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PARLIAMENT OF TASMANIA

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PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS

# West Coast District Hospital Development

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*Presented to His Excellency the Governor pursuant to the provisions of the  
Public Works Committee Act 1914.*

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MEMBERS OF THE COMMITTEE

LEGISLATIVE COUNCIL

Mr *Harriss* (Chairman)  
Mr *Hall*

HOUSE OF ASSEMBLY

Mr *Best*  
Mrs *Napier*  
Mr *Sturges*

By Authority: Government Printer, Tasmania

## INTRODUCTION

To His Excellency the Honourable William John Ellis Cox A.C., Governor in and over the State of Tasmania and its Dependencies in the Commonwealth of Australia.

## MAY IT PLEASE YOUR EXCELLENCY

The Committee has investigated the following proposal: -

### West Coast District Hospital Development

and now has the honour to present the Report to Your Excellency in accordance with the *Public Works Committee Act 1914*.

## BACKGROUND

### The Existing Facility

First constructed in 1939-40, the West Coast District Hospital consists of a two-storey masonry building connected to nurses' accommodation that was added in 1966. The hospital has undergone a number of engineering upgrades, principally in the 1980's. The Lyell Wing was added in 1995. The main building complex remains largely unaltered since its original construction.

The hospital is built into the hillside and the site falls steeply towards the town. Generally the buildings are arranged along the contours, with a public car park and helipad at the rear of the buildings. Vehicles and pedestrians use the access way without any separation.

The site is developed with road works and car-parking for visitors, staff and servicing. The location of the vehicle access to the site and of the public car park is poor. Pedestrian access is via a steep hillside from the town, and is extremely difficult for disabled, frail or aged persons.

The buildings are constructed of reinforced concrete floor slabs and columns, with block work external and internal in-fill walls. The roofing consists of galvanised steel decking over a timber framed structure spanning between the walls and columns.

The "Hospital" building contains a single lift to serve the two floor levels together with one internal and one external stairway. Neither of the buildings is adequately thermally insulated and the external windows and doors are single glazed.

The current buildings are inflexible and not easily adapted to changes required by the functions that they now contain.

Generally the services have exceeded their economic life by some margin, but are in a reasonable condition. The services do not meet current standards. The particular areas that are deficient are lighting, cooling/heating, ventilation, communication and emergency lighting.

Because of the solid construction, the installation of new services and changes in ward sizes, particularly the addition of en-suites, would require major work.

The condition of the structure although safe and in reasonable condition is at the end of its economic life. The roof and associated plumbing has also reached the end of its economic life and is likely to require major maintenance or complete replacement. In relation to internal finishes and fittings, the building requires a complete refurbishment of internal surfaces, i.e. painting, floor finishes, curtains and blinds.

#### Current Services

Currently the services provided at the West Coast District Hospital include:

- Acute services (10 beds)
  - Outpatients and minor trauma emergency
  - 24 hour on-call emergency care
- Residential Aged Care (16 beds incorporating high care and low care)
- Community nursing and home care
- Ambulance Services
- Tele-health

Visiting service providers to site:-

- Pathology
- Radiology
- Physiotherapy
- Occupational Therapy
- Palliative Care
- Diabetes Services
- Continence
- Podiatry
- Staff/student accommodation

Other visiting service providers to Queenstown include:-

- Domestic Violence Crisis Centre
- Child & Adolescent Mental Health
- Women's Health Service
- Disability Services
- Child & Family Services
- Oral Health Service
- Cancer Council
- Breast Screen Tas
- Youth Justice
- CASA – Centre Against Sexual Assault
- Alcohol & Drug Service
- Psychiatrist (MSOAP)

The West Coast District Hospital is also a University Department of Rural Health Teaching Site (student accommodation currently utilises former nursing home on hospital campus).

Historically the WCDH had 23 acute inpatient beds. With these bed numbers actual bed occupancy was only 23%. During the Clinical Services Review it was determined that a more appropriate bed stock was 10. Based on the 10 beds capacity for the financial year to 30 June 04 occupancy was 54.7%, a low rate of occupancy in comparison to other district hospital facilities. This confirms that 10 beds are more than adequate to meet the needs of the West Coast community.

### COMMUNITY PARTICIPATION

The Healthy Horizons Framework endorses the establishment of community partnerships to enable local communities to determine an appropriate mix of services based on identified needs, local priorities and appropriate service models.

There is a high level of expressed interest from the West Coast community regarding the implementation of this project because of the significant benefits to the town both in the short term construction period, and the ongoing activity and health benefits generated through the delivery of a health facility with a wide range of services. It is fair to say also that many are concerned that there will be a reduction in services, at least compared to those that have been available in the past.

There has been widespread interest from the community concerning the proposed new West Coast District Hospital facility. Some public meetings highlighting aspects of the development have been held, site plans posted in selected sites around the West coast, but it is unfortunate that the final site plans were not displayed around the West Coast, before the Committee met.

With approval of the project it is anticipated that the design process will involve further community consultation through the project working group.

### DESIGN REVIEW AND CONSULTATION

A community consultation program did not appear to have ensured that the local community fully understood the scope of the project with some members of the community arguing to the Committee that they did not have adequate opportunity for input into the decision making.

The consultants and project committee have met on a number of occasions with key stakeholders and the various users.

The feed back from this was mainly positive and assisted in ensuring that the facilities as planned were meeting the specific needs of this rural community.

The Project Steering Committee facilitated design review meetings at both Queenstown and Burnie using Value Management Principals to rigorously test the proposal.

Participants tested for adequacy in planning, design and budget and maximising value by improving the relationship between various services and related functions.

Recommendations were made regarding priorities and areas where cost saving changes could be made without adversely affecting the outcome, services required or functionality.

The meetings confirmed that the design with minor amendments meets community and service delivery requirements.

## DESIGN RESPONSE

The proposed facility will provide an opportunity to make a valuable contribution to the health and community services and spirit of the community.

The new facility must consolidate and enhance the existing services. It is important that all of the services provided on site be accessible and linked. This will enable better site security and enable the facility to be run more efficiently. It is also important that the new facility is attractive to potential service providers.

