EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO ATTENTION DEFICIT DISORDER AND ATTENTION DEFICIT HYPERACTIVITY DISORDER IN WESTERN AUSTRALIA

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
WEDNESDAY, 25 AUGUST 2004

SESSION 1

Members

Mrs C.A. Martin (Chairman)
Mr M.F. Board (Deputy Chairman)
Mr R.A. Ainsworth
Mr P.W. Andrews
Mr S.R. Hill

Co-opted Member
Mr M.P. Whitely

Committee met at 10.10 am

PATTERSON, MR MURRAY JOHN
Chief Pharmacist, Pharmaceutical Services, Department of Health
PO Box 8172 PBC,
Perth, examined:

The DEPUTY CHAIRMAN (Mr M.F. Board): Before we commence, I am obliged to tell you that this hearing today is seen as a proceeding of the Parliament and therefore warrants the same respect as the Parliament. Any deliberate misleading of the committee is seen as a contempt of the Parliament. Have you read the witness document and have you signed the "Details of Witness" form?

Mr Patterson: Yes, I have read the document and I have signed it.

The DEPUTY CHAIRMAN: We appreciate your submission and the fact that you can appear before the committee today. I hope first names are okay.

Mr Patterson: Yes.

The DEPUTY CHAIRMAN: What we normally do, Murray, is give you an opportunity to talk to your submission. You are aware of our terms of reference and what we are all about. We are particularly interested in the performance of the new regime and in your opinions about amendments to the Pharmacy Act and where they should be going and, generally speaking, where you would like to see those things happen. We have the opportunity through this report to accelerate some change in this area and we believe we can do that. Whatever you can tell us today will be very useful.

Mr Patterson: Can I just clarify, is that the Pharmacy Act or the Poisons Act?

The DEPUTY CHAIRMAN: Whichever one is relevant.

Mr Patterson: I guess, briefly, it may be useful just to go back over the regulatory scheme that has been introduced and that came into operation on 1 August 2003. Prior to that date - and you are probably aware of some of this background -

The DEPUTY CHAIRMAN: Yes. For the purpose of people reading our report, it might be a good idea if you elaborate on what the changes have been in that regime and how they are performing.

Mr Patterson: Yes, I am happy to do that. Prior to the changes that came into being in August of last year, consultants who were treating patients with ADHD or other specialised medical conditions such as narcolepsy or depression, were able to prescribe stimulant drugs without getting or seeking authority from the department, provided they prescribed within specified guidelines. That left us in a position where we were unable to know what the diagnosis was for the patients or what the ages of the patients were, and our database was very limited from that point of view. From 1 August last year the new scheme came into being. That scheme was a two-part process. The first step was the registration of the consultant medical practitioners; they registered with the department. The second part of the process was that when they wished to initiate treatment with a stimulant drug for any condition, they would complete a notification form. That enabled a database to be developed that provided some demographic data about the patient, such as his or her gender and age and those types of things. It also enabled us to provide or develop a database about the diagnosis and the dose that was being prescribed. The consultants were also required to send in a renotification, you might say, when circumstances changed, when the drug changed, when there

was a significant change in dosage and those types of things, to allow us to collect data to try to understand what was happening with the prescribing of stimulant drugs. That is where we have got to. We have just completed the first 12 months of that process and right now we are going through that data as best we can to try to analyse it and report on what our first 12 months have shown. What we have found in that process - and I think you have some of the data before you - is that initially we had an estimate of about 20 000 patients who were being prescribed stimulant drugs in Western Australia. That was based upon prescription history being reported to the department. The number of notifications as at the end of July came to about 15 500, which leaves us a little bit short of our 20 000. We are actually in the process of trying to find that extra 4 500 patients. This could have occurred for two primary reasons: one of the reasons is duplicate patients on the database previously, so we are having to manually go through those 4 500 names to try to match them up with the existing notifications; or, secondly, people who no longer want to be prescribed stimulant drugs. We are in the process of going through that. Once we have gone through that process we should be able to analyse some of the data and provide some of the information about the rates of ADHD in this State, some of the age demographics etc.

