EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO GENERAL HEALTH SCREENING OF CHILDREN AT PRE-PRIMARY AND PRIMARY SCHOOL LEVEL

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
WEDNESDAY, 30 JULY 2008

SESSION THREE

Members

Mr T.G. Stephens (Chairman)
Mr J.H.D. Day
Mr P. Papalia
Mr T.K. Waldron
Mr M.P. Whitely

Hearing commenced at 11.28 am

ZUBRICK, PROFESSOR STEPHEN
Head, Division of Population Sciences,
Curtin University of Technology,
Centre for Developmental Health,
examined:

TAYLOR, ASSOCIATE PROFESSOR CATHERINE
Researcher, Curtin University and Telethon Institute for Child Health Research,
examined:

The CHAIRMAN: Welcome to the committee. Thanks for being available and for your submission. We have got the task of reading you some formal words simply to remind you that you are at a hearing which is a proceeding of Parliament and warrants the same respect that the proceedings in the house demand. You are not required to give evidence on oath but deliberately misleading the committee may be regarded as contempt of Parliament. I am required to ask of both of you: have you completed the "Details of Witness" form? I need you to give audible answers for the purposes of Hansard.

Prof Zubrick: So completed, yes.

Prof Taylor: Yes, completed.

The CHAIRMAN: Do you understand the notes attached to it?

Prof Zubrick: Yes.

Prof Taylor: Yes.

The CHAIRMAN: Did you receive and read an information to witnesses briefing sheet regarding giving evidence before parliamentary committees?

Prof Zubrick: Yes.

Prof Taylor: Yes.

The CHAIRMAN: Finally, would you please state your full name, professional address and the capacity in which you appear before the committee?

Prof Zubrick: My name is Stephen Zubrick. I am Professor at Curtin University of Technology in the Centre for Developmental Health, which is located at the Telethon Institute for Child Health Research.

Prof Taylor: I am Associate Professor Kate Taylor. I am a researcher in the Centre for Developmental Health, Curtin University, based at the Telethon Institute for Child Health Research.

The CHAIRMAN: I am going to change the order in which I do this at the moment, if you do not mind. I will go to your submission and ask five quick questions and then ask you if you want to make some other opening remarks in reference to it. In reference to page 1, can you please describe why you think the ADI is so effective and how it does better than the existing health screening processes?

Prof Zubrick: This sort of backfoots us. I have a four-minute story that I could tell you, that would take you straight to that space. There is a logic to it that the question cuts across.

The CHAIRMAN: Go for it.

Prof Zubrick: With your permission?

The CHAIRMAN: After you finish your presentation, if you will just look at me rather than be distracted by other members of the committee!

Prof Zubrick: We are cognisant of your terms of reference and the amount of time that you have in this sort of activity and we would like to make some general opening comments.

Children with clinically defined disorders and disabilities in Western Australia are reasonably well identified. This includes conditions such as intellectual disabilities, autism, cerebral palsy, deafness, significant visual disturbance, congenital abnormalities and birth defects and overall global delay. There are some qualifiers to this. There is no common pathway for screening and detection, nor is one developmentally possible. Key players in the detection of clinically defined disorders are parents, GPs, infant and child health nurses, paediatricians and, later, teachers and school nurses. The time course for detection ranges from pre-natal detection through to about the age of eight years. Existing population registers and specialist registers provide good evidence that our detection of clinically defined disorders is about where we would predict it should be in percentage terms in the state of Western Australia. There is, however, variation in the detection of these clinically defined disorders by urban and rural location.

[11.30 am]

As parliamentarians, you would be well aware of the plight of rural people in trying to get good quality services generally that detect and much less treat the kinds of problems that I mentioned previously.

We have no real concern with the detection of these clinically defined disorders in percentage terms. Certainly, there will always be calls for more and better screening. We would note that there has been a systematic erosion and neglect by government departments of the state maternal and child health service workforce, along with poor support for and wide variability in the provision of school nurse services. This is resulting in delays in some detection rates and wasteful burdens on families looking for assistance. We would also note a disproportionate underidentification of at-risk children from families who do not, cannot or will never seek assistance.

Children without a clinically defined disorder are far more problematic and confronting for governments and agencies in terms of managing the demand for screening and the consequences of meeting demand. We would note two particular groups of children as posing substantial challenges. The first are children with a primary language disorder—by that I mean they have no impairment other than a failure to acquire and develop language normally—and the second are children with extreme social and economic disadvantage who are ill-prepared to start school and are not detected until they fail at school. These children are from families who are less likely to seek or be able to seek help for themselves. I want to make a couple of comments on both those groups, and then I will return my gaze to you.

