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**JURISDICTION** : CORONER'S COURT OF WESTERN AUSTRALIA  
**ACT** : CORONERS ACT 1996  
**CORONER** : Michael Andrew Gliddon Jenkin, Coroner  
**HEARD** : 11 FEBRUARY 2025  
**DELIVERED** : 17 FEBRUARY 2025  
**PUBLISHED** : 17 FEBRUARY 2025  
**FILE NO/S** : CORC 34 of 2023  
**DECEASED** : Bubba E

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*Legislation:*

*Coroners Act 1996 (WA)*

*Child and Community Services Act 2004 (WA)*

**Counsel Appearing:**

Mr D McDonald appeared to assist the coroner.

Ms M Watson (State Solicitor's Office) appeared on behalf of the Department of Communities.

Ms G Papalia (Aboriginal Legal Service of WA Inc.) appeared on behalf of Bubba E's family.

**SUPPRESSION ORDER**

**On the basis that it would be contrary to the public interest, I make the following order pursuant to section 49(1)(b) of the Coroners Act 1996 (WA): There be no reporting or publication of the deceased's name and/or any evidence likely to lead to the child's identification. The deceased is to be referred to as "Bubba E".**

**MAG Jenkin, Coroner (11.02.25)**

Coroners Act 1996  
(Section 26(1))

**RECORD OF INVESTIGATION INTO DEATH**

*I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of **Bubba E** with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 11 February 2025, find that the identity of the deceased person was **Bubba E** and that death occurred on 3 September 2023 at Millstream Road, Fortescue, from Multiple Injuries in the following circumstances:*

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## INTRODUCTION

1. Bubba E was eight-years of age when she died from multiple injuries following a car crash on 3 September 2023.<sup>1,2,3,4,5,6</sup> At that time, Bubba E was in the care of the Director General of the Department of Communities (the Department),<sup>7</sup> and was therefore a “*person held in care*” and her death was a “*reportable death*”.<sup>8</sup>
2. In such circumstances, a coronial inquest is mandatory and where, as here, the death is of a person in care, I must comment on the quality of the supervision, treatment, and care the person received. I conducted an inquest into Bubba E’s death on 11 February 2025, which was attended by members of her family.
3. The inquest focussed on the supervision, treatment and care Bubba E received while she was in care, as well as the circumstances of her death. The documentary evidence tendered at the inquest consisted of one volume, and the following witnesses gave evidence:
  - a. Det. Sen. Const. Glenn Burley (Investigating officer);<sup>9</sup> and
  - b. Mr Glenn Mace (Executive Director Service Delivery).<sup>10</sup>
4. On the basis that it would be contrary to the public interest, I made an order on 10 February 2025, suppressing Bubba E’s name and any evidence likely to identify Bubba E. The terms of that order are set out on the cover page of this finding.<sup>11</sup>
5. In order to protect Bubba E’s identity, I have referred to her mother as “Ms A”, her father as “Mr B”, her foster carer as “Ms C”, and her siblings as “DW” and “JJ” in this finding. No disrespect is intended to any person.

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<sup>1</sup> Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (03.09.24)

<sup>2</sup> Exhibit 1, Vol. 1, Tab 2, Report - Det. Sen. Const. G Burley (31.03.24)

<sup>3</sup> Exhibit 1, Vol. 1, Tab 3, Life Extinct Forms (03.09.23)

<sup>4</sup> Exhibit 1, Vol. 1, Tab 4, P92, Identification of Deceased Person - Visual Means (03.09.23)

<sup>5</sup> Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (23.10.23)

<sup>6</sup> Exhibit 1, Vol. 1, Tab 5.1, Post Mortem Report (07.09.23)

<sup>7</sup> Exhibit 1, Vol. 1, Tab 21, Report - Mr G Mace, Department of Communities (17.06.24)

<sup>8</sup> Sections 3, 22(1)(a) & 25(3), *Coroners Act 1996* (WA)

<sup>9</sup> Exhibit 1, Vol. 1, Tab 2, Report - Det. Sen. Const. G Burley (31.03.24) and ts 11.02.25 (Burley), pp6-18

<sup>10</sup> Exhibit 1, Vol. 1, Tab 21, Report - Mr G Mace, Department of Communities (17.06.24) and ts 11.02.25 (Mace), pp18-31

<sup>11</sup> Section 49(1), *Coroners Act 1996* (WA)

## MANAGEMENT OF BUBBA E

### *Background*<sup>12</sup>

6. Bubba E was born in Tom Price in 2015, and was eight years of age when she died.<sup>13</sup> She had two siblings (DW and JJ) and a half-sibling, and she was attending primary school, which she enjoyed. Bubba E had no significant health or medical issues, and was not receiving treatment for any chronic illnesses at the time of her death.<sup>14,15</sup>

7. In a report prepared for the Court, Mr Mace (the Department's Executive Director Service Delivery) outlined numerous concerns regarding the welfare of Bubba E and her siblings, and noted:

