**CORONERS COURT**
**OF NEW SOUTH WALES**

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| **Inquest:** | Inquest into the death of Huy Neng Ngo |
| **File number:** | 17/214664 |
| **Hearing dates** | 23-27 September 2019, 14-18 October 2019<br>2-6 March 2020, 22 – 23, 25-26 June 2020,<br>29 June- 3 July 2020 (23 days) |
| **Date of findings:** | 19 November 2021 |
| **Place of findings:** | Coroners Court, Lidcombe |
| **Findings of:** | Deputy State Coroner Magistrate E. Truscott |
| **Catchwords:** | CORONIAL LAW – Defective Takata Airbags - Product Safety- Voluntary Recall - |

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| **Representation:** | **Counsel Assisting the Coroner**<br>Mr D Kell SC and Ms T Phillips<br>nstructed by Ms J Geddes and Mr I Linwood of the NSW Crown Solicitors Office<br><br>**The Ngo Family**<br>Ms M Cheong of Law Partners, Sydney, NSW<br><br>**Honda Australia Pty Ltd**<br>Mr A Moses SC and Ms D Tang<br>nstructed by Mr M Tooma of Clyde & Co, Sydney, NSW<br><br>**Department of Infrastructure, Transport, Cities and Regional Development**<br>Mr R Lancaster SC and Ms C Melis<br>nstructed by Ms J Vogel of Australian Government Solicitor, Canberra, ACT<br><br>**Australian Competition and Consumer Commission**<br>Ms C Webster SC and Mr J Harris<br>nstructed by Ms A Hughes of Corrs Chambers Westgarth, Melbourne, VIC<br><br>**Peter Warren Automotive Pty Ltd**<br>Ms A Avery-Williams<br>nstructed by Mr B Hearnden of Hunt & Hunt, Sydney, NSW<br><br>**Federal Chamber of Automotive Industries**<br>Ms W Thompson<br>nstructed by Mr M Water of CIE Legal, South Yarra, VIC<br><br>**Transport for New South Wales** (formerly Roads and Maritime Services)<br>Mr T Glover instructed by Ms C Holt of Sparks Helmore, Sydney, NSW |
| **Non publication order:** | Pursuant to s. 74 of the *Coroners Act 2009* there is to be no publication of the name and identifying details of [redacted] |
| **Findings:** | Huy Neng Ngo died on 13 July 2017 at the intersection of Malle and Church Streets, Cabramatta NSW from a penetrating injury to the neck sustained from a piece of metal propelled from a defective Takata airbag which malfunctioned when it deployed in a minor collision, which occurred when the Honda CR-V that Mr Ngo was driving was struck by another vehicle whose driver had failed to give way. |

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| **Recommendations:** | Contained in back pages |

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## A. Introduction

1. Huy Neng Ngo (**Mr Ngo**) died on 13 July 2017, when the defective Takata airbag in the 2007 Honda CR-V vehicle (**Vehicle)** he was driving malfunctioned. The defect of the airbag relates to the inflator so that when the airbag deployed – in the course of what was otherwise a relatively minor motor vehicle collision – it shot out a piece of metal, which struck and pierced Mr Ngo's neck, causing an injury comparable to a gunshot wound. Mr Ngo was pronounced dead at the scene of the accident.

2. By reason of the circumstances surrounding Mr Ngo's death, in particular, that relating to the recall of Takata airbags, the coronial investigation was wide ranging, and a number of parties were given leave to appear at the inquest. The inquest progressed over 23 hearing days and was followed by a timetable for written submissions. The length and content of these findings is reflective of the detailed nature of the evidence and submissions and the complexity of some of the issues. These findings significantly adopt the structure, chronological information, and factual content of the evidence as set out in Counsel Assisting's detailed and lengthy written submissions. The submissions for the interested parties also included lengthy factual summaries however I have not included these other than where they have contested the facts set in Counsel Assisting's submissions.

## B. Background and Summary of Relevant Events

3. Mr Ngo was born in Cambodia and migrated to Australia when a young man. He was married to Ngak Chea and they had three children, 2 daughters and a son, whom they raised in Cabramatta, Sydney where they had lived for 32 years. Together, Mr Ngo and Ms Chea, owned and operated a small supermarket in Claymore working with each other seven days a week.

4. Mr Ngo had his 58$^{h}$ birthday on 1 July 2017. Ten years prior he and Ms Chea had bought a 2007 Honda CR-V. It was registered to Ms Chea. Whilst under

warranty they had the vehicle serviced by a Honda Australia dealership after which it was serviced by their local mechanic in Cabramatta.

5. On 13 July 2017, Mr Ngo was driving the Vehicle, in Cabramatta with Ms Chea in the front passenger seat. They were returning to their shop after having collected an order of supplies.[1]

6. At about 1pm the Vehicle was involved in a collision with another vehicle, the circumstances of which are further described below.

7. At the time of Mr Ngo's death, the Takata airbags in the Vehicle were the subject of a voluntary recall campaign by Honda Australia Pty Ltd (**Honda Australia**). The driver' airbag had a recall code "5ZV" (**5ZV recall**) and the front passenger airbag had a recall code "6CA" (**6CA recall**). According to Honda Australia, as at 14 July 2017 its 5ZV recall had a completion rate of about 86.4%.[2]

8. On 30 March 2017, after receiving recall correspondence from Honda Australia in the mail, Ms Chea arranged to have the Vehicle booked in at a Honda dealership, Peter Warren Automotive Pty Ltd at Warwick Farm (**Peter Warren**), for airbag replacement on 11 July 2017.

9. On the scheduled service date of 11 July 2017, the couple's daughter, Julie Ngo, was running late for the booking. Upon phoning Peter Warren to advise that she was running late, she was told that the airbag replacement service needed to be rebooked, and a date of 5 October 2017 was allocated.

10. Mr Ngo's fatal accident occurred just two days later, on 13 July 2017.

11. The voluntary recall that Honda Australia[3] was conducting at the time of Mr Ngo's death was overseen by the Commonwealth Department of Infrastructure and Regional Development (or **DIRD** – as the Department was then named)[4] and the Australian Competition and Consumer Commission (**ACCC**).

12. There are no detailed legal requirements in relation to *how* a voluntary recall of motor vehicle components is to be conducted, but there have been guidelines

[1] Exhibit 1 1/12/82 at 87 interview with Ms Chea 15 October 2017.
[2] Exhibit 1, 9/87v/2753. Other documents indicated a completion ratio of about 83.3% at this time: Exhibit 1, 11/111/3260. Mr Collins was not in a position to explain this difference in the attributed figures: Tpt 523.14.
[3] And other numerous vehicle suppliers.
[4] In about December 2017 DIRD was renamed the Department of Infrastructure, Regional Development and Cities. On 30 May 2019 that Department was again renamed, and is presently called, the Department of Infrastructure, Transport, Cities and Regional Development. On 1 February 2020, the Department was again renamed, and is presently called, the Department of Infrastructure, Transport, Regional Development and Communications. For ease of reference, it will generally be referred to here as "DIRD".

promulgated by the ACCC in addition to an industry recall Code of Practice that has been published by the Federal Chamber of Automotive Industries (**FCAI),** which is an Australian industry body for automotive companies.

13. Honda Australia's voluntary recalls of vehicles containing Takata airbags of the kind installed in Mr Ngo's Vehicle were superseded by a compulsory recall scheme – introduced by the Commonwealth – which took effect from 1 March 2018 to at least 31 December 2020 (**compulsory recall**). The compulsory recall was given effect by the *Consumer Goods (Motor Vehicles With Affected Takata Airbag Inflators and Specified Spare Parts) Recall Notice 2018* (**Compulsory Recall Notice**),[5] which was issued by the Assistant Minister to the Commonwealth Treasurer under s 122 of the *Australian Consumer Law* (**ACL**), (which is Schedule 2 to the *Competition and Consumer Act 2011* (Cth) (**CCA**). The Compulsory Recall Notice applied to all vehicles with a frontal driver or passenger inflator made by Takata that uses either Phase Stabilised Ammonium Nitrate (**PSAN**) without desiccant or PSAN with calcium sulphate desiccant. In addition, since the establishment of the compulsory recall there have been ongoing voluntary recalls in relation to other airbags which have not been subject to the compulsory recall.

## C. Risk posed by Takata Airbags

14. At the time that the compulsory recall commenced in March 2018, the misdeployment of Takata airbags had been associated with more than 20 deaths and at least 230 injuries globally.[6]

15. At the commencement of the hearing of the inquest, Mr Ngo's death was the only known fatality in Australia as a result of a defective Takata airbag. In addition, however, on 24 April 2017 – some 2½ months before Mr Ngo's death – a 21-year-old woman was seriously injured in the Northern Territory when the driver side airbag in a 2005 Toyota RAV 4 misdeployed during a collision and she was struck in the head by a piece of shrapnel from the Takata airbag inflator casing.[7] Further, in the course of the hearing of the inquest, there were media reports that a defective airbag, thought to be a Takata model, was attributable to the death in September 2019 of a male driver of a BMW vehicle in New South Wales and that the airbag in another BMW was attributable to a South Australian woman

[5] A copy of the Compulsory Recall Notice is at Exhibit 1, 2/49/556.
[6] ACCC Background Paper at [2.4], Exhibit 1, 9/83/2489.
[7] Exhibit 1, 9/83/2490. That vehicle had been subject to recall.

sustaining serious injuries. Each of these reported events is an important reminder of the potentially tragic consequences when a defective airbag deploys.

16. It is quite possible that there have been other deaths (both in Australia or overseas) related to defective Takata airbags, but that the real cause of these deaths has gone undetected as a result of injuries thought to have been sustained by reason of the force of a car accident and other shrapnel, rather than from a defective airbag mechanism.

17. As at 31 May 2020, approximately 3.64 million Takata airbags of the kind subject to the Compulsory Recall Notice had been replaced in approximately 2.7 million Australian vehicles; and there were about 197,413 airbags in 168,695 vehicles that had not been replaced or otherwise accounted for.[8] These included vehicles in which an airbag had already been replaced under the voluntary recall campaign, and where the replacement airbag was itself defective (**like-for-like replacement**).

18. The above figures *exclude* many tens of thousands of other types of Takata airbags voluntarily recalled by manufacturers- including the NADI 5-AT airbag which was not subject to the Compulsory Recall Notice and which has been attributed to the death of the Australian driver in September 2019.

19. A firm message arising from this inquest is that consumers, who have not already done so, should take immediate steps to check whether their vehicles are affected by a Takata Airbag recall and take action immediately. Their life, or that of their loved ones, may depend on it. Further, for such period as the affected Takata airbags remain on the road, the risk they pose to drivers and passengers increases as they degrade as they age, particularly in hot and/or humid conditions.

20. Consumers should continue to regularly check whether their vehicle is subject to an airbag recall. This is because, as new learning becomes available, further vehicles, including those with different models of Takata airbags, have become subject to recall. It may also be the case that further learnings reveal that replacement airbags that have previously been installed in vehicles, including what have been referred to as “like-for-like” replacements,[9] have become unsafe as well.

[8] See Statement of Timothy Grimwade dated 18 June 2020, Exhibit 1, 14/142D/4058-2 at [5].
[9] That is, airbags using non-desiccated ammonium nitrate technology: Tpt 519.49 to 520.10.

## D. Issues in the inquest

21. Against the above background, the inquest was principally concerned with the manner and cause of Mr Ngo's death, consistent with the Coroner's obligation under s 81 of the *Coroners Act 2009* (NSW). Although the date, place and the cause of Mr Ngo's death are readily discernible, the inquest was concerned with the manner or circumstances surrounding Mr Ngo's death, with a particular focus on the nature of the risk posed by defective Takata airbags of the kind that fatally injured Mr Ngo and the steps taken and that may yet be taken – by each of Honda Australia, Peter Warren, DIRD and the ACCC, amongst others – to address that risk.

22. The issues that have been principally examined in the course of the inquest have been as follows.

    1. What events occurred on the day of the fatal collision?

    2. What was the risk posed by defective Takata airbags, of the kind within the Vehicle Mr Ngo was driving when he died, to drivers and passengers?

    3. What arrangements were made with Peter Warren for the replacement of the airbags in the Vehicle, which had been scheduled for 11 July 2017, and what were the circumstances in which the replacement service was postponed?

    4. What steps were taken by Honda Australia to notify Mr Ngo and his family about the safety risks posed by the airbags in the Vehicle and to recall the Vehicle so that the airbags could be replaced? As part of this:

        a. What was the manner, mode and content of recall correspondence sent by Honda Australia to Mr Ngo's family?

        b. What communications were there between Mr Ngo's wife, Ms Chea, and the Honda Recall Call Centre?

    5. Were communications between Honda Australia and Ms Chea in relation to the recall, whether verbal or written, cast in sufficiently clear or urgent terms to notify Ms Chea of the relevant risks?

    6. What relevant regulatory provisions, policies, procedures or protocols were and are applicable in relation to the conduct of a voluntary recall of motor vehicles with defective Takata airbags?

7. To what extent were the risks posed by defective Takata airbags and the steps taken by Honda Australia to notify consumers of that risk and recall vehicles with affected airbags monitored by Government agencies prior to the date of Mr Ngo's death?

## E. Persons given leave to be represented

23. A number of persons or entities were notified as being persons whose interests may be affected by the inquest and were given leave to be represented at the inquest. They include:

    a. Honda Australia Pty Ltd;

    b. The Ngo family.

    c. Peter Warren Automotive Pty Ltd;

    d. ACCC;

    e. DIRD;

    f. Federal Chamber of Automotive Industries (FCAI);

    g. Transport for New South Wales (TfNSW) (formerly Roads and Maritime Services).

## F. Evidence before the inquest

24. A large number of written statements were obtained during the coronial investigation and are compiled in the brief of evidence tendered during the inquest, together with other documents such as recall letters, police records and business records of Honda Australia and Peter Warren, as well as documentary responses to requisitions and subpoenas.

25. Some witnesses were called to give evidence in person and persons with a relevant interest in the matters the subject of their evidence had the opportunity to test the evidence in relation to those matters.

26. The witnesses called included:

    a. The Officer in Charge of the coronial investigation, Senior Constable Mark Racker, who gave evidence of his attendance at the scene of the collision and about the course of the investigation more generally;

b. Forensic pathologist, Dr Lorraine Du Toit-Prinsloo and forensic radiologist, Dr James Raleigh, each of whom gave evidence about the nature of the injury inflicted upon Mr Ngo by the metal fragment propelled from the airbag;

c. Cheryl Waterford and Vince Marciano, each of Peter Warren, who gave evidence as to the arrangements in place at that dealership for performing airbag replacement services on Honda vehicles, and for booking in Ms Chea's vehicle for rectification;

d. Stephen Collins of Honda Australia, who gave evidence about, amongst other things, steps taken by Honda to communicate with Mr Ngo's family about the voluntary recall;

e. Steve Hather, an expert in recall communications and strategies;

f. Sharon Nyakuengama of DIRD;

g. Jeremy Thomas, formerly of DIRD;

h. Timothy Grimwade of the ACCC;

i. Dean Wright, formerly of the ACCC; and

j. Julie Morgan of TfNSW.

27. Each of those witnesses, and, where applicable, the organisations or agencies that they represented, provided considerable assistance to the inquest for which I wish to express my appreciation.

## G. Medical evidence as to cause of death

28. In her autopsy report, forensic pathologist Dr Lorraine Du Toit-Prinsloo concluded that the cause of Mr Ngo's death was a "*penetrating injury to the neck*".[10]

29. Dr Du Toit-Prinsloo explained that the features of this injury included:

a. a wound to the right carotid artery measuring about 3x3cm;

b. fractures of the C5-C7 vertebrae; and

[10] Limited Autopsy Report for the Coroner, Dr Lorraine Du Toit-Prinsloo, 9 August 2017, Exhibit 1, 1/5/17. See also Tpt 4.6.

c. a tube-like metal object, which was located in the right side of the neck.[11]

30. Dr Du Toit-Prinsloo stated that the injury observed in Mr Ngo was a sharp force penetrating injury, and that he did not sustain blunt force injuries of the kind typically observed in fatal motor vehicle accidents.[12]

31. She described the "*wound tract"* or path of the metal projectile that caused the fatal injury as follows:[13]

> "The object punctured the skin and travelled through the neck where it perforated the right thyroid lobe, the right carotid artery and the larynx/trachea as well as severing the spinal cord at the level of the 6th cervical vertebrae. The object shattered three vertebrae and was located on the right side of the neck in the posterior aspect."

32. Dr Du Toit-Prinsloo stated that the injury caused by the recovered metal fragment resembled a shotgun wound.[14] She said:[15]

> "… it was this round, circular wound that nearly had the impression of the barrel of a shotgun that had been pressed on ... the skin … I've seen it [the type of wound] in previous shotgun wound injuries …".

33. The cylindrical metal object recovered from the deceased's neck was about 3 cm x 3 cm (roughly the size of a 20 cent piece).[16]

34. Dr Du Toit Prinsloo stated, in relation to that object:[17]

> "[I]t looks like the part that actually inflates the airbag that could break off and that would explain, it looked like that portion of the inflator that entered the neck and was present at the back of the neck."

35. In her evidence before the inquest, Dr Du Toit Prinsloo referred to a 2018 article in a forensic science journal relating to the death of a man in Malaysia.[18] That article included a photograph of a tubular cylindrical metal fragment, found by the authors of the report to have originated from an airbag booster canister which

[11] Tpt 4.9 to 5.25.
[12] Tpt 5.40-6.40.
[13] Statement of Dr Lorraine Du Toit-Prinsloo, 4 December 2018, Exhibit 1, 1/6/26.
[14] Ibid, at [11].
[15] Tpt 4.37.
[16] See photograph at Exhibit 1, 1/9/47.
[17] Tpt 5.6 to 6.12. Dr du Toit-Prinsloo said that although Mr Ngo sustained minor blunt force injuries, these were not regarded as the cause of death.
[18] S Jothee, M Swarhibshafie and F M Nor, "Fatal Penetrating Neck Injury due to Defective Airbag Inflator" (2018) 291 *Forensic Science International* E4-E7: Exhibit 1, 12/119/3530.

shattered upon deployment.[19] The images included in that article depict a piece of metal with striking similarities to the object recovered from Mr Ngo's neck.[20]

36. The inquest also received evidence from Dr James Raleigh, forensic radiologist, in respect of the post mortem CT scans and what these indicated about the wound tract and skeletal damage caused by the metal projectile.[21] The images depict a metal object lodged at the back of Mr Ngo's lower neck, and considerable damage to the bones of the neck.[22] Dr Raleigh described several vertebrae as "disintegrated".[23] He explained that the outcome of such an injury to the vertebrae – had the patient survived – would be "high quadriplegia", that is, "an inability to move pretty much all limbs".[24]

## H. Motor vehicle collision on 13 July 2017 (Issue # 1)

37. The immediate circumstances relating to Mr Ngo's death, were set out in a statement of the investigating officer, Senior Constable Mark Racker;[25] and were elaborated upon by Senior Constable Racker in oral evidence before the inquest. Senior Constable Racker attended the scene of the motor vehicle collision at about 1.30pm on 13 July 2017 and conducted investigations for the purposes of the inquest.[26] His investigations, and the other material before the inquest, indicate the following.

### *The collision*

38. On 13 July 2017, Mr Ngo was driving the Vehicle in a suburban street in Cabramatta. Ms Chea was in the front passenger seat. It was a clear sunny day.[27] At approximately 12.45pm, in a "T-bone" collision, the front of Mr Ngo's vehicle impacted with the front of a Toyota Celica (**Toyota**), being driven by a Mr Dawood al Dawood. Immediately prior to the collision, Mr Ngo was driving southbound down Church Street towards the intersection with Mallee Street. Mr al Dawood

[19] Tpt 6.21 to 6.45.
[20] There was no suggestion before the inquest that the metal fragment that was recovered from the deceased, in the present case, was anything other than a part of the inflator mechanism of the Takata airbag in the Vehicle.
[21] Statement of Dr James Raleigh, 7 December 2018, Exhibit 1, 1/8/36-38.
[22] Tpt 9 to 12.
[23] Tpt 12.20.
[24] Tpt 12.26.
[25] Exhibit 1, 1/9/40.
[26] Tpt 16.7.
[27] Tpt 16.30.

was travelling along Mallee Street in an easterly direction towards Church Street.[28]

39. Following the collision, the Honda CR-V travelled in a south east direction and mounted the kerb before colliding with fencing.[29]

40. Senior Constable Racker, after noting the damage sustained by each of the vehicles in the collision, gave evidence that "based on the damage sustained to both vehicles it [the collision] was relatively minor, [as] there was no intrusion damage to either vehicle … [that is] damage to the cabin of the vehicle".[30] Nonetheless, the impact of the collision was sufficient to cause both the passenger's airbag and the driver's airbag in Mr Ngo's Vehicle to deploy.[31]

***Cause of collision***

41. The intersection between Mallee Street and Church Street is controlled by "Give Way" signage. All traffic travelling upon Mallee Street in both east and westbound directions must "Give Way" to traffic upon Church Street.[32]

42. On Ms Chea's account, as provided to Senior Constable Racker, Mr Ngo was travelling within the speed limit of 50km/h before the collision occurred and she did not see the Toyota prior to impact.[33]

43. Mr al Dawood's account of the incident, which corresponded with that of the passenger in his vehicle, Martin Gorail, was that he did stop at the Give Way sign but that he could not see whether there was oncoming traffic in Church Street.[34]

44. One witness near the scene of the collision stated that he heard a Toyota Celica revving quite loudly prior to hearing the collision.[35]

45. Another witness local to the area stated that she heard what sounded like a speeding car prior to the collision.[36]

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[28] Tpt 16.40 to 17.5; Tpt 17.40 to 18.50.
[29] Tpt 22.45 to 23.19.
[30] Tpt 23.28 to 23.31.
[31] Statement of Leading Senior Constable Elisa Bow, 7 September 2017, Exhibit 1, 1/29/244 at [8]; Tpt 23.42.
[32] Tpt 20.35 to 20.48.
[33] See ERISP Transcript of Ms Chea, 15 October 2017, p 7, Exhibit 1, 1/12/89.
[34] ERISP Transcript of Dawood al Dawood. 20 July 2017, Exhibit 1, 1/18/148. See also ERISP transcript of Martin Gorail, 20 July 2017, Exhibit 1,1/22/183.
[35] ERISP Transcript of Richard Durr, 28 July 2017, Exhibit 1,1/23/196.
[36] ERISP Transcript of Melissa Luu, 15 November 2017, Exhibit 1,1/24/208.

46. Senior Constable Racker noted that that there were no tyre marks on the road to show that there had been harsh breaking prior to the impact.[37]

47. In his statement, Senior Constable Racker stated that "it is not known whether Al Dawood has brought his vehicle to a complete stop at this intersection before proceeding over Church Street".[38] However, whether or not the Toyota stopped entirely, Senior Constable Racker considered that Mr al Dawood failed to give way as required at the intersection.[39] Mr al Dawood underwent blood and urine testing following the collision. He was not found to have been under the influence of any substance at the time of the collision.[40] Further, the police investigation did not identify any mechanical faults in the Toyota Celica that would have contributed to the collision.[41]

48. The evidence pertaining to the circumstances of the collision indicates that the motor vehicle accident was the result of a failure by Mr al Dawood to give way to Mr Ngo's Vehicle.

***Attendance of first responders at scene of accident***

49. Police and paramedics attended the scene of the accident at about 12.49pm and 12.53pm respectively.[42]

50. One of the first responders, Leading Senior Constable Elisa Bow, reported attending the scene and seeing a large amount of blood in the Honda CR-V vehicle.[43] After checking the driver for signs of life, it appeared to her that he was not breathing and she was unable to find a pulse.

51. Ms Chea reported that the bleeding from the injury to Mr Ngo's neck was like "a water tap".[44]

52. An emergency doctor from Bankstown Hospital, Dr Toby Fogg, attended the scene with paramedics and attempted resuscitation. There was, tragically, little that could be done to save Mr Ngo.[45]

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[37] Tpt 24.12.
[38] Statement of Senior Constable Mark Racker, OIC, 22 January 2018, Exhibit 1, 1/9/46 at [19].
[39] Ibid, at [92]; Tpt 21.12.
[40] Expert Certificate of Judith Perl, NSW Police Service, Clinical Forensic Pharmacologist, 14 November 2017, Exhibit 1, 1/21/177.
[41] Tpt 21.28.
[42] Statement of Senior Constable Mark Racker, 22 January 2018, Exhibit 1,1/9/49 at [23].
[43] Statement of Leading Senior Constable Elisa Bow, 7 September 2017, Exhibit 1, 1/29/244 at [8].
[44] See ERISP transcript of Ms Chea, 15 October 2017, Exhibit 1, 1/12/91.
[45] See ERISP transcript of Dr Toby Fogg, 7 August 2018, Exhibit 1, 1/28/236.

53. At about 1.15pm on 13 July 2017, there being no signs of cardiac or brain activity, Mr Ngo was pronounced life extinct.[46] This was approximately 20 minutes after the collision.

54. Ms Chea suffered a fractured sternum as a result of the collision and was conveyed by ambulance to Liverpool Hospital.[47]

55. The driver and passenger of the Toyota involved in the collision were also conveyed to hospital with soft tissue injuries.[48]

***Investigation relating to deployment of airbags in the CR-V Vehicle***

56. Upon attending the collision scene and observing the damage to each of the vehicles involved, Senior Constable Racker formed the view that the motor vehicle accident was relatively minor in terms of the impact and damage caused by both vehicles.[49] He also observed the injury to Mr Ngo's neck. Senior Constable Racker gave the following evidence as to his observations at the scene:[50]

> "A. … Based on that there was no damage through the windscreen or the window it appeared that whatever penetrated Mr Ngo's neck had to have come from inside the vehicle. We then made inquiries inside the vehicle …and it was then become apparent that there was a tear in the airbag.
>
> Q. Yes, … and so you had noticed that … both airbags in the Honda deployed?
>
> A. Yes.
>
> Q. And did you examine the driver's side airbag?
>
> A. Yeah, whilst processing the scene, yeah at some point there we did examine, it wasn't immediately but as we went over the vehicle to look at damage and interior we noticed obviously a lot of blood around the airbag and at that point when we went to photograph we've noticed the tear in the airbag.
>
> Q. All right, and that's on the day of the collision?
>
> A. That's correct.
>
> Q. And what did you observe in terms of a tear of the airbag?
>
> A. There was a hole in the middle of the airbag basically.

[46] ERISP transcript of Toby Fogg, 7 August 2018, Exhibit 1, 1/28/240, q 19.
[47] Statement of Senior Constable Mark Racker, OIC, 22 January 2018, Exhibit 1, 1/9/57 at [44].
[48] Exhibit 1, 2/43/436.
[49] Tpt 24.35 to 24.41.
[50] Tpt 24.49 to 25.40.

> Q. And what was the size of the hole approximately?
>
> A. Approximately it was a 50 cent piece, possibly slightly larger. It sort of, it had like a cloth, so a tear…
>
> Q. And what did that indicate to you at that time?
>
> A. Based on [the fact] that nothing had come through a windscreen or a window that something had to have shot through the steering wheel through the airbag, something had come from behind."

57. In addition to the metal fragment recovered at autopsy from Mr Ngo's neck, another piece of metal shrapnel was recovered from the driver's side footwell.[51]

58. Subsequent to becoming aware of those metal fragments, Senior Constable Racker commenced investigations in connection with Takata airbags.[52] He learned of the RAV-4 Northern Territory incident where the driver had suffered serious eye and head injuries when an airbag misdeployed.[53] A piece of metal photographed in connection with that incident looked very similar to the metal pieces recovered in this case.

59. Senior Constable Racker conducted interviews with members of Mr Ngo's family, including his wife and daughters, who, understandably, were and continue to suffer extreme grief as a result of Mr Ngo's death.[54]

60. Senior Constable Racker also met and corresponded with representatives of Honda Australia and Peter Warren. On 11 October 2017, he was provided by email with what were described by representatives of Honda Australia as "replica copies" of customer letters sent by Honda Australia to the Ngo/Chea family.[55] At the time that Senior Constable Racker received these documents, he understood that the customer letters provided were copies of the actual correspondence that had been sent by Honda Australia to the Ngo/Chea family.[56] However, the documents provided to Senior Constable Racker were in fact copies of pro forma letters and were not actual copies of the correspondence sent to the Ngo/Chea family.[57]

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[51] Tpt 27.5.
[52] Tpt 29.36.
[53] Tpt 29.38 to 30.15.
[54] Tpt 31.2.
[55] Tpt 31.30 to 33.40. See also Exhibit 1, 5A/60C/1625-32 to 38.
[56] Tpt 34.10 to 34.22.
[57] The documents are said to be versions of letters that were sent by Honda Australia to Ms Chea.

61. Senior Constable Racker concluded from his investigations that the airbag inflating unit in Mr Ngo's CR-V had malfunctioned, leading a metal object to project from the unit and penetrate Mr Ngo's neck.[58]

62. In light of those conclusions and the medical evidence, I find that the cause of Mr Ngo's death was a penetrating injury to the neck sustained from a piece of metal propelled from a defective Takata airbag which malfunctioned when it deployed in a minor collision, which occurred when the Honda CR-V that Mr Ngo was driving was struck by another vehicle whose driver had failed to give way.

## I. Risks of Takata airbag malfunction (Issue # 2)

63. Following Mr Ngo's death, and in circumstances returned to in further detail below, the ACCC commenced an investigation into the issue of defective Takata airbags.[59]

### *Takata*

64. Takata Corporation was[60] an automotive parts company based in Japan which manufactured airbags used by a variety of vehicle manufacturers, including Honda. Takata's global headquarters were in Tokyo and it had manufacturing plants and sales centres in many other countries, including the USA, Mexico, Brazil, Europe, Africa and various other countries in Asia.[61]

65. On 26 June 2017, Takata (including its related companies) filed for bankruptcy in Japan with liabilities exceeding about AUD $11.5 billion – then the largest ever Japanese manufacturer bankruptcy. Takata's US subsidiaries also filed for bankruptcy in the USA.[62] The Takata business was subsequently acquired and responsibility for international recalls of Takata airbags now rests with TK Global, the successor to Takata in the United States.

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[58] Tpt 30.24.
[59] Documents prepared by the ACCC as a result of that investigation as well as other material produced by the ACCC were before the inquest and provided information about the mechanics of defective Takata airbag inflators of the kind in Mr Ngo's Vehicle.[59] What follows below is drawn, in part, from that material which includes the ACCC's Background Report.
[60] The company filed for bankruptcy in 2017 and its assets were acquired by a competitor, Key Safety Systems.
[61] Exhibit 1, 9/83/2478.
[62] Exhibit 1, 9/83/2479.

***Airbags***[63]

66. Airbags are designed to deploy and deflate at a precise rate to catch the occupant of a vehicle following a collision and absorb some of their momentum. This slows the occupant's movement, reducing or preventing injury caused by the occupant otherwise impacting on a part of the vehicle (generally the steering wheel or dashboard).

67. An airbag is sometimes referred to as a Supplemental Restraint System (SRS). The parts of an airbag include the crash or impact sensors which are at various points in a vehicle and the airbag module which includes an electronic control unit, an inflator and a fabric bag. When a vehicle's impact sensors are triggered, they send information to the airbag electronic control unit, which uses algorithms developed to determine whether the crash event meets the criteria necessary to deploy the airbag(s). The algorithms assess data such as the severity of impact, speed and brake pressure. An airbag is designed to deploy when the algorithm determines that the nature and extent of the collision warrant deployment.

68. A frontal airbag module is concealed in the driver's steering wheel or the passenger's dashboard, behind plastic flaps or doors which are designed to pop open under the force of the airbag inflating. The module's inflator system contains steel tubing (known variably as boosters, housing, chambers, cannisters or casings) which contain pyrotechnic chemical mixtures known as the propellant. Once the airbag control unit triggers an airbag deployment, it sends a signal to the inflator to ignite and burn the propellant, which rapidly produces gas that enters and fills the fabric airbag instantaneously. The propellant is shaped so as to burn in layers, which serves to control the speed at which the gases in the propellant chamber are generated. When the pressure in the propellant chamber exceeds a certain threshold, this breaks the tape seal covering the small vent holes in the inflator housing and the gases escape to inflate the airbag. All of this happens within milliseconds from the time that the vehicle sensors detect a crash.

69. There are many different designs or variations of Takata[64] airbag inflators, with each vehicle manufacturer having different specifications based on their requirements for the airbag's performance.

[63] Exhibit 1, 9/83/2478.
[64] And other "brands" not relevant for this inquest.

70. Airbags and airbag performance may differ as a result of their propellant shape and size, the type and position of airbag (eg, driver, passenger etc) and whether the inflator mechanism contains a desiccant or not and the type of desiccant that is used.[65] Although, there have been concerns about safety risks posed by certain models of Takata airbags for over a decade, it appears that the variability in Takata airbag inflators has meant that there has been progressive learning about the nature and cause of those risks, and the inflators affected by them.

***PSAN Propellant[66]***

71. Since the early 2000s, Takata has used different chemical compositions of what is known as "phase stabilised ammonium nitrate" or PSAN propellant in models of its airbag inflators. The PSAN propellant in Takata airbag inflators is made by mixing the relevant chemical components into a powder and pressing this into various shapes (eg, "batwings", "wafers" and "tablets").[67]

72. The descriptor "phase stabilised" means that the physical integrity or condition of the ammonium nitrate is not supposed to change over the lifetime of the airbag inflator. But, as has become apparent, the danger with Takata airbag inflators containing a PSAN propellant arises because the propellant can become unstable or degraded over time.

73. Research has shown that when the PSAN propellant is subject to moisture or "thermal cycling" – essentially a vehicle repeatedly heating up and then cooling down – this causes the propellant to lose density. This can lead to over-pressurisation of the propellant when it is ignited, causing it to combust too aggressively. This can lead to an explosion the force of which causes the entire steel inflator housing to rupture and propel steel fragments into the vehicle cabin. Though the use of the word fragment suggests something very small, the pieces or parts of the broken casing have been known to be up to 5 cm long.

74. Given the risks that arise when PSAN propellant is subject to moist conditions, drying agents known as desiccants have been integrated into some – but not all – models of PSAN Takata airbag inflators to absorb moisture;[68] and different types of desiccant have been used for this purpose. One such desiccant is calcium sulphate, which is now known to be unreliable

[65] Exhibit 1, 9/83/2483.
[66] Exhibit 1, 9/83/2481.
[67] See Exhibit 1, 9/83/2481.
[68] Exhibit 1, 9/83/2482.

***United States Takata Recall***[69]

75. In November 2008, Honda in the United States notified the National Highway Traffic Safety Administration within the United States Department of Transport (**NHTSA**) of what is understood to be the first recall in the United States, by any vehicle manufacturer, of vehicles with Takata driver-side inflators with improperly manufactured propellant wafers. Ongoing rupture incidents and further investigations subsequently led Honda to expand its recalls to other vehicle models.[70]

76. In April 2013, Takata filed a defect report with NHTSA advising that certain passenger side airbag modules may rupture as a result of manufacturing errors that are aggravated by exposure to hot and humid environments.[71]

77. In May 2015, a United States based Takata entity – TK Holdings Inc – filed four "573 defect filings" with NHTSA disclosing that a defect may exist in some of its airbag inflators. This led to a US nationwide recall by various car manufacturers of approximately 22 million inflators in the United States.[72]

78. On 23 May 2015, Takata entered into a First Consent Order with NHTSA which, among other things, compelled Takata to co-operate with NHTSA's investigation into defective Takata airbags and provide proposals for implementing recalls and for testing the safety of replacement inflators.[73]

79. On 3 November 2015, Takata entered into a Second Consent Order with NHTSA which compelled Takata to: (i) pay a civil penalty (of up to US $200 million); (ii) phase out the manufacture and sale of non-desiccated PSAN inflators in the United States by 31 December 2016; and (iii) demonstrate to NHTSA's satisfaction that its inflators were safe, or declare a defect and issue a recall.[74]

80. Also on 3 November 2015, NHTSA issued a Co-ordinated Remedy Order to a number of vehicle manufacturers which required acceleration of the recall of certain vehicles with Takata Airbags.[75] That order stated (emphasis added):[76]

> "[29]. Without a conclusive determination of root cause, the source of the problems with certain Takata inflators remains unknown.

[69] See Exhibit 1, 9/83/2495.
[70] Exhibit 1, 9/83/2495.
[71] Exhibit 1, 9/83/2495.
[72] Exhibit 1, 9/83/2496.
[73] Exhibit 1, 9/83/2496; 6/67/1820.
[74] Exhibit 1, 9/83/2496; 6/67/1830.
[75] Exhibit 1, 9/83/2496.
[76] Exhibit 1, 6/67A/1875-1 at 1875-12.

What is known, however, is that the propellant in inflators covered by the Inflator Recalls and the recalls within the scope of this Order have, at various rates of frequency, a propensity to ignite and/or burn in an unexpected way that may cause the pressure inside the inflator to increase too quickly, causing the inflator to rupture. **That rupture causes the metal canister of the inflator to break away in hot, shrapnel-like fragments, which shoot out of the air bag into the passenger cabin and towards the driver or any occupants who are nearby.**

[30]. As of October 30 2015, there have been 99 confirmed incidents in the United States where a **ruptured Takata air bag inflator** allegedly caused death or injury. Many of these incidents resulted in serious injury to vehicle occupants**.** In seven of the incidents, the vehicle's driver died as a result of injuries sustained from the rupture of the air bag inflator. In other incidents, vehicle occupants suffered injuries including cuts or lacerations to the face or neck, broken or fractured facial bones, loss of eyesight, and broken teeth. **The risk of these tragic consequences is greatest for individuals sitting in the driver seat, where one in ten individuals' whose air bag inflator ruptured has died.**

Findings

Based upon the agency's analysis and judgment, and upon consideration of the entire record, NHTSA finds that:

…

[32]. Each **air bag inflator with the capacity to rupture, as the recalled Takata inflators do**, presents an unreasonable risk of serious injury or death. Seven individuals have already been killed in the United States alone, with at least 92 more injured. Since the propensity for rupture increases with the age of the inflator, and increases even more when the vehicle has been exposed to consistent long-term HAH [high absolute humidity] conditions, the risk for injurious or lethal rupture increases with each passing day. While each of the Initial Vehicle Manufacturers has made efforts towards the remedy of these defective air bag inflators, acceleration and coordination of the inflator remedy programs is necessary to reduce this risk to public safety. Acceleration and coordination will enable vehicle manufacturers to establish priorities based on principled rationales for risk assessment, coordinate on safety-focused efforts to successfully complete their respective remedy programs, and allow for the organization and prioritization of remedy parts, if and as needed, with NHTSA's oversight."

81. The Co-ordinated Remedy Order dated 3 November 2015 set out recall completion deadlines for the United States based on vehicle priority groups.

82. The Co-ordinated Remedy Order was later amended on a number of occasions to address new evidence regarding:

a. ruptures and additional testing information about the nature of the defect;

b. challenges posed by a lack of replacement inflators; and

c. issues with communications with consumers.[77]

83. The vehicles originally the subject of the NHTSA Co-ordinated Remedy Order included Honda CR-V models from 2002 to 2006. Such vehicles were classed in a different order of priority depending on whether or not they were from a "high absolute humidity" (**HAH**) region. At least in its original form, the Co-ordinated Remedy Order seemingly did not cover 2007 Honda CR-V models. However, the Co-ordinated Remedy Order appears to have been drafted so as to automatically incorporate any future recalls of Takata inflators commenced by vehicle manufacturers.[78] The recall in the USA was subsequently expanded to include 2007 CR-V models.[79]

***Development in understandings about nature of inflator risks***

84. The misdeployment of Takata airbags is generally characterised by a ruptured inflator occurring upon the ignition of the propellant. By late 2015, there had been more than 10 fatalities overseas reportedly caused by the misdeployment of Takata airbag inflators.[80]

85. It appears that, despite these fatalities, for some time, there was a degree of uncertainty – at least from the perspective of United States and Australian regulators – as to the precise root cause of Takata airbag inflator ruptures, and whether this was attributable to a manufacturing/production line error, a design flaw, or both. The causes of Takata inflator ruptures was one of a number of issues discussed by an Australian "Takata Airbag Working Group", being a working group first convened at the instigation of DIRD in August 2015 and which was initially comprised of representatives of DIRD, the FCAI and various suppliers of motor vehicles, including Honda Australia.[81]

86. As at the date of Mr Ngo's death, Takata airbag inflators containing PSAN propellant had been classified – by motor vehicle suppliers including Honda

[77] Exhibit 1, 9/83/2496; 6/67A/1875-29.
[78] See Coordinated Remedy Order paras 45, 46, 48 at Exhibit 1, 6/67A/1875-21.
[79] The apparent expansion of Honda's United States recall to include 2007 model CR-Vs is reflected in the Third Amendment to the Coordinated Remedy Order, dated 9 December 2016, p 22: Exhibit 1, 6/67A/1875-29 at 1875-67, 1875-81.
[80] See Exhibit 1, 9/83/2490-2491.
[81] Exhibit 1, 9/83/2519.

Australia as well as by US and Australian regulators – as either “alpha” or “beta” airbag inflators.[82] In general:

a. “Alpha” inflators were those under recall in the US in January 2014 for identified manufacturing faults[83], and were produced in particular production periods. Alpha inflators had been associated with an up to 50% risk of rupture in the event of deployment; and

b. “Beta” inflators were those not under recall in 2014 and were subject to propellant degradation but not some other identified manufacturing issue.

87. In the USA, to assist with identifying and verifying the root causes(s) of the Takata inflator ruptures, NHTSA engaged Dr Harold Blomquist – an industrial chemist with experience in formulating a PSAN based gas generant for airbag inflators – to prepare a report which included a review of other expert reports and his conclusions as to the root cause of the ruptures.[84]

88. Dr Blomquist furnished his report as to the cause of the Takata inflator ruptures in about May 2016 (**Blomquist Report**).[85] The ACCC background report provides[86]:

> “In summary, the Blomquist Report, inflator ruptures occur through the following sequence of events:
>
> - affected inflators are inadequately sealed for protection of the moisture sensitive PSAN based main propellant;
> - this allows moist air to enter the inflator;
> - this causes damage to the physical structure of the main propellant, e.g., the formation of pores, channels and micro-cracks;
> - over the course of years, the extent of damage progresses by a slow process driven by daily temperature fluctuations. This is sometimes referred to as "ripening";
> - during a motor vehicle accident, the airbag inflators are triggered;
> - during combustion, the extremely hot gas enters the pores/channels which have formed in the damaged propellant over time; and

[82] Exhibit 1, 9/83/2484; see also Tpt 329.10 to 330.24; Tpt 824.46-825.35.
[83] This description is additional to the propellant degradation and described in the Blomquist report “characterised by low density propellant” – see Ex 1 9/90/2856 [10.b].
[84] Exhibit 1, 9/83/2487.
[85] Exhibit 1, 9/90-9/2883.
[86] Exhibit 1, 9/83/2487-2488.

- this causes a transition from layer-by-layer burning to burning *en masse* that overpressurises the steel shell and causes catastrophic failure (rupture) with fragmentation hazardous to vehicle occupants."

89. The Blomquist Report concluded that all non-desiccated Takata frontal driver and passenger PSAN inflators contained a propellant that degraded over time and that the degradation was principally the result of long term daily temperature cycling. The report concluded that the fact that the inflator design permits moist air to enter the inflator is a design defect that, with the passing of time, will lead to the degradation of the moisture-sensitive PSAN propellant which will lead to over-pressurisation during airbag deployment. According to the Blomquist Report, it is a question of when, not if, degradation will reach an unsafe level.[87]

90. On or about 4 May 2016 and following publication of the Blomquist Report, NHTSA released an Amended Consent Order which stated that:

> "NHTSA has concluded that at some point in the future all non-desiccated frontal Takata PSAN inflators will reach a threshold level of degradation that could result in the inflator becoming dangerous."[88]

91. The Amended Consent Order (of May 2016) reflected NHTSA's position that all such Takata airbags – that is, both alpha and beta airbags with non-desiccated PSAN inflators – should be subject to a recall by 31 December 2019.

92. Factors which NHTSA found to contribute to or influence the rate of degradation of the PSAN propellant and thus the risk of inflator rupture included the following:[89]

> "1. **age of the inflator** – older inflators are at a higher risk of rupture;
>
> 2. **geographic region** – vehicles in locations with high temperature fluctuation/cycling and high humidity have a higher risk of inflator rupture;
>
> 3. **design of the inflator housing** – ineffective or permeable seals that allow moisture ingress and movement in the inflator component increase risk of rupture;
>
> 4. **type and size of vehicle** – characteristics such as vehicle size influence the environmental conditions experienced by the inflator;

[87] Exhibit 1, 9/83/2529; Blomquist Report at Exhibit 1, 9/90-9/2894.
[88] Exhibit 1, 6/67/1863.
[89] See ACCC Background Paper, Exhibit 1, 9/83/2487-2489.

5. **booster propellant used and its age** – the booster propellant can influence moisture absorption of the main propellant and can act as a desiccant;

6. **whether a desiccant was used** – … desiccant is designed to absorb moisture to protect the main propellant from moisture; and

7. **density of the PSAN propellant** – …the propellant shape and manufacturing standards and whether the tablets/wafers were compressed according to design specifications have a bearing on the density of the propellant at the time of manufacture and may influence the rate of degradation arising from field exposure."

93. NHTSA is of the view that, over time, the propellant in all such Takata airbag inflators (ie both alpha and beta) will deteriorate to such an extent that they will present a risk of rupture.[90]

94. The ACCC considers that the Blomquist Report, and the views set out therein, remains the best explanation available of the root cause of the rupture of Takata PSAN airbag inflators that are non-desiccated or that have a calcium sulphate desiccant.[91]

***Adoption by ACCC and DIRD of Blomquist findings***

95. On about 3 June 2016, DIRD wrote to Honda Australia enclosing a copy of the Blomquist Report, and summarising the announcements made by NHTSA in reliance on that report, including the significant expansion of the US recalls to include all Takata airbags powered by non-desiccated ammonium nitrate.[92]

96. DIRD stated in its letter to Honda Australia, under the heading "Department's Preliminary View", that in light of those announcements, DIRD was reviewing its position on the matter but that DIRD had formed the preliminary view (which was supported by the ACCC) that it was no longer acceptable to have any airbags powered by non-desiccated ammonium nitrate and that manufacturers should recall all relevant vehicles, which may include vehicles that have already been rectified under existing recalls.[93] Honda Australia was given an opportunity to respond before that position was finalised, and was asked whether Honda Australia was still supplying new vehicles containing alpha or non-desiccated

[90] Department of Infrastructure and Regional Development, *Recall of Vehicles in Australia Fitted with Takata Airbags- Report on Progress and Status of the Recalls*, p 15, Exhibit 1, 2/45/470.
[91] See ACCC Background Paper, Exhibit 1, 9/83/2529; Tpt 1522.44 (Grimwade); see also Tpt 824.23 (Nyakuengama).
[92] See USB at Exhibit 1, 11/110 (**DIRD Material**), Vol 2, Tab 73.
[93] DIRD Material, Vol 2, Tab 73, Tab 74; Tpt 1242.38-.50.

airbags and whether all vehicles supplied with alpha or non-desiccated airbags had been recalled.

97. At the Takata Airbag Working Group meeting held on 17 June 2016 – the first such meeting attended by ACCC representatives – there was discussion around how Australia should respond to the NHTSA announcements arising from the Blomquist Report.[94]

98. At about the time of that meeting, DIRD finalised its broad view that vehicles fitted with either alpha or beta Takata airbags should no longer be provided to the Australian market and that vehicles fitted with either type of non-desiccated Takata airbag should generally[95] be recalled.[96] The ACCC supported this view.[97] In Australia, the number of vehicles recalled and number of affected vehicle manufacturers substantially increased following the publication of the Blomquist Report and the views adopted by DIRD in light of it.

99. DIRD's adoption of the broad position that both alpha and beta non-desiccated PSAN airbags should be recalled meant that some previously recalled vehicles needed to have a previously replaced inflator replaced again.[98] Mr Collins gave evidence to the inquest that while the root cause of the airbag defect remained uncertain, some vehicles were fitted with what is known as a "like-for-like replacement" which have subsequently been recalled again as they require further replacement. Honda Australia stopped using any Takata airbags as replacement airbags in its vehicles from about July 2017.[99]

***Classification of airbag inflator in Mr Ngo's Vehicle***

100. As at the date of Mr Ngo's death, there were approximately 19 known fatalities globally caused by the misdeployment of PSAN Takata airbag inflators, the first of which had occurred in May 2009 in the United States. Many of the injuries and fatalities were reported to have occurred in Honda vehicles.[100]

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[94] See DIRD Material, Volume 2, Tab 80; Volume 3, Tab 99.
[95] There were exceptions for certain inflators made in the Freiburg Unit in Germany at Tpt 746.41, Tpt 915.46-.916.5.
[96] Tpt 824.44-825.35.
[97] Tpt 1457.28-.35.
[98] Department of Infrastructure and Regional Development, *Recall of Vehicles in Australia Fitted with Takata Airbags- Report on Progress and Status of the Recalls,* p 18, Exhibit 1, 2/45/472; ACCC Background Paper, Exhibit 1, 9/83/2519-2520.
[99] Tpt 520.40.
[100] See Exhibit 1, 9/83/2489-2492; see also, ACCC Media Release dated 5 May 2020, Exhibit 1, 13/138A/3861-1.

101. The driver's airbag in the Honda CR-V driven by Mr Ngo contained a PSAN non-desiccated airbag inflator from what is known as the "SDI" inflator family[101] and a tablet-shaped PSAN propellant.[102] As at 13 July 2017, this inflator, subject to the 5ZV recall initiated by Honda Australia, was classified as a beta airbag inflator. So too was the passenger airbag inflator in the CR-V Vehicle, which was then the subject of Honda Australia's 6CA recall. At the time of Mr Ngo's death, those recalls were not being prioritised by Honda Australia in the same manner as recalls of alpha airbags.[103]

102. Following Mr Ngo's death, in August 2017 the board of Honda Australia classified airbag inflators the subject of the 5ZV recall, as well as other SDI inflators, as "critical", and implemented steps to prioritise recalls of those airbags in the same manner and with the same degree of urgency as then applied for alpha airbag recalls.[104]

103. According to Mr Collins, Honda Australia's decision to categorise this family of inflators as "critical" was made by the board of Honda Australia in response to Mr Ngo's death.[105] This step was, according to Mr Collins, "unprecedented", as it was not taken under instructions from Honda Motor Co (**Honda Japan**) but instead was a matter determined by the local board of Honda Australia.[106]

104. Mr Collins accepted that there was no impediment to Honda Australia conducting its operations so as to class airbags the subject of the 5ZV recall as "critical" prior to when it in fact did so.[107] In this respect, at the time of Mr Ngo's death, there had been deaths in Malaysia attributable to SDI airbags in Honda vehicles, of which Honda Australia had been made aware.[108]

105. In the course of the inquest, Honda Australia was asked to identify how, in its view, the airbag in the Vehicle driven by Mr Ngo malfunctioned during deployment. By way of answer Honda Australia set out that it had not carried out an examination though having regard to the fragments that were recovered, assumed that what

[101] Exhibit 1, 9/83/2492, 2533; Tpt 331-332. A Smokeless Driver Inflator (SDI) refers a gas efficient inflator that produces minimal particulate matter. See glossary Exhibit 1, 9/83/2610.
[102] Exhibit 1, 9/83/2433; see also letter from Clyde and Co to CSO dated 14 October 2019, Exhibit 1, 12/128/3639.
[103] see also Tpt 329 to 330; Exhibit 1, 2/54/690.
[104] Tpt 333, 336.35, 338.20; National Service Technical Bulletin 2017-08-033, Exhibit 1, 2/54/698.
[105] Tpt 333.42; see also Tpt 576.36 to 578.14.
[106] Tpt 496.25.
[107] Tpt 578.40.
[108] Tpt 335.44.

had occurred was as set out in the explanations provided in the Blomquist Report.[109]

106. The ACCC's investigation into Takata airbags included examination of features of "families" of affected inflators to try to ascertain the design features of airbags that have been involved in rupture events. The proportionately high number of incidents associated with Honda vehicles has been referred to by the ACCC as follows:[110]

> "… The most problematic inflator family in terms of deaths and injuries is the PSDI which has caused 13 deaths and 157 injuries as a result of field ruptures. The PSDI is used only in Honda vehicles and uses a batwing shaped propellant. Ruptures in the PSDI-4, which also uses a batwing shaped propellant, are responsible for injuring 17 people.
>
> …the batwing design is understood to be particularly susceptible to degradation. This coupled with its use in frontal, driver-side inflators may explain why it has been involved in the majority of deaths and injuries resulting from affected Takata inflator ruptures globally."

107. In late 2017/early 2018, the ACCC also analysed the risk profile associated with the different propellant shapes, and identified that the "batwing" shape had then been associated with 13 deaths and 174 injuries, the wafer shape (used only in passenger side inflators) had been associated with no known deaths and 49 injuries and the tablet shape (being the propellant shape associated with Mr Ngo's driver airbag), [111]had been associated with 10 deaths and 6 injuries.[112]

***Conclusion on Issue #2***

108. In relation to the risk posed by the driver airbag in the Vehicle driven by Mr Ngo the evidence establishes that:

    a. prior to its deployment on 13 July 2017, the Takata airbag inflator in Mr Ngo's Vehicle was at risk of rupture by reason of its physical properties as identified in the Blomquist Report; and

[109] Exhibit 1, 12/128/3640 to 3641.
[110] Exhibit 1, 9/83/2532. PSDI refers to Programmable Smokeless Driver Inflator ("Programmable" refers to the presence of a dual booster that enables deployment of one or both chambers depending on crash severity. See glossary Exhibit 1, 9/83/2610.
[111] Exhibit 1, 10/109H/3180-39.
[112] Exhibit 1, 9/82/2532-2533.

b. on the date of Mr Ngo's death, that risk materialised, as a result of which the inflator did rupture and a metal fragment forming part of the inflator mechanism was projected into Mr Ngo's neck.

109. The actions taken by various persons and entities – including Peter Warren, Honda Australia, DIRD and the ACCC – to address the risk posed by the driver airbag in the Vehicle prior to 13 July 2017 are circumstances relating to the manner of Mr Ngo's death.

## J. Arrangements for airbag replacement booking with Peter Warren (Issue #3)

110. In evidence given to the inquest, Mr Collins explained that, upon initiation of any voluntary recall, Honda Australia engages with the Honda Dealers that carry out replacement/repair services and that Honda Dealers are provided with Bulletins in relation to how to conduct the relevant repair.[113] Mr Collins also gave evidence as to the systems in place at the Honda Australia Recall Call Centre to arrange to book in vehicles for airbag replacement service with Honda Dealers, which is further described below .

111. Peter Warren Automotive holds a number of automotive franchises and sells and services a number of car brands, one of which is Honda[114] . Each brand or franchise has a separate sales area and its own dedicated service workshop[115] occupying an area of 22 acres in Warwick Farm, a suburb in Western Sydney[116]. The use of the term Peter Warren in these findings refers to Peter Warren's Honda Service Division unless otherwise indicated. Peter Warren's Honda service catchment area, known as the Prime Marketing Area (**PMA**), had the largest number of Honda vehicles containing recalled airbags in Australia[117].

112. The inquest heard and received evidence from two representatives of Peter Warren: Cheryl Waterford, a Manager in Peter Warren's Customer Development Centre (**CDC**) responsible for its Toyota and Honda telephone service team;[118] and Vince Marciano, a service manager at Peter Warren, who works with various vehicle brands, including Honda.[119] Their evidence broadly related to the circumstances in which Ms Chea's Vehicle came to be booked in for airbag

[113] Exhibit 1, 3/55/734 at [26].
[114] Tpt 55.35.
[115] Tpt 172.25-48.
[116] Tpt 90.21-24.
[117] Tpt 498.46-499.6
[118] Tpt 56.11. This department dealt with Chrysler, Jeep, Dodge, Toyota and Honda Vehicles: Tpt 128.46.
[119] Tpt 171.

replacement at Peter Warren and the relevant appointment which was subsequently rescheduled.

***Ms Chea makes contact with Honda Recall Call Centre on 30 March 2017***

113. On 30 March 2017, Ms Chea telephoned Honda Australia's Recall Call Centre (**HARCC**) for voluntary recalls, in response to having received recall correspondence from Honda Australia a few days prior.[120] A transcript of this telephone call was obtained by the inquest.[121]

114. Once the HARCC telephone operator had identified Ms Chea's vehicle, and Ms Chea had provided her mobile phone number and address, the operator informed Ms Chea that Peter Warren in Warwick Farm was the closest Honda dealer to her. The operator asked Ms Chea if she would like to go there, or if she had "anyone else in mind" who she preferred. Ms Chea said she would go to Warwick Farm, as it was "close to my house". The operator then informed Ms Chea that Peter Warren would be sent the booking request, and that Peter Warren would contact her on her mobile when the parts were ready, any time in the next two and half weeks, and Peter Warren would arrange with her a date and time for her booking.[122]

115. The HARCC telephone operator did not give any information to Ms Chea about the risks posed by the Takata airbags in her vehicle, or what might happen if they deployed in the time before the airbags could be replaced.

116. As at March 2017, once a consumer contacted the HARCC in relation to an airbag recall and a particular Honda dealer was identified to carry out the airbag replacement service, the HARCC representative would prepare a "case" in the relevant computer system (Salesforce) with the consumer's details (ie, name, contact details, vehicle VIN number and registration number and outstanding recall codes). The case would then be transmitted electronically to the relevant Honda dealer. The dealer to which a consumer was referred by the HARRC would generally be the dealer whose PMA covered the consumer's geographic location.[123] Ms Chea's suburb of residence was within Peter Warren's PMA.

[120] See below at [210]. Ex 1 1/12/82 interview with Ms Chea 15 October 2017.
[121] Exhibit 1, 3/55/755.
[122] Exhibit 1, 3/55/758.
[123] Tpt 68.1 to 68.8.

***Peter Warren's capacity to undertake airbag replacement services***

117. In early 2017 there was a group of staff within Peter Warren's Honda service department that performed work, including service and maintenance of new and older vehicles, warranty repairs, general mechanical work and recalls.[124]

118. In late 2015 the Honda workshop, which at that time, had eight service bays, commenced a planned renovation and the construction work continued to mid-May 2017. During this period the workshop occupied a temporary onsite facility which had only six service bays. Upon completion, the new Honda workshop had nine bays.[125] It is significant and unfortunate that the reduction in workshop bays coincided with Honda Australia actioning the 5ZV recall.

119. From 2016 Peter Warren had a three-month delay for its Takata airbag recall bookings.[126] Despite the large volume of vehicles involved in the 5ZV recall there was no shortage of supply of replacement airbags from September/October 2015[127]. The delay related to Peter Warren's capacity to carry out the required number of replacements.

120. In accordance with its Honda franchise agreement Peter Warren implemented a system whereby every vehicle that was booked in for its scheduled service or maintenance would be checked to determine if it contained an airbag subject to recall (also referred to as an "affected" airbag) and if so, it would be removed and replaced at that service. [128]

121. Since 2016 and continuing until shortly after Mr Ngo's death, Peter Warren allocated booking time to replace Takata airbag recalls in vehicles that were not otherwise being serviced or maintained by Peter Warren. Peter Warren allowed for replacement bookings for 15 airbags per weekday and three airbags per Saturday. (This was in addition to those airbags replaced in vehicles that were otherwise being serviced).[129] Thus, where a vehicle requiring two airbags to be replaced was booked in on a weekday, it would be allocated two of the 15 booking slots.[130] Mr Marciano explained that he set the number of recall booking slots

[124] Tpt 173.26. Peter Warren was also carrying out Takata airbag recall replacements for other brands in those dedicated workshops.
[125] Tpt 239.25-240.19.
[126] Tpt. 201.24-201.27.
[127] Tpt.418.15-35.
[128] Tpt 224.7.
129 Statement of C Waterford, 8 August 2018 at [20], Exhibit 1, 2/50/577; Tpt 71.32, 97.47, Tpt 207.49, 208.9
[130] Tpt 208.19 to 208.34.

based upon the service department's ability to carry out its service and maintenance work, as well as recall work for active customers bringing in cars for regular services.[131]

122. The 15 recall bookings equated to a maximum of about 12 hours a day dedicated to airbag recall replacements (additional to any replacements carried out on vehicles being otherwise serviced).[132]

123. Mr Marciano's evidence was to the effect that Peter Warren's Honda service department was taking the steps that it could to progress Takata airbag replacements, having regard to space and staff capacity at the time, as well as its ongoing service obligations to customers.[133] Mr Marciano explained that the capacity issues and delays experienced in the first part of 2017 by Peter Warren's Honda service department, in terms of completing airbag recalls, were attributable to the volume of vehicles subject to the recall, Peter Warren's staffing capacity, its space capacity to undertake the work and the number of cancellations and re-bookings that occurred.[134]

124. From about mid 2015 Honda Australia started a dedicated Takata airbag recall team based in Melbourne[135] which would have meetings with Peter Warren to discuss the rectification rate and Peter Warren's capacity to carry out the recalls within Honda Australia's targets[136]. Aside from the reduced number of workshop bays and the large volume of vehicles needing bookings, there were numerous other issues affecting Peter Warren's capacity to meet Honda Australia's rectification targets.

