THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET AT HENTY HOUSE, LAUNCESTON ON 9 DECEMBER 2004.

WEST COAST DISTRICT HOSPITAL DEVELOPMENT

Mr PHILIP MORRIS, STATE MANAGER, AGED RURAL AND COMMUNITY HEALTH; **Mr SCOTT CURRAN**, PROJECT ARCHITECT, ARTAS ARCHITECTS AND PLANNERS; **Mr PETER ALEXANDER**, MANAGER, FACILITIES MANAGEMENT BRANCH; **Mr BILL COCHRANE**, SENIOR PROJECT MANAGER, CAPITAL WORKS WERE RECALLED AND RE-EXAMINED. **Mr DAVID ORPIN**; **Mr ALAN COOTE**, KINGSTON AND ASSOCIATES; AND **Ms LISA NELSON**, HERITAGE CONSULTANT WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Harriss) - We have received further correspondence, Bill, and thanks for that. There is information there that we do need to consider. In the first instance, can we get you, or whoever you nominate, to lead us through some of that further information. I might just recap some concerns clearly and, obviously with the engineering consultants here, the committee was interested to discuss some more detail about the airconditioning and the air movement through the building. Also, there were the other matters associated with the heritage impact of the Gaiety Theatre. I think, if it is the wish of the committee, we will look at the airconditioning side of things first. I don't know how you want to handle that, Bill - perhaps you could get the consultants to lead us through that process first of all.

Mr COCHRANE - The issue of wood smoke pollution is not one that had been brought to our attention before or one that we had picked up in any of our health assessments that had been undertaken previously. After we left the hearing we looked at that problem. Some of that information we provided about where we were proposing to build the new site. We don't consider, even if anecdotally, there is a problem on some nights of the year or that the new site presents any greater problem than where the existing hospital is. They are on similar elevations, as we are pointing out. If you have a look at the town map of Queenstown you see that there are similar domestic residences around them. I suppose the new site may have the benefit that it has the old Catholic school on the other side of the road and some bigger institutional buildings around it, if you like, that don't generate any wood smoke but how we might treat that or mitigate that is a problem and I will pass that over to Kingston and Associates to answer any questions you may have.

Mr ALEXANDER - We have done a reasonably extensive search to see if we can find any evidence that should have alerted us that there was an issue. We haven't been able to find anything at all that is even directly related to Queenstown as some generic stuff, but that generic stuff, is related more to health outcomes and it doesn't pinpoint wood smoke as a cause. That doesn't make it any less of a concern to us. Maybe one of the good things that has come out of this is that we have spoken to public and environmental health and the Department of Primary Industries, Water and Environment on this issue and they haven't been aware of it. They can't point us to any reports about it, but as a result of this they are talking - and I can't say in what time frame - of investigating that further to see if there is a public health risk.

CHAIR - So clearly at the moment your position is that the health reports to which Mr Schulze referred last week in his evidence don't specifically acknowledge the impact of wood smoke necessarily on the health of the people of Queenstown?

Mr ALEXANDER - No. He certainly made a connection and we are not in a position to deny that connection. There is information relating to the health profile of the west coast and there is information relating to the effects of wood smoke. He has made that connection, which may be a correct assessment, but we haven't been able to substantiate that the effects of that in Queenstown would be significant. We have also done a bit of work to see if the effect of shifting the position of the hospital would alter any current conditions. Although it is a steeper climb to the old hospital, there is actually only a 7.5-metre difference in their elevation. There is some evidence, which is related to sampling of air quality, which says that within a 100-metre spread there is very little evidence. So I guess there are two things: we are not denying that there may be an issue; we are saying we need to look at that further. We will do what we can obviously to preempt any issue that might be there but we certainly don't think we are creating any worse an issue than already exists and probably exists in most country towns in Tasmania.

Mr COCHRANE - Our previous health assessment reports also recognised the higher mortality and morbidity rates in Queenstown but they relate them to other causes. That evidence is based on empirical evidence from the division of general practice in the north-west medical records.

Mr MORRIS - Yes. I think it is acknowledged that in the west coast area the mortality and morbidity rates are higher. That is one of the reasons we have to actually improve things and to broaden the scope of our actual service needs, so it is part of this project for all the health services coming out of the one banner.

Mr COOTE - That's one of our objectives: to become more engaged with community health issues.

CHAIR - Any other questions at this stage, before we go on to the consultant engineers. Mr Coote or Mr Orpin, are there any issues you have?

Mr COOTE - If there is an issue with wood smoke, there are steps that can be taken with the mechanical ventilation systems to mitigate the effect of that. It is basically impossible to exclude it, short of having a hermetically-sealed box to eliminate it all. There is always natural infiltration to the building; there are doors that residents can open to the outside; exhaust systems will run at night automatically and they will draw air in. A lot of that air can be drawn in through filtered air make-up systems. The air will take the path of least resistance so you may get certain amounts coming in through gaps around sliding doors - there is always natural infiltration to the building. We have outlined there some different levels of filtering that can be undertaken. Whilst it is not that expensive to take our the particulate matter, it is very difficult to get rid of the odour of wood smoke. If we really need to, there are additional maintenance costs involved. The more complicated filtering that is undertaken, the more expensive it becomes to maintain.

At present, the bedrooms within the aged-care component are detailed to have ceiling-mounted radiant heaters. We have outlined reasons why that is preferred in nursing homes these days. It is mainly to keep them out of the way so that they don't cause obstruction and gives you free use of a room. You can put the wardrobes where you want and it doesn't create a burning hazard. They don't move the air around so there is no movement of air particulate as such. They are responsive - we are talking about the latest technology from Europe; we are not talking about the units that used to glow red on the wall. We have then gone into some options. If we go to airconditioning and the reasons that nursing homes would have airconditioning in them, based on our experience in numerous homes throughout Tasmania, one is to get an additional point on the aged-care accreditation scheme and also to offer a better level of comfort and to attract people into the home, otherwise the ceiling-mounted radiant heaters will satisfy aged-care guidelines.

One of the important criterion is for residents to have control over their own heating or cooling within the room. A full ducted system throughout all areas does not provide that level of control, so again you can lose points on the aged-care accreditation. To give people individual control costs a little more but, as on option 3 with the DRV system, we have one outdoor plant which will supply all indoor units. They can either have heating or cooling on an individual room basis, depending on what they need. So that satisfies the control criteria.

We then add in filtered fresh air, and with these options, unfortunately, the cost is going up all the time. With filtered fresh air to each room you are not reliant upon natural ventilation, via opening the doors and windows to the room, to satisfy the building code of Australia. I suppose that would be the optimum solution. It is effectively pressurising the rooms to keep any smoke out of the rooms, so it does have that advantage. We could just put the fresh air system in with the radiant heating, which again would pressurise the rooms and provide that level of fresh air to satisfy the building code of Australia. As I say, the options are there and the more you do the more it is going to cost.

Mr HALL - The ceiling-mounted radiant heaters, they are part of the system?

Mr COOTE - No, the ceiling-mounted radiant heaters are a static, all-electric element.

Mr HALL - Yes, I realise that.

Mr COOTE - At present we have those, and we have exhaust systems in the ensuites and the same heaters in the corridors. We have heating and cooling only in the living areas at this stage.

Mr HALL - I was probably confused when I was reading you summary there. I think you talked about a couple of options, I think option 3 or option 4.

