REVIEW OF ISSUES RELATED TO THE ACQUISITION AND MANAGEMENT OF CONTAINER ACCOMMODATION IN THE NORTHERN TERRITORY AND THE MANAGEMENT OF ACMS ON PRESCRIBED COMMUNITIES FOR THE DEPARTMENT OF FAMILIES, HOUSING, COMMUNITY SERVICES AND INDIGENOUS AFFAIRS.

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Findings

1. In my opinion:

Finding 1: The management structure dictated by government and based on the effective separation of the Operations Centre from the Department resulted in fragmented responsibility and accountability at least in relation to accommodation issues.

Finding 2: The time scales imposed resulted in managing to deadlines which gave little opportunity for detailed consideration and planning including risk management and an acceptance of higher risks than would normally be the case.

Finding 3: Despite the size of the task and the problems caused by the imposed structure and time scales the Operations Centre and the departments have very largely achieved the outcomes required as part of the Northern Territory Emergency Response (NTER). The issues identified below have not, to date, been critical to the achievement of those outcomes.

Finding 4: Apart from some aspects of the contract documentation with Royal Wolf, which is being separately reviewed by FaHCSIA's Legal and Compliance Group, the Department's management of the procurement of the containers was adequate in that:

(a) the decision to use appropriately fitted-out containers was reasonable in the circumstances;
(b) the fumes issue could not have been reasonably foreseen;
(c) the decision to convert the original leasing arrangement to a purchase arrangement was appropriate given the business case; and
(d) the requirement that the fitted-out containers met the relevant Australian Standards was appropriate.

Finding 5: The response to the concerns raised by Government Business Managers ("GBMs") was not adequate in that:

(a) In the case of the Operations Centre:

i. No effective action was taken to determine the nature and extent of the problem despite numerous and detailed reports from GBMs, although the potential for there to be Occupational Health and Safety (OH&S) implications was recognised when the fumes were first reported. Other OH&S issues raised were not effectively pursued;

ii. The apparent assumption that the issues reported were not serious was not justified; and

iii. Many of the GBM reports relating to accommodation risks were not registered as required by the NTER Project Plan and by the Strategic Accommodation Plan nor were they reported to a senior Officer as required by those Plans.

(b) In the case of National Office:

i. When the potential seriousness of the fumes issue was recognised in the Operations Centre and reported to National Office (NO) the action taken by NO did not reflect the urgency of the issue until the Simmons & Bristow report was received from Royal Wolf ("RW") in April 2008 when decisive action was taken; and

ii. Whilst the initial reference to RW for assistance in identifying the nature of the problem was appropriate the continued reliance on RW was not justified given the difficulties experienced in obtaining promised "data sheets" and reports and the recommendation from the Department's OH&S area that an independent assessment of the nature and seriousness of the problem be obtained.

(c) Both the Operations Centre and NO failed to consult appropriately and effectively with both GBMs and other stakeholders.

Finding 6: In the light of this case the Departments OH&S management and escalation procedures were not adequate in that:

(a) I have been unable to identify any departmental escalation procedures of general application;

(b) The risk management strategies identified in the NTER Strategic Plan and particularly in the Strategic Accommodation Plan which would have provided a focus for the management of the OH&S issues were not followed by the Operations Centre or NO;

(c) Despite the fact that as previously identified, the OH&S implications of the fumes issue were raised and acknowledged on 8 November 2007 by the Operations Centre, the OH&S section of the Department was not officially informed until late January 2008;

(d) The OH&S section did receive unofficial advice that there were issues with the container accommodation in December 2007 but in the absence of formal notification and given its on going work load took no action;

(e) Recognising that there will always be question of judgement involved, there was insufficient recognition within the Operations Centre of the responsibility of line managers to identify and report potential OH&S issues in relation to the accommodation and to take action to deal with them;

(f) The report that was prepared by the senior OH&S Officer was treated both by the Operations Centre and in NO as advisory only rather than as a report requiring management action;

(g) There was inadequate follow up by the OH&S section on the matters raised in the OH&S report; and

(h) The OH&S section is under resourced for the tasks it is asked to do, lacks appropriately qualified staff and is not adequately supported at senior levels.

Finding 7: Other matters which arose during the investigation:

(a) The division of responsibility between the Operations Centre and NO and therefore accountability between the provision, installation and management of accommodation in the “Top End” confused the handling of the accommodation issues;

(b) The “installation” and “hand-over” of the accommodation complexes was not well managed and was a significant source of discontent amongst GBMs and a risk to the contractual interests of the Department;

(c) There was insufficient capacity to identify and manage the risks inherent in the “Top End” accommodation strategy;

(d) Given the time pressures involved in the initial implementation of the accommodation strategy there was a failure to provide for “review and catch-up” processes to identify and remediate problems in a systematic way;

(e) Considerable effort and resources were devoted to establishing the risk management strategies in the NTER Strategic Plan and the Strategic

Accommodation Plan. Even allowing for the very real problems caused by the timetable set by government neither was effectively used in managing the provision and installation of the container accommodation. Indeed the difficulty experienced in establishing the existence of the Plans in the course of the review suggests that risk management is not effectively used in the Department when it comes to the implementation of project plans;

(f) In part as a direct result of the handling of the accommodation issues both by the Operations Centre and in NO there is a serious loss of confidence in management within the GBM network that can only be addressed by the senior management of both;

(g) Despite, or perhaps because of, the voluminous provisions on the subject in the GBM handbook, there is a need to clarify and refine the role and priorities of GBMs particularly as that role relates to other officers working in or visiting communities;

(h) The different employment conditions applying to officers working in similar circumstances often on the same community is a cause of dissatisfaction with both GBMs and CEBs;

(i) There is a need for an objective and transparent method for appraising the performance of GBMs;

(j) A major issue for a number of GBMs and a serious limitation on their willingness to extend their posting, should that be offered, is that the accommodation effectively precludes their being accompanied by their partners;

(k) Consideration should be given to involving Legal and Compliance Group early in the establishment of contractual arrangements such as those that related to the acquisition of NT container accommodation; and

(l) There is a need for officers to recognise that sending emails is not a substitute to taking action to resolve issues.

