IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 003665

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Aluel Ajak
Date of birth:	18 July 2013
Date of death:	5 July 2023
Cause of death:	Multiple injuries sustained in a motor vehicle incident (pedestrian)
Place of death:	Shaws Road, Werribee, Victoria
Keywords:	Public housing – child – disability – risk of absconding – housing transfer application – home modifications

INTRODUCTION

1. On 5 July 2023, Aluel Ajak was 9 years old when she passed away from injuries sustained when she was hit by a motor vehicle near her home. At the time of her death, Aluel lived in Werribee with her mother, Adit Deng, and her three siblings. She is also survived by her father, Atem Garang.

BACKGROUND

2. Since October 2016, Aluel had lived with her family in public housing at 144 Shaws Road, Werribee. Public housing is overseen by the Department of Families, Fairness and Housing (**DFFH**). The property was a corner block situated at the intersection of Glenda Street. A low-lying fence had been erected along the boundary facing Glenda Street and Shaws Road. Shaws Road is a busy road and consists of a single lane of traffic in either direction. The speed limit is 60 kilometres per hour.

3. Aluel's medical history included autism spectrum disorder, severe global developmental delay and moderate intellectual disability. She had been prescribed clonidine and risperidone by her paediatrician. She was predominantly non-verbal, and her mother and siblings supported her with all daily activities including dressing, washing, eating, sleeping and communicating.

4. Aluel received multiple disability support services funded by the National Disability Insurance Agency (**NDIA**), including occupational therapy, speech pathology, and specialist behaviour management and support coordination. Some of those services were provided by Ability Action Australia.[1] Ms Deng had also received support and assistance from Baptcare.[2]

5. Aluel displayed several challenging behaviours, including a tendency to wander from the family home. In her statement to police, Ms Deng described two occasions on which Aluel absconded from the home. On the first occasion, Aluel left during the day by the front door but was observed by family and redirected before she could venture too far from home. On the second occasion, Aluel left during the night and was later found by her mother at a supermarket on Tarneit Road.

6. Ms Deng stated that after the second incident, she contacted DFFH to inquire about obtaining improvements to the home, including enhancing security of the doors and windows and modifying the low-lying fence to mitigate the risk of Aluel absconding.

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[1] A registered NDIS provider of therapeutic, positive behaviour and supports across Australia.
[2] A faith-based non-profit organisation that provides support and services, including integrated family support services.

7. The issues regarding Aluel's ability to abscond from the home were well-known to her treating clinicians and service providers, many of whom authored letters in support of Ms Deng's requests to DFFH.

8. In a statement to police, Dr Deborah Morawetz, Aluel's treating paediatrician of IPC Health, recalled that Ms Deng had raised concerns on multiple occasions, as early as 2018, regarding the location of the family's public housing on a main road and the risk it posed to Aluel given her history of absconding and her ability to climb the low-lying fence. Further, Ms Deng expressed concerns to Dr Morawetz regarding the inability to lock the windows and the absence of a gate at the home. Dr Morawetz personally wrote to DFFH regarding these safety concerns on four occasions, on 24 January 2018, 29 November 2018, 24 June 2020 and 13 July 2022.

9. Ms Deng made three applications to the DFFH for housing transfers, supported by correspondence from Dr Morawetz, her family General Practitioner, and Aluel's National Disability Insurance Scheme (**NDIS**) care workers and allied health professionals, each of whom emphasised the risk posed by the house's location due to Aluel's history of absconding and her having no awareness of traffic or road safety. In the alternative, Ms Deng continued to seek improvements to the fence and locks for the windows.

10. At the time of Aluel's death, Ms Deng's application for priority transfer had been approved and she had been advised she would be contacted if a suitable property became available.

THE CORONIAL INVESTIGATION

11. Aluel's death 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.

12. 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.

13. 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.

14. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Aluel's death. The Coronial 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. The Court also obtained evidence directly from the DFFH and NDIA after conducting a Mention Hearing on 13 December 2023.

15. This finding draws on the totality of the coronial investigation into Aluel's death including evidence contained in the coronial brief. While 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.[3]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

16. On 5 July 2023, Aluel spent the day at home with her mother and siblings. They had dinner at around 6.00pm after which Ms Deng gave Aluel her prescribed dose of clonidine.