Mr COOTE - The options differ on, firstly, whether you want to bring in fresh air to pressurise the room or you just provide heating and cooling for whatever reason. The ultimate solution is to give residents full climate control plus fresh air.

Mr HALL - Yes, I am with you.

Mr ALEXANDER - Mr Chairman, could I just ask Mr Kingston to give a short clarification. I think we have two issues to deal with. One is a filtration issue of particulate or other matter and the other is the comfort or temperature issue. Filtration, to my understanding, isn't dependent upon airconditioning, fresh air, tempered air coming into the building.

Mr ORPIN - They can be treated as separate issues. You could have the radiant heating and then just have a fresh air system that will provide tempered air into the bedrooms. If there is wood smoke outside, you didn't want to open the doors so you are still getting that fresh air and you are getting heating but you don't have the cooling factor as well.

Mr ALEXANDER - If you need to cool the building there is a lot less chance of it being wood smoke because it is by definition warmer weather, so the tempered fresh air may have some advantages.

Mrs NAPIER - Would that system actually be filtered air, fresh air going in?

Mr COOTE - Fresh air, but it would be filtered by one of these filters.

Mr ORPIN - There are two issues here: the climate control and the smoke air. Under the building code of Australia it requires fresh air. Under the current design that is achieved by using natural ventilation, which is basically openable windows or doors. That is our basic approach at the moment. Then we have provided our climate control via radiant heaters. If we wish to stop or reduce the likelihood of smoke coming in you really need to have the doors and windows shut, which means therefore that you don't have any fresh air coming into your room apart from natural infiltration from the gaps et cetera. That is when you introduce the air by mechanical means. So that is the second option, to introduce air by mechanical means which then means we can filter it and take out any particulates. The level of filtration goes from taking out leaves right through to operating theatre level. So the option we put there is one that would take out smoke particulates and then you treat that air such that you're not, in the middle of winter, pumping 2 deg.C air into the room, which is why you end up with the tempered fresh air system. That fresh air system is only a small amount basically to stop the room becoming stuffy. The amounts are defined by the Australian standards. It will not condition the space; it is just providing a little bit of fresh air by mechanical means.

Mrs NAPIER - So what we're saying is, in the winter when it is most likely that there would be smoky conditions, residents would still be responsible predominantly for their own individual heating control but that it may be possible to provide a filtered air system that has the air warmed up a little bit. If that was done, would you assume that individuals wouldn't be able to make choices about whether they had windows and doors open?

Mr ORPIN - They still could, yes.

Mrs NAPIER - It happens in this building all the time.

Mr COOTE - It won't be a lock-down situation, but with that little bit of fresh air coming in, it does two things: it will pressurise against that natural infiltration leaking in through doors and windows; it will also provide some make-up air when the exhaust system operates in the ensuite as well.

Mrs NAPIER - So that's built in? Is that what is currently proposed in the design?

Mr COOTE - No, we don't have the fresh air system in.

Mrs NAPIER - How much would that cost?

Mr COOTE - We're talking about $20 000.

CHAIR - Mr Cochrane, there was something you were going to refer to.

Mr COCHRANE - I'm not sure, Mr Chairman, whether we left this document last time - this shows the heating and airconditioning zones currently specified. When David said that we weren't providing any make-up air, that basically was to the residents' living areas. There are other areas in the building where we are providing airconditioning and that fresh-air system.

CHAIR - We certainly circulated that last time.

Mr COCHRANE - I didn't know whether you had a copy, so I brought it along.

Mr COOTE - There are internal areas that do have this make-up air system now and that would provide some make-up air for the exhaust. The closest system is for the nurses stations and it is a fairly tenuous route for the air to take, but it could provide something.

Mrs NAPIER - If it's just $20 000 we're talking about, that would appear to give us an option.

CHAIR - I guess it raises a whole range of points, from where I sit, if it's deemed necessary as part of the design.

Mr COOTE - It's not deemed necessary by the Building Code of Australia, but if you have a situation where you say, 'There is a lot of wood smoke outside and no-one is going to open their doors' and then you saying it's not really practical to have that as a natural ventilation system.

Mr COCHRANE - And from our perspective, we certainly don't consider that unreasonable.

CHAIR - I guess what we are hearing is that it is likely to be built into the design?

Mr COCHRANE - Yes.

Mrs NAPIER - Questions were being asked about fire safety in one of the submissions that came before us.

CHAIR - Well, let's stay with the air treatment at the moment and if we've dispensed with that - and I sense that we have -

Mrs NAPIER - What we appear to be saying is that it is important for individuals who are living in the centre to have as much control as possible over their own living circumstances, including whether they have the door open or not. But, at the same time,

in the winter we are saying that the issue of smoke would most wisely be accommodated and that could be done through an air-flow system. That was my main concern. I didn't want to have people locked into an airconditioning system, I have to be honest, in an aged-care centre. There needed to be a mechanism to deal with that central health consequence.

CHAIR - I think we've addressed that. I don't know whether there's any impact from your firm with your design with regard to fire safety because there will be some questions.

Mr COOTE - There may be some.

CHAIR - So let's move into that area. We will hear from Mr Sutton and Mr Stringer later and we would invite you to stay while they give their evidence. There will be some questions which arise relative to the aged care area being placed above what could be classed as potentially the most volatile area of the building, that is the kitchen - the plant generator, you have oxygen and combustibles immediately under that corner of the aged care facility - and there has been a question raised which we will flesh out further on.

My suspicion would be that the design in no way breaches the requirements of the Building Code of Australia, otherwise we wouldn't have been sitting here with this in front of us. There is fire separation given the nature of the first floor structure, but nonetheless that question has been raised with regard to the stairwell which again as a requirement of BCA, would be fire-rated, as would the liftwell et cetera. Does anybody want to make a preliminary comment about that before we take that too much further?

Mr CURRAN - I can probably answer that, Mr Chairman. There are a number of areas on the ground floor that are required under the BCA to be fire-isolated. Apologies for the size of this drawing but we can see there the areas that we have indicated in blue are areas that we are fire-isolating. Medical records need to be fire-isolated. The lift shaft needs to be fire-isolated and so does the stair. This blue line through here is the fire separation area for the kitchen: we have slightly altered our design with the fire wall to encompass the laundry as part of this area so the kitchen, stairs - the lift is outside that zone - and the laundry are now all within that fire-isolated compartment.

The slab is 200 millimetres thick and that is a pre-tension slab. That has a fire rating of two hours on it so any fire that would potentially start in the kitchen would take two hours to get through that slab up to the area above. Any penetrations that we have through that slab are also required to be fire-isolated as well so that they achieve the same fire-separation rating as that concrete slab. So all of those issues I think are pretty well covered.

The fire separation is a fairly detailed design exercise as we continue through the process but our preliminary work shows - and we confirmed with our building surveyor that he is happy with the way we are fire-isolating this building and his opinion will meet all the requirements of the code. That is not to say that there won't be some minor refinements as we are going through but at this stage he is happy with our level of compliance.

Mr COCHRANE - Again, Mr Chairman, once we get our documentation sufficiently developed to where we are looking for building approval we have to provide with that a

certificate of likely compliance under the code which again will be vetted by council for technical compliance.

Mr ALEXANDER - I can add one comment to that - compliance isn't our main driver; when it comes to fire safety we don't compromise. We really don't.

Mrs NAPIER - So if a question was asked about the time required for residents to get out of the building and the need to use lifts and stairwells - presumably the lift, because it is quite possible that many residents might not be able to use the stairs - what is your response to that question?

