REVIEW OF INVESTIGATION

AND PROSECUTION OF

TOWNSVILLE GYMNASTICS ASSOCIATION INC.

CONCERNING THE DEATH OF

MICHELLE MAITLAND

MICHAEL J. BYRNE Q.C.

INTRODUCTION

By letter dated 1 February 2011, the Director-General of the Department of Justice and the Attorney-General engaged my services to conduct an independent review of an investigation and subsequent prosecution undertaken by Workplace Health and Safety Queensland (WHSQ) in relation to the death of Ms Michelle Maitland ('Ms Maitland') at Townsville Gymnastics.

BACKGROUND

On 18 June 2009 Ms Maitland was participating in a recreational gym class at the gymnasium operated by Townsville Gymnastics Association Inc. At approximately 8:15pm she had been participating in an activity on the 'tumble tramp'. Ms Maitland had performed a gymnastic manoeuvre called 'round-offs', at the end of which she somersaulted and landed on the 'crash mats' and then fell onto an area beyond the mats, being a concrete surface. As a result Ms Maitland suffered head injuries and died the following morning, 19 June. It seems that Ann Maitland (Michelle's Mother) contacted the police at approximately 7:30am that morning and they in turn contacted WHSQ. Subsequently, at 8am, 'Inspector A' an inspector from WHSQ, received a call from his Regional Director who detailed him to meet with officers from the Queensland Police Service ("QPS") at the gymnasium. Shortly after 'Inspector A' attended at the gymnasium and took up with the officers.

Upon attendance, gym employees were engaged in cleaning the relevant area of the gym; they were directed to restore the site to the configuration it had been in at the time of the fatal incident. Photographs were taken. No strict measurements of the scene seem to have been taken at that time.

On 17 September 2009 an interview was conducted with 'Person B', of Townville Gymnastics Inc by 'Inspector A' and 'Inspector B', another WHSQ inspector. Thereafter, the ongoing investigation was case managed, both formally and informally, by 'Inspector C', and the legal officer responsible for the region, 'Legal Officer A', who conducted the prosecution.

A Complaint was issued on 9 February 2010 alleging that Townsville Gymnastics Association Inc failed to discharge its obligation under section 24 of the *Workplace Health and Safety Act 1995*.

The defendant company pleaded not guilty and a trial was held. On 1 October 2010 the Industrial Magistrate delivered his reasons and convicted the company. A fine of $70,000 was imposed.

An appeal against the decision taken to the Industrial Court was dismissed on 22 March 2011.

REVIEW

On 7 April 2011, I spoke at length with Ann Maitland, in the presence of 'Person A', a person with a gymnastics background who had made contact with Ann Maitland following media coverage of the death of Ms Maitland. Ann Maitland provided

detailed information, produced a series of documents and referred me to a range of further relevant information from various sources. Subsequently, Ann Maitland has forwarded further information to me by email.

On 8 April 2011 I interviewed the WHSQ inspectors involved in the investigation of this matter, ‘Inspector A’ and ‘Inspector B’, and ‘Inspector C’.

On 14 April 2011, I interviewed ‘Legal Officer A’, who prosecuted the matter before the Industrial Magistrate, Townsville and ‘Legal Officer B’, the officer in charge of the Legal Unit at WH&S.

I have considered the relevant legislation, law, policies, procedures and guidelines (See Appendix A).

I have read the investigation report, transcript of the trial and the appeal decision.

Ann Maitland’s concerns

Ann Maitland’s desired outcome, as expressed to me, is that Townsville Gymnastics Inc, or one of its officers, be charged with the homicide of her daughter.

She has raised in her report tabled in Parliament, and with me, numerous specific concerns in relation to the investigation, the prosecution and the WHSQ process, including the perceived lack of communication with her.

I note that the WHSQ is largely aware of Ann Maitland’s concerns from her previous communications with the department and the tabled report.

In brief those concerns are:

- the lack of a ‘genuine’ or impartial investigation, particularised, among other things, by a failure to:
    - conduct a timely investigation, including interviewing witnesses months after the incident,
    - discover important evidence, including other eye witnesses and the existence of a previous relevant incident,
    - secure the scene of the incident and accurately record details such as specific measurements,
    - identify or recognise industry coaching or equipment norms,
    - gain familiarity with the relevant physics and biomechanics or industry terms and expressions, and
    - obtain and use independent experts, and
    - the lack of communication with herself and other family members.

In relation to the prosecution, Ann Maitland's position is that the account given to the court about the incident was false, on the basis that no opinion given by an independent expert gymnastic would have supported it. Ann Matiland's concerns have been exacerbated by the fact that 'Witness A', who was the expert, and only eye witness, relied upon by the prosecution was not independent, he at the time having been associated with and / or employed by Townsville Gymnastics Associations Inc for many years and, as the person coaching the recreational class, being potentially liable.

Ann Maitland has provided various other pieces of information, which support her assertions about these matters. Some of these are referred to below. These also include statements from two eye witnesses, taken within days of the incident, who were not called to give evidence at the trial and who did not support the version given by 'Witness A'. These versions are referred to below.

Ann Maitland is particularly disturbed about what she considers to be fictions in relation to the circumstances of the fatal injury occasioned to her daughter that were allowed to be put before the court, uncontested. These fictions include that her daughter was suicidal, that she was a senior level competitive gymnast, and that there were no previous relevant incidents.

In addition Ann Maitland perceives a lack of impartiality on the part of the investigation – by the failure to identify independent witnesses – and of WHSQ, because of the failure to pursue Townsville Gymnastic Inc for other perceived breaches, such as failure to notify the department of the incident.

Finally, Ann Maitland is concerned about the absence of any attention by WHSQ to the gymnastics industry prior to her daughter's death.

For Ann Maitland the issues also seem to be the question of public confidence in the workplace health and safety regime and that 'it is a matter of public safety' that the realities, as she sees them, are clarified.

SUMMARY OF RELEVANT INFORMATION

THE WHSQ INVESTIGATION

In brief, the investigation principally involved the initial attendance at the scene on 19 June 2009 - at which photographs[1] of the scene, were taken; a record of interview with 'Person B', Townville Gymnastics Inc on 17 September 2009; the taking of measurements (recorded in the inspector's notebook at approximates because of the difficulty with the material of precision) of 'the existing situation; and what was done

[1] Industrial Magistrates Court Transcript of proceedings at p 19 in referring to the photographs being shown to the court, the prosecutor says: 'Your Honour, if I could apologise for 'Inspector A'. He obviously isn't a proficient photographer. They're very dark.
It is not entirely clear from the material when these photographs were taken and by whom. 'Inspector B' also took photographs. It is also noted that QPS Scenes of Crime took photographs but they were – except for one – not used.

to comply with the prohibition notice'[2]; and the taking of further photographs also on 17 September 2009 ; the taking of a statement taken from 'Witness A', who was called as the only eye witness and solely relied upon to give expert evidence even though employed by Townsville Gymnastics Inc.; interviews with other witnesses about the demeanour of Ms Maitland prior to the fatal incident; and it seems some attempts to locate other possible eye witnesses and expert evidence.

