Inquest into the death of Mason Jet Lee

Review of public servants' conduct

July 2020

Queensland Government

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Introduction

On 2 June 2020, the Deputy Coroner released *the* Findings of the Inquest into the death of Mason Jet Lee (the coroner's report) finding the handling of Mason's case was "…a failure in nearly every possible way by the relevant employees…" of the Department of Child Safety, Youth and Women (the department).

The Director-General, Department of the Premier and Cabinet instructed the Public Service Commission (PSC) to conduct a review of the coroner's report to:

- consider the conduct of the public servants involved
- review the previous investigation by the department's Ethical Standards Unit (ESU)
- advise if any grounds exist for further disciplinary action under the *Public Service Act 2008* (PS Act) for the public servants involved.

This report details the review findings and provides recommendations. It should be noted that individual employees have not been named in this report but have been referred to using the same identifiers used in the coroner's report.

The following employees were considered in the scope of this review:

- CSO1, CSO3, CSO4, CSO6
- STL1, STL2, STL3, STL4
- Manager 1
- the intake officers (collectively).

Summary of conclusions

1. There is no scope for further discipline under the PS Act for eight of the nine frontline officers (with the exception of Manager 1) who were the subject of the ESU investigation, because the department:
   a. has concluded disciplinary action, or
   b. did not commence post-separation disciplinary action in time.

2. The disciplinary action that was taken against frontline officers is manifestly inadequate, given the objective seriousness and extent of the officers' failings identified in the coroner's report and the ESU investigation. It is worth noting that in the correspondence to employees, the decision maker did not provide reasons that were sufficient to explain the discipline imposed.

3. With the exception of Manager 1, the coroner's report did not identify grounds for discipline against any employees who have already faced discipline.

4. The department has implemented a range of systemic reforms to address failures by intake officers and frontline officers.

Recommendations

1. The department delegates authority to the PSC to commence a disciplinary process against Manager 1 for the failures noted in the coroner's report and the ESU investigation.

2. The department delegates authority to the PSC to conduct an investigation into the management decision making chain to determine whether disciplinary action should be taken against responsible officers for their role in the management of resourcing and workloads of the Caboolture Child Safety Service Centre (CCSSC).

3. To improve the department's practice with respect to discipline under the PS Act, the department be required to seek independent expert advice from Crown Law on all disciplinary processes for the next two years, subject to periodic review by the PSC.

Background to the review

The coroner's report highlights the circumstances that led to Mason's death. The PSC review does not provide additional commentary about this tragedy and relies on the detailed description of events contained in the coroner's report.

Mason was only 22 months old at the time of his death, and as the Deputy Coroner notes, was entirely dependent on others to protect him. The Deputy Coroner concluded the handling of Mason's case "…was a failure in nearly every possible way by the relevant employees of the department to comply with their statutory obligations, their manual, their policies and procedures".

The PSC review:

- considered whether there are any grounds for further disciplinary action under the PS Act for those public servants involved
- outlined options available to the Queensland Government with respect to possible further action
- provided a summary of proposed reforms to further support a disciplined public service, a public service that is fair, an employer of choice and a leader in public administration.

The PSC review considered the following materials:

- the coroner's report
- the department's ESU investigation report and attachments, including the desktop review
- documentation relating to disciplinary processes commenced on completion of the ESU investigation report
- documentation of management action relating to the ESU investigation report
- relevant departmental policies and procedures
- *Commission Chief Executive Guideline 01/17: Discipline*
- *Code of Conduct for the Queensland public service*
- Chapter 6 of the PS Act.

The integrity framework for the Queensland public service is supported by the:

- *Public Service Act 2008* – provides for the administration and management of the public service, including discipline.
- *Public Sector Ethics Act 1994* – declares the ethics principles and sets the framework for the Code of Conduct for the Queensland public service.
- *Public Interest Disclosure Act 2010* – promotes the public interest by facilitating public interest disclosures of wrongdoing in the public sector.
- *Crime and Corruption Act 2001* – directed to continuously improving the integrity of, and to reduce the incidence of corruption in the public sector.
- *Criminal Code Act 1899* – establishes specific offences for public officers.

