PUBLIC ACCOUNTS COMMITTEE

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

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 13 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 10.39 am

Dr TARUN STEPHEN WEERAMANTHRI
Chief Health Officer, Department of Health, examined:

The CHAIR: On the behalf of the Public Accounts Committee, I would like to thank you for appearing today to provide evidence relating to the committee's inquiry into the management and oversight of the Perth Children's Hospital project. My name is Tony Buti. I am the committee chair and member for Armadale. With me today on my right is the member for North West Central, Mr Vince Catania, and to my left is the member for Darling Range, Mr Barry Urban. The committee's deputy chair, Mr Dean Nalder, the member for Bateman, and committee member Mr Simon Millman, the member for Mount Lawley, both forward their apologies. 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 might say outside of today's proceedings.

Do you have any questions in regard to your attendance here today?

Dr WEERAMANTHRI: No, I do not.

The CHAIR: We, of course, have your report from July 2017, but would you like to make any brief opening statement before we commence with questions?

Dr WEERAMANTHRI: Thank you, Dr Buti. I might just clarify that I have two roles and just distinguish between them, because that might go to some of the questioning, if that is okay?

The CHAIR: Yes.

Dr WEERAMANTHRI: My first role is as assistant director general of the public health division in the Department of Health. In that role, I report directly to the director general of Health. That is a straightforward management role, if you like, in the public service. In addition to that, I have a statutory appointment as Chief Health Officer. That is under the new Public Health Act. In that role, I report directly to and am appointed directly by the Minister for Health. There is a statutory role and there is a traditional public service role. I am appearing today, I think, mainly in my Chief Health Officer statutory role. Even in that role, there is a distinction to be made. The first is as the regulator—so the person responsible for the public health safety system in this state. In that role, I have the power to close a water supply under the Health (Miscellaneous Provisions) Act. That is on the one hand, but, on the other hand, I have also recently been asked by the Minister for Health, as the Chief Health Officer, to step back and do a review, which is the document you have in front of you. That was a review where I did not use any powers under the act, but I used, if you like, the symbolic power of being Chief Health Officer to encourage people to cooperate with the review, which they did, and then presented a report back to the Minister for Health. That is not a traditional regulatory role, so it should be distinguished from that. At the completion of that review process, I actually wrote back to the Minister for Health, handing the report to him and saying that I would then step back into my more traditional regulatory role.

As well as that, inside the department, I have also communicated to the director general that given these two roles, I would focus on the regulatory side and if there were particular decisions to be made as assistant director general, that would be handled by my deputy. I have actually even within the department distinguished between those two roles, because I need, and ultimately as the

regulator, to make a decision about the safety of the water supply, and clearly there is a conflict or potential conflict of interest if I am also advising the government about how to achieve compliance.

The CHAIR: When you say you have stepped back from the assistant director general role, has someone actually replaced you?

Dr WEERAMANTHRI: What I have said is that I head up the public health division. One of those directorates is the environmental health directorate, so there is the director of Environmental Health. I also have a very senior colleague, Dr Andy Robertson, who acts for me when I am away. But I have said to the director general, "If you want specific advice around your decisions in terms of what you are going to do to open the hospital and your strategies, then that should go through, first of all, Andy and then to Mr Jim Dodds, as director of environmental health." I have just separated—I will stay as the regulator, because, ultimately, I will have to make the decision as the regulator about whether the state has achieved what it set out to achieve in terms of a safe water supply.

The CHAIR: Just to clarify that, because it is quite complicated —

Dr WEERAMANTHRI: It is quite complicated.

The CHAIR: — it is in your role as the Chief Health Officer that you have the responsibilities in regard to Perth Children's Hospital; is that correct?

Dr WEERAMANTHRI: I have a responsibility at the time it becomes a water supply. Now, at the moment, it is not. I have made a decision that it is not yet a water supply because no one is drinking the water. At the point it becomes a water supply, my regulatory responsibilities kick in and I have the power to actually close a water supply. But the state has taken a commonsense approach to this, which is to say, "If a person has the ability to close a water supply, we are going to seek that person's opinion as to its safety prior to opening." That is a commonsense position for the state. Even though I have no, as yet, formal regulatory responsibility, I have advised government as to my likely approach and the criteria I would use and the things that would influence my assessment about what would constitute a safe water supply. I think it is more than fair to let people know what I will be thinking about, so I provided that information to the task force over the last nine or so months to help them develop a strategy that would lead to a safe opening.

Mr V.A. CATANIA: Were you engaged by Strategic Projects to sit down or did you engage them?