125. Those issues included the payment structure for carrying out recalls and the fact that Peter Warren was required to discharge its franchise obligations to meet Honda Australia's targets for providing Periodic Maintenance Work **(PMW).** To assist or incentivise Peter Warren to increase its rectification rate, in May 2016 Honda Australia commenced paying the full retail labour rate for recall replacements and in about May 2017 Honda Australia reduced Peter Warren's PMW target rate so more time could be dedicated to airbag replacements. Despite those changes the Peter Warren booking slot limits were not immediately

[131] Tpt 224.7.
[132] Tpt 225.45 to 226.2. That is, leaving aside consumers who drove in requesting replacements or who had otherwise brought their vehicles in for service and also required airbag replacement.
[133] Tpt 268-269, 277-278, 282, 287.
[134] Tpt 241 to 243.
[135] Tpt 498.6-26.
[136] Tpt 498.46-499.6.

increased to address and reduce the delay between booking and performing the recall replacement.

126. Another issue was securing sufficiently qualified mechanics to carry out the replacements as unlike some other States, NSW legislation required a qualified mechanic to carry out airbag replacements rather than a qualified technician and Peter Warren had difficulties recruiting suitably qualified staff. In November 2016 Honda Australia provided assistance in a recruitment drive but unfortunately this did not result in securing additional mechanics.

127. Mr Marciano agreed that throughout 2017 there was pressure on Peter Warren by Honda Australia to undertake replacements of all Takata airbags as quickly as possible, and to try to replace alpha airbags within five days of a booking request.[137]

128. Mr Marciano said that the service department moved into the renovated workshop in mid-May 2017 which meant the service workshop had access to nine service bays (three more than it had since late 2015) but Peter Warren did not have the staff to work in those bays until recruitment occurred some months later.

129. Despite the steps taken by Honda Australia to assist Peter Warren's capacity, there appears to have been inadequate planning or preparation by its recall team or by Peter Warren to maximise the staffing level for the newly renovated workshop. Accordingly, allocations of the number of booking slots for recalls remained unchanged for some time.

130. When asked whether he had a view as to whether, from January up until 13 July 2017, Peter Warren could or should have done more to accommodate recall bookings for defective Takata airbags, Mr Collins said:[138]

> "…My understandings from our recall team is they [Peter Warren] were responding to requests from us. Whether they could've or should've done more I can't answer because I wasn't involved in the discussions with them. But I understand that they were very open to the issues that we were raising and trying to solve those issues."

[137] Tpt 178.20 to 179.10.
[138] Tpt 504.14 to 504.23.

***Systems in place at Peter Warren and Honda Australia for managing airbag recall bookings***

131. Ms Waterford's telephone service team in Peter Warren's CDC scheduled recalled airbag replacement bookings according to Mr Marciano's allocation of 15 airbags per weekday and 3 airbags per Saturday.[139]

132. In the ordinary course, once Peter Warren received a "case" from Honda Australia, a staff member of Peter Warren's CDC would contact the consumer to arrange to book their vehicle in for the recall replacement to be carried out.[140]

133. Bookings for airbag replacements were also sometimes made by consumers directly with the Peter Warren service department rather than via the CDC telephone service team, including if consumers walked into the service department or contacted the service department directly.[141] Accordingly, each morning the Peter Warren Service Department would send to Peter Warren's CDC an updated recall booking availability schedule so that the telephone operators could provide consumers with the next available date for booking a recall.[142]

134. Once the booking was made, it was entered onto the Salesforce computer system, and the bookings were then able to be viewed not only by relevant staff at Peter Warren's CDC and Service Centre but also by Honda Australia. Accordingly, the length of time between the date a booking was made and the scheduled service date was evident.[143]

135. For the purposes of facilitating calls with consumers whose airbag recall case had been referred by Honda Australia to Peter Warren, staff in the telephone service team at Peter Warren were provided with a "script" for conversations, which was prepared by Ms Waterford and updated from time to time.[144] Ms Waterford recalled that the script, in early 2017, indicated that first available appointments were to be allocated to alpha airbags.[145]

136. According to Ms Waterford, typically, for a vehicle such as Mr Ngo's Vehicle with two or three outstanding recalls, the consumer was advised that the vehicle was

[139] Tpt 70.23, 223.35 to 224.5.
[140] Tpt 56.45 to 59.35, 64.24.
[141] Tpt 174.49, 178.15, 179.42.
[142] Exhibit 1 2/582,584 show the available allocations as at 30 March 2017 and 11 July 2017 respectively.
[143] Tpt 179.30 to 180.7; see also Tpt 507.32 to 507.44.
[144] Tpt 83 to 85.
[145] Tpt 86.30, 91.5. Ms Waterford was unable to locate a copy of the script as utilised as at 30 March 2017, as it had been saved over with amendments that were subsequently made to it: Tpt 85.31.

needed for a full day, whereas, for a vehicle with only one outstanding recall, the consumer was typically quoted that their vehicle was needed for half a day.[146] Mr Marciano's evidence was to the effect that consumers were told that a single airbag replacement required two hours and that four hours was needed for two airbag replacements.[147] He said that the actual airbag replacement could be done in approximately 15 to 20 minutes for a driver's airbag and 30 to 40 minutes for a passenger airbag, which was more complex to replace. However, the booking time advised to consumers was longer than this, given the time taken to carry out administrative and associated tasks as part of the replacement process.[148] Where a vehicle was subject to multiple recalls, including one or two Takata airbag recalls, Peter Warren did not have a practice of splitting the recall work over multiple bookings.[149]

137. Peter Warren personnel could not access information regarding availability of recalled airbag bookings at other Honda dealers, or book in vehicles for recalled airbag replacement with other Honda dealers.[150] However, the Peter Warren telephone team staff were instructed that, if a consumer complained about the delay for an airbag replacement booking with Peter Warren, the CDC could refer the consumer back to the Honda Recall Call Centre.[151]

138. Where such a complaint was made a comment to this effect was to be entered by the Peter Warren staff member into the Salesforce system in accordance with a bulletin that had been issued by Honda Australia.[152] However, the entry of such a comment would only occur if a consumer voiced their dissatisfaction with the delay and there may well have been occasions where a consumer was in fact unhappy about the delay time for a replacement booking but did not express this, in which case there was no comment entered by Peter Warren in Salesforce.[153]

139. In relation to the processes concerning airbag replacement bookings being scheduled by Honda dealers, Honda Australia's National Service General Bulletin No 2016-030073 issued to its dealers stated:[154]

[146] Tpt 155.16, 157.1 to 157.6.
[147] Tpt 211.1 to 212.19.
[148] Tpt 220.31 to 220.50.
[149] Tpt 167.19.
[150] Tpt 110.25 to 111.1.
[151] Tpt 151.5 to 151.22; 180.45.
[152] Tpt 163.41, 195.35 to 195.50.
[153] Tpt 196.33 to 197.8.
[154] Exhibit 1, 2/54/644.

> "5. Dealer to update OneView[155] with the agreed booking date and any other feedback complaints they feel are necessary for Honda to be aware.
>
> 6. When the OneView file is received by Honda the customer will be called to check they are happy with the actions, booking date etc.
>
> 7. Where customers are unhappy Honda will contact the service manager to assess what can be done to resolve the customer's issue.
>
> 8. If the date is a concern and over 3 weeks for metro and 2 weeks for rural dealers they will be asked for an earlier booking date. If not then Honda may refer the customer to another dealer who may be able to carry out the recall in a shorter time."

140. Having regard to this bulletin, Mr Marciano understood that Honda Australia would contact customers once they had booked their vehicle in with Peter Warren to confirm the customer was happy with the timing of the booking.[156] Mr Marciano said that, on occasion, he received a call from Honda Australia, noting that a consumer was not happy about the timing of their replacement booking, and seeing if they could be squeezed in at an earlier time.[157] In addition, Mr Marciano said he could recall a couple of occasions where a customer who had made an airbag replacement booking at Peter Warren was re-allocated by Honda Australia to an alternative Honda dealer who could do the airbag replacement in a shorter time frame for the customer, but Mr Marciano could not recall the specifics.[158]

141. Although Mr Collins was not personally familiar with National Service General Bulletin No 2016-030073, his understanding of the relevant process was that Honda Australia was to try to facilitate a consumer being sent to a different dealer (i.e. with earlier availability) where a concern was raised by a consumer *or* where the consumer faced a delay of more than two or three weeks.[159]

142. Mr Collins said that by October 2016 the number of Honda vehicles subject to Takata airbag recall totalled some 436,000 which represented every Honda vehicle manufactured and sold in Australia over the previous ten years[160] and that as at about 30 March 2017 Ms Chea's wait time of 3 months with Peter Warren was consistent with a number of dealers in Sydney.[161] Mr Collins said that due to

[155] OneView was the precursor to the Salesforce computer system Honda used
[156] Tpt 197.21 to 197.50
[157] Tpt 198.33.
[158] Tpt 188.21 to 190.45.
[159] Tpt 507.21 to 507.30.
[160] Tpt 452.45-50.,
[161] Tpt 547.12-29.

the sheer number of recalls, since late 2016 and throughout 207 prior to Mr Ngo's death, Honda Australia was not monitoring the Salesforce system as part of any rectification rate strategy to redistribute recalled airbag replacement work over various PMAs. [162] As a result, the reallocation of a customer to a different dealer would only occur if the customer raised a concern or complaint about the delay.[163]

143. Though Honda Australia was aware of the three month delay it did not seek to redistribute any of the outstanding bookings to other Honda dealers within nearby PMAs. Mr Collins said that there were a number of Sydney dealerships with the same delay as Peter Warren.[164] Accordingly, it is unclear whether there would have been another dealer with any better availability than Peter Warren even if Honda Australia had sought to reallocate customers to lessen Peter Warren's delay.

144. Under the systems then in place Honda Australia provided advance notice to dealers that a recall was to occur relevant to their PMA, however, these notifications did not indicate the numbers (the quantity) of affected airbags that fell within the dealer's PMA.[165]

145. Mr Marciano gave evidence to the effect that there would have been benefit in Peter Warren receiving advance notice of such numbers to assist it with resourcing and the distribution of consumers.[166] In turn, Mr Collins' evidence was to the effect that it would have been possible for Honda Australia to provide dealers such as Peter Warren with information about the number of vehicles in their PMA.[167]

146. Counsel Assisting has suggested a recommendation that Honda Australia, if it has not already done so, implement a system whereby Honda dealers are given notice of the numbers of consumers in their PMA that are to be affected by a recall to be announced by Honda Australia (and particularly recalls affecting high volumes of vehicles). Both the ACCC and DIRD support this recommendation. Honda accepts the recommendation and submits it should be extended industry wide. The FCAI is prepared to consider the issue when it undertakes its review of the FCAI Code of Practice. I agree that it is desirable that such a recommendation be made and accordingly I recommend to Honda Australia that, if it has not already done so, implement a system whereby Honda dealers are given notice of the numbers of

[162] Tpt 508.4-.47.
[163] Tpt 507.15-.30; Tpt 508.4-.14; see also, Tpt 531.27-.39.
[164] Tpt.547.20
[165] Tpt 183.31; Tpt 546.7.
[166] Tpt 183.35 to 183.43.
[167] Tpt 546.25.

consumers in their PMA that are to be affected by a recall to be announced by Honda Australia (and particularly recalls affecting high volumes of vehicles).

147. Prior to 11 July 2017, the script used by the Peter Warren CDC telephone operators did not contain any text to explain to the consumer why Takata airbags were being replaced, or the risk posed by Takata airbags. Ms Waterford said this was because Peter Warren understood that Honda Australia would have already provided that information to the consumer when they were advised that they needed to bring the vehicle in for airbag replacement.[168] Though that is a reasonable explanation, (noting, however, that Ms Chea did not herself receive such information when she called the HARCC) given the 3 ½ month booking delay it may well have been untenable for a Peter Warren CDC telephone operator to advise a consumer about the risk the airbag posed and expect the consumer to be satisfied with such a long delay.

148. Ms Waterford said that at the time of the inquest the script used by the Peter Warren CDC telephone operators had been changed to inform consumers of the importance of keeping their appointment due to the serious risk of injury if the airbag deploys.[169] Referring to the risk in the context of advising the consumer of the importance of keeping the appointment is an improvement to reduce the number of "no-shows" which in turn improves the rectification rate and reduces the delay.

***Airbag replacement booking made with Peter Warren on 30 March 2017 for 11 July 2017***

149. The Salesforce log shows that the Honda Australia Recall Centre created Ms Chea's case at 10.55 am[170] and sent an email to Peter Warren requesting "please book customer" "Priority High" at 10:56 am on 30 March 2017[171]. A phone log produced by Peter Warren indicates that, at 12.01pm on 30 March 2017, its telephone service team received an inbound call in relation to Ms Chea's Vehicle and booked it in for 7.30 am 11 July 2017.[172]

150. Ms Chea (or a family member) may have phoned Peter Warren, rather than waiting for them to call her (as instructed by the HARCC operator), but I think it more likely

[168] Tpt 93.27 to 93.36
[169] Tpt 146.5 to 146.22, 164.48 to 165.20.
[170] Ex 1 3/55/750.
[171] Ex 1 2/54A/731-1.
[172] Exhibit 1, 2/50/583. See also Tpt 104.26, 106.17.

that, as suggested by Ms Waterford, a member of the telephone team, upon receiving the email, called Ms Chea and as was their practice upon the phone not being answered left a message and Ms Chea returned their call soon after. Peter Warren does not have an audio recording or other file note of Ms Chea's call.[173]

151. An SMS log shows that at 12:00 Peter Warren sent an SMS to Ms Chea's mobile phone number confirming the booking for 7.30am on 11 July 2017 at 1 Todman Rd Warwick Farm.[174] Neither the SMS, nor the Honda Australia Recall Call Centre operator, advised how long the replacement service was likely to take but Ms Waterford said that if the recall involved 2 or 3 (recalls) a full day would be quoted (to the customer).[175]

152. As at 30 March 2017, the earliest available date for a recall booking at Peter Warren was 27 June 2017, with one booking available on that day.[176] The earliest date on which two booking slots (for the two airbags in the Vehicle) were available was 29 June 2017 and there were five booking slots available on 11 July 2017.[177]

153. As at 30 March 2017, the 5ZV recall was not identified by Honda Australia as relating to the alpha category of inflators that Peter Warren and other Honda dealers had, at that time, been asked by Honda Australia to treat with priority.[178] Ms Waterford said that for vehicles with a recall code indicating the presence of a beta airbag rather than an alpha airbag (as was Ms Chea's vehicle), "we would probably offer a booking lower down the date range available" given that alpha airbags were given priority.[179] Mr Marciano's evidence was to similar effect.[180]

154. The precise day that was offered to any given consumer for a recall booking was a matter left to the judgement of the particular telephone service operator within Ms Waterford's team.[181] Having regard to this practice, Ms Waterford considered that it was likely to be the case that, on 30 March 2017, the first available booking date offered to consumers with beta airbags was 11 July 2017.[182] Ms Chea's vehicle was subject to three recalls – being the two airbags and an earlier recall

[173] Exhibit 1, 2/51/587; Tpt 91.46 to 91.50.
[174] Statement of C Waterford 22 November 2018, Exhibit 1, 2/51/588-595.
[175] Tpt 109.48, 155.21.
[176] Statement of C Waterford 8 August 2018, at [25], Annexure C, Exhibit 1, 2/50/577, 582; Tpt 73.22.
[177] Tpt 83.5.
[178] Peter Warren had received a bulletin from Honda Australia in February 2017 identifying the recall codes for "alpha" inflators, and the list did not specify either the 5ZV or 6CA recalls: Tpt 81.28, 331.15 to .21; Exhibit 1, 1/54/690.
[179] Tpt 73.35 to 74.47.
[180] Tpt 210.37.
[181] Tpt 82.29.
[182] Tpt 83.15.

for a child seat anchor point. On the basis of three recall slots being required and the fact that the airbags were not an alpha airbag, the vehicle was booked on the earliest date available as at 30 March 2017. It is highly regrettable that the earlier date to have the airbags replaced was lost due to a child anchor restraint inspection which the Ngo family apparently did not require.

155. It seems that criteria not factored into the booking priority process were the delay between the initiation of the recall and the consumer response to it. The booking date was one day after the second anniversary of Honda Australia's notification to the ACCC and DIRD that they were going to conduct the 5ZV recall. On Honda Australia's account, the 5ZV recall letter sent in March 2017 was the 5th recall letter sent to Ms Chea. A customer making first contact at that point in the recall could have, had a system been in place, warranted a priority replacement booking.

156. Mr Collins accepted that the delay of some three and a half months between Ms Chea contacting the HARRC on 30 March 2017 and the scheduled booking date of 11 July 2017 was too long.[183] Though Honda Australia continually engaged with Peter Warren to improve rectification rates, Honda Australia's apparent acceptance of a three month delay visible through Salesforce may have effectively indicated to Peter Warren that this was an acceptable delay. Consistent with Honda Australia's National Service General Bulletin No 2016-030073 Honda Australia should have been monitoring the booking delays and accordingly, should have attempted to secure an earlier booking with Peter Warren or another Honda dealer for the replacement of the defective Takata airbags well before 11 July 2017.

157. It is regrettable that, as at March 2017, Honda Australia had ceased monitoring the delays through its Salesforce system and only took steps to re-allocate consumers facing delays of this length to other dealers where the customer made a complaint. Had Ms Chea (or a member of her family) voiced complaints about the delay of the planned replacement of the defective airbag it is likely that it could have happened sooner than what was scheduled.

158. Mr Collins advised that Honda Australia now monitors the dealer delays on a weekly basis and there are now formal processes in place to rectify the wait time at a particular dealer irrespective of whether a consumer raises a complaint.[184] Mr

[183] Tpt 503.10 to 503.25. Mr Collins said, in this context, that there was no parts shortage at that point in time: Tpt 503.31 to 503.50.
[184] Tpt 508.35 to 508.50, 530.25 to 531.37.

Collins said that "our desire was always to do them [ie, airbag replacements] as soon as possible and not delay…and I think the lesson that we've learned that we've implemented for some time now is the need for us, essentially, to micro-manage dealer by dealer and that's what we now do".[185] Mr Collins said that his understanding was that there were no longer any unreasonable delays in rectifications being conducted.[186]

***Events on 10 July 2017***

159. On the evening of 10 July 2017 a member of the Peter Warren service team printed out a repair order from the dealer management system, which recorded the work required to be undertaken on Ms Chea's Vehicle the following day.[187] As shown by the repair order, the repairs that were to be carried out on the Vehicle on 11 July 2017 were the replacement of the driver's airbag inflator pursuant to Bulletin 2015-09-101, the passenger airbag inflator pursuant to Bulletin 2016-08-068 and the anchorage point inspection pursuant to Bulletin 2012-06-018. The repair order was pre-populated so as to read "Time Received" as 7.30am and "Date & Time promised" as "11/07/2017 04.45pm".

160. Although the usual practice of the Peter Warren Honda service department was to send a reminder to customers on the day before the booking,[188] Peter Warren's IT department was unable to identify records indicating that such a reminder SMS was sent to Ms Chea on 10 July 2017.[189] Ms Waterford accepted that no such reminder SMS was sent, and that such a message should have been sent.[190] Whilst the SMS should have been sent, it was without consequence, as Ms Chea had not forgotten about the appointment. On the evening of 10 July 2017 she had arranged with daughter Julie to take the car in for the booking.

***Cancellation of airbag replacement booking for Vehicle on 11 July 2017***

161. On the morning of 11 July 2017, Julie who seems to have thought that the booking was for 8.00am, (rather than 7.30am as reflected on the repair order and in the

[185] Tpt 530.25. Mr Collins later clarified that, in giving this evidence, he was referring to conducting dealer-by-dealer analysis of booking times, to enable Honda Australia to take steps to fit customers in earlier with an alternative dealer: Tpt 551.11 to 551.33.
[186] Tpt 531.16.
[187] Exhibit 1, 2/53/618.
[188] Statement of C Waterford 8 August 2018 at [18], Exhibit 2/51/589; Tpt 135.25 to 135.38; Tpt 136.46. See also Tpt 253, where Mr Marciano explained that the SMSs needed to be batch sent, manually, by the service clerk.
[189] Statement of C Waterford 22 November 2018, Exhibit 1, 2/51/589; Tpt 110.16.
[190] Tpt 136.35-137.7.

booking confirmation SMS sent to Ms Chea on 30 March 2017) overslept and went straight to work thinking that she would take the car in a little late.[191]

162. At approximately 10.11am Julie phoned Peter Warren from work. The call was answered by a CDC telephone operator. It lasted 6 minutes and 40 seconds.[192] The telephone operator was, according to Ms Waterford, an experienced operator who, by the time she left in January 2018, had worked within the telephone team for about two years.[193] Peter Warren has no contemporaneous record of what was said in the phone call and there is no audio recording of the call.[194]

163. There is a telephone log record, which shows that Julie Ngo was placed on hold for a total period of 3 minutes and 30 seconds in the course of the call.[195] The phone records do not identify, however, the point in time during the call when she was placed on hold, or whether there was a single hold period or multiple hold periods.[196] Ms Waterford considered it to be likely that, during this hold period, the telephone operator was contacting the Peter Warren Honda service department to ascertain availability to service the Vehicle that day.[197] However, as any such internal calls are not displayed on the available phone log,[198] it is not possible to conclude with any certainty whether, during the hold period, the telephone operator in fact sought to contact, or spoke with, the Peter Warren service department. In this respect, at least part of the hold period might have been attributable to the telephone operator seeking to check available future booking times before offering Julie Ngo another booking date.[199]

164. Following the call, the telephone operator sent an email to the Peter Warren service department rebooking the Vehicle for service on 5 October 2017.[200] At the same time, she recorded in the telephone log that an inbound call had been received in relation to the Vehicle.[201]

165. According to information obtained by Senior Constable Racker from Julie Ngo in the course of the coronial investigation, Julie Ngo placed a call to Peter Warren at about 10am on 11 July 2017 to ask whether she could bring the Vehicle in late and

[191] ERISP Transcript, Julie Ngo, 16 November 2017, pp 6-7, Exhibit 1, 1/13/117-118.
[192] Ex 1, 2/51A/595-3, 595-9; see also Tpt 49-50; Tpt 118.40 to 119.29.
[193] Tpt 122.7, Ex 1 2/50/578.
[194] Tpt 95.49 to 96.4.
[195] Tpt 119.32; Ex 1, 2/51A/595-9.
[196] Tpt 119.34 to 120.5.
[197] Tpt 120.8.
[198] Tpt 115.41 to 116.7.
[199] Tpt 123.44 to 123.50.
[200] Exhibit 1, 2/51A/595-6; Tpt 117.23 to 118.26.
[201] Exhibit 1, 2/51A/595-10.

she was told a new booking was needed, with next availability on 5 October 2017.[202] Julie Ngo told Senior Constable Racker that she raised the Recall Letter during the call to Peter Warren, but that the potential consequences of not replacing the airbag immediately were not explained to her.[203] A record of interview with Julie Ngo records her stating, in respect of the call placed to Peter Warren:[204]

> "… I just wanted to, yeah, express that she didn't even think twice about the booking. … She, uh, I called her up saying that it's late, a 2 hour late appointment … She just said [n]o, um, without hesitation, without checking with the service team … whether we can bring it in or not. … She just said, "no" the next availability is the 5th of October", and I felt like I couldn't do anything about it."

166. Ms Waterford agreed that she had no record that would dispute Julie Ngo's account that the telephone operator cancelled the booking for the Vehicle without first checking with the service team.[205] However, Ms Waterford's evidence was that the usual practice, where people contacted the telephone service team at Peter Warren if they were running late for a scheduled appointment, was for the operator to place the customer on hold and for the operator to ascertain from the service department staff whether the recall could still be completed on that day.[206] Mr Marciano's evidence was to similar effect.[207] If the relevant vehicle could not be accommodated on the particular day, there was a process of rebooking the vehicle for the first available date or an available date of their choice thereafter.[208]

167. Julie's account to Senior Constable Racker was given to him nearly five months after she had made the telephone call. Whilst she did not refer to being placed on hold for over three minutes she did detail that she told the telephone operator that she still wanted to bring the car in and she asked if she could "bring the car in to fix some parts first and then the rest of the parts on the 5th of October" and she was told "no it's a whole, it takes a whole day to service the car". It may well be that the telephone operator, on learning how many recalls the Vehicle was subject to and how late the car was, did tell Julie straight away that there was insufficient time left in the day to bring the car in.

168. However, the telephone log shows that there was a total hold period of 3 ½ minutes during the call, which is consistent with the time it may have taken the telephone

[202] ERISP Transcript, Julie Ngo, 16 November 2017, p 7, Exhibit 1, 1/13/118.
[203] ERISP Transcript, Julie Ngo, 16 November 2017, p 8, Exhibit 1, 1/13/119.
[204] ERISP Transcript, Julie Ngo, 16 November 2017, pp 8-9, Exhibit 1, 1/13/119-120.
[205] Tpt 152.29 to 152.35.
[206] Tpt 95.7 to 95.21, 157.42 to 158.1.
[207] Tpt 237.5.
[208] Statement of C Waterford 8 August 2018 at [29], Exhibit 1, 2/50/578; Tpt 95.33 to .34.

operator to contact the service department and it is possible she did so without Julie realising that she was doing so.

169. Julie Ngo told Senior Constable Racker that she had not read the recall letters sent to her mother and that the telephone operator did not explain to her in detail what were "the consequences … if we … don't get it serviced".[209]

170. Ms Waterford's evidence was that, in a case where a person called to rebook their Takata airbag replacement to a later date, the caller *should* have been told by the telephone operator that it was "important to have the vehicle fixed because there was a strong risk the airbag could deploy and cause injury".[210]

171. However, in respect of the call placed by Julie Ngo to Peter Warren on 11 July 2017, Ms Waterford did not know whether such a warning was given.[211] Indeed Ms Waterford accepted that a warning of that kind most likely would not have been given to a person who had called asking to bring their vehicle in late but who had been told that they could not do so and that the earliest available date was over 3 months away.[212]

172. Julie made it clear to the telephone operator that she was opposed to having the replacement deferred and in those circumstances the operator would not have, and I find, did not, provide Julie with information about the risks the airbags posed.

***Peter Warren's capacity to perform airbag replacement service after 10.30 am on 11 July 2017***

173. On 11 July 2017, 37 vehicles[213] were booked into Peter Warren's Honda service department. Of these 37 vehicles, 12 were booked in for service only and did not require airbag replacements. Of the 25 vehicles requiring airbag replacements three vehicles also had a service offer.[214] The 22 vehicles booked in for just the recall airbag replacement without a service offer required a total of 33 airbags to be replaced. There is no evidence of how many airbag replacement bookings came through the CDC but I note that Mr Marciano said he allowed for the CDC to make 15 recall airbag replacement only bookings per week day. Noting that bookings for airbag replacements could also be made directly through Peter Warren's Honda service department, it could be that half of the bookings for that

[209] ERISP Transcript, Julie Ngo, 16 November 2017, p 8, Exhibit 1, 1/13/119.
[210] Exhibit 1, 2/51A/595-4; Tpt 93.7.
[211] Tpt 92.25 to 94.6.
[212] Tpt 96.31 to 97.1.
[213] Tpt 232.20, see also Exhibit 1, 2/53A/621-621-46.
[214] Tpt 228 to 231.

day were made via that mechanism. Whether that amounted to an "overbooking" of airbag replacements is unclear. Mr Marciano gave evidence that "we would overbook with the anticipation of a number of no shows".[215] He did not indicate the extent of the overbookings.

174. Indeed, on 11 July 2017, half of the 22 vehicles booked in for recall airbag replacements only, did not arrive. All but two of those vehicles required both airbags to be replaced and three of them had allocated time to carry out the inspection recall of the child restraint anchorage point.[216] This accounted for 20 airbag replacement time allocations.

175. All the 37 vehicles were booked in between 7.30am and 10am, other than one customer who brought their vehicle in at 12.14pm that day to be repaired for a first 1000 km service.[217] Each of the airbag replacement vehicles (which included Ms Chea's vehicle) had been booked in for 9.30am or earlier. Given the number of "no shows", as at 10am on 11 July 2017, Peter Warren's Honda service department may be thought to have had sufficient time for replacing the two airbags and inspecting the child restraint anchorage point in Ms Chea's vehicle.

176. On the predicate of the service department having been contacted by the telephone service team at about 10 or 10.30am on 11 July 2017 asking if a customer running late could still bring in their car, Mr Marciano said that, given the number of no-shows that day, "I would have to assume that, yes, we would have been able to do the repair".[218] Mr Marciano also agreed that, between 10am and 10.30am on 11 July 2017, the service department at Peter Warren would have been in a position to know whether or not they had capacity to carry out the repair.[219]

177. At a later point, however, Mr Marciano gave evidence that the four mechanics working in the Honda service department at Peter Warren on 11 July 2017 each completed work well past the end of their shift, so that, as things transpired, they did not have any work hours available or unoccupied on 11 July 2017.[220]

178. In his statement Mr Marciano[221] advised that in July 2017 the Peter Warren Honda service department employed seven licenced mechanics (one of whom was the

[215] Tpt 251.49.
[216] Exhibit 1, 2/53/614 at [9]; Tpt 233 to 235. Ex 1 2/53A/621-4 to 621-46.
[217] Tpt 232.36, 234.45 to 234.49.
[218] Tpt 238.5.
[219] Tpt 238.25.
[220] Tpt 288.
[221] Exhibit 1 2/53B/621-48.

workshop foreman), two apprentices (neither of whom were qualified to carry out airbag replacements) and two service advisers (one of whom was also a licenced mechanic). In total, there were 8 licenced mechanics. However, on 11 July 2017, four of the mechanics (including the foreman) were absent so the remaining three mechanics were assisted by the service adviser who carried out 5 airbag replacements. I note that the foreman and the first year apprentice (who could have assisted with the vehicles being serviced) were on annual leave and one mechanic was attending a Honda Technical training workshop in Auburn. Regrettably one mechanic was on workers compensation leave and another was on sick leave, events that would not have been foreseen three months previously when the airbag recall bookings were made.

179. There is no difficulty in inferring that, in those circumstances, if a telephone operator from the Peter Warren CDC had contacted the Peter Warren Honda service department at about 10.15 am on 11 July 2017 to see if there was capacity to take a late vehicle for a recall involving 2 airbags and checking the child restraint anchorage point, the operator would in all likelihood have been told, "no". If the CDC telephone operator had not contacted the service centre, it may have been because the operator, by the time Julie Ngo had called, was aware of the lack of capacity at the service centre that day.

180. Whether or not Julie Ngo ought to have been told to bring the vehicle in, even though it was late, Mr Marciano said that, had a customer running late for their appointment physically arrived at Peter Warren on 11 July 2017 at around 11am seeking an airbag replacement, the repair would have been carried out and the customer would not have been turned away; "we would have done the recall";[222] "if the vehicle turns up with an airbag recall it's always been our policy to not allow the car to leave without the recall being done".[223] Tragically, Julie Ngo could not have known that to be the case.[224]

181. Notwithstanding the reduction in staffing capacity at the Peter Warren Honda Service Centre on 11 July 2017, with a view to attempting to conduct the airbag replacement service as promptly as possible, Peter Warren should have advised Julie to bring the vehicle in that day. The vehicle was 10 years old, which by then, was known to be a significant factor in the degradation of propellant and thus risk of an abnormal deployment. The recall campaign for the driver's side airbag had,

[222] Tpt 235.35 to 236.28.
[223] Tpt 238.10.
[224] See Tpt 285.7.

as at 11 July 2017, been ongoing for 2 years. There had been a delay of 3 months for the booking and if postponed it would be a further delay of another 3 months. The recall campaign was experiencing significant "no shows" but Julie Ngo was a customer who was willing and able to bring the vehicle in by about 10.30 am on a day that the service department was relieved of replacing the other 18 airbags for the vehicles which also had not attended.

***Peter Warren's increase in Takata airbag replacement capacity after 13 July 2017***

182. Shortly after Mr Ngo's death, a meeting was held between members of the Honda Australia recall team and Peter Warren's management to identify ways in which as many outstanding recalls could be completed as quickly as possible.[225]

183. Following this, an agreement was reached between Peter Warren and Honda Australia resulting in the creation of a "recall team" within Peter Warren consisting of four mechanics drawn from other Peter Warren (non-Honda) service departments who were dedicated to managing the airbag recalls for Honda vehicles.[226] This recall team was provided with a dedicated workshop area in a different part of the Peter Warren premises in which to carry out airbag replacement work.[227] That area had been the facility temporarily occupied by the Honda Service team whilst renovations were undertaken. The team occupied four of the six bays. [228] The creation of this recall team had the consequence that the number of bookings taken by Peter Warren for Honda airbag recalls increased significantly, ultimately to 75 bookings per weekday and 15 bookings per Saturday.[229]

184. The Peter Warren dedicated Honda recall team commenced on 8 August 2017 and by the end of November 2017 any delay between booking date and replacement date was reduced to about 1 week.[230] The recall team was then dismantled and since that time Peter Warren has continued to manage the volume of recall vehicles maintaining a delay of less than a week.[231]

185. According to Mr Marciano, as at the time he gave evidence at the inquest, a vehicle

[225] Tpt 247.41 to 248.8.
[226] Tpt 270.1 to 270.13.
[227] Tpt 100.32 to 101.32, 250.25 to 251.13. Mr Marciano explained that this area was previously occupied by the Honda service department, while the Honda service workshop area was being renovated, so that prior to mid-2017 it could not have been used to provide a dedicated recall area: Tpt 289.37.
[228] Tpt 289.6-32
[229] Exhibit 1, 2/53B/621-49 at [12].
[230] Tpt 201.33.
[231] Tpt 270.24.

could be booked in at Peter Warren for replacement of its airbag inflators within a single business day, or, for vehicles categorised as "critical", generally on the same day that the customer makes contact.[232]

186. Counsel Assisting raise that Peter Warren could have taken steps to implement measures prior to 13 July 2017 to ensure rectification of vehicles with minimal delay. Peter Warren's response to those submissions was to highlight the lack of capacity due to the difficulties related to franchise obligations, workspace and staff levels to deal with the large number of vehicles subject to recall.

187. There has been no explanation as to why steps were not taken or why a programme was not put in place in anticipation that the Honda service department was moving from the temporary facility back to a refurbished and enlarged workshop. The delay in engaging additional mechanics to occupy the nine bays suggests that insufficient regard was given to reducing the recall delay. There is no evidence suggesting that Honda Australia or Peter Warren had given consideration, prior to Mr Ngo's death, to using the soon-to-be vacated temporary workshop as a dedicated recall facility. There is no evidence from Peter Warren that the mechanics seconded from other service departments were not available from mid-May 2017.

188. That such an arrangement could be put in place within three weeks of Mr Ngo's death suggests that if there was the will to address the delay earlier Peter Warren and Honda Australia would have found a way to do so.[233] However, there was no evidence at the inquest as to why such planning had not been implemented and there was no evidence to indicate that upon the establishment of the recall team pre-existing bookings were brought forward so that their airbags were replaced sooner. Accordingly, it is unclear whether Ms Chea's booking for 11 July 2017 would have been changed to an earlier date had such a recall team been put in place by Peter Warren around mid-May 2017 and before 11 July 2017.

***Conclusion on Issue #3***

189. The arrangements for the replacement of the airbags in the Vehicle should have involved a booking slot at a time earlier than 3 ½ months of Ms Chea's phone call. Honda Australia should have continued to monitor Salesforce and had they done so, should have attempted to reallocate Ms Chea's booking to another dealer with

[232] Statement of V Marciano, 16 November 2018, Exhibit 1, 2/53/616; Tpt 256.40.
[233] Tpt 252.18-.22; Tpt 504.14-.23.

earlier available booking slots. By failing to do so Honda Australia effectively indicated to dealers that a delay of about 3 months was reasonable in the circumstances. The consequence of this tolerance may have impacted on Peter Warren running its refurbished Honda Service Centre below maximum staffing capacity until shortly after Mr Ngo's death.

190. On 11 July 2017 Peter Warren should have been in a position to accommodate and therefore should have accommodated Julie's request to bring the vehicle in despite being three hours late. As at July 2017, given the completion of the refurbished service department facilities three months earlier, Peter Warren should have been fully operational with more staff to complete the replacement of recalled airbags.

## K. Honda Australia's 5ZV recall and recall correspondence with Ms Chea (Issue # 4)

191. At the time of Mr Ngo's death, the Vehicle was relevantly subject to two voluntary recalls that had been notified by Honda Australia as further described below: (i) the 5ZV recall for the driver's side airbag; and (ii) the 6CA recall for the passenger's airbag.[234] The process by which these recalls were implemented by Honda Australia is outlined below.

### *Approach taken by Honda Australia to initiating Takata airbag recalls prior to July 2017*

192. Mr Collins' evidence was to the effect that, from 2009 onwards, Honda Australia acted on instructions and information from Honda Japan as to which vehicles containing Takata airbags were to be recalled.[235] The advice to recall a particular group of vehicles would be sent from Honda Japan to the technical manager/service manager of Honda Australia.[236] The advice ordinarily included a short description of the defect, a list of the models affected and repair instructions.[237] Honda Japan also provided Honda Australia with technical bulletins indicating how Honda dealers were to action a repair for a particular recall, which Honda Australia in turn provided to its dealer network.[238]

193. On 30 July 2009[239] Honda Japan sent its first Takata airbag recall advice called

[234] Exhibit 1, 3/55/732 at [9].(The recall relating to inspection of the child restraint anchor was a 2012 recall)
[235] Tpt 340.4 to 340.20; 355.2
[236] Tpt 356.24 to 356.38.
[237] Tpt 342.22. Ex 1 5/58/1468-1469.
[238] Tpt 343.1 to 343.33.
[239] Tpt 354.27; Exhibit 1, 5/58/1272 at [17].

"Recall Information" to Honda Australia which involved about 1,323 Honda Accords manufactured in 2001 and 2002[240].[241] The information from Honda Japan in relation to that first recall (given code 5SZ) described the defect as follows:

> "At the time of driver side airbag (module) deployment, the inflator body is rupturing due to excessive internal pressure created by propellant explosion. It may cause metal fragments to tear through the airbag cushion material". On the second page of the Recall information is a diagram labelled "Inflator Body" with an arrow and words "This part is rupturing".[242]

194. Honda Japan also provided a Question and Answer sheet with the notification which indicated that "it is thought that the problem occurs due to aging deterioration[243] and it indicated that the possible consequence of metal fragments passing through the airbag cushion material was "causing injury to vehicle occupants"[244]. A question about whether there had been any injuries or fatalities and how many was accompanied by the answer "A few injuries have occurred and one fatality is linked to the recalled part. I'm sorry but we can't get into any detail about those injuries or fatality".[245]

195. Various further Honda models with defective Takata airbags were progressively recalled by Honda Australia leading up to 2017, with each group of vehicles recalled being given a different recall campaign code.[246] The 5ZV recall, notified on 10 July 2015, was the tenth recall campaign[247] and the 6CA recall (for the passenger airbag) notified on 9 June 2016 was the thirteenth Takata airbag recall by Honda Australia[248].

196. Honda Australia was not itself involved, from 2009 to 2017 (nor since[249]) in any investigations into which vehicles not already earmarked for recall by Honda Japan posed a risk due to their Takata airbags and Mr Collins said that Honda Australia did not and does not have the technical capability to conduct such investigations; its role was to be an importer, seller and marketer of Honda vehicles in Australia.[250] Honda Australia relied solely on the information provided by the investigations

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[240] Exhibit 1, 5/59/1272 at [17], see also 5/59-3/1311-2.
[241] Tpt 354.27; Exhibit 1, 5/58/1272 at [17].
[242] Exhibit 1, 5/58-3/1311; Tpt 356 to 357.
[243] Exhibit 1,5/58/1313 qu.2.
[244]Exhibit 1,5/58/1313 qu.1.
[245]Exhibit 1,5/58/1313 qu.3.
[246] Exhibit 1, 5/58/1272 to 1275; Tpt 357.
[247] Exhibit 1, 5/58/1275 at [52]; Tpt 359.4.
[248] Tpt 359.45-50.
[249] Tpt 365.48.
[250] Tpt 365.40 to 366.38.

conducted by Honda Japan.[251] Honda Australia did not make any decisions about which Honda vehicles containing Takata airbag inflators would be recalled nor did Honda Australia initiate any recalls of its own volition, independently of those made by Honda Japan.[252]

197. Mr Collins could not explain why it was the case that different Honda models with Takata airbags were recalled at different times by Honda Japan, and said that Honda Australia was "not privy to the decision making that happens in … Japan in terms of actioning recalls".[253]

198. Although Honda Australia did not itself conduct technical investigations into Takata airbags, Mr Collins agreed that, by July 2015, there was an accumulated body of learning within Honda (including Honda Australia) to the effect that, for vehicles with defective Takata airbags, the inflator body could be subject to excessive internal pressure and rupture which could cause metal fragments to tear through the airbag cushion material.[254] By this time, there had been a number of deaths overseas attributable to such misdeployments of Takata airbags in Honda (and other brand) motor vehicles, which Honda Australia had learned about through communications from its regional office, Asian Honda Motor Company Ltd based in Bangkok, Thailand.[255]

199. Honda Australia was guided in the implementation of its Takata airbag-related recalls, including the 5ZV recall, by various internal documents, including a recall checklist and later, from May 2016 a Standard Operating Procedure for recalls (**SOP**).[256] The SOP drew upon the FCAI Code of Practice for Voluntary Recalls (**FCAI Code**) which Honda Australia, as a member of the FCAI, had adopted.[257] A record of Honda Australia's implementation of the recall is contained in a document "AUH Recall Processing Check Sheet' which Mr Collins, in his statement of 12 November 2018 identifies as the "Recall Check" Sheet which he states is updated over time to confirm the date the tasks were completed and by whom at Honda Australia.[258]

200. Mr Collins agreed that the objectives of Honda Australia when conducting its

[251] Tpt 366.8.
[252] Tpt 341.50 to 342.5.
[253] Tpt 341.9 to 341.21.
[254] Tpt 359.
[255] Tpt 365.17; 365.30.
[256] Exhibit 1, 3/55/734 at [22]; and 775-781 (1 May 2015 SOP version 001), 768-774 (1 December 2016 SOP,version 002) 782-768 SOP version 0030, Tpt 367.15-368.37.
[257] Exhibit 1, 3/55/734 at [23]; Tpt 368.40, Tpt 376.17.
[258] Exhibit 1 5/59/1277 and Ex 1 5/58.55/1560.

voluntary recalls, including the 5ZV recall, were aligned to the objectives outlined in the FCAI Code, which included undertaking a recall service as soon as possible, informing the relevant authorities/regulators, informing customers and the public and preventing the distribution and sale of a product until completion of the recall service.[259]

201. Mr Collins agreed that the defect the subject of each of the 5ZV recall and 6CA recall was one that required urgent rectification.[260] He also agreed that the FCAI Code did not prevent Honda Australia from implementing additional procedures in conducting a voluntary recall beyond those set out in the Code.[261]

***Steps taken by Honda Australia to implement the 5ZV recall***

Notification to the ACCC and DIRD

202. On 9 July 2015 Honda Japan notified Honda Australia of the 5ZV recall.[262] Honda Australia commenced the 5ZV recall in Australia upon the basis of the advice received from Honda Japan to do so.[263]

203. The recall information from Honda Japan referred to a range of VIN numbers for 2007 model CR-Vs, which included the VIN number of Ms Chea's Vehicle.[264] The recall affected 91,934 vehicles[265], which was significantly greater than the number of vehicles that had been affected by Honda's previous nine airbag recall campaigns in Australia.[266] According to Mr Collins, the number of vehicles affected by the 5ZV recall was "totally unprecedented".[267]

204. On 10 July 2015 Honda Australia notified both the ACCC and DIRD of recall 5ZV; (which is dealt with in detail below).[268] Notification of this kind, as regards commencement of a voluntary recall, was a requirement of s 128 of the ACL, and the notification was given to the regulators within the two-day period consistent with the FCAI Code.[269]

205. The language in the notification that Honda Australia provided to the ACCC and

[259] Tpt 373.6 to 374.30.
[260] Tpt 381.29.
[261] Tpt 376.43.
[262] Exhibit 1, 3/55/733 and 761.
[263] Tpt 378.4.
[264] Tpt 361.47.
[265] The original number was 92,274 but later revised to 91,934.
[266] Tpt 416.35.
[267] Tpt 418.18.
[268] Exhibit 1, 5/56/1561 to 1566.
[269] Tpt 375.110 to 375.33.

DIRD for the 5ZV recall generally reflected the language used in the notification provided to Honda Australia by Honda Japan, consistently with what Mr Collins said was Honda Australia's usual process at the time.[270] In particular, and notably, the notifications to the ACCC and DIRD were couched in similar tentative language as that used in the notification from Honda Japan as regards the 5ZV recall, in that they referred to a "potential defect" and "precautionary measure" and notably did not refer to the prospect of the airbag inflator rupturing or causing metal fragments to tear through the airbag cushion (see further below).

206. Counsel Assisting submit that Honda Australia should have clearly identified in its correspondence to the ACCC and DIRD notifying them of the 5ZV recall that the risk to be addressed by the recall involved the potential rupturing of the inflator and the fact that metal fragments could tear through the airbag cushion upon misdeployment.[271]

207. In support of this submission, Counsel Assisting put forward that in his evidence, "Mr Collins agreed that information of this kind could have been included,[272] and that he knew at the time that the metal part of the inflator could rupture.[273] In this regard, although Mr Collins' evidence was that Honda Australia's process was to "replicate" what Honda Australia had been told by Honda Japan, it does appear that Honda Australia has exercised some judgement in terms of the language used in recall notifications to the Australian regulators."[274] This issue is dealt with in greater length below with other submissions related to findings as regards Honda Australia.

<u>Recall correspondence sent to Ms Chea</u>

208. After notifying the ACCC and DIRD of the commencement of the 5ZV recall, Honda Australia commenced to communicate with consumers affected by the 5ZV recall. The strategy adopted by Honda Australia to notify consumers of the recalls (including the 5ZV recall), prior to Mr Ngo's death, was limited to direct communications with consumers by way of recall notification letters. These letters were to be sent by post to addresses that were stored in National Exchange of

[270] Tpt 402.1 to 403.5, .41.
[271] Mr Collins agreed that Honda Australia could have "easily put more information" into the notification letter to the regulators: Tpt 403.48; 408.38-409.49.
[272] Tpt 411.35.
[273] Tpt 565.20-.38.
[274] There was some evidence that communications by Honda Australia to DIRD about prior recalls did not precisely mirror the language provided in the notification received from Honda Japan, and were expressed in more moderate terms than the notification that Honda Japan had provided: Tpt 556 to 557, 558.27, related to the 5SZ recall.

Vehicle and Driver Information System (**NEVDIS**) data made available to Honda Australia, or to addresses that were otherwise stored in Honda's customer databases.[275]

209. In respect of the Vehicle in which Mr Ngo was killed, Honda Australia indicated that, prior to 13 July 2017, it had arranged to send to Ms Chea five separate recall notification letters, being letters said to have been dated and sent as follows:[276]

    a. 18 November 2015 (sent by standard mail, for the 5ZV recall);[277]

    b. 19 May 2016 (sent by standard mail, for the 5ZV recall);[278]

    c. 20 October 2016 (sent by registered mail, for the 5ZV recall);[279]

    d. 7 March 2017 (sent by standard mail, for the 6CA recall);[280]

    e. 15 March 2017 (sent by registered mail, for the 5ZV recall).[281]

210. In an interview with Senior Constable Racker, Ms Chea said that she recalled seeing only one recall notice, which had prompted her to book the car in for a replacement service – which she did on 30 March 2017. (Presumably Ms Chea was referring to having seen either or both of the notices dated 7 and 15 March 2017).[282] Ms Chea's daughter, Julie Ngo – with whom Ms Chea resided – told the Officer in Charge that she had seen only recall correspondence dated 7 and 15 March 2017[283] and that "we never received" other recall correspondence.[284]

211. Thus, there is an issue as to whether the Ngo/Chea family received recall correspondence dated 18 November 2015, 19 May 2016 and 20 October 2016 (or thereabouts), as claimed to have been sent by Honda Australia. In respect of that issue, the inquest received evidence which included the following:

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[275] Tpt 381; 453.36.
[276] See Tpt 398.
[277] A so-called "replica copy" of which is at Exhibit 1, 3/55/750.
[278] A so-called "replica copy" of which is at Exhibit 1, 3/55/751.
[279] A so-called "replica copy" of which is at Exhibit 1, 3/55/752.
[280] A copy of which is at Exhibit 1, 3/55/753.
[281] Exhibit 1,3/55/754; statement of Stephen John Collins dated 10 August 2018, [11], Exhibit 1, 3/55/732.
[282] ERISP transcript of Ms Chea, 15 October 2017, p 21, Exhibit 1, 1/12/103. See also oral evidence of Senior Constable Racker at Tpt 42 to 43.
[283] The recall letters that were provided by Mr Ngo's family to the Officer in Charge are at Exhibit 1, 1/15/140 and Exhibit 1, 1/16/141.
[284] ERISP transcript of Julie Ngo, 16 November 2017, Exhibit 1, 1/13/115-117.

a. A statement of Grant Allen, who is a representative of Direct Mail Corporation (**DMC**), the mailout company that was engaged by Honda Australia to prepare its recall correspondence to customers.[285]

b. A statement of Carmelo Sciglitano, a representative of Australia Post.[286]

c. A statement of Ms Chea dated 30 July 2019;[287] and

d. A statement of Stephen Collins of Honda Australia dated 6 September 2019.[288]

212. This evidence indicates the following:

a. In relation to 5ZV recall, DMC was requested by Honda Australia to send recall correspondence to customers on or about each of 18 November 2015, 19 May 2016 and 20 October 2016. The request that Honda Australia made to DMC on each of these occasions enclosed a pro-forma customer letter, to be populated by DMC's software with addressee information, as well as a spreadsheet of intended recipients of the correspondence. The spreadsheets produced to the inquest by Honda Australia show that, on each occasion, Ms Chea's correct name and mailing address was included.[289] DMC's mailout systems were designed so as to print correspondence and envelopes with the addressee information provided to it.

b. There were a very large number of letters printed by DMC in the course of each recall mailout conducted on behalf of Honda Australia for the 5ZV recall. Neither DMC nor Honda Australia has retained original soft or hard copies of recall letters printed on or about 18 November 2015, 19 May 2016 and 20 October 2016, in the precise form in which they were sent to intended recipients, including Ms Chea.[290] However, "template" recall letters from each mailout were retained by Honda Australia, together with excel spreadsheets that were provided to DMC for the mailout. These show the nature of the letters that DMC was instructed to send, and the customers to whom DMC was instructed to send the letters.

[285] Exhibit 1, 6/68/1876.
[286] Exhibit 1, 6/68/1921.
[287] Exhibit 1,1/12A/110-2.
[288] See Exhibit 1, 5A/60B/1625-5 to 1625-8 at [7]-[24].
[289] See Exhibit 1, 5A/60B/1625-5 to 1625-8 at [7]-[24]; Tpt 420 to 421.
[290] Tpt 421.18.

c. Insofar as Honda Australia and/or DMC previously provided what were described as "replica copies" of recall letters dated 18 November 2015, 19 May 2016 and 20 October 2016 to the Officer in Charge in the course of the coronial investigation, these were, effectively, "recreations" of letters that Honda Australia and/or DMC understood to have been sent to Ms Chea, based on the arrangements that were then in place between Honda Australia and DMC and the records that remain accessible, as described at (a) and (b) above.

d. Australia Post is unable to confirm whether articles of post sent by standard mail are received by the intended recipient.

e. Australia Post records indicate that on 28 October 2016 a registered post article was delivered to an occupant [291]who signed for or as N Chea. [292] Ms Chea's evidence was that she did not recall receiving a letter from Honda on or about 28 October 2016 and that she did not recognise the signature appearing on the Australia Post "proof of delivery record".[293]

213. Although there are no original file copies available of *actual* recall letters sent to Ms Chea on or around the relevant dates,[294] having regard to the printing and mailout system that DMC employed, as described by Mr Allen, and the apparently contemporaneous evidence of the mailout requests and spreadsheets that Honda Australia provided to DMC, it is likely that a recall notification letter addressed to Ms Chea's correct address was printed by DMC and placed in an envelope and posted to Ms Chea on or about each of 18 November 2015, 19 May 2016, and 20 October 2016.[295]

214. Though it is not possible to determine with certainty whether the recall letters addressed to Ms Chea, and sent by standard mail on or about 18 November 2015 and 19 May 2016 actually reached their intended recipient,[296] it would appear that the recall notification letter from Honda Australia dated 20 October 2016 (or thereabouts) sent by registered post was received by either Ms Chea, or by another person on her behalf. If each or any of the letters had been received it

[291] See Ex 1 6//69/1923: The Post Office records indicate that the March 2017 registered letter was on 22 March 2017 "Attempted delivery Customer Not in Attendance" and was then sent from Leightonfield DF to the Cabramatta Post Office and from there collected by Ms Chea on 25 March 2017.
[292] Exhibit 1, 6/69/1923, 1/12B/110-5.
[293] Exhibit 1, 1/12A/110-2.
[294] Tpt 427.7.
[295] See Tpt 427 to 428.
[296] Cf Exhibit 1, 5/57/1279 at [87]. That such letters were not returned as "returned to sender" is not conclusive of whether or not they were received by the intended addressee.

may be that the person who received the letter did not understand or fully appreciate its contents at the time. [297]

***Timing of recall correspondence for 5ZV recall***

215. Having regard to the foregoing, it appears that, prior to 13 July 2017, Honda Australia took steps to arrange for letters to be sent to Ms Chea for the 5ZV recall at the following dates / intervals:

    a. a first letter on about 18 November 2015 – being around 4 months or 130 days after the 5ZV recall was notified to Honda Australia by Honda Japan;

    b. a second letter on or about 19 May 2016 – being around 6 months after the first letter was arranged to be sent;

    c. a third letter on or about 28 October 2016 – being around 5 months after the second letter was arranged to be sent; and

    d. a fourth letter on or about 15 March 2017 – being around 4 months after the third letter was arranged to be sent.These consumer letters are important as they were the sole means by which Honda Australia sought to convey to the Ngo/Chea family that they should have the affected airbag replaced. The FCAI Code provides a guideline to its members that consumer notification letters are to be sent at 90 day intervals. Later I return to the issue of the timing of these pieces of correspondence.

***Content of Honda Australia's recall correspondence prepared for 5ZV recall prior to 13 July 2017***

216. The inquest examined in detail the appearance and content of the template recall letters that were prepared for the 5ZV recall. Mr Collins' evidence was that the appearance, content and language of these letters was determined by Honda Australia, without any instruction by Honda Japan.[298] An aspect of the inquest was to consider how such recall correspondence, relating to defective Takata airbags, informed the consumer about the defect and risk of the airbag

[297] Tpt 430.3.
[298] Tpt 588.50.

inflator. The inquest heard evidence of how such correspondence might be improved.

217. The template letter dated 18 November 2015,[299] being the first recall letter used Honda Australia's standard format letter for vehicle recalls.[300] The letter had a red header which stated "Honda: IMPORTANT CAMPAIGN NOTIFICATION" followed by the words, in black, *"Product Safety Recall: Driver's Front Airbag Inflator"*. The letter commenced (underlined emphasis added):

> "Through continual product evaluation, Honda Motor Company has determined that a potential concern may exist with the driver's front airbag inflator in your vehicle and a Product Safety Recall will be conducted".

218. The letter proceeded (underlined emphasis added):

> "During testing of the driver's front airbag inflators, it was observed that there was a wide range of density variations within the inflator propellant. This can lead to abnormal airbag deployment in the event of an accident, potentially increasing the risk of injury. As a precautionary action, the driver's front airbag inflator will be replaced."

219. Mr Collins accepted that, based on his subsequent experience and learnings, there were deficiencies in this recall notification.[301] That acceptance by Mr Collins is justified. The letter was inadequate in a number of regards, relevantly that:

    a. There is no clear or direct explanation of the nature of the "abnormal airbag deployment" or how that event may in fact injure the driver or passenger (ie, by metal fragments piercing the airbag cushion).

    b. There is no reference to the airbag defect potentially causing serious injury or being fatal.

    c. The letter states that a recall "will be conducted" and not that a recall is *being* conducted, which may obscure the messaging. Indeed by the time the first letter was sent to Ms Chea the 5ZV recall had been underway for a period of four months.

    d. The relevant risk is identified in tentative and qualified terms and the notice does not present any urgent call to action. The "concern" is described as merely "potential" rather, than as being an actual concern about a risk that

[299] Exhibit 1, 3/55/750.
[300] Tpt 474.27.
[301] Tpt 454.47.

could, if it materialised, potentially cause serious injury or death. It was accepted on behalf of Honda Australia that it would have been preferable if words such as potential and potentially were not in the letter.[302]

e. The letter contains verbose and technical language, eg, "a wide range of density variations within the inflator propellant" and "abnormal airbag deployment".

220. The letter does not effectively visually attract attention to key messaging through use of prominent text or images.

221. The recall letter for the 5ZV recall dated 15 March 2017[303] – of which there is no issue that Ms Chea received[304] – was in a similar form to the letter of 18 November 2015, albeit with somewhat more impactful language and fonts. In terms of its effectiveness as a communication to consumers, the recall letter dated 15 March 2017 is an improvement but nonetheless has some deficiencies. The following is noted:

a. Unlike the letter dated 18 November 2015 the salutation uses Ms Chea's first name, which would have more likely engaged her attention.

b. The heading, "Urgent Honda Recall Notification", is in more trenchant terms than the heading "Important Campaign Notification" Mr Collins agreed that the word "Urgent" was included to underscore the recipient's need to respond to Honda Australia's call to action.[305] Further, there is capitalised red text at the top of the page stating "Your immediate action is required". Although these inclusions reflect a degree of urgency (which was missing in the 18 November 2015 letter), the notice still proceeds to state that Honda Motor Company has determined that "a ***potential*** concern ***may*** exist with the driver's airbag inflator in your CR-V and a Product Safety Recall will be conducted". The continuation of this qualified language was capable of leading to mixed messaging.

c. Under the heading "Recall Description", the letter states that "if an affected airbag inflator ruptures, metal fragments could be propelled towards the driver and passenger, potentially causing injury". This information about the defect is more direct and less technical than the

[302] Tpt 470.4.
[303] Exhibit 1, 3/55/754.
[304] A copy of the original letter received by the Ngo family is at Exhibit 1, 1/14/141.
[305] Tpt 484.46.

information included in the 18 November 2015 letter. Mr Collins accepted that this was information could helpfully have been included in earlier letters.[306] However, unlike the 7 March 2017 letter relating to the 6CA recall for the Vehicle's passenger airbag which states the risk of the defect as "potentially causing injury or fatality",[307] and the 20 October 2016 letter (Honda Australia's third 5ZV recall letter) referring to the defect being identified as "the cause of death in some cases in overseas markets", there is no reference in the 15 March 2017 letter to the defect potentially causing death. Mr Collins could not explain why this was so.[308] Given what was known by Honda Australia at the relevant time about the risks posed by defective Takata airbag inflators (including those the subject of the 5ZV recall),[309] the recall letter dated 15 March 2017 should have referred to risk of injury being serious injury and should have referred to there being a risk of death.

d. The 15 March 2017 letter set out the hours in which Honda Australia could be telephoned about the recall, but the opening hours were shorter than those indicated in the 18 November 2015 letter.[310] Mr Collins said that the Honda Recall Call Centre had always been open on a Saturday, and he did not know why this was not indicated on the 15 March 2017 letter.[311] It would clearly have been preferable if the correct opening hours were identified in the letter.

e. The 15 March 2017 letter contained a red lined box containing red text, which set out a heading: "*Important Notice*" and a statement that:

> "Honda Australia has fulfilled its obligations under the Federal Chamber of Automotive Industries (FCAI) Code of Practice for Product Safety Recalls. The responsibility lies with you to take whatever action is necessary to ensure this recall is actioned by an authorised Honda dealer".

222. Mr Collins stated that this was standard wording included in Honda Australia's recall letters, whether for Takata or non-Takata related recalls, from the third notification (recall letter) onwards.[312] The inclusion of a disclaimer of this kind, in

[306] Tpt 485.45 to 486.5.
[307] Exhibit 1, 3/55/753.
[308] Tpt 485.21.
[309] See Tpt 411.17-.35.
[310] Tpt 478.
[311] Tpt 479.16.
[312] Tpt 481.36.

the boxed format appearing in the notice (making the disclaimer the most visually prominent aspect of the body of the notice), had the capacity to impede delivery of the intended message to consumers that the airbag defect posed a serious risk and that they should take prompt steps to have their defective airbag replaced.[313]

223. The language in the 15 March 2017 letter was generally less verbose and technical than that in the 18 November 2015 letter. This reflected Honda Australia's efforts, at that time, to try to ensure that consumers responded to the call to action. However, the visual layout of the page could have been significantly improved in terms of its ability to attract consumers' attention, as was ultimately adopted in the recall correspondence prepared by Honda Australia following Mr Ngo's death[314]

***Evidence of Steve Hather***

224. Mr Steve Hather is the director of a consultancy called the Recall Institute. He has considerable experience and expertise in product recall and crisis management,[315] and gave evidence before the inquest in relation to the recall correspondence prepared by Honda Australia for the 5ZV recall prior to Mr Ngo's death. Although Mr Hather had not himself been involved in a motor vehicle recall, he considered that his experience with other product recalls enabled him to comment upon the communications strategies used by Honda Australia in its recall given that, on his evidence, communications in all product recalls are directed to ensuring that consumers understand the nature of the relevant risk and what to do about it.[316] Mr Hather's written and oral evidence was of significant assistance in considering the content of Honda Australia's recall letters for the 5ZV recall, and the provisions of the FCAI Code.

