JOINT STANDING COMMITTEE ON THE CORRUPTION AND CRIME COMMISSION

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

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 15 MAY 2019

SESSION ONE

Members

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

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Hearing commenced at 9.54 am

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

Dr ANDREW ROBERTSON
Chief Health Officer, Assistant Director General, Public and Aboriginal Health, Department of Health, examined:

Dr ROBYN LAWRENCE
Chief Executive, North Metropolitan Health Service, examined:

Mrs ELIZABETH MacLEOD
Chief Executive, East Metropolitan Health Service, examined:

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

Ms ANGELA SPAZIANI
Director, System-wide Integrity, Department of Health, examined:

The CHAIR: Good morning. On behalf of the committee I would like to thank you for agreeing to appear before the committee today. As you are aware, my name is Margaret Quirk and I am the Chair of the Joint Standing Committee on the Corruption and Crime Commission. The other member of the committee who is present is Mr Matthew Hughes, member for Kalamunda. We anticipate that Hon Alison Xamon will join us shortly. Hon Jim Chown is undergoing a medical procedure, ironically, so he will not be with us today.

As we have said on previous occasions, 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, the privilege does not apply to anything that you might say outside today's proceedings.

Director general, do you want to make a general statement?

Dr Russell-Weisz: Thank you, Chair. It will be very brief. We welcome the opportunity to once again update the committee on the work that has been completed or is underway regarding procurement integrity in governance within WA Health. You have met my colleagues. We will be joined shortly by Dr Robyn Lawrence, chief executive, North Metropolitan Health Service, who has a prior meeting with the minister this morning but who will come immediately that is finished. Dr Robertson, Mr Thompson and Ms Spaziani are experts in their particular fields and will be very happy to answer any questions relevant to their expertise. Mrs MacLeod and Dr Lawrence are very experienced and astute health leaders who can provide particular insight into the comprehensive work that has been undertaken at our health service provider level.

We are making significant progress in the areas of procurement integrity in governance. The WA health system's integrity fraud and corruption, or IFAC, project, is well underway, while our health support services continue to build on earlier reforms to strengthen procurement processes across the system. I also note that there has been recent commentary in the media and at some of this

committee's hearings about WA Health's integrity and procurement functions. I welcome today's opportunity to put some extra context around these comments should the committee wish. We also provided you with a submission late last week on a number of areas that Vanessa indicated to us that you would like to explore. As stated in my recent submission to the committee and at previous hearings, WA Health remains absolutely committed to addressing the issues and executing the necessary improvements and actions in practice in culture and compliance.

The CHAIR: Thank you. You mentioned the IFAC program. Hansard is not very happy with acronyms, so maybe you could explain what it stands for?

Dr Russell-Weisz: Yes, it is the integrity, fraud and corruption project. It is what we put in place late last year.

The CHAIR: You say that it is well underway.

Dr Russell-Weisz: It is well underway.

The CHAIR: When do you expect that to be finalised or implemented?

Dr Russell-Weisz: It is ongoing. I do not see it being completely finalised in the next few months. I think this is going to be work that we continue to do. The job is never done in these areas; you can always improve. You can always be extra vigilant. We have provided now two submissions to the Minister for Health in relation to the progress of this project. It tracks a number of activities that the health service providers, led by the chief executives and the Department of Health, are doing in detection and education in relation to fraud and corruption. We have a comprehensive spreadsheet of activities, some of which are complete, some of which are in progress. I would say that this project will be ongoing because we do not want to become complacent.

The CHAIR: If we can just go back to when the CCC released its report, there have been a number of reviews and, as you say, you have commenced implementing this program. Can you tell us what has happened and also the outcomes of the reviews and what steps have been taken as a result of those reviews?

Dr Russell-Weisz: Could I ask, first, Mr Thompson to talk about procurement and then Liz MacLeod to talk about the specific improvements that have been made at one of the area health services that Liz leads?

Mr Thompson: As a result of the CCC investigation we undertook a forensic audit across two years of transactions at Health Support Services. The good news is that we did not find any evidence of fraud, but we found some challenges with some of our controls. We have some control issues around our master data management for procurement, which we are addressing. We had some issues with controls around separation of duties that we can improve in the procurement space, which we are addressing across the system. We also found some issues with our system in terms of how it works and some of the features that we had not enabled, which we are addressing. Fraud-wise, we did not find any evidence within HSS in that review, but we did find some issues of where we can improve controls and we have projects in place for those.

[10.00 am]

The CHAIR: You mentioned the word "challenges". What exactly do you mean by that? Is that some sort of euphemism for deficiencies?

Mr Thompson: They are weaknesses. They are things that maybe in a contemporary organisation you would see that for some reason in the past they have not been switched on, so we are looking at those and increasing the amount of preventive controls in our financial systems.

The CHAIR: Such as?

Mr Thompson: We have a thing called "self-approved requisition", so for very low level purchasing people are able to raise a requisition and approve it. We are now going to switch off that feature because, obviously it was not against any of our policies, but it is not an amazing control so we are looking to improve those controls.

The CHAIR: Given that Health has a budget of over $9 billion, low level might be quite high. What do you describe as low level?

Mr Thompson: Most of those transactions would be $1 000 or below. I might ask Liz to comment, because the majority of those transactions do occur at a health service level and all of the chief executives have thrown themselves in behind this project and have done a lot of work at a local level.

Mrs MacLeod: Our immediate response involved a significant amount of communication to staff. We have maintained our view that although we can have policies and procedures, it is important that our staff understand the applicability and relevance of it to all staff, and it involving all staff. We have had a high level of communication to all staff.

Immediately following the CCC report we met with our senior leadership team, which is approximately 70 people across the organisation, so the board, chair and myself met with the team and impressed upon them the importance of what we would be embarking on doing. We immediately checked that our facilities management and procurement staff had their criminal record screening up to date and did immediate checks to make sure that none of the staff had extended periods where they had not taken leave, so looking for immediate flags in those areas. We also did an immediate check as to whether any of the referred building organisations had any contracts with them. There was one of the organisations where we did: Swan Builders were doing work at Armadale and we went through State Solicitor's advice for the appropriate management to work that through, and that has now come to a conclusion.

