

JOINT SELECT COMMITTEE ON END OF LIFE CHOICES

**INQUIRY INTO THE NEED FOR LAWS IN WESTERN AUSTRALIA
TO ALLOW CITIZENS TO MAKE INFORMED DECISIONS
REGARDING THEIR OWN END OF LIFE CHOICES**



**TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
MONDAY, 30 APRIL 2018**

SESSION NINE

Members

**Ms A. Sanderson, MLA (Chair)
Hon Colin Holt, MLC (Deputy Chair)
Hon Robin Chapple, MLC
Hon Nick Goiran, MLC
Mr J.E. McGrath, MLA
Mr S.A. Millman, MLA
Hon Dr Sally Talbot, MLC
Mr R.R. Whitby, MLA**

Hearing commenced at 4.41 pm**Dr JOHN HAYES****Member, Palliative Care Western Australia, examined:**

The CHAIR: Dr Hayes, thanks for your patience, and thank you very much for coming in at very short notice to give evidence today.

Dr HAYES: It is a pleasure to be here.

The CHAIR: On behalf of the committee I would like to thank you for agreeing to appear today to provide evidence in relation to the end-of-life choices inquiry. My name is Amber-Jade Sanderson and I am the Chair of the joint select committee. We have Mr Simon Millman; Hon Dr Sally Talbot; Mr John McGrath; Dr Jeannine Purdy, our principal research officer; Hon Colin Holt; Hon Nick Goiran; Mr Reece Whitby; and Hon Robin Chapple. The purpose of this hearing is to examine the adequacy of the existing laws and resources for end-of-life choices from your perspective. It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege. However, it does not apply to anything you might say outside of today's proceedings. I advise that the proceedings of this hearing will be broadcast live within Parliament House and via the internet. The audiovisual recording will be available on the committee's website following the hearing. Could you please introduce yourself for the record.

Dr HAYES: My name is Dr John Hayes. I am a fellow and life member of the Royal Australasian College of Physicians. I hold specialist qualifications both as a general physician and as a rheumatologist.

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

Dr HAYES: No.

The CHAIR: Do you want to make your statement for the committee?

Dr HAYES: Yes. My interest in end-of-life matters is somewhat personal, in that I was diagnosed with cancer some years ago. Fortunately, I survived. Professor Fred Hollows had the same renal cancer, and he did not. Let me start by saying that there is no call from the medical profession to legalise euthanasia. Two years ago, the AMA had a formal members' poll throughout Australia and only 38 per cent of AMA members supported euthanasia. More recently, the *Medical Journal of Australia* InSight poll published just two months ago revealed that doctors oppose euthanasia 61 per cent to 37 per cent. In other words, the result was similar to the same-sex marriage postal vote, which was regarded as overwhelming. I therefore represent the silent majority of doctors who oppose euthanasia. Doctors have never been in the business of ending patients' lives. It is a frank violation of the Hippocratic oath, which has been the bedrock of medical ethics for 2 500 years and which also predates modern religions. In the AMA code of conduct, special recognition is given to the Hippocratic oath. In other words, it is not out of date. The prestigious World Medical Association, which is the world association of 109 national medical associations, periodically meets and has issued strong condemnation of both euthanasia and physician-assisted suicide. It spoke out publicly during the recent assisted-dying legislation debate in Victoria and strongly urged doctors to ignore it, even if it is legalised.

Ninety eight per cent of patients die peacefully with palliative care. I plan to submit an open letter to politicians from 101 palliative care physicians, in which they outline this in detail. So, 98 per cent of people die peacefully with palliative care. For the remaining two per cent, there is the option of palliative sedation, which is also used in the Netherlands under the classification of euthanasia. In

Australia, it is permitted. When football legend Jim Stynes died of cancer, his widow Sam publicly thanked “the team at Cabrini Palliative Home Care”. Jim Stynes died peacefully surrounded by family and friends. Sadly, 26 per cent of Australians die without access to palliative care. Palliative care service provision often depends on one’s postcode, which is the wording of Dr Richard Chye, who is the head of palliative care at St Vincent’s Hospital in Sydney. At lunchtime today, I was down at Subiaco station. Here is a petition to members in relation to access to palliative care, that states, “We, the undersigned, are concerned that health patients of Joondalup, Midland, Peel, Fremantle and Bentley Hospitals either have no or limited access to specialist palliative care.” That is the significance. One in four people needlessly die in pain because they are deprived access to palliative care. The message from the medical profession is to fix palliative care. If palliative care was available for all dying patients, there would be no need for euthanasia. In an open letter to Victorian and New South Wales politicians, a copy of which I will present to the committee, 101 palliative care professionals rejected euthanasia and called for greatly improved palliative care services for all Australians. Also, research by the Productivity Commission and the Grattan Institute confirmed that there are major deficiencies in the provision of palliative care and called for increased government funding in this area.

