STANDING COMMITTEE ON ENVIRONMENT AND PUBLIC AFFAIRS

PETITION NO 23 — MENTAL HEALTH BEDS FOR ADOLESCENTS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 2 JULY 2014

SESSION THREE

Members

Hon Simon O'Brien (Chairman)
Hon Stephen Dawson (Deputy Chairman)
Hon Brian Ellis
Hon Paul Brown
Hon Samantha Rowe

Hearing commenced at 11.10 am

Mr TIMOTHY MARNEY
Commissioner, Mental Health Commission, examined:

Ms KIRSTEN JAMES
Senior Program Officer, Mental Health Commission, examined:

The CHAIRMAN: On behalf of the committee, I would like to welcome our witnesses to this morning's meeting. I will introduce my colleagues. On my right are Hon Samantha Rowe and Hon Stephen Dawson, and on my left is Hon Brian Ellis. I think you have met our advisory officer, Ms Amanda Gillingham, and you have dealt with our committee clerk recently as well. You will have both signed a document titled Information for Witnesses. Have you read and understood that document?

The Witnesses: Yes.

The CHAIRMAN: These proceedings are being recorded by Hansard and a transcript of your evidence will be provided to you. To assist the committee and Hansard, please quote the full title of any document you refer to during the course of the hearing for the record. I remind you that a transcript will become a matter for the public record. If for some reason you wish to make a confidential statement during today's proceedings, you should request that the evidence be taken in closed session. If the committee grants your request, any public and media in attendance will be excluded from the hearing. Please note that until such time as the transcript of your evidence is finalised, it should not be made public.

Mr Marney, I think you are familiar with a petition received by the Parliament. Our focus in this inquiry is about matters arising from that petition. In relation firstly to acute inpatient beds for children and adolescents, in what circumstances do children and adolescents need inpatient care? Is it characterised by certain psychiatric conditions that present, by any particular age group or by the extent of which family and social backgrounds might figure in the patient's history?

Mr Marney: In many respects, the question relates to the clinical assessment process around the individual when they present and the referral paths by which they find themselves at an acute facility. That can be through referral from general practitioners, school psychologists or mental health supports in schools, or directly through presentation to emergency currently at PMH. An assessment is undertaken when an individual presents and that determines whether or not the best treatment setting for the individual is an acute setting or outpatient-based treatment. In terms of the factors which lead the individuals to be there, they can be varied and it depends very much on the individual as we know that the nature of mental illnesses can vary greatly and are determined by a range of factors including genetic factors, factors in terms of the way individuals are raised, their family environment, and any trauma that they have experienced during their life. All of those things go into the mix in terms of causal factors for mental illness.

The CHAIRMAN: Part of the anecdotal evidence that we have received together with various government reports including the Stokes report indicate that in some areas the mental health system is not adequately meeting the needs of young people. What is the turn-away rate for acute inpatient mental health beds for children and adolescents where a child is unable to access an inpatient bed when they require one, they cannot be transferred from an emergency department to a dedicated children's inpatient bed, or perhaps a child is provided with an adult bed in an otherwise inappropriate facility?

Mr Marney: I would have to take that as a supplementary question and consult with the child and adolescent mental health service. CAMHS would hopefully have that data readily available. I would have to consult with it to report that back to you.

The CHAIRMAN: If you could take the question on notice and provide it as supplementary information because it seems to me that this is a key point of focus for the inquiry that we are undertaking. We have requested information in similar terms from the Department of Health and I am disappointed that we have not received that information so I am hoping that you will be able to provide it.

Mr Marney: I will chase that up for you. I am reliant on Health being able to provide that information. If that data is not collected, then we will seek some qualitative assessment of the issue raised. Just to be precise in terms of the question, is it this: of those individuals who are clinically assessed as requiring admission, how many are not admitted due to bed capacity issues?

The CHAIRMAN: That is very good, and as ever Mr Marney, if you have some other observations that you feel need to be brought to attention in responding to that question, I am sure you will feel free to provide us with that information. We would be very pleased to receive it.

Mr Marney: It is unlike me to remain unnecessarily silent, as you know. That distinction though in terms of an individual who is assessed as requiring admission is really important because if someone presents and they are not assessed as requiring admission, it do not necessarily mean that their families or carers are not still wanting them admitted, but the clinical assessment may be that admission is not the most appropriate form of treatment. There can be a disconnect, if you like, between what the family and carers want for the individual and what the clinical assessment is.

