LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

(Reference: Appropriation Bill 2012-2013 and Appropriation (Office of the Legislative Assembly) Bill 2012-2013)

Members:

MS A BRESNAN (The Chair)
MR J HARGREAVES (The Deputy Chair)
MS M HUNTER
MR B SMYTH
MR A COE

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 5 JULY 2012

Secretary to the committee:
Ms S Salvaneschi (Ph 620 50136)

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

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Amended 9 August 2011

The committee met at 2.03 pm.

Appearances:

Gallagher, Ms Katy, Chief Minister, Minister for Health and Minister for Territory and Municipal Services

Health Directorate
Brown, Dr Peggy, Director-General
Thompson, Mr Ian, Deputy Director-General, Strategy and Corporate
MacCullagh, Ms Jeanette, Acting Executive Director, Division of Critical Care
Redmond, Ms Judy, Chief Information Officer, E-health and Clinical Records

THE CHAIR: Good afternoon and welcome to this 13th public hearing of the Select Committee on Estimates 2012-2013. The Legislative Assembly has referred to the committee for examination the expenditure proposals in Appropriation Bill 2012-2013 and the revenue estimates in the 2011-2012 budget. The committee is due to report to the Assembly on 14 August 2012.

The committee has resolved that all questions on notice will be lodged with the Committee Office within three business days of receipt of the uncorrected proof transcript, with day one being the first business day after the transcript is received. Answers to questions taken on notice will be returned within five business days after the hearing at which questions were taken, with day one being the first business day after the question was taken.

The proceedings this afternoon are focused on expenditure proposals and the revenue estimates for the Health Directorate, output class 1, health and community care, specifically strategic objective 17, emergency department timeliness.

Minister for Health, as you would be aware, at the time strategic objective 17 was discussed on 21 June 2012 the committee raised that no results were available and was advised that these would not be available until investigations into reporting of emergency department information had been completed. Subsequent to that hearing on 21 June 2012, the report of the Auditor-General's performance audit of emergency department performance information and the report of the forensic investigation by PricewaterhouseCoopers have been released. You wrote to the committee on 4 July 2012 noting that the aforementioned reports had been released and that you believed it would be in the public interest to have relevant Health Directorate officials and you appear before the committee to provide an explanation on details of the report and the government's response. I welcome you, health minister, and officials from the directorate.

I also wish to note that, in accordance with the resolution of the appointment of the Standing Committee on Public Accounts, all reports of the Auditor-General, after presentation to the Speaker, stand referred to that committee. That committee will determine how it wishes to progress its consideration of Auditor-General's report No 6 of 2012.

I also emphasise to members and witnesses that the misreporting of data has been

referred to the police for investigation, so questioners need to be mindful of this process and should be careful not to stray into areas that are currently under consideration by the police.

I remind witnesses, although I am sure you are very familiar with it, of the privilege statement, which is on the blue card in front of you. Can you indicate that you are aware of the information and implications in that?

Ms Gallagher: Yes, thank you, chair.

THE CHAIR: I also advise that proceedings are being recorded by Hansard and are being broadcast today.

Health minister, before we go to questions from the committee, I would like to invite you to make an opening statement if you wish.

Ms Gallagher: Thank you, chair, and certainly I welcome the opportunity to speak with the committee again and answer questions that you might have on emergency department timeliness reporting, output class 1.1 and strategic indicator 17, and indeed the recent reports that have been released from the Auditor-General and PricewaterhouseCoopers.

Just as background, back in April anomalies in emergency data department were brought to my attention. Since that time, I have provided all the information that I can on this to the community. The two reports released this week make several recommendations which, to the large part, will be implemented to minimise the risk of this situation occurring again.

It is important to note that the changes made to the data in no way reflect on the quality of care provided at the Canberra Hospital's emergency department or on the professionalism of the doctors, the nurses or the allied health staff within the ED. The care provided within the emergency department has not been affected by any changes to the data, as these data changes were made after the care in the emergency department had been completed.

The issues identified in the Auditor-General's report and by PricewaterhouseCoopers clearly indicate that this is about data and data systems, not about patient care. The primary purpose of EDIS, which is the IT system used in the emergency department, is to support staff to deliver patient care in the emergency department, and it is the clinical care in the ED that must remain paramount.

I am deeply disappointed that a staff member, who has accepted responsibility for the vast majority of the changes, of the ACT Health Directorate would show such an error of judgement in deliberately manipulating the ED performance data. Whilst I acknowledge that the hospital is a high pressure environment, I do not believe there is any excuse to deliberately interfere with or change data.

The Auditor-General's report discusses the increasing pressure that emergency departments are placed under nationally. Her report also shows that presentations to the emergency department in the ACT are increasing at a rate that is both higher than

the rate of emergency departments elsewhere in Australia and significantly higher than population growth. At the same time, there is intense attention from a range of quarters on and calls to improve ED timeliness which I believe have created additional pressure on hospital staff.

The Auditor-General's recommendation for developing broader measures of ED performance is supported, and the Health Directorate acknowledges problems identified with the controls and management of the EDIS system at the Canberra Hospital and will work to implement the agreed recommendations in the report.

Resources will be dedicated to implementing the action plan, starting immediately. Some of the recommendations require changes to technical functionality of the existing system, and the Health Directorate will commence working with the software vendors on those. Work will also commence immediately in relation to other performance indicators for the ED that measure clinical outcomes and patient satisfaction. I think this work needs to be led nationally, and there is an expert panel established under the national partnership agreement on improving public hospital services, the AIHW and the National Health Performance Authority to further explore development of a more rounded suite of outcome indicators for emergency department care.

I have also indicated that I will commission from independent experts a data integrity strategy to implement across the Health Directorate. Preparatory work is already underway on setting out the various data and information systems in use and their current governance and reporting mechanisms.

We will also establish a new position of director, data integrity, which will be appointed in the Health Directorate. It will sit outside of the hospital structures and report directly to the director-general.

At a national level it is essential that we have agreed definitions for the use of ED data, and this is not the case at the moment. We have to put a stop to the variable interpretation that currently exists around data definitions and reported data, ensuring that we obtain and report data that is comparable between states and territories. This goes for elective surgery data as well, and I have been saying this for some time.

A regular national audit across all jurisdictions could further strengthen this process, and I will discuss this further with my ministerial colleagues. A national audit process would ensure that all jurisdictions are audited regularly and under the same audit methodology.

Ensuring strong governance of the hospital system is another area that requires consideration. I will be extending an invitation to Professor Mick Reid to conduct a review of governance across the Health Directorate. Professor Reid has a wealth of experience of running health systems and he also headed up a review into ACT Health back in 2002. From the government's point of view, this review would assist the directorate in strengthening, where appropriate, its corporate governance across all facets of the organisation, including at the Canberra Hospital.

I have also extended an invitation for the Auditor-General to conduct a progress

review in 12 months to ensure that the directorate is on track, making the necessary changes and improvements.

From my point of view, I want to assure the committee that the recommendations from the audit are being taken seriously and that the work and resources will be allocated to ensure that necessary improvements are made as soon as possible. Thank you.

THE CHAIR: Thank you, health minister. I will go to my first question. You have—

MR SMYTH: Madam Chair, can I just ask a question that I think needs to be on the record? I note that the deputy director-general responsible for the hospital is not with us today. What would be the reason for that?

Dr Brown: Mr Martin is unwell. He has been unwell for several weeks. I think I indicated last time we appeared before the committee, when he was here, that he was not well. He has been off work the last two weeks. He had been sick prior to that as well and had some time off.

MR SMYTH: The reason I ask is: who will be occupying the seat in his position today?

Dr Brown: Ms Katrina Bracher is the acting deputy director-general. She is here with us. We can bring her to the table if you wish.

MR SMYTH: I am sure that might occur during the course of the day. It was just for the record. We may well know, but the record will not reveal that unless it is asked.

THE CHAIR: Okay. I will go to my first question then. It has been addressed in your opening statement, minister, and it is about the qualitative indicators. For me, one of the recommendations in the report stood out. I know you are very familiar with that report, but I will just read that out:

> The Health Directorate should review its performance indicators for publicly reporting the performance of Canberra's hospitals' emergency departments to include and give a greater emphasis to qualitative indicators relating to clinical care and patient outcomes.

And I also think it is worth noting that page 8 of the report says:

> An Expert Panel review of the introduction of the NEAT identified that there are risks associated with the introduction of quantitative targets such as the NEAT. The Expert Panel recommended that the targets themselves may pose a risk to safety and quality of patient care, in the absence of a balanced suite of indicators which measure different dimensions of quality.

I asked questions about this when you appeared previously before estimates. Given that concerns have been expressed by the expert panel associated with the hospital reform process, why have both the state and federal governments pursued so vigorously this particular measure around emergency department waiting times? We have this advice and we have evidence from overseas as well, particularly from the

UK, that there are concerns with this indicator as a stand-alone indicator in particular and that it can actually have an impact on quality outcomes. That has come out very clearly, I think, in this report.

Ms Gallagher: In terms of the four-hour rule, or the NEAT target, it was a prerequisite of national health reform. It was conditional for states and territories to receive any extra funding through that national partnership to agree to implement the NEAT target as an element of that. There was discussion at the table at the time around the risks associated with a four-hour rule. It had been implemented in WA by that point, and the WA government spoke very strongly in favour of the NEAT, or the four-hour rule as it was called.

I think at the time it was being negotiated it was just prior to the UK moving away from the four-hour rule. But from my point of view—and I was at the table—the ACT government certainly did not see this as the best indicator of ED performance. Indeed, we raised our concerns through the roundtables that were held at the time around the COAG table, but it was a pre-requirement of the commonwealth agreement.

THE CHAIR: Yes, and I am aware it is a pre-requirement. You referred to the UK, and as the report states—and this is something I had heard previously too—there had been widespread manipulation in the UK with this particular indicator. I realise it was a prerequisite, but I am trying to get a sense of why it was pursued so vigorously given we have got that and given the expert panel is saying, "We are concerned about this." I know the ACT did not, but other states did. In the last couple of days a number of groups have been saying that having payments attached to this creates a very difficult situation and does not necessarily lead to any better outcomes for patients.

Ms Gallagher: My recollection of the expert panel was that that was part of the agreement reached around some of the concerns with implementing the four-hour rule and seeking their advice around how the four-hour rule was going to be implemented, particularly around situations where there may be very good reasons why people exceed the four hours but are not admitted to hospital. That was the group that provided advice around that. So I think the shortcomings potentially that were identified with the four-hour rule were discussed at the table and the view was to get advice from the expert panel rather than walk away from the four-hour rule.

Dr Brown: Can I just add to that, though. I think we need to look at the context in which the decision was made. It was around a national health reform agreement that had changes broader than just the four-hour rule in the ED—it also established at the same time the National Health Performance Authority and established as a permanent entity the Australian Commission on Safety and Quality in Health Care. Both of those are tasked, particularly the performance authority but also the Commission on Safety and Quality in Health Care, with developing indicators for reporting. There was acknowledgement of the risks attached to the four-hour rule in the emergency department and the need for a suite of broader indicators. There was also established at the same time the avenues by which that further work could be done, and it clearly needs to be done at a national level and not just at a jurisdictional level.

THE CHAIR: I realise that. Given, as I said, we have got the UK experience, what research has actually been done to show this is a best practice indicator to pursue? So

many concerns have been expressed about it, and I would be interested in hearing what other states have said about what has happened here. I hear what you are saying, but here we have got a situation where we do not have those quality indicators going alongside it.

Dr Brown: We do record some of them. It is just that we have not at this stage got a well-linked suite. But we report a number of indicators around hospital safety and quality; for example, hospital-acquired infections, falls, pressure injuries and those sorts of things. There are other indicators you would want to add to ensure that you are not getting gaining of the system.

In terms of your question about research, work has been done overseas and you would be aware of some of the publications from Australia around the WA experience. Claims are being made there that there is reduced mortality associated with a timely flow through the emergency department. Like much of what is published in the medical literature, there are people who contest those claims. They contest the data on which they have been reported. There have been claims to say we need to actually monitor this closely for a longer period of time before we can actually say definitively one way or another that it actually is working.

But it was an initiative commenced in the UK and implemented first in WA and elsewhere in response to the growing demand for emergency department services. That has been an international trend. And we know from the Auditor-General's report, and certainly lots of other reports, that emergency department presentations are growing at a rate far greater than population growth. In the ACT we actually exceed even the national rate of growth presentations to emergency departments.

Partly that is associated with a growing and ageing population. But it is also associated with other factors—things like access to primary care services, alternative services et cetera. So in the face of growing demand in the emergency department it was felt that there needed to be a response, and this was one of the initiatives. Whether it is the right one, I guess the fullness of time will tell us. There are a lot of people monitoring this.

THE CHAIR: I understand that. I recognise that has to be a part of what you look at because of those demands. But how do we then make sure that we are not getting a situation where it potentially leads to manipulation because we have not got those other indicators going? Even this morning the AMA and the ANF were expressing quite significant concerns about it and the impact it is going to have on them in delivering the care they want to provide.

Dr Brown: The risks are that there could be manipulation or there could be gaining. And that comes to having a very robust system and a nationally consistent robust system that ensures that you have got the safeguards against that and that you have got the regular audit. One of the problems that we have is that the system nationally is not as robust as perhaps we might like it to be. There is still the capacity for variation in the interpretation of the data definitions. That has been noted in investigations undertaken in New South Wales and Victoria, where issues were found—either data manipulation or gaining. We need a national approach to this. We need a strengthening of the whole process nationally.

THE CHAIR: As it says in the report, we have heard concerns in Victoria and New South Wales. There has been a Victorian Auditor-General's report, we have had the UK and we have got this situation now and this report where our Auditor-General is expressing concern about this indicator. The same systems are being used in other jurisdictions using the same indicator with payments attached. Is there going to be a rethink about what we are actually doing here and if we are doing the best thing?

MR SESELJA: This seems to be her biggest concern.

Dr Brown: I think the minister has indicated she has raised that previously with her ministerial colleagues and is doing so again now the report is available.

MR SESELJA: This is the number one concern.

MR HANSON: Bizarre.

MR SESELJA: That is the number one concern.

Dr Brown: Certainly I have—

MS HUNTER: This is about quality of care.

Dr Brown: —raised the issue with my D-G colleagues sending them a—

MR SESELJA: Do not worry about fraud. You are not concerned about fraud?

MS HUNTER: Do you want quality of care or do you want a sausage factory?

THE CHAIR: Excuse me, members, please. I cannot actually hear Dr Brown answer the question.

Dr Brown: Likewise, I am sending all of my D-G colleagues a copy of the reports and have flagged to them that we would like to have a discussion about what this means. I think the minister has indicated that she also wants to take this back to the expert panel and also make a reference to the AIHW and the National Health Performance Authority in terms of expert entities that can engage in this discussion. I think it needs to be a very serious discussion.

THE CHAIR: So do we have any guarantee it is actually going to happen at a national level? That we are going to—

Ms Gallagher: Well, look—

THE CHAIR: There are a lot of people expressing concerns about this.

Ms Gallagher: I have raised it prior to these reports, particularly around the level of reporting that has come through the national health reform, which was meant to streamline and standardise the processes. I think that is a work still in progress. I do not think we have standardised processes. We have got the myhospitals website, we

have got the AIHW, we have got the COAG Reform Council, we have got the Department of Health and Ageing, we have got our own performance reporting that is done. So there are layers upon layers.

