Submissions on behalf of Jessica Wilson

1. Introduction

These submissions attempt to focus on those Terms of Reference in the Letters Patent that relate to the death of Marcus Wilson, specifically:

(a) the processes by which the Australian Government made decisions about the establishment and implementation of the Program, and the bases of those decisions, including how workplace health and safety and other risks relating to the Program were identified, assessed and managed;

(c) whether, in establishing or implementing the Program, the Australian Government:

  (i) failed to have sufficient regard to workplace health and safety or other risks relating to the Program

(d) whether the death of Marcus Wilson 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;

(e) whether the Australian Government should have taken action, in relation to the identification, assessment or management by the Australian Government, of workplace health and safety and other risks relating to the Program, that you consider would or may have avoided the death of Marcus Wilson;

(f) the effects of the Program on Jessica Wilson, the sister of Marcus Wilson;

(g) whether the Australian Government should change its laws policies, practices, processes, procedures or systems for the purpose of seeking to prevent the recurrence of any failure identified in the inquiry.

2. Summary of the submissions on behalf of Marcus Wilson

As to (a): these submissions attempt to touch upon these matters in some detail.

As to (c): it is submitted that in establishing and implementing the Program, the Australian Government failed to have sufficient regard to workplace health and safety risks relating to the Program.

As to (d): it is submitted that Marcus Wilson's death was readily preventable by the appropriate identification, assessment or management by the Australian Government, of workplace health and safety relating to the Program.

As to (e): Action that should have been taken by the Commonwealth that would or may have avoided the death of Marcus Wilson includes:

- early commissioning of a risk assessment focussing on the risks to installers themselves;
- more extensive consultation with stakeholders with respect to program design;

- more extensive consultation with stakeholders as to the competency requirements for people to work under the HIP;
- active engagement with WorkCover NSW to establish a workable system of enforcement and compliance of workplace safety;
- early attention to the design and development of a system of audit and compliance that could enhance workplace safety.

As to (f): Ms Wilson provided a statement dated 17 January 2014 to the Royal Commission. It sets out the impact upon her of the death of her brother.

As to (g): Whilst there are probably many laws policies, practices, processes, procedures or systems that could be changed, the two matters stressed on the part of Ms Wilson are:

(i) That there be a recommendation that in all future programs to be delivered by the Commonwealth that involve the employment of non-Commonwealth and/or non-State/Territory workers there be a comprehensive risk assessment conducted at an early stage, that encompasses the assessment of risk to the workers themselves.

(ii) That in all future Commonwealth programs that involve the employment of non-Commonwealth and/or non- State/Territory workers there be clear agreements (Memoranda of Understanding) between the Commonwealth and relevant States/ Territories as to obligations of each party and the provision of adequate funding for the enforcement of workplace safety.

3. A short summary of relevant facts regarding the death of Marcus Wilson

Marcus Wilson died on 21.11.09 at Nepean Hospital from complications arising from hyperthermia as a consequence of installing roof insulation in high temperatures in western Sydney.

A registered installer named Pride Building NSW Pty Ltd ('Pride') had subcontracted the relevant installation work to Calum McLean and Colin Cini. Neither of these men met the competency requirements imposed by the HIP. 'Pride' conducted work over a wide geographical area in regional and metropolitan parts of NSW.

Mr McLean was ill on 21.11.09. He asked Marcus Wilson to work in his place. Arrangements were made for Mr Cini to pick Mr Wilson up at Gosford Railway Station on the Central Coast of NSW. The two men completed a job in that area and then travelled to St Clair in outer western Sydney to complete a second job.

At the inquest there was evidence from Mr Cini that Mr McLean was to invoice 'Pride' an amount of $200 for the work performed by Mr Wilson. Mr McLean had planned to pay Mr Wilson $100 in cash.[1] That Mr Wilson was to work in Mr Maclean's place that day was not communicated to the management of Pride. The company had no backup plan to replace sick workers in any event.

The external temperature recorded in the locality at the time when Mr Wilson was undertaking the second installation job was 42.1 degrees centigrade. The temperature in the roof cavity would have been significantly higher. During the hour period spent in the roof cavity Mr Wilson was observed

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[1] Mr Maclean denied that this had been his intention when he gave evidence at the inquest.

to have a carbonated drink on one occasion. Mr Wilson collapsed and subsequently died after completing the second job.