Hon STEPHEN DAWSON: We heard evidence this morning that people have been clinically assessed as needing acute inpatient care and not receiving it because of the beds. That is really where the question comes from.

Mr Marney: I am not denying that at all, I am just clarifying that in some cases there is that disconnect. Ultimately, the continuum of treatment and care should not be such that we actually keep people out of inpatient settings, particularly acute settings.

The CHAIRMAN: Indeed. In relation to providing residential services—and I imagine it is the same if you are doing so in a hotel, a hospital, a prison or an army barracks—the authority providing that accommodation and the staff that go with it has to balance with the demand, which may have peaks and troughs. How do you establish a formula for how many beds the Mental Health Commission provides?

[11.20 am]

Mr Marney: The Mental Health Commission technically purchases bed capacity from the health system, so in this case from child and adolescent mental health currently through PMH predominantly. The number of beds is determined using—I will go back a step. Historically, the number of beds that existed in the system was maintained, albeit there has been a shift in the model of care over the past few decades that saw those inpatient settings decline with more community-based supports and general practitioner–supports being the increased focus. That is the long-term trend. Looking forward, we are currently in the process of finalising the modelling for the 10-year mental health services plan. That modelling is based on taking population and epidemiology parameters and applying that through rigorous estimating tools to establish what is, of the population and its makeup, what would you expect to be the incidence of mental illness in that population; and, with that, what would you then expect to be the range of services needed to address that demand, with that range of services being from community-based supports through to psychologists, psychiatrists and general practitioners right through to subacute settings and community subacute settings through to acute inpatient settings. The modelling is very much

statistically driven and is based on the national agreed estimated tool for mental health demand, and with that, estimation of the supply that is required to meet that demand.

The CHAIRMAN: In its practical application, do you have a target point for vacancy in accommodation rates that indicates that the system is providing services in the quantum required? For example, it may be over a period of time that an average of 85 per cent occupancy might be a good setting for, say, a hotel, to balance the needs of providing expensive infrastructure and staff, but also being able to cater for peaks in demand. Do your services work that way as well?

Mr Marney: Again, the service is provided by child and adolescent mental health. I would have to take as supplementary information what the vacancy rate runs at. I suspect the occupancy rate is much, much higher than 85 per cent. Generally speaking from memory, across the entire health system it is my understanding that the occupancy rate in acute settings is more about 92 per cent to 94 per cent. I suspect, if anything, it is a little bit higher in the child mental health settings, certainly the acute settings. I will take that as supplementary information.

The CHAIRMAN: My reason for asking is that it seems to me that if you have an accommodation average occupancy in the high 90s in whatever field you are providing accommodation, that does not leave much room for a further peak in demand, though it could be seen as maximising the efficient use of resources.

Mr Marney: That could be the conclusion. My observation would be that our occupancy is probably running too high certainly in the acute child mental health settings, because our shortfall, if you like, in the continuum of services is in the subacute area. Kids who present with mental illness, unfortunately there is not the secondary care setting of sufficient quantity to prevent them from deteriorating further and ending up needing an acute inpatient setting. In broad answer to the petition, our modelling suggests—and it is certainly my view—that our acute bed settings are adequate based on our population and epidemiology, but they are adequate if we also have the other elements of the system in adequate supply. At the moment we do not have the other elements of the system in adequate supply. We are letting people get too sick and they need the highest severity of treatment. A big part of the modelling we are doing is telling us that we need to invest more in the subacute and community-based care settings.

The CHAIRMAN: My colleagues and I will come back to that very point and explore it further. I note your observations are consistent with other expert evidence that we have received.

Going back to the petition and those associated with it, what is the answer for a mother, for example, who has a daughter who has a history of attempted suicide who is at risk of again attempting to suicide and who really needs to be admitted, but is told that no bed is available? How might we deal with that situation, which does arise from time to time?