There are no standard definitions or agreements. I am not talking just emergency departments here; I am talking elective surgery targets as well. I do not think you could say—and I do not think anyone will dispute this—we are measuring apples with apples. I think we are measuring apples with oranges. I think it will be very difficult to get national agreement, but I think these reports certainly provide us with the material we need to pursue it nationally.

MR HANSON: This—

THE CHAIR: I will go to Mr Hargreaves for a supp; then I will go to you.

Ms Gallagher: I do not think any health minister can ignore the issues that have been—

MR HANSON: There is a myth going on here, Ms Bresnan.

THE CHAIR: Excuse me, Mr Hanson!

MR HANSON: The myth is—

THE CHAIR: Mr Hanson!

MR HANSON: The doctoring—

THE CHAIR: Mr Hanson!

MR HANSON: The doctoring was not about NEAT data—

THE CHAIR: Mr Hanson, you will direct your—

MR HANSON: The doctoring started four years ago.

THE CHAIR: Mr Hanson! Excuse me, Mr Hanson, I am speaking to you!

MR HANSON: It has nothing to do with the NEAT data.

THE CHAIR: Mr Hanson!

THE CHAIR: Mr Hanson, you are not a committee member. I am speaking to you.

MR HANSON: Eleven thousand records—

THE CHAIR: I am speaking to you.

MR HANSON: Eleven thousand records—

THE CHAIR: Can you please stop? Ms Gallagher.

MR HANSON: predate the NEAT—

THE CHAIR: Mr Hanson!

MR HARGREAVES: There is a standing order to deal with people like this.

THE CHAIR: Mr Hanson, I said to you that Mr Hargreaves indicated he had a supplementary. I will go to you when Ms Gallagher has finished answering the question. Thank you.

MR HANSON: Just covering up.

THE CHAIR: Mr Hanson, if you have any issues, direct them straight to me, please.

MR SESELJA: He did.

THE CHAIR: Excuse me.

MR HANSON: You are trying to fabricate—

THE CHAIR: Have some respect for the committee process, please.

MR HANSON: You are trying to fabricate—

THE CHAIR: Mr Hanson!

MR HANSON: Madam Chair.

THE CHAIR: Please, Mr Hanson. Thank you. Ms Gallagher, can you finish that answer, please. Thank you.

Ms Gallagher: Thank you, yes. I think it will be difficult to get agreement nationally, but I think these reports give us the material we need to pursue it vigorously and see what happens from there.

THE CHAIR: Thank you, Ms Gallagher. I just remind members of standing order 234 as well.

MR HARGREAVES: 234, okay, thank you.

THE CHAIR: Thank you. Mr Hargreaves, then I will go to you, Mr Hanson.

MR HARGREAVES: Thanks very much, Madam Chair. I want to talk with you a little about these indicators. By way of background, when I was executive officer of the community health division in the late 1980s, 1990s, the same conversation was held then around the throughput for community medical practitioners and there was pressure put on the community medical practitioners to put more patients through their books in a day. Some were doing 12, some were doing 40. That was resisted by

the community medical practitioners on the basis that, unless you have qualitative indicators which talk about the quality of service, you are just using these things as throughput, they are just numbers, and the danger there is to people's safety.

Would you agree that the national pressure to just talk about throughput is, in fact, a very dangerous thing, not only for the patients themselves but also for the man in the street looking on and saying whether the ED is doing particularly well or not? It is only, is it not, a throughput measure? It has got nothing to do with whether people go in there and come out and drop dead in the car park. You can have as many people as you like go through, but if they drop dead in the car park, it is a fat lot of use, is it not?

Ms Gallagher: Yes. My own view is that timeliness is—and I said this at estimates when I appeared previously—a performance indicator. It should not be seen as the only performance indicator. The problem in the emergency department at the moment is that timeliness is seen as the only performance indicator. It is easy to measure. And it is easy to report.

The COAG Reform Council recently released a report on patient satisfaction within the EDs. And the ACT emergency departments were ranked the best in the country. That is a harder story to sell, because the indicators are length of time taken by a doctor to treat a condition, the information that was provided to you, the care that was provided by the nurse. In all of those, the ACT ranked much higher than the national average and the best in the country.

That report certainly has not received the attention that the timeliness reports do, but we are not walking away from timeliness as an important indicator of performance within the hospital. But it is not and should not be seen as the only indicator. And that is probably the issue when it comes to pressure and people feeling under pressure about that.

MR HARGREAVES: Without wishing to minimise the seriousness of manipulating data for whatever reasons people may have, I do note the report says at page 6 that the managerial pressure has not manifested in direct or indirect instruction or guidance to deliberately manipulate the records, and there was no direct or indirect instruction by any person, including you, minister.

Having regard to the publicity around this issue, is it fair to say that the public's consciousness out there about the administrative failure which is obviously at play here is going to focus people's attention on throughput instead of the quality of care that they receive there—people like me, for example, who have had a heart attack? I have absolutely no quarrel with the service or the timeliness of that, thank you very much. The Liberal Party may, because I am here. But that is bad luck. I am concerned that taking too much overemphasis from the throughput figures is not in any way a measure of performance. It is just a measure of how quickly you can deliver that performance.

Dr Brown: I would agree with the sentiment of where you are coming from. I think any member of the community who has to wait in the emergency department is interested to know what the average waiting time is. I do not think we can be seeking to disregard that at all. But is that the only thing that they are interested in? No, they

actually want quality of care. We could admit everybody to the wards and our timeliness data would look fantastic, but it does not mean to say they all need admission. Equally, we could send them all home in under four hours. That would not be the right thing to do. The quality of that care would be inferior. We are not seeking to do that.

We are seeking to provide quality of care; hence the comments that have been made around a suite of indicators that actually speaks to the patient outcomes as well as the timeliness, as well as things like patient satisfaction. As the minister has indicated, the 2012 report on government services does actually contain that table that looks at patient satisfaction in public hospital emergency departments—

MR HARGREAVES: What page is that on?

Dr Brown: Page 1055, table 10.10, patient satisfaction, public hospitals, 2010-11. It has indicators around whether doctors, specialists or nurses always or often listened carefully to the patients, whether they always or often showed respect to them and whether they always or often spent enough time with them. And on five of those six measures, we certainly exceeded the national average and were the leader in the country in terms of that.

MR HARGREAVES: And in terms of the perspective in which the person out in the street is going to be looking at this particular discussion, it is fair to say that the data that has been interfered with, in fact, does not relate to category 1 patients at all?

Dr Brown: No.

MR HARGREAVES: It actually relates to people who are in a life serious position and less but certainly not in a life threatening position; so nobody out there in the community need feel unsafe because of the overweight of this particular—

Dr Brown: Can I say to you that this manipulation of the data did not change in any instance the care delivered in the emergency department. It was done after the care was completed. So the experience for the people of Canberra was not altered, and that information that I just read to you tells us that the people of Canberra say they are actually having a good experience in the emergency department. Yes, there may be some waits to experience that care. This same report actually speaks to the issue of comparison of the timeliness data and it actually offers a comment that says:

> The comparability of emergency department waiting times data across jurisdictions can be influenced by differences in data coverage … and clinical practices—in particular, the allocation of cases to urgency categories.

So they are almost saying, without saying the actual words, that you cannot absolutely compare this data. It is not necessarily apples with apples.

MR HARGREAVES: Thanks for that. I will come back to that.

MR HANSON: A supplementary.

THE CHAIR: A supplementary, Mr Hanson.

MR HANSON: There are two myths being perpetrated here. One is that there is no linkage between quality and the time. I will quote from the Auditor-General's report on page 35:

> Staff generally supported an overall 'length of stay' target, as the concept of minimising a patient's stay in the Emergency Department was widely supported in medical literature and a 'length of stay' indicator could consequently serve as a useful quality indicator.

So there is a definite link between the amount of time it takes you to be seen and the quality of care. I think that is self-evident. If you are waiting in emergency and you are sick, the longer you wait there the worse the clinical outcome.

The second point is about the doctoring of the data. The doctoring of the data started in 2009, long before the four-hour rule was even considered. Of the 11,700 records that were doctored, some 11,000 predate the NEAT data, which is linked to the money. So 11,000 of them were nothing to do with the money. It was all to do with providing political coverage in the doctoring of the data. So these are two important points that need to be made of clarification, because there are myths being permeated here. They are just falsehoods.

Ms Gallagher: In response, in relation to Mr Hanson's first point, I would say that I have consistently said here that timeliness is a performance indicator and an important part of performance indicators. I have not said that was not the case.

In terms of the manipulated data, yes, in relation to the NEAT target, but, as I presume all members are aware, prior to the NEAT target coming in there were other measures of timeliness in the emergency department. So I think that point needs to be made. And I totally reject Mr Hanson's further allegation about providing a particular form of coverage, as he alluded to. He has got no evidence to support that.

MR SMYTH: Minister, you spoke earlier about people under pressure and feeling pressure. On page 88 of the report the officer involved says:

> Having been constantly told things like "Fix the numbers", "I don't care if you have to go down and stand at triage yourself to make sure they are referring patients to the Walk In Centre, get it done", "I have told the Minister that we will be at 70% of patients being seen on time by December so make sure it happens" and "Your staff are not able to do their jobs and show no leadership" I could see no way out.

Minister, are the feelings of fear stated by the officer common to staff in the emergency department, and what factors do you base your answer on?

Ms Gallagher: I would say, from my dealings with emergency department staff, that they certainly will speak of a high pressure environment that they work in. And I do not think any of us would believe it was not that case. So on a level I would agree that it is a high pressure environment, and I think the officer's comments there, while I cannot substantiate them because I am not in a position to, allude to that high pressure

environment.

MR SMYTH: Have you asked that those statements be investigated?

Ms Gallagher: No, I have not asked that those statements be investigated. As you would know, I got this report. It is a letter that is provided. There is a process underway by the directorate, appropriately, to manage a disciplinary process, and those issues will be examined through that. I was aware that that process was underway.

MR SMYTH: Are you concerned by those statements?

Ms Gallagher: I am concerned by a number of elements of this report, Mr Smyth. I think all of us are.

MR SMYTH: Who is in the chain of command above the officer responsible through to you? What are those positions and who occupies those positions?

Dr Brown: In terms of the line of management from the executive, there is the Deputy Director-General of Canberra Hospital and Health Services, Mr Lee Martin, then it comes to me and then to the minister. In relation to the comments that you read out, Mr Smyth, I would say that I had a conversation yesterday with someone who is a very senior retired manager who said to me, "I see absolutely nothing wrong with saying to an executive, 'I expect you to actually be on the floor and managing this particular situation. That is what managers—

MR SMYTH: But do you think it is acceptable that that led then to feelings of fear, isolation and distress? This is an occupational health and safety issue as much as anything else. But why should somebody work in a climate of fear, isolation and distress? We had reports earlier of the toxic culture at the hospital. Is that toxic culture continuing—that this person felt fear, isolation and distress?

Dr Brown: That is one person's account. I can say to you that the emergency department at the Canberra Hospital—in the last two culture surveys that have been conducted—in the 2009 survey was in a culture of success. It was the only emergency department in the country at that stage that had ever been in a culture of success. It remains in a high-end culture in the most recent culture survey.

I have at the table Ms Jeanette MacCullagh, who is the acting executive director for critical care at Canberra Hospital. She oversees the emergency department. I am sure she is able to speak to the question of whether or not it is a culture of fear and distress in the emergency department.

MR SMYTH: Before we go to Ms McCullagh, though, who would have been in a position to give these directions to the officer involved?

Dr Brown: I think it is very clear that Mr Martin was the supervisor of Ms Jackson. Ms Jackson has been working as an executive director since about March or April 2011. Prior to that she was employed in a different role in the emergency department and had a different line manager.

MR HARGREAVES: Can I have a supplementary on that, please—

MR SMYTH: If I can just finish—

MR HARGREAVES: It goes to your point.

MR SMYTH: I will finish my point—

MR HARGREAVES: It goes to your point.

THE CHAIR: Hang on. We will just let Mr Smyth finish and I will come to you, Mr Hargreaves.

MR HARGREAVES: Okay.

MR SMYTH: I go back to the minister: minister, yesterday in the ABC interview you said the thing that stood out most for you in the findings was the extent of the manipulation. Given that we knew that the manipulation had been occurring—and, okay, the PWC report gives us an extent of that—were you not more concerned by the reports from this officer of the climate that existed in the organisation of fear, isolation and distress?

Ms Gallagher: My comments yesterday on the ABC were correct. The thing that shocked me the most on reading the report was the extent and the time that was taken to make these changes to the data. Again, I cannot speculate on the motivations behind the individual and the choices that were made. But I do understand, from a personal point of view, the need to explain those choices in a way that the officer has in that letter.

I do not work closely with staff at the hospital, but from my own work and from my own point of view the hospital has been going under significant restructure and reform over the last 12 months or so, and I have no doubt that those changes that are being implemented are being made for a positive outcome. But I cannot speculate, Mr Smyth, on why this occurred or why the officer has chosen to explain the motivations in a particular way. I think if you—

MR HANSON: Don't we need answers, though?

Ms Gallagher: I think if you read the other letter, on the next page, and some of the comments from the Auditor-General in relation to that matter, under 4.6, you will see again that there are some mixed and varied views on the change that was underway at the hospital.

Dr Brown: Can I perhaps also—

MR SMYTH: But if we go—

MR HARGREAVES: And my supplementary—

THE CHAIR: Hang on—one person speaking at a time, please.

Dr Brown: add to the question about the culture. You have talked about the culture at the hospital. It is very clear: this is something that we actively assess. We have undertaken four culture surveys over the last seven years. We go out, we ask every single member of our staff to come back and tell us about the things that we do well, the things that we do not do so well and that we need to improve. And we have got evidence from those four successive surveys that the culture is continuing to improve.

We specifically this time asked about the issue of bullying and harassment, because it has been an issue that has come up in the past, as you know. We have got very good results from that. Some of our staff say 27 per cent increases—from 10 to 27 per cent increases in terms of the questions around bullying and harassment. Do they feel that managers are prepared to report it and do something about it? Are team members prepared to do something about it? Has training increased et cetera? We are actively addressing the culture and we are demonstrating gains.

That is not to say that you will not get instances where there is a complaint or there is an issue. But we also have—

MR HANSON: This is a very senior level. These allegations are at a very senior level.

MR HARGREAVES: I have a supplementary—

THE CHAIR: Just wait, members, please.

Dr Brown: We also have an approach where we talk openly to our staff about it. We have training in place. We have processes in place, and where there are issues, we address it.

MR SESELJA: You seem to be suggesting that the—

MR HARGREAVES: Can I have my supplementary, please, Mr Seselja?

THE CHAIR: Just—

MR SESELJA: Well, it is just—

THE CHAIR: Members, please. One at a time.

MR SESELJA: I have not had a question at all, so—

THE CHAIR: Mr Seselja!

MR SESELJA: Yes.

THE CHAIR: One person—I will go to Mr Hargreaves. He had identified he had a supplementary. Then I will go to you, Mr Seselja.

MR HARGREAVES: Thank you very much, Madam Chair. I might remind

members I have not asked a substantive question as yet.

THE CHAIR: Thank you. Just if we can ask—

MR HARGREAVES: There seems to be from the line of questioning an insinuation that Mr Martin, in fact, has put some sort of pressure down on to the executive.

MR HANSON: Well, that is what the allegation is by the person that wrote this letter.

MR HARGREAVES: I was not talking to you. Why do you not just wait?