I shall also present a research paper published in the prestigious *The New England Journal of Medicine* in the second half of last year, so nearly eight months ago, headed, “End-of-Life Decisions in the Netherlands over 25 Years”. This revealed that the overwhelming majority—73 per cent—of patients were in fact dying and that they received the same end-of-life treatments that are already provided and permitted by palliative care in Australia. Twenty five per cent died when treatment was withdrawn, 25 per cent received palliative sedation and 50 per cent were so-called double effect deaths—that is, when patients are dying, analgesia is given on demand to dying patients, even if it shortens their life. Cases like that of Andrew Denton’s father’s death 25 years ago do not occur now; there have been major advances and changes in the provision of palliative care services throughout Australia. Hence, palliative care in Australia provides the same services to dying patients as euthanasia does in the Netherlands, and without any need to change the law.

[4.50 pm]

Each year in the Netherlands, approximately 14 000 people request euthanasia. This is in a country with a population of 17 million—roughly eight times the population of Western Australia. Fifty-five per cent of those who requested were granted euthanasia. These figures rise by 10 per cent each year and have risen by 310 per cent since the law was introduced in 2002. The other incredible case is that 23 per cent of all euthanasia cases in the Netherlands are unreported. At least this is better than in Belgium, where at least 50 per cent are unreported. In 2016, only 10 cases were referred for investigation, and over a 15-year period not one Dutch doctor has been prosecuted for abusing the law.

Turning to Belgium, euthanasia in Belgium is simply out of control. Fifty per cent of cases are unreported. A publication just in the last few weeks suggests that in the Flanders region, only about 15 per cent of cases are reported. The prestigious magazine *The New Yorker* reported that in Belgium, quote, “... people have also been euthanized because they had autism, anorexia, borderline personality disorder, chronic-fatigue syndrome, partial paralysis, blindness coupled with deafness, and manic depression.”

Mr Andrew Denton is on record praising and calling for a Belgian-type euthanasia law in Australia. Mr Denton is also on record supporting euthanasia for the elderly, the mentally ill and, quote, “anyone who is suffering”. He stated this in the Richard Fidler *Conversations* interview and also in numerous newspaper articles around Australia. Mr Denton has also made public attacks on

palliative care that are documented in the open letter from the palliative care physicians. Clearly, Mr Denton is not a credible witness.

The driving force behind euthanasia in Australia for more than 20 years has been Dr Philip Nitschke, who praised the “rational suicide” of a 45-year-old depressed Perth man, Mr Nigel Brayley, in 2016. Following this, support for euthanasia absolutely plummeted. Even the Prime Minister, Mr Turnbull, was quoted as declaring that he believed the euthanasia lobby could not get its house in order. It was following this, and the defeat of more than 30 state euthanasia bills, that the euthanasia lobby regrouped and the abrasive, bullying Dr Nitschke was replaced with the smiling, charming persona of Mr Andrew Denton as its euthanasia spokesperson. Hence, euthanasia 2.0 was launched with the pledge that euthanasia would be limited to, quote, the “terminally ill”.

However, since then we have heard columnist Nikki Gemmell on the ABC TV’s *Australian Story* demanding euthanasia for people with chronic pain, like her mother, who was a closet Exit International member who suicided because of chronic foot pain. There are 2.5 million chronic pain sufferers in Australia; she wants euthanasia for all of them. At this hearing about a month ago, the WA Chief Psychiatrist also supported euthanasia for the mentally ill. Former AMA WA state president Dr Scott Blackwell was speaking on ABC Radio with Geoff Hutchison and came out supporting euthanasia for frail aged patients with advanced dementia in nursing homes. How can these people give permission for euthanasia when they have advanced dementia?

