CITATION:	*Inquest into the death of Reginald Gugulpi Roy aka Reginald Yunupingu* [2022] NTLC 009
TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0160/2020
DELIVERED ON:	20 May 2022
DELIVERED AT:	Darwin
HEARING DATE(s):	15, 16 March 2022
FINDING OF:	Judge Elisabeth Armitage
CATCHWORDS:	**Sixteen year old lost to mental health follow up shortly after being discharged from inpatient unit, died due to high voltage electrocution**

REPRESENTATION:

Counsel Assisting:	Kelvin Currie
Counsel for Health:	Tom Hutton
Counsel for Territory Families:	Maria Pikoulos
Counsel for Dr Nandini Das	Sally Ozolins

Judgment category classification:	B
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0160/2020

In the matter of an Inquest into the death of

REGINALD GUGULPI ROY AKA REGINALD YUNUPINGU

ON: 15 October 2020
AT: MINYERRI

FINDINGS

Judge Elisabeth Armitage

Introduction

1. The deceased's mother indicated that the deceased should be referred to by his first name, Reginald or 'Reggie'. Reginald was born 12 September 2003 in Ngukurr to Roseanne Roy and Daniel Yunupingu. Both his parents attended the inquest. I thank them both for their participation and offer my sincere condolences for the loss of their son in traumatic circumstances.

2. Reginald mainly lived between Ngukurr Community and Jilkminggan Community, primarily with maternal aunts and uncles. He was known as a quiet child who was fun to be around. His father and his paternal aunts and grandmother lived in Darwin. In more recent years, his father was diagnosed with schizophrenia and lived in assisted accommodation. His mother lived in Katherine and had sporadic contact with Reginald.

3. Reginald went to primary schools in Ngukurr and Jilkminggan. Results of a 2013 school psychology report confirmed he had an intellectual impairment. He also suffered from mild conductive hearing loss. His school attendance rates declined from when he was 10 years of age. By the time he was 14 he

attended school about 20% of the time. From 2018 onwards Reginald did not attend school.

4. Between 29 September 2009 and 6 April 2020 the Department of Children and Families and Territory Families received thirteen notifications concerning the wellbeing of Reginald. The notifications included concerns about him being exposed to and being the victim of domestic violence. The primary perpetrator was a partner of his mother, who spent time in custody in respect of some incidents of violence.

5. On 18 April 2017 there was an Application for Assessment sent to the Volatile Substance Abuse (VSA) team by the local Health Centre. It was alleged that Reginald was one of four youths caught petrol sniffing. No further reports of petrol sniffing were received and the application was closed on 10 August 2017 without the assessor seeing Reginald.

6. By Christmas 2018 Reginald's mother said that he was hearing "evil". On 4 July 2019 his uncle said he was found with a container of petrol. He was reported to be behaving strangely. The fuel was taken off him.[1] During the same year his family observed him to be experiencing visual and auditory hallucinations.

7. In early 2020 he and his younger sister were with family in Katherine for a funeral ceremony. He was acting bizarrely and aggressively and on 20 January 2020 his family took him and his sister to Katherine District Hospital. While waiting for an assessment at the hospital, he ran away. He was brought back with police assistance in an ambulance the next day. He was uncooperative, agitated and threatening and required significant doses of psychotropic medication to safely manage his behaviour. He was sent by Careflight to the Youth Inpatient Unit and admitted into the Youth Inpatient Program (YIP) at Royal Darwin Hospital.

[1] Sunrise Health records

8. He was assessed as being acutely psychotic and sectioned under section 39 of the *Mental Health and Related Services Act*. The diagnostic impression was of "first episode psychosis in context of cannabis and brain injury from chronic volatile substance use".[2] This psychosis was considered intense and complex. Within hours of arrival in YIP he became combative. He escaped the ward and was brought back by an Aboriginal Liaison Officer. Initially he had a one-on-one "security special" with him. He was noted to be aggressive toward staff and displaying odd and disorganised behaviours. He was experiencing auditory hallucinations with themes of the devil and a number of "clever men" with long hair who were following him. However, over the next two weeks he improved a little. On 3 February 2020 Reginald's inpatient status was changed to voluntary.

9. At a review meeting on 10 February 2020 his father said that after release Reginald would stay with family in Darwin. Planning commenced to identify a discharge residence and, because it was planned he would stay in Darwin, the clinicians organised for the Headspace Youth Early Psychosis Program (hYEPP) team to visit him in the inpatient unit in the expectation that they would support him as an outpatient when discharged.