Finding 8:

In relation to the management of ACMs on prescribed communities:

(a) The actions taken by the Department to determine the nature and extent of the hazard arising from the presence of ACMs on those communities and the possible risks to health have been appropriate;

(b) The strategy now being proposed for managing ACMs on those communities appears appropriate;

(c) A comprehensive plan for managing the risks associated with ACMs should have been prepared and agreed to at the appropriate executive level – I have been unable to establish that this was ever done;

(d) The Minister should have been briefed about the ACM issues as soon as practicable after assuming office in the event the Minister was not advised about them until 28 May 2008;

(e) The Secretary should have been briefed about the ACM issues as soon as practicable after the material was first identified;

(f) Corporate Support, and in particular the OH&S section, should have been informed that ACMs had been identified as soon as the Department was alerted to their presence;

(g) The OH&S section should have had a major role in determining the strategy to be followed in dealing with ACMs;

(h) As identified in Finding 6, the OH&S section is under resourced for the tasks that it is asked to do (and should do), lacks appropriately qualified staff and is not adequately supported at high levels; and

(i) More attention needs to be given to managing the concerns of persons, including departmental officers, living and working on communities where ACMs are identified.

Recommendations

I recommend that:

(a) The OH&S issues be reported to and monitored by an appropriately senior departmental committee similar in role to an audit committee;

(b) The capacity of the OH&S section be reviewed with a view to better equipping it to meet the OH&S challenges now facing the Department;

(c) The responsibility of officers to report OH&S issues to the OH&S Section be identified and reinforced;

(d) All officers, but particularly those in managerial positions, be made aware of the seriousness with which the Department regards OH&S issues and of their individual responsibility for taking appropriate action on those issues;

(e) The need to prepare risk management plans for all program and project activities be reinforced and that standard formats appropriate to those activities be used;

(f) Unless there are demonstrable reasons for departing from approved risk management strategies managers be required to operate in accordance with those strategies;

(g) Given the not inconsiderable investment in developing the Strategic Accommodation Plan that any decision not to use the same methodology on future accommodation projects be reviewed;

(h) The structure and level of resourcing for managing GBMs be reviewed having particular regard to their role and that in any such review regard also be had to the roles and relationships of the ICCs and the two newly created Regional Coordinator's positions;

(i) That particular attention be paid to achieving meaningful two way communication with GBMs and to achieving a consultative and effective management model that appropriately reflects the expectations of and experience with GBMs;

(j) A transparent methodology for appraising the performance of GBMs be developed and implemented;

(k) The advantages of retaining the services of effective GBMs for extended periods (say 3 years) be recognised;

(l) Consideration be given to allowing GBMs, on appropriate communities, to be accompanied and if agreed, that appropriate conditions, including accommodation be provided;

(m) The employment conditions applying to officers working and living in similar conditions in communities be reviewed with a view to providing standard conditions;

(n) The role of GBMs and their relationship to other Commonwealth Officers working on or in communities be clarified;

(o) Legal and Compliance Group be involved in developing contractual arrangements; and

(p) The department identifies appropriate arrangements to be made to take proper account of the individual circumstances of officers exposed to either the fumes or asbestos. I also recommend that all officers both past and present who have occupied the containers, or have been exposed to asbestos be kept appropriately informed of, and involved in, the development of the responses to the issues involved.

Introduction

2. I have been commissioned by the Secretary of the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) to investigate the circumstances surrounding the issues with the use of container accommodation for Commonwealth Public Servants involved in the Northern Territory Emergency Response (NTER). My Terms of Reference are at **Attachment A**. In particular I am required to:

   "Review the sequence of events from the Department's decision to acquire accommodation for GBMs, through the process of deployment and management of the response to concerns and complaints raised by staff and advise on:

   (a) The adequacy of the Department's management of the procurement of the containers;
   (b) The adequacy of the Department's response to the concerns raised by one or more Government Business Managers (GBMs);
   (c) The adequacy of the Department's OH&S management and escalation procedures in light of this case;
   (d) Any other matters that arose from the investigation; and
   (e) Make recommendations for actions or reforms to address any deficiencies in procedures, structures and communications".

3. I was further asked on review the Department's processes and procedures that have been used in the management of the asbestos situation in Areyonga and other NTER communities.

4. The Review involved discussions on the courses of action taken by officers of FaHCSIA including members of the NTER Operations Centre in Darwin, OH&S Officers and Accommodation Project Officers within National Office FaHCSIA.

5. During the course of the Review, in company with Ms Amanda McIntyre of FaHCSIA, I inspected the accommodation on a number of communities. I conducted a number of interviews with both past and present GBMs, CEBs and

with Operations Centre staff and Officers of FaHCSIA both in National Office and the Northern Territory Office.

6. The aim of discussions with staff (which were relatively informal) was to obtain an understanding of the issues, not to collect evidence. Information provided by individuals was used to establish the systemic issues which, with the value of hindsight, may have allowed for earlier mitigation of a number of the issues which arose with the use of container style accommodation.

7. In preparing this report I have been conscious of the pressures that the departments and agencies have been and are working under. I am also aware of the staff demands involved both in terms of individuals and the organisations. In my opinion what has been achieved has been remarkable. There are, however, not surprisingly, things that could have been done better.

8. I am grateful to all those who contributed to the Review. Their involvement has highlighted issues, which will, I believe, provide a number of valuable lessons arising from the NTER accommodation issues and more generally.

9. As always it is easy to be wise after the event. To the extent that this Report is critical of and reflects on organisations or individuals because of the advantage of hindsight, I can only say that that is the inevitable result of an Inquiry such as this. To the greatest extent possible I have sought to focus on systemic issues and not on the actions of individuals.

10. I am aware that responses to a number of the issues raised in this report are already well in hand. Notwithstanding that I have dealt with them as they presented themselves during the review. In part I have done so because I believe they often illustrate a wider underlying issue. One such issue, which is by no means confined to FaHCSIA, is a seemingly widespread view that the sending of an email somehow relieves the sender of the responsibility to really do something to resolve an issue. There is some evidence of that view being alive and well in the handling of the accommodation issues discussed in this report.

11. I am aware that there is to be a comprehensive review of the NTER. To some extent my review has involved some aspects which will, almost certainly, be canvassed in that wider review. I have sought to confine my comments to those matters which relate to, or result from, the accommodation and asbestos issues. In my opinion, however, the implications of some of those matters identified go well beyond those issues.

