



**Public Accounts Committee**

# **PCH - A Long Waiting Period**

**A critique of the State's management and oversight  
of the Perth Children's Hospital project**

**Report No. 3  
March 2018**

Legislative Assembly  
Parliament of Western Australia

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Report No. 3

Presented by

**Dr A.D. Buti, MLA**

Laid on the Table of the Legislative Assembly on 22 March 2018



## Chair's Foreword

**W**estern Australians would be hard pressed to name another major infrastructure project beset with the magnitude of difficulties and setbacks experienced by the \$1.2 billion Perth Children's Hospital (PCH).

What went wrong? Plenty!

The history of the PCH project is a protracted and concerning story.

Back in 2004 the Health Reform Committee recommended the replacement of Princess Margaret Hospital as the State's designated paediatric hospital. Prior to the 2008 state election, the Carpenter Government committed to building a new children's hospital at the QEII Medical Centre site. On 25 November 2010 the Barnett Government approved a \$1.17 billion business case for the PCH project and on 1 July 2011, John Holland Pty Ltd (JHPL) was announced as the Managing Contractor (MC) for the project. Construction commenced in early 2013, with practical completion scheduled for 30 June 2015.

The government would formally extend the date for practical completion to 31 August 2015, after negotiating a variation to the scope of works to include an additional 24-bed surgical short stay unit. However, JHPL failed to meet this extended practical completion date, and would also fail to meet a further 15 revised practical completion target dates.

Practical completion was finally achieved on 13 April 2017, with the McGowan Government issuing a certificate of practical completion to JHPL on 20 April 2017 – 591 days after the revised 31 August 2015 deadline. On 29 November 2017, the Minister for Health, Hon. Roger Cook, MLA, announced that the hospital will open in May 2018, two and half years late – a long waiting period.

This long waiting period has been a source of much despair and frustration for the government and the WA public alike. It is this history that prompted the Public Accounts Committee (the Committee) – which has the function and responsibility to inquire into and report to the Legislative Assembly on matters dealing with expenditure of public moneys – to undertake an inquiry into the PCH project, specifically focussing on:

- (i) the effectiveness of the project's overall governance structure in identifying and responding to risks;
- (ii) the processes in place to provide assurance that materials and systems used on the project meet the required standards; and
- (iii) the risks and benefits associated with granting practical completion.

Two aspects of this inquiry should be made clear. First, the focus of our inquiry was not the performance of JHPL, although evidence presented to the inquiry warrants a conclusion that JHPL, in its performance as MC, was unsatisfactory. Instead, we were focussed on investigating and reporting on how effectively the State managed risks and issues on the project, both before and after they emerged. Second, our inquiry did not seek to find the source of the lead problem in the potable water servicing the PCH; we were focussed on the governance and assurance issues relating to the lead contamination, among other construction and commissioning issues.

In conducting the inquiry, the Committee has considered 18 written submissions, received four briefings, and heard evidence from 28 witnesses across 17 formal hearings. The Committee also received 67 pieces of correspondence answering various questions associated with the inquiry, and examined more than 5,000 pages of third-party correspondence and other documentation associated with the PCH project. The Committee has worked collaboratively throughout the process of receiving and considering this evidence, and I would like to take this opportunity to acknowledge the hard work and contribution of my fellow committee members: Mr Dean Nalder, MLA, Deputy Chair; Mr Simon Millman, MLA; Mr Vince Catania, MLA; Mr Barry Urban, MLA (until December 2017); and Mrs Lisa O'Malley, MLA (from February 2018). Further, on behalf of the Committee, I would like to thank our secretariat: Principal Research Officer Mr Timothy Hughes; Research Officer Mr Michael Burton; and Acting Research Officer Dr Kyle Heritage, for their excellent assistance and dedication throughout this inquiry.

So what did we find and conclude through this inquiry into the much-plagued PCH project? And just as importantly, what lessons should government take from the conclusions we have reached?

The Committee has made 52 findings and 11 recommendations. We believe that all of them are important. Some, however, are crucial.

First, the State accepted an extremely competitive bid from an entity without previous experience at managing a construction project of the scale and complexity of the PCH project. This bid contained almost no room for error, which – even if the magnitude of the problems that eventuated could not have been predicted – should have raised concerns right at the outset of this project. Accepting an aggressive bid made it imperative that the State's governance structures could proactively oversee and address any issues associated with the performance of the MC. To a significant extent this did not happen.

The dual governance structure used by the State presented difficulties. Under the dual governance model, the PCH Commissioning and Transition Taskforce (the Taskforce) operated as the lead entity, but the authority for delivering the entire project was divided between Strategic Projects and the Department of Health who both sat on the Taskforce. This structure was ill-equipped to handle difficulties associated with the performance of the MC, as well as the ensuing level of acrimony that developed between the Department of Health and Strategic Projects.

We do not agree with the views expressed in the *Special Inquiry into Government Programs and Projects* (the *Langoulant Report*) that the dual governance model is appropriate for major construction projects. The *Langoulant Report* expressed confidence in the dual governance approach, on the basis that it has been successful in overseeing other projects. Our view is that there are weaknesses inherent to the dual governance model, and while these weaknesses may not become apparent on projects where there are no significant construction challenges, when there are significant issues – such as with the PCH project – the dual governance model is found wanting.

As noted by the Director General of Health, the dual governance arrangements resulted in ‘confusion with regards to the role of Chair of Taskforce in reporting to the Minister of Health and Cabinet, and the role of SP&AS [Strategic Projects] in its direct line of accountability to the Treasurer.’

Ongoing confusion as to roles and responsibilities of officers in relevant departments, coupled with the Minister for Health and the Treasurer at times receiving different briefing notes on the same project, is unacceptable for a complex construction operation experiencing significant difficulties. We agree with the Director General of Health that, as the client agency, the Health Department, and *ipso facto*, the Minister for Health, should have had full accountability for all PCH project work streams, including construction.

For future projects we recommend that the dual governance model be dispensed with, and that overarching construction responsibility be vested with the relevant client agency. Where the client agency does not have the necessary planning expertise, it would be prudent to retain the services of Strategic Projects. But it needs to be clear that the client agency is the responsible and accountable body. This is crucial because, as the PCH project highlights, the dual governance model meant that on occasions it was unclear whether it was Strategic Projects, the Department of Health or the Taskforce that was responsible for any particular problem.

We also recommend that government appoint independent chairs with appropriate expertise to multi-agency steering committees for the oversight of major projects. This will reduce the demands on the time and level of responsibility placed on steering committee members. It will also provide assurance to these members around projects and risk management issues.

A major concern with the governance of the PCH project was the quality of briefing notes provided by the Department of Health and Strategic Projects to their respective ministers, being the Minister for Health and the Treasurer respectively. This reporting repeatedly failed to convey the gravity of the situation on the ground, and was often excessively optimistic. Strategic Projects was overly reliant on the data and information provided by the builder to provide status reporting on the construction program. Strategic Projects also failed to proactively critique and analyse the data provided by the MC. This was a major failing and, coupled with the tensions between Strategic Projects members and other members on the Taskforce, it severely compromised the governance of the construction phase of the PCH project.

The Committee was concerned with the time taken by Strategic Projects to advise the Taskforce and responsible ministers on the issue of elevated lead levels in the water supply. We were also alarmed by the manner in which this issue was brought to the attention of the Taskforce.

The Executive Director of Strategic Projects claimed in his testimony before the Committee that he escalated the elevated lead issues with the Taskforce on 2 August 2016. However, the totality of the evidence before the Committee does not support this assertion. In fact, the Executive Director of Strategic Projects only acknowledged the issue when the then Deputy State Solicitor, acting on a rumour, raised the issue at the end of the 2 August 2016 Taskforce meeting. Even after that, the Taskforce minutes indicate that Strategic Projects downplayed the significance of the risk for at least another six weeks, and the Chief Health Officer and Building Commissioner were not notified until early September 2016. This is unacceptable.

The unsatisfactory quality of ministerial briefing notes prepared by Strategic Projects and the Department of Health is exemplified by both the failure to detail the findings of the five gateway reviews that each identified deficiencies in the governance process on the PCH project, and the understating of the potential significance of the dead leg attached to the QEII ring main as a potential source of the lead problem. This can be contrasted to the attention given to the October 2016 PCH Foundation Fundraising Gala Dinner, updates on which were provided in at least three separate briefing notes.

The advice and information being presented to ministers by their respective agencies and the Taskforce at times fell short of what was required. But what about the responsibility and performances of the ministers themselves?



The former Treasurer, Dr Nahan, has stated in Parliament that: 'We were doing nothing more than publicly announcing advice from our respective departments. It proved to be wrong in most cases but it was the advice.' This statement indicates that Dr Nahan and his ministerial colleagues were reliant upon, and unquestioning of, the advice they received.

This is not good enough.

Ministers are busy people, with massive workloads. However, the approach as explained by Dr Nahan in Parliament is fraught with danger, particularly in the case of a project like the PCH, where repeated failures to meet practical completion deadlines, especially throughout the latter part of 2016, put the government on notice that there were problems with its construction. It is just not acceptable that Dr Nahan and other relevant ministers appeared to repeatedly accept overly optimistic forecasts and convey them to the public without challenging the veracity of the information they were receiving.

We acknowledge that the ministerial briefing notes understated some critical aspects of the water contamination issue during Dr Nahan's tenure as Treasurer, including the dead leg within the QEII ring main. But these briefing notes did mention the dead leg and water contamination issue more broadly, even if obliquely. It is therefore concerning that Dr Nahan and presumably other relevant ministers adopted a reactive rather than a proactive approach in pursuing critical information on the water contamination issue. This is particularly concerning in the latter part of 2016, when there was little consensus about either the diagnosis or remedy of the contaminated water supply.

It is worth noting the observation of the former Director General of the Commonwealth Department of the Prime Minister and Cabinet, Professor Peter Shergold AC, that in providing information and advice to ministers, the public service 'should seek to identify the risks, envisage unintended consequences, indicate threats to successful implementation and proffer alternative options.' And, further and conversely, ministers should 'demand that advice on the most challenging issues they face should be presented in written form.' These are important standards and principles that the Committee remains unconvinced were being complied with by either the relevant agencies or the responsible ministers throughout the latter part of 2016, when a series of major issues, including the water contamination, were affecting the PCH project.

Finally, practical completion of the PCH was granted on 13 April 2017 with a number of unresolved issues – most notably the contaminated water supply – characterised as minor defects. Before granting practical completion, the State had to consider the risks and benefits. It would seem that the determining factor in granting practical completion was that it allowed the State to take control and possession of the hospital site, and thus conduct orthophosphate treatment on the potable water supply. JHPL had refused to cooperate in facilitating the start of this treatment, which the State had identified as part of its preferred suite of remedial actions. The need to grant practical completion in order to overcome the MC's refusal to cooperate brings into question whether the contract levers available to the State were sufficient, and whether the State was too reluctant to use some of these levers before this impasse was reached.

I return to where I commenced. The PCH project is a protracted and concerning story that provides a number of lessons for the bureaucracy, for ministers, and for the State. For the sake of the Western Australian public, it is imperative that these lessons are heeded, and necessary changes made to ensure that future significant and complex state infrastructure projects provide an efficient return for the expenditure of public funds.



DR A.D. BUTI, MLA  
CHAIR

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## Executive Summary

*Complex projects are not delivered on time or on budget by accident. Success is almost always the result of hard work and meticulous planning overseen by a rigorous governance mechanism.*<sup>1</sup>

**G**overnment infrastructure projects like the new Perth Children's Hospital (PCH) are complex undertakings that require rigorous and effective governance. Robust governance structures promptly identify risks and actively manage issues as they emerge, thereby increasing the likelihood that a project stays on track.

The PCH is an ambitious and laudable undertaking that has suffered numerous significant setbacks. These setbacks have delayed the opening of the hospital by more than two years. Both the State<sup>2</sup> and John Holland Pty Ltd (JHPL), the company engaged to oversee the construction of the hospital under a two-stage Managing Contractor (MC) contract, have struggled to manage this project. This calls in to question the effectiveness of their respective governance structures.

In this report, we have focused on the effectiveness of the State's governance regime. The State was aware that JHPL was looking to establish itself as a viable alternative to other companies the State had dealt with under MC contracts for top-tier construction projects. The State was also aware that JHPL submitted an extremely competitive bid with negligible margins when tendering for the PCH project.

Under such circumstances, we would have expected the State's governance structures to be attuned to the risks that might be encountered if the project ran into difficulty. Unfortunately, this appears not to be the case. Throughout this inquiry, we have observed a situation where the State's governance processes were consistently falling short of best practice principles. This has undoubtedly undermined the State's capacity to manage the project and the multitude of challenges it presented.

One of the fundamental principles of effective governance is the need to establish clarity around key roles, responsibilities, and accountabilities as early as possible. This was even more pertinent to the PCH project which, like most major public projects in Western Australia, operated under a dual governance structure, with Strategic Projects<sup>3</sup> responsible for overseeing construction, and the Department of Health responsible for the hospital's commissioning. Regrettably, confusion over roles and

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<sup>1</sup> Education and Health Standing Committee (39<sup>th</sup> Parliament), *More than Bricks and Mortar: The report of the inquiry into the organisational response within the Department of Health to the challenges associated with commissioning Fiona Stanley Hospital*, 10 April 2014, p. 16.

<sup>2</sup> The State in this context refers to both the government and the public sector entities responsible for the project.

<sup>3</sup> A division of the Department of Treasury until July 2017.

responsibilities continued to plague the State's governance structure into 2017. With such confusion enduring, it is not surprising the State's main oversight body, the PCH Commissioning and Transition Taskforce (the PCH Taskforce), operated without fully integrated project management and risk reporting processes for the majority of its four-year, 156-meeting, existence.

The governance structure was further enfeebled by an unhealthy level of tension between the construction (Strategic Projects) and commissioning (Department of Health) project teams. It appears that the PCH Taskforce, which comprised members of both agencies, was ill equipped to manage these tensions.

We have also found the quality of project reporting, both to the PCH Taskforce and the Executive branch of government, to be problematic. Reporting around the ever-changing forecast practical completion date suffered from increasing levels of unjustified optimism, and some critical issues were under-reported to the responsible ministers (the Treasurer and the Minister for Health). One glaring example is the findings of five gateway reviews commissioned by the Department of Health and Strategic Projects between June 2015 and July 2017. While they made salient criticisms of the State's governance structures, the findings of these reviews do not appear to be the subject of any briefing notes to the ministers or the Cabinet.

Given the shortcomings in some of the reporting to the Executive, we were somewhat surprised by the fact that the responsible ministers—throughout 2016 in particular—accepted much of the advice they were receiving, seemingly without question.

The collective governance shortcomings we observed have left us questioning the appropriateness of dual governance structures for major projects. We have formed the view that a single senior responsible officer, with ultimate authority and accountability for the project, would have been better placed to resolve many of the issues that emerged throughout the PCH project. In addition, we see merit in appointing full-time independent chairs to multi-agency oversight committees. We believe independent chairs would provide a much-needed level of assurance and advice to oversight committees, senior responsible officers, and responsible ministers, around project and risk management issues.

We have also recommended the Minister for Finance engage an independent expert to evaluate the efficacy of the commercial levers within the contract with JHPL and the manner in which they were utilised by Strategic Projects (as the State's representative). We were alarmed to learn that by the time elevated levels of lead were discovered in the water supply, the State was literally operating on goodwill with the managing contractor because it felt it had no contractual levers left to pull.



Another area we examined was the quality assurance and quality control systems the State adopted to ensure materials used on the project met the required standards (contractual and regulatory). Ultimately, we found a range of issues that indicate systemic deficiencies in the various assurance regimes (both public and private sector) operating in Western Australia. Foremost among the issues we identified was an over-reliance on third-party certification *in lieu* of pre-installation inspection and testing. With supply chains becoming longer and more complex, this approach increases the risk of non-conforming products coming on to construction sites. We believe a regime of proactive pre-installation inspection and testing is essential until such time that certification offers a more reliable form of assurance, and have called upon Strategic Projects to adopt this process.

Finally, we considered the risks and benefits of the State's decision to grant practical completion on 13 April 2017 with the still unresolved water issue classified as a minor defect. Consistent with our terms of reference, we do not offer a view on the merit of the decision. Instead, knowing the PCH Taskforce debated the issue at length in the weeks prior we seek to identify the arguments for and against as articulated by the agencies who had responsibility for the decision. It appears that the ability of the State to conduct orthophosphate treatment on the potable water supply—part of its preferred suite of remedial actions—was a major influence behind the consensus position that was eventually reached.

The question remains whether the decision to take practical completion arose because of the inadequacy of the contractual levers, or the general reluctance to use them (or a combination of both).

Our inquiry coincided the *Special Inquiry into Government Programs and Projects* (also known as the Langoulant Inquiry), conducted by former Under Treasurer John Langoulant. The Langoulant Inquiry examined 26 programs and projects entered into by the government between 2008 and 2017, including PCH. We met with Mr Langoulant on two occasions for private briefings where we discussed our respective lines of inquiry.

While we tried to avoid replicating each other's lines of investigation, there are some instances where we make findings about similar aspects of the PCH governance structure. In some areas, our views are reasonably aligned. Like Mr Langoulant, we make recommendations directed toward improving the efficacy of future contracts for major projects.

In other areas, our views are sharply divergent. This is most evident in our respective assessments of the merit of dual governance structures on major projects. Mr Langoulant calls for their retention. We call for their removal, arguing the structure was not effective in dealing with extraneous issues that emerged during construction at

PCH. Nor was it effective in dealing with the numerous internal issues and conflicts that afflicted the State's governance processes.

We also think it is important to highlight a possible misconception readers might draw from the Langoulant Inquiry's final report. In Volume Two of his report, Mr Langoulant correctly states that '[t]he cause and solution' of the lead contamination of the potable water supply at PCH 'has been the subject of much conjecture and review.'<sup>4</sup> However, it could be inferred from Mr Langoulant's ensuing sentences that the Public Accounts Committee would make definitive findings about the source of the contamination and the optimal solution. This is not the case. While we have questioned relevant entities extensively on this issue, our main focus has been on how the State's governance processes dealt with it as it emerged. The courts will likely rule on how the lead came into the water supply and expert bodies will continue to deal with the preferred remedy.

Throughout this inquiry, we resolved to take a significant amount of evidence in closed session. This enabled witnesses to speak more freely on a range of highly sensitive issues and we thank them for their candour. It is important to note, however, that we and other committees of the Legislative Assembly retain the right to publish or disclose closed evidence by resolution of the committee or the House.

With this inquiry, we used much of the closed evidence to shape our overall findings, but sought to be judicious with its use in the report via direct quote or reference. Nonetheless, there were some instances where we felt disclosure was critical to supporting the veracity of certain key points. In those instances, we contacted the relevant parties advising them of our intention, and asking them to inform us of any concerns we should take into account as part of our deliberations. We have sought to accommodate those concerns as much as possible in our final report.

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<sup>4</sup> Government of Western Australia, *Special Inquiry into Government Programs and Projects: Final Report*, Vol. 2, February 2018, p. 131.

## **Ministerial Response**

In accordance with Standing Order 277(1) of the Standing Orders of the Legislative Assembly, the Public Accounts Committee directs that the Premier; the Minister for Finance; and the Minister for Commerce and Industrial Relations report to the Assembly as to the action, if any, proposed to be taken by the Government with respect to the recommendations of the Committee.



# Findings and Recommendations

## Chapter 1 – Background

### Finding 1

Page 7

For the Perth Children’s Hospital project, the State accepted an extremely competitive bid, with little margin for error, from an entity it had not previously used to manage construction projects of such scale and complexity. Therefore, it was incumbent upon the State to ensure its governance structures could proactively oversee, and where necessary address, any issues that might arise out of the performance of the managing contractor.

## Chapter 2 – A complex project; a convoluted governance structure

### Finding 2

Page 15

The governance structure established by the State to oversee the delivery of the Perth Children’s Hospital was convoluted. Adding to the complexity of this structure was the dual governance / dual accountability arrangement, under which the Department of Treasury was responsible for the construction of the hospital while the Department of Health was responsible for all aspects of its commissioning.

## Chapter 3 – Governance

### Finding 3

Page 21

Confusion around key roles and responsibilities continued to plague the governance structure well into 2017. We find it difficult to comprehend how this confusion was not resolved throughout the almost four-year, 156-meeting, life of the Perth Children’s Hospital Commissioning and Transition Taskforce (the PCH Taskforce). The failure to settle these internal issues meant that the PCH governance structure was not in an optimal position to manage the project and the multitude of challenges it presented. It is especially difficult to reconcile this failure with the knowledge and experience of the individuals on the PCH Taskforce.

### Finding 4

Page 21

Because of long-standing confusion over governance roles and responsibilities, the PCH project was operating without an agreed overview design or implementation plan for information and communications technology (ICT) as late as June 2015. This was despite Cabinet approving a \$245 million business case covering the hospital’s ICT requirements in November 2013.

**Finding 5****Page 24**

It is surprising that the minutes from the PCH Taskforce meeting of 20 January 2015 noted that the Department of Health did not know ‘how the PCH project is tracking financially.’ This is arguably attributable to the ongoing failure to establish agreed and fully integrated project and risk management processes within the PCH governance structure.

**Finding 6****Page 31**

Key participants within the PCH governance structure offered largely positive assessments as to its effectiveness in identifying and responding to risks. We have found these assessments difficult to substantiate.

**Finding 7****Page 32**

The Integrated Program Management Office (IPMO) was engaged in September 2015 because the PCH Taskforce was operating without independent assurance as to how the overall project was tracking against key milestones.

**Finding 8****Page 32**

We agree with the decision to engage the IPMO, but question why such an entity was not engaged much earlier.

**Finding 9****Page 33**

The challenges the IPMO experienced in its initial dealings with Strategic Projects is one of several examples that demonstrate how the PCH governance structure was, on occasions, undermined by combative and siloed mentalities rather than a consistent spirit of openness and collaboration.

**Finding 10****Page 34**

A September 2016 gateway review of the PCH commissioning program found that the PCH governance structure was operating without an effective critical path program. Consultants engaged to operate the IPMO had made similar observations twelve months earlier.

**Finding 11****Page 34**

The failure to establish an agreed critical path and an effective integrated master program in a timely manner is alarming when considering the lessons that should have been drawn from the highly problematic commissioning of the Fiona Stanley Hospital.

**Finding 12****Page 35**

The PCH project has been remarkable for the number of ultimately inaccurate public statements made by ministers and senior bureaucrats concerning the construction program and opening date.

**Finding 13** **Page 36**

The fluidity of the construction deadlines John Holland Pty Ltd submitted to Strategic Projects certainly provide some explanation for the persistent inaccuracy of these statements. However, there were also problems with some of the reporting processes that existed within the PCH governance structure.

**Finding 14** **Page 37**

Having viewed a substantial number of briefing notes provided by the Department of Health and Strategic Projects to their respective ministers, we have identified a concerning number of instances where status reporting failed to convey the true gravity of the situation on the ground. Some reporting was overly optimistic and there was a lack of transparency around the status of some critical issues. Outside of the joint briefing notes that were prepared together by both agencies, there was a general inconsistency in the level of detail provided to the respective ministers.

**Recommendation 1** **Page 37**

The Premier and the Cabinet review the quality and standard of briefing notes provided by departments to ministers to ensure improvements in the consistency of structure and adequacy of content across the public sector.

**Finding 15** **Page 41**

Testimony from the Under Treasurer indicated that under the Managing Contractor model used for the PCH project, Strategic Projects was overly reliant on the data provided by the builder to provide status reporting on the construction program. If Strategic Projects was unable to adequately interrogate program data provided by the builder, the procurement model used for this project may well be fundamentally flawed.

**Finding 16** **Page 42**

A degree of excessive optimism was evident within the PCH governance structure around some status reporting linked to key construction milestones, such as the forecast practical completion date.

**Finding 17** **Page 42**

It seems that the responsible ministers continued accepting overly optimistic forecasts and conveying them to the public without challenging the veracity of the information they were receiving.

**Finding 18****Page 42**

The qualities associated with effective reporting were not always evident within the PCH governance structure. Consequently, the PCH Taskforce—a body established by Cabinet to oversee the delivery and commissioning of PCH—did not always receive the level of information necessary to perform its functions properly

**Finding 19****Page 44**

John Holland Pty Ltd appears to have had difficulty managing several of its sub-contractors throughout the construction of the Perth Children’s Hospital. Relations with its main ICT sub-contractor were especially problematic.

**Finding 20****Page 44**

Given the significance of the issue and its impact of construction activities, John Holland Pty Ltd’s difficulties with its major ICT sub-contractor were under-reported both into and out of the PCH Taskforce.

**Finding 21****Page 45**

Strategic Projects should have advised the PCH Taskforce and the responsible ministers much earlier about the lead in the water supply, especially in light of how late the project was already running, the unprecedented nature of the problem, the uncertainty surrounding its source and how difficult it was going to be to rectify.

**Finding 22****Page 47**

The manner in which the issue of elevated lead levels came to the PCH Taskforce, through confirmation of a rumour, was unacceptable. In his testimony to the committee, the Executive Director of Strategic Projects said his agency ‘effectively escalated’ the issue to the PCH Taskforce after the initial flushing program failed to lower the lead levels. This interpretation of events is not supported by evidence, including PCH Taskforce meeting minutes and the testimony of other Taskforce members.

**Finding 23****Page 48**

Notwithstanding the number of joint briefing notes that were prepared by Strategic Projects and the Department of Health, we remain concerned about the scope for inconsistent reporting to their respective ministers that was facilitated under the dual governance arrangements on the PCH project.



**Finding 24****Page 53**

The level of detail in ministerial briefing notes relating to the PCH project was not always adequate. Neither Strategic Projects nor the Department of Health issued briefing notes detailing the findings of five gateway reviews that were highly critical of governance processes on the project. The potential significance of the dead leg attached to the QEII ring main was also understated. The lack of coverage of these issues is difficult to comprehend given there were at least three briefing notes from the Department of Health providing updates on an October 2016 PCH Foundation Fundraising Gala Dinner.

**Finding 25****Page 53**

The Director General of the Department of Health advised that he ‘may have informally verbally briefed’ the Minister for Health about the findings of the five gateway reviews conducted between June 2015 and July 2017. It is unacceptable that the findings of these reviews were not included as part of a detailed written briefing to the Minister for Health, the Treasurer, and the Cabinet.

**Finding 26****Page 53**

We share the former Treasurer’s view that briefing notes relating to the water contamination issue—and in particular the dead leg linked to the QEII Medical Centre ring main—understated the significance of the problem. However, in such circumstances, when projects are clearly running into regular difficulty, it is also incumbent upon ministers to demand they receive written briefings covering all critical issues in an appropriate level of detail.

**Recommendation 2****Page 53**

The Premier take the appropriate actions to ensure that the findings of gateway reviews undertaken by agencies are the subject of detailed briefing notes provided to any relevant minister.

**Finding 27****Page 54**

Under the dual governance model, the PCH Taskforce operated as the lead entity, but in reality, the authority for delivering the entire project was divided between two government agencies—both of whom sat on the PCH Taskforce.

**Finding 28****Page 55**

There is sufficient evidence to suggest that the project lacked the level of ongoing collaboration necessary to ensure effective governance. Operating within a dual governance structure, the PCH Taskforce seemed ill equipped to handle the level of acrimony that emerged between its two leading entities, the Department of Health, and Strategic Projects.

**Finding 29****Page 56**

As the PCH project demonstrates, dual governance structures make it very problematic for a client agency or a steering committee to maintain control of a project when matters go awry with construction. From a ministerial and parliamentary scrutiny aspect, it is also difficult to identify clear lines of responsibility.

**Recommendation 3****Page 57**

The Minister for Works (currently the Minister for Finance) amend the *Public Works Act 1902* (WA) to remove dual governance structures by vesting overarching asset delivery responsibility with client agencies.

**Recommendation 4****Page 58**

The Government appoint independent chairs with appropriate expertise to multi-agency steering committees for the oversight of major projects in future.

**Finding 30****Page 65**

The PCH Taskforce noted concerns around the efficacy of the State's contractual levers as early as February 2015. By May 2016, when the lead issue emerged, the Under Treasurer confirmed the State felt it had no levers left to pull. It is clearly unsatisfactory that the State found itself in this position. It is also difficult to reconcile this outcome with the Acting State Solicitor's description of the contract as an 'extremely favourable contract for the State in terms of risk allocation.'

**Finding 31****Page 68**

The use of contractual levers by the State was variable and generally ineffectual. There was a seeming reluctance to use some of the levers available. For example, Strategic Projects issued only one formal direction requiring John Holland Pty Ltd to employ more resources on site, despite frequently engaging in discussions with the company about the adequacy of resources deployed during construction.

**Finding 32****Page 68**

The reluctance to use several of the levers within the State's contract with John Holland Pty Ltd calls into question why such levers were written into the contract in the first place. It also seems to suggest that the State took a conservative and reactive approach to contract management.

**Finding 33****Page 68**

PCH Taskforce members appear to have held the general view that the suite of levers within the State's contract with John Holland Pty Ltd were not sufficient to ensure the required level of compliance and performance the State was seeking from the builder.

This must serve as a clarion call to improve the quality and application of commercial levers on future major government contracts in this state.

**Recommendation 5****Page 69**

The Minister for Finance engage an independent expert to evaluate the efficacy of the commercial levers within the construction contract for Perth Children's Hospital and the manner in which they were utilised.

The findings and recommendations from this evaluation should be used to ensure future contracts provide greater leverage and confidence to the State in its commercial dealings.

## **Chapter 4 – Assurance**

**Finding 34****Page 76**

The number of significant non-compliance issues that emerged during the construction of Perth Children's Hospital point to systemic deficiencies in the various assurance regimes operating in Western Australia.

**Finding 35****Page 81**

It is unacceptable that the State's quality assurance and quality control processes left it unable to determine how a critical task such as the commissioning of the Perth Children's Hospital water supply was undertaken.

**Recommendation 6****Page 81**

The Minister for Finance ensure that Strategic Projects and, where applicable, Building Management and Works, implement more robust assurance measures for the commissioning of water supplies on future projects.

**Finding 36****Page 87**

Building materials for Perth Children's Hospital were often sourced through multiple layers of sub-contracting with complex, international supply chains. This, coupled with an over-reliance on third-party certification, increased the risk of non-conforming products being installed.

**Finding 37** **Page 88**

Under current processes, the State and industry do not always have adequate visibility or complete assurance over supply chains on major building and infrastructure projects.

**Finding 38** **Page 90**

There were mixed views as to the effectiveness of the State's assurance regime on the PCH project. While Strategic Projects' assurance regime identified a significant number of defects, the failure to identify certain key defects in a more timely manner was problematic for the project.

**Finding 39** **Page 90**

More proactive pre-installation inspection and testing measures are essential until such time that certification becomes a reliable form of assurance.

**Recommendation 7** **Page 91**

The Minister for Finance ensure that Strategic Projects and, where applicable, Building Management and Works, conduct risk-based pre-installation testing and inspection of materials on future projects.

**Finding 40** **Page 93**

The Australian Building Ministers Forum has agreed on the need for jurisdictions to strengthen the regulatory framework to address the incidence, and impact, of non-conforming building products. So far, Queensland appears to be one of the leading jurisdictions addressing this issue.

**Recommendation 8** **Page 93**

The Minister for Commerce and Industrial Relations review Queensland's *Building and Construction Legislation (Nonconforming Building Products – Chain of Responsibility and Other Matters) Amendment Bill 2017* and determine its appropriateness for Western Australia's regulatory framework.

**Finding 41** **Page 96**

Regulations to promote water efficiency under the Water Efficiency Labelling Scheme (WELS) appear to be more thorough than those designed to ensure plumbing materials are fit for purpose and promote public health under the national WaterMark certification scheme.

**Finding 42** **Page 96**

The WELS scheme requires compliance at point of sale, whereas the WaterMark scheme requires compliance at point of installation.

**Recommendation 9** **Page 96**

The Minister for Commerce and Industrial Relations work with the Australian Building Codes Board to establish the national requirement that the WaterMark certification system apply at the point of sale of plumbing products.

**Finding 43** **Page 97**

Australia has a higher level of allowable lead content in brass compared to the United States and Canada.

**Recommendation 10** **Page 98**

The Minister for Commerce and Industrial Relations report to Parliament on the status of the Building Commissioner's April 2017 recommendation, which sought national action to determine whether lead leaching from brass plumbing fittings is contributing to lead levels above the Australian Drinking Water Guidelines (ADWG) in Australian buildings.

**Finding 44** **Page 101**

Key stakeholders to this inquiry supported the view that the Building Commissioner should have a more proactive role in providing assurance to state government construction projects. A formalised proactive audit function could promote greater public confidence in the quality and safety of taxpayer-funded construction projects and offer a deterrent against sub-optimal workmanship.

**Recommendation 11** **Page 101**

The Building Commission should conduct proactive audits on major state government building projects.

**Finding 45** **Page 103**

It is concerning that Building Commission's plumbing inspectors failed to identify the non-conforming components of the TMV assembly boxes given they are the agency responsible for enforcement of plumbing regulations.

**Finding 46** **Page 103**

The Western Australian Building Commission has eleven plumbing inspectors. According to the Master Plumbers and Gasfitters Association of WA, Queensland has 295, Victoria has 35, Tasmania has 29, and the ACT has 12.

**Finding 47** **Page 104**

Given the powers available to the Building Commissioner, we are surprised at the lack of consequence that came from the Building Commissioner's findings in response to multiple instances of poor workmanship by the plumbing sub-contractor at Perth Children's Hospital.

## **Chapter 5 – Practical completion**

### **Finding 48**

**Page 113**

One of the major risks of accepting practical completion prior to knowing exactly what work would be required to remediate all identified minor defects is the risk of excessive delay between taking control of the site, and being able to actually open the hospital.

This can give rise to the realisation of other risks including the diminution of the opportunity and financial cover offered by the two-year defects liability period, and the heightened risk of staff morale issues.

### **Finding 49**

**Page 115**

On 28 March 2017, the PCH Taskforce received an update from the IPMO on the status of 13 areas of the construction program requiring closure before practical completion could be granted. These included the problems with the potable water system. Ultimately, practical completion was granted with at least three of these issues, including the potable water issue, characterised as minor defects.

### **Finding 50**

**Page 116**

At meetings of 4 and 11 April 2017, PCH Taskforce members engaged in extensive and robust deliberations regarding the advantages and disadvantages of the State granting practical completion with the potable water issue classified as a minor defect.

### **Finding 51**

**Page 120**

The ability of the State to conduct orthophosphate treatment on the potable water supply appears to be a major factor behind its decision to grant practical completion. The Under Treasurer claims that John Holland Pty Ltd's refusal to agree to this treatment was 'the straw that broke the camel's back in terms of granting practical completion.' Notably, the Director General of Health, who held significant reservations about granting practical completion for an extended period of time, has since confirmed his unequivocal support for the decision.

### **Finding 52**

**Page 120**

A final assessment on the overall merit of granting practical completion of the PCH on 13 April 2017 cannot be made until such time as the hospital is open and has been running effectively beyond the defects liability period.

# Timeline of Key Events



### The plans begin to change

**September 2013**

The Government adds a 24-bed, Surgical Short Stay Unit to the PCH, for \$37.1m

**November 2013**

Cabinet approves \$245m in additional funding for the PCH project

**4 December 2013**

First PCH Taskforce meeting

**11 June 2014**

A topping-out ceremony confirms the final concrete pour at the site

**12 December 2014**

Leighton Holdings confirms a deal to sell JHPL to China Communications Construction Company

### Issues begin to emerge, and completion is delayed

**12 March 2015**

The Health Minister confirms that the timetable for construction has slipped, pushing the opening date into early 2016

**30 June 2015**

Original contractual date for practical completion

**31 August 2015**

Revised contractual date for practical completion

**14 October 2015**

The Government confirms that there have been 122 variations to the MC Contract, worth a total of \$38.5m

**December 2015**

Damage is evident in a significant proportion of PCH façade panels

**15 March 2016**

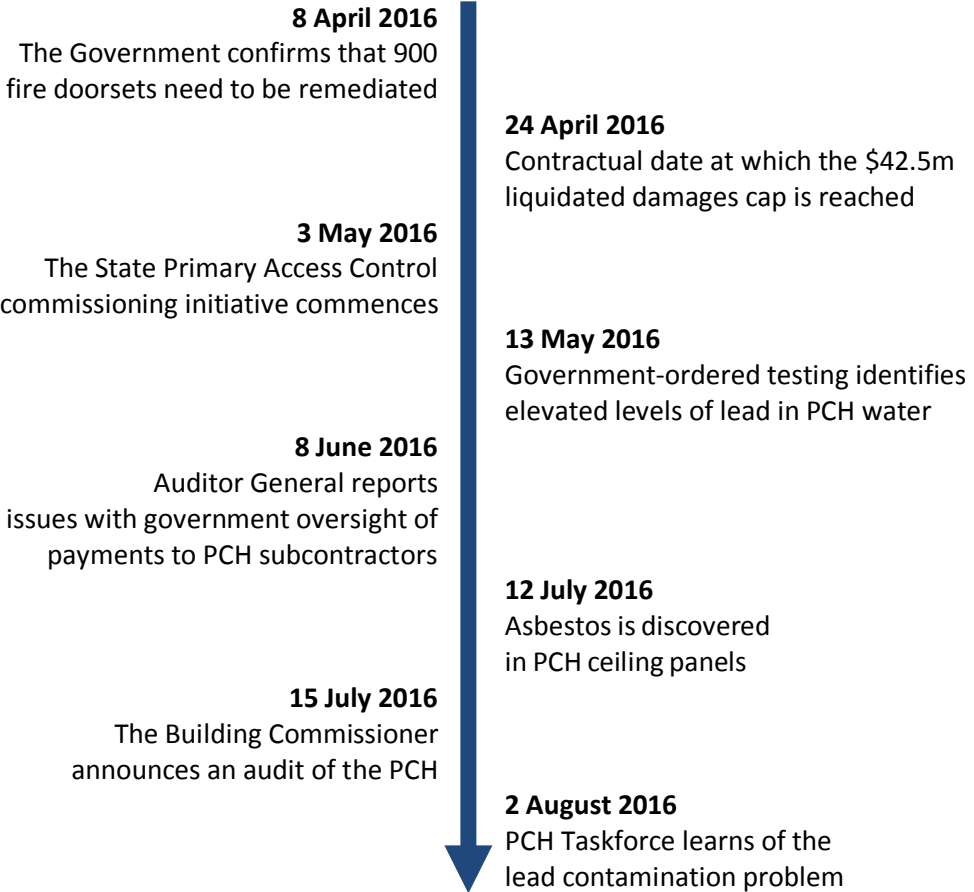
The Government states that the PCH should open in the second half of 2016

**March 2016**

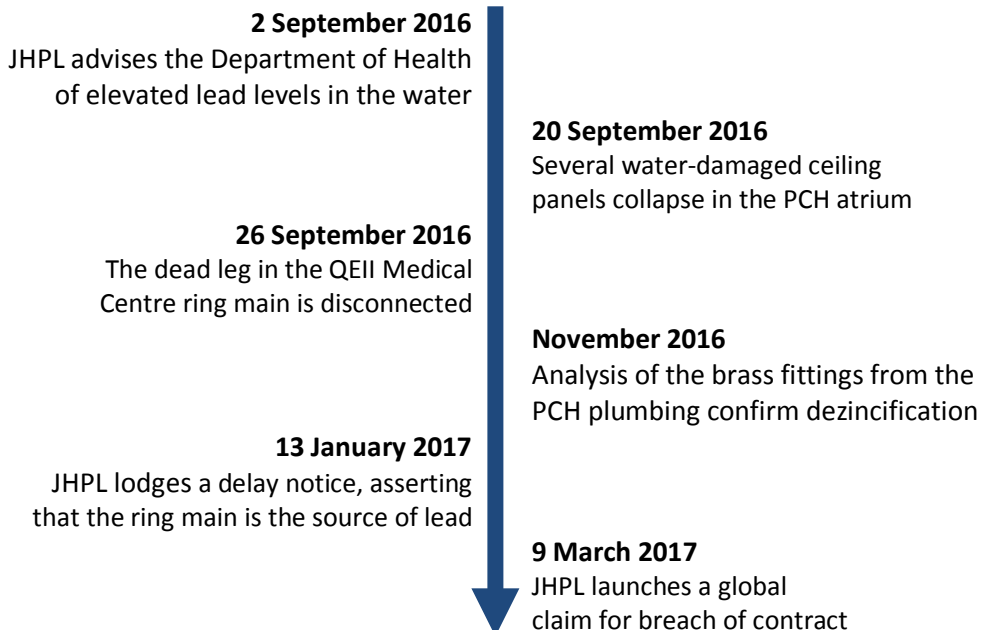
Corrosion and leaking is identified in the PCH stainless steel pipes



### The project becomes beset by major issues



### Water contamination becomes a critical issue



### **A new Government**

**11 March 2017**

State election; the McGowan Government is formed

**4-11 April 2017**

PCH Taskforce has robust discussions over the merits of granting practical completion

**13 April 2017**

Practical completion is achieved

**20 April 2017**

Certificate of practical completion is issued, with water contamination listed as a minor defect

### **The State takes over**

**21 April 2017**

Analysis of the water confirms lead from brass fittings as a source of elevated lead levels

**24 April 2017**

The Building Commission releases its final report on the PCH, identifying four possible sources of the lead

**26 April 2017**

Premier McGowan states that there will be a parliamentary inquiry into the project

### **Water treatment becomes the main focus**

**5 May 2017**

Orthophosphate treatment of the plumbing network commences

**5 July 2017**

The Chief Health Office begins a review of the PCH water system

**10 August 2017**

The PCH Taskforce is dissolved, and replaced by the PCH Commissioning Oversight Committee

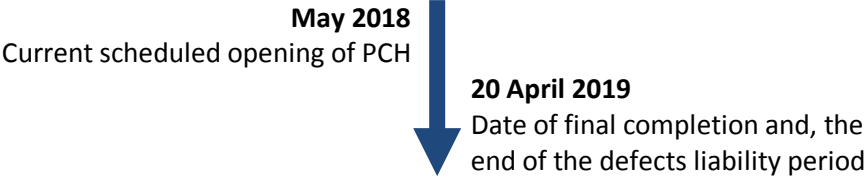
**11 August 2017**

The Chief Health Officer recommends that brass fittings be replaced

**29 November 2017**

The Government announces that the PCH will be open in May 2018

**Future events**





# Chapter 1

## Background

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### **Perth Children’s Hospital – a laudable, but frustrating project**

- 1.1 The new Perth Children’s Hospital (PCH) is a \$1.2 billion health infrastructure project. When completed, PCH will replace the 109 year-old Princess Margaret Hospital (PMH) and will operate as a 298-bed tertiary paediatric hospital and research facility within the QEII Medical Centre site in Nedlands.
- 1.2 On 5 July 2011, the State<sup>5</sup> engaged John Holland Pty Ltd (JHPL) to build PCH under a two-stage Managing Contractor (MC) contract (the MC Contract). The contract granted JHPL site access from 3 January 2012 and included a practical completion date for the construction phase of 30 June 2015. Following practical completion, the Department of Health was to assume control of the site to oversee a final commissioning program that would enable the hospital to open in November 2015.
- 1.3 The State established a “dual governance” structure to oversee the delivery of the hospital. Under this structure, the Strategic Projects & Assets Sales (Strategic Projects) division of the Department of Treasury<sup>6</sup> has managed the construction program and has acted as the State’s counterparty to the contract with JHPL. Separate to this, the Department of Health manages six other commissioning work streams necessary to ensure the hospital, and its staff, are ready for the opening.
- 1.4 Health officials have asserted that PCH will form the future ‘centrepiece of the WA child health care system.’<sup>7</sup> This is a laudable aspiration and one that Western Australians would generally share. However, over the last three years, this trouble-plagued project has instead been a source of ongoing government frustration and public despair.

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<sup>5</sup> Throughout this report, we use the terms “State” and “government” interchangeably. These terms encompass both the elected governments of the day that are / were ultimately accountable for the policy decision to build the hospital, and the public sector entities responsible for overseeing its delivery.