10. His behaviour escalated again on 11 February 2020 after traditional healers visited. He ran away from his father and staff when being escorted for a scan. On 13 February 2020 he was once again sectioned (s39). His inpatient status changed back to voluntary on 17 March 2020.

11. In conversations with YIP staff Reginald admitted that he had been sniffing volatile substances before entering YIP and an application for an assessment to the Volatile Substance Abuse team was made. On 18 March 2020 he was assessed by the Volatile Substance Abuse team. During this assessment he said he had not used volatile substances since living in Jilkminggan in 2017.

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[2] Department of Health Form 13 Notification and Clinical Details Supporting Involuntary Admission dated 18/02/20

That was unlikely to be true given his admission of use to YIP staff, his presentation at Katherine District Hospital and noting that petrol was taken off him in mid-2019. However, he was assessed as low risk while on the ward and there was no further involvement by the team.

12. While in YIP he attended school classes. He was said to be operating at "transition level", well below his chronological age. On 2 April 2020 the Community Allied Health Team commenced, but were unable to complete, a developmental and functional assessment of Reginald. Additional components of the assessment were delayed because of COVID-19 and, although it was planned that the additional components would be completed after he left the hospital, COVID-19 prevented this from happening.[3] Based on the completed components of the assessment, it was identified that Reginald suffered from: severe receptive, expressive and pragmatic language difficulties; below average fine motor and visual motor skills; intellectual impairment and hearing loss. The completed components strongly indicated that Reginald had significant support needs, and likely met the diagnosis of Neurodevelopmental Disorder associated with Fetal Alcohol Spectrum Disorder (FASD). Substantial and detailed recommendations were made concerning his need for further assessments and therapeutic interventions including: paediatric and psychological review, ongoing mental health monitoring and input, referral to NDIS, speech pathology, occupational therapy, school reengagement and transition out-of-school supports. None of these recommendations were progressed.

13. On 12 March 2020 the family were referred to FACES (Family and Children's Enquiries and Support), a Territory Families telephone service that links families to relevant services.[4] However, there was no evidence of any successful engagement between FACES and Reginald's family.

[3] Additional document 11; Email from Top End School of Flexible Learning to Registrar YIP dated 2 April 2020
[4] Affidavit of Wilton Wilton dated 8 March 2022, Annexure WW-3

14. Reginald and his sister were discharged from the Youth Inpatient Unit on 31 March 2020. At the time he was suffering only "low grade psychotic symptoms" and he was discharged with a diagnosis of "schizophrenia, polysubstance abuse – volatile substances and THC, and intellectual disability". It was identified that if he was not appropriately supervised, he was considered to have a moderate to chronic risk of misadventure and a moderate to high risk of substance abuse (cannabis and volatile substances).

15. Frequently, patients discharged from YIP are referred to the Child and Adolescent Mental Health Services (CAMHS) for on-going outpatient care. However, because Reginald had early psychosis and the plan was for him to remain in Darwin, he was referred to Headspace. In preparation for this discharge plan, Headspace practitioners had already been involved in his care while he was in YIP.

16. Both Reginald and his sister were discharged to the home of a paternal aunt. His aunt lived in a two bedroom unit with her mother (the children's paternal grandmother), her two year old daughter and another young male. While there had been discharge planning discussions with Reginald's paternal grandmother and father, and to a somewhat lesser extent with his mother, the aunt had not participated directly in those discussions. It was explained to the paternal grandmother and father that Reginald would require a high level of supervision and care which those family members agreed to provide. However, given the high levels of assistance Reginald received on the ward, it was recognised that the family may struggle with his care needs and it was identified that Reginald might require assisted accommodation. It was not optimal discharging Reginald and his sister into the home of an aunt who the clinicians had not met and to whom the complexities of his condition had not been explained.[5]

[5] Evidence of Dr Das transcript p 21

17. On the date of discharge Reginald was said to be “bright and cheerful, calm and cooperative”. He agreed to comply with monthly depot injections (Aripiprazole 400mg). He was dropped off at the aunts house with his father and sister.

18. The next evening (1 April 2020 at 8.30pm) the aunt, to whose home he was discharged, called the Mental Health Line because she was concerned about his behaviour. She said that Reginald had paced the house all night and “disappeared” that morning and had not returned. She was worried about his mental health and non-compliance with COVID-19 restrictions. She was told that on his return she could either call the police who could take him to the emergency department or she could call back to receive advice regarding his mental health.