17. At around 7.40pm, Aluel had yoghurt in the living room with her mother before taking herself to bed. Ms Deng followed Aluel to her bedroom, which she and Aluel shared, and settled her into her cot. Ms Deng recalled that Aluel looked comfortable underneath her blanket and she left her to sleep.

18. At around 8.30pm, Ms Deng returned to the bedroom and observed Aluel to be asleep. She left the bedroom door open and went to the kitchen. Ms Deng then sat on the couch with her youngest child.

19. CCTV footage obtained from a neighbouring property depicted Aluel at around 9.02pm climbing outside the house from her bedroom window. She then stepped over the boundary fence and walked north along Glenda Street before turning east onto the footpath along the southern side of Shaws Road.

20. At this time, a motorist travelling west along Shaws Road recalled having to swerve to avoid Aluel who had been standing in the middle of the road.

[3] 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.

21. Almost immediately afterwards, another motorist was driving along Shaws Road, in an easterly direction. She was driving a blue 1997 Nissan Pulsar hatch. In her statement to police, she recalled that it was not raining and although the roadway was dark, she could see the road in front of her clearly with her headlights. She estimated that she was travelling at around 60 kilometres per hour when something struck her windscreen.

22. After pulling over and exiting her car, the motorist realised she had struck a person, who was later identified as Aluel. She sought assistance from passing motorists who contacted emergency services. They also provided assistance to Aluel but observed that she was unresponsive and not breathing. They commenced cardiopulmonary resuscitation (**CPR**). Victoria Police arrived a short time later and took over the performance of CPR.

23. Shortly after 9.00pm, Ms Deng's son drew his mother's attention to red and blue flashing lights outside the house. Ms Deng immediately went to her room and observed that Aluel was no longer in her cot. As the family left the house to look for Aluel, they were met by a neighbour and then they observed Aluel laying on the road receiving CPR.

24. Ambulance Victoria paramedics arrived at the scene at approximately 9.13pm and continued CPR. Despite their best efforts, responding paramedics were unable to revive Aluel and she was pronounced deceased at 9.30pm.

25. Police were shown to Aluel's bedroom, where they observed the partially open bedroom window and flyscreen that had been pushed outwards. Measurements taken by police at the scene estimated that Aluel was approximately 70 metres from home at the time of the collision, which occurred outside 148 Shaws Road.

26. The motorist later provided a blood sample for toxicological analysis, which did not detect any alcohol or illicit drugs. She was not charged with any offence arising from the collision.

27. A Victoria Police reconstruction expert examined the scene and assessed that Aluel had been walking or standing in the middle of Shaws Road at the time of the collision and that the motorist had not been driving at an excessive speed. It was dark at the time of the collision, but street lighting had been operating.

Identity of the deceased

28. On 6 July 2023, Aluel Ajak, born 18 July 2013, was visually identified by her mother, Adit Deng.

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

Medical cause of death

30. Forensic Pathologist Dr Linda Iles from the Victorian Institute of Forensic Medicine conducted an examination on 7 July 2023 and provided a written report of her findings dated 12 July 2023.

31. A post-mortem computed tomography (**CT**) scan showed serious and extensive injuries

32. Toxicological analysis of post-mortem samples identified the presence of hydroxyrisperidone.[4]

33. Dr Iles provided an opinion that the medical cause of death was *1(a) Multiple injuries sustained in a motor vehicle incident (pedestrian)*.

34. I accept Dr Iles's opinion.

HOUSING APPLICATIONS

35. DFFH manages social housing (including public housing) through Homes Victoria. Housing services are delivered across two teams, the Tenancy and Property Team (**TPT**) and the Housing Advice and Assistance Team (**HAAT**).

36. Housing applications which meet the relevant eligibility criteria are placed on the Victorian Housing Register (**VHR**).

37. The TPT is the primary contact for a renter and responsible for all aspects of the rental agreement between the renter and Homes Victoria, including requests for maintenance. The HAAT manages applications on the VHR.