Children with primary language disorders is the first group that we want to mention here. These children have no impairment other than a failure to acquire language at the expected age and to develop language that achieves the normal adult model over time. About nine per cent, or 2 000 Western Australian children, per year can be screened and found to have a primary language disorder. Our work shows that identification of these children before the age of four is neither reliable nor efficient. If screening is carried out earlier—say, for example, at the point where the child is not talking at the age of two—many of these kids—about 75 per cent—will go on to be just fine, without any intervention at all. The best age to screen for a primary language disorder is at age four. We have reliable, valid and efficient methods to do this. This could be done in the preprimary period of school entry.

However, the real issue for your committee is the consequences of screening for primary language disorder. We are not sure that we can advise you to invest the money in screening because of the

treatment and management consequences in terms of costs, facilities and services. Moreover, the best treatment for these children should not be based on the belief that they will catch up on their language development—research is showing this to be a lifelong condition—but, rather, on optimising their communication and ability to succeed at school, and to minimise behavioural, emotional and social consequences. At present, these children are shuttled between health services, school services, the private sector and, at times, child mental health services.

The second and the final group I will mention are children with extreme social and economic disadvantage. The likelihood that a child will fail in their capability to participate socially, economically and civically is increased through exposure to extreme social and economic disadvantage. This typically entails poverty across two or more domains that include poverty of income or time, both quality and quantity, human capital, social capital and psychological capital. Children with extreme social and economic disadvantage who are ill-prepared to start school are not detected until they actually start and fail. We do not believe that screening individual children for social and economic disadvantage makes sense. Programs that address the needs of these children are programs that can be aimed at all children. Evidence shows that four major services are particularly effective in improving the developmental prospects of very young children who are exposed to extreme social and economic disadvantage. They are enriched educational childcare, parenting programs, behaviour management programs and school readiness programs. These work at a population level to lift the capabilities of all children.

To determine where children are doing relatively poorly or better, we are recommending the use of the Australian Early Development Index. The AEDI is a population measure, and it is important to note that it is a population measure of children's developmental progress over the first five years of life. It is a measure of how children in their first year of schooling are doing in their language, physical health, communication, emotional maturity and social competence. The AEDI is completed by a classroom teacher and results are anonymously compiled not on individual children, but on children living in their local suburb or postcode area. This generates a community profile that allows communities, local area governments and agencies to compare the relative school readiness of children living in that area. This assists in the planning, arrangement and delivery of early childhood developmental opportunities that are, in the first instance, aimed at all children. The use of the AEDI enables us to see how children are faring in their first five years. It motivates families, schools, local governments and agencies to ask, "What's in this area that supports child development?" and to ask, "What works and where do I get it?"

The CHAIRMAN: Just in reference to the AEDI, the AEDI website states that the AEDI has helped facilitate improved collaboration between agencies involved with young children and their families. Do you have any quick comment on that?

Prof Zubrick: It has certainly proved to do that in the communities that we have gone out to following the release of community profile data and engaged with in terms of, "What did you make of the findings? What actions does this enable?" and really deal with community consultations around the next steps following good quality provision of information.

The CHAIRMAN: So there is the collaboration of agencies. Which agencies are we talking about here?

Prof Zubrick: That will vary depending on where we are. For example, if we go out to one of the urban communities that has been involved, we see agencies from local government to health, education, family and community services and the Smith Family. It is a mix, depending on who is there on the ground.

The CHAIRMAN: I will finish with this question in reference to the website. AEDI data and maps can help identify, among other things, where there have been successful early childhood programs. Do you have any further information on what these successful early childhood programs have entailed or where information pertaining to these programs can be obtained?

[11.40 am]

Prof Zubrick: The general preamble focused on good quality programs that looked at early enriched childcare, parenting programs, behavioural programs and school readiness programs. Largely, it motivates the community to look at what preventive and developmental opportunities are being provided locally for children. Communities need to come together to do that, and to look at what they have currently operating and what could be done better.

Mr M.P. WHITELY: My question relates to the use of the AEDI. I understand its function as a population measure—in other words, it is used to identify suburbs and areas in which there may be many kids who are disadvantaged and need support—but what about as an individualised measure? At the top of the page on the second page of your submission you talk about how the AEDI was not designed as an instrument for the diagnosis of children with specific developmental disabilities. It allows teachers to assess children's development in a systematic manner and identify those individuals who may require further assessment. Can you elaborate on that? I am a little confused. I have looked at your website, and they are very generalised measures.

