PUBLIC ACCOUNTS COMMITTEE

INQUIRY INTO THE MANAGEMENT AND OVERSIGHT OF THE PERTH CHILDREN'S HOSPITAL PROJECT

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
MONDAY, 9 OCTOBER 2017

SESSION ONE

Members

Dr A.D. Buti (Chair)
Mr D.C. Nalder (Deputy Chair)
Mr V.A. Catania
Mr S.A. Millman
Mr B. Urban

_____

Hearing commenced at 12.15 pm

Mr MICHAEL ANTHONY BARNES
Under Treasurer, Department of Treasury, examined:

Mr ALISTAIR DAVID JONES
Executive Director, Strategic Policy and Evaluation, Department of Treasury, examined:

Mr STEFANOS TOUTOUNTZIS
Director, Performance and Evaluation, Department of Treasury, examined:

The CHAIR: On behalf of the Public Accounts Committee, I would like to thank you for appearing today to provide evidence relating to the committee's inquiry into the management and oversight of the Perth Children's Hospital project. My name is Tony Buti. I am the committee Chair and member for Armadale. With me today, to my left, is Hon Dean Nalder, the committee's Deputy Chair and member for Bateman. To my right is the member for Mount Lawley and fellow committee member, Mr Simon Millman. To his right is Mr Barry Urban, the member for Darling Range. Mr Vince Catania, the member for North West Central, we hope will join us at some stage.

It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege. However, this privilege does not apply to anything that you might say outside today's proceedings. Do you have any questions about your attendance today?

The WITNESSES: No.

The CHAIR: Just to let you know that when the draft transcript has been completed by Hansard, it will go up on our site, so it will be on the public record.

Mr BARNES: Sure.

The CHAIR: Do you have any problems about your submissions being also posted publicly?

Mr BARNES: No, Chair.

The CHAIR: Before we ask you some questions, do you have a brief opening statement?

Mr BARNES: I do. Thank you, Mr Chair. I would just like to take this opportunity to make a few opening remarks regarding the governance of the Perth Children's Hospital, or PCH, project and the Department of Treasury's involvement. The Under Treasurer was nominated as co-chair of the task force from its commencement in September 2013. Upon taking up the position of Under Treasurer in February 2014, I delegated this function to the executive director of strategic policy and evaluation, Mr Alistair Jones—to my right. This reflected my involvement at the time on the Fiona Stanley Hospital commissioning and major hospitals transition task force and Mr Jones' responsibility in Treasury for the Health portfolio. In Mr Jones' absence from PCH task force meetings, this role was delegated to Mr Steve Toutountzis, director of performance and evaluation, on my left. During the life of the PCH task force, the division of strategic projects and asset sales was part of the Department of Treasury. Mr Richard Mann, executive director of strategic projects and asset sales, had responsibility for day-to-day project construction issues, and was nominated as a task force attendee. However, I had agreed with both the past acting director general of Health, Professor Bryant Stokes, and the current director general, Dr David Russell-Weisz, that Mr Mann be

treated as a full member of the task force and be included in all task force member-only discussions. This approach thus supported at least two senior Treasury officers attending task force meetings, an approach which was maintained until the dissolution of the task force in August 2017. Outside the task force forum, I received weekly briefings from Mr Mann on the progress of the PCH project and was also present at the weekly meetings where Mr Mann provided PCH project updates to the Treasurer. I also had regular discussions with the director general of Health on the construction and commissioning of PCH, including approaches to dealing with the various issues that had arisen with the project. My executive and senior leadership team were further kept informed of the project's progress through fortnightly and weekly briefings on task force discussions and project issues. Mr Toutountzis has also been a member of the PCH project control group since February 2011 and remained on that governance committee until it was abolished in August 2017. The project, to date, has been subject to a total of eight gateway reviews, six of which were undertaken during the period the task force was operational. Mr Mann, Mr Jones and Mr Toutountzis have been interviewed as part of those processes. In addition, the task force has provided a total of five project status updates to cabinet, each of which has incorporated Treasury feedback and consideration in relation to projects risks and issues. Treasury has also provided advice and recommendations to government through successive budget and midyear review processes.