Background to the NTER

12. The background to the NTER has been canvassed at length in numerous reports, but to establish a context for this report it may be summarised as follows:

- The NTER was initiated by the then government in response to the report of the NT Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse;
- That report proposed that "Aboriginal child sexual abuse in the Northern Territory be designated as an issue of urgent national significance by both the Australian and Northern Territory governments";
- On 21 June 2007 the then government announced national emergency measures to protect Aboriginal children in the NT;
- the NTER has three "phases";
  - a "stabilisation phase",
  - a "normalisation phase", and
  - longer term "support phase" based around the same norms and choices enjoyed by other Australians.
- elements in the NTER included:
  - Policing,
  - Community Improvement including the Community Clean Up program,
  - General Health Checks,
  - Welfare Reforms,
  - School enrolments and attendance,
  - Community Safety, and

- measures to deal with substance abuse, Pornography and Permits.

Consideration of the Issues

13. The NTER was and is a whole of government response. As a consequence, its governance structure inevitably reflected a complicated matrix of interests and in my opinion a confused set of accountabilities. In part that was inevitable given the genuine interests of the departments and agencies involved but also, and significantly it resulted from the need to accommodate the directions of government in relation to the management of the Response which added to that complexity but which did provide a decisive focus for implementation of the programs.

14. A particular consequences of those directions was the creation of the NTER Operations Centre which reported on paper to a Taskforce, but which had direct access to the then Minister. For reasons I am unable to either explain or understand the Secretary FaHCSIA was not a member of the Taskforce. The Taskforce was not part of the interdepartmental structure which reported to the Minister/Prime Minster through a body identified as the Secretaries Sub Group. That structure had FaHCSIA as the lead agency. The structure is outlined in **Attachment B.**

15. Whilst effective cooperation was achieved between some individuals the division of responsibilities and accountabilities reflected in this structure was problematic and in my opinion was a factor in what I regard as inadequacies in the management of the accommodation related issues.

16. In my opinion other factors included the spread of and changes to functional responsibilities across FaHCSIA and the loss of key personnel at critical times. Whilst the latter could not be avoided it did highlight the need for a clear authoritative focus for the coordination of effective delivery of those elements of the Response which were the direct responsibility of the Department and on the

importance of the relationship with the Operations Centre. In my opinion that focus was lost at some critical times.

17. The coordination problems inherent in the division of responsibility between the Department and the Operations Centre have been recognised and clearer reporting lines have been established. These are represented in **Attachment C**. With the phasing out of the Operations Centre, at least in its current form, in December 2008 FaHCSIA will assume operational control for coordinating its functional responsibilities and the need to manage the effective delivery and maintain the central focus will become an internal problem. This presents an opportunity to improve accountability and responsibility.

18. Having regard to the history of the accommodation problems, that new arrangement will in my opinion require very clear lines of responsibility and accountability. It is likely that that can best be achieved through an organisational structure designed to meet the special needs of the NTER – in effect an Operations Centre within the FaHCSIA Northern Territory Office ("NTO") but with appropriate "command and reporting" lines. A critical issue is likely to be management of the roles of the Indigenous Coordination Centres ("ICCs") and the GBMs.

The Use of Container Accommodation

19. Underpinning the NTER intervention and critical to its ongoing success was the introduction of GBMs as the point of contact for the Commonwealth within each Community. To meet the timeframes demanded by government GBMs were initially identified via an expression of interest process addressed to SES and Executive Staff within FaHCSIA (see **Attachment D**), but was quickly broadened beyond FaHCSIA. GBMs were brought on progressively by the Operations Centre via a recruitment process run by FaHCSIA National Office, People Branch. That process is now run by the Operations Centre with National Office support but is being taken over by the NTO by 1 July 2008. Currently 51 GBMs are engaged and service 72 communities. A similar process was undertaken by

DEEWR to recruit Commonwealth Employment Brokers who are also servicing prescribed communities. GBMs and CEBs were intended to be co-located as far as accommodation was concerned and that is still the general intention.

20. The provision of suitable accommodation in the communities in prescribed areas was, and is, crucial to both the GBM and CEB roles. Initially, a stock of demountables, previously used at the Woomera and Baxter detention centres by the Department of Immigration and Citizenship, were identified for this purpose. However, it was determined that these were not appropriate for use in cyclone prone areas and that suitable demountable accommodation could not be provided from other sources within the timeframes involved.

21. Once it was determined that suitable demountable structures were not available, attention focused on the use of suitably fitted out containers as a short term (3/4 years) expedient because of their extensive and apparently satisfactory use in the mining industry under seemingly comparable conditions. After inspection it was decided that they would be suitable as temporary accommodation on communities for resident and visiting government officers. Illustrations of RW containers, including the inside of a typical accommodation container are provided at **Attachment D**.

22. In my opinion that decision was reasonable in the circumstances.

23. That said, even given the tight time constraints imposed by Government it would appear that little was done to confirm with other users that their containers were "fit for purpose" and that the ways in which they were being used was comparable to the use intended by the Commonwealth. It is likely however that such enquires would not have had a material affect on the decision.

24. In order to meet that short term need for living and office accommodation a contract to lease appropriately fitted out shipping containers was entered into on 6 September 2007. The supplier was Royal Wolf Trading (RW), a company providing customised containers for uses similar to that required by FaHCSIA, across a wide range of users including the mining industry in Qld, WA and the

NT. The fact that RW is a preferred supplier to the Department of Defence was relevant to the decision to proceed with them as a supplier.

25. Because a stock of appropriately fitted out containers was not available in Australia, RW contracted to provide containers fitted out in China.

26. As identified at paragraph 24 the fact that it was a Royal Wolf were preferred suppliers to the Department of Defence was relevant to the decision to use containers supplied by RW. Enquiries made as part of this review identified that although the Australian Defence Force (ADF) use RW the containers they are fitted out by Defence either in Australia or on site overseas. I am advised that in every case Australian materials are used in the fit out. Defence has advised that it had not experienced fume problems.

27. Given the expectation that the containers would be required for at least two to three years, and that the simple payback period if they were to be purchased was 2.4 years, on 21 September 2007, the lease arrangement was converted to a purchase arrangement. I believe that was appropriate. By 25 October 2007 a total of 150 containers had been purchased. An additional 45 containers were purchased on or after 18 January 2008 although the fumes issue had by then been recognised as a problem. Only 12-15 of the 195 containers purchased have yet to be installed.