225. In particular, Mr Hather expressed the view that the recall letters prepared by Honda Australia for the 5ZV recall prior to Mr Ngo's death could have been improved by:

    a. using simpler and non-technical language so as to minimise the prospect that consumers would "switch off" when reading them and to remove barriers to compliance with the messaging;[317]

    b. using imagery/graphics to capture consumers' attention and convey

[313] Tpt 482.15 to 482.38.
[314] See generally, Tpt 489.
[315] See Tpt 609 to 613.
[316] Tpt 615.24 to 616.10; see also Tpt 640.5 to 640.23; Tpt 653.29.
[317] See Tpt 616 to 617.

messaging;[318] and

c. avoiding words or phrases that serve to downplay risk in the eyes of affected consumers such as "potential concern" and "precautionary action".[319]

***Timing of sending first recall correspondence aligned to availability of replacement parts in the 5ZV recall***

226. Mr Collins stated that, since the implementation of the first voluntary Takata airbag recall by Honda in 2009, there had been an increased demand globally for the supply of parts required to replace defective Takata airbags, and that Honda Australia has sought to ensure those parts are sourced as quickly as possible so as to be made available to Honda dealers.[320] He said that, as a director of Honda Australia, he was "always of the view that we [Australia] were getting our fair allocation of parts" when compared to Honda entities in other countries.[321]

227. Mr Collins said that the delay between notifying the authorities of the 5ZV recall (ie on 10 July 2015) and commencing to send out customer letters was "because we were waiting on parts, and then we staggered communications based on parts coming into the country".[322]

228. Around 10,000 current Honda customers whose vehicles were subject to the 5ZV recall were sent a letter in about August 2015, before parts became available, notifying them of the recall and advising that parts were not yet available. As Ms Chea was not such a customer (her local mechanic serviced the Vehicle), she was not sent such a letter.[323]

229. Mr Collins said that the parts shortage resolved about October 2015 and that the first recall letter was sent out to Ms Chea (in November 2015.[324] Mr Collins said that there were no parts supply issues after that time.[325] Mr Collins said he was not aware of a parts availability issue causing a delay in booking in the Ngo Vehicle

[318] Tpt 618.12.
[319] Tpt 618.44 to 619.
[320] Exhibit 1, 3/55/735 at [32].
[321] Tpt 417.18.
[322] Tpt 418.1 to .10.
[323] Tpt 432 to 434, 447.42 to 448.10.
[324] Tpt 430.35 to 431.31; Tpt 446-447.2.
[325] Tpt 569.48.

for replacement airbags in 2017.[326]

***Steps taken by Honda Australia to improve its recall communications after March 2017***

230. By the end of 2016, there was about a 60% recall completion rate for Honda Australia's voluntary recalls then on foot, but the rate of replacement had started to slow down.[327] As a result, in March 2017, Honda Australia decided to conduct research to determine the most effective manner in which to communicate to consumers in relation to the Takata airbag recalls, including the 5ZV recall.[328] The research conducted involved a series of interviews with recall consumers who were "acceptors" and "rejectors" of the Consumer Recall Notifications that Honda Australia had been sending. The interviews were facilitated by Probe Group (Honda Australia's call centre provider) and Honda Australia's advertising agent, Leo Burnett.[329]

231. On or about 5 May 2017, Leo Burnett provided to Honda Australia a report as to its findings.[330] Following receipt of this report, Honda Australia implemented a number of changes to its recall communications,[331] including the preparation of the revised form of the recall letter so that it contained images and language translations, and utilisation of SMS and electronic messages services.[332] Another recommendation that Leo Burnett made was to place recall letters in plain envelopes rather than branded envelopes to enhance the prospect of people opening the letter.[333]

232. It is to Honda Australia's credit that steps were being taken by around mid-2017 – prior to Mr Ngo's death and prior to the Compulsory Recall Notice introduced with effect from 1 March 2018 – to improve the form of its communications with consumers. Indeed, some of the steps rendered compulsory following the commencement of the compulsory recall were already being undertaken by Honda Australia at that time.[334] Unfortunately, a number of these measures were not yet

[326] Exhibit 1, 3/55/736 at [41].
[327] Tpt 515.27 to 516.21.
[328] Tpt 454.12.
[329] Exhibit 1, 3/55/738 at [57].
[330] Exhibit 1, 3/55/910.
[331] See generally, Tpt 490 to 491.
[332] Exhibit 1, 3/55/738 at [58]-[80].
[333] Tpt 430.24.
[334] Tpt 509.45 to 511.

in place at the time of Mr Ngo's death on 13 July 2017, or at the time that Ms Chea made contact with the Honda Recall Call Centre and Peter Warren in March 2017.

233. In particular, in October 2017, after Mr Ngo's death, Honda Australia prepared a recall letter for the 5ZV recall (and other then current recalls)[335] that contained coloured graphic images and simplified language which was much clearer than the language used in previous letters. The letter stated:

> "Your CRV driver and/or passenger airbag is faulty and dangerous. **This could be fatal or cause serious injury to the occupants** of your vehicle. We want to do whatever we can to fix your airbag, absolutely free of charge" (bold emphasis in original).

234. There was then a heading in red which stated: *"CHOOSING NOT TO ACT COULD BE DEADLY"* followed by an explanation which stated*:*

> *"*An accident, even at low speed, could cause your airbag to go off. If this happens, a faulty inflator could shoot metal fragments into your head and body. The result could be tragic. Think about the safety of you and your family. This is not something you can put off, you must act now*".*

235. This letter contained sequential photographs headed with the words "1 in 5 Australians have had a crash in the past five years" and showing an inflated airbag with the fragment penetrating the fabric, a headrest with a hole pierced by a fragment and a punctured car roof and the piece of ruptured inflator metal. Each photograph is captioned in capital letters: "METAL FRAGMENTS SHOOT FROM AIRBAG, TOWARDS YOU AND YOUR LOVED ONES, HARD ENOUGH TO PUNCTURE THE ROOF".

236. There is also a diagrammatic representation of the path of the fragment. At the bottom of the letter, some text appeared in several foreign languages. This messaging makes it clear that a vehicle's recalled airbag/s is a real and serious risk to the occupants of a vehicle.

237. The October 2017 recall letter was a vastly significant improvement upon the earlier recall letters sent in the 5ZV recall prior to Mr Ngo's death, in terms of communication of the nature of the risk and the likelihood of engaging consumers to act with some urgency to have the defective airbag replaced. Mr Hather considered that the October 2017 letter conveyed a "very clear message" that consumers needed to pay attention.[336] In her statement to the Officer in Charge,

[335] Exhibit 1, 1/17/142.
[336] Tpt 619.38.

Julie Ngo said that, if she had received a letter of the kind later sent in October 2017, "we would not have driven the … car at all …. we would be too cautious to drive it … cause … we would know how dangerous it is to drive it anywhere".[337]

238. Another recommendation made by Leo Burnett, and implemented by Honda Australia after Mr Ngo's death, was to identify the correct opening hours for the Honda Recall Centre.[338] Leo Burnett also recommended changes to the process used to book vehicles in with dealers, including a "live booking" process whereby the booking with a dealer would be made as soon as customers contacted the Honda Australia Recall Call Centre, so that the call is transferred to the relevant dealer, after which the Honda Australia Recall Call Centre follows up with the customer.[339]

***Honda Australia's Communication and Engagement Plan under Compulsory Recall Notice***

239. On about 25 May 2018, the ACCC approved Honda Australia's "Communication and Engagement Plan", which was submitted in accordance with the requirements of the Compulsory Recall Notice.[340]

240. The inquest received copies of recall letters from Honda Australia to consumers that the ACCC approved for the purposes of Honda Australia's Communication and Engagement Plan.[341] The form of such recall letters is eye-catching, impactful and emotive, and stands in stark contrast to the form of recall letters that Honda Australia utilised for the purposes of the 5ZV recall prior to Mr Ngo's death.

241. Honda Australia's Communication and Engagement Plan also made provision for notifications to be sent to consumers not only by post, but also by SMS, electronic messaging and Facebook advertising.[342] In addition, the notification schedules under the compulsory recall regime provide for more regular contact with consumers than the default 90-day intervals referred to in the FCAI Code.[343] Mr Collins said that Honda Australia considered this to be appropriate given the seriousness of the issue.[344]

[337] See Exhibit 1, 1/13/129-130.
[338] Tpt 479.5 to .45; Tpt 492.15 to .25.
[339] Tpt 492.40 to 493.40.
[340] Exhibit 1, 10/100/2993 and 2996.
[341] Exhibit 1, 10/106/3103 to 3111.
[342] Tpt 511.
[343] Tpt 529.8.
[344] Tpt 529.27.

Effect of Honda Australia's recall efforts

242. The strategies that Honda Australia has employed since Mr Ngo's death, both as part of its voluntary recalls and subsequently in response to the Compulsory Recall Notice, in conjunction with the FCAI television campaign and the media attention generated by the inquest as well as the ACCC media engagement led to an increase in recall replacement rates. Mr Collins reported that as at 16 October 2019, Honda Australia had a 91.4% completion rate for its Takata airbag recalls (comprising 97.1% for active customers and 90.5% for non-active customers), having rectified 383,350 vehicles (which equates to 662,011 inflators) while nonetheless having outstanding 53,615 vehicles (which equates to 61,959 inflators, including 14,935 alpha inflators).[345]

***Conclusion on Issue #4***

243. Counsel Assisting has submitted that I could find that the recall letters that Honda Australia utilised in respect of the 5ZV recall were deficient in terms of their capacity to effectively notify or inform consumers such as Ms Chea as to the nature of the defect and risk, or the hazard posed by defective Takata airbags which the recall was going to remedy.

244. Counsel Assisting submit that the letters did not accord with the guidance for recall communications as set out in the Consumer Product Safety Recall Guidelines published by the ACCC.

245. Further, Counsel Assisting submit that notwithstanding the efforts undertaken by Honda Australia to seek to contact 5ZV recall consumers prior to 13 July 2017 (and since then), Honda Australia should have taken additional steps, prior to Mr Ngo's death, to inform Mr Ngo's family of the nature of the risks involved in the defective Takata airbags in the Vehicle and the need for urgency in having the airbags replaced. Counsel Assisting advance that such steps may have involved one or more of the following:

    a. Sending Ms Chea a letter (or other form of communication) between July and October 2015, explaining the risks arising from the defective Takata airbag in her Vehicle (and that parts were not yet available), to enable her to decide whether to use the Vehicle in the interim.[346] In this respect, Jeremy Thomas, who worked for DIRD in this period, considered it to be

[345] Tpt 525.45 to .50.
[346] See Tpt 434.36; Tpt 450.13 to 450.21.

appropriate for suppliers to inform consumers when their vehicle was under recall, even if parts were not yet available, and that "a person has the right to know that there's a risk no matter how remote or unlikely that their vehicle may have a significant safety issue …because a person can start to take steps at that point", including placing pressure on the manufacturer or choosing not to drive their vehicle.[347] He thought that a delay of four months in notifying a consumer after a recall was announced was "less than ideal".[348] Although such a letter was apparently sent to some 10,000 current customers affected by the 5ZV recall, Mr Collins' evidence was that there were quantum-related logistical issues that prevented such a letter being sent to all 90,000 consumers with vehicles the subject of the 5ZV recall.[349]

b. Significantly reducing the interval between the first and each subsequent recall notification letter arranged to be sent to 5ZV recall customers. In respect of the approximate 6-month period between the first and second recall letters, and the approximate 5-month period between the second and third recall letters (each of which was in excess of the 90-day default period identified by the FCAI Code), Mr Collins said "[c]learly, I don't think that's ideal", but that this was "a function of the difficulty we were having in dealing with the quantities of recalls coming through at the time".[350]

c. Using colourful graphics and simplified, impactful language, of the kind appearing in the October 2017 recall letter sent by Honda Australia (and in letters subsequently sent by Honda Australia as part of the compulsory recall), in recall correspondence sent to Ms Chea prior to Mr Ngo's death. Mr Collins effectively agreed that, "knowing what we now know [about the strategies to enhance effectiveness of communication], we would have done a lot of things [in terms of content of recall correspondence] differently".[351] Honda Australia could have used such graphics in earlier 5ZV recall correspondence.[352]

d. Sending text messages to Ms Chea or calling her (prior to Ms Chea first making contact with the Honda Recall Call Centre on 30 March 2017). As

[347] Tpt 1046.40-1047.10.
[348] Tpt 1048.47.
[349] Tpt 450.13 to 450.33.
[350] Tpt 452.1 to 452.40. See also, evidence of Ms Nyakuengama Tpt 860.26.
[351] Tpt 460.45.
[352] Cf Tpt 473.33-474.3.

to this, Honda Australia had on file a mobile telephone number for Ms Chea in what was referred to as its "old system"[353] which could be accessed by Honda Australia staff or Probe staff who were Honda Recall Call Centre operators.[354] However, no contact (or attempt at contact) was made by Honda Australia with Ms Chea, using her mobile phone number, prior to Mr Ngo's death.[355] The FCAI Code provided that members should take steps to contact the customers of recall products by email or SMS "if deemed appropriate". Mr Collins agreed that it would be appropriate to make contact with consumers by telephone or email or text message where Honda Australia had telephone or email contact details for the consumer, and they had not responded to a first recall letter.[356] Mr Collins also accepted that it would have been highly desirable to have sent an SMS message to Ms Chea to advise her to take steps urgently to have her airbag replaced.[357]

e. Organising television and/or radio advertising about the risks involved with Takata airbags. While the FCAI Code contained provisions providing for TV or radio advertisements to be issued in relation to a recall where considered by a member to be necessary or desirable, prior to 13 July 2017, Honda Australia did not undertake or arrange such advertising in relation to the 5ZV recall, 6CA recall or its Takata Airbag recalls more generally.[358] Mr Collins agreed that, looking back, the release of TV and radio advertisements about the recall could have helped to increase the number of consumers that responded to recall letters.[359] This is plainly correct. In this connection, it should also be noted that, prior to July 2017, Honda Australia had raised with the ACCC and DIRD whether they would consider an information and advertising campaign to inform and encourage consumers to participate in recall campaigns.[360] According to

[353] OneView, which came to be replaced by Salesforce; see also Exhibit 1, 5/58-61/1587, Tpt 393.30 to 394.18.
[354] Tpt 389.20. Mr Collins said that the number did not get transferred to the Salesforce system: Tpt 389.37. However, it was clearly provided to the operator at the Honda Recall Call Centre who took her call on 30 March 2017: Tpt 392.10 to 392.24.
[355] Tpt 389.40 to 390.30. (That is, there was no outbound call/SMS by Honda Australia, leaving aside the call placed by Ms Chea on 30 March 2017 to the Honda Recall Call Centre).
[356] Tpt 388.24 to 388.49.
[357] Tpt 510.5 to 510.23. Mr Hather also stated: "if two notices hadn't triggered a response, perhaps they're not very effective. So continuing to send letters when it's clear that they're not being effective, you know, personally I would have tried a different approach … I just don't think you should rely solely on any one measure. You should always use a variety of means to communicate": Tpt 621.33 to 621.50
[358] Tpt 384.
[359] Tpt 386.20 to 386.44.
[360] Exhibit 1, 8/77-A7/2286.

Mr Collins' evidence, Honda Australia considered that any media release or media campaign needed to be a joint industry approach.[361] However, he accepted that Honda Australia could have engaged in such media strategies of its own accord; that is, without needing or waiting for broader industry or regulatory assistance.[362]

246. Counsel Assisting advance a finding that had any one or more of the potential improvements to the communications from Honda Australia to Ms Chea set out above been implemented prior to 13 July 2017, members of Mr Ngo's family may have taken steps to:

    a. book the Vehicle in for a replacement service earlier than in fact occurred, whether at Peter Warren or another dealer;

    b. complain about a 3.5 month delay when the airbag replacement appointment was made with Peter Warren on 30 March 2017, which may in turn have led Honda Australia to re-allocate the booking to another dealer for an earlier allocated date;

    c. otherwise take steps to ensure that a recall replacement service was completed by Peter Warren or another Honda dealer on or before 13 July 2017; and/or

    d. cease or limit their use of the Vehicle until the airbags in the Vehicle had been replaced.

247. Honda Australia submits that there is no evidence to support a finding about what, if any, actions the Chea/Ngo family would have taken. However, contrary to this submission, there is evidence contained in the police interview with Julie Ngo on 5 December 2017 when she said that had a letter such as the October 2017 letter been sent to Ms Chea before Mr Ngo's death, they *"would not have driven the car at all…would be too cautious…we would just leave it until we can bring it in for the day to get fixed...we would try and get someone to come and pick up the car...to get it fixed cause …we would know how dangerous it is to drive anywhere…if we got this letter before the accident…it would have changed our lives…".*[363]

[361] Tpt 583.44; 599.32 to 600.11. It is noted that, as part of the compulsory recall, a comprehensive media campaign has been implemented by manufacturers at an industry-wide level, co-ordinated by the FCAI: Tpt 553.35 to 553.47.
[362] See Tpt 386.10-.21.
[363] Exhibit 1, 1/13/129-130 Q171-182.

248. Further, by its own submission, Honda Australia says that had there been a joint advertisement and education campaign between industry and the regulators, Ms Chea and Ms Ngo may have had a greater awareness of the risk associated with the recall, which may have resulted in them taking steps to press Honda Australia and Peter Warren for the recall service to be completed at an earlier date.[364] This submission indicates an acceptance by Honda Australia that the Chea/Ngo family were inadequately informed about the risks associated with the recall in the letters sent to them by Honda Australia.

249. Further, in a similar vein, Honda Australia, in its submissions support a finding that confusion between ACCC and DIRD about their respective roles may have contributed to the public not being sufficiently warned as to the dangers associated with Takata airbags prior to Mr Ngo's death. This submission necessarily involves acceptance that there was lack of sufficient warning of the risk to the Australian public and that the Ngo family, being members of the public, were not sufficiently warned.

250. I find that Honda Australia's 5ZV recall letters prior to Mr Ngo's death did not sufficiently warn the public, and specifically the Chea/Ngo family, as to the dangers associated with the defective Takata airbags. The content and layout of the letters, including the March 2017 letters, contained insufficient warning and information about the risks of the airbags in the Vehicle.

251. In dramatic contrast the 5ZV recall letter of October 2017, which followed Mr Ngo's death, did sufficiently provide such warning. Had such a letter been sent to the Ngo family it is more likely than not they would have either not driven the Vehicle at all as advanced by Julie in her interview with the police or at least they would have had the vehicle repaired earlier by pursuing any of the other three options put forward by Counsel Assisting.

252. Honda Australia advances a finding that the Chea/Ngo family did in fact receive the letters sent by standard and registered post from November 2015 to March 2017 and that as a result of receiving at least one of the letters, contacted the Honda Australia Recall Centre and made the booking for the replacement.

253. Ms Chea confirms that she recalled seeing one recall notice in March 2017. There were two recall notices sent to her by Honda Australia in March 2017- the fourth 5ZV recall letter by registered mail around 15 March 2017 and the first 6CA recall

letter by standard mail 7 March 2017. Ms Chea must have received both of these letters because she gave them to Julie on 10 July 2017.

254. It is likely that at least one of the earlier letters, probably the third 5ZV recall letter which was the one sent by registered mail around 20 October 2016 and, as evidenced by Australia Post records, was received by someone in the household. However, it is unclear who accepted the October 2016 letter. The signature on the receipt of the letter appears not to be Ms Chea's signature. It seems that the occupant who took delivery of the October 2016 letter either did not provide it to Ms Chea or Ms Chea had forgotten that she had seen it when she was interviewed by police in November 2017. If she had seen it, it did not result in her calling the Honda Australia recall centre which may be due to the content of the letter.

255. I find that Ms Chea did receive and respond to either or both of the letters sent by Honda Australia in March 2017. Given that the registered post letter was collected by Ms Chea on 25 March 2017 and she called the Honda Australia call-centre on 30 March 2017, it seems likely that the registered letter is the one that she recalled and responded to.

256. In the context of hindsight, Honda Australia does not take issue with Counsel Assisting's characterisation that the description of the defect and hazard notified to the ACCC and DIRD in 2015 and to Ms Chea in 2015 and 2016 was inadequate in that it did not include the words *"…in the event of an inflator rupture, metal fragments could pass through the airbag cushion material possibly causing serious injury or fatality to vehicle occupants".*

257. Counsel for Honda Australia submit that those words were not used until shortly prior to March 2017 when the consumer recall letter was sent to Ms Chea because it was only by that time that Honda Australia had become aware that the risk of metal fragments being propelled towards the driver or passenger casing injury was associated with all Takata airbag recalls and that Honda Australia was learning, as the recall progressed, as to what was and was not working as effective communication to consumers. Honda Australia, in its submissions, does not advance any particular process that Honda Australia engaged in to arrive at that position or what gave Honda Australia cause to change the letter, however suggests that it was only by December 2016 that Honda Australia became aware that the risk posed by the 5ZV was an unreasonable risk.

258. Honda Australia's submission overlooks the fact that Honda Australia learned on 28 September 2016 that a death had occurred four days earlier in Malaysia which involved a ruptured airbag causing metal fragments to shoot out. As a result of learning this Honda Australia included in the letter sent to Ms Chea in October 2016 that the defect had been identified as "the cause of death in some cases in overseas markets". Mr Collins gave evidence that the public relations unit of Honda Japan would on a semi-regular basis provide to the Honda Divisions in the Asia-Oceanic region information about incidents such as that on 24 September 2016 in Malaysia. When Honda Australia received such a notification from its parent company, it would make a report to the ACCC under s131 of the ACL. The September 2016 death in Malaysia involved a Honda City vehicle of the type recalled in the 5ZV campaign. That the March 2017 letter sent to Ms Chea referred to metal fragments but did not identify the risk of death as did the October 2016 letter is an anomaly that Mr Collins could not explain.[365]

259. I do not accept the position put forward by Honda Australia. It was May 2016 not December 2016 when the NHTSA's Third Consent Order indicated that "all non-desiccated frontal Takata PSAN inflators will reach a threshold level of degradation that could result in the inflator becoming unreasonably dangerous". It was in May 2016 that the Blomquist Report stated "the length of time until the subject inflators present a risk of rupture ranges from six to twenty-five years from the date of inflator manufacture". That understanding does not explain the delay in changing consumer letters until March 2017. In any event, Mr Collins' evidence was clear that as at the time the 5ZV recall was announced and thereafter, Honda Australia knew of no mechanism other than inflator rupture and metal fragments being propelled into the vehicle cabin to be associated with defective Takata Airbags.[366]

260. Honda Australia submits that it complied with its recall process as set out in its Recall Check Sheet and SOPs[367] and that *"at all relevant times, Honda Australia exercised due diligence by: assessing the risk based on what was being communicated to it by its parent company, Honda Motor Co Ltd"* and *"communicating the risk effectively, transparently and as it was understood at the relevant time, to consumers and government regulators"*.

261. In as much as the above statements in Honda Australia's submissions suggest that Honda Australia changed the contents of the consumer letter as a result of

[365] Ex 1, 12/128/3677, Tpt 345-349, 351.40, 574-578.
[366] T411.16-24
[367] The Recall Check Sheet had been in use since 2013 and the SOP commenced in May 2016.

Honda Japan communicating a newly identified level of risk to Honda Australia, there is no evidence of any such communication. I further note that whilst the Honda Australia consumer letters were changed, the notification of the risk contained in the notification to the ACCC and DIRD was not.

262. As these submissions of Honda Australia encompass both the consumer letters that were sent to Ms Chea as well as to the notification of recall 5ZV that Honda Australia sent to the ACCC and DIRD, addressing these submissions involves a discussion about the regulatory framework of a voluntary recall which is set out in section L of these findings. However, before doing so the process relating to the notification to the regulators which Honda Australia adopted is first set out.

263. Mr Collins' evidence is that the process Honda Australia adopted in relation to the content of the notification of recalls sent to the ACCC (and DIRD) was (and still is) to replicate information received from Honda Japan[368]. Mr Collins explained that the replication process was because "each recall was separate, coming through at different times, some were precautionary and some were not".[369] Mr Collins' evidence was unequivocal that as at 10 July 2015 Honda Australia knew that a defective airbag could explode due to excessive internal pressure and that such a rupture may cause metal fragments to tear through the airbag cushion.[370] He agreed that despite that knowledge Honda Australia did not include such in the notification to the ACCC because Honda Australia had adopted this "replication process"[371]. How it was that some recalls were treated by Honda Japan and *inter alia* Honda Australia as "precautionary and some were not" is discussed below and though there was no direct evidence referred to by counsel for Honda Australia there is evidence to suggest that it was a change in this distinction that gave rise to Honda Australia, in March 2017, changing the contents of its consumer letter in relation to the 5ZV recall letter.

264. In my view, Honda Australia's practice of replicating Honda Japan's recall notification for the purpose of Honda Australia's notifications inherently involves a lack of any inquiry into or assessment of risk, or inquiry as to the nature of the defect or hazard or the description thereof. Accordingly, in relation to the notification of the 5ZV recall to the ACCC, there does not seem to be any force in the submission by counsel for Honda Australia that Honda Australia exercised due

[368] Tpt 409.09-409.50.
[369] Tpt 409.32-25.
[370] T408.20-.38, T411.10-.26.
[371] Tpt 400-412, Tpt 409.09-409.50 .

diligence by “assessing the risk based on what was being communicated to it by its parent company”.

265. Given that the defective Takata airbag could cause serious injury or death it is particularly regrettable that Honda Australia perpetuated the characterisation of the 5ZV recall as a precautionary or preventative measure, as doing so effectively suggests that it is an unnecessary recall falling short of the criteria that the consumer good (product) “will or may cause injury”.[372]

266. The purpose of a recall is to remove consumer products that are or may be a danger to the public and to do so as quickly as possible. The term “precautionary” suggests a removal of a product from the market even though it does not reach the threshold of risk. The term “preventative measure” does not describe a defect at all and is merely a restatement of the purpose of a recall – namely to prevent harm to the consumer or Australian public. Finally, to categorise the recall as precautionary or preventative had a tendency to suggest that Honda Australia in recalling 5ZV vehicles was doing so as a matter of courtesy rather than legal requirement.

267. Honda Australia submits that it was only by virtue of the (NHTSA) Third Co-ordinated Remedy Order on 9 December 2016 that Honda Australia learned that all recalled non-desiccated PSAN Takata airbag inflators had a capacity to rupture which presented “an unreasonable risk of serious injury or death” and that Mr Collins’ evidence agreeing that Honda Australia could have put more information into the notification to the ACCC on 10 July 2015 was evidence given with the benefit of hindsight. The submission continues that due to the FCAI Code providing that a supplier is to notify the ACCC within 48 hours, Honda Australia had insufficient time to obtain any further information about the 5ZV defect and hazard from Honda Japan.

268. Honda Australia relies on Mr Collins’ response to Mr Kell SC’s question about the notification letter of 10 July 2015:

> "…Do you think looking back at the letter now, that you could’ve taken the opportunity to put further information in there in terms of notification of the defect description and the nature of the risk including reference that we’ve seen in the HTI (Honda Technical Information) document to explosion?
>
> I think back at that point in time, there’s a lot that we didn’t know, and I think the process was very much to replicate what was told to us by

[372] s128(a) Australian Consumer Law

> Honda Motor. Clearly, we know a lot more now than what we knew back then, so I think that this was very much a replication of what we were told by Honda Motor.
>
> And since this point, we've obviously learnt a lot including the recourse because at this point in time, there was still discussion about precautionary-and of course, we didn't know the recourse, so yeah, I believe that knowing what I know now, we could very easily have put more information into this letter but we – I certainly didn't know that or we didn't know that at the time."[373]

269. Later in his evidence Mr Collins made it clear that as at 10 July 2015 Honda Australia understood that a defective Takata airbag in Australia, was due to excessive internal pressure connected with the propellant which could cause the inflator body to rupture as a corollary of which metal fragments could tear through the airbag cushion creating a risk to both a driver and a passenger inside the vehicle.[374] He confirmed that Honda Australia at that time did not know of any other aspect of a Takata airbag defect or risk.[375]

270. Honda Australia submits that "the undisputed evidence of Mr Collins was that it was only through the December 2016 Third Coordinated Remedy Order, in conjunction with the identification of the root cause in the Blomquist Report, that he became aware that all of the Takata Airbag inflator recalls posed an unreasonable risk as a result of metal fragments being propelled towards a driver or passenger".

271. Honda Australia's submission refers to Mr Collins being asked whether the changes made in the 15 March 2017 consumer letter to Ms Chea came from those sources to which Mr Collins replied:

> "I don't know specifically but logic would say that we had more information, including the information from NHTSA at or just before that time, yes".[376]

272. Mr Collins' evidence in this regard does not support a finding that the consumer letter was changed on the basis that information was not known by Honda Australia until December 2016. Mr Collins said that though a copy of the Blomquist and NHTSA report was provided to Honda Australia on 6 June 2016 he downloaded the report himself in 2016, but as to when, he could not say.[377] This information in addition to the many question and answer sheets, technical bulletins and sheets

[373] Tpt 403.40-49.
[374] Tpt 408.5-409.24.
[375] Tpt 411.15-412.06.
[376] Tpt 593.25-597.30, 604.10-50.
[377] Tpt 603.40-604.50.

and photographs provided by Honda Japan to Honda Australia over the currency of the recalls are all indicative of Honda Japan keeping Honda Australia apprised of the of the nature of the Takata airbag defect.[378]

273. In submissions, Honda Australia refers to a table created for the purpose of submissions encapsulating some information for all the 19 recall notifications contained in the brief of evidence[379] to demonstrate Honda Australia's knowledge of the known cause for each recall at the time of each notification as indicated by Honda Australia's notifications to the ACCC and DIRD. This table usefully shows the variation of descriptors of the defect and hazard Honda Japan provided to Honda Australia which in turn was replicated and provided by Honda Australia to the ACCC and DIRD. Of particular note, the 2015 notifications do contrast significantly to the contents of the notifications provided in the years 2009-2015 and the years 2016-2017.

274. In relation to the 5ZV recall, the defect is described as a "preventative measure following the identification of wide ranges of density variations in inflators returned to Takata". The hazard is identified as "Abnormal airbag deployment". That information alone supports Mr Collins' evidence that as at 10 July 2015 Honda Australia understood the nature of a defective Takata airbag. Honda Australia already knew that if such an airbag underwent "abnormal deployment" the inflator body would rupture and metal fragments could tear through the airbag cushion creating a risk to both a driver and a passenger inside the vehicle.

275. Three notifications in 2015 did not even identify a hazard (5VZ, 5JV and 5UN, involving a total number of 38,366 drivers' side airbags and 109,551 passenger side airbags). I note that later both 5VZ and 5UN were revised – 5VZ to indicate that the hazard was "Abnormal airbag deployment" and for 5UN the numbers were reduced from 109,551 to 28,100 yet, according to Honda Australia's table the hazard remained "Not identified"

276. Though Honda Australia could at any time revise its recall notifications to the ACCC and DIRD and notwithstanding that, on its own submission, by December 2016 it had learned that "all of the Takata airbag inflator recalls posed an unreasonable risk as a result of metal fragments being propelled towards a driver or passenger", it did not seek to amend or revise any previously filed notifications which had not made that clear. In relation to 5ZV it could have done so and should

[378] Exhibit V5 T58.
[379] Exhibit 1, V5 T58 P1272-1276 and T58 (3)-(11) (17-)-(32)(43)-(50), P1311-1507.

have done so not only in compliance with its ACL obligations but also so that the ACCC website would properly inform the public. That Honda Australia was not required to do so by DIRD or ACCC is discussed further below in section L.

277. Honda Australia submitted that due to the FCAI Code[380] providing that a recall notification is to be sent within 48 hours to the ACCC it did not have sufficient time to include in the Consumer Recall Notification information beyond what had been received from Honda Japan. Though Mr Grimade in his evidence accepted that "Honda Australia…did not otherwise [ie, but for language provided by Honda Japan] have any factual basis to alter the description of the hazard",[381] there was no evidence persuading me that there was anything preventing Honda Australia from exercising due diligence to obtain an informed understanding of the defect and the nature of injury or risk so that it did adequately describe it in its notification to the ACCC.

278. If 48 hours was insufficient time to do so then Honda Australia should have carried out due diligence shortly thereafter to ensure that the description of defect and risk is accurate and fully complete. Further, the FCAI should consider including in its guidelines that, within 7 days of a supplier notifying a recall to the ACCC/DIRD, the supplier should carry out such due diligence. To do so would require the Australian supplier to ask the appropriate questions of the parent company so that the supplier can provide the appropriate information and warning to the Australian consumer.

279. By focussing its submissions on the presence of knowledge of an unreasonable risk as at December 2016, counsel for Honda Australia overlook that the ACL requires a description of the defect and the danger should the risk of failure of the product eventuate: see below at paragraphs [295] and [296]. The ACL does not require the notice description to be as to whether or not the risk is unreasonable.

280. Likewise, the ACL does not require a supplier to describe the cause of the defect. Nor does it require the supplier to notify the basis of knowledge of the cause. Those matters might be important in assisting a supplier to determine how to stage a recall such as prioritising older vehicles such as when it is known that a propellant degrades over time and more rapidly in certain climatic conditions

[380] Consistent with Cl 8.2 MOU Ex 1 , 9/84/2649.
[381] Tpt.1719.21-to .24

281. Mr Collins' statement of 12 November 2018[382] has attached to it a recall notification letter dated 4 February 2016 sent from Honda Japan to Honda Australia in relation to the 11[h] recall which was Recall 6ZV of a Driver Front Airbag Inflator (Single Type) which identifies "…in the event of an inflator rupture, metal fragments could pass through the airbag cushion material possibly causing serious injury or fatality to vehicle occupants". The diagram attached to that notification is similar to that of the 5ZV recall notification but with the addition of a photograph of propellant tablets and a diagram of the cross-section of the inflator (SDI).[383] This description predates both the Blomquist Report and the NHTSA remedy order of December 2016 upon which Honda Australia seek to rely as reflecting a time by which Honda Australia had knowledge to include such a descriptor. I do not accept Honda Australia's submissions as to the reasons why Honda Australia did not include in its notification to the ACCC or its letters in 2015 and 2016 to Ms Chea the information that metal fragments could cause serious injury or death.

282. If Honda Australia had applied similar language as that contained in the 6ZV recall notification of February 2016 to their correspondence in the 5ZV recall letter to Ms Chea in October 2016, the recipient of that letter may have responded to it by booking the vehicle in for airbag replacement.

283. Counsel for Honda Australia rightly points out that neither the ACCC or DIRD at any time required Honda Australia to amend its 5ZV notification of 10 July 2015. The reason for this was either an oversight or as Mr Collins expressed that all parties had the same understanding of the defect and risk.[384]

284. Honda Australia submitted that the March 2017 letter included reference to the metal fragments because in addition to the learnings by December 2016, Honda had cause to consider how to improve its rectification rates (primarily for consumers who were not ongoing customers) by obtaining a better response by consumers to those letters.

285. Honda Australia engaged Mr Leo Burnett to advise on their recall campaign strategy in terms of marketing but did not ask him to look at the consumer letters drafted by Honda Australia until after the March 2017 consumer letter was sent to Ms Chea. Leo Burnett had not provided a report to Honda Australia until May 2017, and as said by Mr Collins in his evidence, Leo Burnett's engagement does not

[382] Exhibit 1 5/58/1275 [54].
[383] Exhibit 1 5/58/1473.
[384] Tpt 411.45.

explain the change to the March 2017 5ZV letter. Likewise, given that the letter is dated 15 March 2017 it would appear that the changed letter was drafted prior to the Takata Working Group meeting of 14 March 2017. In any event the Takata Working Group tasked suppliers with drafting a letter with explicit injury information to advance a consumer response rate in relation to airbags with a characteristic described as alpha identifying that it had a 1 in 2 chance of misdeployment. The Chea Vehicle did not contain such an airbag.

286. There is insufficient evidence as to how it was that the letter of 15 March 2017 to Ms Chea came to include reference to metal fragments causing injury but there seems to be no good reason as to why the consumer letter of at least October 2016 did not contain those words.

287. From the remarks above it is fairly evident that Honda Australia as an Australian supplier of overseas manufactured vehicles should not continue a practice of replicating Honda Japan's notification of a public safety recall. Rather, an Australian supplier should make appropriate inquiry and interrogation and conduct due diligence with its parent company to ensure that a description of both the defect and the nature of the risk is adequately and accurately communicated in its notifications to the ACCC, DIRD and consumers.

288. I consider it desirable to recommend to Honda Australia that when Honda Australia receives notice from Honda Corporation Ltd that a motor vehicle and/or componentry is subject to recall that, rather than replicate the language of the notification conveyed to it, Honda Australia make appropriate inquiry and interrogation and conduct due diligence with its parent company to ensure that a description of both the defect and the nature of the risk is adequately and accurately communicated in its notifications to the ACCC, DIRD and consumers, and ensure that any updated knowledge about the description of defect and the nature of the risk is notified in a timely manner.

289. This standard of proper inquiry should be contained in the FCAI Code and, accordingly, I recommend that the FCAI consider in its review of the Code incorporating such a standard for its members.

290. Counsel for Honda Australia acknowledge that the timing of Honda Australia's 5ZV recall letters to Ms Chea did not comply with the FCAI Code guideline that a consumer letter be sent every 90 days until either the replacement is effected or the third letter is sent. The second letter to Ms Chea was sent some 6 months after

the first. Honda Australia submit that it was not possible as a practical matter to comply with the FCAI Code guidance with reference to Mr Collins' evidence that at that time, Honda Australia was doing its very best in a very difficult situation, being inundated with recalls. In any event the FCAI Code allows for a variation of the 3 months if the supplier considered it appropriate.

291. Honda Australia staggered its consumer letters to cope with the volume of vehicles which were having airbags replaced. This appears to have had the effect of lessening the delay at the Honda dealerships which were, at least at some Sydney dealers, already running at 3 months. However, the gap between letters to consumers likely adversely impacted on consumer response. It is in those circumstances that Honda Australia continued to send out letters to consumers beyond the third letter suggested by the FCAI Code. It is likely due to that persistence, together with the improved communication in the March 2017 letter, that Ms Chea responded and booked the Vehicle in for airbag replacement. That such persistence was required was likely due to the delay between the letters and the failure of the original letters to convey adequate information to the consumer in the first place.

## L. Regulation of Voluntary Airbag Recalls – Issue # 5

292. Mr Ngo's death occurred in circumstances where:

    a. the Vehicle that he was driving posed a safety risk;

    b. the Vehicle was subject to two voluntary recalls by the manufacturer and local supplier in respect of its airbag inflators and as the recalls were voluntary the supplier was the primary entity responsible for the conduct of the recall;

    c. the FCAI Code provided a guide to the local supplier to conduct its recall;

    d. two Commonwealth bodies, the ACCC and DIRD, had a role in those voluntary recalls and each was a party to a Memorandum of Understanding as to the conduct of a motor vehicle recall.

293. The inquest considered the regulatory frameworks, provisions, policies and procedures applicable in relation to the conduct of a voluntary recall campaign of motor vehicles with specific reference to defective Takata airbags including the guidelines published by the ACCC and those contained in the FCAI Code of Practice.

***Powers and Functions of ACCC in respect of motor vehicle recalls***

294. The ACCC has broad responsibilities for consumer product safety, including enforcing the ACL.

295. Section 128 of the ACL imposes a requirement on suppliers to notify the ACCC if voluntary action has been taken to recall a vehicle that is a consumer good because the vehicle:

    a. will or may cause injury;

    b. will or may cause injury as a consequence of a reasonably foreseeable use (including a misuse);

    c. does not comply or is likely not to comply with a safety standard that is in force; or

    d. was supplied in contravention of an interim or permanent ban that is in force.

296. Under s128(7) a supplier undertaking a voluntary recall is to set out in the notification to the Minister (a) the nature of the defect and (b) the circumstances of use or misuse which may lead to danger.[385]

297. Motor vehicle recalls that are notified to the Minister responsible for the ACCC under s 128 are listed on the ACCC's "Product Safety Australia Website" which, at all relevant times, has been administered by the ACCC (**PSA website**).[386]

298. Under s 122 of the ACL, a responsible Minister (being the Commonwealth Minister administering Part XI of the *Competition and Consumer Act* and State Ministers administering cognate State legislation) may, by written notice published on the internet, issue a recall notice for consumer goods of a particular kind if it appears, *inter alia*, that such goods may or will cause injury to any person or if a safety standard is in force for the relevant goods and the goods do not comply with the standard. (The Compulsory Recall Notice that ultimately issued in February 2018 in respect of affected Takata airbag inflators was made pursuant to this power).

299. Under s 131 of the ACL, suppliers have an obligation to report if they become aware of consumer goods associated with the death or serious injury of a person.

[385] 10A/109J/3180-47 at [1.9]
[386] ACCC Background Paper, p 39, Exhibit 1, 9/83/2473 at section 4.2, p 2512; see statement of Timothy Grimwade, 21 June 2019, Exhibit 1, 9/90/2819 at [10].

***DIRD's relevant statutory framework prior to 13 July 2017***

300. At the date of Mr Ngo's death, DIRD administered the *Motor Vehicle Standards Act 1989* (Cth) (***MVS Act***) and was responsible for the regulation of vehicles imported into Australia and supplied to the Australian market.

301. All such vehicles were (and are) required to comply with the Australian Design Rules (**ADRs**) – being national standards that relate to, *inter alia,* motor vehicle safety – before they can be supplied to the Australian market for use in transport. Under s 41 of the *MVS Act*, national standards relating to motor vehicle safety are safety standards within the meaning of the ACL.[387] DIRD, as the national vehicle safety standards regulator, has a compliance and enforcement role with regard to the application of the ADRs.

302. As at the date of Mr Ngo's death, DIRD did not have any statutory powers to compel a recall of defective motor vehicles. Sharon Nyakuengama, who was General Manager of the Vehicle Safety Standards Branch (**VSSB**) within DIRD between April 2016 and October 2019,[388] gave evidence that:[389]

> "No statutory powers, functions or duties in relation to recalls – voluntary or compulsory – are conferred upon or available to the department [ie DIRD] by the CCA [*Competition and Consumer Act 2011* (Cth)] or any other legislation in force at the time of Mr Ngo's death."

303. However, DIRD performed various functions in respect of the monitoring of voluntary motor vehicle recalls. Ms Nyakuengama stated, in this regard:[390]

> "Where a notice of a voluntary recall is given under s 128, as a matter of good public administration, those recalls are monitored. Where the voluntary recall involves road vehicles, the department [ie DIRD], as the Commonwealth agency with relevant specialist knowledge … monitors [the] recalls."

***Australian Design Rules and Vehicle airbags***

304. Ms Nyakuengama told the inquest that while, since at least 2014, it has been part of the role of DIRD as the national vehicle safety standards regulator to monitor compliance with the ADRs, the ADRs do not themselves make provision for testing

[387] ACCC Background Paper, p 39, Exhibit 1, 9/83/2473 at section 4.2, p 2511.
[388] Tpt 793.8-.20. In that role she was responsible for around 55-65 employees, of which about three to five were involved in the voluntary recall process involving Takata airbags, amongst their other duties: Tpt 845.25-.40.
[389] Exhibit 1, 11/110/3182 at [5].
[390] Exhibit 1, 11/110/3182 at [6].

airbags or the stability of the propellant in airbags.[391]

305. Though an airbag is a component of a vehicle, there is no ADR for an airbag. Rather it falls within a criteria known as "occupant protection standards" which is a performance based test. Ms Nyakuengama explained*, "in order to allow innovation and, and in order to provide vehicle manufacturers the opportunity to progress technological advancements in order to, to meet those standards. An airbag is just one of the strategies that a vehicle manufacturer might employ in order to meet the occupant protection standards. Others are crumple zones, vehicle structural integrity, seatbelts et cetera"*. For a vehicle to pass the occupation protection standard, it is subjected to impact crash testing and provided the crash test dummy doesn't exceed an injury limit the vehicle passes the test. [392]

306. The durability and life expectancy of airbags is not a matter that is regulated under the *MVS Act*.[393] Australia does not have any rules or standards relating to the use of chemical propellant in an airbag inflator.

307. Ms Nyakuengama's evidence was to the effect that the development of a new standard for airbags would involve a "long and novel process", at least in part because the performance of an airbag is dependent upon its mode of integration into the particular vehicle in which it is installed.[394] Nonetheless, she accepted that, having regard to the safety risk posed by defective airbags, the introduction of a standard related to airbag performance could be an important development;[395] and her evidence was to the effect that though standards relating to the testing of airbag mechanisms apply overseas, they do not apply in Australia.[396]

***Memorandum of Understanding between DIRD and the ACCC and arrangements preceding it***

308. A Memorandum of Understanding between the ACCC and DIRD dated 19 October 2016 (**MOU**)[397] set out a "framework for cooperation between [DIRD] and [the ACCC] with regard to the regulation of consumer products and motor

[391] Tpt 701.20 to 701.47; Exhibit 1, p 3610-3.
[392] Tpt 702.22-36
[393] See letter from AGS to CSO dated 11 October 2019, Exhibit 1, 12/124A/3619-2 to 3619-3.
[394] Tpt 794.8-.20; see also Tpt 990.10-993.
[395] Tpt 794.25.
[396] Tpt 795.19-.32.
[397] Exhibit 1, 9/84/2649.

vehicles".

309. The purpose of the MOU, as stated in clause 2, was:

> "… to provide a framework that facilitates:
>
> a) effective operational liaison and rapid information exchange between the Parties regarding product and motor vehicle safety matters;
>
> b) efficient administration of product and motor vehicle recalls;
>
> c) preparation and issue of joint media and public statements;
>
> d) simplicity and clarity for third parties whose activities are regulated by the Parties; and
>
> e) cooperation in investigations of mutual interest under the Parties' respective legislation."

310. The agreed principles underpinning the MOU, as set out in clause 6.1, were:

> "(a) a coordinated and cooperative approach will form the basis of the arrangements established under this MOU; and
>
> (b) the timely exchange of knowledge and information and an open dialogue will enhance the efficiency and effectiveness of the Parties' respective roles."

311. Clause 8 of the MOU, headed "Recall Administration", provided as follows:

> "8.1. Recalls of unsafe or ADR non-compliant vehicles are generally undertaken voluntarily by suppliers in accordance with the Federal Chamber of Automotive Industries (FCAI) voluntary Code of Practice. However, if a supplier declines to undertake voluntary recall action where Infrastructure believes such action is warranted, the Parties may initiate a coordinated response.
>
> 8.1.1. The ACCC is responsible for the administration of recalls of unsafe consumer goods (i.e. it ensures that voluntary recall notifications comply with the notification requirements of s.128 of the ACL and are consistent with the ACCC's Product Safety Recall Guidelines).
>
> 8.1.2. Infrastructure as the national vehicle safety standards regulator is responsible for assessing and monitoring compliance with ADRs and negotiating (where necessary) voluntary recalls of vehicles by suppliers as specified in 10.1.
>
> 8.1.3. The ACCC may assist with voluntary recall negotiations of vehicles at Infrastructure's request.

> 8.2. The ACL requires that the Commonwealth Minister be notified by suppliers of their voluntary product safety recalls within two days of beginning recall action.
>
> 8.3. The Parties will notify each other about receipt of product safety recall enquiries affecting motor vehicles and related consumer goods as soon as is practicable.
>
> 8.4. Infrastructure is the principle (sic) point of contact for suppliers that have recalled vehicles and takes a lead role in monitoring recall progress and engaging with suppliers about improving their recall strategies.
>
> 8.5. The Parties will share expertise and information to manage the administration and monitoring of recalls in the most efficient way possible for the benefit of consumers and suppliers.
>
> 8.6. The ACCC implemented a new database and website for managing recalls in August 2016 and will endeavour to provide Infrastructure with access. Any such access will be subject to a protocol agreed by the Parties."

312. Clause 10 of the MOU, setting out the division of the roles of the ACCC and DIRD in respect of consumer product recalls, relevantly provided that:

> a. DIRD will take the lead in recalls of consumer products covered by the ADRs, with the ACCC providing advice/support: clause 10.1;
>
> b. DIRD "will provide advice and support to the ACCC regarding the testing of parts, assessment of technical and engineering reports, and negotiations with third parties": clause 10.2; and
>
> c. the ACCC will provide advice and support to [DIRD] regarding negotiations with third parties, negotiation of changes to the current FCAI recall code of practice, and recall administration: clause 10.3.

313. DIRD advised the inquest that, in practice, the arrangements under the MOU meant that:[398]

> "…the Department [DIRD] engages with suppliers of consumer goods that are vehicles covered by the ADRs to negotiate recalls of those consumer goods. The Department maintains contact with the ACCC on vehicle recalls, which the ACCC publishes on the productsafety.gov.au website. The Department also maintains contact with all affected vehicle suppliers to monitor the progress of voluntary road vehicle recalls and (in accordance with the FCAI Code of Practice) receives monthly reports from suppliers, to ensure that affected vehicles are rectified quickly.

[398] Exhibit 1, 8/79/2417 to 2419; see also Ms Nyakuengama's evidence at Tpt 710.26.

> Once the Department [DIRD] has received advice from an FCAI member that they have taken action to voluntarily recall road vehicles, the Department then monitors the progress of the recall, and updates the ACCC as necessary and in accordance with the MOU."

314. Thus, whilst at the time of and leading up to Mr Ngo's death, the ACCC (through its responsible Minister), rather than DIRD, held statutory powers to escalate a voluntary recall to a compulsory recall, DIRD was allocated responsibilities under the MOU for negotiating (where necessary) and monitoring the progress of voluntary recalls of motor vehicles by suppliers as well as engaging with suppliers about their recall strategies.[399]

315. DIRD advised the inquest that:[400]

> "[p]rior to entering into the MOU, the agencies communicated regularly in relation to the administration of voluntary recalls of vehicles that are consumer goods in a manner consistent with the terms of the MOU. The MOU formalised these long-standing working arrangements".

316. According to Ms Nyakuengama, the unwritten arrangements that were formalised by the MOU had been in place as between DIRD and the ACCC for around 15 years.[401]

317. Similarly, Mr Timothy Grimwade of the ACCC stated that the MOU "formally documented the settled practice in existence for several years prior to 2016".[402]

318. Notably, on 1 September 2015, when the terms of the then proposed MOU were being considered by DIRD and the ACCC, Jeremy Thomas, Director of the Operational Policy Section of DIRD between mid-2015 and February 2017, emailed Jan Klaver of the ACCC, stating, *inter alia*:[403]

> "Under current arrangements, there is a level of duplication and lack of clarity for industry about recall arrangements. For example:
>
> - In initiating a recall, the manufacturer will generally approach the ACCC with a draft recall notice—where there is concern from the ACCC about the form of the notice, Infrastructure may be consulted; but

[399] See Tpt 711.10 to 712.2.
[400] Exhibit 1, 8/79/2412 at 2416.
[401] Tpt 961.15.
[402] Exhibit 1, 9/90/2817. Statement of 21 June 2019, Mr Timothy Grimwade, who has been the Executive General Manager of the ACCC's Consumer, Small Business and Product Safety Division of the ACCC since 3 April 2017
[403] Exhibit 1, 15/21; see also Tpt 1203.34-.37.

- Once a recall has been initiated, Infrastructure will monitor its progress, and chase up with manufacturers where progress is too slow.

  Over time, Infrastructure sees itself as having a more significant role in the recalls of new vehicles. Ideally over time we would like to:

- Approve draft recall notices

- Work with industry on improving the demarcation between recalls and service campaigns.

  · Use the ACCC database for managing recall monitoring.

  However, we understand that we are moving into ACCC's regulatory space here, so this might require some thought."

319. Counsel Assisting advance that there was not only a "lack of clarity for industry" around recall arrangements but it was also the agencies themselves which were confused. Counsel Assisting submit that there was a "lack of clarity" as to the delineation between the roles of the ACCC and DIRD in respect of motor vehicle recalls and submit that this lack of clarity persisted despite the execution of the MOU in October 2016, at least insofar as the Takata recalls were concerned.

320. Counsel Assisting submit that this lack of clarity caused or was accompanied by "a level of confusion" or "significant confusion" between the government departments as to who was responsible for what in the recall campaign. Finally, it is submitted that this lack of clarity or confusion resulted in suboptimal monitoring of the voluntary recalls.

***The allocation of responsibilities between the ACCC and DIRD***

<u>DIRD's understanding of its role in respect of the Takata airbag recalls</u>

321. In her oral evidence, Ms Nyakuengama generally[404] resisted the proposition that DIRD was responsible for "managing the voluntary recall process" for Takata airbags undertaken between 2015 and 2017 as, in her view, "voluntary recalls are inherently managed by the recalling manufacturer"; and it was the ACCC which held the relevant statutory recall powers.[405] Ms Nyakuengama said, in this respect:[406]

> "…[W]e [DIRD] don't consider ourselves a regulator of the recall, we consider ourselves a regulator of the supply of motor vehicles to

[404] Although cf, eg, Tpt 742.14, Tpt 850.34, 851.1, Tpt 944.19.
[405] Tpt 866.49-867.15.
[406] Tpt 717.10; see also Tpt 717.29.

> the market and we monitor the recalls that are undertaken under the ACL."

322. Similarly, Mr Thomas considered that the ACCC (rather than DIRD) was the "principal regulator" of the voluntary recalls of defective Takata airbags, albeit that the ACCC "outsourced" a supporting role to DIRD, in respect of particular responsibilities.[407]

323. On Mr Thomas' understanding, the responsibilities that had been outsourced by the ACCC to DIRD under the MOU (and the informal arrangements that preceded it) included an examination of the documentation provided by a supplier in association with a recall – namely, the notification of the recall, the technical service bulletin relating to the recall, and, frequently but not always, the proposed consumer letter explaining the defect and what was to be done.[408]

324. On Mr Thomas' account, in examining such material, DIRD's focus was on assessing whether the technical defect had been correctly identified and whether the proposed mode of rectification was sound and likely to fix the defect so as to make the vehicle safe and compliant with the ADRs.[409]

325. Mr Thomas said other tasks outsourced by the ACCC to DIRD included interacting with industry and conducting technical assessments (and monitoring recalls in other countries that could potentially be relevant to the Australian market).[410]

326. Though Mr Thomas' understanding was that the ACCC remained responsible for considering the exercise of any compulsory powers it had at its disposal, including the ordering of a compulsory recall or a product ban,[411] he accepted that part of DIRD's role included considering whether a matter should be referred to the ACCC so that the ACCC could consider the potential exercise of its compulsory powers.[412]

<u>ACCC's understanding of its role in respect of the Takata airbag recalls</u>

327. In a document that DIRD prepared and provided to the ACCC on 21 September 2015, the arrangements then in place in respect of motor vehicle recalls were

[407] Tpt 1013.38-.1014.36; Tpt 1154.46-1155.21.
[408] Tpt 1014.40-1015.28, 1016.11.
[409] Tpt 1019.32-1020.17, 1021.6-.21. 1023.19-.23.
[410] Tpt 1016.29-.46.
[411] Tpt 1017.33-.46.
[412] Tpt 1018.29-.37.

described as follows:[413]

> "Under current arrangements, the Australian Competition and Consumer Commission (ACCC) is responsible for administering recalls for consumer goods (including new vehicles), and the Department provides a supporting role in providing technical guidance to industry and the ACCC."

328. In relation to this statement, Mr Grimwade disagreed that the ACCC was responsible for administering the voluntary recalls of Takata airbags; and he disagreed that DIRD's role was limited to a supporting role in providing technical guidance to the ACCC.[414]

329. According to Mr Grimwade, prior to July 2017, from the ACCC's perspective:

    a. DIRD had assumed responsibility as the lead regulator of voluntary airbag recalls pursuant to the MOU entered into in agreement with the ACCC.[415] The ACCC was not "the regulator" of the Takata airbag recalls during the period from 2015 until July 2017.[416] In addition, the ACCC does not see it as part of its role to "regulate the regulators" that are conducting a monitoring role in relation to voluntary recalls.[417]

    b. The ACCC was not itself monitoring the Takata airbag recalls.[418] The ACCC would defer to DIRD's recall monitoring and assessment, and rely on what DIRD told it in respect of the recalls, and would provide assistance or take action to intervene at DIRD's request.[419]

    c. DIRD was the agency responsible for evaluating manufacturers' recall strategies, including communications with consumers,[420] and DIRD's role involved engaging with suppliers about improving their recall strategies.[421]

    d. It was not part of the role of the ACCC Consumer Product Safety Division to educate consumers about the risks posed by Takata airbags, beyond publishing notifications on the ACCC's PSA website and bringing attention to those notifications[422] and providing information to consumers about their

[413] Draft media handling brief - Exhibit 1, 9/90-2/2840.
[414] Tpt 1280.5-.11.
[415] Tpt 1261.22; Tpt 1649.31-.1652.47.
[416] Tpt 1261.29-.32; Tpt 1541.42-1542.4.
[417] Tpt 1281.30-.32; see also Tpt 1706.28.
[418] Tpt 1547.32-.50; Tpt 1556.48.
[419] Tpt 1262.47 -1263.12; Tpt 1543.5; Tpt 1557.39-1558.8; Tpt 1568.1-.10; Tpt 1642.6-.15.
[420] Tpt 1260.34.35.
[421] Tpt 1263.26-.43.
[422] Tpt 1260.21-.27; see also Tpt 1271.11-.13.

consumer guarantee rights in relation to affected vehicles.[423] The ACCC expected DIRD to undertake such a role as the lead regulator including, where necessary or appropriate, using media alerts.[424]

e. The ACCC, rather than DIRD, held compulsory powers to take action in respect of recalls. Accordingly, the ACCC had not outsourced or subcontracted its responsibilities for recalls to DIRD.[425]

330. In contrast to Mr Grimwade's evidence, the understanding of Dean Wright, who was Assistant Director of the Recalls and Hazard Assessment Section with the ACCC's Product Safety Branch from about October 2010 until mid-2016,[426] was that the ACCC *did* have responsibility to monitor the effectiveness of the Takata recalls.[427]

331. Mr Wright said he understood that part of the role of the ACCC was to use education and campaigns in order to improve product safety awareness as to the dangers associated with Takata airbags.[428] Further, Mr Wright did not agree that, during the period in which he was Assistant Director, the ACCC had "outsourced" its responsibilities in relation to examining documentation associated with recalls, interactions with industry, monitoring recalls and identifying safety issues to DIRD:[429]

A level of confusion

332. In his oral evidence, Mr Thomas accepted that there was a "low level of confusion" as between DIRD and the ACCC as to who was responsible for what in relation to the voluntary recall processes in relation to Takata airbags;[430] and also that there was some confusion amongst industry as to the agencies' respective roles in terms of "manufacturers not being quite sure about whether to come to [DIRD] or to the ACCC first".[431] He agreed that any confusion about the division of responsibilities between agencies in connection with voluntary recalls of Takata airbags was

[423] Tpt 1460.10-.14. Material of this kind (eg, Exhibit 1, 14/140A/3999-3) would be accessible to consumers who were looking for such information on the ACCC's website, but was not part of a broader announcement directed to making consumers aware of the Takata airbag issue in the first place: Tpt 1460.16-.29. Further, the consumer rights information that was before the inquest did not refer to the involvement of DIRD in the voluntary recalls: see Tpt 1478.50-1479.6.
[424] Tpt 1673.40-.1674.6.
[425] Tpt 1565.9-.1566.2.
[426] Tpt 1290.27-.32.
[427] Tpt 1298.27-.50.
[428] Tpt 1364.25-.38; Tpt 1385.3-.7.
[429] Tpt 1379.34-.42. cf Mr Thomas' evidence referred to at [322]-[325].
[430] Tpt 1222.15-.21.
[431] Tpt 1203.34-.37; Tpt 1245.14-.16.

undesirable from a safety and public policy perspective and was something that should not have occurred, and should have been resolved by at least mid-2015 or earlier.[432]

333. Mr Grimwade said that looking back over the voluntary recalls, in his view "there was lack of clarity in relation to the boundaries of the roles of the ACCC and DIRD;[433] as well as a "lack of detail in relation to what is expected of an agency that's responsible for monitoring a recall and evaluating recall strategies as risks change".[434] He agreed that some officials within DIRD had a different understanding of the role that it was meant to be undertaking than the ACCC had.[435] He thought that there "need[ed] to be greater clarity" in the MOU and that it had caused confusion in relation to the respective roles of DIRD and the ACCC concerning the Takata airbag recalls.[436] Mr Grimwade also accepted that there was a "level of confusion" in documents that were prepared by the ACCC or otherwise reviewed by it over the period from 2015 to 2017 as to what its role was in respect of the Takata recalls.[437]

334. In relation to the MOU itself, Mr Grimwade was unable to explain why, despite the two year review mechanism within clause 17 of the MOU, no review had been undertaken.[438]

335. Counsel Assisting submit that at a high level, there was significant confusion as to the allocation of responsibilities between DIRD and the ACCC in relation to the Takata airbag recalls exemplified by exchanges that took place between representatives of DIRD and the ACCC in August 2017, following Mr Ngo's death. On 8 August 2017, DIRD provided the ACCC with a draft of its report (to the Minister of Urban Infrastructure) outlining the actions that had been taken, up to then, relating to the Takata airbag recalls.[439] The draft report included the following statements:[440]

> "Under current arrangements, the ACCC is responsible for administering recalls for consumer goods (including new vehicles),

[432] Tpt 1244.40-.1245.6.
[433] Tpt 1271.24-.26.
[434] Tpt 1271.34-.36.
[435] Tpt 1723.34-.39.
[436] Tpt 1652.24-.30; Tpt 1667.26-.30.
[437] Tpt 1561.41-.44. As to this, see, in particular, Exhibit 1, 17/158-15/4606, which references the NRMA letter dated October 2015 at Exhibit 1, 9/90-3/2849; and the September 2015 Media Handing Brief at Exhibit 1, 9/90-2/2840 (which the ACCC had a role in reviewing); see also, ACCC Talking Points Prepared for the Northern Territory incident in April 2017, Exhibit 1, 18/165/5234.
[438] See Exhibit 1. 9/84/2657; Tpt 1672.32-.1673.12.
[439] Exhibit 1, 14/142F/4058-48.
[440] Exhibit 1, 14/142F/4058-55.