Prof Taylor: It is a move away from identifying individuals. The reason for that is that the focus is on putting resources into the kinds of programs that Steve mentioned, rather than the very costly identification of children. For children with social and economic disadvantage, there is no way to really measure that on an individual level. It is a better approach to do that on a community level. Our position is that, in terms of limited resources, there is good evidence for the kinds of programs that are going to assist children to be ready for school, and not very good evidence for the systematic screening of children at an individual level. The notion that all these programs are available for all children takes away the necessity to then screen individuals. Essentially, if we were to screen individual children—for example, a child with a language difficulty or a child from an impoverished home environment—the kind of intervention would be the same, and so to that end we would put resources into intervention.

Mr M.P. WHITELY: I still have trouble reconciling the second part of the sentence, which refers to allowing teachers to identify those individuals who may require further assessment. I have looked at the website and I have looked at things such as social competence, emotional maturity, and language and cognitive skills. I can understand how some of them, such as gross and fine motor skills, could relate to a specific child.

Prof Taylor: To get back to second-level identifications, as Steve said, there is no single pathway to the identification of children—even those with serious developmental disorders, such as intellectual handicap. The screening of an entire class of children using the AEDI could detect children who may have been missed in the system and may need a referral for that formal identification.

Mr M.P. WHITELY: Can you talk about the pathway from there? Where will those kids go? That is an area of great concern to me. Where do the kids go who are identified as having significant developmental problems?

Prof Zubrick: They go everywhere. Again, there is no single pathway. I am not necessarily recommending that there should be; however, depending upon the skills and abilities of the parents and their persistence, a variety of avenues can be searched for services, facilities and treatments for children. That may take some families to the private sector, or it may take the more vocal parent to a classroom teacher or to a special ed meeting to deal with the particular needs of the child.

Mr J.H.D. DAY: You mentioned the four major services that are particularly effective in improving the developmental prospects of very young children. As you have listed them, they are enriched educational childcare, parenting programs, behaviour management programs and school readiness programs. Are you of the view that they really should be made available on a universal basis?

Prof Zubrick: I am of that view, and I am of the general view that the state needs to implement a coherent and sensible early years strategy for children in this area. We have a train wreck out there.

Mr J.H.D. DAY: I was going to ask how well we are doing at the moment. Can you elaborate on that?

Prof Zubrick: Yes. When we look across the agencies that have to be involved with children, we see that there is no one service that can handle this; children are not born in portfolios. We do not have an integrated policy framework that guides action across our agencies in terms of advancing child development and human development broadly. We do not have a policy framework that has fidelity across those agencies, and we do not have policy frameworks that endure beyond the lives of governments or systematic ways to build children into the adults that we want.

Mr J.H.D. DAY: My sense is that there are quite a number of people doing things in these areas, but pretty much on an ad hoc basis and without any sort of consistent guidance or comprehensive approach. Is that a fair observation?

Prof Zubrick: That is an accurate judgement, yes.

Mr J.H.D. DAY: In relation to the use of the AEDI, assuming we had all the services you referred to available on a universal basis, would the role of the AEDI then be to provide additional services in areas of need, or not?

Prof Zubrick: The role of the AEDI is to supply good quality information about child development within the first five years, and what child development looks like in the areas in which people live. It is a device that can be used to empower parents, communities and agencies in general to find out why they are not doing better, or to realise that they are not doing too badly at all. It can really motivate the focus and discussion about what it could look like when children are growing up.

Mr J.H.D. DAY: In theory, if the service was available on a universal basis, we would not need the AEDI. Is that right?

Prof Taylor: It would answer the question about how well we are doing.

Prof Zubrick: We would have a way of monitoring our progress.

Mr J.H.D. DAY: This question is probably a bit of a Dorothy Dixer. Is there an area or jurisdiction in which things are done well in this respect?

Prof Zubrick: I refer the member to the maps that have been generated, which show the gradients or differences for children across the state.

Mr J.H.D. DAY: I meant in terms of governments providing these services; governments, communities, and private sector involvement.

Prof Zubrick: I certainly could not pull an answer to that out of the hat. I do not have an answer to that question.

Mr J.H.D. DAY: Are there good examples, in your view?

