



ATTORNEY-GENERAL  
MINISTER FOR JUSTICE

Parliament House  
State Square  
Darwin NT 0800  
Minister.Paech@nt.gov.au

GPO Box 3146  
Darwin NT 0801  
Telephone: (08) 8936 5588

## REPORT TO THE LEGISLATIVE ASSEMBLY

Pursuant to section 46B of the *Coroners Act 1993*

In the matter of the Coroner's Findings and recommendations regarding the death of  
Mr Reginald Gugulpi Roy (also known as Reginald Yunupingu)

---

Pursuant to section 46B of the *Coroners Act 1993* (the Act), I provide this report on the findings and recommendations of Her Honour Local Court Judge Elisabeth Armitage, the Acting Territory Coroner, dated 20 May 2022, regarding the death of Mr Reginald Gugulpi Roy (also known as Reginald Yunupingu) (the Deceased) (refer Attachment A).

The Report includes the responses to the recommendations from Dr Frank Daly, Chief Executive Officer (CEO) of the Department of Health (DoH) (refer Attachment B) and Mr Ken Davies PSM CEO of the Department of Territory Families, Housing and Communities (DTFHC) (refer Attachment C).

The Deceased, a 17 year old Indigenous boy, died at 7.31 am on 15 October 2020, at Minyerri Health Centre, near Katherine. The Forensic Pathology report determined the cause of death as the consequences of reported mental disorder / psychosis (not otherwise specified) giving rise to high voltage electrical injury.

### Recommendations of the Coroner

The Acting Territory Coroner made the following recommendations:

- '53. I **recommend** that in addition to reforms stated in the Mental Health response, in cases where a young person from a remote community is receiving care in the Young Inpatient Unit, there should be a referral to Child and Adolescent Mental Health to engage relevant and appropriate service providers (including primary care agencies) to establish care arrangements and support for young people and their families within community;

54. I **recommend** that the Department Territory Families, Housing and Communities review the Central Intake Team Procedures and the Structured Decision Making Tool with a focus on incorporating the full section 20 considerations for when a child is in need of protection and deliver professional development for CIT Staff in relation to the revised practice; and
55. I **recommend** that the Department Territory Families, Housing and Communities include the "Further Inquiries" workflow/case type in the child protection response framework in the CARE case management system to be implemented in 2022.'

Further, the Acting Territory Coroner noted that 13 notifications received in relation to the Deceased, including reports made by his aunts and mother on 6 April 2020 explaining no family member in Darwin was capable of providing him care and that his mental condition was deteriorating, should have prompted concern and raised proper consideration as to whether the Deceased had suffered from cumulative harm.

The Acting Territory Coroner also noted the DTFHC post-incident review determined that the notification made on 6 April 2020 should have been 'screened in', rather than 'screened out', and warranted the conduct of a child protection investigation (refer paragraphs 46 to 48 of the Coronial Findings).

### **Responses to coroner's recommendations**

A copy of the Coronial Findings was provided to the CEOs of DoH and DTFHC on 20 June 2022, in accordance with section 46A(1) of the Act.

A written response was received from the CEO of DoH dated 18 August 2022, as required by section 46B(1) of the Act, advising that:

- The Top End Mental Health Services have implemented procedures for young people following their discharge from the Youth Inpatient Unit (YIP), comprising seven day follow-ups to be managed by the Child and Adolescent Mental Health Services (CAMHS) Community Team, with all discharges from YIP emailed to the CAMHS 'Intake Inbox' along with a discharge plan and up-to-date contact details.
- The CAMHS team is actively monitoring compliance with the seven day follow-up procedures for young people, which is a national key performance indicator for Mental Health Services that aims to address the need for early readmission.

In addition, DoH provided the following updates (attached to its letter dated 18 August 2022 and by subsequent email dated 3 October 2022) in connection with a number of reforms mentioned by Dr Luke Butcher, General Manager, Top End Mental Health and Alcohol and Other Drugs Service, at paragraph 43 of the Coronial Findings:

- A single point of entry to the Mental Health Service is now in place through a dedicated NT Mental Health Line, with resources and brochures being developed to publicise the health line number and single point of entry procedure.
- All relevant forms and discharge planning documents have been updated and uploaded to the Policy Guidance Centre in conjunction with an ongoing audit schedule to ensure compliance.

- YIP has adopted the 'MiYA Patient Journey Board' which outlines tasks associated with patient care, discharge plans and estimated discharge date.
- Upgrades to Electronic Patient Boards are progressing with revised target dates indicating completion by December 2022. Further, the Complex Client Needs and Solutions Working Group is updating the Terms of Reference to include review of patients who have a long length of stay on mental health inpatient units including YIP and will be considered as of October 2022.
- The Aboriginal Mental Health, Alcohol and Other Drug Community of Practice Committee was established to ensure 'the integration and collaborative care planning for Aboriginal patients' and conduct regular meetings on fortnightly basis.
- Roll out of 'ACACIA', a central health record digital database, is being undertaken in conjunction with the Department of Corporate and Information Services (now the Department of Corporate and Digital Development).
- The review of partnership arrangements with external mental health service providers is underway and this reform is anticipated to be completed by 31 October 2022. The Service Level Agreement with Headspace has been formally executed; the Service Level Agreement with Danila Dilba is currently undergoing formal approval; and the existing Service Level Agreement with TeamHealth is currently under review.

A written response was received from the CEO of DTFHC dated 21 August 2022, as required by section 46B(1) of the Act, accepting the recommendations and advising the following actions that DTFHC has taken to implement those recommendations:

Recommendation in relation to Central Intake Team (CIT) procedures, the Structured Decision Making (SDM) tool and section 20 of the *Care and Protection of Children Act 2007*

- a) DTFHC's Clinical and Professional Practice Leadership Directorate (CPPLD) developed a Practice Guidance resource for central intake workers, providing advice and direction on all aspects of receiving and gathering information, assessing, determining and recording outcomes with respect to intakes. The Practice Guidance will be implemented in conjunction with a practice intensive training session conducted by CPPLD at the end of the year.
- b) The Practice Guidance emphasises the use of SDM as a decision support tool not a decision maker, with frontline intake workers encouraged to use discretion to override the SDM when making a decision if appropriate to do so, including where relevant considerations under section 20 of the *Care and Protection of Children Act 2007* are relevant.

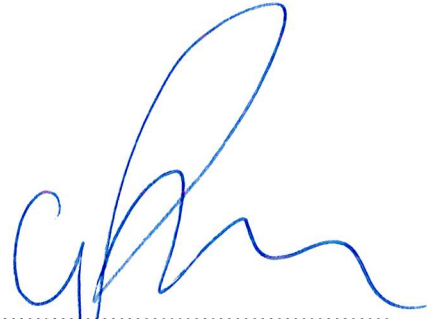
Recommendation in relation to the 'Further Inquiries' workflow/case type in the CARE case management system

- a) As part of the improved case management and decision-making tools for case workers in CARE, a new workflow type called 'Further Inquiries' is being developed to assist with intake cases where more information is required to determine the next steps, prompting additional engagement with parents, family members and relevant stakeholders and the exploration of options at this point of the workflow.

- b) Establishment of a 360 Degree View of a Child Data Hub, that facilitates information sharing between relevant agencies and service providers, reducing the need for children to repeat their story while assisting in the development of a holistic understanding of a family's circumstances and delivery of timely care and protection services.

I am satisfied that the CEOs of DTFHC and DoH have considered the recommendations of the Acting Territory Coroner and that they are taking necessary steps to implement the recommendations.

DATE: 10/10/22



.....

CHANSEY PAECH