IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 1286

FINDING INTO DEATH WITHOUT INQUEST

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

I, PETER WHITE, Coroner having investigated the death of ATHIEL DENG

without holding an inquest:
find that the identity of the deceased was ATHIEL DENG
born on 1 January 1954
and the death occurred 26 March 2013
at 1 Roberts Crescent, Sunshine West 3020
from:

1 (a) HEAD INJURY

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Athiel Deng was 59 years old at the time of her death. She resided in Sunshine West with her youngest son, Majang Ngor. Ms Deng is survived by her children.
2. Ms Deng was originally from Sudan and arrived in Australia in 2005 with her children, after spending five years in a Kenyan refugee camp. The family had a close relationship and frequently spent time together.

BACKGROUND AND CIRCUMSTANCES

3. On 26 March 2013 at approximately 5.30am, a neighbour, Ms Dida Paraschiv reported hearing 'moaning screams…like the screams of someone who was in pain', stating that she heard about seven in a row but could not identify where they were coming from. Another neighbour, Ms Phyllis Zammit also reported hearing screaming coming from the house at 1 Roberts Crescent, Sunshine West at approximately 5.30am. Neither neighbour contacted police.

4. At approximately 7.15am, Ms Thi Vu was in her driveway of her home at 10 Felstead Avenue, Sunshine West. Mr Ngor approached her and attacked her with a knife. Fearing for her life she ran to the neighbouring house of Ms Kien Do at 7 Felstead Avenue, where they locked themselves inside. Mr Ngor followed Ms Vu holding a knife, banging and kicking the front door and smashing a window beside the front door. Ms Do's son, Mr David Nguyen called emergency services at approximately 7.25am requesting police assistance.

5. Mr Chau Van Nguyen who resided at 12 Felstead Avenue, was alerted via telephone about the attack. He left his home via the side gate. When Mr Ngor, saw Mr Chau Van Nguyen he ran to him and attacked him with the knife. His partner, Ms Huong Dao and neighbour Mr David Nguyen came to his assistance. Mr Ngor punched Ms Dao in the face, then ran back to his house at 1 Roberts Crescent.

6. At approximately 7.53am, Police attended 7 Felstead Avenue. They were met by neighbours who told them that Mr Ngor had returned to his home. A Critical Incidence Response Team (CIRT) with a trained negotiator was requested. The CIRT negotiator attempted to contact Mr Ngor without success. Police members observed Mr Ngor taking items of clothing and a mattress from the main house into a bungalow situated in the rear yard.

7. Mr Ngor's brother, Mr Thomas Ngor arrived in the neighbourhood at approximately 9.10am. He advised police that he had unsuccessfully tried to contact his mother, but despite this, he reported he had no concerns for his mother's safety. At approximately 9.20am, CIRT approached the house to determine if Ms Deng was inside. When they knocked on the front door calling her name, Mr Ngor responded and exited the house holding a tomahawk. He advanced on police ignoring their commands to put down the weapon. He was eventually apprehended by police and arrested.

8. At approximately 9.30am, CIRT located Ms Deng in the bungalow. Her body was partially covered by items piled on the floor. Ms Deng was clearly deceased with significant injuries to her head and face.

POST-MORTEM EXAMINATION

9. Dr Kate Strachen, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed a scene investigation, external examination and a post-mortem examination. Dr Strachen reported the external examination revealed extensive blunt force injuries to the head and face. Routine toxicological examination detected the presence of paracetamol, no alcohol or

common drugs and poisons were identified. Dr Strachen estimated that Ms Deng died within the 12 hours prior to the discovery of her body on 26 March 2013.

10. Dr Strachen determined the cause of death to be head injury.

CORONERS DETERMINATION

11. On 27 March 2013, Mr Ngor was formally charged with the murder of Athiel Deng, the attempted murder of Thi Vu and the attempted murder of Chau Van Nguyen. He was remanded in custody at Thomas Embling Hospital to appear at the Melbourne Magistrates' Court for Committal Mention on 19 June 2013. The matter was subsequently adjourned to a further Committal Mention on 17 July 2013.