Veteran journalist and editor-at-large of *The Australian*, Paul Kelly, remarked that once euthanasia is legalised, quote, “... there is only one debate—it is over when and how to expand the sanctioned killings.” Mr Paul Kelly also made another statement, quote —

Claims made in Victoria that strict safeguards will be implemented and sustained are simply untenable and defy the lived overseas experience, as well as political reality.

Legislators are simply naive if they believe that euthanasia will be limited to the terminally ill. This will go down in history as the great euthanasia deception. The media are meant to ask questions and demand answers; this has not happened in the euthanasia debate, sadly. Thank you.

The CHAIR: Thank you, Dr Hayes. I have a question about some of the statements in your opening statement around Belgium and the Netherlands, when you said that 50 per cent of voluntary euthanasia is not reported. If that is the case —

Dr HAYES: Twenty-three per cent in the Netherlands.

The CHAIR: Yes, and 50 per cent in Belgium.

Dr HAYES: The Flanders region of Belgium.

The CHAIR: In Flanders.

Dr HAYES: That was reported in an article published in *The British Medical Journal*.

The CHAIR: Right. Can you just explain: if they are not reported, how is that data collated?

Dr HAYES: I am not sure how. I cannot really answer that question. But even in the Netherlands, every five years they hold a close analysis, and the figure they came up with at the last five-year period was that 23 per cent are not reported. That is their figure, not mine, coming from the body that oversees euthanasia in the Netherlands.

Hon ROBIN CHAPPLE: Thank you very much indeed, Dr Hayes. I note from your submission and your email to the committee that you make the comment that the end-of-life treatments in the Netherlands use methods that are used by palliative care in Australia.

Dr HAYES: That is correct.

Hon ROBIN CHAPPLE: Twenty-five per cent die from withdrawal of treatment, twenty-five per cent receive terminal sedation, and 50 per cent were so-called double effect. We have heard from palliative care that that does not happen, so how can you come up with those figures?

Dr HAYES: The figures are published in this paper on end-of-life decisions from *The New England Journal of Medicine*. The paper also has an appendix which, in fact, few people would probably bother to open. The findings in the appendix are very interesting and elaborate in detail these figures.

Hon ROBIN CHAPPLE: Can we have a copy of that, please?

Dr HAYES: Yes, I will submit a copy. How I reach those figures, for instance, sedation was 18.3 per cent in 2015. That is 18.3 per cent of 73 per cent, which works out at roughly 25 per cent. The double-effect deaths were 36 per cent of 73 per cent, which is around 50 per cent. That is how those figures were bridged.

[5.00 pm]

Hon ROBIN CHAPPLE: I can understand your analysis.

Dr HAYES: When people are dying, that is the way those three methods are used. They were not given intravenous injections or doses of poison. I will submit that paper.

Hon ROBIN CHAPPLE: You were suggesting that people are having what we call the dose of double effect, something we have looked at, and that people were being in a sedated or palliative sedation or terminal sedation state through palliative care.

Dr HAYES: What is the question?

Hon ROBIN CHAPPLE: I am trying to say, you are saying that palliative care was using the dose of double effect?

Dr HAYES: Palliative care in Australia?

Hon ROBIN CHAPPLE: Yes.

Dr HAYES: Yes.

Hon ROBIN CHAPPLE: All right.

Dr HAYES: When people are dying in Australia under palliative care, analgesic is given on demand for pain relief even if it shortens the patient's life. Cases like Andrew Denton's father do not occur with modern management of palliative care.

Hon ROBIN CHAPPLE: I was not questioning Andrew Denton's father, I was more questioning—because we have met with innumerable people from Palliative Care—the organisation; the 22 or 23 specialists here in WA—and they say it does not happen.

Dr HAYES: What does not happen?

Hon ROBIN CHAPPLE: Terminal sedation or the use of double effect.

Dr HAYES: The open letter from 100 palliative care physicians, which is from Australia-wide, I will read it out —

Current Australian data indicates that no more than 2 in every 100 Palliative Care patients would be in moderate or severe pain at the end of life. In these unusual cases where when all other methods of palliation for pain and other symptoms is inadequate, and if the patient agrees, palliative sedation therapy is available to provide adequate relief of suffering.

Signed 100 palliative care professionals from all around the country. I will submit that paper.

Hon ROBIN CHAPPLE: Yes, please.

Mr J.E. McGRATH: Do you believe that figure, that it is only two per cent of palliative care patients?

