JOINT STANDING COMMITTEE ON THE CORRUPTION AND CRIME COMMISSION

AN INQUIRY INTO PUBLIC SECTOR PROCUREMENT OF GOODS AND SERVICES AND ITS VULNERABILITY TO CORRUPT PRACTICE

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 17 OCTOBER 2018

Members

Ms M.M. Quirk, MLA (Chair)
Hon Jim Chown, MLC (Deputy Chair)
Mr M. Hughes, MLA
Hon Alison Xamon, MLC

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Hearing commenced at 10.03 am

Dr DAVID RUSSELL-WEISZ
Director General, Department of Health, examined:

Mr ROBERT TOMS
Chief Executive, Health Support Services, Department of Health, examined:

Mr LEON McIVOR
Acting Assistant Director General, Strategy and Governance Division, examined:

Mr MARK THOMPSON
Chief Procurement Officer, Health Support Services, examined.

The CHAIR: On behalf of the Joint Standing Committee on the Corruption and Crime Commission I would like to thank you for agreeing to appear today. I am Margaret Quirk and I am the Chair of the committee. On my left is Hon Jim Chown, MLC, the Deputy Chair, and on his left is Hon Alison Xamon, MLC. Matthew Hughes, the other member, is an apology for today. 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 you may say outside today's proceedings.

Before we start with specific questions, Dr Russell-Weisz, is there anything you would like to say at the start of proceedings?

Dr Russell-Weisz: I have an opening statement, if you are happy for me to make that.

The CHAIR: Yes.

Dr Russell-Weisz: Thank you. In my opening statement I would like to set the scene from the Department of Health's perspective. The first thing I would like to say is that I remain very concerned by the conduct which was revealed in the Corruption and Crime Commission's "Report into bribery and corruption in maintenance and service contracts within North Metropolitan Health Service" in 2018, which outlined the deliberate steps taken by three named public north metro officers, along with named contractors, to covertly deviate from established and rigorous procurement policies and procedures and manipulate the processes for personal gain. The actions of the named officers are deplorable and in complete contradiction to the values of the Department of Health and the health service providers. The WA health system will not tolerate or condone a repeat of these types of actions and the behaviours of public officers outlined in the report.

Through the WA health reform program—this was commenced in 2015—the governance of the WA health system has changed significantly over the last few years, more so to drive local responsiveness, transparency and accountability. With the enactment of the Health Services Act 2016, which replaced the old 1927 act, health services and health support services were established as health service providers in their own right, with separate statutory authorities governed by a board and/or chief executive. These current health service providers, which I am sure we will refer to today, are the north metropolitan, south metropolitan, east metropolitan, child and adolescent, WA country health, the Quadriplegic Centre, PathWest and Health Support Services.

Health service providers operate within a broad public sector accountability framework and have accountability obligations under other legislation, including the Financial Management Act 2006,

the Public Sector Management Act 1994, the State Supply Commission Act 1991 and the Health Services Act 2016, as well Premier's circulars, national accreditations, independent audit and review agencies, such as the Auditor General, Ombudsman, Treasury, Public Sector Commission and the Corruption and Crime Commission.

Prior to this reform, which came into being in 2016, all authority and accountability rested with the Director General of the Department of Health. With an annual budget of $9 billion, approximately 44 000 staff and more than 90 hospitals, the WA health system was too large and complex to operate under this outmoded model of governance. Since the release of the 2018 CCC report, I have conducted extensive consultation with the health service provider chief executives, the board chairs, and also the key Department of Health executives. They all remain deeply concerned by the collusion and corrupt conduct I detailed earlier and at the fundamental breach of trust that occurred. The Department of Health and the HSP—health service provider—boards share a commitment to enhancing vigilance and systems to prevent, detect and manage fraud and misconduct, and, in particular, to supporting and empowering staff to speak up and question when they have concerns regarding public officers' or contractors' conduct.

As the chief executive officer and system manager for the WA health system, I am responsible for leading and stewarding the system, monitoring the performance of these health service providers and taking remedial action when performance does not meet expected standards. I will ensure that the HSP board chairs and chief executives and my department's executive team take responsibility as WA Health for driving the required cultural change and for implementing and executing appropriate actions and strategies.

I would like to take a moment to note that the CCC's recent investigation found that whilst the North Metropolitan Health Service had robust policies and procedures in place, and acknowledge that this is in large part due to the significant procurement reform program that the WA health system embarked on in response to the 2014 CCC report. In 2014, the CCC presented a report detailing the findings of an investigation, noting that it considered the WA health system did not have adequate measures in place to prevent fraud and corruption. In response, and I admit there is much more work to do, the WA health system took action to address each recommendation, the most significant of which was establishing the office of the Chief Procurement Officer. This was established in 2014, and between 2014 and now, the Chief Procurement Officer developed and implemented three strategic procurement programs to embed comprehensive and contemporary procurement policies, systems and controls, which were found to be lacking in 2014, and undertake and promote training and education and complete procurement audits and reviews. Whilst we have seen improvements in procurement, there is no doubt that the findings in the most recent CCC 2018 report have sharpened our focus on progressing even more planned reform in fraud corruption prevention, detection and education and the promotion of integrity more broadly. It is important to acknowledge that it is the broader integrity framework that we are concentrating on, which includes procurement.

In response, the WA health system has established an integrated program for integrity, fraud and corruption management. This project contains two streams of work: first, three key deliverables led by the Department of Health, which will include a mandatory integrity policy framework, systems for data capture, trending and reporting, and integrity promotion and capability programs. Second, an integrated reporting program on the implementation of the commitments made by the whole WA health system to the Minister for Health on 7 September 2018 in response to the 2018 report. We are taking the most urgent of these actions across the system and moving forward and I intend to embed the following three key lines of defence across the WA health system: an enhanced culture

of integrity through accountable and ethical leadership, good systems which enable support and good policy practice in reporting, risk management and assurance.

In closing, I take this opportunity to affirm the WA health system's senior leadership teams and my personal commitment to address these issues and execute the necessary improvements and actions in practice, culture and compliance. I am grateful for the committee's provision of a shortlist of questions in advance of today's hearing and we would welcome the opportunity to provide a comprehensive written report to the questions you have outlined.

[10.10 am]

The CHAIR: Just before we get onto substantive issues, and just for background, as a result of this CCC report there are now a number of inquiries going on, probably to some extent at cross purposes. Perhaps you could let us know the extent to which you know the progress of those various other inquiries. I think there is a Public Sector Commission inquiry.

Dr Russell-Weisz: Firstly, there is the Public Sector Commission inquiry, which has been commissioned by the minister. That Public Sector Commission inquiry is about to kick off this week. Obviously there has been liaison with the Department of Health and North Metropolitan Health Service in relation to this inquiry over the last few weeks, but the first meeting we actually have today with those who have been commissioned to do the inquiry by the Public Sector Commission. It is an inquiry for the minister, so the Department of Health, health support services and north metro health service will cooperate fully. It relates to the time period between October 2014 through to May 2016.

The CHAIR: What is the reason for that particular time frame?

Dr Russell-Weisz: That was the time frame that was alluded to in relation to what led up to the CCC—the CCC took over Operation Neil in May 2016. It has been well reported that the liaison between the CCC and between north metro and the department, going right back to October 2014 and right up to May 2016, may not have been optimal, and that is why the inquiry has been called. Clearly, we want to learn from that period of time. I would say that in December 2015 when I received a letter from the CCC commissioner saying that they were unhappy with the department's progress in relation to this —

The CHAIR: So in other words the CCC referred the matter back to Health, Health did an investigation, and the CCC was not happy, so it goes back to that period.

Dr Russell-Weisz: It goes back a long way, but in 2014 there was a whistleblower. The whistleblower went to the CCC. The CCC then referred it back to Health.

The CHAIR: All right, so that is why that time period is set. Are there any other inquiries going on?

Dr Russell-Weisz: I would say there is a huge amount of activities going on. Obviously the Department of Finance, I understand, is looking into the actual contractors who were involved in this particular inquiry. All the health services. This is why we would probably like to do a very detailed response to you, because each health service provider has a suite of activities that they are doing. The majority are doing forensic audits. The majority will be doing education programs. I think as a global health system, we are trying to have the same approach as we do with safety and quality. With safety and quality, 20 years ago we had an approach that was not as good as we have now, where we ask people to call out things that have gone wrong in our clinical system. We are trying to do the same here—for people to actually speak to us; to go to the health service provider chief executives. If there are issues that they are concerned about, we want people to be free. We have public interest disclosure legislation now, so it is very much about asking people to report.