Dr WEERAMANTHRI: No, I was not engaged by Strategic Projects. Prior to practical completion and subsequently, there was the Perth Children's Hospital task force, which you know, and the chair of the task force, who also happens to be the director general of Health, asked me to come along and share with the task force some of my considerations around what I would like to see in order to inform them about the bar that they needed to reach. In addition to that—this is complicated, Dr Buti—I also had an environmental health directorate which was actively looking at the results that were given to it and also providing, because we have expertise as regulators, our interpretation of what we could see. Because we do not have that many experts in water quality, environmental health et cetera, we do not have the luxury of a completely separate department and a completely separate regulatory system, but we are used to handling this and we do it around a range of issues. I am personally used to handling this kind of issue, and we have made the appropriate, I believe, separation of roles and we are accountable for that.

The CHAIR: Your work as the Chief Health Officer is empowered by the Public Health Act and also section 131 of the Health (Miscellaneous Provisions) Act 1911 in regard to the closure of a water supply if you do not think it is of the quality it should be; is that correct?

Dr WEERAMANTHRI: That is correct. I am appointed as Chief Health Officer under the Public Health Act and my powers in relation to this matter relate to that section you mentioned.

The CHAIR: Practical completion was not the key for your regulatory responsibility; that will occur once the water is flowing.

Dr WEERAMANTHRI: That is exactly right, Dr Buti, and I actually said that to the task force. That was the kind of discussion we had when those kinds of issues came up. What I said was that from my perspective as a regulator, the point of practical completion is not the critical one; the point is at what point does it become a water supply. I was on leave for much of March and April and when I came back, practical completion, I think, had been taken by that point—I have to remind myself, I am sorry, of the exact date. I actually then wrote to the chief executive of child and adolescent health services, who was also responsible for PCH commissioning and confirmed that the restrictions around use of water were the same as prior to practical completion so that I could confirm for myself that it was still not a water supply and there was no intention for it to be a water supply. I received that confirmation in writing and so up until today, or until I am told, as far as I am concerned, it is still not a water supply because the same restrictions are in place as were in place prior to practical completion.

[10.50 am]

The CHAIR: We understand about the regulatory emission, which will happen when the water is running, but when did you first become involved with the Perth Children's Hospital project?

Dr WEERAMANTHRI: I first became involved when the director general asked me to give him advice around the asbestos exposure incident, which I think was in July 2016. That was not in my regulatory role, because the appropriate regulatory authorities were, I think, Comcare, at the commonwealth level, and WorkSafe, but as a public health expert, the director general of Health asked me to come in, have a look at the situation, give him some advice and meet with the task force, which I did, and I have provided written advice to the task force.

The CHAIR: John Holland notified you on 2 September 2016 in regard to their concerns with regard to the water quality?

Dr WEERAMANTHRI: That is correct. It was early September 2016. That was kind of an official process where if any water supplier is concerned, they have a duty to notify us, and even though it was not technically a water supplier, John Holland did go through that process and tell us in September.

Mr V.A. CATANIA: What is that process and what is the time frame? Is there a time limit of when they have to report that there is a problem with the water quality?

Dr WEERAMANTHRI: There is no specific time frame, but we would expect that all water suppliers take their responsibilities very seriously in this state. We have a fantastic record in terms of water quality. We would expect them, as soon as there is an issue that they are concerned about, to let us know. What we do is we work with them. They are still responsible in terms of the supply and whether the contingency —

Mr V.A. CATANIA: But there is no requirement for them to inform you?

Dr WEERAMANTHRI: I would have to check the legal requirements. I am sorry; I should know that, but I do not.

Mr V.A. CATANIA: I am happy to take it on notice.

Dr WEERAMANTHRI: If you could provide the question in writing, I am happy to do that.

The CHAIR: Can I refer you to your report "Perth Children's Hospital Potable Water: Chief Health Officer Review, July 2017" and pages 19 and 20? You mention that there was a striking lack of documentation about key parts of the construction process critical to the cause of the dezincification process evidenced by a remarkable lack of clarity around chlorination of the water distribution system. You mentioned there was sustained failure of proper assurance processes. Can you take us through that or elaborate on that if you do not mind?

Dr WEERAMANTHRI: I am happy to. The key to this report was that the Minister for Health actually asked me to step back and do a review as a regulator in my regulatory position, but also as a public health expert who has been around for a while and, if I could, find a way forward, because obviously this project is overdue and there have been a number of strategies tried. The report was triggered by some baseline-approved Chief Health Officer testing that showed that the results were not yet up to the mark that they needed to be as part of what I said would be my approval for this opening. The state had not yet reached that mark and so the Minister for Health said, "Let's step back; let's take a few weeks. Can you go back and look at all of the documentation, which is voluminous, but also see whether you can take a different approach?"

