QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Mason Jet Lee**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2016/2338
DELIVERED ON:	2 June 2020
DELIVERED AT:	Brisbane
HEARING DATE(s):	11 June 2019, 9 December 2019 & 16 – 17 March 2020
FINDINGS OF:	Jane Bentley, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, child death, child protection, Department of Child Safety, Youth and Women, SCAN, information sharing, adoption, permanency orders.

REPRESENTATION:

Counsel Assisting:	Dr Jacoba Brasch QC with Ms Sarah Lio-Willie
Department of Child Safety, Youth & Women:	Mr Jeffrey Hunter QC with Ms Karen Carmody (instructed by Gilshenan & Luton Legal Practice)
Qld Corrective Services:	Ms Taylor Mobbs (Qld Corrective Services)
Metro North Hospital & Health Service:	Mr Geoff Diehm QC (instructed by Metro North HHS legal service)
Department of Health:	Mr Geoff Diehm QC (instructed by Corrs Chambers Westgarth)
Commissioner of Queensland Police:	Ms Janice Crawford (instructed by QPS Legal)
Qld Children's Hospital & Health Service:	Ms Anna-Maria Lofaro (Minter Ellison Lawyers)
STL4:	Mr Mitchell Rawlings (instructed by Susan Moriarty & Associates)
Anne-Maree Lee:	Ms Wendy Mulcahy (Mulcahy Ryan Lawyers)
Mission Australia:	Ms Amelia Avery-Williams (Hunt & Hunt Lawyers)
Dr 1:	Mr David Schneidewin (instructed by Moray & Agnew Lawyers)
Police officers:	Mr Troy Schmidt (instructed by Gnech Lawyers)

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INTRODUCTION

1. Section 45 of the *Coroners Act 2003* provides that when an inquest is held the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to officials with responsibility over any areas the subject of recommendations. These are my findings in relation to the death of Mason Jet Lee. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Coroners Court of Queensland.

2. These findings and comments:

    1. confirm the identity of the deceased person, the time, place and medical cause of his death;
    2. consider whether the actions or omissions of any third party contributed to his death; and
    3. consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

BACKGROUND

3. Mason Jet Lee was 22 months old when he died. He was totally dependent on others to feed, nurture, love and care for him. Those who should have cared for and protected him allowed him to be abused and neglected to the point that the injuries inflicted on him caused his painful and prolonged death.

4. The purpose of this inquest is to discover why Mason was allowed to die rather than being protected, and whether any changes can be made to ensure that children such as Mason are better protected in the future.

CORONIAL JURISDICTION

5. An inquest is a fact finding exercise and not a process for allocating blame. The procedure and rules of evidence used in criminal and civil trials are not adopted. "In an inquest there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish the facts. It is an inquisitorial process, a process of investigation quite unlike a trial."[1]

6. The purpose of an inquest is to inform the family and the public about how the death occurred and, in appropriate cases, to make recommendations with a view to reducing the likelihood of similar deaths. As a result, a coroner can make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances.

7. A coroner is prohibited from including in the findings or any comments or recommendations any statement that a person is, or may be, guilty of an offence or civilly liable.

[1] *R v South London Coroner, ex parte Thompson* (1982),126 S.J. 625

8. The *Coroners Act 2003* provides that if, from information obtained at an inquest or during the investigation, a coroner reasonably suspects a person has committed an offence, the coroner must give the information to the Director of Public Prosecutions in the case of an indictable offence and, in the case of any other offence, the relevant Department.

9. The findings of a coroner must be based on proof of relevant facts on the balance of probabilities. The principles set out in *Briginshaw v Briginshaw* are applicable.[2] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard. A coroner also is obliged to comply with the rules of natural justice and to act judicially. This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding.

ACRONYMS AND ABBREVIATIONS USED IN THESE FINDINGS

10. It is accepted that every employee of the Department of Child Safety, Youth and Women, Queensland Health, the Queensland Police Service and Mission Australia and those who knew Ms Lee and/or Mr O'Sullivan and had any involvement with Mason during his short life have been greatly affected by his tragic death.

11. Naming those persons in these findings will not advance the purposes of the inquest. Therefore, no names are used in these findings. Relevant persons are identified by acronyms. An explanation of the abbreviations and acronyms used is set out in Appendix 1 to the findings.

THE DISCOVERY OF MASON'S DEATH

12. Mason was born on 16 August 2014. He was the fifth child of Anne-Maree Louise Lee.

13. Just over a year before Mason's death Ms Lee commenced a relationship with William Andrew O'Sullivan. They did not reside together but lived about a kilometre apart. Mr O'Sullivan lived with his five year old son. Mr O'Sullivan had a housemate, 17 year old HM, who moved in about two weeks prior to Mason's death. HM's girlfriend, Ms S did not reside at the house but was a regular visitor.

14. In the period before Mason's death Mr O'Sullivan kept Mason at his residence.

15. At about 12.50am on 11 June 2016 police officers of the Queensland Police Service and paramedics of the Queensland Ambulance Service attended Mr O'Sullivan's residence at Caboolture. On their arrival Mr O'Sullivan ran into the front yard holding Mason in his arms. He passed Mason over the top of the front fence to paramedics on the other side.

[2] (1938) 60 CLR 336 at 361

16. Mason was obviously deceased and had been for some time. He was wearing a dirty white singlet and nothing else. Police officers and paramedics immediately observed bruises on his face, arms, legs and body as well as severe injuries to his anus.

17. Mr O'Sullivan told police that he had fed Mason when he got home that night. He said Mason vomited so he cleaned him up. He said that his friend arrived. Later he removed Mason's nappy and gave him a bottle. While he was sitting in the kitchen with his friend he heard a coughing noise and saw that Mason's lips were clamped on the bottle and his lips were blue. He said he phoned 000 and commenced CPR at which time Mason had begun to "blow up like a balloon". He said he forced his fingers into Mason's anus in an attempt to release the air in his stomach thereby causing the visible injuries. Mr O'Sullivan also gave differing versions as to what occurred that night.

18. Mason was pronounced deceased at the scene.

THE AUTOPSY

19. A full autopsy was conducted on Mason on 14 June 2016 by a Forensic Pathologist and the report was peer reviewed by a Senior Forensic Pathologist. The autopsy included a CT scan which was conducted by a Consultant Paediatric Radiologist, and a full toxicology.

20. The autopsy revealed that Mason was in the 50th percentile for his age in relation to his height and weight and had no underlying medical conditions which contributed to his death. Apart from the injuries inflicted upon him he was a healthy and normal two year old.

21. However, the examinations conducted on Mason revealed that he had been severely mistreated for some time before his death.

22. Toxicology was positive for the illicit substances methylamphetamine and amphetamine. Whilst these substances were at a low level and did not contribute to Mason's death it is clear that someone had given or allowed Mason access to the dangerous drug.

23. The injuries that Mason had suffered at the time that he died were as follows:

    - Rash on his face and around his face;
    - Weeping lesion under his eye;
    - Three mouth ulcers;
    - One ulcer in his ear;
    - Five anal fissures the most severe being 24mm long and 4mm deep;
    - A partially prolapsed rectum;
    - A total of 46 separate bruises to his body:
        - two on his head;
        - twelve on his trunk;
        - four on his buttocks;
        - one on his forearm;
        - eighteen on his left leg;
        - nine on his right leg;
    - An old fracture of his left tibia;
    - Six internal haemorrhages on his scalp;

- Severe injuries to his abdominal and pelvic cavity:
  - tear of small bowel behind his belly button;
  - ragged laceration of small bowel mesentery overlying horizontal portion of duodenum which was necrotic with 10mm full thickness perforation;
  - haemorrhages within the soft tissue posterior to his duodenum and within the pancreatic tissue;
  - his large bowel was collapsed;
  - focal haemorrhage within the subcutaneous tissue of the area of his rectum overlying his sacrum and coccyx;
  - anterior displacement of coccyx;
- Fracture of the coccyx which had occurred more than several days prior to his death.

24. In summary, Mason had suffered displacement of his large bowel and rectum, displaced fracture of his coccyx, a fracture of his tibia, 46 bruises to his body, mouth and ear ulcers, scalp haemorrhages consistent with head trauma and hair pulling and severe bowel injuries which led to infection of the peritoneum and sepsis.

25. The Forensic Pathologist stated that the main finding was the presence of abdominal injuries consisting of inflammation and perforation of the small intestine and surrounding tissue as well as a laceration of the supporting structures of the bowel at a separate site. Due to these injuries faecal contents escaped from Mason's bowel into the adjacent abdominal cavity resulting in infection (peritonitis). The infection progressed to Mason's blood stream (sepsis) and that led to his death.

26. Those injuries were caused by blunt force trauma which could have been in the form of squeezing or impact (such as is seen in a high velocity motor vehicle collision or by a fall onto a focal point). Both of the abdominal injuries could have been caused by a single blow or by two separate incidents of trauma.

27. The coccyx fracture was caused by a separate blunt force trauma of moderate to severe force such as a punch or a kick. That injury was inflicted on Mason several days prior to his death.

28. The Forensic Pathologist could not ascertain the cause of the anal fissures but they were not recent.

29. The bruises on Mason's body were caused by multiple blunt force traumas.

30. From the time he received the abdominal injuries until he died Mason was in severe pain, feeling extremely unwell, vomiting and febrile and experiencing altered levels of consciousness.

THE DAYS LEADING UP TO MASON'S DEATH

31. Ms S met Mr O'Sullivan, Ms Lee and her children, including Mason, about three weeks before Mason's death. She met them at Ms Lee's house one evening. Mr O'Sullivan told Ms Lee he was going home and he was taking Mason with him. She did not seem concerned and Mason seemed happy to go with him.

32. Ms S thought that Mason was too quiet for his age. He was not talking or interacting with anyone. She drove them back to Mr O'Sullivan's house and saw that Mason had "really bad nappy rash" which she described as "nothing like I had ever seen before". She described it as going down nearly to his knees. She could see it even when he had his nappy on. She described it as "red raw" and "weeping blood". She told Mr O'Sullivan that he should take Mason's nappy off and put him in underpants with a pad on his bottom and to get some nappy rash cream to apply. She was shocked at the state of his legs and didn't know "how he was walking around".

33. A couple of days later Ms S visited Mr O'Sullivan's house again. Mason was there. He was sleeping on Mr O'Sullivan's bed when she arrived and then he woke up and was walking around. He seemed fine to her and she saw that his nappy rash looked as though it was getting better. It wasn't weeping or bleeding but it was still red with split skin. His nappy was full and hanging down to his knees.

34. The next time she saw Mason he was walking around and he walked into Mr O'Sullivan's room and Mr O'Sullivan shut the bedroom door. HM told her that Mason wakes up in the middle of the night and Mr O'Sullivan takes him into the shower and he can hear Mason crying. She thought that behaviour was abnormal.

35. Mason was at Mr O'Sullivan's house on 6 June 2016.

36. At about 12.30pm that day Mason was heard to be crying on the CCTV installed at the house.

37. Mr O'Sullivan said, "Oh, shut up."

38. Mason continued to cry and then screamed.

39. I find that it was at this time that Mr O'Sullivan struck him forcefully in the abdomen. The blow perforated his duodenum and tore the proximal jejunal mesentery. These injuries caused chemical peritonitis followed by bacterial peritonitis and septicaemia.

40. Mason continued to cry on and off throughout that day.

41. At 6pm that day Mr O'Sullivan was yelling at Mason.

42. Mason was vomiting by 9am on the morning of 7 June 2016.

43. A friend of Ms Lee saw Mason in the back of Mr O'Sullivan's car at school drop-off on the morning of 7 June. He said that Mason looked really white and didn't look well.

44. At about midday that day a police officer saw Mason with Ms Lee and Mr O'Sullivan at a local shopping centre. He saw that Mason "generally looked like he was unwell." Mason was crying and Ms Lee was trying to calm him down.

45. Mason was to attend a follow up appointment at the Caboolture Hospital on 7 June 2016. Although Ms Lee and Mr O'Sullivan were out shopping with Mason they did not take him to the hospital.

46. Ms Lee was at Mr O'Sullivan's house on 7 June 2016. She left there at 1.11 pm. They were arguing as she left. Mr O'Sullivan was extremely angry and abusive towards her. She left Mason with Mr O'Sullivan. She took some white shopping bags home with her. She returned to the house some time before 2pm and left again with more white bags. She again left Mason there.

47. Mason continued to cry sporadically throughout the afternoon.

48. Ms Lee returned at 7.59pm that night and asked to take Mason home with her. Mr O'Sullivan refused to let her take Mason home. She said that she would call the police but took no further action to protect Mason. Mr O'Sullivan told her he would return Mason to her first thing the following morning. That did not occur.

49. At about 9pm on 7 June 2016 Ms Lee knocked on her neighbours' door and said that one of her children had dropped a shopping bag on their driveway and there was broken glass there. The neighbours swept it up. Ms Lee told them that if she was found dead it would be Mr O'Sullivan who had killed her. She told them that he had Mason and would not give him back to make sure that she didn't leave the house. She said he was using ice and had a machete and if she left the house he would kill Mason and then come kill her and the other children. The neighbours said they would call the police but Ms Lee begged them not to saying that if the police didn't detain Mr O'Sullivan he would come and kill them all. The neighbours asked Ms Lee if she wanted them to call the department and she said she did.

50. The neighbour emailed the CCSSC requesting someone call her and called Caboolture Domestic Violence Service and spoke with someone who gave her advice.

51. Ms S went to Mr O'Sullivan's house at about 3.30pm on 8 June 2016. Mason was in the bedroom with Mr O'Sullivan.

52. CSOs went to Ms Lee's house that day but didn't ask to see Mason.

53. Ms S returned to the house at about 8pm that day. Mason was in the bedroom with Mr O'Sullivan who said that Mason had just vomited all over him and "on the fucking floor". He said that Mason had been vomiting for three or four nights.

54. Mason had vomit all over his face and in his eyes.

55. Mr O'Sullivan pointed to a towel on the floor and said, "I rubbed his fucking face in the vomit, he will learn".

56. She told Mr O'Sullivan that Mason needed to go to hospital and he could not learn not to be sick.

57. Mr O'Sullivan replied, "I'm over the fucking cunt spewing."

58. She saw that Mason looked pale and dehydrated. His eyes were dark and he was staring blankly.

59. Ms S had an argument with HM about taking Mason to hospital and threatened to call the police and the department. He told her to shut up or Mr O'Sullivan would bash him and Ms Lee.

60. On the afternoon of 9 June 2016 Ms S attended the house but did not go inside. She heard Mason crying from inside the house. She saw Ms Lee and Mr O'Sullivan arrive at the house. She had a conversation with Ms Lee who told her that she wanted to leave Mr O'Sullivan but she was scared and had nobody to help her. She said that he kept taking Mason home so that she couldn't leave him. She said that he had threatened to kill Mason and if she tried to leave him he would kill Mason. She said she didn't want to call the police as she didn't want to be a "dog".

61. Ms S left the house.

62. A friend of Mr O'Sullivan's also attended the house that day. He saw that Mason was very pale and had a temperature. He told Mr O'Sullivan he should take Mason to hospital and gave him some children's paracetamol for Mason.

63. That day Ms Lee met with two CSOs at a medical centre. She told them that Mr O'Sullivan was extremely violent and using ice and she wanted to get out of the relationship.

64. At about 2pm that day Mr O'Sullivan picked up Ms Lee at her home. He had Mason with him. They went to Mr O'Sullivan's house.

65. Ms Lee and HM helped Mr O'Sullivan clean up the house (after Mason's death police found many bags of blood-stained dirty nappies in rubbish bags at the house of Mr O'Sullivan).

66. Ms Lee must have known that Mason was unwell that afternoon. It is possible that they cleaned up the house in anticipation of a visit by a CSO after Ms Lee's meetings with CSOs on Wednesday afternoon and that afternoon.

67. Ms Lee left there at 5pm. She took Mr O'Sullivan's child with her but left Mason there. Mason could be heard weeping and vomiting on the CCTV recording as she left the house.

68. Ms Lee told police that she saw Mason during that visit and he was sitting on Mr O'Sullivan's bed. I do not accept that Mason was sitting up at that time. He would have been extremely ill.

69. Ms S returned to the house at about 7pm. She said the house was in a terrible state – there were dirty dishes and mouldy food in the kitchen. There was dog faeces all over the bathroom floor and wall.

70. Mr O'Sullivan told her that Mason had vomited all over him again. He said again that he had rubbed Mason's face in the vomit to teach him not to do it. She told him that he couldn't do that.

71. Mr O'Sullivan said, "If he's old enough to eat he's old enough to learn not to spew".

72. She saw that Mason was on the bed. He had vomit on his face and in his hair. He was only wearing a nappy and he had tears on his face. She saw that

Mason had a red mark on the side of his neck like he had been grabbed, and red marks on his arms and ribs and bruises on his legs. She asked Mr O'Sullivan why Mason had red marks on him. He said that Mason marked easily and pinched him on the stomach to show her. Mason didn't react at all when he was pinched.

73. Ms S said that if Mr O'Sullivan didn't take Mason to the hospital she would. She then cleaned up the bathroom, got some takeaway food for herself and HM and left the house, leaving Mason there.

74. At about 9pm Ms Lee texted Mr O'Sullivan and asked what Mason was doing. He replied that Mason was nearly asleep. Later that night and into the early hours of 10 June Ms Lee and Mr O'Sullivan texted each other about their relationship.

75. At about 8.15am on 10 June Ms Lee asked Mr O'Sullivan to get some groceries for the school lunches. He spent some of the morning at Ms Lee's house. He left Mason at home.

76. Ms S went to Mr O'Sullivan's house that morning. She heard Mason crying inside. HM told her that Mr O'Sullivan had left Mason at home and gone out. HM told her that Mr O'Sullivan had locked him in and he couldn't get out of the house. They talked through the front door. Mason was crying for about twenty minutes. She left at around 10.30am.

77. Mr O'Sullivan returned home at 12.15pm. Ms Lee texted him at about that time and invited him to have lunch with her. At 1pm he replied saying that he was changing Mason's nappy and would come over.

78. That afternoon Mr O'Sullivan went to see Ms Lee. Mason was left at Mr O'Sullivan's house.

79. At 9.17pm HM left Mr O'Sullivan's residence. Before he left he saw Mason lying on the floor in Mr O'Sullivan's bedroom. Mason was wrapped in a towel and his lips were blue. He was making a grunting sound. Mr O'Sullivan was asleep in bed.

80. At 10.09pm Mr O'Sullivan left his house, without Mason, and went to visit Ms Lee. He was angry and looking for HM who he thought was with Ms Lee at her house. Ms Lee said that she had never seen him so angry and he was threatening to get a shotgun and kill her and HM.

81. At 10.16pm Ms Lee phoned HM but spoke to Ms S who told her that Mason was not well. Ms Lee asked her to go and pick Mason up. Ms S refused as she was looking after her own children and told Ms Lee she should call the police.

82. Ms Lee refused to call the police stating, "I'm no dog, last time I told Will I was leaving he said he would kill Mason."

83. They had a conversation about Mason and Ms S asked Ms Lee why Mr O'Sullivan took Mason into the shower with him. Ms Lee said that he did it at her house too and she had heard Mason crying and tried to get in but the bathroom door was locked.

84. Ms Lee said that she would get Mason back the next day. Ms S agreed to meet her at Mr O'Sullivan's house to take Mason back.

85. At 10.50pm Mr O'Sullivan returned to his house.

86. At 10.56pm he sent a photo of Mason, via text message, to Ms Lee. He was asleep on his stomach on a bed in a blue outfit with what seems to be vomit on the bed beside him. There was a puppy lying with its head across his neck. That photo had actually been taken that morning.

87. At 11.32pm Mr O'Sullivan's friend arrived at the house and they talked in the kitchen.

88. At 12.16am Mr O'Sullivan went into his bedroom. He came out after about 20 minutes with Mason in his arms and said, "Help me."

89. Mason was unresponsive, his stomach was swollen and his lips were dark purple. There was vomit on his face. His eyes were open and fixed. Mason was dead.

90. At 12.38am the friend called 000.

91. Queensland Ambulance Service paramedics attended the residence. They saw Mr O'Sullivan in the front yard with Mason in his arms. They could not enter the yard as the front gate was locked. Mr O'Sullivan forcibly passed Mason's body over the fence to a paramedic.

92. Although it was midnight in winter Mason was wearing only a dirty singlet. He was clearly deceased and had been for some hours. His lips were blue. His stomach was extremely distended. The paramedics saw numerous bruises on his body and severe injuries to his anus.

93. Mason had been vomiting since hours after he suffered the abdominal injury on the Monday. Over the next period, he became dehydrated. He suffered from abdominal pain and distension. He had a fever. He became lethargic then went into shock. His organs began to fail and he had impaired levels of consciousness and altered breathing patterns.

94. Eventually Mason died on the floor of Mr O'Sullivan's bedroom. He stayed there for some hours. In those hours Mr O'Sullivan went into the bedroom and saw him and then went out to the kitchen where he continued to socialise with a visitor. Eventually Mr O'Sullivan brought Mason's lifeless body out into the kitchen and the visitor phoned 000.

95. Regardless of Mason's obvious need for urgent medical treatment Mr O'Sullivan left Mason to die in pain and misery, alone on his bedroom floor, and then waited for hours to alert the authorities to his tragic death.

96. Mr O'Sullivan did not demonstrate any remorse for killing Mason and nor did he confess to causing the injuries to Mason. In fact, he denied doing anything to him which could have caused his fatal injuries. Further, he attempted to blame Mason's 11 year old sister for causing the injuries saying that she was evil. He blamed the paramedics for taking too long to arrive and said that the doctors he had taken Mason to see were negligent and so was Ms Lee. He said that Mason had not been ill before he died. All of those statements were

obviously untrue. The only person who caused Mason's injuries was Mr O'Sullivan.

97. As well as the injuries that caused his death Mason suffered other injuries in the period leading up to his death which were discovered in the autopsy. Mason's head was injured by either forceful hair pulling or rubbing 2 to 3 days before his death. Mason's coccyx was fractured several days prior to his death, probably by kicking but definitely by the infliction of moderate to severe force. Mason had numerous bruises over most parts of his body caused by blows or grabbing.

98. Mr O'Sullivan inflicted those injuries on Mason in the days before his death and when he was already extremely ill, vomiting, in pain and dying from his abdominal injuries.

PREVIOUS NEGLECT OF MASON AND HIS HOSPITAL ADMISSION

99. In the months before his death Mason suffered an undiagnosed and untreated spiral fracture of his tibia. He also developed cellulitis of his leg for which he was hospitalised in February 2016. On admission he was found to have peri-anal injuries.

100. On 12 February 2016 Ms Lee called the National Home Dr Service because Mason had a fever and a swollen leg. A doctor attended Ms Lee's house and after seeing Mason, called an ambulance to take him to hospital.

101. Mason was taken to the Emergency Department at Caboolture Hospital. He was admitted. On 13 February 2016 he was transferred to the Lady Cilento Children's Hospital (LCCH) where he spent 22 days. He was transferred back to the Caboolture Hospital and discharged from there to Ms Lee's care on 8 March 2016.

102. The most serious medical issues treated at LCCH were:

- Severe right leg cellulitis;
- Severe peri-anal fissures with ulcerated skin involvement requiring extensive surgical and medical management:
  - No clear initial cause could be determined but the doctors opined that the cause was probably a mixture of infection, inflammation and trauma;
- Anaemia requiring a blood transfusion;
- Mouth ulcers;
- Healing spiral fracture of left tibia (shin bone).

103. The anal injuries were described by an experienced paediatrician as the worst he had seen in over 40 years of practice.

104. Mason was in severe pain on admission to hospital and required a narcotic infusion. He underwent surgery on his leg, which was swollen to twice its normal size. He required the placement of a rectal stent, blood transfusions, antibiotics, antifungal and dressing care. Mason was diagnosed with severe and erosive Jacquet's dermatitis which is a type of irritant contact dermatitis. The primary cause is irritation of the perianal skin by faeces and urine which

can occur due to infrequent nappy changes, failure to clean the area and chronic diarrhoea. It can be further exacerbated if nutritional deficiencies exist which was the case for Mason.

105. Ms Lee and Mr O'Sullivan lied about having taken Mason to doctors prior to his admission to hospital for treatment of his "nappy rash".

106. In fact he had seen a GP on 17 January 2016 for a minor head injury. He had a tender left shin and would not weight bear. The doctor was not asked to nor did he look at Mason's bottom. The doctor advised that Mason should be taken to the hospital. That did not occur.

107. On 5 February 2016 Mr O'Sullivan took Mason to see a GP for a mouth rash. He was not asked to treat any nappy rash.

108. Both Mr O'Sullivan and Ms Lee stated that Mr O'Sullivan had been performing all of Mason's nappy changes and baths in the months leading up to his death.

109. Mason was seen in the out-patients clinic for follow up on 18 April 2016. He was well and had put on some weight. A further appointment was made for him on 7 June 2016. Mason was not taken to that appointment.

CRIMINAL PROCEEDINGS

William O'Sullivan

110. Mr O'Sullivan was charged with Mason's manslaughter and cruelty to Mason between 23 December 2015 and 13 February 2016.

111. It was alleged that Mr O'Sullivan inflicted the fatal injury to Mason (manslaughter) and failed to obtain medical attention for him in relation to his fractured tibia and peri-anal injuries (cruelty).

112. The matter was listed for contested sentence when the indictment was presented on 18 May 2018 as Mr O'Sullivaqn did not accept that he had caused the fatal injuries. However, at sentence on 28 August 2018 he accepted the Crown case in full on the basis that he did not recall inflicting the injuries as he was severely affected by drugs but accepted that he did so. At the time of sentence he stated that he loved Mason and was profoundly remorseful for his death.

113. On 30 August 2018 Her Honour Chief Justice Holmes sentenced Mr O'Sullivan to 9 years imprisonment for the manslaughter with a concurrent term of 12 months imprisonment for the cruelty offence. Her Honour declined to make a declaration that Mr O'Sullivan was a serious violent offender but ordered that Mr O'Sullivan serve 6 years in prison and imposed a parole eligibility date of 29 July 2022 taking into account pre-sentence custody. Her Honour commented that Mason had endured a life of neglect, pain and misery.

114. The Crown appealed that sentence on the basis that it was manifestly inadequate. The Court of Appeal allowed the appeal and substituted a sentence of 12 years imprisonment for the manslaughter.

Ann-Maree Lee

115. Ms Lee was charged with the manslaughter of Mason on the basis that she had failed to provide him with medical treatment. She told police that it was the fault of the department who hadn't done their job properly. She said she had not obtained medical treatment for Mason's injuries as she had not known what to do. She falsely said that she had taken him to doctors and that his fractured tibia had been diagnosed as a sprain.

116. The case against Ms Lee was based upon her failure to remove Mason from the care of Mr O'Sullivan on and from 6 June 2016. She failed to do so knowing that Mr O'Sullivan's treatment of Mason in the early part of that year had resulted in his hospitalisation, that Mr O'Sullivan was a heavy drug user, that he was paranoid and violent to her and her children.

117. Ms Lee must have known in the days after Mason received the fatal abdominal injury that he was gravely ill but did nothing. She could have asked the department workers for help but didn't. She refused to call the police.

118. Ms Lee was with Mason (and Mr O'Sullivan) at a shopping centre on 7 June. By that time he had received the fatal injury and would have been in pain. It was identified by others who saw him that he was unwell but Ms Lee took no action to protect him or get him medical assistance or attend the long-booked appointment at Caboolture Hospital. When she saw Mason on 9 June at Mr O'Sullivan's house, by which time he must have been obviously ill, she did nothing for him even though she was cleaning up nappies full of blood and faeces. Someone else told her he was very ill on 9 June 2016 she still did nothing and left him with Mr O'Sullivan.

119. Ms Lee was charged with cruelty on the basis that she was the primary caregiver of Mason and failed to obtain medical attention for him in January and February 2016 when he had a fractured tibia and severe peri-anal injuries.

120. Ms Lee told police that throughout her relationship with Mr O'Sullivan he made her feel like a failure as a mother. He took Mason and wouldn't let her change or bath him. He would take Mason into his room and "do whatever he wanted to do with him."

121. Ms Lee said that Mr O'Sullivan was violent towards her and her children. He threatened to smash in her face with a rock in the garden. In the last couple of weeks before Mason's death he kicked her other son. He threatened to smash her face in with a baseball bat. He threatened her with a machete. She wasn't allowed a phone or a bank card. She could not visit Mason in hospital because Mr O'Sullivan would accuse her of having sex with other men. When Mr O'Sullivan came to her house her children would run and hide in their bedrooms.

122. Ms Lee told police that shortly before Mason's death she wanted to end the relationship but she did not know how to do it. She was too scared to contact the police as she thought Mr O'Sullivan would kill her, however, she didn't think he would hurt her children. She spoke to CSOs in the week leading up to Mason's death, however, she did not disclose that Mason was at Mr O'Sullivan's house and she could not get him back or that Mason was very ill.

123. In a pre-sentence report tendered at her sentence, a psychiatrist stated that in the period leading up to Mason's death Ms Lee was suffering from post-traumatic stress disorder and an unspecified mood disorder. Ms Lee viewed her submission to Mr O'Sullivan's control of her as normal. The situation and her frame of mind meant that Ms Lee's "emotional field of vision narrowed to the point that she did not recognise the threats to Mason's wellbeing and did not register in the last week that he was gravely ill."

124. The psychiatrist said that Ms Lee's delegation of Mason's care to Mr O'Sullivan was consistent with her subordination of herself, her rights, her interests and her opinions to a dominant and violent man.

125. On 20 February 2019 Her Honour Justice Dalton sentenced Ms Lee to 9 years imprisonment for the manslaughter and a concurrent sentence of 3 and a half years for the cruelty offence. Her Honour declared 936 days pre-sentence custody as time served and set a parole eligibility date of 19 July 2019.

