JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	BRENDYN DEAN NELSON, CORONER
HEARD	**:**	2 & 3 JULY 2026
DELIVERED	**:**	23 JULY 2026
FILE NO/S	**:**	CORC 104 of 2023
DECEASED	**:**	CHILD MA

Catchwords:

Nil

Legislation:

Children and Community Services Act 2004 (WA)
Coroners Act 1996 (WA)

Counsel Appearing:

Ms E Lynch and Ms G Horstmann assisted the Coroner

Ms Y Tamba (Aboriginal Legal Service) appeared on behalf of MC (name suppressed)

Ms D Ward SC (instructed by Clyde & Co) appeared on behalf of Life Without Barriers

Ms J Buller and Ms J Tower (State Solicitor's Office) appeared on behalf of the Department of Communities

Case referred to in decision:

Nil

SUPPRESSION ORDER

There be no publication of the name of, or any evidence likely to lead to the identification of, the deceased, including the names of the deceased's siblings and parents.

The deceased is to be referred to as Child MA.

Order made by SH Linton, A/State Coroner (30/06/2026)

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Brendyn Dean Nelson, Coroner, having investigated the death of ***Child MA (name suppressed)*** *with an inquest held at Kalgoorlie Courthouse, 208 Hannan Street, Kalgoorlie, on 2 and 3 July 2026, find that the identity of the deceased person was* ***Child MA*** *and that death occurred* ***on 1 October 2023*** *at* ***an ungazetted road in Kanowna, Western Australia*** *from* ***multiple injuries*** *in the following circumstances:*

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Introduction

1 Child MA was a popular and well-liked 15-year-old Ngadju Noongar boy living in the Kalgoorlie region who died on Sunday 1 October 2023 in Kanowna, Western Australia.

2 At that date, Child MA was in the care of the Chief Executive Officer of the Department of Communities (**Department**) and therefore a person held in care for the purposes of the *Coroners Act 1996* (WA) (**Act**).[1]

3 As such, his death was reportable,[2] a coronial inquest was mandatory,[3] and in addition to determining the cause and manner of his death, if possible, I am required to comment on the quality of the supervision, treatment and care that Child MA received while a person held in care.[4]

4 Child MA was known to be kind-hearted,[5] and someone who loved his family and would advocate for, and protect, his family and friends.[6]

5 He was respectful, and enjoyed spending time with his friends at the local skate park,[7] as well as camping and fishing and spending time outdoors.[8]

6 Those who knew him viewed Child MA '*as a really great kid*'.[9]

7 Child MA was in the care of CEO of the Department from 2011. He was initially placed in a care arrangement living with his paternal grandparents and some of his siblings.

8 Sadly, Child MA's mother died in 2015.

9 Due to concerns about Child MA's grandparents being able to provide a safe care arrangement individually following their separation, Child MA was transitioned to a family group home referred to as '*Whitlock House*' operated by Life Without Barriers (**LWB**) in August 2020.

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[1] The Act, s 3 (par (a)(i) of the definition of 'person held in care').
[2] The Act, s 3 (par (e) of the definition of 'reportable death').
[3] The Act, s 22(1)(a).
[4] The Act, s 25(3).
[5] Ts 192.
[6] Ts 50-51.
[7] Ts 94.
[8] Exhibit 2, tab 1, par [6.4].
[9] Ts 160.

10 Child MA was initially transitioned with two of his older sisters, and his younger brother joined them at Whitlock House in September.

11 Child MA lived at Whitlock House until his death.

12 During that time, he was initially cared for by a couple who acted as live-in carers, who I will refer to in these findings as **EM** and **GM**.

13 In June 2023, EM and GM left their respective roles at Whitlock House, and LWB ultimately engaged two new staff members who lived in the family group home as carers, for seven days each on alternating weeks.

14 The transition was managed by LWB and the Department, who identified this period as one of change that would be difficult for Child MA.

15 By August of 2023, some challenging behaviours that Child MA had exhibited when he first transitioned into Whitlock House, including school refusal and absconding, had returned.

16 Around this time, the Department approved a standing arrangement where Child MA would be allowed to stay overnight with his older sister, who I will refer to as **MZ**, on Saturday each week.

17 MZ had lived with Child MA at his paternal grandparents' home and at Whitlock House, and had more recently moved into her own accommodation after turning 18 years of age.

18 It became apparent that despite the efforts of LWB, the Department and MZ, Child MA would not always adhere to the arrangement. A safety plan was developed by the Department to address the risks arising.

19 Child MA also began, on occasion, to fail to return to the group home at reasonable times at night, as expected, and carers and staff from LWB were required to attempt to locate and communicate with him and encourage him to return.

20 On 30 September 2023, Child MA was dropped off at a local event by LWB staff, with the plan that he would stay with MZ that night.

21 The following day, after attending church, MZ drove Child MA and some of his friends in her vehicle to Kanowna.

22 While out in the bush, Child MA and his friends took turns driving the vehicle, with two people in the cab and the other four in the back tray.

23 While a friend of Child MA's, who I will refer to as **EM**, was driving the vehicle, he lost control, causing the vehicle to roll over.

24 Child MA sustained extensive and fatal injuries.

25 The inquest occurred on 2 and 3 July 2026 in Kalgoorlie.

26 The inquest focused on issues concerning Child MA's supervision, treatment and care which the Court had identified from review of the documentary material.

27 The Court also examined some issues arising from material supplied by solicitors acting for Child MA's older sibling, who I will refer to as **MC**.

28 MC was represented by counsel at the inquest.

29 Both LWB and the Department were represented at the inquest by counsel, and assisted the Court by provision of additional documentary material in relation to matters that arose.

30 Child MA's father was able to attend part of the inquest, and provided a brief statement to the Court on 10 July 2026 which I have not received as formal evidence, but which I have read and for which I am grateful.

Issues raised at the inquest

31 The inquest was primarily focused on:

(a) whether Child MA's seemingly escalating behaviours in August and September 2023, following the transition in his care arrangement, were identified and managed by LWB and the Department;

(b) whether there were any communication issues between LWB and the Department that impaired management of Child MA's care;

(c) whether Child MA's arrangement to stay with MZ was appropriate; and

(d) whether Child MA's connection to culture and his family was adequately developed and fostered, and whether members of Child MA's extended maternal family (including MC) were permitted input into the Department's decision-making.