19. On 3 April 2020 at 12.06pm the aunt rang the YIP Social Worker. She said that Reginald disappears for hours and she was unsure if he was using substances. She said he was not sleeping or eating. She requested a home visit. She was again told that if she thought his mental health was deteriorating she should contact the Mental Health Line and if she had safety concerns she should contact the police. On this day police attended Knuckey Camp. They spoke to Reginald who was with another aunt and they described him as quiet, placid and compliant.[6]

20. The aunt called the Mental Health Line the next day, 4 April 2020 at 4.45pm. She said Reginald was walking in and out of the house day and night and leaving the door wide open, he was not listening to her, not sleeping or eating and was talking to himself. She was not happy, he was sent to her without her permission and she did not want Reginald staying with her. She said she had concerns for herself and her baby. She was again

[6] NT Police Summary case 9263992

told that if she had safety concerns she should call the police and to call the Mental Health Line when he returned so that a clinician could talk to him.

21. The aunt called the Social Worker the next day, 5 April 2020. She said that Reginald and his sister had been discharged to her house without consultation and that she could not look after them in her two bedroom unit with her baby and her mother (Reginald's paternal grandmother) on dialysis. She wanted to know why they could not be sent back to community. She sounded distressed. The Social Worker said he would need to call her back with a possible plan. The aunt was advised to ring emergency services if necessary but the aunt said she was not confident police would assist if she called as she had experienced being "dismissed" by police in the past.

22. On 6 April 2020 The Mental Health Access Team (MHAT) met and discussed Reginald and his sister. They planned to contact the aunt to arrange an urgent medical review, however the MHAT were subsequently informed that Reginald was in the care of Headspace and the MHAT "should not interfere".[7] Later the same day, at 12.40pm, Headspace spoke to the aunt. The aunt seemed confused as to who Reginald's carer was and said that he could not stay with her but that she would support him to get to Headspace for his appointment on 8 April 2020.

23. Another aunt called the YIP Social Worker on 6 April 2020 at 3.14pm. She requested a referral to Territory Families for supported accommodation "as no one in the family was in a position to adequately look after him in Darwin". The Social Worker contacted the aunt where Reginald was living. The aunt said that although she had initially agreed for the children to come, Reginald's behaviour was a concern and she would like the children sent back to community.

[7] Affidavit of Mr Luke Butcher dated 8 March 2022 at [180]

24. The Social Worker then rang Territory Families. Territory Families notes of the conversation include the following statements:

- Reginald is still mentally unwell.
- There is no one able to supervise or care for him in Darwin.
- His father has his own mental health issues and stays in a shelter so cannot assist.
- (His mother) has not been his …main carer for years.
- There are no safe persons in Darwin capable of caring for the children.
- The children are very vulnerable at this time as they are not obeying the requests from their aunts.
- Aunty has no control over him and he is very vulnerable.
- Aunty was going to speak with Larrakia Nations to support financially in getting the children back to Ngukurr community.
- Nil stable carer is available in Darwin for either child.

25. The notification was referred to the Territory Families assessment team. Their assessment concluded, "Although the notifier has identified some concerns regarding the care and wellbeing of the children, there is still insufficient information to suggest that the children have been neglected or placed at risk of neglect due to no care(r) being willing or able to meet their needs. Due to the insufficient information received it is recommended that the intake remain screened out". It was further determined that, "There are no immediate safety concerns that have been identified that would warrant statutory intervention for Reginald". The referral was "screened out" because it did not meet the "definition of harm". However, the family were again referred to FACES.

26. That same afternoon (6 April 2020 at 4.36pm) Reginald's mother rang the Mental Health Line. She was concerned that Reginald's mental state was deteriorating. She said he walked around the house at night talking to himself and not sleeping. The call taker then spoke to his father who expressed similar concerns. The call taker then spoke to Reginald who said he was "fine" and handed the phone back to his mother.

27. The following day (7 April 2020 at 9.45am) Reginald's mother called Headspace. She said that he was continuing to have command hallucinations that told him to go for walks and to get a rope. She requested that he be reviewed that day. A review was organised with the psychiatrist at 2.00pm. The psychiatrist was of the opinion that his presentation was similar to what it had been at the date of discharge from YIP. Reginald told the psychiatrist that he wanted to get back to Ngukurr and that his father was arranging bus tickets.