The new facility has been designed to maximise the sunlight penetration into each ward and residents' rooms enhancing the environment and quality of accommodation for the patients, residents and their visitors. The building has been designed to allow all of the patient areas to have direct access to sunlight during the day. Views from these rooms are either into courtyards, distant mountain or street views. The rear of the building accommodates all of the services that are required of a modern facility. These are areas that do not require views or sun but require close proximity to the wards.

Another feature of the design is the discrete separation of the day facilities from the wards. These facilities such as dental, child health, physiotherapy etc. require separation but are also required to be in close proximity to the staff areas and services that are shared.

The facility has areas that have been designed as service zones that can be isolated or shutdown if the need arises. The ability to be able to isolate these areas when they are not required or in use will give substantial savings in running costs and long term maintenance.

After hours access and security is also an important consideration for the community. The meeting room, doctor surgeries and the public toilets have all been located with this in mind.

The need for long term flexibility of the spaces has also been considered and this will be achieved by rationalising the structure to enable easy future modification. The services are also easily accessible directly above corridors and underneath floors.

## Construction

The new facility will be constructed using a combination of precast concrete panels, steel framed construction, lightweight cladding, and traditional brick veneer

construction. The materials have been selected to reflect the traditional building materials currently found within the district, and to minimise long term maintenance costs.

Internal walls will be plasterboard with metal stud framing and insulation to ensure compliance with the required acoustic ratings.

Waiting areas will have suitably different materials to subtly define these within the corridors.

The roof is a traditional skillion roof using roofing trusses and colour bond custom orb roof sheeting. All trusses will span between external walls, eliminating load bearing internal walls.

All materials have been selected to minimise the long-term life cycle costings associated with the facility.

#### Fire Detection and Protection Services

- New addressable Fire Indicator Panel
- Smoke/thermal detectors to all areas
- Fire panel interfaced to paging units will indicate which area has an activated detector.
- Manual call points to AS1670.1 to all areas
- Emergency warning and intercommunication system (EWIS) to all areas
- No sprinkler system to be installed

#### Nurse Call Services

New nurse call system throughout the ground floor of the new building and consulting, treatment, physio, x-ray, dental and pathology collection within the existing building.

- Computer for monitoring/logging and display at Nurse Call station

#### Bedrooms

- 2 ensuite call/cancel points (waterproof) – 1 ceiling mounted
- Ensuite emergency call/cancel point
- Bed pendant type call point and cancel point on wall (2 additional sockets for radio pendant or out-of-bed monitor)
- Bedroom emergency call/cancel point
- Corridor indicators to be installed

#### Dementia Wing Requirements

- Security/wandering patient monitoring – Motion detectors
- Out of bed monitoring – Mattress sensors

#### Servicing of Living Areas

- Call/cancel points for living areas, toilets, etc, including emergency call.
- Radio call points from bracelets optional.

## Security Services

- Reed switches to be fitted on all external doors including bedroom sliding doors
- Separate zoning with motion detectors on lower ground floor and the existing building
- External doors monitored for opening by nurse call with programmable monitoring periods
- Provide security camera on main entrance, ambulance bay, day centre entrance, courtyard entry between the two buildings, consulting rooms waiting area and deliveries areas with switcher and hard disk recording in main nurses station

## Paging System Services

- Alpha-numeric hand held paging units to allow display of all nurse call functions and text
- Two interface units at each nurse call station to allow typed messages to be broadcast
- Paging units zoned for multiple groups or individual calls and shift changes
- Number of paging receivers to be nominated (see DECT as well)

## Telephone Services

- New infrastructure cable (100 pair) from street
- Phone services to be provided by Tasinet. No PABX system to be provided
- Outlet for public telephone where required

## Mobile Telephone Services

- DECT local mobile telephone system to allow staff inter-communication, fully integrated with Tasinet
- Combined paging and DECT/telephone function.
- No power failure phone required if DECT system installed
- Number of handsets to be nominated
- From front entry, intercom to call DECT handset, automatic release of doors remotely from DECT handset

## Data/Telephone Services

- Telephone outlet wired to each bedroom – Category 5E
- TV outlet wired off central antenna system to each bedroom, living rooms, reception, etc.
- Telehealth outlets to be provided in treatment room, day centre and accident & emergency (A&E) room and ground floor staff room
- 3 of Cat 5E data links to all offices etc back to central communications rack

## Power Supply Infrastructure

- Metering on 2 tariffs - Hot water tariff 43 and general tariff 22
- No check metering
- New main switchboard and consumer mains
- New distribution boards and submains
- Body Protected Areas to all patient areas including bedrooms and associated ensuites, A&E room, treatment rooms, physio, x-ray, dental and pathology collection
- Emergency power supply to be provided by diesel generator serving 1/3 lighting in corridors
- Single lights in acute bedrooms, nurses stations, consulting and treatment rooms, morgue, kitchen and access toilets
- Full lighting in A&E room
- Power to nurse call, DECT, medical gases and LPG gases systems
- Single GPO in acute bedrooms, nurses station and kitchen
- 5 double GPO's in A&E room

## Mechanical Services

- General laundry exhaust and fluing for dryer with tempered make-up air system
- Cool room and freezer room for kitchen.
- Kitchen exhaust hood for cooking area/dishwasher plus tempered make-up air including supply to office
- Refrigeration system for morgue
- General exhaust systems in each ensuite (individually controlled by motion detector in conjunction with light) and pan rooms, assisted bath, bath, staff WC's, access WC's, cleaner's closet and store, dirty linen, sterile clean, staff change room, photocopier workroom, tea making and dental procedure
- Tempered fresh air system to main nurses station and associated office
- Air conditioning to be provided only to dental treatment rooms, accident and emergency kitchen and aged care living and dining areas
- LPG reticulation to kitchen hot plates and laundry dryer (equipment must be provided with flame failure)
- Reticulated medical oxygen and air system including central supply, control equipment and wall outlets to AS2896-1991 to all acute bed areas and A&E.
- All other areas to be naturally ventilated by external openings or borrowing from adjoining spaces

## Heating and Air Conditioning to Aged Care

Ensuites	Tastic type ceiling heater with timer to activate.
Bedrooms	Ceiling mounted radiant heater (CMRH) with thermostat control.
Offices/Meeting Rooms	CMRH with thermostat/time clock control.
Corridors	CMRH with thermostat/time clock control.



