

ANZSOG Case Program

The Best Laid Plans: Australia's Home Insulation Program (Epilogue)

2017-190.3

Sadly, the death of Matthew Fuller was not an isolated incident.

18 November 2009: Rueben Barnes was completing a job laying fibreglass batts in a Stanwell (QLD) residence. With him were two other installers, one acting as site foreman. They had been using a long metal pole and a wooden stick to place the batts. As they prepared to finish up, Rueben's colleagues watched him suddenly become stiff and unresponsive. Realising that he had been electrocuted, they called for the owners to switch off the power and dial an ambulance. They then dragged Barnes from the roof and commenced resuscitation which paramedics continued until he was declared dead at the scene. He was 16 years old.

An investigation revealed that during the construction of the house, a metal screw had pierced a cable, electrifying one of the metal ceiling battens. It wasn't clear who was holding the metal pole at the time.

21 November 2009: It was late morning when Marcus Wilson (19) arrived at his second job of the day, a house in St Clair, NSW. The forecast was for very hot conditions and by 1.30pm, the temperature in nearby Penrith reached 42 degrees. Despite the weather, Wilson and his colleague were keen to finish, fearing they would be penalised by their contracting company. During the installation, Wilson started flagging and his colleague suggested he stop for a drink. He had one or two breaks for some cola. At the end of the installation, Wilson seemed upset and agitated. His colleague sent him out to

This case was written by Marinella Padula for Associate Professor Michael Di Francesco, Australia and New Zealand School of Government. It has been prepared from published materials as a basis for class discussion rather than to illustrate either effective or ineffective handling of a managerial situation.

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wait in the air-conditioned truck but instead he ran from the house and collapsed a short distance away. He was transported to hospital where he died of complications arising from heat-stroke. Wilson's death was attributed to insufficient hydration and performing manual labour in excessive heat.

4 February 2010: Mitchell Sweeney and two other installers were leaving the roof of a house in Willa Willa (QLD) where they had been installing foil insulation. The trio were heading towards the manhole when twenty-two-year-old Sweeney appeared to trip. His colleagues called out to him but he failed to respond. One approached him, only to receive a jolt of electricity. The men switched off the power and the resident called an ambulance. Attempts to revive him were unsuccessful and he was pronounced dead.

Investigators discovered that the men had been using metal staples to affix the insulation when one ruptured a lighting cable. They also found a pre-existing electrical fault.

Coronial inquests found serious deficiencies in the workplace policies, training and/or supervision of all four victims. Three of the four companies received substantial fines.¹

Rollout fallout

'I think it is fair to say that both the Minister and I were in shock in the days following the first fatality', recalled Garrett advisor Matt Levey. 'From my perception, it came as a genuine surprise to the Minister that there were serious safety issues with the HIP. The priority was making the program safe'. 2 Garrett began to suspect DEWHA was not necessarily the best source of information:

I was aware that Minter Ellison had been engaged to conduct a risk assessment process. It was comprised of a risk management plan and a risk register, neither of which I was shown. The department chose what aspects of the risk management process should be referred to me through briefings. At no time were the risks of death or serious injury communicated to me through this process. DEWHA provided me with regular briefings some of which noted ongoing risk assessment issues and actions that were being undertaken to ensure installers were aware of their responsibilities and risks. The briefs I received did not alert me to any significant safety issues that DEWHA anticipated in implementing the Government's decision.³

He wrote to DEWHA Secretary Robyn Kruk 'expressing concern about the capacity of the Department to satisfactorily manage the program'. ⁴ In response, she detailed her plans to review systems and procedures, including compliance arrangements. Avril Kent stood down as HIP Risk Manager. However, Margaret Coaldrake, who claimed she had never been warned about risks to installers, and admitted that she did not contribute 'one tittle of hard substantive input into the Department's risk

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¹ The Queensland Coroner determined that the induction and training of Fuller and Barnes had been 'clearly deficient'. Sweeney, by contrast, had completed an installation course but it did not properly address electrical safety and Reflective Foil Laminate (RFL). He had also been warned by his employer about metal staples but continued to use them since they sped up installation. In all three cases, supervision and workplace protocols were deemed inadequate. The coronial inquest into Wilson's death in NSW identified several contributors to his heat stress including the company's lack of safety policies regarding high temperatures and the pressure contractors felt to complete jobs irrespective of conditions. QLD workplace authorities eventually imposed substantial fines on three companies: QHI Installations Pty Ltd (Fuller) was fined \$100,000; Arrow Property Maintenance Pty Ltd (Barnes) was fined \$135,000; and Titan Insulations Pty Ltd (Sweeney) was fined \$100,000. NSW workplace health and safety authorities opted not to prosecute Pride Buildings NSW Pty Ltd which contracted the services of Marcus Wilson.

² Statement: Matt Levey,

http://www.homeinsulationroyalcommission.gov.au/hearings/Documents/Evidence21March2014/STA.001.003.0001.pdf.

3 Statement, Peter Garrett http://homeinsulationroyalcommission.gov.au/Hearings/Documents/Evidence13May2014/STA-001-069-0001.pdf.

⁴ Ibid.

assessment and risk management planning', was retained as consultant. In Kent's place, DEWHA established a Risk Management Committee, while the Project Control Group was disbanded. DEWHA began an urgent review of the Risk Register which was updated to include occupational health and safety, plus the possibility that the HIP would end early. Consultancy firm PriceWaterhouseCoopers (PWC) had been engaged in September to take over audit and compliance activities, with a focus on fraud. DEWHA later expanded their purview to include risk management and quality assurance. A functional compliance regime was finally put in place in October 2009.

Several days after the initial fatality, the Department issued a notice to installers advising them to switch off electricity to the roof and take special care with cables and downlights. It also mentioned the hazards of high roof temperatures but did not reference Matthew Fuller's accident or specific precautions relating to foil. This was justified on the basis that the circumstances of his death were still under investigation. The next day Garrett met with Master Electricians Association (MEA) CEO Malcolm Richards. He was dismayed by the Department's advice and assumed that it had 'been written by someone with no technical knowledge'. Foil insulation, he explained, was generally unsuited to retrofits and stapling foil into ceilings was still risky, even when nylon staples were used in place of metal. He strongly suggested withdrawing RFL from the Program and urged them to ban metal staples immediately, as more lives could be lost. Richards also recommended compulsory electrical checks before and after foil installations.

'Safety is a priority for this program,' Levey recorded the Minister as replying: 'I am alarmed to hear you say there could be more fatalities. Don't say this in the media but this sets my alarm bells ringing. We have comprehensive audit and compliance program. Foil insulation is a relatively minor component of a large program. I am advised it is the most relevant in certain climate zones. I note your issues with DEWHA advice. We will get advice on your issues with that. I have a dim view of those who breach the guidelines. If some components of the program are not meeting safety requirements, I will take advice'. Richards left the meeting unsettled.