The CHAIR: We have a bit to go through, so if you can confine yourself to the question, we will then ask additional questions if we need to. Are police doing any investigation at all?

Dr Russell-Weisz: Yes, we certainly understand they are. They have not contacted us at this stage. North metro and the department will cooperate with the police. They have not formally been in touch with us at this stage.

The CHAIR: Since the report came out, have you had any meetings with the CCC?

Dr Russell-Weisz: Yes, we have. The CCC did a presentation to all directors general about six weeks ago. That was extraordinarily useful. That was not just on north metro health service but on other inquiries. I then asked them to do the same session to the whole health service executives, so the chief executives, the board chairs and also to the Department of Health executives.

The CHAIR: Also to try to set the scene, you have been in your current position how long?

Dr Russell-Weisz: Since August 2015.

The CHAIR: And before that you were where?

Dr Russell-Weisz: I was the chief executive of the Fiona Stanley Hospital commissioning project.

The CHAIR: That was from what period to what period?

Dr Russell-Weisz: That was from November 2012 to basically May 2015, because I took a bit of leave between the two roles.

The CHAIR: Are you aware of whether the CCC has any other health department matters that it is currently investigating?

Dr Russell-Weisz: I am not aware of any other matters of this ilk that it is investigating, no.

The CHAIR: Before I let my colleagues loose, you have given some evidence that subsequent to the 2014 earlier report of the CCC, a chief procurement officer was appointed and other measures and frameworks were put in. But after the CCC returned this investigation back to you and said, I think in your words, that it was suboptimal, did you do anything in terms of investigations within the department? Did you make any changes there?

Dr Russell-Weisz: I might, if I may, Chair, ask Mark to speak exactly to what was done in the procurement space since that report, because we can give you some details. Since the 2014 report, there was a whole reform program put in place.

The CHAIR: But that related to procurement. I am concerned that the CCC has said, "We have given you this investigation to look at. It is not satisfactory. We are going to take it back." Within the department's investigative arm, did you do anything to beef it up, change how you investigate or generally encourage whistleblowers? What did you do as a result of being told that the investigation that was conducted internally was unsatisfactory?

Dr Russell-Weisz: I think going back to 2013–14, we did have some governance reviews that showed failings at that time. The whole governance reform—that is, the establishment of the boards and putting the accountability to north, south, east, country and child and adolescent—actually showed that we were taking governance seriously. We put accountability at the local level. We put new legislation in, so we reformed the legislation. That then meant that all integrity functions and all procurement functions, whilst we mandated policies from the Department of Health, stayed with the health service providers. We also have set up, since the CCC's earlier report, an integrity unit in the department, which we have beefed up significantly of recent times. If people are coming to us with integrity concerns, they may go back to their health services providers as well. But there is a gradual and quite significant focus on integrity. I would say that the report came down in August.

We have taken a whole suite of actions since that report. The actual report came down in only August, but the reform —

The CHAIR: With respect, there have been a series of reports and a series of failures to act. It is not just this report.

Dr Russell-Weisz: Yes, and I think we can go through exactly what was done since 2014. It failed to pick up this corruption, which was hidden from people at the north metro health service. If I can go back to that period, the CCC originally wrote to the then director general and said, "We have got a whistleblower. That whistleblower has said that there are issues." There were two reports then commissioned by the then director general, quite rightly—one into north metro. It was sent back to north metro at the time to say that it needed to strengthen these avenues. In December 2015, I got a letter from the CCC saying that it was unhappy with the department's progress on this. I got a new investigator in to investigate at that time. That investigator found some serious issues. We then handed back to the CCC, because we did not have the powers, as a Department of Health, to be able to investigate. They then issued us with section 42 notices in May 2016.

[10.20 am]

The CHAIR: About what time was that?

Dr Russell-Weisz: In May 2016, they issued us with section 42s.

The CHAIR: So, you are on notice as of that day that there is a lack of vigilance, if you like. I am concerned that you are coming along today and saying, "We have done all of this since the report." I am wondering what happened between 2014 and 2016.

Dr Russell-Weisz: If I can ask Mark to go through the themes, because it is intricate detail what we have done with procurement reform.

Hon JIM CHOWN: If I could just interrupt, commissioner. Before you get Mark to go through the themes, there have been red flags with regard to procurement issues since 2010. There are a number of CCC reports to that effect. In fact, a 2014 report found that, and I quote, WA Health "does not know what its fraud and corruption risks in procurement are" and that it did "not have adequate controls to prevent, identify and deal with fraud and corruption in procurement." The CCC found evidence of "widespread non-compliance with state-wide legislation and policies across WA Health." You have a cultural issue here, and now you are telling us that in 2015 you put in processes to address this.

Dr Russell-Weisz: It was 2014—going back from the CCC report.

Hon JIM CHOWN: No, this report was in June 2014. You became the director in 2015. At the opening of this inquiry you read out a statement talking about processes to address breaches in the procurement process of WA Health. How are you going to address the cultural matters within this incredibly large department and ensure that the breaches are closed off? You have had a meeting with the commissioner of the CCC, and so have we. He has stated that the process across most departments are adequate, but they are not policed properly to ensure that breaches are addressed. I have not heard you say and outline how you are going to address future breaches or change the culture of this department in regard to procurement. I do not want to lecture. I would like you to tell us how you are going to address that.

Dr Russell-Weisz: There are two elements to that—one is what we did from 2014. If I can go back to then and then I will answer what in addition we are doing from then. It might just set the scene. I am happy to say what we are doing now. I did cover it in my opening statement, but I did not want

to go into intricate detail because you did not want me to speak for probably 15 minutes. Can I go back to 2014 and maybe ask Mark to speak about what we have put in place on procurement?

The CHAIR: It was a fairly specific question: what was your reaction and what action did you take when the CCC came back to you and said that your investigation was inadequate? I do not want to talk about procurement processes or anything else. I know that that is what the inquiry is about, and we will get onto that in due course, but I am really curious to know that when the CCC came back to you, what your reaction was and what you personally did.

Dr Russell-Weisz: It was in December 2015 when they came back to me. That was the first time that they let me know about this investigation. I took immediate action. We got a new investigator in. The new investigator found things that the previous investigator had not, and we then referred that inquiry back to the CCC. But at that time —

The CHAIR: What I am asking about is that you did not have to wait for the CCC report to know that there was all this —

Hon ALISON XAMON: Irregularities.

The CHAIR: Irregularities. So you think, "Mate, this looks like a problem", and you ring up whoever.

Dr Russell-Weisz: There was already a program set up by my predecessor, and a good program, to address the 2014 report. So the 2014 report —

The CHAIR: No, I am not talking about that; I am talking about this one. You are getting the heads-up, to use the vernacular.

Dr Russell-Weisz: Yes, we are.

The CHAIR: You got the heads-up in 2014 when they came back and said that the report was not adequate. What I want to know is what processes were put in then? It seems as though you waited until the CCC did its report.

Dr Russell-Weisz: We did not. We put in very clear processes in relation to procurement, and also authorisations and delegations. We found—this is what we acted on in 2014–15—that people were acting outside of their delegations. They were not clear about: at this level you can spend this and at this level you can spend that. When the Health Services Act came in in July 2016, we then had robust delegations, authorisations and procurement activities in place, so we acted. I cannot take all the credit for that. My predecessor started that—I continued that—from 2014. The minute we had the heads-up from the CCC, yes we took action on this, but we also continued our procurement reform program. We also made sure that when the act came in in July 2016, that the health service providers had their integrity units in place and that they also had authorisations and delegations. We found that people were not necessarily adhering to them. That is why I wanted to give you specifics of exactly what we have done. We have also gone out and educated. We have had about 3 800 sessions on procurement to educate staff, because staff will spend money from $100 to $1 000. Health has 44 000 staff. We procure very large to very small capital works. The most important thing is understanding what people can approve and then what people do in relation to that approval, but also asking people to call out issues in relation to integrity, which they had actually done in 2014, it just had not been acted on quickly enough.

The CHAIR: Would it be true to say—you talk about an overall budget of $9 billion.

Dr Russell-Weisz: Overall health budget.

The CHAIR: Clearly the sorts of sums that arose in this CCC investigation are, by health standards, chicken feed. Would it be true to say that that lower level of procurement is what goes under the radar and that there was an unacceptable level of complacency about it?