[12.20 pm]

As the committee would be aware, the task force and project control group were abolished in August 2017. Following practical completion in April this year, the PCH site transitioned to the Health ministerial body, with care and control under the director general. The director general also holds overarching governance responsibility for the clinical commissioning of PCH up to final move day. Following this change in responsibilities, the functions of the task force and project control group have been amalgamated, reviewed and refocused, and represented in the terms of reference for the PCH commissioning oversight committee. This new governance structure provides better focus within the health system on commissioning activities, strengthens the appropriate accountabilities and streamlines decision-making processes in the lead-up to the opening of PCH. Treasury was consulted on and was fully supportive of these changes, which I note are consistent with the recommendations of the most recently completed gateway review. I am sure this committee is well aware of the challenges this project has encountered, particularly in relation to the performance of the managing contractor, John Holland Pty Ltd. In addition to quality issues, including the discovery of roofing panels containing asbestos and the current potable water issue, the inability of the managing contractor to establish and meet clear time frames has constrained the state's efforts to support an efficient commissioning process, and has obviously resulted in significant delays to the project. The contractual remedies available to the state, namely claims for liquidated damages, was subject to a cap of $42.5 million, with this cap being reached in April 2016. While the contract includes recourse to performance bonds and a parent company guarantee, calling upon these would have had little to no impact on incentivising the managing contractor to improve its performance. Further, the lengthy commercial processes, which would follow these contractual matters, would not support a practical outcome in terms of the project's physical completion. In the face of these challenges, in April and May 2016, the state negotiated a state primary access control process, which allowed for the partial progression of commissioning activities in certain areas while construction was still being undertaken. While this resulted in duplication and inevitable rework in some instances, it was critical to maintaining project momentum. The state continued to support the managing contractor in pursuit of revised practical completion dates. The committee has already heard from the director general of Health that the managing contractor failed to deliver on 16 successive forecast practical completion dates. At the end of March 2017,

there were approximately 2 000 defects reported by the managing contractor as requiring resolution. It was becoming increasingly apparent that a circuit-breaker was required to move the project forward. In particular, the investigation and attempted remediation of elevated lead levels in the PCH potable water system was, and remains, a complicated drawn-out process.

The task force was first alerted to concerns regarding lead levels in excess of the Australian drinking water guidelines on 2 August 2016. Commencing in August 2016, Treasury's former Strategic Projects and Asset Sales division, as the state's project manager for the delivery of PCH, has overseen an extensive program of flushing, testing and sampling of the water system and a number of corrective actions including filtration and replacement of stainless steel pipes in the system. In April 2017, the managing contractor advised that it considered it had rectified the defect associated with lead levels in excess of the Australian drinking water guidelines including through installation of temporary water filters. The state did not agree with this position and directed the managing contractor to undertake polyphosphate treatment of the system. The managing contractor's refusal to proceed with this direction was a key issue underpinning the decision to grant practical completion. The decision to award practical completion was made after obtaining advice from the acting State Solicitor on classifying the water issue as a minor defect. Granting of practical completion allowed the state to take control of the PCH site, support efficient commissioning and more effectively and efficiently progress water remediation actions, including the polyphosphate treatment without limiting John Holland's liability for defect rectification. While we all acknowledge there remain challenges to completion of the PCH project, had practical completion not been granted earlier this year, it is my clear view that the project would not be as advanced as it is today.

Finally, the committee may be aware that the 2017–18 budget provided additional recurrent and capital funding of $24.6 million in 2017–18 for the costs associated with the further delays in opening the hospital. This funding is based on a final move day in late December. As noted in the statement of risks in budget paper No 3, any further delays to the project beyond December 2017 will result in additional cost pressures with this risk to be closely monitored and managed as defects rectification and commissioning approach completion.

Mr Chairman, I trust that these comments are of some assistance to the committee. We will be happy to take any questions the committee may have.

The CHAIR: Thank you very much for that comprehensive opening. Between the three of you, was there always someone in attendance at the task force meetings?

Mr BARNES: Correct. There would always—I say always; at least in 99 per cent of cases—be two Treasury representatives at task force meetings, one being Mr Richard Mann and the second person being either Mr Jones or Mr Toutountzis.

Mr JONES: Just to clarify, chair, on a couple of occasions, especially when either myself or Mr Toutountzis was on leave or task force meetings fell on a day like a budget day or a midyear review day, our health team manager, Mr Felix Hudson, actually attended I think a couple of the meetings, but it was only a handful at most.

The CHAIR: Will you be able to supply us with the dates of those meetings when neither one of you were at them?

Mr JONES: Sure.

The CHAIR: In your submission, it states that 18 joint briefings were held with the Treasurer and the Minister for Health since August 2016. Were there any joint meetings prior to that date?

Mr BARNES: Not that I am aware of, Chair.

Mr JONES: Not that I am aware of, either, no.

The CHAIR: In your submission, you state that along with the Treasury executive, you have met weekly with the Treasurer to discuss a broad range of topics but it appears that only from November 2016 was the PCH a standing agenda item at those meetings. Considering the project was way behind schedule even at that stage, why was it not a standing issue before that?