> and the Department provides a supporting role in providing technical guidance to industry and the ACCC.
>
> The Department also maintains contact with the ACCC and all affected vehicle manufacturers to monitor the progress of motor vehicle recalls, to ensure that vehicles are rectified as soon as practicable."

336. In response to receiving this draft, on 9 August 2017 Mr Grimwade emailed various DIRD officers, including Ms Nyakuengama, stating:[441]

> "I have just started to go through the report you sent through yesterday and am a little concerned that it may misrepresent the role of the ACCC in relation to motor vehicle recalls in a number of ways, and is inconsistent with the MOU between the ACCC and DIRD. In particular, our concern is that it states that the ACCC is responsible for administering recalls of new vehicles[442] with DIRD playing only a supporting role, and this implication is repeated at various points in the report (including in the first sentence of the Executive Summary).
>
> We would be concerned if this report were made public in its present form, as it is not consistent with our understanding nor the agreement as to the delineation of roles in relation to the management of vehicle recalls. Section 8 of the MOU covers the respective roles, and reflects that the ACCC's administrative role is to ensure the voluntary recall notification requirements are complied with, but that DIRD is responsible for negotiating voluntary recalls, and that the ACCC may assist with recall negotiations at DIRD's request. The MOU also states that it is the ACCC that supports DIRD in recall administration, not the other way around as expressed in this document."

337. On 10 August 2017, Ms Nyakuengama emailed Neville Matthew of the ACCC disputing the ACCC's interpretation of the position under the MOU as referred to in Mr Grimwade's email, stating: "overall we are of the view that it [the Department's report to Minister Fletcher] accurately reflects [what] DIRD's actual role is given our current legislative powers (none), resourcing and capability".[443]

338. In a later email from Mr Matthew to Ms Nyakuengama on 10 August 2017, Mr Matthew observed that "we seem almost diametrically opposed on some role aspects".[444]

339. In his oral evidence before the inquest, Mr Grimwade similarly accepted that on

[441] Exhibit 1, 14/142F/4058-47. See also, Mr Grimwade's evidence at Tpt 1550.41-.46.
[442] Mr Grimwade later clarified that despite the reference in his email to "new vehicles", there was no delineation or differentiation in the respective roles of the ACCC and DIRD depending on whether or not vehicles being recalled were new: Tpt 1563.13-.37.
[443] Tpt 1553.22-.27; Exhibit 1, 14/142I/4058-102.
[444] Exhibit 1, 14/142I/4058-101.

his reading of the draft report provided by DIRD,[445] and Ms Nyakuengama's response to his email, the ACCC and DIRD seemed almost "diametrically opposed" as to some aspects of their roles.[446] Mr Grimwade agreed that one of the lessons learned during the course of the inquest was that there appeared to be confusion between the ACCC and DIRD as to what their respective roles are.[447]

340. Mr Grimwade advised the inquest that work had recently been done around clarifying "what we [the ACCC] consider a lead regulator role should be under the MOU", and he referred to a project being in place to develop a new MOU with DIRD.[448] As to this, in a paper dated 12 May 2020 entitled "Clarification of roles under 2016 Memorandum of Understanding", the ACCC provided suggestions to DIRD as to how there could be clarification of their respective roles under the MOU, including in relation to the nature of the "lead regulator role", the nature of the "advice and support role", matters concerning the "escalation of recalls and safety issues" and the exchange of information between the ACCC and DIRD.[449] Mr Grimwade accepted that, in addition to the matters set out in this paper, it would be prudent to clarify the scope of consumer products that are subject to the responsibility of DIRD as lead regulator, and the extent to which this includes airbags.[450]

341. Counsel Assisting submit that in the context of the voluntary Takata airbag recalls and in the lead up to the death of Mr Ngo (and continuing) there was, as between DIRD and the ACCC, substantial confusion in relation to the MOU arrangements between DIRD and the ACCC as reflected in the exchanges referred to above and further submit that the confusion as between DIRD and the ACCC extended to the following matters relevant to the circumstances surrounding Mr Ngo's death:

    a. reviewing and settling the **content of recall notifications** published on the ACCC's PSA website;

    b. which of DIRD and/or the ACCC were responsible for engaging with motor vehicle suppliers about their **recall strategy**;

    c. which of DIRD and/or the ACCC were responsible for reviewing motor

[445] Mr Grimwade's reading was seemingly supported by Mr Matthew of the ACCC: see Exhibit 1, 14/142I/4058-102; Tpt 1637.25-.40.
[446] Tpt 1635.9-.15.
[447] Tpt 1667.26-.33.
[448] See, eg, Tpt 1533.42-1534.1, Tpt 1564.1-.10; Tpt 1567.4.
[449] Exhibit 1, 14/142J/4058-213 to 4058-216; Tpt 1667.12-.18.
[450] Tpt 1674.14-.49.

vehicle suppliers' **plans for communication** with affected vehicle owners;

d. which of DIRD and/or ACCC were responsible for reviewing consumer recall letters (from motor vehicle suppliers to affected vehicle owners) to ensure their effectiveness as a means of consumer communication. (It is noted that there was no express designation in the MOU as to which agency was to take the lead in reviewing such **consumer communications**);[451]

e. which of DIRD and/or ACCC were responsible for bringing the risks posed by Takata Airbags to the **attention of the public**, including through any media or information campaign or media releases.

342. As to this, but for clause 11 of the MOU (which broadly provides for media releases/public announcements to be cleared by each party thereto), there is no provision in the MOU expressly specifying which agency is to engage with **media** about voluntary motor vehicle recalls.[452]

343. Mr Grimwade accepted that confusion between DIRD and the ACCC as to their respective roles in relation to Takata airbags may have contributed to the public (which includes the Ngo family) not being (sufficiently) warned as to the dangers associated with Takata airbags prior to the death of Mr Ngo.[453]

***Statutory powers conferred on DIRD in relation to recalls of motor vehicles since Mr Ngo's death***

344. The position that applied at the time of Mr Ngo's death, in relation to the respective statutory powers and administrative functions of the ACCC and DIRD, changed as a result of the enactment, in December 2018, of the *Road Vehicle Standards Act 2018* (Cth) (***RVS Act***). The *RVS Act* gives force to rules providing for the Transport Minister to issue a (compulsory) recall notice to suppliers of vehicles or components of vehicles, non-compliance with which can result in substantial criminal and civil penalties: *RVS Act*, ss 37, 38.

345. The *Road Vehicle Standards Rules 2019* (Cth), made pursuant to the *RVS Act*, provide that the responsible Minister may, by legislative instrument, issue a recall notice for road vehicles or approved road vehicle components of a particular kind if, broadly, the vehicle or component poses a relevant safety risk or breaches a

[451] Tpt 1274.14.
[452] Tpt 1274.19.
[453] Tpt 1722.30-.34.

relevant standard and it appears to the Minister that one or more suppliers have not taken satisfactory action to prevent the vehicle or component from causing injury: clause 206.

346. Upon the commencement of the relevant provisions of the *RVS Act* and *Road Vehicle Standards Rules 2019* (Cth), both DIRD and the ACCC possess the power to compulsorily recall motor vehicles that are consumer goods.[454] Which agency exercises that power in particular circumstances is subject to administrative arrangements between the ACCC and DIRD.[455]

***Guidelines for Suppliers of Motor Vehicles – The FCAI Code of Practice for Automotive Recalls***

347. The FCAI is the Australian automotive industry's peak body. The inquest received a statement from Anthony Weber, the Chief Executive of the FCAI, who explained that the FCAI's membership is comprised of organisations operating in the motor vehicle industry, including importers of motor vehicles.[456] The FCAI Board is comprised of representatives from upper management in a number of those organisations, including Honda Australia.

348. The FCAI has developed a Code of Practice for the Conduct of an Automotive Safety Recall, which is published on its website for use by its members. The version of the FCAI Code in force at the time of Mr Ngo's death was "version 1.2" dated February 2017,[457] and this remains the current version.[458]

349. The provisions in that version have been materially in the same form since about 2011.[459] In his statement Mr Weber explained the process by which the FCAI Code was prepared.[460] Each of DIRD and the ACCC was invited to and did provide comments on the drafting of the FCAI Code.[461] Ultimately, the Code was submitted to the FCAI Board and approved.

350. Although the FCAI Code is not binding on members, in clause 8.1 of the MOU between ACCC and DIRD, there is an acknowledgement that recalls of unsafe or ADR non-compliant vehicles in Australia are generally undertaken voluntarily by

[454] Tpt 732.32.
[455] Tpt 732.35 to 733.49.
[456] Exhibit 1, 6/70A /1928-1.
[457] See at Exhibit 1, 6/71/1929.
[458] Letter from Mark Waters, CIE Legal, to Johanna Geddes, 1 March 2019, Exhibit 1, 6/70/1924.
[459] Tpt 373.20 to 373.28.
[460] Exhibit 1, 6/70A/1928.
[461] Tpt 714.26; see also Exhibit 1, 6/70A/1928-6 to 1928-10, 12/127/3638.

suppliers in accordance with the FCAI Code.[462]

351. Given that Honda Australia's implementation of the 5ZV recall was sought to be conducted in accordance with the FCAI Code, it is appropriate to outline relevant provisions of the FCAI Code.[463]

    a. The FCAI Code is not legally binding and is expressed to be subject in all respects to the provisions of the ACL and other legislation: FCAI Code, clause 2.3.

    b. The FCAI Code describes the procedures to be followed when an FCAI member is advised (or becomes aware) that one of its products may have a safety defect.

    c. Where a safety defect is found to exist in any model, type or category of the member's products that have been delivered to customers, the member is required to conduct a safety recall in accordance with the Code: clause 6.1.

    d. Clause 8 of the FCAI Code sets out the steps to be taken by a member in preparation for a safety recall, which include notifying the member's dealers of the recall and of the actions which the member and the dealers are to take in initiating and conducting the recall.

    e. Clause 9 provides that:

> "When the Member has identified the nature of the Safety Defect and the Recall Products and determined the manner in which the Safety Defect will be rectified, the Member must take such actions as are necessary to ensure that the Member's Dealers have, or will have at the appropriate time, the parts, assemblies and/or materials and the technical and other instructions required to rectify the Safety Defect when the Customers present the Recall Product."

    f. Clause 10 of the FCAI Code refers to the steps to be taken in relation to publication of the Safety Recall. These include furnishing a notice to the member's dealers pursuant to clause 8(a)(ii), publishing an advertisement if required by clause 12 (where customers' names and/or addresses are unknown) by an appropriate news release to the media/other advertisement, mailing or emailing the recall notice to customers and, if

[462] Exhibit 1, 9/84/2652.
[463] Exhibit 1, 6/71/1929.

deemed appropriate, contacting customers by telephone, email, text message, personal visit, or other means. The FCAI Code does not prescribe, with any particularity, the required content or appearance of recall letters to customers.

g. Clause 11.3 refers to steps that should be taken where customers do not respond to safety recall notices by returning the recall product for inspection or, where appropriate, rectification. In broad compass, where this does not occur within 90 days (or such longer or shorter period as is appropriate in the circumstances) after the mailing of the original notice to the customer, a second notice is to be sent (clause 11.3.1) and, where there is a failure to respond to a second recall notice within 90 days (or such longer or shorter period as is appropriate in the circumstances), a third recall notice must be sent by registered post to the address maintained by NEVDIS for the vehicle: clause 11.3.2. The FCAI Code does not include any requirements for further attempts at notification of a customer after there has been a failure to respond to a third notice. Where this occurs, the member is to advise the vehicle registration authority in the State or Territory in which the last known address of the customer is located of the existence and details of the relevant safety recall and of the fact that the customer has failed to respond to the safety recall to have the recall service carried out: clause 11.3.3.

h. Suppliers are required to advise both the ACCC and DIRD when they have taken voluntary recall action and to submit a monthly performance report to DIRD to facilitate monitoring of the progress of the recall: clause 11.1, clause 18.

352. In his evidence, Mr Hather expressed concerns about what he described as the "benchmark" recall communications plan for which the FCAI Code provides, being a series of mailed letters staggered by 90 days.[464] Although the FCAI Code does not specifically prescribe 90 days as the period that *must* elapse between recall notices (but rather refers to 90 days "or such longer or shorter period as is appropriate in the circumstances"), and also provides in clause 10(e) that members, if deemed appropriate, should arrange for customers to be contacted by "telephone, email, text message, by personal visit or other appropriate means", Mr Hather's concerns were essentially that the FCAI Code does not specifically tie

[464] Tpt 623 to 626; Exhibit 1, 7/73/1983 at [44].

the member's communications plan with the recall product's assessed level of risk.

353. Counsel Assisting submit that the FCAI Code should be reviewed with particular regard to:

    a. making express provision in the Code for the need for members to consider what is appropriate at all stages of a recall communications strategy to communicate with customers about the existence of the recall (including the mode, frequency and content of notifications to consumers), having regard to:

        i. the nature of the safety defect;

        ii. the assessed level of risk arising from the safety defect (including the nature of the risk or potential harm arising from the safety defect and the probability of the harm materialising); and

        iii. the urgency for rectification of the product in which the safety defect is found to exist;

    b. providing more detailed guidance to members about the development of recall strategies, including the use of telephone, email, text messages and social media to communicate with customers about a recall and the need to amend such strategies based upon customer response and revised understandings of risk;

    c. providing more substantive guidance to members about the appearance and contents of written recall communications, including the use of visual aids and clear and explicit language that does not downplay risk; and

    d. providing clarification in relation to the interaction between the FCAI Code and any recall guidelines issued (or that may in due course be issued) by the ACCC and/or DIRD.

354. Mr Weber indicated that the FCAI is undertaking a review of the Code in light of the new *RVS Act*. He also noted that the FCAI will take into consideration any recommendations made in this inquest in relation to the FCAI Code.[465] The FCAI has reiterated in its submissions that regardless of whether recommendations are made as sought, the Association will give consideration to these issues when

[465] Exhibit 1, 6/70A/1928-3 at [12]-[13].

undertaking the review of the Code.

355. **Recommendations are made to the FCAI in regard to these and other matters as set out in paragraph 798.**

***ACCC Consumer Product Safety Recall Guidelines***

356. In addition to the FCAI Code, another resource available to motor vehicle suppliers conducting a voluntary recall of consumer goods is the Consumer Product Safety Recall Guidelines published by the ACCC (**ACCC Guidelines**).[466] The following refers to the version of the ACCC Guidelines dated December 2015.

357. The purpose of the ACCC Guidelines is stated to be "to assist suppliers in effectively conducting a product safety recall in accordance with Australian consumer law".[467] The ACCC Guidelines expressly provide that they are for guidance only, and are not legally binding.

358. The introduction to the ACCC Guidelines states: [468]

> "The product safety recall system that a supplier has in place should be tailored to the specific products they supply and the degree of risk those products may pose to consumers. Suppliers may seek their own independent advice (including legal advice) regarding the systems they develop for conducting a consumer product recall."

359. The background section of the ACCC Guidelines also includes the following:[469]

> "Goods that are monitored by other specialist Commonwealth regulators, such as the Therapeutic Goods Administration (TGA), the Australian Pesticides and Veterinary Medicines Authority (APVMA), Foods Standards Australia and New Zealand (FSANZ) and the Department of Infrastructure and Regional Development (DIRD), also fall within the jurisdiction of the ACCC. However, as a matter of administration and in recognition of the mandate and specialist expertise of those agencies, goods regulated by specialist Commonwealth regulators are not normally subject to direct action under the ACL.
>
> On occasion, the ACCC becomes involved in specialist matters when a regulator's powers are insufficient to satisfactorily address safety issues. In addition, the breadth of the definition of consumer goods under the ACL allows the ACCC to act as a 'safety net' and ensure that there are no gaps in Commonwealth regulatory coverage."

[466] Exhibit 1, 7/73C/2020.
[467] Exhibit 1, 7/73C/2022.
[468] Exhibit 1, 7/73C/2022.
[469] Exhibit 1, 7/73C/2023.

360. Section 1 of the ACCC Guidelines, entitled **"Legal Requirements, Roles and Responsibilities"**, relevantly provides:[470]

> "… A voluntary recall occurs when the supplier of a consumer product initiates the recall and voluntarily takes action to remove the goods from distribution, sale, and/or consumption. A voluntary recall may also be negotiated with a supplier following enforcement or compliance action by the ACCC. The word 'voluntary' is not intended to infer that a supplier may choose not to remove the product from sale. When a recall occurs, all of the goods subject to the recall must be removed from the market place.
>
> Section 122 of the ACL empowers the Commonwealth Minister responsible for consumer affairs to order a supplier to recall goods that may cause injury to any person if it appears to the Minister that the supplier has not taken satisfactory action to prevent the goods from causing injury. The Minister's recall order will stipulate the manner and timing of the recall. These are known as 'compulsory' recalls."

361. Section 2 of the ACCC Guidelines, entitled **"Mitigating a product safety risk"** states, under the heading "Identifying a consumer product safety hazard", that where a supplier becomes aware of a potential safety hazard associated with a consumer product, they should immediately take certain steps including conducting a comprehensive risk analysis. The ACCC Guidelines proceed to state that "[t]he most appropriate recall action will depend on a number of factors, including the nature of the risk, the distribution of the product, and also its expected lifecycle".[471]

362. Under the heading **"Conducting a successful recall"**, the ACCC Guidelines state:[472]

> "The supplier has prime responsibility for implementing a recall. A recall should be implemented in accordance with the supplier's pre-planned recall policy and after consultation with the ACCC.
>
> In order for the ACCC to be assured that the recall will meet its objectives, suppliers should undertake the following actions:
>
> - notify the regulator/s of the recall, which includes providing details of other entities within the supply chain that have been notified
> - prepare a recall strategy for submission to the relevant regulator/s

[470] Exhibit 1, 7/73C/2024.
[471] Exhibit 1, 7/73C/2027.
[472] Exhibit 1, 7/73C/2028.

- retrieve the affected product from consumers and from within the supply chain

- submit regular progress reports to the appropriate regulator/s."

363. Under the broad heading of **"Recall Strategy"**, the ACCC Guidelines then state:[473]

> **"**In order for a recall to meet its objectives efficiently, a supplier should submit a recall strategy to the ACCC upon initiating a recall.
>
> A supplier should also negotiate the content of the recall strategy with the ACCC prior to submission.
>
> Submitting the recall strategy for consideration is the first stage of the recall process and will assist the ACCC in assessing whether the product safety risks associated with the product have been adequately addressed.
>
> Some details of the recall strategy should be supplied to the ACCC at the time of initiating the recall. However, other details will not become evident until the recall has progressed, and these are to be provided at agreed intervals.
>
> **Elements of a recall strategy**
>
> A supplier's recall strategy should include:
>
> (a) an explanation of the problem, including the hazard associated with the product and the supplier's assessment of the level of risk presented to the user
>
> (b) the supplier's assessment of how the defect occurred, including detailed identification of the component or materials at fault and at which stage of supply the fault occurred (whether during the design, testing, manufacturing, packing, inspection or shipping stages)
>
> (c) the number of units supplied to consumers and other entities within the supply chain
>
> (d) details of any known injuries or incidents associated with the product
>
> (e) information about the life cycle of the product
>
> (f) a summary of the proposed communication with consumers, including the method of communication, how frequently it will be repeated and details of the message. This should be negotiated with the ACCC to ensure maximum efficacy. Guidance as to the types of factors that a supplier should consider when developing a communication plan is provided in attachment A
>
> (g) information about the way in which the supplier will manage contact from consumers about the recalled product, including any complaint-handling procedures

[473] Exhibit 1, 7/73C/2030-2032.

(h) information about the manner in which the recalled product will be collected, destroyed or rectified

(i) contact details of the manufacturer and/or importer of the product

(j) contact details of other entities in the domestic supply chain to whom the product has been supplied

(k) contact details of overseas recipients of the product (such as distributors or retailers)

(l) a summary of actions taken by the supplier to identify and correct the cause of the hazard, including the outcome of any root cause analysis or the time period in which the analysis will occur.

**Communication plan**

The purpose of communicating with consumers about a recall is to ensure that product related injuries are prevented by either removing or rectifying unsafe products. The goal in communicating a product recall is to ensure consumers comply with the recall notification.

It is important to match the communication medium to the consumer in order to achieve the objectives of a recall as efficiently as possible. Communications regarding the recall should therefore be directed towards the particular consumer demographic for the recalled product by using an appropriate communication method.

Although there are various means by which a supplier can convey a recall notification to consumers, there are some minimum requirements for written communication.

A **written recall notice** should include:

(a) **Product description** – a clear description of the product, including the name, make and model and any distinguishing numbers, such batch or serial numbers. Dates the product was available for sale should also be included.

(b) **Picture of the product** – a photograph or drawing of the product will provide the consumer with a convenient and effective means of identification.

(c) **Description of the defect** – a clear description of what the defect is. The defect should be described in simple terms so that the average consumer can understand what the problem is. Suppliers should refrain from using overly technical terminology wherever possible

(d) **A statement of the hazard** – a description of the maximum potential hazard and associated risk. Where available, an appropriate hazard symbol should be included.

(e) A section titled "**What to do**", which explains the immediate action the consumer should take. For example, "Cease use immediately and return the product to the place of purchase for a full refund". It should be clear that the consumer should return the product and not dispose of it. Suppliers should ensure they

minimise the inconvenience to consumers in order to encourage consumer compliance with the recall notice.

(f) A section titled, "**Contact details**", which explains who consumers should contact in order to receive a refund or have the product repaired or replaced. Business and after-hours telephone numbers should also be included (preferably toll free), as well as suitable email and website addresses."

364. The content of the ACCC Guidelines partly dovetails with, but is not identical to, the content of the FCAI Code. Mr Hather recommended in his report that the various guidelines available to Australian suppliers conducting a motor vehicle recall should be aligned to ensure that consistent, effective advice is provided for the conduct of a product recall.[474] Whereas, from Mr Collins' perspective, Honda Australia's recall policies were guided predominantly by the FCAI Code, Ms Nyakuengama said that she saw the ACCC Guidelines as forming the principal guidance for the conduct of voluntary recalls, with the FCAI Code being "supplement[al]".[475] There is no explanation, within either of the ACCC Guidelines or the FCAI Code, as to how those voluntary guideline documents are intended to interact with each other.[476] Ms Nyakuengama said that there would be utility in an explanation being provided as to the interaction between the recall guidance provided in the ACCC Guidelines and in the FCAI Code.[477]

365. Mr Grimwade advised the inquest that, arising from learnings from the inquest and from the Takata recalls (both voluntary and compulsory) more generally, the ACCC is undertaking a review or complete re-write of the ACCC Guidelines, which involves the inclusion therein of developing knowledge and research with the aim of better informing suppliers about how they can undertake voluntary recalls.[478]

366. Counsel Assisting submit that such engagement should be on a continuing basis and to the extent not already done, DIRD and the ACCC should liaise:

    a. to provide the FCAI with any suggested changes to the FCAI Code;

    b. in relation to the development and publication of guidance material from the regulators' perspective as to the intended interaction between the ACCC Guidelines and the FCAI Code (including any revised form of those documents); and

[474] See Exhibit 1, 7/73/1991 to 1993.
[475] Tpt 715.10.
[476] Tpt 730.47 to 731.15.
[477] Tpt 731.14.
[478] Tpt 1537.40-.44.

c. to ensure that any revised recall guidelines published by them specify the intended interaction between such guidelines and the FCAI Code.

367. As stated previously the FCAI is receptive to any such input and both the ACCC and DIRD in their submissions have likewise indicated their intent to engage with the FCAI in any such review. Accordingly, I make the recommendation as set out in paragraph [366a-c].

***Overview of DIRD's involvement in voluntary Takata airbag recalls***

368. During the period from 2015 to 2017, DIRD's focus in respect of the Takata airbags recalls was to monitor media and publicly available information concerning defective Takata airbags, bring that information to the attention of suppliers and monitor the voluntary recalls that were being undertaken by suppliers.[479]

369. In this respect, in a document provided to the inquest, DIRD advised that:[480]

> "The Department actively monitored world media and the US National Highway Traffic Safety Administration's (NHTSA's) website for new information about the risks associated with Takata airbag inflators and followed up with NHTSA and vehicle suppliers to obtain as much information as possible. As more information about the nature of the safety problem became known and regulatory action was undertaken in other countries, the Department continued to assess the implications for vehicle models in the Australian market (such as whether the voluntary recall needed to be expanded) and the actions being taken by Australian suppliers of affected vehicles and shared information with the ACCC as it came to hand."

370. DIRD monitored the Takata airbag recalls as a "thematic recall campaign"; that is, by monitoring the defects shared across manufacturers rather than at an individual manufacturer's level, as would ordinarily be done for other vehicle recalls.[481] The purpose of this monitoring role was, according to Ms Nyakuengama, to ensure that the recalls were "progressed at an appropriate rate".[482]

371. Between around June 2015 to mid-2017, there were up to nine staff members working within the "Operational Policy Section" of the VSSB at DIRD, which was the section that dealt with recalls.[483] These staff members included the Director of

[479] Tpt 882.27-.37.
[480] Exhibit 1, 8/79/2417.
[481] Tpt 850.25-851.2.
[482] Tpt 865.29.
[483] Tpt 1006.42-1007.37.

Operational Policy (and Associate Administrator of Vehicle Standards), Jeremy Thomas (who was replaced by Alison Whatson when Mr Thomas left DIRD in February 2017);[484] Carmine Finucci (the recalls manager, who worked with a small team including Karl Brown);[485] Erik Connell (who led an investigations team with two other investigators);[486] Sue Loxton (an administrative officer);[487] and another EL1 with administrative law related responsibilities.[488]

372. Monitoring recalls of Takata airbags was only one aspect of the work done by the Operational Policy Section (and by Mr Thomas in his capacity as director of that section).[489] The Section also monitored other (non-airbag related) motor vehicle recalls and had other responsibilities, including following up reported non-compliances with ADRs and the *MVS Act*.[490] According to Ms Nyakuengama, in the period from 2015 to mid-2017, about three to five staff within the Operational Policy Section were working on the Takata recalls (although this was only one aspect of their work).[491]

373. Amongst these staff members were persons, including Mr Finucci who was an automotive engineer and Mr Connell who also had an engineering background, who had expertise in identifying defects in vehicles that had the potential to cause harm or injury.[492] However, there was no staff member within DIRD's Operational Policy Section with specific airbag expertise, including expertise to carry out research and testing of Takata inflators, and DIRD did not have any capability to assess for itself the degree of risk of harm posed by various inflators / propellants.[493]

374. At least prior to the publication of the Blomquist Report in May 2016, DIRD had limited understanding as to the technical basis upon which particular vehicles/VIN ranges were selected by vehicle manufacturers for recall.[494] Mr Thomas' evidence was that "…we knew that they were ammonium nitrate Takata airbags. I think at some point it became clear that some had desiccants in and some didn't but we

[484] Tpt 1006.6-.11; Tpt 1151.3-.9.
[485] Tpt 1007.2-.29; Tpt 1101.7.
[486] 1007.27.
[487] Tpt 1007.29.
[488] Tpt 1007.31; Tpt 818.5.
[489] Tpt 1010.20.
[490] Tpt 798.
[491] Tpt 797-798. Ms Nyakuengama's evidence was to the effect that there was sufficient staffing and resources allocated within DIRD to the task of monitoring Takata airbag recalls between 2015 and 2017: Tpt 799.1-.37.
[492] Tpt 956.1-.40; Tpt 1159.11-.28.
[493] Tpt 882.39-.48; Tpt 947.24; Tpt 1159.5-.35.
[494] Tpt 1039.34-.42.

knew very little".[495]

375. DIRD was aware that parent manufacturing companies of Australian vehicle suppliers would take the lead in testing inflators, but DIRD expected local vehicle suppliers to seek the support of their parent companies in undertaking testing.[496] Given that there were no airbag manufacturers in Australia, DIRD's general understanding, at least by 2016, was that suppliers were reliant on information being provided to them by airbag manufacturers.[497] As a result of the limitations in DIRD's understanding, at least prior to May 2016, as to the nature of the risk posed by Takata airbags, Mr Thomas considered that it "would have been very difficult [for DIRD] to undertake [a] risk assessment".[498] After the Blomquist report neither Honda Australia nor DIRD carried out a risk assessment in relation to the recall other than identifying that airbags subject to recall prior to 2014 would be considered a higher risk than airbags recalled after 2014.

***Overview of ACCC's involvement in voluntary Takata airbag recalls***

376. In response to requests for information as part of the coronial investigation, the ACCC advised that its role in relation to the voluntary recall of Takata airbags was as follows:[499]

> "Prior to the compulsory recall, the ACCC 's role was supportive to Infrastructure [DIRD] which is the regulator responsible for negotiating voluntary recalls of vehicles, monitoring the progress of vehicle recalls and engaging with suppliers about improving their recall strategies. The ACCC's role was primarily administrative in nature in receiving suppliers' voluntary Takata recall notifications, assessing information received to ensure it complies with the notification requirements under section 128 of the ACL and is consistent with the ACCC's Product Safety Recall Guidelines to publish this information on the PSA website for consumers."

377. The ACCC was also kept generally appraised by DIRD of the status of Takata–related recalls over the course of mid-2015 to mid-2017. Mr Grimwade's evidence was that:[500]

> "Consistent with the key principles and provisions regarding information exchange under the MOU, the Department [ie, DIRD] and the ACCC share information on request or as needed. In

[495] Tpt 1039.40.
[496] Tpt 878.7-.28.
[497] Tpt 882.5-.11.
[498] Tpt 1162.38.
[499] Exhibit 1, 9/82/2455.
[500] Exhibit 1, 9/90/2820 at [12].

practice, this might occur frequently and informally at a staff level, whether in meetings, telephone discussions and/or emails".

378. Mr Grimwade agreed that there were constant discussions between DIRD and the ACCC about the recalls.[501] In this regard, in the period from mid-2015 to mid-2017, Jeremy Thomas, who was then the director of the Operational Policy Section within the VSSB at DIRD, met monthly with Jan Klaver, his counterpart at the ACCC with whom he dealt with most frequently,[502] to discuss a range of issues – including but not limited to the Takata airbag recalls – and there would be various other staff members of each agency present during those conversations.[503] DIRD provided updates to the ACCC, addressing a variety of matters over time.[504] Other discussions and email exchanges took place between officers of the ACCC and DIRD around the time of significant developments in respect of the Takata recalls, such as (but not limited to) the publication of the Blomquist Report.[505] DIRD and the ACCC also consulted each other in relation to updates to Takata media strategies, question time briefs and Senate estimate briefs.[506] Representatives of the ACCC also attended the Takata Airbag Working Group meetings held on and from 17 June 2016.

379. As was the case for DIRD, Mr Grimwade's evidence was that the ACCC was reliant on manufacturers' identification of the nature of the risk posed by Takata airbags.[507] He clarified that the ACCC did not engage with overseas vehicle manufacturers, but that it was reliant on information provided by local suppliers.[508]

## M. Steps taken by Commonwealth regulators in respect of risks posed by Takata airbags prior to Mr Ngo's death (and since) – Issue # 6

380. Having summarised the regulatory landscape between 2015 and 2017 for voluntary consumer recalls of motor vehicle products in Australia, this section addresses the steps that were taken in that period, by each of the ACCC and DIRD, to monitor the recalls with a view to ensuring that the suppliers were in the conduct of the recalls addressing the risks posed by defective Takata Airbags, particularly insofar as such steps are relevant to the 5ZV recall and thus the circumstances pertaining to Mr Ngo's death.

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[501] Tpt 1699.49-1700.2.
[502] Tpt 1012.30.-39; Tpt 1211.2.
[503] Tpt 1011.21-.42.
[504] Exhibit 1, 9/90/2827 at [30].
[505] Tpt 1011.45-1012.2.
[506] Tpt 1012.17-.24.
[507] Tpt 1277.14.
[508] Tpt 1277.21-.38.

***DIRD's first awareness of Takata airbag recalls***

381. The issue of defective Takata airbags was first brought to DIRD's attention on 3 August 2009, when Honda Australia notified DIRD that it had initiated a voluntary recall for 1,323 Honda Accords manufactured in 2001 and 2002.[509] Honda subsequently notified DIRD of additional voluntary recalls that it had initiated in relation to other Honda vehicles fitted with Takata airbags – 19 recalls in total were notified by the end of 2017.[510]

382. On 22 August 2009, DIRD was contacted by a representative of Takata's Washington DC office in relation to the defect then known to affect Honda Accords and Honda Civics. An invitation was extended to DIRD to attend a meeting with Takata so that the nature of the defect could be explained, but this was not taken up.[511] Ms Nyakuengama agreed that it would have been good practice for DIRD to communicate with Takata in response to see what information could be provided.[512] Although it is unfortunate that DIRD did not take up this opportunity, at that point in time the full scale of the Takata airbags problem was yet to be realised.

383. By the time Honda Australia notified the 5ZV recall, (its tenth Takata airbag recall) to DIRD on 10 July 2015, over 200,000 Honda vehicles had already been subject to recall, the majority since 2013. Following the 5ZV recall another 300,000 were added in the 24 months up to the time of Mr Ngo's death. It is fair to say that as at mid 2015 Honda Australia were "mid-stream" in the Takata airbag voluntary recall.

384. At the time Ms Nyakuengama took up her position in April 2016, the Blomquist Report was just about to arrive on the new VSSB General Manager's desk and she was about to lead the VSSB which had responsibilities for a recall process she been told little about.[513]

***DIRD's system and processes for monitoring Honda Australia's voluntary airbag recalls***

385. Over the relevant period from 2015 to 2017 DIRD communicated with Honda Australia in respect of its various airbag recalls.[514]

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[509] Exhibit 1,11/110/3183 at [9]-[10]; see also Tpt 796.18-.35. related to 5SZ recall, the later revjsed to 703 vehicles
[510] Exhibit 1, 11/110/3195; Tpt 712.
[511] DIRD Documents, Tab 1; Tpt 880.38-881.37.
[512] Tpt 881.32.
[513] Tpt 946.15-.40, 962.1-.17, 969.8-.15, 984.38
[514] See, eg, Tpt 766 to 767.

386. Each notification of a recall received by DIRD was recorded in DIRD's Safety Investigations and Recalls System (**SIRS**), to support tracking of the rectification rates.[515] Consistent with DIRD's expectation arising from the FCAI Code and the ACCC Guidelines,[516] Honda Australia provided DIRD with periodic progress reports (generally monthly) by email on all active recalls.[517] These reports contained data in relation to the point-in-time rectification rates for each of Honda Australia's active recalls.[518] The information on the progress reports was then entered by DIRD into the SIRS system.[519]

387. DIRD assessed the progress of recalls notified to it, including Honda's Takata airbag recalls, having regard to what are described as "benchmark recall rates".[520] Ms Nyakuengama explained that these "benchmark" rates are derived from a "historical data analysis" of replacement rates in prior voluntary recalls of road vehicles; and that they are normally 50% rectified within 1 year; 70% rectified within 2 years; and 80% rectified within 3 years.[521] These benchmark figures are based on data from recalls which preceded the proliferation of social media and electronic messaging. The benchmark rates do not have regard to the risk profile of the various recalls for which the relevant data has been compiled. The benchmark rates also do not have regard to the age of the vehicles that were involved in the historical recalls.[522] Over the course of the voluntary Takata airbag recalls, DIRD's expectation continued to be that manufacturers would reach about an 80% rectification rate within 3 years of the commencement of a recall.[523]

388. As part of its overall monitoring of the Takata airbag recalls between 2015 and 2017, including Honda's voluntary airbag recalls, DIRD initiated what came to be known as the Takata Airbag Working Group, which met for the first time in August 2015. The meetings were held quarterly. A representative of Honda Australia attended each of the meetings of the Takata Working Group that were held from August 2015 until July 2017.[524] (It should be noted that DIRD engaged in a number of other tasks related to the Takata airbag recall.)

[515] Exhibit 1, 11/110/3185 at [17].
[516] Tpt 714.44 to 715.11.
[517] Tpt 714.17; 712.48. See also reports at Exhibit 1, 11/111/3226 to 3319.
[518] Tpt 714.40.
[519] Tpt 821.17.
[520] Exhibit 1, 11/110/3186 at [21]; 11/110A/3225-5 at [12(g]; Tpt 857.10-.31.
[521] Tpt 756.46 to 757.4; Exhibit 1, 11/110/3184.
[522] Tpt 757.43 to 759.5; 763.40.
[523] Tpt 819.8-820.17.
[524] Exhibit 1, 8/77-A5 to A10.

***Publication of recall notifications on ACCC's Product Safety Australia website***

389. In his first statement to the inquest dated 21 June 2019, Mr Grimwade said:[525]

> "In practice, the ACCC's responsibilities in relation to notifications of voluntary product safety motor vehicle recalls to the Responsible Minister as required under section 128 of the Australian Consumer Law (the ACL), are administrative. Once it receives such a notification on behalf of the Minister, the ACCC checks that it has the information required to be notified under section 128 and that it is consistent with the ACCC's Product Safety Recall Guidelines. The ACCC may liaise with the supplier and/or the Department, as the specialist regulator with subject matter expertise, regarding any technical language so as to provide clear wording concerning the nature of the hazard, the risk of harm, and instructions for the consumer on the Product Safety Australia website (the PSA website). The ACCC then publishes the information on the PSA website, which it administers and which hosts information about all product safety recalls of consumer goods notified to the Minister."

390. Similarly, according to Mr Dean Wright, in the period in which he was Assistant Director of the Recalls and Hazard Assessment Section (approximately October 2010 up to mid-2016),[526] a role of that section was to receive notifications under s 128 of the ACL in relation to vehicles with defective Takata airbags and to ensure that those notifications correctly described the hazards associated with Takata airbags and that the remedy for the defect was communicated clearly to motorists.[527]

391. According to Mr Jeremy Thomas (who worked within DIRD between around May 2015 and February 2017), there was no policy in place between DIRD and the ACCC about the form and content of recall material published on the ACCC website relating to Takata airbag recalls.[528] Although Mr Thomas recalled that DIRD had discussions with the ACCC about the content of recall notices published on the ACCC website, he could not recall whether DIRD finalised each of those notices on a case by case basis.[529]

392. In his evidence, Mr Grimwade accepted that the notifications that were published on the ACCC's PSA website in respect of the Takata airbag recalls "did not reflect, in hindsight, the defect or hazard that we now know, existed at that time [between 2015 and July 2017]".[530] He also accepted that it may have been beneficial for the

[525] Exhibit 1, 9/90/2819 at [10].
[526] Tpt 1290.27-.32.
[527] Tpt 1297.12-.37.
[528] Tpt 1018.16-.19.
[529] Tpt 1016.10-.20.
[530] Tpt 1267.12.

ACCC to take steps to ask manufacturers to amend the communications messages to consumers that were published on the ACCC's website in circumstances where those notifications "weren't revisited after they were published, even though [knowledge of] the risks of that particular recall or the products that are subject to that particular recall may have evolved over time".[531] Looking back, Mr Grimwade considered that such occurrence was undesirable.[532]

393. Mr Grimwade said that the processes deployed by the ACCC in relation to its website recall notifications have since changed, such that suppliers are now requested to ensure that their recall notifications appearing on the ACCC's website accurately align with any changes in risks known to arise for a particular product.[533]

394. The particular notifications published on the ACCC's PSA website for Honda's 5ZV recall are referred to in more detail at [418]-[420] below.

***Processes in relation to regulators' receipt/review of customer recall letters***

395. Ms Nyakuengama's evidence was to the effect that, if a customer letter was not provided to DIRD at the same time as a manufacturer's original notification of a recall, such a letter would be expected to be provided to DIRD thereafter and that the practice of DIRD, in respect of each voluntary recall, was to send an email requesting copies of a first recall letter when it had not been provided.[534] She said:[535]

> "The primary reason [why DIRD might seek to obtain letters to consumers] would be to make sure that there was one and that the manufacturer was doing what was required under the FCAI code and then when we look at the letters our focus was on the description of the defect and whether it accurately described the nature of the defect and the potential risk….
>
> …so I mean we clearly need to say that there was a risk of injury or death as a result of the malfunction of the component or the vehicle, so we'd be looking for that level but not necessarily the specific nature of the injury or how it might occur."

396. Ms Nyakuengama was not aware of any practice on DIRD's part to request second, third and fourth customer letters beyond the first communication with consumers about a recall.[536] As is apparent from the events discussed below at

[531] Tpt 1503.7-.19.
[532] Tpt 1503.21-.22.
[533] Tpt 1486.37-1487.1; see also 1536.35.
[534] Tpt 720.1 to 721.15.
[535] Tpt 722.29 to 723.44.
[536] Tpt 727.5 to 727.26.

paragraphs [624] to [629], DIRD did not adopt any systematic process for ensuring that it received even the first customer letter from Honda Australia for its Takata recalls.

397. For the letters to consumers it did receive, on its own account, DIRD was "not involved in settling, commenting on or approving the content of manufacturer developed customer letters",[537] in the sense that the Operational Policy Section of DIRD "did not scrutinise every letter [it received] for its content".[538] In this respect, Ms Nyakuengama indicated that, between 2015 and 2017, DIRD looked at the terms of customer letters only to see whether the defect was correctly described; and not in order to assess their effectiveness as a communication to consumers.[539] Ms Nyakuengama referred to limitations on DIRD's staffing capacity to review customer letters for all of the manufacturers' recalls that were occurring from 2015 to 2017,[540] as well as limitations in DIRD's expertise in consumer behaviour at that time.[541] She said that no one in DIRD had the expertise to check whether recall letters being sent to consumers effectively communicated the relevant risks to them.[542]

398. Mr Thomas' evidence was relevantly consistent with that of Ms Nyakuengama. Mr Thomas gave evidence to the effect that up until the time that he left his role in February 2017, he was of the view that it was not the responsibility of DIRD to review recall letters to consumers to see if they were effective communications to consumers.[543] He said that his staff "were not qualified or competent to make those sorts of judgements".[544] In addition, according to Mr Thomas, it was not until around 2016 that it became generally understood, within DIRD, that there was a portion of the population who do not respond to letters from manufacturers in relation to the recall of their vehicles, and that the issue of encouraging consumer responses started to be raised in the context of the Takata Airbag Working Group meetings from around that time.[545]

399. Ms Nyakuengama considered that, as far as DIRD was concerned, the assessment of whether a recall letter to a consumer was appropriate as a means

[537] Exhibit 1, 8/79/2413.
[538] Tpt 801.6-.21.
[539] Tpt 800-801; Tpt 851.46-852.5.
[540] Tpt 737.18 to 738.35.
[541] Tpt 738.41 to 739.5; Tpt 799.45-800.6; 957.16.
[542] Tpt 957.6.
[543] Tpt 1194.40-.45.
[544] Tpt 1024.44-1025.3; see also Tpt 1094.19-.22.
[545] Tpt 1024.2-.20.

of communication and call to action was generally a matter within the expertise of the ACCC, rather than DIRD, and that DIRD's position was that this was something that was impliedly within the remit of the ACCC.[546] On her evidence, it was not a priority of DIRD to assist with encouraging consumers to bring vehicles in, to the extent that suppliers were raising a concern that there was a problem getting consumers to come and in and get their vehicles fixed.[547] Rather, she considered that any efforts by DIRD to encourage consumers in this way would be reliant on "the ACCC's advice or assistance … in communicating risks to consumers".[548]

400. Ms Nyakuengama candidly admitted that there was "an absence of direct allocation of responsibility" as between DIRD and ACCC in relation to which agency was to review consumer letters from vehicle manufacturers for the purposes of assessing their effectiveness as a consumer communication.[549] She said:[550]

> "I think it was probably something that we probably didn't, between the two agencies pay enough attention to as to who was taking responsibility for that part and what was actually happening…"

401. Ms Nyakuengama was not aware of any communications between DIRD and the ACCC, between mid-2015 and mid-2017, about the type of language used in Honda Australia's consumer letters for its Takata recalls, other than discussions which took place in the context of Takata Airbag Working Group meetings.[551] For his part, Mr Thomas said that while he was in his role at DIRD, he was not aware of any instances where the ACCC's media team wrote to vehicle manufacturers to ensure that they were communicating clearly to owners about the seriousness of hazards posed by Takata airbags.[552]

402. In evidence Ms Nyakuengama accepted in hindsight that examination of suppliers' customer letters (including subsequent letters sent to consumers for a given recall) was something that DIRD could and should have usefully done, given developments over time in the understanding of the risks involved, and as a further strategy to assist manufacturers to rectify the greatest number of vehicles by

[546] Tpt 811.44-812.41.
[547] Tpt 985.32-.39.
[548] Tpt 986.28.
[549] Tpt 812.28-.37.
[550] Tpt 740.2.
[551] Tpt 808.42-809.7.
[552] Tpt 1195.9-.14.

engaging with them, including in conjunction with the ACCC, about how consumer responses might be improved.[553]

403. Ms Nyakuengama advised that steps were being taken to develop this capability within DIRD in the context of the implementation of the *RVS Act* amendments.[554]

404. Mr Grimwade advised the inquest that consumer letters in relation to motor vehicle recalls have not historically been provided to the ACCC by suppliers upon notification of a recall, unless they were specifically requested.[555] Although on 1 June 2015, Mr Wright suggested in some internal ACCC correspondence that a request should be made of recalling manufacturers for a copy of their recall letter to consumers so that a link could be included thereto on the ACCC's website, according to Mr Grimwade, between 1 June 2015 and 13 July 2017, the ACCC did not have a practice of systematically seeking consumer letters from manufacturers.[556] Nor was Mr Grimwade aware of any general practice whereby a link to consumer recall letters was made available on the ACCC's PSA website.[557]

405. Mr Grimwade's evidence was to the effect that, prior to Mr Ngo's death, the ACCC understood that DIRD would be considering the effectiveness of consumer communications in relation to the voluntary Takata recalls;[558] and that, from the ACCC's perspective, it was no part of the ACCC's role to do so.[559] Correspondence from the ACCC provided in late 2018 similarly indicates an (albeit incorrect) understanding on the ACCC's part as at that date that, over the period from 2015 until July 2017, DIRD had been involved in reviewing letters from vehicle manufacturers to vehicle owners to ensure that the letters adequately explained the risk of the relevant defect.[560] Mr Grimwade agreed that the inconsistencies between the understandings of the ACCC and DIRD as to their respective roles in reviewing customer recall letters reflected a lack of clarity in the allocation of responsibilities between the two agencies.[561]

406. Mr Grimwade indicated that, prior to hearing Ms Nyakuengama's evidence at the inquest, he was not aware that DIRD had not undertaken such a review of

[553] Tpt 728.30 to 729.22; see also Tpt 737.9-.23.
[554] Tpt 739.2-.5.
[555] Tpt 1487.36, 1488.15-.17; Tpt 1273.22.
[556] Exhibit 1, 10A/109K/3810-130; Tpt 1497.36-.44; Tpt 1737.20.
[557] Tpt 1490.1-.5; cf some indications in the evidence of Mr Wright at Tpt 1333.46.
[558] Tpt 1273.19-.38.
[559] Tpt 1490.27-.30.
[560] See Exhibit 1, 9/82/2455; Tpt 1495.9-.31.
[561] Tpt 1273.47-.50; 1490.41; 1496.3-.9.

customer letters for the Takata recalls,[562] or that DIRD faced constraints on its expertise in connection with consumer communications of the kind identified by Ms Nyakuengama.[563] Nonetheless, at a later point in the inquest, Mr Grimwade said that he did not think that a high degree of expertise was required "to be able to meaningfully and clearly convey to consumers a hazard and a defect and what consumers should do".[564] Mr Grimwade nevertheless accepted that the ACCC had more expertise and capability concerning communications with consumers than did DIRD.[565] He said that there was a team within the ACCC that, had its assistance been sought out prior to Mr Ngo's death, could have assisted DIRD to look at communication strategies in respect of Takata airbag defects to try to bring consumers in, particularly in relation to the wording of letters to consumers.[566]

407. Mr Wright's account of the ACCC's role in relation to reviewing letters to consumers for the voluntary airbag recalls differed somewhat from that provided by Mr Grimwade. According to Mr Wright, although there was no requirement in the ACL for them to be provided, his team received *some* customer letters from vehicle suppliers "in the interests of ensuring that the recalls would perform maximally".[567] If a supplier's customer recall letter was not provided to the ACCC in conjunction with a recall notification received by the ACCC, Mr Wright expected that it would be provided subsequently to the ACCC by DIRD,[568] albeit that DIRD did not as a general practice provide the ACCC with any subsequent customer communications that DIRD may have received from a supplier for a given recall.[569]

408. Mr Wright considered that the ACCC had a role to play in attaining and reviewing recall notification letters from vehicle suppliers to consumers, and that this was "common practice" and "part of the agreement between the ACCC and DIRD that had developed over time".[570]

409. If the practice had developed at some point, it was not apparent to Mr Thomas who took up his position at DIRD in early 2015. His evidence and that of Ms Nyakuengama was to the effect that there was no such practice. Mr Wright, could not recall any particular case of recall correspondence from the Takata airbag

[562] Tpt 1495.38-1496.1.
[563] Tpt 1273.40-.43.
[564] Tpt 1758.38-.44.
[565] Tpt 1698.10-.12; see also Tpt 1738.11-.23.
[566] Tpt 1721.29-.35.
[567] Tpt 1335.5-.13.
[568] Tpt 1336.37-1337.19.
[569] Tpt 1338.8-.12.
[570] Tpt 1335.20-.45.

recall he may himself had reviewed[571] but I note that Ms Atkinson from the ACCC did receive, upon request, a number of Honda Australia consumer recall letters as at 2 June 2015 which is somewhat consistent with Mr Wright's evidence that the ACCC had a role to play in that regard.[572]

410. Mr Wright said that the ACCC had expertise in reviewing the effectiveness of recall correspondence from a vehicle supplier to a consumer and that the ACCC had a role in preventing what he referred to as "weasel words" being used in consumer communications.[573] On Mr Wright's understanding, DIRD held similar expertise in reviewing the effectiveness of consumer correspondence;[574] and, from Mr Wright's perspective, DIRD "probably negotiated the recalls plan[s] and perhaps even DIRD would have vetted the recall notice itself".[575] Mr Wright's use of such tentative language in this regard suggests that he is unsure as to whether, at the relevant time, this in fact occurred. Mr Grimwade advised the inquest that the ACCC's practices in respect of reviewing suppliers' consumer recall letters in motor vehicle recalls monitored by DIRD have now changed. He said:[576]

> "The practice that we've engaged in recently now is we are asking for letters and working with [DIRD]. So we now have a process where [DIRD] is reviewing a consumer letter from a manufacturer and it is marking up the changes it considers to be the best method by which the consumer can access and understand the defect and hazard. Then they're providing their mark ups to us for us to review as well and by that way [DIRD] can learn by doing, which we're doing as part of a transition to when they take full responsibility for motor vehicle safety recalls from 1 July next year."

411. Particular reference is made below to the nature of the understanding of DIRD and the ACCC as to the content of letters to consumers that Honda Australia utilised for the 5ZV recall.

***DIRD's and ACCC's awareness of Takata airbag risks as at May 2015***

412. On 20 May 2015, Erik Connell, Senior Investigations Officer at DIRD received a call from the Office of the Assistant Minister for Infrastructure and Regional Development (**AMO**), requesting talking points on the Takata recall for the AMO's media advisor.[577] That afternoon, Mr Connell sent the AMO some "words on recent

[571] Tpt.1341.17
[572] Exhibit 1, 10A/109K/3810-126.
[573] Tpt 1336.16-.25.
[574] Tpt 1338.23-.27.
[575] Tpt 1342.4-.6.
[576] Tpt 1488.1-.9. See also Tpt 1498.1-.8.
[577] Exhibit 1, 17/160/4641, 4550.

airbag related recalls".[578] A couple of hours later, Mr Connell emailed various ACCC officers, including Dean Wright, advising that DIRD had been "seeing increased [media] coverage in relation to [T]akata airbags and associated recalls",[579] and providing them with the terms of the update that had been provided to the AMO, which he indicated would "be used by the AMO in responding to media inquiries" (with potential modifications).[580]

413. Accordingly, it was apparent as at May 2015 that officers of both agencies (DIRD and the ACCC) had been made aware of the following:[581]

    a. A number of vehicle manufacturers had announced voluntary recalls in Australia relating to potentially defective airbags.

    b. Takata had announced an extension to a previous announcement about its potentially unsafe airbags.

    c. For unsafe airbags, there was "a chance that the airbag may deploy incorrectly, and metal shards (from the airbag inflator housing) may be projected at the occupant".[582]

    d. Six deaths and more than 100 injuries had been attributed to faulty airbags, worldwide.

    e. NHTSA had announced that there was no definitive root cause of the airbag fault, as yet, and that research was still being carried out.

    f. There were approximately 585,000 vehicles affected in Australia (including vehicles supplied by BMW, Chrysler, Honda, Mazda, Nissan and Toyota).

    g. There had been no reports of deaths or injuries in Australia resulting from deployment of airbags in potentially affected vehicles.

414. On 25 May 2015, an ACCC officer sought advice from DIRD about whether it was "safe to drive cars with the airbags as is".[583] It appears that DIRD did not advise,

[578] Exhibit 1, 17/160/4652.
[579] Exhibit 1, 15/9.
[580] Exhibit 1, 15/9.
[581] Tpt 921.35-924.23.
[582] In the light of the content of this update, Mr Grimwade agreed that as at May 2015, ACCC officers had been informed that a risk that may arise where some Takata airbags deployed incorrectly was that metal shards might be projected at the occupant: Tpt 1275.23-.30.
[583] Exhibit 1, 15/10.

at that time, (or at any other times prior to Mr Ngo's death), that vehicles with recalled Takata airbags should not be driven until their airbag could be replaced.[584]

***Notification to DIRD and ACCC of 5ZV recall***

415. As noted, on 10 July 2015 the 5ZV recall was notified by Honda Australia to the ACCC and DIRD.[585]

416. The notification letter to each agency was materially identical, and relevantly stated:

> "RE: Recall 5ZV: Driver's Front Airbag Inflator (Single Type)
>
> Honda Australia Pty. Ltd would like to advise that Honda Motor Co. Ltd. Has initiated action to conduct a "Product Safety Recall" for the vehicles listed in this letter.
>
> Honda Motor Co. Ltd. has determined that a potential defect relating to the driver's front SRS airbag inflator may exist.
>
> **Defect description**
>
> As a result of investigating parts returned from the market, some driver's front SRS airbag inflators were confirmed to have wide ranges of density variation within propellants.
>
> Although the cause has not been determined and since there is a risk of abnormal airbag deployment, relevant inflators will be replaced with new parts as a precautionary action.
>
> **What is the risk?**
>
> If the airbag does not deploy correctly, there is an increased risk of injury to the driver during a collision.
>
> **Remedy of the defect**
>
> Once parts availability is confirmed, owners of affected vehicles will be contacted by mail in accordance with the Federal Chamber of Automotive Industries Code of Practice and advised to take their vehicle to a Honda Dealer. The Dealer will replace the driver's front SRS airbag inflator, at no cost to the customer.
>
> The total number of affected vehicles in this recall is 92,274. The vehicles are identified by the Vehicle Identification Number (VIN) and affected vehicles are within the ranges listed below…."

417. In relation to the language "precautionary action" appearing in this notification letter, Mr Grimwade advised the inquest that the ACCC had a practice, which he

[584] Tpt 929.2-.12.
[585] Exhibit 1, 5/56/1561 to 1566; see also Tpt 1479.37-.48.

thought extended back to 2015, whereby the ACCC "would be averse to putting in a notification published on our website the word 'precautionary'", because "we [the ACCC] don't think it would sufficiently incentivise a consumer to seek the remedy that is being offered in terms of the particular notification".[586] Significantly, the term "precautionary" was not used on the PSA website. However, Mr Grimwade was not aware whether the ACCC followed up with Honda Australia about the use of the "precautionary" language appearing in the 5ZV recall notification letter.[587] Given what follows, it is apparent that the ACCC did not do so. There is also no evidence that DIRD did so. There is evidence that the word precautionary was used in the 5ZV recall consumer letters. Also significantly, the description of the hazard does not include words to the effect that metal shards (from the airbag inflator housing) may be projected at the occupant nor does it identify that the consequence could be serious injury or death.

***Publication of 5ZV recall notification on the ACCC Product Safety Australia website***

418. The initial public-facing notice placed on the ACCC's Product Safety Australia website in respect of the 5ZV recall, from about 15 July 2015, included the following information:[588]

> **"Honda Australia Pty Ltd – City, CR-V, Insight, Jazz**
>
> PRA number: 2015/14819
>
> Date published: 15th July 2015
>
> **Product information**
>
> **Product description**
>
> 2009-2012 YM City
>
> 2007-2011 YM CR-V
>
> 2010-2012 YM Inslght
>
> 2006-2012 YM Jazz
>
> **Identifying features**
>
> See attached VIN list.

[586] Tpt 1480.15-.25.
[587] Tpt 1480.40.
[588] Exhibit 1, 14/142C/4057 see also Tpt 1483.44-1486.1.

**What are the defects?**

As a result of investigating parts returned from the market, some driver's front SRS airbag inflators were confirmed to have wide ranges of density variation within propellants.

**What are the hazards?**

If the airbag does not deploy correctly, there is an increased risk of injury to the driver during a collision.

**Where the product was sold**

Nationally

**Traders who sold this product**

Honda Dealers

**Supplier**

Honda Australia Pty Ltd

**What should consumers do?**

Once parts availability is confirmed, owners of affected vehicles will be contacted by mail and advised to take their vehicle to a Honda Dealer. The Dealer will replace the driver's front SRS airbag inflator at no cost to the consumer."

419. Relevantly, a year later as at 28 July 2016, materially identical information appeared on the ACCC's PSA website.[589] By this time, the ACCC was aware of the content of the Blomquist Report, and that the risk posed by airbags such as those the subject of the 5ZV recall was that metal fragments could be propelled from the ruptured inflator causing possible injury or death to vehicle occupants.[590] This risk, although then known to the ACCC, was not identified in the public-facing messaging appearing on the ACCC's PSA website for the 5ZV recall as at 28 July 2016.[591]

420. Mr Grimwade accepted that the omission of this information from the website entry involved "… a failure in our [ACCC's] processes to review notifications in light of changing risk". Mr Grimwade also noted that "the notifications that are published on our website … come from suppliers who identified that risk and publish through our website that risk".[592] Mr Grimwade did not point to any evidence of the ACCC

[589] Exhibit 1, 14/142C/4047-4048; see also Tpt 1483.44-1486.1.
[590] Tpt 1486.16-.21.
[591] Tpt 1486.27.
[592] Tpt 1486.32-.35

having liaised with DIRD or Honda Australia about the content of the 5ZV recall entry on the ACCC's website. He accepted that "there should have been liaising with both [DIRD] but also with Honda as well".[593] Mr Grimwade also accepted[594] that the website notification published from July 2015 until July 2017 for the 5ZV recall was, in hindsight, inadequate.[595]

***Non-provision of recall strategy for 5ZV recall***

421. Although Honda Australia provided to DIRD regular progress reports of the rectification rates for its various airbag recalls, Honda Australia does not appear to have provided any "recall strategy" to DIRD in the period from 2015 to 2017, in the sense of a particular document or series of documents of the kind described in the ACCC Guidelines, and which set out an explanation of the airbag problem, the level of risk presented and how Honda Australia proposed to communicate with consumers. Though, in regard to its proposal of communicating with consumers, in the information contained on the PSA website and notification to DIRD, Honda Australia did indicate it would be communicating with consumers by postal mail. According to Ms Nyakuengama, it was not part of DIRD's practice over the period from 2015 to July 2017 to receive recall strategies from motor vehicle suppliers.[596] The evidence indicates that DIRD did not at any time request such a recall strategy from Honda Australia.[597] There is no evidence that Honda Australia provided any document styled as a recall strategy to DIRD.