Mr V.A. CATANIA: When was this approach made to the Minister for Health?

Dr WEERAMANTHRI: When the minister asked me? Just prior to July. There is a letter from the minister, which is appendix 1, but he actually, I think, asked me a few days before that so I could start it, and then he followed it up with a letter. I met with the task force. The key was, "Find a way forward if you can." The whole purpose of this report is to tell the minister, as the responsible minister on behalf of the state government, what I thought was helpful in getting this hospital open. We did different kinds of things. We did a series of scientific experiments, which are documented here. We tested various hypotheses and we also did a series of interviews with key stakeholders, the list of which is in the report as well. Part of my job is to work with proponents of all sorts of things that hinge on public health and get a sense of the proponent and get a sense of what they are trying to achieve. There is almost always some kind of public good involved. People are trying to do things that will benefit others; there might be a commercial or other factor driving it, but that is fine. The state government obviously wanted to open a hospital, and that is a good thing. I had to sense what people were saying, what fitted together, what was consistent, what was discrepant between people and what the different views were—clearly after such a long period of time there were different views—and to kind of synthesise that and make some sense of it and weigh different opinions up, because people are going to have different opinions. I thought it was important to speak plainly, and so you can see there is an emphasis in the report; the first 30 pages or so are pretty much written in plain English for the public and the minister to understand what I thought. My recommendations are pretty clear. The back end is all of the science, if you like, and the technical documentation that people are free to look at and encouraged to look at.

When I go to this paragraph, I am giving my personal view as an experienced regulator and I am saying I was struck by the lack of consistent documentation for what I considered a key event, which is the chlorination of the water supply, because it had been accepted by the state and its various consultants that dezincification of brass fittings was a highly probable cause of what we were seeing in terms of the elevated lead levels. If so, I would have expected that the initiating events for that dezincification would have been thoroughly looked at. Clearly, chlorination and its levels could contribute to that dezincification process. When we looked at and asked for evidence about the chlorination events, that was on top of what the task force had already asked for and looked at, so we had access to some of the task force materials. I was struck by the lack of consistent documentation of the events, which, even up until the point of the Jacobs report that was finalised in April, did not contain a full list of all the chlorination events. We found evidence that was given

to us in the review process that there had been a chlorination event in September 2015, for example, but that was not in the Jacobs report. Not only was there no clarity from the various reports about how many events there were, there was lack of documentation of the amounts of chlorine introduced, the duration that it was introduced for and the monitoring of levels. For whatever reason, that documentation was not there, which the Building Commissioner also found in his report and commented upon. It makes it very, very difficult to ascertain exactly what happened. I am just feeding that back. To me, trying to look for a way forward, I think you have to understand that getting this stuff right is really, really important. There is phosphate being introduced into the system. I did comment that in contrast to the lack of chlorination documentation, the phosphate documentation was exactly what you would expect. I am a regulator and I am looking for the proper assurance processes. I put a great deal of value on written documentation, because that allows for transparency and accountability. I will provide that myself, as I have tried to in this report, so people can look at it, read it and comment on it. But I also put a great deal of value on that from the proponents of major projects. You would expect that proponents have the same assurance processes in place. I could not see that, and we asked. In fact, I had evidence that even the state's consultant had not got a complete record of all the chlorination events as late as April 2017.

[11.00 am]

The CHAIR: I have a question I want to ask with regard to that, but just before I do, I refer to page 22 of your report in which you mention —

> The findings around lack of important documentation, and 'groupthink', may in part explain why the problem with the TMV Assembly Boxes was not identified earlier.

What do you mean when you talk about "groupthink"?