As DEWHA and the Minister looked at ramping up site inspections and tightening program guidelines, Levey recalled that, 'At this time we (meaning the Minister and myself) pushed for a co-payment because it was really clear to us that householders had no investment in this process. They weren't checking whether the installer was doing a good job. We also wished to slow the program down. So one way to do all of that would be to require the householder to meet 30% of the cost. That never happened, because it was defeated in Cabinet'. While Garrett was meeting with Richards, Anthony Leverton, Policy Director of Queensland's Electrical Safety Office sent a request to DEWHA's chief legal advisor David Hoitink. Rising concern about foil insulation led Leverton to seek access to the Department's register of approved installers for Queensland, particularly, the types of insulation each installer had been approved to use. Hoitink declined, citing 'privacy issues' and noting that, in any

 $\underline{http://www.homeinsulationroyalcommission.gov.au/hearings/Documents/Evidence 21 March 2014/STA.001.003.0001.pdf.}$

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⁵ Hanger, I. *Report of the Royal Commission into the Home Insulation Program,* Commonwealth of Australia, August 2014, p112.

⁶ Ibid, p261.

⁷ Statement: Matt Levey,

⁸ Statement: Matt Levey

⁹ Hanger, I. *Report of the Royal Commission into the Home Insulation Program,* Commonwealth of Australia, August 2014, p194.

¹⁰ Op cit.

event, the register did not contain product details. ¹¹ After Garrett's meeting, Kevin Keeffe sent him a brief which counselled against banning RFL products. It stated that:

The Department has consulted with a range of relevant organisations in relation to the issues raised by the Master Electricians. The view of the Australian Building Codes Board (ABCB), the Housing Industry Association (HIA) and the Master Builders Association (MBA) is that:

The risks associated with foil are proportionally no more significant than the risks associated
with entering a roof space for other retrofit construction work, or with installing other
insulation types, providing that all appropriate safety measures are taken by competent
installers.¹²

Yet it did not mention that DEWHA staff had recently been in touch with the New Zealand Government regarding its experiences with RFL insulation. Garrett did not accept the recommendation but opted to consult further before making a final decision. DEWHA met with the Queensland Electrical Safety Office and the National Electrical and Communications Association (NECA) which said, 'the Guidelines should have been stronger and that there should be electricians involved in every single installation'. ¹³ At a later industry meeting Kevin Keeffe recalled that, 'The Minister listened to the stakeholders including an argument that foil should be banned under the HIP. We took the view that metal staples were the problem and that plastic staples should be used. Previously, the foil industry association had argued against plastic staples in that they often jammed in the gun and were inefficient'. ¹⁴

In late October, DEWHA released another HIP advisory, reminding employers and supervisors to observe OHS regulations. Supervision, however, was still not defined. The Department warned against the use of metal staples and 'highly recommended' taping or nylon/plastic staples. Installers were also cautioned that switching off mains power did not guarantee that all roof and ceiling cables were safe. Post-installation checks by licensed electricians were suggested. Several days later, metal staples were banned under Program Guidelines and though Cabinet would not agree to a co-payment, Prime Minister Kevin Rudd approved a reduction in the HIP maximum rebate to \$1,200 – effective 2 November. DEWHA also announced plans for compulsory risk-assessments prior to installation from 1 December.

Finding fault

The deaths of Barnes and Wilson in quick succession intensified the crisis engulfing DEWHA. A tragic one-off now seemed part of a disturbing trend. ¹⁵ Several injuries had also been reported. The Minister's office had to triage a volley of issues and enquiries: 'How to de-register installers whilst ensuring procedural fairness?'; 'Which imported insulation products are compliant with Australian standards?'; 'Should registration incorporate police checks?'; 'How many inspections had already taken place?'. The problems kept coming.

 $\frac{\text{http://www.homeinsulationroyalcommission.gov.au/Hearings/Documents/Evidence31March2014/STA.001.015.0001.pdf.}{14 \text{ Statement: Kevin Keeffe,}}$

 $\underline{http://www.homeinsulationroyalcommission.gov.au/Hearings/Documents/Evidence 31 March 2014/STA.001.015.0001.pdf.}$

 $\underline{http://www.homeinsulationroyalcommission.gov.au/hearings/Documents/Evidence9May2014/AGS.002.008.1805.pdf}$

¹¹ Hanger, I. *Report of the Royal Commission into the Home Insulation Program,* Commonwealth of Australia, August 2014, p236.

¹² Ibid, p204.

¹³ Statement: Kevin Keeffe,

¹⁵ It was difficult to gauge the extent to which deaths and injuries occurred in the insulation industry. At the time, however, there were approximately 50 fatalities per year related to construction. Safe Work Australia later revealed that it had no records of workplace deaths involving insulation installation dating back to 2003.

'At the same time we were in a fairly torrid political environment,' explained Levey, 'and so we were attempting to start piecing together the process that had brought us to a point where someone had died doing work under the program, and that included figuring out: what were these warnings, who received them, what did they say, and what action was taken? Primarily this would have been through me asking the department, "Do you have any record of this person contacting us? And if you do, find it for us, let us know". I recall there were Question Times when I literally had to sprint through the corridors of Parliament House and put a letter in the Minister's hand in the chamber as he was being asked a question about it and it was letters that we hadn't seen before'. ¹⁶ He continued:

I would have expected the Department to filter correspondence based on a range of criteria but to exercise at least some basic judgment. If someone was raising a significant issue, like a national electrical safety body, you would want that to be taken further. You would want them to either escalate it to the Minister or his staff, or at the very least ensure that if they weren't escalating it, it was because they were satisfied that the concerns raised were absolutely covered off in actions that were already being taken. It seemed to me that the Department felt that they had adequately already addressed the issues that were being raised, so there was no need to involve the Minister. ¹⁷

'It was not unusual for my office to receive a large volume of correspondence including communications such as these,' Garrett recalled. 'I would not necessarily see all letters and emails or be informed about every phone call made to my office. It was the role of the relevant policy advisor to draft a reply or refer the letter to the Department. Advisors needed to prioritise their work. Replies to correspondence could run late especially during busy periods. I expected my staff to exercise judgment and raise issues with me as necessary'. 18 Garrett was particularly perturbed to learn about the issues with RFL and decisions made regarding installer training – matters he felt should have been better explained: 'As more information came to my attention concerning potential gaps or risks in the framework I sought to immediately address them. I followed DEWHA's advice, until it became apparent to me that the existing architecture was insufficient. For example, it had not occurred to me when approving the Terms and Conditions of Registration and Program Guidelines in May that "supervision" could be interpreted as other than a person physically onsite supervising the installation'. 19 Neither, apparently, had Avril Kent: 'I thought that it was reasonable risk management that, if there is an unskilled installer, that he or she be supervised by a skilled supervisor...It was not until the HIP went on that I realised in some cases the supervisor simply dropped off employees at a site and then picked them up at the end of the job'. 20