THE CHAIR: Members, please.

MR HANSON: It is not an insinuation. It is what is in the A-G's report.

THE CHAIR: Members! Mr Hargreaves, ask your question.

MR HARGREAVES: Thank you very much.

THE CHAIR: Thank you.

MR HARGREAVES: Am I correct, Dr Brown, in assuming that from the executive's comment contained in the report that the manipulation started in 2010? Did that precede Mr Martin's appointment?

Dr Brown: Yes. Mr Martin commenced at the end of February 2011.

MR HARGREAVES: So it would be an incorrect thing to assume any correlation necessarily between those two events?

Dr Brown: Yes.

MR HARGREAVES: Yes.

Dr Brown: The changes, by the officer's own admission, commenced in late 2010. Mr Martin, as I said, commenced at the end of February 2011.

MR HARGREAVES: Thank you very much.

THE CHAIR: Mr Seselja, then I am going to come to Ms Hunter, who has not actually had a question.

MR SESELJA: So on those quotes that Mr Smyth read to you, Ms Brown, you seem to be suggesting that that was reasonable—terms like "fix the numbers". Is it your position that it is okay for a supervisor to tell a senior executive that it is about fixing the numbers rather than actually fixing the problem? I am just not quite sure what you were saying there when Mr Smyth put all those quotes to you and you said you spoke to someone senior who had said it is not uncommon. Is it not uncommon for people to be told simply to fix the numbers? Are you not concerned by those kinds of directions?

Dr Brown: What I was intending to convey, Mr Seselja, was that I expect my executive managers to manage. That is about setting performance expectations, being clear to people about what is to be delivered and assisting them in terms of how to achieve those targets and those responsibilities. That quote you read out, yes, it did say those three words, "fix the numbers", but it also talked about doing what you have to do to make things better. I have not got it in front of me, unfortunately. But it was conveying an overall picture, not saying, "Manipulate the data."

MR HANSON: Part of this was about fixing the numbers for the minister. The quote is, "I've told the minister that we'll be at 70 per cent of patients being seen on time by December. So make sure it happens." This seems to be pressure that is coming down from the minister—agreements that have been made with the minister that have then flowed down the chain to this individual.

Ms Gallagher: Well—

MR HANSON: And that is the view—

Dr Brown: Mr Hanson, I—

MR HANSON: —of the individual; that is not my view. That is what the individual is saying.

Dr Brown: This is one person's account. The Auditor-General equally did not say that this was the absolute truth.

MR SESELJA: Do you believe it, though?

Dr Brown: The Auditor-General gave an account. She also gave an account of Mr Martin's perspective.

MR HANSON: Which is true?

Dr Brown: She is not making an assessment of which—

MR HANSON: Which is true? What is your view?

Dr Brown: What is my view of what, Mr Hanson?

MR HANSON: Well, you have got two differing accounts here. What is being done to investigate which is the correct account?

Dr Brown: We—

MR HANSON: What is being done to validate the comments of either Mr Martin or the person that has made the complaints?

Dr Brown: We have an officer who has said she has been under pressure. Since that has become public, that officer has been off now for 10 weeks, I think, whilst this

investigation has been underway. I have not had the opportunity to undertake a further investigation or conversation with her—

MR HANSON: Are you going to do that?

Dr Brown: Well, at the moment there is a process around misconduct, and that needs to be completed. I am not attempting to have any conversations with that officer during that period of time. I do not want to distort any investigations whatsoever. She was clearly instructed not to discuss the matter with anyone. In terms of—

MR HANSON: It seems that you and the minister are dismissing her claims. The officer has made have very serious allegations and you are essentially calling her a liar.

Dr Brown: No, no, I am not. I am simply saying she has made an assertion. Mr Martin has responded to that. I do not know the validity of that, but I do not believe, even if there was pressure, that the only response to that would be to manipulate data. I had one-on-one meetings with Ms Jackson. We had discussions about her role—

MR HANSON: Is it appropriate to be naming the individual?

Dr Brown: It is in the public domain now, and my legal advice was that we should seek not to have named her during the investigations whilst they were underway.

MR SESELJA: Are there not disciplinary proceedings underway now? So why is it appropriate?

Dr Brown: It is a misconduct proceedings. It would have been preferable for her not to have been named during that misconduct proceedings, but there is no legal impediment. That is the advice that I have had.

MR SESELJA: So why was she named?

Dr Brown: That was an error in my office, Mr Seselja.

MR SESELJA: How did that occur? How does a letter from the Auditor-General accidentally get put into media packs?

Dr Brown: Because, Mr Seselja, as you know, the Auditor-General published her report online. The ministers organised a press conference to bring down the PWC report. In wanting to be open and transparent with the media, we provided them with copies of the report so they could see them both together. The letter was unfortunately attached to the back of the report when it was photocopied. That was my error. I accept responsibility—

MR SESELJA: So it seems—

THE CHAIR: Sorry, minister, you wanted to say something?

MR SESELJA: It seems a little convenient when you are looking to make one person the scapegoat that their name gets leaked when we were told in the Assembly that it would breach their privacy to leak their name.

Dr Brown: During the course of the investigation, that was the legal advice we had. It was not intended to release her name during the process of the third investigation. That was an error. I accept full responsibility for that.

MR HANSON: It seems to be error on error. You have got a report that is about sloppy data management—

Dr Brown: No, it was one error.

MR HANSON: —and in responding to a report on sloppy data management, you leak someone's name. It is extraordinary.

Dr Brown: It was one error out of my office, for which I accept full responsibility.

MR HANSON: Well, you do not accept any errors that have been happening at the hospital that are—

THE CHAIR: Sorry, members, can you direct questions through me?

MR HANSON: —part of this report.

THE CHAIR: Mr Hanson. Can you direct questions through me, please.

Dr Brown: This—

THE CHAIR: And the minister actually wants to say something. Dr Brown, I will let you finish, but you were trying to say something, minister.

Ms Gallagher: It was before we got on to this other issue, so I am happy to—

MR SESELJA: Well, could I ask either the minister or Ms Brown, given—

MR HARGREAVES: Dr Brown.

MR SESELJA: Dr Brown. Given the individual has now been named and given there are some procedures still to go through, what checks have been made in relation to her welfare by the directorate or otherwise?

Dr Brown: I have had contact with the individual yesterday and the day before. I spoke with her also a week ago. She has also had contact with another senior executive in a supportive role during that time.

MR SESELJA: I am sorry, I am a little confused. I may have misunderstood you before. I thought you indicated before you were not having contact with—

Dr Brown: I am not discussing the data manipulation with her. I have had a number

of contacts with her during the course of this in a pastoral care type sense to check on her wellbeing. As an employer I have a responsibility in that regard, and I have been endeavouring to fulfil that responsibility.

MR SESELJA: And counselling services?

Dr Brown: She was advised in writing and verbally about the availability of the employee assistance program, which is free of charge to all employees.

THE CHAIR: I am actually going to come to Ms Hunter, because she has not had a question.

MS HUNTER: I wanted to go back to internal audit and the audit committee. In the 2010-11 annual report it states that the audit and risk management committee plays an essential role by providing assurance to the director-general on directorate governance and oversight in relation to risk management, internal systems and legislative compliance. An internal audit review of the directorate's enterprise risk register that includes operational and strategic risk was in progress at 30 June 2011. The Auditor-General's report states that there were no other processes which provide assurance over the integrity or accuracy of the timeliness information in the records. The audit examined the Health Directorate's internal audit activities. It appears there has not been some sort of audit of the activities since 2007-08. Is that the case? Have we had a bit of a gap?

Dr Brown: Sorry, an audit of the activities of what?

MS HUNTER: Of this timeliness information and data.

Dr Brown: Look, we—

MS HUNTER: What has been going on there? How have we been auditing that in an independent way? What has been going on?

Dr Brown: Yes, we do have an internal audit program every year. The bulk of those internal audits are, in fact, conducted by an external company like PWC or one of the other big firms. We also look at the strategic and operational risks for the organisation and set a program each year. I think it is correct that there has not been an audit in relation to the emergency department timeliness since that time. We actually did have it on our internal audit program for this year. We identified with the focus on this as part of the national health reform that there were risks attached to the emergency department data; so it was on our program. It is just that this came to the fore ahead of that audit actually being able to be conducted.

We do, however, as I said, undertake a range of audits, which we have done over the last three years, I think it is. We have had seven audits that have looked at various aspects of IT security, for example. So we do look at a range of governance procedures as part of that internal audit program. As you indicated, we had an audit around our enterprise risk management approach. That was discussed at the most recent committee where we actually review our risk processes. We have effectively completed or closed off all recommendations arising out of that audit. We do track the

progress of our implementation against recommendations coming out of audit. We do that on a quarterly basis.

MS HUNTER: In your opening remarks, minister, you spoke about some changes that are going to happen. I noted down here "data integrity strategy across the directorate" that you spoke about. It would be improving governance and reporting, that there would be a director of data integrity. You also spoke about Professor Mick Reid, who would also be looking at governance across the directorate. There was also talk about—you mentioned the Auditor-General doing a progress report in six months' time.

Ms Gallagher: Twelve months.

MS HUNTER: Twelve months time.

Ms Gallagher: I have invited—I have written to the auditor suggesting, but that is open—that is up to her whether she chooses to pursue that.

MS HUNTER: So with these other changes you are talking about—a director of data integrity and the data integrity strategy—what is the time line on getting these things into place and actually have some implementation on the ground?

Ms Gallagher: There are changes that have been made already to make sure that this cannot occur since—that was since the anomalies were brought to attention back in April. So there was some immediate changes put in place, and those will continue.

In relation to data integrity, I see that as more of a directorate-wide approach. There has been some work done already that Dr Brown has commissioned since April, but I think from the government's point of view, as Chief Minister I think I need some independent analysis of that work just to provide me with some assurance.

In terms of the director of data integrity, I think that is an important change. I think one of the issues that struck me again on reading the PWC report was that this issue actually was identified through Health's own internal processes back in February where an officer within the Health Directorate did identify that changes were being made. Unfortunately for that staff member, the report—they reported what they had found to the person who has admitted now—since admitted making the data changes, so that it was not appropriately investigated. PWC identify that on page 7 of their report.

When I have discussed that with Dr Brown, I think there is an issue about IT or data quality administrators reporting within the hospital environment based on what we know now. Perhaps a position like director of data integrity will ensure that the data that comes from the hospital goes through a reporting channel outside of the hospital. We are not able to remove those people from the hospital because they need access to patient records and clinical staff, but I think if there was a change—if they had not been reporting through that channel, the chances are this would have been picked up in February and not in April.

MS HUNTER: In respect of the issue of generic logins, I picked up that outside of

the ED generic logins will be taken out of the system. Is that right? But within the ED they will stay? I am just trying to understand why they will stay within ED? Why not have an identifier for anybody who logs into the system?

Dr Brown: I think the issue here is about the capability of the system and how long it takes to log off and log back on unless you have got one computer per staff member, which at the moment we do not have—how long it takes one individual to log on and then log off if someone else wants to come and use the system. At the moment the system is slow to load up. It is slower than the clinicians need for effective flow of the work on the floor of the emergency department to have log on, log off, log on, log off. The risk is—we could go to unique identifiers for individuals on the floor, but the risk is—and we know this happens in some other jurisdictions that have unique logins—that one person logs in and everyone uses the same login.

MS HUNTER: Yes.

Dr Brown: So how do you guarantee that you are effectively achieving what you are aiming to achieve, even if you have got a different system? The ideal would be when you can come in and swipe your swipe card in front of the computer and that will log you on and log you off. We are working on that technology. We have been working on it for a number of years. At the moment there are some issues about the interface between EDIS and that new system that is coming. But that is what we will be working towards ultimately.

In the interim, we need to ensure that the work flow of the emergency department still is able to effectively continue. But we will be looking to ensure that we minimise the number of logins to EDIS and that we actually have some processes in place.

MS HUNTER: So could you explain to me, you said that this work around a sort of swipe-in system has been underway for some years. Is this being done locally or is this a national project?

Dr Brown: We might ask Judy Redman, who is our Chief Information Officer to come and explain that. The Auditor-General refers to this in her report as identity and access management and rapid sign on. They are separate systems, but there is some relationship. With the rapid sign on, there are two different components to that as well, but Judy can explain that.

Ms Redman: Yes, with the identity and access management system, we have actually just launched the first phase of that this week. The first phase of it is to establish the checking of the correct identity of people when they actually are issued with both logon to PCs and equally any access to buildings and swipe card access to any facilities within the Health Directorate.

Now that anyone who is presenting to the Health Directorate for any logon has to go through is 100-point check to actually obtain access to the systems. So we are issuing swipe cards as part of that process. The next phase of the identity and access management solution will be integrating the applications with the overall government login. There are some issues—need to work through and look at each of our systems to see their capacity to be able to do that.

MS HUNTER: So how close are you to getting this work completed?

Ms Redman: We are hoping that over the next 12 months we will have the ability to have the swipe card access. Once again, it will be—we have to work through each of the applications and the capability to be able to integrate with the whole-of-government user logons.

MR COE: If I might ask a—

MS HUNTER: Can I just ask about—

THE CHAIR: Mr Smyth said he had a supp and Mr Hargreaves, and then I will come to you, Mr Coe.

MS HUNTER: I just finish off about the Auditor-General's report, page 48. It does talk about Health and Shared Services where each thought the other was responsible for technical aspects of the EDIS system. Has that been sorted out?

Ms Redmond: We are just about to launch a project to look at the whole business systems management. With the healthy futures program we are also introducing a lot more e-health programs and applications. As a part of that we will be working through with Shared Services to look at the current model we have for the support of our applications and developing over the next six months, hopefully, an appropriate framework and way forward for how we manage our applications.

Dr Brown: But Mr Thompson has already had some discussions with management in Shared Services ICT around this issue of that greyness that has been identified in this particular report.

MS HUNTER: And how did that greyness come about? Why do we even have greyness? From an outside point of view, you would just expect that the Health Directorate would have been driving this particular thing. I am just wondering how this greyness or uncertainty with Shared Services came in?

Mr Thompson: I think the first issue is that, in a jurisdiction the size of the ACT, the most efficient way to organise IT services is to have a single network. If you have got a single network, you have to have a single organisation responsible for the network; otherwise the network's integrity will not be maintained. However, beyond that, what we have is a series of other applications and processes related to that network which are more or less technical and more or less clinical or operational from a business point of view.

Unfortunately—and I believe it is inevitable—there will always be some grey areas. When does this cease to be a technical issue and when does it become an operational issue? That is what we are dealing with here. Data administrators in the emergency department dealing with the EDIS data need to deal with the EDIS system. That is an integral part of what they do. However, the point at which their dealings with the EDIS system go beyond data related into technical is a grey area.

MS HUNTER: Thank you.

THE CHAIR: Mr Coe, then I will come to you, Mr Hargreaves.

MR COE: A couple of questions about the nuts and bolts of the EDIS system, especially with regard to additions or alterations to the data. When a record is created, is there a time stamp at the back end of the database?

Ms Redmond: Yes, there is.

MR COE: At each alteration, is there a time stamp associated with each action?

Ms Redmond: The system actually has an audit trail capability. So, yes, you can actually track any modifications made to the application.

MR COE: So in amongst that audit trail capability is the terminal or the actual computer on which the alteration was made also recorded in the system?

