PUBLIC ACCOUNTS COMMITTEE

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

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
FRIDAY, 22 SEPTEMBER 2017

SESSION TWO

Members

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

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Hearing commenced at 9.34 am

Dr OMAR KHORSHID
President, Australian Medical Association (WA), 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. My name is Tony Buti; I am the committee chair and member for Armadale. With me, to my right, is the member for Bateman, Hon Dean Nalder, who is also the committee's deputy chair. To my right is Mr Simon Millman, the member for Mount Lawley. To his right is the member for Darling Range, Mr Barry Urban. We apologise that the member for North West Central, Mr Vince Catania, cannot be with us. 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 of today's proceedings.

Thank you for already providing a written submission. We intend to post that online as a public document. Do you have any concerns about that?

Dr KHORSHID: No concerns.

The CHAIR: Do you have any questions about your attendance here today?

Dr KHORSHID: No.

The CHAIR: Before we ask you some questions, do you have a brief opening statement that you would like to make?

Dr KHORSHID: I do. Thank you very much for the opportunity to address the committee on this really important project and what has turned into what most people would concede as a bit of a debacle. The AMA, like all patients, staff, doctors and the community, have been really excited by the investment in Perth Children's Hospital. We have watched it rise from the initial concrete slab. It is very close to the AMA's building. Many of us drive past it every day. It is extremely frustrating to see a completed, very beautiful building with no patients, no families and no doctors or nurses in there doing anything useful.

The Perth Children's Hospital is certainly very much needed. Princess Margaret Hospital is up to 100 years old. Everyone is aware of how it has been falling apart and is really not fit for the purpose of modern healthcare. However, after spending $1.5 billion or whatever it is—I do not know the exact number—two years late, we are still looking at that empty building. I guess, for the Australian Medical Association, as a non-expert in contract management and building very large projects, we have a series of questions, which has been the basis of our submission. It really gets down to: how has it come to this? I guess that is what you have been doing throughout this process. Our specific questions are around the original decisions that were made, both in the design and contract management.

The specific areas that we are particularly interested in were the size of the hospital—there was a lot of media at the time where the AMA was calling very loudly for the hospital to be the building that would underpin the delivery of health services to children for the next several decades and not be a building that is affordable to run now, based on current demand. A group of doctors and the AMA made very strong statements at the time that we felt the hospital was too small and that for a

reasonably modest investment, it could be future-proofed by adding floors, not necessarily fitting them out, just putting in the basic infrastructure that you need so that if and when the decision down the track—whether it be five years, 10 years or 20 years later—it is a straightforward thing to make your hospital big enough to deliver the services that are required. A lot of people at the time said, "We are going to move care closer to the home." That was the basis of the Reid report. The reality that we see is that care closer to home, for paediatric services, has been very difficult to deliver. Where we as members of the community might be keen to see care close to the home, when it comes to our children, we want the best care. What patients are doing is voting with their feet and going to Princess Margaret Hospital because they perceive that is the best care. The services close to home are harder to deliver, especially when you get down to the highly specialised areas, which is where PMH and the new PCH will be focusing. That initial decision confounded us. It confounded the doctors and we would like to know who is responsible for those sorts of decisions. Why would you build such a large building with such a huge investment in public infrastructure and not have it be the underpinning of your delivery of services for decades to come?

[9.40 am]

We have some questions about the design. It is a beautiful building. I have not actually had the pleasure of going in there myself but certainly from the outside it is extraordinary. It is going to be an inspiring place to work and to be treated. I presume that comes at a cost. When we are being told that you cannot future-proof the hospital by adding on extra floors, what could you have done if you had made the building a little bit more boring, for instance? Could it have been bigger and better, functionally, if it did not look so good? That is a question that we certainly have. Another specific design decision early on was to go with almost all single rooms for the children. We note that this has been done for good clinical reasons and that there is a concern about cross infection between patients in hospitals. Single rooms are thought to reduce cross infection. However, single rooms are not how most hospitals in the country are delivered. ABF funding, which is the new currency in health, looks at the average health delivery, not the best health delivery, so you are being marked against hospitals that do not have these infrastructure issues that cause you to have a more expensive model of care. The reality is that to look after children properly, if they are by themselves or if their mum has had to go to the toilet or go to the shop or look after another child and you have a child by themselves, to make that safe, you cannot rely on the other parents in the room anymore, you are now going to have a level of nursing supervision that is going to cost more for delivery. We are not certain that the hospital will be appropriately funded to deal with that issue—the same issue that I have seen at Fiona Stanley Hospital.