126. That sentence was not disturbed on appeal. The Court of Appeal accepted that Ms Lee was genuinely remorseful and that she was simply unable to recover Mason from Mr O'Sullivan due to her history and his domination of her.

127. The Court of Appeal stated:

> *A mother's grievous neglect of her child leading to the child's death is an affront to community values but an understanding of the reasons for the neglect lessens the sense of indignation that is felt. [Ms Lee's] personal circumstances, as O'Sullivan's victim in an oppressive relationship and as the victim of her own upbringing, operate heavily in mitigation of her moral culpability for Mason's death.*

INVOLVEMENT OF THE DEPARTMENT WITH MASON AND HIS FAMILY

The Child Protection Framework

128. In order to understand Mason's involvement with the department it is necessary to understand the child protection framework and the department's relevant policies and procedures.

The Child Protection Act 1999

129. The purpose of the *Child Protection Act* 1999 "is to provide for the protection of children".[3]

130. The main principle for administering the Act is that the safety, wellbeing and best interests of a child are paramount.[4]

131. Other general principles set out in the Act include[5]:

- A child has a right to be protected from harm or risk of harm;

[3] Section 4
[4] Section
[5] Section 5B

- The preferred way of ensuring a child's safety and wellbeing is through supporting the child's family;
- If a child does not have a parent who is able and willing to protect the child, the State is responsible for protecting the child;
- In protecting a child, the State should only take action that is warranted in the circumstances.

132. A child who has suffered or is suffering significant harm and does not have a parent willing and able to protect the child from harm is defined as a child in need of protection (CINOP).[6]

133. If the chief executive (including an authorised officer) of the department becomes aware of alleged harm or risk of harm to a child and reasonably suspects the child is in need of protection the officer must immediately investigate the allegation and assess whether the alleged harm or risk of harm can be substantiated and, if it can, assess the child's protective needs or take other appropriate action. [7]

134. If it is reasonably believed that the alleged harm may involve criminal conduct the officer must immediately give that information to the police commissioner.[8]

135. The process of investigating and assessing whether a child is a CINOP is referred to in the department as "Investigation and Assessment" (I&A).

136. If an authorised officer investigates an allegation of harm to a child or assesses a child's need of protection one of the child's parents must be advised of the allegations and advised of the outcome of the I&A as soon as practicable after its completion[9] (parental notification of I&A).

137. If it is assessed that a child is in need of protection the department is responsible for the provision of ongoing intervention. An Intervention with Parental Agreement (IPA) occurs when the department intervenes with a child and family based on the parent's agreement to work with the department to meet the protective and care needs of the child without the need for a court order.[10] That is, the parent agrees to work with the department and the department does not then make an application to a court for a child protection order (CPO) granting guardianship of the child to the department. If a CPO is made a child no longer resides with its parents.

138. An IPA is applicable when there is no child protection order in force granting custody or guardianship of the child to anyone and the chief executive is satisfied the child is a child in need of protection (CINOP) and needs ongoing help under the Act. An IPA can only occur where the chief executive is satisfied that the parents are able and willing to work with the chief executive to meet the child's protection needs and it is likely that the parents will be able to meet the child's needs by the end of the proposed intervention.[11]

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[6] Section 10
[7] Section 14
[8] Section 14(3)
[9] Section 15
[10] Section 51Z
[11] Section 51ZB

139. The Act requires the department to develop a case plan for meeting the protection and care needs of a CINOP and reviewing it every six months.[12]

The Suspected Child Abuse and Neglect System

140. The SCAN system is mandated by the Act.[13] It is a multi-agency team based response system, the purpose of which is to enable a coordinated response to the assessment and protection of children in cases of suspected child abuse and neglect.

141. It enables a coordinated response to the protection needs of children by facilitating the sharing of relevant information between members of the system and the planning and coordinating of actions to assess and respond to children's protection needs and a holistic and culturally responsive assessment of a child's protection needs.[14]

142. There are numerous SCAN teams across Queensland each of which has a designated geographical area.

143. The department is the lead agency for the SCAN team system.

144. SCAN meetings are constituted by members of the department, QPS, Qld Health and Department of Education. Other entities, such as RAI and IFS can be asked to attend meetings.

145. The SCAN team Manual sets out that each team must include the following members from the department:

- Team coordinator;
- Team administration officer; and,
- A CSO.

146. A SCAN team does not have distinct decision making authority. Rather, it is for the SCAN team upon reviewing information shared about a child to formulate and agree upon recommendations to be put to the department for the coordination of a multi-agency response to the assessment and protection of the child. Each of the agencies brings information about the child to the team but the ultimate decision making rests with the department.

147. SCAN does not act as an oversight for departmental decisions.

148. Recommendations made at a SCAN meeting are valid only if a quorum is formed.

Referral for Active Intervention (RAI) Program and Intensive Family Support (IFS) Program

149. From January 2016 the RAI service began the transition to become the Intensive Family Support (IFS) Service.

[12] Sections 51A and 51B
[13] Section 159I
[14] Section 159J

150. There were a number of non-government organisations delivering the RAI in Queensland. Mission Australia was one of these. The guidelines for the program were written by the department.

151. The program aimed to provide early intervention, prevention, and outreach case management support for families at risk of entry, or re-entry, into the statutory child protection system. It was funded by the department.

152. The RAI program was a service at the secondary level of intervention, meaning that it worked with a range of families including those that normally manage to care for their children but were experiencing pressures requiring additional targeted support, those who had been the subject of notification to the statutory child protection system and those that had previously been in the statutory child protection system. Families who were currently working with the department under court orders or IPA's were not eligible for support by the RAI or IFS programs. Once a child was the subject of a CPO or an IPA the RAI would have to close their case.

153. The purpose of the program was to improve the wellbeing and safety of children, young people and their families, build the capacity of families to care for and protect their children and prevent entry or re-entry to the child protection system.

154. The RAI service was voluntary. Families could choose whether or not to participate and whether or not to engage with their case worker. A family entered the program by referral. Families could self-refer or referrals could be made by government agencies or community organisations, for example, schools, hospitals, housing services, child mental health services, Centrelink and Family and Child Connect. The department could also refer families.

155. RAI workers usually engaged with families in their homes and offered support in the areas of parenting, housing, family violence, mental health, health, finances and education. Families were offered support for six months with the possibility of extension where they had ongoing needs. The goals of the program were to improve family stability and well-being.

156. The IFS program is also funded by the department and is very similar to the RAI program. It provides a more intensive level of support for a period of six to nine months to improve child safety and family functioning.

157. One of the changes that was implemented when the RAI changed to the IFS program was the introduction of a Principal Child Protection Practitioner (PCPP) from the department who was allocated to work with each IFS service and provide support and advice. If the IFSP requested it, the PCPP could provide historical information about a family's engagement with the department. The PCPP role was designed to be the link to historical department information only when sharing of that information was deemed to be necessary.

Child Safety Practice Manual

158. The CSPM sets out a comprehensive set of procedures that guide and inform the delivery of child protection services by the department. It sets out the roles and responsibilities of Child Safety Officers (CSO).

Chapter One

159. Chapter 1 of the CSPM sets out the procedures for "Intake". When information about a child is received by the department it undergoes an initial screening process and is recorded as one of the following:

- A child concern report (CCR):
  - When allegations of harm are received that do not meet the threshold for a notification and the child is not reasonably suspected to be in need of protection;
- A notification:
  - When it is reasonably suspected that the child is in need of protection; or,
- Additional notified concerns (ANC).

Chapter Two

160. When information is recorded as a notification by an intake officer, the matter is investigated and assessed (I&A) by a CSO. The procedures are set out in Chapter 2 CSPM which states that the department must:

- Determine if the child is safe;
- Investigate the allegations;
- Undertake an assessment of the child and family in their home environment;
- Determine if the child is a CINOP;
- Decide whether there are supports that the department or other agencies can provide to the child and family.

161. The relevant key steps in the I&A are:

- Plan the I&A;
- Engage the family and gather information;
- Assess the concerns and the child's need for protection; and,
- Finalise the I&A.

162. The relevant standards include:

- All I&A are to be commenced within the response timeframe (RTF) of the notification (applied by the intake officer based on the seriousness of the allegations etc);
- All subject children are to be sighted and interviewed where age appropriate;
  - Contact with a child is key to determining the immediate safety of the child;
  - The CSO must have personal contact with the child and make careful observations of the child's physical and cognitive developmental stage, behaviour, reactions, presentation and interaction with family members and others;
- Alleged persons responsible are to be interviewed;
- The safety of the child in their home is to be assessed;
- The protection needs of the child are assessed;

- All outcomes are recorded and clearly identify any unacceptable risk of future harm and a rationale for the assessment of the parents willingness and ability to protect the child;
- The parent is informed of the allegations and outcome of the I&A;
- Any suspected criminal conduct is reported to police immediately.

Sighting the Child and Contact with the Child

- The subject child and any other children identified during the I&A as at risk of harm are to be sighted;
- Personal contact with a child is key to determining the immediate safety of the child and should include careful observations of physical and cognitive development, behaviour, reactions, presentation and interaction with others; speaking with the child and interviewing them if appropriate;
- When physical injuries are suspected or alleged, the CSO should ask the parent to adjust or remove whatever clothing is necessary to see the alleged injuries;
- Sighting and interviewing may be undertaken by another professional if the "differential pathway response" is used to complete an I&A only in exceptional circumstances where everything has been done for the I&A except for sighting the child and it has been assessed that it is appropriate.

Safety Assessments

163. A Safety Assessment is completed at the commencement of an I&A and they are repeated throughout intervention when new information is received or there is a change in circumstances which indicates a possible threat to a child's safety but does not meet the threshold of a notification e.g. where there is a change in the household membership.

164. The purpose of the safety assessment is to decide:

- Whether there is an immediate threat to a child;
- What interventions are required to maintain the child's safety;
- A "safety decision" for the child;
- The development of a safety plan to ensure the safety of the child who remains in the home where immediate harm indicators have been identified.

Finalisation of the I&A

165. An I&A must be completed and approved within two months of the date of the notification or, where the decision has been made that a child will have a "substantiated – CINOP" outcome and a referral is made to the family group meeting convenor (for the case plan to be developed), the I&A must be completed and approved within seven days of the date of referral.

Chapter Three

166. Ongoing intervention refers to intervention by the department that occurs with a child and their family following the completion of an I&A when it is assessed that the child is a CINOP.

167. It can occur with the consent of the parents (an intervention with parental agreement – IPA).

168. The relevant steps for ongoing intervention are:

- decide on the type of intervention required;
- undertake intervention activities;
- close an ongoing intervention case.

Chapter Four

169. A case plan must be developed for each CINOP. It provides for the structure of ongoing intervention and guides what needs to occur to address the child's protection and care needs. It is a written document that sets out why the child needs protection, key information about the child and roles and responsibilities of all participants, the overall goal for the child and outcomes to achieve.

170. The relevant steps for a case plan are:

- assess and prepare to develop a case plan;
- plan for a family group meeting (which is to be held within 30 days of the decision that a child is a CINOP);
- develop the case plan;
- implement the case plan;
- review and revise the case plan (at least every 6 months).

Chapter Six

171. Chapter 6 outlines the process for an IPA i.e. ongoing intervention for a CINOP when the parents are able and willing to work actively with the department to reduce the level of risk in the home, and a child protection order is not appropriate.

172. An IPA enables the department to provide support and assistance to a child and family in circumstances where all of the following apply:

- the child is in need of protection;
- the parents are able and willing to work actively with the department to reduce the level of risk in the home;
- it is assessed that the child is safe to remain at home for all, or most of the intervention;
- it is likely that the parents will be able to meet the protection and care needs of the child once the intervention is completed.

173. The aim of an IPA is to build the capacity of the family so that the child can remain at home and no longer be a CINOP at the end of the intervention. An IPA is generally short term and intensive and the child usually remains at home for all or most of the period.

174. The willingness of the parents to work with the department does not lessen the department's responsibility to ensure the child's safety.

175. The level of risk in the home must be constantly monitored and assessed to ensure the ongoing appropriateness of the intervention.

176. Where illicit drug use has been identified as a contributing factor the parents must agree to regular and random drug testing as part of the case plan.

Structured Decision Making (SDM)

177. SDM is a major practice initiative which was implemented across Queensland in 2005 to assist the departmental practitioners in making decisions about children, young people and families.

178. It incorporates a set of evidence-based assessments and decision making guidelines designed to provide a higher level of consistency and validity in the assessment and decision-making process. It is a method of targeting resources to families who are most likely to abuse or neglect their children.

179. SDM allows practitioners to organise facts and evidence gathered and is used in conjunction with their professional judgement to assist them to make decisions. The process leads to a recommendation for action which must be approved by a team leader.

180. The SDM minimum contact requirements for in-home, high risk cases is four face to face per month with parents and child and four support contacts.

Policies

181. Departmental staff are required to comply with the relevant policies that outline their roles and responsibilities in terms of the principles, objectives and scope of I&A and IPA events.

Public Sector Ethics Act 1994

182. This Act is the statutory authority that prescribes the ethics principles and their associated set of values expected to be adhered to by public officers. The "Code of Conduct for the Queensland Public Service" explicates these principles, values and standards of ethical behaviour which are deemed as essential to robust public sector integrity and accountability.

183. Public officers must also comply with all relevant legislation, policies and standards applicable to their operation and function.

184. The four principles of the Code that are relevant to the conduct allegations in relation to the death of Mason are:

    1. Integrity and impartiality

185. Public officers should seek to promote public confidence in the integrity of the department as well as the broader public sector. This is achieved by ensuring advice is objective and impartial and decision-making is ethical.

    2. Promoting the public good

186. Public officers should value and seek to achieve excellence in service delivery and enhanced integration of services to better service clients.

3. Commitment to the system of government

187. Duties should be undertaken to give effect to the policies of the elected government and decisions should be implemented professionally and impartially. Public officers are expected to comply with laws, policies and standards.

4. Accountability and transparency

188. The public trust in public office requires high standards of public administration, therefore, public officers should value and seek to achieve this. They should be committed to exercising proper diligence, care and attention and seek to continuously improve performance. By ensuring due diligence in public administration, lawful powers and authority should be exercised with care and for the purpose for which these were granted.

Child Protection History of William O'Sullivan

189. Mr O'Sullivan was known to the department as a child.

190. He was an only child whose mother left his violent father and married his stepfather when he was 5 years old. His stepfather suffered from schizophrenia and abused alcohol.

191. The department's records show that as a 13 year old he was subject to verbal and physical abuse by his step-father including being hit in the head, attempted strangulation and having his head hit repeatedly against a wall.

192. He was subject to a long term guardianship order from 14 years of age. He was housed in a residential facility. He stopped going to school and started using drugs. He became addicted to methylamphetamine. From about 17 years of age he was living on the streets.

193. Mr O'Sullivan had little work history. He married in 2008 and there were four children to that marriage including his son who lived with him at the time of Mason's death.

194. He initially met Ms Lee in 2014 and they both used methylamphetamine. His drug use escalated in 2016. His criminal history is mostly comprised of drug offences but includes an Attempted Robbery and a Serious Assault in 2018 and he had been sentenced to terms of imprisonment.

Child Protection History of Ann-Maree Lee

195. Ann-Maree Louise Lee was born 4 March 1989 in Victoria. She was the youngest of four children. Her mother left the family when she was two years old. She was physically and sexually abused by her father as were her siblings. The sexual abuse ranged from touching to sexual intercourse. He beat her with instruments including a riding crop, burnt her and choked her. When she was 9 years old she and her siblings were removed from her father's care into the care of the state of Victoria. Her father was later convicted and imprisoned for his abuse of his children. Ms Lee's education was greatly interrupted and

she eventually turned to drugs and sex with much older men and became homeless.

196. Ms Lee had an interstate child protection history from when she was younger than 4 years old.

197. Ms Lee became pregnant to a 24 year old man when she was 15 years old. He was violent and controlling as were all but one of her subsequent partners. She moved to Queensland with that partner.

Child Protection History with Ms Lee's Children Prior to Mason's Birth

198. In 2005 the department received concerns about 16 year old Ms Lee presenting to the hospital to give birth to her first child, a daughter (Sibling 1). It was said that at the time she was under the influence of alcohol and her partner was violent to her. The matter was recorded as "substantiated."

199. From 2005 the department received notifications about Ms Lee and her family nearly every year for the next ten years. The reported risk factors were domestic violence perpetrated by nearly all of her partners, unhygienic and neglected households, lack of parental supervision, misuse of alcohol and drugs including intravenous use of amphetamine, physical abuse of the children, homelessness and limited support networks.

200. Ms Lee's next daughter (Sibling 2) was born in 2008 and the department continued to receive concerns and conducted I&A's in relation to the residence being unhygienic and Ms Lee and her partner abusing alcohol.

201. Ms Lee's first son (Sibling 3) was born in 2010. Her new partner was violent and reported to be assaulting the children.

202. Further notifications were received in July, and August 2011 in relation to Mason's siblings. The concerns raised from 2008 until August 2011 were deemed to be "unsubstantiated."

203. On 3 October 2011 further notifications were received in relation to Mason's siblings. They were found to be substantiated and the children in need of protection from their father.

204. Ms Lee's third daughter (Sibling 4) was born in 2012 and in 2013 the department received notifications that Ms Lee was using speed and ice, hitting the children and experiencing domestic violence. The matter was recorded as "no outcome."

The Department's Involvement with the Lee Family Subsequent to the Birth of Mason

April 2015 to 8 December 2015

205. Mason was born on 16 August 2014. He was the fifth child of Ms Lee. At the time of Mason's birth the department had no current involvement with the family.

206. On 27 April 2015 the department received concerns that the children were unsupervised, and that Ms Lee was using and selling drugs. The concerns were recorded as a CCR i.e. the children were assessed as not being in need or protection.

207. In July 2015 the department became aware of Mason after concerns were received indicating that Ms Lee and her children were homeless and staying with an older male, Ms Lee was using drugs and had assaulted another person. This information was also recorded as a CCR.

208. On 21 September 2015 there was a further CCR recorded in relation to an alleged sexual assault of Siblings 3 and 4 by the juvenile son of a family friend and Ms Lee's response to that assault.

209. At 5.39pm on that date, Dr 1 emailed CSO1 about her concerns for Ms Lee and her family. CSO1 later copied the contents of the email into a CCR.

210. Dr 1 reported:

- Ms Lee displayed a lack of emotional regulations and threatened the juvenile perpetrator with violence;
- Ms Lee was overwhelmed;
- Ms Lee was unable to follow through on referrals e.g. RAI from FACC, Legal Aid, Centrelink, Department of Housing;
- Ms Lee was living in a garage with her children;
- Ms Lee required a mental health assessment but was resistant to engaging with a psychologist and that she was displaying significant anxiety and possible PTSD;
- Ms Lee was "willing and protective of her own children".

211. At 9.51am on 22 September 2015 CSO1 replied to Dr 1 advising that her concerns had been recorded as a CCR.

212. At 12.04pm Dr 1 further advised CSO1 that she had contacted QPS and Ms Lee had not assaulted the alleged sexual offender (only threatened to) and had not been charged with any criminal offences.

213. Follow up information provided was that Ms Lee and the children had engaged with sexual abuse counselling and been referred to Referral for Active Intervention (RAI) via Family and Child Connect (an independent provider of family support) in early August 2015.

214. A social worker from Mission Australia (RAI1) was allocated the Lee family case. RAI1 organised housing for Ms Lee and the family and referred the children for sexual abuse counselling.

215. The department made the decision to record a CCR as it was considered that Ms Lee had acted protectively, the children were not at immediate risk of harm and Ms Lee was engaged with RAI1.

216. On 11 November 2015 two further notifications were received regarding the sexual assault as per the notification in September 2015. However, there was further information provided that Ms Lee had assaulted the alleged juvenile perpetrator with a baseball bat and that the juvenile's stepfather, who was a

friend of Ms Lee, had suggested to the juvenile that he sexually assault Mason's sibling.

217. Further information was provided that Ms Lee and her five children were residing in a friend's garage and the friend (not the older male referred to earlier) had recently punched her own baby in the face because he would not go to sleep. That person was said to abuse alcohol.

218. The department recorded a notification with a five day response time frame (RTF) required by the Caboolture Child Safety Service Centre (CCSSC). The intake officer was concerned that Ms Lee was not acting protectively of the children in regard to the people she was staying with and associating with and that her substance misuse, mental health and that unresolved past trauma was likely to impact on her ability to protect the children.

219. Complicating factors identified by the intake officer included:

- Ms Lee's mental health;
- Ms Lee's choice of partners and friends that were violent to her and the children;
- Ms Lee's history of alcohol abuse;
- Ms Lee not engaging well with services;
- Ms Lee's assault of a young person;
- Ms Lee and her children continued to reside with a friend despite concerns being raised about that person's suitability and care of her own children.

220. A QPS referral was completed and emailed to the Child Protection and Investigation Unit of the QPS (CPIU).

221. On 8 December 2015 CSO1 contacted CPIU (not in regard to the Lee I&A but in regard to the sexual assault notification).

I&A between 9 December and 25 December 2015

222. The Lee I&A should have been completed 5 days after its receipt on 11 November 2015. In fact, it was commenced almost a month after the required time frame - at 3.30pm on 10 December 2015.

223. On that date, CSO1 was allocated the I&A by his team leader, STL1.

224. On the same day CSO1 and CSO2 briefly interviewed Siblings 1, 2 and 3 at the residence of the alleged juvenile's stepfather i.e. the house of a person who had allegedly sexually assaulted his own children.

225. They also spoke to Ms Lee and the juvenile's stepfather. He denied the allegations.

226. Ms Lee said that the stepfather was a good support for her and she had no concerns about him but she would not leave her children with him unsupervised (she was not questioned about these conflicting statements).

227. She said she had recently obtained accommodation following six months of homelessness when she and the children lived in a friend's garage.

228. Ms Lee said she was not in a relationship. Had CSO1 contacted QPS for a routine check, he would have discovered that she had called police about Mr O'Sullivan in September 2015 at which time she stated they had been in a relationship for two weeks. She denied any drug use or mental health issues and said she was coping well (none of these statements were explored).

229. Ms Lee disclosed that she had been sexually abused by her father as a child and said she had not reported it to authorities as she was protective of him and did not want him to "get caught".

230. Mason (referred to as Nathan in the department records) was sighted but observations of him were not recorded.

231. CSO1 reported that the children were happy and felt safe and the stepfather was one of the people they identified as being a safe person for them.

232. After the interviews CSO1 told Ms Lee that the outcome of the I&A would be unsubstantiated.

233. On 11 December 2015 CSO1 contacted the family's medical centre. They were unable to provide details of the family's involvement and engagement with the centre.

234. CSO1 obtained information from RAI1 who advised that Ms Lee had engaged well with her, had recently secured housing and would be moving in the following week, that Mason's brother and sister had been referred to therapy re the sexual assault. RAI1 said she had no concerns about Ms Lee's willingness and ability to care for her children and she was a loving mother who had "*gone to great lengths to help her children to feel comfortable and secure through their recent lengthy period of homelessness."*

235. However, RAI1 also advised that Ms Lee had not been answering her phone for a week.

236. CSO1 also contacted the children's day care centre and was advised they were no longer attending but when there they had been polite, well cared for and attached to Ms Lee. The director said that there had been a previous incident involving police and that Ms Lee was under a high degree of stress due to homelessness.

237. CSO1 submitted the Safety Assessment to STL1 on 11 December 2015.

238. He also completed an "assessment and outcome" (A&O) of the I&A. He determined that none of the children had been harmed or were considered to be at risk in Ms Lee's care and the outcome for each child was unsubstantiated and not in need or protection.

239. On Saturday 12 December 2015 CSO1 completed a Family Risk Evaluation (FRE) for the family. In it he noted that Ms Lee did not have a criminal history or current or past drug or alcohol misuse (inconsistent with information known to the department). He stated that Ms Lee had a history of abuse as a child. He stated that Ms Lee had safe, stable shelter (although she had not moved in to her new house and, in fact, he did not know where she was staying at that time and had not sighted her housing). He noted there had been no DV in the

last year (which was inconsistent with information held by QPS and which could have been obtained had he investigated). He ticked "no" to past or present mental health problems for Ms Lee but the department records indicated otherwise. He also ticked "no" to any past or present drug and alcohol abuse (which was plainly incorrect on the department's own files.

240. Due to the information provided by CSO1 the combined total risk of the FRE was "moderate". A decision was made not to open an ongoing intervention. Had the assessment been completed correctly the risk would have been found to be "high" and a different approach would have been required.

241. CSO1 submitted the FRE to STL1 that day.

242. STL1 approved the FRE and the Safety Assessment on 14 December 2015.

243. On 15 December CSO1 contacted the therapist the siblings were said to be engaged with. That person advised that they were linked into the service but had only completed one session. Ms Lee was said to be a mother with good attachment to and interactions with the children.

244. On 15 December 2015 CSO1 submitted the interviews and the A&O for the I&A to STL1 for her approval. She returned them to him on 24 December 2015 indicating there was further (unidentified) work required. He resubmitted them the same day but STL1 did not approve the documents for another three months i.e. on 30 March 2016. There are no records of the further work required or that anything further was actually done (although it seems very improbable that there was) prior to the approval months later.

245. The outcome of this I&A was "unsubstantiated".

246. CSO1 stated that the children were:

> *Not in need of protection via out of home departmental foster care or IPA ongoing interventions from the department ….. [Ms Lee has] a sound capacity for insight into the protection of her children … It would be deemed as overly intrusive if the department was to commence ongoing intervention with [Ms Lee] and the subject children in mention (sic) at this point*

Hospital Admission 12 February to 8 March 2016

247. On 8 January 2016 Mason was taken to a GP with a head injury and a limp. He was not weight bearing. Ms Lee was advised by the GP to take Mason to Caboolture Hospital however, she did not do so.

248. Mason was admitted to the Caboolture Hospital at 11.05pm on 12 February 2016 and was transferred to LCCH (as it then was) at 1.30pm on 13 February 2016.

249. In February 2016 a CCR was recorded regarding concerns of medical neglect and/or abuse following Mason's admission to hospital.

250. Dr 2 is the Consultant Paediatrician at Caboolture Hospital. Dr 2 has worked in the Paediatric Unit of the hospital since March 2006.

251. Dr 2 was involved in the care of Mason from 13 February to 18 April 2016 and more specifically when Mason was a patient of the Caboolture Hospital.

252. Dr 2 was the Consultant Paediatrician working in the Caboolture Hospital Paediatric Ward when Mason was admitted. The records at that time indicated that Mason had presented to the hospital with Ms Lee the previous evening and had been seen by a Paediatric Registrar. The Registrar noted that Mason had severe cellulitis of the right lower leg, severe perianal lesions and mouth ulcers. The Registrar telephoned Dr 2 as she was concerned that the perianal lesions were not part of the reason for Mason's presentation and had been discovered by nurses when he was examined. She was concerned about possible neglect and abuse.

253. At 11am on 13 February 2016 Dr 2 spoke to Ms Lee. She told him that she had taken Mason to a GP in Caboolture a couple of days prior and that Dr had diagnosed hand, foot and mouth disease and prescribed no medication. She spoke of her male partner being involved in Mason's care. She said that Mason's leg had become swollen over the last 24 hours and she then brought him to the hospital. Ms Lee said that a month before Mason had developed a nappy rash which was extensive and she had taken him to see several different doctors at the 7 Day Medical Centre in Morayfield and all had told her that it was nappy rash. She said she had been applying cream to the area and had been reassured by all the doctors who had seen Mason that is was "just a nappy rash."

254. Dr 2 examined Mason. Mason was febrile with a temperature of 39 degrees. He had a heart rate of 180 bpm. He appeared unwell and he was in pain. His right leg was grossly swollen to twice the size of his left leg – he had cellulitis above and below the knee. There were indications of bacterial sepsis. Dr 2 examined the perianal/perineal lesions. There were several areas of deep skin loss which resembled a burn injury. There were areas that resembled deep punched out ulcers. Dr 2 was of the opinion that the lesions were chronic and deep-seated and could never be mistaken by a reasonable person, much less a GP, as simply a nappy rash.

255. Dr 2 stated that the injuries to Mason's anus were, by far, the most severe skin lesions he had ever seen in the perianal/perineal area in the 45 years he had worked in paediatrics. He did not believe the history provided by Ms Lee.

256. Dr 2 gave evidence at the inquest. The Dr explained that the cellulitis on Mason's leg which he saw on 13 February 2016 could have been caused by infection of a minor injury such as a mosquito bite, however, by the time of his examination it had become very serious. Mason's left leg had swollen to twice the size of his right leg. He was in a great deal of pain. His vital signs indicated that he was a very ill little boy.

257. Dr 2 noted the injuries to his buttocks and anus at that time but, due to the seriousness of the cellulitis and the possibility for it to cause very grave complications, he did not examine Mason's bottom in any great detail.

258. However, Dr 2 did note that Mason's anus seemed to be gaping and that there were 5 separate areas on his buttocks where the whole of the skin had been lost. Dr 2 said he had never seen anything like the kind of excoriation he saw on Mason's buttocks. He considered initially that it might be caused by some kind of rare infection or fungus.

259. At 1.30pm Dr 2 phoned the North Coast Regional Intake Service of the department (NRIS) and made a verbal report. That was assessed as a CCR.

260. Dr 2 advised NRIS that Mason had presented to the hospital on 12 February 2016 with a severe cellulitis infection on his leg and a number of very abnormal areas around his anus that looked suspicious. He said that Mason had reportedly had a nappy rash which had developed into chronic, ulcerated areas around his anus with the anus being quite large, gaping and very abnormal resulting in the need for skin grafts and further medical investigation.

261. Dr 2 reported that there were inconsistencies in Ms Lee's story about GP's telling her Mason had nappy rash and his presenting condition. Dr 2 stated that he was concerned that the condition had been left to become so severe prior to Mason's presentation.

262. Dr 2 then organised for Mason to be transferred to LCCH as a matter of urgency as he was concerned that the cellulitis would require surgery or could develop into necrotising fasciitis.