We then developed a more robust plan in which we looked at prevention, detection, improvement and reporting and we have had a number of strategies through that. We have developed a fraud and corruption control plan, including having done a fraud risk assessment and incorporating that into our plan. We have developed a procurement and contract management manual that goes through and provides detailed information about the different level of processes that people are required to do. We have made that readily available in an electronic format on our intranet to again try to make it accessible for staff rather than it being a manual on the shelf. We are doing communications around that at the moment. We have agreed to the separation of functions and facilities management area where, as Mark said, some of the things are around the self-approval, so the separation of functions is important. We are just in the process of recruiting the additional person so there will be a separation of contract management and the procurement in the facilities management area.

The CHAIR: Sorry, you said that there will be.

Mrs MacLeod: There will be.

The CHAIR: When will that occur?

Mrs MacLeod: By the end of the year. We have a job description form developed. It needs to go through our HR processes to get that formalised.

We have done more training for staff. We have identified 45 staff who have a high level of involvement in procurement. We ensured that they had all done the training for the procurement development system. We ensured that they had all undertaken the training required for that. Equally, we have amended job description forms for those 45 staff to reflect the role of procurement

and following government policy in that area. We have undertaken six external audits led by our internal audit team. They have then come with a number of other recommendations as well that we are implementing with similar themes to those Mark alluded to. One of the additional ones we are looking at is data analytics. We are just in the process of that. We have a scope of work that we are going out to tender for at the moment. We are doing that in conjunction with our colleagues at North Metropolitan Health Service and going out for tender for data analytics to have a program that can run and pick up anything using artificial intelligence.

Mr Thompson: If I may, just to add to Liz's point, since we talked to you last time—I believe it was in October—we trained an extra 736 people in the procurement process, procurement policy and procurement guidelines. We are trying to get through that. We have 4 500 buyers in the system, so we are just trying to get through as many people as we can to revamp their education.

The CHAIR: In addition to the training on procurement practices, has there been any training of supervisors and senior management in terms of identifying personnel who might have the profile of tendency towards corruption?

Mr Thompson: I can talk from a health support services perspective. The CCC representatives came in and gave a presentation to the executive and senior leadership team, profiling the type of individual or flags that you may look for. That has been a piece of ongoing work for us.

Mrs MacLeod: From an east metro perspective, one of the other pieces of work we are doing is combining all of our training requirements. There is contract management training, we are looking at the procurement, and we will equally be picking up some of that. We have a piece of work at the moment where we are trying to have a combined training for our senior staff and who that will be.

The CHAIR: Welcome, Dr Lawrence. I am sorry you have had to be in two places at once. Can I ask: generally, how is morale in north metro at the moment?

Dr Lawrence: I think morale is variable across the organisation; I think that is the simplest word. I have not got a robust measure of it. All I can tell is how it is going when I talk to people. Obviously, when we get the minister's survey results, we will have a better understanding of where we are placed. Multiple things have impacted, but there is no doubt that the team that was most directly involved with the people who were identified in the CCC report were very, very shaken by that, and some of them are still quite traumatised and emotional. On the other hand, they are working really hard to develop a more robust system moving forward, and the senior team are very committed to that. Cautious optimism might be what I would place us at, at the present time. Of course, apart from this issue, we have a raft of other issues in north metro which also impact on that, so we are working across the board through all of those things.

The CHAIR: Director general, we have heard a bit about some of the activities that have taken place as a result of the CCC report. As I understand it, one of the reviews was by KPMG. It notes that there have been a number of reports in recent years and recommendations following those reports, and that progress has been too slow generally. How can we have any confidence that this later activity will be done with due expedition?

Dr Russell-Weisz: I am not exactly sure which report. I know that certainly the Public Sector Commission is using KPMG to do its review. We had one done for the minister—it is the minister's review, not mine—into that period of time, and that has not come back to the department as yet, so I have not seen the final report for that. What I can say is that it was identified going back to probably 2013–14 that there needed to be procurement and integrity reform. Procurement reform did start from 2014, but I would say that I am very optimistic. The work that is being done and is being tracked—this is not us just saying that work is being done; we are tracking this and we are

reporting to the minister on every single activity. That is every activity in relation to procurement and integrity, we are reporting when a milestone is met and when we believe it is complete. The Department of Health—Royal Street itself—has done very similar audits into our contract management functions, so we are replicating the work that is being done by the health service providers, although the bulk of the spend does come from the health service providers.

Liz mentioned communication. We all have now integrity tabs, so we are all promoting; we are not waiting for people to come to us. I have done a video—I know that is only one element—and I know other chief executives have as well, saying to staff, "If you see something, say something. We want you to come to us without fear or favour. You can come to us through public interest disclosure. You can come to us in any way possible. You can report it to our integrity function or the health service provider integrity function. We actually want to hear from you." We want the same approach as we do that we have with safety and quality. With safety and quality we want to hear about reports so we get better, so we understand that if we do cause harm or there is a mistake when we are taking care of patients, and we want exactly the same with this.

We are reporting to the minister, and subject to the minister approving, I am very happy that the committee sees every integrity, fraud and corruption report, because that shows each strand. It shows every health service provider, what they have committed to, where they are up to, what is complete and not complete, and what is late. We are being very honest about what is late. We are also doing exactly the same with the department. The evidence is there. It is not just saying that we measure that. The Health Executive Committee, which is every assistant director general and every chief executive, meets monthly. On a monthly basis, we review the process in relation to our IFAC. We actually review that progress and we talk about specific issues that may be of challenge or might be slipping. I am pleased to say that the majority of milestones have been met across the board, but as I said in my opening statement, I do not think we can ever stop. This will be an ongoing issue for us, although, as Mark has said, in everything we have done, and the projects we have done, we have found no fraud like that found by the three public officers at north metro. We have found nothing of that ilk, but we have found areas that we can tighten up—there is no doubt about that—in the Department of Health's contract management function, and the themes are very similar going through. I can assure you that the work has been extraordinarily comprehensive.

[10.10 am]

The CHAIR: I have just two follow-up questions and then I will defer to my colleagues. Dr Lawrence, you mentioned a survey that the minister released. Can you tell us a bit more about that?

Dr Lawrence: That is the minister's staff survey, which is done for all of Health. I understand that it is with him, and we will receive the results once he is happy to provide them.

The CHAIR: What areas does that cover?

Dr Lawrence: There were a lot of questions. There were about 60-odd questions.