Bringing up Fiona Stanley Hospital, what has been really obvious to us and, I think, to every member of the community, is the huge contrast between that enormous project, which was a little controversial as it opened but from my point of view working there has been extremely successful. The building itself was delivered on time and on budget. The hospital itself opened only slightly behind time due to staffing and IT issues, not building issues. Then we look at this project, and it is such a contrast. How has it come to pass? Why is it different? I guess that is the area where the AMA has no expertise whatsoever but a lot of questions about where the accountability lies for choosing the builder. There has been a lot of blaming of the builder out there in the media from government and from the health department. It seems, as a layperson, to be true. Somebody appointed that builder and somebody managed that contract. There are very serious questions as to how that decision was made. Was it just the cheapest bid and therefore this was potentially foreseeable? Was their track record fantastic and this has been an aberration as a project? Those are questions that the AMA and, I think, every doctor and patient in the community wants to know the answers

to. It is just not good enough, in our view, to just blame the builder and say that they are a terrible builder.

The contract management itself, as I said, is not an area in which we have much expertise, but I imagine you do not just give a project to the builder and say. "Off you go. We'll see you $1.5 billion later." I presume there is very close management of these contracts and milestones along the way, which we understand the builder missed. Would it have been possible, if that had been done better, to divert some of these things and to deliver the project more on time and more on budget? Really, that comes back to transparency and accountability. It is not clear how these decisions get made. We are sure they are made in good faith but, clearly, a mistake was made here and we would like to know how that can be avoided in the future.

It has been great to see the investment in health infrastructure over the last few years. Most of those projects have gone very well. This one has not. We would really like to know that the next time a big investment is made in health, or in any other area, that these mistakes are not made again. The impact has also been on the staff. You have all heard of the troubles that are going on at Princess Margaret Hospital. They are not just related to this issue but this issue has made it a whole lot worse. You have the negatives of a big move about to come and changing models of care and changing staffing structures without the positive of actually being able to move into the new facility. The absolute uncertainty hanging over everybody is that two years late we still do not have a date for opening.

When it comes to the lead, obviously, this is a complex issue and I know you have been talking about this a lot. From a medical profession's point of view, we want the hospital open as soon as possible but it must be safe. Any water that comes in contact with patients or any water that is going to be drunk or consumed has got to be safe. We do not support opening the hospital early on the basis of some future rectification works. Those things need to be done first. If there is any thought of potentially not rectifying some of the building, if it is proven that you know where the lead comes from and it is too hard, too expensive or will take too long to replace all those fittings in non–patient facing areas, that is reasonable as long as there is not an expectation that you are going to go back and do it later because we are certain that no-one is going to go back and do it later. Once the hospital is open, you cannot be closing parts of it to do major rectification works.

The last point I wanted to make is that the lead is not the only issue here. There have been a lot of issues. There was asbestos, there were roofs collapsing, there was the bridge that cannot be used for patients, there are firewalls that are non-compliant and this lead issue that no-one knows the answer to that has not happened in other projects. It raises the obvious question of what else is waiting in this building. What are we going to find out about when we first move in or at some other point in the future? From my point of view, I would like to know that the time that has been wasted, the time in which patients are not able to use this facility, is being used to make sure that there are no other surprises coming and that this building will be fit for purpose the moment it opens and will be the house of healing for children and their families for decades to come. At the moment we will never be certain that the building is fit for purpose and safe. That is a really worrying situation.

Mr S.A. MILLMAN: All excellent questions. That is precisely the reason that the Public Accounts Committee has initiated this enquiry— to examine all of the questions that you raise. I understand that your predecessor as president of the AMA was Dr Andrew Miller. What proactive steps during the process did the AMA take to elevate these issues to government and what role did the government permit or allow for the AMA to participate in canvassing these issues that you now raise? If you will forgive me for saying it, we all have 20/20 hindsight. It would be great to know when you were first concerned about these and what your organisation did to ventilate them.