Mr BARNES: Chair, it would be discussed, I guess, as and when required at those weekly meetings with the Treasurer before that date, but from that date, as we got to the pointy end of the process, it became a standing item on each weekly agenda. But that is not to say it was not discussed before then; it was, just on an as-required basis.

The CHAIR: So you had these regular meetings. Also, in your submission you talk about the reports provided to the Treasurer on a required basis, or on an as-required basis. You may not be able to answer this and you may take this on notice, but can you provide an update on how many times there was that advice on a required basis and, if possible, also copies of those reports?

Mr BARNES: We will take that on notice, Chair, sure.

Mr D.C. NALDER: You just made a comment in your opening about you believe it was the right thing to take practical completion of the building. What risk analysis was undertaken to form that view?

Mr BARNES: A lot of risk analysis was done within Treasury, with the Department of Health, and probably most importantly, with the State Solicitor. Those risks included obviously the contractual risks to the state, if any, arising from granting practical completion and I suppose triggering the defects liability period, but also the risks on the other side of the equation of further delays in terms of the risk to the budget—the cost to the budget—and also I guess the clinical and staff morale risks of keeping PMH open for that much longer. Between Health, Treasury and the State Solicitor, we tried to take account of all of those sort of competing risk factors and reached a balanced view in the end that granting practical completion in April was the right thing to do at the time.

[12.30 pm]

Mr D.C. NALDER: Just on that, from what I understand from what you were just saying, the biggest risk from a financial perspective is the defect risk of issues because it triggers the start date of the —

Mr BARNES: That was just one factor we had to take into account. I guess what I am trying to highlight there is the trade-offs involved in making the decision around practical completion. On the one hand, the sooner we could grant practical completion and the state could take control of the site and in a hands-on way, I guess, try to deal with the water issue ourselves, our view was that to the extent we could do that, the sooner the better because that will reduce the direct cost to the budget of further delays. On the other hand, we did acknowledge that as soon as PC is triggered, then the two-year defects liability period would commence from that date. They were a couple of the differing factors we were trying to balance up.

Mr D.C. NALDER: Does it increase the risk from a contract perspective of seeking rectification back off the construction company? With this lead issue in the water, is there a risk that we have to fix it and therefore we will be funding it, whereas if we had not taken practical completion they would have had to fund the fix?

Mr BARNES: That was the very key question that I sought advice from the State Solicitor on; exactly that question. The question in my mind was if we did grant practical completion whilst the water issue was still unresolved, would that change the risk allocation under the contract in any way, shape or form. That is what I sought advice from the State Solicitor on. His response came back that no, it

would not—the risk allocation under the contract would not be changed at all and that John Holland would still be liable for defects rectification.

Mr D.C. NALDER: And therefore liable for paying for the lead issue if the state is now funding the process of fixing that and can find fault that it was in the original construction and therefore their responsibility?

Mr BARNES: Yes.

Mr D.C. NALDER: So no change to risk whatsoever was the advice.

Mr BARNES: That was the advice from the State Solicitor, correct.

Mr S.A. MILLMAN: Mr Barnes, I have a couple of questions, following on from Mr Nalder's questions, about the risk allocation in the contract. What I want to try to understand is whether or not the state could have put itself—with 20/20 hindsight obviously—in a better position by, for example, negotiating a three-year defect liability period rather than a two-year defect liability period with the managing contractor; whether or not the state would have put itself in a better position by having an increased damages cap. $42.5 million is a very, very small percentage of a $1.2 billion project, and obviously contracts are negotiated based on the relative bargaining position of the parties, so I accept that. Number three: you mentioned in your opening statement that you had to negotiate a variation on the contract in order to allow the state government to access the site in the months leading up to, or prior to, practical completion. For future contracts of this sort, would it be your suggestion that we try to get some sort of site access clause negotiated into contracts so we do not have to go through that process, that it is something that is automatically a right that the state can enjoy under future contracts?

Mr BARNES: I think that is certainly worth investigating, sure.

Mr S.A. MILLMAN: And the other two?

Mr BARNES: The other two being the liquidated damages cap —

Mr S.A. MILLMAN: The damages cap and the defect liability period.

Mr BARNES: It is very difficult. As you say, with the benefit of hindsight perhaps we could have set a higher liquidated damages cap, but at the time you negotiated the contract—this was back in 2011; so well before my time as Under Treasurer—you have differing commercial objectives you are trying to weigh off against each other. You are weighing off the liquidated damages cap and the defects liability period against the overall contract price, obviously, and there are trade-offs there. Was the right balance at the time struck? I do not know.