Prof Zubrick: We see more robust approaches to handling the early years in states such as South Australia and Victoria. They are out there batting above their weight with an integrated approach and with policy fidelity to handle this epoch of life.

Mr M.P. WHITELY: I have had some experience—through another issue in which I have a very strong interest—of the Victorian system and the Child and Adolescent Mental Health Service. In my experience, they provide relatively excellent services and they have a holistic, team-based approach. I think you were talking about something broader than that. Can you elaborate on the comments you made about what they are doing right? On the ground, how does it translate into them doing things better in Victoria?

Prof Zubrick: The better example is probably South Australia. It is important to appreciate that the view that Kate and I have is particularly fixed on the first five years of life. If the committee wants us to work across the broader range of developmental ages, we can certainly do that. We think that the committee's views—I am sure it has been attracted to that by other submissions—really need to attend to the fact that I do not think that at some levels anybody is doing particularly well. I tend to move around the country in my role as the chair of the Longitudinal Studies of Australian Children group; I visit jurisdictions and see what they are in action with. In South Australia—we see this happening in Victoria now—there has been a better level of what I call policy fidelity and attention paid to the business around the first five years of life.

[11.50 am]

I cannot pull a bright buckle out of a basket and go, "Here, there is an example of it." We have just got a sense of being able to compare the state that we are in. Historically, this state has had some marvellous things happen for children. We used to have a leading maternal and child health service for children; we used to have far better school nurses and a psychology service for schools that handled this sort of stuff. We see, for example, in other jurisdictions, the implementation of speech pathology services within schools. We have got examples of the kinds of things that are done in other states, and I cannot say we have seized the opportunity that we currently have to lift the game in the first five years of life.

Mr M.P. WHITELY: If I can ask a question at the risk of annoying my fellow committee members. One of the things that I have a particular interest in is ADHD. The rates of diagnosis of ADHD in South Australia and Victoria are amongst the lowest in Australia.

Prof Zubrick: Yes.

Mr M.P. WHITELY: I wonder if this is a consequence of them actually having better services in place to actually get to the nub of kids' problems earlier. I know that is a very specific question —

Prof Zubrick: It may. We could wind up arguing the toss on this; I do not know. We do not have empirical studies that really address that question.

Mr M.P. WHITELY: Is there somewhere we can go to find out more information about how they do things in South Australia and Victoria? I hear what you are saying about an integrated—but I would like to pare it down to another level and get some detail of it.

Prof Zubrick: I cannot get a name like that for you, but if I am allowed to supply information post the meeting, I will be more than happy to do that.

The CHAIRMAN: Sure.

Mr T.K. WALDRON: You were talking about the early childhood and nought to five programs such as Better Beginnings and Smart Start. Are they the kind of programs you were talking about?

Prof Zubrick: They are one of the —

Mr T.K. WALDRON: They are part of it?

Prof Zubrick: They are one of the developmental opportunities that we like to see for children.

Mr T.K. WALDRON: Are you saying that we need to develop those programs more or have programs similar to them running in conjunction?

Prof Zubrick: The short answer is yes, if it is in the framework of an integrated approach to asking the question about what do we want the developmental opportunities in the state of Western Australia to look like, because they will be different in Karratha to what they are in Albany, to what they are in Floreat Park.

Mr T.K. WALDRON: That is where the AEDI comes in and then you provide the service that is needed—it might be something like a Smart Start, Better Beginnings or something that I do not even know about.

Prof Taylor: Yes.

Prof Zubrick: Or a better mix of what is already there.

Mr T.K. WALDRON: So we need to coordinate it, looking at —

Prof Zubrick: Yes.

Prof Taylor: Yes.

Mr T.K. WALDRON: Right.

Mr P. PAPALIA: AEDI has been referred to by other people making submissions. I am not sure how knowledgeable they are about its actual purpose and the way it should be utilised, being that it is aimed at assessing a community rather than an individual. Without any knowledge of the actual assessment is it possible to misuse that test, focus on an individual, and use it as an assessment tool in many regards —

Mr M.P. WHITELY: Yes, that was my concern.

Mr P. PAPALIA: — possibly in a subjective fashion, resulting in a diagnosis of an individual who may be incorrectly diagnosed as having some condition. Is that possible?

Prof Zubrick: Anything is possible.

Prof Taylor: Anything, yes.

Prof Zubrick: Anything is possible.