Dr KHORSHID: As you are probably aware, the AMA meets regularly with the director general of Health and the Minister for Health, no matter which side is in power at the time, and we are constantly communicating. I guess the issue we had the most communication with the government was over the size. That was through extensive discussions as soon as we became aware of the size. This stuff does not necessarily get released easily. It filters through to members while they are going through a consultation phase. Our members brought us concerns that this hospital was about the same size as PMH. We then asked the questions. You eventually get some answers and then you escalate it. That particular issue was escalated right onto the front page of the newspapers and was very strongly advocated for. Although there were 24 extra beds found within the infrastructure—you could call a small win—that was one fight that the AMA did not win in terms of adding extra buildings.

The issues around contract management and decision-making are probably not something that the AMA foresaw because we saw the other projects going well. We talk a lot about consultation with doctors and making sure when you are spending the money to consult with people who are going to use the facility. We certainly have advocated that. But we were not expecting this outcome from this project because we had seen the other projects delivered, comparatively, very well.

Mr S.A. MILLMAN: Forgive me for interrupting you on that point, but do you envisage a greater role for the AMA? It seems to me that that sits incongruously with your objects as an organisation. The AMA is not a contract management or construction infrastructure sort of organisation.

Dr KHORSHID: I would call the AMA a stakeholder as an advocate for doctors, our members, and also for health in the community. We do not have a direct role in contract management—absolutely not. We have no expertise.

The CHAIR: Your submission basically outlines that, but you have a number of questions, which are questions that we are seeking to find answers to. Presumably, you do not have answers to them, otherwise you would not have asked them. In your submission you seem to suggest that you have concerns about the tripartite relation between the QEII Medical Centre trust, the Department of Treasury and the director general of Health in regards to the governance of the projects. Presumably, if you have concerns, they must be based on something.

Dr KHORSHID: I think that is based on the fact that something has gone wrong. One of the things that seems to us to be unusual about the project is—I presume all major projects are run out of Treasury—that Health will be the body that runs the building and then you have the QEII Medical Centre, which is a separate entity with its own agendas and rules. There are the issues of parking and various other things that are related there. Did that governance structure complicate things? That would be the question. Did it make the management of the contract, and the decisions that were made different if it had been a simple structure and all been run out of health or all been run out of Treasury? Would that have made the project more easy to govern?

The CHAIR: Have your members expressed strong points of view on that?

[9.50 am]

Dr KHORSHID: They have not. The member's interaction with the project is usually at the consultation level so that the frustrations that have been expressed to us have been around the size. When you have a consultation process for a big project like this they do go down to individual clinical group levels such as, "What do you need? How do you want to run your thing?" There is a lot of frustration when you get answers—the doctors and nurses come up with a model that they think is going to work and then it does not get implemented. They say, "We think you need to build the outpatient clinic in this way" and then the decision is something completely different. They do

not have any transparency as to why that decision was made. That is the frustration that clinicians feel and that filters through to us. These other issues are bigger picture issues that the clinicians do not face until they read about it in the newspaper.

Mr D.C. NALDER: You talked about the size. What methodology is AMA using to determine what is an appropriate size?

Dr KHORSHID: There are lots of different measures. WA has a lower number of hospital beds per head of population than other states, for instance. Even the definition of a bed is quite a rubbery thing. You might think it is obvious but it is not.

Mr D.C. NALDER: I am just trying to be specific. The health department has made recommendations to government on what is an appropriate size. The AMA has come out and said that it is not big enough and that it should have an extra floor. On what basis? There must be a methodology based on something that determines what you believe is an appropriate size for the population we have or are expecting to have.

Dr KHORSHID: I was not involved at the time but there was a simple calculation done based on population growth and projected demand. For the hospital itself, the initial plan was effectively the same size as PMH so clearly it did not build in any potential for growth. The extra two floors were not so that we can have an extra 27 beds tomorrow. It is because we said that we are building a huge building. You are not going to build on it again. You are not going to close it to add onto it. You are not going to build another children's hospital in 20 years' time in the south—we do not think, anyway. We do not know exactly how many beds you are going to need in 20 years, but if you add 20 million, 50 million, 70 million, as I think we were told, for two floors, you have the potential to add if and when you need it. You look at population growth. We are not going backwards. We may have had a little dip in the last couple of years but our population growth is going to be sustained for many years to come. Unless you have major changes in service delivery models, that means you need more beds.