263. Dr 2 spoke to the Child Protection Registrar at LCCH about Mason and relayed his concerns that Mason had been significantly abused.

264. Mason was transferred from Caboolture Hospital to LCCH later that day.

265. On 13 February 2016 Mason was admitted to LCCH.

266. Dr 3 was the Consultant medical practitioner on call for the Child Protection and Forensic Medicine Service (CPFMS) from 13 to 14 February.

267. The CPMFS is a multi-disciplinary tertiary service providing child protection clinical and consultation services and assessment of the health needs of children who have been harmed or are at significant risk of harm as a result of child abuse and neglect. The service operates 24 hours per day with a team of members on duty during normal business hours and medical coverage available on-call at all other times.

268. The core business of CPMFS is to optimise recognition of, and response to, suspected child abuse and neglect, to provide forensic medical evaluations and to provide paediatric health care to children in contact with the child protection system.

269. Referrals to the CPMFS can be internal from LCCH or made by QPS, the department and medical teams from other hospitals or health service providers.

270. Dr 3 continues in that role up to the current time, working 6 days per fortnight. She also works as a private paediatrician at the Child Development Network, specialising in child development and behaviour and she is also a Child Protection Advisor for Children's Health Queensland Hospital and Health Service and a core representative for the Pine Rivers SCAN Team.

271. Dr 3 did not see Mason or Ms Lee. She was involved in his treatment as the Consultant in the CPMFS.

272. Dr 3 received a phone call from the department at 1.42pm on 13 February 2016 in regard to Mason's transfer from Caboolture to LCCH for surgical management of perianal wounds and a right leg abscess. She was told that a doctor at Caboolture had been concerned that Mason had been subject to sexual abuse.

273. Dr 3 was of the view that more information was required before a definitive view could be reached as to the cause of Mason's injuries. She was shown photographs of Mason's perianal and rectal wounds soon after his admission. She had a number of conversations with the doctor who was overseeing Mason's medical management.

274. Dr 3 was told that Ms Lee had advised that Mason had recurrent constipation and she had tried a number of treatments for this including Senna, a laxative. Ms Lee had also reported that Mr O'Sullivan was responsible for Mason's nappy changes.

275. Departmental notes indicate that, at 4.28pm on 13 February 2016, Dr 3 contacted CCSSC after hours service. The notes made by the department record that Dr 3 stated that Mason's anal injuries were as a result of contact burns caused by the laxative "Senna" and "it is not a child protection matter".

276. The matter was recorded as a CCR.

277. As Mason underwent treatment it became Dr 3's opinion that there was no readily identifiable medical explanation for his presenting condition. It was apparent to her, however, that he had been presented very late for medical review which raised a suspicion of neglect.

278. The medical team sought to clarify the information provided by Ms Lee in relation to previous medical attention and checked his medical records. This revealed several inconsistencies in the information provided by Ms Lee and the medical records i.e. Ms Lee said that she had seen numerous doctors who diagnosed that Mason had nappy rash but there were no records of such medical appointments.

279. The records revealed that Mason had been taken to a doctor some months previously in relation to an inability to bear weight on one of his legs and that Ms Lee was advised to take him to the hospital but she had not done so. Ms Lee denied this when questioned by the medical team.

280. Dr 3 then considered that neglect was likely. The medical team performed a skeletal survey which, on 2 March 2016, revealed a healing fracture of the left tibia.

281. Due to this finding the medical team lodged a report of suspected abuse or neglect with the department on 3 March 2016.

282. The department was advised that:

- Mason had been an inpatient of the general paediatric team of the LCCH for three and a half weeks, that he had been diagnosed with "very severe nappy rash" and perianal excoriations with fissuring which required surgical dressings, multiple reviews under anaesthesia, burns dressings and stomal cares due to their significance;

- ongoing care would be required;
- although Ms Lee advised she had taken Mason to the GP on at least three occasions there was no record of those visits;
- on 17 January 2016 a GP who saw that Mason had a limp advised that he be taken to the hospital but Ms Lee did not take him;
- a skeletal survey revealed an old left tibial fracture.

283. The information was recorded by the department as a Notification and the RTF of 10 days was overridden and a five day response was applied.

284. On 4 March 2016 one of the Registrars in CPMFS, under the supervision of Dr 3, completed a detailed report to the department regarding Mason. The report and photos of Mason's perianal injuries were sent to the department that day.

285. The report set out:

- Main medical issues:
  - Severe right leg cellulitis;
  - Severe peri-anal fissures with ulcerated skin involvement requiring extensive surgical and medical management:
    - No clear initial cause but appears to be mixture of infection, inflammation and trauma;
  - Anaemia requiring a blood transfusion;
  - Mouth ulcers;
  - Healing spiral fracture of left tibia (shin bone):
    - Likely to have occurred mid January; could have been caused by falling with a rotation mechanism;
- Ms Lee gave differing accounts of household composition – sometimes she lives separately to Will, sometimes they live together and Will does all nappy changes for Mason;
- *"since the time of admission, there have been persistent concerns that Anne could not provide sufficient detail about the toddler's day-to-day cares. Anne reports that her partner, Will, was doing majority of the nappy changes.";*
- Ms Lee reported seeking advice from numerous doctors but the hospital has ascertained that no preceding visits to GP's since 17 January 2016 when Ms Lee took Mason to GP for head injury:
  - GP noted that Mason was not weight bearing and recommended he be taken to hospital for review;
  - Ms Lee disputes she was told this;
- Ms Lee gave an account of Mason falling onto his left side onto tiled surface after a collision from older siblings;
- Concern re neglect due to late presentation of preventable complications of nappy rash and missed lower leg fracture.

286. Dr 3 remains of the view that Mason's perianal condition was likely the result of a combination of causal factors, including trauma, infection and chronic inflammation. Dr 3 could not exclude perianal trauma from insertion of an object or penetration. Dr 3 stated that constipation is a common childhood ailment and does not usually progress to perianal trauma of the magnitude suffered by Mason.

287. Dr 3 stated that Mason's perianal injuries and the injury to his leg would have caused him pain for some time before his admission to hospital and would have

been obvious to those caring for him. The failure to seek medical treatment for him amounted to neglect.

288. On 5 March 2016 Mason was transferred from LCCH to Caboolture Hospital. The discharge summary from LCCH noted that Mason was diagnosed with the following:

- Jacquet's napkin dermatitis;
- Severe cellulitis right leg – diagnosed as a Staphyloccoccus aureue;
- Chronic anaemia – indicating he was iron deficient; and,
- Constipation;
- Healing spiral fracture of mid-shaft left tibia.

289. Mason was prescribed Ferro-Liquid twice per day as an iron supplement and some topical emollient cream for the dermatitis.

290. In regard to Mason being diagnosed with Jacquet's napkin dermatitis, at the inquest, Dr 2 said that it was a rare condition. He had never seen another child suffering from that condition. At the time he had never heard of the laxative Senna causing such injuries and he had never seen that occur.

291. Dr 2 said that a spiral fracture of the tibia is not necessarily an indication of child abuse in a toddler but the fact that Mason was not taken for medical treatment at the time the fracture occurred was evidence of neglect. Mason would have been in considerable pain and unable to walk on his leg for some time after the fracture. This would have been evident to anyone caring for him.

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292. Despite the information received from LCCH, on 7 March 2016 the department decided that Mason could be discharged to the care of Ms Lee that day and advised medical staff that CSOs would follow up with the family.

293. On 7 March 2016 CSO3 commenced an I&A whilst Mason was still in hospital. An I&A ought commence when the child is sighted; that did not occur.

294. STL1 emailed Medicare requesting Mason's medical information be provided within five hours. In fact, that information wasn't received until 9 March 2016.

295. STL1 didn't know that the request hadn't been complied with in the time provided as she did not follow it up. When the information was provided by Medicare on 9 March 2016 she didn't read it. There is no record of anyone else from the department reading it either.

296. At 11am STL4 had a telephone conversation with a Senior Social Worker, Child Protection Unit, Caboolture Hospital, (CPLO) whose notes indicate:

> *Discussed with team leader, STL4 Caboolture child safety regarding discharge. [STL4] is happy for discharge to occur today with child safety to speak with the family tomorrow.*

297. At 11.28am on that day STL1 emailed STL4 and advised that she had allocated the Lee I&A to CSO3 that day. There was no further information provided in the email.

298. At 11.41am CPLO emailed STL4 and flagged the email "High Importance":

> *Further to our earlier conversation re Mason Lee – current inpatient at Caboolture Hospital, we have only seen the parents on one occasion and they stayed for about 1 hr. We have not seen them since. The doctor has expressed concerns to me that staff have observed Mason to be very lonely, requiring comfort and entertainment to be provided by staff. We are aware that the parents visiting Mason at LCCH was limited – with several reasons noted included travel time, cost of parking, etc. However, the family live at Caboolture, and Mason has been in Caboolture Hospital since Saturday, so these reasons no longer seem valid. Doctors are questioning the interest the parents have shown to their baby and his medical needs. Given this, and the likelihood that we (QH) will need to phone to (sic) parents to organise discharge, do you wish us to continue to go ahead with discharge of Mason today?*

299. There is no record of STL4 replying to that email, however, she forwarded the email to CSO3 and STL1 at approximately 11.44am.

300. At 12pm CPLO recorded that she had a conversation with CSO3 who had advised her:

> *Child safety to commence investigation with parents at home this afternoon, and will present to hospital once this has occurred. Child safety have requested Qld Health hold off on discharge until this occurs.*

301. At 3.15pm on 7 March 2016 RAI1 contacted NRIS and reported additional concerns which were assessed as a CCR. In summary RAI1 advised:

- Ms Lee was concerned she was being judged by the medical staff at LCCH;
- She is struggling with anxiety and has not been presenting well at the hospital because of the anxiety;
- Ms Lee said that she had taken Mason to various GP's prior to his admission;
- Ms Lee has not been told when Mason would be discharged;
- Ms Lee occasionally leaves the children in the care of unknown people;
- RAI1 is concerned that Ms Lee left Sibling 1 in the care of her father despite him being an inappropriate carer.

302. The NRIS assessed the information as not warranting any change to the RTF and it was to be assessed as part of the current I&A.

303. At 3.30pm CPLO made a further record:

> *Child safety have advised that they have been unable to establish contact with the mother and will now head unannounced to the family home. Await further contact.*

304. At 4.30pm CPLO made a further entry in the hospital records noting that she had emailed CSO3 requesting an update re the status of Mason's discharge into the care of his mother.

305. Departmental records indicate that the I&A was commenced by CSO3 and CSO4 at 4.30pm that day when they interviewed Ms Lee and Mr O'Sullivan at Ms Lee's residence. During that interview Ms Lee stated:

- She had taken Mason to doctors in relation to his nappy rash (inconsistent with information provided by hospital and medical records);
- Mason hurt his leg when the other boys accidentally knocked him over and she took him to the doctor who told her to strap it – Mr O'Sullivan strapped it and three days later Mason was running around outside and "seemed fine" (this was not checked for veracity with the medical staff and was inconsistent with a fractured tibia);
- It was not good enough that the hospital and the department were saying different things about Mason (not explored what she was referring to);
- Mason had been constipated and she gave him laxatives (no details requested);
- She and Mr O'Sullivan were non-drinkers and did not take illicit drugs (inconsistent with departmental records);
- She and Mr O'Sullivan had been in a relationship for about a year.

306. Mr O'Sullivan stated:

- Mason's nappy rash started before Christmas (this was not explored further);
- His mother had been helping them a lot (no details of the mother were requested and no investigations carried out as to whether she was an appropriate person to care for the children, if, in fact, she was which seems improbable).

307. Following that inappropriate and insufficient interview and without discussing the matter further with medical staff or conducting any further investigations, CSO3 told Ms Lee that Mason would be discharged to her care and CSO3 instructed the hospital to do so.

308. CSO3 told Ms Lee to contact the hospital the following day as she thought Mason would be discharged. She said she would be in contact with Ms Lee the following week.

309. CSO3 did not make any further inquiries or sight any of the children on that day. Neither did she see Mason at any time while he was in hospital or prior to his discharge.

310. On 7 March 2016 CSO3 completed an initial safety assessment in relation to all four of Mason's siblings. She identified no harm indicators and deemed the children to be "safe".

311. Hospital records indicate that Ms Lee contacted the ward at 6pm on 7 March 2016 and advised that she had been told by the department that Mason was cleared for discharge and she should have picked him up.

312. The department contacted the ward soon afterwards and offered to contact Ms Lee to organise Mason's discharge.

313. At 7.15pm Ms Lee called the ward and enquired about Mason's discharge. She was told to attend the next morning.

314. Dr 2 saw Mason on the morning of 8 March 2016. That same morning Dr 2 discussed Mason with CSO3 and told her of his "high level of concern regarding neglect".

315. Dr 2 told CSO3 that he was very concerned about neglect and potential abuse. He listed his reasons for his concerns as including:

- The lack of any adequate explanation from Ms Lee re the severe injuries to Mason's perianal area;
- The undiagnosed limb fracture which would have been a painful injury requiring presentation to a doctor;
- LCCH reported that Ms Lee had not visited Mason with any frequency during his stay there.

316. STL4 went on leave on 9 March 2016 without actioning the safety assessment. She returned to work on 4 May 2016 and on 23 May 2016 sent it to STL1. STL1 returned it to STL4 on 31 May 2016 who then sent it to STL2 on 1 June 2016. STL2 returned it to STL4 on the same day and STL4 eventually approved it on 2 June 2016.

317. CSO3 told medical staff at Caboolture Hospital that Mason could be discharged into the care of Ms Lee and that the department would visit Mason's home at 9am on 9 March 2016 to formulate a plan for support and ongoing follow-up by the department.

318. Dr 2 was comfortable that it was appropriate to discharge Mason from hospital from a medical point of view, but was very concerned that he was to be discharged to the care of Ms Lee. He accepted the assessment of the department as it was responsible for child protection decisions.

319. At midday on 8 March 2016 CPLO emailed CSO3 and advised of the follow-up plan for Mason including outpatient appointments, occupational therapy, dietician, general practitioner and speech pathology. Mason was to continue taking iron supplements and medication and cream prescriptions for his bottom. Dr 2 indicated that his bottom was "almost completely healed" and may not require cream for much longer.

320. Hospital records indicate that at 3.30pm on 8 March 2016 Dr 1 and CPLO were awaiting "the child protection plan regarding discharge" and they were dealing with an upset Ms Lee who said that she did not understand the delay or the involvement of the department.

321. At 4pm CSO3 phoned the hospital and advised that Mason was to be discharged to the care of his mother and that the family would be visited at 9am the following day to formulate a plan for supports and ongoing follow up by child safety.

322. At 4.10pm it was recorded that Ms Lee was distressed that Mason had not been discharged.

323. There was a further phone call with CSO3 who confirmed that Mason was to be discharged.

324. At 5pm on 8 March 2016, when the medical staff had done all they reasonably could to prevent his discharge to the care of his mother, and at the insistence of CSO3 supported by STL4, Mason was discharged from Caboolture Hospital into the care of Ms Lee.

325. At the inquest Dr 2 said that if he was involved in a case like Mason's again i.e. where he disagreed with the decision of the department in relation to the discharge of a child from hospital, he would escalate the matter to his Executive Director of Medical Services. Dr 2 said that he was not aware of any Qld Health policies and/or procedures in relation to such an action by medical officers

326. On the same day CSO3 completed a safety assessment for Mason. She stated that there were no immediate harm indicators for him and submitted it to STL1 who approved it on 11 March 2016.

327. At 10am on 9 March 2016 CSO3 and CSO4 visited Ms Lee's residence and interviewed Ms Lee and Mr O'Sullivan together.

328. RAI1 attended as well on the invitation of Ms Lee.

329. CSO3 advised that she needed to discuss the concerns that Mason was not taken to hospital earlier for medical treatment.

330. Ms Lee again provided responses that were inconsistent with the information provided by the medical staff in that she reiterated that she had taken Mason to doctors and "everyone" kept saying it was nappy rash.

331. CSO3 told Ms Lee that the hospital could not locate any medical centre records in regards to Mason's nappy rash. Ms Lee became "very upset" and said she didn't understand. This line of questioning was not pursued by CSO3.

332. Ms Lee said that Mr O'Sullivan was a good support for her.

333. Ms Lee complained she was being treated as a bad mother by the hospital staff and this was causing her a great deal of stress.

334. CSO3 and CSO4 then interviewed Sibling 4 at the residence. She spoke about the garden being smashed by Mr O'Sullivan "when he hated mum".

335. Ms Lee was asked about this disclosure and responded that she was the person who ripped the plants out of the garden and Mr O'Sullivan helped her re-plant them.

336. CSO3 said that she would interview the rest of the children later in the week by themselves. Mr O'Sullivan became upset on hearing that the children were to be interviewed and said he thought that his son might make things up.

337. There is no record of Mason being present at the house on 9 March 2016 or CSO3 or CSO4 asking about his whereabouts or his welfare despite the I&A commencing because of neglect of Mason.

338. On 9 March 2016 CSO3 queried the school of Sibling 1 re her attendance and was told she usually attended but arrived late.

339. Also on 9 March 2016 (two days late) Mason's Medicare history was provided to the department. It revealed that Ms Lee's claims about taking Mason to the doctor were false.

340. On 10 March 2016 RAI1 emailed CSO3 and advised clearly of her concerns in regard to Ms Lee and Mr O'Sullivan. She relayed that she was concerned that Ms Lee and Mr O'Sullivan did not want the children interviewed by themselves, in particular, Mr O'Sullivan said that his son had a wild imagination and could make things up that would be interpreted as concerning. She also advised that she had concerns that Ms Lee would miss Mason's follow-up appointments.

341. RAI1 received no response at all from CSO3. It is doubtful that anyone from the department read the email.

342. Dr 1 is an experienced paediatrician and was the Child Protection Advisor for the Caboolture and Kilcoy Hospitals.

343. Her duties in that role included acting as the representative for Qld Health at the Caboolture SCAN meetings and reviewing all reports that were submitted to SCAN by those hospitals, considering and assessing the reports and the response from the department and deciding whether to table those reports at a SCAN meeting.

344. Although Dr 1 had some involvement with Sibling 3 and Sibling 4 with respect to the sexual assaults that occurred in 2015 she first became aware of Mason on 10 March 2016 when she was informed of his admission to hospital and subsequent treatment by Dr 2 and his concerns about neglect and the inability of Ms Lee to ensure he received adequate medical treatment upon discharge.

345. Dr 1 gave evidence at the inquest that on 10 March 2016 she was shown photos of Mason's bottom after his admission to hospital. She said she had never seen injuries like his before. She was concerned about the potential causes of those injuries. She said that she had seen burns from the laxative Senna but they were not as extensive as Mason's injuries.

346. Dr 1 gave evidence at the inquest that she would have been comforted if the department had disclosed a plan to ensure Mason's safety prior to him being discharged but that did not occur.

347. She said that it was difficult for Qld Health staff to know whether he should be discharged to the care of his mother because they did not have the information available to the department in regard to his family circumstances. She was told by the department that an IPA would be opened and the department would work intensively with the family and it was on that basis that Qld Health and QPS acquiesced with the decision of the department to discharge Mason.

348. Dr 1 decided to request Mason's case be tabled at the next SCAN meeting and submitted the appropriate report detailing the concerns which was circulated to the SCAN team members. She also asked RAI1 to attend as she believed RAI1 had relevant information for the SCAN members in relation to the Lee family. RAI1 had contacted the hospital because of her concerns about the family.

349. On 11 March 2016 Dr 1 phoned RAI1 to discuss Mason. RAI1 summarised her work with the family and also reported her concerns about Mr O'Sullivan, in

particular his guarded and defensive response to the interviewing of the children.

The SCAN meeting of 15 March 2016

350. On 10 March 2016 Qld Health made a referral to SCAN seeking a meeting to discuss their concerns about Mason.

351. Qld Health provided all the medical information they held about Mason's hospital admission and his injuries.

352. Qld Health provided further information about Mason including the concerns that Ms Lee was disengaging with support services, it was uncertain as to who was caring for Mason on a daily basis, inconsistent versions about the living arrangements of Mr O'Sullivan and his son, Mr O'Sullivan's articulated concerns that he did not want the children interviewed due to the risk they would say something untrue and concerns that Mason had been withdrawn and not talking.

353. Qld Health articulated their ongoing concerns that Mason's injuries were caused by neglect and that Ms Lee's versions about medical treatment were inconsistent with the medical records.

354. Department of Education records were provided to the SCAN team and indicated Mason's siblings had a poor attendance record at school – in a one month period Sibling 3 had been absent for 20 days, Sibling 1 had been absent for 29 days of year five and Sibling 2 had been absent for 32 days of the year.

355. QPS also provided information about Mr O'Sullivan's criminal history dating back 20 years which included numerous drug offences and breaches of probation. QPS records also revealed that Mr O'Sullivan had a history of perpetrating domestic violence towards Ms Lee and previous partners. On 22 September 2015 Ms Lee had reported him to police due to DV but quickly retracted her statement.

356. CSO3 who attended the meeting didn't read any of the material that had been provided to the department for the SCAN meeting. There was no planning about Mason's case prior to the meeting.

357. Although STL1 was the core representative for the department at the meeting she also did not read any of the information that was sent to her prior to the meeting and neither did she provide any information held by the department in relation to Mason to the other representatives.

358. When interviewed by the ESU STL1 said she couldn't remember exactly what was discussed at the meeting. It was clear that she had no recollection of anything that was said at the meeting and neither she nor CSO3 took any case notes.

359. The department provided no information to the SCAN meeting despite the fact that the department held pertinent information about Mr O'Sullivan being:

- he had a substantial pattern of domestically violent behaviour dating back to 2014 in Queensland;

- he was abusive to his ex-wife and department records contained instances of verbal abuse, degrading name calling, physical attacks and escalating threats and harassment particularly subsequent to separation;
- he had reportedly committed acts of DV in front of his four children.

360. Dr 1 attended the SCAN meeting on 15 March 2016. At the meeting she raised the following concerns:

    - There was very little information about the living arrangements of the Lee family and who was caring for Mason on a day to day basis;
    - It appeared that Mr O'Sullivan was actively involved in the care of Mason despite Ms Lee previously stating they were not in a relationship;
    - There was very little known about Mr O'Sullivan or his history;
    - Ms Lee was reliant on Mr O'Sullivan for the care and treatment of Mason and this was concerning given her history of leaving her children in the care of inappropriate people;
    - Mason's future care and treatment requirements and concerns that no follow up appointments had been made for him to attend a dietician or speech pathologist.

361. Dr 1 recalled that QPS were also concerned about the potential for Mason to be neglected and RAI1 was uncertain about the family's living arrangements and had concerns about Mr O'Sullivan.

362. Dr 1 agreed that at the meeting Mason's injuries were discussed and the opinion was that the majority of his injuries could be explained by causes other than abuse. However, that did not change the fact that his late presentation for medical treatment indicated neglect.

363. RAI1 attended the meeting and shared the information she had about the Lee family and her concerns about Mr O'Sullivan. She asked the QPS representative whether they could look into Mr O'Sullivan and whether he had a criminal history. She advised that she was concerned that Ms Lee had allowed Sibling 1 to be cared for by her father who did not seem able to care for a child and that she had not been attending school.

364. It was at the meeting that RAI1 was first provided with any information from the department or Qld Health about Mason. She was told about his injuries and that the cause/s of them remained unclear. She was told that Ms Lee had provided a history to the Drs which was inconsistent with the injuries and the facts.

365. RAI1 gave evidence at the inquest that Dr 1 and the police officer present at the meeting were unhappy about Mason being discharged to Ms Lee's care and she said, "There was tension in the room".

366. RAI1 was then told that she would be contacted by the department the following week to request her presence as a support person for the children when they were interviewed.

367. RAI1 was frustrated by the lack of resolution at the meeting as to what was to be done concerning the family. She asked CSO3 if the matter was going to be an IPA – CSO3 glanced at STL1 who nodded and then answered, "Yes".

368. The IPA response indicated to RAI1 that her involvement with the family must end as per the department guidelines (funding for RAI and IFS ceases upon intervention by the department). She understood that her role would be to provide support for the transition from the RAI1 to the IPA and the exiting of her services to the family. However, there was no plan discussed with her during or after the meeting. At the inquest she was critical of the lack of a "warm handover".

369. RAI1's professional opinion was that there remained many unanswered questions about Mason and his family and she considered that he met the threshold for the department to intervene. She considered that an IPA was the minimum intervention required but believed that the department would have continued to assess the situation and that Ms Lee should have been required to engage and comply with Mason's follow up medical requirements. RAI1 was reassured as she was told by CSO3 that there would be intensive support for the family.

370. Dr 1 said that upon RAI1 providing the information she had she was asked to leave the meeting by CSO3 or STL1 as further information about the Lee family could not be shared with her.

371. Qld Health SCAN representatives (Dr 1 and CPLO) made notes of the meeting:

> *… insufficient information was provided by [the department] to QH prior to this meeting to allow any searches in relation to other individuals in the family, including William O'Sullivan. The CPLO had to request this identifying information during the SCAN meeting. The CPLO remembers clearly noting O'Sullivan's name and date of birth during the meeting for later searching. It would be normal practice for this information to be provided prior to the meeting so that relevant QH information on household members can be provided for the meeting.*
>
> *Dr 1 remembers stating in the SCAN meeting that she had been in touch with [RAI1] who informed Dr 1 that she (the caseworker) was concerned about the resistance and lack of engagement from Ann-Maree (Mason's mother). Dr 1 requested to invite the RAI1 caseworker to the next SCAN meeting.*

372. The QPS representative advised the meeting that they were concerned about the delay in treating Mason's cellulitis and that he was not taken for medical treatment for his leg fracture. It was noted that the children should have been interviewed at the police station rather than the family home. QPS said they were investigating serious neglect and questioned Ms Lee's capacity to care for Mason upon discharge and felt more assessment was needed and "more intensive support" as it was a case of chronic neglect where Mason had not been given proper care for a broken leg and a severe burn or nappy rash.

373. QPS stated they could not see any security for Mason in the short term because if Ms Lee did not attend to Mason's injuries he would have to return to hospital.

374. CSO3 told the group that there wasn't enough evidence to remove Mason from the care of his mother and the department would monitor him closely.

375. STL1, as the SCAN team coordinator from the department, agreed with CSO3 and told the core representatives that "the family is likely to be subject to an IPA."

376. This decision was made in the middle of an I&A whereby new concerns were being raised regularly and without any planning, discussion or consideration of the material provided by the agencies.

377. The recorded recommendation from the SCAN meeting was "to check on mother continuing treatment and medications for Mason" and Qld Health was to "arrange a mental health assessment for the mother".

378. Dr 1 said that CSO3 and STL1 assured her that Mason would be sighted three times per week after his discharge from hospital by RAI1. (RAI1 gave evidence that she was not aware of this and it was not possible for her to do so as the funding did not allow such intensive support and it was not within the program to provide it).

379. Dr 1, on being told that the department only sighted Mason once between his hospital discharge and his death (being the documented sighting on 18 March 2016) remarked that the department's response was "incredibly disappointing" and "a tragedy".

380. On 16 March RAI1 attempted to phone Ms Lee to check on Mason. Mr O'Sullivan answered the phone and told her she couldn't speak to Ms Lee as she was unwell. RAI1 emailed CSO3 to update her with the information and advised that she hadn't seen the family that week and asked, "Please let me know if there is anything else I can do."

381. At 3pm on 18 March 2016 CSO3 and CSO5 visited Mason's home. It was a brief visit – it lasted five minutes and took place at the front door. Mason and Sibling 4 were sighted. CSO3 saw that Mason was walking awkwardly but did not ask to see his bottom. Ms Lee told her it had almost healed but also said that the cream wasn't working. Despite the obvious evidence to the contrary and the fact that Dr 2 had told the department on 8 March 2016 that Mason's bottom had almost completely healed, CSO3 made no further investigations and accepted Ms Lee's assurances. (CSOs have the power to direct a parent to remove clothing or a nappy to allow for visual inspection of a child).

382. This was the last time anyone from the department saw Mason. It was also the one and only time that anyone from the department saw Mason between his discharge from hospital and his death.

383. On 23 March 2016 Ms Lee called RAI1 and asked her to attend interviews the next day.

384. On 24 March 2016 CSO3 called RAI1 and asked her to attend the interviews and also asked her to ask Ms Lee to arrange for a check-up for Mason. RAI1 did so. She sat in on the interviews conducted by CSO3 and a CPIU police officer. Neither Mr O'Sullivan nor Mason were present.

385. Sibling 2 was interviewed and said:

- She feels worried about Mason getting hurt
- Worried that a bad guy might smack him – she was asked whether that had ever happened – she answered – no, not really
- and if it happens he might die

- Sibling 1 looks after Mason when she gets home from school
- She panics when he cries – she reckons he's gonna get hurt like really badly
- Hurt in what kind of way? – punched
- Or get pushed over

386. Sibling 2 was asked by CSO3 who would do that to Mason. She didn't respond and then CSO3 prompted her, "You don't know?" to which she replied, "Nuh."

387. After the interviews RAI1 asked CSO3 about the progress of the IPA. CSO3 told her it was just commencing. In light of that, RAI1 decided to continue to provide support to the family until she knew that they were properly engaged with the department.

388. CSO3 also told RAI1 that there would be a second SCAN meeting but that her attendance was not required. No reason was provided for this.