Dr WEERAMANTHRI: Again, similar to the forward-looking nature of what I am trying to do here, I am trying to assist or offer suggestions to the state about what it might need to do in order to get to a safe water supply. I have to be honest, because I think the Minister for Health wanted my best advice. I have to point out that as far as I am concerned—we have talked about chlorination—that was not good enough from an assurance point of view. You would expect that those things would be sorted out in future. If you are going to alter the chemical milieu, you need to be able to document it properly, with something as critical as chlorination, especially given that you have to manage the risk of dezincification et cetera. The state would need to show me, as the regulator, in future that it really understood this and was going to put in the appropriate risk management and the proper assurance processes, unlike what I had seen until that point with the chlorination. Similarly, I had to reflect that when I did the interviews, you make an assessment about what people are telling you, and, again, you are asking questions, you are open and you are talking to experts who know more about their own particular field than you do. You are talking to engineers and you are talking to metallurgists, so you respect their views and you are trying to synthesise all of the different things that they are saying to you. You say things like, "On the one hand, you said this, but this other person told me that. What do you think about that?" In the course of those interviews, it was striking that—I chose my words carefully in this document. In regard to that point, I will go to page 21 where it says "I noted the following". I am noting it, but then I am making a kind of recommendation at the end. I am noting —

> a significant and surprising level of 'groupthink' (evident from some of the interviews) that the whole PCH potable water issue is simply an artefact of the testing program and/or analytic methodology.

The people I interviewed were not on the John Holland side. I made a decision that, given that we were trying to do this review in a short time period and the legal complexities around it, I did not want to have to navigate through lawyers et cetera, and that people should come voluntarily and just talk to me, as they did, which I appreciate. We only interviewed, if you like, on the state side or something like that—so, the state and its consultants and the testers et cetera. These are the people responsible for the strategies and fixing the problem. I think the good news is that the government, both prior to the election and following the election—so throughout this period that I have been involved—has been consistent in that it has seen a problem and it is trying to remedy a problem, as you said, Dr Buti. This problem was reported to us by John Holland in September and the whole premise is that there is a problem that needs to be fixed. How do we best do that? They have also been respectful of my role as the independent regulator. Both ministers I have worked with on this issue, as well as the director general of Health, have been very respectful. They understand my role and the testing methodologies we put in, and have not queried that. But having said that, when I spoke in the interviews to some of the people who were involved in the process—not all, but some—there was clearly a belief that there was no problem as I thought was understood to be a problem, and that the problem was actually an artefact of the testing program and/or the analytic methodology. That to me was surprising. What I was saying to the minister representing the state was "If you wish to open this hospital and get strategies to open the hospital in as timely a manner as possible and meet the safety standards, you need to know this and you need to get your best team forward and everyone needs to be on the same page." I think that is absolutely the case in terms of what I have seen following the report. People are entitled to their views. It is not as though people are not entitled to their views, but I thought that the state needed to know that if I am dealing with a proponent and some of the proponent's officers, if you like, are kind of giving me a double message—on the one hand, they are trying to fix the problem, but on the other hand, they do not think there is a problem—it is not conducive to me and to the most timely fixing of this problem.

The CHAIR: When you mention the minister, I assume you mean Minister Cook.

Dr WEERAMANTHRI: The Minister for Health, yes.

The CHAIR: Just further with regard to page 22, you then go on to state —

> Put another way, failures of the contract management and assurance function during the construction phase may underpin both the emergence of the problem and the failure to identify and address it in a timely fashion.

The general sense you get from reading your report is that you were disappointed or frustrated with the lack of documentation and how long it took to investigate the issues or try to work out a solution to the issue. Would that be correct?

Dr WEERAMANTHRI: As an experienced regulator, I am probably in my fourteenth year of doing this kind of role, firstly in the Northern Territory and my tenth year in Western Australia. I have seen a lot of these kinds of issues, probably nothing at this level of scrutiny, but you want to bring that experience to bear and to be honest with proponents. Yes, this was a very complex project with a very complex governance set-up and some striking failures in terms of what I would think would be proper assurance processes, and I have said that.

The CHAIR: You mentioned that you interviewed people. Are you able to provide us—not today—with a list of those people you interviewed?

Dr WEERAMANTHRI: That list is in the report.

The CHAIR: It is in the appendix, is it?

Dr WEERAMANTHRI: Yes, it is. But given that people were coming to me voluntarily, they did not ask for, and I did not provide them with, any written consent materials or how I would use the information. I am not going to divulge what individuals told me, but I thought I could make a general comment on some of what I heard.

The CHAIR: You said that some people stressed there was not a problem. Were they located in Strategic Projects?

Dr WEERAMANTHRI: I am not willing to divulge who said what.

The CHAIR: Could we go into closed session to try and elaborate on that, because it is quite important for our inquiry to know?

Dr WEERAMANTHRI: I have no problem with that.

The CHAIR: We will do that at the end.

Mr B. URBAN: What is the relationship between the task force particularly and also the Building Commission in light of the Building Commission's final report, which was done in April 2017? The reason I am asking that is did you have any input to assist them with their report?