Mr D.C. NALDER: Part of the argument is around centralisation vs decentralisation, it would appear, rather than, necessarily, a different methodology than what Health was using.

Dr KHORSHID: Our understanding is that Health thought it should be bigger too. That is what we heard on the grapevine. It came across like the building is going to be this size because it costs this much to build it. If demand is going to be bigger than that, it can be dealt with at Joondalup, Fiona Stanley or Rockingham and they can grow, rather than saying that this is the best way to deliver services and this is, therefore, the modelling that we need. The plans for decentralising paediatric services have been around for quite some time. My understanding is they have not been implemented particularly well. The services are not as big as they were planned to be and they are not as effective as they were planned to be. Patients are still voting with their feet and coming to Princess Margaret, despite the problems at Princess Margaret. We know from Fiona Stanley and the Royal Adelaide, which has just been built, that when you have a shiny new building, what is going to happen to demand? It is going to go up and it is going to go up above all your predictions.

Mr D.C. NALDER: On your argument about decentralisation and centralisation, your argument earlier was that people will seek the best and, therefore, that will bring them in. If we end up with one central hospital, as it grows you need more doctors anyway. They are going to have to be spread amongst all the doctors anyway. What is the difference with some of those doctors being spread out to other locations as opposed to being housed in one? They cannot all see the same specialist, given the demand. Therefore, you require additional doctors. I am trying to understand why they cannot be located at Joondalup health campus or Midland and make sure that the kids are closer to where mum and dad are.

Dr KHORSHID: They can be for certain services. Where that is a good model, it is supported by everybody—by the doctors, by the AMA. I set up an orthopaedic surgery service at Rockingham, which is still, seven years later, struggling to be efficient. The reality is that we need certain throughputs to be efficient. You need to be able to teach and do research. You may need equipment. Certain services need very high technology equipment and it is not efficient to plonk that machine or that technology in an area where it is not going to get used very much. It is quite complex. You cannot just take services and put them there; you have to do the proper modelling to make sure that they are going to be efficient and sustainable both in staffing, quality, throughput et cetera. Especially for surgical services and, I guess, high-impact services—cancer services et cetera—you get better results from bigger units, full stop. That has been shown throughout the world in many, many ways. If you can set up a big unit that happens to have satellites, that sort of works as a model somewhat, but it is not as efficient as one big unit. But isolated units running their own show will often have a different type of workforce, not have the commitments to training and research that drive clinical improvements, and it is often not a good model.

Mr D.C. NALDER: My understanding is that it was supposed to be a bit of a hub and spoke where things that require greater specialisation would be here, but things where people are moving down a level, they could move out and be closer to home. That is my understanding of what the health department was talking about.

Dr KHORSHID: That is often talked about, but as a clinician who has to implement that, it just does not work that way. For instance, in my area of orthopaedic surgery, it is very inefficient to do the operation at a central place and then put them somewhere else for their rehabilitation because you have to transfer, you have clinical risk, you have the logistics of doing that—you will waste a whole bed day taking someone from one hospital to another. The reality is that you are better off just delivering your full service in one place or the other. This sort of stepdown works for some areas; you need good technology. We have hospitals all on completely different technology things. I can guarantee that Joondalup is not running the same IT and health information system as PCH is going to be running, so you cannot simply transfer a patient there. Say they had their acute stay in Perth Children's and then they were going to be followed up in Joondalup, we do not have the IT systems to underpin that safely, yet. We should, but we do not.

Mr D.C. NALDER: So what you are suggesting is that the IT systems will be different; they cannot talk to each other. Is that confirmed?

Dr KHORSHID: I have no idea what Joondalup runs, but they are a private provider so it is highly —

Mr D.C. NALDER: But you just made a statement that you cannot transfer because you cannot —

Dr KHORSHID: You can transfer, but you cannot transfer efficiently and safely. We do transfer.

Mr D.C. NALDER: Is that an absolute statement or is that an assumption?

Dr KHORSHID: That is an opinion from somebody who works across —

Mr D.C. NALDER: I am just trying to understand the truth of it because —

Dr KHORSHID: Well, it is true —

Mr D.C. NALDER: I agree they would be on different platforms, but I would be surprised if you could not transfer a patient. That is a surprise to me.