28. Installation was carried out under a contract with Indigenous Business Australia (IBA) a statutory corporation established under the Corporations (Aboriginal and Torres Strait Islander) Act 2006 (CATSI) Act. By agreement, IBA subcontracted the work to Spinbrook Pty Ltd trading as NT Link and Notaras Pty Ltd (NT Link).

29. I have not reviewed the contractual arrangements in detail but from what I have seen I consider that the documentation raises a number of issues. I am aware that FaHCSIA's Legal and Compliance Group is reviewing those contractual arrangements.

30. The acquisition and installation of the containers was managed by NO through the contract with IBA. I am informed that the configuration of the accommodation complex was developed by NT Link as part of their contract with IBA. I am further informed that no professional or technical advice was separately involved in the design of the configuration of the complexes and that the design was agreed by both the Operations Centre and NO.

31. A typical complex currently consists of four accommodation units, a laundry/kitchen/dining unit and an office unit. Apart from the office unit, the other units are grouped around a central, elevated, secure, insect screened and roofed common use breezeway. The individual configuration is dependant on site considerations but broadly the set up is as identified above and as illustrated at **Figure 1**.

32. The complexes exhibit a number of design faults which were reported by GBMs. A major and illustrative issue has been the "flooding" of the breezeway rendering it effectively unusable during the wet. This has happened because insufficient roof overhang was provided. Arrangements are in hand to extend the roofing if and when the containers are to be reoccupied. This which will remediate the problem but at a significant cost which could have been avoided.

33. The explanation given for not providing adequate roofing is that the leasing arrangement originally entered into precluded any modification to the containers which more extensive roofing would have required. That ceased to be an issue once the decision was made to purchase the containers. There is no evidence however that before the decision to purchase was made there was any attempt to negotiate an arrangement that would have permitted an agreed modification to the containers. At the time the decision to purchase was made no containers had been delivered. I have found no evidence that once the decision to purchase was made the issue of the adequacy of the roofing was revisited. It would seem likely that the significance of the inadequacy of the roofing was simply not appreciated until the flooding happened.

34. Other design issues relating to liveability and security have been identified. They range from potential fire hazards which could see occupants unable to exit through the breezeway (which, along with a number of other problems, could have been solved, admittedly at some cost both as to the price and time by the containers having a window as is the case with the kitchen containers), through to the occupants being unable to secure the heavy container doors in the open position giving rise to the possibility of them being locked in. Presently the doors can only be opened through ninety degrees without them blocking the light and ventilation from "corridors" between the containers and at ninety degrees the doors intrude significantly into the breezeway space. At present they cannot be 'folded back" against the side of the container, but this and the capacity to secure them in that position, should be possible once the roofs and breezeways are extended and secured as is proposed.

35. In my opinion, the outer doors themselves present some OH&S risks. The weight alone would cause problems for many officers. A compounding problem is that when the doors are closed they are effectively self sealing resulting in them being difficult to open. On one community visited during the review both the GBM and CEB (both males) had to work in tandem using a "hammer" and lever to open the containers, at some risk to their persons.

36. It would seem that at least some of these problems could have been avoided had appropriate professional advice been sought and acted upon both at the time of acquiring the containers and in the design of the complexes.

37. A significant issue for some of the officers who have used the containers is the lack of any private space apart from their quite cramped bedroom accommodation. Depending on the outcome of the "fumes" issue this may be overcome by the intended provision of additional containers suitably fitted out. The impact of the demountable accommodation to be provided will presumably impact on the need for these additional containers.

38. These accommodation shortcomings were compounded, particularly for some families, by the fact that some officers recruited early in the process were not

made aware that they could be sharing the complex, or that the other occupant might have been a person of the opposite sex. All officers are now appropriately informed of the possibility of living in shared often difficult, uncomfortable and relatively isolated circumstances. The lack of suitable accommodation is a major issue for officers who have had to leave their partners. A number of those officers expressed to me their enthusiasm for continuing in their roles if they could be joined by their partner. I know that the Department is aware of this issue. I recommend that if possible action be taken to provide suitable "accompanied" accommodation.

39. Many of the underlying accommodation problems appear to have been overtaken by the immediacy of the fumes issue. In my opinion however, that issue whilst now the most urgent issue, is not of itself reflective of any systemic failing. The way in which the issue was handled however is.

40. That said, I should record my view that having visited some of the affected containers, quiet apart from any health issue, those units were in my opinion uninhabitable at the fume concentrations experienced in those that had been closed up for any length of time. Even where they had been "aired" for some time the smell was strong enough and unpleasant enough to make living in the containers problematic.

Risk Management

41. From the outset the NTER was a high risk strategy because of:
    - The scale of the intervention;
    - The timeframes demanded by government without apparently much appreciation of the issues involved;
    - The social issues involved; and
    - The organisational structure effectively imposed by government.

42. A Project Plan was established for the NTER. It has been updated and extended a number of times with the most recent version being promulgated in January 2008

after consultation. Within the Project Plan a section dealt specifically with risk management. The unavailability of suitable on ground accommodation for CEBs and GBMs was identified as a high risk issue. The monitoring and review strategies required the maintenance of an issues register and the briefing of relevant senior managers. In my opinion, the Plan, assuming they were aware of it, should have raised the awareness of the officers dealing with accommodation issues to the need to treat seriously any issues which raised questions about the continued availability of "on ground accommodation". The handling of the problems does not indicate that level of awareness.

43. In relation to the provision of the container accommodation I was advised that no risk assessment had been undertaken. In the course of this review however I became aware that a comprehensive Staff Accommodation Plan (SAP) had in fact been prepared in August 2007. That SAP included a risk assessment methodology and an appropriately detailed risk management strategy. Despite being signed off by appropriate officers, I have been unable to establish that the SAP was used effectively throughout the planning for and implementation of the "Top End" accommodation project and every indication suggests that it was not. Certainly the quality inspections as envisaged in the SAP were not carried out. Had the SAP methodology been used I believe many of the problems, other than the fumes issue, could have been avoided or at least ameliorated.