Mr Marney: I guess the first port of call for an emergency circumstance like that is the Mental Health Emergency Response Line to seek advice. It will respond with assessment, particularly prioritised where there are issues of self-harm. The child and adolescent mental health service is trialling a new assessment model that means that people do not queue for assessments. Basically, if an assessment is required, it is done and it is done in a timely fashion. The issue that is raised is that bed numbers are finite. There is an issue of the system's capacity to deal with that. If a bed is not available, a bed is not available. Unfortunately, although it is certainly desirable, it is going to be very difficult to ever fully meet demand. It is more a matter of how we manage that demand and that requires investment in preventing people from reaching that stage of severity. That does not solve the immediate problem of the mother and her daughter who is at risk of self-harm, is presenting and cannot get a bed.

Hon STEPHEN DAWSON: For the committee's benefit, can you specify the number of beds in each facility that are available for children, young people and adolescents?

Mr Marney: Currently there are six residential pathway beds in Bentley. There is the Bentley acute adolescent unit, which has 12 beds and Princess Margaret Hospital has eight beds.

Hon STEPHEN DAWSON: Are they for zero to 16 years, 16 years to 18 years and 18 years up to 25 years?

Mr Marney: The Bentley acute adolescent unit is up to 17 years. I think the rest are also up to 17 years. Actually, Princess Margaret's eight beds are for under 16s with under 16 being what we would characterise as a child and then youth being 16 years to 25 years.

[11.30 am]

Hon STEPHEN DAWSON: So, sorry, what beds are available for that youth-up-to-25 category?

Mr Marney: At the moment we have only got up to 17 at Bentley acute, and that is 12 beds; however, once Fiona Stanley Hospital is up and running we will have 14 dedicated youth beds, so age 16 to 24. That is, if you like, a shift in model of care from where we are at the moment to actually focus on that 16 to 24-year-old cohort where we know roughly 75 per cent of mental illnesses manifest in that age cohort. So it is particular important to have targeted that model of care to, again, intervene early and support in the acute circumstances as required.

Hon STEPHEN DAWSON: This morning we heard evidence from the royal college of psychiatrists who indicated that it is their view that we need about 70 beds for people between the ages of 16 and 24. Does the Mental Health Commission share that view—not withstanding that we will not have that amount of beds in the system?

Mr Marney: I would be fascinated as to where they came up with that estimate, and it would encourage you to inquire further; however, the preliminary results from the modelling that we are currently doing are not that far away from that sort of ballpark figure.

Hon STEPHEN DAWSON: I will say that they were public hearings this morning and everybody was welcome to sit in and listen to everybody give evidence, so it was disappointing that the commission did not have someone here; you could have perhaps got the answers if you had someone here.

Mr Marney: I will certainly read the transcript, but I understand as being an observer sitting at the back, I do not get to ask questions.

Hon STEPHEN DAWSON: Sure. Mr Marney, in this year's budget, and there is a budget bulletin from the Mental Health Commission website that talks about—this is across the board in mental health—the fact that there are 136 new and replaced mental health beds across the system. Can you give me a sense of how many of those 136 are actually new and not replacing beds being shifted from somewhere else?

Mr Marney: I did have information, but I have not got it to hand. I will take that on supplementary, if I can, because you are right, a component of the total beds that are new is replacement of beds from elsewhere. I am happy to take that on supplementary; I think it is supplementary 3.

Hon SAMANTHA ROWE: If I can ask, in one of the earlier sessions we heard that in the state there is a shortfall of around 50 per cent in terms of having a child psychiatrists. Do you see that as a problem?

Mr Marney: Again, that is something that we are identifying through the modelling that we are doing, so that demand modelling also has as part of its modelling parameters the number of psychiatrists required, and we are currently finalising that, so I do not have a figure on that, but we will do as part of the 10-year mental health services plan, which will necessitate a workforce development plan as well.

Hon SAMANTHA ROWE: Obviously that would then assist with what I was hearing before that there is a problem, that we need to intervene at an earlier stage so that we do not have the shortfall of beds. Addressing that would be good.

Mr Marney: Having both the appropriate numbers and the appropriate mix of workforce is crucial in ensuring that people get the appropriate treatment at an appropriate stage in their illness and, as you have said, that we do not unfortunately wait until they get really, really ill and then require inpatient settings as a default. Inpatient settings should be the last resort, not the default.

Hon BRIAN ELLIS: I would just like to clarify: you mentioned the beds, the six beds at Bentley, did you say that is up to 25-year-olds?

Mr Marney: No, 17, and it is 12 beds.

Hon BRIAN ELLIS: They are 12 acute ones; did you not mention six before that?