<sup>6</sup> On 1 July 2017, Strategic Projects & Assets Sales moved from Treasury to become a unit of the Department of Finance. It has also reverted to the name Strategic Projects. For simplicity, we have chosen to use the title “Strategic Projects” throughout the entirety of the report.

<sup>7</sup> Department of Health, *About Perth Children’s Hospital*, no date.

## Chapter 1

- 1.5 The main source of frustration surrounds the construction program, which has suffered ongoing slippage around forecast practical completion dates. On 30 June 2015, Treasury agreed to extend the contracted practical completion date out to 31 August 2015. This extension covered a variation to the scope of works by government to accommodate an additional 24-bed surgical short stay unit.<sup>8</sup> Ultimately, JHPL failed to meet this latter deadline, and numerous others. According to Treasury and the Department of Health, JHPL put forward 16 forecast practical completion dates, but met none of them.<sup>9</sup>
- 1.6 Public reporting around the construction delays have focused on exceedances of lead in the potable water system and the discovery of asbestos-contaminated materials in the roof panels. Yet by the time these issues emerged in May and July 2016 respectively, the construction program was almost an entire year behind the revised practical completion date.<sup>10</sup>
- 1.7 At least six other major issues appear to have caused delays during the earlier stages of construction. The first was the scope change for the additional 24 beds, put forward and approved by the government in September 2013. This was one of at least 236 contract variations around scope and (predominantly) design changes agreed to between the State and JHPL throughout the construction stage.<sup>11</sup>
- 1.8 The second issue was JHPL's management of its sub-contractors. As early as 9 September 2014, questions emerged in the Parliament regarding possible non-payments, and in 2016 the payment of sub-contractors formed the basis of a report by the Auditor-General.<sup>12</sup> One of the more significant disputes involved the main technology sub-contractor. From at least June 2015, the project's main oversight body (the Taskforce) was discussing JHPL's management of its technology sub-contractor,

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<sup>8</sup> JHPL sought an extension to 30 November 2015. Treasury rejected this request, arguing that JHPL did not provide sufficient evidence to support the five-month claim. Dr David Russell-Weisz, Director General, Department of Health, 'Perth Children's Hospital Commissioning and Transition: Project Overview and Status Update, 17 March 2017, p. 12.

<sup>9</sup> Mr Michael Barnes, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 9 October 2017, p. 10; Dr David Russell-Weisz, Director General, Department of Health, *Transcript of Evidence*, 18 September 2017, p. 1. The committee asked JHPL to confirm how many revised practical completion date forecasts it provided the State. JHPL elected not to answer this question claiming that the question was seeking information about a dispute that was private and confidential. Mr Lindsay Albonico, WA Region Manager, John Holland Pty Ltd, Letter, 3 November 2017, p. 11.

<sup>10</sup> Reports to the PCH Commissioning and Transition Taskforce indicated that by 3 May 2016, JHPL was working off a revised practical completion forecast date of 4 August 2016. Submission No. 12 from Department of Health, 1 August 2017, Attachment F, p. 3.

<sup>11</sup> Not all variations increased the scope of works. Indeed some resulted in reductions to the lump sum construction price agreed to in the MC Contract. Submission No. 6 from Department of Finance (Strategic Projects), 28 July 2017, p. 13.

<sup>12</sup> Hon. Kate Doust, MLC, WA, Legislative Council, *Parliamentary Debates* (Hansard), 9 September, 2014.

and the impact this issue was having on the delivery of PCH's information and communications technology (ICT) requirements.<sup>13</sup>

- 1.9 The third issue related to the change in ownership of JHPL during the project. In December 2014, media reported that JHPL's parent company, Leighton Holdings, was in the process of selling its shareholding to China Communications Construction Company Limited (CCCC). Strategic Projects and Treasury claimed that this change in ownership, which was finalised on 20 April 2015<sup>14</sup>, had an adverse impact on JHPL's management of the building schedule.<sup>15</sup> JHPL would not confirm whether it was on track to meet the original practical completion date of 30 June 2015 when the change of ownership took place.<sup>16</sup>
- 1.10 The fourth issue was the replacement of 1,641 damaged vitreous enamel (VE) panels, which are a key component of the hospital's internal and external facade. In December 2015, JHPL requested its panel supplier provide replacements for the damaged VE panels. Following a prolonged dispute with its original supplier, JHPL opted to source replacement panels from an alternative supplier in April 2016.<sup>17</sup> The replacement process for these commenced in December 2016 and was due to take up to a year to complete.<sup>18</sup>
- 1.11 The fifth issue was corroding and leaking stainless steel water pipes. JHPL's licensed plumbing contractor first identified defective piping in March 2016 and organised to have it replaced. Some of these replacement pipes corroded within 14 days and were replaced a second time. Further investigation identified 60 other areas of defective

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<sup>13</sup> Confirmed in numerous minutes of the PCH Commissioning and Transition Taskforce meetings from 25 June 2015. JHPL confirmed it was in a commercial dispute with its technology sub-contractor as at October 2016, but it would not confirm how long the sub-contractor's delay in completing its work delayed the overall achievement of PC. JHPL claimed this question sought information about a dispute that was private and confidential. Mr Lindsay Albonico, WA Region Manager, John Holland Pty Ltd, Letter, 3 November 2017, p. 14.

<sup>14</sup> John Holland Pty Ltd, 'John Holland Acquisition Finalised', 21 April 2015.

<sup>15</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), *Transcript of Evidence*, 18 September 2017, pp. 1-2 (closed evidence); Mr Alistair Jones, Executive Director, Strategic Policy and Evaluation, Department of Treasury, *Transcript of Evidence*, 9 October 2017, p. 11.

<sup>16</sup> JHPL claimed this question sought information about a dispute that was private and confidential. Mr Lindsay Albonico, WA Region Manager, John Holland Pty Ltd, Letter, 3 November 2017, p. 11. In response to a separate question, which asked whether the sale had any effect on the management of the PCH project in terms of the departure of key staff, Mr Albonico replied 'As a result of the transaction happening, did our new owners go through a program of reducing workforce numbers or staffing numbers or ask about a program to do that? No.' Mr Lindsay Albonico, WA Region Manager, John Holland Pty Ltd, *Transcript of Evidence*, 13 October 2017, p. 1 (closed evidence).

<sup>17</sup> Building Commission, *Final Report: Perth Children's Hospital Audit*, April 2017, pp. 62-65.

<sup>18</sup> *ibid.*, p. 65. Mr Lindsay Albonico, WA Region Manager, John Holland Pty Ltd, Letter, 3 November 2017, p. 8

## Chapter 1

pipework throughout PCH and replacement work continued through as late as 31 March 2017.<sup>19</sup>

- 1.12 The sixth issue related to non-compliant fire doorsets. PCH has 937 fire doorsets. Concerns around whether the installation of these doorsets complied with Australian standards emerged in late-2015. By April 2016, the government confirmed that more than 900 fire doorsets would need to be reinstalled. It was not until January 2017 that Strategic Projects could advise that all fire doorsets were fully compliant.<sup>20</sup>
- 1.13 Other issues have plagued the construction program in the period after the discovery of elevated lead levels and asbestos-contaminated materials. These include the ongoing replacement of VE panels and corroding steel pipes and a decline in the level of cooperation from JHPL regarding the provision of accurate program reporting.<sup>21</sup>
- 1.14 Frustration with the construction program ultimately drove the State, by this time under a new government, to grant practical completion on 13 April 2017 with 23 ‘minor defects’<sup>22</sup> requiring remediation by JHPL. Foremost among these was delivering a potable water system with a lead content that complied with the Australian Drinking Water Guidelines.
- 1.15 When the State issued the practical completion certificate on 20 April 2017, it took ownership of the PCH site—598 days later than the revised practical completion date of 31 August 2015 agreed to in the MC Contract.
- 1.16 Eleven months after practical completion was granted, the hospital remains unopened. The latest update from the Minister for Health, Hon. Roger Cook’s office indicates that PCH is ‘now on track’ to receive selected outpatients in May 2018, with the final move of all patients from PMH scheduled for the following month.<sup>23</sup> While orthophosphate treatment undertaken by the State has improved water quality, the water supply has not yet been deemed safe to drink. In the post-practical completion period, key aspects of the hospital’s ICT requirements have proven difficult to complete. Other problems have also emerged including the discovery of non-compliant plumbing components and

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<sup>19</sup> Building Commission, *Final Report: Perth Children’s Hospital Audit*, April 2017, pp. 46-51.

<sup>20</sup> *ibid.*, pp. 62-65

<sup>21</sup> Submission No. 12 from Department of Health, 1 August 2017, Attachment F, pp. 9-11.

<sup>22</sup> Under the terms of the Practical Completion Certificate, minor defects are defined as defects that are ‘capable of rectification in a manner that does not prejudice the convenient use of the Works and can be performed so as to minimise any disruption and inconvenience to the facilities in the Reserve and the operation of the Hospital.’ Submission No. 13A, State Solicitor’s Office, 3 August 2017 (closed evidence).

<sup>23</sup> Hon. Roger Cook, MLA, (Minister for Health), *Perth Children’s Hospital opening timetable announced*, Media Statement, 29 November 2017.



ongoing difficulties in rectifying defects within the central sterilisation and air-handling units.<sup>24</sup>

## How did it get to this?

- 1.17 The responsible government agencies have generally attributed the difficulties and delays at PCH to the complexity of the project and the performance of the managing contractor. The Director General of the Department of Health acknowledges the building and commissioning of a tertiary children's hospital 'was always going to be an extraordinarily complex task.'<sup>25</sup> However, his assessment of JHPL was blunt:

*To put it simply—there is no doubt about this—we are late because the builder did not complete the job.*<sup>26</sup>

- 1.18 The Under Treasurer, provided a similar assessment:

*The governance arrangements were not broken. The issue that we had was the challenging nature of the project, being both a construction and commissioning project, as I said, but the other issue we had was, frankly, the performance of the managing contractor.*<sup>27</sup>

- 1.19 The Building Commissioner, who has audited several aspects of the PCH project, was more guarded, but still critical of JHPL:

*Delayed completion, complaints, material failures and contractual disputes suggest that the registered building contractor may have failed to properly manage and supervise the project.*<sup>28</sup>

- 1.20 From the managing contractor's perspective, JHPL acknowledges the hospital:

*...has been one of the most challenging projects recently undertaken in Australia and everyone involved from John Holland is extremely disappointed about the delays.*<sup>29</sup>

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<sup>24</sup> Building Commission, Supplementary Report: Perth Children's Hospital audit – firewalls, 23 October 2017; Weeramanthri T.S., Walker C.E., Davies A.L., Tan H.S., Theobald R.G & Dodds J.C., Report on Perth Children's Hospital Potable Water: Chief Health Officer Review, July 2017.

<sup>25</sup> Dr David Russell-Weisz, Director General, Department of Health, *Transcript of Evidence*, 18 September 2017, p. 1.

<sup>26</sup> *ibid.*, p. 3.

<sup>27</sup> Mr Michael Barnes, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 9 October 2017, p. 10.

<sup>28</sup> Building Commission, *Final Report: Perth Children's Hospital Audit*, April 2017, p. 3.

<sup>29</sup> Mr Lindsay Albonico, WA Region Manager, John Holland Pty Ltd, *Transcript of Evidence*, 13 October 2017, p. 2.

## Chapter 1

- 1.21 Nonetheless, JHPL argues the changes of scope put forward by the government ‘were significant and contributed to delays.’<sup>30</sup> Overall, while acknowledging that it has ‘had lessons learnt, as we do from every project,’ the company has expressed satisfaction with how it managed the project.<sup>31</sup>

### Governance and assurance the focus of the inquiry

- 1.22 While we believe the State’s frustration with JHPL is warranted, the builder’s performance was not the focus of our inquiry.
- 1.23 We have been more concerned about investigating how effectively the State managed risks and issues on the project, both before and after they emerged. With this project, the potential performance of the managing contractor was foremost among the risks the State faced for two key reasons: contract cost and contractor capacity.
- 1.24 The State was aware of the narrow margin for risks and contingencies JHPL would be operating under due to the extremely competitive nature of its bid. The State’s representative to the contract confirmed:

*John Holland were extremely competitive on this project—very competitive—to the point where we actually had an assessment done by the State’s quantity surveyors to ensure that it could in fact be built. It was deemed that it could be built, but that there would be minimal margin in it for John Holland.*<sup>32</sup>

- 1.25 On this issue, the State’s representative went on to add:

*There was in fact a discussion with them [JHPL], and they made it clear that they acknowledged that, but that for a company that had traditionally been a civil engineering contractor this was a project that they had targeted several years beforehand and they had built up a capability and this was intended to launch them into becoming a building contractor, as opposed to a civil engineering contractor.*<sup>33</sup>

- 1.26 This statement indicates the State was also aware it was engaging an entity looking to establish itself as a viable alternative to other main operators the State had dealt with under MC contracts for top-tier construction projects. Notably, while it was not part of the formal criteria for evaluating competing bidders for the contract, there was a

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<sup>30</sup> Mr Lindsay Albonico, WA Region Manager, John Holland Pty Ltd, *Transcript of Evidence*, 13 October 2017, p. 2.

<sup>31</sup> Mr Lindsay Albonico, WA Region Manager, John Holland Pty Ltd, *Transcript of Evidence*, 13 October 2017, p. 1 (closed evidence).

<sup>32</sup> Mr John Hamilton, former Principal Project Director, Strategic Projects & Asset Sales, *Transcript of Evidence*, 18 October 2017, p. 12.

<sup>33</sup> *ibid.*

‘general feeling’ that the decision to engage JHPL offered an opportunity to expand the pool of contractors at this level.<sup>34</sup>

- 1.27 Certainly, there is nothing wrong with the State seeking to promote competitive tension among major contractors tendering for government work by opting to choose alternative entities. Nor is it necessarily problematic for the State to pursue the most competitively priced bid, even it comes with negligible margins. However, such decisions are not without risk.

### Finding 1

For the Perth Children’s Hospital project, the State accepted an extremely competitive bid, with little margin for error, from an entity it had not previously used to manage construction projects of such scale and complexity. Therefore, it was incumbent upon the State to ensure its governance structures could proactively oversee, and where necessary address, any issues that might arise out of the performance of the managing contractor.

- 1.28 Accordingly, we have considered the effectiveness of the State’s governance arrangements for the delivery of PCH. Did these structures provide robust oversight and management of the project? Did government ministers receive prompt, adequate, and accurate reporting on all key developments? If so, particularly as construction issues beset the project, how rigorously did ministers challenge the veracity of the information they received? How well did the Department of Health and Strategic Projects collaborate across their respective work streams to ensure a smooth transition from the construction to the commissioning phase? To what extent did the contractual levers available to the State enable it to ensure an appropriate level of compliance from the managing contractor? How willing was the State to use these levers? How have key decision-makers obtained assurance that the materials and practices used on the project met required standards?

- 1.29 We have also considered the decision to grant practical completion with several key defects, including the water supply, yet to be fully rectified. This decision has been the subject of significant debate in both its lead-up and aftermath. While the decision is not without risk, it has at least enabled the State to go about addressing the problems pertaining to the elevated lead levels.

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<sup>34</sup> Mr John Hamilton, former Principal Project Director, Strategic Projects & Asset Sales, *Transcript of Evidence*, 18 October 2017, p. 1 (closed evidence). Turner & Townsend Thinc, the company engaged as a technical adviser to Strategic Projects, confirmed the State saw a potential benefit in having an additional ‘tier one’ contractor available, but stressed that this was not a formal factor in the decision-making criteria. Mr Cade Dawkins, Regional Manager (WA), Turner & Townsend Thinc, *Transcript of Evidence*, 9 October 2017, pp. 4-5 (closed evidence).

## Chapter 1

- 1.30 This report is mostly critical. This is unavoidable given the circumstances that have unfolded. More than two years after it was due to open, the doors of this vital facility remain closed. PCH is now costing at least \$8.2 million per month to operate, without treating a single patient. Thus far, the State has allocated an additional \$88.7 million to cover the ongoing delays.<sup>35</sup> The most recent tranche of additional funding (\$24.6 million) allocated in the 2017-18 budget assumed a late-December 2017 opening day.<sup>36</sup>
- 1.31 There is also legitimate risk that morale among staff at PMH will fall further the longer the much-anticipated move to PCH is delayed.
- 1.32 Therefore, we have sought to highlight shortcomings in structures, processes, and implementation to help current and future governments avoid similar mistakes.
- 1.33 In his 2015 review of major Commonwealth projects, *Learning from Failure*, former senior public servant Professor Peter Shergold AC expressed some views we found quite apt in the context of this inquiry. Professor Shergold recognised that '[t]he work of government is hard. Its challenges are wicked.'<sup>37</sup> Equally, he argued it was still entirely appropriate to scrutinise 'the manner in which ministers and public servants administer policy' given the profound impact mistakes can have.<sup>38</sup> Where mistakes occur, 'it is crucial that organisations and individuals are able to learn' from them.<sup>39</sup>

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<sup>35</sup> Dr David Russell-Weisz, Director General, Department of Health, Letter, 31 October 2017, pp. 1-2.

<sup>36</sup> Figure of \$24.6 comprised and an additional \$18.3 million 'to meet the costs associated with delays' and \$6.3 million to 'support the deployment' of ICT systems across the hospital. Department of Treasury, *2017-18 Budget Paper No. 3 (Economic and Fiscal Outlook)*, 7 September 2017, pp. 67-68, 116, 179.

<sup>37</sup> Professor Peter Shergold AC, *Learning from failure*, 12 August 2015, p. ix.

<sup>38</sup> *ibid.*, p. 3.

<sup>39</sup> *ibid.*, p. 4.

## Chapter 2

### A complex project; a convoluted governance structure

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- 2.1 The Australian Auditor General observes that ‘good governance is an essential precondition for successful implementation.’<sup>40</sup>
- 2.2 Governance is a broad concept. For the purpose of this inquiry, governance incorporates a clear decision-making, accountability, and reporting framework that is capable of promptly identifying, articulating, and managing risks as they emerge.
- 2.3 Projects of greater complexity can lend themselves to more complex governance arrangements. This is certainly the case with the structure put in place by the State to oversee the delivery of PCH. Oversight of the PCH project has occurred under a dual governance / dual accountability framework, incorporating a wide-array of bodies and individuals.

#### The main governance entities explained

##### Cabinet

- 2.4 The Cabinet of Western Australia sits atop the PCH project’s governance structure. Chaired by the Premier and comprising all ministers, Cabinet is the government’s supreme policy-making body. It was the Cabinet of the previous government, led by Hon. Colin Barnett as Premier, which approved the design and construction procurement strategy for PCH on 29 November 2010.<sup>41</sup>

##### Treasurer and Minister for Health

- 2.5 Under the *Public Works Act 1902* (WA), the Minister for Works (now known as the Minister for Finance) has ultimate responsibility for undertaking infrastructure development on behalf of the State. It has been customary for the Minister to delegate this responsibility to the Treasurer and the PCH project operated under this convention. The Treasurer subsequently delegated responsibility for the day-to-day management of the construction contract and program to Strategic Projects, which

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<sup>40</sup> Australian National Audit Office, *Successful Implementation of Policy Initiatives*, October 2014, p. 11.

<sup>41</sup> Submission No. 6 from Department of Finance (Strategic Projects), 28 July 2017, p. 9.

## Chapter 2

operated as a division of Treasury up until 1 July 2017. Throughout the project, the Treasurer provided reports from Strategic Projects to the Premier and Cabinet.<sup>42</sup>

- 2.6 As Minister responsible for the client agency, the Minister for Health is accountable for the commissioning and overall delivery of the hospital. In the period up to practical completion, the Minister for Health was required to report to the Premier and Cabinet on behalf of the project's cross-agency steering committee, the PCH Commissioning and Transition Taskforce (Taskforce). The Minister for Health has retained similar reporting responsibilities under the revised post-practical completion governance arrangements (explained below at paragraph 2.28).

### **Under Treasurer and Director General, Department of Health**

- 2.7 As head of the Department of Treasury, the Under Treasurer has been accountable to the Treasurer for completing the delivery of the asset 'according to the Project's approved time, scope and budget parameters.'<sup>43</sup> The Under Treasurer has reported directly to the Treasurer on matters relating to the project. The Under Treasurer was also the nominated co-chair of the Taskforce.<sup>44</sup>
- 2.8 The Director General of the Department of Health has managed all aspects of the clinical commissioning program to ensure the operational readiness of the hospital. The Director General has regular reporting requirements to the Minister for Health on 'key matters impacting the Health portfolio'<sup>45</sup>, including PCH. The Director General has also chaired the Taskforce and now chairs its successor, the PCH Commissioning Oversight Committee (PCOC).

### **The PCH Commissioning and Transition Taskforce (Taskforce)**

- 2.9 Original oversight of the PCH project was allocated to a body known as the Major Health Infrastructure Projects Steering Committee (MHIPSC). The MHIPSC was established in 2009 to 'provide leadership' for numerous health projects that had been allotted to Strategic Projects for delivery.<sup>46</sup> This entity oversaw multiple projects concurrently before its abolition towards the end of 2013.
- 2.10 In September 2013, Cabinet established the PCH Taskforce in recognition 'of the need for wider central agency oversight... particularly given the size and complexity' of the

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<sup>42</sup> Submission No. 6 from Department of Finance (Strategic Projects), 28 July 2017, pp. 2-5; Submission No. 13 from State Solicitor's Office, 3 August 2017, p. 2.

<sup>43</sup> Submission No. 6 from Department of Finance (Strategic Projects), 28 July 2017, p. 3.

<sup>44</sup> A role he delegated to the Executive Director, Strategic Policy and Evaluation, upon becoming Under Treasurer in February 2014. Mr Michael Barnes, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 9 October 2017, p. 1.

<sup>45</sup> Submission No. 12 from Department of Health, 1 August 2017, p. 6.

<sup>46</sup> Submission No. 6 from Department of Finance (Strategic Projects), 28 July 2017, p. 3.

project.<sup>47</sup> The Taskforce was required to meet at least monthly and operated through until August 2017 when the PCH Commissioning Oversight Committee (PCOC) became the main oversight body. The Taskforce was based on the model used for the commissioning and transition phase at Fiona Stanley Hospital.

2.11 The full list of Taskforce responsibilities are outlined in its Terms of Reference (included at Appendix One). The first of these was to ‘oversee the delivery and commissioning of PCH.’<sup>48</sup> While this sounds all encompassing, in practice, the Taskforce was predominantly a commissioning oversight body. Its work was unavoidably dependent upon construction activities.

2.12 In matters relating to construction, the Taskforce ‘had no formal influence or decision making authority’ around the contract with JHPL.<sup>49</sup> Nor did it liaise directly with JHPL or provide technical advice around contractual matters.<sup>50</sup> However, it was required to consider any issue that would ‘result in delay or possible delay to key activities or critical milestones.’<sup>51</sup> It was also required to consider issues that might result in changes to the scope or cost of the project, or impact timelines or patient safety. The Taskforce was also expected to ‘consider and assess any risk’ across the project, if that risk was assessed as ‘high’ or ‘extreme’ by one of its relevant subsidiary bodies.<sup>52</sup>

2.13 In terms of its composition, the Taskforce had five permanent members. These included the Director General of the Department of Health and the Under Treasurer, whose broad roles were described above. The other three members were the Deputy State Solicitor Commercial from the State Solicitor’s Office (SSO), and both the Director General and the Executive Director, Cabinet and Policy Division, of the Department of the Premier and Cabinet (DPC). The SSO representative provided legal support and advice, and offered relevant governance experience having served on steering committees of other large infrastructure initiatives. The DPC representatives provided an additional conduit for reporting to the Premier on the status of the project.<sup>53</sup>

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<sup>47</sup> Dr David Russell-Weisz, Director General, Department of Health, ‘Perth Children’s Hospital Commissioning and Transition: Project Overview and Status Update,’ 17 March 2017, p. 6.

<sup>48</sup> Submission No. 12 from Department of Health, 1 August 2017, p. 23.

<sup>49</sup> *ibid.*, p. 8.

<sup>50</sup> Submission No. 13 from State Solicitor’s Office, 3 August 2017, p. 5.

<sup>51</sup> Submission No. 12 from Department of Health, 1 August 2017, p. 9.

<sup>52</sup> Risks classified as “low” or “medium” were generally handled by the relevant project work stream, or in the case of the construction work stream, by either JHPL or Strategic Projects. Submission No. 13 from State Solicitor’s Office, 3 August 2017, p. 11.

<sup>53</sup> Mr Nicholas Egan, A/State Solicitor, State Solicitor’s Office, *Transcript of Evidence*, 18 September 2017, p. 1; Ms Lyn Genoni, Former Executive Director, Policy, Department of the Premier and Cabinet, *Transcript of Evidence*, 30 October 2017, p. 1.

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- 2.14 Throughout its existence, the Taskforce met at least 156 times. It reported to the Premier and Cabinet through the Minister for Health on a quarterly basis, or as it otherwise resolved.
- 2.15 Taskforce meetings were also open to as many as eleven formal attendees made up predominantly of senior staff from the departments of Treasury and Health. These included Treasury's Executive Director of Strategic Projects, who managed the construction program on behalf of the State. This was a significant position within the PCH governance structure as it 'had responsibility for day-to-day project construction issues.'<sup>54</sup> Notably, the Under Treasurer and Director General of Health came to an agreement whereby the Executive Director of Strategic Projects 'would be treated as a full member of the Taskforce and be included in all taskforce member-only discussions.'<sup>55</sup> The Executive Director of Strategic Projects reported to Taskforce, the Under Treasurer, and the Treasurer regarding the status of construction.<sup>56</sup>
- 2.16 Another notable attendee was the Chief Executive of Child and Adolescent Health Services (CAHS) and PCH Commissioning, who was managing the commissioning process on site prior to the hospital opening. An employee of the Department of Health, this officer was required to provide regular updates to Taskforce on the status of the six non-construction work streams.

### **The Project Control Group (PCG)**

- 2.17 The Project Control Group (PCG) sat immediately below the Taskforce and provided reporting to it from all work streams across construction and commissioning.
- 2.18 The PCG was originally required to provide 'oversight and coordination in relation to the finalisation of the construction phase of the PCH Project.'<sup>57</sup> It was also responsible for providing update reports to the Taskforce's predecessor, the MHIPSC, and assessing 'strategic issues' and risks emanating out of the project's work streams.<sup>58</sup>
- 2.19 However, in the aftermath of a highly critical 2015 gateway review into the PCH's governance structures, the PCG's role was reconfigured. Under its revised Terms of Reference (included at Appendix Two), the PCG's primary function was to act as 'an intermediary body' to consider and (ideally) resolve issues without the need to involve the Taskforce.<sup>59</sup> For example, the PCG had to identify, manage, and report on all project risks, including those relating to costs and timelines. Only those risks assigned a

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<sup>54</sup> Mr Michael Barnes, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 9 October 2017, p. 1.

<sup>55</sup> *ibid.*, p. 2.

<sup>56</sup> Submission No. 6 from Department of Finance (Strategic Projects), 28 July 2017, p. 5.

<sup>57</sup> Department of Health and Department of Treasury, *Perth Children's Hospital Project Governance Framework*, May 2015, p. 8.

<sup>58</sup> *ibid.*

<sup>59</sup> Submission No. 13 from State Solicitor's Office, 3 August 2017, p. 7.



high or extreme rating were elevated to the Taskforce. Similarly, the PCG had to 'monitor and assess all project milestones, leaving the Taskforce to deal with only those milestones considered 'key or significant.'<sup>60</sup> The PCG also provided a closer level of 'management oversight' of 'all aspects of the project.'<sup>61</sup>

2.20 The PCG met at least weekly up until its abolition (along with the Taskforce) in August 2017.

2.21 Like the Taskforce, the PCG was a multi-disciplinary body comprising senior officers from Treasury, Health and the State Solicitor's Office. The nine permanent members included the Chief Executive CAHS and PCH Commissioning who was (*ex-officio*) the PCG Chair. The Executive Director of Strategic Projects, served on the PCG and the Taskforce and, as such, provided an important link between the two entities.

2.22 In addition to its permanent members, the PCG had up to 14 formal attendees participate in its meetings. Prominent among these was the Principal Project Director of the PCH Project, who worked for Strategic Projects as the State's representative on the contract with JHPL. It is important to note that while the PCG exercised oversight of matters relating to construction, it was ultimately the Principal Project Director who determined how the contract was administered. While the Principal Project Director reported to the PCG, this position was ultimately accountable to the Executive Director of Strategic Projects. It was through the Principal Project Director that the Executive Director prepared reports for Taskforce. Moreover, it was through the Principal Project Director that Strategic Projects was, effectively, 'the first point of contact for most risks relating to construction and the construction phase.'<sup>62</sup>

### **The Project Advisory Group (PAG)**

2.23 The Principal Project Director also served as a member of the PCH Project Advisory Group (PAG), which reported to the PCG. The PAG was the formal vehicle by which representatives from Treasury and the Department of Health could discuss matters relating to the construction contract with key personnel from JHPL.

2.24 In addition to the PCH Principal Project Director, PAG members included: the Chief Executive CAHS and PCH Commissioning; the Executive Director of Strategic Projects, and up to four project directors from JHPL, including their representative on the contract.<sup>63</sup>

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<sup>60</sup> Submission No. 13 from State Solicitor's Office, 3 August 2017, p. 8.

<sup>61</sup> *ibid.*, p. 7.

<sup>62</sup> *ibid.*, p. 10.

<sup>63</sup> Based on a copy of the Minutes for PAG Meeting No. 65 held on 13 April 2017, provided by Mr Lindsay Albonico, WA Region Manager, John Holland Pty Ltd, 3 November 2017 (closed evidence).

## Chapter 2

### The PCH Program Management Office (PMO)

2.25 In 2013, the Department of Health established a PCH Program Management Office (PMO)<sup>64</sup> to assist CAHS with transition and change management activities associated with the planned move from PMH. The PMO was also responsible for providing 'independent advice' to Taskforce on the status of the project and operating as the 'central coordination point for all Workstream Program reporting and monitoring activities.'<sup>65</sup> The PMO's formal remit further extended to coordinating the 'resolution, reporting and escalation,' of issues and risks as they emerged across the project.<sup>66</sup> CAHS established the PMO in early 2013 and engaged Ernst and Young (EY) to provide the PMO's services from July 2014.<sup>67</sup>

### The Integrated Master Program (IMP)

2.26 The Integrated Master Program (IMP) was a supporting body to the overarching governance framework managed by Strategic Projects. A key function of the IMP was to take data from across all work streams and produce a monthly report on the 'tracking of key milestones, dependencies and impact on scope changes on delivery timeframes.'<sup>68</sup> It was also expected to 'manage and report on overall program dependencies.'<sup>69</sup> Created in March 2014, after Strategic Projects had engaged a firm to identify the linkages between the design, construction, and commissioning programs,<sup>70</sup> the IMP operated until September 2016, when it was disbanded following criticisms as to its effectiveness.

### The Integrated Program Management Office (IPMO)

2.27 In September 2015, the Director General of the Department of Health engaged PricewaterhouseCoopers to provide an Integrated Program Management Office service. The IPMO's remit was to provide independent advice to the Taskforce on a weekly basis on the status of key activities, critical milestones and risks across the entire project. The role of the IPMO appears similar to what the PMO could have been providing considerably earlier in the project. The fact that such a role was not

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<sup>64</sup> For the full list of PMO roles and responsibilities, see Appendix Three. Please note, submissions and other evidence to the inquiry referred to the PMO as both the PCH Program Management Office and the PCH Project Management Office.

<sup>65</sup> Except those relating to project finance. Department of Health and Department of Treasury, *Perth Children's Hospital Project Governance Framework*, May 2015, pp. 8-9.

<sup>66</sup> Except those issues relating to design. *ibid.*, p. 9.

<sup>67</sup> Submission No. 13B from State Solicitor's Office, 4 October 2017; Mr John Hamilton, former Principal Project Director, Strategic Projects & Asset Sales, Letter, 15 November 2017, p. 3.

<sup>68</sup> Department of Health and Department of Treasury, *Perth Children's Hospital Project Governance Framework*, May 2015, p. 9.

<sup>69</sup> *ibid.*, p. 10.

<sup>70</sup> Mr John Hamilton, former Principal Project Director, Strategic Projects & Asset Sales, Letter, 15 November 2017, p. 3. Submission No. 6 from Department of Finance (Strategic Projects), 28 July 2017, p. 18.

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established earlier in the project is something we discuss later in the report (see 3.58 through 3.60 below).

### **The PCH Commissioning Oversight Committee (PCOC)**

- 2.28 Following practical completion, the PCH site transitioned over to a Health Ministerial Body under the control of the Director General of Department of Health. This effectively negated the ongoing requirement for a dual governance structure, although the Taskforce continued to operate until August 2017.
- 2.29 At this time the PCOC was established after a July 2017 gateway review questioned the ongoing utility of the Taskforce as the main oversight body. According to the Department of Health, the PCOC is intended to ‘improve management efficiency’ through reduced reporting and streamlined decision-making. It will also have a predominant focus on activities within the health system.<sup>71</sup> The PCOC is chaired by the Director General of Health and receives regular reports on outstanding construction matters from the Executive Director of Strategic Projects.<sup>72</sup>
- 2.30 The flow chart on the following page attempts to illustrate the main linkages within what we have found to be a convoluted structure.

### **Finding 2**

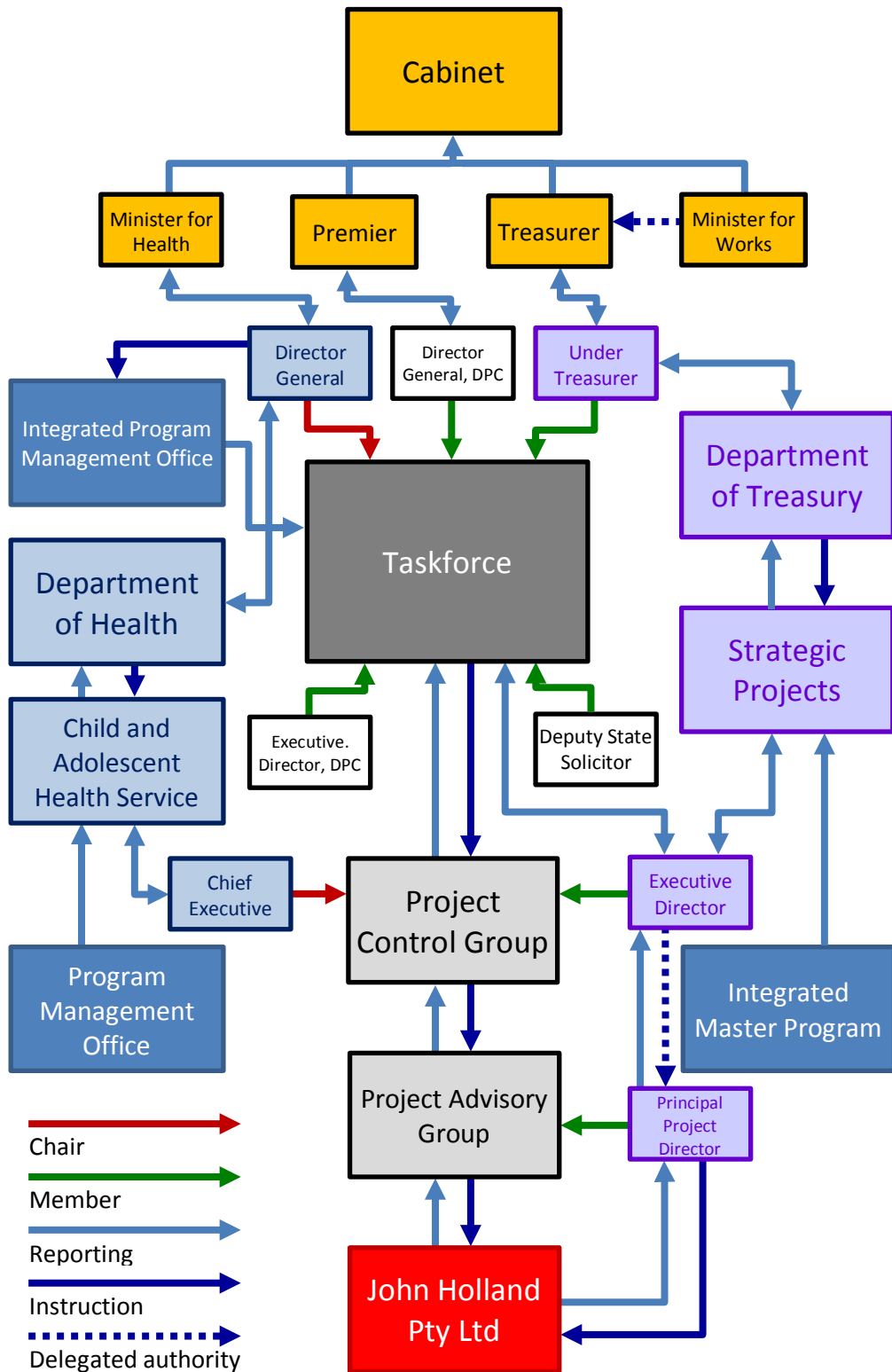
The governance structure established by the State to oversee the delivery of the Perth Children’s Hospital was convoluted. Adding to the complexity of this structure was the dual governance / dual accountability arrangement, under which the Department of Treasury was responsible for the construction of the hospital while the Department of Health was responsible for all aspects of its commissioning.

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<sup>71</sup> Dr David Russell-Weisz, Director General, Department of Health, Letter, 30 October 2017, p. 10.

<sup>72</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), Letter, 13 October 2017, p. 9.

**Figure 1: Main entities within the PCH Governance Structure—September 2013 through August 2017.**



# Chapter 3

## Governance

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### A governance structure that came up short

- 3.1 The A/State Solicitor, himself a Taskforce member, described the PCH governance structure as ‘appropriately and necessarily complex to deal with the complexity of the PCH project.’<sup>73</sup> He added that, notwithstanding this complexity, the structure ‘has been sound and effective in identifying and responding to project risks.’<sup>74</sup> The Under Treasurer, a fellow Taskforce member, described the governance structure as ‘very robust.’<sup>75</sup>
- 3.2 While the complexity of the governance structure was indeed unavoidable given the multifaceted nature of the PCH project, claims to its overall effectiveness are harder to reconcile with events that transpired.
- 3.3 We have identified several key elements essential to effective governance that were either too slow, or failed entirely, to materialise across the PCH project. In particular, the governance structure was deficient in terms of:
- clarity of roles and responsibilities;
  - comprehensive project and risk management practices; and
  - complete, open, and accurate reporting.
- 3.4 Had these deficiencies been addressed earlier, it is possible that key decision-makers within the governance structure could have dealt more efficiently with the extraneous and internal issues that emerged.

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<sup>73</sup> Submission No. 13 from State Solicitor’s Office, 3 August 2017, p. 8.

<sup>74</sup> *ibid.*, p. 14.

<sup>75</sup> Mr Michael Barnes, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 9 October 2017 p. 10.

## Key roles and responsibilities remained unclear for too long

- 3.5 For governance structures to be effective, key roles, responsibilities, and decision-making authority must be clearly defined and appropriately delegated.<sup>76</sup> This is particularly important for multi-agency bodies like the PCH Taskforce. The Australian National Audit Office (ANAO) advises that any such entity should give ‘early attention’ to its governance arrangements that ‘the process of collaboration’ is facilitated.<sup>77</sup>
- 3.6 The governance structure for the PCH Project certainly included documentation that attempted to provide the necessary clarity for encouraging proper management and oversight. The Taskforce and Project Control Group’s respective terms of reference, along with supporting documents like the 2015 PCH Project Governance Framework and the Decision Making Matrix-PCH Commissioning Project, are evidence of this attempt.<sup>78</sup> However, despite their intent, these initiatives failed to address some apparent longstanding confusion among key figures working on the project.

## Significant confusion about key roles and responsibilities

- 3.7 The Chief Executive of CAHS and PCH Commissioning ordered a readiness for service gateway review<sup>79</sup> as the construction program neared its original practical completion date of 30 June 2015. The review was ordered after it was confirmed this date would be missed and the project was now operating under a revised practical completion date of 30 November 2015.<sup>80</sup> The review, which took place 21 months after Cabinet established the Taskforce, identified the overall quality of governance as one of six ‘critical issues that needed to be addressed.’<sup>81</sup>

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<sup>76</sup> Professor Peter Shergold AC, *Learning from failure*, 12 August 2015, p. viii; Australian National Audit Office (ANAO), *Successful Implementation of Policy Initiatives*, 15 October 2014, p. 26; Submission No. 1 from the Australian Institute of Project Management, 12 July 2017, p. 1.

<sup>77</sup> Australian National Audit Office (ANAO), *Public Sector Governance. Strengthening Performance through Good Governance*, 26 June 2014, p. 61.

<sup>78</sup> Department of Health and Department of Treasury, *Perth Children’s Hospital Project Governance Framework*, May 2015. For the matrix, see Submission No. 12 from Department of Health, 1 August 2017, Attachment C.

<sup>79</sup> Gateway reviews provide independent assurance around project development, planning, management and delivery across six key stages, or gates, of a project: strategic assessment; business case; readiness for market; tender decision; readiness for service; and benefits evaluation. Gateway reviews are conducted by independent parties and since 1 September 2016, they have become mandatory on government infrastructure projects valued at \$100 million and above. For more information, see, Department of Finance, ‘Gateway,’ no date.

<sup>80</sup> Dr David Russell-Weisz, Director General, Department of Health, Letter, 6 March 2018, p. 3.

<sup>81</sup> Department of Health, *Gateway Review 5 – Readiness for Service*, 26 June 2015, p. 3.

- 3.8 The review team found that ‘key governance forums’ were ‘not functioning effectively.’<sup>82</sup> Rather than all work streams working together in a collaborative manner, the project was ‘being managed as two distinct entities, which is compromising how the Perth Children’s Hospital build and commissioning project is governed.’<sup>83</sup>
- 3.9 Feedback from interviewees, which included Taskforce members and formal attendees, was particularly insightful. These interviewees reported that the Taskforce was ‘ineffective as a forum for stewardship and decision making for the project.’<sup>84</sup> Critically, just four days before the original practical completion date, interviewees ‘were generally unclear regarding responsibilities and accountabilities across the Program, in particular, the role and function of Strategic Projects & Asset Sales.’<sup>85</sup>
- 3.10 This confusion extended into the realm of the all-important ICT work stream. Here, interviewees remained ‘unclear on several key aspects of the delivery of the ICT systems.’<sup>86</sup> Remarkably, these included determining what the ‘overall solution design for ICT’ was, and who was responsible for delivering it.<sup>87</sup> It is simply unacceptable that the review team had to recommend that ‘an ICT overview design’ for PCH be developed at this time, given Cabinet had approved a \$245 million business case covering the Hospital’s ICT requirements in November 2013.<sup>88</sup>
- 3.11 In its overarching analysis, the review team argued that the Taskforce—instead of functioning as an oversight body—had defaulted to performing the role of a whole-of-project steering committee. Consequently, the review team made a further recommendation that the Project Control Group be ‘reconstituted’ and have its remit broadened to ‘act as the Project Steering Committee for all aspects of infrastructure delivery, commissioning and transition.’<sup>89</sup> This recommendation also called for an update to the Project Control Group’s terms of reference to make explicit the requirement to ‘report directly to the Taskforce.’<sup>90</sup>

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<sup>82</sup> Department of Health, *Gateway Review 5 – Readiness for Service*, 26 June 2015, p. 4.

<sup>83</sup> *ibid.*

<sup>84</sup> *ibid.*, p. 9.

<sup>85</sup> *ibid.*, p. 10.

<sup>86</sup> *ibid.*, p. 7.

<sup>87</sup> *ibid.*, p. 8.

<sup>88</sup> *ibid.*; Hon. Alyssa Hayden, MLC, WA, Legislative Council, *Parliamentary Debates* (Hansard), 20 February 2014, p. 409.

<sup>89</sup> Department of Health, *Gateway Review 5 – Readiness for Service*, 26 June 2015, p. 10.

<sup>90</sup> Previously, the PCG had to provide update reports to the MHIPSC, but its terms of reference had not been updated to reflect the fact that the Taskforce superseded the MHIPSC at the end of 2013.

