Implementation summary: Review of public servants' conduct

Following the Deputy Coroner's release of the *Findings of the Inquest into the death of Mason Jet Lee* (the coroner's report), the Director-General, Department of the Premier and Cabinet instructed the Public Service Commission (PSC) to undertake a review into the conduct of public servants involved, and advise if any grounds existed for further discipline under the *Public Service Act 2008* (PS Act). The review was completed on 6 July 2020, with three recommendations which were accepted by government for action. This implementation summary provides high-level details of the *Review of public servants' conduct* findings, implementation of the three recommendations, plus a timeline of activity.

Overarching findings
The PSC review found that while no one person was solely responsible for failing Mason – when combined, the collective impact of individuals' actions had dire consequences. Further, the discipline imposed at the time was manifestly inadequate and not in any way consistent with that would have been considered acceptable under the PS Act, nor with the public's expectations of public servants. It is the opinion of the PSC that in the most serious cases, some employees should have had their employment terminated, some should have received a reduction in pay and others demoted.

A fundamental feature of the legal system however, is the protection against double jeopardy – that is that people cannot be punished or disciplined for the same action twice – even, where the original discipline imposed is considered inadequate. The PSC was forced to conclude that it wasn't legally possible to take further discipline against any of those employees who had already faced discipline. In parallel, the PSC assessed whether the actions of any employees constituted corrupt conduct. Allegations relating to a number of employees were referred to the Crime and Conduct Commission, however the CCC found that on the evidence provided there is nothing to suggest or support the view that the actions constituted corrupt conduct. This finding further closed possible legal avenues, and the PSC concluded the case against those employees who had already faced discipline is now finalised.

Recommendations
In addition to the overarching findings the review put forward the three recommendations which are now considered closed. Details are in the table below:

Review recommendations	Summary of findings	Considerations	Outcome
Recommendation 1 The department delegates authority to the PSC to commence a disciplinary process against Manager 1 for failures noted in the coroner's report and the Ethical Standards Unit (ESU) investigation.	Only one employee, referred to in the coroner's report as Manager 1, had not had any discipline taken against them and as such did not fall within the double jeopardy rule. Considering this, and the coroner's criticism of Manager 1 the PSC recommended that the option to discipline this employee should be explored. McGrathNicol – specialist forensic investigators – were engaged to understand the role of management relating to the resourcing and workloads of the Caboolture Child Safety Service Centre (CCSSC) (see recommendation 2 below). The investigation found Manager 1: • did not act in isolation • implemented actions in response to the workloads of the CCSSC which were supported by management and executives • managed employee performance issues with the support of human resources.	The evidence in the McGrathNicol report supported findings that Manager 1 introduced a management model (the matrix model) to deal with workload issues with the approval of regional management. Issues regarding workload and resourcing issues were escalated to regional management who acted appropriately by escalating them to the department's head office. More than four years have passed since the events that led to Mason's death. There is no suggestion of any concerns with Manager 1's conduct or performance since that time. The PSC considered whether to issue a show cause notice to Manager 1 by examining in detail the conduct of Manager 1 as detailed in the coroner's report and ESU investigation.	Taking into account the new information in the McGrathNicol report that became available after the coroner's report was finalised, the PSC concluded that legally there were no grounds for discipline against Manager 1, and as such no discipline can be pursued. The PSC case and recommendation to commence discipline against Manager 1 is now considered closed.

Recommendation 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 CCSSC.
	Neither the coroner's report nor the department's ESU investigation considered the role of the decision making chain in Mason's case. Specifically, if discipline should be taken against anyone for their role in the management of resourcing and workloads in the CCSSC. The PSC recommended investigating the role of management.
	
	McGrathNicol – specialist forensic investigators – were engaged to support PSC in this recommendation.
	
	The PSC found:
	• there may be a basis for discipline against members in the management decision making chain if they were aware:
	  ○ of the significant resourcing issues in CCSSC and they did not actively take steps to address or respond to those issues
	  ○ that the matrix model of management which had been uniquely introduced at the CCSSC, and was considered a complicating factor in Mason's case, was not suitable
	  ○ of ongoing issues with the workplace culture at CCSSC and that these were not addressed.
		The matrix model:
		• was introduced with regional management knowledge
		• received initial feedback which was mainly positive
		• later received mixed feedback which was escalated and resulted in a review of the system
		• the review resulted in a decision to discontinue the matrix model in June 2016, prior to Mason's death.
		
		In relation to management:
		• there were no system deficiencies identified within the CCSSC relating to escalation, consideration and management of resourcing and workload issues within the management chain
		• issues regarding employee management of the CCSSC were appropriately escalated to the chain of management and human resources
		• regional management had escalated concerns regarding insufficient resources and the misalignment of resources with workload with departmental executives in head office.
		
		McGrathNicol did not examine the senior executive response to the escalation of issues, or the degree to which resourcing limitations and competing service delivery priorities at the time might have constrained their ability to address those issues.
			The McGrathNicol investigation found that regional management escalated concerns regarding insufficient and pressured resourcing to departmental executives, as was their responsibility.
			
			For these employees there was no case for them to answer.
			
			The PSC also found that all senior executives involved above regional management level have since left the Queensland public service.
			
			The PSC recommendation into the management decision making chain is now considered closed.

Recommendation 3 To improve the department's practice with respect to discipline under the *Public Service Act 2008*, 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.	The PSC determined that there were significant failures in the discipline processes conducted by the department. The discipline imposed were manifestly inadequate and disciplinary documentation failed to contain reasoning that adequately supported why more serious discipline was not taken.	Failures in the discipline process conducted by the department at the time were so significant that the review recommended that a Deputy Director-General (DDG1) identified in the coroner's report, could face discipline for deciding to impose discipline that was clearly inadequate and not supported by the facts, given the seriousness of the breaches by employees. DDG1, however no longer works for the Queensland public service and separated more than two years ago. As such there are no legal avenues available to pursue this person for discipline. While there are no grounds for further action against any public service employee, a recommendation from this review will see the (now) Department of Children, Youth Justice and Multicultural Affairs make significant changes to its processes for managing discipline.	While DDG1 was responsible for failures in the discipline process conducted by the department, they are unable to face discipline as they have left the Queensland public service. The case against this employee is now closed. To address the systemic mismanagement of poor performance the department will now require independent advice from Crown Law on all discipline processes for the next two years. PSC will also monitor departmental discipline processes over the next two years. Terms of reference for this work has been finalised and the first meeting of the community of practice to support this recommendation has commenced. The PSC recommendation to improve the department's discipline practice is now considered closed, and has moved to implementation.

Timeline of review and implementation of recommendations