12. On 24 June 2013, Mr Ngor was located deceased while in custody at Thomas Embling Hospital. On 1 July 2013, the criminal charges against Mr Ngor were withdrawn.

13. Pursuant to section 52(3)(b) of the *Coroners Court Act 2008* (Vic) the coroner is not required to hold an inquest if a person has been charged with an indictable offence in respect of the death being investigated by the coroner. Pursuant to section 71 of the *Coroners Court Act 2008* (Vic) the coroner is not required to make any of the findings specified in section 67 if the coroner has decided not to hold an inquest because a person has been charged with an indictable offence in respect of the death and the coroner considers that the making of the findings would be inappropriate in the circumstances.

14. In these circumstances I have determined to make a finding pursuant to section 67(1) of the *Coroners Court Act 2008* (Vic) where the coroner must find the identity of the deceased, the cause of death, the circumstances in which the death occurred and any other prescribed particulars.

CORONERS PREVENTION UNIT REPORT

15. The Coroners Prevention Unit[1] conducted a review into the death of Ms Deng as it met the criteria of the Victorian Systemic Review of Family Violence Deaths[2]. I have drawn on this report to assist in my finding.

---

[1] A specialist service for coroners created to support their prevention role and provide them with expert assistance. Hereafter referred to as 'CPU'.

[2] Positioned within the Coroners Court of Victoria, The Victorian Systemic Review of Family Violence Deaths (VSRFVD) provides assistance to Victorian coroners to investigate the circumstances in which family violence deaths occur. In addition, the VSRFVD collects and analyses information on family violence related incidents. This contributes

16. The review identified the following risk factors relating to both Ms Deng and Mr Ngor as relevant to the fatal event.

Individual risk factors

Cultural and Linguistically Diverse Background

17. Ms Deng was Sudanese, her husband died in Sudan during the conflict and she and her children were refugees in a camp in Kenya for five years before arriving in Australia. In Australia, Ms Deng had the support of her adult children, who lived in the neighbourhood and had regular contact with her. She relied on these informal family supports when feeling threatened by Mr Ngor's behaviour. Ms Deng did not speak English and this may have created a barrier for seeking formal support when her son's mental state deteriorated.

18. Ms Deng attended family meetings with Orygen Youth Health. She attended with one of her other sons, but as she did not speak English she would have required interpretation of information and this may have resulted in reduced communication and understanding of critical issues such as risk factors for relapse and signs of a deteriorating mental state.

19. The Department of Health has identified that a lower level of health literacy among culturally and linguistically diverse (CALD) communities has the deleterious effect that people who 'presented for treatment at crisis point, were unable to effectively manage their own health needs and had reduced quality of life' and that for CALD Victorians, increased health literacy requires access to clearly communicated, high quality, in-language information and information that is available in a variety of formats, including audio-visual and pictorial resources.[3] This recognition of a need for improved health literacy in CALD communities would also apply to mental health issues. Ms Deng, as Mr Ngor's informal carer, may have benefitted from access to information in her native language around mental health symptoms, risk factors and responses to a deteriorating mental state.

20. A report by the Australian Domestic and Family Violence Clearinghouse outlines that there is a lack of information and research on the prevalence of family violence within immigrant and refugee communities:

> *Prevalence is uncertain; however some cultural practices may expose immigrant and refugee women and girls to additional risks of violence. Trauma from previous*

---

to the development of a broader knowledge base for dissemination to the community and agencies working with victims and perpetrators of family violence.

[3] http://www.health.vic.gov.au/news/boosting-health-literacy-for-victorias-multicultural-communities.htm.

experiences of violence, particularly for refugees who have fled persecution and who have spent time in refugee camps, urban areas or immigration detention in countries of asylum, may also leave women and girls vulnerable to further violence in the home.[4]

Mr Ngor's substance use and mental health

21. It was reported that Mr Ngor began smoking cannabis at the age of 18 and it escalated to daily use by the age of 19. Prior to Mr Ngor's first psychotic episode in February 2012, Mr Ngor was reportedly smoking two grams of cannabis per day. Proximal to the fatal incident, Mr Ngor reported to his brother that he was using cannabis, khat[5] and methamphetamine.