It is important to highlight that (the Department) have had long term involvement with (Bubba E) and her family, throughout the course of (Bubba E's) life. (AB's) biological mother passed away when she was young and (AB) was raised by...(her mother's sister) who in kinship terms is considered as her mother. There were issues of alcohol abuse and domestic violence (FDV) within this household, as well as involvement with (the Department).<sup>16</sup>

8. In a statement provided to the Court, Bubba E's mother described Bubba E as an affectionate child who "*had a big smile that would go all the way back to her ears*". Bubba E enjoyed camping, fishing, riding, swimming, and travelling to new places. Bubba E also had a very close relationship with her family, especially her siblings, and she enjoyed spending time with them.<sup>17</sup>

9. It is very clear from her mother's statement that Bubba E was a dearly loved little girl, whose death was a terrible shock to, and is keenly felt by, her family and friends.<sup>18</sup>

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<sup>12</sup> Exhibit 1, Vol. 1, Tab 21, Report - Mr G Mace, Department of Communities (17.06.24)

<sup>13</sup> Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (03.09.24)

<sup>14</sup> Exhibit 1, Vol. 1, Tab 22, Medical Records - Tom Price Medical Centre

<sup>15</sup> Exhibit 1, Vol. 1, Tab 28, Statement - Ms A (04.02.25)

<sup>16</sup> Exhibit 1, Vol. 1, Tab 21, Report - Mr G Mace, Department of Communities (17.06.24)

<sup>17</sup> Exhibit 1, Vol. 1, Tab 28, Statement - Ms A (04.02.25), paras 8-24

<sup>18</sup> Exhibit 1, Vol. 1, Tab 28, Statement - Ms A (04.02.25), paras 27-31

*Bubba E is taken into care*<sup>19</sup>

10. On 3 September 2022, Bubba E and two of her siblings (DW and JJ) were taken into the care of the Director General “*on the grounds of substantiated harm as a result of Neglect, Physical Abuse, and Emotional Abuse*”. Bubba E and her siblings were placed into the care of their maternal grandmother (Ms C) under an Interim Placement Arrangement.<sup>20</sup>
11. On 30 March 2023, by way of a consent order, the Children’s Court of Western Australia granted the Department a protection order for two years in respect of Bubba E and her siblings. Having carefully considered the available evidence (which I have chosen not to detail in this finding), I am satisfied that the Department’s decision to take Bubba E and her siblings into care was reasonable and appropriate.
12. In his report, Mr Mace detailed the neglect, and the physical and emotional abuse that Bubba E and her siblings were all subjected to. Mr Mace also explained that following eight child safety investigations between 2016 and 2022, it was determined that the only option available to the Department was to take Bubba E and her siblings into care.
13. In November 2022, the Department began investigating the possibility of safely reuniting Bubba E and her siblings with their parents, and a reunification plan was developed on 28 November 2022. The plan permitted Ms A to visit Ms C’s home whenever she wished, and to have unsupervised contact with Bubba E (and her siblings) at the discretion of Ms C or any other family member who was home at the time.<sup>21</sup>
14. A quarterly care report prepared by the Department on 29 February 2023, noted no concerns with Bubba E’s welfare, and that she had presented well. A further quarterly care report on 19 July 2023, noted that Bubba E had said she was feeling “*happy and safe*” living with Ms C. It was also noted that Bubba E was in good health and was attending school regularly. Bubba E was also having regular contact with Ms A, and phone contact with Mr B.

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<sup>19</sup> Exhibit 1, Vol. 1, Tab 21, Report - Mr G Mace, Department of Communities (17.06.24)

<sup>20</sup> Exhibit 1, Vol. 1, Tab 21, Report - Mr G Mace, Department of Communities (17.06.24), p17

<sup>21</sup> and ts 11.02.25 (Mace), p30

15. By January 2023, the Department had determined that reunification between Bubba E (and her siblings) and their father (Mr B) was not in their best interests as the Department had:

[C]ontinued to receive information regarding (Mr B's) perpetration of domestic violence towards his current partner; and concerns regarding (Mr B's) substance abuse.<sup>22</sup>

16. Reunification between a child and their primary caregiver(s) is a well-established aspect of foster care, and is consistent with departmental policy. In Bubba E's case the Department's reunification goal was expressed in the following terms in Mr Mace's report:

The goal of reunification of (Bubba E and her siblings) with (Ms A) included: (Bubba E and her siblings) living in a stable, consistent, and nurturing home free from violence, alcohol and drug abuse, where they are cared for by a safe and sober adult, feeling physically and emotionally safe, able to grow up feeling healthy, happy, safe and with all their care needs met, and with a strong spirit.

