Submissions on Behalf of the Sweeney Family

Introduction

1. These submissions are made on behalf of Martin Sweeney (father); Wendy Sweeney (mother); and Justin and Brendan Sweeney (brothers) and Sarah Sweeney (sister in law) of Mitchell Sweeney who was the last person fatally injured as part of the Home Insulation Program ("the HIP") on 4 February 2010. Mitchell was electrocuted in Millaa Millaa in Far North Queensland when one of the metal staples being used by him and his colleagues to fix Reflective Foil Laminate ("RFL") insulation penetrated a live electric cable.[1]

Circumstances Leading to Mitchell's Death

2. Mitchell's employer, Titan Insulations Pty. Ltd. ("Titan") was registered under the HIP on 16 September 2009.[2] The directors, Nicholas Lindsay ("Lindsay") and Frederic Palomar ("Palomar"), had no previous experience in installing insulation. Lindsay was a carpenter and Palomar had a diploma in engineering.

3. Mitchell underwent a theoretical and practical competency assessment by Phillip Smith ("Smith") of Australian Construction Training Services. Smith answered an expression of interest to run the course and used CPSISC materials (with little alteration).[3]

4. Smith claimed to the coroner that he would have warned attendees about metal staples.[4] This is an easy claim to make after the fact. Smith's statement says that the Construction Industry Pocket Course formed part of the course materials.[5] Smith says that electric safety matters were covered in accord, inter alia, page 35 of the Pocketbook.[6]

5. Mitchell sought and was granted recognition for prior learning.[7]

6. Mitchell's written assessment[8] shows very basic knowledge testing. There is one reference to electrical hazards (Q.10) and one reference to foil (Q.19). The report of the practical testing is even less informative.[9]

7. Mitchell was being paid $2 per square metre for laying insulation by Titan. He paid half of that to his co-worker, Chase Martin. [10]

8. The WHSQ report indicates that Mitchell was electrocuted when his head or back came into contact with the metal roof of the house (when leaving the roof cavity) thereby completing a circuit. 240 volts of electricity passed through Mitchell's body as a result. It appeared that a

[1] The term "RFL" will generally be used during these submissions on most occasions even though references may be being made to evidence that uses a more generic term such as "foil".
[2] QIC.001.001.0001, page 171
[3] QIC.001.001.0001, page 173
[4] QIC.001.001.0001, page 173
[5] QIC.005.001.0831, paragraph 7(a)
[6] QIC.005.001.0833, paragraph 17
[7] QIC.005.001.0832, paragraph 11
[8] QIC.005.001.1106-1113
[9] QIC.005.001.1114-1125
[10] Page QIC.005.001.0018

metal staple had come into contact with the positive wire of a lighting cable thereby rendering the roof live.[11]

9. It is not clear whether Mitchell or one of his two co-workers, Chase Martin and Andres Palomar, had placed the staple in question. Each of them was using metal staples.[12]

10. Shane Horne, one of Titan's other workers, provides evidence that nylon staples did not work in hardwood.[13]

11. Mitchell was one of at least 30% of installers who continued to use metal staples after the ban was imposed at the beginning of November 2009.[14] This continued use was understandable. Not only did nylon staples not work but workers had been introduced and accustomed to a system where metal staples were *de rigeur*. Mitchell had used metal staples with approval for at least four weeks when the rules changed.[15]

12. Mr. Doriean's evidence explains the high percentage of installers who continued to use metal staples. He stated that it is exceedingly difficult to get plastic staples to penetrate the hardness of Queensland hardwoods used in old Queensland houses.[16]

13. Mr. Doriean also explained that a piece work system of payments was likely to increase the frustration of using the ineffective plastic staples and to increase the likelihood that it would be the outlawed metal staples to which installers would turn.[17]

14. Mr. Duncan Herbert also had relevant experience and confirmed Mr Doriean's observations.[18] See also Mr Combet on piece work payments.[19]

15. The lack of guidance that Mitchell and his co-workers received from their employer was shown by the fact that Mr. Lindsay positively believed that RFL was not electrically conducted.[20]

Some Preliminary Observations

16. It may be observed that the use of RFL sheets was an exceedingly dangerous practice because of the conductivity of the foil; the large number of old and poorly wired houses in Queensland residential areas; the thickness of the foil sheets; the absence of a practical

[11] Page QIC.005.001.0017
[12] Page QIC.005.001.0039, paragraph 5
[13] Page QIC.005.001.0056, paragraph 36
[14] See PWC document dated 11 February 2010, annexure U (STA.001.010.0131) to statement of Ms Kruk, STA.001.010.0001
[15] Mitchell started working for Titan on 29 September 2009: QIC.001.001.0001, page 41. The coinciding announcements of a ban under the Guidelines and under Queensland regulations took place on 1 November 2009: QIC.001.001.0001, page 97
[16] RCI.006.001.0100, page 3033, lines 10-40
[17] Ibid
[18] RCI.006.001.0100, page 3138, line 25 – page 3140, line 45
[19] RCI.006.001.0100, page 4971, line 20 – page 4972, line15
[20] QIC.001.001.0001, page 49

fixing method other than the use of metal staples; and the impracticability or impossibility of turning off power while installing the RFL sheets.[21]

17. DEWHA had the means of knowing from almost the beginning of their work that RFL insulation[22] carried unnecessarily high dangers for the people whom the scheme was designed to assist with employment.

18. The narrative that has emerged from the evidence is a story how those warnings were neglected; lost; or channelled into areas where they could have marginal effect on the safety of workers who would come to install RFL.

19. It may be said that the mistakes that were made by public servants were brought about by the haste with which it was ordained that the HIP was to be rolled out and implemented. The death of Mitchell Sweeney is, for that reason, attributable to the decision which required that the HIP phase 2 must commence on 1 July 2009. How that decision came to be made has not been the subject of detailed evidence.[23]

20. But another narrative that emerges from the evidence is the failure of senior public servants to call a halt to what must have appeared to most of them as madness. No senior public servant advised her political masters that 1 July was both dangerous and untenable. No public servant expressed that view in writing such that her colleagues had to address the point.[24]

21. On 14 October 2009, Matthew Fuller was electrocuted using RFL affixed with metal staples. On 18 November 2009, Rueben Barnes was electrocuted when a metal pole he was using to position batts came into contact with a pre-existing electrical fault in the ceiling. On 21 November 2009, Marcus Wilson died of hyperthermia.

22. Starting with the death of Matthew Fuller, a new political dynamic was created. The warning information about the dangers of RFLs was re-discovered.[25] On the face of Mr. Garrett's public statements, public servants were no longer under pressure to make quick decisions at the cost of safety.[26]

23. A crucial question for the Commission concerns the decision making during this period of time. Why were public servants so reluctant to recommend the suspension of RFL so that its

[21] DEWHA was able to ascertain these matters and to convey them to their Minister in a brief dated 15 January 2010: AGS.002.013.3072. See also QIC.006.001.1999; AGS.002.017.0056; AGS.002.017.0065; and AGS.002.030.0453.
[22] AGS.002.017.1602, MIA.002.001.0005 and AGS.002.014.1381
[23] Mr. Rudd provided his tentative theory that it was the date on an earlier draft policy which was carried through to the announcements of 3 February 2009.
[24] Mr Mrdak, in paragraph 53 of STA.001.009.0001, refers to some conversations with Mr. Rudd and Mr. Arbib about the 1 July roll-out date. He expanded upon these in STA.001.009.0026. Although some of these conversations raised a possible later start date, Mr. Mrdak did not put any of his questions into writing. Nor does he appear to have pressed the matter with strong arguments about the problems going to training, compliance and production of the pocketbook associated with a I July start.
[25] Levey, STA.001.003.0001, para 321. See also Mr Forbes' evidence.
[26] STA.001.003.0001, para 331: "Safety is a priority for this program".

safety issues could be thoroughly analysed. Why was there so much timidity to do anything other than mimic what Queensland regulators were prepared to do.

24. The evidence reveals continued timidity which left RFL available as part of the HIP with only tinkering, including the ineffective ban on metal staples the response to Matthew Fuller's death.

25. The failure to investigate the dangers of RFL fully and in a considered way in October and November 2009 is the policy decision and failure most clearly linked to Mitchell Sweeney's death.

26. Like most disasters,[27] the failings of the HIP and its eventual result in the deaths of four young men are multi-factorial. The inter-linked failings which emerged in the evidence constitute a form of system failure. The phrase "perfect storm" was heard many times in the corridors of the Royal Commission during the public hearings.

27. While recognising system failures and making recommendations for improvement is important, it is also important to recognise the individual errors which contributed to the tragic result. Almost without exception, the witnesses impressed as good people and conscientious public servants. Nonetheless, it was haunting how almost every witness managed, during 2009, to contribute, in some way, to a looming tragedy.

28. These submissions will descend to the detail and identify a number of these individual mistakes.

29. Perhaps, the lessons of numerous and well-shared mistakes is that an ethos change is required. Perhaps, the goodwill and good intentions of most public servants can only be harvested if we expect more of each public servant. Perhaps, only the rising tide of increased expectations can raise the group to a higher level and save both the Service and those they serve therein from future disasters.

30. These submissions have been written over a period of time that extended from the end of the first five weeks of hearings until the close of the submissions period. It became clear during the process of writing that it would be impossible to deal with the whole chronology of events in the detail that the evidence deserved.

31. Accordingly, while the evidence of some early witnesses (which covers the early part of the chronology) is examined in the pages which follow, the latter part of the submissions focus on the period which followed Matthew's death on 14 October 2009. The focus is particularly upon the decisions (and failure to decide) that culminated on 28 October with the announcement of changes to guidelines on 2 November 2009.

32. The discussion of this period is conducted as a holistic one looking at evidence from many sources and the actions of many people. This discussion is then supplemented by looking at the evidence and role of three individuals, Mr. Keeffe, Mr. Forbes and Mr. Hoffman each of whom may have particular parts to play in the events of that period.

[27] As well as being an orphan: http://en.wiktionary.org/wiki/success_has_many_fathers,_failure_is_an_orphan

33. The submissions then look at the decision to suspend (and subsequently abandon) the HIP on 19 February 2010. This examination is mainly done for the contextual light it throws on the actions and decisions of October 2009. Incidentally, it throws light on the whole period of the HIP.

34. The semi-final part of the submissions looks at the specific harm suffered by the parents, brothers and sister in law of Mitchell Sweeney as a result of the way in which the HIP was poorly conceived and poorly executed.

35. The very final part looks at possible recommendations available to the Royal Commission to make the kind of tragedy and more generalised disaster that the HIP came to be much less likely to happen in the future.

Mary Wiley-Smith

36. At the beginning of 2009, Ms. Wiley-Smith was Acting Assistant Secretary of the REED division of DEWHA.[28]

37. Ms. Wiley-Smith's primary involvement in the development of the HIP was her preparation, with Ms Brunoro, of costings; a risk assessment; and a delivery paper for the proposal which would, after the announcement on 3 February 2009, become the HIP component of the government's stimulus package.

38. The preparation of these documents was achieved, almost without other assistance, by Ms. Wiley-Smith and Ms Brunoro over the Australia Day weekend, 2009.[29]

39. Ms. Wiley-Smith had done preliminary policy development work on energy efficiency schemes during 2008.[30] As a result, she and Ms. Brunoro had a number of important insights concerning the challenges involved in delivering such policies and methods which were likely to deal with those challenges and deliver optimal results. Drawing on these insights, Ms. Wiley-Smith and Ms Brunoro delivered costings for delivering the home insulation over a five year period as well as over the two year period which was the subject of the primary request made of them.[31]

40. Ms. Wiley-Smith and Ms Brunoro also drew on their prior knowledge to recommend a method of delivering the policy. This was described as a regional roll-out model.[32] The regional roll-out model had been used previously by DEWHA[33] and Ms. Wiley-Smith had seen it used in a UK insulation program. The concept involved tight contracts or funding agreements with established companies which specified the standard of performance required by the Commonwealth. Ms. Wiley-Smith was particularly persuaded by the

[28] STA.001.001.0271, paragraph 4
[29] Ms. Wiley-Smith's first contact leading to her costing work occurred on 21 January 2009: see paragraph 10, STA.001.001.0271
[30] Ibid, paragraphs 5-9
[31] Ibid, paragraph 31
[32] Ibid, paragraph 55. The model had other names including lead proponent model.
[33] For example, in the Solar Cities Program

circumstance that the established companies would have established reputations that they would be ill-prepared to risk by performing their obligations in a shoddy manner.[34]

41. The regional roll-out also carried the advantage of being able both to get a better handle on demand issues by commencing in one region at a time and also to improve delivery by adjusting subsequent launches in other regions by reference to the earlier experiences on other contracts in other regions.[35]

42. A five year delivery, as it turned out, would have allowed the regional roll-out model more time and space in which to operate.[36] However, when the announcement was made on 3 February 2009, a two year delivery period and a 1 July launch date for phase 2 were built in. This rejection of the advice provided with the costings by Ms. Wiley-Smith and Ms. Brunoro was a crucial decision and a primary cause of the mistakes, errors, disaster and tragedy which followed.

43. It is significant that Ms. Wiley-Smith gave evidence that the regional roll-out method and its contract with lead proponents were intended by her as an important method of delivering on training and workplace health and safety for the Plan. It was proposed that workplace health and safety would be handled through the very tight contracts with the lead proponents or regional brokers.[37]

44. Ms. Wiley-Smith also envisaged that the regional roll-out model would be well calculated to deliver the training that would be required by installers in an expanded industry. The large and established installation companies subject to the government contracts would also train their new employees.[38]

45. It was envisaged that express safety obligations would also be built into the contracts with established companies with established reputations.[39]

46. In many respects, then, the failures of the HIP can be traced to the failure of the government to follow the advice of Ms Wiley-Smith and Ms Brunoro.

47. It may also be seen that Ms Wiley-Smith and Ms Brunoro also contributed to the subsequent decision failure.

48. The delivery document was one of the first documents delivered to Mr Johnston at the end of the Australia Day weekend travails.[40]

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[34] Ibid, paragraphs 23-24.
[35] Ibid, paragraph 34
[36] This was foreshadowed in the delivery paper written with the costings. See extract at paragraph 36, STA.001.001.0271
[37] Ibid, paragraph 23
[38] Ibid, paragraphs 53 and 54
[39] Ibid, paragraphs 55 and 56
[40] STA.001.001.0291: email dated Sunday, 25 January 2009, 6.48 PM. The email commences annexure 5 to Ms Wiley-Smith's statement. The delivery document commences at page 0293.

49. The delivery document does articulate the risks associated with the policy proposal. It identifies risks of over subscription; risks of fraud; and risks of price increases.[41] The document recommends that the delivery period be expanded to 5 years and it recommends delivery using the regional method using lead proponents.[42]

50. The five year period was rejected by 3 February 2009. However, DEWHA, with Ms. Wiley-Smith, no longer engaged in the HIP, continued to contemplate using regional delivery and contracts with lead proponents. The push to abandon that model appears to have come from Mr Mrdak, the coordinator-general and his officers. Their arguments appear to have had little effective challenge because it was obvious to most officers that an Australia wide roll-out on 1 July 2009 would not have been possible using contractually bound lead proponents.

51. The problem, from the perspective of the Commission, is that the documents produced by Ms Wiley-Smith and Ms Brunoro on Sunday evening, 25 January 2009, fail to articulate the importance of established firms (with reputations to defend) to the key areas of workplace safety; safety more generally; and training, itself, a key constituent of safety and quality.

52. Ms Wiley-Smith acknowledged this absence in her oral evidence on day 1 at page 100 as follows:

    "MR KEIM: Yes. Okay. Now, are you able to take us to anywhere where you specifically indicated that workplace health and safety issues, and I guess I would mention training issues as well, where you've expressly said, "This is the way that's going to be dealt with by the lead proponent contracts"?

    THE WITNESS: Not in the documentation here. No.

    MR KEIM: Yes. And I'm just –is it possible that it's in documentation that we're not able to see, or is it not dealt with in that document at all?

    THE WITNESS: I'm not sure that it was in that document because it was just an assumption. I mean, between Beth and myself, we had managed these types of issues before - - -

    MR KEIM: Yes.

    THE WITNESS: - - - with those types of contracts. And so it was something that we didn't feel like we had to say. It was manageable within the model. We would work across with our legal providers, and also, with other agencies to ensure that we had all of the provisions in those lead contracts, and it would seem that it had worked in previous program roll-outs. Though, the other program roll-outs weren't of this size, which is why we suggested that you actually have a trial first.

    MR KEIM: So I guess I'm interested in this. It might be fair to say that you're trying to persuade those who were making the final decision with regard to the roll-out and the sake

[41] STA.001.001.0291 at 0293 and following
[42] At STA.001.001.0295: See also page 0299 under "Delivery Technical – Medium"

of the program. You were suggesting to them fairly strongly that a five-year roll-out would allow objectives to be achieved much more readily, and would be much less risky. But was there anything in what you're able to produce over that long weekend which indicated workplace health and safety and training issues are a matter of real concern, which you will really have to address if you don't go with a five-year rollout? Was there any signposting like that for those people who were acting with the benefit of your advice?

THE WITNESS: I don't believe that there was any signposting in some – in the material. There could have been discussions around it, but I'm not sure."[43]

53. It may be unlikely that persuasive lines by Ms. Wiley-Smith in the delivery document would have changed the government announcement on 3 February. It may have been an equally forlorn hope that the officers of the coordinator-general would have been diverted from their commitment to 1 July as a commencement date.

54. However, the effect of Ms. Wiley-Smith and Ms. Brunoro keeping the health and safety issues to just an assumption between themselves could be seen when the decision to abandon the lead proponent model was being discussed at the end of March. The more senior officers of DEWHA involved in those discussions, Mr Carter, Mr Keeffe and Ms Kruk, were completely unable to articulate, and apparently completely unaware of, the importance of, lead proponent contracts to ensuring training and safety.[44]

55. As a result, the lead proponent strategy was abandoned without any real consideration of implications for safety of so doing.

56. Ms Wiley-Smith ceased to be involved with the HIP after 3 February.[45]

57. One is left to regret that the delivery document did not contain the sorts of phrases such as "in the proposed model, safety would be a primary concern for the contracted parties" which now occurs in Ms Wiley-Smith's evidence. One is left to speculate that such language may have been the start of an articulated strategy that set out the safety benefits of the lead proponent model.