Discipline

Queensland public service disciplinary framework

Publicly reported conduct and performance data shows the vast majority of Queensland public service (public service) employees meet or exceed the standards of conduct and performance expected of them. Data shows that misconduct is not widespread – the most serious cases represent less than 0.1 per cent of the public service. Agencies, by and large, manage these most serious cases in a timely and effective way.

Punishing an employee is not the focus of disciplinary action against employees. The majority of employees who face discipline remain in public service employment, supporting the underlying principle that discipline is as much about maintaining a disciplined workforce as it is about implementing corrective action. Taking considered corrective and supportive actions promote integrity in the public service.

The PS Act establishes the framework for discipline processes in the public service. Grounds for discipline are specified at section 187, and the framework allows an agency chief executive to take disciplinary action where a ground is established. The PS Act provides examples of disciplinary action that range from reprimand – at the least serious end of the scale – through to termination of employment for the most serious breaches of discipline, usually in cases of misconduct.

Misconduct is defined as:

- inappropriate or improper conduct in an official capacity (see section 187(4)(a) PS Act); or
- inappropriate or improper conduct in a private capacity that reflects seriously and adversely on the public service (see section 187(4)(b) PS Act).

Specific provisions exist to impose a disciplinary declaration for people who leave government employment and who would otherwise have faced serious disciplinary action (post-separation disciplinary action).

Section 188A of the PS Act allows a disciplinary process to be commenced against a former employee and make a disciplinary declaration only where, if their employment had not ended, the disciplinary action taken would have been termination or reduction of classification level.

The disciplinary declaration must be made within two years after the person leaves government employment.

Employees cannot be disciplined twice under the PS Act for the same conduct. Any such decision would be susceptible to challenge based on double jeopardy.

The principle behind double jeopardy is that a person cannot be punished twice for what is substantially the same act.

To commence a new or further disciplinary process without offending the principle of double jeopardy, there would need to be a different factual basis for commencing a further disciplinary process, or new evidence in relation to an employee's conduct.

Discipline against frontline officers

Eight of the nine frontline officers (with the exception of Manager 1) identified as subjects of the ESU investigation have already had discipline processes commenced and finalised in relation to Mason's case. Of these:

- five of the eight officers disciplined received a reprimand (CSO1, STL1, SLT2, SLT3 and SLT4)
- only one officer (CSO6) received a penalty more serious than a reprimand – a post-separation discipline declaration, stating that the discipline action of reduction in classification level would have been taken had the employee's temporary employment not ended
- two of the officers who left the department (CSO4 and CSO3) received no discipline action or post-separation discipline action. It appears the basis for this is that their conduct was not considered sufficiently serious as to have warranted termination or reduction in classification, had their employment not ended.

It is the PSC's view that the discipline imposed (particularly for CSO3 and CSO6) was manifestly inadequate.

Each allegation against the frontline officers was found by the department to be grounds for discipline. This was on the basis that the employees had performed their duties carelessly, incompetently or inefficiently under section 187(1)(a) of the PS Act.

This finding significantly understates the seriousness of the frontline officers' conduct given the extensive failures to comply with the legislative, policy and Child Safety Practice Manual requirements (particularly by CSO3, CSO6, STL1 and STL4).

It was open to the decision maker to regard the conduct as misconduct within the meaning of section 187(1)(b) of the PS Act, on the basis that it amounts to inappropriate or improper conduct in an official capacity within the meaning of section 187(4)(a) of the PS Act.

Considering the nature and the seriousness of the conduct, disciplinary action of more serious consequence should have been implemented. A summary of the disciplinary action reasonably open for each frontline officer is in Attachment 1.