At the time of his death Marcus Wilson was 19 years of age. It was his first day installing insulation as part of the HIP.

Whilst the Coroner noted that Mr Wilson had undertaken a training course in insulation installation at TAFE, he had no previous experience in undertaking installation or in working in hot ceiling cavities. He had not participated in any training course established by the HIP.

The Coroner found that Pride had no meaningful safety policy concerning working in high temperatures and no instructions for ensuring regular breaks. This was despite having received an installer advice notice from DEWHA in October 2009 that included a specific warning about heat stress. Whilst the company employed a "supervisor" named Alan Lawson, he was not required to be on-site during insulation installation. Mr Lawson largely spent his time inspecting previous work in response to homeowners' complaints about the quality of the installation work.

There was evidence that 'Pride' failed on multiple levels to provide a safe working environment. There was no attention paid to training or on the job induction directed at specific workplace risks. There was no system for on the job supervision of unskilled, inexperienced and untrained workers by a competent installer.

Pride appears to have exhibited the unacceptable approach to installer safety described in evidence by a number of witnesses during the Royal Commission.

4. Observations about the unusual features of the HIP

The HIP formed part of a suite of initiatives contained in the National Building and Jobs Plan announced on 3.2.09 by the Commonwealth Government and was estimated to cost $2.7 billion. The Energy Efficiency Homes Package was announced on 5.2.09 envisaged ceiling insulation in 2.7 million Australian homes.

The reason for the selection of DEWHA as the vehicle for the HIP originated from the role of the Department as part of the Renewable and Energy Efficiency Plan in 2008. At around that time a request was made by PM&C for a two page description of a technology neutral rebate which had an insulation focus.

On 23.1.09 a formal request was received by DEWHA from PM&C for a program involving a home insulation policy utilising a model where 'the Government would tender for suppliers'. This became known later as 'the brokerage model'. A preliminary risk profile based on that model was prepared during the period 24-26 January 2009.

The Cabinet Committee resolved to announce the program effective from 1.7.09 with the final design to be settled between DEWHA and PM&C.

Almost without exception Departmental officers regarded the timeline presented by the 3.2.09 announcement to be 'ambitious' or 'challenging'. The HIP had key government parameters which Minister Garrett did not have ministerial authority to change, unless with the co-operation of colleagues. Any change of the rollout date would have required a change of policy on the part of Government.

DEWHA had experience in previous programs where the regional model utilised lead agencies to deliver services. The regional brokerage model utilised what was known colloquially as 'skin in the game'; existing companies with access to suppliers of a range of insulation types.

Notwithstanding the clean energy features of home insulation, the primary driver of the HIP was workforce participation. Aspects of the HIP relied on engagement with other government departments as well as input from industry. As a consequence, PM&C appointed staff to the Commonwealth Office of Co-ordinator General with general oversight over aspects of the stimulus package. The extent of the participation of that Office in policy development and the implementation of the HIP by the rollout date of 1.7.09 had core implications for management of risk by DEWHA.

A number of Departmental officers expressed the view that there was a lack of clarity in the early policy development phase as to which department was making key decisions as between the Office of Co-ordinator General and DEWHA.

DEWHA staff gave evidence of the power dynamic between senior bureaucrats in the PM&C and 'line agency' departments such as DEWHA. It was said that the culture of the Public Service was to respect authority and to try to comply with what was being demanded. In this case that attitude contributed to the failure to foresee the fundamental changes that would flow from the change in the delivery model.

The issue of when public servants are expected to provide 'frank and fearless' advice to immediate superiors, or indeed those higher in the departmental hierarchy is particularly relevant in the context of the rollout of the HIP. Most officers considered the role of public servants was to advise the Government but also to strive to implement government policy. The Commission received little evidence[2] to suggest the Public Service alerted the Government to the problems posed by the HIP prior to commencement.

DEWHA did not anticipate the extent of take-up of the HIP by consumers. By 11.8.09 there was discussion within the Department about suppressing demand, due to concerns that the budgetary allocation of $2.7 billion for the HIP would be exhausted well before the two year completion date expired.

5. Early problems

DEWHA had no experience of a program with features similar to those of the HIP. It was also a very busy Department, running at or above capacity even before the HIP was announced.

By 18.2.09 the policy framework had been devised and the initial work by departmental staff centred on meetings with stakeholders leading to the first 'industry roundtable' meeting. Some of the later deficiencies in governance of the HIP had their genesis at this time.