38. On 1 November 2018, Ms Deng submitted a priority access transfer application which included supporting documentation from Dr Morawetz and Baptcare. In previous correspondence to DFFH dated 24 January 2018, Dr Morawetz had stated:

> "*The house is on a main road, which poses a significant safety concern for Aluel who is at high risk of absconding and is very adept at climbing fences, making the chance that she could abscond and accidently be hit by a car a real risk.*"

[4] A metabolite of risperidone, an antipsychotic drug effective against the positive and negative symptoms of schizophrenia.

39. On 2 November 2018, the application was assessed by the HAAT and was not approved for priority access transfer. Ms Deng was encouraged to discuss maintenance issues with the TPT. On 4 December 2018, a member of the TPT conducted a site visit at Ms Deng's home and she was advised that Housing Victoria could not alter the height of the front fence or install deadlocks on the doors. Further, it is a requirement for public housing that windows not have keyed locks.

40. On 7 May 2019, Ms Deng submitted her second priority access transfer application which included supporting documentation reiterating the risk presented to Aluel by the location of the house. On 7 May 2019, the application was assessed by HAAT and not approved.

41. On 26 November 2021, Ms Deng submitted her third priority access transfer application which included supporting documentation reiterating the risk presented to Aluel by the location of the house. The application was assessed by HAAT and approved on 22 February 2022 and placed on the VHR, awaiting the availability of a suitable property.

42. According to records provided by DFFH, Ability Action Australia and IPC Health both sought updates on Ms Deng's applications in June and September 2022, respectively. DFFH confirmed on each occasion that Ms Deng's applications had been approved and she was placed on the waiting list, however they were unable to provide a timeframe for her being offered alternative housing. Several factors were cited, such as "*limited availability and low turnover properties*", "*preferred location, bedroom size and the number of applications already [approved] on the Victorian Housing Register*".

43. There are many factors which can contribute to the delay experienced by an applicant for public housing, including the number of applicants, and the number of properties and their vacancy rates. There is a very high demand for public housing. As at September 2023, there were 6,149 transfer applications on the VHR in the priority access category.

44. DFFH has conceded, with the benefit of hindsight, that a number of things could have been done differently in processing Ms Deng's applications, including:

    a) Putting Ms Deng's first transfer application on hold while further information was sought to avoid the need for her to submit new applications;

    b) There could have been more effective consultation and coordination between the HAAT and TPT staff;

c) Consultation with a senior manager may have enabled lateral thinking about what could be done to better assist the family; and

d) There did not appear to have been any connection drawn between Ms Deng's various applications which would have enabled a cumulative assessment.

45. Homes Victoria have made a number of the changes since Aluel's death including the following:

a) Implementation of a range of improvements to reduce the likelihood of delays in processing maintenance requests (including increased resourcing and the engagement additional contractors);

b) New learning programs have been implemented for TPT and HAAT staff which cover location requirements and exemptions, and special accommodation requirements;

c) Strengthened communication between HAAT and TPT staff when processing transfer applications, through reviewing team practices and processes to ensure comprehensive assessments are completed and strengthening supervision, designed to ensure a coordinated single-system integrated response to the applicant;

d) HAAT staff are now required to escalate to their manager all priority transfer applications for current public housing renters where the renter is applying for a transfer due to modifications required for their current property. The HAAT manager is then required to notify the TPT manager of the applicant and their circumstances so that appropriate action can be taken by their staff, including making referrals and monitoring the progress of the transfer application. This process provides TPT staff with an opportunity to work with the renter and consider property modifications or strategies to mitigate risks, and support them to remain in their home safely while awaiting another property to become available; and

e) Implementation of learning programs for leadership teams and frontline staff to identify gaps and develop approaches to learn from the past, and support staff to reflect on and improve the way they work to support renters.

46. There was clear and unsatisfactory delay in the processing by Homes Victoria of Ms Deng's applications for improvements and a housing transfer. They were aware that Aluel was a very vulnerable child and they had been made aware of the safety risk posed by the location and

configuration of her public housing. Homes Victoria had been on notice of the risk for over five years. It is accepted that there is a very high demand for public housing and delay in processing applications is unavoidable. However, the delay in Aluel's case, given her extreme vulnerability, is unacceptable. Further, while the transfer application was being processed, Homes Victoria could have considered applying for a permit with the local council to install a higher fence.