Meanwhile, DEWHA officials maintained that safety and quality was chiefly a state issue. 'That advice persisted right into the late stages of the program and frankly became untenable,' recalled Levey. 'That was the point at which the Minister started reaching above and beyond it'. ²¹ Levey saw Garrett's confidence in his department plummet:

I think there was an extreme level of dissatisfaction from the Minister with the level of performance of some departmental officials. It wasn't limited to this program but this was probably the biggest example of it...We had a repeated series of events where we didn't believe [we'd] been given adequate

 $\underline{http://www.homeinsulationroyalcommission.gov.au/hearings/Documents/\underline{Evidence21March2014/STA.001}.003.0001.pdf.$

¹⁶ Statement: Matt Levey

 $[\]frac{\text{http://www.homeinsulationroyalcommission.gov.au/hearings/Documents/Evidence21March2014/STA.001.003.0001.pdf.}{17 \ lbid.}$

¹⁸ Statement, Peter Garrett http://homeinsulationroyalcommission.gov.au/Hearings/Documents/Evidence13May2014/STA-001-069-0001.pdf.

¹⁹ http://homeinsulationroyalcommission.gov.au/Hearings/Documents/Evidence13May2014/STA-001-069-0001.pdf ²⁰ Statement: Avril Kent,

 $[\]underline{\text{http://www.homeinsulationroyalcommission.gov.au/hearings/Documents/Evidence8March2014/STA.001.012.0001.pdf}.$

²¹ Statement: Matt Levey

information or that the department was performing at all satisfactorily and the Minister expressed extreme frustration on a number of occasions directly to the Secretary. And I think staff changes flowed from that.²²

Kevin Keeffe left DEWHA in mid-November to become a State Manager at the Australian Government Department of Families, Housing and Community Affairs (FAHCSIA). Following the death of Barnes, Garrett asked DEWHA for advice on the implications of introducing mandatory pre-qualifications for installers under the HIP.²³ The Brief recommended: 'That you agree to await the results of the audit of competencies you have recently agreed prior to making a decision on the introduction of mandatory training for installers'.²⁴ It also stated: 'There can be no guarantee that mandatory training will prevent future episodes of incidents, accidents or death. Training cannot take the place of adequate supervision by a trained professional and the business owner taking all appropriate measures to ensure a safe working environment'.²⁵ Garrett did not accept the advice. Over the next 8-9 weeks, Garrett approved a series of significant changes to the HIP, including:

- enhanced training material for installers;
- a two quote requirement prior to installation;
- <u>all</u> installers to provide proof of minimum training (or equivalent) from 12 Feb 2010; and
- the creation of an approved list of insulation products.

The last straw

Mitchell Sweeney's death in early February 2010, led to DEWHA banning RFL and introducing the Foil Insulation Safety Program (FISP) several days later. All HIP homes insulated with foil would be eligible for free electrical safety checks and rectification, if due to poor installation. The Government also appointed Dr Allan Hawke to undertake a review of the HIP. On 11 February 2010, Garrett finally saw a copy of DEWHA's risk management plan, though he did not see the original risk register until later in the month. (Asked later about the matter, Kruk claimed that, in her experience, a Minister would not normally receive Risk Registers, unless requested. ²⁶) Upon receiving the results of a PWC audit report, it became clear to Kruk that there was no way forward, despite some lingering support for the HIP within Government. She wrote to Garrett indicating 'that the Department did not believe the safety risks to households could be reasonably managed' and recommending that the Program be halted. Garrett suspended the HIP from 19 February. ²⁷ Several days later, the Special Priorities Budget Committee (SPBC) led by Prime Minister Rudd decided to establish the Home Insulation Safety Program (HISP) to extend safety checks to other types of insulation, where problems were suspected. The Insulation Workers' Adjustment Package (IWAP) was announced to help affected workers transition to alternative employment.

Looking back, Kruk sought to explain DEWHA's approach: 'What was important was to get a good understanding of what had actually happened. And to do that quickly was often difficult'. ²⁸ In terms

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²² ibid.

²³ The States were also pushing for a review of HIP training and qualifications, in particular, Queensland.

 $^{{}^{24}\,}Statement, Peter\,Garrett\, \underline{http://homeinsulationroyalcommission.gov.au/Hearings/Documents/Evidence13May2014/STA-\underline{001-069-0001.pdf}.}$

²⁵ Ibid

²⁶ Transcript of Proceedings, Royal Commission into the Home Insulation Program, 28 March 2014, http://homeinsulationroyalcommission.gov.au/Hearings/Documents/Transcript28March2014.pdf.

²⁷ Statement, Peter Garrett http://homeinsulationroyalcommission.gov.au/Hearings/Documents/Evidence13May2014/STA-001-069-0001.pdf.

²⁸ Op cit.

of RFL, she acknowledged there were 'obvious issues to unilaterally ban something that had been in use' noting that, 'the foil associations were very active involved in advocating the interests of their product'.²⁹ However, she strenuously rejected any suggestion that those factors delayed the ban: 'The advice was very clearly that [foil insulation] per se was not flawed. The issue was to look at what could be done in relation to minimising the risks associated with its appropriate use... My Department, I think, sensibly, went to the expertise that they did not have about what the appropriate response was. I don't think anyone would question that the people that they were seeking the advice from were truly independent experts in their area and a credible source of advice'.³⁰

She couldn't nominate who, specifically, told them that metal staples were the main problem but admitted that, in retrospect, they might not have chosen the best path — especially since up to a third of foil installers continued using metal fasteners after the ban. Truk agreed that she, and others like Mike Mrdak, had failed to anticipate how the market would respond to the HIP and wrongly assumed people would do the right thing. The staple issue, noted Kruk, 'gave an indication about the limitations that we had, under the program, to actually get behavioural change...We assumed that by banning [metal staples] we would get a behavioural change on the ground, and we didn't'. With regard to training and supervision, Kruk said:

I think, in hindsight, the issue is we focused very much on the existing [insulation] business. And we focused on putting in place a requirement over and above what was currently already in play. I've said it earlier, this is an area where I could put insulation in a roof, and that's scary. It's ...wisdom in hindsight. And it's really hard when you look back, when you're in a position like this and say, well, "Should we have actually mandated [training] early?" And it's easier to say that when you're at this point in the scheme of things. 33

Calls for Garrett's resignation echoed across tabloid media and talkback radio. Opposition Leader Tony Abbott suggested he was responsible for 'industrial manslaughter' and that the HIP, commonly dubbed the "Pink Batts Scandal" was another example of the Government's ineptitude. Further reports of house fires, fraudulent conduct and devastated families amplified demands for the Minister's dismissal. Garrett's insistence that 'unscrupulous, sometimes illegal and shonky operators' were to blame for the HIP's problems failed to mute his critics. Despite Rudd earlier declaring that he had 'full confidence' in Garrett, responsibility for HIP rectification programs was reassigned to the Department of Climate Change and Energy Efficiency (DCCEE) on 26 February. Assistant Minister Greg Combet would oversee the process, while Garrett retained his diminished portfolio. Although an alternative program was mooted for June 2010, it never eventuated.