[11.10 am]

Dr WEERAMANTHRI: Thank you for that question. The Building Commission was, I think, involved for some months, but I think had their particular involvement with the Department of Health while I was away in March and April. So it had discussions with the acting Chief Health Officer at that time, and I saw some of that correspondence. I am not quite sure whether it was in his role as acting Chief Health Officer or acting assistant director general, but there was correspondence between the department, my area and the Building Commissioner. We saw some drafts of his report, made some comments et cetera prior to him releasing it. After I returned and just prior to this review process, I met with the Building Commissioner for an hour just to go through and understand his report a bit more, about why he had come to particular conclusions. I found it really helpful and, in fact, that helped me determine my strategy of doing these interviews, because I found you can read the Building Commission report, but that extra hour you spend just talking through with another regulator the various things he had found and why, and how he had weighted them, that was really useful. I actually used that template as the template for the interviews I did in the review. I have no other relationship with the Building Commissioner.

I presented the report back to the Minister for Health. In part of my covering letter I suggested that it is minister's report but that he might think about who he should share this with and get a formal response from, including the Building Commissioner, because there are clearly some differences between my report and the Building Commissioner's report—that is fairly obvious—but there are also some similarities. With task force, I was asked by the chair of task force to attend some of their meetings. I did that from around the September mark through to early this year, at which time I stopped attending task force regularly. We also, from the environmental health directorate point of view, provided at least for a period of a few months—two or three months—a weekly report to task force, where we would analyse the data we had been given. Now, we did not have control—I made this point very clearly to task force—at that point of the testing or treatment strategies, but we were given all of the information. We would ask our expert staff to analyse it and then provide a weekly report back to task force. That is consistent with what I have said, which is we really value data; we will provide written interpretations so that we are accountable back to task force—we are accountable to, and we are accountable to the public—and this is what we are thinking at this point in time. So you can go back and look at our reports that were given to task force and see what we were thinking at any point, because there is a date, a report and a signature on the bottom.

Mr B. URBAN: Were you given any data from the Building Commission particularly in regard to its testing of the brass samples, because page 2 of its report quite clearly states —

> Brass plumbing fixtures and fittings in the PCH meet the required standards for lead content.

Looking at your report, it is quite the contrary.

Dr WEERAMANTHRI: You would need to ask the Building Commissioner exactly why he thought that. My understanding is—this would need to be tested with the Building Commissioner—that they were basically doing a document review and looking at what had been provided in terms of certification et cetera. I am not an expert in plumbing and/or plumbing certification, and/or building and plumbing regulations; that is for the Building Commissioner and people who administer the plumbing code et cetera. But my understanding is that the initial certification looked fine. What I did in my review is we actually went in and opened up the boxes and looked, took photographs, examined with the naked eye and in more detail microscopically the actual components and came up with some discrepancies, which we did not make a judgement on but which we handed back to the Building Commissioner saying, "Look, the certificates say this; we're not sure about it. Could you as the expert now look at this further?" So we have provided some further material for the Building Commissioner to look at without ourselves being in a position to make a judgement about whether they met Australian standards or whatever.

Mr B. URBAN: Six sets of brass fittings were removed from the Perth Children's Hospital.

Dr WEERAMANTHRI: There were six. We chose six assembly boxes, each of which contained multiple brass fittings.

Mr B. URBAN: In your report, and also the Curtin University report—I am going to go through the line of evidence for continuity—there is no location in any of the reports of where you actually took them from in the hospital, is there?

Dr WEERAMANTHRI: What we described is why we chose those boxes. I am pretty sure it would be in the detailed appendices, but if we have not said exactly where, it is probably not as relevant as knowing why we took them. The reason we took them is we took four assembly boxes next to outlets that had consistently high lead levels, and we took two boxes from outlets where we had had data that showed consistently low lead levels. We wanted to take the range and see if there was a difference between those. It is kind of a little beside the point in terms of the experimental design exactly whether it was in block A, B, C or D.

The CHAIR: You do talk about location on page 57.

Dr WEERAMANTHRI: Thank you.

Mr B. URBAN: The appendices were not given to us. My next question is: what are your thoughts on potable water and brass fittings particularly, as a generic statement or question?

Mr V.A. CATANIA: Can I add to that? Do you have an opinion on brass fittings and how they are banned in certain parts of the world? What are your thoughts on Australia still having brass fittings?