Mr S.A. MILLMAN: Who knows. It is impossible to answer that question.

Mr BARNES: Yes; I do not know. But certainly in terms of the access arrangements that were subsequently struck, I think that is a good point, that that is something that similar projects going forward should be cognisant of right up-front for sure.

The CHAIR: Between May 2016 and at least until September 2016 it appeared that the former Treasurer, the former Premier and health minister maintained a position that the hospital would be open by the end of the year. Was that consistent with the advice that you were giving to the government at the time?

Mr BARNES: Chair, it was consistent with the advice that we were getting and the information we were getting from the managing contractor. We were very reliant on the program that the managing contractor was putting forward. As I mentioned, that program had 16 changes of forecast PC date over the journey. We were reliant on that information. Obviously, we scrutinised that information

to the best of our ability, but with a managing contractor contract like this one you are reliant on the managing contractor's program and the dates that that program spits out. That is what the program was telling us at the time.

The CHAIR: Are you able to tell us when you and the other two with you were first made aware of the lead issue?

Mr BARNES: My recollection is that that was first raised with task force in August.

Mr JONES: Early August.

Mr BARNES: Early August 2016. I think that that would be the first time we were —

Mr JONES: I think so, and there may have been discussions a week or two before it at the project control group, and Mr Toutountzis could probably —

Mr TOUTOUNTZIS: I have actually looked at the minutes to verify myself. In August and September of last year, I was on leave so I heard the lead issue on radio, and in terms of the July period leading up to that we were dealing with the asbestos issue. That occupied quite a bit of the time of both the PCG and the task force in terms of what the remediation process through that would be and the investigation about how a noncompliant product found itself in it. Although the minutes indicate 2 August is when it was raised with the task force, I note in terms of the discussions that Strategic Projects was aware through routine testing in May when the water, the plumbing part of the process of commissioning the building, was to go through the routine investigation to verify that it is properly constructed. That process, I understand, is when it was discovered and that is when the flushing and the debris and the gunk that was in the system started to flush out commenced that process. But in terms of the task force, in the PCG, the discussions did not start occurring until about August in terms of the persistence of the lead being in the pipes.

The CHAIR: Mr Jones, were you at the meeting in August when it was first mentioned?

Mr JONES: Chair, I would have to check back, but I was certainly aware of the issue in August. Whether I was at that 2 August one, I would have to check whether I was actually at that meeting. It would be fair to say in the initial discussions about lead, it was more about the gunk that Mr Toutountzis talked about, that had been in the settling tanks was being flushed out of the system and it contained lead. We were not aware until probably a bit later that the issue was probably a little bit more serious than simply flushing out —

The CHAIR: When you say "a bit later", when?

Mr JONES: Lead became an issue through August, September and October. There were reports commissioned through Strategic Projects—the Jacobs report and others. Those reports showed there could be a number of different types of sources of lead. I think from memory the Jacobs report identified originally there were about 16 different possibilities, and then it was probably over a three or four-month period. Basically, they were doing testing and investigating to see which ones needed to be actually removed from that list of 16 and then ended up coming to the conclusion it was from the brass fittings.

Mr S.A. MILLMAN: When you say three or four months, you are talking about three or four months from August?

The CHAIR: No —

Mr JONES: Yes, basically.

Mr S.A. MILLMAN: So August, September, October, November.

Mr JONES: I would have to go back and find out when we got the first draft of the Jacobs report. The first one I saw had identified that there were a number of possible causes of the lead, once they had got past the fact that it was not just the sediment in the tanks. There was a process of elimination then and you have probably received evidence from others.

The CHAIR: I suppose there might be cross-purposes to my question. Granted that the possible source may be from August onwards for three or four months, but the lead was first detected in May.

Mr JONES: Yes.

The CHAIR: When we talk about three or four months, you are talking about the possible source of —

Mr JONES: From when we were aware of it, yes.

The CHAIR: Was anyone in Strategic Projects aware, prior to you being notified in August, about the lead issue?

[12.40 pm]

Mr JONES: You would have to ask Mr Mann and Mr Hamilton that, because obviously we were not privy to that level of detail into the project.

Mr S.A. MILLMAN: You can understand my concern if Mann or Hamilton are aware from the managing contractor in May that lead is present, and the hypothesis put forward is that it is detritus that is just sitting there, that is fine. That is in May. Allow some time for the natural flushing processes that always occur on significant construction projects to alleviate that problem or ameliorate that problem, then by August we do not have a problem anymore, unless there is an underlying situation. If you conflate both periods, what you are talking about now is three to six months in order for that detritus to be flushed out of the system, which is, in my view, a phenomenally long period of time just to get the gunk out of the system. So questions ought to have been asked at that stage about when it was first identified.