Ms Redmond: It is not currently recorded. The capability is there to be able to track—

Dr Brown: My understanding from the Auditor-General's report and my discussions is that the current way EDIS is configured is that it actually logs every computer as workstation 14. Our computers have individual identifier numbers, so that capability should be there. It relates to how EDIS is currently configured.

MR COE: So what you are saying is there is no possible way to work out which terminal has been used—

Dr Brown: That is right.

MR COE: All you can say is what logon was used, and they are generic logons. So does the system allow multiple logons with the same user name, simultaneous logons?

Dr Brown: I cannot answer that. If it is logged on to a computer, one computer—

MR COE: If a nurse is logged into one terminal, can another person log in using "nurse"?

Dr Brown: I cannot answer that.

MR HANSON: There is a nod down the back there. I do not know if there is someone down the back there who can answer that, but someone is nodding.

Ms Redmond: We will just take some advice on that and come back.

THE CHAIR: So you will just take it on notice and come back.

MR COE: Would you please advise whether simultaneous logons are available and what information is available that is recorded in the audit trail as it has been

configured in the past. So what fields are recorded next to each alteration?

THE CHAIR: So that is clear? That is taken on notice.

MR COE: Thank you.

THE CHAIR: Thank you. Mr Hargreaves, did you have a follow-up on this? You had indicated—

MR HARGREAVES: Yes, I have, on the EDIS system. We are talking about the recommendations and the directorate's acceptance of the recommendations that there would be changes made to the security protocols and generic logons et cetera. I am curious to know whether, given that it says in the audit report that this system is used in over 190 emergency departments across Australia, New Zealand, Canada and the UK, you have the proprietary right to actually get in there and change those protocols?

Dr Brown: We have to work with the vendor in relation to any changes around EDIS. We will need to do that in relation to these recommendations.

MR HARGREAVES: And would you anticipate that the vendor would say, "Okay then, we'll modify the program, but it needs to go global," so therefore it will take considerably greater time to do it than you guys really need?

Dr Brown: Generally speaking when we deal with software vendors there is the generic version they offer for sale and then there is the capacity to individualise it or tailor it to your local needs. I am not privy to the specifics of EDIS, but my understanding is that we are likely to have some localised alterations. I do not think that should necessarily delay the implementation of the recommendations. We will be working with the vendor.

The thing I would add is that we are anticipating the upgrade of EDIS at the Canberra Hospital. As you are aware, Calvary hospital implemented EDIS in January this year. Canberra Hospital was due to do it shortly thereafter, but because Calvary experienced problems with that version—it is not uncommon to get some small problems with a new upgrade—the decision was taken to actually take the time and allow those problems to be worked through and sorted out before we go ahead with the implementation of the upgrade at Canberra Hospital.

So in making any changes that we need to make we would obviously want to do it in conjunction with the implementation of the upgrade at Canberra Hospital. There are things that we can do that do not require any modification to the software that we will obviously be looking to implement in a very timely way, but we just need to keep that in mind as well.

THE CHAIR: So they will happen in the meantime while that is—

Dr Brown: Yes.

THE CHAIR: because if we have got the situation where it is—

Dr Brown: With the logins and the computers and all of that, yes, absolutely.

THE CHAIR: Because we have the situation that generic logins are still going to happen, so it is still open for this to happen?

Dr Brown: We will probably still need to use some generic logins. But we will review that. We will certainly be looking at the number of logins, who has them and tightening up the administration of that.

MR HARGREAVES: I noticed that it has been talked about in the audit report that, in addition to the software difficulties—if you want to call generic logons difficulties—it also talks about a lack of procedural policy, or not so much policy but procedures and processes, documented methodology, all of that sort of thing. And I notice that the same comment was made about Calvary. So this is not something unique to TCH.

Dr Brown: Yes.

MR HARGREAVES: A couple of things on that: is that the sort of thing that is overlaid on top of EDIS? I imagine from what you have just said that it probably is and it is something you can start work on. Will you be doing that in partnership with Calvary so that you have one set of processes and procedures and procedure manuals?

Dr Brown: Yes, indeed.

MS HUNTER: And could I just add to that that I note that the Health Directorate—your—response to this issue being raised by the Auditor-General said only supportive of working with Calvary to implement this recommendation. Could you explain why that was the response?

Dr Brown: As opposed to actively collaborate?

MS HUNTER: Yes.

Dr Brown: Perhaps just because we did not think of those words at the time.

MS HUNTER: Okay.

Dr Brown: We do have some documentation there. It was found to be inadequate. We will obviously be strengthening that in line with the recommendations. Calvary has done some of this work to support its recent implementation of EDIS. We work very collaboratively with Calvary and in terms of being efficient in terms of how we approach this certainly we will seek to collaborate actively with Calvary.

THE CHAIR: Okay.

MS HUNTER: The other thing about the system was about being able to retrospectively go back and alter records. I understand that this is allowed as a gap, a window, where you can go in—the idea is if there was for some reason some inaccuracy, or for some reason there might be a legitimate cause—and correct the data

in there. What are you putting in place? Is that capability going to be taken out of the system? Or, if it is to remain, what are you putting in place to ensure that there is some oversight, some double checking, of what is going on here?

MR COE: How long is that gap?

Dr Brown: We have already put in place some of those changes. The window at the time was 72 hours. We did reduce it down to 24 hours. What we found when we did that was that it actually interfered with the flow of work on the emergency department floor. The clinical director of emergency department rang me and said, "Peggy, this is a problem for us." So we had to take it back out to 48 hours. The system only allows you the three options, 24, 48 and 72. So we took it out to 48 hours. But what we have also implemented is a weekly process of doing random audits of ED files, and where there have been changes made we actually go back to the clinical record to validate that there is a legitimate reason for that.

In addition we have implemented some monthly checks to look for suspicious activity. So we have already implemented some of those additional things. Whilst we need to have that window open for the flow, we have got those checks in there about: if it has been changed, why has it been changed and is it legitimate?

Ms Redmond: The primary reason for that 48-hour window is completion of the GP discharge letters. It is important that we continue with the care of the patient in completing those discharge letters. So that is the primary reason why it is set at 48 hours.

THE CHAIR: Mr Smyth.

MR SMYTH: Staying on the system, on EDIS, how many people actually have a logon to EDIS or the ability to log on to EDIS?

Dr Brown: I think the number is in the report somewhere. I do not have the figure in my head; I am sorry. It is about 500. I can find the precise number if you want.

MR SMYTH: And we know who those people are? You could do a printout of the list of people who can access EDIS?

Dr Brown: Yes.

MR SMYTH: There are four main logons. You have got "doctor, "nurse", "bedman" and "clerk". Then apparently there are another 19 user names. What are those other 19 user names?

Dr Brown: They are people like EDIS administrators, so people who have a specific function, requirement, to work in EDIS.

MR SMYTH: So the administrators would have an individual logon, so you know when an administrator comes in and out of the system, but everybody else uses "doctor", "nurse", "bedman" or "clerk"?

Dr Brown: By and large, that is my understanding.

Mr Thompson: There are some individual logons that are not administrators. They are related to people who have got specific functions that relate to management predominantly of the emergency department.

MR SMYTH: All right. So what positions would have those individual logons?

Mr Thompson: As I said, they are people who have predominantly management responsibilities related to the emergency department.

MR SMYTH: All right. So the ICU unit manager would have one?

Ms Thompson: I do not know.

Ms Gallagher: We can certainly provide you with all that. I think there are different levels of access. There are people who can view EDIS but cannot add data into it. So we can provide you with that.

THE CHAIR: So that is taken on notice.

Ms Gallagher: Yes.

MR SMYTH: All right. So do we know what percentage of the 19 are management and what percentage are administrator?

Dr Brown: I am sorry; I do not know that. Again, we can seek to provide that.

THE CHAIR: So that is taken on notice.

MR SMYTH: All right. Do all of the people that report to the officer responsible for the manipulation—we know who they are—have access to EDIS?

Dr Brown: Does everybody who reports to the executive director involved—

MR SMYTH: So everybody in ICU, in the emergency department, in critical services, medical—

Dr Brown: I would say no.

MR SMYTH: imaging, patient flow, the MAPU, the surgical assessment unit—

Dr Brown: No. They certainly do not.

MR SMYTH: So how is it determined how somebody gets access to EDIS?

Dr Brown: Again I would need to take the specifics of that, but essentially there is a case put forward that this person needs access to EDIS for this reason. It goes up for approval, and then once that approval is granted the access is actually facilitated.

MR SMYTH: And physically when you log on to EDIS—do I have to type in "Brendan Smyth" and then "nurse" or "doctor" or whatever it is?

Dr Brown: You need a user name and a password.

MR SMYTH: So every time somebody logs on we actually know who they are and what logon they have used?

Dr Brown: The problem is that people are using generic user names rather than individual user names.

MR HANSON: It is mostly in sort of managerial positions or the positions that are running a section or something like that, is it, rather than the—

Dr Brown: I do not purport to be an expert in EDIS, but on the emergency department floor where you have nurses and doctors seeing patients EDIS is primarily a work flow tool. It is designed to aid the work of the people. It records when someone presents, what their triage category is, what bed they are in, what investigations they are having. So it allows you to tell at any stage through the process—

MR HANSON: So the patient's progress from ED through other bits of the hospital—you can tell where they are?

Dr Brown: In the ED system. Once they get admitted to the ward, it is through a different system. There is a need for, as I understand it, some other parts of the hospital to have access; for example, in terms of managing the bed flow. But, in terms of the workers in ED, yes, the bulk of the nurses and doctors probably do need to have access to EDIS. In other units, it is not the bulk; it would be selected individuals.

MR HANSON: A number of them.

THE CHAIR: Ms MacCullagh, did you have anything to add?

Ms MacCullagh: Yes. I have a working knowledge of the emergency department information system. The primary role for that is to, I guess, move, electronically, patients around the emergency department and for the medical staff to document the time that they have seen the patient—use it as a tool for discharge summaries et cetera.

The questions that have been put to Dr Brown with regard to the logon: in the emergency department there are two primary generic logons, which are "doctor doctor" and "nurse nurse". There are multiple users on those generic logons at any given time. With regard to the logons external to the emergency department, the Medical Assessment Planning Unit, MAPU, and the Surgical Assessment Planning Unit, SAPU, have access to the EDIS system purely as a tool to identify patients who may fit their admission criteria and use that as a tool to facilitate an early movement of those patients from the emergency department.

The only use that the staff on those wards have for that system is to identify the patients for the medical staff and ask them to review them, with a possible view to

expediting their movement out of the emergency department. They use it as a view-only system. They do not enter any data into that system.

The other external generic logon is "bedman", which the access unit or bed management, for want of a better word, use, and that is used to facilitate or, I guess, electronically facilitate a bed request from the emergency department to the bed management unit and then for the allocation of a bed to an inpatient clinical unit.

We have a bed allocation officer who is responsible for undertaking those duties and a patient flow manager and a bed manager who use that system purely to allocate beds. They use the bed request screen. They pull that up. They allocate the bed electronically. That goes back to the emergency department and the emergency department move the patient off to the inpatient area. I am happy to stop there if that has answered your question.

MR SESELJA: Obviously the Auditor-General identified one individual and suggested there may be or there are likely to be other individuals who had manipulated data. What kinds of people are we talking about who could have potentially manipulated that data other than the one individual who has been identified in the Auditor-General's report?

Ms MacCullagh: The training that the people external to the emergency department have received is for a view-only access and they do not enter any data into the system. So they are not aware of the meanings of the different screens. They are not trained on the different screens and the different parts of the EDIS.

MR COE: But if the passwords are commonly known to be "nurse nurse", "doctor doctor", which I hope, incidentally, have changed already, just because they have been trained to view information, surely if they were to put in one of those passwords they could then change the information?

Ms MacCullagh: As was mentioned before, the difficulties of having individual logons for each member in the emergency department when you have up to 20 nurses—

MR COE: I understand that. I mentioned the capability. The capability is still there. Even somebody who has been trained just to view the information could well put in "nurse nurse" or "doctor doctor" and change that information; is that correct?

Ms MacCullagh: They are the only people that have access to that. The EDIS system is only on one computer in each of those wards.

MR SESELJA: Who are those people that have access to them? How many individuals are we talking about?

Ms MacCullagh: The people who primarily use that system on those wards are the senior staff on a shift. So it could be the team leaders on the shifts.

MR COE: Is the computer permanently turned on?

Ms MacCullagh: Yes, but EDIS is not permanently up on the screen.

MR COE: If the computers are permanently turned on, what is stopping absolutely anybody who works at the hospital going on to that computer and opening up the program and typing "nurse nurse"?

Ms MacCullagh: I cannot answer that. I do not have an answer for you on that.

MR COE: So there is nothing?

Dr Brown: EDIS is loaded on a number of computers. It is not on every computer around the hospital. One of the recommendations was to reduce the number of computers that it is loaded on. It is primarily in the emergency department in an open environment, a very busy environment, a 24/7 environment, and if there was someone outside of the staff who came in and sat down at the computer there would be someone noticing and doing that.

There are also different levels of access to EDIS, and there is a view only. There are different levels for the doctors, nurses, EDIS administrators, others et cetera. So there are some safeguards in there.

MR HANSON: It is more likely to be someone that works in that area, that is used to working in that area around the hospital, who has been doing this, the other person?

Dr Brown: We have an individual who has admitted to making the changes. The advice from the forensic data audit is that the vast majority of those changes can be linked to that individual.

MR SESELJA: I am interested in exploring this point. The Auditor-General's report certainly does conclude that it is very likely that others were involved. It says:

> Audit also notes that the executive admitted to making approximately 20 to 30 changes to hospital records each day. This appears to fall short of the number of records that have been changed on some days. For example, up to 120 records had been changed using the generic NURSE login ID on some days.

Are you able to explain to us how you are going to get to the bottom of who was making all of those other changes which have not been admitted to by this individual, and are you concerned about the number of individuals who may be there who have been manipulating data?

Dr Brown: I would say three things in response to that. One is that the Auditor-General said that it was probable that someone other than the individual had been making the changes, particularly in relation to her noting that there were changes for a few months in 2009 that the individual did not admit to making changes.

MR SESELJA: And when they were on leave?

Dr Brown: There were a small number of changes when the individual was on leave. The PWC view differs from that of the Auditor-General. They believe that, apart from

the 2009 changes, it is not possible to say one way or the other. Their view is that there is no evidence one way or the other whether there were other people involved or not.

MR SESELJA: But the Auditor-General has found that it is very likely and in fact identifies a number of reasons why they have drawn that conclusion.

Dr Brown: Yes.

MR SESELJA: What will you now be doing to get to the bottom of it? Have you, for instance, asked all staff who have access to sign statutory declarations? This came from an admission, I understand, initially. Have you asked all other staff to sign statutory declarations? Have you made further investigations to try to get to the bottom of it, instead of concluding that it is one individual, given that a lot of the evidence points to the fact that it may well be more than one individual?

Dr Brown: We have not at this stage asked other staff to sign statutory declarations in relation to the changes. The advice from both the Auditor-General and PWC—and we did discuss this with them—in terms of verifying one way or another, even if you did have another admission, whether any individual was involved, I think the reports say that it is almost impossible to verify that from the way the system is currently configured.

They said to us, "Your efforts are best directed at fixing the system to ensure that this is not going to happen again." As we have indicated, we have been making changes already and we will be proceeding to make the remainder of the changes that have been agreed in the recommendations.

MR SESELJA: So you are not concerned about the fact that, while one individual has been scapegoated, there may well be other individuals who are still working for ACT Health who have been manipulating data? Are you saying to us that now no efforts will be made to actually identify who they may be?