It is not possible to understand the rationale of the departmental decision makers that supported such lenient disciplinary action being imposed.

A conventional discipline process would involve a decision maker, supported by human resource professionals providing advice about the evidence available, making a finding on an alleged disciplinary breach. In the event a discipline breach was substantiated, further advice would be expected about the range of disciplinary action that could be imposed.

For the discipline processes related to Mason's case, the department could not locate any formal briefing notes or advice of substance provided to the decision maker. The disciplinary letters provided to the frontline officers do not contain reasoning that adequately supports why more serious disciplinary action was not taken.

Mitigating factors relating to workload and the undocumented matrix model of supervision implemented by Manager 1 – which led to double handling and lack of ownership by team leaders – were referred to. It is the PSC's view these do not outweigh the seriousness of the conduct nor reflect the significant extent of the failings by the frontline officers.

Can further disciplinary action be imposed?

Given the discipline processes have already occurred, any further discipline action considered by the department against the frontline officers is likely to be challenged based on the principle of double jeopardy. That is, an employee cannot be punished twice under the PS Act for the same conduct.

It is unlikely that new facts could be established given the comprehensive nature of the department's ESU investigation report.

For the employees who resigned before discipline action was imposed, the PS Act allows a chief executive to make a post-separation disciplinary declaration within two-years following the person ending their public service employment.

It is unclear why the department chose not to make a declaration, particularly in respect of CSO3's most serious conduct, however the two-year time limitation has now expired.

Discipline against intake officers

In addition to the frontline officers, there were a number of employees of the department (both child safety officers and senior team leaders) who had conducted intakes of child protection concerns in relation to Mason and his siblings. Between 20 September 2015 and 15 April 2016, there were six separate intake events involving Mason and/or his siblings.

There were 13 intake officers identified in the ESU desktop review, although two of the employees considered as part of the desktop review were also frontline officers (CSO1 and STL1).

Each of the intake officers were found to:

- have failed to conduct an intake of child protection concerns, or
- have inappropriately approved an intake of child protection concerns that was not conducted in accordance with legislation and/or departmental policy and practice guidelines.

By its very nature, the desktop review did not involve the intake officers being interviewed as part of a formal investigation, rather desktop review findings were made on the basis of the available documentary evidence.

In May 2017, 10 employees (excluding CSO1 and STL1) were sent letters by a Deputy Director-General (DDG2) advising them of the outcome of the desktop review. The employees were each advised that the allegation against them was capable of being substantiated but that no further action would be taken.

The process was finalised with a detrimental action (see section 17 *Public Service Regulation 2018*) – a record placed on the employee's file that could be considered detrimental to the employee's interests.

The department has implemented a range of systemic responses to the issues identified by various reports completed following Mason's death.

These changes are summarised in the coroner's report, and reforms include changes to policy and processes, systems and a restructure of caseloads and resourcing for the Moreton Region. The PSC review does not evaluate the systemic responses however, it is apparent these are designed to address the failures by intake staff.

Can disciplinary action be imposed?

The principle of "double jeopardy" would apply to the intake officers in the same way it applies to frontline officers, as the process has been finalised with a detrimental action. The department concluded no further action would follow for any of the officers.

Further, given the vast difference in seriousness of the actions of the frontline officers compared with those of the intake officers, it would likely be found to be disproportionate and unreasonable to now impose reprimands on the intake officers.

For the above reasons it is the PSC's view that with the implementation of systemic changes, and the imposition of a detrimental action, the intake officers have no further case to answer.

Discipline against Manager 1

Manager 1 was not disciplined by the department. During its investigation, the ESU found the following allegation against Manager 1 was not capable of being substantiated:

> *"Between 9 December 2015 and 11 June 2016, Manager 1 failed to appropriately manage the Caboolture Child Safety Service Centre and/or failed to ensure the Caboolture Child Safety Service Centre leadership team provided an appropriate level of supervision and support to staff during service delivery."*

This conclusion was accepted by the decision maker, Deputy Director-General (DDG1), who determined not to commence a disciplinary process. DDG1 informed Manager 1 that they had accepted the ESU's findings that the allegation was not capable of being substantiated.