To achieve this (Ms A) needed to have a strong safety network around her, keep the children safe from violence, alcohol and drug abuse, maintain safe and stable accommodation, attend all meetings with (the Department) to progress reunification, address her own alcohol, violence, and drug use issues.<sup>23</sup>

17. On 9 January 2023, Bubba E told her "*separate representative*"<sup>24</sup> that she considered Tom Price was her home and that although she enjoyed living with Ms C, ultimately she:

[W]anted to return to living with her mum; that she would like contact with her father if this was to take place in Tom Price, but would not want to live with him, especially as he resided away from their Country.<sup>25</sup>

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<sup>22</sup> Exhibit 1, Vol. 1, Tab 21, Report - Mr G Mace, Department of Communities (17.06.24), p22

<sup>23</sup> Exhibit 1, Vol. 1, Tab 21, Report - Mr G Mace, Department of Communities (17.06.24), p22

<sup>24</sup> A separate representative is a legal representative appointed to represent the child's interests

<sup>25</sup> Exhibit 1, Vol. 1, Tab 21, Report - Mr G Mace, Department of Communities (17.06.24), p22

18. The Department noted Ms A was regularly staying at Ms C’s home (which was listed as an alcohol restricted home) and that Ms A was assisting Ms C to care for Bubba E and her siblings. There were no reports that Ms A was drinking alcohol or using cannabis at her new home, nor were there any reports of “*unsafe people*” visiting or staying there. As a result, the Department decided that it would progress its application for a protection order: “*with the intention to work towards reunification of (Bubba E and her siblings) with Ms A*”.<sup>26</sup>
19. Following an incident at Ms C’s home on 26 July 2023, Bubba E told Ms C she “*wanted to go home to mum*”. Bubba E subsequently refused to return to Ms C’s home, and told departmental staff she did not feel safe as “*there’s lots of fighting there*”. As a consequence, the Department developed a safety plan which enabled Bubba E (and her siblings) to stay with Ms A for a four-week period with “*supports and monitoring from the Tom Price Primary School and other supports in the community*”.<sup>27,28</sup>

***Comment on management in care***<sup>29,30,31</sup>

20. After carefully considering the available evidence, I find that the Department’s decision to take Bubba E (and her siblings) into care on 3 September 2022 was appropriate, given the “*substantiated harm as a result of Neglect, Physical Abuse, and Emotional Abuse*” which the children were then being exposed to.<sup>32</sup>
21. The decision was also clearly consistent with section 7 of the *Children and Community Services Act 2004* (WA) which provides that: “*In performing a function under this Act in relation to a child, the paramount consideration is the best interests of the child*”.
22. In his supplementary report, and at the inquest Mr Mace conceded that a “*high level review*” of Bubba E’s case had identified some “*missed opportunities*” in relation to her care.<sup>33</sup>

<sup>26</sup> Exhibit 1, Vol. 1, Tab 21, Report - Mr G Mace, Department of Communities (17.06.24), p22

<sup>27</sup> Exhibit 1, Vol. 1, Tab 21, Report - Mr G Mace, Department of Communities (17.06.24), p23 and ts 11.02.25 (Mace), pp22-24

<sup>28</sup> Exhibit 1, Vol. 1, Tabs 26.1 & 26.2, Draft Safety Plan (09.08.23), and Signed Safety Plan (09.08.23)

<sup>29</sup> Exhibit 1, Vol. 1, Tab 21, Report - Mr G Mace, Department of Communities (17.06.24) and ts 11.02.25 (Mace), pp18-31

<sup>30</sup> Exhibit 1, Vol. 1, Tab 25, Care plan (16.08.23)

<sup>31</sup> Exhibit 1, Vol. 1, Tab 27, Stability and Connection Planning document (11.12.23)

<sup>32</sup> Exhibit 1, Vol. 1, Tab 21, Report - Mr G Mace, Department of Communities (17.06.24), p17

<sup>33</sup> Exhibit 1, Vol. 1, Tab 29, Report - Mr G Mace, Department of Communities (06.02.25), pp1-2 and ts 11.02.25 (Mace), pp26-30

23. These missed opportunities included an “*incident focus rather than a family and domestic violence informed approach*” in relation to the multiple incident reports received concerning Bubba E and her siblings. Mr Mace said the review had identified that it may have been appropriate to have taken “*intervention action*” in relation to Bubba E at an earlier stage, noting:

There were critical decision points prior to (Bubba E) coming into the CEO’s care in 2022, where assessments did not consider cumulative harm that was experienced by (Bubba E) between 2015 and 2022. Each time Communities received a new referral there was an opportunity to assess the new information received against the historical assessments Communities had undertaken that reflected a pattern of abuse and neglect over time.

Further, Child Safety Investigations undertaken identified that no harm was substantiated, despite there being significant concerns for Ms A’s capacity to parent (Bubba E). Considering these factors may have led to Communities undertaking intervention action for (Bubba E) earlier than September 2022.<sup>34,35</sup>

24. Mr Mace said the review had also identified that the policy requirement for “*Stability and Connection meetings*” to be conducted monthly had not been met in Bubba E’s case. These meetings are intended to assess the relevant child’s “*primary and secondary care plans*”, and are typically attended by the child’s case worker and other professionals as well as the child’s family, safety network, and carer.<sup>36</sup>
25. In Bubba E’s case, the requirement to hold monthly meetings had not been achieved due to logistical difficulties in getting all relevant parties in one location at a suitable time. In my view, this was understandable, especially given the “*complexities arising in regional areas*”, not least of which are the vast distances between towns and communities in the Pilbara region of Western Australia.<sup>37</sup>