Dr Russell-Weisz: It was his culture survey. It was an election commitment he gave that it would be done annually. It is about the culture within the health services and Department of Health. It was completed around three weeks ago. The report has just come in and it is with the minister.

The CHAIR: Would you anticipate that that would become public or not?

Dr Russell-Weisz: I would anticipate it would become public, yes.

The CHAIR: There was also an election commitment about directors general having key performance indicators. Have you negotiated your key performance indicators for the minister and does that include anything relating to corruption prevention?

Dr Russell-Weisz: I have always had a performance agreement between the Public Sector Commissioner and the minister, and I signed off one in August last year, or just before this report came out. I do not think it has anything specific about this, but I can assure you that I will be measured on my ability, and our ability, to deliver the IFAC project. I am sure that in my next annual performance agreement it will be there.

Hon ALISON XAMON: I just wanted to pick up on what you said, Dr Russell-Weisz, about how you had not found any other matters that have been of the seriousness of what was uncovered with the CCC report. Presumably, though, you have found other instances of wrongdoing. I would be surprised if through your close examination you did not find anything.

Dr Russell-Weisz: I can give you some examples generically of what I see reported, say, through misconduct. I am not saying that there is no misconduct out there; of course, there is. Yesterday, I signed off a number of things where a chief executive will alert me to the fact that they may be going through a misconduct matter with a nurse or a doctor or a staff member—it might be clinical; it may not be clinical—and the activities they are taking. What we have now, which is so much better than we had before, is that they will alert me to what action they are taking, and I make the determination whether I tell any other health service provider or I seek any other information. There is a process now that if a staff member is being investigated for misconduct. We do have certain reporting requirements. The reporting requirements go to the Public Sector Commission or the CCC; and, also, if it is clinical it goes to the Australian Practitioners Health Regulation Authority.

There are certain reporting requirements but I will be honest: I take a very cautious approach. I will tell other health service providers where there is, on balance, you say, "This actually only affects one health service provider; it's never going to affect somebody else." We actually tell other health service providers about staff members who are under misconduct, so I do not want to give you the impression that we are not finding anything. Of course, it is business as usual and this, to coin one of my colleague's phrases, is enhanced business as usual. This is actually making sure that we are double-checking and triple-checking, but there is a whole process that goes on every day in the health service providers, and they tell us, and within the Department of Health.

Hon ALISON XAMON: I am curious because your workforce is enormous and obviously spread out over the entire state. Surely you are not personally made aware of every single matter of misconduct, because you would never do anything else, I would assume. I am interested to know the point at which you are made aware, where it is deemed to be of such seriousness that you need to know. For example, if a staff member has made an allegation of bullying against another staff member, surely that would just be dealt with by HR; it would not necessarily —

Dr Russell-Weisz: It would be. I will ask Angie to let you know the processes of what we do, and then one of the chief executives might want to take it from what they do at a local level.

Ms Spaziani: I think the biggest change for the health system in total was in 2016 when the Health Services Act came into being and health services were established as statutory authorities. That made them responsible for all the misconduct matters, if you like, with their own health service providers. I think that really increased the visibility of things that were occurring and the agility, I guess, to manage them. So from a Health perspective, also what came about as part of the Health Services Act was part 10, which is about reporting of criminal matters and misconduct. That introduced a new requirement for all health services to provide responses or reporting to the CEO, so it shifted the responsibilities of the health service providers more locally for misconduct matters and reporting. Each of the chief executives has a responsibility under the Corruption, Crime and Misconduct Act to report notifiable matters—so there are serious and minor—to both the Public Sector Commission and the Corruption and Crime Commission. That is their responsibility, but the

section in the Health Services Act that requires it reported to the CEO relates to criminal charges and relates to serious misconduct that ends in termination, or high risk to the safety of patients. They are the things that the HSPs are obliged to tell the CEO. They are also obliged to tell the chief executive officer about misconduct, professional and performance, and they are the matters that are reported through to AHPRA. They are the things that the CEO gets to see. He has system-wide integrity services that deal with all that incoming information and assists him to provide recommendations around what more information we might need from the health service provider, and it is always about putting the safety of the patients first. That is the critical issue. That allows him to make a decision about what other health service providers need to know about any particular employee. Sometimes these are matters that are not proven; sometimes they are allegations at a very early stage. So it is a really low threshold, which we think is really adding value to —

Hon ALISON XAMON: So you are hearing a lot of it, then?

Dr Russell-Weisz: I am hearing it, but as Angie says, it is at a higher level. I might just ask Liz to comment from a health service provider perspective. When Angie talks about a CEO, she means me, the director general; CEO of the Department of Health, but the chief executives of the health service providers have that accountability.

[10.20 am]

Mrs MacLeod: We have an integrity and ethics officer and the reporting for the misconduct will go through that person. As Angie and Russ have both said, we initially can have an allegation. The person is notified of the allegation, and once that allegation or suspicion is confirmed, we can go into an investigation. As chief executive, we do the notification to either the CCC or the Public Sector Commission. Those letters come from me, so I am actually aware of that. We also then have a register of all the misconduct cases that are currently going on in the organisation at any one time, and I go through that with the team fortnightly or monthly, depending on the severity of what the matters being undertaken are, noting that there is a process in an investigation process that needs to occur, so you do not want to intervene in any of the process or decision-making that is going on until the investigation has been completed and there has been a determination on whether the allegations have been substantiated or not. Certainly, while that is happening, it is keeping an eye on the process and that it is moving through as quickly as you would like it to move through. Then at the end, depending on the level of the misconduct and the findings, there may or may not be an action for the chief executive. Our delegations have any termination as a consequence of misconduct being something the chief executive does, so if that requires my involvement at that time, it will be provided and then I make the determination based on the evidence provided whether the termination is deemed appropriate.

Hon ALISON XAMON: To what degree will the various boards be advised? You mentioned before about the new act, but when will they become aware that misconduct has been uncovered?

Mrs MacLeod: We provide a monthly report to our board that includes the number of misconduct cases.

Hon ALISON XAMON: Is that all of them? I am just wondering about the degree to which the health boards are enabled to be able to determine if there is a systemic problem in a particular area of health or in an actual location.

Mrs MacLeod: I can take some of this on notice and get the exact time frames. I think what we provide monthly is the number of misconduct cases that are currently in progress. That is not preceding people working out if there has been a case to answer to, so there is often a bit of pre-work before that occurs. That is monthly and we break it into time frames for between zero and six

months, six to 12 months, over 12 months, so the board can have an understanding of that. Six monthly, we break it down into the different types of misconduct and the outcome and the consequence of the misconduct, so we provide that.