Mr P. PAPALIA: I mean practically, if you could —

Prof Zubrick: We have watched this roll out across tens of thousands of children and we do not have any instances—I am sure they are there, actually—of where there has been a misfiring or a misapplication of the instrument. The way the instrument has been designed and used is principally to generate population level estimates of capability on children—okay? At a more local level, where teachers have been involved in filling the questionnaire out on their classrooms, the anecdotal information that they have provided us was that this has been a useful exercise. It structures their views around particularly developmental areas that they might not otherwise have considered. Where it has raised issues they felt confident to take them, you know, forward within the context of the school to ask a more focused question about how the child is doing. We have not embarked on or positioned ourselves to look at this as an individual measure of risk; that is not where—in fact, our general view is that had we even started there it would have killed the whole thing. They are deep philosophical —

Mr P. PAPALIA: I worry that your tool, which seems quite valid and appropriate at a community and a population level, may be misinterpreted or misused to result in the incorrect targeting of children —

Prof Zubrick: Then you are back to asking what do you want to worry about; do you want to worry about something you know or something you do not know? In the absence of it, it is going on out there, anyway. What we can do is attest to the validity and reliability of the instrument for what it is used for, and the issue of its value as an individual diagnostic measure can be empirically investigated.

Mr P. PAPALIA: Yes, it would be interesting to do that.

Mr M.P. WHITELY: Well done. That is my concern. It is —

Mr P. PAPALIA: It is not a criticism of —

Prof Zubrick: No, no; I am not a salesman for the AEDI.

Mr M.P. WHITELY: If it going to be used in my electorate and identify that in Lockridge, for instance, we need to put in extra resources, I would welcome that.

Prof Zubrick: Yes.

Mr M.P. WHITELY: If it is going to be abused at Lockridge Primary School to identify that little Johnny should be going off and seeing, you know—as part of that marketing exercise that little Johnny should be headed off in this direction—having said that, I mean if it had real screening of little Johnny has got fine motor skill problems that need to be addressed, that is great.

Prof Zubrick: Yes.

Mr M.P. WHITELY: But there is that real danger in it—and it does concern me—that is why we focused on that sentence that I identified earlier on.

Prof Zubrick: Sure; I can understand that. At this point I would actually like to have examples of where it has misfired.

The CHAIRMAN: Is the national audit still going on for 2009?

Prof Zubrick: Yes, yes.

The CHAIRMAN: Do you have some indication as to when the data will be available to schools from this —

Prof Zubrick: I do not, actually. I am speaking really on behalf of Sven Silburn and Sally Brinkman, who are both away.

The CHAIRMAN: Can I just probe another area; it is the area of learning difficulties and language difficulties. We are having described to us, by professionals, a ballooning problem, with delays in learning and language difficulties amongst youngsters. Are you across any studies of the impact of pedagogy on the successful language development of youngsters going into schools, and is this an area of your own expertise or not?

Prof Taylor: So examples of programs within schools?

The CHAIRMAN: Yes, the impact of pedagogy on successful response to language development.

Prof Taylor: I guess that is really Bill Louden's area, is it not?

Prof Zubrick: I participated in the literacy and numeracy review and chaired the subcommittee on that review for early childhood. We have pretty well written up, I think, a direct answer to the question that you are posing. The answer is yes, there has been an impact in changing pedagogy on literacy and numeracy in children. The education system does not often like the empirical results of those reviews. You wind up with deep philosophical and pedagogical divisions about: are we going to go with phonics; are we going to go with a whole-of-language process? The evidence, we have written for Parliament and tabled; it is there for you.

The CHAIRMAN: That is in the Louden report, is it?

Prof Zubrick: It is.

The CHAIRMAN: That deals with both literacy and language development?

Prof Zubrick: Yes, absolutely.

The CHAIRMAN: Thanks. The provision of the copy of the AEDI instrument, the questions and answers; is it possible to get a copy of the AEDI instrument?

Prof Zubrick: I do not know. I could find that out, though.

The CHAIRMAN: That would be great. Thanks. I think we are wrapping up.

Mr J.H.D. DAY: Steve, I think you earlier said that we used to have a very good child and maternal health service and speech pathology services, I think, and other child development services. Implicit in your statement, I think, is that we do not now; what has gone wrong?