Materials received at the inquest

32 To make the necessary findings under the Act, and to address the issues identified above at par [31], I received the documentary evidence in the coronial brief, several exhibits tendered during the inquest, and the following witnesses gave evidence:

(a) Ms Lucy Fitzgerald, a senior child and family practitioner employed by LWB who worked with Child MA from 2020;

(b) Ms Queen Chilenga, who worked with Child MA as a LWB child and family practitioner, from May 2023;

(c) Ms Carly Jacobitz, Deputy Chief Executive with LWB, who gave evidence in relation to an overarching report produced to the Court concerning that organisation's involvement in Child MA's care;

(d) Ms Ellie Walsh-Johnsen, a senior child safety practitioner within the Department who was Child MA's case manager from August 2023;

(e) Ms Michelle Atkins, the team leader within the Department responsible for managing Child MA's care in 2023;

(f) Ms Narelle Davey, the District Director for the Goldfields district within the Department in 2023; and

(g) Ms Rochelle Binks, Executive Director North – Child Protection and Family Support of the Department, who gave evidence in relation to overarching reports produced to the Court from the Department concerning Child MA's care, supervision and treatment.

33 At the conclusion of the evidence, I also received oral submissions from the solicitors acting for MC, in relation to the concerns she had identified prior to the inquest.

34 I also received submissions from counsel for the Department in relation to some issues on which I had expressed provisional views at the conclusion of the evidence.

35 I have considered those submissions and addressed them in the context of the findings and comments below.

Factual findings

36 Findings of this nature cannot traverse all of the circumstances of a child's time in the Department's care – not least the circumstances of Child MA, given he spent nearly the entirety of his life in care.

37 The fact that some matters concerning Child MA's treatment while in care are not the subject of detailed factual findings, does not mean that the evidence has not been carefully examined and considered in making the findings and comments required under the Act.

38 It also does not mean that parts of Child MA's life, and people within his life, were or are of any less significance.

39 In this part, I make factual findings primarily about the circumstances leading up to and including Child MA's death, including any findings necessary to make comment on the issues identified at par [31] above.

Child MA's personal background and entry into care

40 Child MA was born in 2008.[10]

41 He was one of seven children born to his parents.[11]

42 His mother was a Ngadju woman,[12] and he had two maternal half-siblings.[13]

43 His father was non-Aboriginal.[14]

44 Both of Child MA's parents had substance abuse problems and were frequently violent towards each other including in the presence of Child MA and his siblings.[15]

45 Child MA first came to the attention of Department in 2008, the year he was born.

46 Between September 2008 and March 2022, he was recorded in 22 interactions with the Department relating to, amongst others, child protection and family and domestic violence.[16]

[10] Exhibit 1, tab 23, p 1.
[11] Exhibit 1, tab 23, p 1.
[12] Exhibit 1, tab 21.1, p 9.
[13] Exhibit 1, tab 23, p 1; exhibit 2, tab 1, par [4.2].
[14] Exhibit 2, tab 1, par [4.1].
[15] Exhibit 1, tab 21.1, p 10.

47 He was the subject of six child safety investigations by the Department from 2008.[17]

48 Child MA was subsequently determined to have been the subject of physical and emotional neglect.[18]

49 Child MA and his siblings were taken into the provisional protection and care of the CEO pursuant to a warrant issued under s 35 of the *Children and Community Services Act 2004* (WA) on 24 February 2011.[19]

50 The warrant was the result of substantiated harm, namely emotional abuse and family and domestic violence, identified following a child safety investigation.

51 The Department undertook an investigation because of concerns regarding the children, including Child MA, being witnesses to or involved in significant and multiple family and domestic violence interactions between their parents, as well as reports of neglect, physical abuse and concerns relating to Child MA's mother's mental health.[20]

52 In 2011, the Department developed a provisional care plan in relation to Child MA and provided opportunities to both the maternal and paternal families to participate in meetings and contribute to care planning decisions at that time.[21]

53 At the time Child MA was placed in care, he had been living with his paternal grandparents as part of a family arrangement.[22]

54 On 21 February 2012, the Children's Court made a two-year protection order (time limited) in relation to Child MA.[23]

55 On 2 June 2015, the Children's Court made a protection order (until 18) in relation to Child MA and three of his siblings.[24]

56 Child MA remained in the care of his paternal grandparents at that time.

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[16] Exhibit 1, tab 23, p 3.
[17] Exhibit 1, tab 23, p 2.
[18] Exhibit 1, tab 21.1, p 10.
[19] Exhibit 1, tab 22, p 3.
[20] Exhibit 1, tab 22, p 3.
[21] Exhibit 1, tab 29, p 4.
[22] Exhibit 1, tab 23, p 8.
[23] Exhibit 1, tab 23, p 2.
[24] Exhibit 1, tab 23, p 2.

57 Child MA had a number of living arrangements during the course of his time in care, which included long-term and short-term placements.[25]

58 His most significant care arrangements were with his paternal grandparents between 2011 to 2020, and at Whitlock House from 2020.[26]

Child MA's care arrangements with his paternal grandparents

59 Child MA's paternal grandparents were approved by the Department as family carers on 15 March 2011.[27]

60 The care arrangement from 2011 to 2020 with the paternal grandparents was considered by the Department to be the most appropriate arrangement at the time, as it enabled Child MA to remain placed together with siblings and still with family; and the Department considered that there was no viable care arrangement with Child MA's maternal family.[28]

61 It is unnecessary to set out, in full detail, the course of Child MA's care arrangement with his paternal grandparents. The course of Child MA's care by his paternal grandparents is summarised in detail in the documentary evidence, including in the Department's report to the Court.

62 I note the following matters of significance:

(a) in 2015, the paternal grandparents raised the prospect of obtaining special guardianship orders in relation to Child MA;

(b) the Department did not support this course, including because of a concern about the potential impact on Child MA's contact with the maternal side of his family;[29]

(c) in August 2015, the Department's Goldfields District received concerns from Community Mental Health relating to the care of Child MA by his paternal grandparents;[30]

[25] Exhibit 1, tab 22, p 3.
[26] Exhibit 1, tab 22, p 3.
[27] Exhibit 1, tab 23, p 9.
[28] Exhibit 1, tab 29, p 9.
[29] Exhibit 1, tab 29, p 10.
[30] Exhibit 1, tab 23, p 6.