44. I understand current thinking within the Department may be to not use the SAP for future accommodation projects. In my view the SAP represents an effective project management tool which builds on the Departments own methodology, enhanced by some elements borrowed from Prince2. Given the not inconsiderable investment in developing the SAP I recommend that any decision not to use it on accommodation projects be reviewed.

Occupational Health and Safety Issues

45. In my opinion neither the Operations Centre nor NO responded effectively to the OH&S issues related to the use of the container accommodation well.

46. One cause for my concern is that, despite it being recognised that the "smell" issue had potential OH&S implications it took from 8 November 2007 until the 25th January 2008 for the Departments OH&S staff to be involved, and a further two months before the OH&S recommendation, made following site inspections, to obtain an independent report into the fumes problem, was acted upon. Whilst during that time many emails passed to and fro, there was a real failure of initiative.

47. I accept that from the 29th January 2008 the Department was effectively waiting, in my opinion far too patiently, for advice from RW. I note also the apparently unsupported advice of the 26th February 2008 from RW that the "smell" did not have OH&S implications. However, in the continued absence of the promised "data sheets", the technical report commissioned by RW, the increasing number of complaints, and the Departments own OH&S report I think more should have been done earlier. In the event it took until the 10th of April 2008 for the Department to obtain a copy of the "initial report" prepared by Simmons and Bristow for RW, which I am informed was based on tests on one RW container in their own facility. That report, which bears the date 20 March 2008, identified raised levels of formaldehyde and recommended amongst other things, that "persons who must enter the unit should wear appropriate personal protection masks and [that] sensitive individuals should not enter the unit".

48. Apparently based on that report, on the 10th April 2008 the Department, in my view acted very properly in immediately ordering that the containers be vacated. A decision on the future use of the containers depends on the medical assessment of the results of the testing done for the Department by CETEC. However, a consequence of that decision has been that at least some officers are travelling long distances in conditions that themselves entail serious OH&S risks.

49. A further cause for that concern is that as previously identified, the OH&S concerns raised by GBMs with the Operations Centre and in the Department's OH&S report were by no means confined to the "fumes" issue and raised serious questions about the installation standards. I have found no evidence of any overall plan to address those other issues in a coordinated and comprehensive way.

50. Given the uncertainty surrounding the future use of the containers and whilst they remain unoccupied and or unused, it is now, in my opinion, reasonable that remediation of those other issue be delayed until the fumes issue is resolved. Given the lack of confidence in management exhibited by staff at the recall day I attended however I believe it is important that if the containers are to be used for accommodation those issues need to be addressed quickly and wherever possible before the units are reoccupied.

51. The issues associated with the container accommodation in my opinion highlighted a real need for the Department to have a greater capacity to identify and deal with OH&S problems quickly, professionally and with authority. In that context I strongly support the decision to appoint an additional OH&S officer and to "attach" that officer to the NTO. Until that appointment is made, however, I am informed that the effective investigative strength (ie not including officers involved in rehabilitation work) of the OH&S section is two persons, neither of whom have any formal OH&S qualifications. I have been impressed with the approach and enthusiasm demonstrated by the OH&S officer with respect to the container problems. It was, however, obvious that the officer involved was dealing with a number of urgent matters and that as a consequence had not pursued the container issues. Whilst clearly a decision for management, I believe there must be a question as to whether, given its size and the range of its operations, the Department can fulfil its OH&S obligations without a serious increase in staff numbers and without appropriately qualified staff, well supported by senior management.

52. I am satisfied that, from a management viewpoint, any potential health risks from exposure to the fumes are now being investigated appropriately. I note however

that there is considerable, and in my opinion understandable, concern among some officers that their individual circumstances in relation to that exposure may not be given sufficient attention in the event that a health risk is established. I recommend that in the event that a health risk is identified, arrangements be made to take proper account of the individual circumstances of officers exposed to the fumes and appropriate assurances to that extent be given now. I also recommend that all officers both past and present who have occupied the containers be kept appropriately informed of, and involved in, the development of the responses to the issues involved.

Other Issues related to the Container accommodation

53. At present, and compounded by recent events, there is a generalised, but significant lack of confidence and trust in the way senior management is seen by many GBMs and I think CEBs. This was forcefully demonstrated at the recall day I attended in Darwin on 15 May 2008.

54. The immediate focus for that resentment, which was directed at the messengers who were in an almost impossible position, was the decision not to immediately provide the CETEC test data which GBMs and CEBs believed they had been promised. Despite the explanation that the data needed to be analysed to make any sense, the failure to provide the raw data was seen as indicating that it probably established a real health risk and as management going back on its undertaking.

55. In my opinion the underlying dissatisfaction for many of the officers involved goes beyond the issues relating to the fumes and reflect a perception of a failure by management particularly in the Operations Centre to accept responsibility for the GBMs (and CEBs). In large part, I think the lack of trust stems from a lack of consultation and from communication failures.

56. Whilst unrelated to accommodation but reflective of similar communication problems, a recent cause of concern for the GBMs (and perhaps the CEBs) is the

decision to require them to reapply for their jobs. In the absence of any established system for appraising current performance it is difficult to see how any process other than an open selection process would meet the needs for objectivity and transparency. Presumably however those GBMs who are regarded as having performed well and who wish to be reappointed should or will have a competitive advantage in any such process. The problems for those GBMs who have expressed their frustration at the process is the lack of any structured feedback on performance, the potential loss of experience inherent in the process, the perceived failure to make any attempt to establish those who do wish to continue in the role and those who don't, and a lack of confidence in management to "get it right".

57. The imminent transfer of responsibility for GBMs from the Operations Centre to the NTO provides an opportunity to establish a new and different set of relationships with GBMs. In my opinion a key to that relationship would be a clearer identification of what is expected of GBMs and an understanding of how their individual performance is to be appraised. To be credible any new management would need to build on the experience of the management of the GBM role to date and desirably involve GBMs (or their representatives) in a consultative role in the design of the structure. Based on the experience to date the Department should consider new approaches to the management of GBMs.

58. An issue raised with me by both GBMs and CEBs is the management of their respective roles on communities. The general view appears to be that the GBM needs to be across anything and everything related to Commonwealth Government involvement in the community. Any limitation on the sharing of reports and information with the GBMs was seen as impinging on that role, as having the potential to adversely affect personal relations and as being generally counter productive. Despite the provisions set out in the GBMs handbook I am informed that there are some situations where officers are being directed not to share information. Obviously this is an issue that needs to be resolved between departments having regard to the overall best interests of the Commonwealth in the context of the intervention but in the circumstances I recommend that it be addressed as a matter of some urgency.