Mr ALEXANDER - All the residents will be upstairs and there is a level access to the eastern end so if there were a fire downstairs there is access out onto the street on the ground floor and there wouldn't be any of the residents down there unless they were down there having an x-ray, blood count or something like that. Generally the residents are upstairs and there is a fire separation also upstairs, so they are coming out horizontally along corridors and if you look between - I think that is a fire wall between the acute and the aged care, isn't it, Scott?

Mr CURRAN - Yes. Those walls that we have shown dotted through there form compartments within the hospital itself. So if this department were to catch fire, for example, then the fire is restricted within this area for one hour before it is able to burn through these walls to continue its path through the rest of the hospital.

There are requirements for windows that abut each other and for the distance separating buildings as well. One of the other reasons behind setting this building seven metres apart from the Gaiety Hall is that the minimum you can have is six metres. We have taken an extra metre to get additional separation between those two buildings. Therefore the fire risk between those two buildings has been minimised by the seven-metre setback and the spread of fire throughout the building has also been minimised by these compartments which are required under the BCA. We have to have those; we are not allowed to have areas that exceed 500 square metres, and that is why each of those areas have been compartmentalised.

There was an additional fire stair placed in this area to enable us to have better escape out of the hospital in the event of that stair or this entry being blocked by fire.

Mrs NAPIER - Am I right in thinking that this is the only street-level access?

Mr CURRAN - Yes, this is the only access.

Mr ALEXANDER - And through the ambulance bay.

Mr CURRAN - And through the ambulance bay. So they would be able to exit through the ambulance bay and out into this area.

Mr COCHRANE - And you also have the fire stairs near the staff, which would be difficult for clients but is another lower exit.

Mr CURRAN - Anyone who is in a wheelchair would have access here or here.

With the stairs, because they are two-hour, fire-rated stairs, they give people an opportunity to take people into the stair, to close the door and for them to have two hours to enable them to be rescued by the fire department or the fire authority.

All these things are considered when fire issues are raised. The fire station is, I think, probably less than 300 or 400 metres away from this building, and that is another thing that would be considered.

Mrs NAPIER - If I remember correctly, Mr Best raised the issue of combustibles, basically gas and so on, that would be stored underneath this level on the south-west end. I think in that context, Mr Best was asking what the impact of the combustibles would be. I think we were thinking at the time of the sound and vibration impact on the resident above. One would think that if there is gas et cetera being stored so proximate to people, how does that affect the safety of the residents living above?

Mr CURRAN - The gas is actually across the laneway. This gas was actually moved back across onto the other side of the road because of these detailed design considerations that we were working towards. So we now have the generator in this area - medical gas and oxygen in this area.

Mr ORPIN - There are two gases going into the site. One is the medical oxygen, which I suppose aids fire if there is a fire there, but is not flammable itself. That would be stored in an enclosure in accordance with the code.

The other gas is the LPG for the laundry area, which is flammable and which is being located on the other side of the road, adjacent to maintenance.

CHAIR - I guess the reality is that you have no option but to comply with the building code of Australia, which sets down the fire-simulation and fire-rating requirements. As Mr Cochrane said, you have no choice but to comply and this building will comply.

Mr CURRAN - That's right. With storage of gas, all of those issues, we have no choice but to comply.

Mr COOTE - You will see there are no bedroom windows over the top of this.

Mrs NAPIER - So this would pass the fire services requirements?

Mr COCHRANE - Part of that building approval process is that it goes before Tas Fire Service and they provide a report.

Mrs NAPIER - Has that happened yet?

Mr COCHRANE - No, not at this point. We've developed our documentation subsequent to the various approvals, both external and internal, within the department. We develop our documentations and then around the time we want to go to tender we submit a building application to the West Coast Council. At that stage they will forward a copy to the fire department, asking them for their comments on the fire safety issues.

Mrs NAPIER - It's interesting, though, that it is not approved by the fire services before we have a look at them.

Mr COCHRANE - Our team of building surveyors make sure that we are compliant with all these issues.

CHAIR - I'm certainly relaxed about that process. I understand and accept that that is clearly the process. With integrated building approvals these days the BCA pretty much picks up most of what the fire service regulations used to. So, as an integrated process, the building code now basically sets it all out.

Mrs NAPIER - Is there any further update in relation to the heritage issues associated with the Gaiety Theatre?

CHAIR - There are a number of matters there that we can and will cover, hence Ms Nelson's attendance.

Mr COCHRANE - I will defer to Scott on the heritage issue.

CHAIR - Lisa's the expert; that's why she's here, to address those matters related to the Gaiety Theatre. I guess, Lisa, you are aware and would have been briefed about our concerns about the heritage nature of the building, its significance, the approval processes, the introduction of the Heritage Council and what might be the impact of demolition versus retention.

Ms NELSON - As you know, the Gaiety Theatre or hall is listed in the heritage schedule of the west coast planning scheme. It isn't at this stage listed on the Tasmanian Heritage Register. On page 12 of my report I have outlined the requirements of the heritage schedule of the planning scheme for development of an item listed in that schedule. There are three requirements:

> 'It is beholden upon the applicant to demonstrate that the character or quality of the item can be preserved, enhanced or revealed, or that the character or quality of the item will not be adversely affected, or that there is no prudent or feasible alternative to carrying out the development.'

I think the fact that the scheme has reached this stage of development demonstrates that there is a prudent or feasible alternative to demolishing the hall. The hospital can be fitted onto the site, whilst retaining Gaiety Hall.

In terms of the item itself, I would have to say that it is not the most aesthetically pleasing building in Tasmania. I can understand concerns that people may have about retaining it. Its heritage listing came firstly out of a heritage study undertaken by Gidden Mackay, who are consultants from Sydney. They did quite an extensive heritage study of Queenstown in 1995-96. They identified items of importance and that is how that got onto the west coast planning scheme list. Those consultants are probably the leading heritage consultants in the country, so they have credibility.

In terms of my assessment of the building, it certainly has social significance as a building which was possibly and probably built by the Mount Lyell Company as a dance

hall/music hall/theatre for the entertainment of their employees and their partners. It has had a number of changes of use over its lifetime. In the 1930s it was turned into a picture theatre and then in the 1950s it was purchased by the Education department and turned into a school hall. At that time some rather unfortunate alterations were made to the building, I think Mrs Napier has a very good copy of the report that shows what the façade looked like before the alterations were done by the Education department. This proposal intends to restore the façade of the building to the condition it was in then, with those triple windows and the doors with the sidelights.

I think the planning scheme has quite a strict test of what is appropriate. The first one is that an item must be preserved, so that really rules demolition out of it, and it is supposed to be enhancing and revealed, I believe that this proposal does enhance and reveal the qualities of the item because it is taking away some unsympathetic additions and restoring it to a former and more appropriate and pleasant appearance.

In terms of the qualities or the character of the item that are integral to its heritage significance, it is my view that the form of the building, the flat façade, the parapet wall, the rectangular shape and the pitched gable roof are all part of what tells us that this is an early twentieth century building. The roof is Australian vernacular corrugated iron roof. The pitch of it is typical of an earlier period. You will note that when they added on to the front they also used another corrugated iron red roof with a lesser pitch, which also reveals the evolution and history of the building.