(d) during a Child Assessment Interview, Child MA reported that he felt safe and happy residing with his paternal grandparents, and that he wished to remain in their care;[31]

(e) sometime in 2016-2017, Child MA's paternal grandparents separated, and his paternal grandmother remained as Child MA's primary carer;[32]

(f) in April 2019, Child MA's paternal grandfather raised concerns regarding the care that the paternal grandmother was providing to Child MA;

(g) in January 2020, the Department held an internal meeting to explore future care arrangements for Child MA, noting that the paternal grandparents were, individually, unable to provide a safe care arrangement for Child MA, but were his primary attachments;

(h) a plan was developed at that time, including the sending of a referral to LWB for a possible care arrangement for Child MA and some of his siblings in care with that organisation;[33]

(i) in March 2020, Child MA refused to remain in the care arrangement with his paternal grandmother;

(j) Child MA was placed temporarily with his paternal grandfather, but returned to his paternal grandmother later that month;[34]

(k) a few days after returning, Child MA again refused to remain in the care arrangement with his paternal grandmother; and

(l) Child MA was placed with his paternal grandfather where he remained until 7 August 2020.[35]

[31] Exhibit 1, tab 23, p 7.
[32] Exhibit 1, tab 23, p 9.
[33] Exhibit 1, tab 23, p 9.
[34] Exhibit 1, tab 23, p 9.
[35] Exhibit 1, tab 23, p 9.

Care arrangement with LWB

63 LWB has provided community-based support services in Australia, including for children in out-of-home care since 1995.[36]

64 As at 2020, LWB was operating Whitlock House as a family group home pursuant to an agreement with the Department. A family group home (now referred to as a group foster care arrangement by the Department) is a care arrangement that provides group living for children, with an emphasis on placement for sibling groups together.

65 The CEO of the Department still retains the ultimate responsibility for the wellbeing of the child in such an arrangement, including case management as required, thus requiring collaboration with a provider such as LWB.[37]

66 On 7 August 2020, the Department transitioned Child MA to the LWB family group home programme, with a night at '*Broadwood*', before transitioning to Whitlock House.[38]

67 Steps had already been taken to introduce Child MA to the LWB carers in a gradual and supportive way.[39]

68 Upon moving into Whitlock House, Child MA and his siblings were cared for, on a day-to-day basis, by EM and GM.

69 Staff from LWB in the role of child and family practitioner were also involved in monitoring the care arrangement, and liaising with the Department. LWB provided weekly reports to the Department, in which any issues or concerns regarding Child MA's wellbeing could be raised.[40]

70 As a senior child and family practitioner, Ms Fitzgerald was the staff member at LWB initially primarily responsible for advocating on behalf of Child MA and ensuring that his dimensions of care were being met on a day-to-day basis.[41]

[36] Exhibit 2, tab 1, par [5.1].
[37] Exhibit 1, tab 28, par [34].
[38] Exhibit 1, tab 23, p 9.
[39] Exhibit 2, tab 1, par [4.11].
[40] Exhibit 1, tab 23, p 16.
[41] Ts 12.

71 In due course, Ms Chilenga began working with Child MA, and she became the primary point of contact within LWB, but Ms Fitzgerald would assist and also step in from time to time if Ms Chilenga was unavailable.[42]

Initial behavioural concerns identified by LWB

72 In August 2020, Ms Fitzgerald was involved in the creation of a plan referred to by LWB, at that time, as a '*Absconding Response Plan*' in relation to Child MA.[43]

73 Her observation at the time was that Child MA was absconding and not going to school from time to time, and was finding it hard to settle into Whitlock House.

74 I interpose that in terms of education, Child MA completed his primary education at Boulder Primary School, before transitioning into secondary education at Kalgoorlie Boulder High School.[44]

75 Staff at LWB recognised that Child MA would put himself in challenging situations in order to spend time with family.

76 Consequently, LWB, in addition to the development of the response plan (which was just one planning instrument amongst others created by LWB at that time with the goal of maximising Child MA's care)[45] and with the consent of the Department, LWB worked with family members to support him in maintaining safe and regular contact.[46]

77 After settling at Whitlock House, and being able to build up some routine, Child MA began to abscond less, and attended school more frequently and consistently.[47]

78 Ms Fitzgerald's view was that organised family visits at the group home also assisted in reducing absconding behaviour.[48]

79 EM and GM built a good relationship with Child MA.[49]

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[42] Ts 13, 53.
[43] Exhibit 2, tab 4.
[44] Exhibit 2, tab 1, pars [6.16]-[6.17].
[45] See, e.g., exhibit 2, tab 1.13.
[46] Exhibit 2, tab 1, par [5.16].
[47] Ts 16-17.
[48] Ts 17.
[49] Ts 16.

80 Again, it is unnecessary to set out a full account of their care for Child MA, but the evidence is clear that they created a relatively stable home environment for Child MA and his siblings who also lived with them.

81 On 16 August 2022, Child MA's case was reallocated from Care Team 2 to Care Team 3 within the Department.[50]

82 Ms Atkins was the team leader within Care Team 3. Her view, as at August 2022, was that Child MA was in a good routine and seemed really settled.[51]

Change in LWB carers

83 In October 2022, EM and GM advised LWB that they intended to relocate to Perth.[52]

84 Child MA initially expressed a desire to relocate to Perth with them.[53]

85 I accept that this expression of Child MA's wishes, at that time, resulted in some planning internally within the Department and engagement with LWB about whether this could occur.

86 However, I find that the planning was always in the very early stages, and a relocation was never approved by the Department.[54]

87 Further, I find that no final decision about relocation to Perth had been made by the Department prior to EM and GM deciding to postpone their relocation, and to remain in Kalgoorlie.[55]

88 EM and GM did ultimately relocate to Perth, finishing their roles with LWB on 19 June 2023.[56]

89 By that time, Child MA had expressed his wish to remain living in Kalgoorlie to be close to family.

90 Both LWB and the Department recognised that EM and GM moving away from Whitlock House represented a '*massive loss of relationship*

[50] Exhibit 1, tab 28, par [22].
[51] Ts 128.
[52] Exhibit 2, tab 1, par [5.28].
[53] Exhibit 1, tab 23, p 17.
[54] Ts 158.
[55] Exhibit 2, tab 5, par [53].
[56] Exhibit 1, tab 23, p 18.

between carers and Child MA'[57] and a '*huge adjustment period*' for Child MA.[58]

91 Ms Jacobitz properly acknowledged that Child MA had enjoyed a stable home environment at Whitlock with EM and GM for some time, and that it was generally a positive and safe environment, but that a lot of factors changed for him in a relatively short period of time (including siblings moving out of Whitlock House).[59]

92 On 15 June 2023, LWB convened a complex needs support panel in relation to Child MA's care.[60]

93 Ms Fitzgerald was unable to recall the specific reason why this panel was convened, but explained that panels are convened on occasion due to the number of incident reports that might be coming through, or based on particular concerns identified by a child and family practitioner that they bring to the attention of their supervising operations manager.[61]

94 Ms Jacobitz's evidence was that such panels are a response to ongoing or escalating challenges that are impacting the child or young person.[62]

95 I find that LWB convened the panel due to recognition that this period of transition would be difficult for Child MA, and may result in more challenges arising in his day-to-day care than usual.