28. On 9 April 2020 Reginald attended Headspace with his father and received his depot medication. It was noted that he was still suffering from low grade psychotic symptoms. His next depot was due on 9 May 2020 and his father had the script. There was discussion between the Headspace psychiatrist and the consultant at YIP about the consultant arranging further follow up for Reginald in Katherine.

29. That was the last time Reginald was seen by any health services in Darwin or elsewhere. On 14 April 2020 the Headspace nurse contacted the aunt with whom it was thought he was staying. The aunt said that his mother had taken Reginald and his sister "the other day" and that they were staying at Knuckey Lagoon. On 16 April 2020 Headspace advised the YIP that they would be closing their file. The YIP consultant replied that YIP would send the discharge summaries to the local clinic. Emails were sent although there was no record of those in the electronic health records.

30. It was in the early stages of COVID-19, biosecurity measures were in place for communities, and movement into and out of communities was restricted. Although the parents spoke of their plans to take the children back to a community, it is likely that Reginald stayed around Darwin or Katherine for some months. Records from the father's assisted living residence indicate Reginald visited his father there on 31 May 2020 and on 19 June 2020 his father told staff that his son was still in Darwin. However, at some point his mother took him to Ngukurr and then to Minyerri where he stayed with maternal aunts at Lot 95. It is not known when Reginald arrived in Minyerri.

31. His relatives in Minyerri said that while he was in the community he liked to wander and he liked to climb structures, particularly onto the roofs of houses, something he had been known to do from a much younger age.[8] Two weeks prior to his death family found him 50 kilometres south of Minyerri, walking along a road. He was alone. He was unable to explain why he was there.

32. At about 5.30am on 15 October 2020 Reginald left the residence of his aunt walking towards the police station. At the front of the police station is a power pole with a transformer and high voltage wires. Reginald climbed the power pole and came in contact with one of the wires. He was electrocuted and fell to the ground, landing on his stomach. He was found shortly after with electrical burns to his face, arms, hands, torso and feet. The local school principal came to assist. Reginald was making a raspy sound. He was placed in the recovery position and the school principal called the Health Centre.

33. By the time the Health Centre's staff arrived he had no pulse. Cardiopulmonary resuscitation was commenced and he was transported to the Health Centre. However he could not be revived.

[8] On 10 June 2014 he was admitted to Katherine District Hospital with a fractured humerus having reportedly fallen from a roof.

34. An autopsy confirmed that he died from high voltage electrical injury. The Forensic Pathologist, Dr Marianne Tiemensma, in part stated:

SUMMARY OF MAIN PATHOLOGICAL FINDINGS

- External examination showed:
  - The body of a slender, clad teenage male.
  - Multiple high voltage electrical burn marks to the body including flash burns to the face and neck, numerous electrical burn injuries to the upper limbs and torso, and typical "exit" burns on both feet.
  - Singeing of the scalp hair.
  - The clothing of the decedent, including a cap, shirt, socks and shoes showed some charring and defects overlying some of the cutaneous electrical injuries, including a gaping charred defect on the sole of the left shoe. White paint marks were seen on the back and front of the shirt.
  - No other injuries were visible.

- Internal examination showed:
  - Smear subdural haemorrhage and blush subarachnoid haemorrhage.
  - Internal lung lacerations (with pleural surfaces intact) and contusions, with macroscopic evidence of blood aspiration.
  - Approximately 960 ml of blood in the peritoneal cavity.
  - Liver laceration with deep internal maceration of the liver tissue.
  - Multiple spleen lacerations.
  - Pancreatic and mesenterial contusion.
  - Resuscitation injury (contusion of the anterior intercostal muscles).
  - No significant underlying natural disease.

- Histological examination confirmed:
  - Electrical burn marks of the skin.
  - Multi-focal agonal aspiration of stomach contents.
  - Pulmonary oedema.
  - Coagulation necrosis of the spleen and liver, suggestive of visceral electrical injuries.
  - No significant underlying natural pathology.

- Samples have been collected for toxicological analysis.