Mr M. HUGHES: Can you categorise some of the breakdown of misconduct in certain categories?

Mrs MacLeod: There can be looking at patient notes, so patient privacy-type ones. There can be misuse of drugs, which does come up, or loss of drugs. There can be inappropriate behaviour; that comes up a lot. I am just looking at my colleague on the right.

Dr Russell-Weisz: Also what we see is clinical — I am just looking at what I looked at yesterday. There were two instances of poor clinical practice, but where the core clinical practice is outside a normal clinical policy, so it is not fraud as such, but is actually probably worse because it actually is clinical practice that might harm a patient. As Angie said and everybody around this table has said, quality is paramount, so a lot of them are on clinical practice. What we want to prevent is somebody who has been suspended by, say, the WA Country Health Service for clinical practice seeking employment in another health service, and we also now have the accountability tab on our system. We can flag these people if they are about to be appointed.

Hon ALISON XAMON: Is that new? Is that something you did not have before?

Ms Spaziani: No, we had the ability to flag employees who were terminated for wrongful behaviour. Section 146 of the Health Services Act allowed us to flag people that we think also are a risk, in terms of their behaviour, prior to a finding. That does not mean anything other than they are flagged. When the finding occurs, we can change that flag if there is no finding and no suspicion. If they depart an organisation prior to a process, it allows us to pick them up if they come into another health service, and that is when procedural fairness would need to kick in about where were they in that process, what was the finding, and what decision can an employing authority make about appointing that person. That is how that works at the moment. Does that answer the question?

Dr Russell-Weisz: It does, and I think we might be able to go through the categories of misconduct you asked about. Angie might be able to talk about what categories we actually do collect now. Do you want to run through that list?

Ms Spaziani: We have a case management system that is a requirement for all health service providers to use, to enter in every reported matter that they are dealing with. We are refining these categories as we go, but they are: misconduct; conflict of interest, financial and personal; disclosure of confidential information; inappropriate or unauthorised use, information technology is a different category; fraud, falsification of documentation; fraud—we had meals, entertainment and I do not believe that is still a useful category but it is there; fraud, work hours, overtime—fraudulent timesheets, those categories; stealing, theft of money; stealing, theft of property; stealing, theft of drugs; and personal behaviour is another large category. The integrity officers at each health service provider use that system to log the categories so that we can keep some track of where our trends are.

Hon ALISON XAMON: Okay. If I can confirm I understand, Ms MacLeod is saying that that then is collated every six months. So, potentially for that sort of data you would be able to indicate if there were trends, on six-monthly intervals, within particular area health services around particular types of misconduct?

Ms Spaziani: Yes, the data is available. It is the health service provider data. They look at their own risks. From a system manager perspective we can look at across the system. We are doing more and more of that in collaboration with the health executive committee. There is also an integrity working

group; all of the integrity officers for each HSP come together and we look at that kind of data and we look at the policies and themes from that data.

Hon ALISON XAMON: I did ask the question of when that data started being collated, and the next question is: is it publicly available? Because I am just interested to know whether that is something which people would be able to determine trends from.

Ms Spaziani: The data has not been made publicly available. The case management system has been around since 2009—10.

Hon ALISON XAMON: But tweaked, you say, around categories.

Ms Spaziani: The categories have remained fairly much the same.

Hon ALISON XAMON: Okay.

Ms Spaziani: We are looking at them now. We are looking at whether they need to be broken down a little differently. We are looking at whether the health service providers are using the categories in the same way, so that we are actually comparing apples with apples and there is no risk of interpreting those categories differently. Certainly we have had the data available since 2010.

Hon ALISON XAMON: The other question I have is in terms of when you discover misconduct, are you also keeping records of how that is coming to your attention—for example, whether it has come through your systems or whether it is coming through whistleblowers? Or is there any way of actually confirming how this is coming to you?

Ms Spaziani: There are fields in the systems that are compulsory to have filled in that look at how it came about, who was the complainant, for example, or how the information came to light. There is also capacity to upload all of the information that goes with each case into the system, although some HSPs can use that differently. So there is an ability to find out —

Hon ALISON XAMON: But it sounds like you have to go back a bit, on a case-by-case basis, to determine how that information came about. You would imagine that the interest of the committee is looking at what are those structures and processes?

Ms Spaziani: Yes.

Hon ALISON XAMON: What are the cultural elements that actually enable wrongdoing to be uncovered? So, that data needs to be kept.

Ms Spaziani: It is kept. There are always a number of things that you can do with that data, depending on what you are actually looking for. We are in the process of rebuilding that system so that it is more agile and that we can get the information, I guess, more promptly and we can look for different things. We are in the process of refining the case management system at the moment and looking to build a substantially more integrated system—that is in scope for the next 12 months—because we do have a lot of data. We just need to work out how best we can use it with the risks that present themselves at the time. You can always pull out the data that is representative of the risk that you can see at the time.

[10.30 am]

The CHAIR: Can I dumb that down a bit?

Ms Spaziani: Sure.

The CHAIR: So, if the minister asked the director general tomorrow, "How many of these cases came to light due to a whistleblower and how many were through internal oversight and analysis" —

Hon ALISON XAMON: Processes.

The CHAIR: Processes. Would you be able to get that immediately or would you have to manipulate the system and it would take some time?

Ms Spaziani: It would depend entirely on what he wanted, but for whistleblowers, if it is under the PID—public interest disclosure—legislation, that is kept separately and there is a register of all of those kept separately. All of those matters are kept separately. We can still count them as misconduct matters in our overall data but the actual cases, where they have come from, are treated separately. I think there is a requirement under the Public Sector Commission's entity survey to report PID matters, which are whistleblower matters. There is a separate reporting requirement for that. Is that what you were looking for?

Hon ALISON XAMON: Right, yes.

The CHAIR: Yes, thanks. Has there been any increase in those disclosures of late?

Ms Spaziani: Not notably, no.

The CHAIR: Not notably.

Mr M. HUGHES: Mr Emerson is known to you and he provided evidence to —

Ms Spaziani: Yes.