422. Mr Grimwade advised that in the course of the voluntary recalls of PSAN Takata airbag inflators between 2015 and July 2017, motor vehicle suppliers did not approach the ACCC to negotiate the contents of their recall strategy with the ACCC.[598] He said:[599]

> "We wouldn't expect a recall strategy to be submitted and negotiated with us in relation to a motor vehicle recall. We would expect that recall strategy and the voluntary recall to be negotiated with [DIRD] as per our MOU."

423. Mr Grimwade also said that he would have expected that suppliers' proposed

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[593] Tpt 1487.3-.23.
[594] Tpt 1267.35-.48. Note that, in context, the word "adequate" at 1267.48 appears to be a mis-transcription of "inadequate".
[595] As to measures that have since been implemented by the ACCC to address this issue, see at [393] above.
[596] Tpt 718.21-719.10, 809.22-.32, 908.10-.22.
[597] Tpt 908.6.
[598] Tpt 1481.26-31.
[599] Tpt 1481.45-.48.

communications with consumers would be provided to DIRD and evaluated by DIRD as part of their recall strategy.[600] However, Mr Grimwade was not aware of whether, over the period from 2015 to 13 July 2017, Honda Australia in fact provided to DIRD a recall strategy addressing the elements referred to in the ACCC Guidelines.[601]

424. Mr Grimwade accepted that the there was "insufficient clarity [in the ACCC Guidelines] that a specialist regulator should be receiving the recall strategy".[602] Mr Grimwade considered "the MOU to be sufficiently clear to identify that the specialist regulator is responsible for negotiating the recall and evaluating the recall strategy or improving the recall strategy as necessary".[603] It would appear that the MOU did not have such clarity to either DIRD or the suppliers as there has never existed a documented recall strategy for the 5ZV recall and according to Ms Nyakuengama's evidence, in relation to any other vehicle recall.

***Honda Australia's recall correspondence provided to the ACCC in June 2015***

425. Around the same time as the AMO was seeking talking points about the Takata airbag recall in late May 2015, on 2 June 2015, Sarah Atkinson of the ACCC emailed David Steven of Honda Australia requesting that he provide, *inter alia,* completion rates for all recalls and copies of correspondence with consumers for all recalls.[604] Later that day, Mr Steven provided, by way of response, some "example letters from recent recalls", including those of the 5SK recall.[605]

426. Honda Australia's 5SK recall was first notified to the ACCC in 2013 as relating to 9,980 vehicles. According to the table provided in Honda Australia's submissions, the defect was described as "manufacturing defect associated with insufficient compressing of inflator propellant and incorrect humidity storage handling of inflator propellant" and the hazard was described as "abnormal internal pressure may rupture the inflator canister". In 2014, a revised notification was submitted which involved an adjustment to the numbers of vehicles affected by the recall (33,434) as well as an adjustment to the description of the defect and hazard in that the description for the defect was "manufacturing defect associated with insufficient compressing of inflator propellant" and the hazard was "increased internal pressure may rupture the inflator canister and propel metal fragments

[600] Tpt 1488.19-.41; see also Tpt 1260.34-35; Tpt 1263.26-.43.
[601] Tpt 1482.44.
[602] Tpt 1482.31-.33.
[603] Tpt 1482.33-.37.
[604] Exhibit 1, 10A/109K/3810-126.
[605] A 2013 Honda recall which was revised in 2014. Exhibit 1, 10A/109K/3810-125, 127-128.

towards the windshield or foot well, potentially causing injury to vehicle occupants".[606]

427. That in June 2015 the ACCC would want to review the Honda Australia consumer letters is consistent with Mr Wright's evidence that the ACCC would request motor vehicle recall consumer correspondence. And it is in keeping with ensuring that the PSA website was up to date in that it correctly notified the public about the defect and risk of a product subject to recall. Given that the Takata Working Group had not at that stage been established and the evidence of Mr Thomas and Ms Nyakuengama that DIRD was not involved in reviewing the effectiveness of Honda Australia's communications in regard to the contents of letters to consumers, it is more likely than not that the ACCC did not provide those letters to DIRD. Mr Grimwade was not aware of whether the pro forma letters that were provided by Honda Australia to the ACCC at this time underwent any process of review by the ACCC or its officers; nor of whether any recommendations or suggestions were made to Honda Australia, either by the ACCC or by DIRD, arising from the provision to the ACCC of these example recall letters.[607] He said "at the time we were quite reliant on the defect being identified and the hazard being identified by the notifying party".[608]

428. Mr Grimwade said that, as Honda Australia subsequently expanded the number of Takata recalls affecting its customers, the ACCC did not systematically make further requests of Honda Australia to provide copies of its recall correspondence to consumers.[609]

***Exchanges between Honda and ACCC about website recall notifications in July 2015***

429. On 8 July 2015, David Steven of Honda emailed Sarah Atkinson of the ACCC requesting that the ACCC update the wording of its website notification for the Honda recall with code PRA 2015-14737. The form of words that Mr Steven sought to have included, and which he indicated had been "taken directly from … information provided by Honda Motor Company Japan Ltd", referred to the inflator being replaced as a "preventative action".[610]

[606] Exhibit 1, 10A/109K/3810-125, 127-128.
[607] Tpt 1499.2-.13.
[608] Tpt 1499.11.
[609] Tpt 1499.14-.23.
[610] Exhibit 1, 10A/109K-F/3180-133, 134.

430. From Mr Grimwade's perspective, language to the effect that a recall is "preventative" is undesirable in the context of a public-facing message to consumers on the PSA website.[611] Nonetheless, information that the inquest obtained showed that the ACCC made the change requested by Honda Australia to the relevant website notification.[612] This appears to have been done without the ACCC requiring Honda Australia to enquire of its parent company why the recall action for this recall was described as "preventative".[613] However, background to this terminology and the ACCC's understanding of it is further set out below.

431. Mr Grimwade accepted that, in hindsight, inquiries ought to have been made by the ACCC of either DIRD or Honda Australia in relation to the use of the phraseology "preventative action", which he said he was "uncomfortable with". [614] He said that "[e]ven if we were reliant on others to explain the defect and the hazard and what consumers should do, generally we would have sought to avoid using language like, '[p]reventative action'".[615] Mr Grimwade considered that there was a missed opportunity at the time on the part of the ACCC to make potential improvements to the language used in Honda Australia's recall communications.[616]

432. Counsel assisting submit that such a finding be made in that regard, which is discussed below at [714]ff.

***Honda Australia's recall correspondence raised by a DIRD officer in July 2015***

433. On 13 July 2015, shortly after receiving notification of the 5ZV recall from Honda Australia, a DIRD officer, Robert Hogan, noted in an email to colleagues within DIRD that: "I just noticed that Honda are only advising customers [that their vehicle is recalled] when parts become available".[617] This prompted, Mr Thomas to reply by email:[618]

> "I don't think this is correct. I received a recall notice regarding my Honda Jazz on Friday, and they were quite clear that they don't know when the parts will be available."

[611] Tpt 1499.50-1500.5.
[612] See Exhibit 1, 10A/109J/3180-50 at 1.17(b); see also Tpt 1501.1-.30.
[613] Tpt 1501.41.
[614] Tpt 1501.43-1502.7.
[615] Tpt 1502.12-.15.
[616] Tpt 1502.22-.25.
[617] DIRD Material, Volume 2, Tab 34.
[618] Ibid.

434. On 21 July 2015, Mr Thomas – who had himself received a recall letter for his Honda Jazz – raised a concern with his colleagues at DIRD by email about the recall correspondence that he had received from Honda Australia. In his email, Mr Thomas stated:[619]

> "I think we will need to think carefully about how we would like the car companies to communicate the problem with their clients. Both the letter from Honda, and the call I made to them, were not highly informative with the only descriptions of the problem being "mis-deployment", "over inflation" and "under-inflation". This may not be the right balance between being alarmist and being clear about what the actual problem is." [620]

435. Mr Thomas explained to the inquest that the concern he held about the letter he had received from Honda Australia was that:[621]

> "It said nothing about an injury, it said nothing about a death, and it didn't explain that there could be catastrophic failure of the … inflator casing."

436. Although Mr Thomas did not retain a copy of the letter that he received, as far as Mr Thomas could ascertain, the content of the letter that he received from Honda Australia accorded with that appearing at Exhibit 1, Volume 13, Tab 134(7), p 3771 (being a letter from Honda Australia for the 5UN/5JV recall).[622]

437. The concerns that Mr Thomas expressed in his email dated 21 July 2015 – as to the content and messaging in the recall letter he received from Honda Australia and as to his subsequent telephone conversation with Honda Australia after calling the number on the letter to ask about it[623] – were not taken up with Honda Australia, by DIRD or the ACCC, prior to Ms Ngo's death.[624]

438. That DIRD did not pursue the issue with Honda Australia is consistent with the view that DIRD was not involved in settling or amending the contents of Honda Australia consumer communications. It does not appear that Mr Thomas' personal experience translated, through his involvement with the Takata Airbag Working

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[619] DIRD Material, Volume 2, Tab 36.
[620] Ms Nyakuengama explained that the concern about being "alarmist" was that, if people were led into a state of panic, they may take steps to disable airbags themselves and that, at that time, it was thought by the Department that it was safer to be in an accident with a Takata airbag in place than without one, given the fairly limited reports of misdeployments until that point: see Tpt 772.1 to 772.46.
[621] Tpt 1036.1.
[622] Tpt 1061.15-.1062.32..
[623] Tpt 1036.6; see also Tpt 1042.2-.41. Mr Thomas could recall being told on the call that there was a potential for the airbag in his vehicle to over or underinflate. (In the call, Mr Thomas did not disclose his association with DIRD).
[624] Tpt 769.23; Tpt 1043.3.

Group, to an engagement with Honda Australia about the content of consumer correspondence for the 5ZV recall.

439. Counsel for Honda Australia submit that it wasn't until the Blomquist report in May 2016 that there was any basis for DIRD or the ACCC to approach Honda Australia about the information contained in the 5ZV recall consumer letter. Honda Australia submits that it treated each Takata Recall as a separate or stand alone recall which seems somewhat at odds with the pro forma consumer letters Mr Steven of Honda Australia sent to the ACCC in June 2015 citing that the example letters from recent recalls were aligned to letters Honda Australia had sent out to customers for all the airbag recalls to date.[625] Such an approach is not consistent with treating each recall as a singular recall and in any event, the letter for the 5ZV recall was in quite different terms.

440. It would appear that after June 2015, the ACCC no longer sought customer letters from suppliers on the (mistaken) understanding that DIRD were continuing or at least commencing to do so. If DIRD ever did so it was only to ascertain that the defect and hazard and rectification was adequately described for a purpose other than the efficacy of communication to cause a consumer to respond as part of the ACCC Guidelines. I note that, in any event, in relation to the 5ZV recall, DIRD did not request nor review the 5ZV consumer letter even in regard to the defect and hazard at any stage. Accordingly, the lack of adequate description contained in the consumer letters continued until early 2017 when Honda Australia changed it.

***Formation of Takata Airbag Working Group***

441. Ms Nyakuengama explained that the Takata Airbag Working Group was established by DIRD in mid-2015 in response to the significant increase, at about that time, in the number of vehicles the subject of Takata-related recalls in Australia.[626] In her statement dated 6 March 2019, Ms Nyakuengama said that DIRD established the working group "in order to better understand the status of ongoing voluntary Takata airbag recall campaigns, and to determine whether any additional or different action to improve the progress of the recall campaigns should occur".[627]

[625] Exhibit 1, 10A/109K/3810-125, 127-128.
[626] Tpt 773.45 to 774.22.
[627] Exhibit 1, 11/110/3189 at [34].

442. The first Takata Airbag Working Group meeting was held on 24 August 2015, and was attended by representatives of DIRD, FCAI and vehicle manufacturers including Honda Australia. The minutes of the meeting reflect, *inter alia,* that:

a. Honda Australia indicated to DIRD that its capacity to rectify vehicles had reached 500 vehicles per day;[628]

b. DIRD recommended to manufacturers that notifications to affected customers be sent out "as soon as possible", irrespective of parts availability;[629]

c. DIRD was notified that manufacturers were advising customers that "the recall is precautionary" and that they should not disable the airbag;

d. there was discussion to the effect that "[t]he fault/defect of Takata airbags has changed over time … NHTSA and Takata are still trying to establish the exact cause. Research and remedies are ongoing … Manufacturers are told by parent companies what cars are affected and need to be recalled".[630]

***Preparation by DIRD of "Media Handling Brief" for Takata airbag incident***

443. On 21 September 2015, Mr Thomas of DIRD sent an email to Dr Klaver of the ACCC seeking input from the ACCC in relation to a draft "media handling brief" that DIRD was preparing to respond to (ie, "handle") publicity "in the event of the Takata recall suddenly becoming a major media issue".[631] The purpose of the document was stated to be "to provide a media approach to issues that may emerge from the Takata airbag recall and replacement".

444. Under the heading, "Background", the document stated, *inter alia*:[632]

> "• The defective [Takata] airbag inflators have the potential to cause the airbag to deploy incorrectly, and for metal fragments to strike the occupant of the affected seating position. Depending on the vehicle model, the potential defect may affect the driver or passenger frontal protection airbags. The estimated number of affected vehicles worldwide is approximately 60 million; 927,000 vehicles produced by seven manufacturers between 2001 and

[628] Exhibit 1, 8/77-A5/2276 at 2278; 11/110/3189 at [37].
[629] Exhibit 1, 8/77-A5/2277. See also Tpt 768-769 regarding DIRD's approach to this issue.
[630] Exhibit 1, 8/77-A5/2276.
[631] Exhibit 1, 9/90-2/2839.
[632] Exhibit 1, 9/90-2/2840.

2012 are being recalled in Australia. The manufacturers affected are BMW, Chrysler, Honda, Mazda, Nissan, Subaru and Toyota.

- There have been no reports of death or injury in Australia. Elsewhere worldwide, to date eight deaths and more than 100 injuries have been attributed to defective airbag inflators."

445. Having regard to this update it is apparent that, as at 21 September 2015 (or thereabouts), each of DIRD and the ACCC was aware of the potential for Takata airbags in Australian vehicles to deploy incorrectly and for metal fragments to strike an occupant, causing injury or death.[633]

446. Under the heading, "media strategy", the document stated that "we need to be prepared for negative media in the event an Australian is injured or killed by a defective Takata airbag".[634] It is apparent that, at this time, officers within DIRD considered this eventuality to be a possibility, in respect of which a responsive media strategy was required.[635]

447. The draft media handling brief stated that "as part of the communication strategy on the matter, the Department [ie DIRD] will need to ask some manufacturers to amend their communication messages, especially where they do not state that there is a risk of injury to vehicle occupants".[636]

448. This evidence indicates that DIRD was aware that some manufacturers were not stating that there is a risk of injury to vehicle occupants and that DIRD could and would ask them to amend their communication messages. This cuts across Mr Thomas' evidence that he did not consider it was DIRD's role to tell suppliers what to write in their consumer communications.

449. In her evidence, Ms Nyakuengama explained that that content of the draft media handling brief reflected an expectation that letters from manufacturers would need to be more urgent, if in fact the risk posed by Takata airbags eventuated (in Australia).[637] She also accepted that this indicated that, by this time, DIRD had a concern as to the need to look at the content of communication messages from particular manufacturers to determine whether they stated that there was a risk of injury in connection with defective Takata airbags.[638]

[633] See, eg, Tpt 796.45; Tpt 1040.45-.49.
[634] Exhibit 1, 9/90-2/2841.
[635] Tpt 898.38-899.47.
[636] Exhibit 1, 9/90.2/2842.
[637] Tpt 777.29 to 777.40.
[638] Tpt 778.47.

450. The draft media handling brief was provided by DIRD to the ACCC for comment. In a mark-up of the document provided by Mr Wright of the ACCC to DIRD on 30 September 2015,[639] a change was made that, at least on one available reading, indicated that, at the time of making the change, Mr Wright (or the ACCC more generally) was aware of a case of abnormal deployment of a Takata airbag in Australia. (On another potential reading of the mark-up to the document, the mark-up was intended to indicate that, in the event that there *was to be* a misdeployment incident, the public messaging that would follow would then refer to there having been only that one incident).[640] At the inquest, Mr Wright was asked about these mark-ups and indicated that he was not aware of any reported airbag misdeployment prior to learning of the Mazda 6 incident referred to below (which was notified to the ACCC in November 2015).[641]

451. According to Mr Thomas, DIRD was not aware of any incident of a misdeployment of a Takata airbag in Australia as at September 2015, or at any time prior to September 2016.[642] Mr Thomas' recollection of the exchanges about this document was as follows:[643]

> "We went back to the ACCC saying, "What are you talking about? We're not aware of this," and in some way it dissipated - it was, it was not asserted by the ACCC that this had actually occurred. That's, that's my recollection. I can't recall if it was verbally or in writing."

452. Similarly, the ACCC has advised the inquest that it has searched for and found no evidence of any suspected or confirmed misdeployment or abnormal deployment incident in a vehicle with a Takata PSAN inflator in Australia at the time that Mr Wright made his edits and comments in the media handling brief in September 2015.[644]

453. On 24 September 2015, Dr Klaver (Director of Hazard Analysis and Management, Product Safety, within the ACCC) emailed Glenn Probyn (also within the ACCC), referring to the media points sent by Mr Thomas and noted that "they [ie, DIRD] have assured us that there is minimal risk to Australian consumers".[645]

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[639] Exhibit 1, 15/29.
[640] See Tpt 1119.8-.1120.46.
[641] See Tpt 1351-1354; Tpt 1393-1394.
[642] Tpt 1097.44, Tpt 1119.23.
[643] Tpt 1096.29.
[644] Exhibit 1, 16/148/4077 at [2.3].
[645] Exhibit 1, 16/148/4171.

454. Mr Thomas could not recall having conveyed to Dr Klaver at that time that there was a minimal risk to Australian consumers in relation to Takata airbag defects, but accepted that, as at September 2015, DIRD was in no position to give any such assurance to the ACCC as DIRD had very limited technical expertise in relation to defective Takata airbags.[646] Indeed DIRD had not and has not undertaken its own risk assessment as it is not in a position to do so. However, as pointed out in submissions by Counsel for the ACCC, in May 2015, the Department provided the ACCC with its probability analysis, a risk analysis drawing mainly on statistics from the USA, to estimate the probability of a misdeployment occurring for each of four categories of inflator.[647] The analysis relied on the incidence of misdeployments in the USA, as there had been no misdeployments in Australia. The analysis showed that the worst inflator had a 97.84% chance of deploying normally in an accident, and a 2.16% chance of misdeploying.

455. It Is likely that this information was provided to Dr Klaver and that she was referring to it when conveying the opinion that the Takata airbag defect presented a minimal risk to Australian consumers. Dr Klaver apparently understood that DIRD was adopting a "*risk based approach*" at this time.[648] An approach that there was minimal or little to no risk is consistent with both DIRD and the ACCC not raising with Honda Australia its description of the recall as precautionary or a preventative measure and not conveying to its consumers that injury (let alone death) could occur in the event of the manifestation of risk.

456. The risk-based approach seems to have taken into account the risk of an airbag misdeploying without taking into account the gravity of harm to a vehicle occupant should the airbag misdeploy and cause metal fragments to shoot into the occupant. DIRD's risk-based approach was apparently not reconsidered after the BMW misdeployment in September 2016 or the Toyota misdeployment in the Northern Territory in April 2017 which raises the question as to whether DIRD and the ACCC actively responded to these events at all.

***Concerns raised about the management and monitoring of Takata airbag recall in September/October 2015 by the NRMA***

457. In a letter to the Minister for Small Business dated 2 September 2015, Kyle Loades, President of the NRMA, advised that NRMA members had raised concerns about

[646] Tpt 1165.9-.47.
[647] Takata Air Bag Recall Probability Notes 15/143/011.2 and 011.3; see Tpt 900.3.
[648] See file note 27 Aug 2015 18/165/10/4995.

whether the recall of vehicles affected by faulty Takata airbags was being appropriately managed by vehicle manufacturers or appropriately monitored by the ACCC.[649] DIRD was consulted on, and provided input into, the contents of the letter that the ACCC sent to the NRMA in response.[650]

458. In the ACCC's response letter to the NRMA dated October 2015, the ACCC's Chief Operating Officer stated:[651]

> "The ACCC works with the Department of Infrastructure and Regional Development (DIRD) to ensure that motor vehicle recalls are effective. … DIRD advises the ACCC of its assessment of the safety defect, hazard and proposed rectification, reviews the progress reports[652] and actively monitors overall progress of the recall. This process means any issues with the effectiveness of any recall campaign are rapidly identified and can be resolved by the two agencies."

459. Mr Grimwade considered that these aspects of the letter accurately reflected the arrangements in place as between the ACCC and DIRD between 2015 and July 2017, but he accepted that they "could have been explained … a bit more clearly than it has been".[653] However, Mr Grimwade did not agree with an earlier statement in the ACCC's letter that:

> "The ACCC monitors the progress of recalls".

460. At least insofar as this statement was directed to motor vehicle recalls, Mr Grimwade considered it to be at odds with other parts of the letter.[654]

461. The ACCC's letter to the NRMA also stated:

> "In the case of the Takata airbag related recalls, both the ACCC and DIRD were satisfied with the actions proposed by manufacturers, including the plans for communication with affected vehicle owners."

462. Having regard to the evidence received by the inquest, it is difficult to reconcile this assurance regarding plans for communications as seemingly referring to DIRD being involved with reviewing consumer letters, an activity DIRD claims to have not engaged in because it did not perceive its role as being to do so. Counsel for the ACCC point to this evidence in conjunction with other material evidencing the

[649] Exhibit 1, 6/72B/1972-42.
[650] Exhibit 1, 9/90/2828 at [31(b)]; Exhibit 1, 15/25.
[651] Exhibit 1, 9/90-3/2849.
[652] Ms Nyakuengama advised that the reference in the letter to "progress reports" was likely to be to the kinds of rectification rate reports referred to above at [386]: Tpt 810.31-.34.
[653] Tpt 1503.44-.49.
[654] Tpt 1549.1-.35.

basis upon which the ACCC understood that DIRD was receiving and reviewing the adequacy of consumer letters in regard to the defect and risk of the affected Takata airbag causing metal fragments to be propelled resulting in injury to occupants of vehicle.

463. However, Counsel Assisting point out that in this respect:

a. As at October 2015, when the letter to the NRMA was finalised, the ACCC had not taken steps to obtain vehicle manufacturers' plans for communication with affected vehicle owners or to review such plans.[655] Mr Grimwade said that it would have been the ACCC's expectation at the time that DIRD had done so.[656]

b. As far as Ms Nyakuengama was aware, DIRD did not receive any document from Honda Australia described as a "recall plan" or "strategy".[657] Mr Thomas' evidence was to the effect that DIRD would receive a "high level" document, to the extent that manufacturers would state that they would follow the FCAI Code processes for their recall.[658] Ms Nyakuengama was unable (at least, initially) to explain to the inquest how it was that DIRD could be satisfied with the actions proposed by manufacturers, including their plans for communication, without itself making any assessment of whether their recall letters were an effective means of communicating with customers.[659] She later accepted that DIRD may have indicated such satisfaction in the letter to the NRMA on the basis that the ACCC was so satisfied, and, for DIRD's part, this was a matter within the ACCC's purview.[660]

464. Mr Grimwade accepted that there was a lack of clarity as between each of DIRD and the ACCC in relation to the task of reviewing suppliers' plans for communication with affected vehicle owners. He said "we understood it to be them [DIRD] and from Ms Nyakuengama's evidence, [DIRD] didn't understand that it was to be them".[661]

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[655] Tpt 1504.16, 1504.41.
[656] Tpt 1504.21.
[657] Tpt 809.22-811.13. There was, nonetheless, some discussion in the context of the Takata airbag working group meetings between DIRD and manufacturers as to the approach to be taken by suppliers to notifying consumers: see Exhibit 1, 8/77/2276, Tpt 1740.23-.38, 1742.49-1743.3.
[658] Tpt 1015.37-.48.
[659] Tpt 811.37-.42.
[660] Tpt 812.48-813.5.
[661] Tpt 1504.44-1505.2.

465. Whatever the situation, it is without controversy that DIRD did not request and did not receive and did not review the customer letters in relation to the 5ZV recall. Counsel for the ACCC submit that the ACCC believed that this was an exception to the practice otherwise adopted by DIRD. How the ACCC could have believed that DIRD was otherwise reviewing consumer letters when DIRD submits that at no time was it ever a function or a role that DIRD adopted may be found in the content of Mr Thomas's email relating to the media handling brief he sent to the ACCC on 21 September 2015 in which he referred to DIRD needing to ask some manufacturers to amend their communication messages: see above at paragraph [447]. Given that the manufacturers' communication strategy was limited to consumer letters, it would be reasonable for the ACCC to believe that it was those letters to which Mr Thomas referred. Mr Thomas had met with the manufacturers in August 2015 and it would seem that rather than being involved in reviewing the letters, he was referring to a general discussion about them.

466. Counsel for DIRD rely on the letter to the NRMA as evidencing the close working relationship of DIRD and the ACCC in the Takata airbag recall process and suggests, contrary to Mr Grimwade's position, that the ACCC did, in this way, monitor the progress of the recalls. That DIRD reported to the ACCC about the progress of the recalls sufficiently allows a finding that the ACCC was as aware of the progress of the rectifications as DIRD was and in that way it could be correctly said that both were involved in monitoring the recall, in least in respect of the rectification rates.

467. Though counsel for DIRD in their submission seeks to minimise the lack of clarity as to the respective agencies' roles that existed at the time of the recall it is difficult on the evidence to find otherwise, especially when the lack of clarity or the confusion appeared to remain throughout the course of the inquest.

***An unresolved investigation of a possible airbag misdeployment in August 2015 following the report from "Ms C" indicating a possible airbag misdeployment in Mazda vehicle – November 2015***

468. On or about 6 November 2015,[662] an incident was reported to the ACCC by a consumer ("**Ms C**")[663] whose Mazda 6 had been involved in a collision with another vehicle on 26 August 2015. The nature of the reported incident suggested that there had potentially been a misdeployment of an airbag in Ms C's Mazda 6

[662] See Exhibit 1, 17/160-E/4658.
[663] A non-publication order was made in respect of information identifying Ms C.

vehicle.

469. The evidence before the inquest indicates that this was the first report to the ACCC or DIRD related to a potential or alleged misdeployment in Australia of a Takata airbag inflator.[664]

470. The report that Ms C provided to the ACCC, as reflected in an email sent from the ACCC's "Infocentre Public Mailbox" to the ACCC's Product Safety team, was to the following effect (sic):[665]

> "C owns a new Mazda 6 with a Takata airbag and had a side on collision with another car but states she was only going "5km per hour". On impact C's Takata Airbag has exploded and caused serious injury to C. C states that the air bag release a heavy toxic gas which burn her hands and face. Fragments of the airbag also cut C face and left scaring (sic)…."

471. On 9 November 2015, an officer from the ACCC's "Infocentre" telephoned Ms C in relation the reported incident.[666] According to the ACCC file note made of the call, Ms C reported that the accident had occurred on 26 August 2015 when her car was hit by another vehicle while stationary or virtually stationary, causing the airbags to deploy, which made a sound "like a bomb going off". Ms C reported having sustained a "cut just below the nose" and that "a piece of metal hit her face". Ms C provided consent for her report to be shared with DIRD.

472. The ACCC's records of this conversation with Ms C were forwarded that day by Dr Klaver of the ACCC to Mr Thomas of DIRD, with Dr Klaver stating, "please hold this information in-confidence between our agencies".[667] As to this, there is no indication in the material before the inquest that Ms C asked at that time for her report to be treated in confidence or to have its circulation limited to the ACCC and DIRD, or that the ACCC asked Ms C for permission for information concerning her incident to be released more broadly.[668] According to Mr Grimwade, the ACCC was not bound by any statutory requirements to keep Ms C's report confidential and he was not aware of any policies indicating the extent to which such reports could be circulated beyond the ACCC.[669]

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[664] See Tpt 1310.10, Tpt 1394.36-.44 (Wright); and see above at [450]-[452].
[665] Exhibit 1, 17/160-E/4658; see also Tpt 1443; Tpt 1450.29-.44 (Grimwade).
[666] See Exhibit 1, 17/160-E/4656.
[667] Exhibit 1, 17/160-E/4656.
[668] See Tpt 1445.7-.21.
[669] Tpt 1446.1-.13.

473. In response to receiving the report regarding Ms C from the ACCC, Mr Thomas replied to Dr Klaver, in an email dated 9 November 2015: [670]

> "Thanks very much for this advice. We note your request about keeping this matter in confidence between our agencies and will not contact any other parties without your agreement. In order to investigate properly, it would be best if we could work with Mazda and NSW Pol. Tomorrow we would like to discuss how we can secure [Ms C's] agreement to make those inquiries."

474. On 10 November 2015, Dr Klaver replied to Mr Thomas' email, stating that Ms C had been informed that officers from DIRD would "more than likely to be in touch with her" and that "we [ACCC] are happy for you to make further enquiries on our joint behalf".[671]

475. Late in the afternoon of 9 November 2015, after receiving Dr Klaver's email referred above, Mr Thomas emailed Judith Zielke (DIRD's Deputy Secretary) and others within DIRD, stating:[672]

> "We have just received a report from the ACCC about a purportedly exploding Takata airbag in Australia. The case involves the driver's side airbag of a 2009 Mazda 6 which allegedly misdeployed during a low speed accident. At this stage, we are reserving judgement on whether this is a "legitimate" case of a Takata misdeployment.
>
> However, there are several factors that tell against that outcome:
>
> - The VIN of the vehicle suggest[s] that this was not a recalled vehicle – it is a different sub-model to the 2009 Mazda 6s that have been recalled
> - The 2009 Mazda 6s that have been recalled have potentially misdeploying passenger side airbags (not driver's side as was the case here)
> - While there is a laceration under the nose, this was not serious enough to warrant stitches – the information we have about misdeploying airbags generally involved multiple serious lacerations
> - Most of the other injuries are consistent with normal airbag deployment
> - The case notes indicate that Mazda were informed of the incident – we suggest that Mazda would have informed the Department had [it] been made aware of a Takata misdeployment.

[670] Exhibit 1, 17/160-F/4660.
[671] Exhibit 1, 17/160-F/4660.
[672] Exhibit 1, 17/160-E/4655.

> That being said, we are taking the matter seriously, and will investigate further over the coming days."

476. On 10 November 2015, Mr Thomas had a conversation with Dr Klaver in relation to the Mazda 6 incident in which, according to Dr Klaver's file note, Mr Thomas reported to her that: Ms C's vehicle had not been recalled by Mazda; there was no overseas recall for such vehicles; that the car and airbag could not be retrieved as the vehicle had already been taken by the insurer; and Ms C's injury was very minor, involving a cut below the nose with no stitches.[673]

477. Ms C's case was assigned, within DIRD, to an investigator within Mr Connell's team, Karl Brown.[674] The inquest obtained a copy of the relevant investigation file.[675]

478. A DIRD file note dated 1 December 2015 in the investigation file, includes the following:[676]

> "Contacted [Ms C] on the week of November 9 2015… I explained that the Department [ie DIRD] needed to pass on certain details of her case to Mazda so they can investigate the technical circumstances of her accident and the injuries she claims to have received.
>
> She explained to me that she has emphysema and the accident had caused her to go into hospital with breathing difficulties because of the "gases".
>
> I asked about the accident and she described that the vehicle hit her in the right hand front corner (unsure if it was the side or front on) and the accident deployed the airbags. She described:
>
> - The car hit right hand front while she was nearly stationary;
> - The airbags deployed;
> - The airbags were like bombs going off in the car;
> - The car was full of gas
> - She was injured and taken to hospital.
>
> She described her injuries as being:
>
> - Bruises to her face
> - A piece of metal hit her and split her lip;
> - 3rd degree burns from the airbags;

[673] Exhibit 1, 16/148-A/4082.
[674] Tpt 1100.45-1101.14.
[675] Exhibit 16.
[676] Exhibit 16, p 10.

- "gas" from the airbags affected her emphysema to the point that she had to go to hospital after the accident.

The only treatment she received was for the emphysema and lip (no stiches). She discharged herself from hospital against Drs advice. It is understood that she received no treatment to anything other injuries.

I encouraged her to submit a form and the Department will give the investigation high priority."

479. On 17 December 2015, Mr Brown made contact with Ms C about her complaint about her Mazda 6 and the injuries she received as a result of the accident. On the same day, Mr Brown reported to Mr Thomas that Ms C had not yet submitted her form and "the additional information I requested" and that "the investigation will be stalled until we receive the initial batch of evidence [from] Ms C".[677]

480. A further file note of DIRD dated 16 February 2016 recorded as follows:[678]

"This investigation is closed due to lack of evidence and permissions from the owner of the vehicle for the Department to investigate on her behalf.

[Ms C] verbally indicated:

- Her vehicle was hit in the right hand front corner;
- The front airbags deployed;
- She described the injuries she received by the airbags as;
  - Facial bruising;
  - A split lip;
  - Third degree burns
  - "gas" from the airbags affecting her emphysema;
  - Bleeding from a broken nose.

…

The Department has not been able to determine if the injuries were as severe as indicated. The injuries described were more consistent with a normal airbag deployment rather than what has been described from overseas markets. The injuries and deaths which have been attributed to Takata airbag mis-deployment were far more severe, some causing death on 10 occasions.

[677] Exhibit 1, 17/160-G/4665.
[678] Exhibit 16, p 9.

> The vehicle, a 2009 Mazda 6, is not involved in any of the recalls for Takata Airbag mis deployment.
>
> The vehicle is also not available for inspection as the insurance company has disposed of the vehicle in August 2015.
>
> The Department may re-open the investigation if more information is provided … or if a systemic safety issue becomes apparent in that model Mazda 6."

481. From DIRD's investigation file, it appears that no contact was made by the DIRD investigation team with either Mazda Australia or with the NSW Police in relation to Ms C's case.[679] Nor does it appear that the ACCC made contact with Mazda Australia or police in 2015 or early 2016 in relation to Ms C's report.[680] In this regard, according to Mr Grimwade, where an incident is reported to the ACCC as involving an injury caused to a consumer by a motor vehicle, and the investigation is referred to DIRD, the ACCC's expectation is that DIRD would make any contact with the manufacturer/supplier to investigate the incident.[681] There is no evidence before the inquest that reflects the ACCC having been made aware, by DIRD, of any steps taken by DIRD to raise Ms C's incident with Mazda Australia or with NSW police.[682]

482. In evidence, Mr Grimwade accepted that there would have been a benefit in DIRD engaging with Mazda Australia, as part of its investigation into determining whether Ms C's injury resulted from a normal airbag deployment or a misdeployment, as Mazda Australia may have had an understanding of the nature of any risk that the inflator in her vehicle posed.[683]

483. Mr Thomas was not aware of DIRD having informed the ACCC that the investigation into Ms C's incident was closed (in February 2016),[684] and there is no document indicating that this occurred. Mr Thomas accepted that DIRD should have sent a document to the ACCC in February 2016 that recorded that the investigation file had been closed and setting out the reasons why.[685]

484. For his part, Mr Grimwade was unable to clearly identify the nature of any reports provided by DIRD to the ACCC as to the progress or outcome of DIRD's

[679] See Tpt 1108.21-.36.
[680] Tpt 1446.19-.44.
[681] Tpt 1446.46-1447.4.
[682] Tpt 1452.1-.25
[683] Tpt 1449.18-.34.
[684] Tpt 1192.49-1193.5.
[685] Tpt 1193.23-.29.

investigation into the Mazda 6 incident.[686] Mr Grimwade accepted that there did not appear to have been any protocols in place at the time to ensure that there was information sharing between the ACCC and DIRD in relation to significant incidents in the recall and the outcomes of investigations.[687] In addition, as at July 2020, when Mr Grimwade gave evidence to the inquest, he was not aware of any processes then in place to ensure communications between the ACCC and DIRD as to complaints made and the outcome of complaints investigations.[688] He considered that it would be appropriate for such processes to be put in place to ensure information sharing and communications between the ACCC and DIRD to the extent that this was not being achieved through the existing system.[689]

485. Mr Thomas was not aware of whether DIRD had informed Ms C of the closure of the investigation file,[690] but considered that DIRD should have informed her of the outcome of its investigation.[691] Mr Thomas also indicated that DIRD did not have any specific database dedicated to information concerning reports of potential misdeployments of Takata airbags.[692]

486. On 5 October 2016, Ms C lodged an enquiry with the ACCC Infocentre, via completion of a webform accessible through the PSA website, which asked whether her Mazda 6 was "on the recall list for airbags".[693] On 6 October 2016, she forwarded confirmation of the ACCC Infocentre submission onto DIRD, seeking information about whether her vehicle was subject to recall.[694] On 7 October 2016, an officer within DIRD's Operational Policy section emailed Ms C, seeking her permission to send her email and details to Mazda Australia.[695]

487. On 7 October 2016, Mr Thomas spoke with Ms C and advised her that, according to information she had provided, it appeared that her vehicle had not been caught up in the Takata recall. According to a contemporaneous file note that he made, Mr Thomas advised Ms C that, in order to confirm that conclusion, he would need

[686] Tpt 1450.46-.24.
[687] Tpt 1715.19-.25.
[688] Tpt 1715.30.
[689] Tpt 1715.47-1716.3.
[690] Tpt 1193.5.
[691] Tpt 1193.34.
[692] Tpt 1180.30-.33.
[693] Exhibit 1, 16/145/4060, 4062.
[694] Exhibit 16, p 7.
[695] Exhibit 16, p 8.

her permission to contact Mazda Australia and Ms C did not provide that permission.[696]

488. From photographs obtained of Ms C's vehicle as part of the coronial investigation, it is apparent that both the driver's and passenger's airbag deployed during the collision, and that the force of the deployment of the airbags (or at least the driver's side airbag) may have contributed to the shattering of the front driver's windscreen (given that this area of damage was not proximate to the main site of impact with the other vehicle).[697] In the available photographs, it is not possible to see any breaches of the airbag fabric, but nor could one rule out the existence of such breaches based on what is visible.[698]

489. Mr Thomas' evidence to the inquest was that the view taken within DIRD, in the absence of further evidence, was that Ms C's reported injuries "were principally consistent with a normal airbag deployment".[699] However, Mr Thomas agreed that a Takata airbag misdeployment was "not conclusively disproven" and that a report of being hit by a metal fragment would not be consistent with a normal misdeployment.[700]

490. According to Mr Grimwade, the view formed within the ACCC, at least by the time it conducted its safety investigation in August 2017 following Mr Ngo's death, was that Ms C's incident "was not a misdeployment".[701] He said that the ACCC "saw it very much as the role of [DIRD] to ascertain whether the incident was a misdeployment or not and whether the risk associated with the Takata airbag voluntary recalls needed to be re-evaluated as a consequence".[702]

491. It appears that Ms C made further contact with DIRD in about August 2017 after Mr Thomas had left DIRD. On 15 August 2017, Ms C was advised by email from a DIRD investigations officer, Gavin Klinger,[703] to forward any information she wished to discuss by email.[704] On 17 August 2017, Mr Klinger sent an email to Alison Whatson and Erik Connell of DIRD, attaching one of Ms C's initial reports

[696] Exhibit 16, p 6. This appears to be consistent with information that the coronial investigation obtained from Ms C: see Exhibit 1, 16/152/4504-4505.
[697] Exhibit 1, 16/148E2/4149-4151.
[698] See, in particular, 16/148-E3/4169.
[699] Tpt 1116.20-.22.
[700] Tpt 1116.24-.40.
[701] Tpt 1454.30-.1455.16.
[702] Tpt 1455.31.
[703] Exhibit 1, 17/160-J/4674; see also Tpt 1104.33.
[704] Exhibit 1, 17/160-I/4673.

to the ACCC in respect of her injuries, which was marked up in handwriting to indicate that the "vehicle is included in recall PRA 2017/16232".[705]

492. As to this, information that the coronial investigation obtained from the ACCC and Mazda in relation to Ms C's vehicle indicates that the *passenger* airbag inflator in her Mazda 6 was a Takata model which was within a class of inflators that, from July 2017, was voluntarily recalled by Mazda Australia.[706] It appears from the handwritten notation on the attachment to Mr Klinger's email of 17 August 2017 that DIRD became aware, at about that time, that Ms C's vehicle – had it not been written off – would have been caught up by the Takata airbag recalls. It appears that, after becoming so aware, DIRD officers took steps to try to ascertain whether Ms C's Mazda 6 model also had a Takata driver's airbag inflator, but that Ms C did not permit DIRD to disclose her information to Mazda Australia for the purpose of making such enquiries.[707]

493. In any event, on 18 August 2017, Mr Finucci of DIRD emailed Mazda Australia seeking general information about the *driver* airbag inflators in Mazda 6 vehicles affected by the recall that was applicable to the *passenger* inflator in Ms C's vehicle (ie, without specifically identifying Ms C or her VIN number).[708]

494. On 25 August 2017, a representative of Mazda Australia emailed Mr Finucci stating:[709]

> "We have received some preliminary information from Mazda Japan on this enquiry.
>
> The information indicates that the airbag is a Takata however the inflator is not of the affected non-desiccated ammonium nitrate type.
>
> We are seeking further information and will share it as it becomes available."

495. Mr Klinger reported this response to Ms Whatson, stating, "Erik and I have discussed and thought we should await the further information from Mazda".[710] It

[705] Exhibit 1, 17/160-J/4675.
[706] Exhibit 1, 16/148/4075-4076 at [1.5]; 16/148/E3/4157
[707] See, Exhibit 1, 17/160-K/4676.
[708] Exhibit 1, 17/160-K/4679.
[709] Exhibit 1, 17/160-K/4678.
[710] Exhibit 1, 17/160-L/4678.

appears that no further information was then received by DIRD from Mazda Australia, or otherwise sought by DIRD.[711]

496. On the material before the inquest, though accepting that Ms C suffered injury in the motor vehicle accident, it is unclear whether either of the airbags in Ms C's Mazda 6 vehicle in fact misdeployed at the time of her collision.

497. Even if DIRD (or the ACCC) had taken further steps to investigate Ms C's reported incident, it may be that neither would have been able to conclude, in late 2015/early 2016, that Ms C's incident had in fact involved an airbag misdeployment:

    a. Police who attended the motor vehicle accident did not apparently raise any issue in relation to a potential airbag misdeployment.[712] However, it may be that police attending motor vehicle collision scenes in 2015 were not attuned to look for this possibility.

    b. Ms C's vehicle was unable to be inspected as a result of her contact to the ACCC in November 2015 as it had apparently been destroyed by or on behalf of the insurance company in August 2015.[713]

    c. The ACCC and DIRD were made aware of Ms C's reported incident, for the first time, in early November 2015 at which point an inspection of the vehicle was not possible).[714]

    d. Ms C (whether or not she appreciated the significance of this at the time) does not appear to have provided her consent that DIRD considered it needed in order for DIRD to specifically raise her report with Mazda Australia.[715]

    e. Although Mazda Australia was notified on 8 September 2015 by Ms C's husband of Ms C's account that, in the collision on 26 August 2015, "the impact from the airbags installed was as if a bomb had exploded sending small pieces of shrapnel and powder of some kind directly into [her] face and eyes",[716] Mazda Australia did not lodge any report with the ACCC (or with DIRD) suggesting that there had potentially been a misdeployment-

[711] In information that the inquest obtained from the ACCC, it appears that Mazda Australia has since advised the ACCC (ie, in about May 2020) that the driver's airbag in Ms C's vehicle was comprised of a bag and housing made by Ashmori and an inflator made by Daicel: Exhibit 1, 16/148/4075-4076 at [1.5(b)].
[712] Exhibit 1, 16/153-155/4509-4528.
[713] Exhibit 1, 16/148-A/4082; 16/148-E2/4128.
[714] Exhibit 1, 16/148/4074.
[715] Exhibit 16, pp 6-9.
[716] Tpt 1447.29-1449.16; Exhibit 1, 16/151-8/4406; cf Exhibit 1 16/149/4076.

related injury in one of its vehicles.[717] Mazda is of the view that the incident involved a normal deployment.[718]

498. Counsel assisting submit there are some aspects of DIRD's investigation into the Mazda 6 incident which provide cause for concern giving rise to the desirability of recommendations. These concerns – which are relevant to the investigation in future of injuries of the kind sustained by Mr Ngo and which caused his death – are as follows:

499. ***First***, that the DIRD investigation took into account two factors which did not provide a reasonable basis tending against a conclusion that Ms C's car accident involved a legitimate instance of a Takata misdeployment. Namely, that at the time of the incident the car was not subject to recall and that Ms C's facial injuries/lacerations were relatively minor. In his evidence Mr Thomas accepted that the fact that Ms C's vehicle had not been recalled at the time that the incident was reported did not necessarily support a conclusion that the airbag was not an affected Takata airbag[719] and provided little information as to whether or not this had been an instance of an airbag misdeployment.[720]

500. As things transpired, Ms C's vehicle *was* within a class of vehicles that Mazda Australia recalled from July 2017 as a result of a defective Takata airbag on the passenger side (although Ms C's vehicle had been written off by that time).[721]

501. Significantly as is apparent from Honda Australia's designation of airbags the subject of the 5ZV recall as "critical" following Mr Ngo's death, there may be circumstances in which risk ratings of airbags are only escalated by a manufacturer *after* an incident has occurred.

502. DIRD did not receive any information which directly contradicted Ms C's account as to the injuries she sustained or her reports of a piece of metal striking her.[722] As acknowledged by Mr Thomas, a piece of metal projected from an airbag could well cause a glancing cut, but not necessarily one requiring stitches.[723] The seriousness of the reported injury may therefore not have been a logical basis upon which to conclude that there had been no misdeployment.

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[717] Exhibit 1, 16/148/4075.
[718] Exhibit 1, 16/148/4080, [4.6].
[719] Tpt 1185.47-.50.
[720] Tpt 1113.24.
[721] Tpt 1115.41- 1116.2; Exhibit 1, 16/148/4075-4076.
[722] Tpt 1111.47.
[723] Tpt 1111.11-47; see also 1113.48-1114.3.

503. ***Secondly,*** though DIRD did not apparently secure Ms C's consent authorising DIRD to approach Mazda Australia to make enquiries about the reported incident, it is unfortunate that DIRD did not in 2015 take the approach DIRD adopted when it approached Mazda Australia in 2017. In any event, there may have been ways in which DIRD could have made enquiries with Mazda Australia about the airbags in Ms C's vehicle model on an "anonymous" basis".

504. Counsel assisting suggest that consideration be given to a recommendation to the effect that DIRD and/or the ACCC clarify their policies and publish publicly available guidelines as to when a consumer product safety complaint will be treated confidentially and the circumstances in which such complaints are to be raised with the relevant motor vehicle supplier.

505. ***Thirdly***, there was a lack of clear and contemporaneous communications as between DIRD and the ACCC as to the progress of the investigation, and there should be a formalised process in relation to information sharing between the ACCC and DIRD in respect of reported incidents involving injuries from airbags (or motor vehicles more generally) and investigations that are conducted by either agency into such incidents, and that such policy or protocol be made publicly available.

506. ***Fourthly***, although Ms C reported her accident to the ACCC after her vehicle had already been destroyed, so it seems unlikely that any engagement as between either DIRD or the ACCC and NSW police would have shed light on whether the incident in fact involved an airbag misdeployment, there may be potential benefits, in other cases, of having communications between the ACCC / DIRD and police bodies about alleged incidents of airbag misdeployments and the risks posed by defective airbags more generally. If such communications take place, police may in turn be more attuned to the need to inspect airbag componentry when attending the scenes of motor vehicle accidents and to consider the possible role played by airbags in injuries that are sustained by crash victims.

507. Counsel assisting suggest a recommendation that the ACCC and DIRD develop and publish a protocol pursuant to which reported airbag misdeployment incidents, and risks understood to be posed by particular airbag models more generally, are notified to relevant police authorities and coronial units.

508. Counsel for the ACCC submit that the recommendations suggested by Counsel Assisting as they affect the ACCC are neither necessarily nor desirable. The ACCC submit that the ACCC promptly shared information about Ms C's complaint

with DIRD and DIRD provided a prompt initial response. Though the ACCC did not follow up the results of the investigation, due to its close working relationship with DIRD, the ACCC was aware that should there have been a finding that Ms C's vehicle did have an airbag misdeployment DIRD would have informed the ACCC of this just as DIRD had informed the ACCC about the BMW misdeployment (referred to below) in September 2016.

509. Counsel for the ACC submit that the ACCC does not involve itself in investigations of complaints, which is the role of the specialist regulator. An ACCC policy published in April 2019 called "**Accountability Framework for Investigations**" notes that the ACCC will only refer confidential information (to the specialist regulator) with the consent of the person making the complaint. The MOU between the ACCC and DIRD sets out the circumstances in which information received by one agency will be shared with the other and confidential information will not be shared by either agency without the consent of the third party or unless required by law.

510. Counsel for the ACCC submit that a recommendation that the ACCC and/or DIRD clarify their policies or publish written guidelines in relation to its confidentiality of information is unnecessary because there is already such published policy. Counsel for the ACCC set out that:

> "The primary obligation to hold information reported to the ACCC in confidence arises from s. 155AAA CCA [Consumer & Competition Act], which prevents the disclosure of "protected information", defined to include information given in confidence to the ACCC and relating to a matter arising under the ACL, other than in defined circumstances. Additionally, the ACCC has obligations regarding the use and disclosure of information pursuant to the *Privacy Act 1988* (Cth).
>
> The ACCC has a published Privacy Policy and an Information Policy, which are available on its website.[724] The latter policy notes, among other things, a commitment to treating confidential information responsibly, and that the release of information may have a substantial adverse effect on the party, and may also affect the willingness of other information providers to assist."[725]

[724] <https://www.accc.gov.au/publications/accc-aer-privacy-policy; https://www.accc.gov.au/publications/accc-aer-information-policy-collection-and-disclosure-of-information>.
[725] Ibid at [3.2] (a) and (c).

511. Counsel for the ACCC state that “revisions to the MOU proposed by the ACCC also include information sharing, and the process for assessing reports made under s. 131 of the ACL”.[726]

512. Counsel for DIRD reiterate that their investigation was confined by the need to obtain Ms C’s consent to divulge confidential information to Mazda. In relation to the recommendations relating to policy and protocols, DIRD agreed with the intent of the recommendations in that such issues will be resolved in the ongoing development of written documents clarifying roles and processes between the ACCC and DIRD.

513. In relation to the recommendation involving notification of incidents and risks to relevant authorities such as the police and coroner, counsel for DIRD point out that DIRD already publishes a quarterly ‘Road Vehicle Compliance Update’ which could be used to indicate to relevant authorities’ trends and issues about reported airbag misdeployments and risks understood to be posed by particular airbag models. DIRD resists a role where it would be required to provide broad vehicle safety advice to State/Territory police and State Coroners, submitting that any such process could be confusing if it was limited to defective airbags when DIRD is involved in all vehicle recalls. Counsel for DIRD point out that in regard to airbags the “Is My Airbag Safe” website allows for customers to check their airbag.

514. Whilst I accept Counsel for the ACCC’s submissions that the ACCC is not involved in investigation processes and has sufficient policy and protocols regarding how to treat confidential information, DIRD does not. As the investigating specialist regulator, especially with powers of a regulator as of 1 July 2021, Counsel for DIRD agree that the development of such processes and protocols are necessary.

515. In relation to DIRD keeping relevant police and coronial units informed, the quarterly ‘Road Vehicle Compliance Update” and the “Is My Airbag Safe” are not the appropriate mechanisms for informing police and coronial units about issues with reported airbag misdeployment incidents and the risks understood to be posed by particular airbag models more generally. Airbags are not vehicle componentry specifically covered by the ADR or the vehicle compliance scheme and the mechanism of identifying a vehicle subject to a recall (such as “Is My Airbag Safe”) is not the information that the recommendation is directed to. Given the number of other motor vehicle recalls with which DIRD is involved, it is not

[726] 14/142J/4058-214 at [2] (d) (e) and [5].

suggested that this particular recommendation include motor vehicle componentry generally but rather that it is limited to airbags. Given that airbags have pyrotechnic propellant and that the compulsory recall is complete but voluntary recalls to some degree are ongoing, the dissemination of such information has the capacity to lead to the acquisition of knowledge about airbag risk that could improve investigations into defective airbags and in turn prevent further deaths.

516. Accordingly, I include in the recommendations to DIRD:

    a. That DIRD develop policy and protocols for the carrying out of investigations in relation to complaints involving motor vehicle componentry generally and airbags specifically, such policy and protocols to provide for clear communications and record keeping as to progress and finalisation of investigations and as to the obtaining of consent for information sharing from any complainant and third party including the police, vehicle dealers and suppliers.

    b. That DIRD develop a protocol whereby there is a register kept of misdeployments and investigations of misdeployments of airbags on record and that such information be made available to the public and when a new development arises which may affect a police or coronial investigation into a serious injury or death arising from a misdeployed airbag, that such information be provided to the head of the police and the coronial unit of each State in Australia.

***Honda Australia's use of the term "precautionary" - Concerns about Honda Australia's recall correspondence are raised by Professor Nottage with ACCC – November and December 2015***

517. According to the minutes of the inaugural Takata Working Group meeting in August 2015, DIRD was notified that manufacturers were advising customers that "the recall was precautionary". In December 2015, the ACCC received correspondence from Professor Luke Nottage, a consumer law academic, raising concerns about the content of recall correspondence he had received from Honda Australia.[727] In particular, Professor Nottage expressed concerns that recall correspondence sent by Honda Australia referred to the replacement of Takata airbags being "precautionary", which he considered to be "highly misleading".[728] In

[727] Exhibit 1, 11/116/3339.
[728] Exhibit 1, 11/116/3400.

an email dated 5 December 2015, sent to Lauren Johnston of the ACCC, Professor Nottage referred to having spoken to Commissioner Rod Sims at a recent Consumer Law Roundtable, stating:[729]

> "[Y]ou may be interested in the concern re the Honda recall that I raised below, initially 11 Nov direct/generically to ACCC, then via Kirsten to your colleagues Jan Klaver and Kathryn Duncan. I haven't heard anything back but after hearing Rod Sims' talk opening our Consumer Law Roundtable at ANU last week I guess this may be because the instruction is not to interfere if a specialist regulator is in charge. However, as I mentioned to him afterwards informally, even if the ACCC has limited resources it doesn't "cost" ACCC much at least to make some public announcements to encourage other regulators and their firms to lift their game. (I am particularly worried about Honda directly and via retailers calling this a "precautionary recall" - it seems misleading, and certainly counter-productive if they are trying to avoid injury in Australia by getting the airbags replaced quickly …."

518. In his evidence at the inquest, Mr Grimwade agreed with Professor Nottage's observations in the above email that it is not productive to use the language of "precautionary" in the context of communicating with consumers about an airbag recall, even if the recall is in fact precautionary, because "it wouldn't incentivise as many consumers to comply with the recall as if it were not included in such correspondence".[730]

519. It is unclear if Professor Nottage's concerns that Honda was using the term "precautionary in relation to its recalls were conveyed by the ACCC to DIRD,[731] and to what extent DIRD provided feedback in respect of them.[732] On 9 December 2015, Joshua Leach (who worked in Mr Wright's team at the ACCC) reported to Dr Klaver of the ACCC in an email which included the following:[733]

> "Karl Brown [an officer at DIRD] was able to provide an update on the Takata airbag recalls. Many of the points raised in that discussion should address Mr Nottage's concerns. DIRD is meeting this Friday with all motor vehicle suppliers about Takata airbag recalls. Amongst other issues being discussed is the current status of parts availability and the impact of NHTSA's fine on future parts availability. The suppliers will also be providing more information about the type of desiccant used in the airbags and replacement parts. The Recalls guidelines ask that suppliers do not

[729] Exhibit 1, 11/115/3330. Mr Grimwade was not aware of anyone at the ACCC having indicated to Professor Nottage that the ACCC held an instruction not to interfere with the Takata recalls because of the role played by DIRD as specialist regulator: Tpt 1508.12-.25.
[730] Tpt 1509.11-.20.
[731] There does not appear to be any document before the inquest reflecting the concerns raised by Professor Nottage being forwarded to DIRD in writing.
[732] Tpt 817.45-818.28; Tpt 1509.43.
[733] Exhibit 1, 10/93/3180-5.

> use the word voluntary (sic) recall, encourage consumer compliance with the recall, and avoid overly technical language.…"

520. In respect of this email, Mr Grimwade gave evidence that he was not aware of whether, in December 2015, the ACCC or DIRD made enquiries with Honda Australia about the content of its recall correspondence to consumers with defective Takata airbags.[734] He said that "I think our expectation would have been that [DIRD] would raise these issues".[735] For her part, Ms Nyakuengama was not aware of whether the concerns raised by Professor Nottage were considered within DIRD.[736]

521. On 11 December 2015 Professor Nottage sent an email to Nigel Ridgeway of the ACCC, following up on his earlier correspondence. Mr Ridgeway responded by email on 14 December 2015 as follows: [737]

> "Thanks for following up.
>
> I have checked on this with relevant teams.
>
> We are working very cl[o]sely with the transport re[g]ulatory officials at the Department of Infrastructure and Regional Development as we do with all transport safety matters of common concern.
>
> I understand from the Consumer Product Safety team that Honda has issued quite a number of airbag related recalls and that some are for models not identified by the US authorities.
>
> These may be initiatives that Honda has characterised as precautionary.
>
> Whether that is the case or not, we do urge businesses recalling products to use direct language and to identify the consumer risks associated with the products being recalled.
>
> We continue to be engaged, as I have noted, with our transport safety colleagues a[n]d will explore this further in that context."

522. In evidence, Mr Grimwade accepted that Mr Ridgeway's assurances to Professor Nottage in this email that "we continue to be engaged…. with our transport safety colleagues [and] will explore this further in that context" may have overstated the depth of how closely the ACCC was working with DIRD at the time in relation to

[734] Tpt 1510.17.
[735] Tpt 1510.22.
[736] Tpt 818.28.
[737] Exhibit 1, 11/115/3329.

the Takata airbag recalls.[738]

523. In a subsequent email sent on 14 December 2015, Professor Nottage provided Mr Ridgeway with a copy of the recall letter that he had received for his Honda vehicle (relating to Honda's "5UN" recall campaign).[739] This letter contained materially similar language to the kind included in the recall letter prepared by Honda Australia to be sent to customers affected by the 5ZV recall in November 2015.[740]

524. It appears that, following these and prior to 13 July 2017, neither DIRD nor the ACCC raised with Honda Australia any query about the basis for its use of "precautionary" language in recall communications with its customers;[741] and that the concerns raised by Professor Nottage were not otherwise conveyed to Honda Australia.[742] In his evidence at the inquest, Mr Grimwade accepted that Honda Australia should have been approached, either by the ACCC or DIRD, in this regard.[743] He gave evidence to the effect that a failure to take up those concerns involved a missed opportunity on the part of the ACCC or DIRD.[744]

525. Counsel for DIRD submit that any lost opportunity was solely that of the ACCC's as there is no evidence that Professor Nottage's correspondence was properly provided to anybody at DIRD. Though Joshua Leach refers to Professor Nottage's concerns it is difficult to assess whether DIRD was specifically directed to the concerns raised by Professor Nottage as it is not clear as to what Mr Leach was referring when he wrote "[m]any of the points raised in that discussion should address Mr Nottage's concerns" in circumstances where he later incorrectly states that the term "voluntary recall" should not be used when the term Professor Nottage was concerned about was a "precautionary" recall. Though Counsel for DIRD correctly submit that there was nothing stopping Professor Nottage from contacting Honda Australia directly, that is not a particularly helpful submission and is not really the point given that Professor Nottage's approach to Mr Ridgeway appears to have been a step taken following his discussion with Rod Sims, the commissioner of the ACCC.

[738] Tpt 1514.24-.26.
[739] Exhibit 1, 11/115/3336-3338.
[740] See Exhibit 1, 5A/60C-3/1625-17.
[741] See Tpt 1511.11-.27; Tpt 1512.42.
[742] See, Tpt 1717.50, 1720.11.
[743] Tpt 1511.30-.32.
[744] Tpt 1513.13-.18.

526. Counsel for the ACCC do not contest that this was a lost opportunity but submit that though "it may have been appropriate [for the ACCC] to follow up the inquiry with DIRD to see what the response was to Mr Nottage, this level of oversight was not warranted where the Department was leading the monitoring of the recall and where the ACCC understood….that it [DIRD] was considering the consumer letters". I understand that counsel was not suggesting that it was for DIRD to respond to Mr Nottage but it is unclear as to what actions DIRD was supposed to take with the suppliers given the nature of Mr Ridgeway's assurances to Professor Nottage. In his evidence Mr Grimwade agreed that Mr Ridgeway may have overstated the ACCC's engagement. I agree with this observation however there is ample evidence that DIRD and the ACCC did collaborate, communicate and meet in person to discuss the Takata airbag recall situation.