Mr Marney: There are another six that are residential pathway beds.

Hon BRIAN ELLIS: I just wanted to clarify that. In relation to that, I am just wondering whether you can fill me in on the situation for those patients outside of the metropolitan area. What is available to them? Do they have to relocate to the city to be treated?

Mr Marney: In an acute assessment, yes; so just the same as a child who has an acute physical illness would be transferred to Princess Margaret Hospital at the moment, the same goes for mental illness.

Hon BRIAN ELLIS: Up in Port Hedland or somewhere they could go to a hospital to be treated in that situation, but mentally you are saying they cannot; they have to come to Perth?

Mr Marney: Yes; it is where at the moment the specialised services are located.

Hon STEPHEN DAWSON: Just on the same point, one of the recommendations from the Stokes review, recommendation 5.3, talked about that rural child, adolescent and youth beds should be considered a priority in forward planning and attended to immediately. Has the government started to move on that issue to provide some of these services to regional Western Australia?

Mr Marney: There are a range of services provided across the state and they, appropriately, are more in the community-based services, so services such as Youth Focus, support to general practitioners, school psychologists —

Hon STEPHEN DAWSON: Mr Marney, but they are services to keep people out of beds; I think this recommendation actually talked about physical beds being available in regional Western Australia.

Mr Marney: Again, that is an issue that will be identified as part of a 10-year plan and it depends on the demographics of the regions as to whether or not you need beds—so the demographics of the Kimberley are very different to the demographics of the Pilbara, for example, in terms of age profiles. In fact, the Kimberley is different to just about all areas of the state.

Hon STEPHEN DAWSON: It is a very special place!

Mr Marney: It is!

Hon STEPHEN DAWSON: I have to say that is part of my electorate! Another recommendation, Mr Marney, from the Stokes review, recommendation 5.2 talked about —

> Adolescent beds need to be increased to take into account the increasing population of youths. Beds must also be provided for child forensic and eating disorder patients. These are urgent requirements.

Again, at the moment do you have any dedicated beds for eating disorders at the new children's hospital?

Mr Marney: I think for the Perth Children's Hospital we have 20 authorised beds in total and eight of those have been assigned to eating disorder patients. So we have 20 authorised beds plus an additional eight that are assigned to eating disorder patients on the adolescent ward.

Hon STEPHEN DAWSON: Mr Marney, we heard evidence this morning from parents of teenagers who have presented to Princess Margaret Hospital and have been assessed as needing admission to the hospital, but yet, I think, anecdotally, they have been turned away 50 per cent of the time because the beds simply are not available. What do you say to that? What can we say to those parents? Granted we cannot just keep building beds, but if someone is assessed as needing this, needing admission to hospital, should we not be trying to get them in there?

Mr Marney: As much as possible, yes; I agree.

Hon STEPHEN DAWSON: That 50 per cent astounds me—50 per cent of the time, having been assessed as needing admission, you are turned away.

Mr Marney: If it is 50 per cent, that would be extremely disturbing. As discussed earlier, I have taken on supplementary information to try to get some evidence around that, whether it be quantitative or qualitative, to understand the extent of the problem that has been raised with you. I do not think I can adequately empathise what that circumstance must be like for the parents and the individuals involved.

[11.40 am]

The CHAIRMAN: This harks back to an earlier question, one that I was intending to return to. Firstly, I acknowledge the empathy that you have just expressed. I am sure we all feel that. This is where the petition that we are responding to came from, so it probably is the main point of focus. The situation as it was presented to us was that perhaps 50–60 per cent of the time when a bed was required for a particular case, a bed was actually found. We note your undertaking to review the statistics that are available and get some hard facts around that. We look forward to that, with interest. The central issue is, if a young adult or a teenager with an established history over several years is in effect in a place where they need to be on suicide watch, there should be something, one would think, that we might be able to do to respond. Is there any contemplation of how we might do that, perhaps have some extra capacity not normally available that could be opened up at short notice?