96 I infer, from the content of the summary of the panel, that the intention was for LWB to collaborate, share perspectives of staff involved in Child MA's care, and discuss planning and strategies.

97 The panel determined that Child MA was doing well, despite all the recent change.[63]

98 In August 2023, the Department and LWB conducted a Dimensions of Well-Being review in order to assess what was working well for Child MA, and what issues, if any, needed to be addressed.[64]

[57] Exhibit 3.
[58] Exhibit 1, tab 27, par [39].
[59] Ts 70.
[60] Ts 20; exhibit 2, tab 1.9.
[61] Ts 20-21.
[62] Ts 70.
[63] Exhibit 3.
[64] Ts 25.

99 It is apparent that there was some concern about absconding at around this time,[65] but it is not expressly referenced in the review report.

100 It is possible that it was not discussed,[66] but I infer, at that stage, that any absconding behaviour had not regressed to a point where it was considered to be a critical issue by staff at LWB or at the Department.[67]

Return of challenging behaviours

101 By August 2023, it was apparent that Child MA was missing school more often,[68] and there was one instance where Child MA told LWB staff that he was at MZ's home (as per the standing arrangement approved by the Department), but he had told MZ that he was at Whitlock House.[69]

102 It is evident that by the time Ms Walsh-Johnsen became the Departmental case manager in August 2023 there were concerns about Child MA absconding and his school attendance, because those were her priorities in relation to his care.[70]

103 During this period, there were also instances of Child MA being '*unaccounted for*', which was the term was used by the Department at the time. During Ms Walsh-Johnsen's case management, the Department was notified of Child MA being unaccounted for on about ten occasions, meaning his exact whereabouts were unknown but there was no serious concern for his welfare.[71]

104 Ms Walsh-Johnsen was aware that during these times Child MA would often be at a friend's home or the skate park.[72]

105 It is clear from the evidence that it is not uncommon for teenagers in Departmental care, like Child MA, to be unaccounted for at times.[73] It is also clear that during these times, Child MA was generally contactable by his mobile phone, and that LWB staff would be undertaking steps to identify his whereabouts and encouraging him to return home.

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[65] Ts 32.
[66] Ts 60.
[67] Ts 26.
[68] Ts 57.
[69] Ts 57.
[70] Ts 98.
[71] Exhibit 1, tab 27, par [52]-[53].
[72] Exhibit 1, tab 27, par [54].
[73] Exhibit 1, tab 28, par [79].

106 There was, and is, no evidence that Child MA's health or safety was at acute risk during any of the occasions when he was unaccounted for.

107 In August 2023, a safety plan for Child MA was developed by the Department to address some of the issues arising from Child MA's overnight stays aware away from Whitlock House, including in response to the incident described at par [101] above.[74]

108 On 27 September 2023, Ms Walsh-Johnsen attended the skate park and spoke with Child MA.

109 The engagement was limited, which was unsurprising given she was a new and unfamiliar adult in his life.[75]

110 Child MA confirmed that he felt safe in his care arrangement, despite having previously expressed a concern through Viewpoint,[76] a system used by the Department to assist a child in care to voice any concerns.

Events of 1 October 2023

111 In the afternoon of 1 October 2023, MZ and Child MA picked up their friends EM and three other 14-year-olds in her Holden Commodore utility from near where EM was living in Kalgoorlie at the time.[77]

112 The vehicle was owned by, and registered to,[78] MZ.[79]

113 MZ suggested that the group go driving in the bush near Kalgoorlie. She ferried the group across two trips to a gravel road at Kanowna.[80]

114 Child MA and EM both took turns driving the vehicle, with MZ's consent and everyone else's encouragement.[81]

115 MZ and one of the other 14-year-olds also drove.[82]

116 Child MA drove the vehicle for about 17 minutes, during which time MZ filmed his driving from the tray using her mobile phone.[83]

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[74] Exhibit 1, tab 28, par [81].
[75] Exhibit 1, tab 27, pars [30]-[32].
[76] Exhibit 1, tab 27, par [40].
[77] Exhibit 1, tab 20.1, p 2.
[78] Exhibit 1, tab 9.2, par [7].
[79] Exhibit 1, tab 9.1, p 1.
[80] Exhibit 1, tab 20.1, p 2.
[81] Exhibit 1, tab 20.1, pp 2-3.
[82] Exhibit 1, tab 21.1, p 3.

117 Immediately prior to the incident, Child MA was one of four passengers in the tray. He was sitting in the right-hand corner at the front of the tray, closest to the cab.

118 MZ was sitting in the cab in the passenger seat.[84]

119 None of the passengers were secured.[85]

120 EM was driving the vehicle on an unsealed road at an unknown speed.

121 The road was a wide road, with loose gravel, with sparse bush and soft sand along the sides of the road.[86]

122 Although the exact speed cannot not be identified, I find that EM was driving at speed and performing side to side steering movements which was causing the rear wheels of the vehicle to lose traction and drift in 'S' bends along the straight section of road.[87]

123 EM lost control of the vehicle, which veered to the right side of the road and entered large cavities which caused the vehicle to flip.[88]

124 All passengers in the tray were thrown from the vehicle.[89]

125 Child MA suffered significant head injuries and was killed instantly.[90]

126 MZ called 000 at 3.29 pm.[91]

127 A member of the public was riding his off-road motorcycle in the area at the time of the crash, and was the first person to attend the scene and to render assistance, including by commencing CPR.[92]

128 Ambulance officers arrived at the scene.

129 Child MA had suffered traumatic head injuries and was not conscious or breathing.[93]

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[83] Exhibit 1, tab 21.1, p 3.
[84] Exhibit 1, tab 9.2, par [22]; tab 20.1, p 3.
[85] Exhibit 1, tab 9.1, p 2; tab 9.2, par [15]; tab 20.1, p 2.
[86] Exhibit 1, tab 9.1, p 1.
[87] Exhibit 1, tab 20.1, p 3; tab 21.1, p 4.
[88] Exhibit 1, tab 9.1, p 2; tab 20.1, p 3.
[89] Exhibit 1, tab 9.1, p 2.
[90] Exhibit 1, tab 20.1, p 3.
[91] Exhibit 1, tab 21.1, p 5.
[92] Exhibit 1, tab 9.2, par [41]; tab 21.1, p 6.