There was a lack of experience by departmental staff in developing programs of the magnitude of the HIP. There was insufficient identification of the expertise required of consultants by DEWHA and as a consequence the management of risk was compromised. Consequently there was a lack of appreciation of risk considerations in the design phase as distinct from the implementation phase of the program.

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[2] The second statement from Mr Mrdak appears to be the only evidence that any suggestion was made to members of the Government (in that case Mr Arbib) that the HIP was likely to be unready to commence on 1 July 2009.

6. Removal of installer safety from the risk register

Staff of DEWHA and the PMC designed the HIP under great time pressure. It seems that those involved in the development of the HIP had no more than a general idea of the risks the installation of insulation actually posed to installers. On the evidence the Commission has received, factors such as the condition of an old roof space, the presence of asbestos, the prevailing climate, the need to work at heights, the hard physical nature of the work, the type of insulation to be used and the quality of existing electrical wiring in roof spaces are all relevant in understanding the extent of the risk.

Risk mitigation, whilst broadly identified as an important issue during this early policy development phase, was not comprehensively addressed in the risk assessment process.

Margaret Coaldrake, a consultant with Minter Ellison, was engaged as a risk consultant on 23 March 2009. It is submitted that the work of Ms Coaldrake was largely ineffective. The approach taken to defining what risks required treatment was restricted, eventually, to those perceived to involve the Commonwealth.

Ms Coaldrake conducted the earliest risk identification workshop. At that workshop Ms Sascha McCann (nee Kaminski) linked the choice of a delivery model selected by DEWHA to risks associated with poor industry practices. She identified lack of internal governance as a 'critical' consequence of the lack of program delivery model.[3]

Even at that stage it is clear that the extent of dishonest and irresponsible behaviour on the part of registered installers was underestimated as a risk to the program.

Subsequently Ms Coaldrake prepared a draft risk register that included 'installer injury' as an identified risk. The document was then circulated to EL2 level officers for input. For reasons never clearly identified, the reference to 'installer injury' thereafter does not appear on the risk register. The lack of a focus on installer safety had the consequence that there was inadequate analysis of this issue with regard to program design for the HIP.

7. The change in program design

The early model proposed by DEWHA staff Ms Brunero and Ms Wiley-Smith proposed a five-year program, the opportunity for a pilot program, and a system using established organisations as brokers across Australia to do the work itself. Such a model would have avoided many of the problems that beset the HIP and would have enhanced the safety of participants in the program.

The mandated parameters of the HIP were such that these benefits were unattainable. The HIP was unusual because instead of being designed from the ground up it was a top down exercise, with the program's funding, scope, start date and objectives all mandated before the agency responsible for delivery (DEWHA) was engaged to even design how it could be done.

There was insufficient time to proceed in a measured way. By using existing players in the industry it would have been possible to actually allocate the risk of installer safety to those organisations. An expectation on the part of the Commonwealth in such circumstances of appropriate training and supervision would have been justifiable and, presumably, contractually enforceable. By having time

[3] Statement of Sascha McCann 16 May 2014 at [18] – [19]

to run a pilot scheme it would have been possible to identify problems and potentially resolve them prospectively. Additional time would have also eased the pressure on those designing and implementing the scheme.

An example of the opportunity to engage with industry in a meaningful, measured, collaborative way was given in evidence by Mr Herbert, an ACIMA representative. He noted that his members were engaged in all facets of the industry, including the manufacture and the installation of insulation. Mr Herbert found the DEWHA meeting with industry in March 2009 to be unduly optimistic. His offer to provide general advice was not taken up.

The evidence received by the Commission strongly suggests that the decision to change the business model from brokerage to mass participation and to insist on a two year rollout without a pilot scheme was made because of the preeminent concern to rapidly create jobs and inject money into the economy. The OCG staff plainly instigated the change in delivery model. They also enforced the 1 July 2009 start date. It is clear that their concern was that the DEWHA model would not easily achieve the stimulus objectives of the HIP and may not have been ready to commence on 1 July 2009.