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- 3.12 The findings of the gateway review were the subject of detailed discussion at subsequent Taskforce meetings. While some members disagreed with the findings and language used to describe the relationship between building and commissioning streams, there was broad agreement around the recommendations regarding the Project Control Group's role and the ICT program.<sup>91</sup>
- 3.13 The Taskforce noted that the Project Control Group had conducted an independent review of the status of the ICT program, the findings of which had 'echoed' the gateway review. This additional review found there was 'no shared cohesive ICT design.'<sup>92</sup> As a result, each key stakeholder (i.e. JHPL's ICT sub-contractor, the Department of Health's ICT work stream, Strategic Projects) had 'differing views on the ICT solutions being delivered' and different implementation plans.<sup>93</sup>

### **Confusion continued despite remedial actions taken in 2015 and 2016**

- 3.14 The Taskforce reacted promptly to address the issues raised in the June 2015 Gateway Review. A follow-up gateway review in March 2016—which was called after the forecast practical completion date had slipped further to late-June 2016—observed 'increased integration' between the Department of Health work streams and Strategic Projects' construction team.<sup>94</sup> It also reported improved 'clarity around the hierarchy of decision making.'<sup>95</sup> This was aided in part by the establishment of a Responsible, Accountable, Consulting and Informed (RACI) matrix for the key ICT stakeholders.<sup>96</sup> The Project Control Group's terms of reference were also updated in accordance with the 2015 gateway recommendation (see 2.19 above).
- 3.15 While the second gateway review acknowledged these improvements, it appears that confusion around key roles and responsibilities continued to plague the governance structure well into 2017. In the month prior to practical completion being granted in April, a briefing from the Director General (and Taskforce Chair) to the new Minister for Health listed several issues that had 'emerged over the project, arising from the current governance arrangements.'<sup>97</sup> These included:

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<sup>91</sup> PCH Taskforce, Minutes of Meeting 25 June 2015, p. 3; PCH Taskforce, Minutes of Meeting 2 July 2015, p. 4 (closed evidence).

<sup>92</sup> PCH Taskforce, Minutes of Meeting 9 July 2015, p. 3 (closed evidence).

<sup>93</sup> *ibid.*

<sup>94</sup> Department of Treasury – Strategic Projects & Asset Sales and Department of Health, *Gateway Review 5 – Readiness for Service*, 11 March 2016, p. 3. Dr David Russell-Weisz, Director General, Department of Health, Letter, 6 March 2018, p. 3.

<sup>95</sup> *ibid.*

<sup>96</sup> Department of Treasury – Strategic Projects & Asset Sales and Department of Health, *Gateway Review 5 – Readiness for Service*, 11 March 2016, p. 24.

<sup>97</sup> Dr David Russell-Weisz, Director General, Department of Health, *Perth Children's Hospital Commissioning and Transition. Project Overview and Status Update*. 17 March 2017, p. 35 (Legislative Assembly Tabled Paper No. 268, tabled on 18 May 2017) (emphasis added).



*...confusion with regards to the role of Chair of Taskforce in reporting to the Minister for Health and Cabinet, and the role of SP&AS [Strategic Projects] in its direct line of accountability to the Treasurer.*

and:

*...lack of clarity of officers in DOH [Department of Health], CAHS and SP&AS with regards to governance and reporting requirements.<sup>98</sup>*

3.16 In addition, a July 2017 gateway review into the post-practical completion governance arrangements indicated that the Taskforce was still assuming roles that were within the remit of the PCG's updated terms of reference.<sup>99</sup>

3.17 It is not possible to definitively assess the impact this ongoing lack of clarity has had on the effectiveness of the PCH governance structure. What is more certain is that the failure to clearly define and agree on the duties and objectives of such fundamental positions and programs is contrary to best practice in governance.

### Finding 3

Confusion around key roles and responsibilities continued to plague the governance structure well into 2017. We find it difficult to comprehend how this confusion was not resolved throughout the almost four-year, 156-meeting, life of the Perth Children's Hospital Commissioning and Transition Taskforce (the PCH Taskforce). The failure to settle these internal issues meant that the PCH governance structure was not in an optimal position to manage the project and the multitude of challenges it presented. It is especially difficult to reconcile this failure with the knowledge and experience of the individuals on the PCH Taskforce.

### Finding 4

Because of long-standing confusion over governance roles and responsibilities, the PCH project was operating without an agreed overview design or implementation plan for information and communications technology (ICT) as late as June 2015. This was despite Cabinet approving a \$245 million business case covering the hospital's ICT requirements in November 2013.

<sup>98</sup> Dr David Russell-Weisz, Director General, Department of Health, *Perth Children's Hospital Commissioning and Transition. Project Overview and Status Update*. 17 March 2017, p. 35 (Legislative Assembly Tabled Paper [No. 268](#), tabled on 18 May 2017) (emphasis added).

<sup>99</sup> Department of Health, *Gateway Review – Readiness for Service (5)*, 7 July 2017, p. 6.

## **Robust project and risk management processes lacking for extended periods**

- 3.18 Sound project management processes help public sector agencies ‘deliver more effective outcomes.’<sup>100</sup> A key element of successful project management is the proactive management of risks, potential and realised, that threaten a project’s successful implementation. The ANAO has observed that ‘many problems’ during project implementation can be ‘alleviated’ via overarching planning process that include ‘proper analysis, consideration and communication of risks.’<sup>101</sup>
- 3.19 In its earlier form, the PCH governance structure included entities—most notably the PMO and the IMP—intended to promote robust project and risk management practices at a whole-of-project level. Notwithstanding the existence of such bodies, it is clear that the overall project suffered some notable failures in project and risk management. This created confusion, particularly across the commissioning work stream, and proved an ongoing source of frustration within the Taskforce.

### **Program management suffered from the absence of a reliable critical path**

- 3.20 The critical path is a key project management tool. While critical path software is now quite sophisticated, the underlying concept is relatively simple. Project managers use a critical path to plot all core tasks, map out estimated timeframes for completion, and identify interdependencies across all the work streams of a project. A robust critical path displays the shortest possible timeframe from start to finish for a project, and demonstrates how a delay in one work stream will affect the overall schedule. This helps managers and governing entities quickly identify vulnerabilities across a project in order to determine the necessary actions to get it back on track.
- 3.21 A robust, reliable critical path was lacking for an extended period within the PCH governance structure. The 2015 Gateway Review acknowledged the existence of the IMP, but noted that it ‘omit[ted] critical activities,’ including some issues previously raised by the Taskforce, and ‘d[id] not have a critical path analysis.’<sup>102</sup> Consultants who joined the project after the 2015 review made similar observations regarding the IMP and the absence of a reliable critical path.<sup>103</sup> They added that these difficulties were

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<sup>100</sup> Mr Peter Achterstraat, ‘Why large public sector projects sometimes fail,’ Audit Office of NSW, September 2013.

<sup>101</sup> Australian National Audit Office (ANAO), *Public Sector Governance. Strengthening Performance through Good Governance*, 26 June 2014, p. 14.

<sup>102</sup> Department of Health, *Gateway Review 5 – Readiness for Service*, 26 June 2015, p. 12.

<sup>103</sup> Ms Tricia Tebbutt, Partner, and Mrs Tanya West, Director of IPMO Services to PCH, PricewaterhouseCoopers, *Transcript of Evidence*, 18 October 2017 (closed evidence).

exacerbated by JHPL's inability to provide Strategic Projects with an appropriately mapped and accurate forecast for the building program.<sup>104</sup>

- 3.22 Interviewees for the 2015 review confirmed that the building program managed by Strategic Projects, 'lacked transparency.'<sup>105</sup> As a result, they found it difficult to determine 'how the activities of the build program informed specific work streams [including design and ICT] and how these work streams, in turn, informed the build program.'<sup>106</sup> Taskforce Minutes for meetings between January and June 2015 also made regular reference to a lack of appropriate communication across work streams and urged the need for a fully integrated program to outline 'interdependencies, risks, and gaps.'<sup>107</sup>

### **No fully integrated risk management process until late-2015**

- 3.23 The 2015 Gateway Review also noted an 'absence of formal risk management' and called for project-wide improvements in this area.<sup>108</sup> It found that the siloed approach adopted between building and commissioning work streams was impeding 'how critical risks were being managed.'<sup>109</sup>
- 3.24 While the building and commissioning-related risks were maintained on separate registers, there was no indication that risks assigned a high or extreme rating were monitored or reviewed by a relevant oversight body, such as the Project Control Group or the Taskforce. Notably, a Risk and Issues Management Plan in place at the time stipulated that these higher-end risks should be elevated to the Taskforce. However, the plan did not refer to construction and design-related risks, which it said were 'managed separately through SP&AS.'<sup>110</sup>
- 3.25 The Taskforce Minutes from its 20 January 2015 meeting provide an alarming example of how this disjointed approach to risk management may have manifested. These minutes note that three years after construction had commenced, the Department of Health, as client agency and ultimate owner of the asset, did not know 'how the PCH Project overall is tracking financially.'<sup>111</sup> Moreover, without integrated risk reporting and analysis accurately linking the building and commissioning programs, Taskforce

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<sup>104</sup> Ms Tricia Tebbutt, Partner, and Mrs Tanya West, Director of IPMO Services to PCH, PricewaterhouseCoopers, *Transcript of Evidence*, 18 October 2017, p. 3.

<sup>105</sup> Department of Health, *Gateway Review 5 – Readiness for Service*, 26 June 2015, p. 10.

<sup>106</sup> *ibid.*

<sup>107</sup> PCH Taskforce, Minutes of Meeting 5 May 2015, p. 4. Other examples are evident in the minutes of the meetings held on 10 February, 19 May, 2 June, and 25 June 2015 (closed evidence).

<sup>108</sup> Department of Health, *Gateway Review 5 – Readiness for Service*, 26 June 2015, pp. 10 and 3.

<sup>109</sup> *ibid.*, p. 4.

<sup>110</sup> *ibid.*, p. 7.

<sup>111</sup> PCH Taskforce, Minutes of Meeting 20 January 2015, p. 2 (closed evidence).

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members became increasingly unsure about a reliable hospital opening date, as JHPL's construction started slipping.

### Finding 5

It is surprising that the minutes from the PCH Taskforce meeting of 20 January 2015 noted that the Department of Health did not know 'how the PCH project is tracking financially.' This is arguably attributable to the ongoing failure to establish agreed and fully integrated project and risk management processes within the PCH governance structure.

### Project Management Office not functioning as originally intended

- 3.26 A Department of Health document outlining the PCH governance structure as at May 2015 implies that the PMO had an extensive range of responsibilities (see Appendix Three). These included coordinating the reporting, monitoring, and management of risks and issues across all project work streams. It was also expected to 'provide independent advice' to the Taskforce on areas within its remit.<sup>112</sup>
- 3.27 The 2015 Gateway Review found the PMO was performing more of a 'reporting and support' role rather than any advisory function.<sup>113</sup> Furthermore, the reports the PMO provided to Taskforce focused mostly on commissioning work streams, and did 'not incorporate critical analysis or interrogation of project reporting.'<sup>114</sup> The review team went on to conclude that the PCH governance structure was operating without 'a dedicated role to provide independent assurance to the Taskforce to validate current reporting on a program-wide basis.'<sup>115</sup>
- 3.28 These findings echoed concerns raised in Taskforce meetings before and after the review. On 5 May 2015, several Taskforce members expressed concern about the lack of independent analysis coming out of PMO reports<sup>116</sup> and a later meeting confirmed that the PMO '[h]ad no oversight of SP&AS in their current contract.'<sup>117</sup> This helps explain why the gateway review found that PMO reports did not sufficiently integrate risk data from the building work stream.

### Corrective measures adopted in late-2015 produce mixed results

- 3.29 The 2015 gateway made four key recommendations targeting improved project and risk management process. This first of these called for the establishment of an entity to provide consolidated reports to the Taskforce with 'critical analysis of time, cost, and

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<sup>112</sup> Department of Health and Department of Treasury, *Perth Children's Hospital Project Governance Framework*, May 2015, p. 8.

<sup>113</sup> Department of Health, *Gateway Review 5 – Readiness for Service*, 26 June 2015, p. 9.

<sup>114</sup> *ibid.*

<sup>115</sup> *ibid.*

<sup>116</sup> PCH Taskforce, Minutes of Meeting 5 May 2015, p. 2 (closed evidence).

<sup>117</sup> PCH Taskforce, Minutes of Meeting 30 July 2015, p. 3 (closed evidence).

quality’ across all project work streams.<sup>118</sup> It also recommended a ‘fully integrated and comprehensive Master Plan be completed’ outlining all high and extreme project risks across the project, and that the reconfigured Project Control Group be responsible for managing them.<sup>119</sup> Finally, it urged that any risks associated with the current level of information sharing between Strategic Projects and commissioning work streams ‘be escalated to Taskforce for resolution.’<sup>120</sup> Each recommendation was designated as ‘[c]ritical and urgent, to achieve success the project should take action... immediately.’<sup>121</sup>

3.30 The findings of the 2015 Gateway Review generated robust discussion between senior figures from the Department of Health, Strategic Projects, and representatives from the PMO service provider at subsequent Taskforce meetings. Health officials—including the Director General (and Taskforce Chair) and the CE of CAHS and PCH Commissioning—expressed concern regarding the effectiveness of the IMP and the lack of clarity around key interdependencies across all work streams. Representatives from the PMO also commented on what they felt was an absence of critical data in the IMP reports that were going before the Taskforce.<sup>122</sup>

3.31 While the Executive Director Strategic Projects offered a spirited defence of the IMP, disputing any assertions around ‘the absence of an integrated program,’ he acknowledged the IMP was ‘incomplete.’<sup>123</sup> This, however, had been due to the absence of ‘realistic plans’ being submitted by JHPL and its sub-contractors—an issue that was being addressed.<sup>124</sup> The following week, in response to the claims made by the PMO, the Executive Director Strategic Projects again defended the IMP. He described it as ‘a robust reporting tool managed by a competent team’ and rejected any inference that the Taskforce was not receiving critical information from the building program.<sup>125</sup> He went on to confirm that the IMP ‘now has a work stream on program analysis that identifies dependencies.’<sup>126</sup> In response, however, the CE CAHS and PCH Commissioning claimed that this program was difficult for non-experts to interpret.

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<sup>118</sup> Department of Health, *Gateway Review 5 – Readiness for Service*, 26 June 2015, Rec 11.

<sup>119</sup> *ibid.*, Recs 3 and 20.

<sup>120</sup> *ibid.*, Rec 14.

<sup>121</sup> *ibid.*, p. 22.

<sup>122</sup> PCH Taskforce, Minutes of Meeting 13 August 2015, pp. 11-12; Minutes of Meeting 20 August 2015, pp. 3-4; Minutes of Meeting 27 August 2015, pp. 7-8 (closed evidence).

<sup>123</sup> PCH Taskforce, Minutes of Meeting 13 Aug 2015, p. 11 (closed evidence).

<sup>124</sup> *ibid.*

<sup>125</sup> PCH Taskforce, Minutes of Meeting 20 Aug 2015, p. 3 (closed evidence). Strategic Projects & Asset Sales maintained this view during this inquiry, arguing that both the PCH Project Control Group and the PMO had regular access to reports it had prepared regarding the status of the construction program and JHPL’s activities. Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), Letter, 13 October 2017.

<sup>126</sup> PCH Taskforce, Minutes of Meeting 20 Aug 2015, p. 4 (closed evidence).

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- 3.32 Despite these differences of opinion, Taskforce members opted to act in response to the gateway recommendations. Foremost among these actions was the production of an updated IMP, incorporating building and commissioning activities. In addition, Taskforce minutes from 30 July 2015 confirm that the development of a ‘high level critical path’ had become a priority and senior figures from CAHS, Strategic Projects, and the PMO ‘were undertaking extensive work to resolve this issue.’<sup>127</sup>
- 3.33 In September 2015, to address concerns regarding the collation, analysis, and reporting of critical information on risks across the entire project, the Taskforce decided to engage PricewaterhouseCoopers (PwC) to operate an Integrated Program Management Office (IPMO).<sup>128</sup> The IPMO’s remit was similar to that originally intended for the PMO, in that it would ‘provide the Taskforce with independent advice from each of the key areas of the project.’<sup>129</sup>
- 3.34 The A/State Solicitor claimed the IPMO’s primary function was to ‘ensure regular information flow’ among all of the project’s key entities.<sup>130</sup> Ultimately, however, the IPMO assumed several other critical tasks. These included providing status reports to Taskforce on the performance of each major work stream program against critical milestones. The IPMO was also required coordinate and report to Taskforce on the resolution of extreme and high-risk issues identified by each work stream’s project team, including the building program. Though the IPMO did not define or manage these risks, they would interrogate the entity elevating the risk by challenging the assumptions upon which risks were based and following up on how they were mitigated.<sup>131</sup> Ultimate responsibility for managing these higher-level risks remained with the soon-to-be reconfigured Project Control Group, as per the gateway recommendation.
- 3.35 Finally, to improve the quality of information sharing between Strategic Projects and commissioning teams, a ‘revised governance and management structure’ was established and several ‘key PCH personnel’ were transferred to the project headquarters on the QEII Medical Centre site.<sup>132</sup>

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<sup>127</sup> PCH Taskforce, Minutes of Meeting 30 July 2015, p. 4 (closed evidence).

<sup>128</sup> The IPMO was also referred to as both the Integrated Program Management Office and the Integrated Project Management Office by different Taskforce members during this inquiry in another example of the confusion that afflicted to governance structure on occasions. Similar issues occurred with the PMO. See Footnote 54 above.

<sup>129</sup> PCH Taskforce, Minutes of Meeting 2 July 2015, p. 6 (closed evidence).

<sup>130</sup> Submission No. 13 from State Solicitor’s Office, 3 August 2017, p. 11.

<sup>131</sup> Ms Tricia Tebbutt, Partner, and Mrs Tanya West, Director of IPMO Services to PCH, PricewaterhouseCoopers, *Transcript of Evidence*, 18 October 2017, pp. 1-2.

<sup>132</sup> Department of Treasury – Strategic Projects & Asset Sales and Department of Health, *Gateway Review 5 – Readiness for Service*, 11 March 2016, p. 25.

### Integrated Master Program abandoned in 2016

- 3.36 The March 2016 follow-up Gateway Review noted ‘better integration of master programming.’<sup>133</sup> This was attributable to the development of an updated IMP—which included ‘both asset and commissioning activities’—and was considered by those on the project to represent a ‘...“single source of truth” regarding program activities.’<sup>134</sup>
- 3.37 Despite all the optimism around the revised IMP emanating from the project in March 2016, it was abandoned within six months ‘due to it being time consuming, unwieldy and largely out of date and therefore, not supporting agile master programming.’<sup>135</sup> In its place, a critical path was being used to manage commissioning activities and milestones. However, a September 2016 gateway review focusing on the commissioning program found this critical path was actually being used as ‘a reporting mechanism rather than as a project management tool.’<sup>136</sup> Moreover, data could not be ‘manipulated in real-time’ and interdependencies were not ‘hard-linked.’<sup>137</sup>

### An agreed best practice critical path remained elusive throughout 2015-16

- 3.38 One of the officers from the IPMO advised that ‘when we started [on the project in September 2015], there was no critical path.’<sup>138</sup>
- 3.39 Twelve months later, the September 2016 Gateway Review made a similar observation, finding that:

*The absence of an agreed and best practice critical path program impedes the project teams from prioritising activities between building and clinical commissioning activities.*<sup>139</sup>

- 3.40 This conclusion is consistent with discussions within the Taskforce around that time. In August 2016, the Chief Executive of CAHS and PCH Commissioning reflected that the critical path then in place did not address all key interdependencies, and lacked a number of critical activities from the construction program. In making these comments, he acknowledged the frustrations that Strategic Projects was having in obtaining accurate and relevant information from JHPL.<sup>140</sup>

<sup>133</sup> Department of Treasury – Strategic Projects & Asset Sales and Department of Health, *Gateway Review 5 – Readiness for Service*, 11 March 2016, p. 25.

<sup>134</sup> *ibid.*, p. 22.

<sup>135</sup> Department of Treasury – Strategic Projects & Asset Sales and Department of Health, *Gateway Review 5 – Readiness for Service (4)*, 22 September 2016, p. 7.

<sup>136</sup> *ibid.*

<sup>137</sup> *ibid.*

<sup>138</sup> Mrs Tanya West, Director of IPMO Services to PCH, PricewaterhouseCoopers, *Transcript of Evidence*, 18 October 2017, p. 5 (closed evidence).

<sup>139</sup> Department of Treasury – Strategic Projects & Asset Sales and Department of Health, *Gateway Review 5 – Readiness for Service (4)*, 22 September 2016, p. 3.

<sup>140</sup> PCH Taskforce, Minutes of Meeting 30 August 2016, p. 7 (closed evidence).

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- 3.41 In September 2016, eleven months after it had been engaged to analyse and report on key risks, the IPMO told the Taskforce it could still not ‘provide full assurance of the critical path as it was not connected to program plans.’<sup>141</sup> This appears to have caused frustration for the Deputy Director General of the Department of Health, who had sought and received assurance on this issue previously from other entities within the governance structure.<sup>142</sup>
- 3.42 Following the September 2016 Gateway Review, the Department of Health created a Strategic Completion Plan (SCP) to operate as a best practice critical path linking all remaining commissioning activities from the completion of the construction phase (practical completion) through to full opening.
- 3.43 A July 2017 gateway review conducted after the State had granted practical completion confirmed the continued existence of the SCP, but made no comment on its effectiveness as a project management tool. However, the review team received feedback stating that the overall program continued to suffer from a ‘lack of transparency in the management’ of JHPL on critical construction issues.<sup>143</sup> The management of the lead contamination in the water supply, which had been ongoing since May 2016, was cited as a primary example. The same feedback indicated that the management of this issue in particular had led, ‘in some cases,’ to a ‘deterioration in the relationship’ between members of Strategic Projects and the commissioning teams.<sup>144</sup> A recommendation from the review called for the working relations between ‘the State’s asset deliverers and the clinical commissioning teams’ to be examined to determine their effectiveness in ‘progress[ing] the Project to an operating hospital.’<sup>145</sup> There is no reference in the remaining minutes of the Taskforce, which had its final meeting on 8 August 2017, as to what action was taken in response to that recommendation. However, it is noted that following that final meeting, the Taskforce was superseded by the PCH Commissioning Oversight Committee (PCOC). The PCOC vested overarching governance responsibility for the remainder of the commissioning program in one officer, the Director General of the Department of Health.<sup>146</sup>

### **The IPMO initiative, while ultimately effective, was impacted by an initial lack of cooperation from Strategic Projects**

- 3.44 Of all the remedial measures undertaken to improve overall project and risk management, the IPMO appears to have been one of the more effective. From when it

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<sup>141</sup> PCH Taskforce, Minutes of Meeting 20 September 2016, p. 13 (closed evidence).

<sup>142</sup> PCH Taskforce, Minutes of Meeting 20 September 2016, p. 13; Minutes of Meeting 27 September 2016, pp. 3-4 (closed evidence).

<sup>143</sup> Department of Health, *Gateway Review 5 – Readiness for Service (5)*, 7 July 2017, p. 6.

<sup>144</sup> *ibid.*, p. 7

<sup>145</sup> *ibid.*

<sup>146</sup> Mr Michael Barnes, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 9 October 2017, p. 2.



joined the project in September 2015, the IPMO proved to be a valuable service the Taskforce.<sup>147</sup> Following the dismantling of the Taskforce, the IPMO has continued to provide comprehensive and intuitive risk reporting and analysis to the PCOC.<sup>148</sup>

3.45 Notwithstanding its ultimate utility, the IPMO was initially hampered by a lack of cooperation from Strategic Projects. The IPMO manager noted that at times there were challenges and a lack of cooperation from Strategic Projects in responding to requests from the Taskforce. The initial relationship with Strategic Projects and in particular the Principal Project Director and his project team were described as very difficult (although this subsequently improved). This contrasted with the IPMO manager's experience with Strategic Projects during the commissioning of Fiona Stanley Hospital two years prior where there were no such issues.<sup>149</sup>

3.46 Information flow was a key challenge that made compiling accurate reports for Taskforce difficult throughout the early stages of the IPMO's engagement. The IPMO confirmed it took approximately five months to establish a standard set of critical milestones and key activities from the construction program for the purposes of reporting to Taskforce. The IPMO manager acknowledges that there were continued challenges, but that its relationship with Strategic Projects improved over time.<sup>150</sup>

3.47 The Executive Director of Strategic Projects agreed that the relationship with the IPMO was difficult 'in the initial stages.'<sup>151</sup> He explained that the Strategic Projects team was 'concerned... the IPMO was placing undue demands for information and reporting, over and above established reporting requirements.'<sup>152</sup> They were also concerned that the IPMO was 'duplicating or re-formatting' information already produced by Strategic Projects and the PMO:

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<sup>147</sup> Submission No. 13 from State Solicitor's Office, 3 August 2017, p. 11; Department of Treasury – Strategic Projects & Asset Sales and Department of Health, *Gateway Review 5 – Readiness for Service*, 11 March 2016, p. 6. Mr Malcolm Bradshaw, A/Deputy Director General, Department of the Premier and Cabinet, *Transcript of Evidence*, 18 September 2017, p. 2 (closed evidence). Mr Bradshaw's positive assessment was based on his limited observations as a Taskforce member from May 2017.

<sup>148</sup> As part of our evidence gathering, the committee has received a copy of the IPMO's Commissioning Program Risk and Issue Dashboard that was presented to the PCOC for its meeting on 24 October 2017.

<sup>149</sup> Ms Tricia Tebbutt, Partner, and Mrs Tanya West, Director of IPMO Services to PCH, PricewaterhouseCoopers, *Transcript of Evidence*, 18 October 2017, pp. 2-3 (closed evidence).

<sup>150</sup> Ms Tricia Tebbutt, Partner, PricewaterhouseCoopers, Email, 20 November 2017 (closed evidence).

<sup>151</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), Letter, 8 December 2017, p. 9.

<sup>152</sup> *ibid.*

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*These perceived unnecessary demands increased pressure on the project team, adding to a heavy workload associated with management of the highly complex PCH project and in particular, administration of the MC [construction] contract.*<sup>153</sup>

3.48 The Executive Director Strategic Projects agreed that the working relationship improved over time after roles and responsibilities were clarified and the IPMO was 'allowed access' to the information management systems within Strategic Projects.<sup>154</sup> The latter initiative in particular resulted in 'less reliance on Strategic Projects resources' for the work the IPMO was undertaking.<sup>155</sup>

### **Deficiencies in some risk management processes still evident in 2017**

3.49 The September 2016 Gateway Review confirmed that processes for identifying, escalating, and mitigating risks had 'improved over time.'<sup>156</sup> The review noted that interviewees from within the PCH governance structure were 'accepting of their role as owners' of the Treatment Action Plans (TAPs) developed to deal with project risks that had evolved into issues requiring action.<sup>157</sup> Processes were also in place whereby TAPs were reported to the Project Control Group and the Taskforce.

3.50 Yet by the time of the July 2017 Gateway Review, problems around the management of higher-end risks and issues had again emerged. This latter review team was unable to confirm how risk owners were actioning TAPs for 'a number' of high and extreme issues that were marked as 'overdue' or 'ongoing.'<sup>158</sup> Nor could they identify 'any consistent documented evidence or approach' demonstrating how either the Project Control Group or Taskforce 'formally interrogate and validate' these plans.<sup>159</sup> The review team recommended these entities urgently establish a protocol to ensure they critique the status, progress, and recommended actions on TAPs for high and extreme risks and issues at their respective meetings.<sup>160</sup>

3.51 The minutes of the final Taskforce meeting on 8 August 2017 indicate that this recommendation had been accepted, and a 'substantial amount of work had already been done' in addressing it.<sup>161</sup>

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<sup>153</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), Letter, 8 December 2017, p. 9.

<sup>154</sup> *ibid.*

<sup>155</sup> *ibid.*

<sup>156</sup> Department of Treasury – Strategic Projects & Asset Sales and Department of Health, *Gateway Review 5 – Readiness for Service (4)*, 22 September 2016, p. 5.

<sup>157</sup> *ibid.*

<sup>158</sup> Department of Health, *Gateway Review 5 – Readiness for Service (5)*, 7 July 2017, p. 5.

<sup>159</sup> *ibid.*

<sup>160</sup> *ibid.*

<sup>161</sup> PCH Taskforce, Minutes of Meeting 8 August 2017, p. 12 (closed evidence).

## Key stakeholders' assessment of governance structure not supported by evidence

- 3.52 Throughout this inquiry, key participants within the PCH governance structure often presented largely positive assessments of project and risk management processes. These assessments are inconsistent with the information contained in the gateway reviews and Taskforce minutes, or indeed with the current status of the PCH project. We therefore find them difficult to substantiate.

### Finding 6

Key participants within the PCH governance structure offered largely positive assessments as to its effectiveness in identifying and responding to risks. We have found these assessments difficult to substantiate.

- 3.53 Examples of these positive assessments include the A/State Solicitor's description of the overarching governance structure as 'sound and effective in identifying and responding to project risks.'<sup>162</sup> He also referred to a 'clear, logical and structured system of risk management,' which was 'complemented by the centralised role performed by professional services firms, and in particular the IPMO.'<sup>163</sup> In his view, the risk management framework ensured 'adequate visibility over risks,' while the governance structure:

*...create[d] an environment where risks are identified, reported, elevated (to Taskforce), monitored, and where possible, mitigated or resolved.'*<sup>164</sup>

- 3.54 Others referred to the healthy level of collaboration that existed across work streams for the majority of the project.<sup>165</sup> Notably, the Department of Health advised that the IPMO 'worked collaboratively' with both the commissioning work streams and Strategic Projects 'to provide Taskforce with consolidated reporting on identified risks and issues.'<sup>166</sup>

- 3.55 The Principal Project Director, who managed the construction contract on behalf of Strategic Projects argued that his team had a 'very well structured process dealing with risk.'<sup>167</sup> Consequently, meetings of the Project Control Group, which he attended, 'did not have a great long list of practical decisions to make.'<sup>168</sup> Turner & Townsend Thinc (TTT), the company engaged as a technical adviser to Strategic Projects, concurred with this view. TTT described the overall governance framework as 'fairly exceptional' and

<sup>162</sup> Submission No. 13 from State Solicitor's Office, 3 August 2017, p. 14.

<sup>163</sup> *ibid.*

<sup>164</sup> *ibid.*, pp. 9 and 13.

<sup>165</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), *Transcript of Evidence*, 18 September 2017, p. 3 (closed evidence).

<sup>166</sup> Dr David Russell-Weisz, Director General, Department of Health, Letter, 30 October 2017, p. 11.

<sup>167</sup> Mr John Hamilton, former Principal Project Director, Strategic Projects & Asset Sales, *Transcript of Evidence*, 18 October 2017, pp. 2-3 (closed evidence).

<sup>168</sup> *ibid.*, p. 2.

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said that Strategic Projects operated a ‘very thorough management team to manage the flow of information and the flow of documentation.’<sup>169</sup>

3.56 While difficulties in managing the project were acknowledged within such assessments, these difficulties were generally attributed to JHPL’s continued failure to provide accurate reporting around the status of its building program.<sup>170</sup>

3.57 Certainly, there seems little doubt the builder’s provision of accurate program information was problematic. However, directing disproportionate focus on JHPL’s flaws risks underplaying critical flaws that were evident within the State’s overarching project (and risk) management processes. In this respect, we think three points need highlighting.

3.58 Firstly, the A/State Solicitor’s largely positive description of the governance structure emphasises the importance of the IPMO without adequately acknowledging the failings in the governance structure that led to the IPMO’s late engagement.

### Finding 7

The Integrated Program Management Office (IPMO) was engaged in September 2015 because the PCH Taskforce was operating without independent assurance as to how the overall project was tracking against key milestones.

### Finding 8

We agree with the decision to engage the IPMO, but question why such an entity was not engaged much earlier.

3.59 We are equally curious as to why the PMO did not have similar functions incorporated into its terms of engagement back in July 2014. PCH governance documents from 2015 (see Appendix Three) indicate that the PMO was responsible for coordinating project status and risk reporting from across all work streams and providing independent advice to the Taskforce. Yet Taskforce minutes from July and August 2015 confirm the PMO’s contract required it only to report directly to CAHS within the Department of Health. While representatives of the PMO attended Taskforce meetings, PMO reports were not ‘presented to enable Taskforce decisions.’<sup>171</sup> When PMO representatives did brief the Taskforce, they appeared to focus predominantly on risks and milestones

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<sup>169</sup> Mr Bradley Richardson, Director, Technical Advisory Team PCH, Turner & Townsend Thinc, *Transcript of Evidence*, 9 October 2017, p. 3.

<sup>170</sup> Dr David Russell-Weisz, Director General, Department of Health, *Transcript of Evidence*, 18 September 2017, p. 4; Mr Michael Barnes, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 9 October 2017, p. 2; Mr Nicholas Egan, A/State Solicitor, State Solicitor’s Office, Letter, 7 November 2017 (closed evidence).

<sup>171</sup> PCH Taskforce, Minutes of Meeting 13 August 2015, p. 16 (closed evidence).

relating to the commissioning activities, as they did not have oversight of Strategic Projects.<sup>172</sup>

3.60 The example of the PMO's engagement once again demonstrates the problems that emerged from failing to establish clear roles and responsibilities earlier within the life of the PCH governance structure. Had an IPMO been established earlier—or if the PMO had simply been engaged to perform functions consistent with the broader remit outlined in 2015 governance documents—the Taskforce would have had the benefit of greater visibility over the project as a whole.

3.61 Secondly, the experiences of the IPMO, once it was engaged to assist the Taskforce, belie claims as to the quality and consistency of collaboration between key entities within the governance structure. Both PwC and Strategic Projects confirm that their working relationship was difficult although estimates as to how long these difficulties continued vary between the parties. PwC was engaged on the back of a gateway recommendation to urgently address a lack of integration on status and risk reporting across all project work streams. Given this urgency, it is disconcerting that Strategic Projects failed to cooperate sufficiently until it was confident that the IPMO would not place an undue burden on the Principal Project Director's team.

### Finding 9

The challenges the IPMO experienced in its initial dealings with Strategic Projects is one of several examples that demonstrate how the PCH governance structure was, on occasions, undermined by combative and siloed mentalities rather than a consistent spirit of openness and collaboration.

3.62 In this respect, gateway recommendations from June 2015 and July 2017 calling for improvements to the level of information sharing and working relations between the building and commissioning work streams are telling. The issue of strained working relations between Strategic Projects and the Department of Health, and the impact this had on effective governance, is something we revisit in later sections of this chapter.

3.63 Thirdly, these positive assessments fail to recognise that the PCH governance structure operated well into 2016 without an agreed system for integrating key information from across all work streams. This made it incredibly difficult for those at the apex of this structure (i.e. the Taskforce and relevant Ministers) to obtain a consistently accurate picture on the true status of the project.

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<sup>172</sup> Although Strategic Projects has since indicated the PMO had 'full access' to status reports from the construction program. Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), Letter, 13 Oct 2017.

### Finding 10

A September 2016 gateway review of the PCH commissioning program found that the PCH governance structure was operating without an effective critical path program. Consultants engaged to operate the IPMO had made similar observations twelve months earlier.

### Finding 11

The failure to establish an agreed critical path and an effective integrated master program in a timely manner is alarming when considering the lessons that should have been drawn from the highly problematic commissioning of the Fiona Stanley Hospital.

3.64 Unfortunately, the findings of a 2014 parliamentary inquiry into the commissioning program at FSH make for depressingly similar reading to the gateway reviews undertaken for PCH. That inquiry found the FSH commissioning project operated for an extended period without a reliable fully integrated program across its 20 work streams. The processes that were in place at FSH ‘were totally inadequate to allow for program management and assurance that timelines were being met.’<sup>173</sup> The failure to develop an ‘adequate integrated program’ earlier in the project ‘made it difficult to identify risks and accurately monitor the project’s status.’<sup>174</sup> Consultants brought in late to review governance processes found that interdependencies across the commissioning work streams ‘were not fully understood, identified and mapped.’<sup>175</sup> The parallels are remarkable and it is extremely unfortunate that several findings of the 2014 parliamentary inquiry could be applied almost word-for-word to the oversight of the construction and commissioning program at PCH. It reflects poorly on the PCH governance structure and its key personnel that such critical lessons from the FSH experience appear to have gone unheeded.

## The quality of project reporting was problematic

*Accuracy of reporting has proven to be difficult throughout the life of the project.*

Dr David Russell-Weisz, Director General, Department of Health and PCH Taskforce Chair, 2017<sup>176</sup>

3.65 Open and accurate status reporting is a core component of quality project management. Project managers or steering committees (such as the Taskforce) rely on such reporting to effectively understand and mitigate risks and issues as they emerge.

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<sup>173</sup> Education and Health Standing Committee (39<sup>th</sup> Parliament), *More than Bricks and Mortar: The report of the inquiry into the organisational response within the Department of Health to the challenges associated with commissioning Fiona Stanley Hospital*, 10 April 2014, pp. 12-13.

<sup>174</sup> *ibid.*, p. 13.

<sup>175</sup> *ibid.*

<sup>176</sup> Dr David Russell-Weisz, Director General, Department of Health, *Perth Children’s Hospital Commissioning and Transition. Project Overview and Status Update*. 17 March 2017, p. 34 (Legislative Assembly Tabled Paper No. 268, tabled on 18 May 2017).

A clearly defined reporting regime also helps ensure responsible officers across a project remain accountable for progress within their respective work streams.<sup>177</sup>

3.66 It is equally important to ensure that government representatives are reliably informed about the true status of major projects. Ministers in particular require ongoing clarity to meet the legitimate demands placed on them by parliament and the public for accurate information. If ministers suspect they are not receiving sufficient clarity or frankness, they should demand it.<sup>178</sup>

3.67 Quality reporting has several essential features. It must be objective and reliable, avoiding any tendency for over-optimistic assessment regarding the severity of problems or the reliability of deadlines. It must also be frank and timely. Bad news in particular needs to be promptly elevated to the highest levels within the governance structure so that whole-of-project impacts can be assessed and remedial measures determined.

### Finding 12

The PCH project has been remarkable for the number of ultimately inaccurate public statements made by ministers and senior bureaucrats concerning the construction program and opening date.

3.68 The period between March 2015 and October 2016 was especially problematic. Throughout 2014, the-then Health Minister, Hon. Dr Kim Hames, and senior Department of Health officials had predicted a November 2015 opening date.<sup>179</sup> In March 2015, Dr Hames confirmed that the construction program was behind schedule and offered ‘March or April 2016’ as the new likely opening date.<sup>180</sup> This revised forecast proved inaccurate.

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<sup>177</sup> Anthony Morgan and Sena Gbedemah, ‘How poor project governance causes delays,’ Paper presented to Society of Construction Law, London, 2 February 2010; Education and Health Standing Committee (39<sup>th</sup> Parliament), *More than Bricks and Mortar: The report of the inquiry into the organisational response within the Department of Health to the challenges associated with commissioning Fiona Stanley Hospital*, 10 April 2014, p. 18.

<sup>178</sup> Professor Peter Shergold AC, *Learning from failure*, 12 August 2015, p. iv.

<sup>179</sup> Kara Vickery, ‘Perth Children’s Hospital executive director Greg Italiano exits amid fears the project is delayed,’ PerthNow, 14 December 2014; Mr Phillip Aylward, Chief Executive, Child and Adolescent Health Service, *Parliamentary Debates* (Hansard), 21 May 2014, pp. 209-244.

<sup>180</sup> Hon. Dr Kim Hames, MLA, WA, Legislative Assembly, *Parliamentary Debates* (Hansard), 12 March 2015, p. 1217.

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3.69 Over the next eighteen months, the government provided a series of revised forecasts for various opening dates deeper into 2016, none of which were met.<sup>181</sup> In March 2016, Dr Hames' successor as Health Minister, Hon. John Day, was quoted as saying 'preparations are well advanced for the opening later this year.'<sup>182</sup> Even as late as 27 October 2016, Treasurer, Hon. Dr Mike Nahan, issued a statement advising that '[i]t is important to note we are still working towards a phased opening of the PCH this year.'<sup>183</sup> This latter statement came when the project was grappling with numerous issues critical to PC. These included the ongoing investigation to determine the source of the lead contamination and a breakdown in the relationship between JHPL and its major ICT sub-contractor.

### Finding 13

The fluidity of the construction deadlines John Holland Pty Ltd submitted to Strategic Projects certainly provide some explanation for the persistent inaccuracy of these statements. However, there were also problems with some of the reporting processes that existed within the PCH governance structure.

3.70 To help determine the adequacy of the State's reporting regime, we analysed the content of approximately 217 briefing notes and memos prepared by Strategic Projects and the Department of Health for their respective ministers from January 2015 onwards. We considered these in the context of public statements from the Premier, Treasurer, and the Minister for Health, as well as Taskforce deliberations on the reporting of critical issues. While the volume of material we considered is substantial, it was often subject to significant redactions based on either legal privilege or cabinet-in-confidence arguments. We also sought, but were denied by the Leader of the Opposition,<sup>184</sup> access to five key status reports the Taskforce provided to Cabinet during this period. Nor did we have access to records from any verbal briefings to Ministers. Notwithstanding these limitations, and the obvious frustrations they present when trying to formulate accurate assessments, we have drawn a range of conclusions from the material that was provided.

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<sup>181</sup> Department of Treasury, *2015-16 Budget Paper No. 2 Volume 1*, 14 May 2015, p. 126; Nicolas Perpetch, 'Perth Children's Hospital completion date pushed back,' ABC News (Online), 6 October 2015; Hon. Alyssa Hayden, MLC, WA, Legislative Council, *Parliamentary Debates* (Hansard), 15 March 2016, p. 958; Hon. John Day, MLA, WA, Legislative Assembly, *Parliamentary Debates* (Hansard), 25 May 2016, p. 251.

<sup>182</sup> Gary Adshead, 'Pages tell of defects, new delays and detail held back,' *The West Australian* (Online), 10 January 2017.

<sup>183</sup> Regina Titellius, 'Perth Children's Hospital set to open as late as March, WA Government concedes,' *PerthNow*, 27 October 2016.

<sup>184</sup> This request was put to the Leader of the Opposition as the representative of the former government, as per the procedure outlined in the 2017 Cabinet Handbook. The Leader of the Opposition, Hon. Dr Mike Nahan, advised that he was acting in line with convention when declining this request. Mr Nick Hagley, Director Cabinet Secretariat, Department of the Premier and Cabinet, Email, 26 February 2018.



## Finding 14

Having viewed a substantial number of briefing notes provided by the Department of Health and Strategic Projects to their respective ministers, we have identified a concerning number of instances where status reporting failed to convey the true gravity of the situation on the ground. Some reporting was overly optimistic and there was a lack of transparency around the status of some critical issues. Outside of the joint briefing notes that were prepared together by both agencies, there was a general inconsistency in the level of detail provided to the respective ministers.

### Recommendation 1

The Premier and the Cabinet review the quality and standard of briefing notes provided by departments to ministers to ensure improvements in the consistency of structure and adequacy of content across the public sector.

### Forecast dates provided by Ministers generally consistent with briefing notes

- 3.71 The majority of the public statements made by former ministers about construction milestones and possible opening dates appear consistent with the written advice they received from their respective agencies throughout 2015 and 2016. In early September 2016, former Health Minister Day was quoted as saying he was ‘hopeful some activities would commence before the end of the year.’<sup>185</sup> Thereafter, he stopped committing publicly to an opening date. This corresponds with the briefing notes prepared for him by the CE of CAHS and PCH Commissioning. One such note, dated 19 September 2016 says that CAHS ‘is continuing to work towards the commencement of clinical services in late 2016.’<sup>186</sup> By 11 October 2016, the department was no longer providing dates, stating only that ‘[o]nce PC [practical completion] is reached, CAHS will be able to calculate the hospital’s opening schedule.’<sup>187</sup>
- 3.72 Notwithstanding the correlation between the content of the briefing notes and public statements by former government ministers, there were numerous instances where Strategic Projects or the Department of Health put forward over-optimistic assessments around the timing of key milestones. It appears the relevant ministers at the time often accepted these assessments without challenging the assumptions upon which they were based.