22. There is an established link between both cannabis and methamphetamine use and psychotic symptoms. Individually cannabis use and methamphetamine use are known risk factors for psychosis in people who have schizophrenia or a genetic vulnerability towards schizophrenia, but there is also evidence that high levels or 'binges' on cannabis or methamphetamine can trigger a transient psychotic episode.[6]

23. In addition to the association with psychotic symptoms, methamphetamine use is linked to violent behaviour. Research shows that approximately one quarter of methamphetamine users had engaged in violent behaviour while under the influence of methamphetamine and that around half of these incidents occurred within a domestic relationship.[7] The strongest evidence for a relationship between methamphetamine use and violence is in the context of methamphetamine induced psychosis. In this context, the violence is likely to be related to persecutory delusions and perceived threat.[8]

24. Consistent with this, Mr Ngor evidenced paranoid, delusional and persecutory beliefs about neighbours, people at the gym and unspecified family members. Mr Ngor had no known psychiatric history prior to his admission to Sunshine Emergency Department on 25 February 2012. His admission occurred following an incident of family violence in the context of a first episode of psychosis. Mr Ngor's psychotic symptoms appeared to resolve after engagement in treatment, compliance with antipsychotic medication and abstinence from illicit substances.

---

[4] http://www.adfvc.unsw.edu.au/documents/Fast_Facts_11.pdf, pg 2

[5] Khat is a stimulant drug from a plant native to countries in East Africa. It is legal in Australia, but importation is strictly regulated and allowed for personal use only.

[6] http://www.mja.com.au/journal/2007/186/7/hospital-separations-cannabis-and-methamphetamine-related-psychotic-episodes

[7] Http://www.boscar.nsw.gov.au/agedbasev7wr/boscar/documents/pdf/cjb97.pdf, pg6

[8] Ibid, pg4

Mr Ngor's exposure to childhood trauma

25. Mr Ngor's medical records from Sunshine Hospital Emergency Department describe him as having a difficult childhood and his medical records from Orygen Youth Health outline that he experienced significant childhood trauma in Sudan and Kenya. Mr Ngor witnessed violence and death as a child and described feeling fearful. His medical records detail recurrent nightmares.

26. Research has consistently found a link between childhood exposure to violence and later violent behaviour. Witnessing violence and victimisation as a child is a predictor of violence in adolescence even when the violence occurs on a community rather than an individual level.[9]

27. Mr Ngor described a feeling of needing to protect himself, and a willingness to retaliate with violence when he felt threatened. Mr Ngor reported that his detainment by police reminded him of violence he had witnessed in Sudan and he had reacted to protect himself from a perceived threat.

Relationship factors

History of family violence

28. Mr Ngor was a perpetrator of family violence which was known to family members and on one occasion known to Victoria Police. Statements from family members and police reported that Mr Ngor was specifically threatening towards his sister-in-law, Ms Ajong Angok, believing her to be a witch or the devil. He expressed an intention to kill her to save his family. During this incident, Mr Ngor also punched his brother, breaking his jaw. Progress notes from a psychiatric review on 28 February 2012, document that he may have had suspicions about other family members but does not detail whom.

29. In support of there not being regular violent incidents, neighbours described the family as quiet, and did not report hearing sounds of violence from the house.

30. There is no positive evidence of Mr Ngor previously perpetrating family violence against his mother. During the police siege, Mr Thomas Ngor advised police that there had never been any issues with violence between his brother and mother, and expressed his belief that his brother would not hurt her. However, it is clear from the later statement by Mr Thomas Ngor that his mother, Ms Deng, was afraid of Mr Ngor two days prior to the fatal incident. In the 48 hours

[9] Weaver, C., Borkowski, J., & Whitman, T. (2008) Journal of Community Psychology 36 (1): 96-112. Violence Breeds Violence: Childhood Exposure and Adolescent Conduct Problems.

before her death, Ms Deng sought the support of her family due to Mr Ngor's behaviour. Mr Thomas Ngor stayed over at the house to help his mother feel at ease.