58. If such a strategy had been developed and articulated, a better discussion may have taken place between 26 and 31 March 2009. In particular, Ms Kruk and Mr Garrett, at the Maroubra meeting, may have been aware of the dangers associated with abandoning the concept of contracts with lead proponents in order to meet a pre-ordained date.[46]

59. A small chance may have been lost to avert the disaster and tragedy that followed.

Beth Brunoro

60. Ms. Brunoro worked with Ms. Wiley-Smith over the Australia Day weekend.

[43] RCI.006.001.0100-0101
[44] See RCI.006.001.0001 at pages 1606 – 1609 and AGS.002.008.0434 (Keeffe); RCI.006.001.0001, pages 439, line 5 – page 442, line 30 (Carter); and page 1236, line 25 – 1238, line 45 (Kruk)
[45] STA.001.001.0271, paragraph 57
[46] On 3 April 2009: immortalised in Mr. Hoffman's infamous summary: AGS.002.008.3542

61. Ms. Brunoro came on 3 February 2009 to her role as the inaugural director of the HIP team[47] with a deal of expertise. Ms. Brunoro had, with her team, been engaged in analysis to identify energy efficiency opportunities since the beginning of 2008.[48] Ms. Brunoro, herself, had been involved in providing analysis support to an energy efficiency team in the Department of Prime Minister from August 2008.[49]

62. As the co-author of the delivery document setting out the advantages of the lead proponent regional delivery model for the HIP,[50] Ms. Brunoro shared Ms. Wiley-Smith's understanding that the model was crucial to delivery on W. H. & S. issues. She also felt it unnecessary to set those considerations out in the document.[51]

63. Ms. Brunoro's actions in respect of certain events of 18 and 19 February 2009 are crucially important to the Commission's inquiry.

64. At an industry consultation meeting on 18 February, Mr. Peter Ruz, a representative of the ICANZ industry group, is recorded as giving a very explicit warning about the dangers of using RFL and, particularly, when mechanically fixing it to timber in the vicinity of live wires.[52]

65. Ms. Brunoro was not the only public servant in a position of responsibility at that meeting. However, her responsibility to ensure that action was taken was heightened by Mr. Ruz's actions both after the meeting and on the next day.

66. After the meeting, Mr. Ruz handed to Ms. Brunoro copies of some newspaper articles reporting the New Zealand deaths.[53]

67. Mr Ruz sent an email to Ms Brunoro (also copied to Ms. Marconi). The email contained a repeat of the warning in the following terms: "Moreover, reflective products when installed as a retrofit in an attic space will typically be stapled to the roof timbers and we need to heed the experience from New Zealand where three contractors doing this type of work were electrocuted."[54]

68. Ms. Brunoro's perception of the industry at the beginning of 2009 was that the insulation industry was neither well-regulated nor coherent.[55]

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[47] STA.001.002.0001, paragraph 5
[48] Ibid, paragraph 7
[49] Ibid, paragraph 13
[50] The delivery document is in STA.001.001.0291, commencing at 0293
[51] Ms. Brunoro sets out her reasons for not mentioning safety in the document in RCI.006.001.0100-0297 at page 297, line 44 – page 298, line 20 of the transcript. Her evidence is very similar on this point to that of Ms. Wiley-Smith.
[52] The minutes are STA.001.002.0141. The report of Mr. Ruz's comments are at page 0145.
[53] STA.001.001.0193 at page 0196, paragraph 24: it would appear that MIS.002.001.0005 is one of those newspaper reports.
[54] AGS.002.017.1602
[55] This is reflected in her evidence at RCI.006.001.0100 at page 299, lines 5-15

69. There are different ways in which Ms. Brunoro could have responded appropriately to the information received by her from Mr. Ruz. Optimally, it should have been responded to as part of a systematic response to the information received and problems identified during the consultation meetings held (together with information received from other sources).

70. One could easily envisage a template document or documents being prepared (and shared) which gathered, under headings such as training; suitable product; quality installation; property safety; and worker safety, each piece of important information received.[56]

71. This template document could have been used to make all involved in the HIP aware of the issues identified. It could have been used to allocate, to team members; industry experts; independent experts; or regulators, the tasks of further researching the issues.

72. The process could have led to some issues being discounted and discarded. It should have led to the dangers of RFL insulation having been identified as a real source of great danger that would have required both careful research and careful decision making on a number of counts.

73. This legacy can be seen to have expressed itself in the period at the end of March when the OCG questioned DEWHA's ability to deliver by the due date using its lead proponent model and DEWHA, effectively, had nothing to say in resisting a change to what became the Medicare business model.[57]

74. For example, Mr. Carter frankly expressed a complete inability, for lack of detailed information, to pursue an argument that highlighted the safety and compliance advantages of the lead proponent model.[58]

75. And, when Mr. Carter and Mr. Keeffe went to Ms. Brunoro for ammunition, on the night of 31 March 2009, all they received was some anecdotal suggestion that Medicare's IT capacity was less than perfect.[59]

76. Alternatively, Ms. Brunoro could have just emailed her team and her supervisor with the information provided by Mr. Ruz and pointed out that the installation of RFL was something that was potentially dangerous and had to be properly considered in setting the HIP in place.

77. It seems passably clear that Ms. Brunoro did not forward her copy of Mr Ruz's email to anyone.[60] There was certainly no effective management of issues arising from industry

[56] Ms. Brunoro was made aware also of the need for effective auditing of installations to ensure success of the program. This came from a record of Ms. Horvat's consultations with industry personnel. See AGS.002.008.0281 at page 0283

[57] RCI.006.001.0001 at pages 1606 – 1609 and AGS.002.008.0434 (Keeffe); RCI.006.001.0001, pages 439, line 5 – page 442, line 30 (Carter); and page 1236, line 25 – 1238, line 45 (Kruk)

[58] For example, see his lack of awareness at RCI.006.001.0100 at page 440, line 14 – page 441 line 3 and page 442, lines 30-40.

[59] The email exchange referring to "ammo" is STA.001.015.0035. Mr. Keeffe's evidence as to the content of Ms. Brunoro's ammunition is at RCI.006.001.0001, page 1446, line 20 – 1447, line 45.

[60] RCI.006.001.0100 at page 303, line 40 – page 304, line 25

consultations.[61] Knowledge of the New Zealand deaths fell completely out of the corporate knowledge base of DEWHA (and the Office of Coordinator General) until further warnings were received after Mr Fuller's death in October.[62]

78. The need for training was accepted and both DEEWR and CPSIC played a role in developing a national training syllabus and materials and the PocketBook.[63]

79. However, the events following the industry consultations in February and March do not exhibit a careful collating of the opinions on training expressed at those meetings leading to research, analysis and decision making. This absence of a careful and informed process may have contributed to the disastrous decision to recant on mandatory training for installers made by the Project Control Group ("the PCG") on 8 May 2009.

80. Ms Brunoro left the HIP team on 21 April 2009.[64] Her departure appears to have been contributed to by ill-health that she was suffering at the time.[65] Regrettably, the corporate knowledge that she carried with her was lost. The lack of systems to store, organise and process knowledge accentuated that loss.

81. The Risk Assessment Process engaged in as part of the implementation of the HIP appears to have used up considerable amounts of time, resources and money.

82. One clear contribution of the Risk Assessment Process was to identify something that was obvious, namely, that to procure all the necessary lead brokers for the whole of Australia and have them operating by 1 July was impossible.[66]

83. The Risk Assessment Process appears to have contributed to hiding a second obvious circumstance, namely, that it was equally impossible to launch stage 2 of the HIP with the necessary training; IP support; controls; safety mechanisms; audit controls; and in situ inspections to ensure that it was passably safe; passably free of widespread fraud; and passably efficiently carried out.

84. Instead of facing this obvious circumstance, decision makers seem to have been seduced by risk assessment jargon to ignore it and to pretend that "risks" were being addressed by "treatments".

85. It is no less concerning that senior public servants seem to have willingly embraced this state of ignorance.

[61] RCI.006.001.0100 at page 302, line 20 – page 303, line 40
[62] And the subsequent warnings from Mr. Asche and others at the Technical Advisory Group meeting on 3 April 2009 went the same way as Mr. Ruz's warnings: AGS.002.014.1432.
[63] As seen above (paragraph 4), Mr Smith claimed to have had used the PocketBook, including the warning at page 35, in his testing of Mitchell for recognition of his prior learning.
[64] STA.001.002.0001 at paragraph 79
[65] RCI.006.001.0100, page 314, lines 30-40
[66] This is strongly expressed in MIN.002.001.1479.

86. Ms. Brunoro gives evidence that, when she left the HIP on 21 April, she recommended that the original Risk Assessment Process be re-assessed in light of the move to a different business model.[67]

87. However, because no document ever set out in clear terms the importance of the lead proponent business model to values such as training; safety; quality; quality control; and auditing, any such process of re-assessment was likely to be, and was, meaningless.

88. Ms. Brunoro's involvement in respect of ensuring that risks to installers were properly taken into account has been called into question in one other respect.

89. On 23 March 2009, a risk identification workshop was held and facilitated by Ms. Coaldrake.[68] In a document coming out of the brainstorming workshop,[69] Ms. Coaldrake produced a summary document which included in box 15, thereof "installer injury" and "installer injuries" as part of a group of risks headed "installation quality".[70]

90. This might be considered a poor second best to identifying the specific danger of stapling RFL (and other specific injury risks identified in consultations)[71]

91. This reference to a risk of installer injury remained in draft risk registers subsequently produced in a process of consultation between Ms. Coaldrake and officers of DEWHA. However, it had disappeared by the time the first final risk register was produced for the PCG on 9 April 2009.[72]

92. It was not until the re-examination of Ms Coaldrake by her counsel, Mr. Treffers,[73] that the evidence suggested that the reference to installer injury in the draft risk register documents was deleted by departmental officers (without identifying the change) in a document sent back to Ms. Coaldrake at 11.13 am on Friday, 27 March 2009.[74]

93. Ms. Marconi's email is copied to Ms Brunoro and others in her team. It refers to the altered document as "containing the Directors input".[75] It does not flag the dropping of the reference to installer safety. Ms Coaldrake identifies Ms Brunoro as a director (along with Mr Hoitink).[76]

94. 27 March 2009 was about the time that officers of the Office of Coordinator-General were about to guide the abandonment of the lead proponent regional broker model.

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[67] STA.001.002.0001 at paragraph 79
[68] Records of the meeting are included in MIN.002.001.5875
[69] See Ms. Brunoro's evidence at RCI.006.001.0100, page 307, line 20 – page 308, line 35
[70] At page MIN.002.001.5882
[71] See the subsequent training workshop of 3 April and its identification of "high likelihood of catastrophic consequence (death or serious injury)" and a need to conduct a risk identification process focussed on installer safety itself: AGS.002.014.1432
[72] Tab 4 in the hard cover book: QIC.006.001.0237
[73] RCI.006.001.0100, pages 2354-2357
[74] MIN.002.001.0117: the document containing the changes is MIN.002.001.0119
[75] No apostrophe is used.
[76] RCI.006.001.0100, page 2356, lines 25-35

95. On 8 May 2009, the requirement for installers to undergo insulation specific training was deleted and replaced with the need only to have a basic OH & S white card (provided they were "supervised").

96. The move to develop some kind of training materials was on foot.

97. It is unlikely, in the light of all the evidence, that two small entries in the risk register referring to "installer injury" would have markedly changed the circumstances in which stage 2 of the HIP was to be launched.

98. However, the dropping of those references remains an unexplained and troubling event. And, on my knowledge of the evidence, Ms. Brunoro's possible involvement in that action has not been resolved, one way or another.

Ross Carter

99. During the period from February to June 2009, and to a lesser degree from June to December of the same year, Mr Carter was the first assistant secretary in DEWHA who had responsibility for the HIP.[77]

100. Mr. Carter's role appears to have been very much as an officer immediately senior to Mr. Keeffe.[78]

101. The records suggest that Mr. Carter attended PCG meetings.[79]

102. Mr. Carter is one of a number of witnesses who orally expressed concerns about DEWHA's ability to deliver the HIP.[80] It appears that there are no written expressions of such concern by Mr. Carter.

103. Mr. Carter had an opportunity to play a role in policy development during the interaction between DEWHA and officers of the OCG in the days before and after and including 31 March 2009. It was during this period that the lead proponent business model was effectively abandoned for a model where anyone who met the Guidelines could register as a supplier and start providing insulation and charging the Commonwealth ("the Medicare model").

104. Mr. Carter states that he and Mr. Keeffe shared a view that the lead proponent model provided significant advantages in respect of controlling risks of fraud and workplace health and safety risks.[81]

105. However, Mr. Carter appears to have raised no argument at all to support retaining the lead proponent model. This appears the case both in terms of arguments presented to

[77] STA.001.001.0340, paragraph 6
[78] This appears generally from the evidence but is consistent with the statement in STA.001.001.0340, paragraph 7. See, also, paragraph 14.
[79] For example, see AGS.002.007.1807 and AGS.002.013.2191.
[80] STA.001.001.0340, paragraph 15
[81] This seems to be the effect of STA.001.001.0340, paragraph 39

the officers from the OCG[82] and in terms of briefing his own department head, Ms. Kruk and minister, Mr. Garrett.[83]

106. This was a pivotal period in the development of the tragic dimensions of the HIP. The OCG officers were wound up to reject a model that had been chosen for considered reasons in favour of a model that nurtured chaos on grounds that were ideological (small players and consumer choice)[84] and time driven.[85]

107. Ms. Wiley-Smith and Ms. Brunoro recall that there were strong safety factors favouring the lead proponent model. It seems to be conceded that the OCG officers were correct in saying that the lead proponent model would not be able to deliver an Australia wide roll-out by 1 July.

108. There was an opportunity for Mr. Carter, as Mr. Keeffe's immediate support and supervisor, to initiative a robust discussion within DEWHA and with OCG about time frames; models; and program delivery and performance. It was appropriate to concede that the lead proponent model would need further time but it was incumbent upon the specialists in the line department to point out all of the fraught implications of proceeding in a new direction for reasons that were ideological and ill-thought out.

109. There was a meeting scheduled for 3 April 2009 at Mr. Garrett's electoral office at Maroubra. There was time to marshal the information and expertise within DEWHA. There was time to brief Ms. Kruk and Mr. Garrett. There was an opportunity to ensure that, whatever decision was made at this juncture, it was an informed and well considered one.

110. Instead, apart from exchanging some late night emails with Mr. Keeffe,[86] Mr. Carter simply stood aside and let the OCG officers have their way.

111. From the point of view of the family of Mitchell Sweeney, an opportunity to introduce a degree of sanity into decision making processes that were defaulted to disaster was lost.

112. Not many further opportunities offered themselves.

The Decision to Decline to Ban Reflective Foil Laminate

113. Matthew Fuller died on 14 October 2009.

114. Matthew's death was caused or contributed to by many actions and omissions that had occurred in the design and implementation of the HIP. These included the decision to inflict an unreasonable timetable on those whose task was to implement the scheme roll-

[82] See RCI.006.001.0100 at page 439, line 5 – page 441, line 15
[83] RCI.006.001.0100 at page 441, line 15 – page 442, line 30
[84] See Mr. Hoffman's email: AGS.002.008.0419
[85] See STA.001.008.0001, para 30 (Mr. Hoffman)
[86] STA.001.015.0035: the inference that flows from all of the evidence is that Mr. Carter's and Mr. Keeffe's strong reactions had more to do with an insult to their professional standing as officers of a line department who had been disrespected by officers of a central department than with the pros and minuses of program delivery models.

out.[87] They included the failure of numerous public servants to pass on and act upon information concerning the dangers of RFL affixed to ceiling joists such as that which was provided by Mr. Ruz at the meeting on 18 February 2009.[88]

115. Another failure concerned the omission to include information concerning the dangers of retro-fitting insulation into homes, as was received at the Technical Advisory Committee meeting 4 April 2009, into the risk assessment documents and other decision making tools of the program.

116. Another crucial failure involved the failure to pass on and act upon information from State and Territory Fair Trading Officers advising, in support of the ACT's Craig Simmons, that the scale of the HIP would change the dynamics of existing market conditions and increase the risk of poor quality work from unskilled labour.[89]

117. The safe implementation of the program was initially premised upon an effective and universal training system; the broad availability of the pocketbook with its easy to access safety information and safety warnings; and a strong and effective audit and compliance system with a strong "in the roof inspections" presence.

118. It was abundantly clear to anyone who cared to look that none of these would be in place until well after 1 July 2009. The obvious response, in the interests of safety and effectiveness, was to delay the start of stage 2.

119. The response was, instead, to cut back on training requirements for installers and to ignore the other missing elements.

120. In doing so, a vaguely worded and undefined requirement for supervision was deliberately chosen in preference to references to on the job training.[90]

121. Many of these initial omissions and failings were, in turn, at least partially, caused by the original deadline for the phase 2 roll-out of 1 July. Public servants working under time pressure appeared to exercise poor judgement on a regular basis.[91]

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[87] The announcement of 3 February 2009 and the failure to depart therefrom

[88] The meeting of 18 February was attended by Messrs. Cox and Wilson (OCG); Holt, Kimber, Keeffe (DEWHA) and Johnston (PM & C) and Mss. McArthur, Marconi and Spence (DEWHA) as well as Ms. Brunoro.

[89] The minutes of the meeting are AGS.002.032.0580

[90] See AGS.002.030.0012 (draft of competencies which includes Ms. McEwen's "training staff on-the-job is permitted …"; AGS.002.023.2897 (new wording by Hoitink and Katrina Leach); and RCI.006.001.0001, page 2900, line 1 – page 2903, line 45 (Mr. Hoitink's explanation of the process). No clarity emerged as to what Mr. Keeffe and Mr. Hoffman had respectively said at PCG meetings to set this process in train. On this point, Ms. McEwen said that her draft referring to training on the job was directed to meet what Mr. Keeffe had said at the PCG on 1 May 2009: RCI.006.001.0001, page 2801, lines 25-35.

[91] There is no rational explanation for the failure of Installer Advices (in the period July to September) to address safety issues in every issue. By this time, the time pressure to roll out was in the past. At the very least, the availability of the PocketBook online should have been advertised strongly. This failure shows a lack of any safety culture or safety consciousness within the sections of DEWHA administering the HIP. It was as if junior officers really had internalised the message that safety was a matter for somebody else and not them. It provides an important context for the competing evidence of Mr Kimber and Dr. Delbridge which also involved the level of concern for safety among the HIP administrators.

122. And Matthew's death, like that of Mitchell almost exactly four months later, was due to the fact that RFL was permitted as a retro-fitting product under the Guidelines of the HIP.

123. This also may be partially attributable to time pressure leading to a failure to recognise the danger of RFL laid over the joists in a ceiling. (Right from the beginning, however, there appears to have been an unexplained desire not to offend anyone by excluding any product from the scheme. This, in addition to time pressure appears to have played a role.)[92]

124. Matthew's death provided the clearest of warning signs about the dangers of RFLs laid over ceiling joists.

125. This was an opportunity and gave rise to an obligation to re-think the dangers associated with the product used in this way.