PATHOLOGIST'S COMMENT

- This was the death of a male teenager who was found outside the Minyerri police station on the morning of 15/10/2020, at the base of a power pole. Ongoing behavioural and mental disturbance of the decedent for approximately 2 years prior to the incident was described in the available medical notes, however no specific psychiatric diagnosis was available.
- Numerous electrical burn marks were present on the body (face, neck, both hands and arms, and torso), with typical "exit" burns on both feet, suggesting that multiple electrical currents passed through the body.
- High voltage electrocution may result in visceral damage, however in this case, the decedent likely fell from a height, and it is not possible to state with certainty whether the internal organ damage (lung, spleen, liver, and pancreatic injury) was a result of the fall (i.e. secondary injuries), the effects of the electrical currents that passed through the body (primary injury), or a combination. Histological examination of the spleen and liver showed areas of coagulation necrosis in the spleen and liver, suggestive of electrical visceral injury.
- Death in high-voltage electrocutions usually results from cardiorespiratory arrest or electrothermal injuries caused by heat generated by the electrical current(s).

OPINION AS TO MEDICAL CAUSE OF DEATH

Disease or condition leading directly to death:	**1 (a) Consequences of high voltage electrical injury**
Morbid conditions giving rise to the above cause:	**1 (b) Reported mental disorder/psychosis (not otherwise specified)**

Issues

Mental Health Service

35. As I expressed during the course of the inquest, this was not a child that "fell through the cracks" of service delivery, it was as if he fell from a cliff. Nine days after discharge he was lost to follow up. He did not see or speak to a health professional after 9 April 2020. He did not receive his monthly depot medication in the six months that followed. It appears that there was no effective follow up of Reginald because there was no person or organisation that understood it to be their role to ensure continuity of his care.

36. As he was discharged to live in Darwin, initial follow up was undertaken by Headspace who saw him on 7 and 9 April 2020. However, when the family told Headspace that Reginald was returning to a community (perhaps Roper River or Galiwinku), Headspace asked the YIP to send referrals to the Katherine Mental Health Service and the community clinics. This was an unusual request, the usual practice would be for Headspace (as the out-patient service provider) to provide the referrals. However, having understood that the consultant doctor in YIP would send the referrals, Headspace closed its case with Reginald.

37. While the consultant doctor in YIP obliged the unusual Headspace request, and sent the referrals, the YIP (an inpatient service) did not retain or resume responsibility for Reginald's out-patient care.

38. Other support services or networks that might have been available to support Reginald and his family failed to engage with the family. The MHAT were advised not to interfere as Reginald was in the care of Headspace. The Volatile Substance Abuse team did not follow him up after discharge because it assessed that there was no evidence of him using such substances since 2017 and his referral was closed on 5 May 2020. Although it was

planned for Reginald to attend the Top End School of Flexible Learning, the school was closed due to COVID-19. In addition, although the family were referred to Territory Families FACES on two separate occasions, FACES never successfully engaged with the family.

39. Following his death the Mental Health Service undertook an 'In-Depth Review'. That was completed on 9 September 2021. However, it was determined that an inquest should be held to further investigate why Reginald was lost to mental health care.

40. The institutional response by Mental Health was provided by the General Manager of the Top End Mental Health and Alcohol and Other Drugs Service, Dr Luke Butcher. He identified a number of issues relating to the coordination of Reginald's care including that: the discharge summary was not completed in a timely fashion; the case file was not closed after discharge (primarily due to delay in completion of the discharge summary); and there was a lack of clarity between YIP (an inpatient unit) and Headspace (an outpatient service) about each of their obligations and responsibilities. That there was a lack of clarity on the part of the family as to who had responsibility for Reginald's outpatient care was readily apparent from the phone calls the family were making following his discharge. The family variously contacted the YIP Social Workers, the MHL and Headspace. Without a single point of call, there was a risk that the full picture of their concerns about Reginald's apparent deterioration and vulnerabilities could be missed.

41. In addition, Dr Butcher concluded that the MHAT should not have been excluded from Reginald's outpatient care. Dr Butcher considered that the MHAT should have conducted a consultation with Reginald and/or provided a referral to the Child Adolescent Mental Health Service (CAMHS) for joint management of his outpatient care with Headspace.

42. Ultimately, Dr Butcher identified that Reginald was not provided with "consistent and ongoing care at all points of the care continuum".