In the course of his interview, 'Person B' was asked to supply to 'Inspector A' a copy of the handbook containing apparatus and matting specifications apparently utilized by Townsville Gymnastics Inc. Despite several attempts made by 'Inspector A' to obtain a copy, that document, if it existed, was never supplied to WHSQ. In addition, a prohibition notice, prohibiting use of the 'tumble tramp' until a risk assessment was done in relation to the fatality was completed. No such risk assessment was received by WH&S, though an inspection revealed that the prohibition notice had been satisfactorily complied with by the addition of further mats.

THE PROSECUTION CASE

The prosecution proceeded on the basis that the obligations imposed upon the defendant pursuant to sections 24 and 28 of the Act are absolute; the source of the risk was the concrete floor and / or the failure to provide adequate protective covering *etc*; Ms Maitland was completing a gymnastic routine (part of the business or undertaking of the workplace) and as a consequence of over-rotating and performing a rebound came into contact with the concrete floor and suffered a head injury which resulted in her death.

In their submission the prosecution relied upon a number of relevant cases, including: *Neilands v CMC Cairns Pty Ltd (2001) 168 QGIG 132* in which the Industrial Court stated:

> '… It is a purpose of the Workplace Health and Safety Act 1995 and the statutory instruments made thereunder to secure the safety within the workplace of workers who are fatigued, who are over confident of their skills and physical powers, and who are inattentive in consequence of repetitive tasks or who are simply careless of their own safety …'.

Watson v AJC Electrical Service Pty Ltd (2004) 175 QGIG 574 in which the Industrial Court stated:

> ' … The obligations verge on the absolute. … To take a simple example, … an employer has an obligation to ensure the workplace health and safety of each of the employer's workers at work. … workplace health and safety is ensured when persons are free from:
>
> (a) "death, injury or illness caused by any workplace, workplace activities or …; and
>
> (b) risk of death, injury or illness created by any workplace …"

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2 Transcript at p 5.

It follows that where a worker is injured at a workplace the workplace is not a workplace whereat safety was ensured and the employer is in breach of the obligation.'

Bowpark Pty Ltd v David Gordon Williams (2003) 174 QGIG 531 at 532 in which the Industrial Court held:

"…..

It seems to me that it follows … that where (as here) death occurred, one could not say of … {the} workers that their workplace health and safety was "ensured'.

…..

Though the obligation cast by {the section} is absolute, liability is not absolute.

…

It would be startling if an employer doing what {the section} requires an employer to do were to be found guilty of failing to ensure the workplace health and safety of the employer's workers … because death, grievous bodily harm or bodily harm had occurred. …

In evidence, the prosecution relied upon 'Witness A', as the sole eye witness and expert, to explain how Ms Maitland came in contact with the floor.

'Witness A' said in his statement to WH&S:

'Her landing position was over rotated resulting in her body position angled backwards slightly. I would estimate this angle to be about 20 – 30 degrees. From this position I saw her rebound from the mat. By rebound I mean a tight body push from the surface of the mat. This caused her to spring backwards through the air at about slightly lower than hip height or to term it another way about a metre from the surface of the mat. I saw that her body was curved in what I would term a dish shape which gymistisists {sic} including Michelle know is the strongest body control position. The rebound has caused her to land with the upper part of her body off the mat.'

In cross-examination, 'Witness A' gave evidence that Ms Maitland acted in a way 'contrary to the normal training' and, rather than collapsing into the mat, rebounded, and this was unpredictable. 'Witness B', a gymnastics coach employed by Townsville Gymnastics Inc., who did not see the incident, in response to a question for the prosecution about the suggestion that Ms Maitland had over rotated and rebounded,

used the term ‘rebound’ but related it to the amount of power generated from the gymnastic manoeuvres leading up to the landing, not a voluntary act by Ms Maitland.

Evidence was also led by the prosecution about Ms Maitland having been affected by the consumption of cannabis.

The prosecution submitted that once it had proved that:

- the Defendant was conducting the class attended by Michelle which was a business or undertaking within the meaning of the Act;
- Michelle was using the tumble tramp to practice gymnastic routines,
- the Defendant had provided and set up the mats in the landing zone,
- the Defendant’s employee ‘Witness A” was supervising the activity;
- Michelle was an ‘other person’ for the purposes of the Act;
- on the relevant date the Defendant provided the facilities for Michelle to attend the class; and
- ‘On 18 June 2009, Michelle Maitland landed off balance on the landing mat after doing the routine and over rotated then rebounded so that her head struck the unprotected flooring and she suffered fatal injuries’.

The Complainant had proved enough, and that the Defendant had failed to discharge its onus of proof and further:

- the Defendant allowed Michelle ‘to use the tumble tramp and the associated landing mats that were of a length that if a gymnast over rotated and rebounded they were exposed to the risk of striking their head on the flooring’;
- by incompletely positioning the mats in the landing area the Defendant exposed gymnasts to the hazard of the exposed floor;
- it is not relevant that it was unforeseeable or remote that a gymnast would have to rebound to be exposed to the risk – it is of importance that ‘Witness A’ said it was possible;
- the Defendant has the obligation to ensure the safety of its workers even if they are careless of their own safety;
- the Defendant had failed to properly assess the risk of the concrete flooring and did not comply with the relevant section of the Act and the Advisory Standard in respect of the management of risk.

The prosecution noted that ‘the Complainant does not have to prove how the incident occurred; it has to prove exposure to risk which resulted in death’ and that ‘it is mere exposure to risk that is the primary offence’. Further, that ‘the Defence, in

concentrating on how the incident occurred and the deceased's culpability, is misconstruing the law'.

The defence relied upon the defences under section 37 of the Act – namely that it chose any appropriate way and took reasonable precautions and exercised proper diligence to prevent the contravention; or that the commission of the offence was due to causes over which the defendant had no control.

The defence led similar evidence to that of the prosecution in relation to the actions of Ms Maitland being 'well and truly outside the normal course of use of a trumble track {sic}', as well as evidence that her psychiatric records referenced episodes of self-harm.