Mr M.P. WHITELY: The previous practice was one of very heavy prescribers, the ones who were supposed to be familiar with the guidelines, who prescribed the lot and were given block authorisations. They were not accountable for individual scripts. They did not have to report information on individual scripts or individual patients. That was levelled out; that was one of the initiatives. I know because I was instrumental in some of those changes occurring. That is also a possible explanation for the rate of decrease, is it not, because we have made some of the heavier prescribers more accountable. Now they are actually responsible for providing information about every individual they prescribe for. That increased accountability could be one of the reasons. On the face of it - and I realise you have to go through and do your audit process - it could be responsible for the drop. A whole host of other reasons could be accountable as well, but that could be an explanation for the different clinical practices as a result of increased accountability.

[10.15 am]

Mr Patterson: The number of 20 000 patients that we are using as a reference guide was based upon our previous database. In that database there is certainly a possibility that we had duplicate patients. Patient identification is an ongoing problem, particularly when a patient with the same name moves address or changes prescribers. Under the old system it was very difficult to try to keep track of them. It could well be that we had that number of duplicate patients in our system. We do not know until -

Mr M.P. WHITELY: It could be either/or, or a bit of both.

Mr Patterson: Until we go through the process of data matching, we will not know exactly what the situation was.

The DEPUTY CHAIRMAN: For the record, could you tell us why you think the change in the regime was necessary in the first place?

Mr Patterson: The approach that the department has taken on this matter is to try to understand why the prescribing of stimulant drugs is higher in this State than in other States. The data that we had prior to the regulatory change did not enable us to have any understanding at all. We are going through a process of, first of all, collecting data. The second part of the process is, if there is money available at the end of three years, to undertake a clinical audit to delve into the diagnosis that clinicians have made.

The DEPUTY CHAIRMAN: Are you convinced that the data you are now collecting is accurate?

Mr Patterson: I have no reason to believe that it is not accurate. The data we are collecting is based upon the information given to us by the prescribers. There is really no reason for them not to give us accurate information. They are aware that there is a possibility of a clinical audit at the end

of three years and that their records, subject to patient agreement, will be looked at by a research group. I see no real reason for them not to give us accurate information.

The DEPUTY CHAIRMAN: If a practitioner's records were found to be wrong, what would be the procedure following that?

Mr Patterson: I would think that it would be the same procedure as with any applications we have; we would refer that matter to the Medical Board.

Mr P.W. ANDREWS: You have mentioned the difference in rates of prescription between Western Australia and other States. For the record, would you like to comment on that? How do you see the difference between them?

Mr Patterson: I am not sure that I can comment much other than that we observed that the amount of stimulant drug, particularly dexamphetamine, used on a per capita basis is higher in this State than in other States. We do not understand why that is occurring. Our investigations, for example, of diversion, which is one area we need to look at, has not found any evidence of diversion out of the supply system. That leads us to the conclusion that it is being prescribed and used on patients in Western Australia.

Mr P.W. ANDREWS: How much higher is it compared with Victoria and New South Wales?

Mr Patterson: I will try to give you some idea. The most recent figures coming from the Commonwealth, when converted to grams of dexamphetamine per thousand persons in Western Australia for the calendar year 2003, is 32.09 grams.

Mr M.P. WHITELY: That is actually a fall. In 2000 I think it was 43 grams. There is evidence of a fall in the rate. That is consistent with the explanation.

Mr P.W. ANDREWS: I am just trying to get it on the record.

Mr Patterson: This is just for dexamphetamine; it does not include methylphenidate.

Mr M.P. WHITELY: It was the same.

Mr Patterson: That is right. The dexamphetamine figures we have from the Commonwealth is 32.09 grams per thousand people. The national average is 9.12 grams per thousand people.

Mr P.W. ANDREWS: Does that national average include Western Australia?

Mr Patterson: I did not do the calculation; I am not sure. Perhaps I can take the question on notice.

Mr P.W. ANDREWS: All I am trying to get on record is that we are looking at 32 grams per thousand people in Western Australia. Is that correct?

Mr Patterson: That is correct.

Mr P.W. ANDREWS: And the national average, which includes the Western Australian average, is nine grams. If we took Western Australia out of the equation, our rate of prescription would be four times that of other States. Would that be a reasonable estimate?

Mr Patterson: It is somewhere between three and four times, yes.

The DEPUTY CHAIRMAN: As part of your role, have you had the opportunity to look at any other alternatives in this area? Do you feel that there may be a lack of alternative treatments? You may not feel qualified to answer but I will ask because it is intrinsic to our inquiry. The lack or cost of alternative treatment and the number of people seeking treatment may be the reason for such a high rate of prescription drugs in this State.