126. That opportunity was squandered and Mitchell's death followed, four months later, as a direct result.

127. As mentioned earlier, these submissions will concentrate on the period between 14 October and 2 November 2009 when the opportunity to ban the use of roll-out foil was spurned in favour of a decision to ban the use of metal staples and other policy changes which took a less robust approach to ensuring safety of the installer. That decision (or failure to decide) may be seen as a direct cause of Mitchell's death.

128. The nature of that decision making process in October is highlighted by the events that swiftly followed Mitchell's death. Public servants, including from DEWHA, suddenly came to a realisation that the HIP could not be conducted in a safe manner. It was as if one more death caused the scales to fall from their eyes.

129. If the same decision makers had been able to read the signs staring at them in October 2009, Mitchell's life would have been saved and Matthew's parents would, at least, have had the satisfaction of knowing that their son had not died in vain. If the decision in October had not stopped at banning foil but had included the suspension of the whole program, the lives of two more young men would have also been saved.

130. It is to a detailed consideration of those events in October to which these submissions turn.

The Death of Matthew and the Immediate Aftermath

The D'Arcy Warning and the Kruk Letter

131. Apparently unconnected with the death of Matthew, Mr. Garrett had requested his Department Head, Ms. Kruk, "to review the systems and procedures underpinning your demand driven programs".[93] Mr. Garrett attributes[94] Ms. Kruk's response to an earlier

[92] This concern not to offend is discussed below, particularly, in the context of evidence of Mr. Keeffe.
[93] STA.001.069.0091, letter dated 14 October 2009 from Ms. Kruk to Mr. Garrett
[94] STA.001.069.0001, para 139

lost letter from him. The letter of Ms. Kruk refers not to such a letter but to a conversation in Hobart, the previous day.

132. The importance of this exchange derives from Mr. Garrett's statement that he had, immediately prior to Matthew's death, had concerns "about the capacity of the Department to manage the [HIP]".[95]

133. It is also clear, from Ms. Kruk's letter, that even a draft report going to changes would not be available until 26 October 2009.[96] That is, his requested changes would not be in place to assist his decision making in the immediate future.

134. In finding the correct policy responses to the death of a young man working in the HIP, Mr. Garrett should have been well aware that he needed to second guess his Departmental advice at every step. Mr. Garrett's tendency to rely on advice coming to him stands in stark contrast to Mr. Combet's later performance of his Ministerial duties where he seemed, from his evidence to the Royal Commission, to be in control of and ahead of events with sufficient awareness to know whether things were or were not going in the right direction.

135. Mr. Garrett's lack of acceptance that he needed to watch his Department's advice giving functions carefully in October 2009 showed a lack of touch with reality on his part.[97]

136. The second warning to the Minister and his staff that DEWHA had not operated to an appropriate standard related to a failure by the Department to pass on crucial information. The warning came with a phonecall from Mr. D'Arcy to Mr. Levey soon after Matthew's death became public.[98] Mr. D'Arcy indicated that information had been previously provided to the government that foil was a risk.[99]

137. Mr. Levey indicates that it was ascertained that Mr. D'Arcy was referring to the consultation meeting on 18 February 2009 at which Mr Ruz warned of deaths in New Zealand using foil.[100]

138. Mr. Garrett stated that he had no recollection of this matter.[101]

139. It is inconceivable, in light of the explosive political significance of the subject at that time, that Mr. Garrett was not made aware of Mr. D'Arcy's suggestion and the subsequent confirmation that such a warning had been provided, at least, to the Department.

[95] Ibid
[96] STA.001.069.0091
[97] RCI.006.001.0001, page 4688, line 15 – page 4689, line 15
[98] STA.001.003.0001, paras 321-325
[99] Ibid, para 321
[100] Ibid, para 324 and RCI.006.001.0001 at page 613, lines 15-40
[101] RCI.006.001.0001, page 4684

140. Having been so warned, it is concerning that Mr. Garrett has no vivid recollection of sending some kind of message to the Department that he would not tolerate any failure to bring important safety information to his notice.[102]

141. This became important within a short time because of the events surrounding the Speranski and Mosher emails.[103]

Malcolm Richards and the Master Electricians Association

142. It is because of the actions of Malcolm Richards that Mr. Garrett was squarely required to consider the question whether RFLs needed to be suspended or banned from the program.

143. Mr. Richards' letter dated 16 October 2009[104] warned that potential fatalities cannot be dismissed. He said that a majority of previous incidents are attributable to two areas, one of which was staples used to hold down aluminium insulation coming into contact with electrical wiring.

144. Mr. Garrett received this letter.[105]

145. In a press release forwarded with the letter,[106] Mr Richards was even more explicit. The release said that the government must withdraw the rebate immediately from metal-based insulation products which were simply not safe. From an electrical point of view, it was said, it is highly dangerous to lay products over cables and staple them in place as these metal types of insulation require.

146. The third document from the MEA was a more detailed set of briefing notes.[107] Mr. Garrett could not recall when he received it.[108] The briefing notes expressly warned Mr. Garrett that installers working in the HIP generally did not have anything more than rudimentary O H & S knowledge and that very few had any electrical knowledge. The briefing notes also warned of many near misses' having occurred.

147. Mr. Richards said that he provided these notes to Mr. Garrett[109] prior to their meeting which took place on Tuesday 20 October 2009.[110] This is confirmed by their being attached to the department brief.[111]

148. Some idea of what was said at the meeting may be obtained from Mr. Levey's notes of the meeting.[112]

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[102] The answer at RCI.006.001.0001, page 4685, lines 35-45 is notable mostly for its vagueness.
[103] If Mr. Garrett was told of the Ruz warnings given back in February, he was also aware therefrom of the substantive content of those warning that "a similar program in New Zealand had to be suspended because three people electrocuted themselves".
[104] QIC.006.001.1999
[105] STA.001.069.0001, para 141
[106] AGS.002.017.0056
[107] AGS.002.017.0065
[108] RCI.006.001.0001, page 4690, lines 15-25
[109] STA.001.033.0001, para 33
[110] See department brief from that meeting: AGS.002.015.1625
[111] Attachment C to AGS.002.015.1625

149. Mr. Garrett's response, as noted by Mr. Levey,[113] has the depressing sound of talking points about it. He states that safety is a priority and that he is alarmed to hear that there could be more fatalities. Immediately, thereafter, Mr. Garrett starts downplaying the problem: We have a comprehensive audit and compliance program;[114] foil is a minor component; it is most relevant to certain climate zones; … I have a dim view of those who break the guidelines."

150. It is the response of someone who does not have the ability or confidence to engage with and probe a source of advice to gauge for themselves the dimensions of the problem and the extent to which further research and consultation needs to occur. Mr. Richards was a golden opportunity for the Minister to increase his knowledge base and obtain a grasp of the issues with which he had to grapple. He did not seize the hour.

151. Mr. Richards also found that meeting disappointing.[115]

<u>The First Briefing</u>

152. In his oral evidence, Mr. Garrett was keen to point out that he did not accept all the advice (post Matthew's death) that the Department provided and that he rejected some and sought more detail.[116] In terms of consultation meetings held on 27 and 28 October 2009, Mr. Garrett claimed that this approach to decision making was driven by him.[117]

153. It is contended in these submissions that the process which Mr. Garrett claimed to have driven turned out to be controlled by Departmental officials. It turned out to be a bad process in that the key matters that needed to be addressed were not canvassed or considered. The safety of installers was not paramount in that process.

154. However, in order to put that process and the government's decision to take measures other than banning RFLs in perspective, it is necessary to look at the advice that was provided to Mr. Garrett and the investigative steps, if any, that underpinned such advice.

155. The first departmental brief is dated 19 October 2009.[118] The brief is signed off by Mr. Keeffe with Ms. Belka as secondary contact.[119]

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[112] STA.001.003.0001, paras 328-326
[113] STA.001.003.0001, para 331
[114] As at 15 October, 255 roof inspections had been conducted and 231 desk top audits of installer competency had been carried out: AGS.002.0081151_0001 (prepared as a report to the PGC meeting of that date). This is hardly comprehensive in the normal senses of the word.
[115] STA.001.033.0001, para 36
[116] RCI.006.001.0001, page 4694, lines 5-10
[117] RCI.006.001.0001, page 4694, lines 35-45
[118] AGS.002.015.1625
[119] Ms. Belka suggested that the content of briefs may have been written by various people in her team including herself and that Mr. Kimber, Ms. Kaminski and Ms. Kortt were involved in writing initial drafts of such briefs. See STA.001.064.0002, paras 11-12 (and RCI.006.001.0001, page 3865, lines 35-45). Ms. Belka states that the team did a lot of research and the brief drew on knowledge in the Department and the advice of industry experts. In her oral evidence, Ms. Belka stated that, as secondary contact, she would generally draft the briefs: RCI.006.001.0001 at page 3777, line 1.

156. One of the first statements made in the brief is that foil insulation is covered by the relevant Australian standard. This misleading statement is symptomatic of DEWHA's technical incompetence.[120] The whole concept of total R insulation performance values were introduced to allow RFLs to comply with the Guidelines. Anybody who had been involved in developing the Guidelines in the first half of the year, including Mr. Keeffe, should have known that it was a misleading simplification to say that retro-fitted foil insulation is covered by the relevant Australian Standard.

157. One would also hope that the Minister, who had been administering the HIP for nine months, would have had a staff member who would be enough on top of the area to recognise the misleading nature of the statement.[121]

158. The brief was for Mr. Garrett's meeting with Mr. Richards. The brief attaches the letter,[122] press release[123] and briefing notes[124] from Mr. Richards. One would expect that the key statements in those documents would be outlined with relevant comments from the DEWHA officers. Mr. Richards' propositions are given only three lines in the brief. The AFIA position gets six lines.

159. The brief quotes AFIA as saying that foil is no more dangerous than other insulation provided it is done with due diligence by competent installers. The qualification goes on to mention a need for knowledge of electrical issues particularly those occurring in older homes. The least that one could expect from briefers is that the comments in the briefing notes concerning the inexperienced and unskilled nature of the installer workforce under the scheme might be drawn to the reader's attention.[125] No such assistance is provided in this brief.

160. The failure is particularly concerning in that the Department had information since August that new entrants to the market did not adequately meet required standards on skill competencies.[126]

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[120] One of the most difficult technical question faced by the HIP team within DEWHA was how to specify what type of insulation would qualify for the scheme. The matter arose immediately after the first set of Guidelines for phase 1 were issued. AFIA, the foil industry lobby group, felt that their products were being excluded and argued for a total R standard and for a term broader than **ceiling** insulation. See the emails at ABC.002.001.2289 and 2291 and AGS.002.010.0719 for the controversy. Note that the recipients of the last email mentioned include Kimber, Marconi, Spence, Beath, Riordan and Keeffe. Mr. Kimber's email on 27 February states: "reflective foil products are outside the scope of that standard". His informant, Mr. Brian Ashe, of the Australian Building Codes Board, sets out the details in STA.001.083.0001 at paras 11-15 and 18-24.

[121] This is not a criticism of Mr. Levey who appeared frank and honest in his evidence and competent. It is more a suggestion that Mr. Garrett should have instructed Mr. Levey or someone else to attend sufficient briefings so that a competent source of insulation technical advice was directly and immediately available to him. Mr. Garrett does not seem to have pursued this kind of technical precision in his political advisors.

[122] QIC.006.001.1999

[123] AGS.002.017.0056

[124] AGS.002.017.0065

[125] The material brought to the Minister's attention should include Mr. Tikey's 1 October acknowledgements in AGS.002.028.0078 as well as Mr. Richards' detailed exposition of knowledge and expertise deficiencies, among installers, in AGS.002.017.0065.

[126] Ms. Kruk in STA.001.010.0001, para 55

161. The brief also attaches an "AFIA Safety Notice-Media Release 16 Oct". Presumably, this is the source of the AFIA statement that is set out in the brief and cited above.[127] It is regrettable that there is no detail of the representations made by Mr. Tikey during October 2009 except for the short note of his statements at the meeting on 27 October 2009.[128] Mr. Tikey's persuasive ability seems to have been given the credit by Mr. Leverton for changing the mind of the State of Queensland on the subject of whether they would advocate for a ban on retro-fitting of foil products.[129]

162. It should be noted that Mr. Tikey (of AFIA) wrote to Mr. Lemmon of DEWHA on 1 October 2009[130] urging DEWHA to introduce mandatory installation training for installers. That letter also acknowledged the existence of bad practices among foil installers which were part of bad installation practices across the industry.

163. One would expect that the briefing officer would have noted this statement in this letter and brought it to Mr. Garrett's attention. It is noteworthy that both Mr. Richards and AFIA had advised that the level of danger was very much affected by whether the work was being done by competent, careful and well-trained installers.

164. The brief also gives a very flattering view of the training requirements under the scheme; the supervision requirements under the scheme; and the audit and compliance aspect of the scheme which, up to this point, had been virtually non-existent.[131]

165. Mr. Garrett, to his credit, annotated the brief to the effect that he was not satisfied.

166. The pattern that emerges from this brief, and all of the Departmental activity in October 2009, is that DEWHA officers, consistently, took a position unreasonably favourable to the product (and method of installation)[132] that had killed Matthew. When Mr. Keeffe was confronted with aspects of this behaviour, he could offer no explanation.[133]

167. Ms. McCann, who unfortunately did not get to give oral evidence, provides a small clue when she says that DEWHA received advice from HIA and early guidance from the PCG that broad representation from insulation industry was the preferred approach so that the existing market share held by each company was not adversely affected by the scheme roll out.[134]

168. Although witnesses have been reluctant or unable during the course of the inquiry to indicate the source of the points of view adhered to, certain values and principles were

[127] I am not aware that that attachment is in the evidence before the Royal Commission. It does not seem to be among the attachments to the statement of Mr. Renouf (STA.001.043.0001).
[128] AGS.002.014.1464
[129] RCI.006.001.0001, page 3979, line 40 – page 3980, line 20
[130] AGS.002.028.0078: part of annexure A to STA.001.043.0001, the statement
[131] See the report in AGS.002.008.1151_0001
[132] Ms. Belka referred to the AFIA spokesman, Mr. Tikey, as an industry expert offering technical advice: STA.001.064.0003, para 9. Her evidence at RCI.006.001.0001, page 3748-3750 gives no confidence that Ms. Belka knew that Mr. Tikey's advice should be treated with the caution appropriate to the spokesperson for a sectional interest.
[133] RCI.006.001.0001, page 1731, lines 1-10
[134] STA.001.086.0001, para 53: statements from Mr. Keeffe to broadly similar effect are discussed below.

internalised and applied by public servants during the implementation of the HIP that placed public and worker safety far from a paramount position.

169. These values were still at play during October.

Experts and Lobby Groups Consulted by Ms. McCann

170. As far as the evidence discloses, Ms. McCann appears to be the only person who has conducted inquiries for the purpose of responding to the concerns expressed by Mr. Richards.[135]

171. On 19 October 2009, Ms. McCann wrote to Max Mosher, a person whom she was told, earlier in 2009, had assisted in developing the Your Home Technical Manual.[136] Mr. Mosher's technical or scientific qualifications are not stated.[137]

172. Ms. McCann sought advice on the dangers of installing RFL insulation. In particular, she asked how likely it is to be electrocuted as a result of stapling RFL insulation across electrical wiring. She also sought information as to the types of staples which are permitted to staple RFLs in place.[138]

173. Mr. Mosher replied on 21 October that it was dangerous to put staples of any length into electrical cables and that a staple so intruding can allow the electricity to flow through the foil thereby allowing electrocution to occur. He also pointed out that electrical cables in a roof space may be damaged and dangerous for other reasons.[139]

174. Mr Mosher replied again on 22 October 2009.[140] He set out a number of extracts from Your Home Technical Manual none of which go to electrical safety. Interestingly, Mr. Mosher prefaces his extracts with the hope that "these references will help with the continued use of RFL in buildings and that the electrical industry will not force a ban on the use of foil".[141] It is not clear whether these hopes are in response to anything that Ms. McCann has said by telephone or simply the enthusiast of the small businessman in Mr. Mosher.[142]

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[135] As far as I have been able to ascertain, there is no evidence indicating any request for information prior to 20 October. The Department had, of course, received the three documents from Mr. Richards and the press release from AFIA.

[136] STA.001.086.0001, paras 47 and 61. The website referred to seems to be here: http://www.yourhome.gov.au/ and here: http://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=4&ved=0CEkQFjAD&url=http%3A%2F%2Fwww.todayshomes.com.au%2Ff.ashx%2FYour-Home-Technical-Manual.pdf&ei=5VGAU_zXPMnYkgW994HYDQ&usg=AFQjCNF5GVU6hB6mdkv4Pglsmgy4I-zlgw&sig2=Aod2pqdh2w7eCQwFpqYSIQ&bvm=bv.67720277,d.dGI.

[137] He appears to be the owner of a business called Comfy House Design: http://www.linkedin.com/profile/pub/max-mosher/16/23/a48?goback=
In the circumstances, he did a remarkably good job, asking questions and recording and passing on answers.

[138] AGS.002.027.2002

[139] Ibid

[140] AGS.002.011.1135

[141] Ibid

[142] Significantly, Mr. Mosher's sentiments did not stop him from sourcing and passing on to Ms. McCann relevant and useful technical information.

175. On 20 October 2009, Ms. McCann wrote to Melanie Foster from the HIA.[143] The content of the question relates to "the role of the supervisor in ensuring installers are meeting safety requirements" which is somewhat distant from the matters raised by Mr. Richards.[144]

176. On Wednesday, 21 October 2009, Ms. McCann received a response from Kristin Tomkins of the HIA. Ms. McCann restates the answer from Ms. Tomkins.[145] The paragraph correctly quotes so far as it relates "any change per se in the insulation requirements". The answer is a technical answer to a technical issue not asked by the questioner.

177. Ms. Tomkins goes on to say that she would defer to ICANZ in respect of "any changes on the products offered under the scheme".[146] She also stresses that the use of RFLs is relatively low. The answer is hardly a strong statement that foil laid over the ceiling joists should not be suspended from the program.

178. The statement from Ms. McCann that she (and, by implication, the HIA) would defer to ICANZ is significant. Mr. Ruz was a director and representative of ICANZ.[147] He had warned of the New Zealand deaths twice on 18 February 2009.[148] And Mr. D'Arcy, who is copied into the email, had gone to the trouble of re-warning Mr. Levey (after Matthew's death) of the warnings in February.[149] ICANZ was not in favour of RFLs laid over joists.