Dr KHORSHID: We can and do transfer patients, but you have to sit there and summarise their stay. You get one piece of paper that goes with the patient—that is if they are an inpatient. If they are an outpatient, you might have a discharge summary, which is the only thing available to the other site; unless they happen to be the same clinician who was looking after them in the central hospital, then

they will remember. But being able to go back in and say, "What antibiotic do we give them on that day?" while they are an inpatient, is extremely difficult. Even in the public sector it is extremely difficult.

Mr D.C. NALDER: We could keep going until —

The CHAIR: It is probably leading us away from very important questions, but probably for another day.

On page 3 of your submission, you state —

> The AMA (WA) has continued to call for increased transparency and accountability regarding the construction issues that have plagued the project and continue to delay the opening of Perth Children's Hospital.

When you say "increased transparency and accountability", what do you actually mean? What are your concerns at the moment with that?

Dr KHORSHID: I guess it is the things that we do not know, which I think is how I opened my statement. There is a lot that we do not know. We do not know how the decision was made on who would be the builder for the project. We do not know how the contract was managed. We do not know how some of the important decisions were made and who made them. It seems convenient to attack the builder, and there may well be major problems with the builder, but from our point of view there is some accountability for government in appointing and awarding the contract and then managing the contract. I think that would be a pretty standard statement across any government procurement, that there is a level of responsibility. If a project does not go well, you cannot just blame the contractor; you have to look at the way that you managed the contract.

Mr D.C. NALDER: The contractor is the same contractor that did the Joondalup Health Campus expansion—is that correct?

Dr KHORSHID: I do not know.

Mr B. URBAN: My question is probably similar to what you sort of skirted around a little bit, I suppose. One of the questions of relevance to the committee, which you raise on page 3 of your submission, reads —

> What were the criteria for the project design and what were the reasons for selecting the successful tenderer?

My question back to you is: what concerns did you have regarding John Holland? Obviously something has triggered that statement in your submission and your concern about John Holland, particularly.

[10.00 am]

Dr KHORSHID: That statement is with the wisdom of hindsight. The AMA had no concerns about the awarding of the contract to John Holland at the time—not that I am aware of, anyway. Obviously, it was a different choice to some of the other major projects, but it is a major builder and we had no concerns. The concern comes from the experience. We hear from the health department that they have been very difficult to work with, that deadlines have been missed, that communication has not been forthcoming, that facts have been difficult to get. The step of having to take practical completion in order to find out some of this stuff implies that there was not a good relationship between the builder and the contract manager. The obvious question is: how did you choose the builder and have they got a track record of delivering this sort of project in a way that was to the satisfaction of the contract manager et cetera? It is really just with hindsight.

The CHAIR: Basically, your submission is raising a lot of questions due to what has happened, but at the time, obviously, you did not know there was going to be a problem. Am I right in saying that for a lot of your questions, you want this inquiry to come up with answers for you?

Dr KHORSHID: Absolutely. We are not appearing as an expert; we are appearing as a stakeholder and an interested party. The big issue, I guess, for us is the size and the design decisions around the single rooms and the fit-out level of the beautiful building. That, to us, regardless of the builder, if you could not for financial reasons futureproof it, for instance, could you have done that if the building was not so pretty? We do not know the answer to that, but we would like to know it.

Mr S.A. MILLMAN: In respect to that one issue you raised as a stakeholder, speaking for myself: if there are materials that you provided to government as part of lobbying for an increase in the size of the hospital, together with any responses that you received from the government as to why it was not going to do that, and you have those and you would like to provide them to the committee or the AMA would like to provide them to the committee—I accept that Dr Miller was the president at the time—I would be happy to see them.

Dr KHORSHID: This would have been years ago. It would have been possibly Richard Choong who was the president. We would be very happy to provide that.

Mr S.A. MILLMAN: Yes; or Dr Capolingua might even have been the president.

Dr KHORSHID: No, not that long ago. That was 20 years ago!

The CHAIR: That is a long time. The issue about the size is not really germane to our inquiry, but, of course, it is of interest. I think we might be coming to the end of questions. When we talked about concerns about the tripartite relationship, what role does the QEII Medical Centre Trust have in the delivery and the subsequent operation of the hospital going forward?