Mr M. HUGHES: — the committee and you have given a response? He obviously is very critical of the capacity of Health to undertake investigations, certainly in terms of matters that occurred prior to 2016. When you last came before the committee you mentioned that a newly appointed investigator—who in fact looked at matters that Emerson had previously looked at in relation to Fullerton—had discovered matters that the previous investigator had not discovered. Can you explain why that occurred?

Dr Russell-Weisz: If I can answer that, I will take the first part of the question about Mr Emerson. I must say, I do not think I have ever met Mr Emerson. He actually left the department in late 2015—he did not leave employment but he actually left the department—so I cannot say I have met him. He was part of a then corporate governance directorate.

Hon ALISON XAMON: Yes, he never said he met you.

Dr Russell-Weisz: What happened with the matter in relation to the north metro offices is that when I was first informed by the CCC about it—which was December 2015—they were unhappy with the actions the department had taken. At that stage when I heard about it then, I was not aware of this previous investigation that had actually been done by Mr Emerson, or anybody else, and we just said, "Let's get a new investigator in." The issue was I then alerted the then assistant director general. That person got a new investigator in, they went in and investigated at north metro, and they made a determination in March 2016—if I recall correctly—that the Department of Health did not have the powers to actually look at this, and we went back to the CCC and then they served us with two section 42 notices in May 2016. That was our response. It was not actually in response to the fact that Mr Emerson had done one investigation. Now, Mr Emerson had done one investigation. It was around a complaint at the time in relation to nepotism. It was not in relation to procurement practices. It was actually in relation to nepotism, as I understand it, at the time; it preceded my time as director general. But in looking at his investigation, he did it between—Angie will correct me if I am wrong—January and June 2015. He completed his investigation and, as I understand it, could not find any evidence of that complaint.

Mr M. HUGHES: Of nepotism?

Dr Russell-Weisz: No. There was a separate issue in relation to procurement practices in relation to the two or three north metro offices at the time and there had been a previous procurement

report—actually at the same time—that I do not think Mr Emerson had anything to do with. For me, the issue was at the time I had a very critical letter from the CCC: we had to act. We got a new investigator in, who actually acted very quickly and then came back to us and said, "I need powers I don't have", and so we went back to the CCC.

Mr M. HUGHES: He does make the comment that the investigatory resources available to Health were inadequate and the system dysfunctional. Would you agree with that, at that time?

Dr Russell-Weisz: I have to say, it is me recalling a time when I either was not there—or also he relates to a time really between 2012 and probably 2015. But we do recognise that we had to significantly increase the services both in the Department of Health—and I will ask Angie to talk about what our current system-wide integrity services look like, and we have certainly bolstered that—but I also think the advent of the Health Services Act in 2016 made local accountability at the health service provider level, and they have set up their own integrity function. So it moved from the department out to the health service providers, but we have also recognised the need to bolster our own integrity services. He makes some criticism about the lead person in the area—we have always had, I think, a level 9 person there—but Angie can talk now about the significant increases we have resourced within the department and how many.

Hon ALISON XAMON: Before you do that, can I just ask a question? My colleague I think has some follow-up questions as well. You talk about the devolved system.

Dr Russell-Weisz: Yes.

Hon ALISON XAMON: I suppose on the one hand, you know, it is good to have those systems that are closer to the ground, but on the other hand there is a risk there in that you can end up with devolved systems in a particular health service that are inadequate or perhaps relationships are formed more closely, whereas if it is centrally determined, then you are more likely to have it hands off. How on earth do you manage that tension and that risk between ensuring that you are close to the action but, at the same time, not getting too close?

Dr Russell-Weisz: Look, having lived in both systems—and there are a number of people around the table who have lived in both—I would say I am much more comfortable with the system now. Under the old system, everything was reported through the director general—everything; 44 000 staff and all clinical services. How could anybody be across everything that was going on, be it integrity, safety and quality, right across the system? When we set up the Health Services Act and when we went to local boards, we looked at what happened in New South Wales, Queensland and Victoria. Victoria has 88 boards. We did not want to go down that road, that is too —

Hon ALISON XAMON: No. That is unworkable.

Dr Russell-Weisz: — unworkable. New South Wales had area health services boards, as did Queensland. We tried to take the good out of what they had learnt and we created seven health service providers—there is actually eight, because we have Quad Centre still, but seven large ones, which include also health support services and, just recently PathWest—because we felt they had economies of scale, they were large enough and they also could respond to their population. It put more local accountability, from the boards and the chief executives and the staff, that they could actually embed themselves more with the local community and actually know what the community's needs were. At the same time, you are quite right, they needed to make sure they had good integrity functions. They have certain stipulated committees at a board level. They have financial, they have risk and audit, and they have safety and quality. Now, they might do things slightly differently. We have mandatory policies. There are certain things that are stipulated under the legislation; the actual health service providers might actually do things differently. But I actually

think we have the balance right. I am still seeing serious misconduct; I am still seeing major issues. The health executive committee get together twice a month. On their agenda is safety and quality, workforce, integrity on a monthly basis; and ICT—information and communication technology—on the other month that we meet. So, we have tried to get the balance together to having really good, robust, devolved governance, but at the same time, operating as one WA Health family.

Mr M. HUGHES: In terms of the observation that Mr Emerson made regarding his view, that the resourcing of the investigative function was inadequate—I think he also used the word "dysfunctional"—tell me why I should believe that the resourcing is now adequate in relation to matters that need investigating? I am particularly interested in relation to the scale of corruption that was eventually uncovered. Do you feel that the new arrangements under the new system in fact would have led to an earlier discovery of the scale of the operations that Fullerton and others were involved in?

[10.40 am]

Dr Russell-Weisz: I might take that first.

Mr M. HUGHES: Is that a fair question?

Dr Russell-Weisz: It is a very fair question, member. He relates all his comments to pre-October 2015. Clearly, there was some dysfunction at that time within the corporate governance directorate. But he himself did one of the first investigations into one of the North Metro offices that found nothing. The other investigation that took place, he had nothing to do with. In retrospect, into procurement, could and should have flagged issues at that time. But what I can say—I will ask Angie to speak about how we now resource our system-wide integrity function—it is transformed. It is so much different than it was. He relates to pre-October 2015.

Mr M. HUGHES: I am not suggesting this, but Mr Emerson, in relation to what he was able to uncover, that is part of history. There is a view, though, and I think, from what I have heard, you share it, in relation to the resourcing of the investigative function within Health. How has it improved? Would the improvements, in fact, have led to an earlier discovery of the scale of corruption that was eventually uncovered?

