his mood, sleep, energy levels, and self-control. He remained abstinent from alcohol and cannabis. He was provided with psychoeducation, relaxation techniques, coping strategies, and cognitive behavioural therapy. On a psychological test Jaymii returned a result of low to moderate psychological distress on 2 May 2018.

40. On 27 June 2018 Jaymii advised he had relapsed into alcohol use and was experiencing increased anxiety. He advised he had self-increased his antidepressants and was encouraged to discuss this with his GP. Jaymii did not attend his next scheduled appointment in July and did not respond to follow up messages. Jaymii was incarcerated at this time, and it appears MDAS were not aware.

41. The CPU considered that the care provided to Jaymii in this first episode of care was prompt, appropriate, and receptive to his identified needs.

42. Jaymii reengaged with MDAS in October 2018 as part of his CCO. During a AOD assessment, Jaymii denied any recent or current self-harm or suicidal ideation, attempts, or intent. He also denied any history of suicide or self-harm. He denied any current mental health issues and advised he was not taking medication. Jaymii advised at this appointment that he had abstained from alcohol since February 2018 and denied use of any other substances. He recognised that in the last year his alcohol consumption had resulted in he or someone else being injured, and

that other people had been concerned about his drinking and suggested he cut down. The plan was to continue with AOD counselling. There are no documented mental state or risk assessments.

43. According to a statement from the Department of Justice and Community Safety, an Exit Report was received from MDAS dated 6 December 2018 which indicated *"Mr Mott successfully completed treatment; attended seven sessions; and had returned to work with his previous employer"*.

44. The CPU considered that the limited documentation in the medical records during this treatment period may indicate that Jaymii was not reporting any issues with his mental health or substance use. However, it precludes a review of whether any assessments and treatment were suitable or evidence based.

Statement from Mallee District Aboriginal Services

45. MDAS were asked to provide a statement to the Coroners Court of Victoria outlining any challenges experienced providing mental health treatment in Mildura, and whether the recommendations made by the Royal Commission into Victoria's Mental Health System cover the areas of need in Mildura.

Service model

46. MDAS advised that the Royal Commission recommendations are sufficient for MDAS to be able to offer better support for people in Mildura. MDAS has commenced work on their business service model in line with the Commissioner's recommendations.

47. They advised of plans to develop a wellness centre, to have the capacity to run wellbeing and therapeutic programs and have Social and Emotional Wellbeing staff available for community members to be able to access in one location.

Access to qualified clinicians

48. MDAS reported difficulties attracting and retaining qualified clinicians. This difficulty results in a loss of skills and impacts on the supports and treatment programs which can be provided. MDAS reported they wish to invest in upskilling staff to become qualified clinicians.

Suicide prevention and postvention

49. MDAS advised they provided suicide prevention training in the past but lost these resources with staff turnover. Training for new staff in the future is being developed. MDAS reported there are three delegates from the Social Emotional and Wellbeing Team which will attend and complete the Aboriginal Mental Health first aid training to better support ground staff.

The Royal Commission into Victoria's Mental Health System

50. Since the passing of Jaymii in 2019, the Royal Commission into Victoria's Mental Health System (**the Commission**) has released its interim report in November 2019 and final report in February 2021, as well as recommendations.

51. The Commission heard evidence on the high rates of psychological distress and mental health disorders in Aboriginal people. The data obtained suggested the prevalence of depression and anxiety was greater among Aboriginal people compared with non-Aboriginal Victorians. The Commission also identified a heightened risk of suicide in Aboriginal people, particularly Aboriginal youth.

52. In developing recommendations suitable to the needs of Aboriginal communities, the Commission considered aspects such as the right to Aboriginal self-determination, the centrality of family and kinship groups, recognition of trauma and the impacts of racism and social disadvantage, strengths-based care and culturally valid understandings of mental health.

53. The shortage of Aboriginal mental health professionals was identified by the commission and is addressed in the Interim Report's Recommendation 4:[11]

> *The Royal Commission recommends the Victorian Government, through the Mental Health Implementation Office, expands social and emotional wellbeing teams throughout Victoria and that these teams be supported by a new Aboriginal Social and Emotional Wellbeing Centre. This should be facilitated through the following mechanisms:*
>
> - *Dedicated recurrent funding to establish and expand multidisciplinary social and emotional wellbeing teams in Aboriginal Community Controlled Health Organisations, with statewide coverage within five years.*

[11] Royal Commission into Victoria's Mental Health System - Recommendations (rcvmhs.vic.gov.au)

- *Scholarships to enable Aboriginal social and emotional wellbeing team members to obtain recognised clinical mental health qualifications from approved public tertiary providers, with a minimum of 30 scholarships awarded over the next five years.*

- *Recurrent funding for the Victorian Aboriginal Community Controlled Health Organisation to develop, host, and maintain the recommended Aboriginal Social and Emotional Wellbeing Centre in partnership with organisations with clinical expertise and research expertise in Aboriginal mental health. The centre will help expand social and emotional wellbeing services through:*

    - *Clinical, organisational, and cultural governance planning and development;*

    - *Workforce development – including by enabling the recommended scholarships;*

    - *Guidance, tools, and practical supports for building clinical effectiveness in assessment, diagnosis and treatment; and*

    - *Developing and disseminating research and evidence for social and emotional wellbeing models and convening associated communities of practice.*

54. Building a skilled workforce is also addressed in the Department of Health and Human Services' *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017-2027.*[12] The Victorian Government has also committed funding to support Aboriginal clinical and therapeutic positions in Aboriginal community-controlled health services. This will improve culturally responsive, trauma-informed services to address the social and emotional wellbeing and mental health needs of Aboriginal people in Victoria.