Dr HAYES: Yes, that is the figure there.

Mr J.E. McGRATH: But you as a practitioner?

Dr HAYES: I am not involved in that field.

Mr J.E. McGRATH: No.

Dr HAYES: But I have heard on Q&A last year, Dr Ralph McConaghy, who is the head of palliative care at a major Brisbane hospital, he was on Q&A and he came up with the same figure that 98 per cent of people die peacefully with palliative care.

Mr J.E. McGRATH: We had someone in today, a clinician, who felt it would be closer to 30 per cent of people who would have died in some degree of pain.

Dr HAYES: That is not what these experts are saying.

Hon Dr SALLY TALBOT: Dr Hayes, I want to ask you about the question of capacity. Obviously, if we were looking at some change in the law that would permit voluntary assisted dying, the question of decision-making capacity would be very pertinent to any such legislation, as it is in Victoria. No matter what data you have presented to us in your submission, there are people in Australia who have expressed and are expressing the wish to be able to end their life at a certain point once they reach a certain level of pain or a level of disability. How do you think that capacity to make that decision might be assessed?

Dr HAYES: First of all, the main reason why people request euthanasia is not because of uncontrolled pain, it is because they feel that they have become a burden to their carers and loss of autonomy. That is the main reason given on numerous studies as to why people request euthanasia—that they have become a burden.

Hon Dr SALLY TALBOT: Let us just talk about loss of autonomy. If somebody make a determination that should they lose their autonomy and they would like to die, how do we assess that capacity to make that decision?

Dr HAYES: The capacity would certainly depend on what benefit and whether they have had access to palliative care, for instance. One in four patients in Australia dies needlessly in pain because they have no access to palliative care.

Hon Dr SALLY TALBOT: Let us go through those processes. Let us say that somebody does have access to palliative care and they still express the wish to die when they get to a certain point.

Dr HAYES: I am sure that palliative care people have that as well. Often, you have to go into the reason. I have had patients with arthritis who have wanted to die and both of them were profoundly depressed because of their disease and then when you get their disease under control and the depression lifted, their suicidal thoughts completely evaporate.

Hon Dr SALLY TALBOT: You can see the direction that my questions are going in. Do you end up—you personally with your set of beliefs—saying that anybody who persists with the desire to end their life must be depressed?

Dr HAYES: It certainly has to be taken into account.

Hon Dr SALLY TALBOT: What about somebody with motor neurone disease who might have been assessed by a psychiatrist as not being depressed?

Dr HAYES: Professor Stephen Hawking was terminally ill for 55 years. He acknowledged euthanasia, but he did not agree with it.

Hon Dr SALLY TALBOT: Yes, but can I just point out to you, Dr Hayes —

Dr HAYES: And he said that where there is life, there is hope.

Hon Dr SALLY TALBOT: Can I just point out to you, just so that we are actually arguing off the same set of premises —

Dr HAYES: The Motor Neurone Disease Association does not support euthanasia.

Hon Dr SALLY TALBOT: Can I just finish?

The CHAIR: Dr Hayes.

Hon Dr SALLY TALBOT: I do not think there is anybody in this side of the room on this committee who is arguing for compulsory euthanasia. Everybody, to the extent that we are examining the option of euthanasia, we are very, very aware that it is voluntary euthanasia so of course Stephen Hawking was able to make that decision for himself.

Dr HAYES: I will read out what the 101 Victorian oncologists —

Hon Dr SALLY TALBOT: What I am asking you is, if a person with motor neurone disease, Huntington's disease, cancer, cardiac disease or respiratory disease is saying to a medical practitioner, "When I get to the stage where I experience a loss of autonomy, I would like to take the option of ending my life at that point", what do you say to that person?

Dr HAYES: I disagree with it.

Hon Dr SALLY TALBOT: You say you do not think that?

Dr HAYES: It is against my personal opinion, it is against the Hippocratic oath and there would be very few people that I think would be in that regard.

Hon Dr SALLY TALBOT: If you do not mind me just pursuing it just for one more attempt, I am just trying to get clarity here. It might be against your Hippocratic oath, but I am talking about a person who is not a doctor who is suffering from one of those conditions that I just enumerated, who says, "When I get to this point, I would like to die." What I am asking you is: how would you assess that person's capacity to make that decision?