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<sup>34</sup> Exhibit 1, Vol. 1, Tab 29, Report - Mr G Mace, Department of Communities (06.02.25), p2

<sup>35</sup> See also: ts 11.02.25 (Mace), pp19-21

<sup>36</sup> Exhibit 1, Vol. 1, Tab 29, Report - Mr G Mace, Department of Communities (06.02.25), p2

<sup>37</sup> Exhibit 1, Vol. 1, Tab 29, Report - Mr G Mace, Department of Communities (06.02.25), pp2-4

26. In his supplementary report, Mr Mace noted that the number of vacant positions in the Pilbara region had decreased, and he outlined other strategies the Department had implemented to assist regional staff. At the inquest, Mr Mace said that in his view, the failure to “*achieve monthly reviews*” had not impacted on Bubba E’s care largely because of the very positive relationship the Department had with Ms A and Ms C. Input about Bubba E was also coming from other sources.<sup>38</sup>
27. I find the Department’s selection of Ms C as foster carer for Bubba E and her siblings was appropriate, and to have been consistent with departmental policy. In his report Mr Mace noted:

Ms C had always played an active role in the lives of her grandchildren...Through their childhood, including periods of (the Department’s) involvement, she consistently made herself available to support her grandchildren and provide a place of stability and consistency. Ms C demonstrated a genuine concern for the children's safety and wellbeing and worked alongside (departmental) staff to ensure (Bubba E and her siblings) needs were being met.

Ms C was identified as an important safety person and someone that could provide a suitable and culturally appropriate placement for the children, which was in accordance with the Aboriginal and Torres Strait Islander Child Placement Principles (set out in) section 12 of the Act. Ms C's naturally occurring support network of extended family members meant that Ms C was able to receive supports, and support contact between (Bubba E and her siblings) and their extended family, including their sister...and members of the paternal family, such as attendance at funerals.<sup>39</sup>

28. The Department’s efforts to reunify Bubba E (and her siblings) with Ms A were timely and appropriate, and consistent with departmental policy. At the time of her death, Bubba E was in the temporary care of Ms A, and she and her siblings were the subject of a safety plan that was implemented on 9 August 2023.<sup>40</sup> The safety plan was discussed with Ms A, who told the Department she understood its requirements.<sup>41</sup>

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<sup>38</sup> ts 11.02.25 (Mace), pp22 & 30

<sup>39</sup> Exhibit 1, Vol. 1, Tab 21, Report - Mr G Mace, Department of Communities (17.06.24), p17

<sup>40</sup> Exhibit 1, Vol. 1, Tabs 26.1 & 26.2, Draft Safety Plan (09.08.23) and Signed Safety Plan (09.08.23)

<sup>41</sup> Exhibit 1, Vol. 1, Tab 21, Report - Mr G Mace, Department of Communities (17.06.24), p25

## EVENTS LEADING TO BUBBA E's DEATH

*Vehicle crash*<sup>42,43,44,45,46,47,48,49,50,51,52,53,54,55,56</sup>

29. On 3 September 2023, Bubba E and other family members (including Ms A) were in a vehicle (the Vehicle) travelling north-east along Millstream Road, an unsealed road near Fortescue. The group was returning home after attending a rodeo event in Pannawonica that weekend.
30. At around the same time a white truck was travelling in the opposite direction (i.e.: south-west) along Millstream Road. The white truck, which had been observed earlier by several independent witnesses, was travelling at speed and said to be “*hugging the centre of the road*”.<sup>57,58</sup>
31. According to the driver of the Vehicle, at about 11.45 am she was travelling between 80 to 100 km per hour as the truck approached her. The truck was travelling in the centre of Millstream Road, and the driver of the Vehicle says that as she turned her steering wheel to avoid colliding with the truck, the Vehicle rolled over.
32. An adult passenger in the Vehicle says none of its occupants were wearing seatbelts and as the Vehicle rolled several passengers (including Bubba E) were ejected.<sup>59</sup>
33. As a result of being thrown from the Vehicle, Bubba E sustained serious injuries and despite extensive resuscitation efforts, she was declared deceased at the scene.<sup>60,61</sup>

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<sup>42</sup> Exhibit 1, Vol. 1, Tab 2, Report - Det. Sen. Const. G Burley (31.03.24) and ts 11.02.25 (Burley), pp6-18

<sup>43</sup> Exhibit 1, Vol. 1, Tab 7, Forensic Reconstruction Scene Notes (04.09.23)

<sup>44</sup> Exhibit 1, Vol. 1, Tab 7.1, Major Crash Investigation Unit Initial Collision Assessment Report (14.11.23)

<sup>45</sup> Exhibit 1, Vol. 1, Tab 8, Preliminary Crash Investigation (13.09.23)

<sup>46</sup> Exhibit 1, Vol. 1, Tab 9, Scene photos (04.09.23)

<sup>47</sup> Exhibit 1, Vol. 1, Tab 11, Statement - Const. J Dwyer (11.10.23)