***DIRD and ACCC meeting – 18 November 2015***

527. Following an exchange of emails in November 2015,[745] ACCC and DIRD staff met on 18 November 2015. According to a file note of the meeting items discussed included the following Takata issues:[746]

> "• [the] NHTSA consent order and how it may change how Australia is handling the issue
>
> • Both authorities may need to get together to work out a collaborative approach
>
> • Possible issues surrounding supply of parts to Australia in light of the consent order
>
> • Types of propellant and their effect on future and past rectifications of vehicles
>
> • Collaborative efforts between agencies to compel suppliers and Takata to provide accurate information on the recall, parts and future protection of the vehicles and their occupants
>
> • (sections 133 and 155 of the CCA)"[747]

528. The recorded outcomes of the meeting included:[748]

[745] See, eg, Exhibit 1, 9/90-5/2856-2859; Tpt 814-815.
[746] Exhibit 1, 9/90-6/2862.
[747] Note that s 155 of the CCA confers a power on the ACCC to obtain information, documents and evidence. Section 133 provides for the appointment of inspectors (and s 133D, which may have been the intended reference, confers disclosure powers in relation to public safety issues).
[748] Exhibit 1, 9/90-6/2863.

> "• [DIRD] (Infrastructure) to contact manufacturers for technical information on Takata recall (details supplied in letter to manufacturers).
>
> • ACCC to assist [DIRD] (Infrastructure) if vehicle suppliers and Takata provide resistance."

529. Consistently with the outcomes of the 18 November 2015 meeting, DIRD, with support from the ACCC, commenced work on seeking information from vehicle manufacturers about their Takata airbag recalls.[749]

530. Although it is apparent that there were discussions at this point in time as between DIRD and the ACCC about the availability of the ACCC's compulsory powers, Mr Thomas' evidence to the inquest was that he was *not* of the view, in November 2015, that it would be desirable for such compulsory powers to be exercised. He said:[750]

> "It was an information-gathering exercise at that point. I saw part of my job as having one eye on the horizon, particularly in relation to the Takata matter, to look for anything that might feed the speedy rectification of vehicles….
>
> My concern was that with the consent order the head offices might say, "Right, this shipment that was going to go to Australia is now going to go to the United States." It was a theoretical eventuality that I identified, as I say, through having a bit of an eye on the horizon for things that could impede rectification and so my thinking was that if it looked as if that might occur using information gathering powers may just give the Australian son-and-daughter companies of the parent companies the idea that the regulators are onto this … So it was a theoretical discussion, as I say in there, about what powers could be used. At no point did we form the view that we should do it; we were exploring it."

531. As at December 2015, Honda Australia reported to DIRD that 21% of vehicles the subject of the 5ZV recall had been rectified.[751] Ms Nyakuengama considered that, four months into the recall, that rectification rate was "very good" relative to other recalls that DIRD was monitoring and of which DIRD had experience.[752]

***Takata Airbag Working Group meetings in December 2015 /April 2016***

532. The Takata Airbag Working Group held its second meeting on 11 December 2015. The minutes reflect that items of discussion included: rectification rates and parts supplies; misdeployment incidents recorded in Australia and overseas markets (in

[749] Exhibit 1, 9/90/2830 at [34].
[750] Tpt 1050.20-.41.
[751] Exhibit 1, 11/110/3190; Tpt 821.27.
[752] Tpt 821.29-.42.

relation to which Robert Hogan of DIRD reported that "the Department ie [DIRD] was investigating one possible mis-deployment in Australia" – seemingly a reference to Ms C's incident; and the NHTSA consent order.[753] According to the minutes, DIRD expressed to manufacturers some desired outcomes from DIRD's point of view, including: [754]

> "• Manufacturers to provide [DIRD] with rectification plans and rates;
>
> • 80% rectification if possible;
>
> • Approximately 3 years from notification of the recall to meet that completion rate".

533. At the third Takata Airbag Working Group meeting which took place on 29 April 2016, it appears that the focus of the discussion related to locating and contacting consumers as the action items arising from the meeting included the following:[755]

> "[DIRD] to examine Nevdis data problems when provided with examples by manufacturers/FCAI.
>
> [DIRD] to examine ways to provide assistance to manufacturers to contact customers.
>
> [DIRD] to examine proposal that vehicle registration authorities notify customers who renew registration of their vehicle that it is the subject of a recall. This may also include a block on transfers of registration and/or renewal.
>
> Manufacturers advised that public concern/media attention has been quite low and manageable. Due to oldest and low value vehicles being particularly difficult to recall, most manufacturers anticipate approx. 80% rectification rate for these types of vehicles.
>
> [DIRD] to discuss with State/Territory Govt. transport authorities if there are any capabilities to assist in recall."

***Publication of the Blomquist Report in May 2016***

534. On 9 May 2016 Jeremy Thomas of DIRD sent an email to Dean Wright and Jan Klaver of the ACCC, attaching a copy of the Blomquist Report as well as an amendment to the NHTSA November 2015 Consent Order. In his email, Mr Thomas relevantly said:[756]

[753] Tpt 8/77-A6/2280-2283.
[754] Tpt 8/77-A6/2282.
[755] DIRD Material, Tab 71.
[756] Exhibit 1, 9/90-9/2867.

> "…I think that the Takata matter is more urgent as every week hundreds of non-desiccated Takata air bags are being fitted as rectifications.
>
> There is a real possibility of rectified vehicles having to go through the process again.
>
> I have attached a couple of new doc[uments] on the matter – a variation to the consent order, and an expert view on the root cause. Both were issued by NHTSA last week.
>
> We would be particularly interested in what powers might exist under the CCA [Competition and Consumer Act] (product bans for instance)."

535. In an email dated 19 May 2016 to Dr Klaver, Mr Thomas referred to having met with ACCC representatives and enclosed a draft letter that had been prepared advising manufacturers of "our preliminary view".[757] This "preliminary view" was that it was no longer acceptable to have any airbags powered by non-desiccated ammonium nitrate. On 25 May 2016, Dr Klaver emailed Mr Thomas advising that the ACCC supported the approach outlined in his proposed letter.[758]

536. On about 3 June 2016, DIRD wrote to Honda Australia enclosing a copy of the Blomquist Report, and summarising the announcements made by NHTSA in reliance on that report, including the significant expansion of the US recall to include all Takata airbags powered by non-desiccated ammonium nitrate.[759] DIRD's letter stated that, in light of those announcements, it was reviewing its position on the matter but that DIRD had formed the preliminary view that it was no longer acceptable to have any airbags powered by non-desiccated ammonium nitrate and that manufacturers should recall all relevant vehicles, which may include vehicles that had already been rectified under existing recalls.[760] The letter also stated that "the Department [ie DIRD] has consulted with the [ACCC] on this matter, who support the Department's views".

537. According to Ms Nyakuengama, the publication of the Blomquist Report was the catalyst to the expansion of the voluntary recalls of Takata airbags in Australia and to DIRD assuming an increased role in monitoring such recalls.[761] She indicated that it was at about this time that, following discussions between Mr Thomas and Dr Klaver, it was decided that representatives of the ACCC should be present for

[757] Exhibit 1, 9/90-10/2899.
[758] Exhibit 1, 15/49; Tpt 1242.42-.50.
[759] DIRD Material, Vol 2, Tab 73, 74; Tpt 822.
[760] DIRD Material, Vol 2, Tab 73, 74.
[761] Tpt 823.22-.29.

discussions with manufacturers, such that the ACCC was then invited to attend the Takata Airbag Working Group meetings.[762]

538. On Ms Nyakuengama's account, having the ACCC present at Working Group meetings meant that manufacturers would "take us [ie DIRD] more seriously when we're saying that we expect action".[763] She said that the ACCC "were there because the issue was becoming larger and we were jointly managing it".[764] She said that although, at that point, DIRD did not consider that the Takata issue needed to be escalated to a compulsory recall, there was an expectation that the recall was going to expand in the light of the Blomquist Report, and that "it was time to start thinking about, not necessarily [a] compulsory recall but what powers might be available to encourage manufacturers to progress the recalls appropriately".[765]

539. Similarly, Mr Thomas' evidence was to the effect that while, in the wake of publication of the Blomquist Report, there was discussion between DIRD and the ACCC about what powers were available to be exercised by the ACCC (such as, eg, product bans and information collecting powers), this was in the context of exploring options that could be utilised in future; and that the ACCC was not asked by DIRD to exercise compulsory powers.[766]

***June 2016 meeting of Takata Airbag Working Group***

540. On 17 June 2016, a Takata Airbag Working Group meeting was held. Dr Wendy Cooper and Kathryn Duncan attended on behalf of the ACCC.[767] This was the first such meeting that the ACCC had been invited to attend; and, according to Mr Grimwade, this was as a consequence of the Blomquist Report and the perception that it would be helpful to have the ACCC present in the room to assist in negotiating an expansion of recalls in the light of that report.[768]

541. The agenda for the meeting indicates that an item of discussion was to be the NHTSA announcements of an expanded US recall, to include all non-desiccated airbags, in light of the Blomquist Report.[769] By about this time, DIRD's position,

[762] Tpt 742.30 to 743.24.
[763] Tpt 911.38.
[764] Tpt 959.14.
[765] Tpt 912.5.
[766] Exhibit 1, 9/90-8/2866; Tpt 1064.13-.50.
[767] Tpt 1458.26. According to Mr Grimwade, it was at about this time that the ACCC established a new team to monitor recalls, but this monitoring team did not have a role in monitoring recalls being overseen by specialist regulators such as DIRD: Tpt 1457.45-1458.21.
[768] Tpt 1458.35-.47.
[769] Exhibit 1, 8/77-A7/2284.

that all non-desiccated ammonium nitrate airbags should be recalled, had crystallised from a preliminary to a fixed view.[770] Honda Australia did not present any opposition to DIRD's views in this regard.[771]

542. The minutes of the meeting recorded, *inter alia,* the following:

    a. That DIRD acknowledged that progress had been made on the Takata-related recall campaigns as well as the co-operation of manufacturers.[772]

    b. That Honda Australia raised the issue "as to whether DIRD or the ACCC would consider an information and advertising campaign to inform and encourage consumers to participate in recall campaigns". [773]

    c. That DIRD and the ACCC would work with State and Territory registration authorities to determine what role they could play when other attempts to communicate with consumers had failed.[774]

543. As to the information and advertising campaign referred to, Mr Thomas agreed that, following the meeting, DIRD was on notice that manufacturers were having significant problems getting owners to bring their vehicles in to be repaired.[775] After the meeting, Matt Evans of Honda Australia spoke with Mr Thomas. In the course of their discussion, it appears that Mr Thomas indicated that DIRD was "sympathetic to the idea of doing a media release" in respect of 219 high risk Honda vehicles (containing a sub-population of alpha airbags); and that Mr Evans indicated that, at that stage, "Honda may want to take up that option a little down the track, but at this stage [Honda Australia] wanted to see how they went with current methods to track down affected owners" although Honda Australia "may also want to pursue the idea of a broader comms [communications] approach a little down the track". Details of this exchange were subsequently conveyed by Mr Thomas to the ACCC in an email dated 14 July 2016.[776] Mr Thomas understood that, at that point in time (ie, July 2016), Honda Australia did not wish to pursue a broader communications approach.[777] However, the topic of government support

[770] Tpt 824.23.
[771] Tpt 826.2.
[772] Exhibit 1, 8/77-A7/2284; Tpt 824.1-.11
[773] Exhibit 1, 8/77-A7/2286.
[774] Exhibit 1, 8/77-A7/2286.
[775] Tpt 1219.5-.12.
[776] Exhibit 1, 12/124D/3619-31; Tpt 1079.22-.37; Tpt 1240.30-.1241.27. See also, Mr Grimwade's evidence at Tpt 1459.15-.32.
[777] Tpt 1241.29-.31.

for advertising the Takata recalls was subsequently taken up at the next Takata Airbag Working Group meeting held in October 2016 as discussed below.

544. As to State and Territory vehicle registration authorities having a role in communicating with consumers, Ms Nyakuengama gave evidence of exchanges she had with State and Territory vehicle standards bodies after June 2016 at a meeting of the Australian Motor Vehicle Certification Board, seeking to encourage those standards bodies to take up with State and Territory registration bodies whether assistance could be provided by them in relation to recalled vehicles that had not been rectified.[778] She also referred to subsequent engagement between DIRD and the States and Territories between about April and July 2017 to seek to obtain owner contact details for vehicles with alpha airbags whose owners had not responded to previous recall notifications.[779]

545. According to Ms Nyakuengama, as at late June 2016, DIRD remained satisfied with the efforts of Honda Australia, to that point, in respect of the voluntary recalls of defective Takata airbags.[780]

***Reported misdeployment of a Takata airbag in Australia – BMW Vehicle – September 2016***

546. On 9 September 2016, Jeremy Thomas of DIRD sent an email to DIRD's Deputy Secretary, Judith Zielke, as well as Ms Nyakuengama and Mr Finucci, reporting that:

> "[t]here has been an important development this week in that we have been advised by BMW that one of their affected Australian airbags recently misdeployed after it was removed from the vehicle" (emphasis in original).[781]

547. Mr Thomas' email reported that BMW had advised that the vehicle in question contained an alpha air bag, that it had been housed in a humid environment (Queensland) for most of its life and that it was an older vehicle, manufactured in

[778] Tpt 828-829; 904.4-.30.
[779] Tpt 829.1-.9; see also statement of Julie Morgan 15 October 2019, Exhibit 1, 12/126A/3636-2 at [8]-[10], p 3636-8.
[780] Tpt 832.13; see also Exhibit 1, 11/110/3196 at [58]-[62].
[781] Exhibit 1, 12/124E/3619-32; Tpt 834.

2004. He attached to his email photographs of the misdeployed inflator and of a metal fragment that, according to his email, was:

> "about 5cm long, and was found on the roof of a nearby building".

548. According to Ms Nyakuengama, this was the first reported and known misdeployment of a Takata airbag in Australia.[782] Mr Thomas also reported in his email that "BMW Germany has taken the part for further assessment as part of its ongoing testing program – BMW Germany are happy to have a teleconference with us to discuss further".[783] Ms Nyakuengama was not aware of whether this invitation was taken up by DIRD.[784] Mr Thomas' evidence was to the effect that it was unlikely that it had been.[785] Given DIRD's role in keeping itself informed about technical issues relating the Takata airbags, there appears to be no good reason why DIRD did not take up the invitation from BMW.

549. Mr Thomas' email in respect of the BMW airbag misdeployment further stated (emphasis in original): [786]

> "**Media issues**
>
> I recently updated our "back pocket" media strategy which we would use if Takata became a major media issue. This strategy is currently with Comms Branch for comment.
>
> However, it appears unlikely that this matter will come to public attention and is currently known to us, NHTSA the ACCC and BMW.
>
> **Next steps for the Department**
>
> This is a significant development in that this is the first known misdeployment in Australia. Ie, it moves the recall in Australia from being purely "precautionary" to one where there has been a real incident. For this reason, we will need to review our strategy
>
> I have only discussed briefly with Sharon at this stage, but we think that there are three major areas where we need to act.
>
> - First, we need to go back to <u>all</u> manufacturers and encourage them to review how they are prioritising their recalls to ensure higher risk airbags are replaced as quickly as possible

[782] Tpt 835.26.
[783] Exhibit 1, 12/124E/3619-32.
[784] Tpt 886.39.
[785] Tpt 1179.35-1180.6.
[786] Exhibit 1, 12/124E/3619-33; See also, Tpt 842.

- Secondly, we need to review the communications approach with industry.[787] This is a tricky business as we do not want to unduly concern people who own vehicles with lower risk Takata airbags, but we need to ensure that owners of "alpha" bags get the vehicles fixed as quickly as possible. There may be other ways in which we and the ACCC can assist with communications.

- Thirdly, we will consider working with the state registration authorities more closely. Generally speaking, registration authorities are reluctant to get involved in recall issues, but we may be able to make a case for them [to] assist with some of the higher risk vehicles that have not been rectified by contacting owners. Communication from a registration authority may be more effective than a further letter from the manufacturer.

We will discuss again next week formalise an approach, which is likely to include us convening our Takata Industry WG in the coming weeks. The ACCC would come to this meeting…."

550. On 20 September 2016, Mr Thomas provided a minute to Ms Zielke, to "provide .. an update on VSSB's strategy on managing the Takata Airbag issue".[788] In the minute, Mr Thomas referred again to DIRD having been notified of the misdeployment of the Takata airbag that had been removed from the BMW vehicle, and stated, *inter alia*:[789]

> "Nobody was injured in the incident, but had the airbag misdeployed during an accident, there could have been very serious (potentially fatal) consequences for the vehicle occupants as a 5cm shard of metal was ripped out of the inflator at considerable velocity.
>
> This is the first misdeployment of a Takata inflator that has been reported to the Department".

551. In the minute, under the heading, "Action required", Mr Thomas stated:[790]

> "As you are aware, the Department has been holding regular meetings with affected vehicles suppliers and the Federal Chamber of Automotive Industries over the past 12 months. This approach has been very successful in ensuring a coordinated and measured response to this issue. The Department is currently scheduling a further meeting of this working group to outline a revised strategy comprising the following elements:
>
> *Share the fact that there has been a misdeployment*
>
> At this stage, the fact that there has been a misdeployment is known only to a limited number of people. We will inform all vehicle

[787] Ms Nyakuengama understood this reference to "the communications approach" as being to the way in which industry was communicating with consumers: Tpt 843.14.
[788] Exhibit 1, 17/161-D/4947.
[789] Exhibit 1, 17/161-D/4947.
[790] Exhibit 1, 17/161-D/4948.

suppliers of the misdeployment, while protecting the commercially sensitive information provided by BMW. We anticipate that sharing this information will further engage industry.

*Improve Monitoring*

Affected manufactures have been reporting rectification rates to the Department each month. However, in some cases, it is unclear whether a specific recall relates to alpha or beta bags, or both. The Department will ask suppliers to provide improved data that allows this breakdown of information.

The Department will use this information to improve monitoring and provide additional support to industry as necessary.

*Ask suppliers to refocus recall efforts*

To date, the Department has not provided strong advice to suppliers about how they focus their recalls. Given the volume of vehicle repairs, a number have focused on repairing as many vehicles as possible. One manufacturer, for instance, is rectifying around 5000 vehicles a week. However, given this recent development and information published by NHTSA in May 2016, it is appropriate to encourage all manufacturers to have a specific strategy to expedite the repair of higher risk vehicles. The Department will use the October meeting to encourage manufacturers to prioritise:

- Alpha bags;
- Older vehicles; and
- Vehicles in areas of high humidity especially where there is significant temperature cycling.

*Renew research*

The Department does not have the capacity to undertake its own research on this matter, and to date has relied significantly on information provided by manufacturers, as well as information published by other regulators, in particular NHTSA.

The Department will renew its efforts to gather information from manufacturers, and engage more directly with regulators. As VSS is undertaking an audit in Japan in the coming weeks, we will use that as an opportunity to meet with officials from the Land Transport Ministry to share information. We will also try to negotiate a meeting with officials from Takata Inc. We will also further engage with NHTSA.

*Revise communication approach*

Several manufacturers have advised the Department that they are having significant problems getting vehicle owners to bring their vehicles in for rectification. Some vehicle owners are ignoring recall notices for reasons that are not currently very clear. Given this

attitude, it may be necessary to provide advice to owners of higher risk vehicles that there are potentially serious consequences associated with not rectifying vehicles. The key to managing this issue will be to encourage owners of higher risk vehicles to act, without causing undue alarm to people who own lower risk vehicles.

Previously, some vehicle suppliers have suggested the Department and the ACCC might support an advertising campaign to be funded by industry. The Department will consider any such proposals should they arise.

*Engage the States and Territories*

One concern that has been raised by the FCAI and several manufacturers is the "quality" of registration data, which is used by suppliers to contact current owners of vehicles. Unfortunately, despite several requests, the Department has been unable to extract the specifics around this issue. The Department will again pursue the details of registration data issues with suppliers and consult with the States and Territories through established consultation forums.

In addition, the Department may ask registration authorities to write directly to owners of higher risk vehicles if other communications approaches are unsuccessful.

*(If necessary) Engage parent companies*

At this stage, the Department has dealt with the Australian representatives of vehicle suppliers. To date, this approach has been successful, and all suppliers appear to be making reasonable efforts to rectify recalled vehicles. However, if we form the view that Australian suppliers do not sufficiently refocus their efforts on higher risk vehicles, we may approach overseas manufacturers at a senior level."

552. On 19 September 2016, Ms Nyakuengama wrote to representatives associated with the Takata Airbag Working Group to advise that DIRD had "recently become aware of the first known misdeployment of a Takata airbag in Australia" and sought to convene a meeting of the Group in the coming weeks, given that development.[791] According to Ms Nyakuengama, the incident involving the BMW misdeployment prompted a sense of urgency on DIRD's part to convene the next meeting more quickly than was otherwise going to be the case.[792]

553. Despite the notification to DIRD of the misdeployment of the removed BMW airbag being, on Mr Thomas' evidence, a key and significant development in respect of

[791] DIRD Material, Vol 3, Tab 105; Tpt 840.29.
[792] Tpt 840.29.

the Takata recalls,[793] and his comments in the minute to the Deputy Secretary under the heading "*Revise Communications Approach"* (as above), DIRD did not take any steps to make a public announcement about this event (that is, an announcement going beyond the participants in the October 2016 Takata Airbag Working Group).[794]

554. According to Ms Nyakuengama, it would have been inconsistent with DIRD's "media posture" at the relevant time for it to have publicised the BMW airbag misdeployment.[795] She considered that DIRD's "main concern was to make sure that all vehicles that should be subject to recall were [being recalled] and that the manufacturers were in a position to rectify the vehicles that were subject to recall… it wasn't our position… to be … the source of this information [as to the reported misdeployment] to the media*".*[796]

555. Accordingly, in her evidence, Ms Nyakuengama did not agree that DIRD should have promptly taken steps to make sure that the incident involving the first known misdeployment of a Takata airbag in Australia was brought to the public attention.[797] Her evidence was to the effect that DIRD's position at the time was that if there was to be such an announcement about the misdeployment, it would be a matter for the ACCC to make it (despite this not having been "a documented or openly discussed position" as between the ACCC and DIRD);[798] or a matter for the manufacturer concerned.[799] She also gave evidence to the effect that, in contrast to the ACCC, DIRD was an "introvert" rather than an extrovert agency.[800] In hindsight, and having regard to events that followed (including the April 2017 incident in the Northern Territory and Mr Ngo's death), Ms Nyakuengama agreed that there was a real possibility that publication of information as to the first known misdeployment of a Takata airbag in Australia would have led to an increase in people responding to recall notifications and getting their Takata airbags checked.[801]

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[793] Tpt 1087.33, Tpt 1088.2. Mr Thomas identified other key developments as being the publication of the Blomquist Report and the November 2015 NHTSA Consent Order,and said the removed BMW airbag misdeployment would be "up there with those": Tpt 1087.36-.42.
[794] Tpt 835.41.
[795] Tpt 836.32.
[796] Tpt 836.25-.50.
[797] Tpt 839.20.
[798] Tpt 837.13-.29.
[799] Tpt 839.24; Tpt 844.5.
[800] Tpt 927.3-.8.
[801] Tpt 837.8-.11.

556. For his part, Mr Thomas accepted that there may have been a benefit and public interest in making information available to consumers about the BMW airbag misdeployment, in terms of encouraging consumers to "bring in their vehicles".[802] He recalls having general discussions about releasing the information, but understood that that could not be done without having permission from BMW, which had provided the information about the misdeployment in confidence.[803] Mr Thomas was unaware of there having been any discussions as between DIRD and the ACCC about whether the BMW misdeployment should be made public.[804]

557. It appears that, as at September 2016, the ACCC was aware of the potential for information concerning the misdeployed BMW airbag to "make its way into the public domain" once it was communicated to manufacturers at the October 2016 Takata Airbag Working Group meeting but understood that DIRD did not intend to circulate news of the BMW airbag misdeployment more broadly than that[805] and supported the approach of DIRD not to notify the public of the incident.[806] The approach taken by ACCC officers was thus to prepare a "back pocket [media] brief" to use only in the event of media attention being attracted.[807] That is, the ACCC did not take steps to publicise the misdeployment beyond the Takata Airbag Working Group meeting participants.[808]

558. Mr Grimwade accepted that the rupture of the BMW airbag confirmed the risk then known to be posed by alpha airbags in Australia and that, from the ACCC's perspective; this was an important development in respect of the Takata recalls.[809] Mr Grimwade said he thought that the ACCC did not turn its mind at the relevant time to whether a media announcement or some other media strategy should have been employed.[810] He said, in this respect, that "I don't think we would have seen that as our responsibility to make that decision, but rather rel[ied] on [DIRD] to advise us should it require our assistance to do so".[811]

559. It would appear that despite the MOU providing a framework to facilitate the preparation and issue of joint media and public statements,[812] there was a

[802] Tpt 1090.13-.17.
[803] Tpt 1091.41-1092.8.
[804] Tpt 1217.19-1217.25.
[805] See Exhibit 1, 18/165/5194, 5202; Tpt 1467.49-1468.39; cf Tpt 1467.2-.5.
[806] Tpt 1685.12-.15.
[807] Exhibit 1, 18/165/5197; Tpt 1685.17-.19.
[808] Tpt 1466.1-.4.
[809] Tpt 1464.20-.35.
[810] Tpt 1467.29-.31; Tpt 1685.10.
[811] Tpt 1466.7-.9.
[812] Cl 2.1(c).

fundamental misunderstanding of both DIRD and the ACCC as to having to wait for the other to consider public statements. However, given the media posturing or position adopted by DIRD (despite ACCC apparently unaware of it) there seemed to be at least a shared reluctance of engaging with the media let alone promoting community awareness of the Takata airbag recall at any stage.

560. Although Mr Grimwade considered that BMW bore the primary responsibility to bring the public's attention to the risk posed by the inflator in the BMW vehicle,[813] Mr Grimwade agreed that the occasion of the BMW rupture provided an opportunity for some media in relation to the Takata recalls, either by the suppliers themselves, or by DIRD or the ACCC.[814]

561. In relation to this, Mr Grimwade understood that BMW was never asked about whether they agreed to have news of the misdeployment circulated more widely than the Takata Airbag Working Group.[815] He considered that it was "a missed opportunity for either the ACCC or [DIRD] … to ask BMW to do that".[816] In this regard, also, neither the ACCC nor DIRD encouraged other manufacturers with vehicles affected by alpha inflators to provide information about the BMW airbag misdeployment to their customers.[817]

562. In his evidence before the inquest, when asked what the ACCC's approach ought to have been, having been notified by DIRD of its proposal to notify manufacturers at the Takata Airbag Working Group of the BMW misdeployment but to otherwise keep the relevant information sensitive, Mr Grimwade said:[818]

> "I think we should have questioned - in hindsight, I think we should have questioned [DIRD's] proposed approach and I also think that we should have asked at the working group meeting which we attended BMW to make public the misdeployment and conduct its own announcement media in relation to that misdeployment as an opportunity to encourage people with not just Alpha inflators but those that were being recalled at that time to have consumers seek a replacement."

563. Mr Grimwade's understanding as to the ACCC's responsibilities in relation to determining whether to publicise the BMW misdeployment was obviously at odds with Ms Nyakuengama's understanding, as reflected by her evidence. Mr Grimwade accepted that the inconsistency in their respective understandings was

[813] Tpt 1756.47-.49.
[814] Tpt 1268.20; but cf, 1467.21-.24.
[815] Tpt 1469.25-.30.
[816] Tpt 1469.39-.40.
[817] Tpt 1470.3-.9.
[818] Tpt 1469.13-.23.

reflective of a shared lack of clarity in relation to the responsibilities of DIRD and the ACCC as at September 2016;[819] as well as of confusion on the part of the ACCC as to DIRD's understanding of the position in terms of making media releases in respect of the Takata recalls.[820]

564. Mr Wright said he personally had no knowledge of the BMW airbag misdeployment at the time that it occurred (he had moved out of the role of Assistant Director by September 2016).[821] However, he considered that had information about that misdeployment been made publicly available, that would have had a positive effect in spurring people on to take action in respect of their defective Takata airbags.[822] Mr Wright was surprised that confidentiality of a supplier was invoked as an obstacle to disclosure of the September 2016 BMW incident[823] and did not believe that there were "any prohibitions on a government agency raising the alarm about a potentially deadly consumer good".[824] Mr Wright considered that it would improve transparency and accountability if there were written guidelines in place within the ACCC about how to determine whether information reported to it should be kept confidential.[825]

565. The September 2016 BMW misdeployment represented a valuable opportunity for DIRD and the ACCC to publicise the substantial risk and dangers arising from defective Takata airbags in Australia. DIRD and the ACCC each failed to take up this opportunity.

566. Counsel Assisting submit that had the opportunity been taken, it would have led to greater awareness by the general public (of which the Ngo family formed part) of the grave dangers posed by defective Takata airbags and, in this context, the need for urgent steps to be taken to remedy any vehicle the subject of a recall. This aspect is further discussed below.

***October 2016 meeting of Takata Airbag Working Group***

567. A Takata Airbag Working Group meeting was held on 25 October 2016.[826] At that meeting:

    a. The Group agreed to redrafting standard letters to owners of vehicles with

[819] Tpt 1466.29-.35.
[820] Tpt 1467.33-.39.
[821] Tpt 1346.28.
[822] Tpt 1347.35-.40.
[823] Tpt 1403.1-.30.
[824] Tpt 1348.38-.40.
[825] Tpt 1403.18-.30.
[826] Exhibit 1, 8/77-A8/2287.

high-risk alpha airbags by making the potential risks to safety more explicit.[827] The misdeployment of the alpha airbag in the BMW vehicle in September 2019 was the catalyst for this action item.[828] According to Mr Thomas, at the time, it was not proposed that those redrafted letters were to be approved by DIRD.[829]

b. There was discussion about possible government involvement in sending out recall letters, including the use of government branding/crest on envelopes sent to customers.[830]

c. There was discussion about how government "could help make it easier for people to check" whether they were subject to the recall. ACCC records from the meeting indicate that there was some discussion, in this regard, about: (i) developing an unbranded government website where people could "look up" their VIN numbers to check whether their vehicle was subject to recall; and (ii) holding a press conference or issuing a media release.[831] Although it is not entirely clear from the meeting notes which entity/agency was being proposed to take these steps, it seems that Honda Australia offered to provide some financial support in respect of them, the amount of which is not apparent on the available evidence.[832]

568. Following the October 2016 Takata Airbag Working Group meeting, there was an exchange amongst ACCC officers in respect of the discussion at the meeting, which indicated that Mr Thomas had mentioned during the meeting that "DIRD probably had no money to support … a ["look-up"] website [for consumers to check their vehicles]".[833] It is unclear whether, and if so, to what extent, the discussion at the October 2016 Takata Airbag Working Group meeting relating to a VIN look-up website was further explored by the ACCC in the period leading up to 13 July 2017.[834]

569. In addition, it appears that neither the ACCC nor DIRD pursued Honda Australia's offer of financial assistance in relation to developing media strategies or other methods to reach consumers. Mr Grimwade agreed that this was a missed

[827] Tpt 841.25.
[828] Tpt 841.32.
[829] Tpt 1137.46-1138.5.
[830] Exhibit 1, 8/77-A8/2288.
[831] See, Exhibit 1, 10/109D/3180-28; Exhibit 1, 10/97/2952-2953.
[832] See Tpt 1761.10-.18; Exhibit 1 10/97/2952-2953
[833] Exhibit 1, 10/109D/3180-28; Tpt 892-893, Tpt 1075.49, Tpt 1084.30-.49.
[834] See, generally, Tpt 1472.28-1473.28.

opportunity.[835]

570. Following this meeting, on 1 November 2016, Mr Thomas sent a minute to Ms Zielke of the ACCC which sought approval for DIRD to support the recall of higher risk vehicles fitted with Takata airbags by:[836]

> "• Providing manufacturers with a formal letter from the Administrator of Vehicle Standards encouraging owners to have their vehicles rectified; and
>
> • Agreeing that these letters may be sent in Departmental envelopes with additional recall information from the manufacturer. ([on the basis that] Manufacturers would not be permitted to include any promotional material)."

571. It appears that the requested approval was provided. On 24 November 2016, Mr Thomas sent an email to James Hurnall of the FCAI and Wendy Cooper of the ACCC stating:[837]

> ''As you are aware, we have executive agreement for manufacturers to send … letters from a Departmental official to owners of vehicles fitted with alpha bags. The letter will be sen[t] in a Commonwealth stamped envelope."

572. Mr Thomas attached to his email what was described as a "draft letter that we have prepared with our comms branch" and sought comments on the draft. In his oral evidence before the inquest, Mr Thomas accepted that his team did not obtain expert advice as to how such letters to consumers from Government should be drafted, in order to attract consumers' attention to bring vehicles in, but that this could have been done.[838]

573. Later on 24 November 2016, Dr Cooper responded to Mr Thomas' email, stating that "the ACCC is happy with the letter".[839]

574. On 27 November 2016, Mr Hurnall sent Mr Thomas some "suggested changes" to the letter and made some comments as to the manner and mode by which the letter might be circulated by manufacturers.[840]

575. In an ACCC Commissioner update dated 6 December 2016, it was reported,

[835] Tpt 1660.21-.32.
[836] Exhibit 1, 17/161/4950; Tpt 1153.3-.9.
[837] Exhibit 1, 14/142A/4018.
[838] Tpt 119712-.20.
[839] Exhibit 1, 14/142A/4020.
[840] Exhibit 1, 14/142A/4022.

relevantly that:[841]

> "• Government badged letter to owners who have not responded to recall has been drafted and rules for use being settled.
>
> • Involvement [of] major CTP insurers and S&T registration authorities looks likely as next strategy for contacting unresponsive owners".

576. In his oral evidence, Mr Thomas agreed that, on the information available as at November 2016, there was a need to "move quickly" and "as a matter of urgency" in sending out the proposed Government-badged letters to consumers.[842] However, the final form of the "government badged" letter that was initially drafted by Mr Thomas ultimately was not circulated to consumers with alpha vehicles until about July 2017. Mr Thomas was unable to indicate why it took so long for the letters to be sent out.[843] Nor was Mr Grimwade.[844] In his evidence Mr Grimwade accepted the delay between the letters being sent to consumers was unacceptable.[845]

577. Counsel assisting suggest a finding could be made that DIRD moved too slowly in this regard. Counsel for DIRD resist such a finding on the basis that the draft had been provided by Mr Thomas to FCAI in November 2017 and it was not until March 2017 that FCAI had returned a settled letter. Accordingly, it was not only DIRD who failed to move quickly but rather, for reasons unknown, that responsibility appears to be shared by the FCAI.

578. Mr Wright's evidence was to the effect that the ACCC could and should have issued letters to consumers on its own letterhead, in the period in which he was Assistant Director (ie, prior to about mid-2016), as a means of advising consumers of the risk posed by the airbags in their vehicle and the remediation steps to be taken.[846] For his part, this was something that fell within the ACCC's remit. [847]

579. Mr Grimwade did not disagree that a Commonwealth badged letter being sent directly to consumers subject to a motor vehicle recall could be a useful strategy

[841] Exhibit 1, 14/142B/4027.
[842] Tpt 1153.44-.47.
[843] Tpt 1153.41; Tpt 1221.2.
[844] Tpt 1690.35.
[845] Tpt 1690.23-29
[846] Tpt 1392.15-.29.
[847] Tpt 1392.33.

to employ.[848] However, Mr Grimwade was not aware of another occasion where the ACCC had badged a recall letter for a product from a supplier to a consumer.[849]

***DIRD's involvement in Takata airbag recalls as at early 2017***

580. Jeremy Thomas left DIRD in February 2017. In a handover note he prepared on about 24 February 2017, outlining DIRD's "Takata Management Plan", Mr Thomas stated, *inter alia*:[850]

> "*Government's role in managing Takata recall*
>
> The Government plays a minor role in most recalls, largely limited to publishing recall notices and monitoring rectification.
>
> However, in this case, the Department with the support of the Australian Competition and Consumer Commission (ACCC) is playing a very active role in supporting industry with this recall. The key aims [of] Government in this recall are:
>
> - Effecting this recall [a]s quickly as is practicable, with priority given to higher risk vehicles
> - Improving data collection and testing, including testing of parts sourced from Australian vehicles
> - Identifying and (where possible) removing obstacles to the rectification of vehicles
> - Identifying and engaging with other parties who are able to facilitate rectification of vehicles
> - Managing communications issues
> - Looking for opportunities to improve recall processes more generally
>
> …
>
> *Communications Strategy*
>
> - To date, the media reporting on this issue in Australia has been very modest – with no sensational reportage. However, this situation could change very quickly, especially if there is a misdeployment in the field and someone is killed or injured.
> - Some time ago, the section developed a back pocket communications package (in consultation with the ACCC and Departmental Communications) to be used in the event of Takata receiving significant coverage. This document is now

[848] Tpt 1471.38-.40.
[849] Tpt 1471.7-.13.
[850] Exhibit 1, 12/124C/3619-24 to 3619-27.

somewhat out of date, and it should probably be reviewed in coming months.

- There is also an argument that the Department should take a more proactive communications approach to this issue…"

581. In his handover note, Mr Thomas also referred to the steps that had then been taken by DIRD to, *inter alia*:

    a. prepare a letter to owners of vehicles fitted with alpha airbags, encouraging them to have their vehicles recalled;

    b. liaise with NSW authorities to relax the qualification requirements for technicians involved in airbag replacement work;[851] and

    c. seek the involvement of registration authorities in assisting with recalls, through engagement via the Australian Motor Vehicle Certification Board.[852]

***March 2017 meeting of Takata Airbag Working Group***

582. A Takata Airbag Working Group meeting took place on 14 March 2017.[853] This was the final such meeting before Mr Ngo's death on 13 July 2017.

583. The first substantive item reflected in the minutes of this meeting was an update on the redrafting of standard letters to owners of vehicles with alpha airbags to make the potential risk to safety more explicit.[854]

584. The minutes also recorded that, in the 12 months to February 2017, the number of vehicles in Australia impacted by the Takata airbag recall had doubled; that the overall rectification rate was 31.8%; and that the rate of rectification of alpha bags was at 58% and had slowed in recent months.[855]

585. Mr Grimwade did not agree that the ACCC should have taken the view, having regard to the information reported about the status of the recalls at this meeting, that the voluntary recalls of Takata airbags then on foot were not being progressed quickly enough or that the exercise of compulsory powers by the Minister in relation

[851] See also, Tpt 904.16-.36.
[852] See also, Tpt 905.13-.35.
[853] Exhibit 1, 8/77-A9/2291.
[854] Tpt 844.47-845.7.
[855] Exhibit 1, 8/77-A9/2292; see also 10/109G/3180-35 to 36.

to the voluntary recalls was desirable at that time.[856]

586. Arising out of this meeting, a DIRD letter on government letterhead about the risks involved in alpha airbags was finalised, but this was sent to consumers only in or after July 2017.[857] As noted, in his evidence, Mr Grimwade accepted the delay in this occurring as unacceptable.[858]

587. As a result of Mr Ngo's death involving a "beta" Takata airbag a letter from DIRD to consumers relating to beta airbags was also prepared in about August 2017.[859]

***Takata airbag related injury in Northern Territory – April 2017***

588. On 24 April 2017, a woman in the Northern Territory was seriously injured when the airbag in a Toyota RAV4 she was driving misdeployed during a collision and she was struck by a piece of shrapnel.[860]

589. According to Mr Grimwade, this incident was the first injury known to the ACCC arising from a Takata airbag misdeployment in Australia (on the basis that the ACCC had not been convinced that the injury sustained by Ms C in August 2015 had resulted from a misdeployment).[861]

590. On 28 April 2017, the details of the Northern Territory incident were circulated to various ACCC officers, including to Mr Grimwade, together with "talking points" that had been prepared for the Minister.[862] The talking points reflected comments that were intended to be released publicly by the Minister only in the event that questions were received about the Northern Territory incident.[863]

591. The ACCC did not issue any media release, or otherwise take any comparable steps, on or after 28 April 2017 reflecting the details then known to it about the Northern Territory incident. Mr Grimwade said that this was because "these recalls were being monitored by [DIRD] and we [the ACCC] expected them to take responsibility for any of the strategies including communication strategies and

[856] See Tpt 1534.15-1535.11.
[857] Tpt 751.14; Tpt 752 to 753; Tpt 825.25-.35; Exhibit 1, 8/79/2439; see also 10/109G/3180-35 to 37; DIRD Material, Tab 195.
[858] Tpt 1690.23-.29.
[859] DIRD Material, Tabs 187, 206; Tpt 753.33-754.2.
[860] Tpt 933.30.
[861] Tpt 1474.16-.19.
[862] Exhibit 1, 18/165/5228; Tpt 1474.30-.38.
[863] Tpt 1474.30-.38.

media strategies to bring attention to the voluntary recalls".[864]

592. However, DIRD did not itself issue a media release (or take any comparable steps) in relation to the reported Northern Territory incident; and Mr Grimwade was not aware of the ACCC ever making contact with DIRD to enquire about whether DIRD was intending to publicly notify Australian consumers about it.[865] Mr Grimwade accepted that the ACCC ought to have either made such an enquiry of DIRD or taken steps itself to issue a media release in relation to the Northern Territory incident along the lines of the talking points that had been prepared for the Minister.[866]

593. Although Mr Grimwade saw the vehicle manufacturer as bearing primary responsibility to bring attention to the risk posed by the relevant inflator,[867] he considered that, in the circumstances, there was a missed opportunity on behalf of either or both of the ACCC and DIRD to engage with the public and bring attention to the voluntary recalls arising out of the Northern Territory incident.[868]

594. In a fashion not dissimilar to the opportunity provided by the September 2016 BMW incident, DIRD and the ACCC each failed to take the opportunity in April-May 2017, to bring to public attention details of the April 2017 Northern Territory incident. Counsel Assisting's submission as referred to above at [566] applies here also, in relation to a finding in this regard.

***Meeting between ACCC and DIRD on 12 May 2017***

595. On 11 May 2017, Neville Matthew of the ACCC sent an email to Sharon Nyakuengama of DIRD which indicated that the ACCC wished to meet with DIRD "to learn more about Takata airbags" and "to work to understand in more detail the current operations of the recall", including "whether there is any value in starting to plan the development of a compulsory recall and establish what the triggers for such will be".[869] Mr Grimwade's evidence was that, at this time, the ACCC's thinking around the introduction of a compulsory recall was no further advanced than having been flagged with DIRD as a potential option.[870] Counsel for both DIRD and the ACCC point out that at no stage did either agency form the view prior to Mr Ngo's death that any step towards a compulsory recall should be taken.

[864] Tpt 1474.46-.49.
[865] Tpt 1475.39.
[866] Tpt 1475.46-.49.
[867] Tpt 1757.10-.12.
[868] Tpt 1475.1-.13, Tpt 1757.17, Tpt 1696.44-46.
[869] Exhibit 1, 11/118/3524.
[870] Tpt 1520.49-1521.2.

Even if, at this time, there had been preliminary steps taken to initiate a compulsory recall, the time involved by the legislation to give effect to such compulsory recall was such that Mr Ngo's death would not have been averted.

596. On 12 May 2017, a meeting was held between Sharon Nyakuengama, Alison Whatson and Carmine Finucci of DIRD and Neville Matthew and Wendy Cooper of the ACCC in relation to the status of the Takata airbag recalls.[871] A file note of the meeting indicates that it was reported that Australian completion rates for airbag replacements were at 33%, with completion rates varying across manufacturers; and that Honda Australia's completion rate was the highest amongst them at 60%.[872]

597. Under the heading, "Comms & escalation strategy - options", the file note of the meeting refers to "Safety Warning Notice; media; escalation strategy".[873] Mr Grimwade was not aware of what consideration was given in the context of this meeting to implementing the options there referred to.[874]

598. Under the heading "Letters, NEVDIS and the FCAI process", the file note of the meeting stated, *inter alia*:

> "• does the FCAI process make sense? – why keep sending letters if no response?
>
> • FCAI process needs review – the Takata experience shows that it does not work as intended…"

599. In his evidence before the inquest, Mr Grimwade indicated that the ACCC has formed the view that the FCAI Code does not operate as effectively as it should and that it needs to be changed.[875]

600. Counsel for the FCAI submit that the conclusion noted on the file *that "the Takata experience shows that it does not work as intended"* shows a misunderstanding of the purpose of the FCAI Code and counsel point out that the Code does provide for recall strategies other than sending letters to consumers. It should be noted that both the ACCC and DIRD were engaged in the development of the FCAI Code. I am of the view that the query noted on the papers that *"why keep sending*

[871] Exhibit 1, 11/118/3526.
[872] Exhibit 1, 11/118/3526.
[873] Exhibit 1, 11/118/3528.
[874] Tpt 1519.26.
[875] Tpt 1519.49-1520.6.

*letters if no response?"* could have also included "why has the industry not engaged in additional strategies?" as suggested by the Code.

601. Mr Grimwade also said that the ACCC has engaged with DIRD on the changes that, in the ACCC's view, ought to be made.[876] In this respect, on or about 13 May 2020, the ACCC provided DIRD with a background paper "setting out some ideas on changes that could be made to the FCAI Code of Practice to provide clarity for suppliers and to better protect consumers".[877]

602. This background paper outlines some potential changes to the FCAI Code, including, amongst other things:

    (i) incorporation of reference to the commencement of the *RVS Act*;

    (ii) inclusion of detail around conducting a risk identification and assessment;

    (iii) inclusion of further guidance on development of a recall strategy, which should adapt to changed understandings of risk;[878] and

    (iv) inclusion of a cross-reference to the ACCC Recall Guidelines or any new DIRD guideline as well as clarification of the interaction between guidelines.[879]

603. Mr Grimwade's expectation is that any communications concerning suggested changes to the FCAI Code will take place as between DIRD and the FCAI.[880]

604. Having regard to the suggestions that have been made by the ACCC in respect of the FCAI Code in this background paper, as well as the various matters raised by Mr Hather, Counsel Assisting advance that the above matters be included in the recommendations concerning potential amendments to the FCAI Code. The FCAI has indicated that any recommendations to improve the Code of Practice will be unreservedly received by the FCAI. Accordingly, in addition to the recommendations to the FCAI as set out in paragraph [355] (and the recommendation to the ACCC and DIRD set out at paragraph [367]), I recommend that the FCAI give consideration to the potential changes suggested by the ACCC in its paper as set out in paragraph [602].

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[876] Tpt 1520.25.
[877] Exhibit 1, 14/142J/4058-208.
[878] As to this, see also. Tpt 1731.24-.47.
[879] Exhibit 1, 14/142J/4058-211 to 212. See also Tpt 1520.4-.26; Tpt 1537.15-.20.
[880] Tpt 1654.45.

***No government-led media or advertising campaign prior to Mr Ngo's Death***

605. From the time of the June 2016 Takata Airbag Working Group meeting (at which Honda Australia raised the issue of whether DIRD or the ACCC would consider an information and advertising campaign to inform consumers) and up until Mr Ngo's death on 13 July 2017, neither DIRD nor the ACCC took steps[881] to implement a public media information or advertising campaign relating to the Takata airbag recalls;[882] or a "look-up" website such as that discussed at the October 2016 Takata Airbag Working Group meeting.

606. As noted, according to Ms Nyakuengama, DIRD's "media posture" did not extend to actively "push[ing] out [media] campaigns" in relation to the administration of recalls, or to releasing public notices dealing with dangers to consumers' safety arising from defective airbags or vehicles.[883] She indicated that DIRD's media posture was to react to issues, and respond to media inquiries, but not actively to take steps to publicise matters connected with recalls.[884] According to Ms Nyakuengama, no one within DIRD had expertise in relation to advertising campaigns concerning recall strategies.[885] She considered that, if there was to have been an information and media advertising campaign in connection with the voluntary Takata airbag recalls, that would generally be a matter for the ACCC rather than for DIRD to coordinate.[886] However, she acknowledged that the allocation of responsibilities in this regard, as between the ACCC and DIRD "wasn't documented"; and she could not recall having had any specific discussion about the respective roles and responsibilities of the agencies in connection with publicising voluntary recalls via the media.[887]

607. Although Ms Nyakuengama was sent Mr Thomas' handover note in February 2017 in which Mr Thomas said there was an argument that DIRD should take a more proactive communications approach in respect of the Takata recalls, she could not recall giving any consideration, between February 2017 and the date of Mr Ngo's death on 13 July 2017, to DIRD taking a more proactive communications approach to the Takata airbags recalls.[888] She said that embarking on an active advertising

[881] That is, separate from the steps taken in relation to the inclusion of Commonwealth badging on letters sent to alpha customers.
[882] Tpt 826.48; Tpt 854.20-855.10; 856.33.
[883] Tpt 826.37-.827.14; Tpt 927.3-.14.
[884] Tpt 957.25, Tpt 997.47-998.5.
[885] Tpt 957.20.
[886] Tpt 827.16-.25.
[887] Tpt 826.21-.25.
[888] Tpt 870.24; 987.45-988.23.

campaign with the ACCC and car manufacturers was "not something that [DIRD] normally did in any of its regulatory roles and … was something that was not budgeted for".[889] Although she acknowledged that Honda Australia had requested DIRD's involvement in an advertising campaign, for her part, this request did not extend to DIRD itself funding any such campaign.[890]

608. In this connection, Mr Thomas' evidence was that:[891]

> "[M]y recollection is that [DIRD] and the ACCC were of the view that it was not appropriate for the Commonwealth to fund such a venture [ie, a big advertising campaign] but there were opportunit[ies] potentially in terms of joint branding and so on. So lending the Commonwealth's name was a possibility but certainly not paying for it, and certainly during my time I think the matter largely ended there. So I don't believe we received a specific proposal either from Honda or the FCAI saying, "This is what the advertising campaign would look like and this is precisely the support that we'd want."

609. From Mr Thomas' perspective, it was appropriate that the vehicle manufacturers be put to the principal expense of paying for any general advertising campaign to encourage consumers to have their vehicles rectified.[892] However, leaving aside the question of who might pay for such a campaign, he considered that it may have had potential benefits in terms of leading to an increase in people returning their vehicles to be rectified.[893] When asked about his comment in his handover note that there was an argument that DIRD should take a more "proactive communications approach" Mr Thomas was unable to elaborate on what he had had in mind, but said that he "would not have been thinking about a proposal [for DIRD] to spend a large amount of money running a media campaign".[894]

610. As far as Mr Thomas could recall, neither the ACCC nor DIRD took steps to raise with each other the steps that might be taken by each agency to publicise the dangers and risks arising from defective Takata airbags (including by way of media release; and leaving aside the other measures that were pursued by the agencies, including the Commonwealth badged letter to consumers).[895] Mr Thomas accepted that the ACCC and DIRD "could have" arranged for media releases

[889] Tpt 872.31.
[890] Tpt 873.1-.9.
[891] Tpt 1075.21-.28; see also Tpt 1212.39-1213.13.
[892] Tpt 1076.12.
[893] Tpt 1076.25.
[894] Tpt 1123.28-.45.
[895] Tpt 1246.12-.21.

telling the public to bring their vehicles in.[896] He was unable to explain why there were no media releases informing the public about the dangers associated with Takata airbags until after Mr Ngo's death, other than suggesting that this would not have been consistent with DIRD's "reactive" as opposed to "proactive" media stance.[897]

611. It was only after Mr Ngo's death that Ms Nyakuengama sought additional resources in relation to DIRD's work in respect of the Takata recalls.[898] She explained that three additional staff members joined the Operational Policy Section, and that the need for this additional resourcing was precipitated by the additional work load brought upon by Mr Ngo's death, including fielding consumer enquiries.[899]

612. In her evidence, Ms Nyakuengama agreed that, in hindsight, had DIRD or the ACCC taken steps to put in place an advertising campaign in relation to the risks posed by defective Takata Airbags from 2016, that may well have encouraged consumers to take prompt action in respect of recall notifications they received.[900]

613. Ms Nyakuengama advised the inquest that DIRD was working on operational policies in relation to its new powers under the *RVS Act* including a position as to the use of media communications,[901] which required additional resources and budget to support that new function.[902]

614. Mr Grimwade said that the ACCC did not give consideration, between the Takata Airbag Working Group meeting on 17 June 2016 and Mr Ngo's death on 13 July 2017, to issuing a joint media release addressing the problems with Takata airbags under recall across manufacturers.[903] He said this was because:[904]

> "We [the ACCC] would not have seen that as our role at the time, because the recalls were being monitored by [DIRD], and [DIRD] was also responsible for the improvement of recall strategies to improve progress on that recall. So we would have seen that as being something the department would be responsible for initiating."

615. According to Mr Grimwade, from the ACCC's perspective, prior to 13 July 2017,

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[896] Tpt 1212.39-.43.
[897] Tpt 1213.40-1214.27.
[898] Tpt 957.27-.43.
[899] Tpt 1000.9-1001.46.
[900] Tpt 856.35-.42.
[901] Tpt 998.47-999.4.
[902] Tpt 999.6-.9.
[903] Tpt 1459.40.
[904] Tpt 1459.43-.47.

the ACCC was not responsible for initiating a media campaign for the Takata recalls as it was not the agency monitoring the recalls or suppliers' recall strategies.[905]

616. Mr Grimwade said that over the course of 2015 to July 2017, the ACCC was not aware that DIRD's media posture was as described by Ms Nyakuengama, and accepted that the ACCC should have been so aware.[906] When asked whether the ACCC would have done anything differently had it been aware of DIRD's "media posture", Mr Grimwade said:[907]

> "I think we would have done one of three things: we would have asked them [DIRD] to take a more active stance in terms of undertaking media, we would have pushed the suppliers themselves harder to undertake media, and if neither of those would have been successful, then I think we [the ACCC] would have engaged ourselves if we felt that a media strategy was going to actually advance the recall progress."

617. Whilst the ACCC may not have been formally notified of DIRD's "media posture", Mr Grimwade accepted that the ACCC *was* aware that DIRD did not, in fact, issue any media releases in respect of the Takata recalls between 2015 and July 2017.[908]

618. Mr Grimwade considered that the ACCC was not itself responsible for undertaking an advertising campaign in respect of the Takata airbag recalls – which he said could be "inordinately expensive".[909] However, he agreed that the issuing of a media release by the Minister does not require much resourcing[910] and indicated that if the ACCC had been asked by DIRD to assist with information and media (eg, through issuing a media release), it would have done so.[911]

619. In this regard, Mr Grimwade did not suggest that, absent some request being made by DIRD, the ACCC was precluded from itself issuing media releases in circumstances where it considered it appropriate to do so.[912] Rather, he accepted that the ACCC was in a position between 2015 and 2017 where it could, of its own volition, initiate and publish a media release in respect of the Takata airbag recalls,

[905] Tpt 1271.11-.13.
[906] Tpt 1268.45-1269.9 ("away" at line 49 should be "aware").
[907] Tpt 1269.11-.23.
[908] Tpt 1269.25-.39.
[909] Tpt 1270.41.
[910] Tpt 1698.35.
[911] Tpt 1270.31-.42.
[912] Tpt 1745.28-.31.

without any specific request being made by DIRD.[913] In addition, he said that the ACCC would have expected a level of collaboration as between DIRD officers and ACCC officers before DIRD itself released information to the media in respect of the Takata recalls.[914]

620. In his evidence, Dean Wright considered that a YouTube campaign of the kind conducted by the ACCC for the "Infinity Cable" recall could have been implemented by the ACCC in connection with Takata airbags as a means to encourage consumers to bring their cars in for airbag replacement.[915] Mr Grimwade's evidence in this respect was to the effect that it was not uncommon for the ACCC to produce or arrange for the production of YouTube clips relating to product safety, with an aspiration that they would be picked up by news outlets.[916] He accepted that this may have been a good idea as a strategy to publicise the risks posed by Takata airbag inflators and encourage consumers to bring their vehicles in.[917] He also accepted that a similar clip "could have been done" in relation to the Takata recalls.[918] However, he indicated that the ACCC deferred to specialist regulators in relation to the strategies that they felt were appropriate to employ to improve progress in relation to a recall, and that the ACCC would have been dependent on a request by DIRD before developing a similar clip in relation to the Takata airbag recalls.[919]

621. After Mr Ngo's death on 13 July 2017, the ACCC took steps to release information to the public about the dangers involved in Takata PSAN inflators of the kind that ultimately became subject to the Compulsory Recall Notice. Further, the ACCC has more recently made public announcements about the NADI 5-AT class of Takata inflators which are not subject to the Compulsory Recall Notice, but which have been attributed to other deaths and injuries in Australia and overseas.[920]

622. Mr Grimwade accepted that, in circumstances where the ACCC did not issue media releases in respect of Takata airbag inflators prior to Mr Ngo's death, but took steps to publicise the risks posed by Takata airbags after his death, there was a missed opportunity to inform the public of the risks involved.[921] Mr Grimwade

[913] Tpt 1746.3-.26.
[914] Tpt 1747.1-.9.
[915] Tpt 1387-1388.14; Tpt 1425.3-.7.
[916] Tpt 1460.37-1461.3.
[917] Tpt 1461.50; see also Tpt 1462.47-1463.14.
[918] Tpt 1697.7.
[919] Tpt 1461.17-.24; Tpt 1697.11.
[920] See Tpt 1476.33-1477.6.
[921] Tpt 1477.48-1478.3.

said that the ACCC employed the learning from this in its response to, and in its provision of assistance to DIRD in respect of, NADI 5-AT inflators.[922]

***Lack of oversight by DIRD and ACCC of 5ZV consumer recall letters***

623. When Honda Australia sent its notification of the 5ZV recall to DIRD and the ACCC on 10 July 2015 it did not include a copy of any proposed customer letter relating to that recall.[923] Given that it was only the previous day that Honda Australia had been notified by Honda Japan of the need to commence the recall, it is unlikely that a draft customer letter existed at that time, though Honda Australia appeared to have a number of pro forma letters such as those sent to the ACCC in June 2015. Further, as set out in the notification letters to DIRD and the ACCC dated 10 July 2015, it was at that time that Honda Australia advised the agencies of its intention to only notify owners of vehicles affected by the 5ZV recall "once parts availability has been confirmed".

624. In about August 2015, Jeremy Thomas requested Carmine Finucci to write to vehicle manufacturers requesting that DIRD be provided with a copy of letters being sent by manufacturers to consumers.[924] The purpose of making such a request, according to Mr Thomas, was to have Mr Finucci check whether the risk of death or injury was plainly stated in the customer letters.[925] In this regard, Mr Thomas said that he was not asking Mr Finucci to assess or vet the letters in terms of their effectiveness as consumer communications.[926] This was not a matter which he considered to be within Mr Finucci's expertise, or something that Mr Thomas considered fell within DIRD's remit more generally.[927] He said that DIRD "had no expertise in drafting… letters to vehicle owners in a way that's likely to prompt them to come in".[928] For his part, Mr Thomas saw it as being the vehicle manufacturers' responsibility, not that of DIRD, to communicate effectively with vehicle owners.[929]

625. On 21 August 2015 (at 11.42am), Mr Finucci sent an email to Matthew Evans of Honda Australia requesting copies of "the latest customer letter sent to customers

[922] Tpt 1478.3-.5.
[923] Tpt 721.45.
[924] Exhibit 1, 12/124B/3619-9 at [13]; 13/130/3714; Tpt 1026.44-1027.10; Tpt 1060.9-.21.
[925] Tpt 1027.21.
[926] Tpt 1028.12-.18.
[927] Tpt 1024.44-1025.3; Tpt 1028.21-.28.
[928] Tpt 1221.15-.16.
[929] Tpt 1028.30-.44

of Takata affected airbags".[930] It may be noted that, at that point in time, no customer letter had yet been sent to Ms Chea about the 5ZV recall.

626. Later, on 21 August 2015, Mr Finucci sent an email to other DIRD officers, copying Mr Thomas, attaching copies of letters from certain manufacturers. Mr Finucci noted that Honda Australia's letters were missing and that they had been asked for but had not been received. Mr Finucci noted that "most manufacturers do notify the owner of the potential for injury. However, Jeremy's letter received from Honda was vague".[931] The reference to "Jeremy's letter" was clearly a reference to the letter that Mr Thomas had received for his Honda Jazz referred to above.

627. It appears that Honda Australia did not provide a response to Mr Finucci's email including in or after November 2015 when, according to Honda Australia, the first letter to Ms Chea in relation to the 5ZV recall was sent.[932] DIRD did not subsequently follow up with Honda Australia to specifically request the provision of a customer letter in respect of the 5ZV recall.[933] According to Ms Nyakuengama, this involved "an oversight" on the part of each of DIRD and Honda Australia.[934]

628. On 4 August 2016, an officer within DIRD, Sue Loxton, requested from Honda Australia, by email, copies of customer letters for various specified recall campaigns that had been notified in the previous months, including for the 6CA recall (affecting the passenger airbag of Ms Chea's / Mr Ngo's Vehicle), but not the 5ZV recall. Copies of the relevant customer letters for such recalls, including the 6CA recall, were in turn provided by Honda Australia on 30 August 2016.[935]

629. It is apparent that, prior to July 2017:

    a. DIRD did not request from Honda Australia or receive copies of any recall letters sent to consumers by Honda Australia in respect of the 5ZV recall;[936] and

    b. the ACCC did not request from Honda Australia or from DIRD, nor receive, copies of recall correspondence to consumers in respect of the 5ZV recall.

