

Review of investigation and prosecution of Townsville Gymnastics Association Inc. concerning the death of Michelle Maitland

Workplace Health and Safety Queensland response

Background

Ms Michelle Maitland died as a result of injuries received after an incident at the Townsville Gymnastics Association Inc. on 18 June 2009. Workplace Health and Safety Queensland (WHSQ) conducted an investigation and subsequent prosecution into the matter. The prosecution was successful and upheld on appeal.

Michelle's mother raised concerns about the investigation and prosecution processes applied by WHSQ. On 1 February 2011 the Director-General of the Department of Justice and Attorney-General engaged Mr Michael Byrne QC to conduct an independent review into the actions of WHSQ in relation to Ms Maitland's death.

On 31 May 2011 WHSQ received the *Review of Investigation and Prosecution of Townsville Gymnastics Association Inc. concerning the Death of Michelle Maitland* (the 'Review Report'), conducted by Mr Byrnes. The Department of Justice and Attorney-General has published the report, with personal names de-identified, and is working to address the deficiencies highlighted through the Review.

Actions to respond to report recommendations

It is the intent of WHSQ, as suggested by Mr Byrne in his report, to view this Review Report as a learning opportunity and as an avenue for ongoing improvement within the organisation. WHSQ welcomes the opportunity to improve its processes to ensure public confidence in the rigour of its investigation and prosecution activities.

The first conclusion of Mr Byrne's report was: *"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]"*.

He further stated that *'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'*.

The Department has commenced an investigations review project for workplace health and safety matters. This project will respond to comments by Mr Byrne in his report regarding the thoroughness of the investigation into Michelle's death as well as to the issue he raises regarding the soon-to-be introduced legislation where he emphasises that "the focus of any investigation and prosecution must be for complete thoroughness on the part of the prosecution". This project was instigated in March 2011 and aims to improve the quality and consistency of investigation processes and briefs prepared. The review will result in the development of practical recommendations on ways to enhance the

effectiveness and efficiency of investigation processes, investigation reports and briefs of evidence. The recommendations will be considered for adoption by WHSQ.

A key deficiency highlighted by Mr Byrne was the inadequate communication with Ann Maitland. He further adds that *“any similar situation in the future is likely to be remedied by the creation of the liaison officer position”*. In this regard the Investigations Liaison Support Officer position was implemented in January 2011.

This role has been developed to facilitate an effective relationship between WHSQ and family members who have been affected by a fatal workplace incident. This is achieved by ensuring initial contact is made with family regarding the role of WHSQ and by providing ongoing support and timely information on the progress of the investigation at regular milestones.

Mr Byrne highlights in his report that, *“...it is most important that the efforts between WHSQ and Gymnastics Queensland for the introduction of new safety procedures within the gymnastics industry continue. This should go some way in addressing [Ann Maitland’s] expressed concern about public confidence in the workplace health and safety regime and the matter of public safety.”*

The Department announced in December last year that the Queensland Government will work with gymnastics clubs across the state to assess the level of safety in the sport. These efforts are still ongoing. WHSQ consulted with industry experts to develop an audit program that involved conducting assessments into the safety of gymnastics activities in gymnastics facilities. These assessments have now been completed, with 25% of all gymnastics facilities in Queensland being audited.

A report is being prepared and the results of these assessments will be used to assess the need for further intervention into this sector. It is anticipated that this report will be completed and published on the Department’s website by the end of August 2011.

Mr Byrne’s final recommendation is: *‘... that consideration be given to WHSQ confirming regional compliance with its policy on the follow up of prohibition notices.’* This recommendation arises from Mr Byrne’s observation that compliance with a prohibition notice that was issued in relation to the matter was not verified by WHSQ. In this regard WHSQ proposes to initiate action to confirm compliance with WHSQ policy on the follow up of prohibition notices. It is expected that this action will be completed by the end of 2011.

WHSQ has reconfirmed with Ann Maitland that it is committed to assisting the Coroner in the event that an inquest is held into Michelle’s death.