179. A third person contacted, indirectly, by Ms. McCann was Gleb Speranski, a Technical Team Manager with the New Zealand Energy Efficiency and Conservation Authority (EECA). The contact was originally to arrange a meeting between DEWHA and EECA officers.[150] Ms. McCann inquired why foil products were excluded from the EECA Warm Up NZ program; advised that she had located an advisory about insulation deaths in New Zealand; and advised of the incident in which Matthew had died.

180. Mr. Speranski's replies are extremely informative.[151] He advised that reflective membranes were originally banned in New Zealand on 1 July 2008. After 1 July 2009, the ban was replaced by a policy which specifies high performance; durability; and minimal safety risks. The effect of the policy is that it is very difficult (if not impossible) for foil to qualify under the policy.

181. Mr. Speranski explained why the use of plastic staples was not considered as an alternative. His explanation specifically raised the lack of efficacy of plastic staples in hard

[143] STA.001.086.0001, para 58
[144] AGS.002.030.0417
[145] STA.001.086.0001, para 59
[146] AGS.002.030.0417
[147] STA.001.001.0193, para 1
[148] In the consultation meeting and in the email to Ms. Brunoro
[149] STA.001.003.0001, paras 321-325
[150] AGS.002.017.2244
[151] AGS.002.017.2244. Mr Speranski's email advising of the ban on foil in NZ arrived on 20 October. The more detailed explanation arrived just before midday on 22 October.

timber (and the expense of finding a way to make them effective) as well as the issue that plastic staples did not fully eliminate the risk of electrocution.[152]

182. Mr. Speranski raised the issue of foil being dangerous to householders long after installation was complete as well as to installers at the time of the work. He also advised that banning foil had faced strong push back from parts of the industry. He also advised that clear specification of performance requirements had stimulated manufacturers to come up with a wide variety of products that matched the requirements. "What is the value of a human's life", said Mr. Speranski.[153]

183. The chain of emails containing Mr. Speranski's detailed information was copied several times to Ms. Belka and Mr. Kimber, as well as Ms. McCann.

184. By 22 October, Ms. McCann's section had available the non-committal answer from the HIA; the motherhood but useful advice on electrical safety from Mr. Mosher; and the very clear advice to ban foil from the EECA in New Zealand.

185. Mr Garrett would, no doubt, have been grateful to have this information laid before him.

The Second Brief of Advice[154]

186. Mr. Garrett had noted on the brief dated 19 October that his staff would be in touch.

187. This appears to have occurred as the brief dated 21 October 2009[155] is expressed to be in response to a request for urgent advice on a number of issues including whether RFLs should be secured with metal staples and whether RFLs should be banned from the HIP.

188. The advice states five propositions, three of which are said to be jointly sourced from the HIA, the Master Builders' Association (the MBA) and the Australian Building Codes Board (the ABCB).[156]

189. By the date of this brief, Ms. McCann had received at least the initial advices from the HIA, Mr. Mosher and Mr. Speranski.[157]

190. The advice that New Zealand had banned foil since 1 July 2008 was not passed on to the Minister. Mr. Mosher's advice about the general electrical dangers in roof spaces (which may have been important background) was not passed on. These omissions appear inexcusable.

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[152] Ibid
[153] Ibid
[154] It should be noted that Mr. Garrett describes this brief having been delivered to him on 23 October 2009: STA.001.069, para 147. The Minister's response is dated 24 October 2009. However, the printed date under Mr. Keeffe's name is 21 October 2009. It is clear that a flood of briefs were being prepared and they were being met with requests for more information. The precise chronology of receipt and response may not be of great importance.
[155] AGS.002.014.0409: It is likely that this brief was emailed to Mr. Levey at 5.51 pm on 21 October 2009. See Mr. Kimber's empty email: STA.001.024.0035 and RCI.006.001.0001 at page 4282, lines 1-15
[156] Ibid
[157] In the previous brief, DEWHA had advised that EECA was being consulted.

191. The three propositions said to come from the three bodies were:

a. The risks associated with retro-fitting foil are no worse than retrofitting of other insulation providing that competent installers take all appropriate safety measures.[158]
b. Rather than banning products outright, effective management of the risks associated each insulation type through training and awareness is the better approach.[159]
c. Foil insulation is covered by the relevant Australian standards.[160]

192. A real question arises whether any of the three quoted groups actually provided this information to the Department. The brief refers to an attachment called "coverage of electrical safety under the program and consultation with industry". I have not been able to locate this in the evidence. It is unclear whether it refers to a future consultation or documents obtained in the consultation that is claimed to have occurred.

193. The communication with Ms. Tomkins[161] does not justify any of the three propositions being attributed to the HIA.

194. It is unclear from the evidence whether any consultation had been conducted with the MBA since 14 October when Matthew died or in response to Mr. Richards' representations.

195. It appears very unlikely that the ABCB had made any statement to that effect. Mr. Asche (who also did not give oral evidence) makes no reference to any communications between the ABCB and DEWHA in October.[162] His earlier communications cited above indicate that the statement about foil complying with the relevant standard was misleading if not untrue.[163]

196. But Mr. Asche had also warned DEWHA, earlier in the year, to do an audit of installer safety and had warned of the myriad dangers associated with the HIP.[164] According to Mr Asche, he was, at least, one of the sources of a number of the conclusions stressing the risks to installer lives and well-being that were recorded in the minutes of the technical advisory group meeting held on 3 April 2009.[165] To cite him in support of the three propositions, in the light of that information, appears to be worse than misleading.

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[158] This is essentially a repeat of what was said in the previous brief and sourced to AFIA. For the reasons stated above, it was unhelpful since both AFIA and Mr. Richards had pointed to the large number of incompetent installers working in the program.
[159] This is a meaningless and unhelpful statement. The real question that needed to be answered was how an acceptably low level of risk could be achieved.
[160] This is a repeat of the wrong statement made in the earlier brief. It went on to make irrelevant statements that did not relate to the retrofitting process under the HIP.
[161] AGS.002.030.0417
[162] STA.001.083.0001
[163] STA.001.083.0001, paras 13-15 and 18-24
[164] STA.001.083.0001, paras 28-35
[165] AGS.002.018.0167

197. The fourth proposition was sourced only to the MBA. It was to the effect that plastic staples did not significantly reduce the risk of electrocution because the conductive RFL insulation can still come in contact with the live wiring exposed by the plastic staple. This was effectively an argument that the unacceptable risks could not be controlled simply by banning metal staples.[166]

198. The fifth proposition was sourced to Bradford CSR. It stated that Bradfords did not support foil laid over ceiling joists for a thermal effectiveness reason. That was also an argument for banning foil since it reinforced the safety ground for banning raised by Mr Richards.

199. The brief recommended that Mr. Garrett note the briefing and that he not ban foil insulation products from the HIP.

200. With the benefit of the evidence available to the Royal Commission, that brief is a proper basis for criticising the officers involved in its authorship. It left out crucial new advices available to the Department. It misquoted the HIA advice. It omitted the EECA and the Mosher advice. It has misstated the legal position concerning the applicable Standards. It seems to have verballed the ABCB. And it has given a completely ill-considered and unargued recommendation not to ban RFLs.

201. The future of RFLs under the HIP was known to involve life and death issues. A man had died. A strong warning of the associated dangers had been given. The Department had already been confronted by a statement questioning the value of particular products against that of a person's life. The Department was under a very strong moral obligation to give the very best advice available and to use its resources to source that advice and to present that information in the clearest and most accurate manner.

202. It seemed to be failing on these counts.

203. Mr. Garrett, again, to his credit, rejected the recommendation and only noted the advice subject to "ongoing discussion with relevant organisations".

204. It is acknowledged that Mr. Garrett did not have all the information now available to the Royal Commission. It is submitted, however, that he should have been at least alerted by the incongruity between the alleged results of the consultation and the drastic recommendation on the life and death issue. His staff might have been asked to interrogate the source consultation documents. He might have inquired as to the results of the New Zealand inquiries.

205. At this juncture, it was no justification to say that a minister has many duties to attend to.

[166] There is evidence before the Commission that plastic staples did reduce the risk of electrocution using RFLs but not completely. The PWC report dated 11 February 2010 found that 15 inspected roofs with RFLs installed had foil insulation that was electrically live. 13 of these involved metal staples but there were still 2 that involved plastic staples. While it appears, from these statistics, lucky that more people were not electrocuted in the HIP, it was also not beyond the bounds of possibility that electrocution would occur with plastic staples.

206. The minister should have known the importance of getting this decision right and spent the time required to obtain a proper understanding of the issues.

207. He might have called the authors of the brief in and questioned them as to the basis of the recommendation.

208. There were many options open to the Minister. In short, he should have exerted his authority and controlled the subsequent processes to ensure that he obtained the best and most thoroughly considered advice.

209. He failed to exert control. Mr. Garrett asked some additional clarifying questions but, in effect, left the process of advising him in the same hands to which it had been entrusted to this point.

The Third Brief of Advice

Prior use of RFLs

210. The brief dated 22 October 2009[167] expresses its purpose as to follow up on the briefing of the previous day "in regards to the banning the use of foil products under the [HIP]".

211. This does suggest that Mr. Garrett was attempting to force his advisers in DEWHA to address the question whether RFLs should be banned.

212. By 1.27 pm on 22 October, Ms. McCann has received the advice from Ms. Tomkins;[168] both advices from Mr. Mosher;[169] and Ms. Belka, Mr. Kimber and Ms. McCann had each received three email advices from Mr. Speranski, the last one providing the NZ policy document, a letter about foil from BRANZ and a list of approved insulation products under the NZ scheme.[170]

213. There is no positive evidence that any of those policy documents were read by DEWHA staff.[171]

214. Having received the results of Ms. McCann's research, one would expect that Ms. Belka's section would take the first opportunity to pass it on to their supervisors and the Minister. This is, especially, the case since Mr. Garrett was making it clear that he was not satisfied with the information that had been proffered in the two briefs provided so far.

215. The second issue dealt with in the brief answers a question whether, in the normal course of events, foil products would not be used for retrofits. This sought, effectively, a technical explanation of the problem of foil. One would expect that the technical group in the HIP team[172] whose members had variously been developing the program; helping to

[167] AGS.002.014.0404
[168] AGS.002.030.0417
[169] AGS.002.027.2002 and AGS.002.011.1135
[170] All emails are in AGS.002.017.2244.
[171] STA.001.086.0011, para 69 does not seem to say otherwise. It is not clear to me whether the attachments to the last Speranski email are part of the evidence.
[172] See Kimber, STA.001.024.0001, para 7 and Belka, STA.001.064.0001, paras 3-9 and 11

draft guidelines; involved in audit and compliance; and consulting with independent technical experts and experts from industry, in various forms, for well-nigh on 8 months would have had a strong layperson's understanding of the products and methods of installation generally referred to as "foil".

216. One can only judge these briefs on the basis of their contents since those who contributed to the authorship, thereof, including Mr. Keeffe, Ms. Belka and Mr. Kimber, are unable to assist with any significant recollection.[173]

217. The advice needed to say, at least, the following things (which have been canvassed in evidence, ad nauseum):

a. That the Australian standards recognise the use of foil products in new homes;
b. Such products, often referred to as sisalation, are inserted into walls and high in the roof space, well away from wiring;
c. The safety risks associated with these uses of these products are well understood and are not a problem for the program;
d. These products are able to be installed when the power is not switched on and checked by electricians after they have been installed;
e. There are also aluminium products of a batt nature which are inserted between the joists;
f. The safety risks associated with these products are likely to fall within the bounds of reasonableness;
g. The foil product and method that has given rise to concern are the RFLs which are laid across the ceiling joists;
h. The safety concerns which arise with this product are of most concern because, in laying across joists, the conductive RFLs may come in contact with pre-existing live wires;
i. There are also dangers associated with the fixing devices for these products penetrating live wires creating fresh electrical dangers;
j. This danger is further exacerbated by the use of metal staples which are, themselves, conductive and add to the problem;
k. Laying RFLs in this way is not covered by the insulation standard. However, it was approved under the program after technical advice from the ABCB indicated that the product could, in certain circumstances, achieve an acceptable total R value. Its usefulness is in hot rather than cold climates.[174]

218. What the brief did include was another misleading plug for the foil industry. It repeated the statement that "foil products meet Australian Standards". It did provide useful information that foil insulation makes up 5 % of the HIP work and that 217 installers report using foil products (although that may have been misleading if it did not distinguish between foil batts and RFLs). It also referred to a steady take up since the beginning of the program.

[173] Mr. Keeffe, for example, fails to link Mr. Richards with the MEA: RCI.006.001.0001, page 1507, lines 15-30. Almost any page of Ms. Belka's evidence would illustrate her lack of recollection but pages 3778-3779 which concern brief AGS.002.015.1625 are apt. For Mr. Kimber, see RCI.006.001.0001, page 4274, line 40 – page 4275, line 45; page 4283, line 30 – page 4284, line 45.
[174] For example, see ABC.002.001.2438 dated 16 January 2009

219. Both Mr. Leverton[175] and Mr. Richards indicated that they first became aware of RFLs laid over joists in August 2009. It would have been easy to talk to foil manufacturers (or Mr. Tikey of AFIA) and ask the specific question as to the extent to which RFLs laid over joists were used prior to 3 February 2009.

220. In the absence of hard information, the correct answer was, probably, that it was not known to what extent RFLs were used prior to the HIP (but that the extent of use may be partially contributed to by shortages of other product).[176]

221. The answer to the question in issue 2 of the brief was technically inept and of no great use to the Minister.

222. A close study of the briefs fails to show any technical advice that clearly set out the nature of the most basic problem which the Minister had to address, namely, what constitutes RFLs and why is this product considered to be dangerous?;

<u>The Training Question</u>

223. Issue 4 in the brief concerned a question whether the HIP's training requirements had no electrical safety component.

224. The appropriate response to a question of this nature was to rehearse the broad safety requirements under the program as well as addressing the specifics of the courses.

225. The answer was misleading because it gave the impression that every installer was required to do a detailed course and that the PocketBook was in use by installers. Both statements are wrong.

226. This failure compounded a wrong, earlier in the year, where the dropping of training for supervision for installers was buried deep in the attachments to the minister's brief and not brought to his attention in the body of the brief, itself.[177]

227. The brief should have said, at least:

a. The training requirements under the HIP require persons doing the actual installing to have a basic building OHS certificate (although there is a further requirement that the installer be supervised);
b. The basic OHS course is generic but, necessarily, should address different kinds of safety issues arising on a work site;
c. Supervisors are required to do one of a number of specified insulation installation courses;

[175] STA.001.066.0001, paras 19-22
[176] Product shortages were a major topic of conversation and subject of concern between August and October: AGS.002.016.1410 and AGS.002.016.0926.
[177] AGS.002.012.1230: This was one error that Mr. Keeffe was prepared to acknowledge. See RCI.006.001.0001, page 1610, line 25 – page 1611, line 15.

d. Some of these were pre-existing to the program but course materials for a special national course suited to the program were developed for RTOs and there has been some[178] take up by RTOs of these materials and this course;
e. A pocketbook has also been developed for the program but, although it is available on the CPSISC website, it has not yet been printed and few installers would be aware of its existence. It has, however, been promoted quite broadly among training organisations;[179]
f. The course materials for the different courses are not always a good guide to how much safety content is taught because the VET industry has a practice of leaving such issues to individual RTOs;[180]
g. The following references to electrical safety are found in the national course materials and the pocket book (or set out in annexures to the brief).

228. The information in the brief covered a whole page. It gave no indication to the Minister what actual training was required or being provided and it gave a completely false impression that the pocket book was out there actually educating installers.

229. This brief was a perfect opportunity for DEWHA to audit its training delivery and provide the Minister with meaningful information.

230. The answer should also have provided whatever information was available from the infant compliance program as to installer competence, supervision and training.

Recommended Actions

231. The advice given under the heading "recommended actions" indicates that DEWHA decision makers were moving in a particular direction with their advice. However, the basis on which those choices were being made have not been revealed in any detail by the evidence before the Royal Commission.

232. The lack of accurate recollection about these matters from officers at various levels leaves many questions unanswered.

233. The definitive recommendation is that the HIP does not ban RFLs unless Queensland regulators decide to do so (or the Queensland Coronial Inquiry (which would have been years in the future) recommended a ban).

234. This is a position that is inherently political. It eschews safety as a basis of policy and, instead, directs itself to allowing someone else to take or share the political heat of the ban.

235. Such a position contradicts every repeated statement by Mr. Garrett that safety was paramount for him, for DEWHA and the HIP.

[178] Specifying how much
[179] STA.001.055.0001, para 14 (Sidney)
[180] STA.001.055.0001, para 31 (Sidney)

236. The first recommendation was to call together industry, educators, and Standards Australia to advise on whether metal staples should be banned and whether training materials should be improved.

237. Mr. Garrett claimed in evidence to drive the idea of a meeting of stakeholders to provide him with advice. His departmental advisors sought to restrict the subject matter to the easiest options, politically.

238. The review of training materials (which did ensue) is almost perverse. The PCG had, on 8 May 2009, ensured that almost no one who actually installed insulation did the training. Now DEWHA, without acknowledging or advising the Minister of that error of judgment, wanted to improve the training materials. There was not even any data provided on how many RTOs had actually altered their scope of courses to teach the training materials.

239. The last two recommendations were for industry associations to produce product specific best practice guides and for installer businesses to be required to complete a risk management matrix to demonstrate knowledge of risks and hazards.

240. The evidence has not disclosed the origins of these recommendations. They might just be the result of two people brainstorming in a room. They also suggest a degree of invisible[181] consulting by which DEWHA officials found out a series of options to which all sectors of the industry could agree with a minimum of inconvenience.

241. They suggest that safety was certainly not paramount.

242. Mr Garrett did not approve the recommendation not to ban RFLs.[182]

243. The content of this brief should have been another clear warning that his DEWHA advisers were either unwilling or unable to provide advice that allowed him to make informed decisions. It should have indicated to him that factors other than safety were driving those who controlled the content of the briefs.

244. Once again, Mr. Garrett should have taken steps to control the processes by which advice was coming to him.

Briefing for the Meeting

The McCann Questions

245. On 26 October 2009, at 10.46am, Ms. McCann sent Mr. Mosher a series of sensible questions.[183]

246. These questions included:

[181] Not documented in the evidence and not documented by file notes or emails confirming conversations
[182] STA.001.069.0001, para 146
[183] AGS.002.030.0451

a. In which roofs is it more dangerous to install foil?
b. Where are the electrical cables likely to be in the ceiling?
c. Are metal staples the only source of risk when using foil insulation?
d. What other methods of fixing foil laminate are available?
e. Do plastic staples create their own risks?