Dr Russell-Weisz: Yes, and not right across the system. We are talking about three individuals. We are talking about one area health service at that time. But certainly at that lower level, the checks and balances and the actions relating to the 2015 report—so the then acting director general sent a report to say, "You have significant issues here to north metro", for them to act on at that time. There were specific things to do in relation to procurement activities. At the same time we were not sitting on our laurels. We were not just saying, "Oh, it is one health service." We were doing a whole suite of procurement work—education, and not just education activities but making sure that people could not spend above their delegations. If I may, Chair, I might ask Mark to give you some facts and figures about this because —

The CHAIR: We will get onto that in a minute because my colleagues have other questions. Before we get off when the CCC came back to you, did you brief the minister or anyone else at that time?

Dr Russell-Weisz: I would have to check whether the minister was briefed at that time. It was a cease and desist. Certainly the minister was briefed recently into the CCC report when I had permission from the CCC to brief the minister. When the CCC contacted me about the release of the report, I sought permission from the CCC when I could brief the minister, and they told me when I could do that.

Hon ALISON XAMON: Can you confirm when that was?

Dr Russell-Weisz: So that I answer that absolutely correctly, could I take that on notice and I will give you the exact date that I did brief the minister.

Hon ALISON XAMON: Can you give an approximate month?

Dr Russell-Weisz: Yes, it was prior to the CCC report. It would have been a week or something prior to the CCC report.

Hon ALISON XAMON: So not long before.

Dr Russell-Weisz: Not sooner, because we were under section 42 notice and I did —

The CHAIR: Which basically says "cease and desist activity". It does not say that you cannot say, "Minister, we have discovered some irregularities in our procurement practices and we are doing X, Y and Z to alleviate those issues."

Dr Russell-Weisz: I think the procurement activities may indeed have been briefed to the minister, but on this—I do recall this—I contacted the CCC saying that we had a draft report and we wanted to brief the minister. They said, "You can brief the minister at this stage." The minute we could brief, I briefed.

The CHAIR: Which was a week before the report came out?

Dr Russell-Weisz: I would like to get the exact date for you, Chair. It was around about that. The exact date before the report was released—it was about a week.

Hon ALISON XAMON: I suppose there are a number of things that this report revealed that were deeply alarming. I note that the report already identified that all the procedures in place were fine—there was nothing wrong with it. You refer to the work that had been undertaken. Clearly those boxes had been ticked, but it did not stop the corruption from occurring. I come back to the issue of culture, because I think that that is the fundamental weakness that we are looking at within the health department. You have talked about the creation of the integrity unit and about talking to people about the importance of integrity. But, with respect, if someone is setting out to defraud, by definition they do not have integrity, so it is not really going to have much effect on them. Picking up on my colleague Hon Jim Chown's line of questioning, I am trying to get an idea of what you can do to really challenge what is happening culturally. You have talked about, effectively, a

whistleblowing culture, but as I understood, the sorts of problematic behaviours that were being demonstrated—the long lunches—were well known within a number of people within the north metropolitan system. How was that not then picked up? How was that not being talked about more broadly?

[10.30 am]

Dr Russell-Weisz: It is a question certainly that I and others have asked in this, but, member, you are absolutely right: this is about culture. I actually have got all the health service provider responses, so I could read from one to say exactly what they have done prior to this report and also what they are doing. It got the whole executive—I have not picked on north metro; I have picked on another health service—they got the whole executive together. They have done a number of globals to staff to encourage them. I think the one thing that I have certainly seen —

Hon JIM CHOWN: But you are talking about the sort of people who —

Hon ALISON XAMON: I do want to hear the response.

Dr Russell-Weisz: Certainly what the chief executives have done is they are trying to actually embed that culture, saying, "We want to hear." It is not, "We don't want to hear." If you have any suspicion about a contractor, about your colleague public servant, about anything, we want to hear from you. That is one of the things that the chief executives are doing. Rob, as chief executive in health support services, can talk exactly in his organisation about what he is doing, because I do not think it is that prescriptive. I think you are right. I do not think you can have policies and procedures in place. You want people to call it out if they are worried.

Hon ALISON XAMON: So since you have established this integrity unit, how many people internally have come forward with complaints?

Dr Russell-Weisz: Again, to this integrity unit, I know of probably around about 20 who have approached me, and I have gone through this integrity unit. That is in the Department of Health, so that is in Royal Street. I cannot answer for the individual health service. Royal Street has around about 820 staff. Some health services have 10 000 staff.

Hon ALISON XAMON: Are we able to get on notice, through Madam Chair, the numbers of people that have approached the various integrity units since that has been implemented?

Dr Russell-Weisz: I think that would be fine.

Hon ALISON XAMON: Can you please talk me through some of what happens with that process? We know there is a history of whistleblowers, for want of a better term, being treated fairly poorly, not just within the Department of Health but more broadly within the state. What assurances are being given that people are coming forward and giving information—you referred to them then being sent back to services particularly—and that they are not then being subject to adverse action, which of course would prevent anyone else from ever coming forward?

Dr Russell-Weisz: Well, I can tell you what I do and what I have done. I will give you the examples I have seen recently. They have come directly to me. Some are anonymous. One, I respond straightaway. Whatever they are asserting I will take seriously. I will immediately forward it to my Department of Health integrity director. They will do an assessment of it. The one thing that we have had fed back is that people do not contact them. I contact them literally immediately to say, "We've got your complaint. We take it seriously." If it is an issue that relates to north, south, east or WA country, we would normally refer it back to them, but we would talk to the complainant first to say, "As they are your employer, we want to refer it back to them." But if it is a complaint about a senior officer, it might be something that remains with us. I am very cognisant of that.

Hon ALISON XAMON: Is there any point that you are referring it through to the CCC?

Dr Russell-Weisz: Yes, there are. Health service providers would refer a number of things through to the CCC. That is stipulated what we do refer. We are overcautious, I would say, in what we refer to the CCC. The CCC then will refer the majority back to us, or we can actually refer to the Public Sector Commission. Health service providers will choose, in a sense, which one to go to, but we have, I think, a culture of health services reporting to the CCC quite regularly. It is a question you can ask the CCC, but I know the amount of reports we send through, some of which the CCC will note and send back. My process for the ones I have had, and I have had a few anonymous ones, is to take it seriously and to actually investigate it. Some are very complex. Some I have seen might go many pages, have different complaints in different areas and need a diligent approach. We also check whether it is made under public interest disclosure, because once it is made under public interest disclosure, we have to stick to rigorous legislation.

Hon ALISON XAMON: Sorry, can I get an idea also of the sort of staffing that is available within these integrity units?

Dr Russell-Weisz: We can do. We can provide that per health service provider.

Hon ALISON XAMON: Can you even give me a basic indication of how many people we are talking about that are undertaking —

Dr Russell-Weisz: Some are investigations. Some will provide education programs. But in my area, it is around about 10—remember, the Department of Health is pretty small.

Hon ALISON XAMON: Is that at Royal Street when you say "your area"?

Dr Russell-Weisz: Yes. There would probably be around about 10 people. But Royal Street is only 820 staff. Even though we will receive some of the complaints, they will come directly to me or to the integrity unit. All health service providers will have integrity units, some of which are linked with their workforce units and some of which are separate.

Hon ALISON XAMON: I just want to pick up on another comment you made before. You referred to what had happened in north metro as "hidden". Can I just say, with respect, based on the information that has been revealed through the CCC reports, it is hard to think of it as having been particularly hidden. People did know that long lunches were being had. People were raising eyebrows about the nature of the relationship between some of the senior officers and the various contractors. In fact, you, yourself, went to lunch, I understand. Can you please give a little bit more information to the committee about how those circumstances came about? Did you question, for example, at the time who was paying for the lunch? I would like to get a bit more information around that, please.

Dr Russell-Weisz: I was at North Metro Health Service as chief executive until October 2012, before I was asked to go to Fiona Stanley. I did not know Mr Ensor, but I knew Mr Fullerton and Mr Mulligan; they worked in the North Metro Health Service. I have been very open in relation to the lunches I had with them; no, sorry, with Mr Fullerton and one other north metro executive. The majority of that—actually all of it—was when I was at Fiona Stanley Hospital. There is no doubt—I will be very clear—that I have done some soul searching. Sure, four lunches over that period is not a lot. I meet my other executives at times for breakfast or dinner, where you do actually do some work. I have questioned what I did not see, but I know other people who were in north metro at the time, without naming them. These are north metro key people who equally are actually quite distraught by what they did not see—senior people that I would trust implicitly and still trust implicitly, about not seeing what was going on. Yes, it might have been known, but in speaking to others at the time—so 2014–

15, at the height of the corruption—certainly people are saying they did not see that. I have got real faith that if they did, those senior people would have called it out.