31. In addition, an undated handwritten note written by Mr Ngor was located by Police which appears to show that Mr Ngor had developed delusional beliefs about his mother. During his first episode of psychosis, Mr Ngor's delusional thoughts were directed towards his sister-in-law, therefore it seems likely that these negative thoughts about his mother were associated with the psychotic episode that occurred proximal to the fatal incident.

Service Contact with Mr Ngor

Community Corrections

32. At the time of Ms Deng's death, Mr Ngor was not under legal sanction or supervision through Community Corrections. Mr Ngor had previously been under the supervision of Sunshine Community Corrections Centre between 21 June 2012 and 20 December 2012. Mr Ngor's Community Corrections Order (CCO) had a requirement that he attend appointments and comply with treatment through Orygen Youth Health until 20 December 2012.

Family violence intervention orders

33. A family violence intervention order was in place against Mr Ngor from 26 March 2012 to 26 March 2013. Ms Deng was not a protected person under the intervention orders. The statements provided by members of Mr Ngor's family indicate that they were aware intervention orders were in place, however they did not consider contacting police when Mr Ngor's mental state began deteriorating, nor when Ms Deng observed him to be carrying a knife in the days prior to the fatal incident. Instead the family attempted to engage Mr Ngor with the health system.

Health system

34. On 25 February 2012, Sunshine Hospital made an involuntary treatment order for Mr Ngor. He was discharged on 26 February 2012, to Orygen Youth Health for involuntary inpatient treatment. On 21 March 2012, Mr Ngor was discharged from his involuntary treatment order and from involuntary patient status as he no longer met the necessary criteria in section B(1) of the *Mental Health Act 1986* (Vic)[10]. He was discharged from inpatient care on olanzapine (antipsychotic), clonazepam (benzodiazepine) and vitamin D. His discharge diagnosis was

[10] I note that on 1 July 2014, the *Mental Health Act 2014* (Vic) commenced and is now the law governing compulsory mental health treatment in Victoria.

documented as "brief psychosis, likely secondary to THC"[11]. His discharge plan was for follow-up with the Youth Access Team (YAT) and then allocation to the Early Psychosis Prevention and Intervention Centre (EPPIC). The identified Crisis Plan involved Mr Ngor or his family calling his outpatient case manager (OCM), or YAT if after hours. Importantly, the Crisis Plan also states: "Majang is high risk of harm to others if he is unwell. A lower threshold for admission should be considered for the safety of his family and the community".[12]

35. Clinical Review and Management Plans dated 10 July 2012, 10 October 2012, and 26 February 2013, state there were no current plans to discharge Mr Ngor from outpatient status but outlined that he would be engaged with a general practitioner on discharge and suggested an appropriate GP be found. In a letter dated 18 May 2012, written by OCM, Mr De Stefanis, Mr Ngor's expected date of discharge from Orygen Youth Health was August 2013.[13] While under the CCO, Mr Ngor reported compliance with his medication and that he engaged reasonably well in treatment although he frequently attended late for appointments or rescheduled. His OCM did not document any concerns about his mental state.

36. From the evidence available, it is clear that Mr Ngor began to disengage from treatment with mental health services when he was no longer required to attend. This is evident from January 2013, at the expiration of his CCO. He stopped attending appointments and he often would not answer his phone. Mr Ngor changed his phone number twice without notifying his OCM. His OCM made considerable efforts to contact him to schedule appointments. He mislead his brother about his attendance at appointments. On 7 January 2013, Mr Thomas Ngor contacted EPPIC expressing concern that his brother had commenced smoking cannabis again.

37. In a telephone conversation on 8 February 2013, Mr Ngor advised his OCM that he was adhering to his prescribed medication and felt 100% recovered from his psychosis. He did not attend his next scheduled appointment on 15 February 2013.