247. This is the first documented occasion where a DEWHA officer has attempted a systematic approach to finding answers to the questions that needed to be addressed by Mr. Garrett.

248. Mr. Mosher consulted broadly among installers of insulation. He provided an extensive set of answers. These did not arrive on Ms. McCann's desk until 27 October when the consultation meeting was already underway.

Mr. Garrett's Guide to Good Conduct

249. Since Mr. Garrett had driven the process of calling regulators, educators and industry together to provide him with the advice he could not get from DEWHA, one might have expected that he would attend the whole of the meeting with members of his staff and ask questions until he was satisfied.

250. Instead, as advised by the Department,[184] he attended for 15 minutes in the middle of the meeting.[185]

251. The options being covered by the group, as set out in the brief, properly, included options to suspend certain products and/or to suspend certain practices such as the use of metal staples.[186]

252. Ominously, however, for Mr. Garrett's control of and input into the process, the group's recommended actions were to be provided to him upon his arrival.

253. Also of concern are the talking points provided for the Minister. Safety is mentioned but with no statement as to its importance, paramount or otherwise. And there is a note that the program is not to over-ride the work of regulatory bodies. Inherently, this is a conservative, do little approach.

254. The brief only recommended noting. Mr. Garrett noted it without qualification or other comment.

27 October 2009

The Mosher Answers: A Devastating Preface

255. Mr. Mosher's answers came at 8.36 pm on 27 October 2009.

[184] The brief is AGS.002.012.1162
[185] AGS.002.014.1464: at final attendance list
[186] Contrary to the rejected recommendations in AGS.002.014.0404

256. This was too late for the consultations, earlier, that evening, but could have been fed into the more exclusive discussions to take place on the following day.[187] They were crucially relevant to the decisions being made.

257. I am unaware of any evidence that suggests that this information went beyond Ms. McCann's computer.

258. Mr. Mosher's advice spans three pages.[188] All of it is tremendously relevant to the questions then facing Mr. Garrett.

259. The following elements are of particular assistance:

a. Foil insulation can make contact with pre-existing electrical faults in the roof space;
b. Installers are not trained electricians and are likely to be unable to detect such faults;
c. One practice in installing RFLs is for one installer to roll it out and for the other to come along and staple. This has the effect that neither installer is able to be aware of the location of the wires;
d. Most electric wires are likely to be on and over and attached to the ceiling joists. This is where RFLs are attached;
e. Plastic staples do not avoid the danger from pre-existing electrical faults;
f. Non-rigid foil laminate requires more stapling and cannot easily be secured by taping or gluing;
g. Gluing and taping may be effective but is more time consuming than the use of staples;
h. Nylon/plastic staples are probably not able to be used in houses where the roof frames are made of hardwood.

260. It is an indictment upon Ms. McCann that this information was not fed to her superiors[189] in DEWHA.[190] It seems very strange that Ms. McCann would go to the trouble of obtaining the information and then not even mention it to those above her in the hierarchy.

261. It is an indictment of everyone else working on the administration of the HIP that this information was not obtained before foil products were included in the program.

262. It is an indictment of everyone involved in working to advise the Minister in October 2009 that this information was not obtained by them and provided to the Minister.

263. It is an indictment of Mr. Garrett and his staff that this type of information was not demanded. If an EL-1, in the form of Ms. McCann, could think to ask the questions, those in more responsible positions than her should have been equally capable of asking the questions and insisting that they were properly answered.

[187] See Key Action number 3 in CPS.002.001.2388
[188] AGS.002.030.0451
[189] But see Mr. Keeffe's evidence at RCI.006.001.0001, page 1727, lines 20-30, curiously sourced to installers (Mr. Mosher's sources of information) and not to the Foil industry as previously stated in his statement at STA.001.015.0001 at para 129
[190] Ms. McCann has not been given an opportunity to answer this criticism.

The Meeting

264. There are three reports (resembling minutes) of the consultation meeting on 27 October 2009.[191]

265. No set of minutes is ever perfect. In this case, each set of notes provide some guidance to the events. The oral evidence of Mr. Richards and Mr. Leverton add to the picture provided by the notes.

Additional Notes[192]

266. This document purports to record what individual attendees said at the meeting.

267. Mr. Richards was able to recall and confirm some of what is recorded in the note.[193] He was clear that the conversation went around the table, once, with each person given a chance to speak once. He recalled the meeting as being quite short and stated that the order of speakers in the notes was incorrect as he was called upon last.[194]

268. Mr. Leverton also seems to confirm the notes with some minor supplementation.[195]

269. What is noticeable from the additional notes is that there is very little discussion of the dangers of RFL insulation installed over the rafters; the ways in which those dangers can be minimised; and little consideration of the effectiveness of different ameliorating steps. There is very little engagement among the speakers.

270. According to Mr. Leverton, Mr Gow of the MBA said, in addition to what is in the notes, that training should be mandatory for all new entrants.[196] This seems to be a challenge to the supervision (instead of training) alternative strategy of the HIP.

271. Mr Harding of the HIA is quoted in the notes as saying that "foil is used for all sorts of reasons and a ban is premature".

272. Mr. Harding may be drawing a distinction between RFLs applied on top of the rafters (dangerous) and foil used as sarking (not dangerous). No attempt is recorded as being made by Mr. Forbes to clarify this ambiguity.[197]

273. Mr. Taylor of EE-Oz is quoted as mainly addressing training options. But he also stated, according to Mr. Leverton's notes, that foil was a disaster waiting to happen; installed properly, it's fine.[198]

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[191] AGS.002.014.1464 ("additional notes"); QIC.006.001.3737 ("meeting in Canberra regarding insulation safety concerns") and CPS.002.001.2388 ("Meeting Summary"). There is also a verbatim engrossment of Mr. Leverton's handwritten notes (QIC.006.001.3589)
[192] AGS.002.014.1464
[193] RCI.006.001.0001, page 5079 and following
[194] Ibid, page 5078, lines 20-35
[195] Ibid, page 3973, line 5 – page 3975, line25
[196] Ibid, page 3973, lines 40-45
[197] Note that, in AGS.002.013.3072, a brief recording discussions on 15 February 2010, the foil industry representatives, themselves, are recorded as advocating for RFL to be used without stapling of any kind. This was an area of discussion where subtleties and fine distinctions were potentially important.

274. The additional notes record Mr. Ross of CPSISC as saying that foil was a disaster to happen in some situations but not all.[199]

275. Mr. Richards is recorded as very clearly calling for the suspension of assistance for the retrofitting of foil under the program.

276. Mr. Tikey of AFIA is recorded as speaking strongly against a ban. However, his actual words are very important. He said: "Foil has been deployed successfully for over 25 years in a retro-fit situation with very few safety problems. Extra protections are needed and plastic staples and downlight covers are useful."

277. This was used as a basis for continuing foil on the basis that plastic staples would replace metal staples.

278. However, closer questioning might have revealed the information provided by the foil representatives on 15 February 2010 that indicated that the 25 years of safe practice was in respect of those particular products that could be installed without using any form of staples for attachment.[200] It might have been helpful for Mr. Garrett to know the basis on which the claim of safe industrial practice was being advanced. Close questioning by Mr. Garrett (if he were present and interested) or Mr. Forbes (if he were not concentrating on putting his consensus together) might have revealed these important facts.[201]

279. Mr. Lamont's statement recorded 8 incidents of electrical shocks; five to installers and three to householders since February. He stated that there was an ongoing safety risk from foil insulation and metal fasteners.

280. Mr. Newhouse of the ABCB is recorded as saying nothing relevant to the question of banning foil.[202]

281. And Mr. D'Arcy of ICANZ spoke against the use of foil insulation in retrofit situations.

282. Of those who spoke, Messrs. Taylor, Ross, Richards, Lamont and D'Arcy stressed the dangers of foil insulation in at least some situations. Only Mr Tikey was unambiguously against a ban.[203]

283. The discussion up to that point provided no basis to abandon consideration of suspending RFLs from the HIP. What it suggested was a need for a much more detailed consideration

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[198] Ibid, page 3974, 15-25

[199] Obviously, this invited a request to elaborate which was not forthcoming from the Chair.

[200] See AGS.002.013.3072

[201] And it might have revealed what was known to Mr. Keeffe, namely, that, previously, the foil industry association (presumably, Mr. Tikey) had argued against plastic staples on the grounds that they often jammed in the gun and were inefficient: STA.001.015.0001, para 129.

[202] In the light of Mr. Asche's statement, STA.001.083.0001, the ABCB may have been able to give more substantive input if encouraged to do so.

[203] And note the selective nature of his remarks set out above.

of the dangers of RFLs; the level of skills and training of existing installers; and the effectiveness of any alternatives to suspension.

284. That did not occur.[204]

285. It should also be noted that, as well as Mr. Forbes, who could have encouraged discussion, Ms. Belka and Mr. Kimber, recent recipients of the Speranski emails[205], were at the meeting. The notes suggest that they did not share the benefits of their information[206] with the others in the room.

286. And Mr. Keeffe, the administrator of the HIP from almost the beginning also had nothing to say.[207]

Mr. Leverton's Notes and the Official Minutes

287. Mr. Leverton made handwritten notes of the meeting[208] and, later, typed a report of the meeting.[209]

288. The Department produced a "Meeting Summary".[210]

289. Mr. Leverton's report (which is supported broadly by his handwritten notes) tracks the statements recorded in the additional notes (above) except that Mr. Forbes is also recorded in the additional notes as having made a statement about the roof audits program (which seems to have been getting going about that time).

290. Mr Leverton's report then states that, before Minister Garrett arrived, there appeared to be a consensus forming between meeting participants around:

a. A requirement for mandatory downlight covers;
b. Recognition of problems with pre-1989 electrical wiring;
c. The need for audits;
d. The reviewing of induction training;
e. The need for effective risk assessments prior to installing insulation; and
f. The distribution of the pocket-book

291. The statement of consensus seems to exclude any possibility of a suspension of foil products from the program. The further problem with that statement is that almost none of the consensus comes from what participants are recorded as saying at the meeting.

[204] Instead, Mr. Forbes derived a consensus which, on the face of the notes, seems quite artificial.
[205] AGS.002.017.2244
[206] Received courtesy of the research of Ms. McCann
[207] Mr. Keeffe was aware that, previously, the foil industry association (presumably, Mr. Tikey) had argued against plastic staples on the grounds that they often jammed in the gun and were inefficient: STA.001.015.0001, para 129.
[208] QIC.006.001.3589
[209] The report is QIC.006.001.3737. The order of his actions is detailed in paras 46-49 of his statement: STA.001.066.0001.
[210] CPS.002.001.2388

292. When asked about this, Mr. Leverton said that it was Mr. Forbes who, after the participants had said what is recorded against them in the additional notes document, reduced this to his consensus as set out above. Mr Forbes said: This is where we got to and this is the platform on which we will base future discussions".[211]

293. If Mr. Leverton is correct, then the meeting sought by Mr. Garrett appears to have turned into a pre-ordained process in which Mr. Forbes played the key role. On that basis, one would have to agree with Mr. Richards' judgement that it was a completely ineffective process and that no consensus was arrived at.[212]

294. The Department's Meeting Summary[213] records the body of the meeting as being very similar to Mr Leverton's Forbes' consensus. This document records four actions:

a. A gap analysis of training materials;[214]
b. A review of Queensland houses already insulated;
c. A later roundtable to discuss training improvements; and
d. DEWHA to meet with AFIA and Queensland regulators to move forward on the safety of foil products.[215]

295. As a result of the process that Mr. Garrett drove, a ban on RFLs was pretty much off the table, exactly as DEWHA had already advised on two previous occasions.[216] The evidence received by the Department had been kept from the Minister and his staff.[217] And the discussions in the consultation seemed to have avoided any process of engagement and working through the issues. What was recorded as having been said by the participants seemed to have little to do with the result.

28 October 2009: Meetings; Faits Accomplits and a Brief

296. Mr Garrett received another brief of advice on 28 October 2009.[218]

297. The brief dealt with targeted inspections of houses that have RFL insulation and training improvements. It recommended immediate changes to the HIP Guidelines as follows:

a. Pre-inspection risk assessments;
b. Mandatory use of down light covers; and

[211] Mr Leverton's evidence on this point is at RCI.006,001,0001, page 3978, lines 1-30
[212] RCI.006.001.0001, page 5078, lines 15 - 35
[213] CPS.002.001.2388
[214] As per the recommendation in the brief AGS.002.014.0404
[215] Mr. Richards stated that the minutes were never sent to him and he was never asked to confirm them: RCI.006.001.0001, page 5084, lines 15-30
[216] AGS.002.014.0409 and AGS.002.014.0404
[217] Namely, the evidence gathered by Ms. McCann; the evidence of previous foil industry attitudes expressed by Mr. Keeffe; the contents of Mr. Tikey's letter of 1 October acknowledging lack of expertise among installers; and the lack of compliance on skills referred to by Ms. Kruk in her statement.
[218] The brief is AGS.002.013.1712 and AGS.002.013.1240. The date below Mr. Keeffe's name is 22 October but that can be ignored. It has a DEWHA stamp of 28 October and Mr. Garrett states that it was received on that day: STA.001.069.0001, para 153. Also Mr. Keefe acknowledges the error at RCI.006.001.0001 at page 1726, lines 10-25.

c. A ban on metal fasteners in favour of nylon/plastic staples or taping.

298. Mr. Leverton threw some light on what had happened, earlier that day.[219] At a meeting in the morning involving Mr. Richards, Mr. Tikey and Mr. Leverton and Mr. Lamont from the ESO, Mr. Keeffe advised that Mr. Garrett had provisionally agreed to:

a. Distributing the pocket book;
b. Introducing a risk assessment for each installation;
c. The possibility of disallowing staples; and
d. Possibility of mandating down light covers.

299. In his oral evidence, Mr. Leverton stated that there was an aggressive person from the Prime Minister's Department there in the morning as well.[220]

300. Mr. Leverton stated that Mr. Richards may have attempted to argue for a ban on foil, that morning, but that it was pretty clear from the previous day's meeting that suspension of foil was not going to be looked at.

301. Then, at another meeting in the afternoon, DEWHA officers tabled a proposal:

a. Disallowing metal fasteners;
b. Mandating the use of downlight covers;
c. A targeting testing program for Queensland houses fitted with foil; and
d. Risk assessments prior to all foil installations.

302. This proposal became the recommendation in the brief produced later that day.

303. Those changes were reflected in the changes to Guidelines announced on 2 November 2009.

304. Although other changes were made at the edges of the Guidelines in December, the events of 27 and 28 October marked the end of any consideration being given to the option of banning RFLs attached to ceiling joists until February 2010 when the death of Mitchell marked a new decision making watershed.

A Conclusion of Sorts

305. These meetings and the drafting of the brief on 28 October made no reference to the body of advice that Ms. McCann had obtained from Mr. Mosher.[221]

306. That advice included the following:

[219] QIC.006.001.3737
[220] RCI.006.001.page 3976, line 35 – page 3977, line 17
[221] Ms. McCann's statement is STA.001.086.0001

a. The mere act of rolling out RFLs carried danger where pre-existing defects existed in the wiring;
b. Gluing as an alternative to staples was time consuming (and hence likely to be spurned for more efficient methods);
c. Plastic staples were unlikely to be effective in hardwood houses (the type of house likely to be encountered in Queensland which was where RFLs were being used);[222] and
d. Plastic staples were dangerous because they could expose a live cable which could then come in contact with the foil.

307. As a result, almost the only relevant and considered advice on the question of suspending foil (or using lesser methods to reduce the risk) was withheld from the whole process.[223]

308. As was Mr. Speranski's information concerning best practice in New Zealand.[224]

309. Ms Belka and Mr. Kimber were privy to the Speranski information.[225]

310. Ms. Belka[226] and Mr. Kimber[227] purported to have no relevant memory about these matters in their evidence to the Royal Commission.

311. Ms. McCann was the only DEWHA official who actively sought to obtain relevant information on the subject of whether RFL insulation should be banned in the wake of Matthew's death.

312. It is not believable that Ms. McCann, an EL1, would have decided, unassisted, to withhold from the Department's decision making processes the information that she actively sought.

313. While Ms. Belka and Mr. Kimber's lack of recollection does not appear genuine, it seems unlikely that they would, on their own initiative, actively withhold relevant information from the Department's decision making processes.

314. One has to look higher in the public service hierarchy (or elsewhere) to find the explanation why such a poor information flow occurred to the Minister and his office.

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[222] See DOR.002.001.0002, pages 11-12 and RCI.006.001.0001, page 3032, line 20 – page 3034, line 20 (Mr. Dorian); RCI.006.001.0001, page 3138, line 25 – page 3140, line 45 (Mr. Duncan Herbert; RCI.006.001.0001, page 4927, line 20 – page 4972, line 15; QCI.005.001.0089 (QCI.005.001.0100), para 48 (Andres Palomar); QCI.005.001.0070 (QCI.005.001.0082), paras 20-22 (Chase Martin (on piecework)); and QCI.005.001.0053, paras 32-37 (Shane Horne)

[223] I have referred previously to the additional material also withheld being the evidence of previous foil industry attitudes expressed by Mr. Keeffe; the contents of Mr. Tikey's letter of 1 October acknowledging lack of expertise among installers; and the lack of compliance on skills referred to by Ms. Kruk in her statement.

[224] AGS.002.017.2244

[225] The last four emails of the chain in AGS.002.017.2244 were copied to Ms. Belka and Mr. Kimber.

[226] RCI.006.001.0001, page 3803, line 1 – page 3804, line 30 and page 3856, line 30 – page 3862, line 45

[227] For Mr. Kimber, see RCI.006.001.0001, page 4274, line 40 – page 4275, line 45; page 4283, line 30 – page 4284, line 45

315. The decision not to ban RFLs in favour of effectively mandating the use of ineffective plastic staples led to the death of Mitchell.

316. The process by which that decision was made was ill-considered and avoided the consideration of almost every piece of relevant information that might have been available. The result appears have been pre-ordained before the meeting. As Chair, Mr. Forbes must take considerable responsibility for the lack of effective discussion at that meeting.

317. Everyone associated with that failure of process bears a heavy responsibility.

Kevin James Keeffe

The Evidence

318. In the early part of these submissions, I have looked at the evidence concerning particular individuals.[228] The next sections of these submissions will focus on several further individual witnesses. However, the examination of these further witnesses will focus largely on their involvement in the period subsequent to 14 October 2009.

319. In his statement to the Royal Commission,[229] Mr. Keeffe devotes all of two paragraphs[230] to the decision making process in the period after Matthew's death.

