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# **HEALTH, ENVIRONMENT AND INNOVATION COMMITTEE**

## **Members present:**

Mr R Molhoek MP—Chair  
Ms SL Bolton MP  
Ms K-A Dooley MP  
Mr JP Kelly MP  
Mr DJL Lee MP  
Dr BF O'Shea MP

## **Staff present:**

Ms K Jones—Committee Secretary  
Miss A Bonenfant—Assistant Committee Secretary

## **PUBLIC BRIEFING—OVERSIGHT OF THE HEALTH OMBUDSMAN AND THE HEALTH SERVICE COMPLAINTS MANAGEMENT SYSTEM**

### **TRANSCRIPT OF PROCEEDINGS**

**Wednesday, 11 February 2026**

**Brisbane**

## WEDNESDAY, 11 FEBRUARY 2026

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**The committee met at 9.35 am.**

**CHAIR:** Good morning, everyone. I declare open this public briefing for the oversight of the Health Ombudsman and the health service complaints management system. My name is Robert Molhoek MP. I am the member for Southport and chair of the committee. I acknowledge the Aboriginal people and Torres Strait Islander people of this state and their elders past, present and emerging. I also acknowledge the former members of this parliament who have participated in and nourished the democratic institutions of this state. Finally, I acknowledge the people of this state, whether they have been born here or chose to make this state their home and whom we represent to make laws and conduct other business for the peace, welfare and good government of this state.

With me here today are Mr Joe Kelly MP, member for Greenslopes and deputy chair; Ms Sandy Bolton MP, member for Noosa; Ms Kerri-Anne Dooley MP, member for Redcliffe; Dr Barbara O'Shea MP, member for South Brisbane; and Mr David Lee MP, member for Hervey Bay.

This briefing is a proceeding of the Queensland parliament and is subject to the parliament's standing rules and orders. Only the committee and invited witnesses may participate in the proceedings. Witnesses are not required to give evidence under oath or affirmation, but I remind witnesses that intentionally misleading the committee is a serious offence. I also remind members of the public that they may be excluded from the briefing at the discretion of the committee. I remind committee members that officers are here to provide factual or technical information. Any questions seeking an opinion about policy should be directed to the minister or left to debate on the floor of the House.

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**ANDERSON, Ms Janet PSM, Health Ombudsman, Office of the Health Ombudsman**

**BEASLEY, Ms Prue, Executive Director, Operations, Performance and Quality, Office of the Health Ombudsman**

**BRAYBROOK, Mr Mark, National Director, Notifications, Health Regulation, Australian Health Practitioner Regulation Agency**

**EDWARDS, Ms Heather, Queensland State Manager, Australian Health Practitioner Regulation Agency**

**EVANS, Ms Kate, National Manager, Professional Misconduct, Legal Services, Australian Health Practitioner Regulation Agency**

**HILL, Ms Maree, Executive Director, Assessment and Regulation, Office of the Health Ombudsman**

**LAMBLEY, Ms Monica, Executive Director, Health Regulation, Australian Health Practitioner Regulation Agency**

**SUTHERS, Mr Aaron, Executive Director, Investigations, Office of the Health Ombudsman**

**CHAIR:** I welcome representatives from the Office of the Health Ombudsman and from the Australian Health Practitioner Regulation Agency who have been invited to brief the committee. I note the public nature of this briefing and therefore I remind both members and witnesses that we are unable to discuss any individual health practitioner matter in a way which may breach confidentiality. If such a matter is raised, I will have to close the briefing and resume in private session.

Public Briefing—Oversight of the Health Ombudsman and the health service complaints management system

For both members and witnesses, please remember to press your microphones on before you start speaking and off when you are finished. I will in just a moment invite both the Health Ombudsman and Ahpra to each make a brief opening statement, after which committee members will have some questions. Before we go to that, I foreshadow that the committee this morning resolved to reduce the time for the public hearing to half an hour and to increase the private session to an hour and a half.

Welcome, Ms Anderson. It is lovely to meet you in person, not just through a paper CV, and I look forward to getting to know you better in the coming months.

**Ms Anderson:** Thank you, Chair. Thank you for this opportunity to appear before you. I am very pleased to have the chance to present an overview of the 2024-25 annual report for the Office of the Health Ombudsman, which I will refer to as OHO. I would like to begin by acknowledging the traditional owners of the land on which we are meeting today and pay my respects to elders past, present and emerging.