The model advocated by the OCG at the meeting on 31.3.09 had direct delivery by the installer to the consumer via both large and small operators, including those described as 'the bloke in the ute'. The argument advanced by OCG and PM&C was that the primary objective of the HIP was job creation and the design of the program should have a 'light regulatory touch' so as not to impede the influx of new installers into the industry. It was considered by the OCG that the latter model accommodated the speed of the rollout; encouraged small business; provided for householder autonomy and did not involve a contractual relationship with the Commonwealth. All those aspects of the model however increased risk of installer injury or death.

The new model, rapidly conceived (apparently by Mr Cox) and supported by senior OCG staff and by Mr Arbib, was adopted with no attention to the risk the new model might pose to installers and with no consultation with any external agency, group or person who might have been expected to make a contribution to sound program design or who might have had insight into the dangers the program posed.

Whilst it is easy to look back on decisions and criticise them with the knowledge of what subsequently occurred, it now seems an extraordinarily bold decision to craft a completely new program in this way. The OCG staff responsible for the change so lacked an awareness of the potential consequences that would flow from the changes that they appear to have not even considered them.

The Commission heard evidence on 12 April 2014 from Mr Arblaster of the main features of the pre-existing Victorian VEET scheme: mandatory training, appropriate supervision, a partial financial contribution by the customer and the expectation of on-site inspections by installers. Each of these features was absent in the HIP.

Once the delivery model changed, all risks thus far identified should have been reviewed. The 'direct delivery model' relied on employers meeting their obligations under OH&S and sanctions available under the States/Territories regulatory framework. From this point forward the Commonwealth abrogated responsibility for installer safety.

The program model change should have elevated both the identification of risk to individual installers and the need for a compliance program that adequately addressed installer safety.

8. High staff turn over and poor systems to retain corporate knowledge

There was high staff turnover, particularly of Departmental staff such as Ms Brunero and Ross Carter in the early policy design phase. The challenge of the design and implementation of the HIP by 1.7.09 clearly had a negative impact on the work environment within the Department. There were consequential pressures on replacement staff as well. The regular departure of senior staff throughout 2009 also contributed to a lack of understanding of the number of compliance issues likely to be encountered and how those issues were to be mitigated.

The Commission heard evidence that DEWHA had poor systems for information storage and retrieval, particularly regarding product safety and industry experience. Information from comparable programs in the United Kingdom and New Zealand does not appear to have been recognised as important at an early stage in policy development. Information relevant to safety concerns such as the email received from Peter Ruz was seemingly not passed on to others within the Department.

9. The changes to the competency requirements for installers

The decision taken by the PCG on 8 May 2009 to amend the competency requirements so as to remove the requirement that all participants meet one of the three defined competencies and thus enabling unskilled, untrained workers to participate in the HIP can be seen as an important factor in the development of the program and a crucial contributing factor to the death of Mr Wilson.

It is well established by the evidence that prior to 1 May 2009 the program guidelines required all installers to meet one of the three nominated competencies. Unskilled, inexperienced workers were to be trained before being permitted to participate. That arrangement imposed a modest barrier to entry to the HIP and would have precluded persons such as Mr Wilson, as he had no relevant trade skills, no practical experience or no training qualification. Training of unskilled new entrants had industry support.

The tension between designing a scheme that could provide mass employment very quickly to people with limited alternative employment options and ensuring that those who did participate were appropriately qualified to carry out the work safely was a recurrent theme in the evidence heard by the Commission.

The evidence reveals that the development of training programs, whilst well advanced, were not going to be sufficiently available to permit the immediate training of all unskilled installers wanting to work in the HIP from 1 July 2009.[4] From the perspective of job creation, this outcome would have reduced the stimulatory impact of the HIP at least in the short term. It appears there was also a concern that there would be an insufficient take-up by workers of the scheme. Of course this concern was shown to be quite unfounded.

Of all of the witnesses who gave evidence about the 8 May 2009 change to the competencies, Aaron Hughes' account was the most comprehensive. Ms McEwan's account was also valuable. The recollection of some senior figures in attendance at the PCG meetings of 1-8 May 2009 as to what was discussed on this issue was surprisingly limited.

Aaron Hughes described how the issue was raised by the PCG on 1 May 2009 and how he was tasked with revising the competency criteria. His evidence was that the changes were required so as

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[4] See evidence of Mr Hoffman and Mr Keeffe

to reduce barriers to entry and so as to attract as many entrants as possible. It is clear that the PCG decided upon the need for the change.