No Heating	Pan Room, Stores, Toilets, Kitchen, Laundry.
Staff Room, Reception, Nurse Stations, A&E, Treatment, Consulting, Physiotherapy, gym, and X-ray.	CMRH with thermostat/time clock control.
Assisted Bath & Bath	Background floor heating plus Tastic

### Cooling

- Air Conditioning to specified areas
- To be achieved by use of portable fans and natural ventilation
- Ceiling sweep fans in laundry

### Lighting

- Generally fluorescent with low loss ballast and polylux tubes
- Low voltage downlights in ensuites over mirrors
- Low voltage dimmable downlights over bed locations or alternatively wall mounted above the bed fluorescent luminaries incorporating reading lamp and ambient light. Two way switched from door and adjacent bed
- Main light in ensuites controlled by motion detector with fans
- Surface mounted fluorescent lights to be used in patient rooms
- Surface mounted fluorescent lights in Store/Linen rooms
- Recessed fluorescent downlights in corridors – switched 1/3, 2/3. and in functional wings
- Recessed fluorescent lights with prismatic diffuser in meeting rooms, offices and Nurse Station
- Tubular fluorescent lamps with colour rendering  $Ra \geq 90$  in consulting and treatment rooms
- Ceiling mounted overhead medical examination light in A&E room.
- Mobile/portable medical examination light in treatment room
- Surface mounted fluorescents in roof space
- Security lighting to building exterior and to staff parking areas – motion detector controlled in places
- Amenity lighting in courtyards for possible after-hours use

### Accessories

- Large pattern switches used except in ensuites and staff only areas
- Bell for kitchen deliveries
- Neon indicator for lights for storeroom etc

## PROJECT BUDGET

The approved funding for the redevelopment is \$6,600,000. The cost of the redevelopment is currently:

Construction costs	\$5,500,000
Site Works	\$300,000
Total Construction	\$5,800,000

Design & Construction Contingency	\$160,000
Professional Fees	\$400,000
Art in Public Building	\$40,000
Current Costs	<u>\$6,400,000</u>

Other items to be accounted for within the project budget

Equipment	\$150,000
Post Occupancy Contingency	\$30,000
Other fees and approvals	\$20,000
Total	<u>\$200,000</u>

Project Total	<u>\$6,600,000</u>
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## EVIDENCE

The Committee commenced its inquiry on Monday, 29 November last with an inspection of the site of the proposed works. The Committee then proceeded to the existing West Coast Hospital whereupon the following witnesses appeared, made the Statutory Declaration and were examined by the Committee in public:-

- Philip Morris, State Manager, Aged Rural and Community Health, Department of Health and Human Services
- Scott Curran, Project Architect, Artas Architects and Planners
- Karen Schnitzerling, Manager, Director of Nursing HealthWest
- Peter Alexander, Manager Facilities Management Branch, Department of Health and Human Services.
- Bill Cochrane, Senior Project Manager Capital Works, Department of Health and Human Services
- Peter Schulze
- Darryl Gerrity, Mayor, West Coast Council
- Ray Shea

## Overview

Mr Morris gave the following overview of the project:-

*... We are seeking approval for the redevelopment of the West Coast District Hospital as in integrated in-patient, aged-care and community health centre, providing a broad range of services to the West Coast municipality.*

As you have seen, the new development is to be located on a new site. In this new facility we will provide a wide range of services - which I will outline in a moment - including in-patient residential aged care, community health, GP and allied health services. We believe that this new development will fulfil a growing need to provide an all-encompassing service that meets the needs of people in rural and remote areas based on the west coast and specifically in and around Queenstown, with more serious treatment referred on to the major centres, such as the North West Regional Hospital, as occurs now.

... Our intention is to develop an integrated, one-stop, health service site in which everything is on the one site. We want this whole building, as well as the services that are in it, to meet contemporary health care standards.

This development is not associated with a cutback in existing service. Rather, it has included every service on the one site, as well as improving patient and client amenity. We think the development of a new hospital will also enhance our ability to attract staff by provision of a higher quality environment. In the Aged, Rural and Community Health program across Tasmania, we do in some areas have challenges in recruiting nursing, medical and allied health staff. One of the things that may make it easier, or at least not go against us, is the ability to provide a high quality built environment where everything is colocated and there is good coordination amongst the services and staff.

The list of services that we hope to be providing from this site is, we believe, quite extensive. It includes 10-inpatient beds; medical and nursing outpatient; 24-hour, on-call emergency care; general medical in-patient care; post-operative and post-natal in-patient care; rehab inpatient care; palliative inpatient care; maintaining the residential aged care; community nursing and home care; ambulance services, tele-health and visiting services. I have enclosed a list in our written submission. So in terms of our project objectives, we want to build a new hospital that will improve patient comfort and amenity, that will match services to community need, that will facilitate community access and use, that will be flexible to meet current and future community needs, and also be functional and easily maintained.

It is also imperative for us that we meet the building codes, the aged care accreditation, as well as contemporary healthcare standards. We talked about the provision of ensuite facilities, for example. That is an example of how the standard has lifted in terms of people's expectations. In the case of aged care it is one of the things that will enhance our ability to meet ongoing accreditation and to secure funding from the Australian Government. We think that by putting all the services on the one site we will achieve a lot of advantages, in that services will be better integrated and coordinated. We all know that those are issues in the contemporary healthcare system. We think if we have a really well-functioning, high-quality environment with a lot of services, then we will be able to attract additional services, because we will have a high-quality

*environment, both in the building as well as in the staff relationships, to attract new people.*

*We also see ourselves as providing a centrally located hub for community activity. One of the things with this building is that there is not really an ideal meeting space - we are in it - and we would like to have more capacity in the new facility to have community use of our services.*

## **Design Concept**

Mr Curran gave a detailed submission in relation to the design concept:-

*Some of the site constraints that we needed to have a look at have been service access and delivery into the building, the provision for disabled access and the ability to service the hospital and to enable people to move around in order to do the day-to-day functions that are associated with a normal hospital.*