320. Mr. Keeffe appears to refer to two meetings on 27 October 2009. The absence of any supporting documentation of an earlier meeting suggests that Mr. Keeffe is confused in his recollection and there was only one meeting on that day. This appears to be the case even though Mr. Keeffe has also confused the NECA organisation with Mr. Richards' MEA.[231]

321. This is not surprising in that Mr. Keeffe claimed to have no direct knowledge of Mr. Richards' warnings against foil in his oral evidence.[232]

322. This is despite having briefed the Minister about Mr. Richards' warnings on at least four occasions.[233]

323. Mr. Keeffe's lack of recollection of these events is simply not credible.

324. Paragraph 129 of Mr. Keeffe's statement raises several issues.

325. Mr. Keeffe commences by saying that, at the meeting, the Minister listened to the stakeholders including to an argument that RFLs should be banned under the HIP.

[228] Ms. Wiley-Smith, Ms. Brunoro and Mr. Carter
[229] STA.001.015.0001
[230] STA.001.015.0001, paras 128-129
[231] The National Electrical and Communications Association is referred to in paragraph 128. The attendance notes of the meeting do not make reference to that organisation: AGS.002.014.1464.
[232] RCI.006.001.0001, page 1507, lines 15-30
[233] AGS.002.015.1625; AGS.002.014.0409; AGS.002.014.0404; and AGS.002.012.1162

This is contrary to the evidence of Mr. Leverton,[234] who indicated that Mr. Forbes had closed down any discussion before Mr. Garrett arrived.

326. Mr. Keeffe then says that "we" took the view that metal staples were the problem and that plastic staples should be used.[235] This sentence appears to confirm a pattern that may be derived from the repeated urgings to the Minister that RFLs not be banned in the briefs signed by Mr. Keeffe during October and in Mr. Richards' and Mr. Leverton's experience of the meeting on 27 October. It suggests that DEWHA officers, probably Mr. Forbes and Mr. Keeffe, at least, had a pre-ordained view and, despite the views expressed at the meeting and elsewhere about the dangers of RFLs, sought to ensure that the lesser result, the banning of staples, was what came out of the meeting.

327. Alarmingly, the only evidence cited in Mr. Keeffe's paragraph is against that view, namely, that the foil industry, itself, had been against plastic staples, because they were ineffective. Mr. Keeffe is saying that he had knowledge of things that might have ensured non-compliance, by installers, with the proposed ban on metal staples[236] but he and his colleagues went ahead regardless and ensured that a ban on staples, rather than banning foil, was the result.[237]

328. And, devastatingly, no mention of the previous advice of the foil industry, that plastic staples often jammed in the gun and were inefficient[238] appears in the brief that reported to the Minister on that meeting[239] or any of the briefs, that October.[240]

329. Mr. Keeffe does not explain how he factored in and dealt with the MBA advice in the brief of 21 October that plastic staples may not significantly reduce the risk of electrocution.[241]

330. Mr. Keeffe, by this one paragraph,[242] identifies himself as a Departmental adviser who, on a crucial life and death decision, failed to provide crucial information to his

[234] RCI.006.001.0001, page 3978, lines 1-25 (in the context of QIC.006.001.3737, page 2
[235] STA.001.015.0001, para 129
[236] That is, that installers under the pressure of piece work earnings for themselves and their employers, might continue to use the banned metal staples because there was no efficient or effective alternative. It is not as if there is no learning on the types of considerations that tend to make particular legal regulations more or less effective: http://en.wikipedia.org/wiki/Law_and_economics; http://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&ved=0CEUQFjAC&url=http%3A%2F%2Fchicagounbound.uchicago.edu%2Fcgi%2Fviewcontent.cgi%3Farticle%3D2879%26context%3Djournal_articles&ei=0vaHU-yZGYinkwW3u4GACg&usg=AFQjCNF96jREkdfYR__SQcGCAGzmKXwFwA&sig2=S1MrnJBBDfCKfUoMaUOfsQ&bvm=bv.67720277,d.dGI and http://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=4&ved=0CFAQFjAD&url=http%3A%2F%2Fencyclo.findlaw.com%2F0710book.pdf&ei=PPeHU__aCcHHkgWkz4HoBw&usg=AFQjCNGSu4k4l-54S0FUre-zTcq7J715-g&sig2=D-GxSicv4g47kl8WEesSQg&bvm=bv.67720277,d.dGI.
[237] This knowledge of jamming, this time from installers, and expense and installer resistance also surfaces at RCI.006.001.0001, page 1727, lines 20-30
[238] Referred to in para 129 of STA.001.015.0021
[239] AGS.002.013.1712
[240] AGS.002.015.1625; AGS.002.014.0409; AGS.002.014.0404; and AGS.002.012.1162
[241] AGS.002.014.0409

Minister. He also reveals himself, in the same decision, as having second guessed the expert advice, at least of Mr. Richards, without identifying or giving any sound evidentiary basis or other satisfactory reason.

331. In his oral evidence, Mr. Keeffe states that he could not recall (excluding Mr. Ruz's warning in February) any calls from any group to ban foil.[243] His statement is contradicted by paragraph 129 of his statement discussed immediately above. Also, as stated above, Mr. Keeffe had briefed the Minister at least four times expressly in respect of Mr. Richards' calls to ban foil.[244]

332. Again, Mr. Keeffe's statement as to lack of recollection is simply not credible.

333. It is difficult to understand why public officials, in the wake of a young man's death and in the face of repeated invitations from their Minister to provide dynamic advice, would fail to give the best and most accurate information available. A small clue is contained in evidence adduced at the Queensland Coronial Inquiry where Mr. Keeffe said that DEWHA was not in a "policy space that would allow us to ban one form of insulation over another".[245] While this was not said directly in the context of the October policy discussions, it seems that DEWHA officers had so thoroughly internalised instructions to that effect that they could not reset their moral compass even when circumstances had dramatically changed.[246]

334. Mr. Keeffe was pressed on these issues but he was unable to assist the Royal Commission.[247]

335. Unfortunately, with so many witnesses having recollections that were non-operational, the Commissioner has not received sufficient assistance as to the source or causes of this conduct.

336. Mr. Keeffe was equally unable to recall a conversation recorded in Mr Levey's notes which showed a momentum to suspend RFLs from the program and would have betrayed Mr. Keeffe's claim that he was constrained from making a policy recommendation that would have banned foil and, thereby, saved Mitchell's life.[248]

337. Last, it is useful to observe the longer version of Mr. Keeffe's explanation of the reluctance to ban any product which he attributes to the policy settings that predated and infused the announcement of 3 February 2009.[249]

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[242] Para 129 of STA.001.015.0021
[243] RCI.006.001.0001, page 1546, lines 35-40
[244] For that call, see AGS.002.017.0056 (press release) and AGS.002.017.0069 (briefing notes)
[245] RCI.006.001.0001, page 1548, lines 30-45. The original is at QIC.002.001.0735 at page 9-85.
[246] Ms. McCann attributed a similar mind set to the influence of the PCG on her and other officers: STA.001.086.0001, para 53. The evidence does not seem to identify any direction by government ministers (or parliamentary secretary) to this effect.
[247] RCI.006.001.0001, page 1627, line 5 – page 1628, line 5
[248] RCI.006.001.0001, page 1628, line 15 – page 1629, line 5
[249] RCI.006.001.0001, page 1626, lines 10 -35. The whole passage extends to RCI.006.001.0001, page 1628, line 10

338. Mr. Keeffe names but declines to blame the Office of the Coordinator-General and "the Minister".[250]

339. And, at the end of the passage, Mr. Keeffe names Mr. Forbes as leading the process that led to the recommendation of 28 October "closely" and as "better placed to answer that question". This seems to ignore Mr. Keeffe's being named in the attendance list for the meeting of 27 October 2009[251] and mentioned in Mr. Leverton's notes as conveying the Minister's position on the morning of 28 October.[252]

340. Mr. Forbes' memory was not all that great but he stuck to the view that there was a consensus at the meeting of 27 October 2009.[253]

341. Interestingly, when confronted[254] with the advices contained in the briefs of October signed by him, Mr. Keeffe did not repeat an explanation by reference to the policy settings of 2 February and their lingering influence upon him. He retreated to not being able to give any explanation at all.[255]

Another Conclusion of Sorts

342. The extent of Mr. Keeffe's lack of recollection on matters which occurred in October 2009 is not credible.

343. Mr. Keeffe's failure to provide a better recollection of the events of that period is a significant reason preventing the Royal Commission from being able to understand fully the reasons why the banning of RFLs was not advanced as a policy option to Mr. Garrett.

344. Nonetheless, Mr. Keeffe, in paragraph 129 of his statement, has revealed his own failure to provide properly informed and complete advice to Mr. Garrett.

345. Mr. Keeffe has given some idea of the policy preconceptions operating on him when this failure occurred. He has not, however, deigned to provide the source of those preconceptions or a complete explanation of his actions.

346. An inference suggests itself that the preconceptions held by Mr. Keeffe may be causally related to the Department's failure, through its more junior officers, to pass on to its Minister the information gathered carefully by Ms. McCann.

347. The Royal Commission is disadvantaged in that, as these matters have emerged over time from a careful examination of the evidence, they have not been put expressly

[250] RCI.006.001.0001, page 1626, line 34
[251] AGS.002.014.1464
[252] QIC.006.001.3737, page 2
[253] RCI.006.001.0001, page 1893, line 25-40
[254] In re-examination by Mr. Wilson QC, counsel assisting
[255] RCI.006.001.0001, page 1731, lines 1-15 in respect of brief AGS.002.014.0409 and RCI.006.001.0001, page 1732, lines 30-40 in respect of brief AGS.002.014.0404

or fully to Mr. Keeffe while he was giving evidence or to the junior officers who were aware of Ms. McCann's information.[256]

Malcolm Andrew Forbes

348. Mr. Forbes' statement[257] provides information about the process of providing a policy response to Matthew's death that is not provided elsewhere. However, Mr. Forbes' evidence also contains vagueness, inaccuracies and ambiguities that make his contributions problematic.

349. Mr. Forbes says that he met with Mr. Richards when Mr. Richards raised with Mr. Garrett his concerns which included the banning of foil.[258] Mr. Richards' letter[259] is dated 16 October 2009. Mr. Richards' meeting with Mr. Garrett took place on 20 October 2009.[260] Mr. Forbes' meeting is not documented. It could have been any time after 16 October2009. It appears not to be mentioned elsewhere in the evidence.

350. Mr. Forbes says that he contacted, immediately after the tragic deaths associated with foil, the Queensland Electrical Safety Office (ESO).[261] There was only one death in October, that of Matthew. This contact must have been by 16 October at the latest (to be "immediately after"). There seems to be no record of the conversation and Mr Leverton makes no mention[262] of speaking to Mr. Forbes.[263]

351. One significant aspect of Mr. Forbes' account of the conversation is that it turned into a choice between banning RFLs and banning metal staples. Second, the participants could not agree on which level of government would be responsible for making the change and there was talk that Ministers would have to be involved in discussions.

352. Mr. Forbes states that he was verbally briefed by DEWHA staff about the deaths in New Zealand after Matthew's death. This may have been raised in the context of his contact with Mr. Richards or the ESO.[264]

353. Mr. Forbes says that he was told that there were relevant differences between Australia and New Zealand to make the NZ experience irrelevant.[265] The giving of

[256] To be fair, not much could be expected to be gained from putting the matters to Ms. Belka or Ms. Kimber whose lack of recollection prevented them from taking the opportunity to explain many of the events in which they were involved.
[257] STA.001.018.0001
[258] STA.001.018.0001, para 64
[259] QIC.006.001.1999
[260] AGS.002.014.0409
[261] STA.001.018.0001, para 65. Mr. Kimber also talks involving executives from his office and the Queensland Office of Electrical Safety: RCI.006.001.0001, at page 2599, lines 25-32.
[262] See STA.001.066.0001, paras 27-49
[263] Mr. Lamont has not provided a statement.
[264] STA.001.018.0001, para 39
[265] Ibid

this advice connotes dangerous ignorance and misunderstanding on the part of the giver of that advice.[266]

354. Mr. Forbes makes a reference to what appears to be the meeting of 27 October although he can place it no better than "sometime in October".[267]

355. Mr. Forbes also states that two officers from the ESO also met with him; other DEWHA staff; and Mr. Hoffman from P.M. & C.[268] This appears to be a reference to the meetings on 28 October 2009 recorded by Mr. Leverton.[269] It confirms Mr. Leverton's uncertain identification of Mr. Hoffman playing an assertive role at those meetings.[270] Mr. Forbes appears to include Mr. Hoffman in the discussion on whether Queensland or DEWHA would be responsible for instituting bans on products or methods.

356. The impetus for Mr. Forbes to be told of the deaths in New Zealand may have been Mr. D'Arcy's contact with Mr. Levey to warn that the February warnings had been given.[271]

357. Another possible trigger could have been receipt by Ms. McCann, Ms. Belka and Mr. Kimber of the Speranski email.[272] The first of that email stream to mention the deaths was dated 20 October. It is hard to tell from Mr. Forbes' statement exactly when he was told except that it was after 14 October.[273]

358. Mr. Forbes nominated Mr. Keeffe as the person most likely to have told him that the NZ experience was not relevant because the process there was different.[274] The relevant difference conveyed to him was that, in New Zealand, foil was stapled to the floor and, in Australia, it was stapled to the floor joists.[275]

359. Mr. Forbes refers to the fact that there were subsequent conversations with Mr Richards and with experts at the meeting on 27 October.[276] He seems to suggest that these further discussions convinced him of the dangerousness of the practice although he omitted to ask Mr. Richards about the matter.[277]

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[266] If it were Mr. Keeffe, as Mr. Forbes later suggested, then Mr. Keeffe seems to have obtained very little understanding of an important aspect of the program he was administering despite attending many crucial meetings.
[267] STA.001.018.0001, para 66
[268] STA.001.018.0001, para 67
[269] QIC.006.001.3737
[270] See RCI.006.001.0001, page 3977, lines 5-20 and page 3979, lines 5-30
[271] STA.001.003.0059, paras 321-325
[272] AGS.002.017.2246
[273] STA.001.018.0007, para 39
[274] RCI.006.001.0001, page 1879, lines 15-25
Ibid, page 1872, lines 25-35
[275] The failure of Mr. Keeffe to understand the relevance of the New Zealand deaths is discussed above. That Mr. Forbes would give it even momentary credence is a dim insight into the understanding of issues he held, week after week, as he chaired the PCG meetings.
[276] Ibid, page 1872, line 35 – page 1873, line 15
[277] Ibid, page 1892, lines 10-30

360. Extraordinarily, as the long term chair of the Project Control Group, Mr. Forbes had no idea until some time in October 2009 that RFLs were stapled onto ceiling joists.[278] A key decision maker in the HIP had no practical appreciation of what was involved.

361. As to the meetings on 27 and 28 October 2009, Mr Forbes struggled to recall but spoke of a consensus reached at those meetings.[279] It was not possible at that stage to put to him Mr. Leverton's evidence concerning Mr. Forbes' role in crafting the consensus.[280]

362. Mr. Forbes, again, spoke of a reluctance to urge change unless the State of Queensland also agreed to act.[281]

363. Mr. Forbes' belief in the necessity of a Queensland consensus is reflected in the official advice tendered to the Minister where it was said that Mr. Garrett should not ban RFLs under the HIP unless the Queensland ESO or other relevant regulators change their current policy positions, or recommendations from the Queensland Coronial Inquiry come forward.[282]

Forbes Conclusions

364. Mr. Forbes' evidence on the decision making in October suffered from his involvement in the details of the events becoming more evident after Mr. Leverton gave his evidence.

365. The Commission's ability to make relevant findings is also not assisted by the imprecision of Mr. Forbes' recollection.

366. What does emerge from the evidence in the context of other evidence is a further cause of reluctance on the part of senior DEWHA officers to advise a policy that might disadvantage some operators in the market created or expanded by the HIP.[283]

367. Mr. Keeffe stated that DEWHA was not in a policy space that allowed it to ban one form of insulation over another.[284]

368. Mr. Forbes does not contradict that statement but his evidence reveals another imperative, namely, that the Minister should not take any action that would not be supported or duplicated by the Queensland regulatory bodies. This imperative appears to have been stronger than the imperative to ensure that the risk of installers' losing their lives was minimised.

[278] Ibid, page 1873, lines 1-15
[279] Ibid, page 1893, lines 25-40
[280] Ibid, page 3978, lines 1-30
[281] Ibid, page 1895, lines 1-15
[282] AGS.002.014.0404
[283] Even though it might significantly advance the safety of people installing insulation
[284] RCI.006.001.0001, page 1548, lines 30-45. The original is at QIC.002.001.0735 at page 9-85.

369. Mr. Forbes, as chair of the PCG[285] and as sponsor of the HIP,[286] must take responsibility for the failure of crucial information (including that obtained by Ms. McCann) from being placed before Mr. Garrett.

370. As chair of the meeting on 27 October, he must take responsibility for the failure of DEWHA to draw from that meeting all of the available technical expertise that would have better informed the Minister as to the advantages and disadvantages of failing to ban foil.

371. He is particularly responsible for the failure to ensure that the Minister was informed of the actual opinions expressed at meeting about the dangers of RFLs.[287]

Martin Paul Hoffman

372. As discussed above, Mr. Hoffman has been identified by Mr. Forbes as being involved in discussions which went to whether the Commonwealth or Queensland should be involved in banning foil.[288]

373. Mr. Leverton also, albeit uncertainly, involved a PM & C officer who he thought was Mr. Hoffman as present and acting assertively in discussions on 28 October 2009.[289]

374. Mr. Hoffman, with his previous knowledge of and involvement in the HIP, may have been able to influence policy responses to a considerable degree. However, for the present, Mr. Hoffman's influence, whatever it be, resembles Mr. Adam Smith's "invisible hand" as his statement indicates no involvement in the HIP between July 2009 and January 2010.[290]

The Decision to Abandon the HIP

Introduction

375. Some perspective on the failure to ban the use of RFLs placed over joists in October/November 2009 may be gained by the fact that, 15 days after the death of Mitchell, in similar circumstances to the death of Matthew, the HIP itself was suspended and later abandoned.

376. Where no political will existed to make a decision opposed by a small section of the industry, suddenly, political will was found to make a decision that massively disadvantaged the whole insulation industry.

377. One is tempted to conclude that just one more death was necessary to achieve strong action from both the APS and the government.