The OHO statutory purpose, which is well understood by the committee, is to protect and support the community through responsive complaints processes and regulatory action, driving positive change and confidence in Queensland's health system. As the newly appointed Health Ombudsman, I would like to acknowledge the work of my predecessor, Dr Lynne Coulson Barr. Under her leadership, 2024-25 was a year of significant achievement for the OHO, marked by new initiatives and improvements to operating processes.

Focusing first on an area of our work that can be overlooked but actually makes an important contribution to our regulatory effectiveness, the OHO continued its efforts to ensure that our services are accessible, inclusive and responsive to the needs of all Queenslanders. The agency pursued this objective through targeted stakeholder engagement with groups and services in the community, including in regional and rural areas. We also strengthened our external communications by creating and publishing easy-read resources on our website. Other external engagements undertaken by OHO contributed to system-wide reform initiatives.

In the current year, we aim to further strengthen our relationships with key stakeholders, including the Department of Health and hospital and health service boards and CEOs, to ensure that our work is having the expected positive impact on the quality and safety of health care and services across Queensland. We will also continue to share with the sector key learnings from investigations to promote better risk management and improved outcomes.

Turning to OHO-specific legislated operational activities, the agency experienced sustained growth in activity levels, with total contacts increasing significantly over the past three years. In the last financial year we received 9,812 complaints and we are expecting to exceed 10,000 for the first time this financial year. This growth reflects the community's trust in our role as a single entry point for complaints and notifications about registered and unregistered health practitioners, students and health services in Queensland. The most common complaints received about practitioners related to professional performance, conduct, communication and medication. We encourage practitioners and services to regard every complaint as a potential opportunity for them to improve their care.

The OHO continued to prioritise effective complaint resolution and maintained strong operational performance, exceeding two key service delivery targets and achieving improved performance on another two targets. I would add that survey feedback provided by callers following their first-touch phone call with one of our intake staff is overwhelmingly positive, commenting favourably on staff's professionalism, empathy and clarity. In 2024-25, 530 matters were managed through local resolution, and I am keen to continue promoting this approach as a timely, flexible and effective pathway for achieving good results for all involved.

Referral of matters to other relevant agencies were another regulatory tool put to good use. Our collaboration with Ahpra remained strong across the year, with 4,015 initial joint consideration consultations finalised and the majority of these completed well within statutory timeframes. Just over 1,700 registered practitioner complaint referrals were made to Ahpra as part of our co-regulatory arrangement.

With respect to complaints that progressed to an investigation, typically after a detailed assessment process, the OHO finalised a record 238 investigations compared with 180 in the previous year, and over half of finalised investigations related to registered practitioners and resulted in referrals for disciplinary action.

It is clear that challenges remain in finalising investigations within 12 months, with a reported 52.5 per cent achieved against a target of 75 per cent. This result was strongly influenced by two factors: first, a significant increase in complaints for investigation in the prior year that flowed through

to 2024-25; and, second, OHO's focus on closing aged matters. I can assure the committee that OHO is progressing a suite of strategies to further improve timeliness, and we expect to start seeing the positive impact of this work in the next six months.

In terms of regulatory action, the OHO has continued to exercise its most serious and consequential powers diligently and responsibly to protect Queenslanders to ensure accountability across the health sector. Information is presented in our annual report on the immediate registration actions, interim prohibition orders and prohibition orders issued.

Consideration by the Queensland Civil and Administrative Tribunal of matters referred by the Director of Proceedings resulted in 43 decisions on sanctions applied to registered practitioners. As of 30 June 2025, the OHO had 309 open practitioner-monitoring cases.

In closing, the OHO's annual report 2024-25 tells a story of significant achievement, strong operational performance and meaningful outcomes for individuals and the health system. The report also highlights areas where further work is required. These priorities are well understood by me and the executive team and we will share the results of our improvement strategies with this committee over time. Today, I look forward to further discussing the agency's achievements of last financial year with the committee and addressing any questions you might have. Thank you.

**Ms Edwards:** Good morning. I am Heather Edwards, State Manager for Ahpra. I appreciate the opportunity to speak with you about the Ahpra and national boards' 2024-25 work. With me today are Monica Lambley, Executive Director, Health Regulation; Kate Evans, National Director, Legal Services; and Mark Braybrook, National Director, Notifications. I would like to acknowledge the traditional owners of the lands on which we meet, pay respect to elders past and present and extend that respect to any First Nations people joining us.