*As we mentioned before, the existing Gaiety Hall is not listed as heritage building at the moment. We believe that the heritage listing is imminent. A lot of people I know have had a look at the building and said it should be pulled down. The advice that we have had from our heritage architect, Lisa Nelson, is that even though the building is not in great condition, it has a number of redeeming historical features. Some of those are that it was a place of gathering for people who worked in Queenstown, where they socially interacted and mixed. Also, it was an example of the Mount Lyell Mining Company and their effort to provide facilities for their workers, and that shouldn't be underestimated. It is also considered to be significant because of the form of construction that it actually has. The rammed concrete formwork walls are quite unusual and relevant to Queenstown, and as such are fairly local to this area and should be preserved. With that in mind, we set about having a look at the building and the constraints that we had. There are a number of allied facilities that need to be located associated with the hospital which we felt would be best served into this hall. Given that we had a roof and we had walls, we felt that the best way to utilise this would be to put in the areas that had smaller rooms and didn't require views or sunlight.*

*The trees that are located in the area have been mentioned as being of significance as well. I've done quite a lot of research into that. As I mentioned before, there are a number of stories about these trees, that they were possibly planted to commemorate World War I. There's another story that they were planted by two school children when they moved to the school site. The best information that we have at the moment is based on some information that we received from the Tasmanian war memorial database, which is compiled by Mr Fred Thornett and which includes avenues of honour, and it does not include any reference to these trees. Mr Thornett was contacted and he said he visited the Queenstown site and recorded the names on the honour board, and*

suggested that he would include a reference to these trees if indeed they'd been planted as an avenue of honour.

If these trees had been planted as a war memorial they would have had a considerable historic, cultural and social significance, therefore reference was made as part of these investigations to the President of the Tasmanian Returned Serviceman's League. His advice was that, given that there were no plaques and no other evidence to suggest that the trees were planted to honour fallen servicemen, the acceptable solution would be to plant a new avenue of honour. We have indeed taken that tack, and we are proposing to plant a memorial walk that will be between the two buildings.

In trying to preserve the historic integrity of this building, what we have also set about doing is to set this building back some eight metres so that it respects this building. We have also had a look at how we could best not mimic this building or copy this building, but to honour this building and also the parts of it that have become important. You will see later on when we move to the elevation just exactly the elevational treatment that we've taken. So you've got the Gaiety Hall, the proposed new hospital, and the service area that runs down Little Orr Street. We're proposing that Little Orr Street becomes a one-way street. We've got the maintenance shed, parking for the spare ambulance and on-site car parking. The advantage of this on-site car parking is that it gives us direct access into this part of the building, and by lowering this section of the building it gives us direct access from the footpath.

We're proposing that there will be gates at either end of this memorial walk so that at night, when this section of the hospital is not operational, it can be closed up and it can be secured to prevent vandalism and people just walking through the hospital late at night. We're also proposing to put a boom gate across this area so that the ambulance can access this area after hours, but also to stop people from speeding and taking a short cut down Little Orr Street.

With Gaiety Hall, we propose to reinstate the façade as it was before, which includes two new windows and new doors. An existing door would be used for the GPs to access this area. We imagine that this would be able to be used when the rest of this hospital is closed down to give some flexibility for the GPs. So we've got two GP consulting rooms. Each of those consulting rooms has a treatment room which is linked back through the corridor. We have toilets and a baby change area. The GP reception area and GP waiting area is actually a self-contained area within this allied health portion. This is the link with the ground floor of the hospital. As patients arrive they will park their car in this area or on Orr Street. They will access up the memorial walk. Both of these doors are fully automatic sliding doors that will open upon approaching, so the patients and visitors can enter through that area. It is basically flat through this area, linking the level with the footpath with Little Orr Street. We propose to put our disabled car parking so that there is direct and easy access into this memorial walk.

There are a number of areas that we have set up as being flexible spaces so that a number of different service providers are able to use those. If, for example, podiatry were to come they could use one of those; speech pathology could use one of those areas. They basically provide some flexibility through this area to cater for different service providers and their different requirements over a different period of time. One of those consulting rooms that we have is one of those flexible consulting rooms. We have a physiotherapy area with a gymnasium and a small office. There is pathology collection, a toilet; x-ray, dental with two surgeries and a reception area, and child health. Each of these areas will be provided with a number of toilets, disabled access toilets, mothers rooms and associated services to enable patients, visitors and staff easy access to those facilities.

This then becomes the ground floor proper, if you like, of the hospital or the lower ground floor. On arriving at the entry area, you would proceed to the reception and then be either directed over towards the allied health or over towards this lift which would take you up onto the next level. We have a number of nursing staff offices through this area here, and associated file and storage areas and photocopy rooms. This room that we have up here, the day centre, is essentially the meeting room associated with the hospital. What we have done is positioned that at the front of this area off Orr Street. We have created a recess back from this area as an area where people can collect and meet and sit, a bit like a small town square, if you like, or small town collection point. This is where meetings such as this, or information evenings, medical seminars, all of those sorts of things would occur in this area.

Back through to the back-of-house services, which is the kitchen and staff and laundry, all of the deliveries would come down Little Orr Street. All the items would be dropped off. The dry store, cool store and freezer are all located close to where the truck would be emptied. There is under-cover access so the trucks can actually back into this area and people can unload goods and provisions without getting wet. That food will then come into the kitchen, be prepared in the kitchen and taken upstairs through the back section of this two-way lift up to the next floor.

The staff dining area has direct access to the kitchen and there is also a small outside eating area off this memorial walk. The laundry for the aged care component is where all the laundry for the residents at the aged care actually have their laundry done. The laundry that is collected for the hospital is actually done off site, so that is collected and put into a car and then taken elsewhere to be laundered.

An important consideration that we have in this hospital at the moment is that staff need to go outside at night to be able to access the morgue. It is visible from the Lyell Wing as well, so what we tried to do with the morgue is to make it very discreet, to have easy access for the staff if they need to use it and also to

keep it very discreet from the public areas. There is a small sitting room that is associated with the morgue, so friends and relatives are able to discreetly come back into this area and sit and be with the body for as long as they want to.

Other associated services like community store are also based in this area to give direct access through to the rest of the hospital.