[930] Exhibit 1, 13/130/3696, 13/134/3726; Tpt 803-804, 808.40.
[931] Exhibit 1, 13/130/3714.
[932] Exhibit 1, 13/130/3697; Tpt 804.45.
[933] Tpt 729.30; 807.1-.14; 808.1-.17.
[934] Tpt 808.19-.26.
[935] Exhibit 1, 12/123/3549 to 3550 see also 12/124/3551 to 3553; Tpt 807.30-.50; Tpt 833.
[936] See letter from AGS dated 28 November 2019, Exhibit 1, 13/130/3695; Tpt 802.

630. Mr Grimwade said that from his perspective, the consumer letters that were sent in respect of the 5ZV recall were inadequate.[937] In the course of his evidence before the inquest, Mr Grimwade was taken to a pro forma customer letter of the type said by Honda Australia to have been sent to customers such as Ms Chea in November 2015 in relation to the 5ZV recall.[938] Mr Grimwade considered that the letter did not provide a clear description to consumers of the relevant defect, but rather used technical language such as "density variations within the inflator propellant".[939] This was contrary to the guidance provided in the ACCC Guidelines to avoid using "overly technical terminology" in describing the relevant defect in a written recall notice.[940] Mr Grimwade also stated that the letter did not notify consumers of the risk of death arising from their defective Takata airbag.[941] This was contrary to the guidance provided in the ACCC Guidelines to include in a written recall notice a "description of the maximum potential hazard and associated risk[942] He also considered that the language of "precautionary action" and "potential concern" that was included in the recall letter was highly undesirable.[943]

631. Mr Grimwade's evidence was to the effect that, had the ACCC received, between November 2015 and July 2017, the 5ZV recall letter of November 2015, it should have taken the view that the letter was inadequate in its description of the relevant defect, in its identification of the relevant hazard and in its use of language such as "precautionary action" and "potential concern".[944] At one point in his evidence, Mr Grimwade said that, had the ACCC received the letter, it would have "engage[d] with the Department and/or the supplier to understand the language better to make it more accessible and understandable".[945]

632. However, I agree with Counsel Assisting's observation that whether this indeed would have occurred upon any receipt by the ACCC of the 5ZV recall letter may be doubted (and is most unlikely), having regard to other opportunities that the ACCC had to engage with Honda Australia about its recall correspondence, but which it failed to take up: in particular, the events concerning Professor Nottage

[937] Tpt 1267.35-.40.
[938] Tpt 1492-1493; see also Exhibit 1, 5A/60C-3/1625-17.
[939] Tpt 1492.46-.1493.6,1494.3.
[940] See Exhibit 1, 7/73C/2031.
[941] Tpt 1493.8-.23.
[942] See Exhibit 1, 7/73C/2032.
[943] Tpt 1493.29-.36; Tpt 1494.9-.19.
[944] Tpt 1494.27, .38, .47; Tpt 1495.7.
[945] Tpt 1494.39-.43.

referred to above and in relation to the amendments made by the ACCC to Honda Australia's notifications on the PSA website referred to above.

633. In this respect, Mr Grimwade later gave evidence to the effect that he expected that, had the ACCC been provided with the recall letter for the 5ZV recall, it would *not* have done anything differently from what it did following the ACCC's receipt from Professor Nottage of the recall letter that he had received.[946] Mr Grimwade also acknowledged that he was "cognisant that we were receiving information like this [that is, of the kind referred to in the 5ZV recall letter] in the [s 128] notification at the time, or earlier than this but in the notification that was published on our website … similar language [to that appearing in the customer recall letter] was used". [947]

634. Counsel for Honda Australia submit that the copies of consumer letters that Honda Australia did provide to DIRD were in similar form and style to the 5ZV recall letters. Counsel for submitted Honda Australia did not fail to provide the 5ZV letter because DIRD never specifically asked Honda Australia to provide them, pointing out that Mr Finnucci's email to Mr Evans sought "the latest customer letter sent to customers…" which at that point in time was for recall 5JV. Regardless of form and style, more relevantly, unlike the earlier 5ZV recall letters, the example letters that Honda Australia did send to DIRD referred to "inflator rupture, metal fragments and the risk of injury". That those words were not included in the 5ZV recall seems to be due to the categorisation of the recall as a "precautionary action" or the risk being described as a "preventive measure" rather than because there had been a discovery that the risk involved a different type of airbag defect.

***Language of Precautionary Action, Preventative Measure, Potential Defect marked the Recall Strategy***

635. During his evidence Mr Grimwade was taken to a series of email communications in June 2015 between the ACCC and Honda Australia. They were in relation to Honda Australia seeking to ensure that the PSA website included reference to a recall being a "preventative measure" and the ACCC requesting copies of consumer recall letters that Honda Australia had sent to customers.[948] Mr Grimwade said that around that time, as there had been an increase in the number

[946] Tpt 1513.29-.37.
[947] Tpt 1494.21-.30.
[948] Tpt 1494.03-1502.25

of recalls, the ACCC was receiving an increase in questions from the public including about whether it was safe to drive the vehicles and the letters from Honda Australia were sought in the context of the ACCC attempting to understand how to respond to such questions. He agreed that it did not appear that the ACCC or DIRD made inquiries to Honda Australia as to why the terminology of "preventative measure" was being used. However, correspondence from December 2014 provides some background to Honda Australia's characterisation of the 5ZV defect as a "preventative measure" and that the 5ZV recall was a "precautionary action" (other than the fact that its practice was to replicate Honda Australia's notification language). That this was apparently, to some degree, understood in November 2015 by the ACCC is evident by Dr Klaver's correspondence to Mr Ridgeway and then by Mr Ridgeway in his letter to Professor Nottage dated 14 December 2015 when he (Mr Ridgeway) said:

> "I understand from the Consumer Product Safety team that Honda has issued quite a number of airbag related recalls and that some are for models not identified by the US authorities....These may be initiatives that Honda has characterised as **precautionary**." (my emphasis)

636. A year earlier, on 11 December 2014 Terry Fitzpatrick, technical manager at Honda Australia had sent an email to the General Manager of Recalls at DIRD in which he advised:[949]

> "Honda Motor Company have advised overnight that they will shortly commence a world-wide Safety Improvement Campaign (SIC) for selected Honda vehicles for both driver and passenger airbag potential failures (These are vehicles that have not been identified as being part of a Product Safety Recall).
>
> Neither Honda nor TAKATA has made a determination that a safety defect exists in the driver or passenger airbag inflators that are installed in the selected vehicles. Honda hopes that the expansion of this action will both address customer concerns and further assist in the ongoing investigation of abnormal airbag deployments.
>
> However, as SICs exist in the USA and not in Australia, I am seeking some guidance as to how Honda Australia may handle this activity, or if it is even possible without issuing a national product recall, which is non-safety related.
>
> Are you in a position to provide me some guidance on this?"

[949] DIRD Documents, Vol 2 tab 8.

637. On 12 December 2014 Carmine Finnuci, the Senior Engineer in VSSB's Operational Policy Section, sent the following email to Mr Fitzpatrick[950]:

> "Terry,
>
> The Department views airbags not performing to specification as a potential will or may cause injury event and a safety related defect.
>
> Following our telephone discussion this afternoon and discussions we have had within the Department regarding the Takata airbags issues, the consensus is that Recall action is necessary".

638. On 17 June 2015 Honda Australia provided a table to DIRD which set out the reasons for the various recalls to date[951] including the 5NN recall on 11 December 2014, the 5UN recall of 14 May 2015 and the 5VZ recall of 28 May 2015 which are all identified as a "preventative measure" whereas the reason for another recall around that time, the 5JV recall, is "to investigate cause". Thus, the basis upon which Honda was describing the recalls was to some extent, but not entirely, set out by Honda Australia to DIRD in June 2015.

639. On 3 June 2015,[952] prior to the commencement of the 5ZV recall, Erik Connell, in the capacity of Acting Director Operational Policy Section, sent an email to Honda Australia in which he asked a series of questions. Honda Australia's reply sent on 17 June 2015 set out its responses to DIRD's questions:[953]

> "What plans are in place for owners who cannot drive their vehicle while awaiting rectification?"
>
> "This recall is a preventative measure in order to make further investigations, therefore we are not advising customers to stop driving their vehicles"
>
> "Is any research being conducted in relation to airbags that have been removed from rectified vehicles?"
>
> "Yes. The investigation is in progress".
>
> Are announced recalls for the purpose of rectifying defective airbag inflators, or for research purposes to identify if rectification of further vehicles is necessary?"

[950] DIRD Documents, Vol 2 tab 11.
[951] DIRD Documents, Vol 2 tab 27.
[952] DIRD Documents, Vol 2 tab 25.
[953] DIRD Documents, Vol 2 tab 27.

> "The purpose of 1 recall (5JV) was to investigate cause, 3 recalls (5NN, 5VZ, 5UN) were conducted for preventative measure. The remaining recalls were for defective airbag inflators. See attached table."

640. The email from Honda Australia to DIRD on 17 June 2015 and the table attached to it pre-dates the 5ZV recall by less than a month however the 5ZV recall also had a defect description as "preventative measure" and a description that the recall was "precautionary". It appears that Honda Japan may have preferred to conduct a Safety Improvement Campaign, though DIRD's position was that due to Australian legislation, Honda should proceed to recall. Accordingly, it appears that Honda Australia conducted its voluntary recalls on the basis of that background.

641. The nature of the campaign appears to have been discussed in part at the inaugural Takata Airbag Working Meeting on 24 August 2015, which Honda Australia attended. As noted earlier, in the notes of that meeting it is recorded that the "Manufacturers are advising customers that the recall is precautionary and they should not disable the airbag".

642. Another note records a discussion that "The distinction between a Service[954] (sic) Campaign and a Recall is not always clear, this is an area where manufacturers are being encouraged to call a recall if in doubt."[955]

643. Counsel for the ACCC in submissions refers to both the ACCC and DIRD being of the understanding that the 5ZV recall (like some others) was precautionary as it depended on whether the airbag was known to have an issue or not. The 5ZV notification to the ACCC that there was known to be "wide ranges of density variation propellants" is, in my view, a clear indication that there was an issue. It is my view that there was a failure of both the ACCC and DIRD to clarify and correct the position taken by Honda Australia. It mattered not that the reason for the defect was unknown when the existence of the defect was known and it was known that an airbag defect could cause the inflator to rupture and cause metal fragments to strike a vehicle occupant.

644. This "precautionary" or "preventative measure" approach was seemingly taken by Honda Australia with the 5ZV recall (as it was with at least three prior recalls) and is evident in Honda Australia's recall campaign as only recall letters were mailed to consumers rather than adopting a wider publicity campaign which prevailed until there was a death in Australia. The content of the consumer recall letters at least

[954] Ie, Safety Improvement Campaign.
[955] DIRD Documents, Vol 2 Tab 44.

until March 2017 effectively failed to convey to the consumer the importance of the need to replace the airbag. The recall strategy failed to bring to the attention of the consumer the risk or danger that the airbag posed. That this approach continued well past the publication of the Blomquist report and that none of Honda Australia, DIRD or the ACCC sought to widen the recall strategy at this time is regrettable. Moreover, as already discussed at paragraphs [256]-[286], it is regrettable that Honda Australia, which had the primary responsibility for its voluntary campaign, did not identify that it should change its consumer recall letter and strategy well before March 2017.

645. It was a failure that the ACCC did not itself or seek DIRD to intervene in Honda Australia's campaign approach when the opportunity arose, such as in 2015 with the NRMA and Professor Nottage communications or indeed in the Takata Airbag Working Group meetings.

***Regulators' satisfaction with Honda Australia's recall actions prior to Mr Ngo's death***

646. Over the period from 2015 to 2017, Honda Australia provided regular updates to DIRD about the progress of its Takata related recalls, including the 5ZV and 6CA recalls, in terms of the completion rates and number of outstanding vehicles that still needed to be rectified.[956]

647. Prior to July 2017, Honda Australia's rectification rates for its recall campaigns, including for the 5ZV recall, were consistently and significantly higher than recall campaigns by other manufacturers;[957] and Honda Australia was meeting or exceeding the recall benchmark rates utilised by DIRD. Ms Nyakuengama referred to Honda Australia having been, in this respect, a "star performer".[958] Mr Thomas similarly accepted that Honda Australia was the "industry leader" in terms of its completion of recalls.[959]

648. Prior to Mr Ngo's death, DIRD and the ACCC did not raise any concern with Honda Australia in relation to its rectification works related to the Takata airbag recalls.[960]

649. According to Ms Nyakuengama's evidence, overall in the period between 2015 and 2017, DIRD was satisfied with Honda Australia's performance in responding

[956] Tpt 399; see also Exhibit 1, 11/111/3227-3319.
[957] Tpt 602.43.
[958] Tpt 743.46.
[959] Tpt 1221.37-.43.
[960] Tpt 602.32 to 602.49.

to the Takata airbag inflator defects.[961] This expression of satisfaction arose from Honda Australia's relatively high rectification rates (when compared to benchmarks and the rectification rates of other manufacturers), its participation in the Takata Airbag Working Group meetings, its provision of information to both DIRD and other manufacturers, and its submission to DIRD of notifications of its voluntary recalls in a timely way.[962] As to the 5ZV recall campaign in particular, Ms Nyakuengama said:[963]

> "…the 5ZV recall had reached 69% at the end of the first year and 90% as at December 2017. It was an outstanding campaign as compared to others when it had over 70,000 vehicles in it. So … that, that also went to my view as to the overall performance that Honda was doing this [responding to the recall] without the need for additional pushing from [DIRD]."

650. It is clear that the expression of satisfaction on DIRD's part referred to above did not arise from any review by DIRD of the first or subsequent recall notification letters sent to consumers for the 5ZV recall, which DIRD did not obtain prior to Mr Ngo's death and thus could not endorse as an effective means of communication in notifying consumers.[964]

651. Mr Grimwade's evidence was to the effect that, during the period from 2015 to 13 July 2017, the ACCC relied on assurances from DIRD in relation to whether safety issues concerning Takata airbags were being satisfactorily addressed.[965] He said that the ACCC did not itself review or audit what DIRD was doing, nor assess the hazard remedies put in place by DIRD.[966] He nonetheless accepted that it was the ACCC's "business to know whether they're [ie, DIRD are] carrying out their functions as promised under the MOU".[967] Despite this, the ACCC had no processes in place during the period from 2015 until the death of Mr Ngo to monitor whether DIRD was undertaking the role that (as the ACCC understood it) had been subject of the agreement under the MOU.[968]

***Absence of an Australian based risk assessment by DIRD and the ACCC prior to***

[961] Tpt 858.41-859.50; Exhibit 1, 11/110/3195-3196 at [57]-[62].
[962] Tpt 858.18-.39.
[963] Tpt 860.36-.40.
[964] Tpt 859.30-860.2; Tpt 860.49-861.2.
[965] Tpt 1662.28-.33.
[966] Tpt 1662.35-.46.
[967] Tpt 1707.7-.13.
[968] Tpt 1723.14-.18.

***Mr Ngo's death***

652. According to the evidence of Ms Nyakuengama and Mr Thomas, there was no risk assessment undertaken, received or requested by DIRD between 2015 and 2017 as to the chance of an accident or death in Australia arising from a Takata airbag.[969] Mr Thomas said that until mid-2016, DIRD was "very much relying on manufacturers to conduct their own risk assessments and identify to us how that risk presented in relation to different inflators".[970] He accepted that a risk assessment should have been undertaken by DIRD, although noted that it would have been "very difficult" to undertake such an assessment, particularly before the publication of the Blomquist Report.[971]

653. Mr Grimwade's evidence was to the effect that the ACCC only undertakes risk assessments in relation to matters over which it has monitoring responsibility, and that the ACCC expected DIRD to undertake risk assessments in respect of defective Takata airbags (in respect of which the ACCC considered DIRD to have such responsibility).[972] Mr Grimwade also agreed that there would have been some benefit if, following the NHTSA consent orders and the publication of the Blomquist Report in May 2016, the ACCC and DIRD had formally assessed the risks arising from defective Takata airbags for Australian consumers.[973] He accepted that an advantage that would have come out of DIRD or the ACCC having conducted a joint risk assessment following from the consent orders in the United States and the publication of the Blomquist Report would be that the terms of the risk, and how the recall should be prioritised, could have been ascertained much earlier than as turned out.[974]

654. Counsel Assisting advance that "on the evidence, there ought to have been a risk assessment conducted by DIRD and/or the ACCC between 2015 and 2017, incorporating analysis of information then available as to the nature of the hazard, its potential consequences and its likelihood of materialising,[975] including so as to inform the approach that was to be taken to monitoring suppliers' recall efforts. That is so even if, as appears to have been the case, DIRD (and, in turn, the ACCC) was reliant at this time on information being received from overseas

[969] Tpt 900.20-.23; Tpt 1159.41-.1160.7, Tpt 1168.42-.48, Tpt 1169.21-.35.
[970] Tpt 1267.21-.24.
[971] Tpt 1162.33-.38.
[972] Tpt 1449.36-.49.
[973] Tpt 1538.22-.33.
[974] Tpt 1539.29-.34.
[975] See, eg, Tpt 1161-1162, 1169 (Thomas).

markets and from the parent companies of Australian vehicle suppliers about the nature of the airbag risks".

655. Mr Grimwade advised the inquest that the ACCC was reviewing the way in which it undertakes risk assessments in product safety matters, with a view to sharing its reviewed approach on risk assessment with specialist regulators including DIRD.[976] Ms Nyakuengama indicated that DIRD has "developed a draft internal operational policy on how we propose to undertake our risk assessment procedures for staff to assess information as it comes in".[977]

656. Counsel for the ACCC in submissions pointed out that DIRD did in fact provide a risk assessment based on overseas data in May 2015, which showed a very low risk. Counsel submit that had Australian data been used it would have shown 0% risk. It is accepted that without DIRD positioning itself to be involved in research or accessing an expert to carry out same, then any risk assessment would be very difficult. The fact that Honda Australia, apparently like all other Australian vehicle suppliers, had no access to and did not prevail upon their parent companies for a risk analysis, meant that any requirement of the ACCC Guidelines to have undertaken such analysis remained unfulfilled.

***DIRD did not request the ACCC to exercise statutory powers prior to Mr Ngo's death***

657. According to Ms Nyakuengama, in the period between 2015 and Mr Ngo's death in July 2017, DIRD did not make any request to the ACCC to exercise its compulsory statutory powers.[978] Although, in that period, there was, as noted above, some engagement between the two agencies as to what powers might be available to be exercised by the ACCC, in connection with the regulation of defective Takata airbags, should this be required,[979] Ms Nyakuengama's evidence was that "there wasn't a point in time where we [DIRD] considered it [the exercise by the ACCC of its powers] was necessary".[980] She said:[981]

> "[W]e [DIRD] were satisfied that manufacturers generally were doing more than in relation to other recalls. They were cooperating with each other. They were participating in the Takata working group. We had identified a range of actions through the Takata working group meetings that were progressing and at all points in

[976] Tpt 1537.47-1538.38.
[977] Tpt 998.47-999.2.
[978] Tpt 813.35.
[979] See, eg, Exhibit 1, 9/90-5/2856-2859; Tpt 814-815.
[980] Tpt 813.37-.42.
[981] Tpt 816.7-.23.

> times things improved, didn't go backwards where every, every measure we took, every measure that manufacturers took improved the situation, so in that context, … it was just, it was always improving.
>
> So, it was not something that sort of had been raised with me as, you know, needing to exercise powers to make things, you know, move faster or, or that anyone was reluctant to, you know, to participate in this recall. The issues that were being discussed at - more around what we could do to help were more on the States and Territory registration side, better data around customer contact information et cetera, so not around manufacturers needing to be pushed to, to do more".

658. Mr Thomas' evidence was similarly to the effect that, in his time at DIRD, he did not reach the view that compulsory powers needed to be exercised by the ACCC (or requested by DIRD to be exercised);[982] he did not express a view to Mr Wright on behalf of DIRD that the voluntary recalls were not working;[983] and at no point did he ask the ACCC to exercise compulsory powers to obtain information from manufacturers.[984] In particular, Mr Thomas' evidence was to the effect that there was no instance where Honda Australia failed to respond to a request made by DIRD for particular information, at least once a follow up had been sent by DIRD. He thus said that there were no circumstances which may have caused him to make a request that the ACCC compulsorily to obtain information from Honda Australia.[985]

659. Ms Nyakuengama could not recall any instance where staff within DIRD raised with her the possibility of requesting the ACCC to exercise compulsory statutory powers in connection with the voluntary recall of Takata airbags.[986] She expected that, had there been any request or recommendation from DIRD that the ACCC use a compulsory power, this would have been done in a formal way and by a senior officer of the Department to a similarly senior officer of the ACCC.[987] However, it is noted that there was no standardised process or written protocol or procedure in place for DIRD to request or recommend that the ACCC issue a compulsory recall notice or take other action under the ACL in relation to motor vehicles.[988] In addition, DIRD has not published any document indicating what is taken into account for the purposes of determining whether a voluntary recall

[982] Tpt 1050.46.
[983] Tpt 1237.20-.21.
[984] Tpt 1054.8; Tpt 1211.37-1211.41.
[985] Tpt 1063.41-1064.11.
[986] Tpt 816.24-.28.
[987] Tpt 916.39-.50.
[988] Tpt 917.1-.48.

should be escalated to the ACCC with a recommendation that a compulsory recall be conducted.[989]

660. Although, in evidence provided to the inquest, Mr Wright drew attention to exchanges between himself and Mr Thomas in late 2015 where mention was made of the powers available to be exercised by the ACCC, he agreed that these exchanges did not entail a request by DIRD that the ACCC exercise compulsory powers, but were more in the nature of exploring what options might be available to be exercised by the ACCC if the need arose. He was not aware of DIRD having made any formal or informal request to the ACCC to exercise compulsory powers.[990]

661. The ACCC's position, as advised by Mr Grimwade, was that no request was made by DIRD of the ACCC, prior to 13 July 2017, that the ACCC exercise any of its compulsory powers in respect of the then voluntary Takata recalls.[991] In his view, prior to 13 July 2017, the ACCC was reliant on a request being made by DIRD for the Minister to exercise compulsory powers.[992] However, Mr Grimwade agreed that there was no "legal trigger" requiring a request to be made by DIRD before the ACCC would exercise its compulsory powers; nor some formal process in place whereby any request by DIRD would need to be made.[993]

662. In contrast, correspondence from Mr Matthew of the ACCC, in making arrangements to hold a meeting with DIRD on 12 May 2017 and raising in his email of 11 May 2017 whether compulsory powers should be instigated, suggests that on his part he did not consider that the ACCC was reliant on a request being made by DIRD to take steps towards a compulsory recall.

663. Mr Grimwade accepted that it would be useful to have a written policy to guide employees of DIRD and the ACCC as to how requests or recommendations should be made from DIRD to the ACCC as to the use of compulsory power in order to ensure that there is no misunderstanding.[994] He also accepted that it would be appropriate to have a written policy as to how the ACCC considers a recommendation or request regarding the exercise of compulsory power under the

[989] Tpt 877.3.
[990] Tpt 1316.5-.37; Tpt 1428.1-.38.
[991] Tpt 1453.35-.44; Tpt 1532.16-.21.
[992] Tpt 1532.32-.38.
[993] Tpt 1533.16-.30.
[994] Tpt 1708.50-1709.5.

ACL.[995]

664. Mr Grimwade advised the inquest that, more recently, the ACCC has worked on clarifying the trigger points which may prompt DIRD potentially to request the ACCC to exercise its compulsory powers, including by amending the MOU with DIRD.[996] He said that while the ACCC did not currently have a written protocol relating to when it should "step in" where a specialist regulator has taken the lead in a recall; this was an area in relation to which clarification was being sought to be added to the MOU:[997]

665. From Mr Wright's perspective, between 2015 and mid-2016, the ACCC's exercise of its compulsory powers was not dependent on a request to that effect being made by DIRD[998] and he considered that the ACCC should have implemented a compulsory recall from about September 2015.[999] Mr Wright considered that as at late 2015 there "was little appetite at the ACCC to get involved in the Takata airbags issue"; and that there was a "certain laissez faire attitude or culture".[1000] Mr Wright thought that the ACCC "dropped the ball" in terms of how seriously it took the Takata airbags issue.[1001]

666. Mr Grimwade disagreed with Mr Wright's criticisms of the ACCC's approach at this time.[1002] He said:[1003]

> "My interactions with members of the product safety branch who were there at the time and remain or were there, when I commenced, they've all indicated to me, to my satisfaction, that from and around that time we were developing more robust processes within the ACCC, more objective procedures within the product safety branch of the ACCC and that there was nothing short of complete commitment by the staff to the mission of the branch and I would not agree that there's a laissez faire or there was a laissez faire attitude or culture in the branch at that time."

667. Counsel Assisting advances that the evidence of Mr Wright, taken in conjunction with the evidence as to the ACCC and DIRD's knowledge in 2015-2016 as to the grave risks posed to Australian consumers, could on its face suggest that DIRD should have agitated for a compulsory recall by at least mid to late 2016 and that

[995] Tpt 1709.18-.29.
[996] Tpt 1533.32-1534.1.
[997] Tpt 1663.21-.25.
[998] Tpt 1327.44-1328.26.
[999] Tpt 1355.25-.38.
[1000] Tpt 1299.20-.33; see also Tpt 1363.46-1364.22.
[1001] Tpt 1358.24-.26.
[1002] Tpt 1530.38-1531.36.
[1003] Tpt 1532.6-.14.

the ACCC should have taken steps to implement a compulsory recall at an earlier stage than it did.

668. However, Counsel Assisting did not submit that such a finding should be made, noting that though the compulsory recall quickly followed Mr Ngo's death, due to the legislative steps required to implement a compulsory recall, those steps took seven months for the compulsory recall to commence so it may not have been in place in any event prior to 13 July 2017. A further basis for not making such a finding is that the issue relates to an industry wide recall which was not within the scope of the inquest and despite the "precautionary" risk/campaign approach taken by Honda Australia, the rectification rate was sufficient so that there was no governmental dissatisfaction with Honda Australia's performance in conducting the voluntary 5ZV recall.

669. Given the evidence that Honda Australia was the "star performer" in its recalls generally, there is no foundation to find that DIRD should have agitated for a compulsory recall of affected Honda vehicles at any stage prior to Mr Ngo's death.

***Actions taken by ACCC / DIRD after Mr Ngo's death***

670. On 14 July 2017, the day following Mr Ngo's death, Honda Australia made a mandatory injury report to the ACCC in relation to his death. This report stated, *inter alia,* that:[1004]

> "Honda Australia has been recalling all vehicles with the same or similar type of airbag inflator. The recall is based on advice from Honda Motor Co (Japan) and Takata Corporation. The vehicle stated is part of an ongoing recall campaign, which is currently at an 86.4% completion rate."

671. On 17 July 2017, Honda Australia similarly notified DIRD of a death that may have been attributable to a Takata airbag.[1005]

672. The minutes of the Takata Working Group meeting held on 19 July 2017 – which was attended by representatives of DIRD, the ACCC, FCAI and vehicle suppliers – refer to the Toyota incident in the Northern Territory (and state that a "beta" bag was involved), but do not expressly refer to Mr Ngo's death. It appears that this was because, at that stage, the potential involvement of a Takata airbag in Mr Ngo's death had been notified to DIRD and the ACCC only on a confidential

[1004] Exhibit 1, 9/87-v/2752.
[1005] Exhibit 1, 11/110/3194 at [51].

basis.[1006]

673. The minutes of the meeting also reflect DIRD having indicated that it was "satisfied that manufacturers are taking appropriate action, beyond normal procedures, to replace airbags as quickly as possible" and that "DIRD and the ACCC will continue to monitor this progress".[1007] I note Counsel Assisting's observation that "[g]iven the notifications in respect of Mr Ngo's death referred to above this apparent expression of satisfaction is somewhat puzzling". The reassurance DIRD sought to convey appears to have contributed to the ACCC having concerns about the voluntary recalls.

674. In the evening of 19 July 2017, Mr Grimwade of DIRD sent an email to other ACCC officers which advised:[1008]

> "As some of you know, we had been advised that there was late last week a fatality in NSW that was suspected to be caused by the misdeployment of a Takata airbag. This has been confirmed today. NSW Police informed DIRD that the death last Thursday was caused by the airbag (shrapnel wound to the spinal cord). The Coroner has given NSW Police approval to advise government stakeholders confidentially. The family will be notified this week, and NSW Police expect they may initiate media. NSW Police will not initiate media, nor will DIRD.
>
> We are updating previous talking points on Takata for all of you and the Minister's office, in the event there are inquiries of us in relation to the recall, which is presently being managed by DIRD. There may be questions as to what if any steps we might take.
>
> I need to speak to the team further, but initial thoughts are that we may need to take over the voluntary recall to push it harder (DIRD appear too passive in managing the VR) and we will also consider whether a compulsory recall is the preferred option. But a very worrying and sad development that warrants immediate consideration of whether we can deal with this more effectively than DIRD."

675. In relation to this email, Mr Grimwade said that, on 19 July 2017, he formed a view that DIRD appeared to have been "too passive" in managing the voluntary recalls.[1009] This view was not communicated to DIRD by the ACCC either before or in the period after Mr Ngo's death.[1010] Mr Grimwade accepted that the initial thoughts that he had expressed in his email about DIRD being "too passive" were

[1006] Exhibit 1, 11/110A/3225-11 at [29]; 10A/109J/3180-60 at [3.6]; Tpt 1515.26-.39.
[1007] Exhibit 1, 9/90-4/2851.
[1008] Exhibit 1, 10A/109K-P/3180-148.
[1009] Tpt 1664.15-.19.
[1010] Tpt 862.36-863.19; see also Tpt 1752.14-.23.

not based on having had a complete picture, as at 19 July 2017, of what DIRD had done in respect of the Takata airbag recalls between 2015 and 2017.[1011] He also accepted, particularly in circumstances in which DIRD had no statutory or regulatory powers in respect of the progress of the recalls, that DIRD had taken numerous active steps to assist and promote the progress of the voluntary recalls.[1012] Nonetheless, Mr Grimwade did not consider that DIRD had taken all of the steps that would have been optimal in the circumstances.[1013] As such, his initial impression that DIRD had been too passive in managing the voluntary recalls, as referred to in this email, was consistent with the view he reached, with the benefit of hindsight, that more could and should have been done by DIRD to progress the recalls of Takata airbags prior to July 2017.[1014] In making these observations, Mr Grimwade specifically referred to the lack of media engagement by DIRD following the BMW airbag misdeployment in September 2016.[1015]

676. In relation to Mr Grimwade's statement in his email of 19 July 2017 that "we may need to take over the voluntary recall to push it harder", Mr Grimwade said, in his evidence before the inquest:[1016]

> "There were a confluence of events that really crystallised my position that evening. … [t]he fact that a fatality had been confirmed that afternoon, so soon after the serious injury was a particular concern, but there was additional circumstances which caused me to express myself in the way I did. The, the general manager of product safety, Mr Matthew, attended this meeting, reported to me at the end of the day after the meeting that he was concerned by a number of things. One was the variability of the approach that he had identified that manufacturers were taking, in particular in relation to the tracing of future consumers. That is, consumers who in the future may take ownership of a vehicle with an affected Takata airbag. And that was concern, a concern because there had been considerable concerns expressed about NEVDIS so far, and yet he was concerned that there still weren't efforts by some manufacturers in, in dealing with those issues in other ways. He also reported to me of a comment made by a representative at the meeting which concerned him, particularly in relation to the urgency with which some manufacturers might be taking the recall. And he was also concerned that in light of the death of Mr Ngo and the issues that had been discussed, that [DIRD] appeared to be satisfied that, with the progress the recalls were making. Which is evidenced in the minutes of that meeting."

[1011] Tpt 1753.26-.30.
[1012] Tpt 1753.40.45.
[1013] Tpt 1766.17-.19.
[1014] See Tpt 1517.46-1518.3, Tpt 1765.35-.49, Tpt 1766.21-.27.
[1015] Tpt 1517.50-1518.15.
[1016] Tpt 1516.30-1517.16.

677. Thus, Mr Grimwade's concerns that the ACCC may need to step in were prompted by: (i) the death of Mr Ngo; (ii) this having occurred soon after the Northern Territory injury; (iii) an appearance of a lack of urgency by some suppliers in relation to the recalls; (iv) an apparent variation in the approach being taken by different suppliers to the recalls; and (v) DIRD's statement at the 19 July 2017 Takata Airbag Working Group meeting that it was satisfied with the progress of the recalls, following it having received the advice about Mr Ngo's death.[1017]

678. For her part, Ms Nyakuengama resisted the criticism that DIRD had been "too passive" in managing the voluntary recalls, given that DIRD lacked statutory power to escalate the voluntary recalls; she said that "we considered we were doing everything that was available to us at the time".[1018] Further, Ms Nyakuengama did not agree with the characterisation of DIRD as having "managed" the voluntary recall process, including because the ACCC was the agency that possessed relevant statutory powers to act in relation to the recalls.[1019]

679. Following Mr Ngo's death, the Minister for Urban Infrastructure, on 24 July 2017, directed the preparation of a report by DIRD on the progress and current status of the voluntary Takata airbag recalls.[1020] In response to this request, in early August 2017, DIRD released its Progress Report dated July 2017 on the progress of the voluntary recalls.[1021]

680. The DIRD Progress Report stated that, as at 13 July 2017, vehicle manufacturers had (voluntarily) recalled approximately 2.2 million of the total 2.35 million affected vehicles in Australia, with approximately 850,000 vehicles rectified.[1022] It was also reported that due to the size of the recall, vehicle manufacturers had faced a number of challenges, including:[1023]

    a. sourcing sufficient parts;

    b. capacity in dealerships to rectify vehicles;

    c. the identification of airbags that present the highest risk;

[1017] Tpt 1543.22-1544.13.
[1018] Tpt 863.24-.864.2.
[1019] Tpt 918.18.
[1020] Tpt 845.42.
[1021] Department of Infrastructure and Regional Development, *Recall of Vehicles in Australia Fitted with Takata Airbags – Report on Progress and Status of the Recalls*, Exhibit 1, 2/45/456; Tpt 846.5, 940.43; see also Tpt 1280.15-.24.
[1022] Exhibit 1, 2/45/476.
[1023] Exhibit 1, 2/45/474.

d. locating owners of older vehicles; and

e. engaging some vehicle owners who had not responded to multiple recall letters.

681. In late July 2017, ACCC staff provided an oral update to the Commission. The update included the following matters that illuminate the ACCC's understanding of the position regarding defective Takata airbags at that time:[1024]

"**Brief History**

- There is a global recall of Takata airbag inflators that affects over 100 million vehicles and a large number of vehicle makes.

- In Australia there are over 2.35 million Australian vehicles and up to 60 car recalls involved. At this time 852,500 (36.3)% have been rectified.

- The affected Takata airbag used the chemical ammonium nitrate to inflate airbags. It can deteriorate when exposed to high airborne humidity and high temperatures. This means inflators can explode with too much force and project shrapnel into drivers and passengers.

- The recall will grow as vehicles with affected Takata airbags become older and more types of airbags are added to the recall list. In July 2017 Takata added the airbags which included a drying agent called a desiccant to the recall. It was thought to eliminate moisture and stop the propellant degrading. In July 2017 experts advised the US regulator (who is leading research and risk assessment) that this was not the case and a further tranche of Takata airbag recalls was necessary. The consensus view is now that ammonium nitrate is not sufficiently stable in the long term to be used as a propellant.

- On Wed 19 July 2017, the ACCC attended the most recent Takata airbag workshop hosted by Department of Infrastructure and Regional Development (DIRD). During that workshop it became clear that manufacturers were adopting different approaches that were assessed as contributing to the differing completion rates. It was also identified that manufacturers were having difficulty in locating owners, but had not been making changes to be able to contact customers in the future who they had sold vehicles to containing the Takata airbags.

- In July 2017 the manufacturers' current overall performance is: Chrysler 16.5%, BMW 38.6%, Ferrari 13.1%, Ford 0%, Honda 65.7%, Mazda 13.5%, Mitsubishi 30.5%, Nissan 34.5%, Performax 0%, Subaru 7%, Toyota 30.3%.

[1024] Exhibit 1, 9/90-13/2921.

**Next Steps**

- CPSB [i.e., ACCC's Consumer Product Safety Branch] and DIRD have developed a five step process. Minister McCormack and Minister Fletcher have announced an action plan and have sent all manufacturers letters asking for full details of recall activities and an update on progress (returns 31 July 2107).

- This complements the five step process agreed by ACCC and DIRD

Step 1 – write to dealers, seek full details

Step 2 – receive and assess each recall strategy that has been put in place

Step 3 – develop our (ACCC & DIRD) acceptable strategy (dealers can always add more)

Step 4 – ask dealers to commit to the revised strategy

Step 5 – commence compulsory process for any dealer who does not want to put in place the revised strategy."

682. This update was noted in the minutes of the Commission's 26 July 2017 meeting, which stated:[1025]

> "The Commission noted the update and decided that CPSB should investigate the approaches taken by suppliers and the progress of each manufactures' recall. The Consumer & Product Safety Branch is to report weekly to the Commission, and provide an options paper to Commission for consideration, preferably on 9 August 2017. The options should include consideration of compulsory recall(s)."

683. On 24 July 2017, the ACCC announced that it was investigating the Takata airbag recall and urged drivers not to ignore recall notifications and to check whether their car was subject to recall.[1026] On the same date, the then Minister for Small Business, the Hon Michael McCormack MP, and the then Minister for Urban Infrastructure, the Hon Paul Fletcher MP, jointly announced that they were writing to affected vehicle suppliers seeking a comprehensive status update on the progress of their recalls and communications with owners of potentially affected vehicles.[1027] Mr Grimwade accepted that it was Mr Ngo's death that was a key reason that led to the commencement of the ACCC's safety investigation.[1028]

[1025] Exhibit 1, 9/90-14/2922.
[1026] ACCC letter dated 9 November 2018, Exhibit 1, 9/82/2452.
[1027] Exhibit 1, 9/82/2452.
[1028] Tpt 1526.16.

684. It is regrettable that the injury caused by the defective Takata airbag in the Northern Territory in April 2017 did not cause the ACCC to be so engaged. That such action only occurred after a death in Australia, when there had been deaths and injuries overseas, is concerning.

685. On about 5 August 2017, the ACCC "Takata Task Force" was formed to conduct the safety investigation into Takata airbag recalls.[1029]

686. Fairly early on in its investigation, the task force retained Dr Blomquist to provide advice on technical issues relating to Takata airbags.[1030] It appears that this was the first time that either the ACCC or DIRD had engaged an expert in airbag technology to provide advice in respect of the Takata recalls in Australia.[1031]

687. In addition, as part of its safety investigation, in August 2017 the ACCC reviewed manufacturers' language in recall notices on the PSA website, as well as more broadly in consumer communications, and took steps to develop model language to be used in connection with voluntary recall measures for Takata airbags.[1032] Although, at this point, there was not yet any compulsory recall on foot, Mr Grimwade said that "we took it upon ourselves to ensure that the language on our website was reflecting the risks as we understood them, and as they were emerging in the investigation".[1033] Mr Grimwade accepted that ACCC officers could have, prior to 13 July 2017, usefully exchanged views in relation to the text to be used in Takata recall notices, in the manner in which they did in August 2017.[1034] He agreed that this "should have been done".[1035]

688. Mr Grimwade's expression that the ACCC took it upon themselves to conduct this review is somewhat odd given that he said there was no lack of clarity by the ACCC as to whose responsibility the PSA website was[1036] – the ACCC had sole responsibility for it at all times.

689. That the 5ZV recall used the term "precautionary" in its language on the website in the first place but continued to do up until this review is concerning as there were numerous occasions which should have or at least could have given the ACCC

[1029] Exhibit 1, 9/82/2460; see also Tpt 1521.33-.48.
[1030] Tpt 1521.50-.16. From the context, it appears that the "2018" in line 16 either as said or as intended was "2017".
[1031] See Tpt 1522.18-.36 (Grimwade); Tpt 875.19 (Nyakuengama).
[1032] Exhibit 1, 16/147/4265 at [1.12]; and see also Exhibit 1, 16/149-J/4347-4349.
[1033] Tpt 1524.28-.35.
[1034] Tpt 1525.24-.28.
[1035] Tpt 1525.33.
[1036] Tpt 1252

cause to conduct such a review, namely: (i) the 2015 NRMA letter; (ii) the late 2015 Professor Nottage correspondence; (iii) the Blomquist report and NHTS orders in May 2016; (iv) the April 2017 injury causing the Toyota misdeployment in the Northern Territory together with (v) the ACCC participation in the Takata Airbags Working Group meetings from June 2016 and (vi) its close working relationship with DIRD.

690. On 5 August 2017, following receipt of responses from affected vehicle suppliers, the Minister for Small Business, Michael McCormack, issued a "Safety Warning Notice to the Public" under s 129(1) of the ACL, regarding possible risks of using motor vehicles containing Takata airbags.[1037] The Safety Warning Notice warned of possible risks involved in the use of motor vehicles containing Takata airbags supplied in Australia, urged consumers to check whether their vehicle had been included in a product safety recall and advised that the ACCC was investigating whether vehicles with Takata airbags will or may cause injury.[1038] Mr Grimwade advised that the purpose of a safety warning notice such as this is to "bring attention to a particular hazard through the [M]inister" and that "used sparingly… they can get quite a lot of publicity and indicate the views of government in relation to a particular hazard".[1039]

691. Mr Grimwade accepted that there was an opportunity, prior to 13 July 2017, for the Minister to issue a Safety Warning Notice – such as that ultimately issued on 5 August 2017 – in respect of the risks posed in relation to the voluntary recalls of Takata airbags.[1040] He accepted that there was a missed opportunity on the part of the ACCC, prior to 13 July 2017, to make a recommendation to the Minister to issue a safety warning notice in relation to the Takata airbag recalls.[1041]

692. If the ACCC was waiting for a risk to materialise to justify a sparingly used strategy to bring to public attention the need to respond to a recall of Takata airbags, the most obvious time that the ACCC should have approached the Minister to issue a Safety Warning Notice was in April 2017 following the Northern Territory injury.

***Introduction of compulsory recall***

693. On 21 September 2017, pursuant to s 132A of the CCA, Minister McCormack issued a "Proposed Recall Notice" for motor vehicles – of a kind ordinarily acquired

[1037] Exhibit 1, 9/82/2452; 2/46/486; Tpt 1523.46-1523.5.
[1038] Exhibit 1, 9/82/2452.
[1039] Tpt 1523.17-.20.
[1040] Tpt 1523.34-.37.
[1041] Tpt 1523.46-.49; Tpt 1659.14-.17.

for personal use – with specified Takata airbag inflators, namely, those "which use a phase stabilised ammonium nitrate propellant and do not have a desiccant or have a calcium sulphate desiccant" (**Affected Takata Airbag Inflators**).[1042]

694. The reasons given in the background section of the Proposed Recall Notice for the proposed compulsory recall included the following:[1043]

> "Commencing in 2008, incidents involving misdeployment of Takata airbag inflators were reported to the United States of America National Highway Traffic Safety Administration (NHTSA) and other authorities around the world.
>
> In determining the root causes of, and factors which influence, the rupturing of airbag inflators manufactured by Takata, NHTSA has relied primarily on three expert reports by Dr. Harold R Blomquist (commissioned by NHTSA) (May 2016); Orbital ATK (on behalf of the Independent Testing Coalition, a group of 10 automakers affected by Takata airbags) (September 2016); and Exponent (July 2016).
>
> These reports identify the root causes of the defect as follows:
>
> 1. inflator design allows moist air intrusion
>
> 2. propellant degradation with exposure to moist air and temperature cycling
>
> 3. over-pressurisation of the inflator housing during airbag deployment.
>
> In summary, these reports indicate that the Takata airbag inflators with PSAN rupture because affected inflators are inadequately sealed for protection of the moisture sensitive PSAN-based main propellant, allowing moist air to enter the inflator air space. This causes damage to the physical structure of the main propellant including the formation of pores, channels and micro-cracks. Over the course of years, the extent of damage progresses by a slow process driven by daily temperature fluctuations. During combustion in the event of a collision, the extremely hot gas enters the pores/channels and this causes a transition from layer-by-layer burning to burning *en masse* that over-pressurizes the steel shell to cause catastrophic failure (rupture), with fragmentation hazardous to vehicle occupants.
>
> …
>
> ***Injuries and deaths reported***
>
> The misdeployment of Takata PSAN airbags has been associated with 19 deaths globally and at least 207 injuries in the US, and one serious injury in Australia. Of the deaths, 13 occurred in the US, 5

[1042] Exhibit 1, 2/47/490.
[1043] Exhibit 1, 2/47/491-492

> in Malaysia, and 1 in Australia. It is likely that there is under-reporting of injuries and deaths related to defective airbag inflators, because first responders and investigators may not always consider this cause of injury or death in the context of a serious vehicle collision …."

695. The proposed recall notice later noted that the ACCC investigation had identified issues with the voluntary recall scheme and that communications with affected consumers, as well as efforts to identify and locate consumers, had varied widely between the different suppliers. It was observed that Honda Australia was one of the suppliers that had made "significant efforts" to locate and contact consumers, which had involved "using multiple sources of information to locate consumers and concerted efforts to contact them, including letters, registered post, outbound calls and SMS".[1044] However, it was noted that despite such efforts, and the fact that Honda had a higher replacement rate than most suppliers, this was still only 78.3%.

696. It was further observed (in relation to the voluntary recalls more generally) that there had been delays encountered by consumers in booking in their vehicles for the replacement of airbags, including the higher risk alpha airbag inflators, and in most instances only limited offers had been made to a small number of consumers to compensate them for alternative transport arrangements during the replacement period.

697. On 9 October 2017, the ACCC held a conference with suppliers and stakeholders to seek views on the Proposed Recall Notice, in accordance with s 132H of the CCA.[1045]

698. The ACCC subsequently recommended that a recall notice, substantially in the form of the Proposed Recall Notice, be issued.[1046]

699. Mr Grimwade accepted that Mr Ngo's death on 13 July 2017 was "a key factor, if not the key factor…" that ultimately triggered the steps which led to the commencement of the compulsory recall in early 2018.[1047]

***Compulsory Recall Notice – February 2018***

700. On 27 February 2018, Michael Sukkar, Assistant Minister to the Treasurer, issued

[1044] Exhibit 1, 2/47/495.
[1045] Exhibit 1, 9/82/2458.
[1046] See Exhibit 1, 2/49/559.
[1047] Tpt 1526.19-.22; see also Tpt 1701.41-.46.

the Compulsory Recall Notice pursuant to s 122 of the ACL.[1048]

701. The Explanatory Memorandum to the Compulsory Recall Notice stated that the Assistant Treasurer accepted the ACCC's recommendation to issue the Notice because it appeared that:[1049]

    a. a reasonably foreseeable use of vehicles fitted with Affected Takata Airbag Inflators may cause injury to drivers and passengers; and

    b. one or more suppliers of vehicles fitted with Affected Takata Airbag Inflators have not taken satisfactory action to prevent those goods causing injury to drivers and passengers.

702. According to the Explanatory Memorandum to the Compulsory Recall Notice:[1050]

    a. between 2009 and 2017, nine vehicle suppliers had voluntarily recalled 2.7 million vehicles with Affected Takata Airbag Inflators, with an overall replacement rate of approximately 63%; and

    b. prior to the issuance of the Compulsory Recall Notice, there were approximately 1,324,477 vehicles in Australia with Affected Takata Airbag Inflators that had not been subject to voluntary recalls.

703. It appears, therefore, that at the time the Compulsory Recall Notice issued (on 27 February 2018), there were around 3 million vehicles in Australia that still needed to have their affected Takata airbag(s) replaced.

704. DIRD's performance monitoring of voluntary recalls of vehicles fitted with Affected Takata Airbag Inflators formally ceased in early 2018, when the function was transferred to the ACCC for monitoring under the Compulsory Recall Notice. [1051] It is noted that DIRD still has a monitoring role in relation to recalls of airbags that fall outside the definition of "Affected Takata Airbag Inflators" within the meaning of the Compulsory Recall Notice.

<u>Requirements of Compulsory Recall Notice</u>

705. The Compulsory Recall Notice dated 27 February 2018 implemented a compulsory recall scheme in Australia for "Affected Takata Airbag Inflators", which are defined therein to mean "a frontal driver or passenger airbag inflator made by

[1048] Exhibit 1, 2/48/517.
[1049] Exhibit 1, 2/49/559
[1050] Exhibit 1, 2/49/558.
[1051] DIRD letter 24.5.2019, Attachment A, item 4, Exhibit 1, 8/79/2418; Tpt 728.24.

Takata that uses either Phase Stabilised Ammonium Nitrate (PSAN) without desiccant (including an Alpha Inflator) or PSAN with calcium sulphate desiccant".

706. The Compulsory Recall Notice requires suppliers to replace all affected Takata airbag inflators in Australian vehicles with new airbag inflators by 31 December 2020 (or such other date as approved by the ACCC): s 5(2).[1052]

707. The Compulsory Recall Notice sets out communication requirements for suppliers to notify consumers of airbag risks. This includes providing the ACCC with a "Communication and Engagement Plan" setting out their proposed strategy for engaging with customers: ss 7(1)-(2) and Schedule 2. The Compulsory Recall Notice does not specify the precise wording and appearance of recall correspondence, but contains the following requirements in relation to the content of consumer communications which must be addressed in the Communication and Engagement Plan:

    a. In all communications with consumers, a supplier must use clear, simple language.

    b. In particular, a supplier must identify the risk presented by airbag inflator ruptures in clear, simple language that emphasises the risk of injury or death from shrapnel in the event of a rupture and avoids unnecessarily technical or scientific terminology.

    c. Supplier communications with consumers must also use appropriately urgent terms.

    d. The assessment of urgency must take into account the age of the vehicle, the type of inflator involved, the location of the vehicle in an area of high absolute humidity, and the location of the relevant inflator inside the vehicle: Schedule 2, clause 5. Certain example messages are provided in the Compulsory Recall Notice.

    e. A supplier must not include information or phrases that are likely to minimise or mitigate the perception of the risk, as these may discourage consumer action to have the Affected Takata Airbag Inflator replaced. Examples of such language that should not be used include: "we are only conducting this recall as a precaution": Schedule 2, clause 6.

[1052] Exhibit 1, 2/48/517.

f. A supplier must use language designed to capture attention and be impactful. A Supplier must use bold text to highlight particularly impactful words (eg, ”urgent”, “kill”): Schedule 2, clause 7.

g. A supplier must avoid using generic or low-impact imagery (eg, scenic pictures): Schedule 2, clause 8.

h. In letter communications, a supplier must:

   i. include a red headline at or near the top of the letter and on the front of the envelope, with prominently featured text, such as "URGENT SAFETY RECALL"; and

   ii. specify the number of attempts they have made to contact the consumer by letter, by including in the heading or subject line, words to the effect of "Contact Attempt Number xx": Schedule 2, clause 9.

i. In email communications, a supplier must use the words "URGENT SAFETY RECALL" in the subject line: Schedule 2, clause 10.

j. A supplier must include relevant information regarding dates, such as the date by which the Recall Notice requires the Affected Takata Airbag Inflator to be replaced: Schedule 2, clause 11.

k. A supplier must tailor communications to the individual consumer and vehicle in issue, to reinforce the message’s credibility and distinguish it from commercial solicitations, including (at least) by addressing communications using the consumer’s name, prominently displaying the supplier’s logo, including details such as the vehicle’s make, model and model-year and ensuring communications include a link to a webpage offering recall specific information: Schedule 2, clause 12.

l. Recall Communications are to be across multiple channels and with escalating forms including post, courier and personal visits, as well as concurrent contact by email, calls and SMS messages, and also via media campaigns: Schedule 2, clauses 13 to 26.

708. The Compulsory Recall Notice also includes requirements around ensuring ready access to information by consumers and efficient scheduling of replacement services, and these matters must be addressed in the Communication and Engagement Plan.

709. The Compulsory Recall Notice requires suppliers to ensure that messaging is accessible to consumers from a culturally and linguistically diverse (CALD) audience. This includes, at a minimum:

    a. in all written communications with consumers and on the supplier's website (including the page featuring the Recall Database), either:

        i. including a short statement outlining the serious safety risks of Affected Takata Airbag Inflators and the need for urgent action in common community languages – including Arabic, Chinese (Simplified and Traditional), Vietnamese, Farsi, Korean, Spanish, Dari, Indonesian, and Hindi; or

        ii. providing links or contact information to a free of charge interpreting/translation service – such as the National Accreditation Authority for Translators and Interpreters (NAATI) or Translating and Interpreting Service (TIS National; and

    b. in all written communications and on the supplier's website, providing details of the National Relay Service for consumers who are deaf or have a hearing or speech impairment: Schedule 2, clause 18.

710. Further, suppliers must obtain consumer contact details using multiple sources, and not solely from NEVDIS: Schedule 2, clause 27.

711. The Compulsory Recall Notice required suppliers to provide the ACCC with a Recall Initiation Schedule by 2 April 2018 specifying the recall initiation dates for vehicles: Schedule 1, clause 2. Suppliers were required to establish a Recall Database on their respective websites that allowed consumers to enter their Vehicle Identification Number (VIN) to obtain immediate information about the Takata recall status of their vehicle: s 8(2).

712. The recall by suppliers under the Compulsory Recall Notice has been required to occur on a rolling basis, with priority given to vehicles registered in areas of high heat and humidity, older vehicles and vehicles with affected driver's side inflators. The recall of alpha airbags, which are considered to pose an immediate and serious safety risk, has also been prioritised: Schedule 1.

713. The inclusion of the details of the voluntary recalls and the later compulsory recall as set out by Counsel Assisting's closing submissions replicated in these findings, provides a useful understanding of the requirements of an effective recall and the

pitfalls and obstacles which may need to be overcome in a voluntary recall. It is evident that much has been learned which will found the development of a best practice guideline for voluntary recalls in as much as they can be effected without the resort to legislative requirement. This may assist not only the FCAI in implementing changes to its Code of Practice for members conducting a voluntary recall, but also both the ACCC and DIRD to achieve best practice in the discharge of their respective roles in consumer and public safety in respect of voluntary recalls. Finally, the replication and adoption of Counsel Assisting's very thorough narrative in these findings may assist those involved in consumer rights and public safety protection and of course encourage the consumer to understand the importance of answering recalls and also understand that their vehicles contain componentry which houses chemical propellant designed for occupant protection.

***Findings relating to the ACCC and DIRD's role in the monitoring of voluntary recalls***

714. The 5ZV voluntary recall was part of the biggest thematic recall of motor vehicles ever experienced in Australia and indeed the world. In examining the 5ZV recall the inquest heard evidence about a number of systemic issues concerning the regulation of the recall which are addressed in Counsel Assisting's submissions. If accepted in full the submissions advanced by Counsel Assisting suggest a finding in relation to the ACCC and DIRD to the following effect:

> A lack of clarity and at times substantial confusion as to their respective roles, together with the lack of a documented system including a process whereby the monitoring of the recall could be escalated, resulted in the ACCC and DIRD inadequately administering and monitoring the Takata Airbag Voluntary Recall during the period July 2015 to July 2017, particularly in that there was a failure to ensure that the defect and hazard of the Takata Airbag in the Honda Australia 5ZV recall was properly described to the Australian public on the ACCC Public Safety Website, in the Honda Australia letters to consumers, or by Australian public media broadcasts in a timely and adequate manner.

715. The following are Counsel Assisting's submissions (which are largely resisted by both the ACCC and DIRD and in part by Honda Australia) in regard to the role

played by DIRD and the ACCC in relation to the voluntary recalls of Takata airbags, and specifically the 5ZV recall, prior to Mr Ngo's death on 13 July 2017:

> ***"First*** *,* there was substantial confusion and a lack of clarity between the ACCC and DIRD as to which agency was to assume what administrative role in terms of monitoring the conduct of the Takata voluntary recalls by suppliers, including Honda Australia. This was wholly unsatisfactory and permeated important aspects of the monitoring process and prevented each agency from operating in as effective a manner as would otherwise have occurred. There should have been a clearer allocation as between DIRD and the ACCC, under the MOU or otherwise, of responsibilities for such matters as:
>
> a. reviewing and settling the content of recall notifications published on the ACCC's Product Safety Australia website: …
>
> b. reviewing suppliers' recall strategies, plans for communication with affected customers and customer communication letters in relation to the voluntary Takata recalls, including the 5ZV recall, to ascertain their effectiveness at prompting consumer action: …; and
>
> c. considering whether to, and if considered appropriate, taking steps to issue public announcements or media releases from Government or other media/advertising as to key developments in relation to the Takata recalls, including in respect of the report received in 2016 as to the first known misdeployment of a Takata airbag in Australia: …
>
> Given the confusion and lack of clarity, DIRD and the ACCC should have taken steps, well before Mr Ngo's death, to remedy such position and ensure that there was no such confusion and lack of clarity. Each agency failed to do so. This failure meant that the agencies did not take steps that they might otherwise have taken and which, at least potentially, could have led to Ms Chea having the airbags in the Vehicle replaced prior to 13 July 2017.
>
> ***Secondly****,* in the absence of a clear allocation to the ACCC under the MOU or otherwise of the responsibilities set out above, DIRD – as the agency that assumed a significant monitoring role in respect of the voluntary Takata airbag recalls – should have ensured that it had, or had access to, expertise to evaluate the effectiveness of recall communications between motor vehicle companies and their customers in respect of the recalls. Had DIRD had or utilised such expertise, it may (and should) have provided input to Honda Australia about the effectiveness of its consumer recall letters (including for the 5ZV recall) such as to prompt Honda Australia to improve these letters well before Mr Ngo's death.
>
> ***Thirdly***, in circumstances where an officer of DIRD became aware, in July 2015, that Honda Australia was sending out recall correspondence in respect of defective Takata airbags that did not clearly refer to the nature of the possible airbag malfunction or the consequential risk of injury and death, this should have been raised with Honda Australia, either directly by DIRD, or by the ACCC, following liaising with DIRD…. Similarly, in circumstances where the ACCC was made aware in late 2015 of Professor Nottage's concern about Honda Australia's recall correspondence, and such concerns were conveyed to DIRD, those concerns should have been followed up with Honda Australia either by DIRD or by the ACCC, so that the relevant concerns could be considered and potentially addressed by Honda Australia.

Had DIRD and/or the ACCC followed up the concerns raised by Mr Thomas and Professor Nottage with Honda Australia, and had Honda Australia responded to such matters as might have been raised by DIRD and/or the ACCC, Ms Chea may have acted sooner to have the airbags in the Vehicle replaced…

***Fourthly***, DIRD should have followed up on its request to Honda Australia for recall letters made on 21 August 2015 (to which Honda did not respond) and should have specifically requested at least the initial customer letter for the 5ZV recall from Honda Australia… At least one of DIRD or the ACCC should have had in place a practice of requesting, receiving and reviewing subsequent customer letters from suppliers for a given recall, so as to enable the applicable agenc(ies) to monitor, over time, the manner in which Honda Australia was communicating with its customers about the 5ZV Recall…

Receipt and considered review by DIRD and/or the ACCC of Honda Australia's customer letters for the 5ZV recall could (and arguably would) have prompted one of those agencies to take steps ensure that Honda Australia's letters for that recall clearly referred to the risk that metal fragments could kill or injure vehicle occupants in the event of a misdeployment, having regard to the knowledge possessed by DIRD and the ACCC, at all relevant times from mid-2015, in relation to the nature of the risk posed by defective Takata airbags.[1053] In this respect, had DIRD requested and been provided with copies of recall letters in connection with the 5ZV recall, and had DIRD provided suggestions about these, Ms Nyakuengama expected that Honda Australia would have given consideration to DIRD's comments, consistent with Honda Australia's receptiveness, over the course of the voluntary recalls, to other matters raised by DIRD.[1054] If steps had been undertaken by DIRD or the ACCC to obtain copies of and provide feedback on Honda Australia's letters to customers for the 5ZV recall over the period from 2015 to 2017 this may have prompted Honda Australia to make improvements such letters, including those that were to be sent to Ms Chea, well before Mr Ngo's death, and upon which she may have promptly acted.

Nonetheless, even if the initial and/or subsequent customer letters for the 5ZV recall had in fact been provided to DIRD and/or the ACCC by Honda Australia at or about the time of those letters being sent to customers, there may be a question as to whether this *would have led* (in the circumstances that in fact prevailed) to DIRD and/or the ACCC requesting any material changes to be made to the recall correspondence. As to this:

a. the 10 July 2015 notification provided by Honda Australia to DIRD and the ACCC in respect of the 5ZV recall did not refer to the prospect of metal fragments being propelled by the inflator upon misdeployment, causing injury or death, and, in response to receiving that notification, it appears that neither DIRD nor the ACCC sought further clarification from Honda Australia as to the nature of the relevant defect: …;

[1053] Tpt 796.45; and see above at [412]-[413]. This is so even in light of the evidence that, although DIRD did not review customer letters from the perspective of ensuring their effectiveness as a piece of consumer communication, DIRD did review customer letters for the purpose of checking whether the nature of the safety defect and existence of a risk of death was correctly identified: Tpt 723.41-.44, Tpt 800.6, Tpt 1028.5, Tpt 1030.9.
[1054] Tpt 730.1-.20.

b. DIRD did not take up, with Honda Australia, Mr Thomas' concerns in respect of the communications contained in the letter that he received from Honda Australia in respect of his Honda Jazz in mid-2015; and

c. the ACCC did not take up with Honda Australia (whether directly, or via DIRD) Professor Nottage's concerns that were raised about Honda's recall communications in late 2015 …, or otherwise take steps to query Honda Australia's use of the language of "precautionary" on notifications published on the ACCC Product Safety Australia website ….