389. Also on 24 March 2016, the SCAN administration officer emailed STL1, STL2 and STL4 significant information received from Qld Health regarding Mr O'Sullivan being:

    - In 2012 Mr O'Sullivan was aggressive and had a history of violence and advised that he controlled his OCD traits by taking "speed";
    - He was a long term speed user and used cannabis daily;
    - He saw shadows and heard voices;
    - In April 2015 he presented to Caboolture Hospital after experiencing homicidal and suicidal ideation about his wife, sister and himself;
    - He described that he had plans to skin his wife, kill his children and hang himself;
    - His wife had left him a week prior to his admission;
    - He said his father and grandfather had suicided;
    - He head butted walls whilst in the emergency department and also made a noose out of a blanket and was looking for somewhere to hang himself
    - He was placed on an involuntary treatment order and admitted as an inpatient for 9 days but then discharged;
    - A month later he continued to experience suicidal thoughts and had been served with an application for a DVO with his wife and four children named as aggrieved persons.

390. None of the STLs recorded any of this information or responded to it in any way. It is unlikely that any of them read it. None of them forwarded it to CSO3 and although she could have accessed it herself she did not do so.

391. When interviewed, STL1 said that all three STLs were responsible for looking at that material and following it up and it raised significant concerns but admitted that she didn't read it.

392. On 25 March 2016 Mason was taken for a check-up with a GP at a local medical centre.

393. On 29 March 2016 the next SCAN meeting was to be held.

394. At 8.41am CSO3 emailed STL1 a summary of the information held by the department for the purposes of the meeting and told her that the siblings had been interviewed and had not made any concerning disclosures. She stated:

Previous SCAN recommendations

- *The department to conduct further assessments of the child's protective needs.*
- *Interviews to be conducted with siblings by CPIU and department.*
- *Further information to be sought about Mr O'Sullivan.*
- *A&O to be completed.*
- *IPA to be discussed with Ms Lee.*

Actions undertaken

- *Interviews with children complete – no concerning disclosures made*
- *Child Safety history obtained for Mr O'Sullivan; 5 x CCRs, including his history of mental health concerns, verbal arguments with his ex-wife in the presence of their children*

395. The meeting scheduled for 29 March 2016 was cancelled due to lack of a quorum as one of the paediatricians was away.

396. Dr 1 gave evidence at this inquest that she later became aware that nobody from the department read the information she provided for the SCAN meeting in regard to her concerns and Mr O'Sullivan's history of serious mental health issues.

397. On 1 April 2016 the department received further additional notified concerns detailing that Ms Lee had told the father of Sibling 1 that she was "escaping child services, who were onto her". Concerns were separately reported that the father had assaulted Sibling 1 and broken her tooth.

398. On 5 April 2016, during the resulting I&A, further information was received alleging that Sibling 1 had been sent by Ms Lee to stay with her father and he had hit her in the face causing her to suffer a broken tooth. The department had information that the father had impregnated Ms Lee when she was 15 years old and he was 24, that he abused alcohol, that he was "very violent" and suffered from schizophrenia and paranoia and had not had contact with Ms Lee or his daughter for the previous ten years.

399. The concerns were recorded as a CCR as the family were already subject to an investigation and that "there is no information that indicates that the children have suffered or are at risk of suffering further significant harm."

400. On 7 April 2016 CSO3 conducted an A&O of the I&A with an outcome that Mason and his siblings had no parent willing or able to meet their needs and were children in need of protection. The risk level was considered by CSO3 to be "high." An IPA was still considered to be most suitable while the children remained with Ms Lee and she worked with the department to address the child protection concerns.

401. That A&O was submitted to STL4 on 16 May 2016. STL4 forwarded it to STL1 on 23 May 2016 who returned it to STL4 on 31 May 2016. STL4 allocated it to

STL2 on 1 June 2016 who returned it to STL4 on the same day. STL4 then sent it to STL1 who approved it on 9 June 2016.

402. On 8 April CSO3 asked RAI1 if she had been in contact with the Lee family and advised that she would be interviewing the children the next week in regard to the allegation that Sibling 1 had been assaulted by her father.

403. RAI1 responded to CSO3 raising her concerns about Sibling 1 being assaulted by her father and the fact that Ms Lee had put her in his care. RAI1 also advised that Mr O'Sullivan was showering with Mason:

> *Mason seemed ok, although when I arrived I noted that neither he nor Will were present in the kitchen/lounge. Anne said Will was having a shower and bathing Mason and that they would be out soon (they did come out about 5-10 minutes later).*

404. Also on 8 April CSO3 emailed STL2 the summary of the departmental information that she provided to her on 29 March 2016 for the SCAN meeting scheduled to be held on 12 April 2016.

405. On 11 April 2016 a police officer from CPIU telephoned CSO3 and told her that the assault of Sibling 1 was being investigated by police and she would be conducting an interview with Sibling 1 on 15 April 2016. She told CSO3 that the interview had been booked to occur on 8 April 2016 but Ms Lee had postponed it.

406. On 11 April 2016 CSO3 replied to RAI1 and advised that Sibling 1 had an interview with police on 15 April 2016. RAI1 agreed to attend. CSO3 stated she would not be part of that meeting.

407. CSO3 also advised that she had been unable to contact Ms Lee at the end of the previous week but would follow up with the family on 18 April 2016 – the date of Mason's follow up hospital appointment.

408. CSO3 asked RAI1 to ask Ms Lee to take Mason to a GP appointment on 11 April 2016 for a general check up. RAI1 agreed to do so but advised that Ms Lee always refused offers of transport so it could be difficult for her to organise.

409. Later that day CSO3 advised RAI1 that she had been unable to contact Ms Lee to organise a GP visit for Mason. RAI1 responded that she would try to check with Ms Lee the next day.

410. CSO3 was using Mr O'Sullivan's phone number to contact Ms Lee as was RAI1.

411. On 12 April 2016 a further SCAN meeting was held.

412. STL2 attended as the STL, the core member and the team coordinator for the department. She told the meeting that the I&A was current and CSO3 had been allocated it. She said that "Mum and Dad" were engaged with RAI1 and that interviews had occurred and "no disclosures" were made.

413. Mason's case was closed to SCAN.

414. On 12 April 2016 RAI1 took Ms Lee to Centrelink and told Ms Lee that CSO3 hadn't been able to contact her. Ms Lee said that she and Mr O'Sullivan had hocked his phone to buy food but they would be getting it back later that day.

415. On 13 April 2016 RAI1 emailed CSO3 and advised her of the above information.

416. On 18 April 2016 Ms Lee took Mason to see Dr 2 for follow up at the outpatient clinic at Caboolture Hospital.

417. Dr 2 noted that a referral had been made to the Child Therapy Service at North Lakes for Mason to receive Allied Health input. As at 18 April 2016 no such appointment had been made.

418. Ms Lee told Dr 2 that she was happy with Mason's progress, that he was active, well, cheerful and had a good appetite. She said he was no longer constipated.

419. Dr 2 noted that Mason seemed well. He had gained 400g. There was mild excoriation of both of Mason's buttocks but the previously deep ulcerated areas had healed well. He had a deep anal fissure approximately 1.2cm long. This could have been caused by constipation but Mason did not appear constipated at the time. It was unclear to Dr 2 whether the fissure was the end result of the previous perianal ulceration noted above. The Wound Nurse recommended that Ms Lee apply Menalind cream to the fissure.

420. Dr 2 was concerned that Mason's immunisations were not up to date and wrote to Mason's GP at a Medical Centre at Caboolture requesting he be advised if Mason's immunisations were not brought up to date in the near future. Dr 2 copied that letter to CCSSC.

421. Dr 2 scheduled a follow-up appointment for 7 weeks later i.e. 7 June 2016, which was also contained in the letter to CCSSC.

422. On 18 April 2016 RAI1 attempted to contact CSO3 to discuss the Lee family. Nobody returned her call.

423. Between 18 April and 17 May 2016 RAI1 attempted to contact the department on 5 occasions to find out what was going on with the Lee family.

424. On 22 April 2016 Ms Lee phoned the Paediatric Outpatients Clinic of Caboolture Hospital and said that Mason's nappy rash had reappeared. She was informed of her next appointment date and given advice about the treatment of the rash and told to contact her GP or to the Emergency Department if further concerned.

425. On 28 April 2016 CSO3 interviewed Ms Lee who made overt statements about her refusal to engage with the department. Despite Ms Lee's now obvious refusal to comply with an IPA CSO3 did not take any action, did not report this to her supervisors, did not conduct any new safety assessments and did not reconsider whether an IPA remained an appropriate type of intervention.

426. Also on 28 April CSO3 had a phone conversation with the father of Sibling 1 who alleged that Ms Lee had physically assaulted Sibling 1.

427. On 4 May 2016 RAI1 phoned CCSSC to speak to someone about the family. Nobody returned her call.

428. On 5 May 2016 CSO3 and CSO5 interviewed Sibling 1 at Ms Lee's residence in relation to the alleged assault by her father. Sibling 1 confirmed that Ms Lee had sent her to live with her father and he had punched her in the face for no reason.

429. CSO3 and CSO5 also briefly interviewed Ms Lee on that day as she was lying on a mattress at the front of the house with a migraine. Ms Lee said she had taken Mason to the hospital and was given cream for his bottom but he was allergic to it and developed a massive rash after two days.

430. Neither of the CSOs asked to see Mason who was not present in the front yard. They did not ask where he was or who was looking after him even though Ms Lee told them that he had developed a "massive rash". They did not ask where and when Mason was taken to the hospital.

431. On 9 May RAI1 called the CCSSC and was advised that CSO3 no longer worked there but that STL4 would be contacting her about the matter.

432. On 10 May 2016 Ms Lee told RAI1 that CSO3 had told her that RAI1 would be asked to cease providing services to the family.

433. On 11 May 2016 RAI1 emailed STL4 seeking an update re the Lee family and asking whether she had to close the case, but again, she received no acknowledgement or reply.

I&A 15 May to 11 June 2016

434. On 16 May CSO3 submitted the interviews held with Sibling 1 and Ms Lee on 5 May 2016 to STL4 for approval. At that time CSO3 had moved to the Alderley office. STL4 forwarded it to STL1 on 23 May 2016 who returned it to STL4 on 31 May 2016. STL4 allocated it to STL2 on 1 June 2016 who returned it to STL4 on the same day. STL4 then approved it.

435. On 16 May 2016 CSO3 emailed STL4 to update her about some of her cases including the Lee case. She told STL4 that the I&A had been submitted to her, that it was an IPA and that once it was approved she could create the case plan.

436. On 17 May 2016 RAI1 sent another email to STL4 noting that her phone calls to CCSSC had gone unreturned and asking for an update and offering her assistance in handover.

437. On 17 May 2016 STL4 finally responded to RAI1's emails. She advised that it was likely that CSO6 would be allocated the IPA but that was not confirmed.

438. STL4 copied STL1, STL2 and STL3 into that reply email.

439. On 19, 26 and 31 May 2016 RAI1 visited Ms Lee's home but she was not there. She left notes. She was attempting to contact Ms Lee on a weekly basis until the department confirmed that she should close her case.

440. On 27 May 2016 STL4 advised CSO6 that she would likely be allocated the IPA and suggested she should "start looking at the history and I&A" to consider "what kind of case planning may be required for this matter." The email contained the email thread containing the information provided by the father of Sibling 1 re concerns for her safety.

441. On 31 May 2016 STL1 emailed STL4 and advised, "I have sent [Lee matter] back to you, I don't know this one, and was not a part of conversation with this one. Thanks."

442. On 7 June 2016 RAI1 again phoned CCSSC and spoke to CSO6. CSO6 said that she had not been allocated the matter but would speak to STL4 about it. RAI1 was surprised to learn that no CSO had been allocated the case.

443. RAI1 told CSO6 that she had been unable to contact the Lee family for the last two weeks and requested that the department conduct a safety check on the family.

444. RAI1 asked whether the RAI files should be closed. Later that day CSO6 phoned RAI1 and told her that she had spoken to a team leader and the case had not been allocated to an IPA worker but a CSO would visit the home in the next few days.

445. On 7 June 2016 Mason was not taken to Caboolture Hospital for follow up appointment.

446. Having reviewed the autopsy report and post mortem photos of Mason, Dr 2 opined that Mason's anal injuries would have been visible for some time before his death – they were chronic and of at least weeks' duration. Further, Dr 2 said that on 7 June 2016 Mason's bruises alone would have required investigation considering that at the time of autopsy he had 46 bruises – a study relied upon by Dr 2 indicated that more than ten bruises in a child of Mason's age, as well as the locations of bruises, indicated abuse.

447. In the opinion of Dr 2, taking into account the factual findings of when Mason's injuries were caused and when he succumbed to those injuries, had he seen Mason for the follow up appointment on 7 June 2016 it is more likely than not that surgery and treatment would have saved his life. That treatment would have included immediate admission, abdominal scans, intravenous fluids and surgery. Dr 2 said that by 7 June 2016 Mason would have presented as very unwell – he would have been dehydrated, vomiting and he would have looked very sick.

448. On 8 June 2016 CSO6 and CSO1 visited Ms Lee's address to conduct a safety check. Nobody was home but the windows were open and the television was on. They spoke to a neighbour who said she was concerned about Ms Lee's partner.

449. Ms Lee contacted them later and they returned to the address. They did not go inside. They spoke to Ms Lee and saw four of the children. Mason was not seen. They did not inquire about his whereabouts or ask to see him.

450. Ms Lee told them that she had stopped engaging with RAI1 as she could not see any more good coming from it. She also said that she wanted the department to stay away and leave her and her children alone. She refused to

provide Mr O'Sullivan's name to them as she was afraid it would get him into trouble.

451. Ms Lee also told CSO6 and CSO1 that "Will" was using ice and became violent and he would hurt Ms Lee but not the children. She said he hated her eldest daughter because she stood up for Ms Lee but he loved the other children. She told them she was 13 weeks pregnant to him but wished to terminate the pregnancy. She said he was controlling and violent and kept her phone and monitored her movements. She said she wanted to get away from him but was scared to involve the police in case it escalated his behaviour making it more unsafe for her and the children.

452. Neither CSO6 nor CSO1 explored the identity of Mr O'Sullivan. It is clear neither of them had obtained any background information about Ms Lee or the family despite it being available to them on the department database.

453. By that time the department had significant information about Mr O'Sullivan, his concerning history and his relationship with Ms Lee. If CSO6 or CSO1 had done any preparation before seeing her by looking at the file they would have been in possession of that information and could have assessed it in relation to the new information she was disclosing.

454. CSO1 simply recorded that Ms Lee "displayed no reluctance or resistance to engage with the CSO under IPA or other supports to be offered to her and the children."

455. CSO6 attempted to contact CSO4 as she apparently specialised in domestic violence but could not contact her. She then told Ms Lee she would organise a meeting with her the next day to discuss the domestic violence.

456. On 9 June 2016 CSO6 and CSO4 met with Ms Lee at a medical clinic. Ms Lee said that Mr O'Sullivan was violent to her and that ice exacerbated his paranoia. She said that the domestic violence included control, manipulation, surveillance and monitoring, accusations of infidelity, physical assaults (including whilst she was pregnant) and threatening her with a machete. She said she felt like a puppet with Mr O'Sullivan pulling the strings to control her. She said that the eldest daughter told her that she'd had enough of him hurting Ms Lee and she would rather that he hurt her instead.

457. CSO4 told Ms Lee that if she could not protect the children the department could take them into temporary custody whilst supporting her to be safe. Unsurprisingly Ms Lee did not voluntarily choose that option. It is inexplicable that the decision was left to her when she told the CSOs she was under the control of Mr O'Sullivan and she was clearly trying to navigate herself and the children safely through a confusing and dangerous situation. That decision was made by the CSOs against a background (known to the department) of Ms Lee being unable to be protective of her children in the past in relation to previous partners.

458. Neither CSO6 nor CSO4 considered whether the children were still safe or whether they should exercise their powers under the legislation or discussed this matter with their supervisors.

459. It was agreed that Ms Lee would meet them the next day at 3pm and then go to a DV Centre for consultation.

460. Later that day CSO6 informed STL4 and STL1 that an appointment had been scheduled for Ms Lee. It was described as a "positive situation" rather than it being discussed that the CSOs were now in receipt of further information indicating that the children were not safe.

461. On Friday 10 June 2016 Ms Lee phoned RAI1 who said that she had temporary access to Mr O'Sullivan's phone but that she wanted to tell her the following:

- CSO4 and CSO6 had visited Ms Lee the day prior and she told them:
  - Will had a really bad ice addiction and mental health issues;
  - He hadn't been taking his antipsychotic medication;
  - He was verbally and physically abusive to her;
  - He had been continuing to change Mason's nappy and was possessive of him
  - His son was extremely distressed recently;
  - He has access to firearms;
- She planned to attend a DV service with CSO4 and CSO6 that afternoon.

462. That was the last contact RAI1 had with Ms Lee or the family prior to Mason's death.

463. Also on 10 June 2016 CSO6 and a family support worker attended Ms Lee's neighbour's house as Ms Lee had named her as a support person. The neighbour was not at home. On the way back to the CCSSC CSO6 and the support worker saw Ms Lee and her youngest daughter walking along the footpath. Ms Lee seemed anxious and nervous and advised CSO6 that Mr O'Sullivan was collecting her children from school and would then come and pick her up. She said he had been calling and texting her incessantly and she didn't feel safe to attend the appointment at the DV Centre for fear he would find out and she wished to cancel it.

464. CSO6 suggested Ms Lee attend the following Monday and lie to Mr O'Sullivan about where she was going.

465. There is no indication that CSO6 gave any consideration at all as to the risk Mr O'Sullivan posed to the children, the safety of the children, where they were or who was caring for them. They knew that Mason was not of school age and Ms Lee had her other child not of school age with her, however, this was given absolutely no consideration by CSO6.

466. At about 4.30pm that afternoon CSO6 received a phone call from Ms Lee's neighbour. She told CSO6 that Mr O'Sullivan was a very violent man. The neighbour told CSO6 that Mr O'Sullivan hits Ms Lee when the children are in bed. She said that she had emailed the department some months before with these same concerns. There is no departmental record of such an email.

467. Critically, the neighbour told CSO6 that Mr O'Sullivan took Mason a lot and used him like a tool to keep Ms Lee in check and refused to let her have him back. She said that Mr O'Sullivan held Mason like a hostage in order to control Ms Lee and so she wouldn't leave him.

468. CSO6 did nothing upon receiving this information to check on Mason and ensure his safety even in light of her knowledge that Mason had not been with

Ms Lee that afternoon. CSO6 merely told the neighbour to tell Ms Lee that her appointment at the DV Centre had been rescheduled for Monday.

469. CSO6 and her supervisors completely disregarded the known serious risk of harm to Mason, instead concerning themselves only with Ms Lee's attendance at a DV Centre.

470. There is no record of any safety planning with Ms Lee in relation to the children taking place after Ms Lee and the neighbour disclosed Mr O'Sullivan's escalating violence and the fact that he was keeping Mason from Ms Lee.

471. CSO6 did not share any of the information provided to her by the neighbour with her supervisors. She only told CSO4 who also did nothing to safeguard Mason and his siblings. Neither updated their case notes, considered conducting a safety check on Mason and the children over the weekend or asking police to do so or consulted with a STL.

472. Mason died that night.

473. The CSOs had been warned by the neighbour that afternoon of the risk to Mason posed by Mr O'Sullivan. They ignored that warning.

474. If CSO6 or CSO4 had acted on the significant information they received that afternoon and asked to see Mason, as was clearly their duty, they may have saved his life.

475. Further, if the more experienced STL1 or STL3 had taken action when they were told that Ms Lee had disclosed serious violence and threats of harm to her children on 9 June 2016, and ensured that someone saw Mason, he may be alive today.

476. It is clear from the significant injuries Mason was suffering at the time of his death that any reasonable person seeing him in the days before his death would have known that he required immediate medical treatment.

477. As referred to above, at the inquest Dr 2 said that Mason's anal injuries would have been visible for at least weeks before his death. Dr 2 also said that the anal fissures present at autopsy were much worse than those he saw in April. Dr 2 said that the fissures present at autopsy would not have been caused by the dermatitis Mason was diagnosed with in March 2016 and he has never seen such injuries caused by constipation.

478. Further, Ms Lee's second eldest daughter had warned the police officer and CSO3 in the interview of 24 March 2016 that she was worried about Mason getting hit or punched by a bad guy and he might die. She said that the eldest daughter was worried about Mason getting hit really hard if he cried so she tried to look after him. She told them that Mr O'Sullivan was violent to her mother. On receiving these disclosures from a young child CSO3 and the police officers chose to simply ignore what she had said and move on to their next question. They made no independent investigations or queried the other children they interviewed that day. They did not persist in questioning Sibling 2 to try to elicit more information from her or ask Sibling 1 about the disclosure of Sibling 2.

479. Despite all of the information available to the department, which clearly indicated that Mason was a child at risk of serious harm, nobody from the

department saw him or checked on his welfare for three months before he was killed. The department had no contact with the Lee family at all between 5 May and 8 June 2016.

480. It is probable that Mason was separated from Ms Lee and kept by Mr O'Sullivan since early 2016 given her lack of ability to give a reasonable account of his day to day activities to the medical staff when Mason was in hospital and inconsistent versions about who cared for him. Unfortunately nobody from the department explored these inconsistences in any way.

REVIEWS AFTER MASON'S DEATH

Systems and Practice Review (SPR)

481. An internal departmental review team carried out a review of the department's involvement in Mason's life and that of his family in the two years prior to his death.

482. The Committee determined that the quality of the assessment, safety and intervention planning did not adequately identify and mitigate the significant safety risks for Mason.

483. The Committee concluded:

- there were inadequate supervision practices;
- there was no evidence of use of a Practice Panel or complex case discussion to support the CSOs in their decision making;
- there was no appropriate escalation processes if a supervisor was unavailable;
- the mechanisms used to manage workload duress were not sufficient;
- there was a lack of robust and timely handover processes with regular monitoring to ensure effectiveness;
- there was no review of processes to ensure information sharing and analysis, safe guards and quality practice systems were operating and in place;
- there were inadequate strategies to address and manage the performance, alleged harassment and bullying issues in CCSSC impacted on the service delivery.

484. The Committee recommended that the Deputy Director General consider whether further action was required regarding the lack of oversight at CCSSC of:

- adequacy of quality assurance processes;
- transfer and handover processes;
- SCAN and quality of SCAN record keeping;
- Service delivery models, governance processes, supervision and practice;
- Decisions of STLs to approve documents despite their lack of quality;
- Failure to record a notification following receipt of information about significant domestic violence.

485. The Committee recommended that all Regional Directors conduct an audit and review of their respective Child Safety Service Centres in relation to:

- The quality of SCAN coordination and record keeping processes;
- Quality and frequency of supervision practices;
- Handover processes.

486. The Committee noted the fundamental importance of sighting children during interaction with families.

Queensland Child Death Case Review

487. On 15 September 2016 the Child Death and Serious Injury Case Review Panel (the panel) was convened to consider the death of Mason. The panel is established by the *Child Protection Act 1999* for the purposes of facilitating ongoing learning and development of departmental services and promoting the accountability of the department.

488. The SPR report was considered by the panel.

489. The panel noted that the SPR report identified problems that had been repeatedly found in child death inquiries in other jurisdictions being:

- Multidisciplinary working and information sharing between professionals and agencies;
- Caseloads, record-keeping, supervision and training;
- Assessment tools and practices;
- Work dominated by responding to incidents and crises rather than purposeful and planned interventions.

490. The panel stated that the above are systemic, multi-factorial problems that are evident in child protection systems worldwide, and for which there are no straight-forward answers, but which emphasise the need for skilled practitioners who receive good supervision and management.

491. The panel recommended that the department give further or renewed consideration to:

- The organisational culture and climate of the CCSSC;
- Review of SCAN operations;
- Enhancing the knowledge and skills of CSOs in responding to DV and appropriate use of specialist DV services;
- Quality improvement in respect to management, governance, workflows and record-keeping in CSSC;
- Professional development and supervision for CSOs;
- Resourcing the non-government family support sector to better match services for vulnerable families.

492. The panel made the following recommendations:

- A program of ongoing training and professional development to enhance the core knowledge, skills and capacity of child safety staff to undertake sound assessment at all stages of child protection work;
- Consideration be given to the following re SCAN:
  - Business processes such as quorum requirements and recording of minutes etc;

    - Management of SCAN team;
    - Processes to ensure relevant people get the information they need for case management;
    - Whether current protocols re sharing of information effective;
    - Whether the current policies for closure of SCAN cases suitable;
    - Whether sufficient attention is given to the planning of joint operations with the department and QPS;
- The department ensure that there is a base level of knowledge about DV for all staff to enhance their capacity to act appropriately at all times without delay;
- The FRE instrument and the 2012 practice paper about DV be reviewed;
- The department review program boundaries, funding and case continuity protocols for RAI/IFS to facilitate consistency and continuity of service delivery to families.

493. The panel noted a number of significant concerns:

    - Lack of communication and handover when CSO3 left CCSSC;
    - Critical information provided to SCAN team was not communicated to CSO3;
    - The handling of information and disclosures made by Ms Lee in the final days leading up to Mason's death.

Department of Health Service Investigation Report

494. On 22 September 2016 the Director-General Department of Health, appointed investigators to conduct an investigation and report on matters relating to the management, administration and delivery of service to Mason.

495. The investigators concluded:

    - The overall management and care of Mason was appropriate and reflective of standard best practice;
    - Communication between Caboolture Hospital and LCCH was comprehensive and effective;
    - The communication and liaison between the Health Service and other government agencies or organisations regarding Mason was effective, however, processes for formal record keeping of SCAN meeting was found to be inadequate;
    - Staff engaged appropriately with the family when they attended the hospitals;
    - The existing legislation, policies and procedures, child protection resources and child protection clinical training and the level of compliance of staff with those was acceptable.

Queensland Family & Child Commission (QFCC) Review

496. In 2015 – 2016 45 children known to the department died.

497. In July 2016 the Commissioner was asked by the Premier to oversee the reviews and investigations into the death of Mason undertaken by the department, the Child Death Case Review Panel, and Qld Health with a view to examine current systems and make recommendations for change to provide an up-to-date child death review system.

498. The QFCC found that whilst a number of agencies routinely carried out investigations into child deaths (for example, the department, Qld Health) there was no death review system which linked all of the agencies.

499. The QFCC concluded that individual agency reports undertaken in isolation do not allow for a systemic analysis. Agencies must act collectively to protect children and should respond in the same manner when reviewing deaths in order to deliver improved joint services.

500. The QFCC made the following recommendation:

> *That the Queensland government considers a revised external and independent model for reviewing the deaths of children "known to the child protection system."*

501. The QFCC recommended that internal reviews of all agencies be mandated and that those internal reviews be provided to the revised child death case review panel which could then make recommendations for improved services from all involved agencies.

502. The QFCC recommended that it would design such a model which would involve the transferring of responsibility for the child death case review panel to an independent government agency.

503. In designing the model the QFCC would consider matters including:

- Extending the scope of powers and the authority of the child death case review panel in the new independent agency
- Reconsider legislative timeframes for reviews
- Reporting to government and public audiences
- Extending the scope to include other government and non-government organisations in the model
- Extending the panel's power to make recommendations and require agencies to take action

504. The QFCC recognised that the child protection system in Queensland has been in a state of reform for a number of years and many of the reforms have been started because of high profile instances of child death or serious harm or abuse.

505. The QFCC 2018-2019 annual report confirmed the Qld Government's announcement on 11 June 2019 that the QFCC would host the Child Death Review Board from mid-2020.

506. On 13 February the *Child Death Review Legislation Amendment Act* 2020 was assented to. The Act amends the *Child Protection Act* to remove Chapter 7A, Part 2 (Child Death Case Review Panels) and creates a new Part 3A in the *Family and Child Commission Act* 2014 headed 'Child Death Review Board' to establish a separate and independent Board located in the QFCC, with distinct functions and powers.

Report of Dr Andrew Whittaker

507. Dr Andrew Whittaker, Associate Professor, is the Head of the Risk, Resilience and Expert Decision Making research group at London South Bank University, London. He specialises in the study of professional judgement and decision making in child protection services.

508. Dr Whittaker examined the actions taken and decisions made by CSOs and STLs in relation to Mason. He was asked to comment on:

    1. The extent to which any cognitive, psychological, organisational or environmental factors might have influenced or impacted on their decisions;
    2. Whether there are any steps that can be taken to enhance the ability of such individuals to better ensure the safety and wellbeing of children in the future;
    3. Any other matters he believes to be relevant to the issues in the inquest.

Cognitive and Psychological Factors

509. Dr Whittaker noted:

> *Mason was to a large extent "hidden from view" in the work with the family. He was rarely seen, and it appears that his bedroom was not seen by a child safety worker ….. It was challenging to find references to workers observing and interacting with Mason directly. The clearest example was in the case recording on Friday 18th March 2016, where the child safety officer stated "Sighted Mason … and Mason smiled at us, walked over to Ms Lee and she picked him up."*

510. In contrast, CSOs could clearly recall the presence of adults and Mason's siblings during home visits. They could recollect conversations with Ms Lee and Mr O'Sullivan and what they were doing at the time for example, a worker could recall Mr O'Sullivan making sandwiches for the children but could not recall which children were present or seen.

511. The CSO who conducted the first home visit could remember her interactions with Ms Lee and had the feeling that the children were there but had no specific memory of them and did not record any specific details. She stated:

> *If he wasn't there, we would have been very confused as to where he was and wanting an explanation for that. The purpose, the main purpose of going out to the home that day was to sight Mason. So, it, I definitely remember him being there. Further investigation would have had to be done if he wasn't.*

512. No departmental worker saw Mason when he was in hospital.

513. Dr Whittaker stated:

> *Although Mason's "hiddenness" could seem surprising, the relative invisibility of children in both home visits and within case recording is a commonly identified issue in previous studies. [It has been found that] workers focused upon adults in the family and their own tasks. By contrast, finding any information that related directly to the child was described as like "searching for a needle in a haystack."*

514. As well as not sighting Mason workers did not view his home beyond the main living areas during any of the home visits. Dr Whittaker concluded there was a lack of curiosity and assumptions were made.