I think that the west coast planning scheme requires the retention of the building. There has been an indication by the consultant planner who works for the West Coast Council that that would be their view of it. I also have anecdotal evidence that there are people within Queenstown who would fight its loss. As far as the Tasmanian Heritage Council is concerned, I am not sure how much you want me to go into that, Mr Chairman.

CHAIR - I think the view of the committee, when we last met, was that we needed to satisfy ourselves of the Heritage Council's intervention in the event that, one, there was a desire to demolish the building as part of new facilities here and, two, how the Heritage Council might be introduced to the equation just because the building is listed in the West Coast planning scheme. Does that put it in a nutshell?

Mrs NAPIER - Especially if West Coast deleted it from the planning scheme.

CHAIR - Yes, what the process would be for them to delete it from their planning scheme if indeed that was the will of the council.

Ms NELSON - If the West Coast Council were to delete it from the heritage schedule, they would have to make a planning scheme amendment, which would go through an advertising process and a hearing process through the Resource Planning and Development Commission, and the methods would be given and whatever. I actually contacted the Tasmanian Heritage Council with regard to this property and they have indicated to me that they have an interest in it and that they are aware of the Godden Mackay heritage study. The Godden Mackay study laid up the data sheet which would form the basis of the Tasmanian Heritage Council listing. The situation with the Heritage Council is that they have probably 5 000 properties in this pending situation and they say they don't have the resources to go through the process of listing these properties.

Mr HALL - Has somebody actually nominated it at this stage? I know it is part of the west coast planning scheme.

Ms NELSON - I don't think so, although they were immediately aware of its listing.

Mr BEST - What is the possibility of, say, preserving the building but perhaps just lowering the roof profile?

Ms NELSON - I think that the roof form, pitch and height is actually intrical to the significance of the building. It is not something that I would recommend. The situation with the West Coast Council is that they don't actually have their own planner on their staff; they have a consultant planner, a GHD to do the planning. Now in the planning scheme it says that when they get an application on something that is in the Heritage Schedule they can, firstly, ask for advice from the heritage council or, secondly, ask for advice from a heritage committee that they may have set up. The most likely thing, because it is the cheapest thing, is to ask the Heritage Council, because they are the State Government. That is the most likely thing that they would do. We are not sure whether they would do that in this case because the heritage impact statement has gone with the application.

If it was to go to the Heritage Council for demolition, I have been informed - and it is totally off the record - that they will not allow that. If it went with an application to remove and replace the roof - I am having to second guess somebody else's opinion - I don't think it is something that they would support.

CHAIR - You indicated, Lisa, that the council may consult the Heritage Council or it may consult any committee which it has set up itself. Is it compelled to consult the Heritage Council just because this building is listed in its planning scheme?

Ms NELSON - No; I think that the wording of the planning scheme is that it 'may' and the wording of the clause of the planning scheme says, 'the applicant must demonstrate'. I guess that's the reason that I was commissioned to do the assessment and write the report. What I think we have demonstrated is that we've complied with the planning scheme in terms of preserving and enhancing the building. They still have the option of consulting the Heritage Council.

The other important aspect of the Heritage Council involvement is that when a property is listed on the Tasmanian Heritage Register it is the entire title, so it's not just the Gaiety Theatre but it would list what is now the playground and will be the hospital site. That means that the Heritage Council would get involved in approving or critiquing the design of the new hospital in terms of its impact on the hall and the Orr Street streetscape, on whatever heritage grounds they believe are appropriate. Mr Curran might have had experience of that process. We are aware that that would possibly slow down things and it would also mean that in the design of the hospital you would have to please other persons.

CHAIR - You indicated that the Heritage Council suggested to you that if an application was made to demolish they would reject that. Is that the end of the story?

Ms NELSON - No, absolutely not.

CHAIR - Is there an appeal process?

Ms NELSON - Yes. That indication was made to me by somebody who certainly is not the person who makes the decision. The Tasmanian Heritage Council is a council appointed by government and they have an adviser. What the actual appointed council does is unknown. We can guess as to what their advice would be. If the Heritage Council got wind of an application for its demolition, I think it is likely they would provisionally list it. Under the Historic Cultural Heritage Act you have a right to object to the listing, but only on the grounds that it doesn't meet any of the criteria for listing. My guess is that you would have no hope of winning that fight because I think it has prima facie significance. I think it has been identified and assessed appropriately by appropriately qualified people, so I don't think you would win trying to stop it being listed. Having it listed doesn't necessarily preclude it being demolished; under the act it says that you can't do anything that adversely affects the heritage significance of a place - and obviously demolishing it pretty much does that - unless there is a proven or feasible alternative. Then you would be appealing to the Planning Appeals Tribunal saying that there is no proven or feasible alternative to demolition of this heritage-listed place. I think they would have some difficulty there because we have a scheme now that fits the hospital line and retains the building.

All these things are based on assumptions and it may not go that way. The Heritage Council could take a different view, but this is based on my experience with them over the years. When I made my inquiries and floated the idea of its demolition, I got a horrified response. I said, 'There are a lot of halls in Queenstown, you know', and I was told, 'Yes, but that's indicative of the fact that it was previously a very large town and the hall is significant'.

Mrs NAPIER - That would include maintaining the facade, not just knocking down the roof.

Ms NELSON - No, I don't think that they would support that.

Mr ALEXANDER - From our point of view as the developer, we are in a different position from a private developer. We feel very strongly about our responsibilities to try to provide the best outcome for the Government. Irrespective of our views otherwise, it may initially have been easier to start with a greenfield site - it always is. As a state government agency at officer level, I don't think that we are in a position to vigorously fight or appeal something which is within another arm of government, if you see what I mean. We can certainly talk with the Heritage Council but I think it would be very unusual, given that the Heritage Council is an instrumentality of the State Government, for us, as officers, independently, to appeal the decision or to take it further without some higher authority to do it.

Mr HALL - As Lisa pointed out, the building is not particularly attractive. It has been significantly altered over past years and a lot of the evidence of its past uses are quite anecdotal; it is not very clear as to what some of the uses were.

I think the other main issue the committee had was the impact of that roof line against the new hospital and the views and everything else. It seemed to be a thin case, notwithstanding what you have said about the heritage values.

Ms NELSON - I have to say that the chances of demolition the building completely are pretty slim. There is nothing stopping you putting in an application to the West Coast Council to remove the roof and replace it with a less steeply pitched roof. That would then almost definitely go to the Heritage Council for advice because the West Coast Council do not have any heritage expertise to guide them as to whether that is appropriate or not.

I have been involved in two elderly persons' facilities which have involved heritage issues and it is my view that in those cases the provision of those much-needed facilities outweighed the heritage issues, albeit heritage being my 'thing'. I think in this case the hospital has been designed around the building, albeit with some negative aspects in terms of views, and I think that the heritage case is fairly strong.

Mr HALL - There was also the point made of the increased cost if it was demolished.

Mr ALEXANDER - I think there is a figure of $425 000.

Mr CURRAN - That's not the cost to demolish the hall; that's an additional cost to rebuild anew rather than to renovate it.

Ms NELSON - I think Mr Curran has the letter from the West Coast Council planning consultant. There has been some detail to assist the application and the heritage report and it says that the council would not be amenable to demolition.

Mrs NAPIER - What date was that? Was that before our hearing or subsequent?

Mr CURRAN - We have had conversations with GHD and their planning officer, Jo Oliver, for quite a period of time. The date on this letter is 2 December; that is when I asked her to formalise her opinions so that I would be able to present this to this committee rather than just have some hearsay.