***Fifthly,*** prior to July 2017, the ACCC and/or DIRD should have taken steps to publicise, in a meaningful manner, the risks posed by defective Takata airbags to the public, including by the issuance of one or more media releases and/or by seeking to co-ordinate a media or advertising campaign with industry…. In particular, steps ought to have been taken by the ACCC and/or DIRD to ensure that the misdeployment of the removed BMW airbag in September 2016 and the incident in the Northern Territory in April 2017 were notified to the public in a manner which identified that the Commonwealth Government held real concerns about the grave risks posed to Australians by defective Takata airbags… Had this occurred, Mr Ngo's family may have been alive to the nature of the risk posed by the airbags in the Vehicle at an earlier time, and Ms Chea might accordingly have taken steps to have the airbags urgently replaced well before 13 July 2017.

***Sixthly,*** DIRD's satisfaction with Honda Australia's replacement rates for the 5ZV recall at all relevant times between 2015 and 13 July 2017 was reflective of the rectification rates for those vehicles when compared to benchmark replacement rates for other recalls or attained by other manufacturers, and other steps taken by Honda Australia in that period. However, DIRD's reliance on benchmark completion rates based on historical average recall performance was inapposite …, and Honda Australia's relatively high rectification rates for the 5ZV recall as compared to those benchmarks and to completion rates for other manufacturers was a reason why DIRD (and, in turn, the ACCC) did not focus on scrutinising Honda Australia's messaging for the 5ZV recall as much as should otherwise have been the case.

In this regard, even though Honda Australia's replacement rates for the 5ZV recall were relatively high, DIRD's state of satisfaction as to Honda Australia's performance in respect of the 5ZV recall should have been reached (if at all) only on the basis of a complete understanding and awareness as to the nature of the steps that Honda Australia was taking to communicate with consumers, including the mode, frequency and content of its recall correspondence, and on the basis of an assessment by either DIRD (or, to DIRD's knowledge, the ACCC) of the effectiveness of Honda Australia's recall communications. DIRD failed to take the steps needed to ensure it had such understanding and awareness. Again, had DIRD scrutinised Honda Australia's communications with consumers subject to the Takata airbag recalls more closely, prior to 13 July 2017, this may ultimately have led to the Vehicle to be booked in earlier to have its airbag replaced.

***Seventhly,*** there ought to have been a documented process in place prior to 13 July 2017, and which was known to officers of both DIRD and the ACCC, as to the means by which DIRD might make or escalate a request to the ACCC as to the exercise of compulsory powers in respect of the Takata voluntary recalls…

That said, it should be acknowledged that, having regard to the administrative functions in fact exercised by DIRD and the ACCC in relation to the voluntary Takata recalls and the apparent confusion between agencies of their respective roles …, had there been such a documented escalation process in place between 2015 and 2017, this may not have prompted DIRD to seek the ACCC's intervention and exercise of its statutory powers in relation to the recalls at an earlier point in time. From DIRD's point of view, over the period of the voluntary recalls, it was satisfied that manufacturers (including but not limited to Honda Australia) – or at least those manufacturers, which, at that time, DIRD understood to have vehicles fitted with defective Takata PSAN inflators[1055] – were taking appropriate action beyond their normal procedures provided for under the FCAI Code to replace airbags as quickly as possible in the circumstances.[1056]

***Eighthly,*** in the course of the voluntary recalls of Takata airbags between 2015 and July 2017, the ACCC and DIRD missed a number of valuable opportunities, including: (i) to take steps to publicise the misdeployment of the BMW airbag in September 2016; (ii) to take steps to publicise the Northern Territory Toyota misdeployment and resultant injury in April 2017; (iii) to engage in strategies to publicise the Takata airbag recalls more generally such as by issuing media releases; (iv) to suggest improvements to the language of Honda Australia's recall communications in the context of the publication of notifications on the Product Safety Australia Website; (v) to take up Professor Nottage's concerns about Honda Australia's recall correspondence including the language of "precautionary"; (vi) to recommend that the Minister issue a safety warning notice in relation to the risks posed by Takata airbags prior to Mr Ngo's death; and (vii) to take up an offer by Honda Australia for the provision of funding for a joint media/advertising campaign.[1057]

Having regard to these missed opportunities, DIRD and the ACCC could and should have done more to increase transparency and publicity around the risks posed to Australians by defective Takata airbags in the period leading up to Mr Ngo's tragic death.[1058] Had DIRD and the ACCC taken up these various missed opportunities (or some or any of them), this likely would have sped up the process of the voluntary recalls, in terms of the number of consumers taking action to have their vehicles rectified.[1059] It may also have led to the defective airbags in the Ngo Vehicle having been replaced well before 13 July 2017. Nonetheless, it will never be possible to know, with any degree of certainty, how these measures, individually or collectively, might have impacted upon Mr Ngo's vehicle and any steps taken prior to 13 July 2017 to have the driver's airbag therein rectified".

716. As indicated above the ACCC and DIRD have responded to these submissions resisting much of what is put forward by Counsel Assisting. I deal with each on a sequential basis as put forward by Counsel Assisting:

[1055] Tpt 915.30-916.35.
[1056] Tpt 857.10-858.16; Tpt 980.11-.21.
[1057] Tpt 1660.32; Tpt 1766.29-1768.2.
[1058] See Tpt 1768.13.
[1059] See Tpt 1768.26-.43.

## 1. Was there a lack of clarity and substantial confusion between ACCC and DIRD as to their respective roles in the monitoring of the Takata airbags voluntary recalls generally and specifically in regard to the 5ZV recall

717. Counsel for DIRD submit that there was no confusion, substantial or otherwise and prefer to use the term "a misalignment of understanding". They submit that the misalignment of understanding was confined to tasks of marginal relevance which have not been shown to have had any significant effect resulting in any act or omission which could be said contributed to Mr Ngo's death. Counsel for the ACCC agree with this argument and submit that though there was a lack of clarity in relation to the boundaries of the respective roles there was no confusion about the basic nature and content of each agency's role. Counsel point to there being active co-operation between the agencies, frequent email contact, monthly meetings, collaboration and sharing of information and from mid-2016 their joint attendance at the quarterly TAWG meetings.

718. Counsel for DIRD submitted that Mr Grimwade's and DIRD's divergent views about the roles DIRD and the ACCC played during the recall only came to light after Mr Ngo's death and as he had occupied his role only from April 2017, it is not evidence of any misunderstanding that actually existed between mid-2015 – 2017.

719. Mr Grimwade's evidence was given on behalf of the ACCC. If DIRD's submission goes to Mr Grimwade having expressed a divergent view after the relevant period as demonstrating that there was no misunderstanding during that period, I note that when Mr Grimwade gave evidence in the inquest he said that he did not know, until he heard the evidence from Ms Nyakuengama, that DIRD did not in fact review consumer recall letters. Just because this was not realised until later it does not mean that the misunderstanding did not exist at the relevant time. The misunderstanding prevails until it is corrected which Mr Grimwade, on behalf of the ACCC, sought to do in August 2017.

720. Counsel for DIRD point to Mr Thomas's concession of "low-level confusion" as only relating to suppliers not being sure about to which government agency they should be providing information. That is incorrect. Though Mr Thomas did raise the understanding of suppliers, he did so when he was giving evidence about which agency had responsibility to do what task. That the suppliers also experienced confusion about the respective roles of the ACCC and DIRD in the Takata recalls only adds to the substance of Counsel Assisting's submissions.

721. Counsel for both DIRD and the ACCC emphasise that the management of a voluntary recall was the responsibility of the supplier, relevantly in this matter, Honda Australia. Counsel for DIRD describes the supplier as the lead or primary manager of its own recall. Whilst the suppliers are responsible for their recall the ACL creates a legislative regime for a supplier to comply with and charges the Australian government through its agencies with responsibility to ensure that the supplier removes its unsafe product from the Australian market and public use as quickly as it can to minimise the risk to the Australian public. Reliance on such submissions tend to minimise the role of the government agencies as well as any consequence for any failure of that role. That said, the fact that the recall was voluntary and the fact that DIRD did not fully understand its role to involve scrutiny of a recall strategy including consumer letters may have contributed to the industry's position not to widen the recall campaign beyond personal letters to consumers prevailing. That those letters, at least in regard to 5ZV, were inadequate in their messaging of defect and risk, in my view, does fairly raise the question of whether the public, and specifically the Ngo/Chea family, would have otherwise had the airbag replaced thus preventing Mr Ngo's death.

722. Whilst Counsel for DIRD acknowledge that DIRD's role in regard to the recall was to "ensure that the recalls notified under the ACL are progressing at an appropriate rate" and that DIRD's role in relation to when a recall is notified is to determine from a technical perspective whether the proposed rectification will address the defect, they do not embrace a wider role.

723. Counsel for DIRD submits "the Department does not have specialist expertise in the conduct of recalls" whereas the ACCC seems to assume it did by referring to DIRD as the specialist regulator. The ACCC, through Mr Grimwade, identified DIRD as the specialist regulator responsible for vehicle recalls. Counsel for DIRD argues that as DIRD does not possess any regulatory powers this is not a correct descriptor.

724. The MOU adopted by both the ACCC and DIRD identifies that DIRD take the lead in monitoring recall progress and engaging with suppliers about improving their recall strategies, yet DIRD thought the ACCC as armed with legislative empowerment occupied that position. In my view, to describe this as a misalignment of understanding is a seismic understatement because it is an issue that goes to the core of the agencies' respective functions in a motor vehicle recall.

725. Counsel for DIRD and the ACCC refer in their submissions to the correspondence sent by the ACCC to the NRMA in October 2015 and to Professor Nottage in late 2015. Both agencies position the success of the collaborative nature of the joint roles of both the ACCC and DIRD and reject Counsel Assisting's submission that the confusion as to roles was of consequence. Counsel for DIRD highlight that the ACCC articulated in its letter to the NRMA that the ACCC "actively monitors the progress of the recall". The ACCC submissions put forward that DIRD "was the agency that monitored voluntary recalls of vehicles… As a result, it had a far more nuanced and detailed understanding of the elements, progress and effectiveness of the suppliers' Takata recalls than the ACCC. The ACCC's understanding of the recalls developed over time, in particular through its attendance at TAWG meetings from June 2016". This submission is consistent with Mr Grimwade's evidence that in his view Mr Ridgeway's letter to Professor Nottage overstated (as at late 2015) the role of the ACCC. It is my view that the ACCC letters sent respectively to the NRMA and Professor Nottage overstated the engagement of the agencies in the voluntary recall to the point that the letters assuaged rather than addressed the concerns of both the NRMA and Professor Nottage.

726. In any event it would appear that the issue was not raised directly with Honda Australia. Whether this was due to the ACCC's acceptance of Honda Australia using the terms "preventive measure" and "precautionary" or whether it was because the ACCC believed that DIRD was going to discuss it with Honda Australia in the next TAWG meeting is unclear. Either way there was no request by the ACCC to DIRD to raise the issue with Honda Australia on behalf of the ACCC or on its own account which is, in itself, indicative of a lack of any clear allocation of responsibilities as between the ACCC and DIRD.

727. That the ACCC considered DIRD the lead regulator in a motor vehicle recall is consistent with the MOU. However, that DIRD did not share that understanding is not a mere misalignment of understanding with minimal to no effect. A clear allocation of regulatory roles is fundamental to the operation of a recall. As a result of not understanding its role, DIRD did not have a policy or any fulsome written document setting out the processes to be followed in the recall. DIRD did not review each recall strategy as contemplated by the ACCC Guidelines. To explain why DIRD did not receive and review Honda Australia's recall strategy for the 5ZV recall, Counsel for DIRD pointed to the ACCC Guidelines indicating to the supplier that its recall strategy was to be submitted to the ACCC. Though the ACCC understood that the supplier recall strategy was not being submitted to it as DIRD

was the lead regulator, the ACCC did not know that DIRD did not have any process of its own in regard to the suppliers' recall strategies nor did it know that the suppliers were not submitting their recall strategies to DIRD. Counsel for DIRD correctly make the submission, which is supported by Counsel for the ACCC, that it was the suppliers who had primary responsibility for the recalls, under the guidance of the FCAI Code. However, as discussed above at paragraphs [352]-[354] and [363]-[366], there were difficulties for suppliers in knowing how the FCAI Code was to interact with the ACCC guidelines.

728. Counsel for the ACCC submitted that there was no confusion between itself and DIRD about the ACCC being responsible for the publication of notifications on its PSA website. Counsel pointed to there being times when there was a need to contact DIRD about technical language and also to the evidence that, in June 2015, the ACCC engaged with suppliers about the contents of the notifications on the website.

729. I accept that it was ultimately the ACCC and not DIRD that had any negotiations with suppliers about settling the contents of notifications to be published on the PSA website. However, the June 2015 emails referred to by counsel for the ACCC relate to the collection rather than the negotiation of notifications to be published.

730. Though Honda Australia intended to include the term "precautionary action" as set out in its notification of the 5ZV recall, the ACCC did not include that term in its notice published on the PSA website. Though Mr Grimwade acknowledged that the information published on the website was inadequate as to description of defect, hazard and risk, counsel for the ACCC submitted that it was at relevant times appropriate given what was then known by the ACCC about the defect and hazard and risk.

731. Counsel for the ACCC submitted in this regard that it was not until the arrival of the Blomquist Report that the ACCC had a proper basis to make enquires with suppliers, in this case Honda Australia, as to the way in which they were communicating the risks posed by Takata airbags, including in relation to the description of the defect on the PSA website.

732. The reason that this was not done appears to be due to lack of guidelines or process. According to Mr Grimwade's evidence that has now changed and the ACCC has implemented a process which requires suppliers to update the ACCC as to information to be placed on the website.

733. However, I do not accept the ACCC submissions that the ACCC had no basis to challenge or question Honda Australia's description of the defect, hazard and risk contained in the 5ZV recall notification. It should have sought to clarify whether the defect would have the same effect and risk as other Takata airbag defects – namely the "inflator rupture causing metal fragments" to strike a vehicle occupant. Without clarifying whether the 5ZV recall involved the same hazard as then known to exist with the previous recalls, given there was no evidence suggesting that there was some other hazard, it would seem that the ACCC, DIRD and the suppliers proceeded on the basis that it was the same hazard but because the recall was classified as "precautionary" or "preventative" the hazard wasn't appropriately described. That it was not clarified or corrected resulted in a failure to ensure that the public was adequately warned of the dangers of the defective airbags. Likewise, as previously discussed, Honda Australia failed to make due inquiry with Honda Japan in this regard though appeared to be aware that Honda Japan was using the terms preventative and precautionary as discussed above.

734. Counsel Assisting's phrase of "lack of clarity" or "substantial confusion" is a measured term and the submissions advanced by DIRD and the ACCC demonstrate rather than diminish the disparity between the ACCC and DIRD as to their understanding of their respective roles and responsibilities when there is ample evidence that such disparity existed.

**2. <u>Should DIRD have obtained expertise to evaluate the effectiveness of Honda Australia's consumer recall letters</u>**

735. Counsel for DIRD submit that DIRD did not have sufficient staff or the expertise to evaluate the efficacy of consumer recall letters and that it did not have a media unit to engage in public announcements on its own account. DIRD submit that it should not have been expected to seek such resources or expertise by obtaining the services of an expert or by making a request of the ACCC.

736. As to this, counsel for DIRD submit that Counsel Assisting's submissions amount to stating that DIRD should have done something that it was not DIRD's function to do at all. Though the MOU says that DIRD "takes a lead role in monitoring recall progress and engaging with suppliers about improving their recall strategies", the MOU did not specifically refer to the ACCC Guidelines being guidelines that would apply when DIRD was the leading agency in a voluntary recall. This anomaly was not identified by either DIRD or the ACCC. Likewise, the MOU does not identify what the ACCC's role, as the non-leader was – the ACCC suggests that it had no

role unless there was a specific request made of it by DIRD. However, the MOU does not identify that is the case.

737. Whilst it would seem that the ACCC may have ordinarily carried out the task of assessing the efficacy of consumer correspondence, as evidenced by Mr Wright and Ms Atkinson's correspondence in June 2015, according to Mr Grimwade's evidence, the ACCC did not engage in such process after that time. It would appear that the ACCC did not tell DIRD that DIRD was solely required to carry out that role. Despite the close working relationship between DIRD and the ACCC throughout the period during which the inquiries of the NRMA and Professor Nottage were made in late 2015, it seems that that in spite of those inquiries neither agency realised that the other was not carrying out those tasks. DIRD had sufficient expertise to fulfil a role limited to a technical appraisal of a supplier's recall notification to ensure that the remedy would repair the defect, however it lacked expertise in relation to assessing the efficacy of consumer recall letters.

738. It is on that basis I find that DIRD should have acquired expertise in that regard whether it was by liaising with the ACCC or otherwise.

**3. <u>Should DIRD and the ACCC have directly raised with Honda Australia that its consumer recall letters should not include tentative language such as "preventative measure" and "precautionary action" and that the letters did not clearly refer to the nature of the defect and the risk of death or injury in 2015 and 2016.</u>**

4. **<u>Should DIRD have sought from Honda Australia the 5ZV consumer recall letters.</u>**

739. On 21 August 2015 DIRD requested Honda Australia to provide copies of consumer recall letters to date but at that stage the 5ZV consumer letters had not been drafted by Honda Australia. Counsel for DIRD does not take issue that DIRD should have had a system in place to request, receive, analyse and make any requisitions relating to consumer recall letters but does correctly point out that DIRD did convey to suppliers in the TWG meetings the importance of consumer letters clearly expressing the hazard.

740. About a month prior to the commencement of the 5ZV recall Honda Australia provided to DIRD copies of pro forma recall letters rather than copies of letters specifically sent for individual recalls. DIRD did not specifically request letters for the 5ZV recall and it should have done so even if it was to carry out the limited role

DIRD identified as one of its tasks – namely to ensure that the defect and risk was correctly described. DIRD should have obtained at least one of the 5ZV recall letters by following up the request made in August 2015 or preferably by specifically making a new request for the 5ZV recall. Had DIRD received the 5ZV recall consumer letter/s, it appears unlikely that DIRD would have identified and taken action in respect of the issues which were concerning to Professor Nottage in late 2015 or indeed Mr Thomas in mid-2015 in relation to the letter he received for his own Honda vehicle. Those issues should have identified and been formally raised with Honda Australia. Again, whether DIRD would have done so had it obtained a copy of the 5ZV consumer letter is questionable given its position as to DIRD's limited role and function. At the least it should have identified that the defect and risk were inadequately described in that it did not mention that metal fragments could cause injury or death to a vehicle occupant.

741. Likewise, the issues raised by Professor Nottage in 2015 should have been formally raised with Honda Australia by the ACCC or by DIRD at the request of the ACCC. There was no process in place for DIRD to be tasked with raising it directly with Honda Australia. Raising it generically in a TAWG meeting was, in the circumstances, inadequate.

**5. <u>Should, prior to July 2017, the ACCC and/or DIRD have taken steps to publicise the risks posed by defective Takata airbags by way of its own media announcement or by co-ordinating a media campaign with the industry.</u>**

742. Under the MOU the ACCC required DIRD to make a request to the ACCC to publicise the recall. DIRD considered that the ACCC had the media resources and regulatory authority to publicise and yet DIRD did not make any request of the ACCC nor did DIRD release any media statements of its own.

743. It is unclear as to whether this was due to the confusion of roles and responsibilities or whether it was due to a shared position that neither the ACCC or DIRD (or Honda Australia and other industry generally) were keen on receiving media interest let alone creating interest. Mr Grimwade said in his evidence that he was not aware until the inquest of the media posture adopted by DIRD but given the joint drafts of the media brief and other communications between DIRD and Mr Thomas' counterparts at the ACCC it is apparent that it was a position shared by the ACCC at the relevant time.

744. Counsel for Honda Australia submits that the supplier's task is to rectify the defect and that the government's obligation is to keep the public safe and, consequently, it was the government's responsibility to bring the Takata airbag safety issue to the public's attention by public announcements. That submission does not point to there being any statutory duty upon either the ACCC or DIRD to do so.

745. However, it is necessary to reiterate that it is a motor vehicle supplier's responsibility not to jeopardise the public's safety in the first place so when it does so, the supplier is rightly required to remove the risk to the public safety - as quickly as possible and by all means possible without regard to brand reputation and marketing protection. According to the FCAI Code the resources that may be deployed to do so include public announcements and public advertising and media campaigns so that the relevant risks are brought to the public's attention and the public will take action by responding to the recall.

746. Despite the Takata airbag recalls being amongst the most significant world-wide vehicle recall campaign ever, Honda Australia did not engage in any public information campaign during the voluntary recall period. Rather, Honda Australia at least in relation to the 5ZV recall, elected to limit its reach to consumers by private postal mail correspondence using technical and tentative language. It appears that though Honda Australia at one point considered a wider campaign, at least for certain affected vehicles, its position was that it would only pursue this if other suppliers participated – apparently a marketing and financial consideration. That other suppliers, particularly any with unsatisfactory rectification rates, did not want to engage in such an advertising campaign to improve consumer response, did not cause either DIRD or the ACCC to consider whether some agency involvement was required so that the recall was publicised. This is regrettable.

747. It would appear that neither the ACCC nor DIRD impressed upon industry the need for suppliers to utilise wider public recall strategies as set out in the FCAI Code; for DIRD's part it did not identify such engagement as being within its role as the recall was a voluntary recall and for the ACCC's part, DIRD did not make any request in this regard to the ACCC .

748. Mr Matthew's emails and the notes of the meeting between the ACCC and DIRD on 12 May 2017 indicate that the ACCC was questioning the narrow scope of the recall strategy commenting that the FCAI Code didn't appear to be working and that the rectification rates were too slow. I accept counsel for the ACCC and DIRD's submissions that it was for the suppliers to co-ordinate and promote an

advertising campaign, and though the ACCC and DIRD could encourage a wider campaign, neither agency had power to compel one. However, rather than adopting a reactive media posture which on one view could be thought to resemble a reluctance to publicise the Takata recalls, both agencies could have adopted a pro-active media posture on their own accord as well as encouraging industry, and in this case Honda Australia specifically, to engage in a public campaign.

749. Whilst the recall was voluntary and neither agency had powers to compel the industry to adopt such a strategy (in the absence of any compulsory recall then having been commenced), a supplier's refusal or failure to engage in such a campaign strategy could have been an escalation criteria by which the agencies could measure the progress of the recall, and which may have motivated industry to engage in such a campaign. Advertising campaign aside, the MOU allowed for the joint settling of media releases issued by the ACCC or DIRD. The only media release that was prepared related to what would be issued in the event of a misdeployment event, rather than considering how the government could bring the recalls to the attention of the Australian public, for the sake of the public safety, in advance of any such incident. As Professor Nottage wrote to Mr Ridgeway at the ACCC at the end of 2015, a government media release incurred no cost. There is no good reason why DIRD and the ACCC failed to issue such a release. Likewise, there was no good reason why Honda Australia failed to do so, particularly given the scale of the recall.

## 6. Should DIRD in its monitoring of the voluntary recalls have relied on more than the "Benchmark rectification rate" in measuring the progress of the 5ZV recall

750. It is uncontroversial that Honda Australia far surpassed other vehicle suppliers' Takata airbag recall rectification rates at all times. Counsel for DIRD submit that there is no evidence to support a finding that the application of any benchmark recall standard resulted in DIRD or the ACCC failing to scrutinise Honda Australia's consumer communications. Counsel for DIRD submit that any failure in this regard was due to this not being identified by DIRD as its role in the first place.

751. The benchmark is based on historical average recall performance applicable to motor vehicle recalls. Counsel for Honda Australia point out that the evidence in relation to Honda Australia's engagement with DIRD and the TAWG would point against making the finding contended for by Counsel Assisting.

752. In that regard counsel for Honda Australia submit that at no time did DIRD give Honda Australia any negative feedback which is I think Counsel Assisting's point – the negative feedback that could have been given would have been to change the 5ZV consumer recall letter and adopt a wider media strategy. In any event, given that DIRD was only meeting with the TAWG every 3 months and was not dealing with each supplier individually and was adopting a thematic approach, the adherence to a benchmark standard was appropriate provided that it accompanied other strategies such as ensuring good consumer communications. Counsel for Honda Australia emphasise that Honda Australia was receptive to DIRD's suggestions and interventions. Whilst that is correct, those suggestions and interventions did not go to these specific issues, and indeed when Honda Australia advised DIRD that they would not proceed with a wider media campaign, DIRD did not at that or any time seek to change that position.

**7. <u>As part of the recall monitoring process, ought there have been a documented process setting out the criteria and means for DIRD to make a request to the ACCC to consider using compulsory powers</u>**

753. Counsel for the ACCC point out that though Mr Thomas gave evidence that he considered that it was part of DIRD's role to consider whether a matter should be referred to the ACCC for consideration of the exercise of compulsory powers, in any event the ACCC can take such action on its own account. Counsel for DIRD submit that as there was at no time a determination that there should be an escalation to use of any ACCC statutory powers, the fact that there was or wasn't a written process is of no significance. It is my view that a written escalation should have been available, as indeed a written policy or process for DIRD to follow in monitoring a voluntary recall should have been available. It is a feature of good administrative practice for any organisation, but particularly a government organisation, to have such structure and documentation. If there had been such a document, which was known to both agencies as well as industry and the public, the expectations generated thereby would have been a useful means and measure of accountability and appropriate progress and process.

**8. <u>If the ACCC or DIRD had not missed the opportunities to bring the defect and risk of the Takata airbag to public notice, is it likely the Ngo/Chea vehicle airbag would have been replaced earlier thus preventing Mr Ngo's death</u>**

754. Counsel Assisting identify seven events which would have been opportune moments for the ACCC and/or DIRD to publicly announce the safety risks or cause the notifications on the PSA website to adequately describe the defect, hazard and risk or improve the Honda Australia consumer letter for the 5ZV recall.

755. Counsel for DIRD do not take objection to the categorisation of those events as missed opportunities. Nor does the ACCC. However, Counsel for DIRD submit it is unfair to advance the proposition that the recall process would have sped up if those opportunities had been taken because Counsel Assisting did not specifically articulate the term "lost opportunity" in the examinations of Ms Nyakuengama and Mr Thomas during the inquest. Given that DIRD does not take exception to the categorisation of the events as missed opportunities and did not challenge Mr Grimwade on his acceptance of them as such I do not accept that the proposition is unfair. Throughout the inquest DIRD was aware that its actions and inactions were being considered in terms of the manner of Mr Ngo's death and it had the opportunity to call evidence and make submissions. There is no basis to Counsel for DIRD's claim of a lack of procedural fairness in this regard.

756. Counsel for the ACCC and DIRD resist a finding that the missed opportunities, or indeed any action or inaction of either agency, contributed to Mr Ngo's death. I note that Ms Chea and her family did not know about the Takata airbag recall and when in March Ms Chea did learn of it having collected the registered letter, she had, within the week, booked the vehicle into Peter Warren's service department for recall replacement. Had she learned of the defect earlier, it would appear that she would have made an earlier appointment. Likewise, had Julie Ngo been aware of the risk of the defective airbag she would have likely insisted that it be replaced on 11 July 2017. Whilst it is not possible to conclude that any action or inaction of the government agencies did contribute to Mr Ngo's death, it is likewise not possible to conclude any action or inaction on their part did not contribute to Mr Ngo's death.

757. Counsel for DIRD point out that Ms Chea says that she only received the March 2017 letter. That is the one she responded to. That letter had a clearer content consistent with the Blomquist Report and correctly identified the defect, hazard and risk. Had that information been contained in an earlier letter and received by Ms Chea or a family member then it is likely the Vehicle would have been booked in at an earlier time. Had there been public announcements then other persons

who had received the earlier letters may have been able to identify the importance of the recall and brought it to Ms Chea's attention.

758. As is apparent from the foregoing responses, I agree with the position advanced by Counsel Assisting. I make the finding that due to a lack of clarity and at times substantial confusion as to the respective roles of DIRD and the ACCC, together with the lack of a documented escalation process against which to monitor and advance the progress of the recall, the ACCC and DIRD inadequately administered and monitored the Takata Airbag voluntary recalls during the period July 2015 to July 2017. The inadequacy particularly arose in that there was a failure to ensure that the defect and hazard of the Takata airbag subject to the Honda Australia 5ZV recall was properly described to the Australian public on the ACCC's PSA website, in the Honda Australia letters to consumers, or by Australian public media broadcasts in a timely and adequate manner.

***Recommendations in respect of future monitoring of voluntary recalls by DIRD and ACCC***

759. Counsel assisting suggest a number of recommendations to facilitate the monitoring and regulation by the ACCC or DIRD, as applicable, of future (voluntary) product recalls involving motor vehicles and/or components:

> ***"First,*** a recommendation that: (a) in the case of a voluntary recall of motor vehicle componentry, relevant written protocols are put in place (to the extent not done already) and made publicly available as to the assignment of responsibility as between DIRD and the ACCC for reviewing the effectiveness of consumer recall communications, in terms of their communications style and likelihood of prompting a consumer response, and that relevant training in consumer communications be undertaken by officers to whom such a task is allocated; and (b) that any recall guidelines published by DIRD or the ACCC, including any updated version of the ACCC Guidelines, are consistent with such protocol.
>
> ***Secondly,*** a recommendation that: (a) DIRD reconsider its reliance upon benchmark recall completion figures, based on aggregated data from historical voluntary recalls, as a means of assessing the efficacy of voluntary recalls related to defective airbags or other motor vehicle componentry; and (b) that DIRD consider developing (and making publicly available) written protocols against which the efficacy of a supplier's recall efforts are assessed by reference to a comprehensive risk assessment, in addition to rectification rates and an assessment of the strategies deployed by the supplier to implement the recall.
>
> ***Thirdly,*** a recommendation that steps be taken by DIRD and the ACCC to finalise (to the extent not already done) a policy document outlining the applicable "escalation process" as between DIRD and the ACCC, in relation to the exercise of powers under the ACL in respect of motor vehicle recalls for which DIRD has assumed the relevant monitoring role. Such a document

(which should be made publicly available) could incorporate the process for DIRD to request the ACCC to recommend the exercise of compulsory powers under the ACL in relation to a motor vehicle product, and the considerations to be taken into account by the ACCC in determining whether to do so.

***Fourthly,*** a recommendation that, to the extent not done already, a written protocol be developed by DIRD and the ACCC (and made publicly available) that makes clear to motor vehicle suppliers:

a. the respective roles of DIRD and the ACCC in relation to a product recall of motor vehicle componentry (and how this might be ascertained for a given recall); and

b. the process that needs to be followed by suppliers if it is sought that information provided to DIRD / ACCC about a safety defect is to be treated as commercially sensitive or confidential, and DIRD and the ACCC's general position about such requests;[1060]

***Fifthly,*** a recommendation that DIRD and / or the ACCC take all reasonable steps to share with Australian vehicle suppliers, police authorities, coronial units and any other relevant regulators with an interest in motor vehicle recalls, information obtained from overseas sources, or other Australian suppliers, about the risks posed by defective Takata airbags and all reported incidents of misdeployment.[1061]

***Sixthly,*** as the experience of this inquest has demonstrated, it is highly desirable that Commonwealth regulators exercise direct oversight and regulatory control as to the design, chemistry and mechanical specification of airbag components, whether as a consequence of provision being made for this in the ADRs or otherwise through the development of a relevant standard. Ms Nyakuengama gave an example of how DIRD's long-standing work with pole side impact standards has led to additional occupant protection standards related to pole impacts becoming mandatory in Australia."[1062]

760. As to the sixth matter Counsel Assisting advance that it would be open for me to recommend that consideration, or continued consideration, be given by DIRD to taking steps to explore the feasibility of all or any of: [1063]"

a. the development of an applicable (international) standard in respect of airbag performance and vulnerability to misdeployment;

b. extending the existing ADRs specifically to cover the performance of airbag mechanisms; and

c. a product ban being imposed (including by the ACCC's responsible Minister, upon a recommendation being made by DIRD) on airbag models

[1060] See Tpt 1403.18-.30.
[1061] See evidence at Tpt 884-885, 889-890.
[1062] Tpt 992.1-.26.
[1063] See Tpt 991-993.

or airbags that use certain chemical components that are known to pose a safety risk.

761. DIRD is largely in agreement with proposed recommendations 1-4 as referred to at paragraph [759] above and points out that there is to be a development of protocols and guidelines in furtherance of its new role under the RVS legislation in any event. Likewise, the ACCC is supportive of proposed recommendations 1-4, and points out the process in relation to 1 and 2 is already underway and remarks that in relation to 4(b), for its part, protocols already exist. The ACCC points out the change of interaction as between DIRD and the ACCC regarding motor vehicle recalls upon the commencement of the RVSA on 1 July 2021. It is expected that the ACCC will have a continuing role in relation to voluntary recalls where DIRD has the equivalent powers under the RVSA. The inquest did not hear evidence in relation to the anticipated interaction between the agencies as to the escalation of a voluntary recall to a compulsory recall under the new scheme but the ACCC submitted that though they agreed with the recommendations that the respective roles should be clarified in the MOU, such utility would cease on 1 July 2021.

762. Regarding recommendation 2 relating to monitoring by reference to benchmark rectification rates, DIRD indicates that there will be a priority rating of recalls dependent on the risk assessment and that such rating will be subject to ongoing review. The recommendation should include the words “extent of “reliance as it is not intended that there be no reliance at all. I note that counsel for DIRD pointed out that it is practically impossible for DIRD to undertake a comprehensive risk assessment for every recall as there are generally 250 voluntary recalls relating to motor vehicles each year.

763. At paragraph [516b] I have set out the recommendation in relation to the fifth matter advanced by Counsel Assisting.

764. Honda Australia oppose the making of a recommendation relating to the airbags being subject to an Australian Design Standard, submitting that it is not feasible for Australia to take any such approach as it is 100% reliant on overseas manufacturers. Counsel for the ACCC, whilst noting that the recommendation is addressed to DIRD, does not support the possibility of a product ban being imposed for certain types of airbags, pointing out that such would involve specifying a vehicle, not an airbag, as product bans are directed at the supply in the course of trade or commerce of consumer goods. Counsel for the ACCC also

note that there is a separate regime for developing safety standards that apply to the product.

765. Counsel for DIRD submits that a “standard” may not the appropriate tool as the current ADR 69/00 Full Frontal Impact Occupation Protection is a performance based standard which recognises the importance of all vehicle safety systems working in concert to protect the vehicle occupants. Counsel for DIRD also points out that the majority of vehicles supplied to the Australian market are imported, but only represent less than 1% of the total world production of motor vehicles. The government seeks to ensure that the ADRs are consistent with the international regulations adopted by the United Nations, except where it is necessary to take account of unique Australian conditions. Such a regime provides consumers with access to the safest vehicles from the global market at the lowest possible cost. Further, there are a range of airbag technologies and products and the issues associated with Takata PSAN and NADI airbags do not appear to be encountered by other airbags. Counsel for DIRD acknowledged that it may be appropriate for DIRD to consider the feasibility of a standard relating to the lifespan of airbags in the Australian context.

766. The lifespan of an airbag, specifically relating to the potential for the degradation of the combustion chemical over time, particularly in the thermal cycle of a vehicle over a time span, was identified in the Blomquist Report, and the consideration of whether or not an airbag should be replaced at a particular age is a matter that DIRD is equipped to investigate and give consideration to. Counsel Assisting point out that the recommendation is only directed to DIRD considering the issue. Ms Nyakuengama’s evidence briefly summarised the difficulties such a scheme would present to the Australian market.

767. I decline to make the sixth recommendation as sought. Even though the issue has merit, it was an issue that was touched upon rather than being sufficiently explored during the inquest. However, the issue as to the management of consumer safety regarding the lifespan of an airbag is an issue which sufficiently arises on the evidence and is a matter which can be focussed upon by DIRD.

768. Accordingly, in relation to the sixth matter advanced by Counsel Assisting, I recommend that DIRD consider engaging in a study to assess the feasibility of setting a Standard relating to the propellant and the lifespan of airbags in the Australian context.

769. I make the recommendations one to four advanced by Counsel Assisting but they are adjusted to take into account that DIRD indicated its engagement with advancing the matters set out therein and the changed position between DIRD and the ACCC with the commencement of the RVSA.

## N. Steps taken to impose registration sanctions in NSW in relation to vehicles with defective Takata airbags

### *Overview of Registration Sanctions*

770. There is no system in New South Wales or Australia whereby the relevant State or Territory motor vehicle registration authority (**STRA**) is automatically notified when a recalled vehicle is not rectified. Further, a failure by a consumer to respond to a voluntary recall initiated by a supplier under s 128 of the ACL or a compulsory recall initiated under s 122 of the ACL does not necessarily result in a vehicle being ineligible for registration under State and Territory road transport laws.[1064]

771. According to information provided by the ACCC, since November 2017, the ACCC has sought to improve the effectiveness of the Takata recalls by proposing registration sanctions by STRAs to motivate consumer responses to the recall. [1065] Over time, the STRAs have progressively determined to implement a registration sanction to help effectively ensure that vehicles with alpha airbags are removed from Australian roads. All States have now implemented a registration sanction scheme for vehicles fitted with alpha inflators, and several (including New South Wales) have also implemented a scheme regarding all vehicles containing Takata airbags with critical status.[1066]

772. To facilitate STRAs imposing registration sanctions, the ACCC provided STRAs with VIN lists of affected vehicles; initially only for alpha airbags but subsequently for critical non-alpha airbags and lastly for all airbags affected by Takata recalls.

773. The ACCC also provided STRAs with lists of VINs for vehicles subject to approved applications pursuant to section 5(3) of the Compulsory Recall Notice,[1067] where suppliers who have been unable to locate and contact vehicle owners can apply to the ACCC for assessment of their compliance with their airbag replacement obligations under the Compulsory Recall Notice.

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[1064] See Exhibit 1, 10A/109J/3180-63 at [4.1].
[1065] See Exhibit 1, 10A/109J/3180-63 to 66 at [4.2(b)]-[4.16].
[1066] Exhibit 1, 14/140/3969 at [11].
[1067] Exhibit 1, 14/140/3969 at [15].

774. Mr Grimwade referred to there having been some delays within the ACCC in assessing suppliers' section 5(3) applications, but said that steps had been put in place to reduce those delays[1068] so that STRAs may impose registration sanctions without waiting for the ACCC to provide a relevant section 5(3) approval.[1069]

775. The inquest received evidence about the engagement of DIRD, the ACCC and STRAs in relation to overcoming the difficulties posed to suppliers by incomplete or incorrect NEVDIS information. However, Honda Australia appears to have held[1070] correct contact details in relation to Ms Chea from around the time of the first 5ZV recall letter of November 2015. Accordingly, findings about the steps that have been taken generally in relation to that issue do not arise.

***Steps taken in NSW for vehicles subject to the Compulsory Recall Notice***

776. On 15 February 2019, the *Road Transport (Vehicle Registration) Regulation 2017* (NSW) (***RTVR Regulation***) was amended in response to the Takata Recall so as to give Roads and Maritime Services (now TfNSW) the authority to refuse, suspend or cancel vehicle registration in cases where a compulsory recall is outstanding on the vehicle: see *Road Transport (Vehicle Registration) Amendment (Consumer Recalls) Regulation 2019* (NSW) (**Amending Regulation**).

777. The Amending Regulation relevantly inserted the following subclauses into the *RTVR Regulation*:

> "**Clause 6 Registrable vehicles eligible to be registered**
>
> (3) The Authority may also refuse to register a registrable vehicle if the Authority is satisfied that the vehicle, or any part of the vehicle, is subject to a recall notice under section 122 of the Australian Consumer Law.
>
> **Regulation 45 Suspension or cancellation of registration by Authority**
>
> (1) The Authority may suspend or cancel the registration of a registrable vehicle in accordance with this
>
> Division if:
>
> ...

[1068] Exhibit 1, 14/142D/4058-3 at [8]; Tpt 1528.1-.29.
[1069] See Tpt 1528.46-1529.34.
[1070] Honda Australia obtained NEVDIS records and created a spreadsheet of addressee's details which were provided to DMC for a mail out – the NEVDIS records must have contained Ms Chea's correct address as it was apparent from the transcript of the telephone conversation recorded by Honda Australia's recall centre on 30 March 2017 that Honda Australia's database did not have Ms Chea's current address or correct contact phone number

(o) the vehicle, or any part of the vehicle, is subject to a recall notice under section 122 of the Australian Consumer Law."

778. According to Julie Morgan, who gave evidence before the inquest on behalf of TfNSW, prior to the introduction of the Amending Regulation, TfNSW did not have any powers to impose a registration sanction on vehicles fitted with a defective Takata airbag under recall.[1071] Since its introduction, the powers conferred under the Amending Regulation have been exercised by TfNSW in respect of registered owners who have been notified of a compulsory safety recall, and who fail to respond within a reasonable time to have the fault rectified.[1072] In this respect, Ms Morgan explained that the steps that have been involved before a registration sanction is imposed, pursuant to clause 45(1) (o) of the *RTVR Regulation*, have included the following:

a. First, the ACCC provides TfNSW on a monthly basis with a list of VIN numbers for affected vehicles (initially this was done for vehicles with an alpha inflator and subsequently for vehicles with a critical non-alpha inflator).[1073]

b. TfNSW then checks that list against its DRIVES system (of registered vehicles in New South Wales) to confirm whether information provided by suppliers directly to TfNSW indicates that there is, in fact, still an outstanding airbag recall on the vehicle.[1074]

c. A warning letter is then issued by TfNSW to the registered owner and a restriction is placed on the vehicle to stop any transactions on it.[1075]

d. Following the warning letter being sent, a notice of intention to suspend registration is sent by TfNSW to the registered owner.[1076]

e. If no action is taken within 28 days, registration of the vehicle is suspended and a letter is sent to the registered owner advising them of the suspension.[1077]

779. Ms Morgan advised that, as at the end of June 2020 the steps referred to above

[1071] See generally, Tpt 1607.43-1609.25.
[1072] See Exhibit 1, 11/112/3324; Tpt 1577.40-.45.
[1073] Tpt 1578.44-.46.
[1074] Tpt 1578.44-.46, Tpt 1579.
[1075] Tpt 1579.10.-.16; Annexure B to statement of Julie Morgan dated 26 June 2020, Exhibit 1, 14/142H/4058-95.
[1076] Annexure C to statement of Julie Morgan dated 26 June 2020, Exhibit 1, 14/142H/4058-96.
[1077] Tpt 1579.18-.25; Annexure C to statement of Julie Morgan dated 26 June 2020, Exhibit 1, 14/142H/4058-97.

have been taken in relation to vehicles with alpha and critical non-alpha airbags, but not in relation to vehicles the subject of the Compulsory Recall Notice with beta airbags.[1078]

780. In addition, according to Ms Morgan's evidence, TfNSW has previously imposed sanctions in relation to vehicles with alpha and critical non-alpha airbags that had been the subject of approved section 5(3) applications under the Compulsory Recall Notice as notified to TfNSW by the ACCC; and TfNSW held an understanding that the ACCC's position was that STRAs should not impose such sanctions before the ACCC had approved the relevant section 5(3) application.[1079] However, by letter dated 16 October 2019, the ACCC advised TfNSW that:[1080]

> "The ACCC supports the use of registration sanctions by STRAs as a tool to improve rates of replacement of faulty Takata airbags in vehicles affected by the Recall Notice. The ACCC initially proposed that STRAs only use such sanctions in respect of vehicles that had been the subject of approved section 5(3) applications (so as not to penalise a vehicle owner who has not been properly notified of the recall). However, once it become apparent that there were barriers to the rapid submission of properly evidenced section 5(3) applications, the ACCC made clear its support of STRAs imposing registration sanctions regarding higher risk vehicles without waiting for an approved section 5(3) application….
>
> More recently, the ACCC has urged STRAs to use registration sanctions for non-critical vehicles as well. While it is a matter for STRAs, for non-critical vehicles, the ACCC recommends that such sanctions only be imposed where there is an approved section 5(3) application.
>
> The ACCC is pleased to hear that RMS is ready willing and able to implement sanctions at any time. We urge RMS to do so immediately for all vehicles with critical inflators…"

781. Ms Morgan's evidence was to the effect that, prior to the ACCC sending this letter dated 16 October 2019; the ACCC had not made clear to TfNSW that it should take steps to impose regulation sanctions without waiting for approved section 5(3) applications.[1081]

782. In contrast, in his statement dated 18 June 2020 Mr Grimwade said:[1082]

> "… the ACCC allows and encourages manufacturers to verify their application in a manner which would allow streamlined processing of the application by reducing the need for the ACCC to verify the

[1078] Tpt 1583.20-.48.
[1079] See Tpt 1603.42-1604.39; Exhibit 1, 14/140/3981.
[1080] Exhibit 1, 14/140/3983 to 3984.
[1081] Tpt 1603.42-1604.39; see also Tpt 1625.15-.19, Tpt 1626.24-.46.
[1082] Exhibit 1, 14/142D/4058-4 at [9].

> adequacy of evidence substantiating the application (in respect of each vehicle). The process (which has been offered since September 2019) allows the manufacturer to simply provide a letter or other written declaration that the manufacturer has completed the required consumer communication processes and has records to substantiate the application which would be available for inspection or audit on request of the ACCC."

783. In his oral evidence, Mr Grimwade was unable to specify the precise time at which the ACCC notified TfNSW that it should take steps to impose registration sanctions without waiting for approved s 5(3) applications.[1083] However, he disagreed with Ms Morgan's evidence to the effect that the ACCC did not make clear that TfNSW could proceed to impose registration sanctions without having to wait for section 5(3) approvals.[1084]

784. On 3 December 2019, Rod Sims, ACCC Chair, wrote to the Secretary for TfNSW, again urging that registration sanctions be advanced "regarding all vehicles with a recall status of critical without waiting for approved section 5(3) applications"; and recommending that "all STRAs extend registration sanctions to affected vehicles with non-critical status". The letter again recommended that sanctions for non-critical vehicles be imposed only where there is an approved s 5(3) application but noted that this was a matter for each STRA.[1085]

785. On 31 January 2020, Stephen Jones, Acting Deputy Secretary of TfNSW, wrote to Mr Sims of the ACCC, stating, *inter alia*:[1086]

> "Transport for NSW agrees with the recommendation in your letter that, considering the stage of the recall and the complexity the ACCC has reported in assessing 5(3) applications from OEMs, the risk associated with outstanding vehicles with a critical status warrants sanction action in the absence of an approved 5(3) application.
>
> The sanction process for NSW registered vehicles with an outstanding critical alpha airbag commenced in November 2019 and on 8 January 2020 the registrations of 136 vehicles have been suspended.
>
> While the ACCC is providing lists of outstanding vehicles, without an approved section 5(3) application Transport for NSW must undertake its own due diligence to confirm that the vehicle owner is aware of the recall, and that the vehicle is still subject to the compulsory recall before suspending the registration. In October

[1083] See Tpt 1677-1681.
[1084] Tpt 1681.39-.44.
[1085] Exhibit 1, 14/140/3987.
[1086] Exhibit 1, 14/140/3990.

> 2019 and December 2019, Transport for NSW contacted customers with an outstanding critical airbag in writing and by phone, to inform the customers that unless the affected airbags were replaced, the vehicle's registration would be suspended. The notification process for suspension of a further 2,500 critical vehicles will commence in February 2020. Transport for NSW also supports the ACCC's recommendation for registration sanctions on non-critical vehicles only where there is an approved section 5(3) application. This will ensure that OEMs have taken the required steps to contact consumers about the recall before the registration is suspended."

786. Counsel assisting suggest that in the circumstances, it would be appropriate to make a recommendation that TfNSW amend or at least consider amending its procedures so that registration sanctions may be progressed in relation to vehicles subject to a compulsory airbag recall, independently of any assurance by the ACCC being provided that the supplier has taken relevant steps to contact the registered owner. However, given that the Compulsory Recall came to an end on 31 December 2020 such a recommendation as applying to compulsory recalls is now redundant.

787. In addition to steps taken by TfNSW to suspend the registration of registered vehicles the subject of compulsory recalls with alpha and critical non-alpha airbags (ie, under clause 45 of the *RTVR Regulation*), as at June 2020, TfNSW had blocked the re-registration of approximately 148,345 unregistered vehicles in New South Wales the subject of the Compulsory Recall (including vehicles with alpha, critical non-alpha and beta airbags) (ie, seemingly under clause 6(3) of the *RTVR Regulation*).[1087]

788. Additionally, in September 2019, TfNSW sent a letter to vehicle owners with alpha and critical non-alpha airbags the subject of the Takata recall which stated, *inter alia* (emphasis in original):[1088]

> "We understand your registered vehicle (number plate) may still be fitted with a faulty airbag which must be replaced under the nationwide Compulsory Takata Airbag Recall.
>
> Faulty Takata critical type airbags pose a very high safety risk. This airbag may eject sharp metal fragments towards vehicle occupants causing serious injury or death if deployed in an accident.
>
> **We strongly urge you to contact your vehicle manufacturer to organise**

[1087] Tpt 1582.16-.1583.15; Exhibit 1, 14/142D/4058-2.
[1088] Tpt 1580.46-.49; Exhibit 1, 12/126A/3636-17

**a free airbag replacement as soon as possible."**

No registration sanctions in NSW for vehicles with Takata airbag inflators subject to voluntary recalls

789. Under the *RTVR Regulation*, TfNSW does not have power to impose registration sanctions in respect to vehicles subject to voluntary airbag recalls.[1089] Ms Morgan indicated that, although, following the introduction of the NADI airbag voluntary recalls, no steps have been taken to expand TfNSW's powers to impose registration sanctions in respect of subject vehicles, that is something that TfNSW would be willing to consider as an option.[1090]

790. Counsel assisting suggest, a recommendation that, to the extent not already done, TfNSW should take steps to consider sending warning letters to owners of vehicles the subject of **voluntary** recalls for defective Takata airbags of the kind referred to at [788] above and/or to introduce registration sanctions for such vehicles.[1091]

791. Counsel for Honda Australia support such a recommendation but point out that registration sanctions should be a measure of last resort as a consumer is unable to be compelled to respond to a recall regardless of whether it is a voluntary or a compulsory recall. Due to the fact that a vehicle's airbag is not a component which can be subjected to a defect notice under road transport law enforcement legislation, the only mechanism of ensuring that vehicles containing affected airbags that have not been repaired is to prohibit them from being on the road.

792. TfNSW has demonstrated its willingness to provide assistance to suppliers and information to owners to assist the recall response. Likewise, TfNSW is supportive of recommendations to enable its role in this regard to voluntary recalls. The ACCC has suggest an extension of Counsel Assisting recommendations that the sanctions extend to all s128 ACL vehicle recalls involving a defect with a risk of serious injury or death rather than be limited to airbags. Counsel for TfNSW has responded that the ACCC proposal lacks detail and notes that not all s128 ACL notifications involve risk of serious injury or death and counsel for TfNSW raises the question as to who would carry out such a risk assessment and what criteria would apply. TfNSW submits that if this process was to be implemented there would need to be further robust and clear guidelines to avoid any ambiguity when determining if a vehicle should be subject to registration sanctions.

[1089] Tpt 1577.34-.38; Tpt 1611.28.
[1090] Tpt 1612.1-.12.
[1091] See also, in this respect, Mr Grimwade's evidence at Tpt 1760.43-.50.

793. Likewise counsel for DIRD agrees with the suggestion to the extent that consideration should be given to such a mechanism, but notes that 'this is an inherently complex area, and further thought should be given as to how and when such a mechanism should be introduced or used."

794. I adopt and commend the concluding remarks of counsel for TfNSW:

> "Irrespective of the mechanics of how registration sanctions should apply, motor vehicle safety recalls are plainly an issue requiring meaningful leadership at a national level. Vehicles affected by the Takata airbag recall were and, regrettably in some cases remain, present on the roads of all states and territories in Australia.[1092] The significant risks to road users posed by defective Takata airbags are, as evidenced by this inquest, apparent. The Transport and Infrastructure Ministerial Council,[1093] comprising Commonwealth, state, territory and New Zealand Ministers with responsibility for transport and infrastructure issues, as well as the Australian Local Government Association, would be an appropriate forum in which the broader issues associated with motor vehicle safety recalls can be considered. It is evident the ACCC, as the product safety regulator, should also be involved in such considerations".

795. I make the recommendation that, to the extent not already done, TfNSW should take steps to consider sending warning letters to owners of vehicles the subject of **voluntary** recalls for defective Takata airbags of the kind referred and/or to introduce registration sanctions for such vehicles.

## O. Conclusion

796. Mr Ngo was a loving, and much loved, family member. His death was tragic and ought not to have occurred. It is regrettable that it was not until Mr Ngo's death that the Australian public received the necessary warnings about the dangers of defective Takata airbags resulting in the Compulsory Recall and widespread advertising and call to action. Though, I am sure it is of little to comfort to those who love and grieve Mr Ngo, it is hoped that these findings and recommendations will assist in avoiding, in future, the circumstances that led to Mr Ngo's tragic and untimely death. It is also hoped that owners of vehicles which contain Takata

[1092] See eg, Brief, vol 2, tab 45.

[1093] https://www.transportinfrastructurecouncil.gov.au The Transport and Infrastructure Ministerial Council was established under the Council of Australian Government (**COAG**). On 29 May 2020, the Prime Minister announced that the COAG would cease and a new National Federation Reform Council (NFRC) will be formed, with National Cabinet at the centre of the NFRC: https://www.pmc.gov.au/news-centre/government/coag-becomes-national-cabinet.

airbags that need replacement ensure that their vehicle is not driven until such replacement occurs.

797. I enter findings pursuant to s. 81 of the Coroners Act:

> Huy Neng Ngo died on 13 July 2017 at the intersection of Malle and Church Streets, Cabramatta NSW from a penetrating injury to the neck sustained from a piece of metal propelled from a defective Takata airbag which malfunctioned when it deployed in a minor collision, which occurred when the Honda CR-V that Mr Ngo was driving was struck by another vehicle whose driver had failed to give way.

798. I now set out the recommendations made as a result of this inquest. I note that, in the course of preparing these findings, I formed a preliminary view to make two recommendations which had not, in their terms, been proposed in the course of the hearing by counsel assisting or any other interested person: one directed to Honda Australia the other to the FCAI: see above at [288] – [289]. The proposed form of those recommendations was sent to Honda Australia and the FCAI for comment and consideration has been given to their respective responses in formulating my final recommendations. The recommendations I make are as follows:

**Recommendations to Honda Australia**

1. If it has not already done so, implement a system whereby Honda dealers are given notice of the numbers of consumers in their Prime Marketing Area that are to be affected by a recall to be announced by Honda Australia (and particularly recalls affecting high volumes of vehicles).

2. Honda Australia implement a process whereby when Honda Australia receives notice from its direct or indirect parent or a related company that a motor vehicle and/or componentry is subject to recall, that, rather than replicate the language of the notification conveyed to it, Honda Australia conduct appropriate due diligence and inquiries with its parent company to ensure:

    a. that the defect and the nature of the risk is adequately and accurately communicated in its notifications to the ACCC, DIRD and consumers; and

    b. that any updated knowledge about the description of defect and the nature of the risk is notified in a timely manner.

**Recommendation to the FCAI**

1. That to the extent not already done so, undertake a review of the FCAI Code, such review to:

    a. include making express provision in the Code for the need for members

to consider what is appropriate at all stages of a recall communications strategy to communicate with customers about the existence of the recall (including the mode, frequency and content of notifications to consumers), having regard to:

i. the nature of the safety defect;

ii. the assessed level of risk arising from the safety defect (including the nature of the risk or potential harm arising from the safety defect and the probability of the harm materialising); and

iii. the urgency for rectification of the product in which the safety defect is found to exist;

b. include providing more detailed guidance to members about the development of recall strategies, which should adapt to changed understandings of risk, including the use of telephone, email, text messages and social media to communicate with customers about a recall and the need to amend such strategies based upon customer response and revised understandings of risk;

c. include providing more substantive guidance to members about the appearance and contents of written recall communications, including the use of visual aids and clear and explicit language that does not downplay risk; and

d. include providing clarification in relation to the interaction between the FCAI Code and any recall guidelines issued (or that may in due course be issued) by the ACCC and/or DIRD, including by inclusion of a cross-reference to such guidelines.

e. give consideration to the:

i. incorporation of reference to the commencement of the RVS Act; and

ii. inclusion of detail around conducting a risk identification and assessment;

f. Include a guideline to the effect:

i. If, in respect of any vehicle imported into the Australian market by a member, a member receives notice from a parent company that road vehicles and/or road vehicle components included in the model and VIN range of those imported vehicles is subject to recall, the member conduct due diligence and inquiries with its parent company to ensure:

A. that the defect and the nature of the risk is adequately and accurately communicated in the members notifications to DIRD, and if necessary, the ACCC; and

B. that any updated knowledge about the defect and the nature of the risk is notified in a timely manner.

ii. If a member receives notification from a parent company that a road vehicle and/or road component is subject to a recall, but the member has not imported that model or VIN range into the Australian market then that advice will be forwarded to the DIRD and as necessary to the ACCC

**Recommendations to the Department of Infrastructure, Transport, Cities and Regional Development and the Australian Competition and Consumer Commission**

1. To the extent not already done, that DIRD and the ACCC should liaise:

    a. to provide the FCAI with any suggested changes to the FCAI Code;

    b. in relation to the development and publication of guidance material from the regulators' perspective as to the intended interaction between the ACCC Guidelines and the FCAI Code (including any revised form of those documents); and

    c. to ensure that the any revised recall guidelines published by them specify the intended interaction between such guidelines and the FCAI Code.

2. In the case of a voluntary recall of motor vehicles and/or componentry:

    a. that relevant written protocols are put in place (to the extent not done already) and made publicly available as to the assignment of responsibility as between DIRD and the ACCC for reviewing the effectiveness of consumer recall communications, in terms of their communications style and likelihood of prompting a consumer response, and that relevant training in consumer communications be undertaken by officers to whom such a task is allocated;

    b. that any recall guidelines published by DIRD or the ACCC**,** including any updated version of the ACCC Guidelines, are consistent with such protocol.

3. Subject to the effects of the scheme under the *Road Vehicle Standards Act 2018* (Cth), that steps be taken by DIRD and the ACCC to finalise (to the extent not already done) a policy document outlining the applicable "escalation process" as between DIRD and the ACCC, in relation to the exercise of powers under the ACL (if applicable) in respect of motor vehicle recalls for which DIRD has assumed the relevant monitoring role. If applicable, such a document (which should be made publicly available) could incorporate the process for DIRD to request the ACCC to recommend the exercise of compulsory powers under the ACL in relation to a motor vehicle product, and the considerations to be taken into account by the ACCC in determining whether to do so.

4. A written protocol be developed by DIRD and the ACCC to the extent not already done (and made publicly available) that makes clear to motor vehicle suppliers:

    a. the respective roles of DIRD and the ACCC in relation to a product recall of motor vehicles and/or componentry (and how this might be ascertained for a given recall); and

    b. the process that needs to be followed by suppliers if it is sought that information provided to DIRD / ACCC about a safety defect is to be treated as commercially sensitive or confidential, and DIRD and the ACCC's general position about such requests.

**Additional Recommendations to The Department of Infrastructure, Transport, Cities and Regional Development**

5. That DIRD develop policy and protocols for the carrying out of investigations in relation to complaints involving motor vehicle componentry generally and airbags specifically, such policy and protocols to provide for clear communications and record keeping as to progress and finalisation of investigations and as to the obtaining of consent for information sharing from any complainant and third party including the police, vehicle dealers and suppliers.

6. That DIRD develop a protocol whereby there is a register kept of misdeployments and investigations of misdeployments of airbags on record and that such information be made available to the public, and when a new development arises which may affect a police or coronial investigation into a serious injury or death arising from a misdeployed airbag, that such information be provided to the head of the police and the coronial unit of each State in Australia.

7. That DIRD consider:

    a. the extent of its reliance upon benchmark recall completion figures, based on aggregated data from historical voluntary recalls, as a means of assessing the efficacy of voluntary recalls related to defective airbags or other motor vehicle componentry; and

    b. developing (and making publicly available) written protocols against which the efficacy of a supplier's recall efforts are assessed by reference to a comprehensive risk assessment, in addition to rectification rates and an assessment of the strategies deployed by the supplier to implement the recall.

8. That DIRD consider engaging in a study to assess the feasibility of setting a Standard in respect of airbag performance and vulnerability to midsdeployment considering of airbags in the Australian context.

**Recommendation to Transport for New South Wales**

9. To the extent not already done, TfNSW should take steps to consider sending warning letters to owners of vehicles the subject of voluntary recalls for defective Takata airbags of the kind referred and/or to introduce registration sanctions for such vehicles.

799. I wish to extend my gratitude to both counsel and the Crown Solicitors Office who assisted me in this inquest as well as counsel and legal representatives of parties in the inquest for their diligence and considered and considerable participation in the complexities of the inquest. I regret the difficulty with my resources and the delay in handing down these findings. I wish to again pass on my sincere condolences to Mr Ngo's family and friends.

800. This inquest is now closed.

E Truscott

Deputy State Coroner

19 November 2021