Mr BARNES: I think you are essentially right, member, in that the managing contractor did detect elevated lead levels in May 2016.

Mr S.A. MILLMAN: Yes.

Mr BARNES: What the Strategic Projects staff knew at that time I am not sure—I do not know—but my recollection is that between May and August, certainly the problem was not well understood. The causes of the problem were certainly not understood. In fact, I think at the time—in May—it was viewed as a reasonably routine issue of detritus in the pipes, which is not uncommon for large new construction projects. So I think at the time it was viewed as reasonably routine, the flushing should do the trick. That was the view at the time. Therefore, I think there was a view that there was no need to elevate the issue, until we got to early August when it was elevated to task force because obviously the flushing had not been doing the job.

Mr S.A. MILLMAN: So the question is: to what extent should representatives of the government have been interrogating the assumptions that had been made by the managing contractor in terms of the managing contractor saying this is a reasonably routine problem and we can fix it?

Mr BARNES: I do know that the state's representative, Mr Hamilton, was raising concerns. I just do not know the precise time frame.

Mr S.A. MILLMAN: It is a question for Mr Hamilton.

Mr BARNES: Sure. But I do know that he was raising concerns about the flushing program instigated by the managing contractor. We have evidence from the Water Corporation, and others, that the volumes of water that were expected to be flushed through the pipes were not. So we had been raising concerns around the flushing program for some time. It is just the precise time frame around that I do not know.

Mr S.A. MILLMAN: Is it through you that we would be able to get that?

Mr BARNES: No; it would have to be through Mr Mann.

The CHAIR: As far as you are aware, as the Under Treasurer, when was the then Treasurer first notified that there was a lead problem—not the source or anything, but that there was a lead issue? You might need to take that on notice.

Mr BARNES: I might have to take that on notice, Chair. It would not have been before August 2016.

The CHAIR: Obviously, because you were not aware of it before then?

Mr BARNES: That is correct.

The CHAIR: But you think it would have probably been pretty close to after you were made aware of it?

Mr BARNES: I would have thought that pretty much straight after the task force became aware of it, the Treasurer would have been made aware, but I can double-check that.

The CHAIR: On 14 September 2016 in Parliament, the then Treasurer stated, and I quote —

> We are in the final throes of identifying it as not in the new Perth Children's Hospital building.

He was talking about the source of the lead. The then Treasurer was subsequently quoted in ABC News on 30 September 2016 as saying —

> "Probably next week we will come out and we will see that there was simply never any risk of lead contamination in the hospital," ….

Is this consistent with the advice you were giving the Treasurer at the time?

Mr JONES: I can probably answer that for you, member. The Under Treasurer said he will take it on notice, but I have looked at my file and the first specific contentious issue brief, which is what we prepare for the Treasurer in Parliament, was dated 5 September from Mr Mann, and that was about the detection of noncompliant levels of lead and other metals in the water supply. So I suspect that the former Treasurer was relying on that contentious issues briefing that was prepared by Mr Mann on 5 September 2016.

The CHAIR: Would we be able to get a copy of that?

Mr JONES: Yes.

The CHAIR: Thank you. You talk about contentious issues. There is a document that we do have, which is dated 10 October 2016. It mentions that the draft ChemCentre interim report provided on 18 September identifies residual construction debris in the PCH water distribution system as the likely cause of the contamination and recommended the implementation of a flushing and testing program to clear the system and demonstrate compliance with the water quality standard. It states also —

> ChemCentre's interim report also recommended the elimination of a dead leg of unused water supply pipe in Hospital Avenue. This work has been completed.

Therefore, the dead leg issue must have been raised prior to 10 October if the ChemCentre interim report had recommended elimination of the dead leg of unused water supply. When did you become aware of the dead leg attached to the interior ring main as being a possible source?

Mr BARNES: I cannot recall precisely, Chair.

The CHAIR: Would you be able to go back and check your records?

Mr BARNES: Sure. We will see what we can find.

The CHAIR: At the same time, would you be able to see whether you can identify, if the advice was given to the Treasurer about the dead leg issue, when that was?

Mr BARNES: Sure, yes; we can take that on notice.

The CHAIR: I know that you always need to be careful about what you read in the media, particularly if it is from unnamed sources, but there is a report dated 28 April 2017 in *The West Australian*, and it states —

> On Wednesday, —

I am not sure what date that was, but the Friday was 28 April, so it was probably 26 April —

> the Department of Treasury said Dr Nahan, now Opposition Leader, was kept informed when he was treasurer.
>
> "The former treasurer was briefed on all aspects of the Perth Children's Hospital water-quality issues at the time," ….