NATIONAL DISIBILITY INSURANCE AGENCY INVOLVEMENT

47. Aluel was an NDIS participant and was in receipt of funding pursuant to her plan.

48. NDIA's responsibilities under the Supports for Participants Rules include "*home modifications for accessibility for a person in legacy public and community housing dwellings on a case-by-case basis*". It is noted, however, that in relation to requests for gates or fencing for public housing property, "*the Agency should consider whether the support is more appropriately provided by the public housing authority because it forms part of the authority's responsibility to maintain housing stock that meets the needs of people with disability*."

49. The NDIA received several communications from support services throughout 2019 to 2022 regarding Aluel's risk of absconding and increased safety risk. As the authors did not make specific recommendations or requests regarding the introduction of fencing or gates, each document was used to support and inform the development of Aluel's NDIS plans.

50. In February 2023, Aluel's support coordinator submitted a request for review of her NDIS plan, citing urgent modifications to submit to the Department to reduce Aluel's safety risk of absconding. However, Aluel's mother spoke with her Local Area Coordinator on 15 March 2023 and agreed to withdraw the request for plan review in favour of a scheduled reassessment "*to access additional supports for therapy and Assistive Technology and Home Modifications*".

51. On 24 March 2023, Aluel's new NDIS plan was approved and there is no record of any discussion regarding home modifications assessment with her occupational therapist, only in relation to increasing functional capacity.

52. The NDIA was aware that Aluel was a vulnerable child whose housing exposed her to a risk of harm from nearby traffic as a result of her absconding behaviour. It is accepted that the NDIA was subject to some constraints in their ability to directly and expeditiously address this risk. However, in my view, given the clear concerns identified by Aluel's NDIS support

coordinator and other care services, it was within the NDIA's remit to proactively assist Ms Deng to navigate a clearer and more direct path to obtain funding for improved security and fencing to mitigate Aluel's risk of absconding.

FINDINGS AND CONCLUSION

53. Having considered all of the circumstances, I am satisfied that Aluel's death was the result of a tragic accident. The motorist who was driving the vehicle that hit Aluel did not have a reasonable opportunity to take evasive action.

54. Aluel was a very vulnerable member of the community in that she was a child with disability and was being cared for by a single parent with limited resources.

55. Aluel's mother, treating clinicians and support workers were all very concerned about the risk posed to her by the location and configuration of the family's public housing. They diligently and repeatedly alerted DFFH and the NDIA to that risk and advocated for it to be mitigated through improvements to the house, and in relation to DFFH, a transfer to suitable alternate accommodation.

56. The system in place at DFFH at the time did not enable Ms Deng's application for a transfer of accommodation to be processed and actioned with sufficient urgency given the obvious risk. Further, the systems in place at DFFH and NDIA did not enable her requests for improved security and fencing to be processed and actioned with sufficient urgency.

57. It is unlikely that Aluel's risk of misadventure could have been eliminated by the transfer of her family to safer accommodation or the carrying out of improvements to the existing property. However, it would have significantly reduced that risk and may have prevented her from being able to so easily abscond from her home undetected as she did on the evening of her death. Aluel's tragic death has devastated her family but has also exposed the motorist and the first responders to significant trauma.

58. Pursuant to section 67(1) of the Act, I make the following findings:

    a) the identity of the deceased was Aluel Ajak, born 18 July 2013;

    b) the death occurred on 5 July 2023 on Shaws Road, Werribee, Victoria, from multiple injuries sustained in a motor vehicle incident (pedestrian); and

    c) the death occurred in the circumstances described above.

RECOMMENDATIONS

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

1. That Homes Victoria review their guidelines for the processing of priority access transfer applications to require that they be given particular urgency in circumstances where they are made aware that the location and/or configuration of the property creates a specific risk of serious harm to an occupant.

2. That the National Disability and Insurance Agency review its guidelines for processing requests for housing improvements for Victorian participants to require prompt and active liaison and coordination with Homes Victoria.

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

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

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

Adit Deng, Senior Next of Kin, c/- Maurice Blackburn Lawyers

Atem Garang, Senior Next of Kin

Transport Accident Commission

Department of Families, Fairness and Housing

National Disability Insurance Agency

Dr Deborah Morawetz

Commission for Children and Young People

Constable Marcus Barber, Coronial Investigator

Signature:

Coroner David Ryan

Date: 28 July 2025

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.