<sup>185</sup> Jacob Kagi, ‘Perth Children’s Hospital: Doubts mount over opening date of problem-plagued facility,’ ABC News (Online), 6 September 2016.

<sup>186</sup> Professor Frank Daly, CE of CAHS, ‘Contentious Issue: 6.2 Perth Children’s Hospital PCH Commissioning,’ 19 September 2016.

<sup>187</sup> Professor Frank Daly, CE of CAHS, ‘Contentious Issue: 6.2 Perth Children’s Hospital Commissioning and Opening,’ 11 October 2016 (closed evidence).

**Status reports prone to overly optimistic assessments by key agencies**

- 3.73 The UK National Audit Office has observed that the difficulties that come with delivering government projects ‘are compounded by the endemic over-optimism which characterises decisions to commit to projects and the subsequent management of them.’<sup>188</sup>
- 3.74 It would not be reasonable to suggest that over-optimism and unrealistic expectations were endemic within the PCH project. Indeed, examples of sober assessments from Strategic Projects regarding the status of the construction program are evident in some Taskforce minutes and briefing notes.<sup>189</sup> However, such assessments are interspersed with numerous examples demonstrating unjustifiable optimism at certain critical stages.
- 3.75 Reporting to Taskforce on 3 February 2015 provides one of the first illustrations. By this stage, Taskforce was operating off a forecast PC-date of 4 September 2015, 66-days beyond the contracted practical completion date in place at that time.<sup>190</sup> In the lead up to the February meeting, the PMO advised that the risk of delay to the project ‘remains as extreme’ as an updated construction program had not been received.<sup>191</sup> The PMO also stressed the need for fully integrated program in order to understand the risks and interdependencies across all project work streams.<sup>192</sup> With the information it had, the PMO confirmed at least 146 overdue project milestones, most of which related to ICT infrastructure.<sup>193</sup> Moreover, Strategic Projects was still awaiting a reply to a letter it wrote on 8 December 2014 to JHPL ‘discussing Project concerns relating to the sale of John Holland’ and the impact this was having on project resourcing.<sup>194</sup>
- 3.76 Notwithstanding the uncertainty surrounding this collection of issues, Taskforce noted the Project Control Group had ‘agreed to report’ an expected practical completion date of 31 August 2015 until Strategic Projects received and reviewed a revised program from JHPL.<sup>195</sup>
- 3.77 A second example was the assessments Strategic Projects provided to Taskforce from mid-2016. By this time the forecast practical completion date had slipped out to 4

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<sup>188</sup> UK National Audit Office, *Over-optimism in government projects*, December 2013, p. 1.

<sup>189</sup> Examples include: PCH Taskforce, Minutes of Meeting 24 February 2015, pp. 4-5 (closed evidence); Mr Richard Mann, Executive Director, Strategic Projects & Asset Sales, ‘Briefing Note for the Treasurer: Perth Children’s Hospital Forecast Completion and Opening,’ 28 August 2015 (closed evidence); and PCH Taskforce, Minutes of Meeting 12 April 2016, p. 3 (closed evidence).

<sup>190</sup> Submission No. 12 from Department of Health, 1 August 2017, Attachment F, p. 1.

<sup>191</sup> PCH Taskforce, Minutes of Meeting 20 January 2015, p. 4 (closed evidence).

<sup>192</sup> *ibid.*

<sup>193</sup> Confirmed at meeting of 17 February 2015. PCH Taskforce, Minutes of Meeting 17 February 2015, p. 2 (closed evidence).

<sup>194</sup> PCH Taskforce, Minutes of Meeting 3 February 2015, p. 10 (closed evidence).

<sup>195</sup> *ibid.*, p. 5.

August 2016, following another three revisions throughout 2015 and early 2016. In June 2016, members of the State's project team on site said they 'were satisfied with the progress of deployment of ICT.'<sup>196</sup> Strategic Projects' Principal Project Director was reported as saying that the forecast practical completion date was 'expected to be retrieved once mitigations were in place.'<sup>197</sup> As late as 12 July 2016, the Executive Director Strategic Projects advised that 'despite the risks [associated with key subcontractors] based on current resourcing levels, 4 August remained achievable.'<sup>198</sup>

3.78 This forecast was made on the same day that asbestos contaminated materials were discovered in the ceiling panels (a scenario that, in fairness to Strategic Projects, could not have been envisaged).<sup>199</sup> Even without the emergence of the asbestos issue, this assessment still seems to be incredibly optimistic given that Strategic Projects had been dealing with an unidentified source of elevated lead in the water supply for two months—a fact it had not yet disclosed to Taskforce.<sup>200</sup> In addition to this, the building program was grappling with other critical issues at this time including: the ongoing re-installation of approximately 900 fire doors; the replacement of 1600 vitreous enamel cladding panels and 450 metres of corroding water piping; and a deteriorating relationship between JHPL and its major ICT sub-contractor.

3.79 With so many significant issues unresolved, it seems incredulous that Strategic Projects would forecast a mid-September practical completion date after JHPL failed to deliver on the 4 August 2016 target (and a follow-up target of 30 August 2016).<sup>201</sup> However, Taskforce minutes of 30 August 2016 record the Executive Director of Strategic Projects advising that 'PC was now expected on/around 14 or 15 September.'<sup>202</sup> When asked to comment on his levels of confidence, he expressed 'certainty in relation to the smoke management system,' but acknowledged that the 'lack of identification of the source of [water] contamination remained a concern.'<sup>203</sup> By 13 September, with at least four major PC-critical issues yet to be completed—including the identification and remediation of the lead contamination—he advised '[a]t this point, the State needed to prepare for PC [practical completion] being achieved on 23 September [2016].'<sup>204</sup>

3.80 Even when this latest date passed, interviewees for the September 2016 Gateway Review (made up of Taskforce members and formal attendees) retained the view that

<sup>196</sup> PCH Taskforce, Minutes of Meeting 7 June 2016, p. 3 (closed evidence).

<sup>197</sup> *ibid.*

<sup>198</sup> PCH Taskforce, Minutes of Meeting 12 July 2016, p. 3 (closed evidence).

<sup>199</sup> A point made by the Executive Director of Strategic Projects at the PCH Taskforce meeting of 2 August 2016.

<sup>200</sup> This omission is discussed in further detail in the section starting on page 44.

<sup>201</sup> The follow-up practical completion target date of 30 August 2016 is noted in Taskforce Minutes of 23 August 2016, p. 2 (closed evidence).

<sup>202</sup> PCH Taskforce, Minutes of Meeting 30 August 2016, p. 7 (closed evidence).

<sup>203</sup> *ibid.*

<sup>204</sup> PCH Taskforce, Minutes of Meeting 13 September 2016, p. 11 (closed evidence).

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‘practical completion is potentially achievable within weeks... barring any unforeseen events in the meantime.’<sup>205</sup> Without labouring the point, other examples of this seemingly excessive optimism are evident in October 2016 and as late as March 2017.<sup>206</sup>

3.81 We recognise the fact that these estimates included assumptions that some major works would be completed as separable portions outside of PC.<sup>207</sup> We also note the responses from the Under Treasurer and other senior officials advising that Strategic Projects had a systematic process for interrogating JHPL’s construction program data and preparing assessments for reporting to Taskforce.<sup>208</sup> Even so, we cannot reconcile the optimism Strategic Projects attached to some of its practical completion forecast assessments with the reality of the situation it was confronting. The assessments offered throughout August and September 2016 remain especially perplexing. The fact that Taskforce ultimately continued to accept these assessments is also troubling.<sup>209</sup>

3.82 Equally troubling is the degree to which Strategic Projects relied upon JHPL’s programs and assurances when formulating its assessments and advice to Taskforce and government during that period. The Under Treasurer confirmed his department was ‘very reliant on the program that the managing contractor was putting forward.’<sup>210</sup> While stressing that Treasury officers scrutinised JHPL’s work program data ‘to the best of our ability,’ he conceded that:

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<sup>205</sup> Department of Treasury – Strategic Projects & Asset Sales and Department of Health, *Gateway Review 5 – Readiness for Service (4)*, 22 September 2016, p. 6.

<sup>206</sup> One example relates to the likelihood of the main ICT sub-contractor meeting key deliverables linked to the smoke management system. PCH Taskforce, Minutes of Meeting 11 October 2016, pp. 6-7 (closed evidence). The Taskforce Chair also expresses concern around the optimism inherent in Strategic Projects assessment of forecast practical completion dates in March 2017. See, Dr David Russell-Weisz, Director General, Department of Health, *Perth Children’s Hospital Commissioning and Transition. Project Overview and Status Update*. 17 March 2017, p. 23-25 (Legislative Assembly Tabled Paper No. 268, tabled on 18 May 2017).

<sup>207</sup> Taskforce Minutes of 30 August 2016 confirm the existence of six separable portions at that time. While not listed in those minutes, a scan of other minutes suggests that these separable portions may have included: the Telethon Kids Institute; the Child Care Centre; the G-Block Link Bridge; and the Northern Green Space. Taskforce actively discussed the idea of including the asbestos remediation and treatment as a separable portion, but ultimately this was not required as the issue was resolved by early November 2016.

<sup>208</sup> Through the Project Control Group. Mr Michael Barnes, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 9 October 2017, pp. 5-6; Mr Alistair Jones, A/Deputy Under Treasurer, Letter, 3 November 2017, p. 8; Mr Richard Mann, Executive Director Strategic Projects (Department of Finance), Letter, 13 October 2017, pp. 6-7; Mr John Hamilton, former Principal Project Director, Strategic Projects & Asset Sales, Letter, 15 November 2017, p. 1.

<sup>209</sup> There are examples within the minutes showing Taskforce members challenging the assessments put forward by Strategic Projects (e.g. 12 July 2016, 2 August 2016, 30 August 2016), but it appears that this scrutiny had little impact on the dates ultimately adopted.

<sup>210</sup> Mr Michael Barnes, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 9 October 2017, p. 5.

*...with a managing contractor contract like this one you are reliant on the managing contractor's program and the dates that that program spits out.*<sup>211</sup>

### Finding 15

Testimony from the Under Treasurer indicated that under the Managing Contractor model used for the PCH project, Strategic Projects was overly reliant on the data provided by the builder to provide status reporting on the construction program. If Strategic Projects was unable to adequately interrogate program data provided by the builder, the procurement model used for this project may well be fundamentally flawed.

- 3.83 In this context, ministers need to be particularly wary of the risk of optimism bias permeating the advice they receive from agencies or steering committees. Comments from the former Treasurer, Dr Nahan, indicate that he and his ministerial colleagues were reliant upon, and unquestioning of, the advice they received:

*We were doing nothing more than publicly announcing advice from our respective departments. It proved to be wrong in most cases but it was the advice.*<sup>212</sup>

- 3.84 Notwithstanding the demands on ministerial schedules, such an approach is fraught with danger, particularly in the case of a project like PCH, which by this time, the government knew to be in trouble. As more and more practical completion forecasts were put up, and missed—especially throughout the latter part of 2016—it seems surprising that the responsible ministers did not appear to challenge the information they were receiving.

- 3.85 According to the UK National Audit Office, it is ‘widely accepted that a bias towards optimism can lead officials to underestimate or understate risks,’ particularly in an environment of short-term political or budgetary pressures.<sup>213</sup> There is little doubt such pressures would have been significant for those overseeing the PCH project as the construction program dragged out well beyond the original June 2015 practical completion date. Under these circumstances, the risk of succumbing to over-optimistic reporting would have been high.

<sup>211</sup> Mr Michael Barnes, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 9 October 2017, p. 5.

<sup>212</sup> Hon. Dr Mike Nahan, MLA, WA, Legislative Assembly, *Parliamentary Debates* (Hansard), 1 November 2017, pp. 5243-5268.

<sup>213</sup> UK National Audit Office, *‘Over-optimism in government projects,’* December 2013, p. 9.

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### Finding 16

A degree of excessive optimism was evident within the PCH governance structure around some status reporting linked to key construction milestones, such as the forecast practical completion date.

### Finding 17

It seems that the responsible ministers continued accepting overly optimistic forecasts and conveying them to the public without challenging the veracity of the information they were receiving.

3.86 Current and future government ministers need to be particularly wary of the risk of optimism bias permeating the advice they receive from agencies and project steering committees.

### Internal reporting lacked transparency on critical issues

3.87 Effective reporting requires a ‘culture of open and honest disclosure.’<sup>214</sup> The ANAO recommends that bad news is ‘dealt with promptly’ and ‘not filtered out of reports’ to project leaders and responsible ministers.<sup>215</sup> Failure to comprehend and appropriately convey the significance of risks or issues that emerge can have profound consequences for a project.

### Finding 18

The qualities associated with effective reporting were not always evident within the PCH governance structure. Consequently, the PCH Taskforce—a body established by Cabinet to oversee the delivery and commissioning of PCH—did not always receive the level of information necessary to perform its functions properly

### Taskforce expressed ongoing concern around the transparency of reports it received

3.88 Concerns around transparency and the level of information across work streams were evident as early as July 2015. Interviewees to the gateway review conducted at the time made particular reference to the lack of transparency in the building program managed by Strategic Projects.<sup>216</sup> In early 2016, both the Taskforce Chair and the Deputy Director General of Health expressed concern at the level of information coming into Taskforce.<sup>217</sup> In February, the Taskforce Chair noted a recent conversation

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<sup>214</sup> Anthony Morgan and Sena Gbedemah, ‘How poor project governance causes delays,’ Paper presented to Society of Construction Law, London, 2 February 2010, p. 8.

<sup>215</sup> Australian National Audit Office (ANAO), *Successful Implementation of Policy Initiatives*, 15 October 2014, p. 22.

<sup>216</sup> Department of Health, *Gateway Review 5 – Readiness for Service*, 26 June 2015, pp. 3 and 10.

<sup>217</sup> PCH Taskforce, Minutes of Meeting 19 January 2016, p. 6 (closed evidence); PCH Taskforce, Minutes of Meeting 16 February 2016, p. 3 (closed evidence).

he had with the Under Treasurer where both had agreed that Taskforce ‘required certainty on the status of the program.’<sup>218</sup> The Chair ‘stressed the importance of transparency and attention to detail’ before reaffirming the importance of all project teams:

*...elevating all relevant matters to the Taskforce for discussion, including the escalation of any new issues or risks as they were identified.*<sup>219</sup>

3.89 While the Taskforce Chair soon after observed a marked improvement in the ‘visibility of the status of the program,’<sup>220</sup> problems persisted with the level of openness from Strategic Projects in at least two critical areas: JHPL’s dispute with its major ICT sub-contractor and the issue of elevated lead levels in the potable water supply.

**The magnitude of the problems with the major ICT sub-contractor were under-reported**

3.90 Taskforce minutes show that concerns surrounding JHPL’s management of its major ICT sub-contractor (and the potential impact of this on the construction program) were discussed as early as July 2015.<sup>221</sup> However, subsequent status reporting on this issue appears to have been variable until early July 2016 when the matter was raised in the third Readiness for Service Gateway Review. In that review, interviewees cited a commercial dispute between JHPL and its ICT sub-contractor as an emerging risk to commissioning activities.<sup>222</sup> The reviewers noted that the issue was not ‘specifically listed’ in the risk register maintained for the building program and recommended it be registered and assigned a dedicated Treatment Action Plan.<sup>223</sup>

3.91 Following this review, Taskforce discussed the sub-contractor dispute at each Taskforce meeting until mid-August 2016 before the matter went quiet again until late-September. The 27 September 2016 Taskforce meeting discussed the findings of another gateway review issued five days earlier. This follow-up review noted interviewee concerns that the dispute was ‘impacting the achievement of practical completion.’<sup>224</sup> Taskforce members asked the Executive Director of Strategic Projects why the issue had not been raised at Taskforce for a month and whether government intervention was necessary. While he acknowledged the issue remained a ‘significant risk,’ the Executive Director of Strategic Projects advised that ‘the relationship issues

<sup>218</sup> PCH Taskforce, Minutes of Meeting 16 February 2016, p. 3 (closed evidence).

<sup>219</sup> *ibid.*

<sup>220</sup> PCH Taskforce, Minutes of Meeting 1 March 2016, p. 14 (closed evidence).

<sup>221</sup> PCH Taskforce, Minutes of Meeting 16 July 2015, p. 8 (closed evidence).

<sup>222</sup> Department of Treasury – Strategic Projects & Asset Sales and Department of Health, *Gateway Review 5 – Readiness for Service (3)*, 1 July 2016, p. 8.

<sup>223</sup> *ibid.*

<sup>224</sup> Department of Treasury – Strategic Projects & Asset Sales and Department of Health, *Gateway Review 5 – Readiness for Service (4)*, 22 September 2016, p. 5.

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are in hand.’<sup>225</sup> He further advised he ‘was confident that no further escalation or Government intervention was needed’ and Taskforce members were told that the issue was discussed at weekly Project Control Group meetings.<sup>226</sup>

3.92 Despite these reassurances, at the Taskforce meeting one week later the Executive Director of Strategic Projects advised that the commercial relationship between JHPL and its ICT sub-contractor was at risk of breaking down completely. To mitigate against this risk, he presented Taskforce with a proposal for noting. The proposal was for the State to provide a guarantee on a portion of JHPL’s payments to the sub-contractor as a \$4.34 million deed of variation to the main contract. This variation was subsequently executed on 6 October 2016 (although no payments were made by the State, as the terms of the deed—which included achieving practical completion by 10 October 2016—were not met).<sup>227</sup> Following this, the issue relating to ICT deliverables was a regular Taskforce agenda item through until February 2017, by which time the water treatment issues had become the dominant focus.

### Finding 19

John Holland Pty Ltd appears to have had difficulty managing several of its sub-contractors throughout the construction of the Perth Children’s Hospital. Relations with its main ICT sub-contractor were especially problematic.

### Finding 20

Given the significance of the issue and its impact of construction activities, John Holland Pty Ltd’s difficulties with its major ICT sub-contractor were under-reported both into and out of the PCH Taskforce.

### **The water contamination issue was not reported to Taskforce or government in a timely manner**

3.93 The handling of the lead contamination issue by Strategic Projects represents the most significant instance of both underestimating a project risk and failing to report it in a timely manner. The key events relating to this issue are outlined in Table 3.1 on the following page.

3.94 We questioned both the Executive Director and the former Principal Project Director of Strategic Projects as to why they did not report the issue to Taskforce sooner. The Executive Director responded that ‘in hindsight we may well have reported it

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<sup>225</sup> PCH Taskforce, Minutes of Meeting 27 September 2016, p. 5 (closed evidence).

<sup>226</sup> *ibid.*, pp. 5-6 (closed evidence).

<sup>227</sup> The terms of the deed provided for a payment of \$4.34m by the State to JHPL ‘to be distributed to itself [JHPL] and nominated subcontractors as detailed in a schedule.’ Mr Richard Mann, Executive Director, Strategic Projects & Asset Sales (Department of Treasury), ‘PCH – State Funding Contribution,’ Contentious Issues Briefing Note, 17 October 2016 (closed evidence).



earlier.’<sup>228</sup> The former Principal Project Director was less committal, stating that ‘[w]hether with hindsight I should have made it a big red flag item—possibly.’<sup>229</sup>

3.95

When elaborating on their responses, these officers confirmed that heavy metal exceedances were almost unprecedented and that this was not an area of expertise for Strategic Projects. Despite this, they were initially of the view that routine flushing would fix the problem given it was not unusual to have problems with construction debris during the commissioning of water supplies. The Executive Director added that in August, when the flushing had proven unsuccessful, ‘we effectively escalated the issue, realising it was more serious.’<sup>230</sup> We remain unconvinced by these arguments.

### Finding 21

Strategic Projects should have advised the PCH Taskforce and the responsible ministers much earlier about the lead in the water supply, especially in light of how late the project was already running, the unprecedented nature of the problem, the uncertainty surrounding its source and how difficult it was going to be to rectify.

**Table 3.1 Timeline of key events relating to the reporting of the water contamination at PCH<sup>231</sup>**

Date (2016)	Event
<b>16 February</b>	Taskforce Chair reaffirms the importance of PCH project teams elevating all relevant matters to Taskforce, including the escalation ‘of any new risks or issues as they were identified.’
<b>16 March</b>	First potable water samples taken from the PCH site. Testing was taken for chlorine, microbiological samples and Legionella.
<b>3 May</b>	Taskforce status reports indicate that JHPL’s forecast practical completion date has moved out to 4 August 2016 (a delay of 339 days against the contracted date of 31 August 2015).
<b>13 May</b>	On the advice of its environmental consultants, Strategic Projects commissions water testing for heavy metals. Test results reveal elevated levels of lead.
<b>Late May</b>	Strategic Projects notifies JHPL and directs it to undertake flushing.

<sup>228</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), *Transcript of Evidence*, 18 September 2017, p. 3.

<sup>229</sup> Mr John Hamilton, former Principal Project Director, Strategic Projects & Asset Sales, *Transcript of Evidence*, 18 October 2017, p. 7.

<sup>230</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), *Transcript of Evidence*, 18 September 2017, p. 3.

<sup>231</sup> Timeline compiled from multiple sources: Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), Letter, 13 October 2017; Mr Alistair Jones, A/Deputy Under Treasurer, Letter, 3 November 2017; Submission No. 12 from Department of Health, 1 August 2017, Attachment F; Mr Peter Gow, A/Deputy Director General, Industry Regulation and Consumer Protection, Department of Mines, Industry Regulation and Safety, Letter, 9 October 2017, p. 4; PCH Taskforce, Minutes of Meeting 16 February 2016 (closed evidence); PCH Taskforce, Minutes of Meeting 2 August 2016 (closed evidence).

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Date (2016)	Event
<b>29 July</b>	Strategic Projects directs JHPL to prevent staff from drinking potable water ‘until notified otherwise.’
<b>2 August</b>	Towards the end of a Taskforce meeting, the A/State Solicitor queries a rumour regarding elevated lead levels in the drinking water. Strategic Projects confirms the rumour, advises testing of the water system was underway and the ‘exact nature of the issue’ is unknown.
<b>16 August</b>	Taskforce receives an update and briefing note on the potable water, which it discusses in detail. Requests weekly updates from Strategic Projects on the issue.
<b>24 August</b>	First record of communication to the Treasurer and Health Minister on the issue via a presentation.
<b>2 September</b>	JHPL advises the Environmental Health Directorate and the Chief Health Officer—the State’s water regulator—of lead levels exceeding the Australian Drinking Water Guidelines.
<b>5 September</b>	Media reports confirm the existence of excessive lead levels in the water supply. Health Minister confirms and advises that the issue arose in August.  First written record of communication on the issue to the Treasurer and the Minister for Health via a briefing note from Strategic Projects. Matter discussed with Treasurer at weekly briefings from that point forward.  The Building Commissioner first becomes aware of the issue.
<b>6 September</b>	Taskforce identifies the potable water issue as the most significant issue impacting practical completion.
<b>20 September</b>	With the source of lead still unidentified the issue is raised to the status of extreme risk on the PCH Commissioning and Construction Program Risk Dashboard.

3.96 Moreover, only three months before the issue arose, the Taskforce Chair had stressed the importance of elevating advice of any new risks or issues ‘as they were identified.’<sup>232</sup>

3.97 We cannot see how the discovery of elevated lead levels in the potable water supply, even if it had proved benign, did not warrant reporting to the oversight body under these circumstances. The uncertainty of this particular issue, its potential impact on other work streams and commissioning activities, and the fact that the underlying asset was a children’s hospital, all provide further compelling reasons why Taskforce should have been promptly informed.

<sup>232</sup> PCH Taskforce, Minutes of Meeting 2 August 2016, p. 3 (closed evidence).

3.98 It is also important to clarify that Strategic Projects did not ‘effectively escalate’ this issue with the Taskforce on 2 August, as the Executive Director claimed in his testimony before the committee (see 3.95 above). The Executive Director only acknowledged the issue when the then-Deputy State Solicitor raised it at the end of the Taskforce meeting—a meeting that took place three days after Strategic Projects directed JHPL to prevent staff from drinking potable water on the site). Even then, Taskforce minutes indicate that Strategic Projects downplayed the significance of the risk for at least another six weeks.<sup>233</sup> The fact that the Chief Health Officer and Building Commissioner were not notified until early September is further evidence that the magnitude of the issue was underestimated.<sup>234</sup>

## Finding 22

The manner in which the issue of elevated lead levels came to the PCH Taskforce, through confirmation of a rumour, was unacceptable. In his testimony to the committee, the Executive Director of Strategic Projects said his agency ‘effectively escalated’ the issue to the PCH Taskforce after the initial flushing program failed to lower the lead levels. This interpretation of events is not supported by evidence, including PCH Taskforce meeting minutes and the testimony of other Taskforce members.

3.99 We acknowledge the fact that under the dual governance structure and commercial arrangements in place, Strategic Projects was the agency initially responsible for the issue, as it was a construction matter. However, Strategic Projects had a clear responsibility as one of seven interdependent project work streams to report this matter to Taskforce (and the Treasurer) far sooner than they did.

## The level of detail in ministerial briefing notes was not always adequate

3.100 Based on our analysis of the ministerial briefing notes received—and with the same qualifications listed in paragraph 3.70 above—we offer the following general observations regarding the level of detail on critical issues.

3.101 The briefing notes prepared by Strategic Projects for the Treasurer and/or the Minister for Health were generally more timely and informative than those prepared by CAHS for the Minister for Health. While Strategic Projects and CAHS compiled numerous joint briefing notes for the Treasurer and Minister for Health, there were a significant number that were prepared by the departments exclusively for their respective ministers. We remain concerned that the inconsistent standard of reporting across

<sup>233</sup> PCH Taskforce, Minutes of Meeting 23 August 2016, p. 12; Minutes of Meeting 6 September 2016, pp. 2-3, and Minutes of Meeting 20 September 2016, p. 3 (closed evidence).

<sup>234</sup> We acknowledge the Chief Health Officer’s regulatory remit only applies once a pipe network becomes a water supply. However, we still feel that under the circumstances it would have been prudent and proactive to keep him informed once the issue arose.

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these notes increased the risk that one of the jointly responsible ministers would end up better informed than the other.

### Finding 23

Notwithstanding the number of joint briefing notes that were prepared by Strategic Projects and the Department of Health, we remain concerned about the scope for inconsistent reporting to their respective ministers that was facilitated under the dual governance arrangements on the PCH project.

3.102 Examples of topics covered promptly and in sufficient detail by Strategic Projects include:

- JHPL's change of ownership and the implication for the project
- The number and veracity of extension of time claims submitted by JHPL
- The status of the Telethon Kids Institute fit-out
- The remediation of the fire doorset and asbestos issues

3.103 While they were late in starting, briefing notes relating to the water contamination issue and proposed remediation strategies were regular and reasonably comprehensive from 5 September 2016 onwards.

3.104 It is arguable that the ICT subcontractor dispute was under-reported in briefing notes. This is not surprising given the committee's finding that the issue was under-reported to the Taskforce. The Executive Director, Strategic Projects first flagged concerns regarding ICT project milestones in two briefing notes dated 12 and 28 August 2015.<sup>235</sup> Subsequent briefings on JHPL's difficulties with the ICT subcontractor were relatively comprehensive, but quite infrequent. It was not until 10 October 2016 that the issue again started receiving coverage.

3.105 The Department of Health briefing notes also provided detailed coverage of some issues. These included the parking lot contract status, the asbestos remediation activities, and workforce provisioning and recruitment needs for the transition from PMH. There was even regular updates on the October 2016 PCH Foundation Fundraising Gala Dinner. The amount of information dedicated to that particular event is striking given the department's tendency to under-report some other critical issues and to understate the gravity of the situation across the project.<sup>236</sup>

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<sup>235</sup> The 12 August 2015 briefing note is addressed to the Premier, but has no author listed. It is possible that this briefing note was prepared jointly by Strategic Projects and CAHS.

<sup>236</sup> For example, there were seven briefing notes prepared between 19 and 31 August 2016, several of which were co-authored by Strategic Projects. None of these provide a detailed description of the water contamination issue even though Taskforce was now demanding weekly updates from Strategic Projects on the issue.

3.106 To demonstrate, Appendix Five shows a briefing note from the CE of CAHS and PCH Commissioning dated 1 November 2016. It is entitled ‘Contentious Issue: 6.2 Perth Children’s Hospital Commissioning and Opening.’ This document lists a range of commissioning activities and updates their current status, but it fails to provide a full update on other issues critical to commissioning. The note confirms that ‘building systems are critical to achieving PC’ and that these include ‘the smoke management system, and the rectification of water quality issues.’<sup>237</sup> However, it fails to acknowledge that the source of lead had still not been identified. Nor, does it articulate the department’s concerns<sup>238</sup> that the problems with the ICT sub-contractor were still affecting the roll-out of the smoke management system and numerous other critical deliverables. The difficulty the State was having in confirming an agreed practical completion date with JHPL is also underplayed. The note simply says that ‘PC has not been achieved and a timeframe for the completion of construction has not been determined.’<sup>239</sup>

3.107 Overall, the detail and coverage of critical issues in Department of Health briefing notes seemed to improve throughout 2017 under the tenure of the current CE of CAHS and PCH Commissioning.

#### **Briefing notes did not refer to gateway review concerns around governance**

3.108 With both agencies, some significant issues were conspicuous in their lack of coverage. Most notable in this respect are the findings of the gateway reviews conducted between June 2015 and July 2017.

3.109 The Director General of the Department of Health confirmed that only the recommendations (not the findings) from the five gateway reviews were provided to the Minister for Health and Cabinet in the PCH status reports that went to Cabinet after each review. The Director General added that:

*...there were no formal meetings between the Minister for Health and the Director General of Health in relation to the outcomes from Gateway Readiness for Service Reviews. However, the Director General may have informally verbally briefed the Minister for Health about the findings received that were of concern to him during regular meetings.*<sup>240</sup>

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<sup>237</sup> See Appendix Five.

<sup>238</sup> Noted in the Department’s own summary of a program report submitted to the Taskforce Meeting of 1 November 2016. Submission No. 12 from the Department of Health, 1 August 2017, Att F, p. 42.

<sup>239</sup> See Appendix Five

<sup>240</sup> Dr David Russell-Weisz, Director General, Department of Health, Letter, 6 March 2018, p. 1 (emphasis added).

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3.110 As has been noted already, the 2015 Gateway Review in particular made some highly critical assessments of the governance processes in place at that time (see 0 above). These include comments on the interactions between the building (Strategic Projects) and commissioning (Department of Health) work streams, which were described as ‘dysfunctional.’<sup>241</sup> Even though the relevant parties strongly disputed this choice of words at a subsequent Taskforce meeting,<sup>242</sup> independent observations such as these should have been elevated to the respective ministers and the Cabinet in written form.<sup>243</sup> It also appears that Department of Health briefing notes did not articulate the Director General’s concerns regarding the quality of information that was coming in to the Taskforce from Strategic Projects (and JHPL).<sup>244</sup>

### **The potential significance of the “dead leg” was understated**

3.111 Another matter that was understated was the existence, and subsequent removal, of a “dead leg” from the ring main of the QEII Medical Centre. On 26 April 2017, Dr Nahan confirmed a Building Commission report tabled two days earlier was the first time he had ‘heard about the existence of the dead leg or the high levels of lead detected in the dead leg.’<sup>245</sup> This is surprising, given JHPL maintains the view that sediment built up in this ring-main—which included the dead leg until it was disconnected on 29 September 2016—was a significant contributor to the lead contamination.<sup>246</sup>

3.112 While Dr Nahan’s statement is not totally consistent with the written advice he received, there is no doubt that both the Department of Health and Strategic Projects placed very little emphasis to the dead leg in briefing notes to Dr Nahan. There are four briefing notes in the period before the change of government that refer to the dead leg, but the comments are brief, and there is no reference to any metals testing.<sup>247</sup> A typical example is a 10 October 2016 joint briefing note from Strategic Projects and the Environmental Health Directorate. One of nine bullet points describing the current situation simply states, ‘ChemCentre’s interim report also recommended the elimination of a “dead leg” of unused water supply pipe in Hospital Avenue; this work

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<sup>241</sup> Department of Health, *Gateway Review 5 – Readiness for Service*, 26 June 2015, p. 3.

<sup>242</sup> PCH Taskforce, Minutes of Meeting 9 July 2015, (closed evidence).

<sup>243</sup> The 2015 gateway review also made findings regarding the lack of an overall ICT design or an integrated implementation plan. A briefing note to the Premier dated 12 August 2015 did confirm these issues, but did not mention they were the subject of findings from the gateway review.

<sup>244</sup> The first clear articulation of this issue we could locate was in a comprehensive briefing note prepared for the incoming government dated 17 March 2017. Dr David Russell-Weisz, Director General, Department of Health, *Perth Children’s Hospital Commissioning and Transition. Project Overview and Status Update*. 17 March 2017 (Legislative Assembly Tabled Paper [No. 268](#), tabled on 18 May 2017).

<sup>245</sup> Jacob Kagi, ABC Television News, 26 April 2017.

<sup>246</sup> Mr Lindsay Albonico, WA Region Manager, John Holland Pty Ltd, *Transcript of Evidence*, 13 October 2017, p. 2.

<sup>247</sup> These briefing notes are dated 30 September, 10 and 17 October, and 3 November 2016.

has been completed.’<sup>248</sup> By contrast, a briefing note from Strategic Projects on 1 May 2017, after the Building Commissioner’s report, confirms the dead leg was removed in September 2016, but adds:

*Testing of sludge and water within the dead leg revealed high concentrations of a range of metals, including lead.*<sup>249</sup>

3.113 We sought to establish why this additional information was not covered in any sort of detail in earlier briefing notes soon after the dead leg was removed. Initially, the Executive Director of Strategic Projects told us he ‘regularly briefed both the Treasurer and the Minister for Health’ throughout late-2016 on the dead leg issue with the QEII ring main.<sup>250</sup> When we sought further clarity on the nature and extent of these briefings, he said ‘it is considered likely its removal was raised in verbal briefings with the Treasurer.’<sup>251</sup> However, regarding the testing of the material within the ring main, the Executive Director said ‘Finance cannot find any evidence of advice to the former Treasurer’ about this matter ‘and has no recollection of any discussion with the Treasurer to this effect.’<sup>252</sup> He went on to explain that Strategic Projects ‘did not consider the existence and removal of the dead leg to be material to the water quality issue.’<sup>253</sup> This view was influenced by the initial investigation by ChemCentre, which had attributed the problem to construction debris within PCH’s potable water system. Notably, the Director General of Health offered a similar view on the under-reporting of the dead leg. He advised that ‘it was never considered as a major issue’ and that Strategic Projects ‘quite rightly never made it a major issue as well.’<sup>254</sup>

3.114 We invited the former Treasurer, and now Leader of the Opposition, Hon. Dr Mike Nahan, to confirm the veracity of his statement of 26 April 2017 and to comment on the briefings he received around this issue. He stood by his statement and said that ‘at no time during any briefings was I shown any photographs of the “dead leg” of unused water supply pipe—with any explanation of its relevance to the lead in the PCH water system.’<sup>255</sup> Dr Nahan added that the term ‘dead leg of unused water supply’ that was

<sup>248</sup> Mr Richard Mann, Executive Director, Strategic Projects & Asset Sales (Department of Treasury) and Mr Stan Goodchild, Acting Director Environmental Health, Department of Health, ‘Elevated Levels of Lead – PCH,’ Contentious Issues Briefing Note, 10 October 2016 (closed evidence).

<sup>249</sup> Mr Richard Mann, Executive Director, Strategic Projects & Asset Sales (Department of Treasury), ‘Perth Children’s Hospital – Water Quality,’ Contentious Issues Briefing Note, 1 May 2017 (closed evidence).

<sup>250</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), *Transcript of Evidence*, 18 September 2017, p. 4.

<sup>251</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), Letter, 28 February 2018, pp. 2-3.

<sup>252</sup> *ibid.*

<sup>253</sup> *ibid.*, p. 3.

<sup>254</sup> Dr David Russell-Weisz, Director General, Department of Health, *Transcript of Evidence*, 18 September 2017, p. 12.

<sup>255</sup> Hon. Dr Mike Nahan, MLA, Leader of the Opposition, Letter, (received 8 March 2018), p. 3.

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used repeatedly in the written briefings, ‘may well be misleading given the Building Commission Report identified it as a possible source of the lead [contamination].’<sup>256</sup> Dr Nahan also stressed that he received no verbal briefings about ‘the “dead leg” of unused water supply pipe having substantial contamination and that it was, until its removal, connected to the PCH water supply system.’<sup>257</sup>

3.115 Speaking recently in the context of numerous statements he made as Treasurer on the broader lead issue, Dr Nahan claimed these statements ‘did not come to fruition because the advice I had turned out not to be accurate, or understated the problem.’<sup>258</sup> We share Dr Nahan’s concerns that briefing notes understated some critical aspects of the water contamination issue during his tenure.<sup>259</sup> We acknowledge this point and believe that Strategic Projects (and the Taskforce once it was aware) should have been more forthcoming with all relevant information given the source of the lead continued to elude them. Even so, we have some concern at the reactive approach ministers appear to have taken regarding the pursuit of critical information. Especially at a time when there was little consensus about either diagnosis or remedy of the contaminated water supply, and practical completion forecasts had become highly unreliable.

3.116 In this respect, we note the observations of former senior Commonwealth public servant, Professor Peter Shergold AC, about the ideal form of communications between senior departmental executives and their ministers. Professor Shergold refers to the ‘important role of senior public servants... to ensure that Cabinet Ministers make their decisions with eyes wide open.’<sup>260</sup> In terms of the information public servants provide, Professor Shergold argues that:

*Advice should seek to identify the risks, envisage unintended consequences, indicate threats to successful implementation and proffer alternative options.*<sup>261</sup>

3.117 However, Professor Shergold also puts some onus on ministers, arguing that they should ‘demand that advice on the most challenging issues they face should be presented in written form.’<sup>262</sup>

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<sup>256</sup> The Building Commissioner also included photos of the dead leg in his report. Hon. Dr Mike Nahan, MLA, Leader of the Opposition, Letter, (received 8 March 2018), p. 3.

<sup>257</sup> *ibid.*

<sup>258</sup> Hon. Dr Mike Nahan, MLA, WA, Legislative Assembly, *Parliamentary Debates* (Hansard), 1 November 2017, pp. 5243-5268.

<sup>259</sup> Professor Peter Shergold AC, *Learning from failure*, 12 August 2015, p. iv.

<sup>260</sup> *ibid.*, p. 5.

<sup>261</sup> *ibid.*

<sup>262</sup> *ibid.*, p. 18.



3.118 By late-2016, with so many issues afflicting the PCH project, we remain unconvinced that the standards suggested by Professor Shergold were being met by either the relevant agencies or the responsible ministers.

**Finding 24**

The level of detail in ministerial briefing notes relating to the PCH project was not always adequate. Neither Strategic Projects nor the Department of Health issued briefing notes detailing the findings of five gateway reviews that were highly critical of governance processes on the project. The potential significance of the dead leg attached to the QEII ring main was also understated. The lack of coverage of these issues is difficult to comprehend given there were at least three briefing notes from the Department of Health providing updates on an October 2016 PCH Foundation Fundraising Gala Dinner.

**Finding 25**

The Director General of the Department of Health advised that he ‘may have informally verbally briefed’ the Minister for Health about the findings of the five gateway reviews conducted between June 2015 and July 2017. It is unacceptable that the findings of these reviews were not included as part of a detailed written briefing to the Minister for Health, the Treasurer, and the Cabinet.

**Finding 26**

We share the former Treasurer’s view that briefing notes relating to the water contamination issue—and in particular the dead leg linked to the QEII Medical Centre ring main—understated the significance of the problem. However, in such circumstances, when projects are clearly running into regular difficulty, it is also incumbent upon ministers to demand they receive written briefings covering all critical issues in an appropriate level of detail.

**Recommendation 2**

The Premier take the appropriate actions to ensure that the findings of gateway reviews undertaken by agencies are the subject of detailed briefing notes provided to any relevant minister.

## Shortcomings evident in dual governance structure

*I have stated that the dual governance of this project has had significant challenges and we should learn for future similar projects.*

Dr David Russell-Weisz, PCH Taskforce Chair, 2017<sup>263</sup>

3.119 The State frequently employs the dual governance structure that was in place for most of the construction phase of the PCH project. Other projects where multi-agency taskforces have operated as the project oversight body include the new Perth Stadium and the current redevelopment of the WA Museum.<sup>264</sup> During this inquiry, we have not considered the effectiveness of the dual governance structure on these other projects. However, we have formed the view that it had limited effectiveness in overseeing the delivery of PCH. Some Taskforce members have expressed similar concerns in their evidence. Therefore, we have considered ways to improve major project governance structures going forward.

3.120 While the concept of a multi-agency oversight body (i.e. taskforces, steering committees) is considered appropriate for complex, multi-faceted projects,<sup>265</sup> several elements are critical to underpinning their success as a governance forum. Ideally, they need the capacity to operate as a lead entity, 'otherwise things fall through the cracks.'<sup>266</sup> Moreover, the remit and authority of this lead entity needs to extend across the entire scope of the project. Finally, all major parties within oversight body need to work collaboratively toward a 'shared objective or outcome.'<sup>267</sup> It is arguable that the governance of the PCH project suffered due to a failure to ensure these elements were in place. This was probably attributable to the lack of a lead agency under the dual governance structure.

### Finding 27

Under the dual governance model, the PCH Taskforce operated as the lead entity, but in reality, the authority for delivering the entire project was divided between two government agencies—both of whom sat on the PCH Taskforce.

3.121 The Director General of Health was the senior responsible officer for the client agency and, as such, was responsible for each of the commissioning work streams. He was also the Taskforce Chair. Meanwhile the Under Treasurer oversaw Strategic Projects, which was responsible for the delivery of the asset to the Department of Health. Under this

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<sup>263</sup> Dr David Russell-Weisz, Director General, Department of Health, *Transcript of Evidence*, 18 September 2017, p. 3.

<sup>264</sup> Submission No. 13 from State Solicitor's Office, 3 August 2017, p. 7.

<sup>265</sup> Australian National Audit Office (ANAO), *Successful Implementation of Policy Initiatives*, 15 October 2014, p. 26.

<sup>266</sup> *ibid.*, p. 24.

<sup>267</sup> Australian National Audit Office (ANAO), *Public Sector Governance. Strengthening Performance through Good Governance*, 26 June 2014, p. 60.

structure, the head of the client agency and the oversight body had ‘little ability to control the progress’ of the infrastructure work stream.<sup>268</sup> This lack of authority and direct visibility around the construction program made it very difficult for both the Department of Health and the Taskforce to mitigate risks to the commissioning program associated with construction delays.

### Finding 28

There is sufficient evidence to suggest that the project lacked the level of ongoing collaboration necessary to ensure effective governance. Operating within a dual governance structure, the PCH Taskforce seemed ill equipped to handle the level of acrimony that emerged between its two leading entities, the Department of Health, and Strategic Projects.

3.122 We would expect multi-agency bodies like the PCH Taskforce to engage in robust deliberations. This is indeed a likely and not unwelcome consequence of assembling experts from key agencies to ensure an appropriate level of rigor is applied to project oversight. However, there appears to have been an ongoing and unhealthy amount of tension between the Department of Health and Strategic Projects in the management of their respective commissioning and infrastructure work streams. These tensions—which are admittedly a major consequence of their shared frustrations with JHPL—were evident as early as the June 2015 Gateway Review, and have continued into current discussions around remediating the water quality problems.<sup>269</sup>

### Amend the *Public Works Act 1902* to deal with dual governance shortcomings

3.123 The dual governance / dual accountability approach reflected in the PCH governance structure is a function of the current provisions of the *Public Works Act 1902* (WA). As noted at 2.5 above, the Act vests responsibility for major infrastructure development with the Minister for Works (currently the Minister for Finance). It has been common practice for the Minister to delegate this responsibility, via the Treasurer and Under Treasurer<sup>270</sup>, to Strategic Projects. As a result, Strategic Projects manages the construction aspects of major infrastructure projects on behalf of government departments, while the departments often remain responsible for final commissioning activities. This structure is a legacy of the period when the State operated its own

<sup>268</sup> An issue that was noted by the Taskforce Chair in the minutes of the meeting held on 16 February 2016.