²⁹ Ibid.

³⁰ Ibid.

³¹ Ibid.

³² Ibid.

³³ Ibid.

 $^{^{34} \, \}underline{\text{http://www.dailytelegraph.com.au/peter-garrett-blamed-for-insulation-deaths/story-e6freuy9-1225829348991}.$

³⁵ Pink Batts was a reference to glass-wool insulation which was typically pink.

³⁶ http://www.theaustralian.com.au/archive/politics/insulation-scams-hit-160000/story-e6frgczf-1225832389556.

³⁷ http://www.theaustralian.com.au/archive/politics/insulation-scams-hit-160000/story-e6frgczf-1225832389556.

Reckoning with the HIP

By the end of the HIP on 19 February, there had been 1,144,099 claims at a cost of \$1.471 billion. Installations varied between just over 3,300 per month to a peak of 176,000 in November 2009.³⁸ Approximately 58,000 homes had received foil insulation, the majority in Queensland. Under the FISP, 31,835 inspections resulted in 13,552 removals and 12,101 rectifications.³⁹ Inspections found that 17% of homes examined had pre-existing defects, while 533 houses had no insulation at all.⁴⁰ The total cost of the FISP was \$77.3 million.⁴¹ By the end of April 2011, 78,904 homes were subject to random or targeted inspections under the HISP: 40,585 were found safe; 18,254 had safety issues that pre-dated the HIP.⁴² The HISP cost close to \$200 million.⁴³ Meanwhile, the Insulation Workers Adjustment Package (IWAP) designed to support insulation workers was worth \$41 million.⁴⁴

Overall, 224 fire incidents were linked to the HIP, including smouldering or smoking insulation; the fire brigade attended 144 events, with 30 resulting in structural damage. Eventual damage. Few properties required extensive repairs. No-one was killed or severely injured. According to a 2011 CSIRO report, most insulation-related fires occurred within 40 days of installation. However, the long-term rate of insulation fire call-outs prior to the HIP and for Phase 2 installations (July 2009-February 2010) was not substantially different (2.4 versus 2.5 per 100,000 installations). The CSIRO also estimated that there were 96-122 fires per annum in the two years preceding the HIP. Tailure to meet HIP guidelines saw 3,456 installers deregistered and 4,000 potential cases of fraud identified. However, de-registrations were often slow to complete. There were 11,874 recorded consumer complaints under Phase 2 of the HIP, 2,883 relating to non-installation. Yet householders or authorities seeking redress were frequently frustrated by businesses that packed up and vanished as quickly as they had been established. Eventually, the Commonwealth would write off \$24 million worth of fraudulent HIP claims, though the true cost of fraud was potentially in the region of \$170 million.

³⁸ Hanger, I. *Report of the Royal Commission into the Home Insulation Program*, Commonwealth of Australia, August 2014, p273.

³⁹ Not all householders opted to have an inspection. Some also chose to remove their RFL even if it was deemed safe.

⁴⁰ Australian National Audit Office, *Home Insulation Program—Department of Environment, Water, Heritage and the Arts, Department of Climate Change and Energy Efficiency, Medicare Australia*, Audit Report No. 12 2010-11: Performance Audit, Commonwealth of Australia, Canberra, 2010, p31.

⁴¹ Hanger, I. *Report of the Royal Commission into the Home Insulation Program,* Commonwealth of Australia, August 2014, p276.

⁴² Ibid, p277.

⁴³ By May 2012 http://www.heraldsun.com.au/ipad/home-insulation-fix-costs-273m/story-fn6bfkm6-1226360690564.

⁴⁴ Hanger, I. *Report of the Royal Commission into the Home Insulation Program,* Commonwealth of Australia, August 2014, p279.

⁴⁵ Ibid, p266.

⁴⁶ Jarrett, R., Guo Lin, X. and Westcott, M. *CSIRO Risk Profile Analysis: Guidance for the Home Insulation Safety Program,* Commonwealth Scientific and Industrial Research Organisation (CSIRO), 31 March 2011. http://homeinsulationroyalcommission.gov.au/Hearings/Documents/Evidence15April2014/ABC.002.001.1341.pdf.

⁴⁸ Australian National Audit Office, *Home Insulation Program—Department of Environment, Water, Heritage and the Arts, Department of Climate Change and Energy Efficiency, Medicare Australia*, Audit Report No. 12 2010-11, Performance Audit, Commonwealth of Australia, Canberra, 2010 p148.

⁴⁹ Ibid, p171.

⁵⁰ Ibid, pp89-90.

⁵¹ Hanger, I. *Report of the Royal Commission into the Home Insulation Program,* Commonwealth of Australia, August 2014, p315.

The HIP soon became one of the most scrutinised programs in Australian administrative history. By the beginning of 2014, at least eight separate reports had been produced on the HIP, or aspects of the program. These included the four coronial inquests plus:

- Hawke, A, *Review of the Administration of the Home Insulation Program*, Department of Climate Change and Energy Efficiency, 6 April 2010.
- Senate Environment, Communications and the Arts References Committee, *Energy Efficient Homes Package (ceiling insulation)*, Parliament of Australia, 15 July 2010.
- Australian National Audit Office, Home Insulation Program—Department of Environment, Water, Heritage and the Arts, Department of Climate Change and Energy Efficiency, Medicare Australia, Audit Report No.12 2010–11, Performance Audit, Commonwealth of Australia, 2010.
- Jarrett, R., Guo Lin, X. and Westcott, M. CSIRO Risk Profile Analysis: Guidance for the Home Insulation Safety Program, CSIRO, 31 March 2011.

Yet by far the largest, and most controversial review, was the 2014 Royal Commission into the Home Insulation Program. Headed by Ian Hanger QC, the \$18 million inquiry was labelled a political 'witch-hunt' and 'payback' by opponents, including the now previous Labor Government. ⁵² They argued it would add little to public understanding, beyond what had already been uncovered, and represented a misuse of the Royal Commission process. They also worried that the Abbott Government's decision to make Cabinet documents from the former government available to the Royal Commission violated the longstanding principle of Cabinet confidentiality. However, Prime Minister Abbott and the victims' families, amongst others, felt that the previous government had not been properly held to account.