515. He concluded:

> *This is a constant challenge in child protection work and is a frequent finding in inquiries and serious case reviews as well as everyday practice … In Mason's case, this was so consistent across a range of workers that this would indicate that it was not simply a failing of an individual worker (otherwise some worker would have been focusing on him while others would be more adult focused) but was a common theme across all who visited the family.*
>
> *In summary, Mason was on the periphery of workers attention rather than at the centre. This is a common challenge identified within previous research studies.*

516. Dr Whittaker opined that Ms Lee was highly successful in engaging with professionals, the workers were influenced by their perceptions of Ms Lee and this had the result of moving their focus from the children in the family to the adults i.e. Ms Lee and Mr O'Sullivan.

517. The CSO's notes and recollections indicate that they believed Ms Lee was engaging as an open, cooperative and willing parent, however, Dr Whittaker points out that in reality, she was not engaging with the workers.

518. He referred to studies which have found that where workers perceived parents as open they tended to feel more reassured. Parental cooperativeness is used by workers to gauge risk which raises the danger that parental deception may be missed.

519. Ms Lee was also perceived as a victim as she had been a child in care, later a victim of domestic violence and presented as a vulnerable, young single parent without any real supports.

520. Dr Whittaker stated that workers can experience genuine empathy for such parents but this can become problematic when it leads to them being hesitant to challenge parents sufficiently.

521. When Mason was admitted into hospital, Ms Lee was perceived as a victim of the negative judgements of health professionals.

> *Ms Lee had framed the situation with herself as "victim" rather than Mason, diverting blame from herself and attention away from him. This engendered in the family support worker a sense that Ms Lee was being treated unfairly and she said that she advocated for Ms Lee based upon what she knew of her at that time.*

522. Workers also perceived Ms Lee as a survivor of childhood and adult abuse and this led to them seeing her as someone who could assess and manage risk to her children.

523. Dr Whittaker concluded:

In conclusion, Ms Lee was variously viewed as "open and willing to engage", a "victim" and a "survivor". Each of these three perceptions had an element of reality but led to associated risks …. Seeing Ms Lee as "open and willing to engage" … [meant that the workers] were quick to take what she said at face value and slow to realise when there was parental deception and disguised compliance which left Mason and the other children at risk of harm.

Similarly, the perception of Ms Lee as … a "victim" … meant that workers moved their focus to Ms Lee and away from Mason ….

Finally, the perception of Ms Lee as a "survivor" … contributed towards workers overestimating her capacity to assess and manage risk to her children.

524. Workers first saw Mr O'Sullivan at Ms Lee's house on 7 March 2016, although he was mentioned in September 2015 and in February 2015 when Ms Lee disclosed that the children were staying with him while she was with Mason in hospital.

525. In March 2016 workers noted that he was supportive, doing tasks, sharing the housework and care of the children and speaking about what was occurring at the hospital.

526. Although no checks had been carried out on him, an STL described Mr O'Sullivan as "a significant person in these children's lives and a great support to mum."

527. Research shows that men who were actively involved in the care of children tended to impress workers who then overvalued their capabilities.

528. On 7 March 2016 Ms Lee told workers she was intending to end the relationship with Mr O'Sullivan shortly. This could have been a strategy to divert attention away from him as checks on his background would have raised significant concerns.

529. Dr Whittaker stated that there were indications that Mr O'Sullivan was being controlling at that visit, in that he was attempting to answer questions for Ms Lee, but workers interpreted him as being "talkative" and "very supportive".

530. In early June 2016, when it became apparent to workers that Mr O'Sullivan had been perpetrating domestic violence on Ms Lee and presented a significant risk to her and her children, their focus shifted to supporting Ms Lee to separate from him rather than undertaking safety planning for the children.

531. Dr Whittaker stated:

The tendency to focus upon adults rather than children is not specific to the workers in this case, or to a specific time or place but endemic in child safety work. There have been long standing criticisms that, when investigating allegations of abuse and neglect, "child protection agencies are obsessed with parental actions and motives rather than what the child is experiencing."

532. Dr Whittaker recognised that building up relationships with parents is necessary but it is a delicate balancing act to also remain focussed on the risks posed to the children.

533. Dr Whittaker identified that there was:

> *…a lack of preparation or reflection of social work tasks to "nudge" workers to keep child protection matters to the fore."*
>
> *One child safety worker challenged what she perceived as Ms Lee's minimisation of the impact of domestic abuse on her children. However, she also noted that she was not aware of the details of the family's situation, nor did she formulate immediate safety plans for the children as she was not the allocated worker so did not have overall responsibility for the case. She perceived her role as only to talk with Ms Lee about domestic violence.*
>
> *When a less experienced worker was asked to do a safety check, she misinterpreted this to refer to the mother rather than the children. When asked why she did not ask mother about Mason's whereabouts, she replied that she had assumed that he was sleeping or in day care, adding "I thought I just had to go and make sure that mum was all right and come back and report."*

534. Managers at the office were aware of the danger of workers being adult focused as they described how they had used the Mandell's Safe and Together Framework but in this case such resources were not used.

535. Dr Whittaker stated that focussing on adult concerns is a common problem and training alone, whilst useful, is not sufficient to address it.

Cognitive Biases

536. Dr Whittaker concluded there were a number of cognitive biases that influenced the decision making of the workers.

The Halo Effect

537. The "halo effect" refers to the positive bias we experience when evaluating another person that we like. We are more likely to judge that person as trustworthy, even where we have insufficient information to base that upon.

538. The two specific aspects that promoted a halo effect in the case of Ms Lee and the workers were her apparent openness and willingness to engage and her observed warm interactions with her children.

539. Whilst parental cooperativeness is used by workers to gauge risk this is highly problematic when parents are engaging in deceptive behaviour and disguised compliance.

540. In this case the observed warm parent-child interactions were used for assessing Ms Lee's capacity to look after and protect her children.

541. In short, her perceived openness and positive interactions created a positive impression that contributed to over optimistic judgements about other areas of her parenting.

The Rule of Optimism

542. A further bias is known as “the rule of optimism” – a term which describes how workers have an implicit expectation that staff members should think the best of parents.

543. This operated through two mechanisms:

1. workers could justify parental behaviour through cultural relativism i.e. behaviour is permitted because it is part of a wider cultural context and it is unacceptable for the agency to impose dominant societal values;
2. the excuse of “natural love” which acknowledges parental deviance but works on the belief that all parents love their children as a fact of nature.

544. In regard to the first point, an experienced worker was overly optimistic in relation to Ms Lee’s ability to assess risks to her children despite evidence that she was not in fact able to:

I assessed that she could. But she could also get tangled up with people that weren’t safe and good people. But she knew how to also balance the safety of her children. I think it was the lifestyle that she was accustomed to, where she was very familiar with people that weren’t appropriate.

545. Dr Whittaker noted:

Ms Lee was regarded as spending time around people who were inappropriate but this was normalised as a lifestyle that she was accustomed to within her cultural milieu.

546. Another aspect of the rule of optimism is accepting information at face value.

547. The workers in this case placed weight on the fact that Ms Lee gave consistent versions. This was so even when those versions were inconsistent with the true facts e.g. visits to her GP.

548. One explanation is that, as studies mentioned by Dr Whittaker have shown, workers valued coherence in parental accounts and the trusting relationship Ms Lee was able to create. Another explanation is that time pressures meant that workers did not have time to check facts and question the information Ms Lee provided.

Parental Deception

549. Disguised compliance is defined as:

A parent or carer giving the appearance of cooperating with child welfare agencies to avoid RAI1sing suspicions, to allay professional concerns and ultimately to diffuse professional intervention.

550. Ms Lee and Mr O’Sullivan were deceptive:

- in the early stages of contact they hid the fact that they were in a relationship;
- Ms Lee falsely claimed she had sought medical attention for Mason;

- They both hid the fact that Mason was staying at Mr O'Sullivan's house and in his sole care (including early June 2016 when Ms Lee met with workers and knew that Mason was ill and Mr O'Sullivan was restricting her access to him but said nothing to the workers).

551. Ms Lee and Mr O'Sullivan were skilful at diverting workers' attention and failing to answer specific questions e.g. in relation to Mason's visits to doctors.

552. Ms Lee also used the tactic of describing herself as the victim when being questioned about Mason's injuries. When she was confronted by doctors at the hospital and questioned by the workers as to why she hadn't sought medical attention for him earlier she responded by becoming upset and stating she felt like she was being treated as a bad mother. She therefore distracted attention away from the issue she did not wish to deal with.

553. Studies show that all people are not very accurate at detecting when somebody is lying, even though they may consider themselves to be so. A UK study noted by Dr Whittaker concluded that workers should have a "respectful uncertainty" towards information received and keep an open mind rather than being "passive recipients" of information.

554. Further, workers find it difficult and stressful to challenge parents particularly when they respond with aggression or defensiveness.

Credibility Bias

555. Credibility bias is the tendency to believe statements to be true if they come from a source perceived as trustworthy. Dr Whittaker notes that when deciding whether to discharge Mason on 7 March they placed significant weight on the information provided by the family support worker who felt that Ms Lee had been treated unfairly by hospital staff and having a difficult time there. This led to workers showing a lack of sufficient professional curiosity.

556. Dr Whittaker identified two organisational factors that were likely to have been influential in encouraging or not challenging cognitive bias.

557. The first was a reactive culture with time pressures.

558. The second was little thinking space provided by supervision to challenge biases and be more critical.

Demands on the Service

559. The CCSSC had experienced a steady growth of children in care over the previous ten years. It had the highest number of incoming notifications every year of any office in Queensland. It had double the number of children subject to orders of most other offices in the State. The geographical area covered by the office was subject to a high degree of deprivation and poverty with 60% of the population falling into the most disadvantaged quintile of Index of Relative Socio-Economic Disadvantage compared to the state average of 20%. There was a high usage of illicit drugs and a high number of drug related crimes in the area. High levels of domestic violence were reported with a low engagement rate with support services.

560. All of these factors impacted on workers' workloads. In their interviews staff described the workload as being relentless, that they were constantly juggling, they were "plate spinning" and working in crisis. There was not enough time to do the job and the supervisors were just as busy so it was difficult for them to provide any assistance.

561. Studies in the UK and Australia have found that time pressures and weak organisational systems led to workers engaging in "speed practices" as a means of getting through work in the time allowed. A lack of professional support and "decision fatigue" can increase the likelihood of errors in decision making.

562. In such circumstances workers can do too little preparation for home visits or other interviews. In Mason's case there was a pattern of workers not reading any or sufficient background information nor preparing for intervention with the family.

563. According to Dr Whittaker:

> *There was, in the Caboolture office, a reactive culture where workers generally relied too heavily on fast, intuitive ways of working without sufficient time for preparation and reflection.*

564. The office was trialling a "matrix model" to attempt to address the lack of leadership in the office. The model comprised three teams with three team leaders. The team leaders operated on a three week roster – one week directly responding to new notifications, the second week following up on that work and the third week, completing documentation and associated tasks.

565. The benefits anticipated included increased team leader availability, clearly defined offline time for staff and shared case knowledge and decision making across the team leaders. Staff could seek advice or support from any team leader.

566. Dr Whittaker noted that what actually resulted was confusion, unclear accountability and reluctance by STLs to challenge decision making of others. Further, the issue of alleged office bullying had a strong complicating influence.

SCAN meetings

567. At the time of Mason's hospitalisation there was no separate designated SCAN coordinator at the Caboolture office so one of the three team leaders had to cover this role.

568. At the SCAN meeting on 15 March 2016 the STL was the coordinator and the duty representative. This meant that there was one person covering two distinct roles and no opportunity for a semi-independent review of the information and decisions.

569. Members other than the department were in favour of Mason's removal from his mother's care because of clear medical neglect by Ms Lee, regardless of how his injuries were caused. However, they reluctantly agreed that he be discharged from the hospital to her care because it was agreed that an IPA would commence quickly and there would be a high level of monitoring.

570. The next SCAN meeting was cancelled as there was no quorum.

571. In relation to SCAN Dr Whittaker stated:

> *An independent chair can have an important role in ensuring that during a meeting all options are discussed without undue influence on the relative power of agencies and personalities in the room. It was likely that the lack of such a chair impacted negatively on the decision-making processes in this case.*

Management, Supervision and Emotional Support

572. Dr Whittaker explained that it can be very emotionally painful for CSOs to seek to understand children's experiences and this may lead to them avoiding engaging in the process so that they don't become "emotionally swamped."

573. Good quality supervision is central in ensuring that workers are able to critically reflect on what they are doing, challenge their own assumptions and manage their emotions. Without it, they can become caught up in a reactive practice.

574. Dr Whittaker opined that the workers in the CCSSC struggled to get effective and timely supervisory responses at points which may have led to reactive decision making rather than more analytic responses.

575. Dr Whittaker concluded that the matrix structure contributed towards this as workers were unclear who their manager was.

Team Dynamics

576. Dr Whittaker found that the alleged behaviour of STL4 seemed to create anxiety in other workers and was therefore likely to have had a significant impact on the team more generally and particularly upon [CSO3] as she felt she had to leave the team in an expedited manner.

Issues and Recommendations

577. Dr Whittaker identified eight core issues that impacted on Mason's case and made ten recommendations in relation to future training and policies to include identification of these issues.

    1. Workers were not focusing sufficiently upon Mason
    2. Ms Lee and Mr O'Sullivan engaged in deceptive behaviour that was not detected
    3. Workers were vulnerable to cognitive biases
    4. Reactive culture with insufficient opportunities for thoughtful practice
    5. Difficulties in gaining access to timely and supportive supervision at times
    6. Support for inexperienced workers was not robust
    7. The implementation of the matrix model was problematic
    8. Quality assurance mechanisms were not always used to their full potential – there was no SCAN coordinator, a SCAN meeting did not proceed due to a lack of quorum, a critical case consult was not undertaken.

578. Dr Crawford, Acting Executive Director of Child and Family Operations, addressed Dr Whittaker's report in her statement provided to assist the inquest.

579. Dr Crawford stated that all ten recommendations have been accepted by the department and three have been completed to date. The department has or is implementing and/or updating the following:

- A new practice focused, multi-team branch called "Child and Family Practice" the purpose of which is to promote consistency and quality in practice across the state in relation to training and support staff arrangements;
- The four day "Safe and Together" training module to provide a focus on parental deception and disguised compliance
- Training to increase awareness of cognitive biases
- Continuing to review workloads for CSSC staff and health and wellbeing of staff as a whole;
- The REACH framework includes a component to address emotional support in supervision;
- The REFLECT coaching program matches coaches and coaches to provide mentoring and a peer support system;
- The matrix model has ceased;
- Procedures in the SCAN manual clearly state that a meeting must not be delayed due to lack of a quorum.

580. I note in regard to the last point that the SCAN procedures that were current at the time of Mason's death did not require that a quorum be required for a meeting to proceed but did state that any recommendations made at such a SCAN meeting would only be valid if a quorum was formed. That clause remains exactly the same in the new SCAN manual which was approved in November 2019.

Report of Professor Ogloff

581. Professor James Ogloff is a fellow and past chair of the Australian Psychological Society (College of Forensic Psychologists) and a Fellow of the PAS College of Clinical Psychologists. He is employed as Foundation Professor of Forensic Behavioural Science and Director of the Centre of Forensic Behavioural Science at Swinburne University of Technology and holds a conjoint appointment as Executive Director of Psychological Services and Research at the Victorian Institute of Forensic Mental Health (Forensicare).

582. In his clinical work, the Professor has had occasion to assess and treat people who have killed their child or children. In his academic work, he has expertise in the area of risk assessment including violence risk assessment, sexual offending risk assessment, and domestic violence risk assessment. He has undertaken studies of homicide perpetrators.

583. The Professor is a registered psychologist in Australia with endorsement in clinical psychology and endorsement in forensic psychology. He holds a B.A. (Psychology), M.A. (Clinical Psychology), Juris Doctor in Law with Distinction and a Ph.D. (Psychology).

584. The Professor's opinion was sought about what is known about harm to children, from a forensic behavioural science perspective and whether more might be done to help prevent or minimise such harm in the future.

585. He opined as follows with respect to Ms Lee:

> *Based on the above characterisation of Ms. Lee's neglect in Mason's death, her role in the death would fit into Resnick's 'accidental filicide' category in which the filicide occurred in the context of the ongoing abuse of Mason which ultimately resulted in his death, but which was unintentional on the mother's part. For her, Mason's death occurred as a matter of neglect.*
>
> *Apart from the disadvantaged background and generally damaged character of Ms. Lee she possessed relatively few of the individual characteristics of filicide perpetrators. This is consistent with the apparent facts in this matter which revealed that Mr. O'Sullivan inflicted injuries on Mason and then both he and Ms. Lee neglected Mason and did not attend to his needs in the lead up to his death.*
>
> *Although Ms. Lee was previously observed to be a loving and caring mother, this is clear evidence of abject neglect in the months that led up to Mason's death, with many examples of her failure to care for her son in even a basic way. Her failures were apparently due, in part, to her low level of intellectual function, her lifetime experience of being victimised by brutal men, and her deteriorating mental state in the lead up to Mason's death. Like Mr. O'Sullivan, she made a number of misstatements in an attempt to deflect blame. It would appear that despite wanting to bring Mason home, she was overcome by her own issues and fear of Mr. O'Sullivan, and failed to realise the very dire situation in which they had placed Mason. Indeed, the evidence is that on some occasions leading up to Mason's death, she did not even actually look in on him even though she had been at Mr. O'Sullivan's house on occasion. The characteristics of filicide perpetrators apply less well to Ms. Lee, perhaps understandably, as she did not instrumentally cause his death, but rather hers were acts of omission.*

586. With respect to Mr O'Sullivan, the Professor expressed the following opinions:

> *Based on the characterisation of Mr. O'Sullivan's role in Mason's death, he too fits the 'accidental filicide' category of filicide perpetrators. His role in the death was not merely one of neglect, however, since he inflicted the blow that initiated the gradual process of Mason's death. Rather, his actions are described by the 'fatal abuse filicide' label. Indeed, Mr O'Sullivan's abusive action in rendering the injury to Mason's abdomen led to the baby's death, in concert with Mr O'Sullivan's later neglect of Mason in the face of what has been described as a period of misery and discomfort that would have been apparent to anyone (as it was to many who witnessed Mason in the days leading up to his death). There is also some possibility that, based on Mr. O'Sullivan's pathological jealous of Ms. Lee that he inflicted the wound to Mason as an act of what Resnick referred to as 'spousal revenge filicide;' however, there is on other evidence that Mr. O'Sullivan's inflicted the injury in retaliation against Ms. Lee.*
>
> *As Mr. O'Sullivan inflicted the injury the led to Mason's death, the question of what first led him to attack Mason arises. Scott's classification system, described above, is helpful for considering this. While the information provided to me is very limited in this regard, the information available support two of the potential explanation offered by Scott: Stimulus arising outside the victim includes displacement of anger with or without revenge or the victim as stimulus leading to exasperation and a loss of temper. These categories mean*

that Mr. O'Sullivan acted in anger either displacing his anger on Mason or targeting Mason out of anger toward him. There is considerable evidence of Mr. O'Sullivan's elevated level of anger and his aggressive behaviour generally. It is believed that the fatal injury to Mason was inflicted on the Monday before Mason's death, as noted by Chief Justice when Mason was heard to have been crying and Mr. O'Sullivan was heard to have yelled at him to shut up.

Mr. O'Sullivan's use of methylamphetamine was seen to have further fuelled his anger.

Taken together, Mr. O'Sullivan shared many of the characteristics with filicide perpetrators as identified in research literature. These characteristics include his own background and his actions and behaviour in the lead up to Mason's death. To the extent that Mr. O'Sullivan shares characteristics with other filicide perpetrators (and child abuse perpetrators generally), the opportunity existed for child protection workers to identify the level of risk that he presented of harming children. Indeed, the information provided to me, the Department of Community Safety eventually formed the view that Mr. O'Sullivan presented an unacceptable risk of harm to children in his care:

> *'On 14 June 2016, the Child Safety team leader expressed serious concern about "the risk of further harm from Will" which was considered to be "unacceptably high." Efforts to were going to be made to connect Ms Lee with DV Connect'*

While it is good that the Child Safety team leader identified the level of risk that Mr. O'Sullivan posed but, by that time, it was too late to assist Mason.

587. Overall, the Professor concluded:

Based on the information available, the context in which Mason was harmed and later died was one characterised by an abusive and controlling 'step-father' and an ineffectual, defeated, and neglectful mother. Mr. O'Sullivan appeared to be an angry man, with limited skills in controlling his anger, and the blow he dealt to Mason appears to have occurred in such a context. Mr. O'Sullivan inflicted violence on Ms. Lee and her children. Mr. O'Sullivan initially denied any role in Mason's death, instead blaming Ms. Lee's eldest daughter. He was deceitful and it is possible, although one cannot be certain given the limited information available, that he realised that Mason was unwell, but may have believed his abuse would have been found out, had he sought medical care for Mason. For whatever reason, he stood by and watched Mason slowly succumb to the sequelae of the injuries he inflicted on him early in the week of Mason's death. Sadly Mr. O'Sullivan exhibited many characteristics consistent with filicide perpetrators but no one with authority carefully evaluated the circumstances and possible risk of ongoing harm to the children, and to Mason in particular.

588. The Professor's evidence was that studies of filicidal males indicate 25-40% of child deaths occur in the context of threatened separation or divorce.

589. Dr Crawford advised that Professor Ogloff's report has been considered and addressed by the department.

Ethical Standards Unit (ESU) Investigation

590. I acknowledge the thorough investigation undertaken by the ESU investigators and the comprehensive report they compiled. I have relied on that report to a great extent in assessing the actions of the officers of the department and I have taken the liberty of using information contained in the report (sometimes by paraphrasing and sometimes by using direct quotes) in these findings.

591. On 12 December 2016 the Deputy Director General of the department authorised Ethical Standards to investigate the adequacy of service delivery relevant to Mason and his siblings.

592. The Ethical Standards Unit of the department investigated 18 allegations raised against 10 employees of the CCSSC in relation to Mason's case.

593. The 18 allegations pertained to three distinct child protection intervention events and one managerial event occurring between 2015 and 2016:

    1. Investigation and Assessment between 9 December 2015 and 25 December 2015 by CSO1 and approval of same on 30 March 2016 by STL1;
    2. Investigation and Assessment between 6 March 2016 and 17 May 2016 by CSO3 in which STL1, STL2, STL3 and STL4 were involved;
    3. Intervention with Parental Agreement scheduled to commence on 15 May 2016 and which remained opened at the time of Mason's death in which STL1, STL4, STL2, STL3, CSO6, CSO1 and CSO4 were involved.
    4. Management of the CCSSC between 9 December 2015 and 11 June 2016 by Manager 1.

594. The relevant events which occurred in the time frames have already been set out in detail in these findings.

595. It was concluded that 16 of the 18 allegations were substantiated on the balance of probabilities. The two allegations unsubstantiated were those concerning event number four in relation to the management of the CCSSC by Manager 1 and event number three in relation to STL3.

    1. <u>I&A between 9 December and 25 December 2015</u>

Allegations

a. CSO1 failed to conduct an investigation and assessment in accordance with the relevant legislation, policies and guidelines
b. STL1 failed to ensure an investigation and assessment was conducted in accordance with the relevant legislation, policies and guidelines
c. On 30 March 2016 STL1 inappropriately approved an investigation and assessment which was not conducted in accordance with the relevant legislation, policies and guidelines.

Interviews

596. CSO1 was interviewed by the ESU investigators in January 2017.

597. He was an experienced CSO who had been employed by the department since 2003 and in early engagement teams since 2011.

598. He said that he had been involved as a CSO with the Lee family since conducting an I&A in August 2011. He had been involved with another I&A in October 2011.

599. CSO1 said that he generally did not have enough time to plan I&A's and struggled to get through the work load even though he was fairly experienced. He said that STL1 would always be available to assist when asked.

600. CSO1 said that he found the matrix model confusing. He wasn't always sure who his supervisor was.

601. In relation to the interviews he conducted on 10 December 2015 he said that he didn't intend to interview Ms Lee that day but that she turned up at the address and he could not do anything else. He agreed that he conducted no follow up investigations in relation to Ms Lee's criminal history or her current housing (by finding out where it was or going there on any occasion). He agreed that if he had completed the I&A appropriately the outcome would have been that the children were at high risk, rather than the false outcome of moderate risk, and that outcome would have required ongoing intervention by the department.

602. CSO1 could not recall seeing Mr O'Sullivan that day.

603. He did not go to the house Ms Lee came from because he did not think that would be a good approach and did not know what risks would have been involved.

604. He agreed that the children were interviewed with Ms Lee present and also in the house of the person allegedly involved in sexually assaulting two of them. CSO1 did not look through the house. He was aware that other males were present in the yard but did not find out who they were or why they were there. He said it was a bit awkward and there were a lot of people present. He just wanted to get through the interview.

605. There was no evidence that CSO1 used interviewing tools with the children to elicit information and he did not obtain transcripts of his interviews.

606. CSO1 agreed that immediately after the interviews he told Ms Lee that the concerns would be found to be unsubstantiated and her children not in need of protection. He agreed that he based that advice only on the 45 minutes he spent speaking to her and the children at someone else's house.

607. CSO2 was also interviewed in relation to the I&A. She agreed that she accompanied CSO1 on 10 December 2015. She did not read any of the information held by the department about the Lee family before doing so as she was not aware that they would see Ms Lee that day. She could not recall any pre-planning with CSO1.

608. CSO2 recalled that Ms Lee's partner, Mr O'Sullivan attended the address and he appeared to be under the influence of a substance – bloodshot eyes, erratic, didn't engage, very thin, gaunt, fidgety and agitated.

609. This was inconsistent with the information recorded that Ms Lee did not have a partner.

610. CSO2 did not give this relationship any thought as she believed it was the responsibility of CSO1 to explore the dynamics of the Lee family and make further investigations.

611. CSO2 could not recall much of the content of the interviews conducted by herself and CSO1.

612. There was no follow up discussion with CSO1 or any STL after the interviews.

613. CSO2 said her role as the secondary I&A investigator was to assist the primary investigator but she didn't in this case as she had no knowledge of the Lee family. She felt very uncomfortable about her lack of knowledge of the history of the Lee family but was aware that CSO1 was taking the opportunity of them turning up to interview Ms Lee and the children.

614. STL1 was interviewed on 2 February 2017. She has more than 15 years experience as a CSO and a STL. She has been a STL since 2005 and commenced in that role in Caboolture in 2006.

615. She had delegations to approve documents and supervise staff. She had oversight for cases and a responsibility for decision making.

616. She was unable to recall whether she was the STL who allocated this matter to CSO1, however, recalled that she undertook the I&A in relation to the friend who allegedly punched her baby.

617. STL1 could not recall any planning with CSO1.

618. STL1 confirmed that, as CSO1's direct supervisor she was responsible for supporting him throughout the I&A.

619. STL1 said that both CSO1 and CSO2 were experienced CSOs.

620. STL1 said that as the I&A interview stated that the interview took place in the family home she expected that the home environment would have been inspected and found appropriate.

621. STL1 did not recall approving the safety assessment dated 11 December 2015.

622. She said that as CSO1 was an experienced CSO she was guided by him and, in effect, only discussed matters with him when he approached her.

623. STL1 admitted that she did not cross reference the FRE with the notification or the child protection history and took it on face value. She was asked whether she should have checked the records and said, "absolutely."

624. STL1 explained the three month delay in approving the I&A by stating she was on leave until early February 2016 and it may have taken her six weeks to catch up on her approvals.

625. She agreed the fathers of the children should have been contacted and that she didn't discuss this with CSO1.

Findings

626. The ESU found that the allegation that between 9 December 2015 and 25 December 2015 CSO1 failed to conduct the I&A in accordance with the relevant legislation, policies and guidelines was established on the balance of probabilities:

- The I&A was unplanned and not discussed prior to its commencement which resulted in CSO1 being unaware of all relevant information which led to CSO1 accepting that the stepfather and the friend were appropriate support persons for Ms Lee;
- The children were interviewed in pairs in the presence of their mother and in chaotic circumstances in the residence of their alleged sexual abuser, CSO1's failure to use appropriate interviewing tools, leading to concerns about the quality of the evidence obtained;
- The communication with Ms Lee was brief and unsatisfactory and occurred at an inappropriate residence;
- Despite being in possession of information regarding Ms Lee's unaddressed mental health issues, drug and alcohol abuse, homelessness and childhood sexual abuse CSO1 took her denial of any current issues at face value, did not challenge inconsistencies in her responses and did not further investigate or corroborate information in any way. Had the true information been obtained it would have resulted in the family being assessed as at high risk and requiring ongoing intervention;
- No household assessments were conducted during the I&A – CSO1 didn't ascertain where the Lee family lived much less sight the house and assess whether it was safe for the children, however, he recorded that he had done so;
- There were conflicting accounts from CSO1 and CSO2 as to whether Mr O'Sullivan was Ms Lee's partner and these went unexplored as did the fact that they both emerged from the same house – the circumstances should have been explored particularly since Ms Lee had a documented pattern of inappropriate and risky males associating with her;
- Ms Lee was not asked where she was returning to that day;
- CSO1 advised Ms Lee that day of the outcome of the I&A which was not in accordance with procedures and the decision was based on lack of planning, superficial evidence gathering and misinformed assessments.

627. The ESU found that between 9 December 2015 and 25 December 2015 STL1 failed to ensure the I&A was conducted in accordance with the relevant legislation, policies and guidelines:

- STL1 approved that I&A, some three months out of time, and without checking any of the incorrect information it contained.

2. <u>I&A 6 March to 17 May 2016</u>

Allegations

- Between 6 March 2016 and 17 May 2016 CSO3 failed to conduct an investigation and assessment in accordance with the relevant legislation, policies and guidelines;

- Between 6 March 2016 and 17 May 2016 STL1, STL4, STL2, and/or STL3 failed to ensure an investigation and assessment was conducted in accordance with the relevant legislation, policies and guidelines;
- on 1 June 2016 STL4 inappropriately approved a record of interview which lacked context and required further work;
- on 9 June 2016 STL1 inappropriately approved an investigation and assessment which was not conducted in accordance with the relevant legislation, policies and guidelines.