Ms NELSON - She said that the West Coast Council may or may not refer the application to the Heritage Council for an opinion. In any respect there is significant qualified evidence that the building has reasonable significance. In making an assessment on the planning application, the council's planner would take into account heritage provisions in combination with any public representations. That is another issue; any works on the building would have to be advertised and proper representations taken into consideration. In respect of the question of demolition as opposed to renovation/conversion of the building, clearly there is a prudent and feasible alternative in the application that you presented. On planning grounds, the intent of the scheme was clear. There are items listed under the heritage code. The planner should in the first instance seek to preserve the character and quality of the item, whereby detrimental impacts can only be considered where there is no prudent or feasible alternative.

I think that the west coast provisions are quite strict in terms of heritage. If you were to propose to remove the brief and replace it with a less steeply pitched roof, then it could be argued that that is having an adverse impact on the character of the building.

CHAIR - Just a superficial intervention, if I might. Even if you halved the slope of the pitch, my estimate would be that people standing in those rooms still wouldn't see over the roof, anyway. It just seems to me that we are pursuing something which isn't achievable if we expect the lowered roof to any way to give an outlook across the roof because that won't happen in, at least in my superficial assessment of what I see in front of me. I don't know if you want to comment on that, Mr Curran.

Mr CURRAN - No, I think that is a fair assessment, Mr Chairman.

Mrs NAPIER - You would need to get rid of the building beyond.

Ms NELSON - Can I just say, Mr Chairman, just to reassure the committee, that I think the building will look substantially better. The roof is going to be painted, the concrete walls are going to be painted grey and with the proposed reconstruction of the façade the building will relate better to the streetscape.

Mrs NAPIER - Would it be possible, then, maybe to paint a murel of the scene that they might have otherwise seen?

CHAIR - I am just looking at a photograph Mr Sutton sent to us. There is a picture of the building behind the Gaiety Theatre and I reckon that is a bit worse than the roof. It is all subjective stuff, I would have thought.

Mr TREVOR STRINGER AND **Mr GORDON SUTTON** WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you, gentlemen, for travelling from Queenstown to be here. Gordon at an earlier time made a submission to us but wasn't able to speak to that submission at the hearing in Queenstown, and we appreciate the fact that you have been prepared to travel to Launceston. It is a clear indication of your commitment to ensuring the process is thorough. Thank you also, Mr Stringer, for your subsequent representation after you heard about the committee convening in Queenstown. We certainly extend a welcome to both of you and we are happy to receive your verbal support of the written submissions, and which we have all received.

Mr STRINGER - I will deal with the fire issues first, if that okay. With due deference to the firies, I am an expert at all. I was looking more at the smoke issue than actual burning. You were talking about airconditioning and particulate matter in the upstairs. I would have thought that any risk downstairs, firewalls or not, would bring smoke into the upstairs. I am sure it will be dealt with as the processes go through. Also, the oxygen bottles near the diesel - oxygen doesn't burn but it's a really high risk, whether there is a firewall there or not. If you get a sufficient fire there, the oxygen shouldn't be anywhere near it. In the existing hospital the diesel generator is removed to one end entirely and the oxygen bottles are well ventilated on the hill at the other end of the hospital - 100 yards away. It is simply an observation of mine and I am sure the fire department will work with it.

The residents are not able to be moved easily. I am not a nurse, but my wife is, and some of those residents would not be able to move quickly at all. The two-hour fire limit on the reinforced concrete floor doesn't allow for smoke - I am not sure, but I don't think it allows for smoke infiltration. You would have smoke in there within minutes, I would have thought, through the stairwell, the lift, the courtyard and any windows that are open. I would have thought that with the money that is being spent on this, it would have been put on a level floor by the old school and that it would be done properly instead of putting everything into one small area. We don't have sufficient flat ground. It doesn't make sense to bring an aged-care centre into the middle of the CBD. It does not make any sense to have it in the middle of town, especially when the existing site is not inaccessible; it is fine.

The hospital, given a different view from the architects, had their brief been to design within the hospital what you require now, I am sure they would have been able to do it. But their brief was to design a new one. In 2001, that was the brief. The studies that were done after that with Di Hollister were, as far as I can see, to justify the brief. The existing hospital and grounds are going to be there for a very long time, regardless of what you do. I am a long-term resident of Queenstown and that is going to make a large hole in the middle of Queenstown. We live there, no-one else here does. It is going to affect our cultural and social amenities in the town. I don't think the new one will improve it at all.

These are the photos of the existing plans for the roof. They are not in keeping with anything in Queenstown. We have gabled roofs, facades and verandahs down the main

street, it's like an old wild west town basically; I don't want to bag the architects, but this is like a collection of chook sheds and lean-to's.

CHAIR - We had a presentation last week on these.

Mr STRINGER - We saw them for the first time yesterday at the council chambers. It clearly shows that the roof extends over the generator set and all the facilities at the back. I believe in fire exits. I am sure you can overcome all of that, but I have great difficulty with the rush to build this facility in the main street. It is 2.4 metres from the main thoroughfare. Have you seen the Lyell Wing on the hill?

CHAIR - Yes.

Mr STRINGER - It is okay. They have views and gardens. The ones who do want to go downtown do go downtown; they go wherever they want. Most of them are happy to sit in the grounds up there. There is plenty of level ground there if you take the car park down two metres, and the costings for that aren't that great. There are so many doubts in this and I would ask the committee to send it back and have them do a study on the hospital and doing it on the existing site. You are destroying part of the fabric of Queenstown. There are a lot of halls in Queenstown and if all the view they have is of a grey painted wall, leave them up on the hill with the rhododendrons and the blackwoods and the views of the mountains.

CHAIR - Mr Stringer, you're addressing specifically the aged-care facilities?

Mr STRINGER - Yes, I am. With the existing hospital, at the acute end, I believe there is plenty of room there to work within the load-bearing walls. The ones they're talking about removing are not load bearing, nor are the widened doorways or the corridors. Correct me if I am wrong, but the main load-bearing walls are the corridors down the centre of the hospital and the external walls and some of the dividing walls. In the acute end there is an enormous amount of room - within the acute beds area.

CHAIR - The committee took substantial evidence last week on that after touring the site. They are the assessments that we will have to make, given the evidence we took from the department's consultants.

Mr STRINGER - I understand that. It is the total picture, though, for Queenstown. It's not just, 'Let's have a new building at all costs'; you then leave acres of grounds and a derelict building. We already have two derelict schools in town, major public buildings open to vandals and just doing nothing.

Mr BEST - We heard last time that we met in Queenstown about the philosophical approach of the department. I think they talked about Campbell Town - I might be wrong about that - and about placing something like this within the CBD. I am not saying everyone is too far away, but the design promotes greater opportunity for contact and engagement with the community and having that movement around people. Whilst they have their own retreat areas - that is, the aged-care people - they are more accessible to that community engagement. What would be your view in relation to that?

Mr STRINGER - I represent the RSL with the war veterans up there; I go and visit them. Two or three who can and want to visit the town do so. There is a steady stream of visitors and people through the Lyell Wing now - friends, family and also visitors like me and other carers. It is an issue that they are closer to the town and that they will see more people and get out more. I simply don't believe that will happen. There is plenty of activity through the Lyell Wing now. They have community and hospital cars that travel to the town, and they do. There are also activities nurses appointed to engage them in a variety of things. They have boat tours in Strahan for the ones who are able to go. That is a major revolution, to get someone onto a boat.