<sup>269</sup> Tensions between the building and commissioning work streams were also reported in the final gateway review, after which the Taskforce was disbanded and replaced with the PCOC. Department of Health, *Gateway Review 5 – Readiness for Service* (5), 7 July 2017.

<sup>270</sup> Strategic Projects was reassigned from the Department of Treasury to the Department of Finance as of 1 July 2017 under the McGowan Government’s first round of machinery government changes. As a consequence, delegation to Strategic Projects from the Minister for Works now occurs through the Minister for Finance.

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public works department, which undertook construction of public infrastructure. Much of this work is now contracted out and managed by Strategic Projects.

### Finding 29

As the PCH project demonstrates, dual governance structures make it very problematic for a client agency or a steering committee to maintain control of a project when matters go awry with construction. From a ministerial and parliamentary scrutiny aspect, it is also difficult to identify clear lines of responsibility.

3.124 Arguably, the PCH governance structure may have worked more effectively if the client agency, in this case Department of Health, had overarching responsibility for the delivery of its own asset. Under this arrangement, Strategic Projects would have retained responsibility for the construction work stream, while being directly accountable to the Department of Health. Such an arrangement would require the client agency to assume ultimate accountability for all aspects and outcomes of the project, from planning through to final commissioning. We think this would encourage client agencies to become more actively invested in asset delivery and allow for clearer lines of authority, accountability, and reporting to be established.

3.125 We note that the Special Inquirer, who recently completed his *Inquiry into Government Programs and Projects*, recommended that the dual governance / dual accountability model be retained. He argued that this model ‘has a positive track record across many major State projects’ and that the ‘significant number of governance issues’ observed at PCH were ‘unique’ to that particular project.<sup>271</sup> The Special Inquirer added that Strategic Projects has ‘achieved considerable success in improving outcomes on major projects’ since its establishment in 2008.<sup>272</sup> He described the PCH as an ‘exception’ and concluded ‘the main cause of the tensions are personality based rather than structural.’<sup>273</sup> Regarding these tensions, the Special Inquirer found the Department of Health and Strategic Projects had been ‘uncompromising in their attitudes towards each other’ and recommended that in future:

*Project peak governance committees are to promptly address relationship issues that arise at the project team level.*<sup>274</sup>

3.126 We concur with the Special Inquirer’s views regarding the relationship issues that beset this project. However, we hold the view that dual governance made these issues far more difficult to resolve than would otherwise have been the case under a single senior responsible officer.

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<sup>271</sup> Government of Western Australia, *Special Inquiry into Government Programs and Projects: Final Report*, Vol. 2, February 2018, p. 165.

<sup>272</sup> *ibid.*, p. 140.

<sup>273</sup> *ibid.*

<sup>274</sup> *ibid.*, p. 168

- 3.127 We also acknowledge the Special Inquirer’s argument about the track record of certain major projects under dual governance, but make the point that these projects did not experience the same difficulties with construction that occurred on PCH. Had these problems occurred on any of those projects, outcomes may well have been similar.
- 3.128 We believe the best way to address these risks in future is through a single line of authority and ultimate accountability. This should rest within the client agency utilising the expertise of Strategic Projects as and when major infrastructure requirements emerge.

### Recommendation 3

The Minister for Works (currently the Minister for Finance) amend the *Public Works Act 1902* (WA) to remove dual governance structures by vesting overarching asset delivery responsibility with client agencies.

### Major project steering committees should have independent chairs

- 3.129 As a complementary measure, we also see significant merit in engaging independent chairs to head up multi-agency major infrastructure project steering committees. We note the 2014 parliamentary inquiry referred to earlier made a similar recommendation after examining the Fiona Stanley Hospital’s commissioning taskforce.<sup>275</sup> The government indicated that the ‘recommendation will be taken into consideration’ for future steering committees, but it opted against this approach with the PCH Taskforce.<sup>276</sup> We think the concept of an independent chair, dedicated exclusively to overseeing similar bodies in future, is worthwhile on several grounds.
- 3.130 Firstly, it will help reduce the demands on time and the level of responsibility placed on taskforce or steering committee members. The Taskforce included three agency chief executives, and formal attendees included numerous senior departmental executives. Between September 2013 and the Taskforce’s final meeting in August 2017, these individuals met on at least 156 occasions for a total period exceeding 350 hours.<sup>277</sup> In preparation for these meetings, they were required to read a substantial number of reports and associated paperwork. Given the other demands of their respective roles, we cannot see how these officials would have been capable of discharging their responsibilities efficiently and effectively. In this respect, the guidance of an

<sup>275</sup> Education and Health Standing Committee (39<sup>th</sup> Parliament), *More than Bricks and Mortar: The report of the inquiry into the organisational response within the Department of Health to the challenges associated with commissioning Fiona Stanley Hospital*, 10 April 2014, p. 92.

<sup>276</sup> Hon. Dr Kim Hames, MLA, Minister for Health, Letter, p. 2 (Legislative Assembly Tabled Paper No. 1814, tabled on 12 August 2014).

<sup>277</sup> Based on the Public Accounts Committee secretariat’s calculations taken from the PCH Taskforce minutes.

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independent chair engaged specifically to focus on overseeing the PCH project would have been invaluable.

3.131 Secondly, an independent chair with expertise in major project delivery would provide assurance to Taskforce members around project and risk management issues affecting the PCH project. Such skills would likely have helped the Taskforce identify and address the shortcomings in the project's integrated reporting and critical path processes more expeditiously. An independent chair would also have been in a better position to manage the frustrations and tensions that emerged between Taskforce members and attendees over these issues. Ideally, an independent chair with the appropriate expertise would ensure that robust processes in these areas were in place at the outset as a proactive measure.

3.132 We note the Taskforce gained greater assurance once the IPMO was established and in a position to properly report on the status of all work streams. This gives us reason to believe that an IPMO working with an independent taskforce chair would make the work of future steering committee members considerably more productive.

3.133 Finally, an independent chair could also provide a similar assurance and advice function for responsible ministers. This would not remove the reporting responsibilities of the accountable authority of the client agency. However, it would improve the likelihood that the minister received comprehensive briefings on the true status of the project and all relevant matters affecting it. In the context of the PCH project, an independent chair could have ensured the Minister for Health and the Under Treasurer were aware of the governance issues identified in the gateway reviews. Such a chair could also have offered a dispassionate view on the practical completion forecast assessments reported into and out of the Taskforce.

3.134 An independent chair could have reduced the demands of Taskforce members, and provided assurance and advice to Taskforce members and responsible ministers around project and risk management issues affecting the project.

### **Recommendation 4**

The Government appoint independent chairs with appropriate expertise to multi-agency steering committees for the oversight of major projects in future.

## A flawed contract undermined the State's ability to manage the builder

*We had a hell of a time with that managing contractor.*

Hon. Dr Mike Nahan, Treasurer, 2017<sup>278</sup>

*...we were constrained by the lack of contractual levers; there is no doubt about that.*

Mr Michael Barnes, Under Treasurer, 2017<sup>279</sup>

3.135 Throughout this inquiry key figures within the governance structure have cited the performance of the managing contractor as one of the major challenges they confronted.

3.136 From the early stages of the contract, Strategic Projects was aware of delays arising within JHPL's design development and structural works programs. Early concerns also emerged around the accuracy and reliability of work programs the builder was submitting for review.<sup>280</sup> The departments of Health and Treasury both claimed that unreliable program reporting culminated in JHPL putting forward (and subsequently missing) 16 revised practical completion forecast dates.<sup>281</sup> This created havoc with commissioning activities, some of which Health had to perform on multiple occasions due to the repeated recalibration of the commissioning program. More broadly, the A/State Solicitor claimed JHPL 'at times materially failed to properly manage the project and deliver on its contractual obligations.'<sup>282</sup> In a similar vein, Strategic Projects submitted that the 'significant delays' to construction and commissioning arose mainly from JHPL's 'failure to comply with its obligations under the MC Contract.'<sup>283</sup>

3.137 The ultimate validity of these claims will likely be determined by the courts if litigation between the State and JHPL proceeds. For the purpose of this inquiry, how the State managed these issues as they emerged was the more pressing concern. This led us to

<sup>278</sup> Hon. Dr Mike Nahan, MLA, WA, Legislative Assembly, *Parliamentary Debates* (Hansard), 1 November 2017, pp. 5243-5268.

<sup>279</sup> Mr Michael Barnes, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 9 October 2017, p. 5 (closed evidence).

<sup>280</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), *Transcript of Evidence*, 18 September 2017, p. 6; Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), Letter, 13 October 2017, p. 7.

<sup>281</sup> Dr David Russell-Weisz, Director General, Department of Health, *Perth Children's Hospital Commissioning and Transition. Project Overview and Status Update*. 17 March 2017, p. 16 (Legislative Assembly Tabled Paper [No. 268](#), tabled on 18 May 2017); Dr David Russell-Weisz, Director General, Department of Health, *Transcript of Evidence*, 18 September 2017, p. 1; Mr Alistair Jones, Executive Director, Strategic Policy and Evaluation, Department of Treasury, *Transcript of Evidence*, 9 October 2017, p. 13.

<sup>282</sup> Mr Nicholas Egan, A/State Solicitor, State Solicitor's Office, Letter, 7 November 2017, p. 4 (closed evidence).

<sup>283</sup> Submission No. 6 from Department of Finance (Strategic Projects), 28 July 2017, p. 14.

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consider the efficacy of the contractual levers available to Strategic Projects to elicit the required level of compliance and cooperation from JHPL. As noted at paragraph 1.23 above, the State was aware that JHPL had submitted an extremely competitive bid and was seeking to establish itself as a viable alternative to the top-tier managing contractors the State had previously used. Under these circumstances, we would have expected the State's contractual structures to be sufficiently robust to mitigate risks that might arise out of JHPL's performance. What we found is concerning. The State generally relied on the levers that had least effect, while some of the more potentially persuasive measures were used either sparingly or not at all because of their perceived detriment to the State's objectives.

### Description of the levers available to the State

3.138 There were numerous contractual levers available to the State. Under clause 8.2, the State could issue directions requesting information or actions from the contractor.<sup>284</sup> The contractor was required to comply within the time specified in the direction or in accordance with the relevant clause of the contract. Directions could be issued requesting alterations to the 'format or frequency' of reports on the status works, which were otherwise required 'at least monthly.'<sup>285</sup> The State, through Strategic Projects, could also issue directions requiring the managing contractor to 'employ more resources' if the State formed the opinion these were required 'for the proper performance' of the contracted activities.<sup>286</sup> This clause co-existed with the requirement, under clause 7.2(d), that the managing contractor 'must devote all resources necessary to properly perform' its commitments in accordance with the contract.<sup>287</sup>

3.139 The State could also issue 'defect notices' requiring the managing contractor to rectify the defect listed in the notice within a specified time.<sup>288</sup> The managing contractor had recourse to dispute the defect, but was still required to comply with the notice and pursue reimbursement afterwards.<sup>289</sup> If the managing contractor failed to rectify the defect within the prescribed time, the State could rectify the work and register it as a debt due and payable on demand.<sup>290</sup>

3.140 Among the more punitive measures available to the State was the power to issue a 'default notice.'<sup>291</sup> This option was available to the State where it felt the managing

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<sup>284</sup> New Children's Hospital Managing Contractor (MC) Contract for the New Children's Hospital on the Queen Elizabeth II Medical Centre Site, 5 July 2011 (closed evidence).

<sup>285</sup> *ibid.*, clause 10.1.

<sup>286</sup> *ibid.*, clause 9.8(c).

<sup>287</sup> *ibid.*, clause 7.2(d).

<sup>288</sup> *ibid.*, clause 20.1.

<sup>289</sup> *ibid.*, clause 20.3.

<sup>290</sup> *ibid.*, clause 20.1(d).

<sup>291</sup> *ibid.*, clause 36.1.



contractor had ‘failed to perform’ any of the contracted works or failed to ‘comply with the terms’ of the contract.<sup>292</sup> Where the default described in the notice was capable of remedy, the State had to provide a date by which it required the managing contractor to perform the remedy or provide a ‘Remedy Plan.’<sup>293</sup> If the managing contractor failed to comply with the terms of the default notice, or if the default was not capable of remedy, the State could pursue termination of the contract.<sup>294</sup>

3.141 As an alternative to the default notice, the State could opt to take any actions required to ‘rectify or mitigate loss or damage’ caused by a breach of contract or failure to perform an obligation.<sup>295</sup> Under this clause, the State could engage third parties to undertake the required actions and seek reimbursement for any debts payable on demand from the managing contractor.

3.142 Several other clauses within the contract provided financial levers to the State. The most immediate and accessible of these was the State’s right to assess claims for payment submitted by the managing contractor.<sup>296</sup> Notably, the State could refrain from paying all or part of a claim if it considered the works for which payment was sought were not properly performed.<sup>297</sup>

3.143 Other levers included performance bonds, which varied in size at different stages of the contract.<sup>298</sup> For the majority of the construction period the State held a performance bond valued at \$20 million. The State surrendered this bond at practical completion and obtained in its place a \$25 million Defects Liability Bond.<sup>299</sup>

3.144 The State enjoyed a further form of surety via a liquidated damages clause.<sup>300</sup> Under this clause, the contractor was required to pay the liquidated damages if it failed to complete its works by the agreed liquidated damages milestone date. Liquidated damages in this contract was capped at \$42.5 million, based on a rate of \$180,000 per day for each day of delay past the extended practical completion date of 31 August

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<sup>292</sup> New Children’s Hospital Managing Contractor (MC) Contract for the New Children’s Hospital on the Queen Elizabeth II Medical Centre Site, 5 July 2011, clause 36.1 (closed evidence).

<sup>293</sup> *ibid.*

<sup>294</sup> *ibid.*, clause 36.4.

<sup>295</sup> *ibid.*, clause 36.3.

<sup>296</sup> *ibid.*, clause 26.3.

<sup>297</sup> *ibid.*, clause 26.4(a)(ii).

<sup>298</sup> *ibid.*

<sup>299</sup> Dr David Russell-Weisz, Director General, Department of Health, *Perth Children’s Hospital Commissioning and Transition. Project Overview and Status Update*. 17 March 2017, p. 9 (Legislative Assembly Tabled Paper No. 268, tabled on 18 May 2017).

<sup>300</sup> New Children’s Hospital Managing Contractor (MC) Contract for the New Children’s Hospital on the Queen Elizabeth II Medical Centre Site, 5 July 2011, clause 22.1 (closed evidence).

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2015. This cap meant liquidated damages were only available for delays out as far as 24 April 2016.<sup>301</sup>

3.145 The final major lever for the State is the parent company guarantee it holds ‘as security for the performance of the [managing] contractor’s obligations.’<sup>302</sup> The State obtained this guarantee from Leighton Holdings Limited, who were JHPL’s parent company when the contract was signed. The State insisted this guarantee remain with Leighton Holdings Limited, after the company sold its interest in JHPL to CCCC in April 2015. The guarantee is capped at \$220 million, except in the event that the contract is abandoned. Under these circumstances, the cap does not apply.<sup>303</sup>

### **The use of levers was variable and generally ineffectual**

3.146 Strategic Projects confirmed that between July 2011 and October 2017, it had issued 3,478 notices and 410 directions to JHPL. Strategic Projects claimed that JHPL ‘generally... responded appropriately... although follow-up has been frequently required.’<sup>304</sup> On the ‘relatively small number’ of times JHPL failed to respond appropriately, Strategic Projects advised this was due to differing contractual positions taken by the builder.<sup>305</sup>

3.147 Other Taskforce members did not share this seemingly benign assessment of JHPL’s responsiveness to notices and directions. The Director General of the Department of Health indicated that JHPL routinely ignored requests for information. The department’s submission indicated that this became a recurring problem throughout late-2016 and 2017.<sup>306</sup> The A/State Solicitor offered a similar view regarding JHPL’s contractual requirement to provide a detailed program of works as and when required by the State, claiming they ‘repeatedly failed to provide it.’<sup>307</sup>

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<sup>301</sup> The contractor did have the right to challenge the validity of a liquidated damages claim in a court of competent jurisdiction. If such a court ruled the State was not entitled to a particular claim, the State retained the right to seek damages at law as an alternative. New Children’s Hospital Managing Contractor (MC) Contract for the New Children’s Hospital on the Queen Elizabeth II Medical Centre Site, 5 July 2011, clause 22.1(j) (closed evidence).

<sup>302</sup> *ibid.*, clause 11.8.

<sup>303</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), Letter, 28 February 2017, p. 1.

<sup>304</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), Letter, 13 October 2017, p. 15.

<sup>305</sup> *ibid.*

<sup>306</sup> Submission No. 12 from Department of Health, 1 August 2017, Attachment F; Dr David Russell-Weisz, Director General, Department of Health, *Transcript of Evidence*, 18 September 2017, pp. 1-3 (closed evidence).

<sup>307</sup> Mr Nicholas Egan, A/State Solicitor, State Solicitor’s Office, *Transcript of Evidence*, 18 September 2017, p. 9.

3.148 The Under Treasurer confirmed that Strategic Projects ‘issued literally thousands’ of directions and notices to JHPL.<sup>308</sup> His frustration was evident when he went on to argue that JHPL ‘either did not perform those directions [and notices] or they ignored them.’<sup>309</sup> The most significant example was JHPL’s failure to comply with a direction to conduct the State’s preferred chemical treatment of the potable water supply in early 2017. This proved to be a major factor in the State’s decision to grant practical completion, so that it could take control of the site to resolve the water contamination problem.<sup>310</sup>

3.149 Strategic Projects has advised that there have been 22 occasions where the State has opted to rectify a defect after JHPL failed to meet the requirements of a defect notice.<sup>311</sup> While clause 20.1(d) of the contract allows the State to seek reimbursement, as a debt due and payable on demand, it has not yet elected to do so. In each instance, JHPL is disputing the status of the item as a defect. Therefore, ‘the cost is being treated (by the State) as a JHPL liability as part of ongoing commercial negotiations seeking to resolve all outstanding contractual disputes and claims.’<sup>312</sup>

3.150 Strategic Projects ‘frequently engaged in discussions’ with JHPL on the adequacy of resources deployed during construction and issued at least 14 notices that ‘formally expressed concern’ on the matter.<sup>313</sup> However, it only issued one formal direction requiring JHPL to employ more resources on site. JHPL challenged the validity of the direction and did not fully comply. Outside of this, the State ‘generally relied on JHPL’s fundamental performance obligations’ under clauses 7.2(d) and 9.8(a) of the MC Contract.<sup>314</sup> While 7.2(d) required the JHPL to ‘devote all resources necessary’ to perform its activities, clause 9.8 required it to ‘make its own determination’ as to what resources were needed.

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<sup>308</sup> Mr Michael Barnes, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 9 October 2017, p. 4 (closed evidence).

<sup>309</sup> *ibid.*

<sup>310</sup> Mr Alistair Jones, Executive Director, Strategic Policy and Evaluation, Department of Treasury, *Transcript of Evidence*, 9 October 2017, p. 5 (closed evidence). Note as at 26 April 2017, JHPL claimed it had not received a defect notice under clause 20 of the MC Contract ‘with respect to lead contamination of the potable water system.’ Mr Lindsay Albonico, WA Region Manager, John Holland Pty Ltd, Letter, 3 November 2017, Annexure 3 (closed evidence).

<sup>311</sup> The State has issued 39 defect notices in total. For the remaining 17 notices, eight were disregarded by mutual consent; five were rectified by JHPL; one resulted in a formal reduction of the contract value to allow for the defect; while three were still awaiting rectification. Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), Letter, 8 December 2017, p. 7; Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), Letter, 28 February 2017, pp. 1-2.

<sup>312</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), Letter, 28 February 2017, pp. 1-2.

<sup>313</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), Letter, 8 December 2017, p. 5.

<sup>314</sup> *ibid.*, pp. 4-5.

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3.151 In terms of the financial levers, the State has not drawn down on either of the performance or defects liability bonds. Nor has it made any claim for liquidated damages, although it has reserved the right to do so on every payment certificate it has issued since these damages became potentially liable. The parent company guarantee also remains uncalled.<sup>315</sup> The Executive Director of Strategic Projects has advised that calling on this guarantee 'is a significant step that would typically only be exercised in response to material [managing contractor] default – for example, abandonment of the contract.'<sup>316</sup> The one financial lever used repeatedly was the State's discretion over payment claims. Strategic Projects confirmed that on 33 of 71 occasions, the amount certified by the State's representative for a progress payment was less than the amount claimed by JHPL.<sup>317</sup>

3.152 Finally, while the State has contemplated terminating the contract on occasions, it has opted against issuing a default notice to JHPL. However, Strategic Projects confirmed that 'several notices' were issued alerting JHPL to the default notice provisions 'as a potential action for the State in the event of continued non-performance.'<sup>318</sup>

### **The ineffective mix of levers left the State relying on 'goodwill'**

3.153 The A/State Solicitor providing the following assessment of the MC Contract:

*As far as the Managing Contractor contract is concerned... it is an extremely favourable contract for the State in terms of risk allocation and has been well drafted. It is certainly a contract which we (SSO) would utilise again having made bespoke alterations to take into account both what was required for a future projects and any lessons learned from the PCH Project itself.*<sup>319</sup>

3.154 Similarly, the Langoulant Inquiry's final report said the State Solicitor's Office described the MC Contract as 'State-friendly.'<sup>320</sup> These assessments from the A/State Solicitor and his team appear to stand in stark contrast with the position the State found itself in during the construction phase of PCH.

3.155 As early as 3 February 2015, the Taskforce knew it had problems with the State's contractual levers. By this time, JHPL's forecast practical completion date had slipped

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<sup>315</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), *Transcript of Evidence*, 18 September 2017, p. 2 (closed evidence).

<sup>316</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), Letter, 28 February 2017, p. 1 (closed evidence).

<sup>317</sup> Submission No. 6 from Department of Finance (Strategic Projects), 28 July 2017, p. 20.

<sup>318</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), Letter, 8 December 2017, p. 7.

<sup>319</sup> Mr Nicholas Egan, A/State Solicitor, State Solicitor's Office, Letter, 31 October 2017, p. 2.

<sup>320</sup> Government of Western Australia, *Special Inquiry into Government Programs and Projects: Final Report*, Vol. 2, February 2018, p. 129.

out to 4 September 2015, 66 days past the contracted practical completion date of 30 June 2015 then in place. Taskforce minutes from 3 February 2015 confirmed the builder was ‘contractually overdue,’ but noted there was ‘limited capability to impose sanctions, unless the State is prepared to put in a breach of contract and prepared to take further action.’<sup>321</sup>

3.156 Twelve months later, Taskforce found itself in a similar position as the building program slipped further behind. By this time, JHPL’s forecast practical completion date had slipped further to 20 June 2016 (a delay of 294 days from the-now extended practical completion date of 31 August 2015). At its meeting of 16 February 2016, the Taskforce ‘reflected on the challenges of working with the MC [JHPL] and noted that all reasonable measures to manage the MC had been exhausted.’<sup>322</sup> Strategic Projects advice at the time indicated ‘all contractual levers had been pulled wherever possible.’<sup>323</sup> This was two months before the liquidated damages cap was reached and three months before elevated lead levels were discovered in the water supply.

3.157 The Under Treasurer subsequently confirmed that by the time the lead issue emerged:

*...we were literally operating on goodwill with the master contractor in the [construction] process, because we had no levers to pull.*<sup>324</sup>

### Finding 30

The PCH Taskforce noted concerns around the efficacy of the State’s contractual levers as early as February 2015. By May 2016, when the lead issue emerged, the Under Treasurer confirmed the State felt it had no levers left to pull. It is clearly unsatisfactory that the State found itself in this position. It is also difficult to reconcile this outcome with the Acting State Solicitor’s description of the contract as an ‘extremely favourable contract for the State in terms of risk allocation.’

3.158 Such outcomes automatically call into question the adequacy of the levers that were available under the MC Contract. Yet when making judgements in this respect, it is important to be mindful of the obvious benefit that comes with hindsight. We have been mindful of this when framing the following observations, which we think the State should take into account when drafting major commercial contracts in future.

3.159 Firstly, the State’s representatives showed little appetite to issue a default notice, let alone to terminate the contract. Taskforce members, and the former Principal Project Director, confirm that the Taskforce and the Strategic Projects project team considered

<sup>321</sup> PCH Taskforce, Minutes of Meeting 3 February 2015, p. 6 (closed evidence).

<sup>322</sup> PCH Taskforce, Minutes of Meeting 16 February 2016, p. 18 (closed evidence).

<sup>323</sup> *ibid.* The minutes add that Strategic Projects ‘had observed response [sic] to these issues from the MC.’

<sup>324</sup> Mr Michael Barnes, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 9 October 2017, p. 11.

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the termination option.<sup>325</sup> Ultimately, they pursued other options, often choosing instead to rectify critical defects independently while reserving the rights to hold the builder subsequently liable. Such decisions came on the back of advice from Strategic Projects and the State Solicitor's Office that highlighted the potential downsides of pursuing termination.<sup>326</sup> These included the risk of further project delays and cost increases associated with engaging a new builder, and dealing with any legal ramifications from the decision to terminate the original contract.<sup>327</sup>

3.160 Based on the explanations provided, we feel it would be unreasonable to be overly critical of the decision to opt against terminating the contract. Indeed, we acknowledge the gravity and difficulty of the ongoing situation key decision-makers were facing. However, given the concerns conveyed at Taskforce meetings, we remain curious as to the sorts of circumstances that would persuade the State to at least issue a default notice (see 3.140 above) and seek a remedy plan on future contracts.

3.161 While we concede this is a challenging issue, we find it far harder to comprehend why the State issued only one formal direction requiring JHPL to employ more resources on site. Equally perplexing is the November 2015 decision to have JHPL perform an additional \$53 million fit out of the Telethon Kids Institute (TKI) as a deed of amendment to the main contract. Notwithstanding any element of convenience this idea presented in the short-term, the decision seems misguided given the legitimate concerns around JHPL's performance that were evident throughout 2015. Just six months later, JHPL opted to withdraw from the TKI fit-out leaving the State subject to further delay as it had to tender out these works to another party.

3.162 Secondly, the State's current failure to seek liquidated damages—or to call on performance bonds or the parent company guarantee—leaves the value of such levers open to question. We acknowledge the State has reserved its rights on these levers and may seek recourse to them as part of an overall global settlement. Therefore, in the case of the PCH project, it will not be possible to assess their ultimate efficacy until such time a final settlement is determined by a court or agreed between the parties.

3.163 For the moment, it is important to highlight the fact that the liquidated damages cap on this project proved to be woefully inadequate to cover the State for the delays that ensued. The final practical completion date of 13 April 2017 came 354 days after the

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<sup>325</sup> Mr John Hamilton, former Principal Project Director, Strategic Projects & Asset Sales, *Transcript of Evidence*, 18 October 2017, p. 11; Ms Lynette Genoni, former Executive Director, Policy, Department of the Premier and Cabinet, *Transcript of Evidence*, 30 October 2017, p. 6.

<sup>326</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), Letter, 8 December 2017, p. 7; Mr Alistair Jones, Executive Director, Strategic Policy and Evaluation, Department of Treasury, *Transcript of Evidence*, 9 October 2017, p. 3 (closed evidence).

<sup>327</sup> Mr Nicholas Egan, A/State Solicitor, State Solicitor's Office, Letter, 7 November 2017, p. 4 (closed evidence); Ms Lynette Genoni, former Executive Director, Policy, Department of the Premier and Cabinet, *Transcript of Evidence*, 30 October 2017, p. 6.

liquidated damages cap (of \$42.5 million) was reached. This represents an extended period where this lever (damages entitlement of \$180 000 per day) no longer acted as an incentive.

- 3.164 The quantum of liquidated damages—as with those of performance bonds and parent company guarantees—is determined during the process of contract negotiations, with any agreed figure being a factor in the overall contract price. JHPL was one of three competing bidders for the PCH project and its contract price was substantially lower than that of its competitors. As we were not privy to the negotiations, we are not able to determine the extent to which the agreed contract price impacted the agreed damages amount or the value of the other financial levers. However, the A/State Solicitor did indicate that bond values are often partly determined by considering risks that might have occurred on similar projects.<sup>328</sup>
- 3.165 With the PCH project, the inadequacy of the agreed financial levels available to the State is obvious, particularly with the benefit of hindsight. The important point for the State’s negotiators is to give due regard to the risks that emerged on this project when contemplating the necessary value of these provisions in future contracts. Equally important is the need to recognise the potential value in foregoing an extremely competitive contract price to retain greater influence over a contractor’s performance via larger financial levers.
- 3.166 A third observation relates to the general efficacy of financial levers, regardless of their dollar value. Important here is the view expressed by the Under Treasurer that calling on the performance bonds or parent company guarantee ‘would have had little to no impact on incentivising the managing contractor to improve its performance.’<sup>329</sup> He went on to suggest that the ‘lengthy commercial processes’ involved in calling on these levers would not support a practical outcome in terms of timely delivery of the required asset.<sup>330</sup> As with the default notice provisions, this suggests a general aversion by the State to the use of more punitive levers. This reluctance appears to have subsequently manifested in an over-reliance on the use of directions and requests for information all of which seem to have had little sustained effect. This reluctance also must raise questions over whether the State should be considered a sophisticated commercial operator, or whether contractual templates routinely used in the commercial world are inappropriate for use by government.
- 3.167 It is difficult to determine whether the overarching aversion to deploying the more punitive contractual levers within the PCH contract was warranted. However, it does

<sup>328</sup> Mr Nicholas Egan, A/State Solicitor, State Solicitor’s Office, *Transcript of Evidence*, 18 September 2017, p. 2 (closed evidence).

<sup>329</sup> Mr Michael Barnes, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 9 October 2017, p. 2.

<sup>330</sup> *ibid.*

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seem the combination of levers in the contract, and the manner in which they were used, left the State in a position of commercial impotence. Certainly, the prevailing sentiment conveyed to Taskforce by mid-2016 was that the State had exhausted all its options. This is consistent with the position still held by senior Treasury officials.<sup>331</sup>

3.168 We note the Langoulant Inquiry also expressed concern regarding the efficacy of the levers within the PCH contract and recommended the State Solicitor's Office 'consider additional levers' to encourage the provision of 'contractually compliant construction program[s] on future projects.'<sup>332</sup> We share the Special Inquirer's concerns in this area, but argue that consideration of contractual changes may need to extend further.

### Finding 31

The use of contractual levers by the State was variable and generally ineffectual. There was a seeming reluctance to use some of the levers available. For example, Strategic Projects issued only one formal direction requiring John Holland Pty Ltd to employ more resources on site, despite frequently engaging in discussions with the company about the adequacy of resources deployed during construction.

### Finding 32

The reluctance to use several of the levers within the State's contract with John Holland Pty Ltd calls into question why such levers were written into the contract in the first place. It also seems to suggest that the State took a conservative and reactive approach to contract management.

### Finding 33

PCH Taskforce members appear to have held the general view that the suite of levers within the State's contract with John Holland Pty Ltd were not sufficient to ensure the required level of compliance and performance the State was seeking from the builder.

This must serve as a clarion call to improve the quality and application of commercial levers on future major government contracts in this state.

3.169 Accordingly, we recommend the Minister for Finance engage an expert body, independent of the public sector, to evaluate the efficacy of the commercial levers within the construction contract for PCH and the manner in which they were utilised. The findings and recommendations from this evaluation should be used to ensure future contracts provide greater leverage to the State in its commercial dealings.

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<sup>331</sup> Mr Alistair Jones, Executive Director, Strategic Policy and Evaluation, Department of Treasury, *Transcript of Evidence*, 9 October 2017, p. 11.

<sup>332</sup> Government of Western Australia, *Special Inquiry into Government Programs and Projects: Final Report*, Vol. 2, February 2018, p. 168.



**Recommendation 5**

The Minister for Finance engage an independent expert to evaluate the efficacy of the commercial levers within the construction contract for Perth Children's Hospital and the manner in which they were utilised.

The findings and recommendations from this evaluation should be used to ensure future contracts provide greater leverage and confidence to the State in its commercial dealings.



# Chapter 4

## Assurance

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4.1 Quality construction projects meet legal, aesthetic and functional requirements.<sup>333</sup> Assuring quality is fundamental to any project, but is particularly relevant to the construction of major health infrastructure like PCH. Robust quality assurance systems minimise project delays and are critical to ensuring assets are fit for purpose and safe for end users.

4.2 In this report, quality assurance refers to:

*...all planned and systematic actions necessary to provide adequate confidence that a structure, system or component will perform satisfactorily and conform with project requirements.*<sup>334</sup>

4.3 Quality control is an element of the quality assurance process and includes specific procedures such as 'planning, coordinating, developing, checking, reviewing and scheduling the work.'<sup>335</sup> The term assurance will be used as a catch-all phrase in this report, encompassing both the overarching systems that ensure conformity with project requirements as well as specific quality control (e.g. inspection and testing) procedures.

4.4 With the construction of PCH, the onus of responsibility for assurance lay with the managing contractor, JHPL. Clause 14.3 of the MC Contract stipulates that JHPL must perform the building works:

- a) *in accordance with the requirements of all Governance Agencies and Laws;*
- b) *in accordance with Best Industry Practice;*
- c) *with due expedition and without unreasonable or unnecessary delay; and*
- d) *in a manner safe to workers, the general public and the Environment.*<sup>336</sup>

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<sup>333</sup> Arditi, D & Gunaydin, H, 'Total quality management in the construction process,' *International Journal of Project Management*, vol. 15, no. 4, 1997, p. 235.

<sup>334</sup> *ibid.*, p. 236.

<sup>335</sup> *ibid.*

<sup>336</sup> New Children's Hospital Managing Contractor (MC) Contract for the New Children's Hospital on the Queen Elizabeth II Medical Centre Site, 5 July 2011, clause 14.3 (closed evidence).

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4.5

Building work inconsistent with Australian standards or the contract is the responsibility of JHPL to rectify. While acknowledging JHPL's role in ensuring that materials and products meet required standards, this report focuses on the assurance systems used by state entities to ensure JHPL met its contractual and legal obligations in this area.

**Table 4.1: Overview of state entities responsible for assurance at PCH**

Entity	Summary of responsibilities
<b>Strategic Projects</b>	Strategic Projects is responsible for reviewing the work of JHPL for consistency with the requirements of the MC Contract and relevant Australian standards. <sup>337</sup> Reviewing compliance with Australian standards does not arise from regulatory powers but from the MC Contract.
<b>Building Commissioner</b>	The Building Commissioner is an independent statutory officer who oversees building, painting, building surveying and plumbing services in Western Australia. <sup>338</sup> The <i>Building Services (Complaint Resolution and Administration) Act 2011</i> (WA) enables the Building Commissioner 'to audit the work and conduct of registered building service providers.' <sup>339</sup>
<b>Chief Health Officer</b>	The Chief Health Officer is an independent statutory officer and the State's water regulator. The <i>Health (Miscellaneous Provisions) Act 1911</i> (WA) empowers the Chief Health Officer to close a water supply. <sup>340</sup> The Chief Health Officer advised the PCH Taskforce on strategies that would lead to the safe opening of the hospital after the discovery of elevated lead levels in the potable water supply. <sup>341</sup> The Minister for Health requested the Chief Health Officer review PCH's water system and make recommendations to enable the safe opening of the hospital. <sup>342</sup>
<b>WorkSafe</b>	WorkSafe is Western Australia's occupational health and safety regulator, responsible for administering the <i>Occupational Safety and Health Act 1984</i> (WA).
<b>Comcare</b>	Comcare is the Commonwealth occupational health and safety regulator, responsible for administering the <i>Work Health and Safety Act 2011</i> (Cth).

<sup>337</sup> Submission No. 6 from Department of Finance (Strategic Projects), 28 July 2017, p. 21.

<sup>338</sup> Department of Mines, Industry Regulation and Safety, *About the Building Commission*, 4 June 2014.

<sup>339</sup> *Building Services (Complaint Resolution and Administration) Act 2011* (WA), s 86(i).

<sup>340</sup> Professor Tarun Weeramanthri, Chief Health Officer, Department of Health, *Transcript of Evidence*, 13 September 2017, p. 2.

<sup>341</sup> *ibid.*, pp. 2-3.

<sup>342</sup> Weeramanthri T.S., Walker C.E., Davies A.L., Tan H.S., Theobald R.G & Dodds J.C., *Report on Perth Children's Hospital Potable Water: Chief Health Officer Review*, July 2017, p. 1.

## A project marred by assurance failures

4.6 Numerous issues have beset the PCH project. While the identification and remediation of defects is a normal part of a hospital delivery process, the magnitude of issues at PCH was atypical.<sup>343</sup> The most significant was the lead contamination of the potable water supply. There have also been various other delays relating to the use of non-conforming building products and materials. These issues are briefly summarised in the following paragraphs.

### Lead contamination of the potable water supply

4.7 Lead is a toxic metal that accumulates in the body over time and is particularly harmful to children.<sup>344</sup> In May 2016, Strategic Projects commissioned the testing of water samples for microbial growth and heavy metals following concerns about aspects of the water system commissioning.<sup>345</sup> Testing found that lead levels exceeded the Australian Drinking Water Guidelines (ADWG) maximum allowable concentration of lead in water of 0.01mg/L.

4.8 The issue remains the subject of a commercial dispute between JHPL and the State. JHPL's position is that lead was introduced into the hospital via sediment in a ring of pipework within the QEII medical centre that predated construction.<sup>346</sup> As such, JHPL does not consider itself liable for rectifying the issue. The State considered the lead issue to be JHPL's responsibility. State representatives believed that JHPL's plumbing sub-contractor commissioned the water supply in a substandard manner, resulting in the "dezincification" of brass fittings in the PCH plumbing network.<sup>347</sup> Dezincification can result in lead leaching from brass in contact with water.<sup>348</sup> The Chief Health Officer released a review of the potable water system in August 2017 after the State had granted practical completion to JHPL with the water issue listed as a minor defect. The Chief Health Officer's review found dezincification to be the source of elevated lead levels.<sup>349</sup>

4.9 In response to the Chief Health Officer's recommendations, the State commenced replacing brass componentry in approximately 1,400 thermostatic mixing valve (TMV)

<sup>343</sup> Mr John Hamilton, former Principal Project Director, Strategic Projects & Asset Sales, Letter, 15 November 2017, p. 6; Dr David Russell-Weisz, Director General, Department of Health, *Transcript of Evidence*, Estimates and Financial Operations Committee, 20 October 2017, p. 26.

<sup>344</sup> World Health Organisation, *Lead poisoning and health*, August 2017.

<sup>345</sup> Building Commission, *Final Report: Perth Children's Hospital Audit*, April 2017, p. 21.

<sup>346</sup> Mr Lindsay Albonico, WA Region Manager, John Holland Pty Ltd, *Transcript of Evidence*, 13 October 2017, pp. 1-2.

<sup>347</sup> Dr David Russell-Weisz, Director General, Department of Health, *Transcript of Evidence*, 18 September 2017, p. 2.

<sup>348</sup> Building Commission, *Final Report: Perth Children's Hospital Audit*, April 2017, p. 29.

<sup>349</sup> Weeramanthri T.S., Walker C.E., Davies A.L., Tan H.S., Theobald R.G & Dodds J.C., *Report on Perth Children's Hospital Potable Water: Chief Health Officer Review*, July 2017.

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assembly boxes with plastic components.<sup>350</sup> TMV assembly boxes are located near water outlets and regulate water temperature. The Chief Health Officer found that brass fittings in TMV assembly boxes demonstrated dezincification and that lead levels were higher the more proximal testing was conducted to TMV assembly boxes.<sup>351</sup>

### Asbestos in roof panels

4.10 Unitised roof panels (URP) were installed in the PCH atrium in mid-2014.<sup>352</sup> On 11 July 2016, workers cut into these panels to fit an additional mechanical smoke exhaust system.<sup>353</sup> This work generated significant dust. Workers expressed concern that asbestos may be present given the discovery of asbestos on a Brisbane construction site that day.<sup>354</sup> JHPL provided samples of the URP's to a National Association of Testing Authorities (NATA)-accredited testing laboratory the following day. These tests confirmed the presence of chrysotile (white) asbestos. It has been unlawful in Australia to 'import, store, supply, sell, install, or re-use' asbestos containing materials since 31 December 2003.<sup>355</sup>

4.11 An exclusion zone was put in place, with clearing and decontamination of the site commencing on 13 July 2016 and concluding later that month.<sup>356</sup> The remediation process involved asbestos containing components being removed in-situ and replaced with compliant materials. This process was completed in November 2016.<sup>357</sup>

4.12 The Building Commissioner undertook an audit into the incident and concluded that there were failures in the procurement, manufacturing and contract management processes.<sup>358</sup> The Builder Commissioner also concluded that JHPL should have implemented better dust controls, but found the incident management and the remediation processes were appropriate. The CFMEU disputed this finding and believed that workers were exposed to significant risk.<sup>359</sup> JHPL stated that '[t]he safety

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<sup>350</sup> Department of Health, *Water Update*, 29 November 2017.

<sup>351</sup> Weeramanthri T.S., Walker C.E., Davies A.L., Tan H.S., Theobald R.G & Dodds J.C., *Report on Perth Children's Hospital Potable Water: Chief Health Officer Review*, July 2017, p. 9.

<sup>352</sup> Building Commission, *Interim Report – Perth Children's Hospital Asbestos*, 13 September 2017, p. 4.

<sup>353</sup> *ibid.*

<sup>354</sup> *ibid.*, p. 15.

<sup>355</sup> *ibid.*, p. 8.

<sup>356</sup> *ibid.*, pp. 15, 25.

<sup>357</sup> Building Commission, *Final Report: Perth Children's Hospital Audit*, April 2017, p. 15.

<sup>358</sup> Building Commission, *Interim Report – Perth Children's Hospital Asbestos*, 13 September 2017, p. 31.

<sup>359</sup> Mr Doug Heath, Union Organiser, Construction, Forestry, Mining and Energy Union, WA Branch, *Transcript of Evidence*, 13 September 2017, p. 4.

of the workforce and other people occupying the building was paramount throughout the isolation and remediation period.<sup>360</sup>

### Non-compliant plumbing fittings

4.13 The Chief Health Officer observed plumbing fittings that lacked Australian Standard identifying markings during his review of the PCH potable water system.<sup>361</sup> In September 2017, the Building Commission issued a rectification notice to JHPL's plumbing sub-contractor ordering the removal and replacement of non-compliant components of TMV assembly boxes.<sup>362</sup> The Chief Health Officer also noted that brass fittings instead of the contractually specified stainless steel were installed in floor level distribution mains.<sup>363</sup> The State's assurance processes did not identify the contractual or regulatory non-compliance.

### Non-compliant fire doorsets

4.14 The fire doorsets<sup>364</sup> at PCH have a crucial role in impeding the spread of fire.<sup>365</sup> In late 2015 and early 2016, Strategic Projects and JHPL's independent building certifier identified compliance issues with a significant number installed doorsets.<sup>366</sup> The non-compliant elements included the spacing between door fixings, unacceptable gaps under the doors and the use of plastic hinge packers rather than metal.<sup>367</sup>

4.15 The manufacturer of the fire doorsets went into receivership prior to the order being completed. As such, JHPL sourced the remaining doorsets from an alternative manufacturer. In March 2016, Strategic Projects requested that JHPL provide testing records and certification to demonstrate that the fire doorsets met relevant standards. According to Strategic Projects, JHPL was unable to provide evidence of this certification.<sup>368</sup> JHPL obtained advice from CSIRO on how to achieve compliance and conducted an audit on all PCH doors.<sup>369</sup> Fire doorsets were subsequently remediated and reinstalled in line with CSIRO recommendations. This was a lengthy process with compliance not met until January 2017.<sup>370</sup>

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<sup>360</sup> Mr Lindsay Albonico, WA Region Manager, John Holland Pty Ltd, *Transcript of Evidence*, 13 October 2017, p. 2.