Mr Patterson: I do not really think that I can answer that to your satisfaction. Perhaps you are alluding to other drug treatments.

The DEPUTY CHAIRMAN: Other jurisdictions seem to have wider opportunities for individuals or families to seek different types of treatment, which do not appear to be available in Western Australia; they are certainly not publicly funded to a great degree. Hence, people may find a cheaper alternative, which is stimulant medication. I wonder whether you have an opinion on that regime. Is it something that you have looked at in your work with the Department of Health?

Mr Patterson: No, I have not been involved in that sort of work.

The DEPUTY CHAIRMAN: Okay.

Mr M.P. WHITELY: I have not seen those latest figures. You quoted 32 grams for 2003. The figures contain a breakdown of all the States, do they not? I would be very interested to see the data that if we can obtain a copy.

Mr Patterson: I will try to do that. Perhaps I can e-mail a copy.

Mr M.P. WHITELY: You have identified that there are 176 individual prescribers in Western Australia. Do you anticipate providing information on how much the top five or 10 prescribers contribute to the level of prescription etc? I know that some prescribers prescribe very rarely - once or twice a year - and others prescribe incredibly regularly. That would be very useful information for the committee in terms of seeing who is responsible for that level of prescription. Will that information be collected and made available?
[10.20 am]

Mr Patterson: I certainly expect it to be part of the reporting process; that is, that after the first 12 months we will be able to break down the number of notifications coming from groups of prescribers.

Mr M.P. WHITELY: It obviously needs to be depersonalised, but would you then be able to identify the age of people being prescribed and also the dosage? It would be very interesting to make a comparison. You have given us information about ages and the average daily stimulant dose. It will be very useful to be able to compare some of the very high prescribers with that data to see whether they are not only high prescribers but also prescribing a dose above the average or prescribing different patterns to different age groups. That would be very useful.

Mr Patterson: We are certainly proposing to analyse the dosage information in a bit more detail than was previously done. We can certainly look at information on dosages by prescriber. If we can work out a way of reporting it in a non-identifying way, we would hope to do that.

Mr M.P. WHITELY: When do you anticipate that the information will be available?

Mr Patterson: I am trying to get it done as quickly as I can. There is a desirability to have access to that information for the work of your committee. It would help us understand what is happening with the process to get it done as quickly as we can. A workshop is planned with prescribers in early October. I would very much like to have it completed by then, but it depends on whether other priorities crop up and take our time away from analysing the data.

Mr M.P. WHITELY: Our reporting date is 28 October.

Mr P.W. ANDREWS: There is one fundamental thing I want to know. As we have heard, we have a high rate of prescription of psychostimulants in Western Australia compared with the rate in other States. We have taken a broad range of evidence, which has often been contradictory. The worry I have is that in 10 years, after I have left Parliament, I will be called back before a committee. The committee will say to me that I knew that these drugs were being prescribed at three to four times the national rate, that children were receiving this medication at an extraordinary rate, and that I did not ask whether long-term harm could be done by this medication. I do not want to be in a position in 10 years in which I do not know whether this medication is safe or unsafe in the longer term. Can you elaborate for me what studies have been done to show, first, that these drugs are safe to use over a long time? That is my first question. I will go on to the others.

Mr Patterson: The department shares your concerns. That is one of the issues that has been raised. I am not aware of any long-term studies that have been published showing the safety or otherwise of stimulant drugs. Most of the studies that are published are very short-term; they are of 12 months duration or less. Most are significantly less than that - a matter of weeks as a rule. The body of published literature is very limited to support or show that long-term use is safe. However, stimulants such as dexamphetamine have been around for a long time. They have been used in medicine for many years. As yet, no evidence has been published to show that there are any adverse effects from long-term use. However, we certainly share your concern.

Mr P.W. ANDREWS: The use of stimulant medication in the past has not been among children; we need to remember that the average age of prescription is eight years of age.

Mr Patterson: For ADHD it has primarily been used in children in the past. We are now moving to adult usage. Previously, stimulant usage for ADHD was for maybe five years. We are now seeing trends for much longer use of the drug; that is, for 10, 15 and potentially 20 years or longer. That is where there are some concerns, as well as whether there is any long-term effect on the child who had the drug as a young person; that is, when he was less than 18 years of age. We do not have that data at the present time.