Dr HAYES: The trouble is that physician-assisted dying places people at risk of coercion that is both active and passive. This is the view of 101 oncologists from Victoria.

Hon Dr SALLY TALBOT: Okay, so if you have established that the person is not being coerced?

Dr HAYES: Well, that all boils down to whether or not they have been provided with all available medical treatment. The medical palliative care physicians say that there is always hope for some people, or they can always provide some help to those patients even though they are desperate.

Hon Dr SALLY TALBOT: Okay, so even if we have eliminated all those possibilities and the person is not being coerced, they are not depressed in the sense that they can be treated with antidepressants and they have been accessing treatment in an attempt to cure their condition for a period of time—so, they have not been deprived of medical services—do you then get to a point where you say, "All right, I'm listening to what you're saying"? Or do you continue to say, "No, I'm going to look for a reason not to offer you this"?

Dr HAYES: I think there is always some way that especially palliative care doctors can provide help and assistance to people who are thinking of suiciding. They go into the psychology, the religious aspect of it, as well as pain relief. In other words, there is a huge realm that is involved in the speciality of palliative care.

Hon Dr SALLY TALBOT: But Dr Hayes, we have heard evidence—and most of this evidence is public, so I am sure that you have read it—from palliative care specialists who say we cannot control everyone's pain and we cannot give anybody the autonomy that they want.

Dr HAYES: They say they can control 98 per cent of people and two per cent they give palliative sedation. The doctors who wrote this open letter certainly would not agree with you.

[5.10 pm]

The CHAIR: Dr Hayes, I just want to go back to some figures that you referred to in your opening statement and in an email to the committee on 7 February. The honourable member has referred to it briefly. I am just not clear on the statement. You said —

The overwhelming majority ... of patients reportedly euthanased in The Netherlands in 2015 were in fact dying, and they received the SAME end-of-life treatment methods that are used by Palliative Care in Australia.

25% died from withdrawal of treatment. 25% received Terminal Sedation and 50% were so-called “double-effect” ...

Are you saying these figures are from the Netherlands or from Australia?

Dr HAYES: They are from the Netherlands. This is the paper I am presenting: “End-of-Life Decisions in the Netherlands over 25 Years”. It is published in the appendix.

The CHAIR: If that is the case, then there would have been no cases of euthanasia in the Netherlands, because your figures add up to 100 per cent.

Dr HAYES: I am talking about people who are dying who made up the overwhelming majority of reported euthanasia cases. In other words, 73 per cent of those in that bracket were in fact dying with only days to live and 27 per cent were not dying. Of those, six per cent were either mentally ill or had early dementia. The other 21 per cent were primarily elderly people with multiple medical conditions. That number has risen from six per cent to 27 per cent over a 15-year period.

The CHAIR: According to which data?

Dr HAYES: It is all in this paper.

The CHAIR: Which you will table for the committee?

Dr HAYES: Yes.

Hon Dr SALLY TALBOT: Can I ask you, Dr Hayes, do you think that doctors in Australia do assist people to die?

Dr HAYES: I think that palliative care physicians help a lot of people to die peacefully. When Jim Stynes died, he had the home palliative care service coming regularly. He died at home; he died with dignity surrounded by the family and friends.

Hon Dr SALLY TALBOT: Do you think some of those deaths occur earlier than they would have done without medical intervention?

Dr HAYES: I think if the person is in a lot of pain, the doctors give analgesia on demand, even if it shortens the patient’s life. I think quite a lot would be so-called double-effect deaths.

Hon Dr SALLY TALBOT: How many of those deaths are reported as assisted dying in Australia?

Dr HAYES: I do not think there is any specific—you would have to ask the palliative care physicians that. Unlike euthanasia, where every death has to be reported, that does not happen.

Hon Dr SALLY TALBOT: None of it is reported?

Dr HAYES: I do not think there is any analysis like that in Australia.

Hon Dr SALLY TALBOT: So none of them are reported?

Dr HAYES: Probably not, because there is no legal framework compelling them to report people’s deaths. The only report would be —

Hon Dr SALLY TALBOT: You are pretty critical of other jurisdictions on the basis that a percentage of assisted deaths are not reported, but none of them are reported in Australia.