130 He was declared life extinct by a paramedic at 5.50 pm.[94]

131 Officers from WA Police's Major Crash Investigation Section determined that there was no evidence of any fault in the vehicle being driven by EM, or that environmental factors contributed to the crash.[95]

Cause of death

132 A forensic pathologist conducted an external postmortem examination only, including CT scans, which showed an unsurvivable head injury with extensive fractures of the skull. There were also fractures of one of the shoulder blades, and ribs.

133 There were no signs of any natural disease.[96]

134 Subsequent review by a consultant radiologist identified further injury of the high cervical spine and blood collection in the soft tissue in the front of the chest.[97]

135 Toxicological analysis detected tetrahydrocannabinol at 2.6 micrograms per litre. No alcohol or other drugs were detected.[98]

136 In view of the additional skeletal injuries identified by the consultant radiologist, the pathologist formed the opinion that Child MA's cause of death was multiple injuries. I respectfully agree with and adopt the forensic pathologist's conclusion as my finding of the cause of Child MA's death pursuant to s 25(1)(c) of the Act.

Manner of death

137 Following investigation of the crash by police, EM was charged with aggravated dangerous driving occasioning Child MA's death, contrary to s 59(1)(b) of the *Road Traffic Act 1974* (WA) (**RTA**), and four counts of aggravated dangerous driving occasioning bodily harm in relation to the other four passengers, contrary to s 59A(1)(b) of the RTA.[99]

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[93] Exhibit 1, tab 8.
[94] Exhibit 1, tab 4.
[95] Exhibit 1, tab 9.1, p 4.
[96] Exhibit 1, tab 6.2.
[97] Exhibit 1, tab 6.3.
[98] Exhibit, tab 7.
[99] Exhibit 1, tab 9.1, p 3.

138 EM was convicted of those offences by the Perth Children's Court upon guilty pleas entered at the earliest available opportunity,[100] and sentenced on 14 March 2024 to a total effective sentence of 12 months' youth detention to be served immediately.[101]

139 MZ was charged on the basis she aided or enabled EM to commit the relevant offences, including the charge pursuant to s 59(1)(b) of the RTA.[102]

140 MZ was convicted of those offences by the Kalgoorlie District Court upon her guilty pleas,[103] and on 16 October 2025 she was sentenced to a total effective sentence of 4 years 11 months' imprisonment, suspended for two years.[104]

141 Where EM and MZ have been convicted of the charge of driving in a dangerous manner causing Child MA's death, the verdict as to the manner of Child MA's death, for the purposes of s 25(1)(b) of the Act, must be unlawful homicide.

Supervision, treatment and care of Child MA

142 Having examined the evidence contained in the coronial brief, and having regard to the oral evidence of witnesses at the inquest, I find that the quality of Child MA's supervision, treatment and care was generally reasonable and adequate during his time in Departmental care.

143 In summary:

(a) Child MA enjoyed relatively stable long-term care arrangements including with some of his siblings, and was able to maintain close connections with parts of his family and his community.

(b) Child MA's physical and mental health was sound and satisfactorily managed, and although there were challenges in relation to his secondary education in particular, it is apparent that there was good cooperation between the Department, LWB and his school regarding the management of issues as they arose.

[100] Exhibit 1, tab 20.1, p 7.
[101] Exhibit 1, tab 9.1, p 3; tab 20.1, p 8.
[102] Exhibit 1, tab 21.1, p 7.
[103] Exhibit 1, tab 21.1, p 21.
[104] Exhibit 1, tab 9.1, p 4; tab 21.1, p 30.

(c) As identified above, some more challenging behaviours arose in the months prior to Child MA's death. I find that those issues arose as a consequence of the unavoidable instability experienced by Child MA around this time, in addition to normal adolescent development. The issues were identified and managed adequately. I do not consider that the issues, or their management by LWB or the Department, caused or contributed to Child MA's death.

(d) The evidence demonstrates that Child MA's connection to culture was sometimes overlooked, and not prioritised. At the inquest, the Departmental staff properly acknowledged that more could have been done to connect Child MA to his Aboriginal culture,[105] and to facilitate contact between Child MA and parts of his maternal family and involve those family members in decision-making.

Management of Child MA's escalating behaviours

144 The evidence demonstrated that both the Department and LWB had adequate risk assessment and management frameworks in place at all relevant times.[106]

145 At the inquest, it was identified that LWB's absconding response plan from 2020 had not been reviewed prior to Child MA's death.[107]

146 I do not consider that the absence of a review represented any failing on LWB's part, and the absence of a review of that plan had no impact on the management of Child MA's behaviours in August and September 2023.

147 It is clear that the plan was developed in 2020 in response to the issues that arose at that time, and that staff were not utilising this document by 2023,[108] such that there was no confusion.

148 Putting the 2020 absconding plan to one side, in order to assess the adequacy of the response by the Department and LWB to Child MA's behaviours in August and September 2023, it is necessary to properly characterise the behaviour.

[105] Counsel for the Department also, appropriately, made this concession: ts 194.
[106] Ts 64-66.
[107] Exhibit 2, tab 4.
[108] Ts 58.

149 Having examined the evidence, I accept that although there was some escalation of disruptive behaviours by Child MA in late 2023, the activities were consistent with fairly standard adolescent behaviour.

150 Child MA being unaccounted for and not returning to Whitlock House was a less severe risk than it might otherwise have been, because he was generally contactable, and was going to and staying at familiar places, known to LWB and the Department.[109]

151 I also consider that although the instances of the behaviour were escalating, they were not occurring with such consistency or regularity to represent an acute risk.