38. At a medical review on 27 February 2013, clinical notes from the treating psychiatrist report that Mr Ngor was documented as aware of the relationship between cannabis use and psychosis. He was adamant he did not want to become unwell again. Mr Ngor did not evidence any psychotic symptoms during this review and was considered to have good insight, although some ambivalence around remaining completely abstinent from illicit substances. The medical

---

[11] Orygen Youth Health Inpatient Unit, Separation Summary, p 59.

[12] Orygen Youth Health, Clinical Review & Management Plan, p 17.

[13] Orygen Youth Health, Letter dated 18 May 2012, p 128.

records indicate that Mr Ngor needed to be monitored around substance use. The treatment plan was to continue prescribed medication and to see his OCM in two weeks.

39. Mr Ngor did not attend the scheduled review on 14 March 2013. Mr Thomas Ngor contacted Orygen Youth Health on 18 March 2013, expressing concern that his brother was using khat on a daily basis and had developed an erratic sleep pattern but said there was no indication of current psychotic symptoms. An appointment was scheduled for Mr Thomas Ngor to bring his brother to Orygen Youth Health on 26 March 2013, the day of the fatal incident.

CONCLUSION

40. The interaction of substance use, psychotic symptoms involving paranoia and persecutory delusions, reduced engagement with treatment providers, and childhood exposure to violence and trauma are all likely to have contributed to Mr Ngor's actions on 26 March 2013.

41. The difficulty Mr Ngor presented to the health and criminal justice system was that when he was well he demonstrated reasonably good insight and his risk of harming others was low. However, when he was using illicit substances, Mr Ngor was at high risk of a psychotic episode and this could result in extreme violence as his psychotic symptoms were of a paranoid and persecutory nature. When unwell, he believed people were trying to kill him, he felt threatened, and developed delusional beliefs about needing to protect himself and his family.

42. When closely monitored under a CCO directing him to treatment Mr Ngor engaged well with Orygen Youth Health, was compliant with the treatment regime and benefitted from the treatment as evidenced by improved mental health. When his CCO expired, Mr Ngor began to disengage from Orygen Youth Health and the service had no opportunity to provide treatment or develop a comprehensive discharge plan. Orygen Youth Health was assertive in their efforts to follow up with Mr Ngor, however, he would not answer his phone or failed to attend appointments when scheduled. When contacted, Mr Ngor would provide an excuse such as being preoccupied searching for employment, advise that he was doing well and would agree to schedule another appointment. There is some evidence of misleading his family about his attendance at appointments and he changed his mobile phone number on two occasions without notifying EPPIC or his OCM.

43. The Chief Psychiatrist has a clear set of guidelines for discharge planning from Adult Community Mental Health Services emphasising the importance of this stage of treatment.[14]

---

[14] http://www.health.vic.gov.au/mentalhealth/cpg/discharge_planning.pdf.

EPPIC also have clear guidelines for discharging clients from treatment including providing support to the young person and their family during the process, assertively liaising with ongoing treatment providers, and ensuring the young person is linked in with a General Practitioner.[15] The anticipated discharge date for Mr Ngor was August 2013, therefore it appears that assertive discharge planning had not commenced. Unfortunately, Mr Ngor's unanticipated reduced engagement in treatment inhibited adequate planning and transition.

44. With the expiration of the CCO, Orygen Youth Health had no mechanism by which to enforce ongoing treatment. Mr Ngor was a voluntary patient and there were no immediate concerns for his mental state or wellbeing to enable an involuntary inpatient admission or community treatment order under the *Mental Health Act 1986* (Vic). Furthermore, although his engagement in treatment was erratic, he maintained a level of compliance, including attending a psychiatric review on 27 February 2013 and reporting adherence to prescribed antipsychotic medication. Therefore, this would not be refusal of treatment under the *Mental Health Act 1986* (Vic).