There are a number of examples of good cross-examination of defence witnesses by the prosecutor highlighting the key issues; e.g. in relation to the risk of the concrete floor in the questioning of 'Person B' culminating in: '*You wouldn't perform it because the hazard there, which is the green concrete floor, and the risk is that some part of their body might hit that and cause injury? - - Sure'*.

The cross examination also alluded to the fact that it was unlikely that Ms Maitland had performed a rebound, putting to the witnesses that the 'mats' were 'inertia mats' designed to absorb kinetic energy.

INFORMATION SUPPLIED BY MICHELLE'S MOTHER

I have not outlined in my report all the information provided by Ann Maitland, but have drawn upon some of the more pertinent excerpts, which outline the basis for her concerns.

Re: 'Witness A's' evidence

Ann Maitland contends that the case proceeded on an erroneous basis, largely as a result of the prosecution relying upon 'Witness A'. She provided information to support her view, including statements of the following eye witnesses.

Statement of 'Person D'

'Person D' says in her statement dated 20 June 2009 that she and Michelle were doing rows of tumbles on the tramp; she went first then Michelle went. Further:

> 'So he ('Witness A') turned around to watch the people on floor and Michelle went again. This time she didn't stop after her Round Off, Flick, Layout, she went straight into the full twist layout and connected it together. When she took off she was leaning way to {sic} far back, and when she actually started twisting, she should of at least been half way through the twist, if she performed the skill correctly.

> She ended up landing it on her feet but with bent legs and leaning really quite forwards, with the power and force behind her, it pushed her back, and as she landed at the end of the three metre long dismount mat, she propelled back she went head first into the green floor.'

Statement of 'Person C'

"Person C' says in her statement dated 22 June 2009 that she had arrived at the gym early for cheer leading training and had been watching Michelle because she was so talented. Further:

> 'At approximately 8:15pm the incident happened. Michelle started right at the end of the long tramp (which she had done several times already that night) and completed three flips (I think a round off then two back handsprings) before launching from the end of the trampoline to complete her final flip. I think this was more of a layout with a twist. Michelle had up a lot of momentum, sprung from the very end of the tramp and overshot her landing. Her feet landed on the large yellow mat, say 50 cm from the end, but she had such momentum that they just touched enough to send her head towards the ground. She did not have time to put hands down and landed directly on the right side of her head.
>
> At the time of the incident, the male instructor "'Witness A' was only 3 or so metres away but I'm not sure if he was looking at her. I think that he was watching some other participants on the floor and had his back to her – but I couldn't be positive that he didn't turn around when he heard her tumbling behind him as I was watching Michelle, not him.'

Re: Other alleged 'fictions'

Ann Maitland asserts that Michelle was not a highly trained athlete, having not been actively involved in gymnastics for some 7 years before taking it up recreationally shortly before the incident, and having not received training in the use of the apparatus and in the manoeuvres she was performing at the time of the incident.

Ann Maitland also points out that contrary to the submissions and evidence accepted by the courts – for example President Hall's comment that: "In saying that I acknowledge the submissions and the evidence that disclosed that the tumble track had been used by the defendant without incident for over fourteen years"; – in fact Townsville Gymnastics Inc had only owned and used the tumbling trampoline for one year at the time of Michelle's death, as disclosed by the statement made by 'Witness A' to the police and, further there had been an incident involving a young woman which was recorded in the Accident Report Book.

Ann Maitland points to information that supports her assertion that the landing mats are utilised absorb kinetic energy and that it would not have been possible to 'rebound' in the way claimed by 'Witness A'. Rather she says that the available information reveals that it was the speed and force of Michelle's momentum from over-rotating that propelled her on to the concrete floor.

She also notes that 'the tumbling tramp manufacturer's own safety guidelines were not presented to the Magistrate'.

Other matters

Ann Maitland says she brought to the attention of the investigation the existence of the two eye witnesses mentioned above, without success. Despite drawing the attention of the investigation to issues of concern for the prosecution, prior to proceedings commencing, no-one sought further information from Ann Maitland or, apparently, anyone else.

Ann Maitland sent numerous emails to WHSQ, and received limited responses. (I have seen a number dated both prior and subsequent to the original hearing.)

INFORMATION GATHERED FROM INTERVIEWS WITH WHSQ INSPECTORS

'Inspector A'

'Inspector A' outlined his role in the matter. He was detailed to meet with the police at the gym. He did so and took 'a quick look around'; spoke to a woman who was cleaning up and told her to reinstate the scene. Scenes of Crime officers took photographs and took measurements. He said that they 'guessed' the measurements at that time, but at a later time WHSQ went back to take further measurements.

'Inspector A' says, as a result of checking industry 'norms' after speaking with the Australian Institute of Sports and the International Federation of Gymnastics, he spoke to a person in Italy 'who couldn't shed any light on it'. He issued a prohibition notice and asked 'Person B' for relevant documents, which were never supplied.

'Inspector A' also explained the case management process and the stipulated timelines. He noted that his visit to Ann Maitland was at the direction of 'Legal Officer A' – this related to the medical file sought by the defence.

In relation to some of the issues of concern to Ann Maitland, 'Inspector A' said the following.

- The term 'rebound' came from 'Witness A'. He ('Inspector A') spoke to AIS about 'Witness A's' qualifications and they advised that he had to be a level 1 coach and also do a salto workshop[3]. He had seen on TV that people go backwards and do a little hop. He accepts that there was a probable over balance at the end of Michelle's routine.

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[3] In this regard I note that Gymnastics Queensland's website contains notes that include the Level One Coach – Salto Workshop does not cover dismounts from apparatus in hung or piked /stretched salto shapes and that the use of trampolines as key teaching tools required a Level Two qualification.

- He did not know about the earlier incident.

- 'Witness A' was relied upon and no other expert opinion was obtained as 'it seemed straightforward'.

- He had no knowledge of Ann Maitland's claim against Townsville Gymnastics Inc and hence of the existence of the relevant documents such as the eye-witness statements.

- There was no bias as they 'had to call 'Witness A' as he was an eye witness and 'Witness B' as she was in charge that night'.

- He 'didn't say to Ann Maitland that the investigation had nothing to do with her as her daughter was over 18'.

- Taking a victim impact statement is not part of the WHSQ procedure.

- He noted that before the establishment of the liaison officer position, there was only a pro forma letter to the next of kin.

'Inspector A' indicated that in hindsight there are things that he would do differently, including taking better and more photographs – he noted that WHSQ now has better cameras – and ascertain and speak to the manufacturer of the mats and get details – he noted that he was at the time unable to find out information regarding the mats as there were no serial numbers. He would, again in hindsight, have tracked down and interviewed all persons present at the time of the incident. (See also below under heading re: 'Witness A's' evidence.)