<sup>48</sup> Exhibit 1, Vol. 1, Tab 12, Statement - FC Const. M Brett (15.11.23)

<sup>49</sup> Exhibit 1, Vol. 1, Tab 13, Statement - Mr T Ta'ala (26.09.23)

<sup>50</sup> Exhibit 1, Vol. 1, Tab 14, Statement - Ms C Toyne (29.09.23)

<sup>51</sup> Exhibit 1, Vol. 1, Tab 15, Statement - Mr A Lewis (06.10.23)

<sup>52</sup> Exhibit 1, Vol. 1, Tab 16, Statement - Mr M Hicks (24.09.23)

<sup>53</sup> Exhibit 1, Vol. 1, Tab 17, Statement - Ms J Williams (03.09.23)

<sup>54</sup> Exhibit 1, Vol. 1, Tab 18, Statement - Driver of the Vehicle (20.09.23)

<sup>55</sup> Exhibit 1, Vol. 1, Tab 19, Statement - Adult Passenger 1 in the Vehicle (03.09.23)

<sup>56</sup> Exhibit 1, Vol. 1, Tab 20, Statement - Adult Passenger 2 in the Vehicle (06.09.23)

<sup>57</sup> See for example: Exhibit 1, Vol. 1, Tab 13, Statement - Mr T Ta'ala (26.09.23), para 12

<sup>58</sup> See also: ts 11.02.25 (Burley), pp7-8

<sup>59</sup> Exhibit 1, Vol. 1, Tab 20, Statement - Adult Passenger 2 in the Vehicle (06.09.23), para 17

<sup>60</sup> Exhibit 1, Vol. 1, Tab 10.1, SJA Patient Care Record KAR27NC (03.09.23)

<sup>61</sup> Exhibit 1, Vol. 1, Tab 3, Life Extinct Forms (03.09.23)

*Police investigations*<sup>62</sup>

34. A Police vehicle examiner inspected the Vehicle on 4 and 5 October 2023, and noted: “*a defect evident with the vehicle, being the right rear passenger seat belt webbing (was) frayed*”. However, the seatbelt was tested and remained “*serviceable*”, and the vehicle inspector’s unsurprising conclusion was that this defect would have had “*no effect on the driver’s ability to control the vehicle*”.<sup>63</sup>
35. Despite extensive enquiries, police have been unable to identify the white truck that was travelling south-west on Millstream Road at the time of the crash, or its driver. This is obviously unfortunate, and I acknowledge that this adds to the distress experienced by Bubba E’s family since her death, because it means that to date, no person has been charged with any offence relating to Bubba E’s death.
36. At the inquest, Detective Senior Constable Burley (Officer Burley), who was allocated the investigation about two weeks after the crash, noted that CCTV footage from the entry/exit gates of Rio Tinto mines in the area (CCTV), and dashcam footage from vehicles on Millstream Road at the relevant time (Dashcam) had not been seized and had subsequently been recorded over.<sup>64</sup>
37. I accept that there is at least a possibility that CCTV or Dashcam footage may have assisted police to identify the white truck and its driver. However, this is by no means certain. For a start, there is no evidence before me that any of the CCTV footage would have shown Millstream Road. Further, from other inquests I have conducted I am aware that dashcam footage can be indistinct and/or that relevant details, such as the vehicle’s number plate and/or the driver’s face, may not be visible.
38. Nevertheless, at the inquest Officer Burley agreed that the failure to seize CCTV and Dashcam footage was a missed opportunity, and that the seizure of such evidence would be regarded as a “*reasonable investigative step*” in an investigation of this nature.<sup>65</sup>

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<sup>62</sup> Exhibit 1, Vol. 1, Tab 2, Report - Det. Sen. Const. G Burley (31.03.24) and ts 11.02.25 (Burley), pp6-18

<sup>63</sup> Exhibit 1, Vol. 1, Tab 2, Report - Det. Sen. Const. G Burley (31.03.24), p3

<sup>64</sup> ts 11.02.25 (Burley), pp8-11

<sup>65</sup> ts 11.02.25 (Burley), pp8 & 13-15

39. However, I note Officer Burley’s evidence that police resources were stretched at the relevant time due to the investigation of four crashes causing six fatalities within a 28 hour period during the relevant weekend. At the inquest, Officer Burley also noted: “*We do have further resourcing at Major Crash at the moment*”.<sup>66</sup>
40. Although CCTV and Dashcam footage was not seized, police made extensive efforts to identify the white truck and its driver. These efforts are set out in Officer Burley’s report, and may be summarised as follows:

Police made enquires with seven Karratha-based companies which owned similar types of vehicles, but none had any vehicles in Pannawonica or on Millstream Road, Fortescue at the relevant time, nor did Rio Tinto at its Pannawonica mine site operation;

A Police vehicle fitted with an Automatic Number Plate Recognition device had been deployed to Pannawonica on the weekend of the Pannawonica Rodeo and registered 966 “white vehicles”. Officer Burley reviewed all 966 of these vehicles, but only one matched the description provided by witnesses;