The CHAIR: The member is actually asking about your specific knowledge.

Dr Russell-Weisz: I had no—and I have said this clearly; if I had had any knowledge of that sort of corruption and collusion between those 11 contractors and two of the executives and one other contractor outside, of course I would have called it out.

Hon JIM CHOWN: I am sure you meant "any corruption or collusion".

Dr Russell-Weisz: Absolutely, but the question was on that time. My integrity is very dear to me. If I had known anything about what this Mr Fullerton and others had been doing, I would have called it out.

Hon ALISON XAMON: One of the things that this committee is needing to examine is not only the best processes that can be put in place in order to avoid corruption around procurement, but also to address those issues of how do you create a cultural environment whereby corruption is not able to exist, and certainly not to prosper. With the benefit of hindsight, and knowing now what you do, what would be your reflections upon what culturally was occurring at the time that enabled that corruption to exist, and also, what do you think would and should have been done differently in order to not enable that to happen?

[10.40 am]

Dr Russell-Weisz: I think, generally at that time there should have been a culture of calling it out. That people who did see—as you have said, the people who knew that was going on—felt free to go to their chief exec at the time. Remember that at the height of the corruption, I actually was not there at that time—at that height. But before, people being able to come to me or come to others or go through to the Department of Health and actually say this was occurring. As I said, it is a bit like the safety and quality culture you want; you want people to call it out when things go wrong.

Hon ALISON XAMON: I guess the concern is that you are talking once again about people lower down the food chain, if you like, calling it out, and yet we have evidence here that people who are higher up the food chain are reflecting on the fact that they should have known what was going on and should have seen what was going on. I am actually asking: for people that were further up in north metro who were in a position to potentially observe and start questioning what was going on, what could and should have happened at that level in order to affect exposure of the corruption?

Dr Russell-Weisz: We should have examined—I said "we"; north metro, at the time—should have examined the conflict of interest registers. We now have gifts, we have travel; we have a much better process for gifts and conflicts of interest registers, but these people were corrupt. They would not have put this down on the conflict of interest register.

The CHAIR: Let's at least make it hard for them, all right? If they are going to be corrupt, you make it a bit more difficult.

Dr Russell-Weisz: Yes, and we have just tabled a report in Parliament on gifts and travel and conflicts of interest, so the minister has tabled that report. We now have much better procedures in relation to the acceptance of gifts, the declaration of conflicts of interest and commercial travel than we ever did I would say probably five or 10 years ago. But these people went about setting up—the CCC would know this better than me—a project director outside and they were colluding with 11 contractors that did not speak up themselves. Not one, as I understand it, went to the chief executives or the other execs at that time to say there is something wrong going on here. Not one contractor spoke up at that time.

The CHAIR: Can I just work out the line of authority: who was Mr Fullerton's supervisor?

Dr Russell-Weisz: The chief executive of north metro health service, from around about the end of 2011.

Hon ALISON XAMON: Was it Mr Wayne Salvage?

Dr Russell-Weisz: It was me for the last year and a bit that I was there. It was then, for 2012 until 2016, the chief executive, so it would have been the chief executive at that time. There were three chief executives through that time: there was an acting chief executive for a while, Dr Fraser; then Dr Shane Kelly got that job; and then Mr Wayne Salvage was the chief executive.

The CHAIR: All right. So there are not a lot of people in between?

Dr Russell-Weisz: No.

The CHAIR: So that is one thing. Two: because he had a reasonably high delegation, he was doing his own thing a lot of the time—would that be an accurate—because he could sign off to a certain level?

Dr Russell-Weisz: He could sign off to a certain level, yes.

The CHAIR: There has been much discussion subsequently about Mr Fullerton's notoriety for taking long lunches. Were you aware of that when you were at north metro?

Dr Russell-Weisz: I was not aware of that.

The CHAIR: All right. But there were some suggestions that there were jokes about it amongst staff?

Dr Russell-Weisz: There was, and that has been reported in the CCC. I was copied in on an email to another executive about meeting for lunch. But certainly in the staff that I have spoken to—the senior staff—they have questioned themselves, as I have. This was not known that Mr Fullerton was going out for these long lunches to me when I was at north metro. It was not known, and I can be absolutely clear about that.

Hon JIM CHOWN: I would just like to ask a question of Mr Thompson, as the chief procurement officer: what sort of mechanisms have you put in place as chief procurement officer to close off these potential breaches to graft and corruption, and how are you educating staff across the whole state, and how are you policing the new regime that you have in place currently? That is three questions. I have one other question in regard to the integrity unit. What subject matter has come forward from whistleblowers or staff in the health system that they are concerned about in regard to procurement?

Dr Russell-Weisz: If I may, Chair —

Hon JIM CHOWN: Mr Thompson might answer first and you can come back later, okay.

Mr Thompson: Maybe I will talk to the education first. Since 2014 we have educated about 3 800 people, and we have been doing that quite steadily from 2014–15. This year to date we have done 818 people, of which 42 per cent has been in north. So we have done a very wide education program. That has been a mixture of procurement overview, right down to ethical behaviour and procurement, so looking at probity and accountability. How that training is delivered: there are three drivers. One, upon request, so a particular hospital area has actually requested training. We have got standard training programs that people can come along, but also some of my team are looking at the systems and where they see some challenges for people, they are actually going out and proactively educating them.

The CHAIR: So what is the length of all of this training?

Mr Thompson: It can vary from a two-hour face-to-face session, and we also have some online videos as well, so it varies quite significantly.

The CHAIR: They are not John Cleese ones, are they?

Mr Thompson: No, they are not. Historically, we have had a focus on policy, process and systems, mainly in the procurement and contract management area and mainly with goods and services. We do have an online website that has all the training material that is available for people and it is widely accessed.

Hon JIM CHOWN: If I can just interrupt, the historical system has obviously been failing, and that has been made public to the department since 2010, at least. Lord knows what happened before then! Your historical system has been failing, so how do you address those failures in the current system that you have in place, and where were the breaches or your areas of concern in regard to procurement across the board that you believe need to be addressed?

Mr Thompson: When you look at procurement, there are three areas: there are services and goods above the $250 000 where we have very rigorous controls; we have a high level of detection controls, a high level of prevention controls and we go through lots of committees, so I am very assured in that space. The $20 000 to the $250 000 is probably a challenging area for us because there is a very high volume of transaction. In our community services areas, again it is very good; there are lots of policies and processes. In our works sub $2 million, that is an area of concern.

Hon JIM CHOWN: This inquiry is finding across the board that it is that low area where a procurement officer can go out and get something for $19 000 five times from the same supplier who he happens to play golf with. So how are you addressing that? Because that is where the issues really lie. We all understand that the large multimillion-dollar contracts do have significant protocols around them and are looked at very closely.

Mr Thompson: So in relation to 2018, we are actually doing forensic audits as we speak. We are using some third parties to come in with a forensic engine and we will give them the two million transactions that we have had over the last two years, to do forensic audits to try to look for order splitting or those types of hotspots. That work has either just started with some of the HSPs, and with HSS we are just about to commence with awarding and agreement on that. So that is the first place, because the transaction volume is huge.

The other piece I am looking at as well is the purchasing process: requisition, approval of requisition, purchase order and receipting. We are finding some anomalies in that space as well.

The CHAIR: On that point, we have some transactions provided from the Department of Finance where there has been an exemption sought for a tender because it has gone over time or it is beyond the value. I am looking at some of these for collection disposable services for reusable sharp containers—something that could have been anticipated—$1.7 million beyond term and value. There is one here for antiseptic and bandages, which I think is about $4 million beyond term and value. That to me is a concern. You can anticipate that you are going to need antiseptic and bandages in the hospital system and they are, if you like, abusing the system by putting the bid in so late that they are requesting that it does not go to tender. What are your comments on that? Sorry—$5.5 million for antiseptics and disinfectants in February this year!

Hon JIM CHOWN: Below the $20 000 works.