'Inspector A' believes that the case management team did a good job.

''Inspector B'

'Inspector B' noted that he went to the site three months after the event and had a role in interviewing 'Person B' and taking photographs.

He acknowledged some deficiencies in the process, including lack of timeliness, and that at the time investigations generally required improvement - but noted that under new management the situation had improved – however concerns regarding the need to investigate certain issues and the reality of the costs issue were impacting upon investigations.

'Inspector C'

'Inspector C' outlined his responsibility for the matter, as the Regional Investigations Manager, and indicated that he keeps a spreadsheet with investigation milestones and holds formal and informal case management meetings for the 'purpose of minimising gaps' in a case.

He noted that all time lines were met in this matter.

‘Inspector C’ says that this matter was only unusual in that it occurred in a ‘sporting field’.

He noted that a prohibition notice was issued in this matter. He also noted generally that there should be a requirement that the recipient of a notice advise the department that it has been complied with; but that there are thousands of notices issued each year, so it would be a very big task to follow up on them all.

‘Inspector C’ says that he spoke once on the telephone to Ann Maitland when she rang. This was because ‘Inspector D’, who was taking most of the contact, was not available. He believed that it was inappropriate to give Ann Maitland information, other than that the investigation was continuing and some timelines; he believed - so as to comply with policy and not compromise the investigation - she was not entitled to information such as witness statements.

In a subsequent email to me, ‘Inspector C’ also said that, as a result of the information provided by Ann Maitland, other potential eye witnesses not previously interviewed by WHSQ were identified and followed up by the investigator. He suggests that the information provided by Ann Maitland was found to be inaccurate and those further inquiries were terminated.

He says that his other contact with Ann Maitland was outside the court, when she said she had information to provide. He said that he was ‘happy for her to provide it but that he was not the person to liaise with and she should raise her concerns with the Regional Director’.

‘Inspector C’ advised his main concern in relation to the elements of the offence was that the mat was not present at the time of the incident. They were looking at the routine and whether the set-up was adequate for it.

In relation to other matters, he says that Ann Maitland’s earlier supply of inaccurate information meant that further allocation of resources based upon her assertions was not justifiable. Further, ‘Inspector C’ asserts that it was their belief that the conflicting information made no difference to the question of culpability, but may have gone to the gravity of the offence. ‘Inspector C’ remains of the view that there was no evidence, other than Ann Maitland’s view that ‘Witness A’ was not adequately qualified for the routine being performed by Michelle, and that Michelle was very experienced and considered competent in performing the moves, having performed the move many times in the presence of ‘Witness A’.

In hindsight ‘Inspector C’ says that there are things that he would do differently now. He referred to taking a broader look at the incident in accordance with the ICAM program, which was implemented post this matter. However, he does not think that bio-mechanical analysis was necessary.

He also noted other issues including that not all the inspectors have experience in the area of gymnastics and that resources fluctuate, which overall is a problem.

Finally, in his subsequent email to me, 'Inspector C' expressed the view that staff, who were involved in this matter, feel unsupported by management which has taken the course of seeking a review of the circumstances of the investigation and prosecution.

'Legal Officer A'

'Legal Officer A' advised me he was part of the case management process for all files for the Townsville Region and would travel to Townsville frequently to review the matters with 'Inspector C' and the various investigators.

He was involved in this matter from the very beginning as there had not been a prosecution involving a gymnasium before. He told me that he had a concern that the subject incident may have resulted in the closure of the gym.

'Legal Officer A''s view was the absence of the mat was at the centre of the whole case. He informed me that he travelled to Townsville two days prior to the summary trial and conferenced witnesses and prepared written submissions during that time. He expressed the opinion that 'Witness A' was a very honest and forthright witness, and that in the circumstances the prosecution did not need to consult other experts.

'Legal Officer A' said that Ann Maitland approached him during an adjournment of the trial and said words to the effect of: "there are some things you need to know or you only know the half of it". He did not respond to that statement, because he had some concerns about information finding its way to the media.

He said that he was not aware of any earlier incident involving the tumble tramp and that, to his knowledge, no records relating to the prior user of the apparatus were obtained from the gym.

'Legal Officer B'

At the outset 'Legal Officer B' expressed some concern about the fact that this review was being conducted, as it had the potential to erode the confidence of legal officers and investigators within WHSQ.

It was 'Legal Officer B's' decision to launch a prosecution in this matter. He too believed that the evidence disclosed this to be a straightforward case.

He acknowledges that in hindsight steps could have been taken to ascertain whether international gymnastic standards were being followed in the Townsville gymnasium.

'Legal Officer B' said that moving forward on this issue an investigations review project has been initiated.

The draft project plan identifies that the project's objective is to formulate practical recommendations on ways to enhance the effectiveness and efficiency of investigations processes, investigation reports and briefs of evidence within WHSQ. The draft project plan identifies as its outcome the improvement in quality and consistency of investigation processes and briefs prepared with respect to incidents or

matters investigated. The draft project plan states that the deliverable will be a report of the review with a series of tested recommendations for consideration by the WHSQ Investigations Governance Group.

Equally, 'Legal Officer B' acknowledges that Ann Maitland should have been consulted from an early stage; however he pointed out that, because of what has occurred in this case, a person in the equivalent position of a 'victim liaison officer' has been employed in the Division.

Re: 'Witness A's" evidence

'Inspector A', 'Inspector C' and 'Legal Officer A' all expressed similar views in relation to the decision not to obtain independent expert opinions. That is, the matter was straightforward in that the set-up at the gymnasium, for whatever reason, allowed for a gym participant's body to come in contact with a concrete floor. Accordingly they did not see any bio-mechanical analysis as being necessary.

In relation to further eye witnesses, 'Inspector A' has said that with the benefit of hindsight he would have obtained a list of all persons who were in the gym at the time of the incident and interviewed each of them.

'Inspector C' has said that his main concern was that there was a gap between the mats, and the focus of the prosecution was upon the routine being performed by Michelle and whether the set-up of the flooring was adequate for that routine. The fact that at the completion of the routine the set-up was such that her head hit the concrete floor resulting in fatal injuries was incontrovertible proof that the Townsville Gymnastics had not complied with their workplace health and safety obligations.

'Legal Officer A' has said that further eye witnesses were not pursued because 'Inspector A' said that he was unable to contact them, and in those circumstances decided there was, in any event, sufficient evidence for a successful prosecution.

OTHER MATTERS

In a recent email to me, Ann Maitland expressed some comfort from a recent meeting she had had with the Acting CEO of Gym Queensland in which she was informed that that organization and WHSQ have had lengthy discussions and quite a few procedures are either being introduced or improved by both organizations.