Hughes was of the opinion that the PCG considered the responsibility for installer safety fell upon the employer. He noted that in the days after 1 May 2009 he consulted Ms McKewen at DEEWR. It is notable that Ms McEwan's suggested amendments, whilst not directly mandating direct supervision, were much more prescriptive than those approved on 8 May 2009.[5] Hughes' evidence was that there was an acceptance by PCG members of the drafting changes. They received approval from Minister Garrett (in troubling circumstances) on 6 June 2009.

It is submitted the Commission will find that the decision to amend the competency requirements was made without a proper appreciation of the risks of death and injury posed to installers of insulation. The change was made because it was anticipated that the competency requirements, if left unchanged, would have impeded the main objectives of the HIP by impeding the mass engagement of workers from 1 July 2009.

Three main reasons are suggested as to why the change occurred without a proper appreciation of the risks posed to installers by the change.

Firstly, no assessment of risk to installers was carried out at any stage of the HIP. This was a crucial and disastrous failing, as the public servants who participated in the PCG were left uninformed about the real dangers posed to unskilled installers during the installation of insulation. The decision on 8 May 2009 was made without adequate information on this issue. Aside from Mr Keeffe, who gave evidence of speaking against the proposed change and of speaking about his concerns with Mr Forbes, it seems no-one involved in the decision appreciated the enormity of the change. Even Mr Keeffe accepted that once the decision was made it was simply implemented without further consideration being given to its possible negative consequences. The briefing note to Minister Garrett was conspicuously uninformative.[6]

Second, there was very little apparent engagement by those designing the HIP with any external persons or organisations to identify what consequences might be expected to flow from the change to the competencies. It seems extraordinary that on the day the competencies were changed so fundamentally by the PCG there was a simultaneous meeting in Canberra of industry representatives to discuss training requirements. Whilst it coincided with the PCG meeting and was obviously planned well in advance[7], there was no advice sought from the training group about the proposed change. Mr Darcey and Mr Hannam gave evidence they were at the training group meeting and were unaware that the competencies were being changed at the same time in another meeting. Mr Rashleigh gave evidence of his opinion regarding training needs and his views of the competency requirements. They would have been invaluable if sought. Mr Hannam was well placed to speak about the dangers posed to installers, as he did in his evidence.

It may be that industry representatives, coming as they did from established companies and organisations with established training programs were not have alarmed by the change in so far as they already managed their own staff appropriately, although the obvious imminent entry to the market of new operators was another matter altogether.

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[5] See AGS.002.023.2897

[6] Mr Garrett's evidence and related requests for briefing on the subject of competencies and supervision suggests there is a real possibility that he never saw the amended competency requirements when he approved them on 6 June 2009. There is a real possibility that he only became aware of the actual state of affairs after the death of Matthew Fuller.

[7] Some attendees had travelled from interstate to attend.

Third, none of the participants in the PCG meeting had any relevant experience of the insulation industry. A consistent theme in the evidence was that members of the OCG were pre-occupied with open access to the scheme and the need to meet the start date of 1 July 2009 and were not persuaded there was a need to proceed with caution. This problem originated from the beginning of the HIP with the Government's arbitrary imposition of the commencement date of the HIP and was also a primary consideration regarding the 31 March 2009 decision as to the HIP delivery model to be used.

Mr Hoffman's role seems to have been a crucial one in this regard. Despite having experience in private industry before joining the Public Service in early 2009, his previous work as an executive in a telecommunications company may have imbued him with confidence in the role of the free market, but it did little to assist in deciding upon proper design and implementation of the HIP.

As noted in the ANAO report [p110], if mandatory training for all installers had been in place at the commencement of the HIP many of the problems with safety of installers may have been averted.

It is no answer to this criticism to say 'well the industry was unregulated before the HIP' and was largely a DIY activity. After 1 July 2009, with a finite time limit for the HIP and the ready availability of a vast sum of cash, it was inevitable that a large number of new operators would enter the industry solely because of the funds being made available by the Commonwealth. The industry was always going to be changed dramatically, with a massive increase in the volume of work being carried out and with the engagement of a large number of inexperienced installers.

10. Failure to define the requirements of supervision

Related to the change in competency requirements was the lamentable failure to adequately define what was meant by supervision. The Commission has received evidence that those who drafted the competency document anticipated that those registered entities engaging unskilled workers would have an obvious obligation to provide on-site supervision.[8] There appeared to be an acceptance that the failure to particularise the requirements for supervision was a mistake.[9]

One nominated reason for amending the competency requirements was to allow for workers akin to apprentices to be engaged in the HIP. These persons would then be able to meet the competency requirements, either through the completion of two years experience or through appropriate training. Implicit in such an approach was the need for appropriate supervision.