628. A further I&A commenced on 7 March 2016 in response to the concerns notified on 3 March 2016 which were assessed as a notification requiring a 4 day RTF.

629. This I&A involved CSO3 (primary investigator), CSO4 (secondary investigator), CSO5 (secondary investigator), STL1 (supervisor, decision-maker and approver of the I&A), STL4 (supervisor, decision-maker and approver of the I&A), STL2 (supervisor and decision-maker), and STL3 (supervisor and decision-maker).

Interviews

630. CSO4 was interviewed in relation to the interviews with Ms Lee and Mr O'Sullivan which took place on 7 March 2016. She said that as the second CSO she had no knowledge of the family, had not looked at any departmental records and was only there to take notes and record conversations.

631. She had little recollection of anything that took place when she was present in relation to this I&A. She couldn't recall which if any of the children were present on 7 March 2016 and similarly could not recall which, if any, children apart from Sibling 4 were present on 9 March 2016.

632. CSO5 was interviewed. She attended Ms Lee's residence with CSO3 on 18 March 2016.

633. She said she became aware of the notification after Mason had been discharged from hospital. She knew that some of the CSOs in the office had seen the photos of his bottom taken at the hospital but she had not, however, she was aware that his bottom was said to look, "like it had been hit with acid".

634. She said the visit (described as an interview by CSO3) was, "just a quick call in … it wasn't an organised one."

635. She said CSO3 had a quick chat with Ms Lee at the front door. Mason was there in his nappy – "he was walking like he still had a bit of pain in his bum … but he's still a young toddler so we didn't assume anything but that he was still healing". Ms Lee told them that the cream was not working for him.

636. CSO5 said that the home visit was just to see how they were going, how he was healing. They just popped in because they were in the area, "It wasn't like it was super serious or needed to go out there … but we saw him … he looked ok."

637. CSO5 said they discussed afterwards in the car whether they should have asked to see Mason's bottom and they were laughing about it, "Like, can you show us your baby's arse … but we didn't ask."

638. ESU investigators noted that CSO3 and CSO5 spent five minutes at the Lee residence on 18 March 2016 and this was the first time Mason had been seen since his discharge from hospital.

639. In relation to the home visit on 5 May 2016, which again took place at the front door, CSO5 said there was no pre-planning or discussions. She said she was, "just … taking the notes," and that remained her understanding of her role when she accompanied the allocated CSO to a home visit.

640. She said that she assumed Ms Lee was sick from taking drugs, "she wasn't … sick from a flu … I think she was just probably drug affected … or recovering".

641. She said the conversation with Ms Lee only took a couple of minutes. She didn't know why they didn't go inside the house. She did not know at that time that a new notification had been received but that she never asked the primary investigator why they were going to a house.

642. CSO5 said:

> *Our arses are murdered for stats. Like absolutely murdered … I never close a family unless I feel comfortable closing it, but I know other people do because of the risk of not having a job … it's a terrible framework for Child Safety to put families at risk.*

643. CSO5 also said, "I think in regards to this case, that it was a bit of a shit heap in regards to processes".

644. CSO3 was interviewed.

645. CSO3 said that after discussing the matter on 7 March 2016 and talking to Dr 2, she and STL4 were comfortable with Mason returning home on the basis that follow-up would occur "straight away".

646. CSO3 could not recall why Mason was not discharged until the following day.

647. In relation to the decision that Mason could be discharged, CSO3 said:

- a paediatrician had ruled out sexual abuse;
- she could not recall reading the notification dated 3 March 2016 which listed Mason's injuries and the child protection concerns;
- she said it was "more about" having discussions with STL4;
- she didn't know when she read the information about Mr O'Sullivan – at some point she realised he had two names on the system and two profiles but didn't read both of his profiles and only read part of his history;
- she did not consider the child protection history of the family before commencing the I&A or prior to Mason's discharge as "it was more about getting out there and … completing initial steps rather than … reading through all that information."

648. CSO3 said that on 7 March 2016 she didn't know Ms Lee's address and had to attend her previous residence where she was given an approximate address and a map.

649. She couldn't recall which children she saw at Ms Lee's residence on 7 March 2016. She did not look at their bedrooms as the living area and kitchen were tidy and hygienic.

650. CSO3 agreed with CSO5 that the role of CSO5 was to take notes.

651. CSO3 said that STL4 had an "extreme dislike" for CSO4 and that had been going on for the previous year and that might have been why CSO4 had not been part of the subsequent discussions between CSO3 and STL4.

652. CSO3 could not recall doing any formal safety planning for Mason after his release from hospital. She agreed that it was the responsibility of her and STL4 to do so.

653. CSO3 agreed that she completed the safety assessment on 8 March 2016 but agreed that she did not see Mason on that day or go to the home. She said she didn't know why she completed it without having seen Mason and she also did not know why she did not submit it until two months later.

654. CSO3 said that STL4 should "absolutely" have picked that up and asked her about it and told her it needed to be amended.

655. CSO3 was asked about the home visit on 9 March 2016 and the fact that there is no record of Mason being present on that day. She said "he was definitely there." But then stated, "If he wasn't we would have been very confused as to where he was."

656. CSO3 could not recall receiving or reading the information that was emailed to the department for the SCAN meeting of 15 March 2016. She could not recall reading the QPS material provided.

657. She had a very poor recollection of the discussions that took place at the meeting. She could not recall if she had discussed the possibility of an IPA prior to the meeting.

658. She said she could have made that decision at the meeting on the basis that the other representatives wanted an answer as to whether the department was going to be involved.

659. CSO3 said she recalled the home visit on 18 March 2016 with CSO5.

660. She said she didn't recall Mason limping on that day or discussing it with CSO5 in the car later.

661. In regard to the interviews on 24 March 2016 CSO3 said she didn't believe there was any information provided that was of concern.

662. CSO3 said she never went to the file to retrieve the information provided about Mr O'Sullivan by Qld Health in relation to his previous threats to kill his wife and children so she didn't know about it despite admitting it was her responsibility to do so.

663. CSO3 could not recall whether she attended the SCAN meeting on 12 April 2016.

664. CSO3 said that when she conducted the I&A she knew she was leaving the CCSSC and to proceed by way of IPA was a "rushed decision" as she had to complete her work.

665. In regard to her assessment that Mr O'Sullivan was a "strength" and a supportive person to the children, CSO3 agreed that she didn't consider the information from SCAN and other sources in making that assessment.

666. CSO3 did not recall RAI1 attempting to contact her, via email and phone, on a number of occasions.

667. CSO3 accepted that between 6 March and 17 May 2016 she failed to conduct an investigation and assessment in accordance with the relevant legislation, policies and guidelines.

668. STL1 was interviewed. She said that she was the online team leader on Friday 4 March 2016 when the notification was received from the hospital and she read its contents and was aware a referral had been made to QPS requesting a joint investigation. She sent off the Medicare request for information that afternoon. She didn't know that the information was not received from Medicare until 9 March 2016 as when it was received she didn't read it.

669. As STL4 was the online team leader the following week she sent it to her on Monday morning for allocation.

670. STL1 said she couldn't remember if she read the report received from the hospital on 4 March 2016 or discussed it with anyone.

671. She said she knew the I&A was to be allocated to CSO3 and she might have had some conversation with her but couldn't recall specific details.

672. STL4 was the team leader who allocated it and she was also CSO3's direct line supervisor.

673. In relation to Mason's discharge from hospital STL1 said that she did not know that Mason had left hospital until she attended the SCAN meeting on 15 March 2016. STL1 could not recall the conversations had at the meeting and could not recall discussing an IPA for Mason. She said she was guided by CSO3 as she had no personal knowledge of the case. She agreed that it was her responsibility, as the pseudo SCAN team coordinator, to forward information received for the meeting to CSO3 but also said that CSO3 should have accessed that information herself.

674. In relation to the I&A that she approved on 9 June 2016, STL1 said she initially returned it to STL4 as she had not been involved in it and did not know enough to approve it. However, after STL4 had returned it and reallocated it and it came back to STL1 on 9 June she decided to approve it because she didn't want it to be sent back and forth again and she was told by CSO6 that an IPA had commenced. She said that, knowing all the information she now knows, she should not have approved it.

675. STL4 was interviewed.

676. She said that under the matrix model there was a "shared vision of leadership" but that all STLs had a degree of autonomy and they all approved their own supervisees' work.

677. STL4 said that she was aware of the notification received on 7 March 2016. She was aware that Mason was transferred from LCCH to Caboolture on that day.

678. Although she was the STL on 7 March 2016 she said she assumed that STL1 would have discussions with CSO3 re the plan for Mason.

679. She agreed that she had a conversation with CPLO re Mason's imminent discharge but could not recall the content of the conversation. She said she knew CSO3 would be commencing the I&A the following day. She said that it was CSO3's job to make notes of those conversations.

680. STL4 and STL1 both said that the other allocated the I&A to CSO3 on 7 March 2016.

681. STL4 agreed she didn't have any handover with STL1 or CSO3 about the I&A – she said she thought STL1 and CSO3 would have already had planning conversations.

682. STL4 commenced leave on 14 March 2016.

683. STL4 could not explain why she told the CPLO that she was happy for Mason to be discharged when she had conducted no form of safety planning with CSO3.

684. STL4 could not recall any planning with CSO3 prior to CSO3 attending the residence on 7 March 2016.

685. She agreed that there were "vulnerabilities" in the interviews conducted on 9 March 2016.

686. STL4 maintained that as at 7 March 2016 there "were no immediate safety [concerns] in relation to those children".

687. STL4 could not recall being part of CSO3's decision that Mason be discharged on 8 March 2016. She could not recall any safety planning with CSO3 on that day.

688. STL4 said, in response to the fact that a safety assessment was conducted on 8 March 2016 by CSO3 without seeing Mason that the purpose of the safety assessment was to determine if Mason was at immediate risk of harm and "neglect isn't usually an immediate factor."

689. In regard to the back and fro of the safety assessment between STL4 and the other STLs, STL4 said that STL1 was the best person to approve it as STL4 had been on leave for two months.

690. STL4 was asked why she then approved it on 2 June 2016 if she didn't have sufficient knowledge of it. She said that she had spoken to STL1 about it, however, there was no case note of any discussion.

691. She said that on 30 May 2016 STL1 emailed STL4 that she didn't know the case so STL4 approved the interview.

692. In regard to the interviews of 24 March 2016 STL4 stated that she read the documents before she approved them on 2 June 2016. In regard to the concerns disclosed by Sibling 2 STL4 could not explain why she approved the document:

> *I remember that when I approved it there were a great number of vulnerabilities … or areas that the …. Interviews could be strengthened. And I found the writing of it to be quite disjointed … So, I was aware of it, and I can't think what I was thinking, but that, yeah, I do remember reading …. I've got nothing.*

693. STL4 agreed that she had no handover with STL2 when she returned from leave in early May.

694. STL4 said that when she received the email from RAI1 on 11 May 2016 in which she asked for an update about the family STL4 forwarded that email to STL2.

695. STL4 could not recall whether she replied to the email of 12 May 2016 asking her to contact the father of Sibling 1 in relation to his child protection concerns and she had made no record of any reply or action taken by her:

> *I imagine that I returned the call but I can't tell you, I don't have a record of it.*

696. She agreed that she should have made a case note of the matter and her response.

697. STL4 denied the allegations against her, however, readily agreed that CSO3, STL1 and STL2 failed in their duties.

698. STL2 was interviewed in January 2017.

699. STL2 was not CSO3's direct supervisor in the period of the allegations, however, she was the online team leader under the matrix model and she was filling in as the SCAN coordinator for some of the period.

700. STL2 could not recall:

- when she became aware of the notification;
- having any conversations with CSO3 about the case;
- reading the report from Qld Health about Mason's injuries;
- receiving or reading or forwarding on any information received for the SCAN meeting on 15 March 2016;
- attending the SCAN meeting on 12 April 2016 or any recollection of the discussion that took place.

701. STL2 said that on 9 June 2016 she and STL1 discussed the case, identified that the IPA was still waiting to be commenced and that the I&A documents had not been approved at that time so STL1 approved them from the in-tray of STL2.

702. In relation to discussions had before they approved the I&A STL2 stated:

> *I don't think we had such an in-depth conversation at that point in time around the decision making … the most appropriate level of intervention, there wasn't a conversation around that.*

703. STL2 said she didn't believe that she had failed to ensure the I&A was conducted appropriately because

> *this specific matter never came to my attention in terms of … those dates … and therefore, I didn't have any direct decision making in terms of the investigation and assessment.*

704. STL3 was interviewed in February 2017.

705. STL3 was the direct supervisor of CSO3 from 21 March to 29 April 2016 whilst STL4 was on leave. She said that when she started in the role there was little handover from STL4. She came from another office. She was introduced to the team and told about the matrix model and that was the end of her induction.

706. STL3 stated that she could not recall:

- Whether she was aware of the scheduled SCAN meeting on 29 March 2016;
- Seeing the information provided by Qld Health for that meeting;
- The particulars of the two ANCs received on 1 April 2016 in relation to Sibling 1;
- Whether she had any discussions with CSO3 about those ANCs
- The DV history of Mr O'Sullivan provided by QPS;
- Discussing the telephone call from the father of Sibling 1 to CSO3 on 28 April 2016;
- Consulting with STL1 or STL2 in regards to the case at all.

707. STL3 stated that Mason's case should have had a panel or critical case consultation.

708. STL3 said that on the return of STL4 there was no handover with her. She said she attempted to speak to her informally on three occasions but STL4 told her she was too busy.

709. STL3 stated that in the five weeks she supervised CSO3, "I could have had a set of discussions with her and planning around the case, in hindsight."

710. She concluded, "I guess … in hindsight we could have all done better."

Findings

711. The ESU found that between 6 March and 17 May 2016 CSO3 failed to conduct an investigation and assessment in accordance with the relevant legislation, policies and guidelines on the following grounds:

- The I&A was deficient by process;

- On 7 March 2016 CSO3 did not consider any of the information held by the department in relation to the accumulation of risks and only focused on Mason's current status in hospital;
- CSO3 did not apply any methodical thought to Mason's immediate and ongoing safety needs prior, during and after his hospital discharge;
- CSO3 commenced the I&A without affording QPS the opportunity to be involved;
- CSO3 only saw Mason once, ten days after the I&A commenced and did not request to see his injuries even though he could not walk normally;
- CSO3 utilised no interview techniques or tools on 24 March and concerns were not addressed;
- On 5 May when Ms Lee told CSO3 that Mason had an allergic reaction to the cream and had a "massive rash" CSO3 did not ask to see him or ask where he was;
- CSO3 did not investigate inconsistencies between information provided by health professionals and that provided by Ms Lee and Mr O'Sullivan;
- CSO3 did not investigate Mr O'Sullivan's concerning history despite that being available to her and therefore did not assess whether he was a risk to Mason and his siblings;
- The ANCs raised during the course of the I&A were inadequately addressed by CSO3;
- CSO3 did not conduct any adequate household assessments in a case where neglect was the primary concern;
- CSO3 did not obtain any corroborating evidence of Ms Lee's willingness and ability to protect her children;
- The decision to commence an IPA was made at a SCAN meeting with no planning or discussion which was inappropriate;
- Analytical thought as to why custodial orders were not warranted should have been documented in I&A records;
- CSO3's conclusions were established on minimal planning, superficial evidence gathering and inadequate risk and safety assessments.

712. The ESU found that between 6 March and 17 May 2016 STL1 failed to ensure an investigation and assessment was conducted in accordance with the relevant legislation, policies and guidelines on the following grounds:

    - She was an STL predominantly responsible for supporting CSO3 during this period;
    - The decision to commence an IPA was made at a SCAN meeting with no planning or discussion which was inappropriate;
    - She was one of the STLs responsible for forwarding the information received from Qld Health to CSO3;
    - As a pseudo SCAN coordinator, as well as a departmental representative at SCAN, she had a responsibility to ensure she was familiar with all relevant documentation to be tabled at the meeting, including the Qld Health information about Mr O'Sullivan.

713. The ESU found that between 6 March and 17 May 2016 STL4 failed to ensure an investigation and assessment was conducted in accordance with the relevant legislation, policies and guidelines on the following grounds:

    - STL4 had a level of case oversight on 7 and 8 March 2016 and between 20 April and 17 May 2016;

- She did not discuss Mason's discharge with CSO3 on the morning of 7 March;
- She did not seek handover from STL1;
- She did not apply any methodical thought to Mason's immediate and ongoing safety needs, prior to, during and after his discharge from hospital;
- She had no discussion with CSO3 in regards to the above at any time on 7 March;
- No handover between STL4 and STL3 prior to or after her period of leave;
- There was no case planning with CSO3 when she was transferred to another office.

714. The ESU found that between 6 March and 17 May 2016 STL2 failed to ensure an investigation and assessment was conducted in accordance with the relevant legislation, policies and guidelines on the following grounds:

    - She failed to distribute the email from Qld Health sent for the SCAN meeting on 28 March 2016;
    - She failed to ensure that it was read, considered and actioned by CSO3;
    - She failed in her responsibility to ensure she was, as the pseudo SCAN coordinator, familiar with all documentation to be tabled at the meeting.

715. The ESU found that between 6 March 2016 and 17 May 2016 STL3 failed to ensure an investigation and assessment was conducted in accordance with the relevant legislation, policies and guidelines on the following grounds:

    - During the time she supervised CSO3 a number of ANCs were raised which were inadequately addressed by CSO3;
    - Her oversight of CSO3's inadequate assessments was not evident;
    - No handover between STL4 and STL3 on or after 4 May 2016.

716. The ESU found that on 1 June 2016 STL4 inappropriately approved a record of interview which lacked context and required further work:

    - STL4 approved the document despite the absence of evidence and the inadequacy of the interview;
    - The lack of oversight and decision making in the first two days of the I&A is of paramount concern and resulted in a missed opportunity to capture an accurate picture of the Lee family's circumstances.

717. The ESU found that on 9 June 2016 STL1 inappropriately approved an I&A which was not conducted in accordance with the relevant legislation, policies and guidelines on the following grounds:

    - She should not have approved the A&O that was sent to her by STL4 on 9 June 2016 if she did not have sufficient knowledge of the case and should have discussed it with Manager 1;
    - She approved the A&O which was a flawed document and should not have been approved.

3. IPA 15 May to 11 June 2016

Allegations

- Between 15 May 2016 and 11 June 2016 one or more of STL1, STL4, STL2, and STL3 failed to ensure the safety and wellbeing of subject children who were assessed as being in need of protection.
- Between 6 June 2016 and 11 June 2016 one or more of CSO6, CSO1 and CSO4 failed to ensure the safety and wellbeing of subject children who were assessed as being in need of protection.

718. On Sunday 15 May 2016 CSO3 formally concluded an investigation and assessed that the Lee children had been harmed or were at risk of harm, had no parent willing and able to protect them and were, therefore, in need of protection. STL4, as CSO3's team leader, knew of this proposed outcome on 6 May 2016 and advised CSO6 that she would likely be allocated the case.

719. Case work for the family commenced one month later, on 7 June 2016, as a direct result of a request made by RAI1.

720. The IPA involved CSO6 (primary case worker), CSO1 (assisting case worker), CSO4 (assisting case worker), STL4 (supervisor and decision-maker), STL1 (supervisor and decision-maker), STL2 (supervisor and decision-maker) and STL3 (supervisor and decision-maker).

Interviews

721. CSO6 in her statement to police said in relation to the above time period:

> *There were no safety concerns in relation to Ann-Maree as a parent and the most pressing concern for the family, at that point in time, was to support Ann-Maree to achieve stability and safety for her and the other children to leave the domestically violent relationship.*

722. Manager 1 stated that she wasn't aware that CSO6 was so inexperienced that she wasn't aware of her statutory duties in relation to the protection of children.

723. STL4, in general, said that she was on leave for some of the period, wasn't sure whether she was the responsible team leader when she was there, that all three team leaders had joint responsibility for the case and that she did not accept the allegations.

724. STL4 agreed, however, that CSO1, CSO4 and CSO6 failed in their duties.

725. STL1 stated that she was not aware that CSO6 was so inexperienced that she did not know what she was supposed to do when she went to see the family.

726. CSO1 said that he accompanied CSO6 to the residence on 9 June 2016 but his belief was that she was commencing the IPA, not conducting a "safety check." He recalls seeing four children but not Mason and did not ask about Mason's whereabouts.

727. It is clear from his statements during the interview that CSO1 felt (and probably still does) that he failed Mason and he has suffered due to blaming himself for Mason's death. To his credit and in comparison to most of the other CSOs and

STLs, CSO1 had no hesitation in accepting that he did not discharge his duties in accordance with the relevant requirements. He said in response to the allegation that he had failed in his duty:

My Mum thinks I do no wrong … "It wasn't you " … fucking oath it was ….

728. CSO6 stated that she had Bachelor and Masters degrees in Literature and a Masters Degree in Social Work. She had been employed as a CSSO by the department between June 2015 to February 2016 and then in a temporary position as CSO in the "Children Under Orders" team from February to October 2016. From October 2016 she undertook the role of CSO in the IPA team.

729. In March 2016 CSO6 took part in CSO training – between 6 June and 10 June 2016 she had some training modules outstanding. She said she did not have a working knowledge and understanding of the child protection framework including the Act and the CSPM.

730. However, CSO6 admitted, "I knew what my role was as an IPA worker …. Ensuring that children at home are safe."

731. She said when STL4 spoke to her about the allocation of the case she did not mention the name "Lee" only the surname of Sibling 1 so she only focused on Sibling 1 and didn't know anything about Mason. CSO6 said that STL4 just gave her the name on a little piece of paper.

732. CSO6 said she did not read the hard copy file or consult with anybody. She said she looked at the ANC but only focussed on Sibling 1 even though she said she believed that she was working with the whole family.

733. CSO6 said she had no handover from the I&A CSO (CSO3) and no handover by or consultation with any STL.

734. CSO6 stated she didn't know the difference between a CPO and an IPA - "I have gone to my team leaders and asked what does CPO mean? What does IPA mean? What is the difference between these two? … And I couldn't grasp …"

735. CSO6 said that she recalled the phone call from RAI1 on 7 June 2016 but she did not realise at that time that RAI1 was telling her about the family of Sibling 1 and didn't know that Ms Lee, to whom RAI1 referred, was the mother of Sibling 1. She didn't know why the call had been put through to her and thought maybe she was taking a message for someone else. She told STL1 about the call who asked her to call RAI1 back and tell her no IPA had been opened. Later that day STL1 asked her to go and do a safety check at the house with CSO1.

736. When she went to the house the next day CSO6 thought she, "just had to go and make sure that mum was all right and come back and report ….. whether [she] was there and whether she was alright."

737. Prior to conducting the "safety check" on 8 June 2016 CSO6 had not read anything about Mason or his situation despite that being the reason why the IPA had been opened. She said that on 9 June 2016 when she updated STL1 and STL2, "there was a name, Nathan, on the ICMS and there was Mason. So

I don't remember when I discussed it … I'm not sure whether … he was Mason or whether the child was Nathan."

738. CSO6 recalled that on 8 June 2016 she saw four children at the house. Ms Lee didn't invite them in so they sat outside the house. Ms Lee looked anxious and said she wanted the department "off my face" and wanted them to leave her alone. Ms Lee refused to tell them Mr O'Sullivan's name. She told them that he hated Sibling 1 but loved the other children. She said that Sibling 1 stood up for her and that was why he hated her – "because she defends me, she stands up for me, that little bitch – she can be a little bitch."

739. CSO6 said, "I did think about the risks to [Sibling 1] … like in my reflections later … not later that day or the next day" but "I did not worry about [Sibling 1] on that night, like what would happen when we leave."

740. CSO6 said she was not aware she should have checked the whole house.

741. CSO6 said she remembered Ms Lee telling her she had another boy but "we didn't talk any more about it, nor did I … think it was Mason … I assumed it was a … baby, it was sleeping inside or something … but I did not think any more of it then. When she said I have one more, nothing stood out … there was (sic) no questions in my head at that time."

742. CSO6 said that when she got back to the office there were no team leaders there and she did not call any of them despite having their numbers. She sat there for a while but nobody came in so she packed up and went home. She did not make any case notes on the ICMS or email any of the team leaders before she left.

743. The next day there were no team leaders available either so CSO6 asked CSO4 to go with her to see Ms Lee. CSO6 was concerned about that – "I told [CSO4] I hope they don't pull me up for taking you out without asking or consulting."

744. CSO6 said she didn't really know why she was involved but thought her involvement might be, "just as an officer of the department because the family was involved with the department … I did not know what case it would be."

745. When she returned to the office she briefed STL1 and STL2 and they looked up the family on ICMS but they were confused about who "Will" was however, they were, "quite satisfied with how everything was going."

746. It was during this conversation that CSO6 became aware of Mason but the team leaders didn't ask whether she had sighted Mason and she didn't disclose that she hadn't.

747. CSO6 said she was not aware that the case was an IPA until after Mason's death.

748. CSO6 said that on 10 June 2016 when she went to visit Ms Lee again she did not think of asking where Mason was, despite him being the youngest child. On that day she spoke to Ms Lee outside the library for 2 to 3 minutes and Ms Lee cancelled the scheduled appointment with the DV service for later that afternoon because she was scared that Mr O'Sullivan would find out she was attending.

749. CSO6 went back to the office and didn't speak to any team leaders about the meeting with Ms Lee. She then received a call from Ms Lee's neighbour just as she was about to leave the office. The neighbour told her that Mr O'Sullivan was holding Mason hostage to stop Ms Lee leaving him. She disclosed violent behaviour by him to Ms Lee.

750. CSO6 said she went looking for a team leader but could not find one, so she spoke to CSO4 who told her, "We'll pick it up Monday." Neither spoke to the managers in the office. CSO6 went home:

> *And I was going home … and there was nothing, no urgency in [the neighbour's] call, she was just returning my call because I'd left a card"*

751. Even though she had received this information from the neighbour, CSO6 stated to investigators:

> *It never crossed my mind that William was looking after Mason. That is what I knew later, that he was with him.*

752. In regard to the information from the neighbour, CSO6 said she took the information literally in that, she thought Mr O'Sullivan took Mason everywhere. She said:

> *Otherwise .. there was nothing else indicating that the child was being neglected from conversations I had with the mum and … whatever information I had about the partner … [Ms Lee] said things like he is only violent when he is on ice, otherwise he's really good, I still love him and he loves me.*

753. In response to whether she had failed to protect Mason, unbelievably, CSO6 said "I can't say yes to that …. I did my best."

754. CSO4 was interviewed in January 2017.

755. CSO4 said that CSO6 asked her to have a chat with Ms Lee on 9 June 2016 as there were issues with DV and perhaps she could provide Ms Lee with some options. She said that it was obvious that Ms Lee was "desperate" as "she had even thought of provoking Will to punch her to lose the baby." CSO4 said that the most immediate safety issue identified on that day was that Ms Lee was pregnant and wanted the pregnancy terminated.

756. CSO4 said her role was only to assist Ms Lee. She could not answer how the children's safety was considered because she was not the investigating officer, was not the seconding officer, was not doing the case work, had no information, had not briefed herself, had not read the case and was not addressing the concerns in totality. She said she was not responsible for assessing whether the children were safe:

> *I came in to do a piece. I'm … not … part of the whole assessment of the child protection concerns because I didn't have the information … I wasn't requested to provide case assistance.*

757. In relation to the threats posed by the DV Ms Lee was experiencing CSO4 said there were "a number of red flags … patterns of abuse and control."

758. In relation to how Ms Lee was going to protect the children CSO4 said, "We didn't get to that level of detail in the conversation."

759. CSO4 agreed that CSO6 had told her about the information she received from the neighbour that Mason was being held like a hostage by Mr O'Sullivan. She said she was only concerned about Ms Lee not keeping her appointment that day and so when it was rescheduled for Monday she said, "We'll pick it up Monday."

760. CSO4 said about the information from the neighbour:

> *I did not give that conversation any degree of assessment or stop, let's have a conversation about what's going on. Right or wrong, I didn't. … Because I was doing my work. It was 4.30 on a Friday and I was far from finishing. Like every day.*

761. CSO4 said the CCSSC was in crisis and not an emotionally safe environment to work in. She said she "was reminded that I didn't fit in … constantly" and she had been told by STL4 and "other people in the office" that she was parent-focused as opposed to child-focused. She said, "I constantly challenged that."

762. CSO4 denied that she failed to ensure Mason's safety and said, "I think, collectively, the system could have done more for that family."

Findings

763. The ESU found that between 15 May and 11 June 2016 STL4 failed to ensure the safety and wellbeing of subject children who were assessed as being in need of protection:
    - Other than a brief discussion between CSO3 and STL1 during the SCAN meeting on 15 March 2016 there is no evidence of any decision-making or discussion for electing an IPA rather than another form of intervention;
    - The I&A was formally concluded and submitted to STL4 on 15 May 2016 but she failed to ensure that the case was dealt with in the appropriate time frame and, in fact, no further contact was made with the family until a month later, on 8 June 2016;
    - Although STL4 considered CSO6 inexperienced she didn't have any discussions about the case with her or supervise her in any way;
    - STL4 stated that STL1 took over supervision of the case but there is no record of her conducting any handover to STL1 before she went on leave in early June and therefore, the case remained unallocated until 7 June 2016 (a month after STL4 returned from leave).

764. The ESU found that between 15 May 2016 and 11 June 2016 STL3 did not fail to ensure the safety and wellbeing of subject children who were assessed as being in need of protection on the basis that STL4 had returned from leave by 15 May and STL3 was no longer involved in the Lee family case.