On the first floor, when you arrive by lift there is a nurses station directly in front of you. You will be guided either into aged care or down into the hospital into the acute area. When we looked at designing the building there were a couple of things we tried to achieve with the rooms as we have been setting them up. One is that we wanted to have external space for all the rooms, so that it did not matter where in the hospital you were, you still had access to sunlight and also to fresh air. So what we have done is provide a series of balconies or courtyards through the facility to enable patients to pull their sliding glass door back to access those areas. We have designed the rooms to orientate them so that each of the patients receives sunlight for a fairly substantial part of the day, whether it be early in the morning, midday or later on in the afternoon.

Each of our bedrooms has been designed with care and attention to enable our patients to move around; for the beds to be moved in and around; and for wheelchairs, walking frames and lifting gear to also be easily accessed into the rooms. One of the big issues that we have with the hospital currently is that you cannot get a bed straight out of a ward without doing about five or six different shuffles to get it backwards and forward and out. That is one of the restrictions that we have with this hospital at the moment: because of the load-bearing walls, it is really difficult to demolish the walls and rebuild them to widen them about 500 millimetres. All the corridors we have through this area are 2.5 metres, which will enable easy access for these beds, if they are required, to come out into the corridor and be moved around.

A door accesses into aged care and we have a number of other doors that contain aged care within this area. At the moment we are still working through the issues of which door should be locked and which door should be open. As you can see, these rooms are orientated to get sun; there are balconies so each of the bedrooms has access onto them. Each of the balconies has a clear-glass balustrading through it and the balustrading will be at 1 050 above the finished level of the balcony.

Associated with the aged care, we have an assisted bath. There is a emergency escape stair. The dotted lines on the plan are fire compartments that we need to set up to meet the Building Code of Australia. They will be fire walls and they will also be smoke walls. In some cases they will be a double wall so that we do not need to penetrate that wall and compromise our fire or smoke walls. All windows associated with these wards are double-glazed so that we can retain heat and so that we can also omit noise from the street. Some bedrooms look back into the courtyard spaces. They will receive morning sun and also have

direct access out into the courtyards, which we see as being spaces where you can have relaxation but also privacy.

One of the other major considerations that we have here is the rain and mould. We will not be putting any pavers into the job. What we are looking at doing is having all-concrete finishes with a sprayed-on finish that enables it to be easily cleaned so that moss and mildew does not build up and form a slippery surface. Another important consideration has been how we lay the roof out. Originally we had a series of gables that went over the top of the roof. After discussions with the maintenance people here it was determined that we should not have any gables with box gutters because of the instances where hail has fallen, it has not melted and as a result has blocked up box gutters and caused those to overflow. As a result of that we went back and redesigned all of the roof. We have a series of skillion roofs now so that we do not have that problem of hail, or indeed snow, into any of these box gutters.

Going through the aged care a little bit further, there is an area for sitting in the dining room. The sun is really good down through this portion of the building. It is quite a pleasant outlook into this area here, and gives the patients an opportunity to see who is coming and going into the hospital up and down this memorial walk. This is larger than the area that they currently have at the moment. What we are examining at the moment is the layout of those spaces and how those people will sit in those rooms, and how they will actually use those rooms. We have a bifold door that folds back to enable this to become quite a large room if that is the need. It is all about trying to create flexibility of space through those areas.

With the construction techniques that we are using on the building, we are looking to maintain as much flexibility as we possibly can. We will have a series of non-load-bearing walls so that in future if any of these areas need to be reconfigured, for whatever reason, if they need to become two-bed wards or three-bed wards, or indeed if they need to be altered for anything else, then the flexibility is also there for us. This section of the slab will be sitting on the ground, but as we leave that section the slab will become suspended and that will also enable us to have flexibility with future things like plumbing installations and water, which is also another major restriction that we have in this hospital here at the moment.

We have a quiet sitting area as well with aged care. One of the things required was the need for a separate space for patients if they needed to retreat to other than their room, or indeed if they needed to have somewhere quiet where visitors could come and talk to them then they could retreat back into this area here. Once again it is a nice sunny spot with the sun moving around the building and views into this courtyard space. We have also tried to get as much glass and light into these corridors as we possibly can, so that even in the middle of winter these spaces are still quite light and bright and cheerful.



There is an outside area that at the moment is a staff balcony. The area dotted has been identified as future expansion. We have also highlighted this purple area, which we see as potential for future expansion if the need for that ever arises. We have another emergency escape stair which goes straight out onto the street. All of the other services - clean linen, dirty linen, pan rooms, sterile rooms, sterile store, drug room - associated with running a hospital are back down through this area. We have some pan rooms and some cleaning stores that are distributed through the rest of the hospital, but the majority of those backroom areas or work areas we located back in towards the back section of the hospital away from these patient areas.

In the acute bed area, these are double-bed wards with a shared ensuite, once again with the ability to go out onto the balconies. There is a nurses station; offices; storerooms; pan rooms; a secondary bath; staff room; staff facilities; ambulance bay with direct access into A&E, and a treatment area; a consulting room, once again to aid with flexibility; storage for equipment such as humidicribs and other things associated with the A&E area; disabled access toilet; and a small waiting area. We have also designed these rooms very much for flexibility, to give an opportunity for them to be used differently in the case of a patient who is dying. There is a flexibility in these rooms that would enable a family member to stay. If a baby is born, it gives the opportunity for the mother to stay here and to have a larger room to keep the baby in the room with her, and for bathing and teaching of feeding and all the things associated with that.

With the Gaiety Theatre, as you can see, the state of the windows as they were before. The doors have been reinstated and the facade is going to be cleaned and tidied up. The roof was replaced some years ago. There is an existing bow in this roof at the moment and that was replaced and repaired leaving the bow and we intend to do that. Concrete was mentioned before in the Gaiety Theatre and we have had some experience with this type of concrete work before. There is a building, not identical to this, at Inveresk in Launceston, which had a similar construction. It was not identical composite-base concrete, but a similar construction where reinforcing - railway tracks, basically - was exposed outside. Large cracks had appeared on the side of the building; they were tooled out and formwork was stripped back and repaired. The building was patched and a Sikaflex system was used. We are two years into that building and that has been a very successful repair job. We have had the Sikaflex man come to have a look at this and he has given his opinion that we can repair the concrete work on this building in a similar manner to the work that was done on the stone building at Inveresk.