Once again, this decision was made without any real appreciation of the likely entry into the industry of unscrupulous operators or of the risks that insulation installation posed to unskilled workers who were not being closely supervised by a competent installer.

There seems little to suggest that untrained workers were really akin to apprentices. Instead, many were simply casual labourers. Many were backpackers. The work appears often to have been of short duration. The evidence from the inquest into Mr Wilson's death was to this effect.

The exception appears to have been employees engaged by the established insulation businesses. The evidence suggests that many established businesses took training, supervision and workplace safety very seriously.

[8] See for example the evidence of Mr Hoffman; also AGS.002.030.0010: an email from Hughes to McKewen.

[9] For example, see the evidence of Mr Mrdak.

The failure to obtain a comprehensive risk assessment can be seen as a contributing factor as to why the supervision requirement was left undefined. That young untrained workers would be working in roof spaces alone or only in the company of similarly untrained workers was plainly not anticipated.

Even once it became apparent in the first two months of phase 2 that onsite supervision was not always taking place, those responsible for the HIP still failed to appreciate the possible dangers this posed. Instead, concern was focussed on the risk of fraud. No attempt was made to amend the competency guidelines to better define supervision, no installer advisory was issued on the subject and no effort was made to investigate those businesses suspected of not providing supervision to see what was happening on the ground.

11. Failure to set up an effective compliance program for stage 2 of the HIP

Project guidelines for the audit and compliance part of the program were not met in the lead up to 1.7.09 rollout. This was identified at a PCG level as partly a resource issue.

The compliance regime for Phase 2 of the Program under the direct delivery model could have utilised the electronic payment of claims via Medicare as a means of enforcing program guidelines. Regrettably, the ability to quarantine the processing of payments to identified 'shonky installers' was not available to DEWHA, relying as it did on a system designed for a different delivery purpose.

Without exception officers within DEWHA viewed the lack of a developed audit and compliance policy mechanism to deter poor industry behaviour as compounding the dangers to installer safety that came with the decisions to change the competency requirements.

The Commission heard evidence that the development of the compliance and audit program was not complete by the time that Phase 2 began on 1 July 2009. Mr Forbes described it as 'skeletal'. Very limited capacity to inspect work existed before September 2009 and even then the focus was on the detection of fraud. The priority had been the roll-out of the HIP. It had been intended that attention would be given to compliance and audit once time was available.

In the early months of Phase 2 there was no ability on the Commonwealth's part to ensure that participants in the HIP adhered to safe workplace practices. In this respect the Commission has heard evidence that DEWHA staff considered the duty of care owed by employers to their staff was the primary factor with regard to installer safety and that enforcement of workplace safety was a State and Territory obligation. Avril Kent gave evidence that she and her colleagues proceeded on the assumption that if the States/Territories needed additional resources to ensure OH&S in the HIP they would approach the Commonwealth. Mr Rudd, the then Prime Minister and Mr Garrett also adopted this position when they gave evidence.

It is not clear that the Commonwealth had any ability to even ensure that those registering on the HIP actually met the competency requirements. The system seemed to largely rely on honesty on the part of those registering as installers.[10]

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[10] The ANAO report noted at p113 that it was only in September 2009 that installers were required to submit evidence of how they met the competency requirements and by then 70% of installers were already registered.

12. Failure to engage with state/territory workplace safety agencies both before and during the HIP

There is no suggestion in the evidence of any real engagement between the Commonwealth and the States/Territories focussed on the possible risks to installers or attention given to measures that could minimise risk.[11] As with so many problems associated with the HIP, the speed of the rollout seems to have precluded the establishment of a working understanding between the Commonwealth and the States on this issue.

The Commonwealth was rapidly setting up a huge scheme in an area it had had no prior experience. The obvious source of such knowledge and expertise lay in the States and Territories, yet no real engagement or consultation occurred regarding who should be responsible for workplace safety.

This issue is linked, as are so many others, to the failure to obtain a comprehensive risk assessment at an early stage. Surely the States and Territories would have had the corporate knowledge to greatly add to the awareness of what risks actually existed and what was likely to happen if the scheme was to be rolled out using the various models under consideration? The commissioning at an early point of a comprehensive risk assessment would most likely have engaged the States/Territories at an early time.