The vehicle identified was a white 2022 Mitsubishi Canter tray-back truck. However, police enquiries established that at the relevant time, this truck was at the Bungaroo water pump site, about 45 minutes south of Pannawonica; and

Although the Police issued several media releases calling for the driver of the white truck seen travelling on Millstream Road at the relevant time to come forward, to date no one has.<sup>67,68</sup>

41. Police enquiries established that the driver of the Vehicle had never held a Western Australian driver’s licence, and a blood test taken after the crash found she had tetrahydrocannabinol (indicating cannabis use) in her system, along with a blood alcohol level of 0.019%.<sup>69</sup>

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<sup>66</sup> ts 11.02.25 (Burley), p15

<sup>67</sup> Exhibit 1, Vol. 1, Tab 2, Report - Det. Sen. Const. G Burley (31.03.24), pp6-7

<sup>68</sup> See also: ts 11.02.25 (Burley), pp9-11

<sup>69</sup> Exhibit 1, Vol. 1, Tab 24, Certificate of Drug Analyst (26.09.23) and ts 11.02.25 (Burley), p12

42. In his report, Officer Burley expressed the following conclusion (with which I agree) about the culpability of the driver of the Vehicle in relation to Bubba E's death: "*As a result of the investigation and evidence collected my analysis identified that (the driver) is not criminally culpable for the death of the deceased*".<sup>70</sup>

43. At the inquest, Ms Papalia (counsel for Bubba E's family) asked Officer Burley to explain how police had arrived at their conclusion that the driver of the Vehicle "*was not criminally responsible for the death of Bubba E*".<sup>71</sup> Officer Burley's response was as follows:

Look, the case law describes dangerous driving as a multitude of factors in relation to a crash. In this instance, the driver of (the Vehicle) gave an account of how she has avoided a head-on collision with another vehicle. In her opinion, that was to save everybody in the vehicle. Unfortunately, Bubba E passed away as a result.<sup>72</sup>

44. For the sake of completeness, I note that in his report, Officer Burley also noted that the police investigation had concluded that there was sufficient evidence to charge the driver of the Vehicle with two charges, namely:

- Driving with prescribed illicit drug in oral fluid or blood; and
- No authority to drive - suspended.<sup>73</sup>

45. On 17 November 2023 in the Magistrates Court of Western Australia held at Perth, the driver of the Vehicle was convicted (following her pleas of guilty) to both charges and fined.

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<sup>70</sup> Exhibit 1, Vol. 1, Tab 2, Report - Det. Sen. Const. G Burley (31.03.24), p9

<sup>71</sup> ts 11.02.25 (Papalia), p17

<sup>72</sup> ts 11.02.25 (Burley), p17

<sup>73</sup> Exhibit 1, Vol. 1, Tab 2, Report - Det. Sen. Const. G Burley (31.03.24), p9

## CAUSE AND MANNER OF DEATH

### *Post mortem examination*<sup>74,75</sup>

46. A forensic pathologist (Dr White) conducted an external post mortem examination of Bubba E's body on 7 September 2023 at the State Mortuary, and reviewed CT scans.
47. Dr White noted that Bubba E had sustained extensive facial fractures, a rotational dislocation of her cervical spine (C1/2) with compression of the upper spinal cord, and "*evident visceral injury, including the kidneys and spleen*".<sup>76</sup>
48. Toxicological analysis of post mortem samples did not detect any medications, alcohol, or common drugs in Bubba E's system.<sup>77</sup>

### *Cause and manner of death*

49. At the conclusion of her external post mortem examination, Dr White expressed the opinion that the cause of Bubba E's death was: "*multiple injuries*".<sup>78</sup>
50. I accept and adopt Dr White's opinion as to the cause of Bubba E's death.
51. Further, on the basis that no person has been charged with any offence of which Bubba E's death is an element, I find that Bubba E's death occurred by way of accident.

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<sup>74</sup> Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (23.10.23)

<sup>75</sup> Exhibit 1, Vol. 1, Tab 5.1, Post Mortem Report (07.09.23)

<sup>76</sup> Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (23.10.23)

<sup>77</sup> Exhibit 1, Vol. 1, Tab 6, Toxicology Report (06.10.23)

<sup>78</sup> Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (23.10.23)

## WEARING OF SEATBELTS

52. As I have noted, at the relevant time none of the occupants of the Vehicle (including Bubba E) were wearing seatbelts. The tragic reality is that had Bubba E been wearing a seatbelt at the time of the crash there is at least a possibility that her injuries may not have been fatal.
53. In a statement dated 4 February 2025, Bubba E’s mother makes the following comments about the fact that Bubba E was not wearing a seatbelt when the crash occurred:

I still blame myself for us not wearing seatbelts. I promised myself that I would bring the children home safely. We were all tired from the big weekend and were dozing in the back seat and forgot to put the seatbelts on. I blame (the driver of the Vehicle) for this too because she was the driver and the person responsible for the passengers. I have faced cultural punishment for this but (the driver of the Vehicle) has not yet.<sup>79</sup>