Mr Marney: That is really at the heart of the modelling in the 10-year plan which was also a recommendation of the Stokes review and a decision of government in response to the Stokes review. That is really being investigated at the moment. I think it is fair to say in very broad terms that, while acute beds is a very important component of the mental health system, it is just one component. It is probably fair to say the other components, if you like, of the continuum of care, treatment and service have, for a very, very long period of time, suffered from significant underinvestment in this state. That is not unique to Western Australia; it is common to a number of states across the country. In some respects mental health has been the poor cousin of the health system. With that underinvestment comes a system that is skewed in terms of the continuum of care and treatment, and leads you to a situation where you simply cannot meet all of the demand at the acute end if you are not managing that demand across the spectrum of severity of illness. It is going to take us quite some time, and the government quite some time, to invest in the system over time to ensure it is a balanced and appropriate system and to ensure that individuals get the appropriate care, whether it be admission to an inpatient facility or community-based support, at an appropriate time in their illness so that it avoids increased severity. An appropriate setting also means an appropriate cost setting. Obviously if we let people get ill enough to all demand acute settings, the cost of an acute setting is far, far greater than a community-based or subacute setting. That shift in the system is going to take a decade in light of probably numerous decades of underinvestment. We have a long way to go.

Hon STEPHEN DAWSON: The Hospital in the Home program was touched on in earlier evidence. It would probably be good, for the benefit of the committee, if you can tell us how the Hospital in the Home program will work, but also if you can give the committee a sense of how step-up, step-down facilities work as well.

Mr Marney: Probably more of a clinician's response is required. So as to be precise in the response, I will take that on supplementary if I may but I will answer it in broad terms. So that we, if you like, nail the definition with clinical precision, we will take that on supplementary. Hospital in the Home, broadly speaking, consists of a range of outreach treatments to individuals. It may involve regular home visits for checking on the individual in their home setting, ensuring that there is regular assessment and appropriate treatments and medications, and that the individual is on track with those treatments and medications; they are going to their appointments with their psychiatrist or they are actually delivered in the home and, if prescribed medication, they are taking that appropriately. It is really essentially outpatient services but in the individual's home. That is it in very broad terms.

Hon STEPHEN DAWSON: So it is never envisaged that somebody who has been assessed as needing acute inpatient care would ever be treated in a Hospital in the Home setting?

Mr Marney: I would say that would be very rare. Again, I will default to the clinical definitions around this, but it may be the case that the individual has appropriate family supports and so on, such that it is feasible.

Hon STEPHEN DAWSON: Sure. It might be feasible, but it would not be the state saying you have got to deal with this at home?

Mr Marney: Whether or not it is appropriate is another question.

Hon STEPHEN DAWSON: I understand from asking questions in the house—it might have been estimates or parliamentary questions—that some adult beds from Graylands have been closed, and I think some of those beds have essentially been moved out into the Hospital in the Home program. Can you tell us how many?

Mr Marney: My understanding at the moment is that it is eight beds. It is due to increase, in another two tranches, by eight over the next nine months or so.

Hon STEPHEN DAWSON: Is that two more tranches of beds that currently exist in the facility will be shifted into the Hospital in the Home system?

Mr Marney: It is actually to replace beds that have already been closed in Graylands due to licensing issues.

The other component of your initial question was step-up, step-down. That is the subacute settings which is really about identifying symptoms early in the manifestation of an individual's illness and ensuring that they have what you would call in broader health terms secondary treatment settings; so, a general hospital setting equivalent facility, if you like, that does not require the intensive acute care that you get in an acute setting. It is to really deal with the symptoms and the illness early before severity is such that it requires acute care and for those stepping down from an acute setting who may not be quite ready to go back into their home setting or the community. They may require some supports to transition out of that acute setting and to ensure that the treatment they have received is working and the results, in terms of improvement of symptoms, are being sustained and just to have that level of confidence that they can transition back to independent living without returning to the system shortly after that with recurring symptoms and/or increased severity. It is to manage that transition.

Hon STEPHEN DAWSON: I think this morning we heard evidence that in one case a young person was discharged from hospital earlier than the family or the young person thought was

necessary or warranted. If this Hospital in the Home system was in place, I guess once they are discharged from hospital they might go into this setting.

[11.50 am]

Mr Marney: Either go into a Hospital in the Home service or through a subacute service just to ensure that what has happened to them in the acute setting has actually worked and they have stabilised to a point that they are ready to not be in a hospital setting at all.

Hon STEPHEN DAWSON: The commissioner did say he was going to give us some supplementary information to a question you asked earlier on. Was that about the turn-away rate? Did we also ask about the average waiting time?

The CHAIRMAN: No, we did not.