I presume that was a statement released by your department?

Mr BARNES: I am not sure where that came from.

The CHAIR: Can you check if there was such a statement, because I would not want to rely on a media release! Are you able to check whether a media statement was released?

Mr JONES: From memory, Chair, I think it was a coordinated response by government. We would have fed information through Mr Mann into that. I think that was in response to questions that were asked by that journalist for that article—I do not think we had a media release or advice per se—and we fed that in through the task force. Richard Mann was involved with Dr Russell-Weisz and the minister's office to prepare that, so we probably would not have that information in a formal document form. We can certainly check our records, but probably Mr Mann is a better person to ask about where that information was provided.

The CHAIR: Before I hand over to Barry Urban, you will provide us with any briefing notes or correspondence that you have given to the Treasurer or other government ministers in regard to what were the sources, or possible sources, of the lead contamination, and when?

Mr BARNES: To the extent that we can, Chair. I do not want to sound overly bureaucratic, but we have a bit of a problem that with the recent machinery-of-government changes, all of the files for this subject have been transferred across to the Department of Finance with Strategic Projects, so we might not be able to access the documents.

Mr JONES: We actually had to request the documents that we have provided, through Mr Mann, for the hearing.

The CHAIR: So do you think our best course would be to direct this question to Mr Mann?

Mr BARNES: I think so, Chair. Mr Mann would have been the author of most of these documents.

Mr JONES: Chair, the document that you quoted before about the dead leg was Mr Mann's contentious issue briefing note dated 30 September.

The CHAIR: That is right.

Mr JONES: It is probably more appropriate that he provide that information than us.

Mr B. URBAN: Mr Barnes, in your opening statement you said that there were 15 updated cabinet briefings. Can you give us the dates of them? I understand that the documents themselves will be closed down, but can you provide the dates of those?

Mr BARNES: Actually, I indicated a total of five project status updates were provided to cabinet. I do not have the dates of those to hand but we can easily obtain those dates for you.

Mr JONES: It would probably be best to talk to Dr Russell-Weisz because they were cabinet updates through the task force and he was the chair of the task force. We obviously provided input into them, but they were sent by Dr Russell-Weisz as chair, and the Minister for Health. They would be able to provide you with that information better than we can, because we would not know when it was actually sent to the health minister.

Mr B. URBAN: Can you provide your observations on the overall effectiveness of the dual governance structure for a project such as the Perth Children's Hospital? Is it an appropriate governance model? What are its benefits; and what are its shortcomings?

[12.50 pm]

Mr BARNES: I will ask Mr Jones to add, but I will just make a few brief comments. I think the dual governance structure was necessary and appropriate, given the nature of the project. It was essentially a construction and a commissioning project at the same time. That made it an inherently difficult project to try to construct such a large and complex building at the same time as you are trying to commence the process of commissioning it into an operational hospital, but that dual construction–commissioning objective made the dual governance structure necessary. My view is that the governance structure and the contract management in this project were probably the most intense I have ever seen on any government project. The governance was, I think, very robust. There was an awful lot of reporting to the task force and then to the Treasurer, the Minister for Health and ultimately the cabinet. It was a very robust governance structure. The contract management was very intense, very active. I have been asking myself this question in recent times: if we could have gone back in time and changed anything in terms of the governance arrangements, what, if anything, would we have changed? I am struggling to answer that question, to be honest.

Mr B. URBAN: Can I give you another question? How did it get to where it is today? How did the Perth Children's Hospital, the governance of it and all the problems—the 2 000 defects and all the rest of the problems, the asbestos and everything else—get to where it is when we had everybody looking at it and nobody acting towards it?

Mr BARNES: People were certainly acting towards it. I mean, the amount of government resource in this project was quite extreme. The amount of government effort on this project was quite extreme. I definitely do not think that the governance arrangements were broken. The governance arrangements were not broken. The issue that we had was the challenging nature of the project, being both a construction and commissioning project, as I said, but the other issue we had was, frankly, the performance of the managing contractor. As I mentioned in my opening statement, we had been repeatedly advised of 16 successive practical completion dates and not one of them was reached; that was the issue we were dealing with. As with the earlier question, the contractual remedies available to the state in that circumstance were limited. They were limited by the contract we were operating under.