45. Mr Ngor's intent to harm others occurred during distinct psychotic episodes in the context of illicit substance use. Therefore, the only time Mr Ngor's family was at risk of family violence was during a drug-induced psychosis. During this time however, there was a high level of risk due to the paranoid and persecutory themes of Mr Ngor's delusions. Orygen Youth Health was cognisant of the risk Mr Ngor posed to others when experiencing symptoms of psychosis and had discussed this with Mr Ngor and his family. During his most recent psychiatric review on 27 February 2013, Mr Ngor was not evidencing psychotic symptoms, reporting compliance with medication, and acknowledged the risks associated with illicit substance use. Mr Ngor did not attend his next appointment with his OCM on 14 March 2013. The OCM unsuccessfully attempted to contact Mr Ngor and spoke with Mr Thomas Ngor on 18 March 2013. Mr Thomas Ngor reported his belief that Mr Ngor was using illicit substances again and developing an erratic sleep pattern, but not psychotic as yet. Another appointment was scheduled for 26 March 2013; this date appears to have been chosen to allow Mr Thomas Ngor to bring his brother to the appointment.

46. There is evidence that Mr Ngor had begun using contraindicated licit[16] and illicit substances proximal to the fatal incident. It is clear that Mr Ngor's mental state was impaired and he was

---

[15] EPPIC, Orygen Youth Health, Australian Clinical Guidelines for Early Psychosis: A brief summary for practitioners, p 14.

[16] Mr Ngor obtained a script for phentermine (a medication utilised in weight loss) from a friend and took it for a two-week period.

experiencing psychotic symptoms two days prior to the fatal incident. It appears that Mr Ngor's vulnerable mental state deteriorated in the context of illicit substance use, namely cannabis and methamphetamine. As Mr Ngor's mental state was influenced by use of illicit substances, his presentation would have varied considerably based on recency and nature of substance use. The psychoactive effects of cannabis and methamphetamine could have induced a sudden acute psychotic episode.

47. In the context of this relatively rapid decline in Mr Ngor's mental state, Ms Deng had limited opportunity to foresee that she was at high risk of harm and to take timely actions to raise the alarm and protect herself. Ms Deng had not previously been the subject of her son's violent behaviour and it appears that neither she nor her family were aware that she had become central to her son's delusional thinking on this occasion. For this reason, while she expressed some general fears in relation to Mr Ngor in the days preceding her death and while her elder son stayed over at the family home to reassure her in this regard, her family remained confident in the belief that Mr Ngor did not constitute a threat to her safety.

48. Unfortunately, Mr Ngor did not engage in help-seeking behaviours when his mental state became impaired and expressed an unwillingness to return to hospital to his family members. Ability to identify triggers or precursors to a psychotic episode is important in both the individual and those around them such as partners and family members. The development of a clear intervention and crisis plan can guide family members in their response to a deteriorating mental state in a loved one. Family education around psychotic symptoms and the need for early intervention is important.

49. From the evidence it is apparent that Orygen Youth Health engaged Mr Ngor's family in his care and treatment, including family meetings. It appears that Orygen Youth Health recognised the risk Mr Ngor posed during period of psychosis and sought to convey that to his family. When Mr Ngor resumed consumption of illicit substances and subsequently exhibited signs of ill health, his elder brother did seek assistance from Orygen Youth Health and scheduled an appointment.

50. Mr Ngor's disengagement from treatment began as soon as his CCO concluded in December 2012, removing any legal requirement that he engage in treatment. A CCO is a punishment imposed by the court for criminal behaviour; therefore completion of a CCO does not necessarily equate to a completion of treatment, or indicate there is no further need for mental

health care. The completion of a CCO should be seen by treatment providers as a milestone event to commence discharge planning to ensure adequate planning and transition.

FINDING

51. I am satisfied, having considered all of the evidence before me, that no further investigation is required.

52. I find that Athiel Deng died on 26 March 2013 and that the cause of her death was head injury.

53. Pursuant to rule 64(3) of the Coroners Court Rules 2009, I order that this finding be published on the internet.

I direct that a copy of this finding be provided to the following:
The family of Ms Deng,
Coroner's Investigator, Victoria Police; and
Interested Parties

Signature:

PETER WHITE
CORONER
Date: **13 April 2015**