Mr Thompson: I will give you some context. Across health we have about 2 000 commercial arrangements. If you said that the average term is five years, you have got 400 expiring every year. These events typically take somewhere between six months to two years to run, so we have a challenge with some of our cycle times because of the complexities and the spread across the HSPs.

So we do have a capacity challenge with executing all of those renewals. With some of those, when we are transitioning from one contract to another, because it takes longer, we need a short-term extension so we can put the new contract in place, but we do have a large number of variations.

[10.50 am]

Mr Toms: Could I just add a comment to that, if you do not mind? As Mark says, there is about $4.2 billion worth of spend on 2 000 contracts. What we find is an area that we need to improve on is around the planning and the actual procurement planning and getting the strategy right up-front. One of the issues that we have is this necessary capability and resourcing capacity to do that planning, which would therefore avoid running into a situation where you are not leaving yourself enough time to relet or retest a contract. If you look at some of the exemptions that come through, quite often it is to do with the planning processes around that particular subject that have led to that request to us.

The CHAIR: I would have thought it was quite easy to have a call-up system. I worked at a law firm where you would get a call-up system saying that the statute of limitations was about to expire. I do not understand why you cannot have some call-up system. You are losing the opportunity to have value for money by leaving it until the eleventh hour and then seeking an exemption from the tender.

Hon ALISON XAMON: Apart from the corruption risk.

Mr Toms: Yes, I completely understand. The other thing that we see is like a sole source, so pharmaceuticals and different things. There are a lot of different reasons why you do not go and retest other than this pool.

The CHAIR: No. A sole source is a different thing; I understand that. But the fundamentals like antiseptics, bandages, sharp containers—stuff that you are going to need all the time, and for millions of dollars—you know, there are variations or time delays. I just do not understand why.

Mr Toms: I think what I would say—Mark, it might be good to get your comment—when you look at the whole of health contracts, of which there is 250, 300 or something like that, those ones are well known, they are defined, they sit within the system and we know what the duration of the contracts are. When you are talking about the lower-value contracts, that is an area that we need to improve on around getting the transparency and planning right around those areas. What you are calling out is absolutely right; it is an area that we need to strengthen and improve on. But in terms of the whole of health contracts, we have got good visibility of that. The system that we use to develop and approve contracts and manage contracts is really clear in terms of that PDMS system as well, but there is an area —

Dr Russell-Weisz: Sorry, we used an acronym there. You need to say what the acronym is.

Mr Toms: It is the procurement development and management system. Any contract that we form essentially has to go through that system. It has got the built-in approvals and checks and balances in place to make sure that is done properly and it is managed.

The CHAIR: So is $5 million a lower-value contract? What are you talking about? I need a definition.

Mr Thompson: In health, that would be one of our lower-value contracts. It is still important.

The CHAIR: But you accept that if it was considered and looked at earlier, you could probably get better value for money. The stuff is not unique and you could get probably a number of people interested in tendering.

Mr Thompson: With every extension since I have been onboard, I have been driving a price negotiation and discussion. So even if we are not able to go to market, because typically we are

picking the same providers and the same products because we are prioritising another bigger piece of work where there is more value of money, we are also having a price negotiation with the vendor.

Hon JIM CHOWN: I am just waiting for the director to respond to my question in regard to concerns by employees that have come forward to your integrity unit—what subject matter they are concerned about, and what course of action has taken place in regard to those concerns?

Dr Russell-Weisz: They are varied. They have not focused on payments to contractors. They have not focused on procurement. They have more focused their complaints about people getting jobs not through the proper process. They have also been about not following proper process where restructures have happened within organisations. They might be complaints about using an external party twice and not going through the proper process. Also, we have had specific complaints in relation to specific health services, where staff are complaining that their complaints that they raised with their own health service have not been adequately responded to. I might be wrong here, but I have not received one in relation to the contractors that were outlined in the CCC report, but I imagine the health service providers would have done.

Hon ALISON XAMON: One of the comments that was made by the CPSU–CSA in their submission to this inquiry was that they relayed that for their members, undertaking a public interest disclosure was considered to be a career-limiting option. They in fact expressed that they would feel much more confidence relaying concerns to a journalist than they would internally. Do you have any comments about that? It is a huge issue, particularly considering that your evidence to this committee today is that you are relying very heavily on staff coming forward in order to be able to expose corruption risks.

Dr Russell-Weisz: We are doing a heap of things, but the first thing we are doing is the forensic audits, and the health services themselves are doing them. So we are not just relying on staff coming forward. I think the CCC themselves presented a report to us when we went to see them that said 47 per cent of these are found through whistleblowers and six per cent through audit, which is concerning generally. This is not for Health; this is generally across the board I think Asia–Pacific-wise. The most important thing for me is making sure staff feel, without fear or favour, that they can come forward, even if it is found not to be the case. That has to be a huge arm. It is about culture. We can have all the audits in place, and we have oversight, obviously, of the boards now with robust allegations, authorisations and accountability. The Auditor General now obviously provides oversight services to the health service providers. We will do intricate forensic audit in relation to the area we are most concerned about, so that lower level. But we felt here, this was found through a whistleblower—this was actually found through somebody putting their hand up.

Hon ALISON XAMON: As I understood it, it was found because they were a whistleblower who became aggrieved. They had been aware that there had been concerns, but as I understand it, that is when they came forward.

Dr Russell-Weisz: I probably should not be aware of all the details, because that was the whistleblower to the CCC. In a sense we just want to know that whistleblowers are happy out there to tell other agencies or tell ourselves and we investigate.

Hon JIM CHOWN: What protection can you, as director, give to a whistleblower in regard to their future career prospects?

Dr Russell-Weisz: The ones I have actually responded to, I have said, "We will take this seriously and you are able to come to me confidentially. If I go to anybody else, if I need to go and ask any questions, I will come back to you." A number of ones that have come to me, not just after 2018—I

do get people writing to me on a reasonably regular basis if they are aggrieved—I would say we will take this seriously. If I then need to go —

Hon JIM CHOWN: The word is "protection". That is the key word in my question, director. If a whistleblower came forward and said, "Look, I'm very concerned about the procurement process X, Y, Z. I am a senior executive or I may be well down the ranks, but before I open up to you, I want you to assure me that I will not be vilified by my colleagues. I actually don't want my name mentioned."

Dr Russell-Weisz: If they asked for that, I would give them that assurance. I do encourage them. If it is, say, in an area like we have had in one area of our health services —

Hon JIM CHOWN: How do you give them this encouragement through the department? Have you sent out a memo to everybody? How have you done this?

Dr Russell-Weisz: We have. There have been globals that have gone out from the area health services. The chief executives and the boards have actually sent to their staff, "Come forward and tell us." They have actually said, "We want to know."

Hon JIM CHOWN: Directly to you—to your office?

Dr Russell-Weisz: No, because they will go to their staff.

Hon JIM CHOWN: Okay. They will go to their line manager, who may be part of the process. They might be the problem, so that will not work.

Dr Russell-Weisz: No, no, no. The chief executives want them to know that they can go to their integrity unit without any fear or favour. The thing is, most people would not necessarily come to the Department of Health in Royal Street because they are part of a clinical health service and they will want to feel that they can go to the top person. We do take complaints from them. I am open to a number. If anybody comes to me, we will take it seriously.

Hon JIM CHOWN: Okay. I am a whistleblower. Outline the process for me in regard to my concerns and how I can get a hearing and at least have the issue investigated, or at the very least, looked at without impinging on my career in the health department.

[11.00 am]

Dr Russell-Weisz: In each health service there is—we can provide this is on notice—an integrity tab that every staff member can go to that says who you go to in the health service if you want to report something that is not your line manager.

Hon ALISON XAMON: Would it be possible to get a copy of that for the committee's information?

Dr Russell-Weisz: Of course, and we can provide it for every health service and the department. They would then go to that integrity tab. They would say, "This is the person I can contact." They clearly can go to their line manager if they feel comfortable to, but a lot of people do not. A lot of people will feel comfortable going to the chief executive, and I know some people have even approached the board. They can approach me. They can also approach the Public Sector Commission. They can report it to the Public Sector Commission and they can report it to the CCC —

Hon JIM CHOWN: I am talking about your internal process. We are all aware of the external processes.

Dr Russell-Weisz: The internal process is—well, again, if I prescribe it so much: "You must go to that integrity person", I might be stopping somebody who says, "I want to speak to the director general", or, "I want to do it anonymously. I want to go to the chief executive of that health service." Yes, we do have integrity units within each and we have someone they can contact, but we also do not want

to stop people contacting people above them, because they might not feet they get an adequate hearing. Again, we try to call it out. My whole mantra about this is: we want to hear from you. It might be useful, Rob, to talk about what you do in health support services because—does that adequately describe what you do?