Mr HALL - Mr Stringer, you're obviously concerned that if the site is changed you would end up with another derelict building in the middle of town. In your opinion, is there any commercial application for that site to be redeveloped?

Mr STRINGER - The only group big enough to do it is Federal Hotels and they have no interest in it at all; it is simply too big and too difficult for them. I work for them occasionally and that's their opinion. They may be spinning their line, too, but I don't think so. It is a large building that obviously needs something done with it. I believe if the architects had been given the brief to design within that area they would have come up with a really good design, but they were given the brief to design a new one and that's why we have this. I think it should be revisited because the residents are quite happy looking at the view they have; we have enough acute beds. They only reason we are short anywhere is that they vacated the top level and crammed all the offices downstairs, which was not sensible if they were going to build a new one. It didn't make a lot of sense at all. It has all been crammed in a very small area down one end of the hospital.

Radiology in the new hospital, I believe, is going to be a portable chest X-ray unit and there is no intention to remove the full X-ray department to the new hospital. Correct me if I am wrong but that is my understanding, that they will not be having a lead-lined room with full hospital X-ray equipment. It is simply going to be a portable unit, which to me is a downgraded service for a start. If you have a fractured long bone and you can have an X-ray there, but for anything else you have to travel two and a half hours for an X-ray.

We have the facility there to maintain a base hospital, without the theatre - and I don't see that coming back - but you still have a base hospital sitting there. If the intention of the Government is simply to close that, if it suits their philosophical reasons or methods in health, then fine, but it should be the stated intention rather than telling us we are having a new hospital simply to have one. The building is sound; the structure is sound. I know it is too big, but what you do about that, I don't know. Put the top floor on care and maintenance. I am still going back to the old hospital. I can't see why they would move to this so readily without looking and spending a few dollars on a proper survey of the old hospital. I believe it should be by an independent architectural firm - independent of the Government and Artas - to go and look at it and explain why it can't be done there. We cannot see a reason - and this is from builders and the locals who work there.

Mrs NAPIER - In your submission, you talked about the proximity of the plant generator and fuel and you talked about the automatic start facility and the potential for it to cause fire.

Mr STRINGER - If the power goes off, the generator kicks in straightaway, I believe - it used to at the old hospital, the existing hospital. The point is that it is remote; no-one is there to press a button. If there is a fault with the wiring in either the starting mechanism for the generator or the alternator that is supplying the power, no-one sees it and it burns. It hasn't happened in god knows how long, but it could happen. It is a potential that you will move from the building. This is design stuff. It was pointed out that there was no morgue in the original plans, so they put one in. So this, if it is a problem, then shift it away. If the oxygen bottles are a problem then put them somewhere else. If the kitchen is a problem, have it elsewhere - on a single floor up the other end. It is a design problem; it is not the end of the world. All the fire risks seem to be put directly under the geriatric wing, as I said, with a lift and a courtyard to updraft and act as a chimney. As a design thing it could be done a bit better - if we had more room, which brings us back to that again. The existing hospital has all the room in the world to do this sort of thing. I know no-one wants to go there, but I am still there because I can't see a thing wrong with it. I know what is going to happen if we move to this: the old one will sit there. They are now looking at the leadlighting in the Lyell Wing for removal. They were doing it two days ago - so they are going to strip the place down. It will be a vacant shell and open to vandals. I don't believe the nurses are going to use the nursing home to live in without the hospital there. They don't feel safe in the damn thing. It is isolated without the main hospital and its activity. Spend a few days there; it is a little cultural and social hub. A lot of people work there, go there, visit and walk through there. I don't believe down town is going to be suitable because you have the noise factor from the schools and you are on a main street. Queenstown does have a problem with main street damage and vandalism, hooning of drivers on a Saturday night and it is right outside of the proposed site. They do burn bins and they throw them up at your windows. It happens on that stretch. It doesn't happen where the hospital is now. And as for fitting in with the rest of the streetscape, that is just another design matter along with the gables and the façade. That is not in keeping with Queenstown as far as I am concerned. It doesn't fit the streetscape at all. I mean, the Gaiety Theatre may be aesthetically not pleasing, but it fits the rest of the street. This is aesthetically pleasing somewhere else but not here. I am not bagging the architects per se. The first drawing of it was fine but then someone told them that the rainfall in Queenstown was above the normal level and they assumed the rain would go off this roofline a lot quicker.

CHAIR - Any further questions. You are welcome to stay as there might be some other things that you want to add further. Mr Sutton.

Mr SUTTON - Mr Chairman, if I can just add what was said the other day - some of the truths that weren't told. The DON mentioned that we had physio now once a week with two people coming down. We had it before, two years ago, with two people coming down twice a week which meant we had 20 hours' work out of the two people for the week and now we only have 10 hours, so that is a service that has just been cut back just recently.

The other thing mentioned was the talk about the helicopter, of only one landing in 28 years. There have been four that I know of and in the press, Tim Hill, the Coroner, said that the helicopter should be used more regularly. It was mentioned that it wasn't even essential to have the helipad there. As you are probably aware, I fought to try to keep the one off Ockerby Gardens, where my ancestors are buried but I was told it was

essential that the helipad went in. I knew that it had to go in. Why take a helipad away from a hospital when you need one? You need one more so down here.

Another point was that the requested area was the recreation ground. Well, I am sure a helicopter won't land on there as that is all gravel. No helicopter will land on gravel as he will do his motor in straightaway - he would suck the dust in - so that is out of the question. So there will be no helipad on the recreation ground, or no landing.

The other point is that there hasn't been a study on doing up the old hospital. I have been a builder here since 1957 and I have just retired a year ago. I know the hospital and I worked in the hospital. They say the doors are too hard to widen. In the x-ray room there is a door there 5 feet wide. I worked on it one morning in 1961 and an old bloke came down the passage and he asked me, 'What are you doing, sonny?' I said, 'I'm knocking a whole in the wall' and I had a gag, which is a long bar, and I had a strike with a big hammer. He said, 'You'd better knock off, sonny' so I knocked off and the boss came along and he said, 'How are you going?' and I said they told me I couldn't do it. By that night we had the wall in there to put in the x-ray door - we widened that door there, we knocked a hole through. I know several people who worked on that. You can refurbish that hospital, I am sure of it.

The story about the car park - for $20 000 I can get a contractor in Queenstown to take that off level so then you don't have any steps. You would still have to put a bit of asphalt on it. The helipad will still remain, all the filling will go over to that old house as you are coming up the hill. He is willing to sell that for $80 000. There is $100 000 and you have your car park levelled and you have got rid of your filling right beside it. You have a bigger car park. It can be done. We have had all those things put against us at all the meetings about the double-glazed windows. Well, it is going to cost you the same for the double-glazed windows up the street as it would to put them in the old building. It is just absolutely stupid.

We went through the New Norfolk Hospital. Which they revamped for $1.5 million. To think that you are spending all that money up the street, which has nothing - at the end of the day we have a new building but we haven't got any more services. Every service that we have will come from Burnie. If you knock on all those doors in that old hall - a 1932 model - I have been through that, too. No-one has nominated that building for heritage. The only heritage building in that street is the Empire Hotel. The other one that should be under heritage is Hunter's Hotel and look at the disgrace of that. It goes back to the days of King O'Malley. If you're going to keep one, you have to keep the lot. I guess that council does not realise that if they are going to put some notification to keep this as heritage, the rest of the street has to be kept as well. The main street is in disarray. As you are well aware, our group has been fighting to keep that hospital on the hill.