The Deputy Coroner clearly came to a different conclusion and a summary of management failures is set out in paragraphs numbered 904-909 of the coroner's report, with a conclusion at paragraph 910 that Manager 1 failed to appropriately manage the Caboolture Child Safety Service Centre (CCSSC) between 9 December 2015 and 11 June 2016.

At paragraph 911 the Deputy Coroner found:

> *"I accept that CCSSC was under resourced and its staff overworked, and Manager 1 was not able to remedy those fundamental issues without additional resources, the allocation of which were out of her control. However, the same could be said of the CSOs and STLs all of whom were held accountable for their omissions whilst Manager 1 was not."*

Can disciplinary action be imposed?

Manager 1 was ultimately not the subject of a discipline process. and commencing a discipline process would not breach double jeopardy rules.

It is acknowledged that a significant period of time has elapsed since the alleged failures occurred, and that a discipline process is likely to have a significant impact on Manager 1.

These issues must be considered in light of the Deputy Coroner's clear conclusions and weighed against the department's responsibility to set clear performance expectations for its employees, particularly when those employees are involved in such critical frontline service delivery aimed at ensuring the safety of children.

The purpose of discipline is to implement corrective action to promote and maintain a disciplined workforce and ensure the best possible outcomes. If a disciplinary process is commenced, it will be open to Manager 1 to dispute any alleged discipline breach and highlight the impact of resourcing or other factors on the management of the CCSSC.

The performance of Manager 1 over the last four years would also be a consideration should the discipline process proceed to a point where discipline action is considered. A discipline process under the PS Act is an appropriate mechanism for these issues to be examined.

So as not to prejudice any such process, and to ensure that any such process is conducted in a fair and transparent way the PSC review makes no findings about Manager 1's conduct.

Recommendation

The department delegates authority to the PSC to commence a disciplinary process against Manager 1 for the failures noted in the coroner's report and the ESU investigation.

Mitigating factors

There are a range of mitigating factors highlighted in the coroner's report, including:

- the failed implementation of the matrix model
- lack of adequate supervision
- workplace culture
- lack of resources, staff workloads and staff retention, turnover and experience at the CCSSC.

The potential culpability of the chain of management responsible for CCSSC, including the Regional Director, does not appear to have been considered by either the ESU or the Deputy Coroner.

It appears to have been accepted that there were significant workload and resourcing issues in CCSSC, though no specific evidence about this was canvassed during the ESU investigation.

If the chain of management for CCSSC was aware of:

- the significant resourcing issues in CCSSC and was not actively taking steps to address or respond to those issues
- the implementation of the matrix model which had been uniquely introduced at the CCSSC and was problematic
- ongoing issues with the workplace culture at CCSSC which were not addressed

this could give rise to a potential basis upon which a disciplinary process could be commenced against them and/or any more senior officer of the department who may have been aware of resourcing and other issues within the CCSSC.

Recommendation

The department delegates authority to the PSC to investigate the management decision making chain to determine whether disciplinary action should be taken against responsible officers for their role in the management of resourcing and workloads of the Caboolture Child Safety Service Centre (CCSSC).

Management of the disciplinary process

The coroner's report acknowledges the thorough investigation undertaken by the department's ESU investigators, and the comprehensive report of investigation findings.

This should have set the department's decision makers up well to commence disciplinary proceedings and to make findings regarding the frontline officers' liability for discipline, and any subsequent disciplinary action that reflected the seriousness of the conduct.

It is unclear why the decision makers took such a lenient approach to discipline.

The PSC review has already highlighted the department was not able to locate any formal briefing notes or advice of substance provided to the decision maker. The disciplinary letters provided to the frontline officers do not contain reasoning that adequately supports why more serious disciplinary action was not taken.