59. Another issue raised with some asperity at the Darwin recall is the different conditions that apply to GBMs and CEBs working in the same community. The examples given ranged from different approaches to leave to attend medical examinations related to the exposure to container fumes, the different approach to allowances and reunion visits, through to different approaches to the fitting of winches to vehicles used in comparable ways on comparable roads. There would seem to be advantages in minimising, as far as possible, the differences in conditions applying to persons living in and under similar conditions. I recommend that consideration be given to establishing common conditions to apply to Commonwealth Officers working in communities as part of the NTER.

60. Having laid some stress on the need for consultation, in concluding this report I should add that, as was to be expected, the reactions amongst GBMs (and CEBs) to the accommodation problems varied. Of those I spoke with:
    (a) Most just wanted to be enabled to get on with the job;
    (b) Almost all expressed great enthusiasm for the work;
    (c) Some regarded the direction to vacate as an over reaction (a view I don't share) and wanted to get back into the containers as soon as possible; and
    (d) Most thought the containers were very satisfactory accommodation for a posting of say up to twelve months or so, at least once the "defects" were fixed.

Review of the management of Asbestos Containing Material on Prescribed Communities

61. I have been asked to include in my review my assessment of the way in which the Department managed issues related to asbestos containing materials (ACMs) found on communities prescribed under the NTER Act 2007.

62. As far as I have been able to establish, the presence of ACMs on those communities was first reported to the Department in August 2007 in the course of meetings related to the Community Clean Up program. At that time the issue was

characterised as relating to the health and safety of the workmen involved in the program rather than as a community issue. By mid September however the department had commissioned a pilot survey involving five communities to determine the likely extent of ACMs, the condition of the materials, the likely risk, and what, if anything needed to be done about any materials found. The survey found significant quantities of ACMs and recommended that remediation work be carried out. The time frames for that work ranged from "within 12 months" to "within 36 months". As a result of the survey a testing program for the remaining 68 prescribed communities is underway.

63. Because the health risk from ACMs results from airborne asbestos fibres and is related to the concentration of those fibres and to the frequency and duration of exposure a program of air testing commissioned by the Department is also underway. To date testing has been carried out on four prescribed communities. That testing as reported has:
"demonstrated that no measurable levels of airborne asbestos fibres and therefore the conditions assessed do not create any increased risk to health from asbestos fibres on those communities"[1]

The report identifies that even on those communities:
"Asbestos however continues to present a health hazard and should be managed in such a way that is does not become a health risk"

64. It is proposed that further air testing be carried out on a limited number of communities selected on the basis of the apparent likelihood of risk.

65. A management strategy based on the results of the testing carried out is being formulated and funding has been sought. I am informed that that strategy will have the flexibility to respond to any change in circumstance.

66. Determining the nature and extent of any asbestos problem, the methods to be used in physically dealing with any problem materials and application of those

[1] Bureau Veritas Report – June 2008

methods are, and will continue to be, matters requiring the involvement of appropriate experts.

67. In my opinion the actions taken by the department to determine the nature and extent of the hazard and the possible risks to health have been entirely appropriate. The proposed management strategy for dealing with the hazards identified in my view appropriately reflects the expert advice received to date.

68. Given some past practices, it is likely that it will be necessary to convince communities and individuals as to the hazards of ACMs and the measures that must be taken to avoid the inherent risks. I am aware that the Department is taking appropriate action in this regard.

69. I am also aware that the Department is in dialogue with relevant NT agencies about the management of ACMs. I am informed that the NT government does not have a comprehensive register of ACMs on communities, although records do exist in relation to Darwin, Katherine and Alice Springs. Records also exist for at least some community schools.

70. In my opinion, it is highly desirable, if not essential, for the work related to ACMs carried out by the Commonwealth on prescribed communities to be closely coordinated with relevant NT Government authorities. It may also be prudent for the Commonwealth to at least liaise with relevant state authorities given the very high probability that similar conditions may exist on communities in those states.

71. Whilst the potential health risks are the most pressing aspect of ACMs other risks are involved in dealing with issues arising from their presence on communities. Those other potential risks include the risk to local support for the intervention and the risk of a loss of public and political confidence in the management processes.

72. I have been unable to establish that any comprehensive risk management strategy was developed to deal with the issues arising from the presence of ACMs on communities.

73. I have commented elsewhere in this Report on what I see as shortcomings in the Departments approach to risk management. In my opinion those comments are applicable to the issues arising from the approach taken to the management of ACMs.

74. One such issue is that, having regard to the notoriety of asbestos, the need for an information strategy to address the concerns of stakeholders and the general public should, in my opinion, have been developed.

75. Clearly the previous Minister was, and the current Minister is, a critical stakeholder. Despite that I have found no evidence of any general briefing being provided to inform either of them that there was an issue with asbestos until the minute from the Group Manager, Indigenous Remote Services Delivery (IRSD) Group on the 28th May 2008. That minute was written against the likelihood of publicity about the situation arising from the presence of ACM at Areyonga.

76. I am aware that as part of the NTER, and in response to a minute from the Group Manager, Indigenous Housing Policy and Programs on 7 September 2007 the then Minister approved funding for a number of tasks including the "removal of asbestos". Although the reference in the minute was general the attachment specifically identified Papunya as the location.

77. In my opinion the notoriety surrounding asbestos is such that the then Minister should have been fully briefed at the latest as soon as the potential seriousness of the situation was recognised. On the evidence available to me that would appear to have been at the time the decision was made to undertake the pilot survey, namely September 2007. The current Minister should have been briefed as soon as practicable on assuming office.

78. That those briefings did not happen, and that the Secretary was also not made aware of any asbestos issue until at least mid March 2008, and then only in relation to the resultant staffing issue at Areyonga , in my opinion, indicates a general failure to routinely and systematically identify and manage risks.

79. As noted earlier, the presence of ACMs was first reported in August 2007. The context in which that was done clearly identified it as an occupational health issue. Despite that I am informed that the OH&S section was not advised of the issue until March 2008. My views on the need to review the departments approach to OH&S issues are identified elsewhere in this Report. In my opinion the management of the ACMs on communities reinforces those views.