We had a meeting the other night and we made a list: in May 2001, the Government announced that they would replace the existing hospital in Queenstown based on a health-needs review. In June 2001, Di Hollister's review gave reasons for not keeping the old hospital: major areas of non compliance for Building Code of Australia. Please identify these areas. Corridor and door widths, not wide enough; not in load-bearing walls; X-ray door widened in 1962 in same corridor. Ensuites not as difficult as stated. Windows, single glazed, replace with double-glazed aluminium. Would not have to demolish to ground level. Untrue, as state of structure is sound but at the end of its

economic life. Not remote from town area; it is only that it is not in the main street and needs better signage. NWRH and NWPH - Mersey Community Hospital out of town. Deficient areas as stated. Lighting, cooling, heating, ventilation, emergency lighting, do not meet current standards. This could be remedied on existing site. Clean air on current site. Noise pollution increased at new site. Other considerations: car park, current site costs to level car park. Helipad has been used and recommendation recently to utilise more. Bigger capacity car park on old site. Proposed new facility, inadequate parking. The aesthetics of the building currently in tranquil setting. Beautiful landscaped gardens with spectacular views of surrounding mountains and secure sites. There are no mountains you are going to see down in that town.

I would like to show you the other side of that hall, which not many people have seen. If you can see those cracks in there, they are the old bedheads they put in for reinforcing. As I said to the committee, I could grab hold of that in my hands and nearly squash it up. I don't know it would be approved to be built on. There was another untruth told, that the roof was replaced in 1950. It was replaced in the late 1970s. The guy who put it in put it in with spring-head nails - the old galvanised nails - and about six years later they lost part of the roof because it blew off. There was about 18 inches of sag in the roof and they had to re-screw it. A guy re-screwed it in the early 1990s. If you were to knock the roof down, you are going to have a ghastly sight on that motel and you're still not going to see a view of a mountain; you will look at the skyline and into all those pipes in the motel.

Compared to the new proposed site it is 2.4 metres from the main thoroughfare of Queenstown, within 150 metres of the school and playground, 50 metres from a funeral parlour. We heard mention that the morgue was a problem because people saw the bodies being taken out. Well, we've got a funeral parlour right opposite, a church beside it, limited gardens, limited views, split levels. Have residents been consulted regarding their preference? What are you offering in the new facility that is not already available or is the facility to be made available in the existing building? Some of the facilities are better that will be offered in the new building - X-ray, pathology and the sterilisation facility which shut down a few years ago, but we are going to get a new one back. In design review and consultation area, what are the identified risks associated with reducing the service profile? I dread the thought of calling into the hospital. I have all my time been saying it is a multipurpose centre and I have convinced people that it is going to be. It is even on the back of the Premier's glossy page 'Health West Medical Centre'. That is what he is going to call it. I believe that if you are going to call it a hospital, put something in it that is serviceable every day, not knock on the door and wait for somebody to come down with the services because at the end of the day there will be nothing there but an aged care home. That is all I have to say.

CHAIR - Thanks, Gordon. Any questions or comments following Gordon's speaking to the various documentation that he has sent us.

Mrs NAPIER - Mr Sutton, in relation to the replacement of the roof, is the pitch of the roof that was replaced you say in the 1970s, at the same angle?

Mr SUTTON - The same angle, the same roofing iron and same pitch. The only thing about it it had that much bow in it that it just popped all the nails. We lost part of the roof. The two guys who did it in the 1970s and early 1990 are still alive. The builders who helped

me at the hospital to do a lot of the work in the late 1950s and early 1960s, we worked on the hospital doorways and walls, and it was not a problem. What you have here today could all be done with no worries at all. The superficial structure of that hospital does not have to be altered at all. Those wards that are there only need a divisional wall between them. They could be replastered and all the plumbing could go round the outside of those wards.

CHAIR - Mrs Napier, anything else?

Mrs NAPIER - Mr Sutton, you would be aware that it has been fairly strongly presented from the West Coast Council that -

Mr SUTTON - But they were already for it before they even saw the picture.

Mr STRINGER - If I may, the decision to build the new hospital was made before any reviews were opened. The Di Hollister review which developed this assessment was started months after the first notification by Ken Bacon that we were going to get a new hospital, so I don't believe they have done a proper review of the old building. As Gordon said, there was nothing new offered in the new building. They say that the health needs of the west coast can only be met to a greater extent with a new building but nothing new is being offered that can't be built into the existing hospital. In their own report, on the last page, they are calling it an integrated multipurpose facility, not a hospital. So it is not a hospital. If the purpose is to remove the hospital and do something else, then tell us. If it is to be a new hospital then there is absolutely nothing wrong with staying in the old building. I cannot see the point of it.

CHAIR - Is there a community problem which is being perceived purely on name, though? If we look at the plans which have been circulated, we have acute care beds, we have nursing facilities, we have ambulance access, we have a range of facilities that may be contended which are consistent with delivery of services in a hospital .

Mr STRINGER - The name is neither here or there. It is the building. The name doesn't matter basically. The service provided can be the same in either building and Dr McGushin, the council man, said that it is only a building, get over it. Fine, it is only a building, get over it, start another one. It is probably not a waste of money, I am not saying that; it is not a downgrading of services, it doesn't have to be, but we have a facility there now which is an integral part of the town. There is no way that you can get a view out of this new one - a view of a grey wall is not a view. A view of a primary school is not a view nor is a shop or a funeral parlour. There are your four corners and your other view is a very big school.

Mr SUTTON - And you can't knock that down either if that is the case because we would nominate all those buildings in the town. We can't knock the hospital down, so you have a problem. If you are going to start on one building, you have to keep going on right around the lot.

Mr STRINGER - If it is a better system, then go for it but one thing I asked the mayor, Daryl Gerrity, is that if we are going to go ahead with this and do it then the old hospital should be costed in with the demolition, so it is not sitting there like a bloody eyesore.

CHAIR - We have received some documentation from the department which has indicated to us that the estimate to demolish the existing hospital and rehabilitate the site will be $590 000.

Mr SUTTON - We would be fighting that then, wouldn't we, because we can't knock it down.

Mr STRINGER - The other take on that was Darryl Gerrity's.

Mr SUTTON - It's not listed.

Mr STRINGER - I don't want to be bloody minded and stop it all costs, but Daryl's other take on that was that the gardens would require the appointment of a full-time gardener because the council would not take it up. Short of that becoming a fire hazard or just a mess, even with the building gone, the council would still be asking the State Government to put in a full-time gardener to maintain it.

CHAIR - You will both appreciate, I am sure, that is the challenge for this committee: to receive the competing evidence we have received from the consultant architects, the department, witnesses last week, you two today and then to make an assessment as a committee as to whether what we have before us is a reasonable proposition as far as expenditure is concerned or whether it's not.

Mr SUTTON - Mr Chairman, there has been nothing done on the old hospital. That's what we've asked for. Over the past 12 months we have asked for someone to come up with the pricing or to get some ideas as to how you could revamp it. It's all there - the structure is there.

Mr STRINGER - There are some reasons given in this document as to why it's not suitable for rebuilding, but I think that was done after they had almost finalised the plans for the new building. I am not trying to do anyone out of a job, but I think the architects should be employed to see what they can do in the old building, without the Government's agenda to build a new one. Just go and look at it objectively. It is obviously quite good; it has acute patients and elderly people in it. There is accreditation in the Lyell Wing for another two years yet, so there is a small window there to bring that up further and plenty of room if you take the carpark down. It would be a bigger building and it is a challenge for the architects to put it in the existing building.