Dr Brown: I am saying to you that the focus of our efforts is on making the system secure. If there are individuals there who are wanting to make changes, if we have the system secure, they are not going to be able to make those changes. As I said, the Auditor-General and PWC indicated to us that, even if someone else came forward, it would be almost impossible to verify any claim.

MR HANSON: But you have to ask the question—

THE CHAIR: Hang on. Wait. I will come straight back to you. We do have to break for 15—I will come straight back to you—

MR SESELJA: Do we have to break right now?

THE CHAIR: I will come straight back—

MR SESELJA: We are just on a line of questioning.

THE CHAIR: Mr Seselja! I will come straight back to you.

MR SESELJA: What is the desperation to break?

THE CHAIR: Because we are due to have a break. I think it would be good if everyone could have a break. I will come straight back to Mr Hanson. We will break for 15 minutes.

MR SMYTH: Would it not—

THE CHAIR: We will break for 15 minutes and come back at 10 to. We will come back at 10 to. We are adjourning for 15 minutes. I will come straight back to Mr Hanson's question.

Meeting adjourned from 3.32 to 3.50 pm.

THE CHAIR: We will resume. Mr Seselja, straight to you.

MR SESELJA: Thank you. Minister, I just wanted to follow on from the questioning there with Dr Brown. I am concerned on a couple of levels. We have got one individual who has admitted fault, but that individual has not admitted to the entire fault and she has been very clear about that. The Auditor-General's report has said very clearly that other people were likely involved, and a lot of evidence is cited to back that up. Yet this individual has been put out there. Her name has been put out there. She has been referred to the police. And everyone else seems to get a free pass.

I am interested in why you are not interested in finding out what happened in your department which appears to go well beyond one individual. Are you interested in getting to the bottom of this? My concern is twofold: one, this individual cops all of the blame, I think probably unfairly; and, secondly, there is a cloud over a whole range of staff because you have not bothered to find out who are the culprits who manipulated the data.

Ms Gallagher: Can I begin by saying that an individual has not been referred to the police. My understanding is that the reports have been provided to the police. We have one individual that has come forward to accept responsibility for the vast majority of the data changes. The audits point to the fact that you cannot rule out other people being involved. The advice to me is that if an individual had not made an admission it would be almost impossible to identify who had been making any of the changes, and that goes to the fact that now, in the absence of an admission, it is almost impossible to find out other people involved, short of them coming forward and making a similar admission.

I do not think it is fair to say in any way that this has not been pursued. It has been. There has been a forensic audit undertaken and there has been an Auditor-General's inquiry undertaken to get to the bottom of the extent of the data changes and the manipulations. But what is clear from both of those is that, because of the systems issues, it is almost impossible to identify—in fact, it is impossible to identify—other people involved.

MR SESELJA: Do you believe that other people were involved?

Ms Gallagher: I have got the reports that you have got, Mr Seselja. In those reports it indicates that it is likely there were other people involved.

MR SESELJA: So do you accept the word of the individual involved, the executive involved, that points very clearly to the fact that there would have been other people involved? She says that it was happening, or the data that was identified was that she was not doing it at the beginning. She says that in many cases she was not able to do the amounts, and in fact the Auditor-General's report finds that. Do you actually believe her evidence that she gave to the Auditor-General?

Ms Gallagher: I do not know the evidence she has given to the Auditor-General. I have seen a letter she has provided to the Auditor-General which has been published, but I am not privy to the evidence she provided to the Auditor-General.

Do I believe what has been said? I must say I am not sure what I believe in relation to this matter, Mr Seselja. When the individual made the admission, I was extremely shocked that it was that particular individual. It is one of those situations where I do not know what to believe. I do not want to say I do not believe her, but I also accept the fact that for a considerable period of time she has accepted the fact that she has been changing data sets at the Canberra Hospital.

MR SESELJA: You seemed to be suggesting on WIN the other night that you did not believe her. You said, "I wouldn't necessarily accept the word of someone who has systemically undertaken years of manipulating data." We are of course taking her word that it was she who did it in the first place, and much of what she has said has been relied on. So do you not believe anything she has said, or is it just the bits that might identify other individuals or might point to other individuals having manipulated the data?

Ms Gallagher: In terms of taking her word, I do not think that is a fair assessment of what has occurred. There has been a forensic audit and an Auditor-General's inquiry that has made certain findings, and those findings are clear in relation to an individual. I can draw you to those sections of the report—

MR SESELJA: If she had not said that she had—

Ms Gallagher: Mr Seselja—

MR SESELJA: If I could—if she had not said that she had actually done it, manipulated the data, it seems from what we have been told and what we are now being told that you would not actually know that it was her; you would not be able to prove that it was her, unless she actually fessed up and said, "Yes, it was me, and I was manipulating data." So aren't you actually relying on her word to determine that the data manipulation has occurred?

Ms Gallagher: There is other evidence involved in the forensic audit is my understanding, Mr Seselja, so it is not just based on her word.

MR SESELJA: So if there is other evidence for her, why can't that other evidence be used to identify the other individuals who have manipulated the data?

Ms Gallagher: As I understand it, there has been a combination of the admissions that the individual officer has made and a range of investigations into thousands and thousands and thousands of pieces of data associated with that individual's work practice, and between the two of them those audits have reached a particular conclusion.

As minister, if there are other people involved, I think it is their responsibility to come forward. What I am saying to you is that the way the system is configured it would be very difficult for a very small number—and we are talking about a very small number of the data changes—to be able to say for sure who those people were.

MR SESELJA: You could seek statutory declarations. You could give an amnesty if you wanted to move on.

Ms Gallagher: The Auditor-General sought evidence under oath and affirmation. It is an offence not to provide information to the Auditor-General, Mr Seselja. So these matters have been actively investigated.

MR SESELJA: But is that from all those who had access to the data or just a select few?

Ms Gallagher: That is a matter for the Auditor-General. The Auditor-General conducted an investigation using her powers under section 14 of the act. They are very significant powers around drawing evidence. You will have to direct questions about the adequacy of that to the Auditor-General, but do not for a moment suggest that this has not been forensically and with significant powers investigated, including taking information and evidence under oath and affirmation.

MR SESELJA: You just do not seem that interested in getting to the bottom of who else it might be. It seems very convenient that you have got one individual—conveniently their name is leaked—and they become the scapegoat for what is a pretty wide-ranging scandal.

Ms Gallagher: No. I do not accept that anyone has become a scapegoat, Mr Seselja. I am sitting here taking responsibility for what has occurred in the Health Directorate. I do not think anyone has been made a scapegoat.

THE CHAIR: Mr Hanson.

MR HANSON: I have questions around the issue of what was taken under oath. On page 73 of the Auditor-General's report she says:

> Health Directorate personnel in the executive's line of reporting up to and including the Director-General, the Minister for Health as well as a family member of the Minister for Health who has a close personal relationship with the executive, have advised Audit, under oath or affirmation …

It is a little bit ambiguous to me whether that means that the family member is in part of that reporting chain or works in Health. I just seek clarification on that point.

Ms Gallagher: In relation to what? And I do not think this is a mystery to you, Mr Hanson.

MR HANSON: Well, I am asking the question: it is a little bit ambiguous in what the Auditor-General says. Does the relative work in the Health Directorate? If so, where do they work?

Ms Gallagher: The family member of mine does work in the Health Directorate and they work as a nurse on the ward.

MR HANSON: In which ward?

Ms Gallagher: In the medical assessment and planning unit.

MR HANSON: In the MAPU?

Ms Gallagher: Yes.

MR HANSON: Right.

Ms Gallagher: As you are very well aware, Mr Hanson.

MR HANSON: Right. What role do they have in the MAPU?

Ms Gallagher: They are the CNC of the MAPU.

MR HANSON: What is "CNC"? That is a senior management role, is it?

Ms Gallagher: Clinical—

Dr Brown: Clinical nurse consultant.

MR HANSON: Clinical nurse consultant.

MR HARGREAVES: CNC.

MR HANSON: Thanks. So it is a senior role. Okay. That is an area that we have not been advised of before, because, minister, in every other statement you have made, you have said that this was a personal relationship, a friendship, and there was a personal connection with a family member. There is nothing that said that this is—that the family member of yours works directly in the area that has been affected by this data changing. This is a revelation.

Ms Gallagher: I doubt very much this is a revelation, Mr Hanson—very much, indeed. Mr Doszpot, on visiting the medical assessment and planning unit some 12 months ago, identified the relationship and spoke of the relationship. So I find it very hard to believe this is a revelation that you are—

MR HANSON: Your public comments, and I can—

Ms Gallagher: If I could answer that question, because there is a very simple answer to it: in relation to the conflict, or the perception of a conflict of interest, that I dealt with first up, it was over the nature of the relationship that existed between a family member of mine and the person who had made an admission. The comments I made were in relation to what could constitute that conflict. I felt that the conflict related to the fact that a family member of mine had a personal relationship with the individual who has made the admission.

MR SESELJA: Do they not have a professional relationship with the individual as well?

Ms Gallagher: I did not believe that that created the conflict that I was trying to address.

MR SESELJA: Is it not relevant? I mean, does this family member have access to this data?

Ms Gallagher: I cannot answer that.

MR HANSON: We were advised before in the evidence that MAPU does.

Dr Brown: And we just checked with Ms MacCullagh in the break. She said that her very clear understanding is that MAPU has view-only access to EDIS—

Ms Gallagher: And I—

Dr Brown: for the purposes of that bed management.

MR HANSON: But the advice that we have had—

Ms Gallagher: I would go on at this point to say that the family member of mine has been interviewed by the Auditor-General, as have I, under oath and affirmation, and the Auditor-General's findings are very clear in relation to this matter. So whilst you, Mr Hanson, might like to whip something up here, I would say that these matters have been actively investigated by the Auditor-General. She has made some very clear findings in relation to this matter.

MR HANSON: I do not think I am whipping anything up at all. If the community, I think, had been—if you had been up-front with the community, this would not be a revelation, and it is. Your comments have been about a personal relationship and there has been nothing that you have said that has identified that a family member of yours works in the area directly related to where this manipulation has occurred. If they are a clinical nurse consultant, they would have access to the computers and would know about all of the logins. Why has this not been made public before? Why have you not expressed this to the community when you declared that you had a conflict of interest? Why have you kept this secret?

Ms Gallagher: Because the potential, I felt, for a conflict of interest related to the personal connection between the family member of mine and the individual that came forward. I have been up-front from the beginning about that, Mr Hanson. Right from the—

MR HANSON: You have not.

Ms Gallagher: Yes, I have. Right from the beginning, and the matters further to that have been actively investigated by the Auditor-General. She has made some very significant findings in relation to that matter.

MR SESELJA: But this goes to a conflict. This goes to a new conflict which you have not disclosed. You have chosen effectively to scapegoat one individual. You are not pursuing who else it might be. Now it emerges that a family member of yours is actually working in the area. We have no idea—as I said earlier, because you are not pursuing it, a cloud is cast over many, many staff, the vast bulk of whom will be 100 per cent innocent.

Ms Gallagher: Yes.

MR SESELJA: But because you are not pursuing those other individuals, because you are not making those efforts, there is a cloud over all of those staff. Now you tell us something you had not told us before, which is that, far from being just a personal relationship, it is a professional relationship. When you said you were being up-front about all this—you said a number of times that you have dealt with it and you have been up-front—why would you not disclose the professional relationship?

Ms Gallagher: As I said, where I felt—and this is about perceptions, and I go back to what I have said about conflict of interest in the past—there was the potential for a conflict of interest for my role, and this is about my role, was in the personal relationship between the officer that had made admissions and the family member of mine. I took advice from trusted advisers in relation to this. I took their advice in taking the decisions that I did. But these matters, as I said, have not been hidden. It has been very clear. Certainly in terms of the Auditor-General's investigations, the relationships that existed were well understood.

I go further, Mr Seselja: this is no revelation to you or your lot. This has been well known for a significant period of time. In fact, I recall when and how Mr Doszpot identified the family relationship at the time. It would have been well over a year ago.

MR HARGREAVES: Is it true—

THE CHAIR: Mr Hargreaves—

MR HANSON: Madam Chair—

MR HARGREAVES: Is it true—

THE CHAIR: Mr Hargreaves has got a—

MR HANSON: Madam Chair—

THE CHAIR: Mr Hanson! He has got a supplementary and then I will come to you.

MR HANSON: I am still questioning.

MR SESELJA: He is still asking questions.

MR HARGREAVES: I have a supplementary, and I have not said anything yet.

MR HANSON: I am still questioning, Madam Chair.

THE CHAIR: Mr Hanson!

MR SESELJA: You have constantly been giving him supplementaries.

THE CHAIR: Please! You have been constantly given supplementaries, as well. I just remind you again of standing order 234—

MR SMYTH: The normal practice—

THE CHAIR: Mr Smyth—

MR SMYTH: The normal practice is—

THE CHAIR: Mr Hargreaves—

MR SMYTH: to allow the questioning to finish—

THE CHAIR: Mr Smyth, I do not need your advice. I do not need your advice. Thank you.

MR SMYTH: Well, after Mr Hargreaves, I—

THE CHAIR: I do not need your advice. Mr Hargreaves has a supp, then I will come straight back to you.

MR HARGREAVES: Thank you very much, Madam Chair. I am interested in the insinuation that the medical assessment and planning unit was the subject of the manipulation of data. I am looking at the organisation chart here and, as I see it, within the division of critical care, there seem to be one, two, three, four, five different units. I do not know quite what you would call them. I suppose "units" will do. The data relates only to the emergency department, does it not?

Dr Brown: That is my understanding, that this is about the time of arrival and discharge from the emergency department.

MR HARGREAVES: Yes, and my understanding also is that the medical assessment and planning unit is a subset of one of those six, but nothing to do with the on-floor work of the emergency department; is that right?

Dr Brown: It is a short-stay unit within the hospital. It is considered as an admission to the hospital. So the ED event or episode of care has completed at the point of admission to a hospital bed.

MR HARGREAVES: So the data that we are talking about being provided around the ED stuff is something entirely different. Any construction of anything otherwise would be erroneous, would it?

Dr Brown: That is certainly my understanding, that this is about the emergency department data.

MR HARGREAVES: Would it be a reasonable thing to assume that each of these six units—not to say at least the people contained within those units—each of those unit heads has a professional relationship with the executive under discussion?

Dr Brown: One would certainly hope so.

MR HARGREAVES: You would hope so, would you not? But you would not know necessarily if they had a friendship going on with—as happens in a tight knit community like a hospital particularly?

Dr Brown: And I have to say that I certainly am not aware of the personal relationships.

MR HARGREAVES: Therefore, it would be the responsible thing, minister, would it not, where something that is a bit unusual—like a friendship, a relationship—to be declared up-front and early, and that did, in fact, happen, did it not?

Ms Gallagher: Yes.

MR HARGREAVES: How many people actually work within that division of critical care, Dr Brown?

Dr Brown: I would have to ask Ms MacCullagh if she could actually produce those numbers, or Ms Bracher. Do we have the numbers of employees within the division of critical care?

Ms MacCullagh: Within the emergency department I can answer on nursing FTE only. I cannot answer for medical—

MR HARGREAVES: Roughly will do for me. I do not want it exactly down to the eyeball count divided by two.

Ms MacCullagh: Okay. I can give you shift by shift.