152 I accept Ms Davey's characterisation that these were '*spot fires*'.[110]

153 I find that Child MA's behaviour in August and September was a result of him seeking independence and taking opportunities from time to time to socialise with friends and older siblings.[111]

154 It is clear from the evidence that Child MA was not absconding regularly and engaging in other high-risk behaviours like serious substance misuse or criminality.[112]

155 He was generally visible in the community, and was, properly, not characterised as a high-risk case.[113]

156 The actions of LWB and the Department must be assessed in that context.

157 It is clear that LWB and the Department recognised August 2023 as a transition period for Child MA.

158 Ms Fitzgerald and Ms Chilenga[114] were both cognisant that the period of time when EM and GM were moving to Perth would be a difficult period of transition for Child MA.[115]

159 Ms Atkins was talking openly with the Departmental case manager about the issues arising.[116]

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[109] Ts 66-67.
[110] Ts 142.
[111] Exhibit 1, tab 28, par [40].
[112] Ts 67, 139.
[113] Ts 66, 156-157; exhibit 1, tab 28, par [26].
[114] Ts 56.
[115] Ts 19.

160 During the June complex needs panel, it was recognised by LWB that the children (including Child MA) could possibly regress in the future (after what was described as a '*honeymoon*' period).[117]

161 I take this to mean that it was recognised that there might have been a novelty in new carers coming into the family group home, but that behaviours might regress in future.[118]

162 I accept Ms Jacobitz's evidence that where there is a change in carers after a lengthy period of relative stability, it would be almost impossible to avoid a period of unsettledness and instability.[119]

163 I also accept that to the extent there was a gap between EM and GM leaving, and new full-time staff being employed by LWB, it was critical that suitable staff were identified given the challenging role.[120]

164 In order to address any instability, LWB ensured regular communication with Child MA, including through home visits providing the express opportunity to voice any worries or concerns. The home visits also included LWB's therapeutic specialist, to be able to ensure Child MA (and his siblings) had an opportunity to talk about what might be worrying them and have any questions answered.[121]

165 Ms Chilenga remained involved during the course of the transition in carers and acted as a conduit.[122]

166 Another step was to maintain contact with EM and GM, including plans to be able to visit them in due course.[123]

167 By the time of his death, staff like Ms Fitzgerald had been working with Child MA for many years. There is always a risk that a child who has experienced trauma may internalise any stress or emotion, but I accept Ms Fitzgerald's evidence that she saw an increase in Child MA's ability to communicate with her and others over time.[124]

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[116] Ts 130-131.
[117] Ts 21.
[118] Ts 21.
[119] Ts 73.
[120] Ts 83-84.
[121] Ts 19.
[122] Ts 57.
[123] Ts 56.
[124] Ts 48.

168 As much as there was change during this period, there was also consistency, including in his relationship with Ms Fitzgerald and his consistent and enthusiastic engagement with additional supports like Clontarf.[125]

169 Child MA had a good rapport and trust with Ms Fitzgerald, to the extent he would, on occasion, walk into LWB's office in order to ask some questions or check in and get something to eat or drink.[126] Child MA would also not hesitate in contacting Ms Fitzgerald on his mobile phone.[127] These were, self-evidently, very positive signs and demonstrated that Child MA considered Ms Fitzgerald part of his support network, even if she was not his carer on a day-to-day basis.

170 Ms Chilenga considered that she had built a good rapport with Child MA, and he would communicate with her including his whereabouts.[128]

171 Ms Fitzgerald was seeing Child MA at least once a week,[129] and Ms Chilenga was seeing him once, sometimes twice a week, and was often in contact by phone.[130]

172 As a consequence, I place significant weight on Ms Fitzgerald and Ms Chilenga's respective efforts to maintain and promote good communication with Child MA during this time, and their ability to meaningfully assess his well-being given their background and experience in working with Child MA.

173 Ms Atkins remained team leader for the Department from 2022 onwards, so there was continuity in the Departmental approach as well, even though there was more changes in case managers than ideal.[131]

174 I am satisfied from the evidence that the changes in Departmental case manager in 2023 were unavoidable, and that Ms Atkins became more involved than she would otherwise have been in order to ensure greater continuity.[132]

[125] Ts 49.
[126] Ts 47.
[127] Ts 48.
[128] Ts 95.
[129] Ts 17.
[130] Ts 53.
[131] Ts 126-127.
[132] Ts 126-127, 131.

175 To the extent that Child MA stayed out later than anticipated and became unaccounted for, I am satisfied that LWB staff (including Ms Fitzgerald and Ms Chilenga) used the means available to them to make and maintain contact with Child MA, and to encourage him to return home.[133]

176 This included attending places where he liked to hang out, and calling and texting him on his mobile phone, and liaising with family members.[134]

177 I accept Ms Jacobitz's evidence that this ability to communicate and maintain contact with Child MA was relevant to the question of any need for LWB to perform some 'fresh' risk assessment in August and September 2023.[135]

178 I accept that Child MA's behaviours had not reached a point where a further risk assessment was unquestionably necessary, including in order to try and identify further strategies to reduce the instances of Child MA absconding or refusing to attend school.

179 Further, I accept Ms Jacobitz's evidence that any strategies that fall out of a risk assessment always have the risk of alienating teenagers, or creating an unhelpful barrier.[136]

180 This would have been a significant consideration in relation to Child MA, where communication was generally good and represented a very strong risk mitigation factor.

181 I am satisfied that Ms Fitzgerald deliberately increased the frequency of her visits to the family group home, both to support Child MA in the transition between carers, and to also assist the new residential carers and ensure that they felt well supported and were helped in building a relationship with the children.[137]

182 I note that visits were deliberately timed to occur during shift changeover,[138] which was a prudent measure to ensure that Ms Fitzgerald was across the exchange of any relevant information.

[133] Ts 28.
[134] Ts 29.
[135] Ts 67.
[136] Ts 68.
[137] Ts 47.
[138] Ts 48.

183 I accept that Child MA experienced trauma, but it is not apparent that he was engaging in any behaviours or experiencing any symptoms, including in August or September 2023, that indicated any psychological interventions were necessary.