Mrs NAPIER - Are you aware that we have received evidence at the last representation that this is a hospital and will remain a hospital?

Mr SUTTON - I don't really know what a hospital is, then. If it has no services, what is it?

Mr STRINGER - It has the same services we have now. It is a hospital, but it is a basically a multipurpose facility, which is all the old hospital is right now. It doesn't have a theatre; the old hospital is an aged-care and multipurpose facility right now.

CHAIR - It would be really prudent to let you both know the function of this committee. The legislation delivers to us the responsibility to either approve or reject a submission. We can't put caveats on our decision. For instance, we can't say, 'The department should

go and investigate the existing hospital before we make a decision on this'. We need to make a decision on this one way or the other, and they are the only two options we have: to approve or reject the submission we have before us.

Mr STRINGER - I thought perhaps you could ask for further information.

CHAIR - As we have done here, getting back here today to get the further information.

Mr STRINGER - But can't you ask for further information on the suitability of upgrading the old hospital or is that outside your terms of reference?

CHAIR - That would be outside.

Mr STRINGER - Then I would ask you to reject the proposal, based on what we've said.

CHAIR - I also get the feeling that there would be no further requirement upon the committee to further question the department.

MESSRS STRINGER AND SUTTON WITHDREW.

Mrs NAPIER - I would quite like to ask a further question about the smoke and updraft issues so that we get it on the record. Mr Curran, you would have heard the representation that indicated that, even if there is a two-hour protection by design from the fire itself, that there would be an impact from smoke that would be drawn into the upper building from the services that are below.

Mr CURRAN - Our main criteria when we were assessing smoke and fire is to get occupants out of the building safely. When we do that what we look at is the travel exits, if you like. What we endeavour to do is to make those resistant to fire and smoke. The doors that we have on the corridors have fire seals and smoke seals as well; the same as the doors to the stairwell. The theory is that if you get into the stair, once the door is closed, the fire and smoke don't get into the stair within that two-hour period. Remember that we have a situation where we have open windows and open balcony doors where the smoke could penetrate into the building, which is outside the normal scope of what we would be trying to do to stop the smoke coming into the building.

Mrs NAPIER - So if I was a resident over and above that plant and equipment, how safe would I be should a fire break out?

Mr CURRAN - In theory the slab is designed to withstand the heat or fire for two hours. So from the moment the alarm is raised, remembering that this whole building has a series of fire or smoke detectors right through it, in theory you would have two hours before that fire penetrates.

Mrs NAPIER - Can the fire get out of the building and come back via the windows?

Mr CURRAN - If you have buildings on top of each other you have two choices: you can either separate the windows from each other with a spandrel panel or you can use a balcony to separate from below. What we have used in this case is a series of balconies, so that the balconies separate the window back 1.2 metres from the edge of the building. If the fire were to lap up from down below and came through a window to get through that other window there is a 1.2 metre buffer before it can get back through there.

Mrs NAPIER - A question was raised about the compatibility of the aesthetics of the building on the northern side with the streetscape. It was argued that it was not consistent with what the rest of the street might be like. What is your response to that?

Mr CURRAN - That is not consistent with the advice that I have been given from our historical consultant, Ms Nelson, and also the advice that I have been from GHD's planner, Jo Oliver. We have had extensive consultation with both of them to ensure that when we design this building it fits in with the streetscape. We are not saying that we want to mimic what is there; what we are saying is that we want a contemporary building that fits in with the historical nature of Queenstown. We have done an analysis of the streetscape where the building is and we have determined that those skillion roofs that we have are appropriate, not forgetting the fact that initially we did have gabled roofs but we have gone away from the gabled roof because of consideration of the rainwater and also of the hail. We have tried to eliminate all of the box gutters across the roof to eliminate any potential problem. That was as a direct request from the maintenance

people who work at the hospital. They say that any box gutters give them huge problems with hail and the amount of water they get.

Mr COCHRANE - If I may add to your question on the fire separation, on receipt of a fire alarm the mechanical services we have in the building to operate a fresh-air system or on other airconditioning drawing air from outside would stop. They would be overriden and stopped so there would be no chance of drawing smoke into the building through those systems. Plus, as part of our certificate of occupancy in getting this new facility operational, we have to provide the fire service with an emergency control plan which shows what would happen in the event of a fire and what actions we would take to make our residents and staff safe. All that ties together with the requirements of the BCA to ensure that we have a comprehensive fire management plan.

Mrs NAPIER - Was there ever a review of the old hospital done by a qualified architect or builder to look at whether it was feasible to redevelop that building as a hospital?

Mr ALEXANDER - There was not an extensive and full review. There was certainly a good look at the existing facility based on the experience of the people. When we sought architectural consultants for the job we sought submissions from four different architectural firms. This was subject to our own review and I guess we sought their opinions also on the potential for redevelopment of the existing hospital.

Mr Sutton talked about New Norfolk and the 'they' he spoke of as redeveloping that hospital were essentially Bill Cochrane and myself anyway, so we do consider that. We have to make the money we have go as far as possible, so we had a solid look at that though we haven't got a documented report on every aspect.

Mrs NAPIER - I wouldn't want to be a nurse living up there if there was a derelict site that I would have to go past. What are the plans for dealing with managing that site?

Mr ALEXANDER - There are a range of options some of which are specific and some of which are generic. Initially when we put the funding submission to Government in 2001 we made provision to demolish the old site - should we have to do that. We have been overtaken by events and we have very recently got a cost escalation factor from the Government because costs have skyrocketed. We talked about that last time. We anticipate that we may have to demolish it but we wouldn't do that until we had tried to find an alternative use, so the demolition will not be imminent. We want to find an alternate use if there is an alternative use and of benefit to the community but invariably if we jump the gun on that we would have people criticising it and saying they hadn't had the opportunity, so we need to have an open competitive process on that.

There is a move across the State away from nurses homes. There are very few left and it makes sense in a lot of cases to provide residential-type accommodation if we can.

Mrs NAPIER - But that one is based on a normal medical school, isn't it - transient stuff?

Mr ALEXANDER - The money that has recently been spent on that nursing home has been spent by the university. The nurses home is sort of being reinvented by the rural medical students, who would see that as a use. We know nurses often don't like living too close to a hospital. In Rosebery, for instance, where the nurses home is adjacent to the

hospital, there was a proposal from the mine to move the nurses hostel so they could redefine their entrance. That was supported by the staff because if you live next to the hospital you have no private life. People will expect that they can knock on the nurses door and all those sorts of things. So in the short term it will continue as a nurses home.

Mrs NAPIER - Are we likely to end up with another Burnie derelict hospital? Have you a time frame on it?

Mr ALEXANDER - No, we're not. The sale and the subsequent business of the Burnie hospital was not a Health department issue. We are not enabled to dispose of property. The actual disposal process goes across to the Treasurer and Department of Economic Development and we have some limited say in that. We have been very careful in that. We currently have a process with the Launceston General Hospital where we have requested specifically to be involved because we feel we have a stronger knowledge of the structural and practical applications and certainly we have learned lessons from those sorts of processes.

CHAIR - Thank you very much for coming back. We do appreciate that.

THE WITNESSES WITHDREW.