There is a memorial walk with trees. We have not decided on the trees that are to be planted there yet. We will undertake some further consultation before it is decided what they should be or who indeed should be commemorated. There is a gathering space at the front of the day centre.

With the construction of the building, we are attempting to give us as great an opportunity as we can to complete the building on time. That will involve us using a series of pre-cast concrete panels to enable us to get the first floor poured. Once the first floor slab is poured, a series of steel columns that will go up and we will have a structural steel grid with timber trusses. The roof is the first thing we will be attempting to build, so that we can finish the inside of the building while we have the roof on. So with things like rain delays or lots of rain, in theory what we can do is proceed to build the building underneath that roof. We have picked up materials that are in Queenstown at the moment; red brick, rendered finishes and also corrugated iron. They are the three building materials we will be using.

When we were looking at how we should design this building, it was thought that the best way to pay proper respect to this building was not to mimic it with a gable, even though we did initially think that that was going to be the best way to go. It turned out that, because of other underlying factors such as hail, it was relevant for us to look at another building form. We had a closer look at it and inspected the buildings that are further down Orr Street. If you have a look at those buildings you will see a number of verandahs with single posts that support those in a shop-front situation. It was felt that that was a much more appropriate form to carry out through to Orr Street until we reached the corner. So just to recap, a series of precast panels will go in; they will be then clad in brick and the cladding in other areas will be corrugated iron.

We are looking to put in a light coloured roof to minimise the heat gain. Balconies are set back and you can see the glazed balustrading and the glass sliding doors that are double-glazed for each of those walls. We put a series of steps into the roof to break up that long elevation. We provided a series of setbacks through the verandahs and also through the toilets. We are projecting some roofs out to be sympathetic with the projections on the roof awnings that go through down in the bottom of Orr Street just around through the corner.

We have a large, glazed roof line over the top of the entry area. Little Orr Street is where you will drive down to access accident and emergency.

We have put in high-level windows to let light back into the corridor. These windows through here will have white film on them so that it lets light into that corridor but people cannot see the action or the activity from the ambulance.

The staff room is where the staff will take their meal breaks. The four windows that we have going down through here are all the service rooms - the sterile store, clean linen, dirty linen and all those other rooms are there.

In the service bay we are proposing a new generator that will provide emergency power for the hospital in the event of power failure. That new generator will go back in this area underneath this building. There is a series of louvered panels to allow ventilation into that. Our medical air and our oxygen

will also be in this area here and also the services associated with the cool rooms.

A window we have at the end of the corridor allows light and distant views as you are walking along the corridors. The roof that I was talking about earlier goes over this area to allow trucks to move in and out of this zone. We have gone back to a timber structure with a gable to be sympathetic and we thought that that was appropriate. There are a number of glazed sections on the roof as it moves down both ends, so essentially as you get onto that memorial walk it provides protection and cover for you entering into the hospital.

With the front of the building, we're trying to create a community gathering space so that before you come into this day centre, weather permitting, it gives you a spot where you can gather. This is very much about activity through this area as well; we're getting a spot where the community can actually gather so that if you come in here and run into somebody you wanted to speak to, it will give you the opportunity to sit somewhere and talk to those people. It's very much about the people who live in the hospital, the sick people who are visiting the hospital, and visitors as well, so that everybody gets an equal opportunity.

With the balcony for the aged care component, we've projected this balcony out a little bit further to create this shop front appearance so that there is protection for people who do need to get out of the rain in this area. As it steps back up Orr Street, you can see the stepped effect we've got with the roof running back up through there.

With the view that we've got from Orr Street back down towards the hall, you can see the gathering points and the trees. The materials will be brick, render and corrugated iron.

There is a space that we would reserve for night shift staff so that they've got easy access in and out of the building. You can see the building is set back quite a long way off Little Orr. The glazed areas that we propose to use on the walkway will maintain a nice light area, covered so that if it is raining there is an amount of protection. Gables and actually two small box gutters in this area enable us to narrow the roof down to a very low point to enable us to joint the two buildings together.

With the view approaching this new entry area, the memorial trees will be on either side, with a grassed area, concrete paving with a spray pattern finish, and automatic opening doors. This is all timber framing through this area to pay some sympathy to the hall that is next door. You will be able to look right through this whole area.

Mr Cochrane added:-

*I would just like to reinforce what Scott said with some of the services, in addition to the layout and some of the other features in the building. We are also having reticulated medical oxygen and medical air to all the bedrooms and Accident and Emergency. The design of the Accident and Emergency links to the treatment room and enables that space to be opened up, and in the event of a multitrauma accident we have quite a large treatment space where we can look after people. The ambulance area is under cover, so an ambulance can back straight in there and get people out rather quickly. In the event that there was a major disaster locally, the under-cover ambulance area can also become a triage area where you can treat people initially, get them stabilised and then hopefully have them evacuated to a major centre as quickly as possible. So that is some of our thinking about that layout as well.*

### **Accident and emergency capability**

The Committee questioned the witnesses as to what capability the proposed new facility would have in relation to accident and emergency services, particularly in cases of multiple casualties. Ms Schnitzerling responded:-

*... you have disaster plans, though certainly there has not been a disaster plan designed for this new building as yet. You always assess the number of casualties that you have coming in and then decisions are made as to what different areas of the hospital are being used. The A & E area is designed to be very close to the nurses' station, and there are certainly acute care rooms very close by to that, so what you would simply do is take people out of those close rooms and put them in other rooms, or make decisions as to who could go home, and use those rooms. There would be a couple of rooms close by that you would be able to use.*

*... There is actually an emergency disaster plan for the hospital. ... You look at the numbers of people you have in and then you make decisions as to who might be required to be sent home to their family and then you make available space for those people you need to care for on site.*

Later, the Committee questioned the witnesses as to whether it would not be preferable to treat, for example, multiple casualties arising from a mining or bus accident on site rather than evacuating them to other facilities. Ms Schnitzerling responded:-

*To do that you would actually need to keep a range of equipment on site. Keeping a range of equipment is one thing, but equipment always needs checking and maintaining. To do that you need staff with the skills to do that on site, so how are you going to maintain those skills of those staff unless they are doing that type of work. From that quality point of view, it is not a good idea to have equipment on site that staff aren't going to use on a regular basis.*