Dr WEERAMANTHRI: I am very lucky in that I have experts who advise me on a range of things. I do not claim to be an expert in air, water, radiation; all the various public health risks. There is a big variety of public health risks. I am responsible for the system design, to make sure that the public in this state have proper risk management for those risks, which means that we have good experts, we build on good science, we also network nationally and internationally. If you think about it, the Australian drinking water guidelines are over 1 000 pages; it is like interpreting the Bible—you need experts. It is not absolutely clear-cut about every single thing; it is a whole lot of very, very sensible risk management principles which you then have to apply in different situations. I am not an expert

in Australian standards and I am not an expert in metallurgy, but I understand that the Australian standard limits the amount of lead to under a specific percentage, and that is then thought, under normal operating conditions, to not lead to a risk of lead leaching into the water.

I understand that in other countries the levels are lower, but I also believe that Australia has good scientific processes. Whether it is for particular drug approvals or lead standards, we have a process. It is rigorous, it is science based, it is national, it is accountable, and you want the best group working and thinking and coming up with the final answers. If there is a need to review those standards, that is fine, and we are always open to that—there are processes in place, again. But I, as a single person, am not going to make a comment about that, except to say that I do trust Australian standards. There is a reason to allow a bit of lead in the fittings, I believe. Again, I am no plumber, but it makes the fittings more malleable and that is the reason you have a bit of lead in them. It seems to me that that small amount of lead, under normal conditions, it is perfectly reasonable to expect that would be held inside the fitting and not released. I have read through all the various expert reports; it is the dezincification process that allows the zinc to come out of the zinc–copper alloy that then allows for the lead to be released. It is not released from a normal fitting.

Mr V.A. CATANIA: The ChemCentre, in the public hearing, mentioned other possibilities, like schools and so forth. Have you been instructed by the Minister for Education or the Minister for Health to have a look at any other buildings that have brass fittings that could have this issue?

[11.20 am]

Dr WEERAMANTHRI: No, I have not been instructed by them. Again, I just point to the really strong record around water safety in this state. It goes back to the beginning of the twentieth century. We have extremely rigorous processes in place with our water suppliers with the drinking water guidelines and with expert processes that have assured the safety of our water. It is a matter of, I think, some pride that mostly the public does not even think about it. I think that is a good thing. The public needs to trust that there are regulators and suppliers working behind the scene to make sure that the water they drink from a tap is safe. We have had that. I place a great deal of importance in that public trust. Obviously, it has got to be based on something. It has got to be based on good science and good risk management. But you need to have strong risk communication leading to that public trust. You do not want to just react to every person who raises a concern. So what I did in preparation for coming here today is read the material that Dr McCafferty provided to yourselves last week. I would be interested in his view. I would be interested in talking to him personally if you wish. He has not written to me with those concerns, and I would expect that if someone really did have concerns, they would write to me. If he had some new data or some new insights and we needed to look at the current risk management, I would consider that. I would probably ask for my water experts to have a look at the material he has provided, just as I would with any other correspondence coming in where someone raises a concern or a complaint.

Mr V.A. CATANIA: So no-one from government has contacted you to have a look at those schools or any other buildings where people may have a concern about any potential leaching of lead?

Dr WEERAMANTHRI: To be honest, no, and I am very comfortable with that. We have a system in place. We take any issues. People are free to write to government or to write to myself directly. We deal with that. We review it. We are always open. But that does not mean we do not assess things. We are open-minded if we get new data or new evidence or new thoughts, but we also assess it and put some kind of weighting on it. But we are not going to turn over and change our whole system of dealing with schools on the notion of one person's opinion. I would want to test that opinion.

Mr V.A. CATANIA: The reason I asked that question was that through media reports, I think the Minister for Education said that the government would be inquiring into or having a look at schools

to see if there is a problem. I am wondering whether there was communication with you, as the Chief Health Officer, to review and have a look at potential issues, if they are potential issues, with schools and any other public buildings. I just wanted to make sure that there was not any correspondence between you and the others.

Dr WEERAMANTHRI: It does go to a point, though, about people's roles and responsibilities. The suppliers actually have a duty to provide safe drinking water. If they have any concerns themselves, they can do whatever assessments they wish. Many of them have water quality management plans and risk management plans for a whole range of issues. If they have concerns, they can seek advice from us. But we do not have a central command and control system where my office kind of controls the quality of water in every single outlet throughout Western Australia. Actually, it would not work.

The CHAIR: In every house.

Dr WEERAMANTHRI: Exactly. It is not possible. It is kind of one of these fantasy things. We have achieved extremely high water quality through the existing system, which actually puts responsibility on to the operators. It might be a caravan park operator in a remote region or a major operator such as Water Corp, each with different risk management processes in place. If there are problems or issues, they can come up through the system. But we try to sort them out locally. It is a bit of a myth that everything can be done through a central command and control. The model of regulation is a bit different from that. It has served us very well. I have just been overseas. I came back a couple of days ago. One of the biggest differences is that surety with which you can go to the tap when you come back home compared with overseas.