By choosing such a course of action, the decision makers effectively undermined the comprehensive investigation, and confidence that the discipline action for frontline officers would reflect the complete failure to perform the fundamental requirements of their role.

The failure by the decision makers to take appropriate disciplinary action is highlighted in the handling of just two of the frontline officers' matters (CSO3 and CSO6) whose conduct arguably amounted to misconduct.

While it is unclear how DDG1 formed their decision, they failed to impose disciplinary action that reflected the seriousness of the conduct, and failed to apply parity of treatment for CSO3 and CSO6 by:

- deciding not to take post-separation discipline for CSO3 – on the basis that had they not resigned, they would have received a reprimand
- taking post-separation discipline action against CSO6 – on the basis had their employment not ended, they would have faced a reduction in classification level.

It is arguable that CSO3's conduct was more serious than CSO6's conduct, though it is the PSC's view that it was open to terminate both officers' employment.

Each of the decision-makers held delegated authority to conduct discipline processes from the Director-General of the department. However, it is important to note that delegating power and functions to a Deputy Director-General did not absolve the Director-General of ultimate responsibility. The Director-General still held responsibility to make sure appropriate decisions had been made and the system of discipline in the department was working effectively to set appropriate standards for the workforce.

Having delegated their power and functions in relation to discipline action under Chapter 6 of the PS Act, the Director-General remained responsible for ensuring the function or power delegated was properly exercised.

Given the gravity of the circumstances leading to the discipline processes, and the extensive and multiple reviews by various agencies and units, the Director-General, even if not the decision maker, ought to have asked to be informed or consulted before decisions were made, and should have ensured that they supported a suitable level of accountability and performance. It is unclear as to whether this occurred.

Had DDG1 remained an employee of the department, or another government agency, consideration could have been given to commencing a discipline process against them in relation to their decision making in the discipline processes.

The two-year timeframe in which a post separation disciplinary process could have been commenced against DDG1 has expired.

Recommendation

To improve the department's practice with respect to discipline under the PS Act, the department be required to seek independent expert advice from Crown Law on all disciplinary processes for the next two years, subject to periodic review by the PSC.

What are the systemic considerations for discipline?

In September 2018, the Queensland Government announced an independent review of the PS Act and other Queensland public employment laws.

A fair and responsive public service for all (Bridgman review) was completed in May 2019, with 99 recommendations about how Queensland public employment laws should be changed to meet the objectives of fairness in the employment relationship, responsiveness of employees to the community and to government and inclusiveness of public sector employment.

While acknowledging the majority of public servants do the right thing, the Bridgman review makes specific recommendations about the way investigations and discipline are conducted to promote greater transparency and fairness in process, and to support the sector to increase accountability.

Reforms proposed in the Bridgman review address some of the department's failures with respect to the handling of the disciplinary processes, by placing additional accountability on departments and providing for greater oversight of public service discipline.

The Queensland Government is currently considering reform priorities.

Referral to Crime and Corruption Commission

The coroner's report highlighted significant failures in the performance of their duties by several employees involved in, and responsible for, the delivery of child protection services for Mason.

There is a reasonable suspicion of corrupt conduct – within the meaning of s 15(1) of the *Crime and Corruption Act 2001* (CC Act) – relating to CSO3, CSO6, STL1, STL4 and Manager 1. These employees could reasonably have had their employment terminated based on their alleged conduct (see Attachment 1).

An argument arises that the conduct of those officers:

- adversely affects, or could adversely affect, directly or indirectly, the performance of functions or the exercise of powers of a unit of public administration (see section 15(1)(a)(i) CC Act)
- results, or could result, directly or indirectly, in the performance of functions or the exercise of powers in a way that involves a reckless breach of trust placed in the person holding the appointment (see section 15(1)(b)(ii) CC Act)
- would, if proved, be a disciplinary breach providing reasonable grounds for terminating the person's services (see section 15(1)(c)(ii) CC Act).