Mr P.W. ANDREWS: What are the possible side effects of the medication?

Mr Patterson: Most of the documented side effects are associated with acute usage. I think that what you are alluding to is perhaps some longer-term side effects, where there will be damage to large organs or other behavioural changes will occur. I do not think we have that information as yet.

Mr P.W. ANDREWS: Psychosis?

Mr Patterson: That is a contrary indication rather than a side effect.

The DEPUTY CHAIRMAN: Murray, this is your opportunity to change some legislation, if you like. From your position, what amendments do you consider would be beneficial? You mentioned the Poisons Act. New South Wales has a tighter regime. What sorts of controls do you think we should have? The Pharmacy Guild of Australia has indicated to us that it would prefer much stronger controls, given some of the pharmacy shopping that goes on. We have not had a lot of strong evidence of that, other than people stating that they believe it happens. The guild feels that there has been a lack of control. What are the sorts of regulatory changes or changes to Acts that you would like to see to make this area a lot easier to control?

Mr Patterson: For stimulants, I think it would be nice to stay with the current system for a year or two to see how that progresses and whether we can collect the data that we expect to collect and are able to analyse it. Perhaps what you are alluding to is a broader issue around the potential diversion of drugs, doctor shopping, forgeries and that type of issue. You may be aware that the minister announced some month or so ago that there was an issue with potential forgeries through pharmacies. As part of that process we are liaising with the consumer organisation to look at whether repeat prescriptions are being kept with a particular pharmacy, which occurs in some other States. We have no hard information about diversion or doctor shopping for stimulants. Reports from the police about the availability of stimulants on the street are anecdotal, and we are not able to pick up any particular trends that are occurring. You may have heard reports from other people that we have not heard.

Mr M.P. WHITELY: We have in front of us some case studies. One example is that of a 17-year-old male who basically filled six repeats of a script. He got a 150-dose supply of dexamphetamine over a period of 13 days. There is another case study for a 40-year-old male. We have also taken evidence from Lenette Mullen of the Pharmacy Guild of Australia, who said that that is something they have encountered quite frequently. She is quite a strong advocate of the New South Wales system, where a patient is tied to a single doctor and a single pharmacist. The pharmacist can then

ensure that the scripts are not being filled again and you do not get the sort of thing happening, such as, "You were here yesterday and just got 25 days' supply. Why are you here again today?" That is exactly what has happened. Do you have any comments on whether that might be appropriate?

[10.30 am]

Mr Patterson: That is certainly the model about which we are talking at present to both the medical profession and consumer organisations, to see whether they will support such changes. I think the information we have would indicate that the majority of patients go to one pharmacy and one particular doctor. It may well be that there is a small group of patients undertaking the behaviour that you have described. However, limiting people to one pharmacy and repeat prescriptions being held in the pharmacy and not given back to the patient should not, in our view anyway at this stage, create any great hardship on people. However, we must balance that against people's ability and right to go to any prescriber at any time.

Mr M.P. WHITELY: It is obviously going ahead in New South Wales.

The DEPUTY CHAIRMAN: Murray, did you finish what you were saying about possible legislative changes? You went down the line of continuing the current regime, but did you finish on the wider aspect?

Mr Patterson: We are certainly looking at the issue of forgeries through a separate process of doctor shopping and forgery. That will happen as a separate exercise to this whole stimulant process. Your committee may or may not be aware that we are also reviewing the Poisons Act at present. That is being done in parallel with the proposed recommendations coming from the Galbally review report. As part of that process, we are proposing at the present time that the primary power on the issue of drugs of addiction be moved into the Act. All the regulatory controls are in the regulations at present but there is nothing in the Act. That would really make it transparent and open, which is what it needs to be, and provide Parliament with an opportunity to say that this is the structure it wants for prescribing drugs of addiction, with the mechanics left in the regulations. So we hope to achieve that sort of process. In that process, obviously, stimulants would be treated as part of the drugs-of-addiction issue.

Mr P.W. ANDREWS: Is there a section, a person or a committee in your department that looks at any updated research from overseas on medications, or is that left to the colleges that are involved?

Mr Patterson: There is no-one in the department undertaking that work, as far as I am aware.