Ms Spaziani: In terms of the first part of the question, I think, reading through Mr Emerson's transcript, in terms of the number of resourcing and the appropriate resourcing, my observation is that is tenfold. Each of the health service providers do have an integrity function. They are staffed a little differently, but there are more staff looking at that. There are investigators in many of those health service providers—a dedicated resource for investigations. We have also spent quite a bit of time over the last two years looking at the skillset of the people that have been conducting the investigations. There are some comments that were made in, I think, the CCC report—the drug discrepancy report—of 2018. We have had some reviews that have indicated that. We have spent quite a bit of resourcing looking at the skills of our HR practitioners if they are involved in those investigations.

Mr M. HUGHES: What is the full-time equivalent of the various officers across each of the health service providers? Within the health department itself, presumably there is an overarching person.

Ms Spaziani: For integrity, there is at least one FTE—there is an integrity manager for each of the health service providers. That is one FTE. I think South Metro has a further two. I think East Metro has a further one FTE for investigation support.

Dr Russell-Weisz: Full-time equivalent.

Ms Spaziani: Full-time equivalent—yes.

Mrs MacLeod: That was a model that we were going to put in place, from an East Metro perspective. That is just how we allocate the budget. We were going to have one full-time equivalent and then, with the remainder of the budget, allocate that and do it on a contractual basis as we need different expertise for different investigations. We have not moved to that at this stage. It has just been the nature of the investigations that we have kept people in through a contractual process, but it means we can get the expertise when we want. From a resource perspective, there is no restriction on how many investigations we do. We do what we need to do. I am sure that North Metro would be the same. There is no, "We have now met our budget allocation. Stop doing investigations." We would just keep going in terms of making sure that everything that requires investigation gets the investigation. That would be a fair statement.

Dr Russell-Weisz: We can provide a breakdown per health service provider on notice. In our letter to you last week, on page 7 out of 36, there is a breakdown of our integrity investigation, freedom of information and support within the Department of Health. I will not go through it, but it is actually there and it shows how we break it down and how we have resourced it. It is page 7 out of 36.

Ms Spaziani: There are four resources there that are available under certain criteria for the health service providers to use investigators, if they so choose to, for reasons best known to them or we agree on what is an appropriate reason to use our resource for that purpose. As I was saying, the certificate IV investigations is something that has been applied across the board, I think, to health service providers in terms of anyone involved in investigations. We are upskilling everyone around the edges as well.

Dr Russell-Weisz: I will ask Mr Thompson to just comment on the resources, because there are resources within his area as well.

Mr Thompson: Just to give you an insight, in terms of procurement, there are a couple of things we have done since we last met. One is to increase the visibility of any non-compliances. We are now reporting that monthly and the CEs get reports. We sit down as an executive to review those. It might not be fraudulent, but it gives an indicator of things. Also, in the purchasing space, there are over a million transactions a year going through the purchasing system. We have some controls in place where the purchasing officers may pick up things and they will raise a non-compliance. They all come through to myself to review on behalf of the whole system.

The CHAIR: Was that done through data analytics or some other way?

Mr Thompson: That is where people are trying to get an invoice paid or raise an order that does not meet State Supply Commission requirements so then that is not processed. They have to write a noncompliance to me or a contract variation and I have to review it and make a decision based on that. Additionally, for our million transactions, we have got increased data analytics now. So, we have very good insights into the behaviour of our buyers. I am starting to share that with all the procurement and supply chain functions within the hospital areas and we are starting to detect some trends and we are starting to change some of our preventive control. So, we have a lot more insight into the —

The CHAIR: What sort of trends are you picking up?

Mr Thompson: We may have a trend whereby there may be some transactions going on with lots of little transactions and when you aggregate them for a year, we should actually have a contract in place. They are not fraudulent, but they are kind of under the radar, so we are identifying those.

The CHAIR: In money laundering terms, of course, it is called smurfing. Just to go back to the director general, quickly, in relation to the investigation that led to the CCC getting involved, so if I could just confirm, you were appointed in August 2015?

Dr Russell-Weisz: I was.

The CHAIR: Then in December that year, you received a CCC letter saying that they were unhappy with the progress. I think we have been through that before.

Dr Russell-Weisz: Yes.

The CHAIR: And then you appointed a new investigator and referred the matter to the CCC subsequently —

Dr Russell-Weisz: The then assistant director general actually appointed the investigator. I did not.

The CHAIR: Yes. That is fine. Now, in February of last year, you met with the CCC commissioner and the counsel assisting, and you were briefed on the investigation.

Dr Russell-Weisz: February, possibly. I certainly was briefed. Clearly there was an investigation going on. I cannot remember the exact date but I can certainly confirm that looking at my diary.

The CHAIR: We are not going to hold you to any particular date or anything. We are just interested in the process.

Dr Russell-Weisz: Yes. Look, there were a couple of briefings with the CCC. They did not tell me necessarily the outcomes.

The CHAIR: But they had obviously had some hearings and they were talking to you about what had come out of those?

Dr Russell-Weisz: Yes.

The CHAIR: All right. Now, in mid-July 2018, there was some advice received from the State Solicitor's Office that they were not comfortable with the minister being briefed about existence of the investigation. Does that ring a bell with you?

Dr Russell-Weisz: It does.

The CHAIR: Part of our role, obviously, is to look at the conduct of the CCC. Were you happy about that?

Dr Russell-Weisz: Not particularly. I felt very nervous not briefing the person I report to, the minister, on what was a substantial investigation. We did not know particularly the findings at that stage, but we knew the CCC were completing their report. And it was obviously like an Auditor General's report, we want the minister briefed. I think I had asked on a couple of occasions could I brief my minister, not necessarily on the findings, because I did not know everything and I had not actually seen the final report, but I eventually got approval, I think, and I have to check this—I think about three days before. I think something like 13 August. This is, from memory.

The CHAIR: That is my notes. So, 13 August—well done. Now, are you able to tell me when Mr McGinty started at the North Metropolitan Health Service as the chair, are you aware of whether he was briefed when he took on that role or not?

Dr Russell-Weisz: He would have been briefed when he took on the role at a time that I was allowed to brief the minister. It would not have been before the minister was briefed.