Hon STEPHEN DAWSON: I am wondering if you can give us by way of supplementary information as well what the average waiting time is for somebody to get into an acute inpatient bed, presuming that is tracked.

Mr Marney: I would say in the myriad of data we collect for various reporting responsibilities, including to the commonwealth, we should have that somewhere.

The CHAIRMAN: Commissioner, how long have you been in your role now?

Mr Marney: Four and a half, five months—I think I started in February.

The CHAIRMAN: So it is early days yet for the new office.

Mr Marney: For me. The commission has been in place for four years and it has not yet merged with the Drug and Alcohol Office, which is subject to passage of legislation. So, the commission itself has not changed. It is just me coming in that is the new element.

The CHAIRMAN: You just raised a point that—I might take advantage of you raising it—the Drug and Alcohol Office to be combined or folded into the Mental Health Commission. Is there any intention to change the name of the commission to reflect the alcohol and drug office?

Mr Marney: The legislation as it is currently drafted and introduced into the Assembly by the government refers to the new merging entity as the Mental Health Commission. So, that is the current position of government. We are very conscious of the need for people with drug and alcohol issues—to ensure that they continue to seek help through the Drug and Alcohol Office and the merged entity and aware of the issue that they may feel, if you like, stigmatised or in some way turned away from seeking help from an agency that has a mental health title and not a drug and alcohol title. People with a drug and alcohol issue may not want to identify with an organisation that is called mental health. So, we are very conscious of that.

In the proposed structure of the merged entity there is a very high-profile, highly visible and highly identifiable area dedicated to drug and alcohol. So, people will still be able to identify with that area within the merged entity without having to, at the same time, identify with mental illness.

The CHAIRMAN: There will be a sign on the door and on the website relating to alcohol and drug services much the same as now; is that the case?

Mr Marney: Yes, pretty much.

The CHAIRMAN: Sorry to do that without notice. I am anticipating a matter we may have to deal with shortly.

Mr Marney: It is a fair enough question. Of course, the merger of the two identities flows from the Stokes review and the government's response to the Stokes recommendations to adequately address the comorbidity and co-occurrence of mental illness and drug and alcohol issues, which is, as pointed out in Stokes, at the moment under-catered for by virtue of segregation of the agencies and the systems of service delivery.

Hon STEPHEN DAWSON: Just briefly, I will leave that issue alone because I asked the commissioner and the minister some questions on that issue in estimates. However, I just wanted to touch on, just going through my notes, the royal college of psychiatrists talked about the eight new mother and baby unit secure facility at Fiona Stanley. I think there are eight beds available at the moment at King Edward Hospital. Are we shifting the King Edward Hospital beds across or is that new beds?

Mr Marney: No, that is new beds. I am not sure if you have had an opportunity to inspect the facility, but I would gladly take you out there and have a look. It is a great opportunity for a contemporary facility with appropriate settings that deal with mother and baby occurrences of mental illness.

Hon STEPHEN DAWSON: Perinatal mental health is a real issue in this state and with federal funding in jeopardy there are big gaps in this area so it is important that the state picks up the slack if we can. I will take you up on your invitation.

The CHAIRMAN: Commissioner, have you got any final observations that you would like to make about the matters we have been discussing this morning?

Mr Marney: I have, hopefully, given you a clear impression that focusing just on acute beds is probably the wrong way to go and we need to be looking at the system holistically to ensure that we have got adequate supply, service and support at each step in the system from community-based settings right through to acute. That way we get a balanced system. If we do not focus the system in that way, then we will never be able to meet the demand through provision of skewed acute services. Again, I just reiterate that I cannot imagine the circumstances of individuals presenting and being turned away when they are assessed as requiring acute inpatient treatment and that is something that, I think, obviously, we are all working to address.

The CHAIRMAN: This hearing, in part, has enabled us to raise issues in a petition to the Parliament specifically with you and you have acknowledged that, so I thank you for that. No doubt we will talk again. Thank you both for your evidence before the committee today. I think you are familiar, commissioner, with the procedures in relation to transcripts.

Mr Marney: Yes.

The CHAIRMAN: We look forward to receiving some supplementary information and indeed if there is any other matters you feel need to be brought to our attention, we would like to receive that further information as well. Thank you again for attending and we bid you a good day.

Mr Marney: Thank you for your time.

Hearing concluded at 11.58 am

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