Mr P.W. ANDREWS: So, because it has been used in America for a longer period, research that has been done in America on the long-term effects of these medications is not being done by the department; it is actually being done by the Australian College of Paediatrics?

Mr Patterson: The department generally does not get directly involved in any research activity, which would include research activity around the trigger for ADHD. That is generally within the province of the medical profession and the colleges.

Mr P.W. ANDREWS: So those people prescribing the drugs would be the ones who are checking on the updated research, rather than the department.

Mr Patterson: We would expect that. You are probably also aware that, as part of this regulatory process, when registered prescribers notify the department of a patient having been initiated on a stimulant, they are required to work within the regulatory guidelines that control age, dose and co-morbidities. As part of that process, if they wish to prescribe outside those guidelines, their application is referred to a stimulants panel. On that panel are representatives of the various colleges. So we would expect any changes in treatment approaches to be brought to our attention through that process.

Mr M.P. WHITELY: Did that panel not replace the previous one? What was it called?

Mr Patterson: It was the stimulants committee.

Mr M.P. WHITELY: Did that committee not have some members who were quite regular prescribers as well?

Mr Patterson: That is correct.

Mr M.P. WHITELY: There was the problem, in a sense, of them policing their own behaviour.

Mr Patterson: Yes.

Mr M.P. WHITELY: Is that no longer a problem?

Mr Patterson: The membership of our committee comprises representation from the public and private sector of paediatricians and the public and private sector of psychiatrists. Because they are involved in the area, some of their patients will potentially come to that panel. The way we deal with it is that all applications are de-identified and any member of that panel who has an application from that group is asked to leave the room and does not participate at all in that discussion.

Mr M.P. WHITELY: Is Perth too small to pool expertise that would not have that conflict of interest in any case?

Mr Patterson: I am not sure where you would get that representation in Perth.

Mr M.P. WHITELY: Is there any representation from pharmacists on that panel?

Mr Patterson: No. The department is represented on that group, but it is primarily associated with diagnosis and treatment. The department does not have a direct requirement to have a practising pharmacist there.

Mr P.W. ANDREWS: I did not want to get conspiratorial and paranoid about these things, but I have heard that the department itself does not review literature from overseas and that those who would be most likely to review this literature are those who are already prescribing the medication. In other words, those who regard it as a disorder that medication can solve are the ones who are doing the reviewing. In other words, there does not seem to be any independent body, perhaps within the Department of Health, that actually reviews studies being done overseas.

Mr Patterson: There really is no requirement for that to occur. The regulatory process, in the way it operates at present, is that we have pre-established regulatory guidelines, which restrict prescribing outside issues to do with age and young children, restrict the prescribing per dose, if it is a high dose, and restrict the prescribing if there are co-morbidities, such as psychosis. When that occurs, then the prescribers are required to send in a notification form with associated documentation, which is set out in supplementary requirements. That is then assessed by the stimulants panel, which is primarily made up of prescribers, to assess whether that type of approach is appropriate. I am not sure how current research fits into that process. If you look at medical treatment across the board, you will see that it has the same process. Developments in the treatment regimes that are occurring are published in the literature and picked up by those members of the medical profession who practise in that area.

Mr M.P. WHITELY: Just as a follow-up question, I am aware of a child as young as 18 months old being prescribed the medication. This was explained to me in the context of that same child at eight years of age having to go through a detoxification process. Obviously this is a practice that is at least six years old, and probably more likely eight years old. What protections are in place now? I know that the medication can be prescribed to children as young as four in this State and I believe it is six in other States. I believe it is six in the UK, although I am not 100 per cent sure of that. In what circumstances can children younger than four be prescribed stimulant medication?

Mr Patterson: The prescriber would have to apply to the stimulants panel to prescribe to someone aged under four years.

Mr M.P. WHITELY: Did they have to do that through the previous stimulants committee?

Mr Patterson: Yes, they would have.

[10.50 am]

The DEPUTY CHAIRMAN: We travelled to South Australia and Victoria, and it was expressed to us by a number of people - paediatricians, psychiatrists and people in national bodies - that there were concerns outside of Western Australia about the rate of prescription in Western Australia. To them it was an anathema, and they said it needed to be studied. You obviously attend Department of Health national conferences interstate. Are things being done in other States, or is funding available in other States that assists with alternatives for people seeking treatment? Are there things that we could have funded in this State that would have assisted with alternative treatment?