In accordance with section 38 of the CC Act, the PSC has an obligation to refer this matter to the Crime and Corruption Commission for assessment of whether the behaviours and actions of CSO3, CSO6, STL1, STL4 and Manager 1 amounts to corrupt conduct.

It will be necessary to await the outcome of the assessment prior to taking any further action. The Crime and Corruption Commission will determine the appropriate course of action.

Conclusion

As requested by the Director-General, Department of the Premier and Cabinet, PSC has conducted a review of the coroner's report and the ESU investigation report to understand the conduct of the public servants involved and determine whether there are any grounds for further disciplinary action for those public servants involved.

The Deputy Coroner notes the "…errors and failings of the individual employees of the department were merely the component parts of the collective failure of the department". This statement is not inconsistent with the principles of public service discipline – that corrective and supportive actions are taken to promote a high-performing workforce that delivers services to the people of Queensland.

The PSC review finds that the disciplinary action that was taken against officers could reasonably be considered manifestly inadequate, having regard to the objective seriousness and extent of the failings which have been identified in the coroner's report and the ESU investigation report.

With the exception of Manager 1, the coroner's report did not identify grounds for discipline against employees that were not already identified in the ESU investigation.

The PSC review finds that based on the material considered, there are no further grounds for discipline for the frontline officers, who have already faced discipline, or the intake officers, who had management action imposed.

Robert Setter

Commission Chief Executive

Public Service Commission

6 July 2020

Attachment 1

Disciplinary action the decision maker could have proposed

Note: It is necessary to cross reference with pages 65 to 93 of the coroner's report for context.

CSO1 – reduction of remuneration level

While CSO1's failure to properly conduct the investigation and assessment in December 2015 resulted in the level of risk not being assessed properly, there were other child safety officers more directly involved with Mason's case after December 2015 and their failings contributed more greatly the ultimate outcome for Mason.

CSO3 – termination of employment (as part of a post separation discipline declaration)

CSO3's actions in discharging Mason from hospital into his mother's care and not properly complying with the intervention with parental agreement over the following 10 weeks amounted to a total failure of their obligations as a child safety officer.

CSO4 – reduction of classification level and consequential change of duties

Although CSO4 did not have primary conduct of Mason's case, they had a discussion with CSO6 on the afternoon of 10 June 2016 after CSO6 took the telephone call from Ms Lee's neighbour. On their own evidence, they were more concerned with ensuring Ms Lee attended a domestic violence appointment than with Mason's safety.

CSO6 – termination of employment (as part of a post separation discipline declaration)

Although CSO6 was only involved in Mason's case for a short time, their failings, particularly their response to the telephone call from Ms Lee's neighbour, are indefensible.

STL1 – termination of employment, or at minimum, reduction in classification level with consequential change in duties

STL1 attended the 15 March 2016 suspected child abuse and neglect system meeting and was provided information at the meeting regarding the significant concerns for Mason's safety and wellbeing. In not acting on that information, they failed to discharge her obligations under the *Child Protection Act 1991* and departmental polices.

STL2 – reduction of remuneration level

Although STL2 was a senior team leader and had some involvement in assessment and approval processes, they did not have direct involvement in the management of Mason's case and were not the immediate supervisor of the CSOs involved.

STL3 - reduction of remuneration level

Although STL3 was a senior team leader, their primary involvement was as a result of them acting in STL4's position while STL4 was on a period of leave. They were not particularly singled out by the Deputy Coroner in the criticism of frontline officers.

STL4 – termination of employment, or at minimum, reduction in classification level with consequential change in duties

STL4 was responsible for re-allocating Mason's case to CSO6 in late May 2016. They failed to provide any proper handover and, despite CSO6 only recently commencing CSO duties, failed to provide proper supervision and guidance to CSO6.

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