I want to acknowledge and thank Dr Lynne Coulson Barr for her service as Health Ombudsman. We now look forward to building on that strong partnership with the new Health Ombudsman, Ms Janet Anderson.

Ahpra works with 15 national boards to regulate 16 health professions under the national law, with the single purpose of protecting the public through effective and fair regulation. Last year, practitioner numbers increased 4.3 per cent, taking Australia to almost one million registered practitioners, with just over 200,000 in Queensland. As a self-funded regulator, registration fees support all of our work.

Our focus this year was on meeting workforce demands and strengthening harm prevention. We made it faster and easier for graduates and overseas trained practitioners to enter the workforce. We registered almost 70,000 practitioners for the first time, including more than 26,000 internationally qualified practitioners, and processed a record 870,000 renewals. We strengthened public protection through new non-surgical cosmetic procedure guidelines, updated safeguards for telehealth and single-medicine prescribing, and issued guidance on the safe, ethical use of artificial intelligence. We also advanced our work to eliminate racism in health care and reached a milestone of more than 1,000 registered Aboriginal and Torres Strait Islander health practitioners nationally, with over 200 of those in Queensland.

Notifications increased significantly. Nationally, we received 13,327 notifications—up 19 per cent—including 1,770 referred from the OHO in Queensland. Despite this, we resolved more matters faster: 81 per cent were closed within six months, our best result to date. We also strengthened our approach to vexatious notifications. Of 125 assessments, 53 were found to be vexatious—a substantial increase—and an early identification in reducing distress for practitioners. Notifications about boundary violations, including sexual boundary concerns, rose 72 per cent nationally to 1,991 cases, with 211 in Queensland—a 21 per cent increase. This increase reflects growing public awareness and reduced tolerance of sexual misconduct across the health system.

Overall, our performance in 2024-25 reflects responsive, contemporary regulation aligned with community expectations. We continue to modernise systems, reduce notification timeframes and improve the experience of notifiers and practitioners. We have completed 16 actions from the Minimising Practitioner Distress recommendations and expect to complete 31 of the 33 by June this year.

Health care is changing rapidly and so must we. In the coming months we will deliver a new five-year strategy focused on supporting a capable and sustainable workforce and ensuring community safety by preventing public harm. Thank you. We are happy to take your questions.

**CHAIR:** Thank you. I turn to the deputy chair.

**Mr JKELLY:** Thanks, everyone, for coming along. Welcome, Ms Anderson. It is very good to have you in the role. I started the day listening to one of Australia's political parties saying they were going to shut down the TGA if they were elected, and the person responding to that rightly pointed out that if you want a cardiac stent or an indwelling catheter that does not work, that is a good thing to do, so thank you for the work that you do.

I know that you have been in the job for only five minutes, Ms Anderson, and I have a lot more questions—I am sure my colleagues have as well—for the private session, but could you give us any early assessments you might have made around what you consider to be high-priority goals or objectives in your role as the OHO?

**Ms Anderson:** I have been struck by both the enthusiasm and the capability of the staff, and that really is the first impression as you walk through the door. At every single meeting I have had—I have progressively extended my reach into the organisation—I have come across high-performing individuals who are exceptionally committed to their work, and I think the previous surveys of staff have made the same point. These are people who might come for a job but stay because they really believe in what we are trying to achieve, and that speaks to a very strong workplace culture. I make that point at the outset because, of course, what we achieve is done through our workforce.

It is hardly a secret that we have an IT network, systems and software which does cause us some degree of difficulty from time to time, and it is the subject of ongoing discussions with the department and other entities across government as to whether and to what extent we can be ambitious about re-platforming or at least upgrading some of the software systems and the IT support that we have access to. If I can just extend that briefly, I suspect you would know, as your colleagues do, just how much reliance a good, high-performing regulator places on data and digital. If it was not once, it now is centre frame. We take in enormous amounts of information. We need to be able to save it, store it and retrieve it but also analyse it and extract from it the essence of a problem in the moment with potentially a complainant and a practitioner or service, as well as see patterns and trends. The regulator I lead and the health complaints entity I lead is going to be one which harvests that very opportunity so that we can get out ahead of risks.