765. The ESU found that between 15 May 2016 and 11 June 2016 STL1 failed to ensure the safety and wellbeing of subject children who were assessed as being in need of protection:

- Other than a brief discussion between CSO3 and STL1 during the SCAN meeting on 15 March 2016 there is no evidence of any decision-making or discussion for electing an IPA rather than another form of intervention;
- STL1 told CSO6 to conduct a "safety check" on the Lee family on 7 June 2016 – there is no evidence of any other discussion or case planning;
- STL1 did not follow up with CSO6 about the safety check until 8 June and then discovered she had not done it
- She then asked her to do the safety check that day with CSO1 but did not follow up with either of them
- On 9 June 2016 CSO6 and CSO4 advised STL1 of the serious DV concerns disclosed by Ms Lee but she did not ensure that they take appropriate action in relation to any safety planning and despite knowing of the previous serious neglect of Mason did not ask about him, his whereabouts or his wellbeing;
- There was no further follow up by STL1 even though she was the only team leader in the office on 10 June 2016.

766. The ESU found that between 15 May 2016 and 11 June 2016 STL2 failed to ensure the safety and wellbeing of subject children who were assessed as being in need of protection:

    - CSO6 and CSO4 advised STL2 of the serious DV concerns disclosed by Ms Lee on 9 June 2016 but she did not ensure that they took appropriate action in relation to any safety planning or make any enquiries about the safety of the children including Mason.

767. The ESU found that between 6 June 2016 and 11 June 2016 CSO1 failed to ensure the safety and wellbeing of subject children who were assessed as being in need of protection:

    - CSO1 and CSO6 did not plan for the home visit on 9 June 2016 and neither were aware of the information on the department database;
    - There was no assessment of the residence on that day;
    - There was no safety planning in relation to the risks posed by the DV that was disclosed by Ms Lee;
    - Neither questioned Mason's whereabouts at the house on that day.

768. The ESU found that between 6 June 2016 and 11 June 2016 CSO6 failed to ensure the safety and wellbeing of subject children who were assessed as being in need of protection:

    - Although CSO6 was not provided with any supervision by STL4 re the IPA, she made no attempt to inform herself of the circumstances of the case and was unaware that the IPA concerned Mason;
    - There was no planning with CSO1 with respect to the home visit of 8 June 2016;
    - She was unaware of the circumstances of the I&A for the family;
    - She did not know why she was visiting the family;
    - The home visit was not child-focused;
    - There was no pre-planning or discussion for the home visit of 9 June 2016 which led to the focus being on Ms Lee again;
    - CSO6 did not take any notice of the discussion CSO4 had with Ms Lee at the medical centre;

- When CSO6 became aware of Mason's existence at the briefing of team leaders on the afternoon of 9 June 2016 she did not disclose that he had not been with Ms Lee and she had not sighted him;
- CSO6 did not consider immediate safety concerns for the night of 9 June 2016;
- CSO6 did not appreciate the significance of Ms Lee avoiding her in the street on 10 June 2016 even though she said she was fearful and anxious;
- There was no safety planning or assessment of risk on 10 June 2016;
- Mason was still not sighted or asked after;
- CSO6 disregarded the seriousness and significance of the information provided by the neighbour in her phone call on the afternoon of 10 June 2016 disclosing Mr O'Sullivan's abuse of the children and his physical use of Mason as a tool to prevent Ms Lee from leaving the relationship;
- CSO6 did not pass that information on to any team leader or manager prior to leaving work that afternoon;
- CSO6 considered that telling the neighbour to call the police if she was concerned was adequate safety planning and stated she had no safety concerns in relation to Ms Lee;
- The apparent lack of CSO6's understanding of the high risks associated with the situation, was of the utmost concern;
- There was no adequate and reasonable risk mitigation strategy employed by CSO6.

769. The ESU found that between 6 June and 11 June 2016 CSO4 failed to ensure the safety and wellbeing of subject children who were assessed as being in need of protection:

- Although CSO4 was not the primary case worker she was a CSO and obliged to ensure children's safety and wellbeing whilst operational in the field;
- There was no case planning or discussion prior to the visit of 9 June 2016;
- The objective was to assist Ms Lee to leave the relationship without knowing that an IPA existed for the children and so the focus was isolated to Ms Lee and the safety of the children was not considered;
- The inadequate risk assessment and inability to consider the immediate safety needs of the children are indicative of CSO4's inadequate skill set;
- There was no consideration of immediate safety concerns on 9 June 2016;
- There was no consideration by CSO4 of the information provided by the neighbour on 10 June 2016 and nothing done to ensure Mason's safety over the weekend;
- CSO4 lacked understanding of the high risks associated with the situation is of the utmost concern;
- CSO4 failed to report the concerns to a decision-maker.

4. <u>CSSC Management</u>

Summary

770. Except for some short periods of leave, Manager 1 was the Manager of the CCSSC between 9 December 2015 and 11 June 2016. She was responsible for the providing direct supervision of STLs including STL1, 2, 3, and 4, who, in turn were delegated to support and supervise front-line CSOs. Manager 1 was

also responsible for the operational functioning of the Early Engagement Team to ensure effective service delivery to children in the Caboolture catchment.

Allegation

771. Between 9 December 2015 and 11 June 2016 Manager 1 failed to appropriately manage the CCSSC and/or failed to ensure the CCSSC leadership team provided an appropriate level of supervision and support to staff during service delivery.

772. The elements of the allegation are:

- The effectiveness of her management of the Early Engagement Team operating within a matrix model of supervision;
- The appropriateness of her oversight to service delivery;
- The quality of dealing with staffing matters and supervision of the leadership team members of the Early Engagement Team to ensure appropriate supervision and support was then offered to front-line staff; and,
- The adequacy of the SCAN function.

Duties of Manager 1

773. The role profile for the AO8 position outlines the principal responsibilities of Manager 1:

> *The role of the Manager is to lead and manage the Child Safety Service Centre in the delivery of high quality, collaborative and integrated child protection services to clients and communities serviced by the Child Safety Service Centre. This is achieved through the implementation of quality casework and case management systems/practices/standards and practice framework, the establishment of enduring productive partnerships with carers, the community, public and non-government sectors, service providers and the ongoing professional development and management of staff.*
>
> *Principle responsibilities of this role are:*
>
> - *support, lead and manage staff in a CCSC to ensure that children's safety, belonging and wellbeing are met and that children and families are included as meaningful partners in the child protection process;*
> - *lead and manage the CSSC ….*

Matrix Model

774. ESU investigators could not be provided with a precise document setting out a visualisation of the matrix model of supervision in place at the CCSSC, however, from the evidence taken from various employees of the department, they were able to ascertain that the model comprised the I&A and IPA teams of CSOs who were supervised by three team leaders. The combined teams formed the "Early Engagement Team". Each of the STLs had their own group of CSOs that they supervised.

775. The model proposed that the three STLs and their working group rotated on a weekly roster to perform either "online" or "offline" tasks. Online duties included

conducting I&A's and case work whereas the offline functions were report writing and in-office tasks.

776. The "online" team leader was predominantly responsible for the allocation of incoming notifications to all online CSOs whether they were part of that STLs direct group or not. The online team leader also attended SCAN meetings. Once a notification was allocated for an I&A the usual supervisory team leader then became responsible for case progression and decisions.

777. If a CSOs usual supervisory team leader was absent, there was an expectation they consul and seek decisions from the other two team leaders.

Documentary Evidence

778. Manager 1 provided handwritten "supervision notes" of group meetings she had with the STLs in the relevant period. Whilst mostly not specifically relevant to the events concerning Mason, they do suggest that "some group supervision occurred, at times."

779. Notes dated April 2016 and early June 2016 disclosed that Manager 1 was aware of the tension between a number of staff, particularly CSO3, and STL4.

Interviews

780. CSO5, CSO3, CSO4, CSO1, STL3, STL2, STL1, STL4, Manager 2 and an Acting Manager were interviewed about the management of the CCSSC.

781. CSO5 said that the matrix model was confusing and it was hard to use effectively and CSOs had to keep repeating the same story to a different STL.

782. She said the process of allocating I&As was not organised – it usually involved "turning up" to work and seeing them on her desk without any previous information or discussion.

783. She said the CCSSC was "severely stats oriented".

784. She said that the team leaders did not know what the CSOs were doing during the day – "to be honest they probably don't even know we're out sometimes." She said CSOs just leave the office because team leaders are unavailable to be told that CSOs are commencing a job.

785. In relation to handover CSO5 said:

> *It's bad. I didn't even know the process until about [two weeks before the ESU interviews in December 2016] because we didn't have a set thing of what needs to be done between each CSO and when it would go to [a different case worker] we don't even … have timeframes.*

786. CSO3 said the matrix model was "quite messy" – nobody had a clear idea of what the team was going to look like when it was initiated and as it went on it was unclear which team leader was responsible for cases. Sometimes responsibilities were passed from one team leader to the next.

787. CSO3 said that on occasion when a CSO consulted a team leader other than STL4 she would get upset and consider that they were being "disloyal".

788. She said allocation planning varied between team leaders and included being sent an email or receiving a hand written note. There was no consistency. Team leaders did not always communicate with each other about cases so CSOs had to repeat their story a number of times.

789. CSO3 said she had specifically spoken to her Manager 1 about her concerns regarding STL4 in January 2015. At that time Manager 1 instigated the conversation because she had observed behaviour by STL4 toward CSO3 that she considered inappropriate. They spoke about the concerns again in April 2016 by which time CSO3 had decided that she could no longer work in the CCSSC because of STL4's behaviour towards her and other CSOs. She described the atmosphere in the office as "really toxic".

790. CSO3 said you couldn't complain about STL4 until after you had left the office, "otherwise you'd just suffer."

791. She said STL4 would, "humiliate people if she felt that they were against her or, you know, she just had that clash with them. And I think trying to turn people against each other too …"

792. CSO3 said she told Manager 1 everything (in April 2016) and then she:

> *… started the process very quickly around following up with me, discussing everything with me again. And she approached other workers as well to see if they wanted to speak with her.*
>
> *… I felt really supported by [Manager 1]*
>
> *… [Manager 1] was trying really hard and she told me …. I'm working really hard to try and get you moved on before [STL4] comes back.*
>
> *… on the Wednesday, the day before [STL4] got back … she said, yep, you're good to start at Alderley on Monday. And I just thought oh my gosh, that's, that gives me two and half days left at this office …. it was quite a whirlwind*

793. CSO3 said it ended up being very uncomfortable because it was left to her to tell STL4 that she was leaving the office and she thought that Manager 1 could have handled it a lot better.

794. In regards to finalising her outstanding cases (of which Mason was one) before leaving the CCSSC CSO3 said:

> *I said to [Manager 1] at that point, I said, look, you know, I've got … list off particularly the pressing cases I had. Ones where there was a still a lot of work to be done. And she said, look, just focus on what you need to do and then we will do some more planning around that.*
>
> *… she said, we'll try and negotiate with [manager at Alderley] a handover and you to have some down time at Alderley to finish off cases.*
>
> *And I thought, well, that sounds okay but we don't know … how busy [Alderley is] … and I just thought it certainly wasn't ideal … it wasn't well planned.*

795. CSO3 said that STL4's erratic behaviour was evident from the time she commenced at CCSSC in 2014.

796. CSO3 said there was a bit personality clash between STL4 and CSO4 and CSO4 was seen to be crying at times and she believed that Manager 1 would have known about that conflict.

797. CSO4 said she did not like the supervisory framework in place at CCSSC. There were a lot of gaps and concerns which is why she no longer works for the department. She said:

> *It's very difficult to bring your concerns to a team leader who is also in crisis.*

798. CSO4 said the matrix model was confusing – "there was no team in that space, no one knew what they were a part of."

799. In regard to the matrix model roster and team leaders being online and offline, CSO4 said:

> *It was just survival. You just did what you could on the day … we didn't go and refer to a matrix, it wasn't that systematic.*
>
> *There was a breakdown in communication … across management, across team leaders, between team leaders and staff. It wasn't an emotionally safe environment to work in …*
>
> *There was seemingly tensions between the team leaders and [Manager 2] at times … staff saw that in the team meetings … in the last couple of months we were stopping having the team meetings of any detail.*

800. CSO4 said that she thought she could approach Manager 1 with any issues – "I think that's a good managerial relationship."

801. CSO1 said with the matrix model, "you wouldn't know who was on and who wasn't and what was going on."

802. He said Manager 1 couldn't manage STL4. He was of the belief that Manager 1 knew of the issues – "Oh yeah, there was staff walking out here and there."

803. He said Manager 1 was:

> *Those sort of managers that … you could go and tell her something and … you'd feel like you told her and she understood that, you just knew nothing was going to change*

804. In relation to Manager 1 being aware of the issues with STL4 he said she must have been aware of them:

> *This big loud woman … yelling, talking like … this … in front of you right there .. like you'd think you're … at the bloody local tavern … if you walked in there you'd think she was allowed to do whatever she wanted*

805. STL3 said she thought Manager 1's management style was good. She was very approachable and open to discussion. She thought that Manager 1 was

not responsible for managing STL4's behaviour as STL4 herself should have been responsible for that.

806. In relation to the matrix model STL3 said when she started in the office all three team leaders had a roster on their door and admin had one too and they were all different so nobody knew which to follow.

807. With regards to allocation and supervision of the Lee family STL3 said, "I guess it was sort of all over the show for this one."

808. STL2 said she could approach Manager 1 when she needed support and her door was always open. They discussed supervision, staffing, HR matters, workload, critical case discussions and decision making and work-life balance. She said that Manager 1 engaged in group supervision for the team leaders within the matrix model and during the meetings there would be "strategic-level thinking about areas which required focus. However, such meetings did not occur regularly. She said the three team leaders discussed circumstances daily and weekly together in the absence of Manager 1.

809. STL2 said that when the team leaders approached Manager 1 about the issues surrounding STL4 Manager 1 told them that they should deal with it – "It would be much more beneficial for STL4 to receive that from you as firsthand people."

810. STL1 said that with regards to the matrix model she had concerns about missing an incoming I&A and "the advice would have been to develop a strategy to manage the issue as a group."

811. STL1 said the CCSSC had never had an independent SCAN coordinator and it was not a good system – that undertaking the additional role of SCAN coordinator as a team leader conflicted with the business of being a core representative at the meeting, representing the department.

812. STL1 said the team leaders should not have been asked to speak to STL4 about the issues with her behaviour and when they did the conversation STL4 only lasted a couple of minutes before she walked out.

813. STL1 said:

> *We didn't have that much to do with [Manager 1] probably …*
>
> *I think [she] did her best … I don't know the full particulars of what was being managed … I do know that [STL4's] behaviours … they did seem to be escalating.*

814. STL4 was of the view that Manager 1 managed the implementation and oversight of the matrix model, supportively, inclusively and in a planned manner. She said Manager 1's management of the Early Engagement Team was successful, the operations of SCAN were managed responsively and staff absences and resultant impacts on service delivery were mitigated through discussion, planning, reprioritisation and email correspondence.

815. Manager 2 was brought in to the CCSSC as the second manager to review the operational function of the matrix model on 11 May 2016.

816. She said when she arrived, “I did find it a little bit confusing because I’d never seen a model work this way.”

817. She said STL1 and STL2 were the only supervising team leaders and STL4 was taking on an administrative function i.e. to manage the allocations of incoming notifications to the CSOs but not to supervise staff.

818. There were no documents that reflected the matrix framework but she thought the team leaders understood how the model was supposed to work. She said she was told by the team leaders, not Manager 1, how the model was supposed to work when she started there.

819. Manager 2 was asked how Manager 1 had been managing the issue of having a backlog and a lot of inexperienced workers and she said:

> *Well I think at that point really it was the actual team leader with the matrix that was the system they were operating under the matrix model so the team leaders were taking on a lot of those roles themselves.*

820. One of the priorities of Manager 2 when she commenced at the office was to change the allocation process which entailed printing off the notifications and putting them in a folder. She said there would always be matters remaining in the folder as it got passed from team leader to team leader as there was not enough staff to allocate to.

821. Manager 2 said she did not know how Manager 1 mitigated any risks. She was asked if she knew who was involved in identifying and implementing the matrix model and said, “I did ask but I didn’t really ever get a clear answer.”

822. She was asked whether Manager 1 was aware of the matrix model and said:

> *I’m not really sure, I think one of the key issues that led to me looking at the matrix model was it was clearly unsustainable to keep going in this way with the amount of work coming in and a growing backlog.*

823. Manager 2 said it was common when she arrived for team leaders to conduct their own I&A’s and she put a stop to that because it was affecting their leadership function.

824. She observed that Manager 1 was a very supportive person in terms of personal relationships.

825. She said it would have been difficult for anyone to manage that office with the amount of work coming in and the resources allocated to it. She didn’t see anything that suggested that the office wasn’t being run efficiently.

826. The Acting Manager was interviewed. She said that in 2015 after a similar case situation to Mason’s she authored a report in an attempt to identify preventative solutions for Caboolture’s growing social disadvantage. She was looking at models which might help the CCSSC address the escalating numbers of disadvantaged clients in the office.

827. She said that Caboolture had a lack of programs and resources. She said:

This was absolutely [known] higher … this went to [the former Regional Executive Director] … he talked to the [former Deputy Director General] about it and you know the message we were getting at the time was that "it's the wrong time", "there's no appetite for this", the worst message was "you're whinging", "you need to stop whinging", that was from [an Executive Director] … [those were] his direct words.

She said that she knows that the former Regional Director was getting the same kind of response:

So you have this service centre that's huge, you've got … more I&As than any other individual CSSC … you've got no resources coming into this area … there's now tonnes of resources coming in but it's all too little too late … one manager for all of that, I mean it makes me quite emotional, sorry.

…the other thing that came out of that is … when the IAs come into this office the substantiation rate is about the same, it's about average for the state but the substantiation child in need of protection is lower and … significantly lower [than the rest of the state] … I tried to work out what it was about … It's about the type of community you've got here, the pressure on those team leaders in terms of kids coming into care. How do you just take all these kids into care? If you took in every kid who was on a substantiated notification here you know like they would be so overwhelmed, [there would] be nowhere for them to go, you couldn't have, you know you can't do it with the number of staff. The other side of the office, the orders team were under such pressure they had so many kids. So I think their thresholds are different here because they're dealing with a community that is in such deep depression …

828. The Acting Manager said that Manager 1 was almost hypervigilant about the risks, she had a very open door policy and the team leaders were in there constantly.

829. She said the matrix model never worked the way it was intended to because the team leaders had such a high volume of work and the team was never fully staffed so they never got their week offline.

830. She said the team leaders had regular morning musters and conversations as well as fortnightly meetings with the senior practitioner and sessions with Manager 1. However, in relation to hand overs between team leaders she said whether that was happening successfully depended on what was happening at the time and the team leaders involved.

831. The Acting Manager said that she was not aware of occasions when there were issues with team leaders taking ownership of work, however, it was clear in hindsight that there were problems. She said it was known that there was a problem with backlog.

832. She said Manager 1 was certainly aware of problems in relation to STL4.

833. The Acting Manager said that Manager 1 managed the office as best as she could within the limitations that the department put on her.

834. Manager 1 was interviewed and said that she had been a manager in a CSSC for ten years, and since May 2013 at Caboolture. She commenced working for the department in 2001 and had worked as a CSO and a team leader.

835. Manager 1 was on leave for five weeks of the relevant period – from 14 March to 18 April 2016 and the Acting Manager filled her role in that time. On 3 May 2016 Manager 2 commenced as a second manager in the office. From that time Manager 2 was responsible for the Early Engagement Team.

836. In regards to the lack of resources in the office Manager 1 said that she believed that there was a belief that the "Carmody reforms" would bring the numbers down but that didn't happen.

837. When asked whether outcomes at the CCSSC were adjusted to reduce the substantiated CINOP matters she said that she was unaware of that and it was not a culture that she had encouraged or fostered.

838. Manager 1 was asked why the deficiencies in practice in the CCSSC which had been identified by investigators had not been known to her as the manager of the office. She said that she had a demonstrated record of dealing with poor performance if it was raised with her.

839. Manager 1 said that she wasn't aware that all of the team leaders and staff were confused by the matrix model.

840. She said she wasn't aware that there were significant issues between numerous staff and STL4 until CSO3 raised it with her in April 2016.

841. She was aware that there was no SCAN coordinator but she could not fill that position because of budgetary restrictions. She said that considered the team leaders could adequately fill that role and as she was not told there were any issues she assumed that was an effective system.

Findings

842. The ESU found that the allegation that between 9 December 2015 and 11 June 2016 Manager 1 failed to appropriately manage the CCSSC and/or failed to ensure the CCSSC leadership team provided an appropriate level of supervision and support to staff during service delivery was <u>unsubstantiated</u>:

- although there was common confusion, frustration and concern for the effectiveness and efficiency of the matrix model Manager 1 obtained the assistance of the Acting Manager and Manager 2 to review and modify the model and thereby contributed to an effective progression forward for the CCSSC;
- It was the responsibility of the team leaders to ensure CSO3's cases were progressed efficiently in the midst of her transfer and shortly thereafter Manager 2 took over the Early Engagement Team;
- Unless Manager 1 was given feedback from the SCAN stakeholders that there were issues of concern with SCAN she operated under the assumption that the process was satisfactory;
- She was a supportive manager and willing to assist staff with any issue they brought to her attention;
- There is no evidence that Manager 1 did not provide useful structured and unstructured supervision to the leadership team;
- There is evidence that Manager 1 was aware of significant and behavioural issues alleged against STL4;

- STL4's behaviour has been considerably disruptive to the CCSSC and has more likely than not had a negative impact on the emotional wellbeing of her colleagues and supervisees and it is highly probable that it impeded the CSOs' service delivery;
- It is outside the scope of the ESU investigation to conclude that Manager 1 failed to address the issues in relation to STL4.

843. In addition to its findings in regard to the 18 allegations the ESU made the following recommendations:

- the allegations in regard to STL4 be resolved in a timely manner;
- departmental wide training to reiterate the responsibility and accountability of every CSO (to address the belief that secondary investigators were only there to take notes);
- the Strengthening Families and Protecting Children Framework has resulted in confusion and caused officers to deviate from utilising a risk assessment framework and there should be departmental wide training to reiterate the importance of identifying and assessing risk to children
- departmental wide training to reiterate that sighting all subject children is integral to risk assessment and to ensure the child's safety and wellbeing.

Desktop Review

844. As well as investigating the 18 main allegations the ESU were tasked with conducting an analytical desktop review which considered whether 13 employees of the department failed to conduct and/or approve adequate intakes of child protection concerns. The ESU found that all 13 had failed to conduct the intakes adequately. Only two of those employees were involved in the 18 main allegations. The ESU found that the employees, when receiving child protection concerns, failed to deal with them in accordance with legislation, departmental policy and practice guidelines in that they:

- failed to conduct relevant investigations;
- failed to follow-up information sufficiently;
- demonstrated a lack of due diligence;
- approved forms without sufficient information;
- approved forms without reviewing and considering all available information;
- failed to complete relevant forms;
- failed to analyse the family's child protection history;
- failed to record Mason's siblings as subject children;
- failed to consider information holistically;
- demonstrated a lack of due diligence;
- failed to check that a referral to QPS had been received and failed to discuss matter with QPS;
- failed to provide information received from Qld Health to QPS;
- failed to notify a CSO that an additional notification had been received.

INQUEST

845. The inquest commenced in Brisbane on 16 March 2020.

846. Dr 1, Dr 2 and RAI1 gave oral evidence before the court had to be closed due to Covid-19 protocols and the inquest continued by way of written questions, answers thereto and submissions.

847. The evidence of Drs 1 and 2 has been incorporated into these findings.

848. RAI1 is an experienced social worker. In 2015 she was an Intensive Family Support Practitioner (IFSP) with Mission Australia providing support to families through the RAI program (now IFS program). RAI1 was supporting 13 to 15 families at any one time and tried to see each of them once per week or once per fortnight.

849. RAI1 was an impressive witness. Her evidence was of much assistance. Her evidence at the inquest demonstrated her continuous but fruitless attempts to gain the support of the department in her efforts to assist the Lee family and her efforts to provide relevant information to the department. Unfortunately the department did not share any information with her and CSO3 and STL4 largely ignored her.

850. Had RAI1 been in possession of the information known to the department it is likely that she would have read and considered it – unlike the CSOs and STLs – and she would have been in a much better position to assess the risks to Mason.

851. RAI1 kept comprehensive contemporaneous case notes of her contacts with and about the Lee family. Those notes, especially considering the lack of notes taken by the CSOs and STLs involved, were of great assistance in the inquest.

852. RAI1 said it was common for her to contact the department if she had child protection concerns but there was no process, known to her, by which the department would provide information to an IFSP about a family. IFSPs were not given access to information held by the department about families they supported.

853. RAI1 did not receive any historical or current information about the Lee family. She knew only what Ms Lee told her and what she gleaned from her own observations.

854. On 7 March 2016 RAI1 called NCRIS and advised of her concerns for the Lee family and the current situation. She was told that the department could not share any information with her.

855. RAI1 attended the SCAN meeting on 15 March 2016. It was the first and only SCAN meeting that she had ever attended in relation to any of the families that she had supported.

856. RAI1 shared the information she had about the Lee family and her concerns about Mr O'Sullivan.

857. It was at the meeting that RAI1 was first provided with any information from the department or Qld Health about Mason. She was told about his injuries and that the cause of them remained unclear. She was told that Ms Lee had provided a history to the Drs which was inconsistent with the injuries and the facts.

858. RAI1's professional opinion was that there remained many unanswered questions about Mason and his family and she considered that he met the threshold for the department to intervene. She considered that an IPA was the minimum intervention required but believed that the department would have continued to assess the situation and that Ms Lee would be required to engage and comply with Mason's follow up medical requirements.

859. RAI1 heard of Mason's death on the news on 12 June 2016. Unsurprisingly, given her attempts to assist and support the family and to advise the department of her concerns on numerous occasions, RAI1 was devastated by Mason's death and struggled to cope with it in the following months.

860. RAI1 gave evidence that it is normal practice, when a family becomes subject to an IPA, that there is a "warm handover" between herself and the CSO. In this case there was no handover at all.

SUBMISSIONS OF THE PARTIES

861. I am grateful for the submissions of the parties and their helpful suggestions in relation to methods of better protecting children such as Mason. I am also grateful for their assistance in identifying changes that have already occurred or are in progress in their departments.

862. I have considered all of the submissions in making these findings and I make further mention of specific matters below in discussing recommendations.

863. It is a reflection of the spirit of cooperation brought to this inquest that the parties largely agree on the resulting recommendations. The department, in its submissions, has indicated that it agrees to 4 of the 6 recommendations I make below.

864. It is acknowledged that the department and the government, immediately upon Mason's death, took comprehensive steps to investigate his death and that many reforms have been made arising out of the findings of those investigations.

COMMENTS, RECOMMENDATIONS AND FINDINGS

RAI and IFS Service Model

865. I find that RAI1 acted professionally and competently in her dealings with the Lee family and went above and beyond what was required of her in an effort to make the department aware of and take action in relation to her concerns about the family. She is to be commended for her efforts to support Mason's family. Had she been able to obtain the information about the family held by the department she would have able to better assist the Lee family and protect Mason.

866. It was not until this inquest that RAI1 learnt of the child protection history of Ms Lee and her family and other information which would have been relevant for her work with them. RAI1 gave evidence, which I wholly accept, that had she had access to the information held by the department about the Lee family her approach to the case would have been completely different.

867. It was not until she was invited to a SCAN meeting, not by the department but by Dr 1, that any pertinent information was shared with RAI1 about Mason's injuries and his hospital admission. That information caused her to be more concerned about Ms Lee and her children. Inexplicably she was told by CSO3 that she would not be required to attend the next SCAN meeting.

868. It is understandable that the department has a duty to safeguard the very personal information it holds about children and their families but it would seem reasonable that at least in the case of children that are considered by SCAN i.e. those for whom there are significant safety concerns, the support workers should be present at SCAN meetings and have access to the information that SCAN considers and are able to contribute the information they have.

869. **I recommend** that the SCAN manual and relevant legislation, policies and procedures be amended to mandate that when a family is engaged with a service provider, and that family's matter is referred to SCAN:
    a. the external support worker must be invited to attend all SCAN meetings relevant to that family; and,
    b. information held by the SCAN members must be shared with the external support worker.

870. The department agrees with this recommendation.

Queensland Health

871. I find that Mason's treatment and management by Qld Health was appropriate and the employees of Qld Health acted appropriately in relation to providing information to the department and as a member of the SCAN team. Drs 1 and 2 were impressive and helpful witnesses at the inquest.

872. Dr 2 gave evidence that he was unaware of any formal procedures for medical staff to escalate a case in which they disagree with a decision of a department relating to the discharge of a child. The doctor said that in future if he was concerned about the discharge of a child such as Mason he would escalate the matter.

873. **I recommend** Queensland Department of Health implement formal policies and procedures for the escalation of a case in which medical officers disagree with a decision made by the department in relation to the discharge from hospital of a child.

874. Qld Health and the department agree with this recommendation.

Queensland Police Service

875. I make no adverse findings in relation to the involvement of any member of the Queensland Police Service involved in this matter. However, it is concerning that the QPS requested the department to provide a copy of its file in relation to the Lee family on 4 April, 27 April, 12 May and 27 May 2016. On 17 May

2016 the department provided a redacted version which was missing relevant information i.e. the version provided by Ms Lee on 10 March 2016 explaining Mason's injuries. QPS were advised on that date that the information had not been provided because it had not been entered into the file. The file provided by the department to QPS was heavily redacted.

876. I find that the department failed to comply with its obligations to share information with the QPS in accordance with sections 159A and 159B *Child Protection Act* 1999 which provide for the sharing by the department of information with QPS and state that a child's safety, wellbeing and best interests are paramount and take precedence over the protection of individual privacy concerns.

877. I find that there was no logical reason why the department provided a redacted file to QPS when investigating officers were aware of the family dynamic and the names of Mason's siblings and other family members. Further, I find that it is inappropriate for departmental officers to make decisions about whether information should be redacted in the context of a police investigation. Such departmental employees are not investigators, may not be aware of the scope of the police investigation and may redact pertinent information.