<sup>361</sup> Weeramanthri T.S., Walker C.E., Davies A.L., Tan H.S., Theobald R.G & Dodds J.C., *Report on Perth Children's Hospital Potable Water: Chief Health Officer Review*, July 2017, p. 9.

<sup>362</sup> Submission No. 12A from Department of Health, 19 September 2017.

<sup>363</sup> Weeramanthri T.S., Walker C.E., Davies A.L., Tan H.S., Theobald R.G & Dodds J.C., *Report on Perth Children's Hospital Potable Water: Chief Health Officer Review*, July 2017, p. 24.

<sup>364</sup> A collective term for an installed door and doorframe, inclusive of fixings and hinges.

<sup>365</sup> Building Commission, *Final Report: Perth Children's Hospital Audit*, April 2017, pp. 58-59.

<sup>366</sup> *ibid.*, pp. 59-61.

<sup>367</sup> *ibid.*, p. 60.

<sup>368</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), Letter, 13 October 2017, p. 12.

<sup>369</sup> Building Commission, *Final Report: Perth Children's Hospital Audit*, April 2017, p. 61.

<sup>370</sup> *ibid.*

### These compliance issues represent assurance failures

4.16 Many of these compliance issues were described as extraordinary events. The lead contamination of the potable water system was ‘unprecedented in not only WA, but also Australia.’<sup>371</sup> The discovery of asbestos in unitised roof panels was a ‘once in a generational incident.’<sup>372</sup> The non-compliance of fire doorsets was an event that ‘just does not happen.’<sup>373</sup> These issues are extraordinary but are not unpreventable. Instead, they point to systemic deficiencies in the assurance regime.

### Finding 34

The number of significant non-compliance issues that emerged during the construction of Perth Children’s Hospital point to systemic deficiencies in the various assurance regimes operating in Western Australia.

### A prime example of inadequate assurance processes: the commissioning of the PCH water supply

4.17 The state contends that the elevated levels of lead in the potable water supply arose from deficiencies in the water commissioning process. Specifically, ‘inappropriate and/or inadequate flushing and chlorination of the potable water system during the construction phase of the project.’<sup>374</sup> JHPL has disputed this, commissioning a report that concluded the QEII ring main was the predominant source of lead.<sup>375</sup> We do not have the expertise to determine the adequacy of the water commissioning process nor the source of the lead issue. However, it is clear that the State did not receive, in its view, adequate evidence of a compliant water commissioning process. This is a significant assurance failure.

4.18 JHPL’s plumbing sub-contractor, was responsible for commissioning the PCH water supply.<sup>376</sup> JHPL also engaged a hydraulic engineering designer who was responsible for designing the plumbing system and the administration of the plumbing contract.<sup>377</sup> The Plumbing Code of Australia requires water commissioning to be conducted in

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<sup>371</sup> Dr David Russel-Weisz, Director-General, Department of Health, *Transcript of Evidence*, 18 September 2017, p. 2.

<sup>372</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), *Transcript of Evidence*, 18 September 2017, p. 10.

<sup>373</sup> Mr Bradley Richardson, Director – Head of Project Management, Turner & Townsend Thinc, *Transcript of Evidence*, 9 October 2017, p. 4.

<sup>374</sup> Dr David Russell-Weisz, Director General, Department of Health, *Transcript of Evidence*, 18 September 2017, p. 2

<sup>375</sup> Mr Ian Law, *Perth Children’s Hospital: Review of lead levels in the potable water system*, 5 September 2017, pp. 36-37 (closed evidence). We note that although this report was finalised after the release of the Chief Health Officer’s report, it made no reference to that report’s findings, including the scientific experiments that demonstrated the leaching of lead from brass fittings that have undergone a dezincification process.

<sup>376</sup> Jacobs, *Synopsis of potable water system*, 21 April 2017, p. 3.

<sup>377</sup> *ibid.*



accordance with *AS/NZS 3500.1:2015 Plumbing and drainage – Water services*.<sup>378</sup> The technical brief for the PCH project similarly stipulated compliance with this standard.<sup>379</sup>

4.19 The commissioning of a water supply commonly involves the use of chlorine to disinfect the system.<sup>380</sup> To comply with Australian standards, chlorine should be added to the water distribution system at a specified level for a maximum of six hours.<sup>381</sup> Flushing of the water system immediately follows until the concentration of chlorine reaches acceptable levels. Regular flushing also prevents the build-up of contaminants.<sup>382</sup> The dezincification of brass fittings and the consequential release of lead in a water supply can result from stagnant water or over-chlorination.<sup>383</sup>

4.20 JHPL's plumbing sub-contractor provided documentation to the Building Commission that showed the PCH water system was charged with water in February and March 2015.<sup>384</sup> There were no records of further flushing until January 2016, where the water system was chlorinated then flushed. The Building Commissioner concluded that with minimal water usage during that time, some parts of the system were dormant for nearly a year.<sup>385</sup> The State's consultant hydraulics advisor reached a similar conclusion.<sup>386</sup> A report commissioned by JHPL also noted periods of water dormancy, particularly in late 2015.<sup>387</sup> However, JHPL did not consider the plumbing system to have been dormant during this period.<sup>388</sup>

4.21 We acknowledge that the Australian standards do not specify the need for ongoing flushing during construction. The Building Commissioner informed us that flushing is a requirement prior to hydrostatic testing, but there is no requirement to flush pipes during the construction process.<sup>389</sup> It is however, 'well known' to be a prudent measure.<sup>390</sup> Notwithstanding this potential deficiency in the current standards, the

<sup>378</sup> Building Commission, *Final Report: Perth Children's Hospital Audit*, April 2017, p. 35

<sup>379</sup> Jacobs, *Synopsis of potable water system*, 21 April 2017, p. 1.

<sup>380</sup> Building Commission, *Final Report: Perth Children's Hospital Audit*, April 2017, p. 35.

<sup>381</sup> Weeramanthri T.S., Walker C.E., Davies A.L., Tan H.S., Theobald R.G & Dodds J.C., *Report on Perth Children's Hospital Potable Water: Chief Health Officer Review*, July 2017, p. 15.

<sup>382</sup> Jacobs, *Synopsis of potable water system*, 21 April 2017, p. 44. Alternatively, the water system should be drained and dried out until required after the disinfection, flushing and testing process takes place.

<sup>383</sup> Mr Peter McCafferty, *Internal report: An assessment of lead leaching from brass following orthophosphate treatment*, April 2017, p. 3.

<sup>384</sup> Building Commission, *Final Report: Perth Children's Hospital Audit*, April 2017, p. 35.

<sup>385</sup> *ibid.*

<sup>386</sup> Jacobs, *Synopsis of potable water system*, 21 April 2017, p. 20.

<sup>387</sup> Mr Ian Law, *Perth Children's Hospital: Review of lead levels in the potable water system*, 5 September 2017, p. 37 (closed evidence). The author concluded that stagnant water may have contributed to elevated lead levels but was not a major contributor.

<sup>388</sup> Mr Lindsay Albonico, WA Region Manager, John Holland Pty Ltd, Letter, 3 November 2017, p. 12.

<sup>389</sup> Mr Peter Gow, A/Deputy Director General, Industry Regulation and Consumer Protection, Department of Mines, Industry Regulation and Safety, Letter, 9 October 2017, p. 12.

<sup>390</sup> Building Commission, *Final Report: Perth Children's Hospital Audit*, April 2017, p. 35

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weight of evidence indicates that water was dormant in 2015 and that JHPL's plumbing sub-contractor did not conform to industry best practice.

- 4.22 The State further contends that there was a lack of information and transparency from JHPL on the chlorination process.<sup>391</sup> The Department of Health stated that they unsuccessfully requested information on the chlorination process from JHPL 11 times.<sup>392</sup> The State's consultant hydraulics advisor noted that they were unable to confirm chlorine levels used.<sup>393</sup> The Building Commissioner used more restrained language in his report, stating that he had 'not seen test results or other documentation to demonstrate over-chlorination.'<sup>394</sup> He was more forthright when he appeared before the committee:

*Clearly, there could be better things done around the management and the recording of what was done in that commissioning process.*<sup>395</sup>

and

*...there is a risk that the chlorine was in there for too long, but we have no evidence in terms of documents of when stuff was put in and flushing happened to really confirm that, but it is a pretty good suspicion.*<sup>396</sup>

- 4.23 The Chief Health Officer was similarly forthright in his review of the potable water system. The Chief Health Officer requested chlorination documentation from JHPL via Strategic Projects. Reportedly, JHPL did not respond.<sup>397</sup> The Chief Health Officer observed:

*...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 (how many times, when, for how long, at what dose, what levels achieved etc).*<sup>398</sup>

- 4.24 We asked JHPL to provide all correspondence evidencing compliance with State requests for documentation on the water commissioning process. In addition, we asked

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<sup>391</sup> Hon. Roger Cook, Minister for Health, *Transcript of Evidence*, Legislative Assembly Estimates Committee B, 19 September 2017, p. 3.

<sup>392</sup> Dr David Russel-Weisz, Director General, Department of Health, *Transcript of Evidence*, 18 September 2017, p. 1 (closed evidence).

<sup>393</sup> Jacobs, *Synopsis of potable water system*, 21 April 2017, p. 8.

<sup>394</sup> Building Commission, *Final Report: Perth Children's Hospital Audit*, April 2017, p. 38.

<sup>395</sup> Mr Peter Gow, Building Commissioner, Department of Mines, Industry Regulation and Safety, *Transcript of Evidence*, 6 September 2017, p. 18.

<sup>396</sup> *ibid.*, p. 19.

<sup>397</sup> Weeramanthri T.S., Walker C.E., Davies A.L., Tan H.S., Theobald R.G & Dodds J.C., *Report on Perth Children's Hospital Potable Water: Chief Health Officer Review*, July 2017, pp. 19-20.

<sup>398</sup> *ibid.*, p. 21.

JHPL to draw our attention to documentation that addressed the Chief Health Officer's comments on the lack of clarity of the water commissioning process. JHPL provided us with six State directions dated between 2 February 2017 and 18 July 2017. JHPL responded on three occasions to these six directions. The State directions requested the provision of certain records from JHPL. According to clause 34.2 of the MC Contract, JHPL must provide records to the State, and any persons or agencies authorised by the State, for any reason, at any time.<sup>399</sup> Clause 8.2 of the MC Contract also stipulates that JHPL must promptly comply with all State directions.<sup>400</sup>

4.25 JHPL did not provide any evidence indicating that they responded to the State directions dated 7 and 18 of July 2017. Critically, these dates correspond to the period of the Chief Health Officer's review of the potable water system. The State direction dated 7 July 2017 requested information on the chlorine dosage and flushing process, noting inconsistencies in previously provided documentation on chlorine dosage.<sup>401</sup> It also contended that previously provided documentation indicated the retention of chlorine in the water system for 24 hours rather than the 6 hours specified in the Australian standards. The State direction dated 18 July 2017 requested various records on the water commissioning process that the State believed to be in JHPL's possession, by virtue of JHPL personnel referring to them in prior correspondence.<sup>402</sup>

4.26 JHPL contended that it provided all requested information on the commissioning of the water supply:

*We have provided all the things that we have been required to provide with respect to your question, including the chlorination events, including when we introduced chlorine to the potable water system, and how we did that. That information we provided to the State and to the Building Commission.*<sup>403</sup>

4.27 We are not in a position to determine whether the information provided by JHPL satisfactorily documented the water commissioning process. However, it is clear that the State, the Building Commissioner and the Chief Health Officer did not consider it satisfactory.

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<sup>399</sup> New Children's Hospital Managing Contractor (MC) Contract for the New Children's Hospital on the Queen Elizabeth II Medical Centre Site, 5 July 2011, clause 34.2 (closed evidence).

<sup>400</sup> *ibid.*, clause 8.2.

<sup>401</sup> Mr John Hamilton, former Principal Project Director, Strategic Projects & Asset Sales, Email to JHPL, 7 July 2017 (closed evidence).

<sup>402</sup> Mr John Hamilton, former Principal Project Director, Strategic Projects & Asset Sales, Email to JHPL, 18 July 2017 (closed evidence).

<sup>403</sup> Mr Lindsay Albonico, WA Region Manager, John Holland Pty Ltd, *Transcript of Evidence*, 13 October 2017, p. 8.

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4.28 Regardless of JHPL's internal assurance processes, the lack of accountability of the water commissioning process highlights failings in the State's assurance system. It is unacceptable that the State is unable to determine how a critical task such as the commissioning of a water supply was undertaken. In his review of the potable water system, the Chief Health Officer stated this represented 'a sustained failure of proper assurance processes.'<sup>404</sup> He also recommended that the State have a fit for purpose governance and management framework going forward.<sup>405</sup> We asked the Chief Health Officer to comment on the aspects of the governance and management framework that were problematic during construction. The Chief Health Officer replied:

*[My] investigating officers were not able to obtain, review and analyse information about critical processes and procedures that were conducted during the construction phase (in particular, with respect to chlorination events). This points to a failure of the governance and management framework to ensure appropriate quality control, technical documentation, and accountability at the interface between the various government and contracting agencies.'*<sup>406</sup>

4.29 Put simply, the State either did not, or was not in a position to, vigorously pursue all the necessary documentation to provide an appropriate level of assurance.

4.30 We acknowledge that the State identified problems with the flushing program in 2016, with the initial testing for lead in May 2016 arising out of concerns that microbial growth may be occurring.<sup>407</sup> Unfortunately, the flushing program remained inadequate until November 2016.<sup>408</sup> The State also appears not to have examined the chlorination process strenuously or urgently following the discovery of lead, 'despite its clear link to dezincification.'<sup>409</sup> The State only began issuing directions requesting further information in February 2017, over a year after the January 2016 chlorination event and nine months after lead was first detected. Issues that could have been better understood and potentially mitigated if identified early instead escalated into significant problems. We concur with the Chief Health Officer, who noted:

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<sup>404</sup> Weeramanthri T.S., Walker C.E., Davies A.L., Tan H.S., Theobald R.G & Dodds J.C., Report on Perth Children's Hospital Potable Water: Chief Health Officer Review, July 2017, p. 20.

<sup>405</sup> *ibid.*, p. 1.

<sup>406</sup> Professor Tarun Weeramanthri, Chief Health Officer, Department of Health, Letter, 16 October 2017, p. 2.

<sup>407</sup> Building Commission, Final Report: Perth Children's Hospital Audit, April 2017, p. 21

<sup>408</sup> Jacobs, Synopsis of potable water system, 21 April 2017, p. 44.

<sup>409</sup> Weeramanthri T.S., Walker C.E., Davies A.L., Tan H.S., Theobald R.G & Dodds J.C., Report on Perth Children's Hospital Potable Water: Chief Health Officer Review, July 2017, p. 22.

*...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.<sup>410</sup>*

4.31 Commissioning a water supply requires robust assurance processes to ensure the safe, clean water expected in Australia. It is the responsibility of JHPL to demonstrate compliance with Australian standards, the design brief and the contract. It is the responsibility of the State to ensure JHPL has complied with their legal and contractual responsibilities. There have been failures from both parties in this regard. The weight of evidence indicates that the water commissioning at PCH was poorly overseen and documented. Future infrastructure projects must have adequate controls in place to ensure transparency and accountability of the water commissioning process.

### Finding 35

It is unacceptable that the State's quality assurance and quality control processes left it unable to determine how a critical task such as the commissioning of the Perth Children's Hospital water supply was undertaken.

### Recommendation 6

The Minister for Finance ensure that Strategic Projects and, where applicable, Building Management and Works, implement more robust assurance measures for the commissioning of water supplies on future projects.

## Improving the State's assurance of products, materials and workmanship

4.32 The State's assurance regime for PCH comprised two streams—physical inspection and the review of certification. For both streams Strategic Projects was supported by Turner & Townsend Thinc (TTT, formerly Thinc), a professional services firm.<sup>411</sup> TTT was appointed in March 2011 as the State's Advisor, a role which entailed the provision of technical support services consultancy. In practice, this meant that if Strategic Projects wanted technical advice on a specific matter they would call on the State's Advisor, who in turn would generally subcontract out the provision of advice to relevant experts.<sup>412</sup>

4.33 The physical inspection process had three components. The first component was the sample submission process. JHPL was required to provide samples of 'all key materials

<sup>410</sup> Weeramanthri T.S., Walker C.E., Davies A.L., Tan H.S., Theobald R.G & Dodds J.C., *Report on Perth Children's Hospital Potable Water: Chief Health Officer Review*, July 2017, p. 22.

<sup>411</sup> Submission No. 6 from Department of Finance (Strategic Projects), 28 July 2017, p. 21.

<sup>412</sup> Mr Bradley Richardson, Director, Technical Advisory Team PCH, Turner & Townsend Thinc, *Transcript of Evidence*, 9 October 2017, p. 3.

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and fittings' to the State for their review and comment.<sup>413</sup> Subcontractors engaged by the State's Advisor reviewed these samples to ensure they met required standards and were fit for purpose. Samples that passed these checks were certified for compliance by the State's Advisor and were able to be installed.<sup>414</sup>

4.34 The second component of the physical inspection stream was the construction quality assessment process. Strategic Projects' Principal Project Director led a team of approximately 35 to 40 staff based at the PCH site who inspected the compliance of works and identified defects:<sup>415</sup>

*We had almost old-fashioned clerks of work engaged on my team so were not just paper-based; we actually had boots on the ground out there doing old-fashioned, quality control inspections rather than purely relying upon a documented quality assurance system.*<sup>416</sup>

4.35 Consultants were also engaged to review construction quality when specialist advice was required. This was primarily through the contract with the State's Advisor.<sup>417</sup>

4.36 A testing and commissioning process was the third component of the physical inspection stream. The MC Contract stipulated certain tests that required 'witnessing' by State representatives.<sup>418</sup> This could include the correct functioning of ICT systems or fridge alarms. Rooms and areas were also 'defected' by the State, including Health personnel, to ensure they met operational requirements and were defect-free.<sup>419</sup>

4.37 The final element of the assurance regime was the State's review of certifications provided by JHPL's accountable representatives, including a building surveyor who was responsible for inspecting compliance with the Building Code of Australia,<sup>420</sup> and a design and specification consultant to oversee specialist areas such as acoustics, hydraulics and ICT.<sup>421</sup> Certification provided by JHPL's representatives on the completion and adequacy of works was reviewed and recorded by the State's Adviser.

### Mixed views on the State's assurance regime

4.38 Overall, we heard that Strategic Projects had a robust quality assurance regime. Many stakeholders considered Strategic Projects' assurance regime to be rigorous and

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<sup>413</sup> Submission No. 6 from Department of Finance (Strategic Projects), 28 July 2017, p. 21.

<sup>414</sup> *ibid.*

<sup>415</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), *Transcript of Evidence*, 18 September 2017, p. 8.

<sup>416</sup> Mr John Hamilton, former Principal Project Director, Strategic Projects & Asset Sales, *Transcript of Evidence*, 18 October 2017, p. 3 (closed evidence).

<sup>417</sup> Submission No. 6 from Department of Finance (Strategic Projects), 28 July 2017, p. 22.

<sup>418</sup> *ibid.*

<sup>419</sup> *ibid.*

<sup>420</sup> *ibid.*

<sup>421</sup> Norman Disney & Young, New Children's Hospital, 29 April 2017.

effective. Strategic Projects had a large on-site presence that identified thousands of defects during the construction of the PCH. Indeed, by the time of practical completion, over 45,000 defects had been identified.<sup>422</sup>

4.39 A representative from State's Advisor offered a positive assessment of the Strategic Projects team:

*I think they have been exceptionally thorough and exceptionally diligent, probably to the frustration of JHPL... they were on them very proactively, engaging with them all the way through.*<sup>423</sup>

4.40 Similarly, the State's architectural advisor believed that PCH would have been in a far worse position if it were not for Strategic Projects' compliance and quality review processes.<sup>424</sup> The Building Commissioner considered Strategic Projects staff to be highly experienced and knowledgeable<sup>425</sup> and concluded that 'PCH was subject to stringent quality assurance and checking processes.'<sup>426</sup> While Strategic Projects did not successfully identify some defects,<sup>427</sup> we acknowledge that the weight of evidence indicates that Strategic Projects rigorously inspected the workmanship of the builder.

4.41 There were, however, mixed views on the tracking of defects, an issue covered in some detail in Chapter Three. Strategic Projects and JHPL used sophisticated software known as BIM-360 to notify each other when defects were identified and to record progress in defect remediation.<sup>428</sup> This included photographic evidence. The Building Commissioner stated that he was 'satisfied with the quality assurance and quality checking process (BIM-360) that is in place.'<sup>429</sup> However, the IPMO manager suggested that 'no single source of truth to prioritise defects for the hospital opening had been organised until October 2017.'<sup>430</sup> Strategic Projects and JHPL's separate BIM software did not consistently reflect agreed commissioning priorities. This was separate to an

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<sup>422</sup> PCH Integrated Program Weekly Update: PCH Construction Program, 11 April 2017, p. 13 (closed evidence). The IPMO Report states that as at 7 April 2017, 45,527 defects were listed on JHPL's version of the BIM-360 software. Most of these defects (43,372) were resolved.

<sup>423</sup> Mr Bradley Richardson, Director, Technical Advisory Team PCH, Turner & Townsend Thinc, *Transcript of Evidence*, 9 October 2017, p. 2 (closed evidence).

<sup>424</sup> Submission No. 8 from Cameron Chisholm Nicol (WA), 28 July 2017, p. 2.

<sup>425</sup> Mr Peter Gow, Building Commissioner, Department of Mines, Industry Regulation and Safety, *Transcript of Evidence*, 6 September 2017, p. 21.

<sup>426</sup> Building Commission, *Supplementary Report: Perth Children's Hospital audit – firewalls*, 23 October 2017, p. 1.

<sup>427</sup> The Building Commissioner's supplementary report on fire walls reported a number of minor issues that the State's assurance system did not identify. Other issues missed included the non-compliant plumbing components and the asbestos in unitised roof panels.

<sup>428</sup> Building Commission, *Supplementary Report: Perth Children's Hospital audit – firewalls*, 23 October 2017, p. 1.

<sup>429</sup> *ibid.*, p. 3.

<sup>430</sup> Mrs Tanya West, Director of IPMO Services to PCH, PricewaterhouseCoopers, *Transcript of Evidence*, 18 October 2017, p. 6 (closed evidence).

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offline spreadsheet maintained by the commissioning project team recording the list of defects and design change requests considered critical to the opening of PCH. The IPMO manager stated that the information recorded on the three sources of data in relation to status and critical priority of defects was inconsistent.<sup>431</sup>

4.42 JHPL also made comment regarding inadequacies in the defect tracking process, stating that it was not uncommon for BIM-360 to contain:

- i. *multiple entries for the same alleged defect (entered by different users);*
- ii. *entries for damage caused by the State's access (i.e. State staff and subcontractors);*
- iii. *entries for work that JHPL had not yet presented to the State as complete (e.g. work that was not defective otherwise than being incomplete) or operational (e.g. defects for power points not working in areas that had not yet been activated); and*
- iv. *entries for damage or alleged defects for which JHPL was otherwise not responsible for.*<sup>432</sup>

4.43 After its engagement in September 2015, the IPMO became responsible for updating Taskforce on delays to the construction program that may affect commissioning activities. The lack of a single, accurate register of defects appears to have undermined the IPMOs ability to perform this function effectively during its initial period of operation.

4.44 Notwithstanding the number of defects identified by Strategic Projects' (and JHPL's) assurance regime, the failure to identify certain key defects in a more timely manner contributed to significant project delays and health risks (e.g. asbestos).

4.45 We have examined how some of these failures arose and have identified some project-specific issues, along with some that are systemic. In the following section, we describe some of these shortcomings and put forward ways to mitigate them in future.

### **Measures to address non-conforming building products were inadequate**

4.46 The key assurance failures largely related to the use of non-conforming building products (NCBP), which are:

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<sup>431</sup> Ms Tricia Tebbutt, Partner, PricewaterhouseCoopers, Email, 20 November 2017 (closed evidence).

<sup>432</sup> Mr Lindsay Albonico, WA Region Manager, John Holland Pty Ltd, Letter, 3 November 2017, p. 8.



*...products that claim to be something they are not, do not meet required standards for their intended use, or are marketed or supplied with the intent to deceive those who use them.*<sup>433</sup>

4.47 Examples of NCBP at the PCH include the unitised roof panels, TMV assembly boxes and fire doorsets. Strategic Projects could have mitigated key risks and delays through increased testing and/or inspection of products and materials prior to installation. More significant though, is the need to strengthen the regulatory framework at a state and national level to reduce the incidence of NCBPs.

4.48 A consistent theme that arose during the inquiry was the complexity of the supply chains through which NCBPs are procured. The State and JHPL had limited visibility over these complex supply chains and demonstrated an over-reliance on documentation to provide assurance. The following examples are illustrative.

### **Roof panels containing asbestos**

4.49 JHPL sourced unitised roof panels containing asbestos through multiple levels of subcontracting in an international supply chain. A comprehensive tendering process resulted in Yuanda Australia being awarded the contract to supply façade panels, including the unitised roof panels.<sup>434</sup> Yuanda Australia's parent company, Yuanda China, engaged an agent to source the fibre cement sheet component of the panels.<sup>435</sup> Fibre cement sheets were supposed to be sourced from one supplier but instead the agent allegedly sourced panels from an alternative supplier.<sup>436</sup> The materials from the alternative supplier not only contained asbestos but used plasterboard rather than fibre cement sheets.

4.50 This situation arose despite concerted efforts from JHPL. The specifications that JHPL provided to Yuanda Australia clearly stipulated the use of non-asbestos containing materials.<sup>437</sup> Representatives from JHPL and the State visited the Yuanda factory in China on 16 occasions to examine the product manufacturing and quality management process.<sup>438</sup> Certification provided to JHPL specified the material was 'non-asbestos.'<sup>439</sup> However, JHPL was unaware that this reflected the mechanical properties of the

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<sup>433</sup> Senior Officers' Group, *Implementation plan: Strategies to address risks related to non-conforming building products*, September 2017, p. 2.

<sup>434</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance) Letter, 13 October 2017.

<sup>435</sup> Building Commission, *Interim Report – Perth Children's Hospital Asbestos*, 13 September 2017, p. 21.

<sup>436</sup> Building Commission, *Final Report: Perth Children's Hospital Audit*, April 2017, p. 22.

<sup>437</sup> *ibid.*, p. 21.

<sup>438</sup> Mr Lindsay Albonico, WA Region Manager, John Holland Pty Ltd, Letter, 3 November 2017, p. 5. Mr Albonico was unable to ascertain how many of the trips were specifically to inspect the unitised roof panels versus other PCH components manufactured by Yuanda.

<sup>439</sup> Building Commission, *Interim Report – Perth Children's Hospital Asbestos*, 13 September 2017, p. 27.

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material rather than the absence of asbestos and as such, no specific testing for asbestos was undertaken.<sup>440</sup> The Building Commissioner concluded that awareness of the risks associated with inadvertently procuring asbestos containing products was low throughout the supply chain.<sup>441</sup>

### Fire doorsets

4.51 JHPL initially procured the fire doorsets from a UK-based company who manufactured the projects in another country.<sup>442</sup> Representatives from the UK company also provided installation advice to contractors at PCH.<sup>443</sup> Once again, comprehensive product specifications were provided, and the documentation suggested compliance. Ultimately, however, the installed product was non-conforming. JHPL confirmed that:

*The drawing and the certification that were supplied ahead of the delivery of the product demonstrated a compliance. What was actually delivered was different to the drawing.*<sup>444</sup>

4.52 PCH Taskforce minutes also noted that the doors were installed according to Welsh installation instructions rather than the method approved for compliance with Australian standards.<sup>445</sup>

### TMV assembly boxes

4.53 JHPL's plumbing sub-contractor procured the TMV assembly boxes from an organisation in Melbourne who had procured the constituent components from other suppliers.<sup>446</sup> The assembly as a whole had appropriate documentation indicating compliance with relevant standards and Strategic Projects did not identify any non-conformance. The Building Commission also found no evidence of non-conformance in documentation for the 20-25 TMV assembly boxes it inspected during construction.<sup>447</sup> Ultimately, the Chief Health Officer identified the non-conformance after more forensic examination of the boxes during his July 2017 review into the potable water system.<sup>448</sup>

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<sup>440</sup> Building Commission, *Interim Report – Perth Children's Hospital Asbestos*, 13 September 2017, p. 27.

<sup>441</sup> *ibid.*, p. 31.

<sup>442</sup> Mr Lindsay Albonico, WA Region Manager, John Holland Pty Ltd, *Transcript of Evidence*, 13 October 2017, p. 21.

<sup>443</sup> Submission No. 17 from L&M Painting and Construction, 16 October 2017, p. 2.

<sup>444</sup> Mr Lindsay Albonico, WA Region Manager, John Holland Pty Ltd, *Transcript of Evidence*, 13 October 2017, p. 21.

<sup>445</sup> PCH Taskforce, Minutes of Meeting, 15 March 2016, p. 6 (closed evidence).

<sup>446</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), *Transcript of Evidence*, 18 September 2017, p. 8.

<sup>447</sup> Mr Peter Gow, A/Deputy Director General, Industry Regulation and Consumer Protection, Department of Mines, Industry Regulation and Safety, Letter, 9 October 2017, p. 11.

<sup>448</sup> Weeramanthri T.S., Walker C.E., Davies A.L., Tan H.S., Theobald R.G & Dodds J.C., *Report on Perth Children's Hospital Potable Water: Chief Health Officer Review*, July 2017, p. 18.

### Stakeholders acknowledge problems associated with supply chain complexities

4.54 The fact that the asbestos and the non-conforming TMV assembly box components were identified largely through chance rather than formal assurance processes reflects the difficulties in identifying NCBPs. It is particularly concerning that the regulatory body responsible for enforcing compliance with Australian standards (i.e. the Building Commission) was unable to identify the non-conformance of the TMV assembly box components. In all of these cases, procurement occurred through multiple layers of subcontracting in an international supply chain and there was a reliance on documentation to provide assurance. Speaking in the context of asbestos, JHPL's representative noted that this was standard industry practice:

*That process has sort of evolved over the last 50 years as an industry... third party accreditation, or third party certification as something that contractors and others could rely upon as being compliant. We relied on that process, and that process failed us.*<sup>449</sup>

4.55 The State advisors also acknowledged this issue. According to TTT, multiple layers of outsourcing and a reliance on documentation result in the State having limited visibility and assurance over the products and materials used in projects:

*...it is the unknown behind the multiple layers of outsourcing and beyond that where I think there is a real lesson learned here for maybe all of us. We do not appear to always, as a state, on our major building and infrastructure projects, have visibility or complete assurance about the entire supply chain that is used to procure a service or a piece of infrastructure.*<sup>450</sup>

4.56 Overall, both the State and JHPL demonstrated an over-reliance on documentation certification from other entities. This did not adequately mitigate the risks associated with procuring products and materials through multiple layers of subcontracting in complex international supply chains.

### Finding 36

Building materials for Perth Children's Hospital were often sourced through multiple layers of sub-contracting with complex, international supply chains. This, coupled with an over-reliance on third-party certification, increased the risk of non-conforming products being installed.

<sup>449</sup> Mr Lindsay Albonico, WA Region Manager, John Holland Pty Ltd, *Transcript of Evidence*, 13 October 2017, p. 17.

<sup>450</sup> Mr Cade Dawkins, Regional Manager (WA), Turner & Townsend Thinc, *Transcript of Evidence*, 9 October 2017, p. 4.

**Finding 37**

Under current processes, the State and industry do not always have adequate visibility or complete assurance over supply chains on major building and infrastructure projects.

**Pre-installation testing or inspection of products was not routinely conducted**

4.57 Neither JHPL, nor any entity representing the State, conducted any destructive testing of the unitised roof panels that were subsequently found to contain asbestos. JHPL relied on the certification it was provided, with destructive testing not part of their assurance regime:

*...they essentially come out as a metal box that is sealed, and they are then set into a sub-frame. In terms of our ability to destruction test, we would have to destroy one of those roof panels and move to a representative testing resume, or some other regime, other than what we did. In respect to that, again, the industry relies upon the integrity of the third party certification.*<sup>451</sup>

4.58 The State in turn relied on the information provided by JHPL. JHPL has since reviewed its procurement policy and introduced additional safeguards in an effort to prevent a reoccurrence of this issue.<sup>452</sup>

4.59 Similarly, the fire doorsets were not subject to pre-installation testing or inspection by the State or JHPL. JHPL's independent building certifier identified the non-compliance. Strategic Projects noted concerns with installed doors and doorframes as early as October 2015.<sup>453</sup> However, it was not until March 2016 that Strategic Projects issued a notice to JHPL requesting certification and testing results for the fire door systems.<sup>454</sup> As a result, non-compliant installation of fire doorsets continued for some time, and a significant number were installed before action was taken relating to the installation method and remediation of door and doorframe components. The exact number is unclear. JHPL's representative stated that it was more than 100 doorframes,<sup>455</sup> while

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<sup>451</sup> Mr Lindsay Albonico, WA Region Manager, John Holland Pty Ltd, *Transcript of Evidence*, 13 October 2017, p. 17.

<sup>452</sup> *ibid.*, p. 2.

<sup>453</sup> Building Commission, *Final Report: Perth Children's Hospital Audit*, April 2017, p. 61. Strategic Projects informed us that they became aware of issues with the compliance of installed fire doors in January 2016. Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), Letter, 13 October 2017, p. 12.

<sup>454</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), Letter, 13 October 2017, p. 12.

<sup>455</sup> Mr Lindsay Albonico, WA Region Manager, John Holland Pty Ltd, *Transcript of Evidence*, 13 October 2017, p. 21.

the Health Minister at the time advised that 935 doorframes needed to be removed and replaced.<sup>456</sup>

4.60 These incidents highlight the importance of pre-installation testing and inspection of products and materials in minimising risks and delays. The State had the power to conduct such testing. Clause 18 of the contract states that the State can inspect the works 'at any time' and direct further testing of any materials or products prior to Final Completion.<sup>457</sup> The State appears to have exercised this power sparingly. While Strategic Projects advised that clause 18 provided the basis for its daily on site presence, it confirmed that the Principal Project Director formally directed JHPL to undertake additional testing of parts or materials on four occasions. Three of these related to water quality testing in various areas.<sup>458</sup> Nor does the State appear to have adopted its sample submission process (see 4.33 above) as standard practice.<sup>459</sup>

4.61 The State's advisor stated that pre-installation testing was now recognised as required when products arrive onshore, but it was not commonly conducted on state government projects. Speaking in the context of the asbestos containing unitised roof panels, a representative of the State's Advisor observed:

*From my perspective, the only way in that situation that asbestos would be detected is if we, as a state, invested in in-country quality assurance and quality control people on the ground physical providing oversight into the manufacturing of those products.*<sup>460</sup>

4.62 His colleague added that:

*...we as a company recommend that to our clients now, particularly around asbestos sheeting. Regardless of what is provided, regardless of what certificate it is written on or what watermark is on the product.*<sup>461</sup>

4.63 Interestingly, Strategic Projects' Principal Project Director, who was the State's representative on the contract with JHPL, did not believe an enhanced pre-installation

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<sup>456</sup> No author, *More than 900 fire door frames to be replaced at Perth Children's Hospital*, ABC News (Online), 8 April 2016.

<sup>457</sup> New Children's Hospital Managing Contractor (MC) Contract for the New Children's Hospital on the Queen Elizabeth II Medical Centre Site, 5 July 2011, clause 18 (closed evidence).

<sup>458</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), Letter, 8 December 2017, pp. 3-4.

<sup>459</sup> For example, Strategic Projects has confirmed that the fire doorsets were not subject to the sample submission process. Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), Letter, 8 December 2017, p. 4.

<sup>460</sup> Mr Cade Dawkins, Regional Manager (WA), Turner & Townsend Thinc, *Transcript of Evidence*, 9 October 2017, p. 5.

<sup>461</sup> Mr Bradley Richardson, Director, Technical Advisory Team PCH, Turner & Townsend Thinc, *Transcript of Evidence*, 9 October 2017, p. 2 (closed evidence).

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testing regime would lead to a more efficient identification of these defects.<sup>462</sup> He believed that the State's assurance process, where assurance was documentation-based prior to installation, was an acceptable process:

*The materials procured on the PCH project were sourced with certification of compliance with respective standards, this certification together with inspection and testing on installation would normally be seen as sufficient due diligence.*<sup>463</sup>

4.64 We disagree with this view. Based on what we have observed, more proactive inspection and testing measures are essential until such a time that certification becomes a reliable form of assurance. The identification of NCBPs is more difficult when a product is already installed and rectifying issues in situ increases the possibility of risks and delays. While it would be impractical to inspect every product prior to installation, a risk-based, random pre-installation testing/inspection process would promote greater vigilance from the builder back through the supply chain and would constitute better due diligence.

4.65 We note that the Australian Senate Economics References Committee held a similar view in their report on preventing asbestos importation.<sup>464</sup> We believe that proactive risk-based testing and inspection of products is important, not only to prevent asbestos, but to ensure all products and materials on state government infrastructure projects meet Australian standards and contract requirements.

### Finding 38

There were mixed views as to the effectiveness of the State's assurance regime on the PCH project. While Strategic Projects' assurance regime identified a significant number of defects, the failure to identify certain key defects in a more timely manner was problematic for the project.

### Finding 39

More proactive pre-installation inspection and testing measures are essential until such time that certification becomes a reliable form of assurance.

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<sup>462</sup> Mr John Hamilton, former Principal Project Director, Strategic Projects & Asset Sales, Letter, 15 November 2017, p. 5.

<sup>463</sup> *ibid.*, (emphasis added).

<sup>464</sup> Economics References Committee, *Interim report: protecting Australians from the threat of asbestos*, 22 November 2017, pp. 50-55. The Committee recommended that the Australian Government require an importer to conduct NATA accredited (or equivalent) testing of imported goods at a high risk of containing asbestos. The Committee also recommended mandatory requirements for procurers of high-risk products to have a due diligence system in place.

## Recommendation 7

The Minister for Finance ensure that Strategic Projects and, where applicable, Building Management and Works, conduct risk-based pre-installation testing and inspection of materials on future projects.

### Regulatory reforms required to address non-conforming building products

4.66 More proactive inspection and testing processes may assist in identifying NCBPs, but it is by no means the complete solution. Interventions to address NCBPs are most effective when targeted early in the supply chain.<sup>465</sup> It is beyond the remit and resourcing of Strategic Projects or the Building Commissioner to investigate and enforce issues earlier in the supply chain. Fortunately, there is increasing awareness across the country of the detrimental consequences of NCBPs. This has prompted collaboration between state and commonwealth bodies to strengthen the regulatory framework.

4.67 The Building Ministers' Forum (BMF), comprising commonwealth, state and territory ministers responsible for building and plumbing, found that:

- *The extent of building product non-conformity in Australia is largely unknown.*
- *The current building regulatory system does not provide an effective overarching framework for identifying and addressing non-conforming building products.*
- *The current building regulatory framework disproportionately focuses on the end of the supply chain.*<sup>466</sup>

4.68 The BMF agreed to a number of actions to address the risks posed by NCBPs at a meeting on 31 July 2015.<sup>467</sup> This included the establishment of a Senior Officers' Group (SOG) to investigate strategies and provide recommendations to address NCBPs. The SOG includes relevant senior officers from across the country, including the Western Australian Building Commissioner.

4.69 The SOG made eight recommendations to address the lack of knowledge on the extent of NCBPs in Australia and the lack of powers in the building regulatory system to address them. The BMF endorsed these recommendations in February 2016 and the

<sup>465</sup> Senior Officers' Group, Strategies to address risks related to non-conforming building products, 19 February 2016, p. 6.

<sup>466</sup> *Building and Construction Legislation (Nonconforming Building Products – Chain of Responsibility and Other Matters) Amendment Bill 2017 (QLD) – Explanatory Notes*, p. 11.

<sup>467</sup> Senior Officers' Group, Strategies to address risks related to non-conforming building products, 19 February 2016, p. 2.

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SOG published an implementation plan in April 2017.<sup>468</sup> There has been considerable progress to date in actioning these recommendations, including:

- Establishing the Building Regulator’s Forum to enhance information sharing and to escalate issues to relevant Commonwealth entities or the BMF as required.<sup>469</sup>
- Launching a national NCBP website that provides information on NCBPs and allows users to report suspected NCBPs.<sup>470</sup>
- Piloting and reviewing improved data sharing arrangements between the Department of Immigration and Border Protection and state and territory building regulators regarding certain building products.<sup>471</sup>
- Appointing an independent research team to ‘clearly determine the scale, nature and prevalence of problems, causative issues and factors relating to NCBPs.’<sup>472</sup>

4.70 Another key action took place at a jurisdictional level when the Queensland Parliament passed the *Building and Construction Legislation (Non-conforming Building Products – Chain of Responsibility and Other Matters) Amendment Bill 2017* in August 2017.<sup>473</sup>

4.71 Queensland’s new building regulation legislation is of particular relevance to Western Australia. The amended act extends the Queensland building regulator’s powers to investigate building product matters and permits the building regulator to enter the premises of businesses in the building products supply chain.<sup>474</sup> It also contains additional duty of care requirements for all participants in the building products supply chain, with new offences and penalties relating to NCBPs.<sup>475</sup> The explanatory note to the amendment bill described these new powers as permitting the Queensland building regulator to:

*...effectively address a point of failure in the entire building product supply chain and pursue a broader range of offenders, rather than being limited to those at the end of the building product supply chain.*<sup>476</sup>

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<sup>468</sup> Senior Officers’ Group, *Implementation Plan: Strategies to address risks related to non-conforming building products*, September 2017, p. 2.

<sup>469</sup> *ibid.*, p. 4.

<sup>470</sup> *ibid.*, p. 6.

<sup>471</sup> *ibid.*, p. 8.

<sup>472</sup> *ibid.*, p. 9.

<sup>473</sup> *ibid.*, p. 4.

<sup>474</sup> *Building and Construction Legislation (Nonconforming Building Products – Chain of Responsibility and Other Matters) Amendment Bill 2017 (QLD) – Explanatory Notes*, p. 6.

<sup>475</sup> *ibid.*, p. 16.

<sup>476</sup> *ibid.*, p. 17.



4.72 The Senior Officers' Group considered the amended legislation to reflect a 'best-practice' approach that can be adapted as necessary to other jurisdictions.<sup>477</sup> It was expected to lead to:

*...higher building product standards, greater attention in the construction industry, more effective regulatory enforcement and ultimately safer buildings.*<sup>478</sup>

4.73 The explanatory note stated that there was in-principle support from other BMF members to review their building regulatory frameworks.<sup>479</sup> We encourage the Western Australian Government to review the Queensland legislation and adapt it to Western Australia. The PCH project demonstrated the risks, costs and delays that arise from NCBPs and the ineffectiveness of current measures to prevent them. We note that the Australian Senate Economics References Committee similarly recommended other states pass similar legislation.<sup>480</sup>

#### Finding 40

The Australian Building Ministers Forum has agreed on the need for jurisdictions to strengthen the regulatory framework to address the incidence, and impact, of non-conforming building products. So far, Queensland appears to be one of the leading jurisdictions addressing this issue.

#### Recommendation 8

The Minister for Commerce and Industrial Relations review Queensland's *Building and Construction Legislation (Nonconforming Building Products – Chain of Responsibility and Other Matters) Amendment Bill 2017* and determine its appropriateness for Western Australia's regulatory framework.

#### Plumbing product regulations also appear to be flawed

4.74 A number of issues emerged at PCH specific to plumbing products, including the elevated lead levels in the potable water system, corrosion in stainless steel pipes and non-conforming plumbing components. Plumbing industry stakeholders considered these issues to reflect specific deficiencies in plumbing product regulation, namely the Australia-wide WaterMark certification system.

<sup>477</sup> Senior Officers' Group, *Implementation Plan: Strategies to address risks related to non-conforming building products*, September 2017, p. 4.

<sup>478</sup> *Building and Construction Legislation (Nonconforming Building Products – Chain of Responsibility and Other Matters) Amendment Bill 2017* (QLD) – Explanatory Notes, p. 4.