The OHO has done that under Lynne Coulson Barr, there is no doubt, and I want to do a lot more of it. I think there is a platform for action that we already have in some of our snapshot reports back to the sector, but I am conscious that one of the rate determiners is our ability to get access to and crunch the data in order to reach those conclusions that then allow us to say something out loud to the sector, or to a group of practitioners. That is something I have been reflecting on.

I know there was an external report done of the resourcing of the entity which, in fact, is mentioned in our annual report. Under Lynne Coulson Barr, there was significant implementation of a number of those recommendations which went to staffing configuration and organisational structure, and it also talked about IT systems. A lot of that work is either done or underway. I have also been impressed by the commitment of staff to ensure we see all of those things through. One of the priorities is to take that to its end of travel so that we can get the full benefits of that external scrutiny and the recommendations they made to the organisation.

Stakeholder engagement is one of the topics I mentioned briefly in my introductory remarks, and, again, it is a strength of the Office of the Health Ombudsman that we do as much as we do. I still think we can further explore that as an opportunity for regulatory impact. Engagement actually is a regulatory tool. It is not often spoken about in that context, but it is. It is about building trust and confidence in the organisation I lead, which means that we need to be capable to back that in, but it is also about lifting awareness within and across the sector about personal and systemic obligation—making sure people are taking seriously their training and education and keeping up to date but also paying attention to the rules, the procedures, the way we do things around here, to always mitigate risk and promote safe, quality care.

To the extent that I, for example, want to engage with HHS CEOs, I want to have an unvarnished, all-cards-on-the-table conversation with them about their systems and processes for risk management and quality improvement and how we can amplify some of those foci to get an even better return on that investment. Often we are a thorn in their sides, and I actually do not make any apology for that because sometimes we find out things which need to be the subject of a conversation and a sharp-edged discussion about whether it was known, how well it was known and what could have been done to prevent something from happening. That is the regulator's job; that is fine. However, if we do it with mutual respect then we can have a conversation with impact.

**Mr LEE:** In the interests of time, going to the question of your internal review process, back in 2022 you reviewed your internal review process on the basis of legal advice. Has that change in process, where you no longer have an internal review process, impacted on the number of matters that have escalated at QCAT?

**Ms Anderson:** I am certainly familiar with the issue you are raising. I could not answer the specifics. I am not sure whether my one of my colleagues can.

**CHAIR:** In the annual report, one of the statistics was that the goal for decisions upheld by QCAT is 90 per cent.

**Ms Anderson:** Yes.

**CHAIR:** The actual for 2024-25 was 50 per cent.

**Ms Anderson:** Chair, I am intervening in your—

**CHAIR:** It may be a question you want to take on notice.

**Mr LEE:** It relates to legal advice under section 24AA of the Acts Interpretation Act.

**Ms Beasley:** My understanding is that you are referring to the Queensland Ombudsman, not QCAT. As you said, we ceased our internal review function as a result of advice we received. The impact of that decision is that we have a very robust complaints framework about our decisions and our actions, but unfortunately we cannot review our outcomes of decisions. We deal with any concerns through our complaints policy from our customers, providers and complainants, through our complaints framework, and we refer the complainant or provider to the Queensland Ombudsman for an external review if their concerns are about the outcome. The Queensland Ombudsman review that decision to ensure our processes were appropriate—our administrative decision-making and our communication was appropriate—but they do not reinvestigate the matter.

In June 2025, we had 93 requests made by the Queensland Ombudsman. Sixty-seven of those resulted in no further action and in five we agreed to rectify or address an issue. We have found in those cases sometimes the person has additional information which was not considered as part of their complaint, and in those cases we are able to potentially open a new complaint because it contains information that was not previously considered.

This year we have received, so far, in the six months between July and December, 69 requests. Of those, 11 were new health service complaints, 41 required no further action by the Queensland Ombudsman, 12 required no further action by the Queensland Ombudsman but have identified some issues regarding communication and improved pathway information in terms of our templates and the information that we provide to people, and two were awaiting an outcome.

**Ms BOLTON:** Ms Anderson, welcome. I do realise, as the member has already said, that you have only been here for five minutes, but you did raise the collaboration with Ahpra. It is quite unique in Australia as Queensland is the only one. I would be interested in how you see that, in your perception or your experience.