NEW LEGISLATION

Very recently, the Work Health and Safety Bill 2011 has been introduced. This proposed legislation makes significant changes to the existing regime including increasing penalties for breaches of the WH&S requirements, providing for the compliance with Director of Public Prosecutions guidelines, requiring officers of corporations to demonstrate due diligence and placing an evidentiary burden upon accused persons to show reasonable cause.

Such foreshadowed legislation should impact positively on ensuring compliance with workplace health and safety obligations.

DISCUSSION

The investigation

There appear to be some inconsistencies and contradictions in the information provided, as between the WHSQ officers and Ann Maitland, and as between what was provided to me and what was before the court. I have not explored these issues as it is not part of my role to do so – this being a review rather than an investigation – and in any event they do not significantly impact upon my role in conducting this review, nor upon my conclusions and recommendations.

The investigators were obliged to comply with the provisions of the various relevant policies referred to in the Appendix and, in particular to conduct a thorough, timely and impartial investigation:

> Inspectors are accountable for the way in which they conduct investigations and for the timelines within which they complete the investigations. Inspectors need to be able to demonstrate that they investigated matters thoroughly and completely[4].

An assessment of the level of compliance with these obligations must take into account the following. This seems to have been the first investigation and prosecution of an incident involving a gymnasium. The prosecution was successful and upheld on appeal.

The investigation was conducted against the background of the law, which includes that the onus of proof is reversed once the death or injury of a person is proved (see The Prosecution Case above and the Current Law in the Appendix). There is a possibility that any coronial inquest will look to the evidence gathered by the WHSQ investigation.

All WHSQ parties to the investigation seem to have considered that the physical set up at the gymnasium, which included an area of exposed concrete proximate to the activity being undertaken by Ms Maitland, meant that a conviction was all but inevitable, and this has arguably affected their decision-making in relation to the investigation and the prosecution.

There was accordingly a failure to seek additional independent and expert evidence as to things such as the forces involved in the gymnastic routines and the physical qualities of the components such as the landing mats, and a seeming lack of urgency in seeking to locate eye witnesses to the incident or to investigate any earlier incidents / injuries resulting from the use of the same equipment.

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[4] Chapter 2 Advanced Investigations Training Manual; Justice and Attorney-General

There also appears to have been some deficiencies in the thoroughness to secure evidence of the physical scene and in the attempts to locate other possible eye witnesses. No independent expert evidence was sought in relation to the gymnastic manoeuvre that led to the death of Ms Maitland, nor the nature and physics of the landing mats – e.g. in relation to the potential to absorb kinetic energy or allow for a rebounding motion. It seems that Ann Maitland was not approached in relation to locating any other eye witnesses – though 'Inspector C' suggests otherwise - nor, were other possible avenues followed, for example, an advertisement put in the local paper calling for eye witnesses to come forward.

Ann Maitland's view - that a more thorough investigation would have discovered the eye witnesses and generally raised concerns about the version of "Witness A' relied upon by WHSQ – is understandable. It also seems likely that if thorough attempts had been made that other sources of independent expert evidence would have been ascertained.

The absence of any independent expert witness and the failure to prosecute Townsville Gymnasium Inc for other possible breaches may well have left Ann Maitland with the perception of a lack of thoroughness and impartiality on the part of WHSQ. It is observed, however, to prosecute for non-reporting is rarely pursued where a substantive breach is prosecuted.

Though Ann Maitland expresses the view that the investigation was not timely, it appears to have been conducted within the timelines required by the WHSQ procedures. Her view may have been affected by the length of time taken for the prosecution to come before the courts, including the appeal, as well as the absence of regular communication.

The lack of communication with herself and other family members

Notwithstanding the WHSQ officers' views about the communication with Ann Maitland, it is apparent that she was not fully consulted as to the progress of the investigation, nor were her views sought upon her daughter's gymnastic background and potential persons who would be able to give independent evidence as to the bio-mechanics of the routine. Indeed, it appears the only communication to have been initiated by WHSQ was a pro forma letter sent to Ann Maitland and one visit to her which was specifically aimed at seeking information about the medical files of Michelle subpoenaed by the defence.

Prosecution

The obligations of the prosecution were to put before the court all available and relevant evidence.

Having regard to the information provided by Ann Maitland, and the subsequent eye witness statements, there is a perception that, among other things, the central issue of whether Ms Maitland proactively rebounded or was propelled by momentum was not properly ventilated before the courts.

It is understandable how the prosecution could have left the impression in the eyes of the family of a degree of ineptness, exemplified by the lack of certainty about whether the apparatus in question was a 'tumble tramp' or a 'tumble track', and the reliance upon the acknowledged poor photographs taken, rather than those taken by the QPS Scenes of Crime Unit (except for one).

President Hall in the Industrial Court adopted the findings of fact made by the Industrial Magistrate:

> 'It is useful to supplement the admissions with findings of fact made by the Industrial Magistrate … :
>
> > "There is no controversy as to the facts in this complaint. Ms Maitland was at the defendant's centre on the 18th June 2009 and was participating in an activity on the tumble tramp. She had successfully completed one routine and completed another, landing safely on crash mats positioned at the end of the tumble track. Immediately after that she pushed off or rebounded from the mats which propelled her toward the edge of the crash mats. Tragically her head and torso went over the edge of the mats and her head struck the concrete floor. She suffered a fatal injury at that point.
> >
> > It is important to note that the term "*rebounded*" is a technical term. In this context it is the act of pushing with the feet and ankles of a gymnast as distinct from bouncing off an object after hitting it with force."
>
> Save for the optimism of the conclusion that there was "no controversy", the findings seem to me to have been open.'

There can be no criticism of these remarks given that the only evidence called at the trial was to that effect found by the Industrial Magistrate. However, these remarks have heightened Ann Maitland's concerns about the manner of the investigation and prosecution.

In particular, the new eye-witness statements clearly suggest that Ms Maitland did not "rebound" in the sense found by the Court; rather that she was simply propelled off the landing mat by existing momentum.

CONCLUSIONS AND RECOMMENDATIONS

A judgement call has been made by the inspectors and legal officers, balancing the requirements of effective investigation management – cost-efficiency, timeliness and thoroughness – in the context of the current law and the strict liability of the defendant; and the apparently comparatively straightforward nature of the case in this matter. Such call has proven to be legally well founded.

However, the absence of a more thorough investigation has led to the understandable adverse perceptions of Ann Maitland, detailed earlier, and the possibility of some ‘fictions’ being relied upon by the courts in reaching their decisions.