The CHAIR: There is only a few days involved, but it seems to me strange that someone's taken on the role of chair of the particular service provider that is problematical and for a few days a week or so, he is operating without knowing that key piece of information.

Dr Russell-Weisz: He may have known there was an investigation afoot. I would have to check when he was briefed about that. He was definitely appointed from, I think, 1 July 2018. I would have to check. I will take that on notice when he was briefed.

The CHAIR: Thank you, if you would provide us with that.

[10.50 pm]

Dr Russell-Weisz: He was briefed on a number of issues. Because, obviously, as Dr Lawrence has made comment on—there are a number of issues affecting the north metro health service at the time that were completely unrelated to fraud and corruption.

The CHAIR: That seems to be undesirable too because, for example, the board might have been making decisions about redundancies or things like that and that has become contentious subsequently, too.

Dr Russell-Weisz: It has, although I do not think it was that board that made any decision about that. It was not that board.

Dr Lawrence: Redundancies do not particularly go to the board. It is a management decision.

The CHAIR: All right. Fine. Thank you. Now, just more generally, and Mr Thompson can probably help us, there is a whole Department of Finance overview of procurement. How are your systems going to run—in parallel or are you going to let them take over the whole show? How is it going to work from a Health perspective?

Mr Thompson: Yes. Just to give you some insight into how we interact with the Department of Finance, when we have a procurement that is over $250 000 as a total contract value, we use a service that they call facilitation, so they help us to go to market, engage the vendors, conclude contract negotiations and then we manage the agreement ongoing. In terms of the reforms they are looking at in terms of the policy area, simplifying things, providing some leadership, we are in collaboration with them. I am actually a member of the state tenders review committee, so I am part of that committee that helps review all the large contracts coming through the system.

The CHAIR: So you are contributing to the ongoing review?

Mr Thompson: Yes.

The CHAIR: What about linking the WA Health contract management system with Tenders WA; is that on the cards?

Mr Thompson: Currently we have our own system. It is PDMS. I will get you the exact acronym for it. That is a workflow system for us. Tenders WA is the system that the whole of government uses to fit in with Department of Finance processes. We have to populate both systems and we actually run exception reporting to say where is the data different between them. There is no linkage between their systems at the moment. You imagine if you pursue that, then every agency would have to take whatever system it is using and try to link it in with Tenders WA.

The CHAIR: Do you think given the volume of transactions coming out of Health, do you think the Department of Finance is currently qualified in terms of conflict of interests or the like to assess them for Health or is that something that should still be done internally?

Mr Thompson: In terms of the facilitation services for the contracts?

The CHAIR: Yes.

Mr Thompson: I am comfortable with the service they provide. I think our key challenge in the system is capacity and cycle times. For the next five years we have over 1 200 agreements that are going to expire. That is a very large workload. In terms of what we are able to work with the Department of Finance in terms of our contribution, Department of Finance resources and the process of clinical resources, we are only able to get to about 100 or 150 contracts a year through that process. Cycle times can vary from six to 26 months. So, we are working currently with the

Department of Finance looking at two things: one, what can we do to reduce cycle times? We have a role to play in Health but also they have a role to play, and we are also looking at what is the two to five-year renewal pipeline and what are we going to need to do in that instance?

The CHAIR: Now, the Perth Children's Hospital was notorious for the number of variations that took place. We have identified that as maybe a backdoor way of there being some impropriety and lack of probity because it does not get the same level of oversight. How is that being addressed for future projects?

Mr Thompson: I have only been in Health for 12 months so I am not aware of what those variations were around. I have to approve all variations above $20 000 and above. If it gets to $250 000 and above, Department of Finance review it as well, and if it gets above $5 million, it goes through state tenders committee. So, there are lots of good review and oversight. Part of the challenge is —

The CHAIR: Is that a recent system? Are you aware of whether that is recent?

Mr Thompson: No, that is always been —

The CHAIR: That has always been there, has it?

Mr Thompson: As far as I understand, yes.

The CHAIR: Is there an issue about how those variations, those multitude of variations —

Mr Thompson: Currently, Department of Finance, that process only looks at goods and services. It does not look at works agreements. So, part of the government reform is to have a look at doing things for works in a very similar way that they have done for goods and services; there has been a separation.

Hon ALISON XAMON: Can I just clarify: works agreements would include what? IT? That is what I am trying to get an outstanding of.

Mr Thompson: No, works would be anything to do with buildings, facilities management, construction and major capital works. They come under a different policy. State Supply Commission is really goods and services, and then the third area is any community service–type arrangements. They are all actually dealt with quite differently with different levels of support.

Hon ALISON XAMON: The reason I am confused is because, of course, there have been, in the past, huge problems around IT, so, obviously, these processes have not always been in place.

Mr Thompson: If I can maybe talk to IT. Part of our preventive controls is when you set up a contract, you need to set up the right preventive controls in your financial system. Instead of relying on individual invoices and adding them up to see if they equate to your total contract value—that has been our previous practice. What we are looking to do now is build preventive controls into our financial system that match our contractual agreements. That has not been a thing we have had in the past.

Hon ALISON XAMON: Okay.

The CHAIR: The director general looks like he wants to say something.

Dr Russell-Weisz: Just on the Perth Children's Hospital, obviously, on infrastructure works, Health did not have the say on that; that was through strategic projects in the Department of Finance. We made calls on the clinical commissioning but on the actual infrastructure build, yes they would come to us.

Hon ALISON XAMON: We will not blame you for that one.

Dr Russell-Weisz: No, just because it was jointly governed.

The CHAIR: Thank you for correcting us on that. Just a couple of other questions before I defer to my colleagues again. Is there any reason why anyone in Health should receive gifts from any contractors? Is there any reason?

Dr Russell-Weisz: No; none.

The CHAIR: But it does occur, I gather?

Dr Russell-Weisz: We have a gift registry. We do education to everybody that they should not receive. At a basic level, I actually say to people do not give me a bottle of wine even for speaking at a conference; please, do not even give me chocolates because I have to go back and declare it and give it to everybody else and go through. It is not worth the hassle; it really is not. Now, that is not a contractor—actually, I do not want it. I would rather not have it. I would rather they just say thank you and we will do it again. But in relation to the actual gifts for contractors, do you want to comment?