**Ms Anderson:** You are absolutely right to talk about it as being unusual and specific to Queensland. I think it works remarkably well. I think, from the outside looking in, people would wonder how it works. From the inside, the operation of it is actually remarkably smooth. We have established—and I am sure my colleagues from Ahpra would second this—very smooth, efficient communication channels and there are literally no barriers between ourselves and Ahpra on the matters that we would be discussing daily, second daily, third daily and so on.

The joint consideration at the initial stages of considering a complaint and so on is very smooth, low-friction engagement, which results in clear-minded, informed decisions about the handling of a particular matter. It will be vanishingly rare for there to be a strong difference of opinion between the parties which I think speaks to a determined alignment of perspective and thinking. Our positioning on issues, our assessment of risk, our understanding of this notion of 'serious' and what that means for who should manage it at one point in the process is very strongly aligned. To be honest, it would not work if it were other than that, but I can say, even on the preliminary experience I have had so far, there is ample evidence of that working very well.

**Ms BOLTON:** If it works so well, why is it not implemented across Australia?

**Ms Anderson:** Member, I think that might be a question for the politicians!

**Ms BOLTON:** Thank you.

**Ms DOOLEY:** Ms Anderson, I add my welcome to you and wish you every success in the role. It sounds like you have a wonderful team. However, my question is to Ahpra. In figure 95 of the Ahpra annual report, there is a flow chart that notes that in Queensland, when a decision is made by OHO, Ahpra is notified, but it does not actually identify how Ahpra notifies the OHO of decisions. Can you explain that process?

**Ms Lambley:** I work very closely with the office of the ombudsman. There are probably two ways. At the start with a joint consideration, we have a common system that we work through. At the end, when there is a decision, we will notify usually in writing, by email or letter, but when there is potentially a conversation that is required, because we have been having engagement about a particular case, of course we will just contact them via phone.

**Ms DOOLEY:** What would be the average time that Ahpra takes to investigate a Queensland complaint? That may be a question to take on notice.

**Ms Lambley:** I might need to take that on notice. Would you want to know details about all notifications, because investigations is a specific process within the notification process? We can provide—

**Ms DOOLEY:** Serious allegations. Previously some of our concerns have been around those serious allegations where there may be criminal investigations, and I know that part of that is referred to Ahpra and some is maintained by OHO. Our concern is around particularly those investigations taking more than two years.

**Ms Lambley:** Definitely. We will take that on notice in terms of getting the data, but I will say that we have been, as the Office of the Ombudsman has too, working towards reducing those timeframes. We can see that in our last report—132 days at the end of December was the average time for a notification. That was across all jurisdictions, but that is the lowest it has been since the scheme commenced, so we are really making efforts to reduce those times.

**Dr O'SHEA:** I want to congratulate you, Ms Anderson, on your appointment and thank you for the work you did in aged care during COVID. It would have been extremely difficult. Thank you. Looking at the OHO report, and looking at the monitoring role that OHO has, I noticed it monitored the implementation of 248 recommendations for systemic issues and by June 2025, as you said, had 309 open practitioner-monitoring cases. Can you explain the monitoring role of OHO in looking at implementing the recommendations for systemic issues and also the monitoring of the practitioners and how it works in a practical sense?

**Ms Anderson:** Member, with your agreement, I will defer to my colleague who is far more expert than I am at this point.

**Ms Beasley:** There are two separate parts to that question. I can answer the question with regard to the monitoring of practitioners. The Office of the Health Ombudsman has a monitoring compliance team. We monitor where action is taken in relation to a health practitioner around immediate action or if there is a prohibition order or if there is a QCAT order in relation to an unregistered practitioner. We monitor their compliance with that action to ensure any risk to the public is mitigated.

We have a risk-monitoring framework. Obviously, with over 309—that was as of June 2025—we cannot monitor everybody, so we have a staged approach. There is stage 1 monitoring, then they are put into stage 2 monitoring, then stage 3 monitoring, and that depends on risk factors: are they running their own private practice, has there been a history of noncompliance and things like that. That influences our risk framework and the checks we do.

We do open-source checking. For those subject to immediate action we can exercise powers to ensure compliance with immediate action, and we do that by engaging with other entities such as private health insurers, Medicare and the monitored medicines unit to ensure the practitioner is complying with a suspension or conditions and things like that.