MR HARGREAVES: Just how many—

Ms MacCullagh: In the emergency department on a morning and an evening shift you would have approximately 20 nurses.

MR HARGREAVES: On a shift, 20?

Ms MacCullagh: Yes.

MR HARGREAVES: How many shifts a day?

Ms MacCullagh: Sorry?

MR HARGREAVES: There are three shifts a day, are there not?

Ms MacCullagh: Yes.

MR HARGREAVES: So we have got 60 there just in the ED alone?

Ms MacCullagh: Yes.

MR HARGREAVES: What about the intensive care unit?

Ms MacCullagh: It would have anything from 20 to 25 nurses.

MR HARGREAVES: Per shift?

Ms MacCullagh: Yes.

MR HARGREAVES: Another 60. That is 120.

Ms MacCullagh: Yes.

MR HARGREAVES: And the retrieval services?

Ms MacCullagh: Retrieval? We do not have—we only have one nursing staff.

MR HARGREAVES: Okay, that is fair enough. What about medical imaging?

Ms MacCullagh: I do not actually—

MR HARGREAVES: Quite a few—

Ms MacCullagh: Medical imaging does not come under my portfolio.

MR HARGREAVES: Okay, now—

Dr Brown: Sorry, I should point out that the organisational—

MR SMYTH: Sorry, chair, is this a supplementary—

THE CHAIR: Mr Smyth—

MR HARGREAVES: It is. It is a supplementary to Mr Seselja's question.

Dr Brown: The organisational structure has actually changed from what is in that and medical imaging no longer sits in that division. It actually sits in surgery and oral health.

MR HARGREAVES: Okay, thank you, doctor, for that clarification. Of those subsets of the critical care division, how many of those units have data access into EDIS as opposed to view only?

Dr Brown: My understanding—and I think what Ms MacCullagh was suggesting—is that they have view access for the purposes of bed management. But they do not have a requirement to actually change anything in the system. So it is a view function to facilitate that bed management.

MR HARGREAVES: Yes. So only the emergency department have data entry capability?

Dr Brown: Apart from those specified individuals, like EDIS administrators et cetera and bed managers.

MR HARGREAVES: So at least 120 of them.

Dr Brown: Yes.

MR HARGREAVES: Yes, thank you.

THE CHAIR: Thank you.

MR HANSON: With regard to the conflict of interest, it was made clear to the public on a number of occasions when you were asked about this that the family member is a close family friend of the person who has been manipulating the data.

Ms Gallagher: Yes.

MR HANSON: But what is new in this hearing today and as a result of the Auditor-General's report is that your family—your relative works directly for the person that manipulated the data—

Ms Gallagher: That is not the case.

MR HANSON: Or works in the chain of command or in the critical care area—

Ms Gallagher: As I understand it, there is a line of reporting arrangements in place.

MR HANSON: Works in the line of reporting under the person that manipulated the data. Your relative has access to the EDIS system and as a senior nurse in the critical care area, from the evidence we have heard today, and the ease with which information can be altered, would have had access to logons. We have also become aware that people who have not been identified have also been manipulating data. We know now that you are not going to be investigating who those people are.

Dr Brown: I am not sure—

MR HANSON: You add all those things up, and there are certainly no allegations being made, but this is not a good look.

THE CHAIR: Dr Brown, did you want to say something, sorry?

Dr Brown: I am just not sure what Mr Hanson is suggesting in terms of the minister's family member.

MR HANSON: It goes to the point that the conflict of interest that the minister declared—

Dr Brown: The Auditor-General—

MR HANSON: It is quite clear—

THE CHAIR: Let Dr Brown answer.

Dr Brown: The Auditor-General very clearly and directly asked the family member were they involved in manipulating or changing data or influencing the change, and she answered that.

MR HANSON: Why is it that the minister did not declare what is quite an extraordinary conflict of interest when this became apparent but just said that it was a family friend and it was a personal relationship—

Ms Gallagher: I have answered that.

MR HANSON: when the relative works in the area and had access to the system? Why did the minister not declare that? That is the point.

Ms Gallagher: I have answered that to you, Mr Hanson. Again, the area where I felt the conflict arose for me—because the conflict was about me and my management of this issue after it came to my attention—was the fact that there was a personal relationship between a family member of mine and the person who had made certain admissions.

MR HANSON: They are in the reporting chain.

Ms Gallagher: If I could—

MR HANSON: It is just not a personal relationship.

THE CHAIR: Please, Mr Hanson!

Ms Gallagher: Mr Hanson, if I could just finish. If that personal relationship had not existed, I do not believe that there would have been a conflict for me that I would have had to declare that would not have been investigated through the normal process

of the Auditor-General and the forensic audit. The thing that made it complicated—and it is Canberra and there are two degrees of separation wherever we go—was around the personal relationship that existed. That is what I had to deal with in terms of talking to my advisers and taking advice about how I dealt with this at a ministerial level.

I am certainly very, very disappointed for you, Mr Hanson, to draw particular attention to a person who has done nothing wrong and who has undertaken and provided evidence through this process and that you have chosen to take this and decide—and whilst you will be very clever about it and say that you are not doing any of these things—to cast aspersions over somebody who has done nothing wrong and who has been cleared by an Auditor-General's inquiry of doing anything wrong.

MR SESELJA: Why did you not disclose the nature of the relationship?

Ms Gallagher: I have never hidden—I have never ever hidden the nature of the relationship.

MR SESELJA: You were asked just this week by Ross Solly: could you clarify the nature of this relationship? Again, you chose not to disclose that it was actually a professional relationship as well as a personal relationship. Do you not think that an ordinary person looking at that might think that that is actually relevant to a perception of a conflict of interest when you have actually got the individual working in the chain of command and there is a professional relationship? Why were you not up-front about that?

Ms Gallagher: I do not think I have not been up-front about this from the beginning. I have been very clear—

MR SESELJA: Very clear not to mention that relationship.

Ms Gallagher: No, that is not true, Mr Seselja. The area where I felt the potential for a conflict existed was between the family member and the person who has made admissions, and it was in relation to a friendship that existed. I felt that with the investigations underway that created the potential for a conflict of interest and I sought to remedy that by the steps that I have taken. But—

MR HANSON: You simply did not tell the truth about that relationship.

Ms Gallagher: No, Mr Hanson. Truth is power and I tell the truth at all times.

MR HANSON: Clearly, you have been found short.

Ms Gallagher: You have made a choice to bring the family of mine into this—

MR HANSON: No, you did.

Ms Gallagher: and to cast aspersions around their involvement, which I find extremely unfortunate, considering that the evidence before you is clear in relation to that matter. Now, you can continue a witch-hunt in relation to the family member of

mine if so you chose—

MR HANSON: This is about your omission—

THE CHAIR: Let the minister finish.

Ms Gallagher: but I will go—

MR HANSON: Glaring omissions.

MR HARGREAVES: Give her a go!

Ms Gallagher: I imagine the community will believe very much more in the work that the Auditor-General has undertaken and the findings that she has reached.

MR HANSON: You are not investigating any of the staff. There is now a cloud that hangs over all of the staff at the Canberra Hospital.

Ms Gallagher: I do not believe that is the case, Mr Hanson.

MR HANSON: So many people—

Ms Gallagher: You would like that to be the case, but I do not believe it is the case.

MR HANSON: So many people have had access to manipulate the data. The Auditor-General has found it is very likely that the individual did not act alone. There are many other people that could have accessed that data. The decision by you and your executive not to further investigate, not to find out who actually worked with the individual, if that is the case, then leaves a cloud over everybody.

Dr Brown: I am sorry, we know who works with the individual. We know—

MR HANSON: Who worked with them to manipulate the data.

Ms Gallagher: And I can tell you that from my understanding all efforts have been made to identify any other people involved. All efforts have been made through the various investigations.

MR SESELJA: What are they? What are those efforts?

Ms Gallagher: Through the forensic audit, through the Auditor-General's inquiry and through direct questioning, as I understand it, of the individual who has made admissions. I draw your attention to sections of the report that you probably are not that interested in where the individual involved stated that she undertook the changes on her own initiative. It is stated that no-one suggested or applied pressure for the records to be changed, and she does not believe that anyone else was aware of the changes.

MR HANSON: The Auditor-General has done a report—

Ms Gallagher: Yes.

MR HANSON: but there has been no action by you or the department to fully investigate who else is involved. I can quote from Dr Brown on 3 July. She said, "It won't be fruitful to try and pursue who those individuals may be." Now, I find it extraordinary—

Dr Brown: Sorry, Mr Hanson—

MR HANSON: that you are not pursuing them.

Dr Brown: if I can clarify that, that was the advice that both PWC and the Auditor-General gave to me, that because of the way the system was configured, we would not be able to verify—even if an individual came forward, it would be highly unlikely—I think the words used are "almost impossible"; that is in the report somewhere—to actually verify whether those claims were true. It is a question of where you invest your effort—

MR HANSON: You are taking the comments and the information about the official that has been essentially stood down—that has been stood down—and their evidence has been used. But you are saying that if someone else came forward, you would not use their evidence?

Ms Gallagher: No, I do not think that is what has been said at all.

MR HANSON: That is exactly what was said.

Ms Gallagher: No.

Dr Brown: No.

MR HARGREAVES: No, it is not.

Ms Gallagher: No, it is not.

Dr Brown: No.

Ms Gallagher: I do not know what part you do not understand, but the advice to me clearly from the directorate through the forensic audit is that if the individual who had made the admission had not made the admission, it would be—whilst you might have suspicions based on access and exit to the buildings and the times that the changes were being made, while you might have your suspicions about who was doing it, in the absence of an admission, it would be almost impossible to identify any other person that was involved.

Dr Brown: I mean, a person came forward and acknowledged responsibility. The forensic data audit looked at the changes. They then looked at: is there evidence to link it with the person who has made an admission? There was evidence that was there that did link it. It is not definitive. It does not give the name of the individual, but there are circumstances in terms of her account, the times, the access to the

building at those times, records found in the office that actually correlated with some of the changes. Those are the sorts of things that allowed the Auditor-General and PWC to make the conclusion they did.

MR HANSON: Dr Brown, you must have a view, then, of who the other people are. The Auditor-General has found that there are likely other people. In your view, who else is doing this?

Dr Brown: I do not have a view, Mr Hanson. What I know is that PWC said to me that there is certainly evidence to suggest that someone made changes in 2009, that there is no evidence either way in relation to the other changes. Now, PWC did the forensic data audit. What they did was look at any change that occurred the day after presentation. If someone presented at, let us say, 9 pm, EDIS clicks over into the next day at midnight. It is unlikely that person was out of the ED then. If there was an error or some reason to make a change, that would have come up as a change in this report. It does not mean to say that it was an unauthorised change.

MR HANSON: The Auditor-General found that there were inappropriate changes made before—a year before—

Dr Brown: Yes, in 2009.

MR HANSON: people admitted—

Dr Brown: Yes, that is right.

MR HANSON: The Auditor-General found that there were changes made whilst the individual was on leave. The Auditor-General found that the individual admitted to 20 or 30 changes a day, and on some days there are over 100. The Auditor-General concluded—

Dr Brown: Let me clarify those two points, if I can?

MR HANSON: No, I am just speaking, thank you.

MR HARGREAVES: Hang on—

THE CHAIR: Please.

MR HARGREAVES: Hang on; who do you think you are?

THE CHAIR: Please.

MR HANSON: The Auditor-General concluded that there were probably other people involved.

Dr Brown: In terms of the 20 to 30, that is the individual's recollection of the average—making 20 to 40, I think, changes a day. The record notes that on some days up to 120 changes were made. That does not say every day. The individual also said they did not make changes every day. Some days she did them in batches, I think she

said—

MR HANSON: So you disagree with the Auditor-General's finding that there are probably other people involved?

Dr Brown: No, I am explaining to you—

THE CHAIR: Let Dr Brown finish, please.

Dr Brown: the context of those comments that you have been reading out. If you save up three days worth of 20 to 40 changes, it gets up to the order of 120. There is also the element of—

MR SMYTH: But that is not what the report says.

THE CHAIR: Just let Dr Brown finish.

MR HANSON: Do you think other people are involved or not?

MR HARGREAVES: Let her finish.

Dr Brown: What I am saying is that PWC, who undertook the audit, said there is no evidence either way. Putting aside the 2009—

MR HANSON: That is what the Auditor-General found.

Dr Brown: Sorry, it is very clear that there were changes in 2009. I have no way of knowing who did that. I have no suspicions as to who did that. It was for a few months. The other changes—I think there is a slight difference of opinion between PWC and the Auditor-General in terms of how they have chosen to interpret that. The Auditor-General said it is probable that someone else has been involved. It is not definitive.

Yes, certainly, I would prefer that there was no evidence but, going forward, I have to ask myself, given that we run an extremely busy department and have a lot of things to do, what is the best return on investment for the resources that I have. Is it to try and find out the individuals who may or may not have made changes when I will not be able to prove it and I will not be able to do anything about it either in a misconduct sense or a police sense? Or will I invest my resources to fix the shortcomings in the system? That is where I am going, Mr Hanson.

MR HANSON: Any other organisation—

THE CHAIR: Ms Hunter, you had a supplementary.

MS HUNTER: I did. The other issue was around leave.

MR SMYTH: Yes, I also had a supplementary.

THE CHAIR: Yes, all right. You had not indicated that.

MS HUNTER: When this person who has made an admission was on leave, was there an explanation around how those changes were made when that person was supposedly on leave?

Dr Brown: If you actually look at the periods the individual was on leave, the number of changes during those days were very minimal. It could well be, as I said, in terms of the explanation that I have given that PWC looked at any change made the day after presentation. It could be a change that occurred for a legitimate reason. But it is not a perfect science. They took a pragmatic approach to doing this forensic audit. When you look at the number of changes, it dipped right down when that individual was on leave.

MS HUNTER: Could I also just clarify who does have access to the system and who can input data? We have touched on it this afternoon but I just want to be very, very clear.

THE CHAIR: It is not clear.

MS HUNTER: Outside of the ED, who can enter the system and change data or enter data?

Dr Brown: We will get that definitive information back to the committee. I am sorry, I do not have it in my head and I do not have it in my notes.

MR HANSON: Anyone who knows the logins—"nurse nurse" login.

THE CHAIR: Thank you, Mr Hanson.

MR SMYTH: Minister, I go back to where we started on this. You said in one of your answers to Mr Hanson that you have been very clear about this from the start.

Ms Gallagher: Yes.

MR SMYTH: I remind you of when this came to light. It was just before Anzac Day, and you said to the community: "This is all the information I have. We have been very public. We are putting it all out there."

Ms Gallagher: Yes.

MR SMYTH: But a couple of days later, on the Friday, you actually had to come back and say: "Now I'm standing down. I'm going to hand over to the Deputy Chief Minister because I've got this conflict of interest because—

Ms Gallagher: No, I did not say that.

MR SMYTH: the individual has a relationship, a friendship, with a member of my family." Then today we find out, or we have been told today, that, indeed, that family member works in ED. It is not just—

Ms Gallagher: No, wrong again.

MR SMYTH: All right, works in the hospital—

Ms Gallagher: Yes, along with several thousand people.

MR HARGREAVES: So does my nephew.

MR SMYTH: and not only has a personal but has a professional friendship. If you had put everything on the table and you have been very clear and you have provided all the information to the community—

Ms Gallagher: Yes.

MR SMYTH: why did you not do that from the start?

Ms Gallagher: I have.

MR SMYTH: You have not.