[12.00 pm]

Prof Zubrick: I am looking through a 30-year lens at the state I live in and love. Broadly, there are leadership and priority issues in all the departments. It started in health and the demands that everybody is faced with regarding high-end health costs, and in the hospital issue that has detracted from consistent leadership in the area of child developmental services in health, education, and community services and, to some extent, in justice also. A prevention program relating to this could be developed in the justice department. We are not looking at the one moment when it went pear-shaped; it has been a very systematic cutting back and erosion of professional development, maintenance of the workforce and modernisation of the knowledge of the workforce around what works. We could even say, "Get the workforce out there", but I am afraid that they will still be practicing things that look like they are out of the 1960s. It is also an issue of how we purchase what we know works and how to make sure that the people can deliver that. We are looking at the effects of a fairly long road here.

Mr J.H.D. DAY: I think you are right in saying that sufficient priority was not given to these areas in the broader health and other systems.

Prof Taylor: The families that actually get through the health door are perhaps not the highest priority families. That involves a fair amount of advocacy from the family's perspective. Our concern is with the families that do not work the system. That is where community health nurses and programs where there are home visits and those sorts of things would be more inclusive.

Mr J.H.D. DAY: Are community health nurses and infant health nurses empowered sufficiently at the moment? Are there sufficient numbers of them?

Prof Zubrick: No. I do not believe that the workforce is sufficiently skilled either.

Mr P. PAPALIA: You might not be able to provide an answer to this question: is there evidence to suggest that the families who are possibly most in need of the services are not accessing them and are subsequently becoming the ones who disproportionately access the rest of the health system at the high-end, expensive end, so that there is an inverted real priority whereby we are spending all our money at the other end? Had we focussed it on those most in need at the start, might we easily have actually prevented all that expenditure, time and energy?

Prof Zubrick: I could not have said it better. We are into burden lowering. There will always be a tail in the distribution that requires care; that will not go away. At the moment, a disproportion number of children are sliding downward towards that tail. That is when we look at better developmental prevention opportunities.

Mr P. PAPALIA: I mean even further; that is, when the children become adults. Is there evidence that confirms they are the ones who consume —

Prof Zubrick: There is good quality evidence of that. To some extent, the whole early years agenda has based itself on quite robust literature and research that documents that the adult who is in prison had a particular course that started very early.

Mr P. PAPALIA: It is just hard to get into the political cycle.

Prof Taylor: The whole concept of developmental health and investing in that.

Mr M.P. WHITELY: Just give us 20-year terms!

Prof Zubrick: That is okay!

Mr J.H.D. DAY: Do you have a view on the standard of child care, generally, when child care is paid for by parents and subsidised by the federal government, whether it be by community childcare centres or the private sector?

Prof Zubrick: My concern with child care generally is that the quality is too much of a lottery. Again, the parents who know what they are looking for and who have a checklist of the desirable components and who have a wallet to match that are out to get the best for their children. We are interested in the total capability of Western Australia and the population that will be here in the future.

Mr J.H.D. DAY: Should more stringent requirements be put in place for funding or for approval of childcare centres, given that the federal government puts in a fair amount of money?

Prof Zubrick: And for the education of the workforce. The answer to that question is yes. The nature of the regulation must focus on the quality elements of what is being regulated. We are about to publish a large, major report from the—this is an advertisement—longitudinal study of Australian children that is looking at child care in Australia and is documenting the relationship between the nature and range of child care on offer and the developmental outcomes for children.

Mr J.H.D. DAY: Who has the primary responsibility for ensuring that the standards are adequate? Is it the federal or the state government?

Prof Zubrick: That is a question you would probably be better placed to find out. I do not know. It looks to me like it is split across a range of sectors. I would not know whose door to knock on to find out what is the standard.

The CHAIRMAN: Is there anything else you want to conclude with?

Prof Zubrick: Nothing more other than to reinforce the importance of the work that you are doing and to thank you for the opportunity to be present.

Mr J.H.D. DAY: And for the work you are doing.

Mr M.P. WHITELY: Would it be possible to get a copy of the —

Mr P. PAPALIA: We asked for that when you were out of the room.

Prof Zubrick: We are being sent out of here with some homework.

The CHAIRMAN: The homework will all appear in the transcript. When you look through the transcript for any errors that you are able to correct, just make sure that you get them back to us within the 10-day period. You will know from the advice given to you that you cannot introduce new material into those corrections or change the sense of your evidence but you can provide any additional information or elaborate on any particular points, along with any other supplementary information, once you respond to the transcript. Send the transcript back with anything else you want to say to us but do not insert it inside the evidence. Thank you for your submission and for meeting with us today.

Hearing concluded at 12.05 pm