*... It is the equipment but also the staff and the training that they need to work alongside specialist teams. You couldn't rely on a specialist team to come in*

*and take over because they don't work here all the time. They need to know where stuff is, so you then need staff who have an understanding of what their needs might be. You are just not going to be able to maintain that type of skill level in staff that don't do that sort of work.*

## **Hospital capacity**

The Committee questioned the witnesses as to the capacity of the hospital. Mr Morris responded:-

*In the clinical services review this matter was looked at at some length. That report has been available to the public for some time. It is fairly evident that when the hospital was 23 beds the occupancy was in the low 20 per cents, which meant that most of those beds were not being used. When you compare that number of beds to other areas around the State with a similar population, that is not a surprise. A decision was made more than 12 months ago to reduce the bed capacity here to 10 beds, following the clinical services review. Occupancy for the last financial year has been about 54 per cent. It shows that relatively low occupancy and it shows to us that 10 beds is probably more than adequate.*

The Committee questioned the witnesses as to what percentage of beds would be 'step-down' beds. Ms Schnitzerling responded:-

*It can vary at any point in time. The clients we accept into our acute beds are general medical-type clients, whether they be paediatric, adult or aged-care clients who need medical care. We certainly have post-operative care clients, post-natal care clients, rehabilitation clients and palliative care clients in our acute beds. So the mix at any one point in time is hard to judge. There could be one or two post-operative patients at any one point in time. I think most of our occupancies come from general medical clients.*

*... We have no issues with people coming back to recuperate. We certainly inform all of our ante-natal clients that we are able to manage them post-natally should they choose to come back from Burnie or wherever.*

## **Community needs**

The Committee questioned the witnesses as to how the needs of the community were assessed in determining the concept design. Mr Morris responded:-

*The clinical services review looked at all the services on the west coast, with a particular reference to what was required here at the West Coast District Hospital. We believed that the blend of services, all being together on the one site, is appropriate. I think the level of services - we talked about 10 acute-care beds - is more than adequate. Bringing the GPs into the site is a new approach here but it is done in some other places around the State and we believe it has a lot of merit. In an area like this, GPs and nursing staff, along with the allied health staff, it's important that they work together. I think we have*

endeavoured to provide a lot of consulting room access so that we can maintain the existing visiting services that we have but also have some flexibility to have more come in here. I think the family and child health and dental will have its own area within this building, as I think Scott showed, on the lower ground floor. That's again consistent with what we're trying to do in some other sites, and we believe that associates this area with all the health services on the one spot.

... The clinical services review was an extensive process. Originally it was initiated after the Government announced the decision that they were going to look at development of the West Coast District Hospital. We felt it was important to review the services that would be located here. As we commenced this project, with some outside members of the community and other health service providers on the committee, all those people on the committee said that rather than just looking at Queenstown we ought to be looking at the whole west coast, which we thought was an excellent idea. So it became the west coast community services review, and it endeavoured to look at the needs of the community right across the west coast.

In so doing, we put out a couple of reports and advised the community of the processes that we were going through. That demonstrated, first of all, the sorts of services and approach that we should take here in Queenstown, but also importantly identified how we might make the whole health system across the west coast work better. It was a very complicated system with lots of different providers, so one of the recommendations of that review was that there be a single auspice provider of health services.

Then there was a subsequent investigation of who that provider should be, with attention given to the west coast health and community services as well as the Department of Health and Human Services. The minister finally decided that the department would be that single auspice provider, so on 1 July this year all health services on the west coast have now come under the management of the department. The point of that is that this will also enhance our ability to coordinate across the whole west coast.

To take one little example, an Allied Health worker might have been contracted by one of those other providers, West Coast Health and Community, or Zeehan Medical Union, to visit that town, while the department was using someone else to visit Queenstown. Each was only doing a part-time role, but maybe if we put the resources together we could have generated enough resources for perhaps a full-time or almost a full-time position. That might then give us the capacity to attract someone here on a more ongoing basis. So those are the sorts of efficiencies and advantages that we think will come about through that. So this hospital development forms part of that whole picture, and in its own way here at Queenstown is an effort to coordinate all those things together on one site.

## Contracted services

The Committee questioned the witnesses as to what contracted services would be available in the proposed new facility. Ms Schnitzerling responded:-

*We have a new contract with Northern Imaging that is the same as the previous contract we had which I think went for ten years. There is a level of service that they are obligated under this new contract to supply us, which at the moment is two days a week of X-ray services.*

*... There are further discussions occurring at the moment with Northern Imaging as to what they perceive their needs are for the new facility, because the equipment here is actually fairly old.*

In relation to pathology services Ms Schnitzerling added: \_

*There was a contract signed a while ago with North West Pathology. Their accredited pathology service is in Burnie, and so pathology was collected and taken to their pathology rooms to be tested and reported on. There certainly has been some pathology testing done here, but that is just point-of-care pathology; that is not an accredited pathology test. Those machines that are being used for that are actually old and obsolete and they will not be going to the new hospital. What North West Pathology are looking at is a point-of-care type machine, which is a much smaller machine that probably will conduct a larger range of tests than are able to be offered at the moment.*

The Committee further questioned the witnesses regarding the availability of paediatric, obstetric and physiotherapy services. Ms Schnitzerling responded:-

*I understand that there has certainly been a statewide shortage of specialists. From the re-look at the Mersey situation there has been a review of obstetric services for the north-west and the recommendations in that are certainly for improved specialist services in relation to obstetrics and paediatrics throughout the entire north-west, and visiting services to areas such as Queenstown and Smithton. Hopefully through that review there will be services around the State once again.*

*We are certainly maintaining the equipment that we will need if a birth is imminent. That can potentially happen in the accident and emergency department or we simply can transform one of the acute care rooms. I think the one opposite A and E probably could be fairly easily transformed with the type of bed that one would use for a birth plus the equipment that is required. That is the aim with all of those rooms in acute care, for those rooms to be flexible so that we can shift a bed out if we require a special sort of bed, or take one bed out and put in a sofa bed for a family who is staying with a palliative care client, so the aim is for those rooms to be very flexible.*