In early 2014, the Royal Commission held public hearings over 36 days and called 55 witnesses, many of whom had not contributed to earlier inquiries. The Commission also received more than 500,000 separate documents relating to the HIP; however, shortcomings in the Commonwealth's document management system and provision process made it difficult to find relevant information in a timely way. A significant number of documents relating to key events either did not exist or could not be retrieved. Under his terms of reference, Hanger was tasked with examining the processes the Australian Government used to develop and implement the HIP, and determine whether risks were appropriately identified and managed. 'My focus was not on the unscrupulous or grossly negligent employers,' wrote Hanger in the Royal Commission report, 'Rather, it is whether the Australian Government as the proponent of the HIP ought to have done more to protect young men such as those that [sic] died, or whether it was sufficient for them to be thrown to the mercy of a market in effect artificially created by the Australian Government'. ⁵³ In the end, he concluded that 'each death would, and should, not have occurred had the HIP been properly designed and implemented. The decision to permit the use of reflective foil sheeting as ceiling insulation was, in my view, fundamentally flawed. It directly contributed to the deaths of Mr Fuller and Mr Sweeney'. ⁵⁴ Also:

The reality is that the Australian Government conceived of, devised, designed and implemented a program that enabled very large numbers of inexperienced workers—often engaged by unscrupulous and avaricious employers or head contractors, who were themselves inexperienced in insulation installation—to undertake potentially dangerous work. It should have done more to protect them⁵⁵...It

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⁵² http://www.abc.net.au/news/2014-09-10/barnett-union-royal-commission/5734818.

⁵³ Hanger, I. *Report of the Royal Commission into the Home Insulation Program,* Commonwealth of Australia, August 2014, p17.

⁵⁴ Ibid, p3.

⁵⁵ Ibid.

ought also to have been obvious to any competent administration that the injection of a large amount of money into an industry that was largely 'unregulated' would carry with it the risk of rorting and other unscrupulous behaviour. ⁵⁶

Relying on others was not sufficient: '[t]he Australian Government should not seek to abrogate responsibility for identified risk. If another party (for example, a State or Territory Government) is identified as being able to mitigate an identified risk, this does not remove the Department's responsibility to take the necessary steps to manage the risk and to ensure that others are doing the same'.⁵⁷ Moreover, '[i]t is no answer for the Australian Government to say that it was the responsibility of those young people's employers to protect them. The HIP ... encouraged participation from a wide spectrum of people and took no steps to ascertain their experience in installing particular types of foil, or indeed their experience in installing insulation at all'.⁵⁸

Though he detailed warnings that went unheard or unheeded, Hanger observed that, '[a]s with most serious failures of public administration, it is not possible to isolate one error or failure that caused all of the problems that emerged with the HIP'. However, Hanger highlighted seven key failings:

- Conflicting objectives: the HIP had both environmental and economic aims; one required thoughtful, detailed planning, the other required speed. The economic aims took precedence, resulting in an unrealistic launch date that DEWHA staff felt bound to adhere to.
- Allocating the HIP to the Department of the Environment, Water, Heritage and the Arts:
 DEWHA was ill-equipped to deal with such a large-scale, complex project. Changing the
 delivery model from DEWHA's preferred regional brokerage model to a direct delivery model
 sped up the rollout but exacerbated risk.
- Poor risk management: the Australian Government failed to properly identify and manage the risk to installers. Inadequate assistance and advice from external consultants contributed to the problem.
- Permitting the use of foil insulation: RFL was manifestly unsuitable for retrofits by novice installers.
- Changing competency requirements: relaxing mandatory training for new installers without specifying the nature of on-the-job 'supervision'.
- Inadequate audit and compliance regimes: Phase 2 commenced without appropriate systems in place.
- Overreliance on other parties: The Australian Government assumed erroneously that the States/employers had the means and motivation to monitor and enforce proper OH&S practices.⁵⁹

'The States and Territories might have done more to inquire about the HIP and its nature', 60 acknowledged Hanger, 'Ultimately, however, responsibility rests with the Australian Government—as the instigator, funder and controller of the HIP—for the absence of OH&S regulation and policing, for not having either assumed regulatory responsibility itself, or taken adequate steps to ensure that those upon which it was placing reliance (State and Territory Governments) knew clearly what was

⁵⁷ Ibid, p309.

⁵⁶ Ibid, p2.

⁵⁸ Ibid, p46.

⁵⁹ Adapted from Hanger, I. *Report of the Royal Commission into the Home Insulation Program,* Commonwealth of Australia, August 2014, p5.

⁶⁰ Ibid, p238.

expected of them and had the resources and information required to discharge those functions'.⁶¹ Mike Mrdak, for example, did not raise the issue of OH&S with State Co-Ordinators General. He also claimed to be unaware that training requirements had been changed in May 2009.

Hanger considered that, '[t]he two most critical decisions taken in the design and implementation of the HIP, against the background of a perceived inflexible start date of 1 July 2009, were the change to the way in which the HIP was to be delivered (the delivery model issue) and the removal of the requirement that all installers have insulation-specific training (the competencies issue)'. 62

Memories and lapses

At the Commission, however, it seemed that 1 July was not carved in stone. 'Had a delay been requested of Cabinet on safety grounds, I have no doubt ministers would have granted it immediately,' wrote Prime Minister Rudd. 'The reaction would have been: 'Hang on here, if there is a problem we need to really look at this,' he also told the inquiry. However, '[a]s Prime Minister you accept responsibility for the good and for the bad, for anything that the government does during the period, of which I am its Prime Minister. And for those reasons, as I've said repeatedly before, I have accepted ultimate responsibility for what was not just bad, but in this case a deep tragedy'. ⁶³ Garrett, who had since left politics, also accepted 'ultimate responsibility' for the roll-out of the program. ⁶⁴

Less inclined to wear blame was Senator Mark Arbib who, during the hearings, insisted that he did not have any decision-making role in terms of the home insulation program. This was contradicted by Rudd who said he asked the former junior minister to keep 'abreast of the detail where things could go wrong' and told him that he needed 'to watch this very carefully so that things can be nipped in the bud if there's a problem'. ⁶⁵ Arbib also maintained that he did not learn of the risks to installers until after deaths began occurring and that he would have acted had he been informed of the New Zealand fatalities. ⁶⁶ Hanger determined that neither Arbib nor Garrett was specifically advised of the risk of injury to installers prior to the first casualty. Arbib, he found, would have received a copy of the Risk Register. Garrett, he determined, didn't receive a copy, though it was established that Levey received at least one that was not passed on. In any case, it was unlikely the register would have mentioned risks to installers, thanks in part to Coaldrake's omission.