Dr HAYES: They are within the legal framework that is accepted by the palliative medicine professional organisation. They write the rules. There are special rules they have to abide by, for instance, using palliative sedation, and I am sure there are rules—and from the point of view of pain relief, that changed in about 2002. Prior to that, analgesia was strictly regulated. That is how Andrew Denton's father died in a lot of pain. That does not happen anymore. Analgesic is given on demand for pain relief, primarily, even if it shortens the patient's life.

Hon Dr SALLY TALBOT: Even on your figures, which are much, much more conservative than anything the committee has heard elsewhere, you are saying that two per cent of people experience pain.

Dr HAYES: They are the figures from an open letter —

Hon Dr SALLY TALBOT: Yes, but you are saying that two per cent of people experience pain that cannot be controlled.

Dr HAYES: That is right. That is what is published in the open letter to Victorian and New South Wales politicians. If you want to contact those people, you can. This is certainly an authoritative statement, which I suggest that you read.

Mr J.E. McGRATH: Dr Hayes, I was just going to ask you one final question. With regard to the Victorian legislation, which we have been told is the most conservative or restrictive of all jurisdictions in the world, yet the former AMA vice-president Dr Stephen Parnis has said that the safeguards in the Victorian legislation are so weak that you could drive a truck through them. Do you agree with that statement and where is it so weak?

Dr HAYES: The Victorian assisted dying legislation only passed the upper house when the—there were four Liberal dissident MLCs and their vote was swung when the government promised to spend \$62 million over a five-year period. Had that been a private member's bill, it would have failed. This is why Mr Andrew Denton was here about two weeks ago, and in the newspaper he is calling for a state government-sponsored bill, because he knows that if it is a private member's bill, it does not have the power to allocate \$62 million to effectively buy the votes of four dissident MLCs.

Mr J.E. McGRATH: I have one final question. What are the shortcomings, in your view, in that legislation that we are told is the most conservative of all jurisdictions in the world?

Dr HAYES: If I read what Dr Parnis had to say —

The proposed legislation is meant to have a number of safeguards to ensure that there is no coercion, that people do this of their own free will and that they get the best possible care.

But having studied this carefully, it's my opinion and that of my colleagues [Dr Haikerwal and Dr Yates] that there are too many places where this can be misused, where people cannot be offered the sort of assessment and care that they fully deserve.

When it comes down to it, if you provide the right palliative care urgently, effectively and confidently, you don't have to have the sorts of deaths that proponents of this legislation are suggesting you can't avoid.

The CHAIR: Dr Hayes, the member was asking your opinion.

Dr HAYES: My opinion was also influenced by the article in Melbourne's *The Age* by two Monash law faculty academics, Professor Mark Sneddon and Dr Sharon Rodrick. The headline was "flawed" and "puts the elderly at risk". In the article, they elaborated on what they were talking about. They also concluded that a lot of work needed to be done on the bill for them to be satisfied with it. This

is coming from two independent law faculty academics. I suggest that you may wish to contact them and ask them to further elaborate on that.

The CHAIR: Thank you, Dr Hayes.

Hon ROBIN CHAPPLE: You say in your letter to the committee on 13 October 2017 “A review of the 25 year history of Euthanasia in The Netherlands”—are you aware when euthanasia legislation was introduced in the Netherlands?

Dr HAYES: Yes, in 2002.

Hon ROBIN CHAPPLE: How can we then have a 25 years’ study of euthanasia in the Netherlands?

Dr HAYES: You will have to put that to the authors of the paper. That is where the “25 years” comes from.

Hon NICK GOIRAN: Further to that, Dr Hayes —

Dr HAYES: “We studied end-of-life decision-making practices in the Netherlands between 1990 and 2015.”

The CHAIR: Dr Hayes?

Hon NICK GOIRAN: Dr Hayes, is it not the case that although the legislation in the Netherlands commenced in 2002, euthanasia was being practised before that time?

Dr HAYES: That certainly appears to be the case.

The CHAIR: Dr Hayes, thank you very much for your evidence today before the committee. A transcript of this hearing will be forwarded to you for correction of transcribing errors. Any such corrections must be made and the transcript returned within 10 working days of the date of the email attached to the transcript. If it is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. If you wish to provide clarifying information or elaborate on your evidence, please provide this in an email for consideration by the committee when you return your corrected transcript of evidence. Thank you very much for taking the time to speak to us today, Dr Hayes.

Dr HAYES: Thank you for inviting me.

Hearing concluded at 5.20 pm