80. In conclusion, I would like again to express my very great appreciation for the willing assistance given by all officers involved in the preparation of this report, and in particular to the invaluable contribution made by Ms Amanda McIntyre.

Attachment A – Terms of Reference

Review of the use of container accommodation
for the Northern Territory Emergency Response

Purpose

The Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) wishes to fully investigate the circumstances surrounding issues with the use of container accommodation for Commonwealth public servants involved in the Northern Territory Emergency Response (NTER).

Background

From September 2007 the Australian Government purchased 195 containers for use as accommodation for Australian Government personnel residing or visiting remote Indigenous communities in the Northern Territory (NT).

Staff of FaHCSIA, the Department of Education, Employment and Workplace Relations (DEEWR) and Centrelink were allocated accommodation in these containers. Other staff and Australian Government contracted personnel were able to reside in the container complexes on a temporary basis using a visitor notification system.

From 8 November 2007, complaints about fumes and smells were being received by FaHCSIA from some of the staff living in this accommodation.

On 10 April 2008 the Minister for Families, Housing, Community Services and Indigenous Affairs, the Hon. Jenny Macklin MP, issued a press release about issues related to some of the containers (**Attachment A**).

On 22 April 2008 the Secretary of FaHCSIA, Dr Jeff Harmer, advised the Minister that he would engage an appropriate person to conduct an investigation into the circumstances surrounding the problems in the accommodation containers.

Required outcomes of this investigation

To address the matters above so that FaHCSIA can ensure that circumstances like this do not arise again, you are asked to:

81. Review the sequence of events from the Department's decision to acquire accommodation for GBMs, through the process of deployment and management/response to concerns and complaints raised by staff and advise on:
    a) The adequacy of the Department's management of the procurement of the containers
    b) The adequacy of the Department's response to the concerns raised by one or more Government Business Managers (GBMs)

c) The adequacy of the Department's OH&S management and escalation procedures in light of this case

d) Any other matters that arose from the investigation, and

e) Make recommendations for actions or reforms to address any deficiencies in procedures, structures and communications.

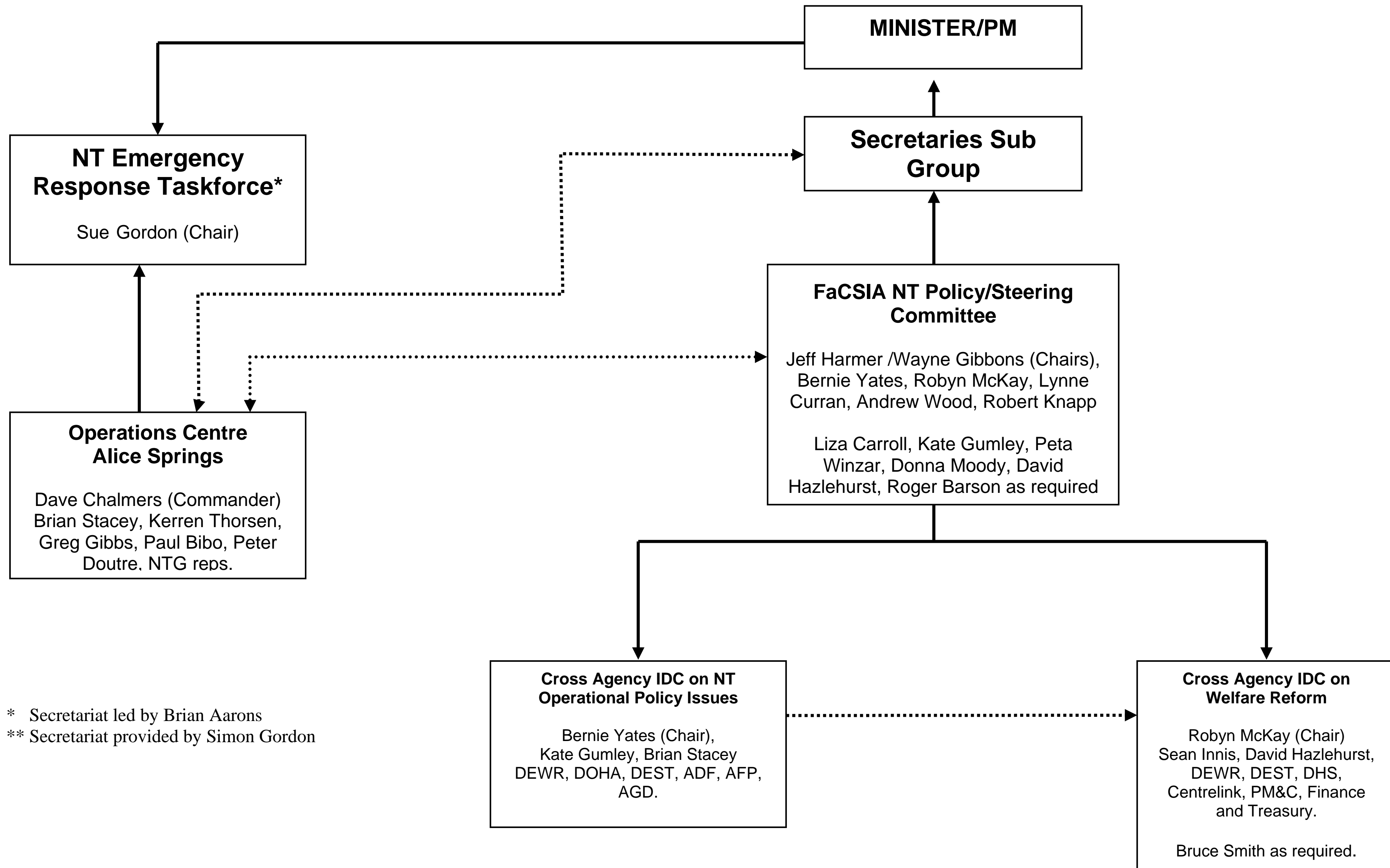
Investigative process

To enable you to complete the tasks outlined above, you may:

1. Interview, at your discretion, any FaHCSIA staff and contractors and (with permissions) relevant staff from other Commonwealth departments and agencies, who were and/or are involved in the purchase, installation and management of container accommodation under the NTER.
2. Interview, at your discretion, any FaHCSIA staff and contractors and (with permissions) relevant staff from other Commonwealth departments and agencies, who resided in or visited the container accommodation provided by FaHCSIA under the NTER.
3. Consult with and obtain relevant information from FaHCSIA staff and contractors and (with permissions) companies, organisations and other Commonwealth agencies which have had an interest or involvement in the purchase, installation and management of container accommodation under the NTER.
4. Access all relevant reports, documents, briefings and information held by FAHCSIA, including relevant technical and professional reports dealing with:
    - The purchase and installation of the accommodation containers in remote Indigenous communities, and
    - The occupational health and safety issues that arose after staff were accommodated in those containers.