Mr Toms: It absolutely does. There is a fairly clear process laid out in regard to if you have got anything that you want to report through to our integrity unit, you know who that person is that you can go to and you can go to them and have a confidential discussion. Each situation is judged on its own merits. If there is any concern around confidential or reprisals, then we would go at lengths to make sure that it is maintained confidentially, and if for some reason we had to take action where that became obvious, then we would negotiate and discuss that with the employee. The other thing is that you may get things that come directly through to the chief executive or go through to an executive and each and every single instance is judged on its own merits. The process is reasonably clear, but what has happened since the report in August is that we have gone to all of our employees and we have actually said, "Here's the process. This is the policy and this is how you do things, but we want every single employee to know that what's happened is disgraceful and we want to you to know that you have the ability to go and talk through these people and to me without fear of reprisal." It is a line of defence, and we actually do not want to suppress that information. We do not want to suppress that conversation and you do have our support. But I think, culturally, what it is going to take is me, as the CEO, demonstrating behaviours that actually support that. When people start seeing that, they will see things changing and they should feel more confident in using those processes. But I cannot say specifically in terms of what every HSP is doing, but in conversations with my colleagues, every single one of them is doing that.

Hon ALISON XAMON: I have a different line of questioning, if that is okay. It is about the role that the reforms that occurred in 2016 have or have not played around issues of oversight and governance. Of course, we know that we have moved to this new board system and, in fact, you just referred to the fact that some whistleblowers are choosing to go directly to the boards. However, we have also had in recent times, concerns that are emerging from those very same boards about a lack of transparency and a lack of information coming to them that enables them to effectively undertake their role. In this devolved system where we have concerns being raised by the boards themselves as to a lack of information, what faith can we have that they are well equipped to be able to provide any level of oversight of the health services for which they have responsibility?

Dr Russell-Weisz: Yes, I am happy to answer that. We actually think the devolved governance allows better transparency because when it was not devolved and everything came through the Department of Health and through the director general, the director general had to be across everything—as I describe it, know what is going in Fitzroy Crossing to Fiona Stanley, in the community to the health services. It was not all about transparency. It was also about more accountability and local health service visibility. This was not tinkering around the edges of the 1927 act. The 2016 act gives accountability and responsibility to the board, and if the board are not getting the information they require from their executive, they are empowered to do so because they have responsibility for clinical and financial management of the health service. They have responsibility for the management of that health service. I issue them with a service agreement. They have mandatory policies they have to follow. They have to follow all the acts I mentioned, which I will not go through again. They are responsible. I would say to a board that says, "We were not given the correct information from our health service", that it is your responsibility to get that information from the health service. If it is information they need from the department and also from health support services, we will provide that. I think that was a criticism that was levelled within north

metro. I must say I have no not heard that from any other board that they are not getting the level of scrutiny or the level of detail that they should be.

Hon ALISON XAMON: I suppose the initial concern I have, though, is that the people on these boards are not doing this full time. Invariably most of them, if not all of them have external jobs that are their primary jobs in addition to their board responsibilities. With respect, you often do not know what you do not know. I am concerned that, effectively, we have created a structure where the buck stops with the health boards, if that is indeed what you are saying, when we are talking about people who are operating in those roles being very part time and who have substantive jobs that are not directly related to their board activity.

Dr Russell-Weisz: Yes, but we have tried to set up a system, learning from the eastern states. They went to devolved governance about five years ago. Victoria did it 20 years ago. They have 88 boards in Victoria, though much less in New South Wales and Queensland. When it was set up, and again, I cannot take credit for that, the work was done because we were not getting the accountability and transparency at that time. We wanted to put in better and more local, rigorous processes. Yes, they are not the full-time jobs but most health service boards are not full-time jobs. What I can say looking at the boards is that the majority of boards have set up processes where they are comfortable. They provide annual reports each year—the annual reports are just out. I think the process we have, it may not be perfect but it is a lot better. It gives me a lot more comfort than it was pre-July 2016.

Hon ALISON XAMON: Even if it is deemed to be an improvement, I suppose the concern I have is that it does not mean that we are there in terms of governance.

Dr Russell-Weisz: We are not.

Hon ALISON XAMON: I suppose I am quite clear that there is a very different skill base involved with trying to determine appropriate service delivery at a particular local level as opposed to providing the diligent, internal oversight that is going to deal with the issues of potential corruption. They are actually quite different roles. Maybe the former is being done with a little more vigour than the latter. I would be curious to know your thoughts on that.

Dr Russell-Weisz: We are not there. It is a bit like safety and quality. As I said, we want to have a safer system this year than last, and a safer system next year than this year. We will have a better governance system next year than we do this year, and I think we have the elements to do it. That devolved governance and not going to a myriad of boards, which we could have done, but actually going to, it is now seven with health support services and PathWest—I think there is a lot of one learnings out of this CCC report and previous CCC reports, but it is not only about the broader governance we need to improve year on year. I would never want to give the committee the idea that I think we have it fixed—absolutely not. This is something that we will continue to learn and continue to improve on. We will continue to do that, but I would not chuck out the governance structure because of what has happened here.

The CHAIR: Can I just go onto the Langoulant report briefly? In particular, Mr Langoulant made some comments about the Serco contract, which went ahead without a business case —

> You would say: how can we possibly, in today's age, go forward with a procurement of over $4 billion over a long period of time for the delivery of essential services into our major hospital without a business case? Yet that was the case. We gave Health seven months to find a business case and it could not find one.

What was your reaction to that finding?

Dr Russell-Weisz: Appalling. They could not find a business case for the FM services, which goes back to, I think, 2009–10. I cannot give you the details at that time as to why there was no business case, but that was a finding. Obviously from my Fiona Stanley Hospital commissioning experience, I dealt with Serco on a regular basis to get the hospital commissioned.

The CHAIR: All right, but what I am saying is, can you put your hand on your heart to the say that that is not going to happen again in the context of procurement?

[11.10 am]

Dr Russell-Weisz: Absolutely. On a $4.3 billion or whatever it was business case—we have now improved, for example, Chair, our ICT governance. I am going from here to an ICT executive board meeting as everybody on that meeting who looks at these larges business cases. We are looking at replacements for some of our large ICT systems. We have improved the governance of that. We will not go up to Treasury without a robust business case. I can absolutely assure you of that. That was a pretty appalling finding.

Hon JIM CHOWN: Just on this matter as well, director, what level of confidence do you have in—using your words—your "evolving processes" to address breaches in procurement on a year-by-year basis? You expect this process to become tighter and tighter, so what level of confidence do you have in it? Secondly, are we hopefully unlikely to see corruption at the level that has been exposed since 2010 within the department?

Dr Russell-Weisz: I would desperately hope so and it was three individuals, and I have said this before, it is three individuals —

Hon JIM CHOWN: Yes, but I have previously stated, director, that this goes right back to 2010.

Dr Russell-Weisz: It does.

Hon JIM CHOWN: There are a number of CCC reports that have not been addressed and you have put in the processes, as you said in your opening statement, that hopefully will address procurement. I am asking what confidence you have in the systems under your direction that are in place currently?

Dr Russell-Weisz: Much better now than I did in 2016, 2015 and 2010. Can I give you a guarantee there will not be bad people doing bad things within a staff of 45 000? I would look a fool if I said that was not going to be the case, but we want to put —

The CHAIR: Conversely, you are saying, "It is only three people." You cannot have it both ways.

Hon JIM CHOWN: But that is a caveat on this matter. This is a very serious matter and as a director, I am asking you for a level of confidence.

Dr Russell-Weisz: I have got a much greater level of confidence and with the integrity framework we are putting in place, and with the forensic audits specifically about those areas in relation to the lower dollar amounts that the boards and ourselves are putting in place, I have a marked increase in confidence. I am much more confident than I was two years ago than we would have been previously. We are doing—it is not just the department. The actual health services are doing forensic audits. They are doing a number of things to make sure that anything that is there we actually find. It is not something that we can just do for one year.

Hon JIM CHOWN: Forensic audits are one thing. When you find breaches, how are you going to address them and what is in place to penalise the individuals who have gone outside of their parameters and deliberately breached the protocols that you have in place, to their personal advantage or to a friend's personal advantage?