878. A Detective Inspector of the Child Abuse and Sexual Crime Group of State Crime Command of the QPS (and Deputy State SCAN Coordinator for the QPS) stated:

> *On the information that I have been able to review I would suggest that although approached as a joint investigation and certain parts were conducted jointly (i.e. interviews with siblings) it appears that the intent of joint investigation was not met.*
>
> *Evidence I have viewed reflects efforts at joint meetings which couldn't or didn't eventuate and in particular a free flow of relevant information did not exist particularly from [the department] to QPS. The apparent need for the investigating officer to obtain 2 separate search warrants …. [to obtain information from the department] seem to fly in the face of the intent of joint investigations and of legislation in the [Child Protection Act] relating to information sharing …*

879. The Detective Inspector stated that, in his experience, it is not uncommon for the department to request police obtain and execute a search warrant before the department will release information.

880. I find that such an approach is not in accordance with the relevant legislation, is unnecessary, is a waste of police resources and could impede police investigations in relation to offences against children.

881. **I recommend** that procedures and policies for the provision of information to QPS be reviewed to ensure that information held by the department is provided to the QPS, upon request, in a timely manner and without redactions and the QPS report annually for the next three years to the Coroners Court of Queensland the number, if any, of search warrants executed on the department for the provision of information in relation to children who are subject to a joint investigation.

882. The department submits that this recommendation is unnecessary since it is unclear from the evidence why the police officer obtained warrants for the disclosure of material in this case and it was not addressed in his evidence. However, the department provided no information which would rebut the Detective Inspector's evidence that it is not uncommon for the department to request police obtain warrants before releasing information. I have therefore come to the conclusion that the sharing of information between the department and the QPS should be reviewed and monitored.

SCAN Meetings

883. The SCAN meeting of 15 March 2016 could have been a turning point for Mason.

884. The SCAN team members (except for the department) had provided information which, taken as a whole, would cause any reasonable person to reconsider the decision CSO3 and STL4 had made on 8 March 2016 to return Mason to his mother's care. However, CSO3 and STL1 failed to fulfil their roles in any meaningful way at the SCAN meeting. They had read none of the information the team members provided, could not therefore take that information into account in deciding at the meeting to commence an IPA but made that decision regardless. The department then failed to fulfil the undertaking they gave the other members which was that Mason would be closely monitored and the IPA would be commenced immediately.

885. I find that Mason's case ought not have been closed to SCAN on 12 April 2016.

886. The case was closed to SCAN although there was no information put before the meeting by the department that the recommendations from the previous meeting had been implemented.

887. I find that the department as the lead agency of the SCAN team did not comply with a number of significant requirements of the SCAN Team Systems Manual. The failure was largely that of the department attendees, however, it was also due to the failure of those responsible for resourcing the CCSSC to ensure that the office could provide a SCAN coordinator (even if that person was acting in that role) and an STL and a CSO for each meeting.

888. **I recommend** that the SCAN manual and relevant legislation, policies and procedures be amended to require cases remain open to SCAN until appropriate feedback has been provided to core members and it is agreed that the recommendations have been fulfilled, or if not fulfilled, are no longer appropriate, and that no further recommendations are appropriate.

889. The above recommendation was suggested by Qld Health and is supported by the department.

890. **I recommend** that the SCAN manual and relevant legislation, policies and procedures be amended to mandate that when a SCAN meeting is inquorate, the available members nevertheless hold a case planning discussion about the matters that would have been subject to the meeting.

891. The department agrees with the above recommendation.

The Department

Most Significant Failures

892. Although 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, there are some failures which are so concerning that they require highlighting.

893. This is not to castigate individual staff but to demonstrate the parlous state of the CCSSC at the time of Mason's death and so that others might recognise similar risks if they become aware of them.

- On 7 March 2016 CSO3 told Drs to discharge Mason to the care of Ms Lee – at that time she didn't know Ms Lee's address – when she went to interview Ms Lee that afternoon she had to go to an old address and ask a neighbour where Ms Lee lived.
- On 7 March 2016 CSO3 deemed all four of Mason's siblings safe without sighting or checking on any of them and after conducting an interview with Ms Lee in the presence of Mr O'Sullivan during which she accepted facts which were patently inconsistent with those provided by medical staff – this had detrimental consequences for Mason.
- On 8 March 2016 CSO3 completed and submitted a safety assessment deeming Mason "safe" despite the concerns of his treating doctors and medical staff that he was at risk of severe neglect and despite not seeing him or visiting the home that day.
- CSO3 commenced and completed the I&A and made the decision that Mason could be discharged to the care of Ms Lee without reading the information the department held about the family and without considering the medical records. On her own admission, "it was more about getting out there and … completing initial steps rather than … reading through all that information."
- The ESU found STL4 and CSO3 "did not apply any methodical thought to Mason's immediate and ongoing safety needs, prior, during and after his hospital discharge to his mother's care" – this is obviously the case.
- CSO3 did not advise RAI1 that Mason was discharged from hospital.
- STL1, 2 and 4 shuffled documents requiring assessment and approval between themselves from 8 March 2016 until 2 June 2016 – they could provide no good reason for doing so.
- Mason was not sighted during the home visit on 9 March 2016.
- CSO3 and STL1 made the decision that an IPA would be commenced at the SCAN meeting on 15 March 2016 without any prior discussion or consideration and on the basis that the other representatives wanted an answer as to how the department was going to be involved.
- None of the three STLs who received information from SCAN team members for the meeting on 15 March 2016 sent it to the case worker, CSO3 and she did not access it herself.
- On 18 March 2016 the home visit was cursory (taking five minutes) and insufficient and CSO3 and CSO5 did not ask to see Mason's injuries despite the fact that he could not walk properly. There was no pre-planning or discussion prior to the visit.
- The ESU investigators stated*:*

It is not apparent from departmental records that from this time any departmental officers, sighted him and the injuries to his bottom and leg, remembered him or his name, or determined his whereabouts, care provision or wellbeing during the IPA case, despite the high risk of ongoing harm and his exceptionally vulnerable medical state as a result of neglect.

- CSO3 failed to acknowledge or follow up serious disclosures by Sibling 2 during the interviews on 24 March 2016 – she in fact insistently ignored them and provided information to STL1 for the next scheduled SCAN meeting in which she said that no concerning disclosures had been made by the siblings.
- Mr O'Sullivan's son was never interviewed despite CSO3 being told that Mr O'Sullivan was concerned about what he would say if he was.
- The SCAN meeting scheduled for 29 March 2016 should not have been cancelled – there was no requirement in the SCAN manual for cancellation of an inquorate meeting.
- CSO3 told RAI1 not to attend the SCAN meeting of 12 April 2016.
- On 5 May CSO3 and CSO5 interviewed Ms Lee who said Mason had developed a massive rash on his bottom – despite being aware of his recent serious injuries they did not ask further about this, neither did they ask where he was even though he was not with his mother and he was 21 months old and he was the subject of an IPA which required face to face contact with him.
- The fact that Mason was to attend a follow up appointment at the hospital on 7 June 2016 was known to the department. Mason did not attend. If inquiries had been made by a CSO who asked to see Mason, his bruises and injuries would have been evident. Had he been taken to hospital on that day it is more likely than not that surgery for his abdominal injuries would have saved his life.
- On 8 June when CSO6 and CSO1 saw Ms Lee they didn't ask about Mason or his whereabouts.
- On 9 June 2016 CSO4 and CSO6 were told about serious DV by Ms Lee but did not consider or assess the safety of the children.
- On 9 June when STL3 and STL1 decided to approve the I&A they had no real discussion about it and did not discuss the appropriate level of intervention for Mason.
- On 10 June when CSO6 and CSO4 saw Ms Lee in the street without Mason they didn't ask about his whereabouts or welfare. Had they done so and gone to Mr O'Sullivan's house or requested police to attend, it would have been evident that Mason required hospitalisation.
- Later that afternoon (10 June 2016) CSO6 was told by Ms Lee's neighbour that Mr O'Sullivan was dangerous and violent and was holding Mason hostage but took no action to assess Mason's safety and went home.
- CSO4 was told by CSO6 about the information received from the neighbour and also took no action and didn't consider it any further.
- The department held information that Mr O'Sullivan had a pathological jealousy, had threatened to skin his wife and kill his children when they had separated and that his "homicidal-suicidal ideations" were in the context of a situational crisis, however, in early June when they were told by Ms Lee that she was leaving him, that he was jealous, paranoid, using ice and violent none of them considered that her children might be at risk of harm from him – none of the CSOs or STLs had read the information. This had detrimental consequences for Mason.

- CSOs who accompanied the primary CSOs to home visits and interviews considered that they were only there to take notes and record conversations. Despite this erroneous view (they were CSOs with the same duties as the allocated officer) the notes that they did take were extremely deficient.
- CSO6, who had a Masters degree in social work and had worked with the department since June 2015, had completed most of her training and was being allocated cases, stated she did not know what a CPO was or the difference between that and an IPA at the time of Mason's death.
- CSO6 thought her only job was to check on Ms Lee when she went to see the family and although she saw Ms Lee on three consecutive days during which Ms Lee made very concerning disclosures regarding DV, CSO6 did not make a single case note until after Mason's death.
- CSO6 apparently had no idea of her basic role or even that her job was the protection of children – when asked to do a safety check of the family she thought she was just going there to see if Ms Lee was ok – "*whether [she] was there … and whether she was alright*"
- CSO6 was told Mr O'Sullivan hated Sibling 1 but didn't consider that was a risk to that child.
- On 8 June 2016 CSO6 was told that there was another child (being Mason) but didn't ask where that child was – "*I did not think any more of it then. When she said I have one more, nothing stood out … there was (sic) no questions in my head at that time*".
- CSO6 had "no questions" because she had absolutely no knowledge of the Lee family because she had read none of the information held by the department and asked no questions before going to visit them – she did not even know of the existence of Mason although he was the reason for the IPA that she was told would be allocated to her.
- On 9 June 2016, when she updated STL1 and STL2, CSO6 was still not aware of Mason: *"there was a name, Nathan, on the ICMS and there was Mason. So I don't remember when I discussed it … I'm not sure whether … he was Mason or whether the child was Nathan."*
- On 10 June 2016, after being told by Ms Lee's neighbour that Mr O'Sullivan was holding Mason hostage, CSO6 didn't tell anyone about that information or seek to have police check on Mason and said that the conversation did not indicate to her that Mason was in danger. Incredibly, she told the ESU investigators:

  And I was going home … and there was nothing, no urgency in [the neighbour's] call, she was just returning my call because I'd left a card

  It never crossed my mind that William was looking after Mason. That is what I knew later, that he was with him.

  Otherwise .. there was nothing indicating that the child was being neglected from conversations I had with the mum and … whatever information I had about the partner … [Ms Lee] said things like he is only violent when he is on ice, otherwise he's really good, I still love him and he loves me.

- When asked if she had failed to protect Mason, CSO6 failed to show any understanding of her role even after Mason's death and answered, "I can't say yes to that …. I did my best."

Failure to Sight Mason

894. Under the CSPM the IPA required that Mason be seen face to face four times per month and have four support contacts i.e. between 15 March and 11 June 2016 he should have been seen face to face 12 times and had 12 support contacts.

895. In fact, he was seen once, on 18 March 2016, for about five minutes, at the front door of Ms Lee's house. CSO3 and CSO5 saw that he was walking awkwardly but didn't ask to check his injuries.

896. Had anyone from the department seen Mason in the weeks before his death they could have saved his life. Had it been known that he was living with Mr O'Sullivan, and had Mr O'Sullivan's history be considered, he should have been removed from the care of his mother and Mr O'Sullivan. Had he been seen in mid-May it would have been obvious, as it was to Ms S, that he was again being neglected due to the state of his "nappy rash" which she could see even when he was wearing a nappy.

897. Had CSOs asked where Mason was and insisted on sighting him at any time in April, May or June 2016 they would have discovered he was at Mr O'Sullivan's residence and should have thereafter made more investigations in relation to Mr O'Sullivan. Had they done so one can only conclude Mason would have been removed from Ms Lee's care.

898. Had CSOs seen Mason after 6 June 2019 he would have been taken to hospital and his life may have been saved.

899. Had Mason been taken to the Caboolture Outpatients' Clinic as scheduled on 7 June 2016 he would have been treated appropriately, including admission to hospital and surgery and he would have had good prospects of survival.

900. Every CSO and STL involved in Mason's case was more concerned about Ms Lee and her issues than ensuring the safety of Mason and his siblings. Whilst it is accepted that supporting families is a recognised and successful method of keeping children with their parents and out of the child protection system, that consideration cannot override the primary consideration of protecting vulnerable children. In this case supporting Ms Lee continued to be the main focus long after it became evident that Mason was at serious risk of harm and long after proper investigations would have revealed that he was not in the care of the person that all resources were going to support i.e. Ms Lee.

901. The department accepts that there was an obvious failure to sight Mason as required and that this is a fundamental requirement of child protection.

902. However, I make no recommendations about this issue given that:

    a. Sighting of the child has always been a fundamental part of child protection and a requirement of which all CSOs should be aware; and,
    b. The department submits that failure to sight children has been addressed by the department by the introduction of the CS Portal – a predictive planning tool that shows a CSO's case load and the dates for required home visits and whether they have been undertaken which can be viewed by an STL who should follow up on the omission.

Failure to Comply with Policies and Procedures

903. I conclude that the department failed in its duty to protect Mason from the risk of serious harm that he faced in the months prior to his death. Indeed, it is difficult to find any step taken in this case that was carried out in accordance with policies and procedures and correctly documented. The fact that the ESU found that 21 employees of the department involved in Mason's case (10 at CCSSC and a further 11 employees involved in intakes) failed to carry out their duties appropriately is indicative of the scale of the failure.

Lack of Oversight in CCSSC

904. I find that there was a lack of appropriate management in the CCSSC in the months preceding Mason's death.

905. None of the CSOs conducted an appropriate investigation, none of them took the time to look at the information held by the department, they did not submit information to SCAN or look at information from SCAN, they did not appropriately consider information provided by the hospital, they failed to make case notes and they submitted inadequate documents for approval. However, none of the team leaders or Manager 1 took any steps to ensure that the CSOs were dealing with Mason's case appropriately.

906. Whilst Manager 1 might have been liked by a number of the staff on a personal level she was not undertaking her managerial duties in an adequate or appropriate manner. The CCSSC was chaotic. There was no supervision. There was no compliance with basic procedures and policies. Nobody understood how the matrix model was working (including Manager 2). STLs were conducting the work of CSOs rather than supervising them. I can only infer that either Manager 1 was unaware of the fundamental failures that were occurring in the office she was responsible for managing or that she knew of the issues and ignored them. In either event she was not undertaking her managerial duties.

907. I do not accept that Manager 1 was unaware of the issues surrounding STL4 until early April 2016. I find that she was aware of the problem at least one year before that but did not deal with it even though it was significantly affecting the service delivery of the CCSSC.

908. Manager 2 and the Acting Manager identified numerous issues of significant concern shortly after each commenced in CCSSC and then took steps to remedy those issues. These included the confusion surrounding the matrix model, the lack of process for allocation of cases and the fact that STLs were conducting case work rather than supervising.

909. The ESU concluded that all of the CSOs involved in Mason's case were accountable for their actions and omissions and all the STLs were accountable for their lack of supervision but inexplicably Manager 1, who was ultimately responsible for overseeing them all, was found not to be accountable in any way for the litany of failures that occurred under her management.

910. I find that Manager 1 failed to appropriately manage the CCSSC between 9 December 2015 and 11 June 2016.

911. 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.

Changes since Mason's Death

912. Numerous changes have been made since Mason's death. Those changes are set out in the information provided to the inquest by Dr Crawford, the Executive Director of Child and Family Operations and Ms Smith, the Regional Director responsible for the CCSSC and explained further in the department's submissions.

913. The scale of changes which have been implemented, and are to be implemented, are demonstrated by the fact that Dr Crawford's first statement comprises 65 pages and 117 annexures.

914. It is said that Doctor Whittaker's recommendations are largely being implemented by the department.

915. It is also said that the recommendations arising out of the Systems and Practice Review, the Child Death Case Review and the ESU report have been implemented.

916. Some employees involved with Mason's case have left the department, been disciplined or reprimanded.

917. Staff at CCSSC have received further training.

918. Extra resourcing has been allocated to the CCSSC.

919. The SCAN team processes were reviewed in November 2016. A new manual was published in November 2019. The Moreton Region now has dedicated SCAN team coordinators and administration officers and meetings occur fortnightly. A new system for sharing SCAN information, IDOCS, has been implemented.

920. A new portal has been developed to provide users in CCSSC with immediate access to SCAN information including criminal histories and domestic violence information.

921. The IFS service provision no longer has to cease upon commencement of an IPA so that external support workers can continue to support a family requiring ongoing statutory intervention.

922. A new supervision framework has been implemented which requires mandatory, documented, regular formal supervision of CSOs by STLs and of STLs by Managers.

923. There has been a restructure of caseloads in the Moreton region.

924. In August 2017 an additional CSSC was created in the Moreton region which took over a significant portion of the CCSSC.

925. Since 2015 there has been additional funding for over 450 frontline and serviced delivery support positions and a further 116 positions to be progressively rolled out over three years from 2019.

926. A state-wide strategy is being developed to improve assessments and responses to domestic violence in child protection matters.

927. The "Safe and Together" model has been implemented which provides explicit training to address parental deception and disguised compliance (as identified in this case by Dr Whittaker).

Child Protection Complexities and Demands

General Considerations

928. The errors and failings of the individual employees of the department were merely the component parts of the collective failure of the department.

929. The failings occurred in a context complicated by issues of mental health, domestic violence, drug and alcohol abuse, homelessness, poor socio-economic status – all of these issues were present for Mason's family.

930. Families that come into contact with the department are typically becoming increasingly complex, with significant needs across multiple disciplines. Sadly, Mason's family situation was not unusual. Statistics collated in November 2019 in relation to families involved with the department demonstrate:

    a. 66% of households substantiated for harm or risk of harm to a child had a parent with a current or past drug and/or alcohol problem;
    b. 50% of families had been impacted by domestic and family violence in the past year;
    c. 42% had a parent who had been abused as a child;
    d. 53% had a parent with a criminal history;
    e. 53% had a parent with a diagnosed mental illness;
    f. 74% of households had a combination of these factors.

931. Every one of these factors was present for Mason's family.

Increased Demand on the Department

932. Funding for child protection is constantly increasing.

933. Methamphetamine use by one or more parents continues to be recorded for approximately one in three children subject to ongoing intervention which has required additional resources.

934. It is becoming more difficult for the department to recruit staff. In 2016 there were 1343 applications for CSO positions – in 2019 there were just 692.

935. The department cannot retain staff. Almost one fifth of CSOs left the department in 2018 – 2019. The high turnover creates a difficulty in regard to the retention of knowledge.

936. I find that the department has high percentage of inexperienced staff who are constantly having to deal with new models, policies, procedures and training modules as the department implements numerous recommendations arising from the many reviews of unfavourable outcomes for children in its care.

Removing Children from the System

937. Despite successive governments providing ever increasing amounts of funding for the child protection system and the government's continuing attempts to improve the system, it continues to be overwhelmed by an increasing number of children being introduced to it. The reasons for this are not within the scope of this inquest but, as acknowledged by the department, include the ice epidemic which has been the scourge of our community and our families for some years and shows no signs of abating.

938. The recommendations resulting from the Carmody Inquiry included recommendations designed to remove children from the system. That has not occurred.

939. As was fully explored and accepted by the Carmody Inquiry, adoption is a method of removing children from the system. Further it recognises the child's rights to be protected above those of parents who are unwilling and/or unable to appropriately care for those children.

940. The emphasis for child safety in Queensland, demonstrated by this case and acknowledged by the ESU, is maintaining family unification or re-unification. That is a philosophy which is oriented towards parents' rights to family rather than a child's unquestionable right to be safe.

941. The Carmody Inquiry report stated:

> *The Commission recognises that adoption may be a suitable permanency option for some children in out-of-home care and should be pursued in those cases, particularly for children aged under 3 years. As such, adoption should be routinely and genuinely considered by Child Safety officers as one of the permanency options open to them when deciding where to place a child in out-of-home care. Given the polarising nature of this placement option for children in out-of-home care, careful consideration must be made before selecting this option. An experienced and judicious approach must be applied to the balance between family preservation and adoption. The Commission acknowledges that adoption within child protection is a contentious issue in Australia; however, while family preservation remains the preferred policy approach, adoption will remain as one option in a suite of permanency options.*

942. Publicly available expert evidence given before the Carmody Inquiry explains the reference to under three years of age in the quote above. In short, well respected medical specialists such as Dr Elizabeth Hoehn and Professor Stephen Stathis gave evidence that a child's first two to three years are formative for developing secure attachments, healthy development and solid neural pathways:

> *MS McMILLAN: And the fact that they may then have children with that cycle continuing?-*

--That's right, yes.

Can I just ask you just in terms of those issues, I take it you know Dr Elizabeth Hoehn?---

I do.

All right. Now, in her statement she talks about "Extensive research" -this is page 5 for anyone who wants to follow it – has demonstrated the importance of the early years of a child's life, especially the first three years in laying the foundation for healthy development and resilience. The brain changes throughout life but it's in the changes in the first three years of life that will have the greatest impact on expressing the brain's potential.

Are you aware of that extensive research?---Very well.

Is it, in your view, fairly much accepted within the psychiatric world that that's correct?---

Absolutely; no question.

All right. She says later, amongst many other things:

Crucial pathways needed for neuropsychological processes such as attention, learning, memory, recognising and regulating emotions, impulse control and speech
and language develop during these first three years?

---Yes, I'm aware of two really important studies, if you don't mind me elaborating.

COMMISSIONER: No, please?---

The first is the Bucharest Early Intervention Project which is now over 10 years old and what they did is they actually took children who were in institutions in Romania and put them into foster placement and they - but it's different from the foster placements we have here. They trained these foster mums up. They paid their foster mums a good wage. It's a European model. These kids were taken and placed in the foster placements. Now, they did it randomly which sounds like an ethical dilemma but the reason they could do that is Romania had no foster placement ethos anyway so they came in and said, "We've got this amount of money. We can't look after all kids but we can randomly assign children," and they assigned them from birth onward and this is what they found. They've followed these children up. This is good foster placement. If the children were placed in foster care before the age of two, they had significant improvements in IQ; in a whole range of mental health issues. EEG changes showed that their brain was recovering, so to speak. After the age of two no change; didn't matter; good foster parents, good foster mums, good foster dads; didn't matter.

Irreversible?---Irreversible, and they've continued that study on. Because now it's a longitudinal study, we're getting increasing evidence that this is the case. You've got two years. You've got two years. Dr Hoehn said three. I respect Dr Hoehn, but from the Bucharest study you've got two years. If you don't act within two years, the door's closed.

All right, so if we can give them a protective, developmentally friendly environment up till three can they withstand a different environment, much more coercive, intrusive, traumatic, for longer as a result of the benefits that they had pre three?---Their brains and themselves by definition therefore have a greater capacity for resilience. …
…

If we do that until they're three they've got more of a chance of surviving what else comes?-

--Yes. Well, if we do that by three we're giving the brain a better chance, a better opportunity, to develop normally.

943. Professor Stathis also noted:

if it [support for parents] does not work the child needs to be taken and permanently placed elsewhere. That's my view.

COMMISSIONER: How long will you give it to work?

---We've got two years, three years, based – if you want the evidence, three years based on the evidence. You don't have a long time, okay.

Okay?

---I mean, you could have permanent placement later of course, but I'm talking about children who are identified at birth?--- At birth or soon after.

Soon after?---Okay.

Yes?
---But for that to work as well that second plank has to have foster parents who also have been trained and educated up and they see it as a vocation and they're paid well too. They're given one, two, three kids, a few kids, and this is their family. I don't care whether you call it adoption or permanent placement or whatever. This is their family until 18 or beyond, okay. This is their family. That's the second plank, but there's a third plank, and the third plank is we can't forget the mums, or often it's the girls, whose kids have been taken from them, because I've worked in a detention centre. These children, and I'll use the word "children" - - -

Children - - -?

--- - - - who are having children - - -

Child parents?

---Yes. They want the child. They will say they want the child because they want someone to love them. That's the irony. They want the child to love them, and it's because they've never been loved. "So I'll have a child and they can love me." Now, if all you do is take that child from them and you stigmatise them and you crush them, they're just going to have another child.

To replace the love that they didn't get from the first one?

---To replace – because that's the only way they've found love. So the child who's having the children has to be nurtured themselves so we can't forget the third plank because if you leave out the third plank, you're just going to have them having more and more children. That's not child's best interests and it's not in the child's child's best interests either.

944. The Queensland Government has recognised that adoption ought be an option in accepting Recommendation 7.4 from the Carmody Inquiry:

The Department of Communities, Child Safety and Disability Services routinely consider and pursue adoption (particularly for children aged under 3 years) in cases where reunification is no longer a feasible case-plan goal.

945. Although it is the position of the department that the recommendation in regard to adoption has been implemented by the department it is obvious that it in fact has not been implemented in any real sense. From 2013 to 2019 a tiny handful of children have been adopted from out of home care. Thirty-two permanent care orders have been made since October 2018.

946. However, as at 17 March 2020, 6,795 children were subject to Long Term Guardianship Orders i.e. under the care of the department until they turn 18 years of age on the basis that they have no parent willing and able to care for them and they will not in the foreseeable future.

947. The New South Wales current position is briefly summarised as:

Every child and young person deserves the chance to have a permanent home for life where they can feel loved and secure. Under the Permanency Support Program introduced in October 2017, a child or young person will have a case plan with a goal to have a safe and permanent home within 2 years of entering care. Where returning to their birth family or guardianship to a relative, kin or other suitable person is not practicable or in the best interests of the child or young person, open adoption will be considered.

In the case of an Aboriginal or Torres Strait Islander child or young person placements should be in accordance with Aboriginal and Torres Strait Islander Child and Young Person Placement Principles in the Children and Young Persons (Care and Protection) Act 1998.

948. The department submits that these findings should not comment on adoption of children as it was not an issue to be explored at this inquest and was not in fact explored at the inquest.

949. I disagree with that submission. The main issue to be explored at the inquest and the task I am bound to undertake is the identification of ways of preventing similar deaths in future.

950. The department submits that the failures which led to Mason's death were the result of overworked, under-resourced and inexperienced staff which is the result of an increased demand for services i.e. an ever increasing number of children requiring protection.

951. Although the issue of adoption was not explored at the inquest, it was fully explored by the Carmody Inquiry and the department has given evidence that

Recommendation 7.4 from the Carmody Inquiry, which was accepted by the Government, has been implemented.

952. The numbers of children on long term orders as compared to those on permanency orders or those who have been adopted reveals that the Carmody recommendation has not been implemented in any real sense. I therefore conclude that a recommendation is appropriate.

953. **I recommend** that:

(a) The department review its policies and procedures to ensure that, in accordance with the Government's acceptance of Recommendation 7.4 of the Carmody Inquiry:
   i. adoption is routinely and genuinely considered as a suitable permanency option for children in out-of-home care where re-unification or unification is unlikely, and should be pursued in those cases, particularly for children aged under 3 years.
   ii. Adoption is routinely and genuinely considered by Child Safety officers as one of the permanency options open to them when deciding where to place a child in out of home care.

(b) The Government consider whether the *Adoption Act 2009* (Qld) should similarly reflect the 2018 amendments to the *Adoption Act 2000* (NSW), expecting children to be permanently placed through out of home adoptions within 24 months of entering the department's care.

(c) The department report to the Coroners Court of Queensland the numbers of children adopted and the details of those matters, every six months for the next five years.

Findings required by s. 45

Identity of the deceased – Mason Jet Lee

How he died – Mason died due to abdominal injuries inflicted by Mr O'Sullivan and the subsequent failure of Mr O'Sullivan and Ms Lee to obtain medical treatment for him.

Place of death – 20 Deanne Court, Caboolture, Queensland

Date of death– 11 June 2016

Cause of death – Abdominal injuries

954. I close the inquest.

Jane Bentley
Deputy State Coroner
BRISBANE

2 June 2020

APPENDIX ONE

A&O – Assessment and Outcome (completed as part of an I&A)

CCR – Child Concern Report (decision is that child is not a CINOP and matter not investigated further)

CCSSC - Caboolture Child Safety Service Centre

CINOP – child in need of protection

CPIU - Child Protection and Investigation Unit of the Queensland Police Service

CPLO – Senior Social Worker, Child Protection Unit, Caboolture Hospital

CPO – Child Protection Order

CSO – Child Safety Officer, Department of Child Safety, Youth and Women

CSPM – Child Safety Practice Manual

CSSC – Child Safety Service Centre

DV – domestic and family violence

DVO – domestic violence order under the *Domestic and Family Violence Protection Act* 2012

FRE – Family Risk Evaluation (completed as part of an I&A)

HM – the house mate of Mr O'Sullivan

I&A – Investigation and Assessment

IFS - Intensive Family Support (IFS) Program

IFSP – Intensive Family Support Practitioner who is employed by an RAI

IPA – Intervention with Parental Agreement

LCCH – Lady Cilento Childrens Hospital

Manager - Manager, Department of Child Safety, Youth and Women

Ms S – the girlfriend of HM

NRIS – North Coast Regional Intake Service of the department

PCPP – Principal child protection practitioner

RAI – Referral for Active Intervention Program

RAI1 – Social worker employed by Mission Australia (as the RAI) and allocated the case of Ms Lee

RTF – Response Time Frame

SCAN – Suspected Child Abuse Network

STL – Senior Team Leader, Department of Child Safety, Youth and Women

The Carmody Inquiry – Queensland Child Protection Commission of Inquiry which was established on 1 July 2012 led by the Honourable Tim Carmody, QC and the final report of which was released in June 2013

The department – Department of Child Safety, Youth and Women