55. The Commission also identified a need to focus on youth mental health and wellbeing and made further recommendations supporting Aboriginal social and emotional wellbeing in youth in their final report.[13]

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[12] Supporting the social and emotional wellbeing of Aboriginal and Torres Strait Islander Victorians (health.vic.gov.au)

[13] Recommendation 33, Royal Commission into Victoria's Mental Health System - Recommendations (rcvmhs.vic.gov.au)

56. The Victorian Government has committed to implementing all recommendations of the Royal Commission into Victoria's Mental Health System as part of a 10-year reform plan.

CPU Findings

57. Jaymii was reporting abstinence to MDAS in October and November 2018, and also advised his CCO Case Manager that he was not experiencing any temptation to consume alcohol. The CPU noted that this is not consistent with the information provided by Ms Higgins, who advised that Jaymii drank to excess, smoked cannabis during the week and took party drugs on the weekend, after leaving prison. It's unclear if Jaymii was misleading his treatment providers, or if he relapsed into substance use after disengaging with MDAS. Due to Jaymii's self-reporting of abstinence, treatment providers did not perceive a need for more intensive intervention such as residential rehabilitation at this time.

58. On 31 May 2019, Jaymii advised he had started smoking cannabis again. It also appears alcohol consumption may have contributed to his suicide, as he was reportedly drinking on the evening of the incident. Access to local residential detoxification and rehabilitation facilities has been identified as an issue in Mildura,[14] and is being reviewed in other coronial investigations.

59. The extent of Jaymii's alcohol and substance use proximate to his passing is unclear. It's difficult to determine what interventions would have been most appropriate. The treatment plan to re-engage with AOD counselling at MDAS was an appropriate one and would have enabled a more thorough assessment of Jaymii's alcohol and substance use and treatment needs.

60. The CPU noted that Jaymii did not have a known history of suicidal behaviour or attempts. Medical records indicate that Jaymii experienced suicidal thoughts in 2015 but did not act on them. His mother advised that he would make suicidal comments, but she was not aware of any attempts. Ms Higgins stated that Jaymii had never reported suicidal thoughts or intent to her during their relationship.

61. In October 2018, Jaymii denied any history of suicide attempts or self-harm and denied any thoughts or intent. On the morning of the incident, Jaymii expressed concern about anger management and substance use. There is no documented suicide risk assessment, however Dr Rashid Bose advised there was no indication Jaymii intended to self-harm.

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[14] Statement from Matt Jones, Chief Executive Officer, Chair Victorian and Tasmanian PHN Alliance, dated 10 July 2020, pg 3.

62. It appears Jaymii was help-seeking and future focussed during the 31 May 2019 consult and agreed to a treatment plan. The treatment plan was appropriate to address the identified issues. Jaymii's suicide appears to have been an impulsive reaction to interpersonal difficulties, potentially influenced by alcohol consumption.

FINDINGS AND CONCLUSION

63. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Jaymii Leslie Mott (Green), born 4 January 1991;

    b) the passing occurred on 5 June 2019 at Alfred Health, the Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004, from diffuse hypoxic cerebral injury and prolonged downtime following neck compression due to self-suspension; and

    c) the passing occurred in the circumstances described above.

64. Having considered all of the circumstances, I am satisfied that Jaymii intentionally took his own life.

65. I support the findings of the CPU in relation to Jaymii's access to mental health support in Mildura. I consider that MDAS provided appropriate treatment to Jaymii prior to his passing.

66. I endorse the recommendations and comments made in the investigation into the passing of Boe Memery (2019/2530) as they are relevant to the circumstances in this finding.

67. I convey my sincere condolences to Jaymii's family for their loss.

68. Pursuant to section 73(1) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

    Tanarah Higgins, Senior Next of Kin

    Jacqualyn Turfrey, Chief Executive Officer - Mallee District Aboriginal Services

    Professor Euan Wallace, Secretary, Department of Health

    Alistair Bonsey, Strategic Projects Lead - Murray Primary Health Network

Keren Day, Director Clinical and Enterprise Risk Management, Alfred Health

Leading Senior Constable Brenton Lewin, Coroner's Investigator

Signature:

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Jacqui Hawkins, Deputy State Coroner

Date : 31 August 2022