Had proper consultation occurred and had the various risks to installers been properly identified, the decision to abandon the brokerage model may not have been made. Proper advice may have enabled the Commonwealth to perceive the risk posed by an enormous influx of new entrants to the industry and have provided a reason to proceed with a measure of caution. It may have impacted on the decision to amend the competency requirements on 8 May 2009.

Crucially, an engagement with the States/Territories would have provided the opportunity to design a scheme that permitted pro-active on site inspection. Funding for this purpose could have been negotiated. It would have been a valuable component of compliance and enforcement. It would also have still achieved the Commonwealth's objective of creating additional employment and injecting cash into the economy, given the States/Territories would have needed additional staff for the purpose of actively enforcing workplace safety.

Instead, it was assumed that somehow the States and Territories would be there to ensure workplace safety laws were being complied with and would therefore come, without invitation, to seek additional funding if it was needed. This was despite there being no communication of this expectation and no consideration of the additional demands that would be imposed on States/Territories even if they were willing to participate.

This expectation also ignored the fact that there was no obligation under State/Territory OH&S laws that the requirements of the HIP (such as adherence to the defined competencies and the provision of supervision to untrained, inexperienced workers) be observed.

There seems no doubt that this was the mindset of those engaged in the design and rollout of the HIP, as witness after witness said as much.[12]

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[11] David Murdoch Smith, a senior public servant from Western Australia gave evidence that his State had informed the Commonwealth that they expected their workplace safety resources would be swamped by the volume of workers entering the HIP, however that issue was not explored in detail after Mr Smith became unavailable.

[12] For example: the evidence of Mr Carter, Mr Mrdak, Mr Keeffe and Mr Forbes.

13. The HIP was impossible to proactively police in any event

The absence of a mechanism whereby DEWHA was able to identify when and where installations were occurring was a major obstacle to identifying lack of supervision of untrained workers after 1.7.09.

Phase 2 of the HIP was based upon registered installers engaging with householders directly. The selection of a particular installer, the provision of quotations, the decision about the type of insulation to be installed and the timing of the actual work were all matters that did not involve the Commonwealth.

The take-up of work after 1 July 2009 was much greater than anticipated.[13] The evidence suggests that thousands of actual installation jobs were being carried out every day across Australia. Whilst the Commission may not have seen any data breaking up the proportion of work being carried out by new entrants to the insulation industry, it can be accepted with confidence that a substantial amount of it was being carried out by new players.

It is very apparent that the Commonwealth had no ability to pro-actively enforce the requirement that unskilled workers be properly supervised. The Commonwealth did not and could not know from one day to the next where particular work was being performed. It thus had no ability to conduct on site inspections, even if there had been the capacity to do so, either directly or with the involvement of the Sates and Territories.

The 'blindness' of the Commonwealth as to where work was occurring can be linked back to the decision to not proceed with the brokerage model. It is possible to conceive a brokerage scheme that allowed for on-site inspections. All that would have been required was the capacity to know where work was being done in advance. If such a capacity had existed it would have been possible to have pro-actively enforced program standards. Poor OH&S practices could have been identified and offending installers either taken to task or deregistered.

The Commonwealth's obvious inability to do anything pro-active to ensure that safe work practices were adopted must have emboldened unscrupulous operators to operate dangerously. Only an actual accident or fatality was going to be a problem for a registered installer. Provided this outcome did not eventuate, it seems there was nothing to fear when it came to non-adherence to matters such as the provision of appropriately qualified supervisors or the implementation of appropriate protocols such as on site risk assessments or policies about working in hot conditions.

14. Failure to anticipate the extent of bad behaviour by installers

Senior staff in DEWHA[14] and PMC[15] acknowledged they had not anticipated the extent of poor behaviour by installers. Some established industry representatives were also surprised,[16] as was Mr Garrett. The same can be said of the approach taken to the obligation to provide supervision.

If the likelihood of poor behaviour had been anticipated at an early stage it may have had a big impact on programme design and competency requirements.

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[13] The unexpected volume of new work was plainly not anticipated. At p29 the ANAO report notes that demand was almost 2.5 times that anticipated. This also raises the failure of the Commonwealth to consult sufficiently. It is difficult to understand why it was feared that there would be a limited or inadequate expansion of the insulation industry given the generosity of the scheme and the massive amount of money to be made in a short time.