In the light of the new legislation, the focus of any investigation and prosecution must be for complete thoroughness on the part of the prosecution. The introduction of the new investigation review project should be of assistance to the WHSQ officers in this regard.

Clearly, in my view, there was inadequate communication with Ann Maitland; any similar situation in the future is likely to be remedied by the creation of the liaison officer position.

As no doubt the Department appreciates, it is most important that the apparent current efforts between WHSQ and Gym Queensland for the introduction of new safety procedures within the gymnastic industry continue. This should go some way to addressing Ann Maitland’s expressed concern about public confidence in the workplace health and safety regime and the matter of ‘public safety’.

In relation to Ann Maitland’s desired outcome that Townsville Gymnasium Inc or one of its officers be prosecuted for homicide, I observe that such an outcome is beyond the scope of this review. However, I note that referral of any evidence for consideration of criminal charges would fall within the purview of a coronial inquest.

I also draw attention to the concerns expressed about the impact of this review on any WHSQ officers, and note the importance of viewing exercises, such as the present, as learning opportunities, both for individuals and the organization.

I also recommend that consideration be given to WHSQ confirming regional compliance with its policy on the follow up of prohibition notices. As reported in the Workplace Relations Ministers’ Council, Comparative Monitoring Performance Monitoring Report, 11th Edition, in 2007-2008 WHSQ issued 2,300 prohibition notices and 14,000 improvement notices. Prohibition notices are only issued in the event of a serious risk. Prohibition notices do not have a compliance slip, like an improvement notice, as they are related to matters that are so serious a follow up by an inspector is required to verify compliance. WHSQ would not rely on a third party advising that the issue has been rectified to confirm compliance.

A policy of follow up of prohibition notices has been reflected in draft national procedures. The burden of follow up of prohibition notices is not considered high, in context if it’s assumed that WHSQ have 100 field inspectors, who are involved in roles that generate prohibition notices (there are of course more that 100 inspectors) at a given time, this would equate to 23 notices to be followed up by each inspector per year. WHSQ has a policy that prohibition notices be followed up. It may be pertinent for WHSQ to review regional compliance with follow up of prohibition notices.

<u>MICHAEL J. BYRNE Q.C.</u>

31 May, 2011

APPENDIX A

RELEVANT LEGISLATION, LAW, POLICIES, PROCEDURES AND GUIDELINES

1. *Workplace Health and Safety Act (WH&S Act)*

The provisions of the Act relevant to this matter are outlined below.

7 [Objective of Act]

(1) The objective of this Act is to prevent a person's death, injury or illness being caused by a workplace, by a relevant workplace area, by work activities, or by plant or substances for use at a relevant place.

Example of an illness caused by a workplace— asthma caused by inhaling spray paint mist from a neighbouring
workplace

Example of an illness caused by a work activity— carbon monoxide poisoning caused by a liquefied petroleum gas operated forklift being used in a coldroom

Example of an illness caused by plant— legionnaire's disease caused by inhaling legionella bacteria from the contaminated cooling tower of an airconditioning unit

(2) The objective is achieved by preventing or minimising a person's exposure to the risk of death, injury or illness caused by a workplace, by a relevant workplace area, by work activities, or by plant or substances for use at a relevant place.

(3) This Act establishes a framework for preventing or minimising exposure to risk by—

(a) imposing workplace health and safety obligations on certain persons who may affect the health and safety of others by their acts or omissions; and

(b) establishing benchmarks for industry through the making of regulations and codes of practice; and

(c) …

(d) ...

(e) …

(f) providing for the appointment of—

(i) …; and

(ii)

(iii) inspectors to monitor and enforce compliance with this Act; and

(iv) …

(g) ….

(4) The achievement of this Act's objective will help—

(a) reduce the human cost to individuals, families and the community caused by these deaths, injuries and illnesses; and

(b) reduce the financial burden on individuals, families and the community caused by these deaths, injuries and illnesses; and

(c) reduce the burden on the workers' compensation scheme caused by these deaths, injuries and illnesses, which in turn reduces costs imposed on industry; and

(d) maintain the community standard for workplace health and safety, which is eroded when persons gain an unfair competitive advantage by not implementing appropriate standards.

24 Discharge of obligations

(3) Designers of structures continue to have obligations under section 30B to ensure workplace health and safety after the structure has been constructed.

(4) Workers and other persons at workplaces have obligations under division 3 to ensure workplace health and safety.

(1) A person on whom a workplace health and safety obligation is imposed must discharge the obligation.

Maximum penalty—

(a) if the breach causes multiple deaths—2000 penalty units or 3 years imprisonment; or

(b) if the breach causes death or grievous bodily harm—1000 penalty units or 2 years imprisonment; or

(c) if the breach causes bodily harm—750 penalty units or 1 year's imprisonment; or
(d) if the breach involves exposure to a substance likely to cause death or grievous bodily harm—750 penalty units or 1 year's imprisonment; or

(e) otherwise—500 penalty units or 6 months imprisonment.

(2) Subsection (1) applies despite Criminal Code, sections 23 and 24.

Editor's note—
Section 23 of the Code deals with a person's criminal responsibility for an act or omission that happens independently of the person's will or for an event which is accidental. Section 24 of the Code deals with a person's criminal responsibility for an act or omission done under an honest and reasonable, but mistaken, belief in the state of things.

(3) If more than 1 person has a workplace health and safety obligation for a matter, each person—

(a) retains responsibility for the person's workplace health and safety obligation for the matter; and

(b) must discharge the person's workplace health and safety obligation to the extent the matter is within the person's control; and

(c) must consult, and cooperate, with all other persons who have a workplace health and safety obligation for the matter.

28 Obligations of persons conducting business or undertaking

(1) A person (the ***relevant person***) who conducts a business or undertaking has an obligation to ensure the workplace health and safety of the person, each of the person's workers and any other persons is not affected by the conduct of the relevant person's business or undertaking.

(2) The obligation is discharged if the person, each of the person's workers and any other persons are not exposed to risks to their health and safety arising out of the conduct of the relevant person's business or undertaking.

(3) The obligation applies—

(a) whether or not the relevant person conducts the business or undertaking as an employer, self-employed person or otherwise; and

(b) whether or not the business or undertaking is conducted for gain or reward; and
(c) whether or not a person works on a voluntary basis.

(d)

29 Obligations of persons conducting business or undertaking

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and any other persons are not exposed to risks to their health and safety arising out of the conduct of the relevant person's business or undertaking.

(3) The obligation applies—

(a) whether or not the relevant person conducts the business or undertaking as an employer, self-employed person or otherwise; and

(b) whether or not the business or undertaking is conducted for gain or reward; and

(c) whether or not a person works on a voluntary basis.