Dr Russell-Weisz: If it is corruption—when you just said there, member, that it would be corruption, then that is a corrupt activity. If that is a corrupt activity, that gets reported to the CCC and we would want them prosecuted for that activity.

Hon JIM CHOWN: Why would you go to the CCC? Why would you not go to the police, go to the fraud squad? Why would you not directly, as director, send them to the fraud squad?

Dr Russell-Weisz: You may.

Hon JIM CHOWN: But you mentioned the CCC here.

Dr Russell-Weisz: I did because we have certain obligations where we have to report to the CCC, so I would certainly report that to the CCC —

Hon JIM CHOWN: But you can also go to the police if you have issues of great concern from your internal investigations.

Dr Russell-Weisz: If there was somebody in the health service doing that today and we found them doing that today, we would likely, for that example you gave at the end, stand them down until it was fully investigated —

Hon JIM CHOWN: By who?

Dr Russell-Weisz: By either, depending on the level, the police, the CCC, the PSC or ourselves.

Hon JIM CHOWN: Who makes that call?

Dr Russell-Weisz: Sorry?

Hon JIM CHOWN: Who makes that decision?

Dr Russell-Weisz: If it is serious, it will be the chief executive of that health service who makes the decision. If for some reason somebody has gone outside their delegations but it is not corrupt—they have signed off something that they should not have signed off—there will be an investigation, there will be a performance review and there might be some counselling. People do make those sorts of mistakes, but if it is corrupt behaviour, we will act on it, but we will report it to the CCC because we have to.

The CHAIR: The CCC referred a profile of certain individuals who are more likely to be corrupt. I understand that the briefing you had with the director generals talked about that.

Dr Russell-Weisz: It did.

The CHAIR: One of the things that has come up is that people who do not take leave, for example, that is seen as being—they want to stay around and keep a lid on everything.

Hon JIM CHOWN: It is a red flag.

Dr Russell-Weisz: It is.

The CHAIR: That a measure, for example. that you could be looking at. Is that being undertaken?

Dr Russell-Weisz: Absolutely. Can I ask Rob to talk to that?

Mr Toms: I will just give you an example of what we do at health support services. We have a monthly report on leave liability and we essentially report on the individuals who have the most leave and we require a leave management plan to be put in place in regard to each of those individuals to ensure that that leave liability is being managed. We have quite regular transparent reports that are reported to myself and the executive committee at health support services that monitor this, and we also report on this on a fairy regular basis through to the Department of Health through financial reports as well. This is an area that we manage from a financial angle but also from

a welfare angle. That recent presentation around them being a characteristic of an individual that may be high risk, it just adds even extra weight to making sure that those reports are done regularly and discussed actively. That is something that we do at HSS on that.

The CHAIR: Mr Thompson, you might be best placed to answer this. Part of the problem at north metro health I think was that there was a bit of a blurring of the lines between project management and procurement, and that meant that there was able to be a closeness with contractors that was inappropriate. I understand now, maybe with the creation of the role that you are in, has that separation occurred or is it in the process of occurring or will it occur?

Mr Thompson: I will talk about north metro. In the works area, what they are starting to do now is separate the people who understand the work that needs to be done and the people who will engage the contractors to do the work. Separation of duties is a really good preventive control in helping improve the outcomes, so that is a piece of work that they have actually commenced already.

Hon ALISON XAMON: When did that begin?

Mr Thompson: That began in August.

The CHAIR: After the CCC report.

Mr Thompson: Yes.

Hon ALISON XAMON: But it was not in place before then?

Mr Thompson: I will take that on notice. They may have done some other things, but I am just aware that they took some action.

Hon JIM CHOWN: That is a very standard process elsewhere around world. I cannot believe that the department has waited until the report to put that in place—seriously.

Dr Russell-Weisz: Sorry, if I could just—we did not bring in today any of the chief executives of the clinical service delivery health service providers, but we felt that you may want a hearing with them so that you see what they are doing on the actual sites. There are five others and that would have been a huge amount of people —

The CHAIR: This is obviously a work in progress.

I want to ask a couple of questions about corporate credit cards. For example, I think, director general, you made some comments about lunches—having working lunches and what have you. What is the sliding scale for credit card limits for various people in the department?

Dr Russell-Weisz: I will ask Mark to talk about that, but normally, if two or three execs go out for a breakfast meeting they normally pay for themselves—it is normally coffee, you just pay for yourself. If I can tell you what I use. I use my corporate credit card if I am at a hotel or a commonwealth meeting.

Hon JIM CHOWN: How many corporate credit cards are in circulation?

Mr Thompson: I can give you the numbers. We have 865 across the metro area. I am still waiting on the WACHS number.

Dr Russell-Weisz: WA Country Health Service.

Hon JIM CHOWN: What is their daily limit?

Mr Thompson: A card will have either a $1k limit for the month, a $5k, a $20k or $50k. It is mainly $5k cards. They are the standard sort of card. A $20k or a $50k card is only because of unique operational requirements. For example, it is more effective to do lots of transactions in the month

with a card. The spend across the cards—the 768, about $21 million a year through 45 000 transactions. It averages out to about $470 a transaction through those cards. In terms of how those cards get issued, they are actually all approved by the chief financial officers of the areas. There is some governance around who gets the cards and who should not get them. Staff can only actually code to certain cost codes. There is a restriction on what they can actually cost to. All of those transactions are approved. Monthly audits are conducted. Every three months, 10 per cent of the transaction are audited, and there are also end-of-year financial audits. Last year's financial audit, only one medium risk was found from the sample, and that was one lost receipt and one late approval. There is a really good mixture of probably preventive and detective controls across cards, and there is good evidence of compliance. In terms of credit cards, it is something that we do really, really well.

[11.20 am]

The CHAIR: While we are finishing off that topic, director general, there was a bit of discussion in the media about you being in a CC to an email, and there were some jokes about Mr Fullerton having a "frequent dining card". What did you understand that to mean when you saw that email?

Dr Russell-Weisz: I think when you saw that I was CC'ed into that email, the guy who was emailing him was seeking a lunch with me and that other fellow, that other executive at north metro.

The CHAIR: No, but the reference to "frequent dining card", it is obviously a joke.

Dr Russell-Weisz: Yes, it was.

The CHAIR: Do you understand what that meant or not?

Dr Russell-Weisz: Well, yes. That that is where he went. That is where—that was the implication that that is where Mr Fullerton went for lunch.

The CHAIR: At the time that that joke was made, you were certainly in on it.

Dr Russell-Weisz: I was CC'ed to it and I was actually at Fiona Stanley Hospital at the time, I think, when that email came through. I met with him and that one other executive at that time. Did I know that Mr Fullerton was then meeting other contractors for these highly expensive lunches? No.

The CHAIR: That is not what I asked. I said, "Did you understand the joke?"

Dr Russell-Weisz: Yes.

The CHAIR: And you understood the joke because —

Dr Russell-Weisz: And looking at it now, I do not remember every email I get.

The CHAIR: No, no, but you understood the joke.

Dr Russell-Weisz: Yes.

The CHAIR: You did not have to ask the PathWest person, who was the other person, what it meant and —

Dr Russell-Weisz: Well, not at that time. I was the chief executive of the Fiona Stanley commissioning. It was—I get a lot of emails per day. I did not go, "Oh, well there might be something going wrong there", at that time.

The CHAIR: No, no, no. You are reading more into my question than I am asking. Just answer the question that I am asking. At that stage, Mr Fullerton was known for liking to go out and lunch? You do not necessarily know who or whether it was under corrupt circumstances.

Dr Russell-Weisz: No.

The CHAIR: You were aware that he liked to enjoy hospitality of some description?

Dr Russell-Weisz: No, I was aware that was one of his restaurants—if you look at that email—that he liked, but was I aware that he went out with contractors? No, not at all.

The CHAIR: That is not what I asked. I said you were obviously aware at that stage there was a joke made. You said that you understood that it was a joke, so you were therefore aware of his reputation of eating out a lot—not who with or were they corrupt or other circumstances.

Dr Russell-Weisz: No. Was I aware of him eating out a lot at that place, at that time for a CC to an email? I would have to say not to that level.

The CHAIR: But enough for it to be humorous and for you to get the joke.

Dr Russell-Weisz: Excuse me, if I remember that email—but I do not—but I was very open at that time and said, "Yes, this is where we met." And it was executives. There were actually two executives there.