[14] For example Mr Forbes.

[15] For example Mr Mrdak.

[16] For example Mr Gow of the MBA.

The Commission is in possession of some information to suggest that the likelihood of poor behaviour was predicted in consultations.[17] The conduct that ensued, whilst disappointing, may well have been predicted had there been more engagement at an early stage with industry, unions and State/Territory regulators.

That senior public servants did not anticipate the magnitude of the poor behaviour is unsurprising, given they were so removed from the realities of the industry. What seems unacceptable is their willingness to make decisions of fundamental importance despite this obvious lack of knowledge. In evidence Mr Mrdak noted that he had not anticipated the extent of poor behaviour and that consultation with the States may have increased the likelihood that it would have been foreseen.

15. A slow reactive process to addressing safety issues after Fuller's death

It seems that in July - August 2009 DEWHA staff were aware that on-site supervision of unskilled installers was not necessarily occurring in some cases. This awareness came from the analysis of claims data processed through Medicare. Nothing appears to have been done to investigate this. As noted, the Commonwealth had little ability to be pro-active in any event, although it must have been apparent which firms were the most likely offenders.

Matthew Fuller's death on 14 October 2009 appears to have been the catalyst for greater attention to installer safety, yet even then the changes to the HIP were limited and the implementation of the changes slow. It is anticipated that submissions on the part of the installers who died from electrocution will address this issue in detail.

Aside from the electrocution danger, Mr Fuller's death also raised the problematic issue of supervision and access to the scheme by unskilled workers.

Aside from the decision to ban metal staples, it seems little else was done in the interim period before the deaths of Reuben Barnes on 18 October 2009 and Marcus Wilson on 23 November 2009. During this period no steps were taken to amend the definition of 'supervision'.

Even the special safety advice (Installer Advisory No 12, issued 26 October 2009) merely referred in passing to 'close supervision' and referred to the need to supervise an installer who did not have a recognised competency. This Advisory also inaccurately stated that only trained installers were allowed to enter the roof space. This was hardly a strong, clear or accurate statement of the requirements imposed by the HIP.

DEWHA also resisted Minister Garrett's stated preference after Mr Fuller's death that all installers be trained. An early decision to impose this requirement would have immediately removed the option of utilising unskilled, untrained workers. Young men like Mr Wilson simply could not have been involved in the HIP.

The decision to impose mandatory training, eventually made by Minister Garrett on 16.12.09 and operable from 12 February 2010, was in the end a pyrrhic one, as it was in place just days before the suspension of the scheme.

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[17] For example the information conveyed by Craig Simmonds at the compliance meeting on 3 April 2009 where he noted the HIP would change the dynamics of the labour market.

16. Suggested changes to be recommended to the development of Commonwealth programs

(i) That in all future Commonwealth programs that involve the employment of non Commonwealth or State/Territory employees there be a comprehensive risk assessment conducted at an early stage, so as to assist with program design and implementation.

(ii) That in all future Commonwealth programs that involve the employment of non Commonwealth or State/Territory employees there be clear agreements (Memoranda of Understanding) between the Commonwealth and relevant States/Territories as to obligations and appropriate funding for the enforcement of workplace safety.

It is submitted that the failure to comprehensively identify the risks to installers themselves was the single greatest failure in the Home Insulation Program. If this issue had been comprehensively addressed, the risk of death or serious injury to installers would have been properly identified as a substantial one.

Having identified the risk, a comprehensive risk assessment would have required that the risks be mitigated and managed. As Mr Ash noted in his statement of 14 May 2014, it may have been that aspects of risk, if not manageable by the Commonwealth, could have been allocated to the States/Territories. This would have forced the Commonwealth to actually engage with the States/Territories and to provide funding if requested and if considered necessary.

A comprehensive risk assessment at an early stage would have allowed consideration of what impact the different models under consideration would have had on risk to the installers themselves. Similarly, the decision to change the competency requirements on 8 May 2014 should have occurred only after consideration of what impact the change was likely to have on the risk to installers themselves.

The second recommendation sought flows directly from the first. It is unrealistic to assume the States/Territories will simply fill the void in program design regarding OH&S without being invited to participate in program design and implementation and without an opportunity to consider how meaningful workplace safety might be enhanced.

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