Mr JONES: Maybe I could add that I spent a lot of time on the Fiona Stanley task force as a permanent proxy for the former Under Treasurer and towards the end of that process, as Mr Barnes said in his statement, he went on to the committee and I went on to Perth Children's Hospital. I mean, literally you had the same people and the same expertise on the two projects. The difference between the two projects was that we finished building Fiona Stanley Hospital well before when it was supposed to be finished and the task force operated in that perspective as a commissioning task force. I have got to say that being involved in this project is probably one of the most frustrating parts of my career. As Mr Barnes said, we literally ran out of contractual levers well over 12 months ago, so essentially we were trying to finish a project based on goodwill with the contractor. We had almost a perfect storm where we had the master contractor basically put up for sale by its owners, so there was a period there when the old owners were probably not as focused as they should have been on the project. You had the upheaval of a sale and then eventually you had the new owners come in and basically it took them a lot of time to get up to speed.

The other issue, which again I could describe as a perfect storm, was the asbestos panels. Again, I am not the expert on that, but my understanding is that samples of that product, the same as every other product that went into hospital, were all cleared. Eventually we had that issue in Queensland and then it was discovered there. No-one would have foreseen the lead in the system, and to be honest we had those all pile up on top of each other and we were literally operating on goodwill with the master contractor in the process, because we had no levers to pull. They had maxed out the contractual remedies for liquidated damages. We could have terminated the contract and I suspect you would still have a half-built hospital with cranes sitting there at the moment. It has been incredibly frustrating to be involved in it. The governance we have used is similar to other major projects. Do we have learnings from it? Yes, we do. I mean, if we were going to build another hospital with another type of contract as complex as this, we would certainly look at things like site access and also liquidated damages and other remedies in our contracts going forward.

The CHAIR: A recurring theme has been the lack of range of the state's contract levers.

Mr S.A. MILLMAN: Part of the problem it seems to me, coming on the back of what Mr Jones and Mr Barnes have just said, is that you have got this conflation of construction and commissioning, so at the same time you are building the hospital you want to try to move in as quickly as possible. Obviously, there are financial reasons for that. The sooner you get out of PMH, the more money you will save the government, which is laudable; it is exactly what we should be doing. Given what has happened in this circumstance though and given what happened with Fiona Stanley in terms of the commissioning process, is there any benefit in looking at decoupling the construction stage from the commissioning stage? We have evidence from Dr Russell-Weisz, who said that there are a lot of moving parts. You have got seven different work streams and unfortunately they are all integrated, but at the same time six of them are all reliant on that one work stream, being the actual building of the premises. It might be a naive question to ask, but is it time to start looking at maybe just getting the thing built and then worrying about commissioning it so we do not have so many moving pieces and we can focus on holding the managing contractor to account?

Mr BARNES: I think that would be ideal if we could do it. As Mr Jones mentioned, the issue we had with Fiona Stanley Hospital is that the construction of the hospital was completed as a separate project, if you like, and then handed over to the Department of Health for the commissioning of the project, and that is where I got involved in the commissioning of the hospital. In that case we were building a brand-new hospital and we were not closing anything down behind it, so you could separate construction and commissioning. In this case, we could not.

Mr TOUTOUNTZIS: Also, whilst the commissioning part is not the transition from PC to actually the final move date to the hospital, which is technically around three months, all the discussions were that you have got to have a minimum of 10 to 12 weeks in terms of facilitating the move from the hospital. But there is a stream of work that happens over a two-year period in terms of getting the transition happening, getting the change management processes and getting the clinical aspects of doing the works, so part of the PCG that I was involved in had a significant agenda of the ICT systems, the equipment, the training to facilitate the new equipment, the training of the nurses in the new environment and the change in management of delivering services in a twenty-first century hospital compared to a hospital that was built 100 years ago. So, all those changes were being put into place. One of the lessons learnt from Fiona Stanley was that when the commissioning was occurring, the decisions in the context of the ICT systems were not facilitated early enough in terms of providing the funding from government. In terms of the Perth Children's Hospital, $245 million was allocated for commissioning and construction early into the project, around the 2013–14 budget process, to make sure that the money was there to facilitate the commissioning aspects and the work that the hospital needed to do in order to facilitate the move and the effective movement in doing that. So that aspect worked quite well. In terms of the 16 missed PC dates, all that sort of conflated into the time line in having the security systems, the protocols, the fire alarms—all that needs to happen in terms of having the facilities management aspects in the contract.

[1.00 pm]

Mr S.A. MILLMAN: So once the building is finished, you will be able to move in pretty quickly.