Dr KHORSHID: I can only answer that from a general point of view; I have not read the documents that would underpin that. But from what I understand, at the broad level, the QEII site is managed by that trust as part of a bequeath from whoever it was and therefore some of the, I guess, site management issues are run through the trust. This is a vague memory, but I understand that there were issues with, for instance, parking and the trust would not allow the hospital to do certain things until they sorted out parking. It just adds a level of complexity. In terms of the actual running of the hospital, my broad understanding is that the trust would not have much to do with the running of the hospital; it is more the site itself—the physical infrastructure, the parking contracts and that sort of stuff.

The CHAIR: Before the member for Darling Range asks his question, your submission mentions that you hope this inquiry might assist with respect to the future development or co-location of King Edward Memorial Hospital at the site. What role do you want the profession—the AMA and associate professions—to play in designing a new hospital?

Dr KHORSHID: That is a very good question. What we want is what the public wants; we want the investment that the government puts in to deliver an institution that is not just world's best practice at that point, but is also still going to deliver very high-level care in 20, 30 and 40 years' time. We know that these infrastructure projects do not just happen all the time; they are huge exercises and they do not get repeated terribly often. So, engagement with the people delivering services—the doctors, the nurses, the clinical units—is absolutely critical in the detailed design level. I happen to know one of the people who was looking after the Fiona Stanley contract and they told me that it was the biggest consultation exercise that had ever been done in the state of Western Australia in terms of engaging with different groups. My next-door neighbour has a son who is quadriplegic and he was in well before the hospital was built looking at the ways the doors were going to open and how the beds were going to be positioned in rooms—really detailed discussions to make sure that

when it was built, it was fit for purpose. I think there is always grumbling—clinicians are never going to be happy, because they do not always get what they want—but on the whole that was delivered well. We would hope that clinicians have that level of engagement with any new projects.

The CHAIR: What level of engagement did they have vis-a-vis PCH?

Dr KHORSHID: I do not have a detailed answer to that question. I know there was consultation and I know there was frustration around the consultation, but I do not know how that compares with Fiona Stanley.

The CHAIR: Are you able to take it on notice to check through your documentation to see whether there is anything that has been written up on that?

Dr KHORSHID: Sure, we can look through that. It was quite a while ago. I guess where the AMA comes into it is the bigger picture—the size, the location, the issues where you stand back and say, "Is this ready for the next 20 years?" That is where the AMA would like to have some input, but I do not think we have any particular role in detailed design decisions. That is for the hospital, the staff who work there and obviously the people managing the contract to look after.

Mr B. URBAN: On page 3 of your submission the AMA demands —

> that Perth Children's Hospital should not open until there is complete confidence in the safety and suitability of the building.

Besides the potable water issue, does the AMA have any concerns around any other issues that could potentially undermine the safety of the building; and, if yes, what evidence can the AMA use to support its concerns? Beside the AMA's concerns about the number of beds in the hospital, are there any other factors the AMA believes may undermine the sustainability of the building?

Dr KHORSHID: That comment is similar to the one I made at the end of my opening statement. It is around, I guess, the experience so far and the multiple areas whereby if it was not for the fact that someone had drilled into a panel containing asbestos, you would never have known asbestos was there. We understand, for instance, that the cladding on the building is okay, but are we really sure it is okay? Has someone drilled into it and checked what it is made of on the inside, because I am sure the documents did not say there was asbestos in those roof panels? It is almost a paranoia having, it seems, so many problems with this build. We are worried that there might be other hidden things. There may be products that have been used that meet specifications in theory, but actually do not or other complex things like the plumbing issue—the lead issue—that you only find out about when you do the testing or perhaps when you move into the building. We do not have any specific inside information of other build concerns with the hospital and certainly no evidence to back those up; it is just a general uneasiness that having found these things so far, we worry about what else there is to find and what will be found when it opens a year later or whatever. Some of the systems and things will only be properly tested when you have 1 000 people or 2 000 or 4 000 people going through the building. It is very hard when you have a commission team roving the corridors to really know how everything is going to work.

The CHAIR: Thank you for your evidence before the committee today. 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 a transcript is not returned within this period, it will be deemed to be correct. New material cannot be introduced by 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. Once again, thank you very much.

Hearing concluded at 10.09 am