Mr Thompson: Yes. There are a couple of things we have done there to strengthen things. I wrote to the 8 500 vendors just prior to Christmas to say, "Thank you for supporting us. You do a great job; please don't send us any gifts." That is a practice I am going to put into place every year around October–November, because it can be practice in other industries. We have also released a supply —

The CHAIR: So that is called the bah humbug letter, is it?

Mr Thompson: Yes, it is, it is the Christmas grinch letter, but I do say thank you up front, but do not send us any gifts. We have also released a supply code of conduct. I released that in, I think, March. I wrote to 8 500 vendors again and told them, "This is our expectations of what you can expect from ourselves, but also what we expect from you." We asked them to call out any challenging behaviours that they might see. So that is a piece. We have improved our standard purchase terms and conditions, which also have that clause in there as well. We are trying to educate as much as we can our vendor base as well as our staff base.

The CHAIR: Certainly New South Wales railways did that. They actually got contractors in that they worked with a lot and trained them as to what their expectations were for compliance, which was excellent.

Hon ALISON XAMON: Is there a reason why you cannot just ban the acceptance of gifts? I understand you have the gifts register and you are trying to discourage, but we have been talking to other agencies that have just gone, "You know what? We've just said no. You can't do it." Is there any reason that you would not do the same?

Dr Russell-Weisz: Certainly, I mean —

Hon ALISON XAMON: Who would be kicking up the most if you were to try to put a ban in place? What is the problem?

Dr Russell-Weisz: Anybody around this table? Do you want to comment, Dr Lawrence?

Dr Lawrence: Yes, I think I will comment. Ultimately, it depends on the determination of what you are going to determine as a gift. The biggest group, which we separate out, is travel.

Hon ALISON XAMON: Yes, always.

Dr Lawrence: And sponsorship of travel.

[11.00 am]

The CHAIR: That is reported to Parliament, so there is an a level of oversight there.

Dr Lawrence: Correct. There are two components which I think would cause certainly a high degree of angst amongst our clinicians, but also amongst us to a certain extent because it has the potential to impact our budget expenditure. Travel is one. Could you just say, "Well, bad luck"? That might be okay for doctors, but there is also a degree of travel that is supported by companies through robust transparent processes now, to staff who otherwise have no funding to do that to attend educational meetings, which support ongoing —

The CHAIR: There are some federal health rules around that I think, too.

Dr Lawrence: There are, and companies have to declare it themselves now. Since all of that happened, it has shrunk and what happens on those events has come back to purely education. There used to be quite lavish events, if you went back 20 years. Now you travel to a meeting, you go to the meeting and you get sent home. The other group is we have sponsorship of educational meetings that occur within the hospital system. Again, they are approved and recorded. We aim to ensure they are not provided by a singular company to a department, and they come in as an offer to support educational events throughout the year.

Hon ALISON XAMON: I am not sure having to attend a meeting in a hospital is much of a gift, I have to say.

Dr Lawrence: Well, they provide morning tea or breakfast or lunch, so the clinicians attend in their lunch break.

Hon ALISON XAMON: So they provide a Tim Tam.

Dr Lawrence: We record those. If we were forced to stop those, would the system stop? No, it absolutely would not, but there would be, I guess, a greater call on our funds to support education that currently is not provided out of our operational money.

Hon ALISON XAMON: Although, of course what we saw with Mr Fullerton is that travel can also be problematically used.

Dr Lawrence: If I may, his travel was quite different. It did not go through the travel system to start with. This was other travel that was going through the travel system appropriately approved.

The CHAIR: Now, credit cards: any different controls on them post CCC report?

Mr Thompson: I reviewed our credit card controls prior to the last time I appeared before the committee. We actually have really good controls for our credit cards. All credit cards are limited to their value, so $5 000, $10 000, $20 000, depending upon the nature of the card. Ten per cent of those are audited and every one of them signed off. They can only be coded to particular things. I am actually more comfortable with our credit card controls than our general controls, which we are looking to bring up to the same standard.

Dr Russell-Weisz: Chair, you mentioned something about the CCC. Could I just add to that. What I said is not quite what you said, but something I fed back to the CCC, and it is an observation. Can I say first, they have been extraordinarily helpful in coming out to all our health service providers and doing education about this and other fraudulent activities. But one thing I have fed back to the commissioner and the CCC—and it is not just this investigation—is that people are frightened; when the CCC talk to them, they are frightened. People are actually quite frightened within a department of talking to anybody else. I think what happened here actually—and the CCC is not telling them not to talk to anybody else. I think there is this inherent thing. Like, we had one officer in the Department of Health who the CCC was liaising with, but was not talking out. I did not get to know about it for the three months until I knew about it from the CCC. I do not think that person was overtly hiding it from me or anybody else, but there is this culture, and I have certainly taken the

temperature of the system, is that when the CCC talk to me, I cannot talk to anybody else. We are trying to say, we want in a sense a CCC policy or a guide to say you can tell your direct boss and you need to tell the chief executive of your organisation, or it needs to filter through. I just want to leave you that comment because that still worries me. We need to get rid of that culture of "I can't speak to anybody else".

Hon ALISON XAMON: That is really interesting feedback because, of course, there is this sense around the CCC that you cannot tell your spouse, you cannot tell—like as soon as you have been hauled up, if you like, that it is 100 per cent confidential. It sounds like that has really become a problem.

Dr Russell-Weisz: At least I asked the CCC if I could brief the minister or SSO, and they said no. But I think within people, not at senior levels in the organisation—again, it is not the CCC saying it, but it is a narrative around it. We have also fed back to the Public Sector Commission that we would like—and I think the whole public sector needs guidance—if people are under either misconduct or certainly under section 42s from the CCC, is how do you treat voluntary severance or anything like that with those people. There is no guidance there. It is done on a case-by-case basis. We have fed back to the Public Sector Commission, can you give us, Health, and others guidance, so if in the future there is a section 42—or not even as bad as a section 42, but serious misconduct—and there is a voluntary severance scheme, what do we do? Who do we talk to? Those are two bits of feedback I happily freely give that we would like some guidance on.

The CHAIR: That is useful.

Hon ALISON XAMON: That is very helpful.

The CHAIR: We have a couple of questions on reports that have not been released, so we will need to go into closed session. You lot might appreciate a five-minute comfort break. If you could return, we will then ask you a quarter of an hour's worth of questions on a couple of reports.

[The committee took evidence in closed session]