Neither former minister could enlighten the Commission as to why 1 July was chosen. Further, Garrett couldn't remember any discussions with DEWHA about problems meeting the deadline and Kruk could not recall any discussions with Garrett that the HIP rollout should be slowed down. ⁶⁷ Mrdak recounted approaching Arbib on several occasions to warn him about deadline difficulties but Arbib drew a blank. He did say, however, that 'I don't accept [the program] was rushed - I accept it was challenging and difficult'. ⁶⁸ Hanger found DEWHA officials to be equally in the dark about why the July deadline was imperative. Hanger concluded that 'there was no compelling reason to commence the main phase of the HIP on 1 July 2009, other than the generally perceived need to commence it as soon as reasonably possible, and because the Prime Minister had publicly announced that as the starting date. That is an important finding because the evidence from very many of the witnesses was

⁶¹ Ibid, p239.

⁶² Ibid, p4.

⁶³ http://www.abc.net.au/news/2014-05-15/rudd-accepts-ultimate-responsibility-for-insulation-scheme/5454834,

⁶⁴ http://www.abc.net.au/news/2014-05-13/home-insulation-royal-commission-daytwo-arbib-garrett/5449104.

⁶⁵ Op cit.

⁶⁶ http://www.abc.net.au/news/2014-05-13/home-insulation-royal-commission-daytwo-arbib-garrett/5449104.

⁶⁷ Statement: Robyn Kruk

 $[\]underline{http://www.homeinsulationroyalcommission.gov.au/hearings/Documents/Evidence 28 March 2014/STA.001.010.0001.pdf.}^{68}\ lbid.$

that they understood this date to be non-negotiable and fixed'.⁶⁹ He also said: 'The short answer to the question of why it occurred is, on the evidence put before me, perhaps as simple as a lack of proper communication'.⁷⁰

However, he did not view Arbib's account as entirely plausible: 'In the end, I am satisfied that Mr Arbib (while not technically having authority to make decisions) at all times pushed the commencement date of 1 July 2009 despite any concerns expressed by others as to whether it was properly attainable. This is entirely consistent with what was believed to be the PM&C approach'. Hanger also believed that many of the public servants were being guarded in their answers, albeit not dishonest:

Many public servants claimed to have no recollection of important events during the life of the HIP. Others were only able to recall matters when shown documents, and then only to the extent of what was revealed in the document. It seemed that no public servant was willing to contradict another; except when forced to do so by the weight of other evidence, documents, or when their personal reputation was at stake. No public servant seemed willing to attribute any blame for the shortcomings in the HIP to any politician, although some were prepared, when pressed, to allude to such matters.⁷²

Kevin Fuller, Matthew's father, had no such difficulty. He conveyed his frustration listening to politicians and public servants testify: '...when people go "I can't recall, I can't remember" Christine and I have the opposite problem—we will never, ever be able to forget what the HIP did to us, needlessly killing our only son Matthew'. The Commission heard how he and other family members continued to be devastated by their losses and Rudd's perceived indifference to their pain at the time. Five years had done little to temper their anger or grief. Also angry were members of the insulation industry which had been gutted by the HIP and its sudden demise. Witnesses recounted bankruptcies, relationship breakdowns and foreclosures in the aftermath of the Program, as well as a lingering public distrust of the industry. Many installers experienced lengthy payment delays after the HIP shutdown. Laurie Moylan of the Australian Cellulose Insulation Manufacturers' Association (ACIMA) described some of what transpired:

It was told to me by members of the fibreglass batt industry that there were at least 1,000 shipping containers filled with fibreglass batts sitting on docks throughout Australia at that time. In addition, there were factories filled with excess insulation, stacked up to 15m high and 200m long. When they realised that the insulation was worth next to nothing, companies had to pay hundreds of thousands of dollars to have excess fibreglass batts taken to the tip. Trucks that had been loaded with fibreglass batts dumped them in shopping centre car parks just so that they could take their next delivery. Somebody came and told us they had seen this happen at the Melbourne Southland Shopping Centre car park, and I went there to have a look. I saw the batts in the car park and people were putting them into the boots of their cars. ⁷⁴

⁷¹ Ibid, p156.

⁶⁹ Hanger, I. *Report of the Royal Commission into the Home Insulation Program,* Commonwealth of Australia, August 2014, p3.

⁷⁰ Ibid, p28.

⁷² Ibid, p13.

⁷³ Ibid, p256.

⁷⁴ Ibid, p287.

Little explored was the effect on DEWHA staff. Kruk stated that Fuller's death had a 'profound' impact on the Department⁷⁵ with Ross Carter noting that many employees required counselling in the HIP's aftermath. ⁷⁶ The consequences, observed Carter, were long-term:

There are quite a number of staff that are still quite affected by the intensity of that time across the work of the Division. Some have left the public sector and some may have ended up not working in management or executive roles because of the pressure and stress placed upon them during this time. As committed public servants, implementing the policies of the government of the day is their duty. However, when the work is difficult and stressful but also results in significant community concern and, in the case of the Home Insulation Program, is associated with the tragic deaths of four people, the stress is exacerbated.⁷⁷

Taking DEWHA to task

In his Royal Commission report, Hanger acknowledged that DEWHA had been under enormous pressure to deliver the HIP with inadequate resources. Staff held the sincere belief, reinforced by the actions of PM&C and the OCG, that there was little choice but to accept PM&C's directives and do whatever necessary to get the job done. Though Arbib and Mrdak denied compelling DEWHA to adopt their model or any other proposal, Mrdak could not cite any instance of DEWHA rejecting a OCG/PMC 'recommendation' in favour of its own plan. Hanger also noted of Secretary Kruk: 'She moved at an early time to identify problems within her own Department with the delivery of the HIP, made such changes as she could and all in the context of a role to which she was new'. He recognized that she had been set a very demanding task she had minimal input into and lacked capacity to control. That said, Hanger observed that HIP managers had made several key mistakes:

- a failure to provide candid advice to Ministers. This was most exemplified by a failure to warn candidly that the 1 July 2009 commencement date was unachievable if the HIP were to be accompanied by the usual protections and terms (including an adequate audit and compliance regime);
- similarly, a lack of candour in the briefings to Minister Garrett concerning the effect and significance of the decision to relax the requirements for training in June 2009;
- a lack of subject-matter expertise in relation to the environment in which the HIP operated, which resulted in advice being inaccurate, based on false assumptions or poorly targeted; and
- a failure to provide leadership of the HIP, by which I mean to assume responsibility for the program as a whole and do what was necessary with the staff working under them to ensure that their time and efforts were efficiently directed. Committees are not well-suited to making decisions and taking action, yet they are common in the Public Service. The Project Control Group (PCG) is a clear example in the case of the HIP.⁸⁰

In the hope of avoiding similar failures in the future, Hanger made many observations about problems afflicting DEWHA and many other parts of the public service:

On governance

⁷⁵ Statement: Robyn Kruk

⁷⁶ Statement, Ross Carter

http://www.homeinsulationroyalcommission.gov.au/hearings/Documents/Evidence20March2014/STA.001.001.0340.pdf.