The CHAIR: You know how the media works. Last week, that was the only thing they picked up on. Before we go into closed session, in response to Mr Urban's question, you said that when you made the statements in your report, it was based on what you knew at that particular time. In your media release in January, you said —

> Based on the data we have seen, and our expert analysis, the public can be assured that the water on the existing QEII site is safe to drink.

Then, a week later, the director general, in a briefing note entitled "Potable Water Issues", said that Strategic Projects had advised the task force of testing of the QEII ring main done on 3 February—a week after your media release—that recorded elevated levels. Did that raise alarm in the sense that on that data that you had been able to access, that was the appropriate assessment or finding that you had come up with, and then a week later elevated levels were reported?

Dr WEERAMANTHRI: There is no necessary contradiction between those two. I am not responsible for what others say. But I think I would have seen all of the data. There were a couple of major bits of data that I had seen at the point I wrote the statement. One was I had seen all the data that had come in through the Perth Children's Hospital process. I had seen much of the data, having been at task force and having our team look at the data in detail. So I had seen much of that data, but I had also seen the specific reports that QEII had commissioned around its own existing water supply, which is separate from the PCH data. There had been a few elevated levels out of hundreds of tests in both sample sets, but nothing to suggest that there was a significant problem with the water on the QEII site—absolutely nothing. In fact, I also would say—my personal opinion—that there has been almost no evidence that incoming water to PCH has been the cause of that problem. You will get an occasional elevated test result. Isolated, that means nothing. You need to know how the sample was taken, when it was taken, how it was analysed, and whether there was any potential contamination or whatever issue. There is always an occasional abnormal result. But as a regulator, if there was some consistency, if there was a plausible hypothesis about why that might be so, we will always work with people. We will retest. If there was a problem yesterday, it is likely to be there

today if there is a significant problem. But if you get an occasional high result and then consistently negative results after that, you would say, "I am not sure why that individual result was abnormal, but we have assured ourselves that there is no ongoing risk." We do this all the time about multiple, multiple issues. We know how to interpret data. We do not ignore data. But we do not jump at odd results, either. We look back at the risk management and at the risk and say, "How can we interpret that data?"

Mr V.A. CATANIA: In your experience, have you come across anything quite like this with any other public buildings?

Dr WEERAMANTHRI: I think that is another important point to make. To me, in my experience, this is a highly unusual set of circumstances. The problems at PCH right from the beginning when we were informed, I think they are very —

Mr V.A. CATANIA: Isolated?

[11.30 am]

Dr WEERAMANTHRI: They are specific to PCH. There have been some understandable flow-on concerns to other water supplies. But I have come out publicly and stated that from what I have seen and will be continuing to see from QEII, there are no issues around the safety of the water supply at QEII, nor should it then be generalised to other areas of the state. If there are new things that we have to consider as a result of this whole PCH learning process, and there is a different way we need to think about regulation, I will take that information and I will introduce it into our national systems. There is nothing specific about Perth schools versus Queensland schools versus New South Wales schools. For example, you do not just change a system without really understanding what you are doing. So if there was some reason to do something different, presumably it would be right across Australia, and we would want the best experts to be thinking about this. I do not think there is. We have not reached that threshold as far as what I have seen. I would be very interested to see what the Building Commissioner does with the information we have provided to him and whether there is any change in how he sees the situation. It would be up to the Building Commissioner to say, for example, that these fittings were Australian standard but they still leak lead, or whatever the issue was, and you might come to a different landing point about whether you thought that was an appropriate Australian standard. But until we have seen that kind of discussion and analysis, there is nothing that I have seen that suggests that the rest of the water supplies in this state should be handled any differently to what we have done so far, which is very rigorous and has had fantastic outcomes over decades.

The CHAIR: I have one final question before we go into closed session. You made it quite clear in your report about the lack of documentation. Have you experienced any problems in obtaining all the available data? There might be a lack of documentation. That is one thing, but of the documentation that there was and that there is, have you been able to obtain all the data that you have needed to look at? Have you experienced any difficulty from any government agencies or any other bodies in obtaining that data?