54. Following Bubba E’s death, the Department continued the reunification process in relation to Bubba E’s siblings and Ms A. In a Stability and Connection Planning document completed on 11 December 2023 for that purpose, the following observation about use of seatbelts at the relevant time is made:

The Department has concerns that (Bubba E and her siblings) were unrestrained in the recent (motor vehicle accident) **however, many community families unfortunately do not prioritise restraints.**<sup>80</sup>  
[Emphasis added]

55. At the inquest, Officer Burley was asked whether he had any knowledge of whether “*it’s not uncommon for people from communities in this area to not wear seatbelts or to prioritise restraints in vehicles*”, and his response was: “*Yes. I’ve attended a number of fatalities in 2024 which resulted in the death of children, Aboriginal children and Aboriginal elders in remote communities for not wearing seatbelts*”.<sup>81</sup>

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<sup>79</sup> Exhibit 1, Vol. 1, Tab 28, Statement - Ms A (04.02.25), para 34

<sup>80</sup> Exhibit 1, Vol. 1, Tab 27, Stability and Connection Planning document (11.12.23), p15

<sup>81</sup> ts 11.02.25 (Burley), p17

56. The issue of seatbelt use has been clearly identified by the WA Road Safety Commission (the Commission). In an Information Bulletin entitled “*Restraints - Seatbelts*”, the Commission outlined the serious risks to occupants of vehicles who are involved in crashes when not wearing seatbelts and noted that:

The Commission will continue to promote the safety benefits of wearing restraints on our roads through: Education and awareness of seatbelt restraints for both drivers and passengers; Education of the road rules relating to seatbelt restraints; The promotion of safe vehicles with vehicle safety features; Opportunities to increase awareness of and compliance with restraint use in regional and remote WA; **In particular Aboriginal road users who are overrepresented in KSI<sup>82</sup> crashes, as identified in regional and remote national and state road safety research.** WA Police Force will continue to enforce wearing of restraints as a Category A Traffic Offence.<sup>83</sup> [Emphasis added]

57. In his supplementary report, Mr Mace noted that the review of Bubba E’s care had identified that a timeframe for a review of Bubba E’s safety plan should have been documented and “*should have occurred prior to 3 September 2023 given Communities had agreed to (Bubba E) being placed with Ms A under a ‘trial period’*”. Relevant to the wearing of seatbelts issue, Mr Mace’s supplementary report also noted that:

Further, given it is largely common practice for families living within regional Western Australia...to travel regularly to attend events or visit family and/or community; a ‘Travel Safety Plan’ would have enhanced practice. Travel Safety Plans can include Communities’ expectations regarding vehicle safety, adhering to driver safety and what to do if there is a medical emergency.<sup>84</sup>

58. At the inquest, Mr Mace advised that the Department is currently considering whether to include a reminder in safety plans that children in care must be restrained by seatbelts when travelling in a vehicle. In my view this would clearly be a sensible amendment to current practice.<sup>85</sup>

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<sup>82</sup> KSI is an abbreviation meaning “killed or seriously injured”

<sup>83</sup> See: [www.wa.gov.au/system/files/2021-08/Restraints-and-Seatbelts-INFO-SHEET.pdf](http://www.wa.gov.au/system/files/2021-08/Restraints-and-Seatbelts-INFO-SHEET.pdf)

<sup>84</sup> Exhibit 1, Vol. 1, Tab 29, Report - Mr G Mace, Department of Communities (06.02.25), p2 and ts 11.02.25 (Mace), pp23-24

<sup>85</sup> ts 11.02.25 (Mace), p24

59. The grave risks of not wearing a seatbelt when travelling in a vehicle are obvious and were tragically demonstrated in Bubba E's case. In my view, the safety of children in the Department's care would be enhanced by reiterating this obvious requirement in a travel safety plan.
60. In remarks made prior to the conclusion of the inquest, Ms Papalia submitted that it was open to me to recommend that the Commission conduct an education program (in a culturally appropriate manner) targeted at Aboriginal drivers and vehicle occupants in regional areas, reminding them of the grave dangers of not wearing seatbelts and strongly urging all vehicle occupants to do so.<sup>86</sup>
61. As the Commission was not represented at the inquest, I asked Mr McDonald (counsel assisting the coroner) to write to the Commission seeking their views about this suggestion. On 11 February 2025, Mr McDonald wrote to the Commission asking whether it was aware of any differences in attitudes to the wearing of seatbelts amongst Indigenous drivers, and whether the Commission had any current (or planned) seatbelt campaigns directed at Aboriginal drivers.<sup>87</sup>
62. In his email, Mr McDonald noted that the Commission had already conducted a number of campaigns to alert drivers to the dangers of not wearing seatbelts. Those campaigns, which are listed below, include several specifically targeted at Aboriginal drivers (highlighted in bold):
- Seatbelts Save Lives (2023/2024);
  - Welcome to Country Roads (2023/2024);
  - **Regional seatbelt radio campaign** (2023/2024);
  - 50 years of seatbelts (2021/2022);
  - Always wear your safety Gear. Belt Up (2021/2022);
  - **Cape Leveque Road campaign (seatbelts and child restraints)** (2020/2021);
  - **Belt Up Stupid - Indigenous Road Safety TV commercial** (2013/2014);
  - **Seat Belts - Indigenous Road Safety TV commercial** (2012/2013);
  - No one plans a crash (2023/2024); and
  - No one plans a crash - Mature families (2023/2024).<sup>88,89</sup>