What obligations under s 28 include

Without limiting section 28, discharging an obligation under the section includes, having regard to the circumstances of any particular case, doing all of the following—

(a) providing and maintaining a safe and healthy work environment;

(b) providing and maintaining safe plant;

(c) ensuring the safe use, handling, storage and transport of substances;

(d) ensuring safe systems of work;

(e) providing information, instruction, training and supervision to ensure health and safety.

2. *The Current Law*

Offences under the WH&S Act are some of the very few in our justice system in which there is a reversal of the onus of proof; it being upon the defence and not the prosecution.

The President of the Industrial Court has, on many occasions, addressed this issue and the strict nature of obligations imposed by the Act with a view to ensuring safety for workers and others affected by the conduct of an undertaking.
To illustrate, His Honour has said –

1. "The obligations verge on absolute …

   It follows that where a worker is injured at a workplace the workplace is not a workplace whereat safety was ensured and the employer is in breach of the obligation"[5].

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[5] Watson v AJC Electrical Service Pty Ltd (2004) 175 QGI 6574

2. “As to the defence of s.37(2) of the Act, it seems to me to misconceive the nature of the defence to assert that” … the Appellant could not possibly have done anything more to avoid Mr Fletcher’s sudden unannounced and unforeseen departure from his normal practice in circumstances where he was being ‘badgered’ by the inspector …”. The breach of s.28(1) and, in consequence, the breach of s.24 was complete before Mr Fletcher fell through the concealed “floor penetration”. So long as the causal nexus between the circumstances of aggravation and the breach was established, it matters not that the precise mechanism of injury was unforeseeable”6.

3. “The Appellant takes a further preliminary point that the Industrial Magistrate refrained from determining whether or not Mr Rodrigues had committed suicide … It is, however, impossible to find anything within the WH& S Act which would justify excision of all cases of self harm from the preview of the Act. Indeed such a construction is inconsistent with a legislative scheme which, on the issue of liability, focuses upon the steps which the employer or occupant of a workplace took or did not take rather than upon the consequences of the steps taken or not taken. There is in my view no substance to the preliminary point7”.

Industrial Magistrate Mack stated in this matter:

> The obligation of is strict and the law settled – for example in *Watson v A.J.C. Electrical Service Pty Ltd [2004] QIC 3; 175 QGIG 574 (2 February 2004)* President Hall indicated (at paragraph 2)
>
> > “The objective of the *Workplace Health and Safety Act 1995* is to prevent death, injury or illness being caused to a person by a workplace, by workplace activities or by specified high risk plant, s7(1). That objective is achieved by preventing or minimising a person’s exposure to the risk of death, injury or illness attributable to a workplace, workplace activities or specified high risk plant, s7(2).
> > …….

President Hall held a different view in this matter, but with the same practical effect:

> ‘... I continue to adhere to the view that the obligations imposed by the Act verge on the absolute …’

Thus, prosecutions under the WH& S Act are conducted in an environment in which once an injury or death is shown, then the onus is upon the defendant to establish a defence.

---

6 Abigroup Contractors Pty Ltd v Newman [2008] QIC 61

7 Lutheran Church of Australia Qld v Newman [2002] QIC 30

Such a context is quite different to, for example, the role of a Coroner following a death or, indeed, to a criminal prosecution where the onus of proof never shifts from the prosecution.

3. *Office of WH&S policy, procedures and guidelines and other relevant documents*

These policies and procedures, relevantly, include the following[8].

3.1 Investigation Policy

The policy provides:

> Investigations into workplace incidents are undertaken … to:
>
> - determine their cause
> - prevent similar incidents recurring in the workplace
> - notify employers of incidents occurring within their industry;
>
> and in some cases
>
> - prosecute offences against the Workplace Health and Safety Act.
>
> ……..
>
> **Investigation Priorities**
>
> **Type one event**
>
> All type one events {includes incidents involving a fatality} will be subject to a comprehensive workplace health and safety investigation unless there is a valid reason not to undertake the investigation.
>
> **Timeframes**
>
> Generally the Division … aims to complete comprehensive investigations within six months. Less serious or complicated complaints will be dealt with more quickly.

3.2 After Hours on call procedure [DWHS/PROC/01/23]

The procedure sets out the action to be taken by an inspector when called by the duty manager to respond to a type 1 incident as follows:

> Actions include:

---

[8] I have relied upon the documentation provided to me by the Department.

- taking necessary action to secure the scene to prevent possible tampering with any evidence

- identifying the possible evidence

- obtaining contact details of potential witnesses

- taking photographs and measurements

- … .

3.3 First response to a Type 1 Event … procedure [WHSQ/PROC/0576]

Rationale

…

The first response actions by an inspector at an incident scene are vital and can often lay the foundation for the ensuing investigation plan as they can provide valuable direction and information for a comprehensive investigation.

Accordingly, it is essential that a thorough and detailed initial scene investigation is conducted. The first response visit may be the first and only opportunity to obtain vital evidence at the scene. The Regional Manager is to ensure that the First Response Events are managed in accordance with this procedure.

….

Procedure

The inspector … will be required to contact the relevant workplace and ensure that the incident scene has been preserved … {and} will then proceed to the scene as a matter of priority.

Upon arrival … the lead inspector must contact the RIM, ROM or PIO and provide a verbal assessment of the circumstances of the event. … the lead inspector may then be requested to conduct the necessary preliminary investigation in accordance with the Investigation Skills DIR Training Manual, Introduction to Workplace Investigation.

3. Contact with Relatives and Friends during Investigations [DWHS/PROC/03/44]

The procedure provides:

Rationale:

It is normal human behaviour for the relatives and friends of a deceased person … to be interested in the investigation into the related incident. …

….

Role:

5. The role of the Regional Director as the Workplace Health and Safety Queensland spokesperson is varied and would include the following key elements:

- …
- utilise active and reflective listening techniques to calm and allay concerns with the process
- impart factual information about the role of the investigation and the timelines. …
- …
- Receive, screen and refer information received as necessary especially by passing on factual assistance to the investigating officer … .

3. Conduct of Prosecutions [DWHS/PROC/02/34]

The procedure provides:

Rationale

The Division of Workplace Health and Safety has a Legal and Prosecutions Unit to coordinate and conduct legal proceedings and to offer advice to regional workplace health and safety staff. The division has also established regionally based investigation teams consisting of suitably experienced staff to conduct, monitor and review the progress of investigations and make recommendations regarding offences under the Workplace Health and Safety Act. The investigation teams will conduct their activities as service providers to the Legal and Prosecution Unit of the Division. …

Procedure

…

8. The RIM is responsible for guiding the deliberations of the CMT to arrive at a recommendation of:

   - further investigation necessary
   - cease investigation, does not meet criteria in prosecution policy

- initiate full breach investigation, strong possibility of meeting prosecution criteria.