[285] STA.001.018.0002, para 10
[286] STA.001.018.0002, para 9
[287] AGS.002.014.1464 in the contributions of the MBA, EE-Oz, CPSISC, MEA, the ESO, and ICANZ
[288] STA.001.018.0001, para 67
[289] See RCI.006.001.0001, page 3977, lines 5-20 and page 3979, lines 5-30
[290] STA.001.008.0001, paragraph 87

378. Mr. Leverton confirms that it was the death of Mitchell that was influential in the Queensland ESO's changing of its position to one of advocating the banning of foil.[291]

Ms. Kruk

379. Ms. Kruk rejected a suggestion that Mitchell's death was the primary causative factor in her decision to recommend suspension of the HIP program in February 2010.[292] Her thesis was that the report of Price Waterhouse Cooper ("PWC")[293] indicated to her as Secretary of DEWHA that the government did not have sufficient mechanisms to achieve the necessary behavioural change to operate the HIP in a way that was safe for installers.

380. Ms. Kruk said that information in the report that 33% of installers installing RFLs were still using metal staples in the period since such staples were banned from the program (through changes to the Guidelines) and banned as a matter of law by the Queensland government.[294] In the same passage, Ms. Kruk said that it was not something that completely surprised her but that it gave her an indication about the limitations that the government had, under the HIP, to get behavioural change.

381. Ms. Kruk also, in the same passage, agreed with a statement of Mr. Mrdak that the government went wrong because it assumed that people would do the right thing.

382. The PWC report is addressed to DEWHA and is dated 11 February 2010,[295] seven days after Mitchell's death.[296] The report stated that, for electrical safety inspections performed on installations on or before 2 November 2009, 81% of foil installations used metal stapling, while only 33% of those installed after 2 November used metal staples."

383. The report seems to state that 756 homes with RFLs installed had been inspected and 10,081 non-foil rooftop inspections had been performed. This can be compared with the situation, as at 15 October 2009, when only 255 roof inspections and 231 desk audits had been completed.[297]

384. If, as Ms. Kruk stated, her decision to recommend suspension of the HIP was influenced by the insight into people's non-complying behaviour, those insights might have been obtained by having an inspections program from 1 July 2009 (or a delayed commencement date for the program). The Panglossian view of human compliance behaviour held by both Ms. Kruk and Mr. Mrdak might have been altered by a detailed breakdown of compliance with the scheme from its very beginnings.

[291] AGS.002.013.3072 and RCI.006.001.0001, page3981, lines 30-45
[292] RCI.006.001.0001, page 1327, lines 15-35; and page 1283, lines 5-20
[293] STA.001.010.0131: the report is dated 7 days after Mitchell's death and two days after foil products had already been suspended from the HIP on 9 February 2010.
[294] RCI.006.001.0001, page 1323, line 25 – page 1324, line 40
[295] STA.001.010.0131
[296] And two days after RFLs were suspended from the HIP
[297] AGS.002.0081151_0001 (prepared as a report to the PGC meeting of that date)

385. This indicates an enduring effect of the original deficiencies with the scheme caused by its premature commencement. The lack of audit and compliance data contributed to the lack of political will in October to ban RFLs. This was because Ms. Kruk (and presumably others) assumed that less thorough going reforms would be effective. However, because there was no inspections program of any note until at least 1 October, no such data was possible.

386. However, Ms. Kruk's statement should not be completely accepted at face value.

387. With only the merest audit and compliance structure in place in the first two months of phase 2 of the HIP, the Department, nonetheless, became aware of participants breaching the rules. Ms. Kruk refers, in her own statement, to "new entrants to the market not adequately meeting required standards on skill competencies and overcharging".[298]

388. This was such a significant problem that a change to the Guidelines was mediated.

389. It is difficult to see how Ms. Kruk could, against that background, be shocked by continued adherence to the use of a method of affixation of RFLs (which was clearly more efficient than any available (lawful) alternative). This was particularly the case when all involved were being paid on a piece work basis.

390. It is even less surprising when this inefficiency was explained, well before hand, to Mr. Keeffe by the foil industry, itself.[299]

391. Ms. Kruk's Department had also been warned by the research conducted by Ms. McCann.[300]

392. It is also revelatory that a document forwarded by Ms. Kruk[301] to Ms Beauchamp on 10 February 2010 had a complete program of inspections of completed houses but made no recommendations concerning the suspension of RFLs from the scheme.[302]

393. The Commission cannot be satisfied that, in the absence of Mitchell's death, that DEWHA would have recommended suspension of the HIP as opposed to some further fine tuning of the Guidelines.

<u>Ms. Beauchamp</u>

394. Ms. Beauchamp became Coordinator-General from 21 December 2009.[303]

395. Ms. Beauchamp noted the suspension of RFLs from the HIP on 9 February 2010, five days after Mitchell's death.[304]

[298] STA.001.010.0001, para 55
[299] STA.001.015.0001, para 129
[300] STA.001.086.0001 and AGS.002.030.0453
[301] AGS.002.008.1283
[302] AGS.002.008.1284
[303] STA.001.067.0001, para 7
[304] STA.001.067.0001, para 17

396. Ms. Beauchamp states that, towards the end of January 2010, work had commenced to address safety issues and to develop options on the future of the HIP.[305]

397. One email stream attached to Ms. Kruk's statement contains documents prior to 4 February 2010. However, this relates to gathering statistics to compare deaths and injuries under the HIP to 2006 casualties in the building industry.[306]

398. Ms. Beauchamp was asked about the information that had come to her since her commencement in the job and between 4 and 9 February 2010.[307] Despite the reference by Ms. Beauchamp to "towards the end of January", there is little documentary or other evidence to suggest that Ms. Beauchamp or her staff in the OCG were concerned to suspend RFLs or suspend the HIP prior to Mitchell's death.

The Taskforce Report

399. The document known only as Taskforce Report – February 2010 ("the Taskforce Report") appears to be the vehicle by which Cabinet decided to bring the HIP to an end.

400. The report is a rambling 24 pages long and accompanied by a 7 page appendix B.

401. The report canvasses many issues many of which had been known for nearly the whole life of the HIP. These include, for example, the lack of experience of DEWHA in delivering "high-volume, demand driven programs".[308]

402. Well known facts of this kind are hardly likely to be the cause for suddenly taking a form of definitive action that appeared impossible on 28 October 2009.

403. It is worth noting that Ms. Kruk's PWC survey results get a mention as well.[309]

404. The most indicative passage is that at page 5 of appendix B where the Taskforce says: "Following the death of two installers following electrical safety issues on foil insulation sites, on the 9 February 2010, the Hon Peter Garrett AM MP, suspended the use of foil insulation under the HIP."

405. Up to that point, the Taskforce Report had gone out of its way to avoid mentioning the death of installers.

406. The Taskforce Report mentions other matters, such as budgetary considerations and the continuing accumulation of house that had to be made safe.

[305] STA.001.067.0001, para 16
[306] AGS.002.008.1355
[307] RCI.006.001.0001, page 4220, line 10 – 4221, line 25
[308] The Taskforce Report, page 7, para (f)
[309] The Taskforce Report, page 13, para 35

407. However, it was Mitchell's death on 4 February which triggered the suspension of the use of RFLs on 9 February 2009. It was that action (which Mr. Keeffe felt he was not permitted to recommend)[310] which allowed all the other dominoes to fall.

Conclusion of Sorts

408. Despite the protestations, one can properly appreciate Mitchell's death as an event that finally transformed the political possibilities.

409. In October 2009, for reasons partially and reluctantly articulated by Mr. Keeffe and Mr. Forbes, the officers of DEWHA were unwilling to recommend that RFLs be suspended.

410. On 9 February 2010, five days after Mitchell's death, Mr. Garrett suspended RFLs from the HIP.

411. Ten days later, on the advice of a Central Agency Taskforce, the whole HIP was abandoned.

412. A political reluctance, in October, 2009, at least on the part of Mr. Forbes and Mr. Keeffe, prevented RFLs from being even temporarily suspended.

413. Mitchell's death as a result of RFLs overwhelmed that political reluctance.

414. The events of October 2009 should, indeed, be viewed through the prism of 4 February 2010.

The Effect of the Program on the Family of Mitchell Sweeney

415. As examined above in the context of Item d(iii) of the Terms of Reference, Mitchell's death may have been averted but for the systemic failures and the malfunction of the Australian Public Service to proffer frank, fearless and comprehensive advice.

416. As one might imagine, the effect of being the mother, father, sibling or sister in law of a young man in the height of his youth dying needlessly in the name of economic stimulus can be devastating and long lasting.

417. Mitchell moved to the Gold Coast in 2009 to live with his brother Brendan at the encouragement of his parents and siblings to make a new life for himself.

[310] [310] RCI.006.001.0001, page 1548, lines 30-45. The original is at QIC.002.001.0735 at page 9-85.

418. When Mitchell was approached by Lindsay to start working for his companies, NCL Group Pty Ltd and Titan Insulations Pty Ltd, Mitchell's family all supported the move with Martin saying words to the effect of "Get out there and make hay while the sun shines".

419. It was recognised by the Sweeney family that this was, as it was designed to be, a new and lucrative industry which could offer Mitchell both occupational and financial stability in the face of a global financial crisis.

420. The Sweeney family expected that the Commonwealth, instigator and administrator of the scheme, had the safety of Mitchell and all the installers in mind.

421. The Sweeney family expected that the Commonwealth would follow due process and procedure and take considered and measured actions in implementing a nationwide insulation program.

422. The Sweeney family expected that the Commonwealth would have foreseen the Program's capacity for fraud and sham contracting arrangements and had measures in place to combat these risks

423. The Sweeney family expected, quite simply, that the Commonwealth would have taken steps to properly understand the risks inherent in such a program.

424. And it was on these expectations that the Sweeney family sent Mitchell off into the roof spaces with RFLs and, ultimately, to his death.

425. The guilt, grief and responsibility the Sweeney family feel in response to Mitchell's death is unyielding, even more than 4 years later.

426. In relation to the individual impacts on the Sweeney family, I note that statements have been provided to the Commission, in addition to Medico-Legal Reports, for Wendy, Martin, Justin and Brendan Sweeney.

[redacted]In relation to the abovementioned documents and the incidences described below, I request that a non-publication order be made in relation to general public distribution of those documents [redacted]

[redacted]

428. My clients would be grateful if their desire for privacy can be accommodated.

429. I confirm that the redacted statements provided by my clients to the Commission do not form part of the request for non-publication.

<u>Impact on Wendy Sweeney</u>

430. Wendy Sweeney learnt of Mitchell's death on 4 February 2010 at work when Brendan Sweeney called her, crying and inconsolable, stating that Mitchell had been killed in a work accident.

431. News of Mitchell's death spread like wildfire to the rest of the Sweeney family.

432. Wendy was grief stricken and cried continuously for months after death of her youngest son.

433. Living in a small town, Wendy and the rest of her family were confronted daily with questions and condolences for their losses.

434. The Sweeney family's contact details came into the possession of various news agencies and soon relentless calls for comment were made of Wendy and her family.

435. As a result, public and media intrusion also contributed to Wendy's psychological injuries which at this stage had been undiagnosed. Wendy became a recluse.

436. Many of the things that brought Wendy purpose and joy, no longer, served that purpose. Her passion for craft and music was waylaid; social outings with friends came to a halt; even laughing was too much for Wendy for at least two years because of the immense guilt she felt that she was here to laugh and Mitchell was not.

437. Wendy initially sought counselling for her grief but found the services in Griffith to be insufficient to assist her in dealing with the magnitude of her loss. Notwithstanding the support of her family, all equally damaged and in pain, Wendy was alone.

[redacted]

439. Wendy's loss was deepened by watching her family rip itself apart in different ways.

Impact on Brendan Sweeney

[redacted]

442. Brendan's [redacted] psychological symptoms led to the degeneration of his sense of purpose, motivation, confidence and concentration.

[311] Report of Dr Alston Unwin dated 20 January 2012 – no ringtail reference assigned and subject to non-publication request.

[redacted]

[redacted]

445. Brendan's psychological symptoms and behaviours led to further losses of his job and his long term girlfriend.

446. Brendan struggles with guilt on a daily basis and feels responsible for Mitchell entering the HIP.

447. Brendan moved from Griffith to the Gold Coast in 2008 and obtained employment in the building industry.

448. Approximately 3 months after moving and after Brendan's insistence, Mitchell left Griffith and moved in with Brendan.

449. Brendan, working in the building industry himself, encouraged Mitchell to make a similar move.

450. Through Brendan, Mitchell was introduced to people such as Chase Martin, who later became Mitchell's co-worker at Titan.

451. Indirectly, Brendan feels as though he put Mitchell in the circumstances that brought Lindsay and Titan Insulations into Mitchell's life.

452. And for that he has never forgiven himself.

[redacted]

454. As a result of Mitchell's death under the HIP, Brendan is now considered to be significantly impaired in terms of adaption, social functioning and social and recreational utility.[313]

Impact on Justin and Sarah Sweeney

455. In the wake of Mitchell's death, Justin Sweeney was tasked with the responsibilities of administering Mitchell's estate.

[312] Report of Dr Alston Unwin dated 31 July 2013 – no ringtail reference assigned and subject to non-publication request.
[313] Ibid

456. Closing Mitchell's accounts, cancelling insurance policies, dealing with government agencies and making his funeral arrangements were daily reminders of Mitchell's death which only consolidated Justin's grief.

457. During the administration of Mitchell's estate, Justin was also under a considerable bout of stress.

458. [redacted] Wendy and Martin watched both of their remaining children plunge into the depths of despair.

459. Justin felt unrelenting remorse that his last conversation with Mitchell was an argument.

460. Justin never got the opportunity to say "I love you" or "I'm sorry".

461. In what appears to be a coping mechanism, Justin distanced himself from his wife, Sarah, and his children, emotionally.

462. Justin threw himself into his work. He spent more and more hours in the office. He found he had less and less patience for his children. Justin's life and his relationships fell apart.

463. Sarah Sweeney's own pain and grief were compounded by [redacted] and absences from the family home.

464. The stress of a young family and the impact of Justin's psychological condition, which was undiagnosed at the time, caused conflict and strain on their relationship.

465. All facets of intimacy between Justin and Sarah declined as a result.

[redacted]

[redacted]

468. Justin lost the promotion to Branch Manager for Aon Insurance for which he had been in training for some months. Justin's employment was jeopardized.

469. Justin sought counselling for both his grief and [redacted] through an Employee Assistance Program and also at the Wagga Wagga Base Hospital.[314]

[redacted]

[314] These records have previously been supplied to the commission and are subject to non-publication request. [redacted]

471. Dr Unwin recommended that Justin and Sarah seek urgent couple therapy.[316]

472. [redacted] However Justin's guilt and remorse for Mitchell's death still remain.

473. Justin had set Mitchell up with the Insurances that Mitchell had needed to be an installer with Titan.

474. Justin still has regular reminders of Mitchell's death as Mitchell's Public Liability Insurance file is still within the Aon Insurance database.

475. In various program reminders, Mitchell's account will be listed as "Mitchell Sweeney – Deceased".

476. Justin has another 2 ½ years before Mitchell's information can be removed from Aon Insurance's active database.

Impact on Martin Sweeney

477. Martin silently shouldered the weight of his wife and children's pain after Mitchell's death.

478. Martin took the steps to verify Mitchell's death with Police, organised for the children to come home to Griffith and assisted with Mitchell's funeral arrangements.

479. Martin was forced to watch Wendy as she cried herself to sleep for months and watch as his children's life and sanity disintegrated.

480. Martin too suffered sleepless nights, loss of motivation and concentration as well as periods of low moods and depression.

481. Martin's enjoyment for life decreased, he found things to have less meaning and felt less driven than he had prior to Mitchell's death.[317]

482. But Martin, being the man that he is, swallowed his pain and kept it hidden from his family. Martin's lifejacket in a sea of despair was to be the rock of his family. He has succeeded in achieving this role.

483. Martin's greatest fear is, once this is all over, once the answers they have searched for are obtained and when his family have recovered, he will be engulfed by the emotions he has kept at bay for years.

484. Whilst Martin was never formally been diagnosed with a psychological injury other than his grief, his pain is still very fresh as his statement to the Commission showed.

[316] Ibid
[317] Report of Dr Alston Unwin dated 20 January 2012 – no ringtail reference assigned and subject to non-publication request.

The interrelationship of terms d (iii) and f(i) of the Terms of Reference

485. Forgetting formal assessments of impairment and other clinical analysis of the impact of Mitchell's death under the HIP, Wendy, Martin, Justin, Sarah and Brendan will never fully recover.

486. Moreover, the Sweeney Family will never receive a satisfactory answer as to why the HIP was allowed to continue as it did after the death of the three other young men.

487. They will only be left with the knowledge that the value of a human life did not overcome the need to placate industry players and further economic agendas.

488. Having regard to our submissions in relation to terms d (iii) and f(i) the Royal Commission is urged to find that

e. The death of Mitchell Sweeney could have been avoided by the appropriate identification, assessment or management, by the Australian Government, of workplace health and safety and other risks relating to the Program for the purposes of term d (iii) of the terms of reference;
f. The action or inaction of the Australia Government as described in paragraph e) has resulted in direct loss to Wendy, Martin, Brendan, Justin and Sarah Sweeney for the purposes of Item f (i) of the terms of reference;
g. The application of the Australian Government's policy, in relation to the HIP, especially in its decision to decline to ban foil, caused or was a causative factor in the unintentional death of Mitchell Sweeney for the purposes of Item f (i) of the terms of reference;
h. The failure of the Australia Government to
    i. take reasonable steps to properly inform itself as to the risks of the HIP;
    ii. to ensure that a proper audit and compliance system was in place;
    iii. to undertake a proper risk assessment and treatment in relation to installer safety and OH&S risks; and
    iv. to give frank and fearless advice (through its Public Service) regarding
        1. The time pressure and extreme risks posed by a 1 July 2009 commencement date;
        2. The risks of RFLs and the "New Zealand Experience" when foil was both allowed in the Program at the outset and after the death of Matthew Fuller;

which caused or was a causative factor in the death of Mitchell Sweeney places the Australian Government under a moral imperative to rectify its failings and recognise the losses sustained by Wendy, Martin, Brendan, Justin and Sarah Sweeney.

Recommendations

489. After all that has happened to the Sweeney family as a result of the HIP, their enduring hope is that, in some way, they can make sure that no family has to experience the tragedy they have faced.

490. At the outset, we are instructed to seek that the Royal Commission make recommendations which give national effect to the Coroner's Recommendations handed down in 2013.[318]

National Public Awareness Program

491. What has emerged from both the Coronial Inquests and this Commission is that the lay person is not aware of nor fully appreciates the inherent dangers in ceiling spaces.

492. At the very least, it appears that the officers of the Department were shocked to learn of the magnitude of electric risk present in ceiling spaces upon the death of Matthew Fuller.