Ms Gallagher: Well, I have, Mr Smyth. In relation to—

MR SMYTH: You can say that, but it is not true, Chief Minister.

THE CHAIR: One person at a time, please.

MR SMYTH: Before Anzac Day it was all on the table. After an Anzac Day there was a possible perception of a conflict of interest; hand over to Andrew Barr. Now today, courtesy of the Auditor-General's report—

MR HARGREAVES: This is an argument, not a question.

MR SMYTH: we find out that your relative not only has a personal or private friendship but a professional relationship—

MR HANSON: In the reporting chain; in the direct reporting chain—

Ms Gallagher: Again, I find it—

MR SMYTH: with the individual.

Ms Gallagher: I am finding it very—

THE CHAIR: Can we let the minister answer.

Ms Gallagher: I find it—

MR SMYTH: Indeed, according to you, works in the unit—

MR HARGREAVES: Let her answer it.

THE CHAIR: Please, let the minister answer.

MR SMYTH: Is it not clear that you have not been—

Ms Gallagher: No.

MR SMYTH: That you have not put all the information on the table?

Ms Gallagher: No.

MR SMYTH: And that—

Ms Gallagher: I totally reject that, Mr Smyth.

MR SMYTH: the reason there is confusion and cloudiness—

Ms Gallagher: As usual, from you.

MR SMYTH: is because you have not been up-front on this—

MR HARGREAVES: Let her answer it, will you?

Ms Gallagher: No. I am very comfortable with what I have said and the issues that I have had to deal with through this process. As I said when I came out before Anzac Day, the information that was available to me was provided to the community in terms of what we understood at the time—

MR SMYTH: But your relationship was not made available to the community that day.

MR HARGREAVES: Let her answer that question.

Ms Gallagher: Thank you, Mr Smyth, and as I have explained, and I have explained in the chamber, this is the first time this issue has happened to me in my time as a minister. I do not think it is unreasonable that I took what was about four working days to have meetings with particular advisers about the steps that I needed to take. Having done nothing wrong, Mr Smyth, I was very mindful of the fact that removing myself as Minister for Health would send, I thought, a very public signal that I was worried that I had done something wrong. So I was looking for options about how to deal with what was a potential for a conflict of interest to arise through the course of the audits.

When I resolved that—and, yes, it took a few days; it has never happened to me before. These things are not black and white. They are grey. They are in the middle of: what should you do? I have done nothing wrong. The family member of mine had done nothing wrong. Yet I felt that there was the potential there for an issue that I had to manage. So, yes, I took advice and I took it from a number of people over those few days. When I resolved on the right path to follow, I went out and explained that to the community.

In relation to the revelation that the family member of mine works at the hospital, I find it very hard to believe that that is a revelation. A lot of people know about that. I did not think that was relevant in the conflict of interest because any issues relating to the professional relationship would have been dealt with through the audit reports that were undertaken and the investigations by the forensic audit.

MR HANSON: Chief Minister—

THE CHAIR: Just let the minister finish.

Ms Gallagher: The family member of mine had a right to be treated just like any other Health employee in relation to those inquiries, which is what happened. The area where there was the potential for the conflict, which is the one I sought advice on, I was very clear to the public on that. You know, when—

MR HANSON: Well, that is rubbish, quite honestly.

THE CHAIR: Just wait.

Ms Gallagher: Mr Hanson—

MR HANSON: The story has been changing, minister.

THE CHAIR: Let her finish.

MR HARGREAVES: Yes, it has been. You have been changing it.

THE CHAIR: Okay, thank you.

Ms Gallagher: No, the story has not changed.

MR HANSON: It has been changing.

Ms Gallagher: The story has not changed at all. Mr Hanson, the story has not changed at all.

MR HANSON: It has been changing.

Ms Gallagher: No, it has not changed.

THE CHAIR: Please, members!

Ms Gallagher: It has not changed at all. I understand, Mr Hanson, that for your political convenience you would like to find or to put a cloud over the family member of mine in your attempt to get to me. I understand the political game that is being played here.

MR SESELJA: It is about your conflict of interest and you failed to disclose it.

Ms Gallagher: But the Auditor-General—

MR HANSON: You did not disclose a conflict of interest.

Ms Gallagher: has examined this. I—

THE CHAIR: Let her finish.

MR HARGREAVES: You are grasping at straws.

THE CHAIR: Members, please!

Ms Gallagher: I did disclose the issue that I felt where there was a potential for a conflict of interest. I disclosed it publicly. It has been publicly aware and known since April. The Auditor-General examined this issue. The Auditor-General interviewed the family member of mine. The Auditor-General interviewed me. I explained the steps that I had taken through that process as part of those investigations. The Auditor-General has made some significant findings. We can go with your beat-up and your fiction, but I am afraid the facts are very clear—

MR HANSON: Well, they are not.

Ms Gallagher: that in this case, the Auditor-General has found, after her—

MR HANSON: How can we trust anything you say?

Ms Gallagher: What? You do not trust—

MR HANSON: How do we trust anything you say?

THE CHAIR: Please, members!

Ms Gallagher: What are you saying, Mr Hanson?

MR HANSON: What I am saying is that we have been deceived—

Ms Gallagher: You do not trust the findings of the Auditor-General?

THE CHAIR: Members, please, can I just—actually, can I just—

MR HANSON: The community has been deceived—

THE CHAIR: Mr Hanson!

MR HANSON: for years—

THE CHAIR: Mr Hanson!

MR HANSON: The community—

THE CHAIR: Mr Hanson! I actually want to remind everyone of standing order 234. Also, minister, can we just have one person speaking at a time. We are going to let the minister answer; then you can ask your question.

MR HANSON: What the Auditor-General found is that our emergency departments have been deteriorating for a decade under Labor. She found that definitively. She also found out that the community has been deceived for years about the status of our emergency departments, that the results have been fabricated. Your story has been changing. The conflict of interest that you declared in April is very different from the conflict of interest that clearly occurs where your relative not only had a personal relationship with the person that doctored the figures but was in the same reporting chain as the person that doctored the figures and had access to the system on which figures were doctored. And you are no longer investigating who else was doctoring figures, even though the Auditor-General thinks that there were other people.

This is the new conflict of interest. This is what you should have declared right at the very start, because how do the people now trust you or anything you say after what we have seen both in the performance of our EDs, the doctoring of the figures and your changing story on the conflict of interest?

Ms Gallagher: I have not had a changing story on the conflict of interest, Mr Hanson. Again, this surprise you have, when you have written a letter to the family member of mine in the past, I find extremely surprising. You have beaten this up today to put a cloud over the family member of mine, who has a distinguished career exceeding 20 years at the Canberra Hospital, for your political gain. It is most unfortunate. It is most unfortunate—not unexpected, though—

MR HANSON: This is about your conflict of interest, minister and—

Ms Gallagher: No.

MR HANSON: it is not about—

Ms Gallagher: No, this is about you getting into the mud.

MR HANSON: an individual.

THE CHAIR: Let the minister finish.

Ms Gallagher: Mr Hanson, you are in the mud. You are staying in the mud. There is no evidence. As the Auditor-General has found, there is no evidence of any other person that she has interviewed being involved in influencing the actions of this individual. Now, you obviously disagree with the Auditor-General's findings, or one of those particular findings. You are happy to pick up other areas. But I think your actions—

MR SMYTH: You are happy to take some of the office's words and not in other cases.

THE CHAIR: Mr Smyth!

Ms Gallagher: today are disgraceful. They are disgraceful, Mr Hanson. I presume the letter you sent to the family member of mine means nothing.

THE CHAIR: Okay, I am actually—

MR SMYTH: If we could just go back to Dr Brown—

THE CHAIR: I have had one question in the last 2½ hours. I am going to ask a question.

MR SESELJA: Because you keep throwing to Mr Hargreaves.

THE CHAIR: Sorry, Mr Seselja?

MR SESELJA: I said it is because I think you kept going to Mr Hargreaves.

THE CHAIR: I actually did not. I think you have been asking questions. You have actually had the most amount of questions of anybody.

MR SESELJA: I do not think that is remotely true.

THE CHAIR: I have been keeping track, Mr Seselja.

MS HUNTER: Anyway—

THE CHAIR: So believe me; thank you.

MR SESELJA: In the first hour we did not get one.

THE CHAIR: You actually did, Mr Seselja.

MS HUNTER: Whinge, whinge!

THE CHAIR: This was raised hours ago but I just wanted to clarify something too. Mr Hanson just said something about perpetuating a myth about indicators. He actually left out the last sentence on page 35, which was about staff support for NEAT. It actually said, "However, some staff asserted that four hours was an arbitrary time frame for which there is no scientific or medical evidence." I just wanted to note that.

Also, I note the fact that I ask these questions because the Auditor-General said that there was a considerable lack of attention on qualitative indicators which may provide a more appropriate, rounded assessment of emergency department performance. I wanted to get that on the record.

I also want to ask another question, because we have heard today obviously about what impact this event might have on our receiving payments from the commonwealth. I think the payment goes up to about $800,000. I know it is difficult to quantify, but what would that $800,000 actually account for in terms of providing services in our emergency department in light of what we spend overall on the

emergency department budget? It would be an interesting indication.

Ms Gallagher: It would be a very, very small component. I think in relation to the emergency department's overall budget in 2003-04, it had a $12 million operational budget. Eight years later in 2011-12 it is $29 million. So it has had 146 per cent increase over the last eight years in terms of resources going forward. In that regard, it would constitute just under one-thirtieth of the overall budget. So not a huge amount.

THE CHAIR: If we were going to get this funding—a lot has been made of that today, that we are not going to get this funding because of this incident—what would it have actually gone towards? We have been talking about improving emergency department performance. Would it have gone towards staff or would it have gone towards things like bed blockage?

Dr Brown: The issue is that it is non-recurrent. There are potentially four years of reward funding, and then it stops. So in terms of how we use non-recurrent funds, generally speaking we do not use them to employ additional staff, because you have a problem obviously when you have staff employed and the funding runs out. So we would use it for non-labour-type approaches.

THE CHAIR: Which would be what?

Dr Brown: That would be equipment, the environment—things like that. I am talking about facilities within the emergency department—equipment, capital works-type things, changes. We have made a number of those over the years. We have made changes in terms of converting beds to chairs and freeing up space. We have created the paediatric waiting area. There is a number of other things that you could do.

You could use it to look at reviewing the model of care around the short-stay units. There is a lot of discussion in the medical literature around what is the right model for short-stay units associated with emergency departments and how they operate. So they are the sorts of things that you could use the funding for.

THE CHAIR: Are there any sorts of parameters put on by the commonwealth about what states and territories are meant to spend this funding on? Is it meant to be spent on actually improving emergency department performance, given that that is what the payments are attached to?

Dr Brown: I do not—

Ms Gallagher: I do not think so.

Dr Brown: No, no.

THE CHAIR: So there is no parameters.

Dr Brown: Mr Foster is shaking his head.

THE CHAIR: Okay.

Dr Brown: I am sure that is right.

THE CHAIR: All right. Obviously, we are attaching this to improving performance and we are talking about it going towards that.

Ms Gallagher: I think the emergency department staff would have a view about where it should be spent—

THE CHAIR: Right; so that is what you are—

Dr Brown: But there is a lot of things that you could use it for in that environment. But it is unlikely, as I say, to be staffing when it is non-recurrent.

MS HUNTER: How are we going to get this baseline data? What has come out of all of this is that it then goes into your negotiations with the commonwealth about what the future holds in respect of payments and so forth? Are we starting from now to build that data or is there a way to resurrect—

Dr Brown: We are in discussions with PWC. I had some further discussion with them today. They are very willing to work with us on the best methodology. Their advice at this point in time is that we should use a modelling approach. They have assured me that that will give us a highly reliable outcome and that we should be able to do that in a timely way. We have given a commitment to the minister to have it done by mid-August, but we may well be able to deliver it before then. Our interest, obviously, is to get it on the public record as soon as we possibly can.

MS HUNTER: Minister, I note in the media today that you have had contact with the federal health minister's office.

Ms Gallagher: Yes.

MS HUNTER: What arrangements have you put in place to sit down to talk through this issue and to move forward in respect of those payments and where the ACT is going to go from here?

Ms Gallagher: The federal minister for health is actually on leave at the moment. I have asked for an urgent meeting with her on her return. The issue I want to discuss with her, and this goes somewhat to the motivation behind amending the data, is that all that has done is place more pressure on the emergency department now in that the baseline that was provided to the commonwealth was over-exaggerated, or better than it actually was. So that is placing more people under more pressure to actually reach the target, because each state and territory had different baselines. So it has been very self-defeating in that purpose, because now we have people working in the emergency department having to reach a harder target than they would have had our data been correct.

I am going to seek a meeting with her and see what can be done there and certainly be arguing around the point—less probably about the money and more about the pressure that it places on people.

MS HUNTER: What has been the morale over there at the hospital? Obviously, this has been a stressful time and these people do work in a stressful environment and provide fantastic service to the community. Particularly with statements like "there is now a black cloud over everybody over at the hospital", what is being done around morale?

Dr Brown: I think it is fair to say that this has been a very significant incident for the staff involved in the emergency department and other areas of the hospital. The person concerned has worked there for a number of years, is well known. In terms of how staff are travelling in the emergency department, I think we also need to put on the record the extraordinary levels of activity that have been coming through the emergency department. We have seen an upsurge in influenza as well as the usual sort of winter upsurge. So they have been extremely busy. The hospital as well has been extremely full. But they are professional staff and they are getting on with it and continuing to deliver that high quality care that gives us the results that were referred to earlier in the day.

The other thing I might mention is this: I did speak earlier about the culture survey results. One of the aspects of the culture survey that we look at is the quality of the employee working life. It is an indicator that is looked at. The Health Directorate scores 15 per cent above the government public health care average and the emergency department scores 25 per cent higher than the average. So they come from a good place. They actually have a very positive working environment.

The factors that contribute to that indicator are job satisfaction, workplace values, team norms—that is, in terms of behaviours—management and leadership skills. So they actually have a very positive working environment. That helps them to get through times when something tough happens, like has happened.

THE CHAIR: Okay, Mr Smyth.

MR SMYTH: Yes, just on the data, I refer to the table, objective 17 on page 63 of budget paper 4. Do you have those numbers that were not available when the budget went to press?

Dr Brown: Sorry, I do not have the budget paper with me. But, no, we do not.

Ms Gallagher: Is this the timeliness data?

Dr Brown: The timeliness data we need still to correct. We are working with PWC in terms of the methodology to do that. We have given an undertaking to the minister to have that by mid-August.

MR HARGREAVES: Can I have a supplementary on morale, please, that Ms Hunter just asked about?

THE CHAIR: Yes.

MR SESELJA: Sorry, he has not even finished asking his question.

THE CHAIR: You guys have been doing it. Do not give me that.

MR HARGREAVES: Minister, did I hear you—did I say—

MR SESELJA: He has not asked his question.

MR HANSON: He just started his question.

MR HARGREAVES: Excuse me, you are a guest. I am not.

THE CHAIR: Thank you.

MR HARGREAVES: I am a member of the committee.

MR SMYTH: I am not getting a question.

MR HARGREAVES: Chief Minister, did I hear you say that Mr Hanson had actually written to the relative of yours?

Ms Gallagher: Yes, that is correct, Mr Hargreaves.

MR HARGREAVES: What was the purpose of that letter?

Ms Gallagher: It was acknowledging her exemplary skills as a nurse at the hospital.