You are requested to provide your report to the Secretary of FaHCSIA.

Attachment B – Initial governance structure NTER



* Secretariat led by Brian Aarons
** Secretariat provided by Simon Gordon

Attachment C – Revised governance structure NTER

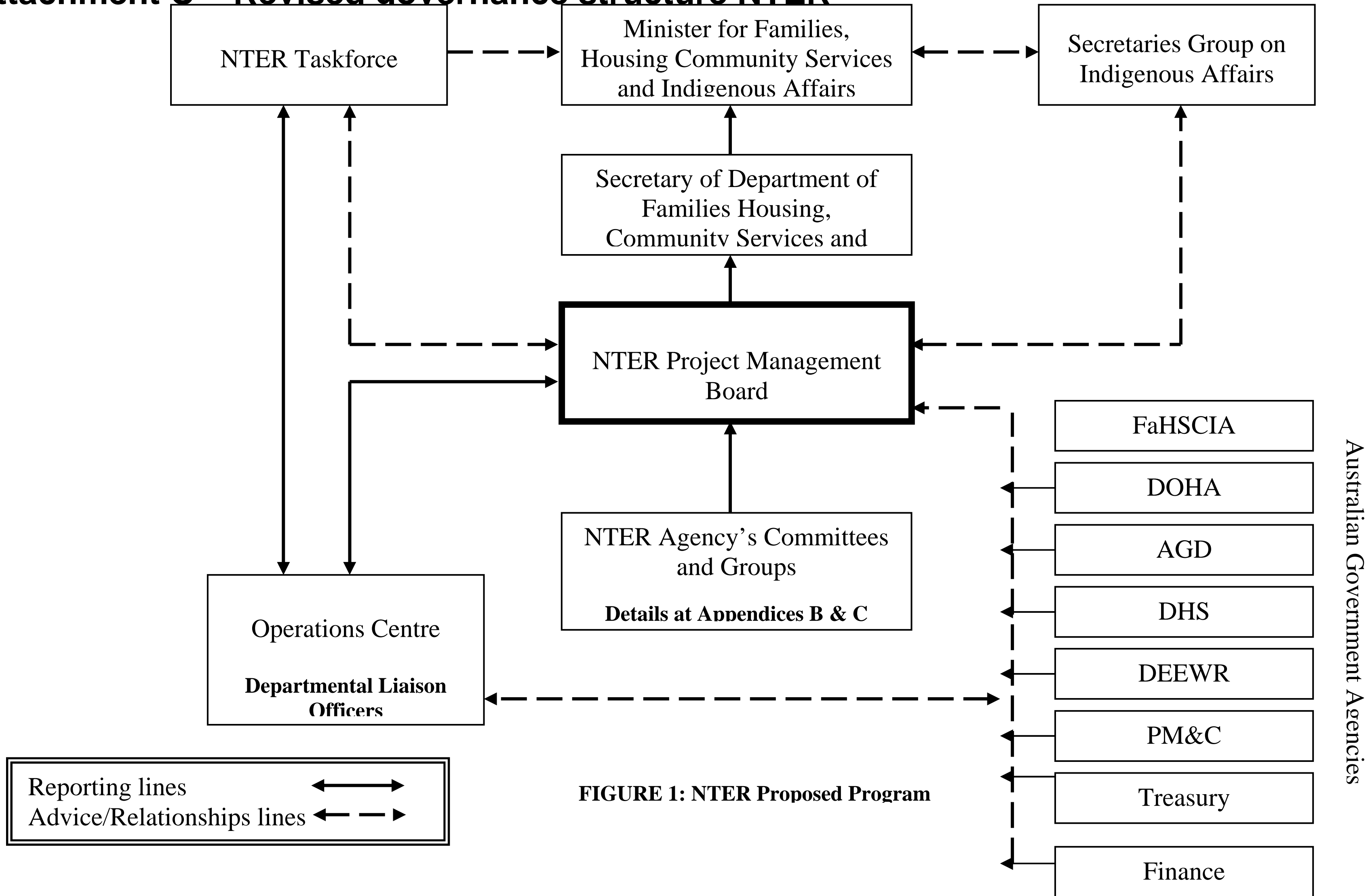


FIGURE 1: NTER Proposed Program

Attachment D – EOI Sent to FaHCSIA staff

EOI Sent to SES, EL2's and EL1's on 25 June 2007

Expressions of interest sought from SES and Executive staff

In response to the national emergency confronting the welfare of Aboriginal children in the Northern Territory, expressions of interest are sought from suitable SES and Executive Level staff to undertake the challenging role of Administrators in remote communities.

Administrators in locations such as Yuendumi will be responsible for managing the provision of Australian Government services and supporting the implementation of the emergency response in the community.

Applicants should note that conditions, such as accommodation, will be basic. The Administrator roles are considered to be **unaccompanied** and as such families and spouses would not be accommodated; however, support for reunion visits will be provided.

It is anticipated that the positions would be of 12 months duration.

An attractive remuneration package is available, taking into consideration the demanding nature of the task involved and the isolation of the posting.

Expressions of interest should be received by Lynette MacLean, People Branch no later than 2 July 2007.

For information relating to these Administrator positions, please contact Lynette MacLean 02 6200 9644 or Stephen Walker, Branch Manager, Department of Families, Community Services and Indigenous Affairs on 02 6200 9599 or by emailing stephen.walker@facsia.gov.au

Jeff Harmer

Attachment E – Examples of Container Accommodation

Example of GBM Office/Kitchen containers

Example of exterior of accommodation containers

Example of layout of interior of accommodation units.

Figure 1 – Container Complex