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<sup>86</sup> ts 11.02.25 (Papalia), pp34-36

<sup>87</sup> Email - Mr D McDonald to Road Safety Commission (11.02.25)

<sup>88</sup> Email - Mr D McDonald to Road Safety Commission (11.02.25)

<sup>89</sup> Email - Ms S Steele, Director Education & Behavioural Change Road, Safety Commission to Mr D McDonald (14.02.25)

63. Mr McDonald also had a comprehensive discussion with the Commission's Director, Education and Behaviour Change, Ms Simone Steele on 14 February 2025. In her detailed follow up email, Ms Steele made the following observations about attitudes to the wearing of seatbelts:

The issues / causal factors around road safety are challenging and wide ranging. Road safety is an outcome of broader socio-economic and society factors, however I would not be confident to comment on the relationship to seatbelt use. The Road Safety Commission is concerned about the non-compliance with seatbelt use across the State. This was confirmed in the mobile safety camera trial's summary of findings with 11,400 drivers or front seat passengers not wearing a seatbelt or wearing it incorrectly identified across the six-month trial. (The) mid-west region (had) the highest rate of non-compliance - 460% higher than the trial average.<sup>90</sup>

64. Ms Steele also noted that 24% of those injured or killed in motor vehicle crashes in the Pilbara region between 2019 and 2023 had not been wearing seatbelts.<sup>91</sup>
65. As to education on the importance of wearing of seatbelts, Ms Steele referred to the Commissions media campaigns listed in paragraph 62 above, and also noted that:

(The Commission) has a strong social media and targeted digital advertising presence. (Commission) content was viewed 84 million times in 2024...(The Commission) also do bespoke media messaging such as specific activities and assets at the Cricket, Wildcats basketball games etc...and uses more traditional approaches such as large-scale billboards, backs of buses, bus shelters, newspapers (including regional newspapers) etc. (The Commission) engages Goorlarri Media Enterprises to deliver bespoke campaign formats for Aboriginal people in the north-west of WA. There is not a similar creative media agency in the Pilbara region at this stage and media developed through local representation may be a helpful strategy to reaching the Pilbara community.<sup>92</sup>

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<sup>90</sup> Email - Ms S Steele, Director Education & Behavioural Change, Road Safety Commission to Mr D McDonald (14.02.25)

<sup>91</sup> Email - Ms S Steele, Director Education & Behavioural Change, Road Safety Commission to Mr D McDonald (14.02.25)

<sup>92</sup> Email - Ms S Steele, Director Education & Behavioural Change, Road Safety Commission to Mr D McDonald (14.02.25)

66. Having carefully considered Ms Steele's helpful response, I have concluded that the Commission's current and previous media campaigns (including those specifically targeted at Aboriginal road users) adequately address the importance of all vehicle occupants wearing seatbelts. I have therefore decided that the recommendation suggested on behalf of Bubba E's family by Ms Papalia is not required.
67. However, I note with approval Ms Steele's observations about how representations from local residents in the Pilbara region may help shape future campaigns. I therefore strongly urge the Commission to actively seek out feedback of this kind when developing future campaigns about the importance of wearing a seatbelt.

### CONCLUSION

68. Bubba E was a much-loved little girl who died from multiple injuries when she was flung from a car whose driver lost control after taking evasive action to avoid colliding with a truck. Bubba E was only eight years, and she was not wearing her seatbelt at the relevant time.<sup>93</sup>
69. For various reasons, neither of Bubba E's parents were able to adequately care for her (or her siblings) and the children were taken into the care of the Director General by the Department on 3 September 2022. After carefully assessing the available evidence, I concluded that this decision was appropriate and was in the best interests of the children.
70. Bubba E (and her siblings) were placed into the care of Ms C, before being temporarily reunited with Ms A in late July 2023. The Department's focus on the reunification of Bubba E and her siblings with Ms A was appropriate and consistent with departmental policy.
71. After carefully assessing the available evidence, I concluded that the care, supervision and treatment that Bubba E received whilst she was in the care of the Director General was of an appropriate standard.

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<sup>93</sup> See: Exhibit 1, Vol. 1, Tab 28, Statement - Ms A (04.02.25), para 34

72. As I said at the conclusion of the inquest, the loss of a child is an unspeakably tragic event, and I cannot begin to fathom the grief and pain which Bubba E's family and friends have endured since her death. I wish to again extend to Bubba E's family and friends, on behalf of the Court, my very sincere condolences for your terrible loss.

MAG Jenkin

**Coroner**

17 February 2025

I certify that the preceding paragraph(s) comprise the reasons for decision of the Coroner's Court of Western Australia.

CORONER M Jenkin

17 FEBRUARY 2025