Hon ALISON XAMON: I am going to come back to this issue of culture, because part of what you were saying would hopefully transform the culture is repercussions if wrongdoing is found. What became apparent in the culture of north metro was that there was not a fear, generally, of repercussions, which is why it was not at the forefront of people's minds to be able to look out for what was going on. It sounds like there was a great deal of trust and potentially friendships that were also perhaps clouding that rigorous oversight that would have been required. In terms of repercussions, I would like to firstly get two reflections. One on the issue of pursuing the redundancies, which have been paid out to the allegedly corrupt officials. I am curious to get your reflections on that. Secondly, since the report has come down, you have talked about how there have been multiple meetings with the senior officers and chief executive officers, and you also refer to the boards. What is happening around trying to, if you like, put the fear of God into these people about what will happen if anything further is uncovered or not addressed appropriately? Because it would seem to me that an appropriate penalty would be a very key incentive to not engage in corrupt behaviour.

Dr Russell-Weisz: I will take the second question first. That is why we are making efforts in relation to the integrity policy framework. We have mandatory frameworks that all health services have to actually follow. If this is now in place, then health services, like with all our other mandatory policies, have to follow them. We also want a culture of people speaking out. It goes to the other member's question about you want to encourage people to speak out without fear or favour so that they do not feel they will be persecuted, but you also want the health service providers to understand that a key role of that health service provider is to promote, detect, educate and prevent fraud and corruption, not just on a procurement level but to actually promote integrity, so wherever you find that you want them to actually act. If you are saying that if they found something and did not act, I believe there would be severe repercussions for that health service provider.

Mr Toms: For us, each health service take a very similar approach. First of all, we send a really clear, unambiguous message to everyone that what happened reflects a standard that we are not willing to accept. Secondly, we have developed an action plan that has a number of different things in it that we are going to do to strength our detection and prevention processes—undertake forensic audits, do more training and do more communication in response to the issues that were identified. Thirdly, with regard to consequences, from my perspective, I would take this type of situation extraordinarily seriously, and from my point of view, I would want to essentially bring down the most significant punishment or consequence that I was able to implement because, again, as much as it is up to me to demonstrate behaviours that encourage people to report issues, it is also up to

me to demonstrate behaviours that show what happens when these issues do arise. Again, I cannot speak for my colleagues, but I know from my conversations with them that they are on exactly the same page.

Hon ALISON XAMON: Could you answer my first question?

Dr Russell-Weisz: Yes, we are pursuing the voluntary severances that were paid out. I actually cannot give you an update today where that is at because we are obviously liaising closely with the State Solicitor's Office about how we do that. I can assure you that we will use every avenue possible to actually recover those voluntary severances. I just give you that assurance. Obviously, it is probably more in the remit of the State Solicitor than it is in relation to us, but we will act on his advice, and we are seeking that advice at the moment.

The CHAIR: It was reported at the time of one of the redundancies that there was some checking with the CCC on whether it was okay to do this, and the CCC did not say anything one way or the other, as I understand it.

Dr Russell-Weisz: In relation to the CCC, there was an approach at the time by the chief executive of north metro through the Department of Health who had liaison with the CCC at the time, to say what would—because we were going through a voluntary redundancy program, a very large one, at the time. These were not singled out. At that stage there was a section 42 notice, so it was, as you said, a cease and desist. There was a query put forward. The CCC did not put anything in writing but they said—these are my words: "You have to treat normally." They did not tell the north metro health service to process the VSS—the voluntary severance. They did not do that and there was a decision then made by the north metro chief executive at the time to process it. You can always retrospectively look at that and say, "Should that have been done?" Clearly, we wish that had not been done, but it was not done out of malice. He had sought some verbal advice. That verbal advice had been given back and he made a call on that at that time. We have fed back to the CCC and also the PSC that we believe there should be a policy in that we can follow across health and the public sector—there is not a policy—that if there is any CCC investigation either prior to it occurring or certainly under a section 42, that maybe voluntary severances do not get given, but there is no such policy.

Hon ALISON XAMON: This is the problem, because there is a lack of visible repercussions for when this is actually being uncovered.

Dr Russell-Weisz: One of the things that we have fed back to the CCC, and again this is my reflection, is that we wish there had been better communication up within the Department of Health and elsewhere during this period. I think that, and we have fed this back to them, when you talk to the CCC especially about something so confidential, there is from really good officers in the department elsewhere, the feeling that they cannot talk to anybody else about it. We have to get that. That is more a cultural thing. They have to be able to talk to their bosses and clearly the bosses of the department or the health service involved. I have suggested a policy for that very issue, should it happen again.

[11.30 am]

The CHAIR: Was the department kept abreast of progress while the section 42 was in place?

Dr Russell-Weisz: Minimal. I was originally called into the CCC over the last few months. I was asked to go when they were getting towards the end of the completion of the report, but not usually, no.

Hon ALISON XAMON: That is to protect the integrity of the investigation.

Dr Russell-Weisz: We would provide anything the CCC asked for during the section 42, as north metro would have done. You would have to ask north metro, I think—sorry, Chair—what communication there was after the section 42.

The CHAIR: So certainly at the stage that an inquiry was made as to whether this person should be given a redundancy payout, it was pretty clear that that person was central to the inquiries of the CCC —

Dr Russell-Weisz: That was why the query was made.

The CHAIR: — and would be named adversely.

Dr Russell-Weisz: At the time no, because I think the issue was there had been no adverse findings made at that stage. At that stage when the VSS was paid out, the report was not drafted and there were no adverse findings at that stage. I would have say no, we were not aware of any adverse findings, but we were clearly aware there was a section 42 CCC investigation into them.

The CHAIR: How is morale at the north metro these days?

Dr Russell-Weisz: I have to say I think it is pretty bruised after what they have been through, but we have a new board. We have a very dynamic, experienced chief executive there now and we are working through—this will be a rebuilding. North metro is a very proud health service. I was there for six years. It is a proud health service, it delivers great services and we want morale to increase as quickly as possible, but it is very bruised.

The CHAIR: I will move onto the conflict of interest register. Have there been any "conflicts of interest" questions generally? Have there been any changes in procedures or is that contemplated?

Dr Russell-Weisz: It has been tightened up over the last few years. We can provide you on notice with how we actually register conflicts of interest. There is now a standing agenda item at every single meeting I chair about whether there are any conflicts of interest and people need to declare it. But it is also up to the person to declare a conflict of interest because obviously people's interests change.

The CHAIR: In terms of due diligence, quite often other corporate entities will be set up as a vehicle to facilitate this corruption. When you are entering into contracts, how much due diligence is done or company search is done in relation to corporate entities to see whether there are conflicts of interest or links?

Mr Thompson: I can talk to that. Just to give you a sense, we have 24 000 active suppliers in our system, of which we transacted last year with about 10 500. Each year the number ebbs and flows. Last year, 2 000 new suppliers came on and about 900 came off, so there is quite a bit of change. Every time we create a supplier, the purchasing teams are the only ones that can actually request it, so an individual can request it, but it has got to come through a centralised purchasing team and then it actually goes to a systems team that switches them on in the site. Before they switch them on, the will go and do an ASIC check and they will also go and check for registered ABN numbers. For some of our top end of town suppliers we will further do a Dun & Bradstreet or a Corporate Scorecard type of report.

The CHAIR: But common directorships or anything else like that does not tend to come up?

Mr Thompson: That is probably an area with the volume that we need to actually do some more work on, and that has been highlighted just recently.

Mr Toms: I have a couple of things to add to what Mark has said. One is that any directors that have a perceived actual conflict of interest would need to declare that as part of their process of being appointed to the board. There are controls set out at the board level probably around those sorts

of things. The only other thing that I would add around conflict of interest is that, again, we have a pretty clear policy that every single employee is required to complete mandatory training, which includes education around conflicts of interest. For us, for example, at HSS we have just re-enacted that that has to be done every two years by every single employee and it has to be done by new employees within the first three months. There has been a lot of promotion around that sort of thing.

Dr Russell-Weisz: We call this the accountable and ethical decision-making. We can provide percentages to you of staff across the health sector on who has actually done that training.

The CHAIR: We are probably going to have to get you back because we need to drill down on the technical stuff.

Thank you for your evidence today. You are providing some additional material, as I understand it. The transcript of this hearing will be forwarded to you for the correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional, which you are in fact doing, 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 very much.

Hearing concluded at 11.36 am

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