43. In response to these issues, Dr Butcher indicated that a number of reforms would be made, including that:

- From 1 June 2022 there will be a single point of entry to the mental health service through the Mental Health Assessment Team's Mental Health Line;
- Discharge planning will start on admission and the admission policy will be revised to focus on planning for discharge, engagement of Allied Health, and engagement of Aboriginal Mental Health Workers;
- Each patient will have a "journey board" to ensure a common understanding among staff as to the tasks that need to be completed during the patients care, and to clearly articulate a focus on discharge planning;
- Patient dashboards will be established to prompt care escalation and secondary review for patients with extended stays in the YIP;
- The Aboriginal Mental Health and Drug and Alcohol Community of Practice will be established to ensure "the integration and collaborative care planning for Aboriginal patients".
- Patient medical records will be held in a central database, ACICIA, which will provide an "integrated view of clinical information within a single login". In addition, the system will have the ability to "report on overdue services and unattended appointments, to ensure that patients are not lost to follow up".
- Partnership arrangements, including with Headspace, will be reviewed "to ensure arrangements support role delineation between agencies

and provide support for stepped care approaches where patients are deteriorating".

44. However, the reforms did not identify the person or entity responsible for a young person once discharged. I asked that consideration be given to that issue. The Department of Health provided a proposed recommendation that I will adopt below.

Territory Families

45. Section 20 of the *Care and Protection of Children Act 2007* (the Act) identifies when a child is in need of care and protection in these terms (emphasis added to (c)):

> **20 When child is in need of care and protection**
>
> A child is in need of care and protection (***child is in need of protection***) if:
>
> (a) the child has suffered or is likely to suffer harm or exploitation because of an act or omission of a parent of the child; or
>
> (b) the child is abandoned and no family member of the child is willing and able to care for the child; or
>
> (c) **the parents of the child are dead or unable or unwilling to care for the child and no other family member of the child is able and willing to do so**; or
>
> (d) the child is not under the control of any person and is engaged in conduct that causes or is likely to cause harm to the child or other persons.

46. Section 20(c) provides that where parents and other family are unwilling or unable to care for a child, the child is in need of care and protection. The information that there were "no safe persons in Darwin capable of caring for

the children" and that they were vulnerable should have prompted concern. Prima facie they were children that may have been in need of care and protection. That information should have been sufficient to ensure the referral to Territory Families was not "screened out".

47. Moreover, this was the thirteenth notification Territory Families had received in relation to Reginald. The combined history of referrals should have raised proper consideration as to whether or not Reginald had suffered from cumulative harm.

48. After Reginald's death Territory Families undertook a case review. It determined that the notification on 6 April 2020 should have been screened in and a child protection investigation should have been conducted.[9] It went on to say that if the same circumstances arose today the response of Territory Families would "highly likely" be different due to the introduction of the Signs of Safety tools and the Multi-Agency Community and Child Safety Teams.

49. However, during the course of the evidence it became less clear that a similar referral would not be screened out. It seems that the assessment tools used by Territory Families are weighted in favour of section 20(a) of the Act, and in particular "harm caused by a parent", and limited weight is given to the circumstances provided for by sections 20(b) – (d) of the Act.[10]

50. Territory Families responded by providing draft recommendations. In my opinion they are appropriate and I will outline them below.

Comment

51. This was the tragic death of a 17 year old who was not afforded basic mental health care for a period of over seven months after he left the Youth Inpatient Unit at Royal Darwin Hospital. He had been in the inpatient unit

[9] Transcript dated 15 March 2022 at pp 66, 73
[10] Transcript dated 15 March 2022 pp 69-70

for almost 10 weeks. While there he was well cared for and his mental health improved. Those from the inpatient unit that gave evidence were genuinely affected by his death. That is understandable given the lengthy period they cared for him. Tragically, within 9 days of his discharge into the community he was lost to mental health services.

52. Pursuant to section 34 of the *Coroners Act*, I find as follows:

(1) The identity of the deceased is Reginald Gugulpi Roy aka Reginald Yunupingu, born on 12 September 2003 at Ngukurr in the Northern Territory.

(2) The time of death was 7.31am on 15 October 2020. The place of death was Minyerri Health Centre.

(3) The cause of death was the consequences of high voltage electrical injury due to mental disorder/psychosis**.**

(4) The particulars required to register the death:

1. The deceased was Reginald Gugulpi Roy aka Reginald Yunupingu.

2. The deceased was of Aboriginal descent.

3. The deceased was not employed.

4. The death was reported to the Coroner by the Minyerri School Principal.

5. The cause of death was confirmed by Forensic Pathologist, Doctor Marianne Tiemensma.

6. The deceased's mother was Roseanne Roy and his father, Daniel Yunupingu.

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 Youth 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 Inquires" workflow/case type in the child protection response framework in the CARE case management system to be implemented in 2022.

Dated this 20th day of May 2022.

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ELISABETH ARMITAGE
TERRITORY CORONER