<sup>479</sup> *ibid.*

<sup>480</sup> Economics References Committee, *Interim report: protecting Australians from the threat of asbestos*, November 2017, pp. 50-55.

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4.75 In Australia, water supply pipes and plumbing fittings must be WaterMark certified. To achieve WaterMark Certification, a product or material must:

- be tested by a registered testing authority;
- comply with an approved specification;
- be manufactured in accordance with an approved Quality Assurance Program; and
- carry a warranty.<sup>481</sup>

4.76 The purpose of the WaterMark scheme is to ensure products are 'fit for purpose and authorised for use in plumbing installations.'<sup>482</sup> Administration of the scheme is the responsibility of the Australian Building Codes Board.<sup>483</sup> The Building Commissioner is responsible for enforcing the scheme on behalf of the Plumbers Licensing Board.<sup>484</sup>

4.77 Consistent with other building and construction regulation, the current regulatory framework for plumbing products places a disproportionate responsibility at the end of the supply chain. The Building Commission polices the scheme at the point of installation. It is not an offence to sell non-WaterMarked products in Western Australia, but it is an offence for a licensed plumber to install them.<sup>485</sup> As a result, the onus of responsibility for installing WaterMarked products rests entirely with licensed plumbers. The Plumbing Products Industry Group (PPIG) argued:

*This is a significant anomaly in a mandatory scheme that is supposed to ensure that the products to be installed are fit for purpose and provide all of the necessary protections to ensure public health and safety...The anomaly becomes almost laughable when hardware stores, other retail outlets and online suppliers can sell plumbing products to uninformed consumers that is not WaterMarked and often is not fit for purpose.*<sup>486</sup>

4.78 The PPIG noted that builders and developers frequently purchased products from overseas on a price basis for the licensed plumber to install.<sup>487</sup> This placed the licensed plumber in a difficult position as they bore the responsibility of non-compliance with the WaterMark scheme despite potentially having little visibility over the supply chain. Further complicating matters is the difficulty in determining whether a product is WaterMarked, as evidenced at the PCH where a TMV assembly box was WaterMarked,

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<sup>481</sup> Building Commission, *Final Report: Perth Children's Hospital Audit*, April 2017, p. 26.

<sup>482</sup> *ibid.*, p. 25.

<sup>483</sup> Australian Building Codes Board, 'WaterMark Certification Scheme,' 2015.

<sup>484</sup> Mr Peter Gow, A/Deputy Director General, Industry Regulation and Consumer Protection, Department of Mines, Industry Regulation and Safety, Letter, 9 October 2017, p. 10.

<sup>485</sup> Submission No. 9 from Master Plumbers & Gasfitters Association WA, 28 July 2017, p. 2.

<sup>486</sup> Submission No. 5 from Plumbing Products Industry Group, 28 July 2017, p. 3.

<sup>487</sup> *ibid.*, p. 4.

but certain individual components were not. A further issue is that plumbing products might be sold that claim to be WaterMarked but have not been subject to proper assurance processes.<sup>488</sup>

4.79 The Building Commissioner informed us that over 5,000 instances of plumbing work were inspected for WaterMark compliance every year.<sup>489</sup> However, industry stakeholders described enforcement of the scheme as lacking. The PPIG stated that regulatory controls were minimal and that it was difficult to identify non-compliance on an already installed product.<sup>490</sup> The Master Plumbers and Gasfitters Association of Western Australia (MPGA WA) stated that compliance was lacking due to the low number of plumbing inspectors.<sup>491</sup>

4.80 The PPIG also believed that surveillance of manufacturers and suppliers was inadequate. The PPIG described factories in the United States and Europe being audited twice a year to ensure the integrity of the production process while Australian factories were primarily subjected to desktop audits:

*A manufacturer or supplier having made an initial application for WaterMark certification may provide a “sample” product from a production run for testing which if successful is issued with a WaterMark license, and may then only be subject to a desk top (paper) audit until the term of the WaterMark license expires.*<sup>492</sup>

4.81 The MPGA WA and the PPIG supported the introduction of mandatory compliance with the WaterMark system at point of sale. This would elevate the burden of responsibility to retailers and wholesalers. The MPGA WA argued:

*This is essential in order to remove the current contradiction that makes it legal to sell non-compliant products, but illegal for anyone to install them.*<sup>493</sup>

4.82 The MPGA WA and the PPIG believed that point of sale legislation assisted all members of the supply chain to understand their responsibility in providing products that are fit

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<sup>488</sup> Mr Murray Thomas, Chief Executive Officer, Master Plumbers and Gasfitters Association, *Transcript of Evidence*, 22 September 2017, p. 3; Submission No. 5 from Plumbing Products Industry Group, 28 July 2017, p. 3.

<sup>489</sup> Mr Peter Gow, A/Deputy Director General, Industry Regulation and Consumer Protection, Department of Mines, Industry Regulation and Safety, Letter, 9 October 2017, p. 11.

<sup>490</sup> Mr Stuart Henry, Executive Director, Plumbing Products Industry Group, *Transcript of Evidence*, 18 September 2017, p. 3.

<sup>491</sup> Mr Murray Thomas, Chief Executive Officer, Master Plumbers and Gasfitters Association, *Transcript of Evidence*, 22 September 2017, p. 6.

<sup>492</sup> Submission No. 5 from Plumbing Products Industry Group, 28 July 2017, p. 3.

<sup>493</sup> Submission No. 9 from Master Plumbers & Gasfitters Association WA, 28 July 2017, p. 2.

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for purpose.<sup>494</sup> It would also lead to consumers being better educated on the importance of compliant products and would permit State regulators to ‘take a product off the shelf and test it’ to ensure compliance.<sup>495</sup> The PPIG noted the success of the Water Efficiency Labelling Scheme (WELS) that requires compliance at point of sale and supported a similar legislative framework for the WaterMark scheme.<sup>496</sup> The WELS scheme is supported by complementary legislation in all Australian states and territories. The PPIG argued that by not having point of sale restrictions on the WaterMark scheme, community health and safety was afforded a lower status than water efficiency labelling.<sup>497</sup>

### Finding 41

Regulations to promote water efficiency under the Water Efficiency Labelling Scheme (WELS) appear to be more thorough than those designed to ensure plumbing materials are fit for purpose and promote public health under the national WaterMark certification scheme.

### Finding 42

The WELS scheme requires compliance at point of sale, whereas the WaterMark scheme requires compliance at point of installation.

4.83

The Building Commissioner stated that point of sale restrictions required further consideration and consultation at a national level.<sup>498</sup> We support further consultation, but ultimately seek action on this issue. The current focus on the end of the supply chain is ineffective. At the PCH this approach was also demonstrably inefficient, given the significant delays in rectifying non-conformance identified only after installation.

### Recommendation 9

The Minister for Commerce and Industrial Relations work with the Australian Building Codes Board to establish the national requirement that the WaterMark certification system apply at the point of sale of plumbing products.

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<sup>494</sup> Master Plumbers & Gasfitters Association Western Australia, *Issues highlight importance for POS legislation*, Master Plumber Western Australia, Issue 18 Winter 2017, p. 20; Mr Stuart Henry, Executive Director, Plumbing Products Industry Group, *Transcript of Evidence*, 18 September 2017, p. 6.

<sup>495</sup> Mr Stuart Henry, Executive Director, Plumbing Products Industry Group, *Transcript of Evidence*, 18 September 2017, p. 6.

<sup>496</sup> Submission No. 5 from Plumbing Products Industry Group, 28 July 2017, p. 4.

<sup>497</sup> *ibid.*, p. 6.

<sup>498</sup> Mr Peter Gow, A/Deputy Director General, Industry Regulation and Consumer Protection, Department of Mines, Industry Regulation and Safety, Letter, 9 October 2017, p. 10.

### The lead content in brass plumbing products remains a concern

4.84 Lead is typically added to brass to make it more malleable in the machining process.<sup>499</sup> In Australia, the maximum allowable lead content in brass is 4.5 per cent by weight.<sup>500</sup> There is no evidence of PCH plumbing fittings exceeding this limit. The State has contended that lead leached out of brass fittings via a dezincification process, leading to the non-compliant lead levels in the potable water supply.<sup>501</sup>

4.85 In contrast to Australia, it has been illegal since 2014 in the United States to install plumbing fittings that contain more than 0.25 per cent lead.<sup>502</sup> PPIG also described Canada as following the lead of the United States.<sup>503</sup> The issue of elevated lead levels at PCH might not have occurred if Australia had the same lead allowance as the United States. In this respect, it is notable that the Department of Health are now replacing brass fittings at PCH with plastic components to eliminate the potential for further lead leaching.<sup>504</sup>

### Finding 43

Australia has a higher level of allowable lead content in brass compared to the United States and Canada.

4.86 ChemCentre considered the use of leaded brass as ‘fraught with danger.’<sup>505</sup> The PPIG referred to research that found ‘commercially available plumbing products pose an appreciable source of exposure to known toxic contaminants.’<sup>506</sup> However, the PPIG also noted that manufacturing costs may increase if lead is eliminated from brass plumbing products and asked for an adequate transition period if any changes to the standards were to occur.<sup>507</sup>

4.87 Both the Building Commissioner and the Chief Health Officer contended lead leaching was not a problem under normal circumstances.<sup>508</sup> The Building Commissioner stated that he was not aware of similar issues with brass fittings in other Western Australian

<sup>499</sup> Mr Peter McCafferty, Chief Executive Officer, ChemCentre, *Transcript of Evidence*, 6 September 2017, p. 5.

<sup>500</sup> Building Commission, *Final Report: Perth Children’s Hospital Audit*, April 2017, p. 26.

<sup>501</sup> Dr David Russell-Weisz, Director General - Department of Health, *Transcript of Evidence* (Estimates and Financial Operations Committee), 20 October 2017, p. 2.

<sup>502</sup> Submission No. 5 from Plumbing Products Industry Group, 28 July 2017, p. 3.

<sup>503</sup> *ibid.*, p. 4.

<sup>504</sup> Department of Health, ‘*Water Update – Wednesday 29 November 2017.*’

<sup>505</sup> Mr Peter McCafferty, Chief Executive Officer, ChemCentre, *Transcript of Evidence*, 6 September 2017, p. 5.

<sup>506</sup> Submission No. 5 from Plumbing Products Industry Group, 28 July 2017, p. 7.

<sup>507</sup> Mr Stuart Henry, Executive Director, Plumbing Products Industry Group, *Transcript of Evidence*, 18 September 2017, p. 7.

<sup>508</sup> Building Commission, *Final Report: Perth Children’s Hospital Audit*, April 2017, p. 30; Professor Tarun Weeramanthri, Chief Health Officer, Department of Health, *Transcript of Evidence*, 13 September 2017, p. 9.

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buildings, but acknowledged that metal testing was rare and there was limited available data on this issue.<sup>509</sup> A recommendation in his final report was:

*...that the Building Ministers Forum requests the ABCB [Australian Building Codes Board] to collate existing test results and commission whatever new testing is required to determine whether lead leaching from brass plumbing fittings is contributing to lead levels above the ADWG in Australian buildings.*<sup>510</sup>

4.88 The Building Commissioner briefed the ABCB on this recommendation in June 2017.<sup>511</sup> This issue was to be raised at the October Building Ministers Forum meeting<sup>512</sup> but the communiqué of the meeting does not refer to it being discussed.<sup>513</sup> This is potentially a significant public health issue. We support urgent action to clarify whether the lead exceedances at PCH was an isolated event.

### Recommendation 10

The Minister for Commerce and Industrial Relations report to Parliament on the status of the Building Commissioner's April 2017 recommendation, which sought national action to determine whether lead leaching from brass plumbing fittings is contributing to lead levels above the Australian Drinking Water Guidelines (ADWG) in Australian buildings.

### The Building Commissioner was not proactive with PCH and may be under-resourced

4.89 The Building Commissioner is Western Australia's building, painting, building surveyor and plumbing services regulator.<sup>514</sup> The Building Commissioner's functions are specified at section 86 of the *Building Services (Complaint Resolution and Administration) Act 2011* (Building Services Act). One of these functions is 'to audit the work and conduct of registered building service providers.'<sup>515</sup> The Building Commissioner is empowered to undertake inspections of building work to ascertain:

(a) *how building services have been or are being carried out;*

<sup>509</sup> Building Commission, *Final Report: Perth Children's Hospital Audit*, April 2017, p. 30.

<sup>510</sup> *ibid.*, p. 68.

<sup>511</sup> Hon. Alannah MacTiernan, MLC, answer to Question on Notice 408, *Parliamentary Debates* (Hansard), 17 August 2017, p. 1.

<sup>512</sup> *ibid.*

<sup>513</sup> Building Ministers' Forum, *Communique*, 6 October 2017.

<sup>514</sup> Department of Mines, Industry Regulation and Safety, 'About the Building Commission,' Mr Ken Bowron is the current Building Commissioner. The former Commissioner who oversaw the issues relating to the Perth Children's Hospital (PCH) project, Mr Peter Gow, is currently the A/Deputy Director General, Industry Regulation and Consumer Protection.

<sup>515</sup> *Building Services (Complaint Resolution and Administration) Act 2011* (WA), s 86(i).

(b) *how building standards (as defined in the Building Act 2011) have been or are being applied;*

(c) *whether a building service Act is operating effectively.*<sup>516</sup>

4.90 The Building Services Act commenced in 2011, but the Building Commissioner did not immediately commence the audit function. The Building Commissioner noted that he reorganised his operations in the past six years to permit what he and the Office of the Auditor General referred to as ‘proactive audits.’<sup>517</sup> Proactive audits on builders commenced in 2014 and building surveyors in 2015.<sup>518</sup> The PCH was the first major, complex construction project audited by the Building Commissioner.<sup>519</sup>

4.91 Pursuant to this function, between July 2016 and October 2017 the Building Commissioner conducted an audit of several elements of the PCH project, following the July 2016 discovery of asbestos.

**Table 4.2: Overview of reports released by the Building Commissioner related to PCH.**

Release Date	Report Description
<b>September 2016</b>	An “interim report” focused specifically on the procurement, management and remediation of the asbestos. <sup>520</sup>
<b>April 2017</b>	The “final report” on contractor and product performance at PCH examined the final remediation of the asbestos issue and other matters relating to plumbing and fire safety. <sup>521</sup>
<b>August 2017</b>	A general inspection report into Yuanda-supplied building products in Western Australian buildings. This report examined whether certain Yuanda-supplied building products contained asbestos and were suitable for use in buildings across Western Australia. <sup>522</sup>
<b>October 2017</b>	A supplementary report into the performance and construction of fire walls at PCH. The fire walls were investigated following the receipt of allegations from an anonymous source and the CFMEU. <sup>523</sup>

<sup>516</sup> *Building Services (Complaint Resolution and Administration) Act 2011* (WA), s 86(i).

<sup>517</sup> Mr Peter Gow, Building Commissioner, Department of Mines, Industry Regulation and Safety, *Transcript of Evidence*, 6 September 2017, p. 23; Office of the Auditor General Western Australia, *Regulation of builders and building surveyors*, Report 12, 22 June 2016, p. 16.

<sup>518</sup> Office of the Auditor General Western Australia, *Regulation of builders and building surveyors*, Report 12, 22 June 2016, pp. 16-17.

<sup>519</sup> Mr Peter Gow, Building Commissioner, Department of Mines, Industry Regulation and Safety, *Transcript of Evidence*, 6 September 2017, p. 23.

<sup>520</sup> Building Commission, *Interim Report – Perth Children’s Hospital Asbestos*, 13 September 2017.

<sup>521</sup> Building Commission, *Final Report: Perth Children’s Hospital Audit*, April 2017.

<sup>522</sup> Building Commission, *General Inspection Report Two: A general inspection into Yuanda-supplied products in the Western Australian building industry*, August 2017.

<sup>523</sup> Building Commission, *Supplementary Report: Perth Children’s Hospital audit – firewalls*, 23 October 2017.

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- 4.92 These audits provided a useful extra level of assurance to the PCH project. The Building Commissioner identified some defects that neither Strategic Projects nor JHPL had identified. These publicly released reports also provided independent scrutiny and transparency to the project.
- 4.93 These audits were not proactive despite their name. After the discovery of asbestos, the Building Commissioner was invited to undertake the September 2016 audit.<sup>524</sup> The Building Commissioner acknowledged that he did not have a proactive role at PCH and did not monitor the construction process throughout the life of the project. Rather, he responded to a number of high-profile reported issues. He also confirmed his team had not undertaken any comparable audits at either Fiona Stanley Hospital or Midland Hospital during their respective construction stages.<sup>525</sup>
- 4.94 Key stakeholders supported the Building Commissioner having a more proactive role in providing assurance to state government construction projects. The CFMEU recommended that the Building Commissioner ‘pro-actively and periodically inspect all work undertaken on State Government projects.’<sup>526</sup> The Executive Director of Strategic Projects replied ‘absolutely’ when asked whether the Building Commissioner should proactively investigate state government projects.<sup>527</sup> The MPGA WA also supported mandatory inspections of significant works, particularly public works.<sup>528</sup>
- 4.95 Interestingly, the Building Commissioner did not advocate for a more proactive role. He noted that he had an audit plan and he attempted to audit issues brought to his attention.<sup>529</sup> He also noted that ‘[q]uality assurance on government building projects is the responsibility of the relevant government body monitoring the contract.’<sup>530</sup> The Building Commissioner similarly did not see himself having a role in contractual matters, such as the decision to grant practical completion. He considered such a role would threaten his independence and was beyond the scope of the Building Commission’s general level of project oversight.<sup>531</sup>

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<sup>524</sup> Confirmed in PCH Taskforce, Minutes of Meeting 18 April 2017, p. 4 (closed evidence).

<sup>525</sup> Mr Peter Gow, Building Commissioner, Department of Mines, Industry Regulation and Safety, *Transcript of Evidence*, 6 September 2017, pp. 22-23.

<sup>526</sup> Submission No. 15 from Construction, Forestry, Mining and Energy Union, WA Branch, 14 August 2017, p. 23.

<sup>527</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), *Transcript of Evidence*, 18 September 2017, p. 11.

<sup>528</sup> Master Plumbers & Gasfitters Association of WA, *Plumbing inspector shortage in Western Australia: Report prepared for Building Commission*, 12 August 2016, p. 5 (closed evidence).

<sup>529</sup> Mr Peter Gow, Building Commissioner, Department of Mines, Industry Regulation and Safety, *Transcript of Evidence*, 6 September 2017, p. 23.

<sup>530</sup> Mr Peter Gow, A/Deputy Director General, Industry Regulation and Consumer Protection, Department of Mines, Industry Regulation and Safety, Letter, 9 October 2017, p. 9.

<sup>531</sup> Mr Peter Gow, Building Commissioner, Department of Mines, Industry Regulation and Safety, *Transcript of Evidence*, 6 September 2017, p. 21.



4.96 We agree that it is clearly inappropriate for an independent regulator to be involved in contractual matters on behalf of the State. However, we believe there is merit to the Building Commission conducting proactive audits on major state government projects. This could promote public confidence in the quality and safety of taxpayer-funded construction projects and offer a deterrent against sub-optimal workmanship, particularly if the Building Commissioner had similar powers to the Queensland building regulator.<sup>532</sup>

#### Finding 44

Key stakeholders to this inquiry supported the view that the Building Commissioner should have a more proactive role in providing assurance to state government construction projects. A formalised proactive audit function could promote greater public confidence in the quality and safety of taxpayer-funded construction projects and offer a deterrent against sub-optimal workmanship.

#### Recommendation 11

The Building Commission should conduct proactive audits on major state government building projects.

4.97 It is important that the Building Commission is adequately resourced to fulfil its statutory functions. We note that the Building Commission was unable to conduct as many construction inspections in 2016/17 as compared to 2015/16 due to ongoing audits of the PCH and Elizabeth Quay.<sup>533</sup> Increased monitoring of state government projects will further strain resources. The Executive Director Strategic Projects did not advocate for increased powers for the Building Commissioner but noted:

*...the Building Commission needs to be strong, it needs to be well resourced and it needs to be capable. It has played an unusual and much more intensive role than it used to on this hospital but I suspect that it will not be the last time that it is going to be called in to perform this sort of strong audit role, if you like, for government.*<sup>534</sup>

4.98 The MPGA WA contended that inadequate resourcing was already compromising the Building Commission's effectiveness as a plumbing regulator. The MPGA WA claimed there were only nine plumbing inspectors in Western Australia.<sup>535</sup> The Building Commission subsequently confirmed it has 11 plumbing inspectors employed across a

<sup>532</sup> Refer to paragraph 4.71 above.

<sup>533</sup> Building Commission, Compliance Report: A summary of technical building inspections 2016/17, 2 November 2017, p. 3.

<sup>534</sup> Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), *Transcript of Evidence*, 18 September 2017, p. 11.

<sup>535</sup> Mr Murray Thomas, Chief Executive Officer, Master Plumbers and Gasfitters Association, *Transcript of Evidence*, 22 September 2017, p. 1.

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10.8 full-time equivalent (FTE) roster.<sup>536</sup> This figure is lower than at least four other Australian jurisdictions. Table 4.3 below highlights the disparity:

**Table 4.3: Number of plumbing inspectors<sup>537</sup>**

Jurisdiction	No of Inspectors	Population
QLD	295	4.9 million
VIC	35	6.3 million
TAS	29	0.5 million
ACT	12	0.4 million
WA	11	2.6 million
SA	10	1.7 million

4.99 The MPGA WA described the plumbing industry as largely self-regulated. While plumbers maintained high standards, enforcement was lacking:

*...they are so thin on the ground, they just try to deal with what they have got... There have been some things that have not included inspections at the level they should have been. These inspections are really important as far as the process is concerned.*<sup>538</sup>

*...they are more or less going on the trust and the self-certification of the plumber to be doing the right thing.*<sup>539</sup>

4.100 It is concerning that Building Commission plumbing inspectors failed to identify the non-conforming components of the TMV assembly boxes given they are the agency responsible for enforcement of plumbing regulations. The Chief Health Officer, a health official without plumbing expertise, ultimately identified the non-conformance. Plumbing inspectors inspected 20-25 TMV assembly boxes and examined procurement

<sup>536</sup> Mr Peter Gow, A/Deputy Director General, Industry Regulation and Consumer Protection, Department of Mines, Industry Regulation and Safety, Email, 2 March 2018.

<sup>537</sup> Plumbing inspector data taken from Master Plumbers & Gasfitters Association of WA, *Plumbing inspector shortage in Western Australia: Report prepared for Building Commission*, 12 August 2016, p. 3 (closed evidence). This did not include the figures for NSW and the Northern Territory. The MPGA WA note that the numbers reflect different models. Queensland’s figure includes 287 local government inspectors, supported by state government senior investigators. Victoria’s figure includes a combination of inspectors, investigators and auditors. The MPGA WA did not have data for New South Wales and the Northern Territory. Population numbers obtained from ‘ABS 3.101 – Australian Demographic Statistics, June 2017’ and rounded to the nearest hundred-thousand.

<sup>538</sup> Mr Murray Thomas, Chief Executive Officer, Master Plumbers and Gasfitters Association, *Transcript of Evidence*, 22 September 2017, p. 6.

<sup>539</sup> *ibid.*, p. 7.

records. They did not inspect all individual components.<sup>540</sup> As with other assurance processes at PCH, there appeared to be an over-reliance on documentation in this instance. This provided insufficient assurance. However, it is unclear whether this was a systemic issue related to staffing levels.

#### Finding 45

It is concerning that Building Commission's plumbing inspectors failed to identify the non-conforming components of the TMV assembly boxes given they are the agency responsible for enforcement of plumbing regulations.

#### Finding 46

The Western Australian Building Commission has eleven plumbing inspectors. According to the Master Plumbers and Gasfitters Association of WA, Queensland has 295, Victoria has 35, Tasmania has 29, and the ACT has 12.

4.101 We were also surprised at the lack of consequence that came from the Building Commissioner's findings in response to identified plumbing deficiencies. The Commissioner's report identified multiple instances of poor workmanship by the plumbing sub-contractor, including:

- poor pipe cutting workmanship, leading to burring and swarf;<sup>541</sup>
- failure to prevent water stagnation; and
- poor record keeping and a 'pretty good suspicion' of water supply over-chlorination.<sup>542</sup>

4.102 Despite this, the Building Commissioner stated that he did not identify any conduct requiring immediate disciplinary action.<sup>543</sup>

4.103 The Building Commissioner has numerous disciplinary and awareness-raising options at his disposal, including providing public warnings of unsatisfactory or dangerous services,<sup>544</sup> formal cautions, prosecution through the Magistrates Court and the suspension/cancellation of licenses (through the Plumbers Licensing Board and State Administrative Tribunal).<sup>545</sup> These powers were not exercised.

<sup>540</sup> Mr Peter Gow, A/Deputy Director General, Industry Regulation and Consumer Protection, Department of Mines, Industry Regulation and Safety, Letter, 9 October 2017, p. 11.

<sup>541</sup> Building Commission, *Final Report: Perth Children's Hospital Audit*, April 2017, p. 2. Later in his report on page 49, the Building Commissioner describes swarf as 'filings and debris.' Swarf is often generated via a machining or manufacturing process.

<sup>542</sup> Mr Peter Gow, Building Commissioner, Department of Mines, Industry Regulation and Safety, *Transcript of Evidence*, 6 September 2017, pp. 18-19.

<sup>543</sup> Building Commission, *Final Report: Perth Children's Hospital Audit*, April 2017, p. 3.

<sup>544</sup> *Building Services (Complaint Resolution and Administration) Act 2011* (WA), s 88(1).

<sup>545</sup> Building Commission, *'Enforcement'*, 30 June 2017.

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4.104 The Building Commissioner informed us that the pipe burring and swarf were better addressed through the MC Contract.<sup>546</sup> No disciplinary action was taken in regards to water stagnation or chlorination as he considered there was insufficient evidence of their contribution to the lead issue.<sup>547</sup> However, much of the difficulty in determining the consequences of the chlorination process has been due to what the State contends is a lack of appropriate documentation. The Building Commissioner relied on the information available to Strategic Projects to form his view,<sup>548</sup> information the State, the Chief Health Officer and the Building Commissioner himself all considered inadequate.

### Finding 47

Given the powers available to the Building Commissioner, we are surprised at the lack of consequence that came from the Building Commissioner's findings in response to multiple instances of poor workmanship by the plumbing sub-contractor at Perth Children's Hospital.

## Occupational Health and Safety

4.105 WorkSafe is the statutory body responsible for administering the *Occupational Safety and Health Act 1984* (WA) (the OSH Act), the primary legislation regulating health and safety in Western Australian workplaces. JHPL is not subject to the OSH Act. As a national employer who is licensed to be self-insured for workers' compensation, JHPL is subject to the *Work Health and Safety Act 2011* (Cth).<sup>549</sup> Comcare is the statutory body responsible for administering the *Work Health and Safety Act 2011* (Cth). As a result, there was some complexity to the oversight of health and safety at PCH. JHPL staff were subject to the Commonwealth's Work Health and Safety Act 2011 while many of its Western Australian based sub-contractors were subject to the local OSH Act.

4.106 The CFMEU expressed concerns about the extent of involvement of WorkSafe in health and safety issues at PCH:

*We believe that WorkSafe were absolutely lax in regard to proactively investigating OHS issues out at the Perth Children's Hospital, simply passing the buck to Comcare, even though most of the workers were actually covered by the system that they were in charge of.*<sup>550</sup>

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<sup>546</sup> Mr Peter Gow, A/Deputy Director General, Industry Regulation and Consumer Protection, Department of Mines, Industry Regulation and Safety, Letter, 9 October 2017, p. 12.

<sup>547</sup> *ibid.*

<sup>548</sup> *ibid.*, p. 11.

<sup>549</sup> Building Commission, *Interim Report – Perth Children's Hospital Asbestos*, 13 September 2017, p. 9.

<sup>550</sup> Mr Doug Heath, Union Organiser, Construction, Forestry, Mining and Energy Union, WA Branch, *Transcript of Evidence*, 13 September 2017, p. 10.

- 4.107 In response to one of our questions, JHPL's representative also noted that WorkSafe and Comcare had not reconciled how to work with one another to determine which entity has the appropriate jurisdiction over right of entry requests.<sup>551</sup>
- 4.108 We have concerns about the allocation of health and safety oversight on projects such as the PCH that come under commonwealth and state legislation. However, we have not examined this issue in great detail as it is currently the subject of an inquiry by the Public Administration Committee. One of the terms of reference of the Public Administration Committee's inquiry into WorkSafe is 'legislative and jurisdictional issues.'<sup>552</sup> We felt it prudent to not to explore this issue in any great depth and instead await the findings of the Public Administration Committee's comprehensive inquiry.

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<sup>551</sup> Mr Lindsay Albonico, WA Region Manager, JHPL, *Transcript of Evidence*, 13 October 2017, p. 12 (closed evidence).

<sup>552</sup> Public Administration Committee (WA), *'Inquiry into WorkSafe – Inquiry Details'*, 27 June 2017.



# Chapter 5

## Practical completion

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- 5.1 Practical completion of the construction of the Perth Children’s Hospital (PCH) was achieved by the Managing Contractor, John Holland Pty Ltd (JHPL or ‘the MC’), on 13 April 2017. The State confirmed this by issuing a certificate of practical completion to the MC on 20 April 2017.<sup>553</sup>
- 5.2 The Managing Contractor Contract (MC Contract) originally specified 30 June 2015 as the ‘Date for Practical Completion.’<sup>554</sup> By a formal variation to the MC Contract, this was later extended to 31 August 2015.<sup>555</sup> The 13 April 2017 practical completion date thus came 591 days after the revised deadline, representing a time overrun of almost 40 per cent against what had been agreed.
- 5.3 Even with this significant overrun, construction of the PCH was some way from being functionally complete by 13 April 2017, with the State identifying and listing 23 outstanding issues as ‘minor defects’ on the certificate of practical completion.<sup>556</sup> One of these minor defects was the lead contamination in the PCH water supply. Perhaps unsurprisingly, the decision to accept that practical completion had been achieved was met with a degree of scepticism by some, insofar as it was made at a time when the lead contamination issue was both unresolved and the subject of considerable public consternation.<sup>557</sup>
- 5.4 We believe an overview of the risks and benefits associated with granting practical completion gives useful insight into a critical aspect of how the departments of Health and Treasury (through Strategic Projects) managed this important milestone in the PCH project.

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<sup>553</sup> Submission No. 12 from Department of Health, 1 August 2017, p. 16.

<sup>554</sup> New Children’s Hospital Managing Contractor (MC) Contract for the New Children’s Hospital on the Queen Elizabeth II Medical Centre Site, 5 July 2011, clause 1.1 (closed evidence).

<sup>555</sup> Submission No. 13 from State Solicitor’s Office, 3 August 2017, p. 17.

<sup>556</sup> Submission No. 13A from State Solicitor’s Office, 18 September 2017 (closed evidence). The table accompanying the practical completion certificate actually listed 24 minor defects, but one item was duplicated.

<sup>557</sup> Hon Roger Cook, MLA, (Minister for Health), *State Government takes control of Perth Children’s Hospital*, Media Statement, 20 April 2017.

## Practical completion as a legal concept

5.5 Practical completion is a legal term of art, which is used in construction contracts to describe the point when the project in question is substantially complete and reasonably capable of fulfilling its intended purpose.<sup>558</sup> The actual completion of construction works will invariably involve final adjustments and the rectification of small or minor defects. In this context, the term ‘practical completion’ essentially provides a mechanism for determining an agreed date for the completion of the contracted works, even if the builder is still required to perform some further (generally remedial) work.<sup>559</sup> At the practical completion stage of a building project, the structure is handed over—and risk is passed—from the builder to the proprietor.<sup>560</sup> As a crucial project milestone, practical completion will also trigger a range of contractual outcomes.

5.6 In a building contract, the requirements for practical completion will be specified in the agreement,<sup>561</sup> with clauses stipulating:

- what must be achieved;
- the date when this event is required to occur; and, usually
- how the builder will compensate the proprietor if the practical completion deadline is not met.

## Practical completion in the MC Contract for PCH

5.7 The practical completion requirements associated with PCH are detailed at clause 19 of the MC Contract, with 19.1(a) defining practical completion to mean that the project works are ‘complete’ and have ‘passed all [contractually-specified] tests’ such that they ‘meet the requirements of [the] contract,’ save for contractually-defined ‘Minor Defects.’<sup>562</sup> Elsewhere, at clause 1.1, the ‘Date for Practical Completion’ (being 31 August 2015) is distinguished from the ‘Date of Practical Completion,’ with the latter representing the date ‘certified by the State... as the date upon which Practical Completion has been achieved’ (being 13 April 2017).<sup>563</sup>

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<sup>558</sup> LexisNexis, *Encyclopaedic Australian Legal Dictionary* (at 19 February 2018), ‘Practical completion.’

<sup>559</sup> LexisNexis, *Halsbury’s Laws of Australia* (at 5 April 2016), ‘Performance of work in building contracts’ [65-935].

<sup>560</sup> *ibid.*

<sup>561</sup> *Emson Easlain Ltd (in rec) v EME Developments Ltd* (1991) 55 BLR 117.

<sup>562</sup> New Children’s Hospital Managing Contractor (MC) Contract for the New Children’s Hospital on the Queen Elizabeth II Medical Centre Site, 5 July 2011, clause 19.1 (closed evidence).

<sup>563</sup> *ibid.*, clause 1.1.



- 5.8 Practical completion of the PCH was the trigger for a series of important events. The A/State Solicitor observed that '[o]nce Practical Completion is achieved... three particularly important things occur,' being:
- (a) first, *control of the PCH site transfers from [the MC] to the State... though [the MC] remains on-site to carry out defect rectification in accordance with its contractual obligations;*
  - (b) secondly, *liquidated damages stop accruing; and*
  - (c) thirdly, *the Defects Liability Period commences.*<sup>564</sup>
- 5.9 Expanding upon this observation, the A/State Solicitor noted as control of the PCH site was transferred from the MC to the State upon practical completion, the State assumed responsibility for building-related liabilities. This naturally required the State to obtain appropriate insurance as the building owner and occupier.<sup>565</sup>
- 5.10 The A/State Solicitor further explained liquidated damages 'are damages which the parties have agreed would be paid by [the MC] to the State in the event that [the MC] does not achieve Practical Completion of the PCH by [the] contractually specified date.'<sup>566</sup> In the MC Contract, 'liquidated damages accrue at \$180,000 per calendar day and are capped at \$42.5 million,' and as such the 'cap was reached on or about Saturday, 23 April 2016.'<sup>567</sup> Insofar as practical completion was achieved almost one year after this cap was reached, the decision had no bearing upon the accrual of liquidated damages (although, in due course, there may be additional compensation for the further delay in achieving practical completion).
- 5.11 Finally, the A/State Solicitor noted '[t]he Defects Liability Period is a two year period commencing on the Date of Practical Completion... during which time [the MC] is required to rectify, at its cost, any Defects arising in the Works.'<sup>568</sup>
- 5.12 Elsewhere in his submission, the A/State Solicitor further observed that 'the test for Practical Completion is... a binary question of fact,' and that as such 'if the State, acting reasonably, considers that the test has been satisfied then the State *must* issue the Practical Completion Certificate; it has no discretion.'<sup>569</sup>
- 5.13 The MC Contract defines minor defects as defects that 'do not prevent the [PCH] from being used for the intended purpose,' and can be rectified in a way that will 'not

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<sup>564</sup> Submission No. 13 from State Solicitor's Office, 3 August 2017, p. 17 (emphasis in original).

<sup>565</sup> *ibid.*, p. 18.

<sup>566</sup> *ibid.*, p. 17.

<sup>567</sup> *ibid.*

<sup>568</sup> *ibid.*

<sup>569</sup> *ibid.*, p. 18 (emphasis in original).

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prejudice the convenient use of the [PCH].<sup>570</sup> Plainly, with its source and solution far from certain in April 2017, the water contamination issue could easily have provided a basis for denying practical completion.

5.14 Practical completion was granted on 13 April 2017 on the basis that the still unconfirmed source of lead contamination in the water supply could be classified as a minor defect.

5.15 Before outlining the risks and benefits relating to this decision, we thought it apt to include a timeline of key events in Table 5.1 below for context.

**Table 5.1 - Timeline of key events associated with the decision to grant practical completion<sup>571</sup>**

Date	Event
<b>30 Jun 2015</b>	Original practical completion date as written into the MC Contract.
<b>31 Aug 2015</b>	Revised practical completion date as written into the amended MC Contract.
<b>23 Apr 2016</b>	Date on which liquidated damages ceased to accrue as per the terms of the MC Contract.
<b>13 May 2016</b>	Testing conducted on behalf of the State confirms elevated levels of lead in the potable water supply at the PCH site.
<b>13 Jan 2017</b>	JHPL lodges a delay notice with the State alleging the source of the water contamination is the QEII ring main.
<b>28 Mar 2017</b>	The PCH Taskforce receives a detailed briefing from the State's technical advisers recommending the addition of orthophosphate treatment to the water to arrest the process of dezincification. At the same meeting, the IPMO provides an update on the status of 12 other 'critical deliverables required for PC,' a limited number of which appear to be completed.
<b>29 Mar 2017</b>	A briefing note from the Executive Director of Strategic Projects advises that 'with the notable exception of potable water compliance, Treasury is satisfied that the MC Contract works are very close to meeting [practical completion] requirements.'

<sup>570</sup> New Children's Hospital Managing Contractor (MC) Contract for the New Children's Hospital on the Queen Elizabeth II Medical Centre Site, 5 July 2011, clause 20 (closed evidence).

<sup>571</sup> Dr David Russell-Weisz, Director General, Department of Health, *Perth Children's Hospital Commissioning and Transition. Project Overview and Status Update*. 27 March 2017, p. 25 (Legislative Assembly Tabled Paper No. 268, tabled on 18 May 2017); Submission No. 12 from Department of Health, 1 August 2017, p. 17; Mr Richard Mann, Executive Director, Strategic Projects & Asset Sales (Department of Treasury), 'Perth Children's Hospital – Practical Completion,' Briefing Note for the Treasurer, 29 March 2017, p. 1 (closed evidence); Jacob Kagi, 'Perth Children's Hospital legal row brews as John Holland claims project completed,' ABC Online, 4 April 2017; Dr David Russell-Weisz, Director General, Department of Health, and Mr Richard Mann, Executive Director, Strategic Projects (Department of Finance), 'Perth Children's Hospital – Practical Completion,' (Legislative Assembly Tabled Paper No. 268, tabled on 18 May 2017); PCH Taskforce, Minutes of Meetings 28 March, 4 April, and 11 April 2017 (closed evidence).

Date	Event
<b>30 Mar 2017</b>	Strategic Projects issues a direction to JHPL requiring it to identify cut-in points for orthophosphate treatment to occur.
<b>31 Mar 2017</b>	A briefing note from the PCH Taskforce Chair to the Minister for Health expresses the Department's 'significant concern' about the prospect of practical completion being granted without a water remediation strategy that is 'fully developed, reviewed or endorsed by the State.'
<b>3 Apr 2017</b>	JHPL submits a formal notice to Strategic Projects stating that it believes it has achieved practical completion.
<b>4 Apr 2017</b>	Taskforce members engage in extensive deliberations on the risks and benefits of the State granting practical completion.
<b>11 Apr 2017</b>	PCH Taskforce is advised that JHPL has not responded to the direction issued on 30 March to identify cut-in points for orthophosphate treatment to occur.  Taskforce members deliberate at length on the question of whether the State should grant practical completion with the potable water issue classified as a minor defect.
<b>12 Apr 2017</b>	A joint briefing note from the Director General of Health and the Executive Director of Strategic Projects to the Treasurer and the Minister for Health recommends that the Treasurer endorse Treasury granting practical completion on the basis that 'the residual water quality issues will be classified as a Minor Defect.'
<b>13 Apr 2017</b>	The State grants practical completion 591 days after the revised practical completion date of 31 August 2015.
<b>20 Apr 2017</b>	Strategic Projects, on behalf of the State, issues a practical completion certificate that lists 'potable water supply defects' as one of 23 minor defects.

## The risks associated with granting practical completion

5.16 Upon granting practical completion, the State assumed responsibility for the risk associated with controlling the PCH site, and the defects liability period commenced. Both of these events would be unremarkable in normal circumstances. Unfortunately in this case, the full magnitude of the identified minor defects—particularly the water contamination issue—was not known at practical completion.

5.17 This meant that the State, in taking control of the PCH, assumed responsibility for managing a risk that was to some extent unknown, being the amount of work—and, therefore, time—that would be necessary to prepare the PCH for clinical use. As such, the primary risk of granting practical completion on 13 April 2017 was that the PCH would not be open within a reasonable time after this date.

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5.18 On 29 November 2017, the Minister for Health announced that the PCH ‘would be open and ready for its first patients in May [2018],’ and that the opening would progress in stages, ‘with the final move day anticipated on a Sunday in June 2018.’<sup>572</sup> Should this timetable prove accurate, the window between practical completion and full clinical operation will be somewhere in the vicinity of 14 months. The time taken between practical completion and clinical use of the PCH will clearly have implications for insurance, and for the defects liability period.

### Insurance

5.19 Upon granting practical completion, the State came ‘on risk’ for building-related liabilities, and accordingly had to begin bearing the cost of maintaining appropriate insurance against that risk.<sup>573</sup> A key risk of granting practical completion without being certain of the opening date of the PCH is, therefore, the cost of maintaining appropriate insurance without the benefit of being able to make use of the hospital for however long the opening of the hospital might be delayed.

### Defects liability

5.20 A more substantial risk relates to the JHPL discharging its responsibility for rectifying defects. Foremost among these defects are the 23 minor defects listed in the practical completion certificate. These defects encompass varying degrees of complexity. In addition to the water quality issue, some of the more significant relate to:

- the specialised dialysis reverse osmosis water systems;
- the air handling units;
- completing works to the integrated extra low voltage head end system (which is critical to many of the hospital’s ICT systems); and
- non-compliant air discharge from the hospital’s Isolation Room.<sup>574</sup>

5.21 In terms of other defects, the MC Contract provides, at clause 20.2, for a ‘defects liability period,’ being the ‘period that begins on the Date of Practical Completion of the Works and ends 24 months after that date.’<sup>575</sup> Under further defects clauses, the MC is responsible for either rectifying or paying compensation in respect of any construction defects identified by the State within that 24-month period.

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<sup>572</sup> Hon. Roger Cook, MLA, (Minister for Health), *Perth Children’s Hospital opening timetable announced*, Media Statement, 29 November 2017.

<sup>573</sup> Submission No. 13 from the State Solicitor’s Office, 3 August 2017, p. 18.

<sup>574</sup> Submission No. 13A from the State Solicitor’s Office, 18 September 2017 (closed evidence).

<sup>575</sup> New Children’s Hospital Managing Contractor (MC) Contract for the New Children’s Hospital on the Queen Elizabeth II Medical Centre Site, 5 July 2011, clause 20.2 (closed evidence).

5.22 In granting practical completion without being certain of the opening date of the PCH, the State ran the risk of compromising the protection ordinarily afforded by the defects liability period. After commencing, the defects liability period runs whether or not the PCH is in clinical use; any delay between practical completion and opening exacerbates the risk that defects associated with clinical use will not be identified until after the defects liability period expires. If, as announced in November 2017, the PCH opens in May-June 2018, there will be approximately ten months remaining in the defects liability period. As such, the State's ability to invoke the protection of the defects liability clause is already somewhat compromised. Ultimately this may result in the State having to bear the cost of procuring replacement equipment or conducting repairs during a period in which they may ordinarily have been covered.

#### **Finding 48**

One of the major risks of accepting practical completion prior to knowing exactly what work would be required to remediate all identified minor defects is the risk of excessive delay between taking control of the site, and being able to actually open the hospital.

This can give rise to the realisation of other risks including the diminution of the opportunity and financial cover offered by the two-year defects liability period, and the heightened risk of staff morale issues.