⁷⁸ Hanger, I. *Report of the Royal Commission into the Home Insulation Program,* Commonwealth of Australia, August 2014, p.135

⁷⁹ Ibid, p105.

⁸⁰ Ibid, p304.

Most PCG members were extremely passive participants. Decisions were routinely taken by exception—that is, in the absence of debate or dissent, it was assumed that there was consensus. Dissent or debate seems to have been rare. In this regard, 'groupthink' might have prevailed in certain meetings of the PCG, such as in respect of the 8 May 2009 decision with respect to the relaxation of training and competencies in particular.⁸¹

On staffing and staff management

What seems to have been left out of account(s)—at least in the case of the HIP—is the way in which these people, many of them new to DEWHA, would work together in an institutional or collective sense. The problem with the lack of experience is that there do not exist the well-established relationships or practices for achieving particular results. The result is that there has never been a testing, in any practical sense, that the mix of people and skills, in the actual environment in which a particular goal has to be achieved, can actually do the task set for them.⁸²

On 'frank and fearless' advice

There were, in all, many hundreds of public servants working on the HIP. Yet none documented in any record produced to this Commission any advice that a 1 July 2009 commencement date was not capable of being achieved without compromise to the safety of installers working under the Program.⁸³

Advice must be multifaceted. It must look at issues beyond the Department's primary objective. For example, in the case of the HIP, advice on the economic impacts should have focused not only on the macro-economic stimulus impacts, but also on the likely impact on the industry itself in both the short and long term.⁸⁴

The lazy use and misuse of language, something of which the public service is particularly guilty, has become a very great problem in recent years. It is common to see, as it was in the Government documents produced in this Commission, the regular use of unspecific words when there exist perfectly apt terms to describe what is intended with precision and clarity. 85

[T]he public service is no longer automatically a lifetime career, nor does it, for many, offer the security of tenure it once did. The changes have not been all bad...But on the other hand, without some security, public servants might reasonably feel less able to give advice to a Minister who, if he or she finds it unpalatable, might take action which threatens that person's employment. ⁸⁶

On outsourcing and insourcing

The Australian Government must better understand what outside expert services are available and the nature of them so that the APS is an informed purchaser of risk management and project management services in particular. It must also be more thoughtful about what service specifically it is that is required, so that the documents defining the provider's role state with clarity what is to be expected of that expert.⁸⁷

It is not enough to say, as so often now occurs, that the agency will or can 'build its capacity'. That is often a euphemism for the agency having a serious gap in its capacity, promising to redress it—but often not knowing how to do so—and under-estimating the difficulty of building institutional (as distinct from individual) competence and capacity.⁸⁸

⁸¹ Ibid.

⁸² Ibid, p300.

⁸³ Ibid, p312.

⁸⁴ Ibid, p308.

⁸⁵ Ibid, p310.

⁸⁶ Ibid, p307.

⁸⁷ Ibid, p312.

⁸⁸ Ibid, p302.

In response to Hanger's report, Environment Minister Greg Hunt released a six-point plan:

- payments for the families of the deceased installers;
- payments for pre-existing insulation businesses adversely affected by the HIP;
- improving safety for workers in roof spaces with the states;
- ensuring Commonwealth programs minimise work health and safety risks;
- improving Government processes through a review; and
- addressing Public Service Code of Conduct matters.⁸⁹

Relating to the final point, Australian Public Service Commissioner, John Lloyd, reviewed the conduct of public servants responsible for the HIP. In early 2015, he concluded that there was not a sufficient basis for formal investigations of individual public servants.

An alternative appraisal

Few public voices contested the media's near unanimous conviction that the HIP was a shambolic exercise in reckless incompetence. By the time of the Royal Commission, the HIP had come to be emblematic of a dysfunctional government with ambitions exceeding its ability to deliver. As such, Hanger's overall conclusions about the program were met in the media with wholesale agreement. However, there were dissenting views amongst informed commentators and academics who noted other legacies of the HIP, for example, that it ultimately raised industry standards and likely prevented future incidents by alerting homeowners and tradespeople to electrical and insulation faults. Even Hanger acknowledged that fire risk was certainly no worse under the HIP, and that the program had likely been a catalyst for improvement. Problems aside, some 99% of recipients were satisfied on and the program saw more than a million homes made more comfortable and energy efficient. Writing soon after the HIP's demise, the University of Sydney's Professor Rodney Tiffen (an authority on the politics of the media in Australia) concluded that the coverage was worryingly one-dimensional:

[W]hat was most striking about the political controversy was the stultifying and misleading narrowness of the news agenda. It was depressing testimony to how seldom a complex or rounded picture emerges in political reporting. The trade-offs in policy – between speed and size on the one hand, and careful preparation and targeting on the other – never emerged in the news. The home insulation program had considerable flaws, but in news reports these all but completely eclipsed its virtues. The economic and environmental achievements of the program never came into focus. 91

The media, he observed, had largely failed to put the events of the HIP into any meaningful context: 'As interesting as the urgent emergence of these problems under Labor was their previous neglect,' Tiffen said. 'Insulation-related fires and electrocutions had been beneath the public radar for a long time, probably decades, and they only received news attention because of the political conflict surrounding the government's scheme. The beguiling narrative of government blame and total failure owes quite a bit to a media that pursues controversies with little curiosity about history and a defiant innumeracy that treats every event as unique, and in the process presents a lop-sided causality and simplistic moral absolutism'. ⁹² He also argued that, 'Every one of the 300 work-related deaths that

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⁸⁹ Adapted from http://www.news.com.au/national/politics/families-accept-compensation-for-home-insulation-scheme-mistakes/news-story/79b132ccc7cfc8bf8c5014b4338d2981.

⁹⁰ Hanger, I. *Report of the Royal Commission into the Home Insulation Program,* Commonwealth of Australia, August 2014, pp89-90.

⁹¹ http://insidestory.org.au/a-mess-a-shambles-a-disaster/.

⁹² http://insidestory.org.au/a-mess-a-shambles-a-disaster.

occur each year in Australia is a tragedy, not only the four associated with home insulation. Every one of them should be an occasion for examining existing policies and practices, and many of them should have received more media and political attention than they have'. For some, HIP and its subsequent assessment reflected the increasingly difficult 'double-binds' government departments must deal with day-in and day-out: to get out of the way and also maintain control; to be flexible, responsive and adaptive whilst adhering to proper process. Others also felt that no one had adequately probed the role Cabinet processes and ministerial staffers played in the program.