184 I accept the inference from Ms Fitzgerald's evidence that if such a need became apparent, it would have been identified and addressed, including through LWB's therapeutic specialist, Ms Ang.[139]

185 I am satisfied that Ms Ang had independent engagement with Child MA,[140] and had formed a view (like Ms Fitzgerald) that a referral to any external service was not necessary at that time. I note that neither Ms Chilenga[141] nor Ms Atkins[142] held any concerns about Child MA's psychological wellbeing at any time either.

186 I find that Child MA's escalating behaviours in the months prior to his death were anticipated by LWB and the Department, were closely monitored and were adequately addressed as and when required.

187 I do not consider that there was any failure by those caring for Child MA to address those behaviours.

188 Further those behaviours, and their management, had no causal link with the events of 1 October 2023.

Communication between the Department and LWB

189 As identified above, the inquest focused on whether any issues in communication between the Department and LWB resulted in inadequate management of Child MA's care and supervision.

190 The focus arose, primarily, as a result of a Departmental case note of a meeting between staff from the Department and LWB regarding Child MA's case in August 2023.

191 The file note suggested that LWB staff agreed during this meeting that they could have communicated more clearly with the Department about Child MA's whereabouts and his missing school.

[139] Ts 37-38.
[140] Ts 39.
[141] Ts 87.
[142] Ts 146.

192 The note also contained an expression of concern on behalf of the Department about a perceived absence of clear communication around a suspension from school.

193 The outcome of the meeting was an agreement for a monthly meeting to be held to improve communications between the Department and LWB.[143]

194 I have no reason to doubt that the file note is an accurate recording of what was said during the meeting. However, self-evidently, the file note is one record in the context of the Department and LWB's care for Child MA extending over three years. It is necessary to consider the note in the context of the evidence as a whole.

195 According to Ms Fitzgerald, Departmental and LWB staff would communicate by phone, email and face-to-face at in-person meetings (including at Whitlock House and at school) and by video conference.

196 The communication primarily related to updates, and challenges or issues that were happening in relation to Child MA.[144]

197 LWB would also provide weekly reports about Child MA to the Department, generally prepared by Ms Fitzgerald or Ms Chilenga,[145] which later became monthly.[146]

198 These reports would be in addition to reports that needed to be made more urgently, for example if Child MA was sick, or suspended from school.[147]

199 If incidents occurred outside of hours, then communication of those incidents would usually occur by LWB's after hours service contacting Crisis Care, with Ms Fitzgerald or Ms Chilenga being advised when they returned to work the next business day (at which time they would generally touch base with their Departmental contact).[148]

200 Ms Fitzgerald's evidence was that she sometimes experienced difficulties in communicating with the Department.[149]

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[143] Exhibit 1, tab 23, p 18.
[144] Ts 13.
[145] Ts 13.
[146] Ts 99.
[147] Ts 13.
[148] Ts 14.
[149] Ts 15.

201 Her evidence was that the relationship was good initially, but it became harder and more difficult later, in the sense that at times it felt like LWB, and the Department were not working toward the same goal.[150]

202 Ms Chilenga suggested that communication could have been better, in the sense that at times requests from LWB were met with resistance or flat refusal by the Department.[151]

203 My impression from the evidence was that these communication issues concerned requests which were unrelated to the issues concerning Child MA arising in August and September 2023.

204 Ms Atkins's evidence was that Departmental staff had a very good collaborative relationship with LWB staff[152] and that LWB were very responsive in relation to Child MA's care.[153]

205 Ms Walsh-Johnsen's evidence was that there was a lot of communication between her and LWB in relation to Child MA, and there may have just been a delay in a few incident reports.[154]

206 I accept, from the documentary evidence, that there was some discussion between Departmental and LWB staff in August about the timeliness of some reporting. LWB conceded that not all incidents involving Child MA were reported promptly to the Department, but most were, and the Department was aware of Child AM's MA's behaviours in and out of school during any periods of suspension.[155] I accept that evidence.

207 Ultimately, I find that one school-related report concerning bullying was not relayed from LWB to the Department in a prompt manner, but in circumstances where LWB had taken steps to address the immediate issue and there was no consequence of the delay in that particular instance.[156]

208 I find that there were no communication issues between LWB and the Department which negatively impacted their management of Child MA's escalating behaviours in August and September 2023.

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[150] Ts 43.
[151] Ts 54.
[152] Ts 130.
[153] Ts 137.
[154] Ts 99.
[155] Exhibit 2, tab 1, par [8.10].
[156] Ts 44-46.

Child MA's arrangement to stay with MZ

209 Given the circumstances of Child MA's death, it would be easy, superficially and with the benefit of hindsight, to query the appropriateness of the arrangement approved by the Department for Child MA to stay with MZ overnight.

210 Based on the evidence, I do not consider that there is any scope for criticism of anyone involved in the approval of the arrangement for Child MA to stay with MZ overnight on weekends.

211 It is clear that MZ loved and cared for Child MA, and that he cherished their relationship.

212 MZ was well-regarded by her previous carers and the Department.[157]

213 She was considered a safe person by Department.[158]

214 There is no evidence to demonstrate that the approval of that arrangement represented acceptance of any known or inappropriate risk.

215 The evidence is to the contrary. The incident in August 2023 referred to above at par [101] only became known due to MZ's communication and transparency with LWB and Departmental staff.

216 MZ's involvement in identifying and addressing that behaviour by Child MA was demonstrative of her ability to enforce the arrangement in a way which minimised risk to Child MA.

217 She clearly had the capacity to communicate with the Department and LWB if Child MA was not adhering to the plan.

Development of Child MA's connection to culture and family

218 Both LWB and the Department were cognisant of the importance of Child MA's connection to culture and family.

219 However, as Ms Jacobitz appropriately recognised, this part of Child MA's care was so critical that it is almost inevitable that everyone could have done more.[159]

[157] Ts 67-62.
[158] Ts 140.
[159] Ts 80.

220 LWB staff listened to Child MA's voice, and tried to ensure contact with family members and people they understood were important to him.

221 Ms Chilenga would have conversations with Child MA about upcoming school holidays, and plans, and considered it was part of her role to consider and discuss opportunities to spend time with family members who were not based in Kalgoorlie.[160]

222 LWB would proactively identify cultural events,[161] and would take Child MA. They were also prepared to provide transport to visit family.[162]

223 LWB staff would also engage with the Department's Aboriginal Practice Leaders, including receiving advice and guidance.[163]

224 Ms Fitzgerald appropriately acknowledged that the updating of Child MA's individual care plan would have been an opportunity from LWB staff to apply fresh thought to what was being done to develop connection with Child MA's maternal family, beyond his siblings also living in Kalgoorlie[164] and his culture, generally.