Mr Patterson: I am not aware of the types of facilities that are provided in various States and jurisdictions, just as I may not be aware of all the types of facilities available in this State. If I speak from a regulatory point of view, and the point of view of the usage of stimulants, I can say that my counterparts in the other jurisdictions are looking very closely at our new scheme, to see whether it provides them with a direction, and is helpful to them in the collection of information, so that they can understand what is going on in their own State. I am not aware of any other subsidy arrangements, for example, for the supply of drugs, in any other jurisdiction. Our usage patterns now for methylphenidate - Ritalin in both the long-acting and the short-acting form - fall within the ambit of the rest of Australia. Dexamphetamine alone is being used at a much higher rate.

Mr M.P. WHITELY: The reality is that dexamphetamine is used in a higher proportion in Western Australia than in other States, but throughout Australia dexamphetamine is the more universally used medication because it is on the PBS.

The DEPUTY CHAIRMAN: I was going to ask you that, Murray. Following on from that, why do you think Ritalin is not on the PBS?

Mr Patterson: I think you would have to ask the PBAC and the manufacturer of Ritalin. I understand the manufacturer did make an application.

The DEPUTY CHAIRMAN: I understand that, for example, in the United States, Ritalin is prescribed at a far higher rate than any other brand. Obviously it is a question of cost. Is that the point?

Mr Patterson: The PBAC, in considering applications, goes through a two-part process. First of all, the drug must be approved for that indication in Australia, so it goes through the evaluation process. Secondly, they do a cost-benefit analysis. If they determine that the value for money, if you like, from the taxpayers' point of view, is not there for the drug that is the subject of the application, they will not approve it. It would appear that, if the manufacturer of methylphenidate in Australia has applied to PBAC, then it has not passed that cost-benefit analysis.

Mr M.P. WHITELY: I understand that methylphenidate, or Ritalin, is actually a single product protected by patent, whereas dexamphetamine is a generic product with a number of manufacturers. Hence, dexamphetamine is cheaper. Mark Latham is protecting us there!

Mr Patterson: I would be surprised if methylphenidate were still protected by patent. It has been around for many years now. Maybe there is some difficulty in the manufacturing process, and there is a smaller market in Australia, compared to overseas areas.

The DEPUTY CHAIRMAN: There is no generic brand of dexamphetamine, is there?

Mr M.P. WHITELY: There is Sigma Pharmaceuticals and GlaxoSmithKline.

The DEPUTY CHAIRMAN: Yes, but there is no pharmacists' own brand.

Mr M.P. WHITELY: No, there is not.

Mr Patterson: It is classified as a generic, rather than a patented drug.

Mr M.P. WHITELY: I want to ask one question, on which you may not have an opinion. The rates of prescription of dexamphetamine in WA, on the face of it, are about four times higher than

they are in the rest of Australia. The rates of abuse of amphetamines- which is mainly illicitly manufactured, so I am not saying that it is the same drug - is twice the national average in Western Australia. Do you have any opinion or comment on that?

Mr Patterson: I am not aware of any information that relates those two issues together at all. My understanding of the illicit drug use issue is that Perth has unique characteristics in its usage behaviour of drugs. I have not seen any information or research that shows any correlation in any area with the usage of illicit drugs.

Mr M.P. WHITELY: It is interesting, because one of the arguments that has been put up for use of amphetamines is that, if you have ADHD and you do not get properly diagnosed and you are not medicated, you then go on to use illicit substances. If that were true, and we were very good at spotting and diagnosing, we would expect the rates of illicit substance abuse to be lower in Western Australia. However, in seven out of eight classes - the only exception being inhalants - the rates of illicit substance abuse are actually higher in Western Australia. Although this is multi-causal, and I am not suggesting that it is as simple as that, at first blush the argument that if you medicate correctly you will not have problems later on does not ring true.

The DEPUTY CHAIRMAN: I am sure you were not going to make a comment on that in any case, Mr Patterson. I thank you for your time, and the way in which you have answered our questions today. It has been very helpful to us. You will receive a copy of the transcript of your evidence, and you will have 10 working days to make corrections, but only where you feel the transcript is inaccurate. However, if you wish to provide additional information or expand on any points, you can send supplementary information in writing and it will be included in the report. Thank you again; we very much appreciate your contribution.