The final chapter

Hanger recommended that the Government use the lessons of the HIP to avoid similar episodes in the future. In response, Environment Minister Greg Hunt commissioned an independent assessment of the failures identified by the Royal Commission (as well as those found by the Independent Audit of the National Broadband Network Public Policy Processes). In early 2016, the Government released Learning from Failure: Why large government policy initiatives have gone so badly wrong in the past and how the chances of success in the future can be improved to address issues raised by the HIP and comparable projects. Authored by esteemed former PM&C Secretary Professor Peter Shergold AC, the report used HIP (amongst other programs) to illustrate how the public service might prevent such debacles.

'The review,' said Shergold, 'is to identify what lessons can be learned both by ministers and public servants and to provide practical recommendations to enhance the capacity of the Australian Government to deliver large programs and projects. The starting point is clear: HIP was an unmitigated disaster that need never have occurred. The capacity of the Australian Government needs to be enhanced. Ministers, their advisers and public servants should all heed the lessons'. Shergold outlined 10 major lessons (*Exhibit A*) including the importance of written argument to supplement oral advice, proper record preservation, confidentiality, workforce diversity and effective collaboration. From these learnings flowed 28 recommendations relating to key reform themes:

- Providing robust advice
- Supporting decision making
- Creating a positive risk culture
- Enhancing project management
- Opening up the Australian Public Service
- Embracing adaptive government.

Although progress in these areas had been made in recent years, Shergold noted, it had often been slow and there was still considerable work to be done. Yet, as his report also observed, in an increasingly fractured political environment, where leaders operated in shrinking circles of trust, a strong and independent public service was more needed than ever.

⁹³ Ibid.

⁹⁴ Shergold, P. Learning from Failure: Why large government policy initiatives have gone so badly wrong in the past and how the chances of success in the future can be improved August 2015, Canberra, p11.

Exhibit A: Shergold report excerpts

First, policy is only as good as the manner in which it is implemented. The development of a policy and its delivery are inextricably linked. Implementation should be integral to policy design. A policy cannot be elegant if its execution is poorly communicated, ineptly administered or inadequately evaluated. The proof of the pudding is in the eating.

Second, policy advice can only be frank and fearless if it is supported by written argument. Good government is founded on good policy, and good policy depends on forthright advice. Ministers look to their public servants (although not to them alone) to provide or challenge ideas. Discussion of proposals should be robust. Yet oral advice, however strongly it is conveyed, can too easily be ignored or misinterpreted. Worse, it becomes possible to argue about whether it was actually given or received.

Third, deliberations, oral and in writing, need to be protected. Ministers (and their advisers) and Secretaries (and their senior executives) need to have complete trust that public service advice will remain confidential. If private discussions become public, mutual respect will be eroded. If confidentiality is not assured, public servants will be tempted to temper their counsel and ministers will prefer to receive advice only orally. That's a bad outcome for governance. Anodyne advice undermines effective decision-making. Oral advice leaves no trace of the reasoning behind the decisions that were made.

Fourth, deliberative documents need to be preserved, whether written on paper or delivered by digital means. Nothing symbolises significance more than handing a minister a sheet of signed advice. Increasingly, though, policy is developed in real time by email and text message communication between departments and ministers' offices. These important electronic documents need to be managed as confidential records. They are the files of the future. They are our protection against 'digital amnesia'.

Fifth, it is up to ministers, not officials, to make policy decisions. The important role of senior public servants is to ensure that Cabinet ministers make their decisions with eyes wide open. Advice should seek to identify the risks, envisage unintended consequences, indicate threats to successful implementation and proffer alternative options. Public servants should not seek to impede a government's ambitions but to help it find the best way to give them effect, ensuring that ministers are cognisant of the full ramifications of their decisions and the impact that they will have on business and community interests and on the general public.

Sixth, the effective management of risk is just as important in the public sector as in the private—perhaps more so. Governments need to be apprised of the strategic, financial, operational, regulatory and political risks to the implementation of major projects. This is particularly the case when successful implementation depends on the co-operation of other tiers of government and/or delivery by third-party agents. Public servants need to indicate how risks can be mitigated or accepted, not avoided. Problems often emerge a long way from Canberra. Risk culture and behaviours need to be embedded across the whole department, from the departmental Secretary to the most junior regional officer. Prevention is the first line of defence.

Seventh, as the public service fully commits itself to measuring results by outcomes, program management needs to be accorded far greater professional status. The *Public Service Act 1999* places equal emphasis on members of the Senior Executive Services (SES) exhibiting the capacity to provide policy advice or deliver programs. That is not reflected in cultural attitudes or behaviours. Too often in the APS, policy advice is accorded significantly greater status than program delivery. In truth, conceptual, analytical and strategic skills (the foundation of SES selection) are just as important to program management as they are to policy design. Project and program managers need to be recognised as a community of practice in the public service, with attributes as important as those who possess legal, accounting, medical or veterinary skills. Capability needs to be progressively enhanced across the APS in a systematic fashion. In the past, public servants tended to administer by the prescription of process. Management directed its attention to the distribution of allocated inputs. Today the focus is far more heavily on performance-based outcomes. Results matter. New professional skills are required.

Eighth, good governance increasingly depends on collaboration across sectors. The private and community sectors are now central to the construction of public infrastructure and delivery of public programs. They are commissioned to deliver government services. The public market is becoming contestable, offering citizens greater choice. Unfortunately, too often the relationship with providers is conceived merely in contractual terms. Their expertise is not given full expression. Public servants need to facilitate the engagement of business

leaders, not-for-profit CEOs and senior academics in the design of major projects. They should be seen as partners rather than as stakeholders. Their experience should be tapped. That will help to ensure that there is more evidence-based policy and less policy-based evidence. The key to transforming the delivery of major projects is to focus less on contract compliance and more on collaborative performance.

Ninth, the APS needs to be further opened up. More opportunities should be found for those who work in business and community organisations to work in the public arena. This is not to suggest that public servants are second class. An increasingly graduate workforce is probably more qualified and capable than ever before. However, there is considerable benefit in increasing the diversity of perspectives brought to public administration. Conversely, public servants should be actively encouraged to undertake periods of relevant work in companies, social enterprises or universities. Greater experience will enhance their performance when they return to the APS. There is significant advantage in enabling people to stand in the shoes of others, appreciating the different constraints under which they operate, and learning new approaches. Such exchanges will not undermine the public sector ethos but reinvigorate it.

Tenth, an adaptive government can respond rapidly to changing circumstances without taking unnecessary (and unforeseen) risks. On occasion, governments have an appropriate desire to act quickly. Public servants are often seen as an impediment. They can be perceived as cautious, guarded, even unimaginative. They can seem risk-averse. Yet their circumspection is based on the knowledge that the rollout of major national programs is fraught with danger. With wicked, complex and deep-seated public problems, it is uncertain exactly what policies will work, or how they should be delivered in the most effective way.

Source: Shergold, P. Learning from Failure: Why large government policy initiatives have gone so badly wrong in the past and how the chances of success in the future can be improved August 2015, Canberra, pp4-6.