11. The RIM has responsibility for managing the breach investigation calling together and supplementing the expertise of the CMT as required.

…

13. At the conclusion of the breach investigation the RIM reviews the Breach Report … in consultation with the appointed Legal Officer and makes a recommendation to the DLPS, within 6 months of the incident. …

14, The DLPS is responsible for the decision whether to prosecute which must be made within 1 month of receipt of the Breach Report and recommendation.

3. Coronial inquest procedure [WHSQ/PROC/07/94]

The procedure provides:

Evidence related to the investigation:

As a general principle, evidence gathered during an investigation is to be available to the coroner. …

Attending the inquest

The investigating Inspector may be called to give evidence at the inquest. This evidence should relate to the circumstances surrounding the death. …

3. Office of WH&S Training Manual 'Fundamental Inspector, Investigation and Witness Skills', procedures and guidelines
Office of WH&S 'Advanced Investigations Training' Manual

Both Manuals contain similar language in relation to the relevant issues.

The passages below are drawn from the WH&S Training Manual 'Fundamental Inspector, Investigation and Witness Skills'.

Chapter 9: Evidence

…

An inspector may be required to gather evidence for any one of the following purposes:

- To determine what happened in respect to a particular incident
- To determine whether to issue an improvement or prohibition notice
- To determine whether any person has committed a breach of the Workplace Health and Safety Act 1995 ("WHS Act") or Regulations.

The passages below are drawn from the Advanced Investigations Training Manual.

Chapter 1: Introduction

… The Division aims to ensure prosecution activity is strategically focused and targeted for maximum impact. That is, there will be a focus on cases that are high value, high profile and high impact.

…

The decision whether to bring a prosecution for a breach of the OHS legislation is one of the most significant as the effect on those impacted by the decision (the defendant, worker or family of a deceased worker for instance) will be considerable. …

…

In determining whether or not to prosecute, three criteria … need to be met. They are as follows:

- the existence of a prima facie case, that is, whether the evidence is sufficient to justify the institution of proceedings
- a reasonable prospect of conviction …
- the public interest …

Chapter 2: Investigation Management

Introduction

….

Effective investigation management ensure the efficient use of resources and the smooth operation of WHSQ as a whole. It filters through to every aspect of the investigation process. It can also:

- affect the outcomes of the investigation;
- improve WHS for workers;
- help prevent recurrences;
- affect the outcomes for the workplace involved in the investigation; and
- influence industry practices.

Effective investigation management can mean the difference between an expensive investigation and a cost-efficient one. It may also mean the difference between a successful prosecution or not.

Ineffective investigation management can lead to lost time …. Ineffective investigation management may also mean that investigation reports will be referred back to the inspector by Management of Legal Officers because of lack of evidence and other inadequacies.

…

Accountability

Inspectors are accountable for the way in which they conduct investigations and for the timelines within which they complete the investigations. Inspectors need to be able to demonstrate that they investigated matters thoroughly and completely. …

Reasons for investigating
…

To successfully achieve {the investigation} outcomes, investigations must be thorough and carried out in a timely manner. …

…

Case to answer

Prior to instigating legal proceedings WHSQ will ensure a legal officer reviews the matter and provides an opinion as to whether there is sufficient evidence to disclose a case to answer. …

…

Chapter 5: Evidence

….

Expert evidence

Expert witnesses may give evidence subject to the following conditions:

- the witness must demonstrate the necessary qualifications and experience;
- the qualifications must relate to the topic …. .

Chapter 15: Mechanics of taking a statement

…

Witnesses

Material witnesses

When deciding to interview a particular witness, the main consideration is that the prosecution is expected to present its case with fairness to the defendant. This consideration asks a number of questions …

Prohibition notices - follow up

INTERNAL MEMORANDUM
WHS_PS/3440

TO: **Regional Directors**

PURPOSE: **Interim Protocol for follow-up of prohibition notices**

At the quarterly Service Delivery Director's meeting held on 10 December 2008, discussion was held on the recommendations from an operational audit by the Internal Audit and Ethics Unit of the Department of Employment and Industrial Relations of prohibition notices.

Regional Directors agreed to start a number of actions to address the audit report recommendations including:

1. Follow up of prohibition notices using the methods of:
   - Visit;
   - Phone call;
   - Email requesting for example, photos or scan of invoices for corrective work; or
   - No follow up if it is considered the risk no longer exists or follow up is no longer appropriate (for example, construction or demolition completed).

   The method of follow up action is at the discretion of the inspector issuing the notice.

2. Record follow up action – CIS is to be enhanced to include specific fields to show where follow up action or resolution of prohibition notices has been undertaken.

3. Regional Operations Managers (ROMs) will review 50% of the prohibition notices issued by each inspector within their region to ensure that they are adequate. The protocol regarding the number of notices and frequency of review will be revisited after 12 months to determine if these benchmarks are to be maintained.

4. A copy of any prohibition notice issued to a person in control is to be sent to the executive officer of the company or owner of the business to ensure that they are aware of the risk to be addressed.

CIS enhancements have been requested that will enable recording of the follow up method used by inspectors and the dates that copies of notices are forwarded to executive officers or business owners. Until the enhancements have been implemented, the following interim policy regarding prohibition notices will apply:

- All prohibition notices issued by inspectors will be followed up in accordance with methods noted in point 1 of this memo. Inspectors are to record the details of follow up action taken in their notebooks; and

- ROMs are to review prohibition notices in accordance with the protocol agreed to in point 3 above. The two 6 month periods to be reviewed will be:

- 1 January 2009 to 30 June 2009; and
- 1 July 2009 to 31 December 2009.

Audit reports that address the points outlined in the 'Regional Audit of Prohibition Notices – Audit Report' are to be forwarded to the systems officer Regional Services Branch no later than 28 days after the reporting period. To assist ROMs review prohibition notices issued within their regions, an audit tool has been developed and is also attached to this memo; and

- Inspectors are to ensure that a copy of any prohibition notice issued to a person in control (if not an executive officer or the business owner) is forwarded to the registered address of the corporation or business with a covering letter.

When the CIS enhancements have been completed the 'Issuing Notices Manual' will be amended to outline the final protocol regarding prohibition notice follow up, and you will be advised accordingly.

Please contact 'Person E", Senior Advisor, to resolve any issues regarding this interim protocol.

Senior Director - Service Delivery
Workplace Health and Safety Queensland
20/03/2009

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