#### **Other risks**

5.23 In its submission, the Department of Health made the important point that '[i]n order to satisfy that it had achieved [practical completion], the MC was required to demonstrate that operations at PCH would not be impacted by remaining minor defects, or the rectification of those defects.'<sup>576</sup> The A/State Solicitor added that while the granting of practical completion did effectively impinge upon the State's ability to identify defective works through clinical use, this decision did not absolve the MC of its contractual obligation to rectify any works identified as defective within the defects liability period.<sup>577</sup> As such, although practical completion was only granted on the basis that 23 outstanding construction issues could be characterised as minor defects, ideally those defects should be genuinely minor in nature. The more significant those defects and the more difficult they are to fix, the greater the potential risk to the State from its decision.

5.24 This fact was succinctly expressed in a submission by the Department of Finance, being that '[t]he key risk associated with granting [practical completion] while issues remain unresolved relates to fitness for purpose arguments,' because:

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<sup>576</sup> Submission No. 12 from Department of Health, 1 August 2017, p. 16.

<sup>577</sup> Submission No. 13 from State Solicitor's Office, 3 August 2017, p. 18.

## Chapter 5

*...if at a later date the State determines that the hospital is not fit for purpose, it may be difficult for the State to advance an argument for MC liability given a Practical Completion Certificate has been issued.<sup>578</sup>*

5.25 In the months prior to granting practical completion, the State identified a series of outstanding construction issues that would need to be remedied and, at a meeting on 28 March 2017, the Taskforce ‘was advised of 13 areas of the construction program requiring completion before PC [practical completion] could be granted, including the potable water system.’<sup>579</sup> In addition to that issue, the ‘program activities to be resolved by the MC’ before practical completion would be granted were the:

- *finalisation of documentation*
- *provision of asset information required for facilities and financial management*
- *completion of all mental health isolation rooms*
- *commissioning and witness testing of all Air Handling Units*
- *completion of exhaust works in nuclear medicine*
- *corrective works related to mental health seclusion doors*
- *finalisation of access control and monitoring required for mental health areas*
- *finalising design requirements for retail cafe ceilings to meet licensing, acoustic and aesthetic requirements*
- *replacement and final inspection of stainless steel pipes*
- *finalised design documentation associated with the roof weather seal solution*
- *resolution of all defects and completion of design change requests required for hospital operations.<sup>580</sup>*

5.26 Notwithstanding this, the State agreed to grant practical completion with some of these issues characterised as minor defects (including the provision of asset information; and final testing and commissioning of the air handling units).

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<sup>578</sup> Submission No. 6 from Department of Finance (Strategic Projects), 28 July 2017, p. 23.

<sup>579</sup> Submission No. 12 from Department of Health, 1 August 2017, p. 17.

<sup>580</sup> *ibid.*, p. 17.

### Finding 49

On 28 March 2017, the PCH Taskforce received an update from the IPMO on the status of 13 areas of the construction program requiring closure before practical completion could be granted. These included the problems with the potable water system. Ultimately, practical completion was granted with at least three of these issues, including the potable water issue, characterised as minor defects.

5.27 Of these, the finalisation of documentation soon became a significant issue. The July 2017 Gateway Review of the PCH project noted that '[t]he decision to grant [practical completion] was made despite the MC's failure to provide a range of asset documentation required under the [MC] contract.'<sup>581</sup> Concern over the lack of asset documentation was now connected to the risk of delay in opening the PCH, as 'deficient asset documentation... was prohibiting an accurate assessment of DoH's [the Department of Health's] risk exposure.'<sup>582</sup> The reviewers recommended an independent investigation be undertaken to determine whether any deficiencies 'in contracts, warranties and other asset documentation' would prevent the State from completing 'a comprehensive asset management... risk assessment.'<sup>583</sup>

5.28 The Gateway Review also noted the performance of the MC in general 'as a key area of risk.' The Department of Health agreed with this assessment in its submission and described the 'risk of continued performance by the MC' as a 'major concern.'<sup>584</sup> Quite understandably, the State would have preferred not to have assumed such unquantifiable risks when contemplating the practical completion question.

### The water

5.29 While each of the identified outstanding construction issues contributed to the risk of granting practical completion, none were of the same magnitude as the water contamination. This was made clear in a 2017 briefing paper from the Executive Director of Strategic Projects written in contemplation of the State's practical completion decision. Explaining the situation '[a]s of 29 March 2017,' this briefing note observed that 'with the notable exception of potable water compliance, Treasury is satisfied that the MC contract works are very close to meeting [practical completion] requirements.'<sup>585</sup>

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<sup>581</sup> Submission No. 12 from Department of Health, 1 August 2017, p. 17.

<sup>582</sup> *ibid.*, p. 18.

<sup>583</sup> *ibid.*

<sup>584</sup> *ibid.*

<sup>585</sup> Mr Richard Mann, Executive Director, Strategic Projects & Asset Sales (Department of Treasury), 'Perth Children's Hospital – Practical Completion,' Briefing Note for the Treasurer, 29 March 2017, p. 1, (Legislative Assembly Tabled Paper [No. 268](#), tabled on 18 May 2017).

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5.30 The Department of Finance (the agency now responsible for Strategic Projects) also characterised the water contamination issue as ‘the primary issue,’ noting that ‘[w]hilst a range of other residual works were outstanding, this issue remains the key driver for ongoing delays to commencement of services at PCH.’<sup>586</sup> Again, despite continued efforts to address the issue, the source of the lead contamination was still unknown at the time the practical completion decision was taken. While classifying this issue as a minor defect did not make the State responsible for its remedy the specific measures that would need to be taken to rectify this issue were not known when practical completion was granted. That said, the State had a preferred option that it was not in a position to implement. As will be demonstrated in the section immediately below, this was a significant factor in the State’s final decision.

5.31 Submissions made by each of the Departments of Health, Finance, Premier and Cabinet and indeed the State Solicitor’s Office all stated that advice was sought from the State Solicitor’s Office on the possible consequences of granting practical completion by classifying the water contamination issue as a minor defect. While this advice would have addressed all of the possible legal ramifications of such a decision, ultimately a definitive source of the contamination was unknown as at 13 April 2017. Nor was the full magnitude of the work that would be required to remedy this issue.

### The arguments for granting practical completion

5.32 In light of the risks, the Director General of the Department of Health made it clear that the decision to grant practical completion ‘was not lightly taken,’ and indeed that:

*...there was intricate and ongoing debate and consideration of all the advantages and disadvantages that ultimately led to a grant of practical completion in mid-April this year.*<sup>587</sup>

### Finding 50

At meetings of 4 and 11 April 2017, PCH Taskforce members engaged in extensive and robust deliberations regarding the advantages and disadvantages of the State granting practical completion with the potable water issue classified as a minor defect.

5.33 Understandably, much of this debate centred around the extent to which the water contamination issue had been remedied. Evidence given by the Under Treasurer provides some context for the practical completion discussions. According to the Under Treasurer, ‘[i]n April 2017, the managing contractor advised that it considered it had rectified the defect associated with lead levels... through installation of temporary

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<sup>586</sup> Submission No. 6 from Department of Finance (Strategic Projects), 28 July 2017, p. 23.

<sup>587</sup> Dr David Russell-Weisz, Director General, Department of Health, *Transcript of Evidence*, 18 September 2017, p. 2.



water filters.’<sup>588</sup> At the time, however, the State rejected this assertion, and directed the MC to undertake orthophosphate treatment of the PCH plumbing system.

5.34 This direction was based on an April 2017 report produced for the Department of Treasury by ChemCentre, which concluded that ‘[t]he use of a low concentration orthophosphate in the water supply offers an economical, safe way of treating brass fittings in situ,’ and thereby addressing the lead contamination issue.<sup>589</sup> The MC, however, refused to undertake orthophosphate treatment.

5.35 According to JHPL’s WA Regional Manager, Mr Lindsay Albonico, there were two reasons for this refusal. First, Mr Albonico explained that the JHPL’s ‘process involved a flushing regime, which, we say—and recorded and demonstrated that that—worked.’<sup>590</sup> In addition, the company ‘had greater concerns around the orthophosphate because there is not a lot of science available on orthophosphate.’<sup>591</sup>

5.36 A different view was expressed by Treasury’s Executive Director, Strategic Policy and Evaluation, who explained that by the time the State directed orthophosphate treatment, the MC ‘had essentially moved on to post-construction and they were protecting their commercial position,’ which made it ‘almost impossible to work with them.’<sup>592</sup> This view was echoed by the Under Treasurer, who characterised JHPL’s refusal to undertake orthophosphate treatment as ‘the straw that broke the camel’s back in terms of granting practical completion.’<sup>593</sup>

5.37 In ordinary circumstances, it would be unusual to characterise practical completion as a contractual event taken through frustration. Equally, however, it should be recalled that the date of practical completion came almost 20 months after the contractually stipulated deadline. In that time, the State claims JHPL had missed 16 forecast practical completion dates.<sup>594</sup> Furthermore, the view expressed by the Department of Health was that from around 2016 onwards, the company had ‘consistently failed’ to:

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<sup>588</sup> Mr Michael Barnes, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 9 October 2017, p. 3.

<sup>589</sup> Mr Peter McCafferty, Director, Scientific Services Division, ChemCentre, *Internal Report: An assessment of lead leaching from brass following orthophosphate treatment*, April 2017, p. 4 (closed evidence).

<sup>590</sup> Mr Lindsay Albonico, WA Region Manager, John Holland Pty Ltd, *Transcript of Evidence*, 13 October 2017, p. 5.

<sup>591</sup> *ibid.*

<sup>592</sup> Mr Alistair Jones, Executive Director, Strategic Policy and Evaluation, Department of Treasury, *Transcript of Evidence*, 9 October 2017, p. 5 (closed evidence).

<sup>593</sup> Mr Michael Barnes, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 9 October 2017, p. 5 (closed evidence).

<sup>594</sup> Dr David Russell-Weisz, Director General, Department of Health, *Transcript of Evidence*, 18 September 2017, p. 1.

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- *maintain a realistic and achievable program of works;*
- *submit crucial information to the State such as key activities, critical milestones and resourcing;*
- *properly estimate the amount of work and resourcing required to achieve PC; [and]*
- *measure the impact of delay.*<sup>595</sup>

5.38 As a consequence, despite being aware of the risk of granting practical completion prematurely, the State was increasingly of the view, as articulated by the Under Treasurer, that ‘the sooner we could grant practical completion and... take control of the site... the better because that will reduce the direct cost to the budget of further delays.’<sup>596</sup>

5.39 The Director General of the Department of Health also expressed conviction in the decision, asserting in September 2017 that ‘there is absolutely no way that [the State] would have made the progress we have without practical completion,’ and indeed that ‘there is no question we would have been in a far worse position if we had delayed granting [practical completion].’<sup>597</sup> This was because, by granting practical completion, the Department of Health was able to take ‘control of the site,’ and thereby:

- undertake the orthophosphate treatment;
- provide the State’s Chief Health Officer with unrestricted access to the building to perform tests;
- identify a way forward for resolving the lead contamination issue;
- identify and replace non-compliant plumbing fixtures; and
- remediate defects that the MC was unwilling to deal with, including sterilisation and other construction issues.<sup>598</sup>

5.40 Prior to granting practical completion and taking control of the site, the activities that could be performed by the Department of Health at the PCH were necessarily limited by the fact that the Department only had partial access to the site.<sup>599</sup> By granting practical completion, the Department could:

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<sup>595</sup> Submission No. 12 from Department of Health, 1 August 2017, pp. 16-17.

<sup>596</sup> Mr Michael Barnes, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 9 October 2017, p. 4.

<sup>597</sup> Dr David Russell-Weisz, Director General, Department of Health, *Transcript of Evidence*, 18 September 2017, pp. 2-3.

<sup>598</sup> *ibid.*

<sup>599</sup> In May 2016, the department had negotiated partial access to the site to perform limited commissioning activities under the State Primary Access Control (SPAC) initiative. However, by

*...undertake commissioning activities under Health's control, with full, unrestricted access to the building and generally have overall control, visibility and clarity about all the work streams.*<sup>600</sup>

5.41 Importantly, the Department of Health agreed to the decision knowing that 'the builder was, and is, still on the hook for any defects during the defects liability period.'<sup>601</sup> This empowered the Department to directly address issues, instead of simply (and, apparently, fruitlessly) attempting to have JHPL address them. According to the Director General:

*...now, having taken PC... if we give a notice and say, "please remediate this", and they [the MC] ignore it or do not do it, we can actually find somebody else to do it, which was much harder pre-PC, because they controlled the site.*<sup>602</sup>

5.42 As to who would pay for remedial work performed at the direction of the Department of Health, the State Solicitor's Office provided advice to the effect that after practical completion 'the risk allocation under the contract would not be changed at all and that John Holland would still be liable for defects rectification.'<sup>603</sup> Equally, if the State does ultimately seek to assert this position at some point in the future, it is important to acknowledge that a court or arbitrator will likely be called upon determine the extent to which JHPL will be liable.

5.43 On this point it must be recognised that invoking a third-party dispute resolution mechanism such as a court or arbitrator is generally regarded as an option of last resort in addressing a contractual dispute. Aside from the time and cost implications, and notwithstanding the advice of the State Solicitor's Office, it must also be acknowledged that it is impossible to be certain how a court might adjudicate a matter. Litigation, that is, always carries an inherent risk—and the extent to which the State is willing to bear this risk remains to be seen.

5.44 Ultimately, the State's decision to base the practical completion decision on legal advice indicates that there was no longer any capacity to resolve the dispute over outstanding construction issues without third-party intervention. By April 2017 it had

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September 2016, a fourth readiness for service gateway review confirmed that while the SPAC initiative had been effective, further commissioning work was now constrained by JHPL's failure to achieve practical completion. Department of Treasury – Strategic Projects & Asset Sales and Department of Health, *Gateway Review 5 – Readiness for Service (4)*, 22 September 2016, p. 3.

<sup>600</sup> Dr David Russell-Weisz, Director General, Department of Health, *Transcript of Evidence*, 18 September 2017, p. 3.

<sup>601</sup> *ibid.*

<sup>602</sup> Dr David Russell-Weisz, Director General, Department of Health, *Transcript of Evidence*, 18 September 2017, p. 3 (closed evidence).

<sup>603</sup> Mr Michael Barnes, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 9 October 2017, p. 5.

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simply become a matter of necessity for the State to grant practical completion and take control of the PCH site. Plainly, there were few advantages left in leaving the site under the control of the MC, noting that the liquidated damages cap had been reached almost one year earlier. Maintaining the status quo had also become untenable, as there was ‘an operational risk with [continuing to use] Princess Margaret [Hospital],’<sup>604</sup> which was a source of ‘clinical and staff morale risks.’<sup>605</sup>

5.45 The question remains whether this dilemma arose because of the inadequacy of the contractual levers, or the general reluctance to use them (or a combination of both).<sup>606</sup>

### Finding 51

The ability of the State to conduct orthophosphate treatment on the potable water supply appears to be a major factor behind its decision to grant practical completion. The Under Treasurer claims that John Holland Pty Ltd’s refusal to agree to this treatment was ‘the straw that broke the camel’s back in terms of granting practical completion.’ Notably, the Director General of Health, who held significant reservations about granting practical completion for an extended period of time, has since confirmed his unequivocal support for the decision.

### Finding 52

A final assessment on the overall merit of granting practical completion of the PCH on 13 April 2017 cannot be made until such time as the hospital is open and has been running effectively beyond the defects liability period.



DR A.D. BUTI, MLA  
CHAIR

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<sup>604</sup> Dr David Russell-Weisz, Director General, Department of Health, *Transcript of Evidence*, 18 September 2017, p. 17.

<sup>605</sup> Mr Michael Barnes, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 9 October 2017, p. 4.

<sup>606</sup> We discussed these overarching concerns with the contractual levers in Chapter 3 starting at paragraph 3.135.

# Appendix One

## PCH Commissioning and Transition Taskforce – Terms of Reference

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### **Terms of Reference**

#### **PERTH CHILDREN'S HOSPITAL COMMISSIONING AND TRANSITION TASKFORCE**

##### **1. FUNCTION**

The Perth Children's Hospital Commissioning and Transition Taskforce (PCH Taskforce) is responsible for supporting the delivery and commissioning of the Perth Children's Hospital (PCH) and key associated impacts across the Western Australian health system.

The PCH Taskforce will focus on the progress of the total project including service transitioning, project risks and risk management strategies.

The PCH Taskforce will support the Director General of the Department of Health to make strategic decisions that ensure PCH and any associated system reconfiguration is delivered successfully. Successful delivery will take into account agreed scope, time, cost and quality parameters, and project benefits.

The PCH Taskforce will function until such time as PCH is fully operational and the PCH Taskforce judges that its oversight is no longer required.

##### **2. RESPONSIBILITIES OF THE PCH TASKFORCE**

The responsibilities of the PCH Taskforce will be to:

- Oversee the delivery and commissioning of PCH;
- Provide a forum that supports robust and effective decision making;
- Monitor the progress of the PCH project against key milestones determined by the Program Management Office and approved by the PCH Taskforce including Information and Communications Technology (ICT), Workforce and Transition Planning, Clinical Commissioning and Facilities Management;
- Provide advice and support on emerging issues or risks for project delivery and commissioning, including remediation strategies. Where the PCH Taskforce's advice is sought on an issue, the Taskforce will be informed of the final decision and outcome;
- Monitor transition planning and system preparedness across any other major Perth hospital sites which will be impacted by PCH coming online;
- Monitor budget parameters authorised by the Economic and Expenditure Reform Committee (EERC) and Cabinet for the infrastructure (including ICT), facilities management, transition planning and operation of PCH; and
- Report to the Premier and Cabinet via the Minister for Health on a quarterly basis, or as requested or resolved by the PCH Taskforce.

## **MEMBERSHIP**

### **2.1 Members**

PCH Commissioning Transition Taskforce Members are:

- Director General, Department of Health (Chair)
- Director General, Department of the Premier and Cabinet
- Under Treasurer, Department of Treasury
- Deputy State Solicitor - Commercial, State Solicitor's Office
- Executive Director, Economic and Deregulation, Cabinet and Policy Division, Department of Premier & Cabinet

### **2.2 Formal Attendees**

PCH Commissioning Transition Taskforce formal attendees are:

- Chief Executive, Child and Adolescent Health Service
- Chief Executive, North Metropolitan Health Service
- Deputy Director General, Department of Health
- Chief of Staff, Office of the Minister of Health
- Commissioner, Mental Health Commission
- Chief Information Officer, Health Information Network
- Executive Director, Strategic Project, Department of Treasury
- Executive Director, Resource Strategy, Department of Health
- Chief Procurement Officer, Department of Health
- Executive Director, PCH Project
- Independent Advisor on ICT.

### **2.3 PCH Taskforce and Program Support**

The following representatives attend PCH Taskforce meetings to support effective facilitation of the forum and to provide program support:

- Director of Program Integration, Department of Health
- Secretariat, Department of Health
- Representatives from the Program Management Office
- Representative from the Department of Treasury (support to the Under Treasurer).

### **2.4 Others in attendance**

Other representatives from the Department of Health, relevant Government agencies, key consultants and/or advisors to the Minister for Health will be invited to attend meetings and provide advice to the PCH Taskforce as required.

## **2.5 Proxy Membership**

Given the PCH Taskforce is required to provide strategic cross-agency direction and guidance at the highest level of Government, proxy membership is not encouraged.

## **3. ACCOUNTABILITY**

The PCH Taskforce will report to the Premier and Cabinet via the Minister for Health on a quarterly basis, or as requested or resolved by the PCH Taskforce.

## **4. MEETING FREQUENCY**

Meetings will be held as determined by the PCH Taskforce however frequency will not be less than one meeting every calendar month.

## **5. MEETING DOCUMENTATION**

All reports, presentations and other information (papers) intended for the PCH Taskforce's consideration at a PCH Taskforce meeting will be provided to the Secretariat a minimum of forty eight hours prior to each PCH Taskforce meeting.

Minutes that clearly record all items endorsed, noted and/or any other actions will be circulated by the Secretariat within five working days of each PCH Taskforce meeting.

A log of decisions made and actions agreed during the PCH Taskforce forum will be maintained by the Secretariat.

## **6. OUT OF SESSION ITEMS**

Where an issue is urgent and requires attention prior to a scheduled meeting, it may be considered out of session.

Items for out of session consideration must be proposed by Members via the Secretariat or Chair (who will determine if an item is to be raised out of session).

The Secretariat will keep a record of responses to out of session items. Items determined out of session will be minuted at the next face-to-face meeting.





## Appendix Two

### PCH Project Control Group (PCG) – Terms of Reference

#### Perth Children's Hospital Project Control Group Terms of Reference

**Name** The group shall be known as the Perth Children's Hospital Project Control Group (PCH PCG)

**Role** The PCH PCG is responsible for oversight of the delivery of all aspects of infrastructure, commissioning and transition for the PCH Project (the Project).

**Responsibilities** The responsibilities of the PCH PCG are to:

- Monitor the performance of all aspects of the Project and provide management oversight and direction.
- Ensure that Project risks and issues are identified, reported and managed appropriately.
- Monitor Project budgets for Infrastructure, ICT and OCR to ensure appropriate controls are in place and endorse budget management actions.
- Consider recommendations and issues raised by the Project Advisory Group (PAG)
- Provide direction to Control Groups.
- Review and endorse key Project decisions and documentation.
- Consider issues escalated to the PCG from any area of the Project and ensure appropriate actions are identified and implemented to address the issues.
- Monitor progress of the Project's delivery against timetables [in] the integrated master plan and ensure appropriate actions are identified and implemented.
- Provide regular reports to the PCH Commissioning and Transition Taskforce (PCH Taskforce).

**Chair** Chief Executive, Child and Adolescent Health Service (CAHS)

**Secretariat** PCH Project, CAHS

**Reports to** PCH Taskforce

**Frequency**

The PCH PCG will meet weekly.

Additional PCH PCG meetings may be convened at the discretion of the Chair to give urgent consideration to priority matters that may arise.

**Groups that report to the PCG**

There are a number of groups that will report or escalate issues to the PCG as required.

- PCH Commissioning Control Group (CCG)
- The Project Working Groups (PWG)
- Technical Control Groups (TCG), and
- The Project Advisory Group (PAG).

It is acknowledged that PAG is a mechanism for managing the contractual requirements for the Project. Members of the PAG attend PCG and will provide updates as required.

**Membership****Members:**

- Chief Executive, CAHS and PCH Commissioning (Chair)
- Executive Director, SP&AS, Department of Treasury
- CE North Metropolitan Health Service (NMHS)
- Director Strategic Policy & Evaluation, Department of Treasury
- Deputy Director General, DoH
- Health Infrastructure, DoH
- Resourcing and Performance, DoH
- Legal Practitioner, State Solicitor's Office
- Assistant Director General; CIO, HSS

**Attendees:**

- PCH Principal Project Director SP&AS
- Executive Director PCH, CAHS
- General Manager, ICT Service Delivery and Operations, DoH
- Director Organisational Development, CAHS
- Director SP&AS
- Project Lead Corporate and FM, PCH, CAHS
- PCH Transition Project Management Office
- PCH Transition Project Management Office
- Executive Director PMH, CAHS
- Director Operational Commissioning, CAHS
- IPMO (PwC)
- Deputy Executive Director PCH, CAHS
- Director ICT, PCH Project, CAHS
- Senior Project Officer, PCH Project, CAHS (secretariat)

Representatives of relevant programs and projects with specific expertise will be in attendance as appropriate with the approval of the Chair.

**Proxies**

If a PCH PCG Member cannot attend a meeting, a proxy may attend to provide comments and feedback on the PCH PCG Member's behalf. The Chair is to be advised prior to the meeting if a proxy is to attend.

**Conflict of Interest (COI)**

A conflict of interest is defined as: "A situation arising from conflict between the performance of public duty and private or personal interests".

It is important to note that it is not always possible to avoid a conflict of interest and in itself, a conflict of interest is not necessarily wrong or unethical. What is important, however, is to appropriately identify/disclose and effectively manage any actual, perceived or potential conflict of interest situations.

Any perceived COI must be formally raised with the Chair. See WA Health Managing Conflict of Interest Policy for advice:

<http://www.health.wa.gov.au/circularsnew/attachments/452.pdf>

**Confidentiality**

PCH PCG Members may at times be provided with access to confidential information relating to the PCH Project. As such, all Members and Attendees should take reasonable steps to ensure that confidential information is kept confidential.



## Appendix Three

### PCH Project Management Office (PMO) – Roles and Responsibilities<sup>607</sup>

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- Central coordination point for all Workstream Program reporting and monitoring activities, except activities related to project finance.
- Provide independent advice to the Taskforce.
- Coordinate the logistics associated with the reporting framework.
- Provide secretariat support and coordination functions to Transition Control Groups.
- Maintain a record of decision making for key decisions made that affect the program.
- Manage change requests and prepare for endorsement by delegated authority.

#### Quality Assurance

- Workstream Program and project management coaching and training to program staff, as and when required.
- Provide program and project management tools, procedures, and knowledge.
- Undertake quality assurance by reviewing key program deliverables when requested to ensure due process has been followed.

#### Reporting

- Roll-up and analysis of project and OCR/ICT Workstream Program information at a program level to derive program reporting required for the various program governance committees and key stakeholders including:
  - Taskforce
  - PCH/PMH Executive

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<sup>607</sup> Taken from Department of Health and Department of Treasury, *Perth Children's Hospital Project Governance Framework*, May 2015, pp. 8-9 (closed evidence).

## Appendix Three

- CAHS Governing Council
- CAHS Board
- CAHS Quarterly Operational Plan
- Report on the Workstream Program to the PCH Taskforce, PCG and PCH/PMH Commissioning Executive.

### **Risk and Issues Management**

- Coordinate the resolution, reporting and escalation as required of all program issues, except those related to design.
- Manage the mitigation reporting and escalation as required of all program risks.
- Coordinate risk and issues at a project-level.

### **Benefits Tracking**

- Establish and manage the Workstream Program change control process.
- Coordinate project and program change control processes.
- Report on Workstream changes.
- Stakeholder management – Manage Key Workstream Program stakeholders.

# Appendix Four

## Strategic Projects Briefing Note – 18 October 2016

### PORTFOLIO: TREASURY/HEALTH

### CONTENTIOUS ISSUE: PCH – PROCESS FOR GRANTING PRACTICAL COMPLETION

#### KEY MESSAGES

- “Practical Completion” (PC) for the Perth Children’s Hospital (PCH) project will be achieved when all works other than Minor Defects have been completed.
- By definition, Minor Defects cannot impact on PCH operations, including during their rectification.
- As is common practice on major projects, PCH includes a number of Separable Portions (SPs), reflecting discrete work packages each with their own PC requirements.
- At PC, control of the facility will transfer from the PCH Managing Contractor (MC) to the Department of Health (Health).

#### BACKGROUND

- Under the PCH MC contract, PC is achieved when all works required under the contract other than Minor Defects (as outlined above) have been completed.
- The MC must submit a comprehensive package of documentation and deliverables as evidence that PC has been achieved, including all necessary certificates of compliance, test results, executed warranties and guarantees, authorisations, reports and plans (including operating and maintenance plans and manuals) and other information as identified in a detailed Testing, Commissioning and Practical Completion Plan, which has been approved by the State.
- These deliverables submitted by the MC must be sufficient to demonstrate that the works (other than for residual Minor Defects agreed by the State) have been completed to the specified standards, codes and guidelines, comply with all relevant legislative and regulatory requirements and are otherwise in accordance with “Best Industry Practice”, defined as the level expected from a reputable and prudent person in delivering similar works.
- When the MC believes it has achieved PC, it will submit a notice to the State.
- If the State’s nominated representative under the MC contract is not satisfied that PC has been achieved they will issue a notice detailing the outstanding items that must be addressed in order to achieve PC.
- When the State’s nominated representative is satisfied that PC has been achieved, they will issue a notice confirming that PC has been achieved and identifying the Date of PC (“PC Certificate”).
- Upon issue of the PC Certificate, the Department of Treasury (Treasury) will formally notify the Minister for Health that PC has been achieved. The Treasurer and Minister for Health will be regularly briefed by Treasury on the status of the works and likely Date of PC.
- Separate SPs apply for the PCH Child Care Centre, “G Bock” Link Bridge (to Sir Charles Gairdner Hospital), Northern Green Space (location of MC amenities), Hospital Avenue Street Lighting and Atrium Roof Panel Remediation. The main hospital facility (i.e. all other works) is defined as “SP1”. The PC process will be applied to each SP.

#### CURRENT SITUATION

- The MC is in the final stages of completion and commissioning works for SP1.
- Items that are critical to PC include: defect rectification; building systems testing (particularly smoke management); building management system testing and commissioning; acoustic testing; remediation of water-damaged ceiling; PC documentation; and potable water quality.
- MC and subcontractor resourcing levels have been increased across all key areas in an effort to meet the PC target date; however, this remains a significant challenge.
- The adversarial relationship between the MC and its key technology subcontractor, Schneider Electric Buildings Australia (SEBA), continues to significantly impact on MC performance.
- Tension between the parties escalated during the week commencing 10 October 2016, requiring the State to implement measures to ensure all project records were secure.
- Work by SEBA is currently continuing; the State is actively involved in facilitating the necessary exchange of information between itself, the MC, SEBA and other subcontractors to enable testing and commissioning of critical building systems to progress.
- The State team has also increased its resourcing to ensure proper surveillance and witness testing of MC activities is maintained and there is no compromise to the PC requirements.

## Appendix Four

- Of particular note, PC of SP1 will not be granted until the State is satisfied that the water quality meets the Australian Drinking Water Guidelines; the PCH project team is liaising with Health's Public Health Division in this regard.

| **CURRENT AS:** ~~40-17~~ October 2016

**CONTACT:** Richard Mann, Executive Director SP&AS, [REDACTED]

| PREPARED FOR PARLIAMENT ~~44-18~~ OCTOBER 2016



# Appendix Five

## Department of Health Briefing Note – 1 November 2016

PCH Corro 154

### PORTFOLIO: HEALTH

### CONTENTIOUS ISSUE: 6.2 PERTH CHILDREN'S HOSPITAL COMMISSIONING AND OPENING

#### KEY MESSAGES

- The Child and Adolescent Health Service (CAHS) is continuing to undertake operational commissioning and staff training activities in preparation for Practical Completion (PC) and the commencement of services at Perth Children's Hospital (PCH).
- CAHS remains vigilant in maintaining the quality and integrity of commissioning activities so as not to compromise patient or staff safety.

#### BACKGROUND

- Operational commissioning and staff training activities prior to PC have been enabled by a program of State Primary Access Control (SPAC), which has facilitated limited on-site access and has resulted in all clinical and operational areas now being available to CAHS.
- PCH staff and external support service providers are undertaking commissioning activities and delivering training under SPAC conditions with some limitations, in collaboration with the Managing Contractor (MC) and Strategic Project and Asset Sales (SPAS).
- The timeframe for the commencement of services at PCH is dependent on PC.
- The CAHS PCH clinical commissioning process cannot proceed to the final stage of end-to-end clinical orientation and testing without prior PC.
- The MC did not achieve the previously scheduled PC dates which has resulted in a delay to the planned staged opening of the hospital.
- The building systems are critical to achieving PC. This includes delivery of the smoke management system, and the rectification of water quality issues.

#### CURRENT SITUATION

- Although PC has not been achieved and a timeframe for the completion of construction has not been determined, CAHS is continuing to undertake operational commissioning, staff training and ICT deployment activities that can be practically progressed under SPAC conditions. These activities include:
  - Over 1800 PMH staff have completed onsite training;
  - ICT deployment is over 82 per cent complete;
  - Initial clinical clean of operating theatres, wards 2A, 2B, 4A, 4B and patient kitchen is complete;
  - Departments have commenced workflow testing of their internal processes to ensure they can be conducted safely in the new environment;
  - Central Sterilisation Services Department performance qualification achieved; and
  - Conditional poisons licence granted.
- The opening day is dependent on PC. Once PC is reached CAHS will be able to calculate the hospital's opening schedule.

**CURRENT AS:** 1 November 2016

**CONTACT:** Professor Frank Daly, Chief Executive CAHS, [REDACTED]

PREPARED FOR PARLIAMENT 8 NOVEMBER 2016



## Appendix Six

### Inquiry Terms of Reference

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On 28 June 2017 the Public Accounts Committee resolved to conduct this inquiry, in accordance with the following Terms of Reference:

*The Committee will examine and report on the how the departments of Health and Treasury have managed the Perth Children's Hospital project, with a focus on:*

- a) The effectiveness of the project's overall governance structure in identifying and responding to risks;*
- b) The processes in place to provide assurances that materials and systems used on the project meet the required standards; and*
- c) The risks and benefits associated with granting practical completion.*



# Appendix Seven

## Committee's functions and powers

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The Public Accounts Committee inquires into and reports to the Legislative Assembly on any proposal, matter or thing it considers necessary, connected with the receipt and expenditure of public moneys, including moneys allocated under the annual Appropriation bills and Loan Fund. Standing Order 286 of the Legislative Assembly states that:

The Committee may -

- 1 Examine the financial affairs and accounts of government agencies of the State which includes any statutory board, commission, authority, committee, or trust established or appointed pursuant to any rule, regulation, by-law, order, order in Council, proclamation, ministerial direction or any other like means.
- 2 Inquire into and report to the Assembly on any question which -
  - a) it deems necessary to investigate;
  - b) (Deleted V. & P. p. 225, 18 June 2008);
  - c) is referred to it by a Minister; or
  - d) is referred to it by the Auditor General.
- 3 Consider any papers on public expenditure presented to the Assembly and such of the expenditure as it sees fit to examine.
- 4 Consider whether the objectives of public expenditure are being achieved, or may be achieved more economically.
- 5 The Committee will investigate any matter which is referred to it by resolution of the Legislative Assembly.



## Appendix Eight

### Submissions received

Name	Position	Organisation
Mr Keith Chidley	Western Australia Chapter President	Australian Institute of Project Management
Mr Geoff Burrell		
Mr Michael Barnes	Under Treasurer	Department of Treasury
Mr Peter McCafferty	Chief Executive Officer	ChemCentre
Mr Stuart Henry	Executive Director	Plumbing Products Industry Group Inc
Mr Bill Sullivan	A/Director General	Department of Finance
Mr Richard Hayers	Executive Director Operations – Central West	Jacobs Building and Infrastructure
Mr Peter Keleman	Director	Cameron Chisholm & Nicol (WA) Pty Ltd
Mr Murray Thomas	Chief Executive Officer	The Master Plumbers and Gasfitters Association of Western Australia
Bo Yu Chi	Director Advisor	Yuanda Australia Pty Ltd
Mr Rick Hughes	Principal Consultant	Microanalysis Australia
Dr David Russell-Weisz	Director General	Department of Health
Mr Nicholas Egan	A/State Solicitor	State Solicitor's Office
Dr Omar Khorshid	President	Australian Medical Association (WA)
Mr Mick Buchan	State Secretary	Construction, Forestry, Mining and Energy Union, WA Branch
Mr Darren Foster	Director General	Department of the Premier and Cabinet
Mr Michael Beer	Managing Director	L&M Painting / Construction Services
Professor Tarun Weeramanthri	Chief Health Officer	Department of Health





## Appendix Nine

### Briefings

Date	Name	Position	Organisation
7 June 2017	Mr John Langoulant	Special Inquirer	Inquiry into Government Programs and Projects
	Ms Stephanie Black	Inquiry Executive Officer	
21 June 2017	Mr Peter Gow	Building Commissioner	Department of Mines, Industry Regulation and Safety
21 June 2017	Dr David Russell-Weisz	Director General	Department of Health
	Mr Nicholas Egan	A/State Solicitor	State Solicitor's Office
1 November 2017	Mr John Langoulant	Special Inquirer	Inquiry into Government Programs and Projects
	Ms Stephanie Black	Inquiry Executive Officer	



## Appendix Ten

### Hearings

Date	Name	Position	Organisation
6 September 2017	Mr Peter Gow	Building Commissioner	Department of Mines, Industry Regulation and Safety
	Mr Lex McCulloch	WorkSafe WA Commissioner	
	Mr Christopher Kirwin	Director, Industrial and Regional, WorkSafe WA	
	Ms Sally North	A/Director, Service Industries and Specialist Directorate, WorkSafe WA	
6 September 2017	Mr Peter McCafferty	Chief Executive Officer	ChemCentre
13 September 2017	Mr Doug Heath	Union Organiser	Construction, Forestry, Mining and Energy Union, WA Branch
	Mr Campbell McCullough	Assistant Secretary	
	Mr Robert Benkesser	Safety Officer	
13 September 2017	Professor Tarun Weeramanthri	Chief Health Officer	Department of Health
18 September 2017	Dr David Russell-Weisz	Director General	Department of Health
	Mrs Rebecca Brown	Deputy Director General	
	Dr Robyn Lawrence	Chief Executive, Child and Adolescent Health Service	
18 September 2017	Mr Malcolm Bradshaw	A/Deputy Director General	Department of the Premier and Cabinet

## Appendix Ten

Date	Name	Position	Organisation
18 September 2017	Mr Stuart Henry	Executive Director	Plumbing Products Industry Group Inc
18 September 2017	Mr Nicholas Egan	A/State Solicitor	State Solicitor's Office
18 September 2017	Mr Richard Mann	Executive Director, Strategic Projects	Department of Finance
22 September 2017	Dr Omar Khorshid	President	Australian Medical Association (WA)
22 September 2017	Mr Murray Thomas	Chief Executive Officer	Master Plumbers and Gasfitters Association (WA)
9 October 2017	Mr David Smith	Director General	Department of Mines, Industry Regulation and Safety
9 October 2017	Mr Michael Barnes	Under Treasurer	Department of Treasury
	Mr Alistair Jones	Executive Director, Strategic Policy and Evaluation	
	Mr Stefanos Toutountzis	Director, Performance and Evaluation	
9 October 2017	Mr Bradley Richardson	Director, Technical and Advisory Team PCH	Turner & Townsend Thinc
	Mr Cade Dawkins	Director, Project Management (WA)	
13 October 2017	Mr Lindsay Albonico	WA Region Manager	John Holland Pty Ltd
18 October 2017	Mr John Hamilton	Ex-Principal Project Director, PCH	
18 October 2017	Ms Tricia Tebbutt	Partner	PwC
	Mrs Tanya West	Director of IPMO Services to PCH	

# Appendix Eleven

## Glossary

ABC	Australian Broadcasting Corporation
ABCB	Australian Building Codes Board
ADWG	Australian Drinking Water Guidelines
ANAO	Australian National Audit Office
AZ/NZS	Joint Australian and New Zealand Standard
BMF	Building Ministers' Forum
CAHS	Child and Adolescent Health Services
CCCC	China Communications Construction Company Ltd
CE CAHS	Chief Executive, Child and Adolescent Health Services
CFMEU	Construction, Forestry, Mining and Energy Union
CSIRO	Commonwealth Scientific and Industrial Research Organisation
DPC	Department of the Premier and Cabinet
FSH	Fiona Stanley Hospital
JHPL	John Holland Pty Ltd
ICT	Information and communications technology
IMP	Integrated Master Program
IPMO	Integrated Program Management Office
MC	Managing Contractor (John Holland Pty Ltd)
MC Contract	Managing Contractor Contract (the formal description of the type of contract entered into between the State of Western Australia and John Holland Pty Ltd)
MHIPSC	Major Health Infrastructure Projects Steering Committee
MLA	Member of the Legislative Assembly
MPGA WA	Master Plumbers and Gasfitters Association of Western Australia
NATA	National Association of Testing Authorities
NCBP	Non-conforming building products
NDY	Norman Disney & Young

## Appendix Eleven

NSW	New South Wales
PAG	Project Advisory Group
PC	Practical completion
PCG	Project Control Group
PCH	Perth Children's Hospital
PCOC	PCH Commissioning Oversight Committee
POS	Point of sale
PMO	PCH Program Management Office
PPIG	Plumbing Products Industry Group
QLD	Queensland
SA	South Australia
SCP	Strategic Completion Plan
SOG	Senior Officers' Group
SP&AS	Strategic Projects & Asset Sales (now Strategic Projects)
SPAC	State Primary Access and Control
SSO	State Solicitor's Office
The State	A term used to describe both the government and the public sector entities responsible for the PCH project.
TAPs	Treatment Action Plans
TAS	Tasmania
TKI	Telethon Kids Institute
TMV	Thermostatic mixing valve
TTT	Turner & Townsend Thinc
UK	United Kingdom
URP	Unitised roofing panel
VE	Vitreous enamel (façade panel)
VIC	Victoria
WA	Western Australia
WELS	Water Efficiency Labelling Scheme

## Appendix Twelve

### Performance of key roles

Position	Individual	Dates
Premier	Hon. Colin Barnett, MLA	July 2011 (project commencement) – 17 March 2017
	Hon. Mark McGowan, MLA	17 March 2017 – present
Minister for Health	Hon. Dr Kim Hames, MLA	July 2011 – 31 March 2016
	Hon. John Day, MLA	31 March 2016 – 17 March 2017
	Hon. Roger Cook, MLA	17 March 2017 – present
Treasurer	Hon. Christian Porter, MLA	July 2011 – 12 June 2012
	Hon. Colin Barnett, MLA	12 June – 9 July 2012
	Hon. Troy Buswell, MLA	9 July 2012 – 10 March 2014
	Hon. Colin Barnett, MLA	10 – 17 March 2014
	Hon. Dr Mike Nahan, MLA	17 March 2014 – 17 March 2017
	Hon. Ben Wyatt, MLA	17 March 2017 – present
Director General, Department of Health	Mr Kim Snowball	July 2011 – 15 March 2013
	Professor Bryant Stokes	15 March 2013 – 3 August 2015
	Dr David Russell-Weisz	3 August 2015 – present
Chief Executive, Child and Adolescent Health Services	Mr Phillip Aylward	July 2011 – May 2015
	Professor Frank Daly	May 2015 – June 2017
	Dr Robyn Lawrence	June 2017 – present
Chief Health Officer	Professor Tarun Weeramanthri	July 2011 – present
Executive Director, Strategic Projects	Mr Richard Mann	July 2011 – present

## Appendix Twelve

Position	Individual	Dates
PCH Principal Project Director, Strategic Projects	Mr John Hamilton	July 2011 – August 2017
Executive Director, Strategic Policy and Evaluation, Department of Treasury	Mr Alistair Jones	June 2012 – present
A/State Solicitor (formerly Deputy State Solicitor, Commercial)	Mr Nicholas Egan	July 2011 – present
Director General, Department of the Premier and Cabinet	Mr Peter Conran	July 2011 – 16 August 2016
	Mr David Smith	23 August 2016 – 2 May 2017
	Mr Darren Foster	2 May 2017 – present
Executive Director, Strategic Policy and Deregulation, Cabinet and Policy Division, Department of the Premier and Cabinet	Ms Lyn Genoni	July 2011 – March 2017
Acting Deputy Director General, Department of the Premier and Cabinet	Mr Malcolm Bradshaw	May 2017 – present
Building Commissioner	Mr Peter Gow	July 2011 – February 2018



## Appendix Thirteen

### Roles performed by corporate entities

Role	Entity
Operated as the main technical adviser for Strategic Projects. Referred to as the State's Adviser.	Turner & Townsend Thinc (TTT)
Provided multi-disciplinary engineering advisory services (including hydraulics) for Strategic Projects.	Jacobs Australia
Provided analytical chemistry services (water testing) for Strategic Projects.	ChemCentre
Operated the PCH Program Management Office for the Department of Health.	Ernst & Young (EY)
Operated the Integrated Program Management Office for the Department of Health and the PCH Taskforce.	PricewaterhouseCoopers (PwC)
Managing Contractor engaged by the State to manage the construction of PCH.	John Holland Pty Ltd (JHPL)
JHPL's supplier of façade and roof panels.	Yuanda Australia Pty Ltd
JHPL's supplier of fire doorsets.	LeaderFlush-Shapland Ltd
JHPL's building surveyor.	Philip Chun & Associates Pty Ltd
JHPL's main ICT sub-contractor.	Schneider Electric Buildings Australia Pty Ltd
JHPL's plumbing sub-contractor.	Christopher Contracting Pty Ltd
JHPL's restricted licensed asbestos removalist.	L&M Painting and Construction
Engaged by JHPL to perform design and specification work for PCH's hydraulic system.	Norman Disney & Young



## Appendix Fourteen

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