225 LWB staff also followed any cultural support plans provided by the Department.[165]

226 However, in my view, the cultural support plans formulated by the Department were not just delayed at times,[166] but were non-specific and at a level of abstraction so as to be unhelpful to those, including LWB staff, who were required to implement them.[167]

227 Ms Atkins recognised that MC was very proactive around the importance of culture in Child MA's life and development, and she was a strong advocate for maintaining his connection to culture.[168] I accept Ms Atkins's evidence that this advocacy did not fall on deaf ears.[169]

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[160] Ts 91.
[161] Ts 88.
[162] Ts 39, 90.
[163] Ts 40.
[164] Ts 35.
[165] Ts 17, 88.
[166] Ts 134.
[167] Ts 145.
[168] Exhibit 2, tab 5, par [64].
[169] Ts 136.

228 I also accept her evidence that it would be usual practice for Departmental staff to reach out to Aboriginal extended family members as part of cultural support planning.[170]

229 However, there is no evidence that MC was ever consulted in the creation or review of any cultural support plans.[171]

230 The lack of engagement with MC was expressly recognised in the most recent cultural support plan. At the inquest, Ms Atkins agreed that the comment contained in the plan that further work needed to be done in engaging with Child MA's maternal family was to be understood as a reference to the need for further engagement with MC.[172]

231 I reject the proposition contained in a Departmental Needs Assessment Report from 2022 that Child MA's maternal family were reluctant to assist the Department to meet Child MA's cultural learning needs.[173]

232 I can understand why MC would feel degraded and belittled by that comment,[174] for which I have found no support in the materials. It is inconsistent with the evidence, and clearly not the Department's understanding at other times when, as identified above, the planning expressly recognised the importance of such engagement.

233 I accept that not all of the work done by the Department to support Child MA's connection to culture would have been documented. It is inevitable, in the context of heavy caseloads and competing priorities, that work will have been done that cannot be identified later. I make this comment having regard to resourcing constraints being experienced in the Department's Kalgoorlie office in the two years prior to Child MA's death, arising from the challenges around recruitment and retention of staff.[175]

234 I recognise MC's evidence that she feels like she did not get a chance to spend much time with Child MA.[176]

[170] Exhibit 2, tab 5, par [39].
[171] Exhibit 1, tab 25, par [16]; ts 135.
[172] Ts 136.
[173] Exhibit 1, tab 25, par [17].
[174] Exhibit 1, tab 25, par [18].
[175] Exhibit 1, tab 29, p 3.
[176] Exhibit 1, tab 25, pars [7], [30].

235 I accept that in the early stages of Child MA's time in care, the Department made decisions which were directed to ensuring Child MA and his other siblings in care could stay together.[177]

236 This was an appropriate focus, and ensured that Child MA was able to maintain those sibling relationships.

237 I accept the evidence of Departmental staff at the inquest that there were challenges in facilitating contact with family including MC at times, and that there were occasions when contact was arranged but did not occur for reasons outside the Department's control. I note that LWB records indicate that a trip to Esperance for Child MA was being contemplated as of June 2023,[178] and that LWB staff were looking ahead to school holidays as another opportunity to visit family in Esperance.[179]

238 Departmental staff recognised that challenges in organising contact for Child MA with the maternal side of his family could have been managed better,[180] and whenever a child is placed with '*one side*' of the family (as was the case when Child MA was living with his paternal grandparents), there is always opportunity for greater efforts to be made to make sure that connection happens with the other side of the family.[181]

239 The Departmental witnesses accepted that contact between Child MA, and his maternal extended family was, ultimately, more driven by the family contacting the Department, rather than planning for that.[182]

240 This is consistent with MC's evidence.[183]

241 The Department expressly recognised the importance of attempts being made to reach out to MC to engage her in care planning,[184] however, again, there is no evidence that she was invited to care team meetings including the meeting on 17 August 2023.[185]

[177] Ts 166.
[178] Exhibit 3.
[179] Exhibit 3.
[180] Ts 136-137.
[181] Ts 167.
[182] Ts 167.
[183] Exhibit 1, tab 25, par [31].
[184] Ts 108.
[185] Exhibit 1, tab 25, par [15]; ts 128-129.

242 As identified above, I am satisfied that the possibility of Child MA moving to Perth with EM and GM had not reached a point, or been decided, such that consultation with extended family was required.[186]

243 However, given the absence of clear evidence that the Department sought to routinely engage MC in decision-making, I am not persuaded that it can be said with certainty that MC would have been consulted.

244 As Ms Atkins candidly recognised, it was more regular than she would like to admit that the maternal side of the family were not involved.[187]

245 I do not accept the suggestion that any lack of consistent engagement with Child MA's extended maternal family, or decisions as to care arrangements for Child MA, were a consequence of the Department not wanting Child MA to be in the care of the Aboriginal side of his family.

246 However, I can understand how family may come to that view, and hold it genuinely, [188] if there has been inconsistent engagement over time.

247 In terms of improvements since Child MA's death, I note Ms Binks's evidence that each Departmental district now has their own Closing the Gap plan with clear targets and requirements for greater self-determination for Aboriginal families.[189]

248 I am also encouraged by Ms Binks's statement that she is more confident than ever that the Department is focused on the importance and value of cultural planning and districts are more active in seeking family and community-based input.[190]

249 Ms Binks's evidence satisfies me that even if there were oversights in this aspect of Child MA's care, cultural support planning by the Department today is much more closely aligned to care planning, and there is an emphasis on ensuring that information is collected from the family and the child over a period of time.[191]

[186] Ts 128-129.
[187] Ts 133.
[188] Exhibit 1, tab 25, par [34].
[189] Ts 188.
[190] Ts 188-189.
[191] Ts 162.

Conclusions

250 Child MA's death was a terrible event.

251 The inquest process made plain that all of those involved in his life and his care – from family in Kalgoorlie and Esperance, to carers, to LWB and Departmental staff – felt great affection toward him.

252 I extend my condolences to all of his family and those involved in his care.

253 These findings have identified that the supervision, treatment and care afforded to Child MA before his death was adequate, but with some identified areas for improvement that represent a challenge for those involved in the supervision of children in care in the future.

BD Nelson
Coroner
23 July 2026