Mr TOUTOUNTZIS: Yes. All that was happening in conjunction with the construction. What did not happen was the construction did not get done in time and the process happening in order to do that. You cannot necessarily decouple the two because you have to do them in conjunction and it got to the point where this is why we had that process in terms of getting access. It got to the point that the clinicians and the clinical staff had to get into the rooms in terms of testing the equipment that was going to be there to make sure that they would be functional for operations.

Mr S.A. MILLMAN: My problem with that, Mr Toutountzis, is that the contract did not allow you access to the site. I am loath to say it, but it seems to me as though the people who negotiated the contract at the start should have taken into account the fact that we, the state, were going to need that sort of access if we were going to do a commissioning process at the same time as we were concluding a construction process.

Mr TOUTOUNTZIS: The aspect was that those things would have been done, and this is in the lead-up to when they were saying that—the SPAC process started in May because they said the final day would be September because the practical completion date would be sometime in April. That got changed to June. That got changed to September. It is that aspect that every time that a milestone was set through the program, it got missed, so you had to redo the project. I think the theatres were clinically cleaned on about three or four different occasions because they had to go back and do stuff because something was found to be a fault or a default. The air filters were not working as they should be to keep the air—I am an accountant, so, frankly, getting into the clinical aspects of how the air moves in the theatre was beyond my comprehension, but I have learnt a lot through the process. They are the issues that were being confronted in terms of getting a product that was final from a construction point of view in order to facilitate that commissioning aspect from a clinical perspective.

Mr B. URBAN: We will go back to the question which I raised earlier: how did we get to the point of where we are today with the Perth Children's Hospital when we are 18 months or so down the line from it even being opened? How did we get to this point?

Mr JONES: The master contractor did not deliver in line with the contract. I can probably take you back to the example we used before. Again, I think Dr Russell-Weisz has raised this. The lesson we learnt from Fiona Stanley is you do not just build a hospital and then go, "Let's sort the commissioning out", because what we ended up with on that—I was heavily involved in that—was we had to compress a commissioning time. We were very lucky they finished the hospital early. It was Brookfield Multiplex who built it. We were caught on the hop there; the health department had not figured out how to open the hospital and commission it. When the business case and others—obviously, the original contract for the construction of the hospital was before my time, but when we did the commissioning one, we needed an integrated program which tied in with commissioning; otherwise, you were just going to add that time period on the end of your hard finish for your building and you would not be opening your hospital for a period of time. Where we came unstuck was essentially they did not meet their deadlines and it became incredibly frustrating in terms of our commissioning program, because every time they missed a deadline, we had to re-calibrate it. What you saw with the SPAC, the room access, were workarounds to basically try to get the hospital open as quickly as possible. In hindsight, you needed to be in the middle of where we ended up being. Again, I was not involved in terms of the original contract for the construction of the hospital, but when you are 15 months late with the actual construction of the hospital, it is certainly going to have an impact. If we had not done any of the commissioning that Mr Toutountzis has said, literally you would be adding that 15-months-and-more period on the end and then delaying the opening of your hospital. It goes down to a failure to construct and meet the deadlines, because the reports we were looking at weekly in terms of program were out of date essentially the day we got them. As we said, we had 15 or 16 changes in the practical completion date, so people were having to go off and reprogram the commissioning because we kept missing deadlines.

The CHAIR: Arguably, having the commissioning process while construction is happening has some positives because the commissioning process may actually bring up construction problems; they can be fixed while it is still happening.

Just before we go into closed session, Mr Jones, you mentioned before that obviously one option which really was not an option was that you terminate the contract, but you did terminate the contract in regard to the building of the Telethon institute by John Holland. I believe they did not want to continue that in any case.

Mr JONES: Correct.

The CHAIR: Is there anything to be learnt about how one can actually do that?

Mr JONES: I would like to answer that in closed session.

The CHAIR: I think that is appropriate.

The committee has resolved to conduct the rest of the hearing in closed session. Could I please ask all people seated in the public gallery to leave the room. If you intend remaining for the next hearing, please wait in the foyer and the secretariat will advise when we have reopened proceedings. Thank you very much.

[The committee took evidence in closed session]

[1.31 pm]

The CHAIR: I know you have another meeting, but I want to go back into open session, just for a second, because the question I asked about the documentation in regard to when you knew, how you knew and who you then informed, I would like that to be in open session—the evidence. Is that okay?

Mr BARNES: Sure.

The CHAIR: But we will write to you to formalise that.

Mr BARNES: Okay.

The CHAIR: Thank you for your evidence before the committee. A transcript of this hearing will be forwarded to you for correction of minor errors. Please make these corrections and return the transcript within 10 working days of receipt. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be introduced via these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript of evidence. Thank you once again for your time.

Hearing concluded at 1.32 pm

_____