493. Mr Keefe reflected to the Commission on his initial lack of appreciation of the dangers inherent to ceiling spaces:

> "COMMISSIONER: ... you send them up into that space, someone, today or tomorrow – it actually took five months or four months– is going to put a metal staple through foil through an electric lead in an old house because in the old houses, of course, the electrical leads go above the joists as distinct from beside them.
>
> THE WITNESS: Yes, Commissioner, I can understand you coming to that view.
>
> COMMISSIONER: And it didn't occur to you beforehand and obviously not to those people that you were in charge of.
>
> THE WITNESS: I – I have trouble demonstrating the separation of foresight and my point of time - - -
>
> COMMISSIONER: ..... I understand.
>
> THE WITNESS: - - - view at the time, but I consider – I learnt a lot over the period of this time of just how inherently dangerous those workspaces are. I've really come to reflect on how inherently weak the – the safety elements of those – those sorts of jobs are, so all of the conditions that are there were leading to an accident waiting to happen.[319]

494. The electric shocks sustained by three Queensland homeowners whilst the HIP was operative[320] show a strong need for Australian families to be acutely aware of the dangers present in their homes.

495. Mr Richards publicly supported an awareness program noting that:

> "The ceilings of our homes are simply dangerous places to be,"

[318] QIC.001.001.0001 at pages 72 - 74
[319] RCI.006.001.1615 at 1702 lines 5 to 40
[320] ESO Spreadsheet shock reference her;

"We've had that reinforced to us in an all-too-tragic way through the loss of young lives in the home insulation program, and the ramifications of that tragedy are still being felt today as the Royal Commission continues its work."

"My advice to any resident is simply to avoid climbing into your ceiling space unless it is absolutely necessary. There are very real and serious dangers there, potentially from old cables or loose electrical fittings that may have degraded over time."[321]

496. On 16 May 2014, The Queensland Government gave effect to the Coroner's recommendation of a public awareness program on the electric risks in roof spaces.

Improving Electrical Safety Regulations – Extension of RCD requirements

497. The Commission has seen that no one solution is sufficient to guard against electrical risks in ceiling spaces.

498. However, it has been broadly commented upon that, in the existence of a safety switch or "Residual Current Device" ("RC D"), lies one of the most effective ways to minimize electrical risks.

499. Mr Richards noted that, in the MEA's participation in the foil removal project, they identified a huge number of existing electrical issues in ceiling cavities.[322]

500. During the foil removal project, the MEA determined that 1 in 5 houses either had electrical equipment in the roof that was not earthed properly or had bare live terminals exposed.[323]

501. In response to the MEA's findings, Mr Richards has been an advocate for the mandatory installation of RCDs on all circuits and for houses built prior to 1992 without RCDs to have these retrofitted on all circuits.

502. Mr Richards believes that "It would cost a couple of hundred dollars to protect all circuits in a house, and would virtually eliminate all electrical death in Australia."[324]

503. Mr Richards and the MEA made similar recommendations regarding RCDs to the Coroner in 2013.[325]

504. The Queensland Electrical Safety Office continues to advocate for safety switches on all circuits capable of being protected in residential properties.[326] Mr Tinslay of NECA also concurs with this view.[327]

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[321] Master Electrician Australia Press Release: "Electricians back Queensland's campaign for safer ceiling spaces" 16 May 2014, http://www.masterelectricians.com.au/page/About/News/Electricians_back_Queensland_campaign_for_safer_ceiling_spaces/

[322] STA.001.033.0014 at paragraph 46

[323] Ibid at paragraphs 46(a) and (b)

[324] STA.001.033.0014 at paragraph 48

[325] QIC.006.001.0161

505. They also saw the need to assess the existing requirements for RCD in response electrical injuries sustained by, in and outside of the HIP.

506. The Coroner's Report recommended the extension of requirements for RCDs in his findings handed down in 2013 having regard to the Office of Fair and Safe Work Queensland's Regulatory Assessment Statement: 'Extension of mandatory requirements for fitting of safety switches in residential accommodation released in March 2012 .[328]

507. In their Regulatory Assessment Statement, the Office of Safe and Fair Work Queensland undertook an extensive cost analysis of five options regarding the compulsory fitting of RCDs on all circuits.[329]

508. It is submitted that such costing analysis is useful to the determination of the appropriate method of extending existing RCS requirement.

509. It is submitted, in agreement with the Coroner's comments that the Government is best placed to balance the costs involved against the resulting improvements in safety arising from the 2010 Regulatory Assessment Statement.

510. It is noted, however, that nothing has been implemented by the Queensland Government to give effect the Coroner's recommendations.

511. Mr. Richards' evidence shows an alarmingly high rate of Australian Homes with existing electrical defects.

512. Considering the magnitude of the risk facing the public, delay of the kind shown by the Queensland Government in acting in response not only to the Coroner's recommendations but also to the recommendations of the Office of Safe and Fair Work should not be permitted to occur at any level of Government.

513. Accordingly, the Commissioner is urged to recommend the installation (whether retrofit or otherwise) of RCDs on all circuits capable of being protected in domestic premises. The Royal Commission should specify a time frame in which such action ought to be taken. The precise means of delivery thereof may be best left for the Commonwealth to determine.

National Support Program for persons adversely affected by a Commonwealth Program or Scheme

514. What has become apparent in this Commission, quite distinct from the Coronial Inquest, is the staggering scope of lives that the HIP has detrimentally impacted.

515. Not only have the families of the four young men that perished under the scheme been impacted by the HIP. It has been impossible not to notice the evidence that establishes that

[326] QIC.001.001.0001 at page 56
[327] Ibid at 60
[328]
[329] Ibid at 74

the insulation industry in existence prior to the HIP has also suffered as a result. Also, officers throughout the Australian Public Service who were involved with this program have suffered in various ways.

516. Mr Keeffe states that stress levels rose within the Department the further the HIP progressed and many staff did not stay in their roles as a result.[330]

517. Mr Keeffe further considered that the stress levels placed, particularly, on Ms. Brunoro were untenable and likely to be the reason that she left her position in April 2009.[331]

518. Mr. Combet also acknowledged high levels of stress within the Department when he came on board in March 2010.[332]

519. Mr. Combet also conceded that there was an incidence of people leaving work because of stress related conditions.[333]

520. However, it appears that assistance was only provided to those in the APS rather than those persons external thereto that were adversely affected by the decisions the Department made.[334]

521. For those outside of the Public Service, the impacts have been multi-factorial from economic and commercial losses to emotional loss and psychological injury.

522. Alice Jackson, of United Energy, has suffered not only significant financial losses as a result of the HIP but has also sustained serious psychological injuries as a result:

> THE WITNESS: I have severe major depression. It causes a lot of anxiety for me. I'm seeing a psychologist and a psychiatrist. It's – I've had periods where I haven't been able to leave the house. Last year when Kevin Rudd was – took over as prime minister again, I had quite a big breakdown. I – sorry – I just couldn't handle the fact that he had got back in as prime minister. I had to take a week off work and I have really good support from my husband and my parents. Without that, I would have been hospital.
> MR HORTON: And are they all things which you experienced, you say, as a result of the suspension of the HIP and the effect on your business?
> THE WITNESS: Yes.[335]

523. What has emerged from the Commission is that the ripple effect of the HIP is much broader than what was ever anticipated and the majority of persons affected have not been offered any, or any sufficient, help or assistance from the Commonwealth.

[330] STA.001.015.0001 at paragraph 37
[331] STA.001.015.0001 at paragraph 64
[332] RCI.006.001.5009 at page 5013
[333] Ibid
[334] RCI.006.001.4921 at page 5005
[335] RCI.006.001.4007 at page 4013

524. Further, the pursuit of accountability, upon which this Commission is based must also take into account accountability for those that have been adversely affected by Commonwealth action or inaction.

525. Unions in New South Wales have taken the lead in this area and have a support system in place for the families of persons killed in workplace accidents.

526. The Workplace Tragedy Family Support Group is a program that provides counselling and support to families impacted by workplace tragedy.

527. This exists only in NSW. There are no similar programs in other Australian States and Territories.[336]

528. Kevin Fuller laments upon the benefit that such a program might have had for him after the death of his son, Matthew.[337]

529. Arguably, if people like the Sweeney Family or Mrs. Claire Jackson had been offered support and assistance, the severity and permanence of their injuries might have been lessened.

530. What the Commission has also seen is that persons adversely affected do not always live in metropolitan areas where quality counselling and psychological care is available.

531. Indeed, Wendy Sweeney is a prime example of the lack of support services in rural Australia.

532. There is a need for a support system to provide assistance to those not only affected by tragedy but for those who do not have ready access to suitable treatment.

533. Further, it is submitted that such a support program should be called upon to operate in the context of adverse impacts arising from Government Scheme or Program gone wrong. The far reaching impacts of those affected by the HIP go far beyond those immediately linked to the young men who died in the four workplace accidents.

534. In keeping with cost considerations, as referred to in relation to retrofitting RCD, the method of delivery and allocation of funds for such a program is best determined by Australian Governments. However, such a program may be achieved in conjunction with State or Federal based organisations which could assist in the delivery of such a support program – i.e. Unions, Salvation Army, Lifeline.

535. Alternatively, such assistance may be made accessible, through legislative amendment, through the discretionary powers under the *Financial Management and Accountability Act 1997* (Cth), to allow for the provision of counselling and rehabilitative care to those adversely affected by a Commonwealth Program or Scheme.

[336] FUL.002.001.0001 at paragraph 104
[337] Ibid

536. The Commission is urged simply to recommend that there is a system in place to ensure that parties adversely affected as a result of a Government Program or Scheme can access support if required.

Stringent information management and policy within the Public Service

537. The Commission has seen that the failure of systematic information recording allowed for explicit warnings to the administrators of the HIP to be lost or ignored.

538. As discussed above, Ms. Brunoro was made explicitly aware of the risk of electrocution when affixing RFLs across joists in New Zealand on 18 and 19 February 2009 by Mr Ruz.[338]

539. When Ms Brunoro left the Department in April 2009, her explicit personal knowledge of the New Zealand experience left with her[339]. Without any meaningful information management systems in place, the content and the urgency of Mr Ruz's warnings were overlooked.

540. For example, had there been systems in place that made Mr Ruz's documents easily accessible, Mr Carter and Mr Keeffe might have had much stronger ammunition (other than technical defects of the Medicare model) to argue for a lead proponent model.[340]

541. Further, with such ease of access to information, Ms Coaldrake[341] and the Risk Assessment team may have better appreciated the risks posed to installers by RFLs .

542. The appreciation of these risks would have demanded risk treatments like mandatory training requirements for all installers; a proposal which industry had supported in response to Mr Ruz's warnings on 18 February 2009.[342]

543. Arguably, at this stage, if the warnings regarding RFLs were heeded and detailed training was mandatory for all installers, the deaths of the four young installers would not have occurred.

544. Of particular interest to our clients, the ease of access to information may have been the difference between life and death for Mitchell Sweeney where such information would have called for a ban on RFLs immediately after Matthew Fuller's death.[343]

545. Upon Matthew's death, the concerns regarding the safety of RFL insulation resurfaced together with calls for the suspension of RFLs under the HIP.

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[338] The minutes are STA.001.002.0141. Mr. Ruz's warning on 18.02.09 is page 0145. Mr Ruz followed up with media articles on the 18.02.09 and by email on the 19.02.09. AGS.002.017.1602 Email to Ms Brunoro; STA.001.001.0193 at page 0196, paragraph 24: it would appear that MIS.002.001.0005 is one of those newspaper reports.

[339] RCI.006.001.0100 at page 303, line 40 – page 304, line 25

[340] See paragraphs 73-74 above; Carter's lack of awareness of safety components of lead proponent model at RCI.006.001.0100 at page 440, line 14 – page 441 line 3 and page 442, lines 30-40.

[341] Coaldrake denies being made aware of the new Zealand experience during the risk assessment process RCI.006.001.2072 at 2189;

[342] 001.002.0141 at 0145

[343] STA.001.069.0091 Ms Kruk recommendations, whilst being drafted prior to Matthew Fuller's death, were not made available until 26 October

546. Mr Garrett had the power, in October 2009, to ban RFls and indeed terminate the scheme, both of which he did in the wake of Mitchell's death, less than four months later, in February 2010.

547. Mr Garrett, the key decision maker of the HIP, held an expectation that all technical information would have been included into briefing material in relation to RFL insulation.[344] However Mr Garrett was not briefed with information received by his staff from Mr Speranski, Mr D'arcy, or Mr Mosher[345]

548. Mr Garrett conceded that the information provided to him (usually by way of brief) by his staff responsible for briefing him on such matters was insufficient.[346] Mr Garrett denied being abreast of the New Zealand experience prior to Mitchell's death.[347]

549. Had all of the above information been accessible throughout the Department and appropriate caution taken as a result, Mitchell's death may have been averted.[348]

550. The Department was operating in a time pressured, stressed and under resourced environment.[349] The rate of staff attrition was high with knowledge and expertise leaving with them. The need for stringent information management and policy was obvious in these circumstances.

551. The need for stringent information management and policy for Programs such as the HIP in the future is not only obvious but cannot be ignored. However, future information management, to be successful, must be bolstered by technical support and behavioural change.

552. Firstly, the technical requirements demand a system of electronic information management to allow information to be recorded and accessed by relevant parties to a project. The duplicity of documents and references to various "T drives" during the Commission indicate a need for centralised information management.

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[344] RCI.001.006.4619 at page 4701 at line 10 -

[345] Mr D'arcy followed up on Mr Ruz's warnings with Mr Levey after the death of Matthew Fuller STA.001.003.0001, paras 321-325; This information was not passed on to Mr Garrett: RCI.006.001.0001, page 4684; Speranski's emails to Kimber and McCann to be included in briefs to Garrett: AGS.002.017.2244 emails; AGS.002.014.0409 Brief; AGS.002.027.2002 Mr Mosher email of 21 October 2009; AGS.002.011.1135 Mr Mosher emailed of 22 October 2009; Ms McCann had all of this information at the time of briefing the Minister on 21 October 2009 (brief signed by Mr Garrett on 24 October 2009) but it was not included in his brief: AGS.002.014.0409

[346] Ibid at page 4686 at lines 40 -45 Mr Garrett conceded to our proposition that staff responsible for briefing him ought to have brought important information such as the "Speranski emails" in the context of the question of banning foil in October 2009.

[347] RCI.006.001.0001, page 4684

[348] The deaths of Matthew Fuller, Rueben Barnes and Marcus Wilson, although not discussed to the same detail in these submissions, were also eminently avoidable. A better information management system as well as a better planned and implemented HIP is likely to have drastically reduced the likelihood of their deaths as well.

[349] STA.001.015.0001 at paragraph 37 Keefe comments regarding stress and staff attrition

553. In terms of specific technical requirements, the Government is best placed to determine its own information management technical requirements having regard to existing systems and business efficacy considerations.

554. Secondly, information management system must be bolstered by policy and code of conduct provisions making it explicit to staff that these systems must be utilised.

555. As detailed above, the lack of information management was compounded by the sheer failure to utilise, record or make available to others, relevant information. Policy and potential additions to the Public Service Code of Conduct with regards to information management requirements are needed to ensure the efficacy of the technical management component.

556. Accordingly, the Royal Commission is urged to recommend stringent and centralised information management systems and policy to be developed and adhered to for all major Government Projects and Programs.

Tightening of Australian Standards for Insulation

557. An enduring theme of the Department in relation to installer and product safety was that compliance with the Australian Standards was the standard on which they relied.

558. This is evidenced in the Guidelines and the Minimum Competencies which were premised on compliance of installers with the Australian Standards.[350]

559. However, these Standards were not fit for purpose in many ways and the wholesale reliance of the Standards by the Department misjudged the authority these Standards held.

560. For example, guided by the Department's approval of RFLs under the HIP as it was 'compliant with the Australia Standards', Mr Ross of CPSISC disregarded his concerns about RFL insulation. [351]

561. However, Australian Standard AS4200.21994, upon which Mr Ross relied in relation to RFLs, did not contemplate their use as ceiling insulation but, instead, as under ceiling or wall sarking.

562. When Mr Ross was made aware of this at the Coronial Inquest, he agreed, in hindsight, that the method of installing RFL insulation across joists with fasteners was an inherently dangerous practice.[352] It is concerning, in itself, that CPSISC did not identify this issue when developing training materials referencing AS4200.2:1994. Moreover, it is alarming that the Department appeared to have no regard to this Standard when permitting RFL insulation under the HIP.

[350] AGS.002.007.0399 Guidelines Version of at page 5 states that installer eligibility require compliance with the minimum competencies;
[351] QIC.001.001.0001 at page 49
[352] Ibid

563. Perhaps, it is even more alarming that CPSISC or the Department relied on AS3999:1992 *Thermal Insulation of Dwellings – Bulk Insulation- installation requirements* as a core Standard without even checking if it was up to date.

564. Had Review been undertaken, it would have been shown that AS3999:1992 was more than **20 years out of date with current electrical work and safety requirements** and in contradiction to another core Standard governing electrical wiring in ceiling spaces.[353]

565. Notwithstanding the inadequacy of the Standards and the unreasonable reliance upon them by the Department, the installer had no simple way of identifying whether a Standard was mandatory or advisory.

566. The Standards upon which a pillar of installer compliance was based was on a foundation of outdated, contradictory information that did not contemplate the full gambit of insulations to be performed which may or may not have been compulsory to comply with.

567. These defects in the Standards are acknowledged by Standards Australia, the Queensland Electrical Safety Office and the Department of Climate Change and Energy Efficiency who undertook review and amendment to various Standards that operated within the HIP.

568. However, as noted by the Coroner in his findings, whilst progress on many of the Standards had been commenced, the revision of these Standards was still ongoing.

569. The Royal Commission is urged to recommend finalisation of the Standards such as AS3000:2007; AS3999:1992 and AS/NZS4200.2:1994 (and harmonisation of Standards where required) with public ventilation of those changes.

570. The Royal Commission is urged to recommend that whether a Standard is mandatory or advisory must be made explicit on the face of the Standard itself and where ever references to the Standard are published.

571. The Royal Commission is urged to recommend a requirement for review of relevant Standards to ensure efficacy and timeliness to a program or scheme before such program or scheme is implemented.

A brief word from the Sweeney Family

572. As Martin Sweeney expressed in person during the hearing, the family of Mitchell Sweeney wish to again thank the Royal Commissioner and all his staff for their hard work and compassion. They are extremely grateful, not only for the Commissions' exploration of the HIP that will assist in them reaching closure, but also for the kindness that has been shown to them during this difficult time.

[353] Ibid at page 56; Reliance on AS3999.1992 was further marred by the fact that it was inconsistent with another core standard – AS3000:2007 known as the "wiring rules" in relation to the proximity of insulation to electrical cabling or equipment

Stephen Keim SC
Chambers
5 June 2014