MR HARGREAVES: Do you find any conflict between the position articulated in that letter and the obvious insinuations that have happened this afternoon?

Ms Gallagher: I think it is clear that Mr Hanson has formed a particular judgement that is most unfortunate and not substantiated by any evidence.

MR HARGREAVES: Okay.

MR HANSON: If I can—

MS HUNTER: Was this a form letter to everybody at the hospital or was this one particular—

MR HANSON: No, this is a letter that I write to people to congratulate them when they get awards, I believe it is.

THE CHAIR: Oh, really! There you go.

MR HARGREAVES: Really?

MS HUNTER: I just wanted to understand that.

MR HANSON: I think that that would actually make the very clear point that, if I had done so and I have congratulated her, this is not about the family member. This is about the minister's conflict of interest. The very point that Mr Hargreaves made that

I have previously written to this family member to congratulate them goes exactly to the point that this is about the minister's conflict of interest and failure to declare that her family member worked in the reporting chain to the individual, had the access to the system and that there are other people who are involved and who have not yet been identified. This is the conflict of interest. And I agree with you, Mr Hargreaves; it is not about the individual—

MR HARGREAVES: You cannot have it both ways.

MS HUNTER: This is getting very confused.

MR HARGREAVES: You are back-pedalling like crazy.

THE CHAIR: Yes, it is.

MR SMYTH: Just get back to the data, Chief Minister. Ten days ago at estimates you said, "I would see that it is much more important that you meet your timeliness quotas in categories 1, 2 and 3, because they are the sickest people presenting to the emergency department."

The PWC report has found: "We have calculated the average time changed, for example, for triage category 3 in 2011. The original average triage time for these records was 89 minutes and averaged 28 minutes after the changes.

Using your words, how come these sickest patients were downgraded on average by 61 minutes? What has become so bad in the system that the average time was 89 minutes for a category 3 when they are meant to be seen in 30 minutes?

Ms Gallagher: Mr Smyth, I think in relation to that you need to understand that the changes to the data constitute six per cent of the overall emergency department presentations. So 94 per cent of presentations to the emergency department were not changed. In relation to—

MR SMYTH: So what is the average time for the 94 per cent?

Ms Gallagher: I think we will—I do not have that data before me.

Dr Brown: That is that data we will give you once we have got the corrected—

Ms Gallagher: Yes, I do not have that data before me. In relation to pressures on the ED, at times category 3 patients will wait that time. But there are other steps in place. These are the steps that I have put in place. They include nurses monitoring the waiting room in order to make sure people are getting access to pain relief and that people are being monitored and, if there is any deterioration, that they are being adequately provided for.

In respect of timeliness, this is where I go to around national consistency. There is not national consistency around what starts the clock. Here there is treatment provided beforehand, but that does not start the clock. So it is not to say that that patient was not attended to within that time frame.

MR SMYTH: How do you measure what time frame they were measured in?

Ms Gallagher: My understanding is once they are called into the ED and they are seen by a doctor or a nurse.

Dr Brown: It is the commencement of definitive treatment. That is the definition, but the interpretation of what is definitive treatment is where the greyness starts.

MR SMYTH: So if you were in the waiting room for five hours and you are only in the ED, inside the ward, for 45 minutes, you are recorded as 45 minutes?

Dr Brown: No.

Ms Gallagher: No.

Dr Brown: No, sorry; there are different things that get measured in terms of—

MR SMYTH: Yes, but that is what was just said, that you measure from the time—

Dr Brown: There is a difference between the NEAT data and the timeliness data. The timeliness, as I understand it—I stand to be corrected—commences at the time of presentation—

Ms Gallagher: Yes.

Dr Brown: until such time as the definitive—

Ms Gallagher: Sorry, I may have misled you there slightly in my answer.

Dr Brown: Whereas the NEAT, for example, starts from the time of presentation to the time of discharge or admission. So we have different measures measuring different things, which can at times get a little bit confusing. But as I say, there are some definitions there, but it is the interpretation of the definitions where there is scope for inconsistency across hospitals and across jurisdictions.

MR SMYTH: Yes. Just to try and gauge how bad the problem is, the extent of the problem, you said earlier that in the PWC report all they did was identify changes. You said that those changes could have been valid changes, legitimate changes?

Dr Brown: My understanding, my discussions with PWC, is that what they said to me is that they had to start somewhere. So they looked at changes that were made the day after presentation trying to establish whether they were legitimate changes or not.

MR SMYTH: Right.

Dr Brown: That is my understanding of what they did. It could be that someone arrived at 9 pm, did not get seen until half-past midnight and was discharged some time later. My understanding of what they have said to me is that potentially that would have gone into the next day. It does not mean it was 24 hours late. It means it

has gone into the next day. My understanding is that that could have been captured in the numbers that they were looking at.

MR SMYTH: So does that mean that anything that was done within a day, within the midnight-to-midnight period, was not checked? If you are saying all they did was check changes that were made—

Dr Brown: I would have to go back and double-check that—

MR SMYTH: the day after—

Dr Brown: Their terms of reference—

MR SMYTH: the presentation. You said this yourself—

Dr Brown: Yes.

MR SMYTH: that all they did was check something that occurred after the first day. Does that mean that there are other records that have not been checked, and that this problem could be far worse?

Dr Brown: I would need to go back and get the specific advice from PWC. I am happy to do that and provide that to you in terms of the precise methodology that they used.

MR SMYTH: When you do that, you might check this with them also. You also said that using forensic techniques identified the instances where the officer admitted what she had done and they quarantined those. But of the rest, you cannot say whether they were altered legitimately or not legitimately because we do not know who did it.

Dr Brown: Again, my understanding is that, where there were changes made after the period, they looked to see whether there was any evidence to validate the changes being legitimate changes. For example, if they went to the clinical record and could see that it was changed because the clinical record said something different to what was entered into the EDIS system, that was regarded as a legitimate change. But, look, I have to say that I have not got the detailed step-by-step methodology that PWC have used. The Auditor-General used the PWC forensic data—

MR SMYTH: Can you take that on notice, please?

Dr Brown: But we certainly will take that on notice.

THE CHAIR: That is taken on notice. Thank you.

MR SESELJA: Dr Brown, I forget the exact dates the audit report uses, but it talks around about April, I think, that the government or the directorate became aware of concerns over data.

Dr Brown: Yes.

MR SESELJA: Has there been anyone before that who has raised issues with the directorate in any way saying, "Something is not right here," either through their own personal experiences or through some other means? Have these sorts of concerns been raised with the directorate before this time?

Dr Brown: Mr Seselja, I think the report does speak to the issue that was raised in February of 2012 where one of the administration staff noted that changes had been made and reported that. Unfortunately, they reported it to the person who subsequently accepted responsibility for making the changes. It appears that no-one else was made aware in terms of any other managerial staff being made aware of that.

Apart from that, the only other instance I am aware of was in 2005. There were some allegations made then that there had been manipulation of the EDIS. That was investigated through an internal audit. They found no evidence of data manipulation in the EDIS system.

MR SESELJA: At what level was that allegation levelled? Who was the—

Dr Brown: As I understand it from reading the report, there was no specific individual. It appeared to have been a difference between the understanding of the nursing staff and the medical staff as to what constituted the specific definition. It comes back to that greyness in terms of interpretation of definitions. But the finding was that there was no manipulation of the EDIS data.

MR SESELJA: Minister, you have said in the Assembly, I think in May, that in relation to emergency department data there are internal and external validation processes that are robust. Given what has been found, do you still stand by that or was that incorrect?

Ms Gallagher: Certainly, with the availability of the reports, I think it is clear that the validation processes internally need improvement. But on the information available to me in May when I made those comments, that was the advice that had been provided to me. The advice provided to me was that the data changes, it appeared in those early days after the data manipulation had been identified, were being made after the validation processes had been finalised at the hospital in that window before the data was provided into another area of the Health Directorate outside of the hospital. In relation to the external validation processes, I think they are robust.

MR SESELJA: Given this report, I guess there is a question of how it was allowed to get so bad for such a long period of time. It paints a pretty poor picture, not just about an individual—and almost certainly others beyond one individual—who went and did absolutely the wrong thing and manipulated data. It also talks about some pretty poor systems and processes.

Ms Gallagher: It does, yes.

MR SESELJA: You have been Minister for Health now for six years.

Ms Gallagher: Yes.

MR SESELJA: How have you allowed this to happen? Surely these sorts of systems and processes should have been fixed by now, should have been identified. Why are we having this discussion again after so long? How have you allowed it do get so bad?

Ms Gallagher: I have not recalled a discussion like this that we are having again, Mr Seselja. But in relation to my role, I have certainly been let down, as has the community, through this. I have had frequent and numerous discussions with the directorate around data integrity and the processes that are involved. The directorate understands very clearly my views about the importance of correct reporting of health performance data.

I have made that clear not just to Dr Brown but to other directors or other chief executives in their roles. I was certainly—I have not been provided with any information to say that the processes around data within the Health Directorate were not robust or that they needed extra money to improve the systems, to put in additional resources to make those systems robust. So as a minister, in the absence of other information—and I have certainly had no-one come to me and say that there are problems with EDIS—I accepted the advice of my directorate.

Dr Brown: Can I add to that?

MR HARGREAVES: Why don't you know what you don't know?

Dr Brown: Sorry, just to give some more detail to that. In 2005 there were two audits that looked at the emergency department and the EDIS system in those. They made a couple of recommendations in relation to improving audit trails et cetera. Those recommendations were implemented. There was nothing found in those audits that actually talked about shortcomings in the governance.

Subsequent to that, as I said before, we have a program of internal audits every year. We have done seven audits in relation to our IT systems. We actually have an audit that is underway for this year that is around IT security. We had an audit scheduled in relation to the emergency department data, because we did identify a risk.

I think that in terms of governance we have had some reviews. They did not identify it. We do have a process of looking at our governance systems around our IT systems. We had an audit underway around information IT systems security. I think we have a lot of governance processes in there. It is just, in a sense, a shortcoming that is historical in part but it has not been picked up on by the audits that have been done.

MR SMYTH: The 2005 audit, is it possible to have a copy of the audit?

Dr Brown: I am sure we can provide that, yes.

MR HANSON: In terms of the reporting of ED, the minister has been putting out the emergency department report card. That is a recent thing. I think it started in August last year. Whose idea was that?

Ms Gallagher: That was an idea of mine, Mr Hanson, just to make sure that we were

providing up-to-date—as I expected at that time—information on the performance of the emergency department.

MR HANSON: Do you think that your decision to elevate the issue of emergency department waiting times by putting out a separate report, often at short notice, as I noted in December, has elevated in part the pressure that has been applied on individuals that led to this?

Ms Gallagher: I do not believe so. Again, I provided all this information to the Auditor-General. I provided a folder full of information. I already am provided with regular updates on the performance of the emergency department. I saw no reason why that information should not be made public. That was the decision I took. I have to accept that the information that I have been provided with was wrong and we need to correct the record.

MR HANSON: I have raised this with you previously, but I identified that in two report cards that you put out—the one in August last year and the one in December—there were anomalies between the two of them. The data was different. Essentially, the data that you had reported saying "this is what we achieved in July" changed from one report to another. It was extraordinary. We actually raised this issue and we had a brief interchange in the chamber where I had said that there was a problem with the ED data. We then—

Ms Gallagher: I think that was in relation to the four-hour rule, was it?

MR HANSON: No, no, it was not. This was in relation to—

Ms Gallagher: I will have to go back and have a look at it.

MR HANSON: the report card that you put out. We then put a question on notice, because we had identified this discrepancy. How is it that from opposition we were able to identify discrepancies in the information that was being put out sufficient to raise the issue in the Assembly, sufficient to put a question on notice and you were oblivious to this problem and your departmental officials were oblivious to this discrepancy in reporting?

Ms Gallagher: I am going to go back and check the record. I will check the *Hansard* on all of that, Mr Hanson.

Dr Brown: My recollection was that there was an issue—I cannot recall now whether it was to do with ED or elective surgery—to do with calendar year versus financial year. But I do not recall anything else. I am very happy to go back, Mr Hanson, and look at—

MR HANSON: Sure, and we can assist you with that process. The problem is that these report cards were put out—I remember one of them. The AIHW came out and showed that we had the longest waiting times in the nation, the longest in the ACT's history. That very afternoon you rushed out one of your reports, minister.

Ms Gallagher: No.

MR HANSON: Did you not set this system up to fail by that sort of action?

Ms Gallagher: No, I did not, Mr Hanson. I did not do that at all. The information of the AIHW is often quite old. They have improved their timeliness in releasing data. But I was being given different information from the directorate about the performance of the emergency department.

I would go on to say, Mr Hanson—and I am not trying to shift responsibility or attention on this matter—that the reports on emergency department performance, the monthly reports, I do not believe place as much—in fact, I have not had any concerns raised by emergency department staff with me over those reports compared to having to deal with responding to releases of yours calling them the worst ED in the country.

THE CHAIR: Okay. We are out of—

MR HANSON: The worst ED waiting times, and that is what they are.

Ms Gallagher: I think you will find—

MR HANSON: Before you started doctoring them.

Ms Gallagher: I think you will find—

MR HANSON: The worst in the country before they started being doctored.

THE CHAIR: Members—

Ms Gallagher: No, I need to put on the record that I have not doctored any data in relation to the emergency department.

MR HANSON: You allowed this to happen on your watch, minister.

Ms Gallagher: Mr Hanson, I think if you are—

MR HANSON: This happened on your watch.

THE CHAIR: Members!

Ms Gallagher: Mr Hanson—

MR HANSON: You are the minister—

THE CHAIR: Members, please! Members!

MR HANSON: when this happened.

MR HARGREAVES: You have made your point.

THE CHAIR: Mr Hanson!

MR HANSON: The reality is—

THE CHAIR: Mr Hanson!

MR HANSON: that these are the worst waiting times and you doctored them. Will you as the minister take responsibility—

THE CHAIR: Okay, thank you, Mr Hanson.

MR HANSON: for that?

THE CHAIR: Mr Hanson! Please! Okay, just finally—

Ms Gallagher: Madam Chair, I do need to respond to that. Mr Hanson has misled the committee. I have not. I have been cleared by the Auditor-General. It is very clear in her report. I do not think it is acceptable for a member of this Assembly to be lying in a public hearing, and that is exactly what Mr Hanson has just done.

Dr Brown: Can I just read a response into the record, please? In terms of the question of how is it determined who gets access, I am advised that there is an email request sent to the system administrator for EDIS with the justification for the request. Then once that is approved, then it is—sorry, it then goes to the executive director of critical care for approval and then access is grant.

THE CHAIR: Thank you, Dr Brown.

MR HANSON: Final question, minister: do you take responsibility or not?

Ms Gallagher: I have been taking responsibility the entire time, Mr Hanson.

MR HANSON: Thank you.

THE CHAIR: Thank you, members. We are out of time. As mentioned at the commencement of the hearing this morning, there is a time frame of five working days for the return of questions to answers to questions taken on notice at this hearing. Questions on notice for the Health Directorate output class 1, health and community care, specifically strategic objective 17, emergency department time lines, should be lodged with the Committee Office within three business days of receipt of the uncorrected proof transcript, with day one being the first business day after the transcript was received.

On behalf of the committee, I thank you, health minister and officials from the directorate, for appearing today and answering questions.

Ms Gallagher: Thank you.

THE CHAIR: I declare this hearing adjourned.

The committee adjourned at 5.02 pm.