Dr WEERAMANTHRI: The answer is no. The issue, though, is that we have been very clear that we have received, in fact, almost too much data, in a sense. We received a wealth of data which we as experienced regulators—I am talking about my team here, which deals with water every day of the week in all its various issues—have found very difficult to interpret because we did not really know the logic behind the collection of the data. Particularly that was the case prior to practical completion. Things have improved substantially since practical completion.

The CHAIR: In what way?

Dr WEERAMANTHRI: Just because there has been much greater clarity about who owns the site and who is responsible. Essentially, the site was handed over to us for a month for the review process, which was quite extraordinary. It was just done voluntarily through the task force, with the support of the director general of Health. I did not have any official powers, but essentially I was given control of testing and treatment so I was able to take down walls and test along and take down assembly boxes and do everything we were asked to do, and it was very good.

The CHAIR: So practical completion has made your job easier?

Dr WEERAMANTHRI: It has certainly made my job of giving advice much more straightforward; I knew who I had to go to. In terms of the data issue, part of the reason to go to this CHO approved testing methodology was that in December, just before Christmas last year, we were at a meeting at PCH, and all of the various parties were there. I made the point that from what I had seen, which had been given to us on that kind of weekly basis from all the testing that had been done—there were six different people doing various forms of testing at that point—that it would be almost impossible—we would need a couple of PhDs—to interpret this volume of material and reports that was coming through. It was my suggestion—I was trying to be helpful—that we come up with a clean testing process so that I could in a sense put the backlog of tests behind and focus on an approved testing methodology that would tell me ahead of time that if we meet this standard, that would be part of going forward, regardless of the thousands of tests that had been done beforehand. That was my suggestion, drawing on my experience as a regulator, that we come up with an approved testing methodology. That is the basis, and it is in the appendices, of the development of the sampling frame of the 1 200 or so outlets, and then taking a random sample of 300, which is statistically determined to give you confidence that that sample represents the 1 200 and levels at which those criteria for safety would be met. We laid that all out ahead of time, and we even laid out analytic methodology on how we would analyse the results, and we provided that to the state so that the state would be absolutely sure that there would be a standardised, rigorous methodology applied that was scientifically based and that would give the state an opportunity to pass, rather than relying on this kind of smorgasbord of testing that had been performed up until that point. That is still the case.

At the point that the state wishes to come back and get tested again, when it is convinced that it will supply a safe water supply, it can come back to the CHO, and we have an approved methodology ready to run. We have done it once, and there was not sufficient compliance to reach that 95 per cent mark. We actually, as part of the review process, repeated the same methodology on the same 300-odd outlets, because we wanted to see whether the phosphate had had a further impact in the period of time that had elapsed between the first testing and the repeat testing. If we were to do the testing again as part of an approval methodology for the state, we would not go to those same 304 outlets. That was done because we wanted to test a specific scientific hypothesis from June to July or something like that. What we would do is randomly sample the 1 200 again and come up with another 300-odd samples. So every time we do this methodology, we take a different 300 samples.

The CHAIR: The committee has resolved to conduct the rest of the hearing in closed session.

[The committee took evidence in closed session]

[11.42 am]

The CHAIR: The fact that John Holland knew in May last year about the lead issue and you were not notified until September —

Mr B. URBAN: Task force was notified in August.

The CHAIR: Yes; task force was notified in August. It was not your responsibility, but do you think you should have known, you should have been told earlier?

Dr WEERAMANTHRI: Not necessarily, since it was not a water supply.

The CHAIR: It is the definition of a "water supply", is it not?

Dr WEERAMANTHRI: Yes.

The CHAIR: But you did have a role in the environmental part of the department?

Dr WEERAMANTHRI: I could have been asked to comment, like I had been asked to comment on asbestos. But clearly, they are building a hospital, they have got a problem, and they are seeing what they want to do. It is possible they could have told us earlier, but, to be honest, I cannot really comment because I do not have visibility of that time frame. I do not know what they were thinking.

The CHAIR: If you would not want to comment, I understand; but it would have been better if you had known earlier, would it not?

Dr WEERAMANTHRI: I cannot say whether it would have been better or worse. That is the same as commenting.

The CHAIR: Oh well, I tried!

Thank you very much for your time. It has been quite an extensive questioning and answering session. It has been very useful for us.

Thank you for your evidence before the committee. A transcript of this hearing will be forwarded to you for the correction of minor errors. Please make these corrections and return the transcript within 10 working days of receipt. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be introduced via these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript of evidence. I should let you know that the uncorrected version of the transcript will go up when it is ready—it probably will not be for a few days—and also we will be sending you a letter with maybe some additional questions and some of the documentation. Thank you very much.

Hearing concluded at 11.45 am

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