**Dr O'SHEA:** For example, if somebody had to have a chaperone for seeing female patients, how would you monitor that?

**Ms Beasley:** We call them a practice monitor. We have strict requirements with regard to what a practice monitor role does, and that is set out in the schedule of conditions for the practitioner about documentation they must supply, booking, staff—things like that. Depending on the condition, there are certain requirements they have to fulfil in reporting to us and giving us information and ensuring that, if it is a practice monitor, there is a log, it is an appropriate practice monitor with no conflicts of interest and things like that.

**Dr O'SHEA:** Again staying with OHO, I understand the process of local resolution involving resolutions between the complainant and the health service provider, possibly with explanation of treatment or an apology. Can you explain the process of early resolution as opposed to local resolution?

**Ms Anderson:** I will top-end the question, member, and perhaps pass on to Maree. That is a good question. On entering the position I wondered the same thing and we are looking at it more closely. Early resolution—and my colleague will check my accuracy—is the general descriptive for the work we seek to do on initial call-taking. If a complaint comes in and in that first interaction there appears to be something that we can add, ask or suggest which satisfactorily addresses the issue which is presenting then the complaint, on the agreement of the caller, does not have to progress any further than that initial call. That is the general outline of early resolution. Maree?

**Ms Hill:** Thank you, Janet. That was a very good description. Essentially, to add to what the Health Ombudsman has said, it is a service we provide to consumers, complainants and providers, but it needs to be done within the first seven statutory days. A typical example might be that a consumer gives us a call as they are having trouble getting a prescription dispensed. We ask if we can contact the pharmacy on their behalf. We get their consent, contact the pharmacy and try to resolve that. They are not complex matters; they are matters where we can see an opportunity for early resolution might present a good outcome in those first days and matters might not then need to progress into a more formalised local resolution.

**Dr O'SHEA:** I see that more experienced staff members were assigned to triage in this Enhanced Experience pilot. Would OHO be planning to extend that and continue that if it has been successful?

**Ms Anderson:** That is an astute observation, member. It was a deliberate decision, and, again, I will invite my colleague to add. It might be initially counterintuitive because you grade your staffing. If it is a low-complexity matter then it can be dealt with by staff who perhaps do not have that high level of expertise, but in fact we found that this initiative of putting more expert staff at the front end of the process can achieve a better outcome for the caller and possibly a shorter process than might otherwise be necessary if we have to take it into the organisation and it has to go through several steps in our sequence.

**Ms Hill:** That is correct. I think the important part here is that Enhanced Experience is a pilot; it is a program that we are running. We have senior delegates on the phone and we have initially started with an inquiries line. You may be aware that OHO has an inquiries phone line, a notification line, a health service complaint line and a prisoner complaint phone line. We have the seniors on the inquiries lines because what we found through our data interrogation is that, as it is the first option you can push when you call us, some people might push the inquiry line and actually have a complaint as well or a notification. What we are finding through our trial is that the senior delegate can recognise if it is an inquiry and give high-level advice, resources, support and education, but if it is a complaint or a notification they can actually take that complaint or notification then and there and also make the decision within that time, because they are a delegate with that delegation to do so.

**CHAIR:** I am conscious of time because we did want to move into the private session. I wanted to foreshadow that we have spent a bit of time as a committee asking questions about 91C matters, and we did get a response from the previous OHO about process, but we are a little bit concerned about the interaction between the OHO and Ahpra and the fact that it would appear that some of these matters have perhaps from time to time fallen through the cracks. We are very concerned about the fact that there are some matters where there may have been multiple complaints that have been dealt with over time individually, but we are very curious to understand how the OHO and Ahpra deal with a matter where there are systemic complaints or there has been a pattern of complaints. Albeit that some may have been dismissed, they are not necessarily being raised again in later investigations. I think we might get into some direct questioning about that in the closed session.

I will take the opportunity to close this briefing and thank you for your comments. Thank you for the opening statements, too. It is always important to have some context and get that commentary on the public record, because it is important that that is available. Thanks to Hansard. A transcript of these proceedings will be available on the committee's webpage in due course. There was one question taken on notice. We require a response to that by 10 am on Friday, 20 February. I declare this public briefing closed.

**The committee adjourned at 10.14 am.**