*... We actually have a physiotherapy service based from the North West Regional Hospital. We used to have, I think, one physio for two days a week. We now actually have two physios for one day a week. As far as the mines accessing private physio, I am unaware of that. Certainly with our regional health services there is new funding, and we are hoping to have access to it very soon, for other allied health services and there is the potential to top up physio through that for the whole of the west coast.*

In respect to dental services, Mr Curran added:-

*The discussions I have been having with dental are to provide them with a surgery or dental facility the same as the one that we put in the Deloraine Hospital, which is two surgeries and a sterilising area and reception.*

### **Gaiety Theatre**

The Committee questioned the witnesses as to the status of the Gaiety Theatre, specifically as to what additional costs, if any, had been incurred by the decision to retain the building and incorporate it in the design. Mr Curran responded:-

*I think in terms of redevelopment costs, even though we have to spend money to renovate the hall, the cost to actually produce a space within that hall would be markedly cheaper than if we were to build it as a new space. What it has done is impact on the design that we have, and it has forced us to re-look at how we would design that building to enable us to fit it onto the site. I must say that our initial reaction when we saw the site was to get rid of the hall and utilise the whole of the site. When our heritage architect started doing her assessment, it became apparent to us that we would need to keep that building. Even though it wasn't listed at this stage, as we progressed forward it became clear that we should be including that hall as part of our plans, because if we didn't we would become unstuck at the other end because we would be forced to keep it.*

*... Our heritage architect has prepared a report here, which I only received on Friday. There are a number of pages here that talk about maintaining the character and quality of the building, and the significant impact that it has had on the town, not just in the way that the building actually looks, but as a social space and about how people gathered and about how people were entertained. The history of that building over a period of time is significant enough for it to be retained as a building.*

*...Work that we have to do to turn that building into the allied health services building is \$587 149.44*

As to what remediation work needed to be carried out on the theatre building, Mr Curran submitted:-

*There's water damage that needs to be rectified and also I think there are some structural elements that need to be strengthened in there as well. The roof was,*



*I think, replaced in the 1950s when the school took over the hall. The drawings that were done of the roof at that stage showed quite a significant sag in the roof.*

### **Amenity of aged persons beds**

The Committee questioned the witnesses regarding the visual amenity provided by the design, specifically that for aged care clients the outlook will be of the unattractive roof of the adjacent Gaiety Theatre. Mr Curran responded:-

*It is a constraint of the site that we have. When we looked at other alternatives of where to place those aged care beds, it was thought there was a possibility to place them along Little Orr Street, which is back in the area where that service zone is at the moment, with a view back over towards the school. However, given that that side of the building does not get any sun and is a very cold place, when you consider all the constraints that you have on the site it would be better to have sunlight into those rooms. The beds are all orientated against walls, so the views are sideways so that you would be looking along memorial walk. If you rolled straight over in bed and viewed straight out, as we saw on site, you would look straight into the back of that red roof. What we have tried to do is to soften the impact of that building by placing that eight-metre walkway down through the middle and softening that with trees.*

*... they will have an opportunity to see in either direction other than the roof. The roof is directly in front of them, I acknowledge that, and when they look out at their balcony and they look straight ahead they will see the roof, but there is an opportunity for them to view in either direction and also to view down into the memorial walk.*

### **Redevelopment of existing hospital**

The Committee questioned the witnesses as to what consideration was given to redeveloping the existing hospital rather than the proposed works. Mr Cochrane responded:-

*The history of the development I suppose goes back to when the original funding submission was put into Treasury. At that time we went through a project initiation process and our submissions actually listed a series of options. Part of that report was an assessment of this existing facility by a professional consultant and an architect. It was their recommendation, based on the costs at that time, that it would not be cost effective to redo the hospital for the various reasons that were indicated in that report. I don't know whether it actually came up with a specific cost at that time, but all the options were costed and the most cost effective and the optimal way to provide the services was to redo it on a greenfield site.*

*In addition to the cost of redoing the hospital, with what we're planning, these smaller rooms with individual en suites, some of the internal walls are*

structural and where they sit on the slab there are strengthening beams underneath. Those strengthening beams will in every likelihood be in the wrong areas. So it's not just a matter of knocking walls out. If we wanted to build a facility that gives us the same flexibility, it really means in most cases that we would be back to the bare earth. That would include also taking out the current services, because we have old cast iron risers going up the side of the building for plumbing and we have vitreous enamel pipes under the slab. It gets to a point where if you didn't do that you'd be spending money on a building that had some very significant compromises on the longevity of some of the services. We've had two or three professional assessments done and every one has come up with the same conclusion.

One of the major problems with this building - and one of the major strengths, if you like - is that it is very sturdily built. It's a very solid building and if you tried to take out walls or widen doorways or widen passageways, because it's so robust a construction it would become a very difficult process.

### **Evidence of residents**

The Committee received a number of submissions from local residents in relation to the project. Mr Peter Schulze appeared before the Committee and made the following submission:-

*...there has been a lot of public concern about this development. I would like to go through a few points as to why that public concern has developed. ... The first point is that the first announcement proposed a cost that could not possibly provide an adequate facility and I think that was quickly picked up and recognised by the community, so that immediately raised areas of concern in their mind.*

*Secondly, the new building - and that has also been mentioned - has at different times been called both a hospital and health centre. People see health centres as a lesser service, and indeed in some cases they have been and they are. Even in the local council a motion of support was proposed by the local doctor for this new development and the motion called it a 'health centre', so that didn't really help minds to focus on what we were going to get. In fact, there was also concern because that motion that was supported by the West Coast Council, which of course is not the Queenstown Council any more, was not even qualified in terms of saying, 'We support the new development, providing it has the same services as the old one'. Immediately those sorts of things do not help the public perception.*

*The third point is that there has been a downgrading of services here over the years, as I guess is the case in a lot of regional centres with health. In terms of surgery and operating theatres, some of that is often inevitable for reasons explained here today. In other cases we don't see the downgradings as appropriate. There is a continuing suspicion that, if we have a changeover from*

*a hospital from one area to another, in that process we may lose further services and there is a constant consciousness about that...*

*The other area of concern that has been raised in people's minds is that the mining industry has expressed concerns about the level of health services on the west coast. There are some public letters in circulation, that I could perhaps leave with the committee, in terms of the mining industry's concerns.*

*... The other question, Mr Chairman, is about is a new building necessary and I accept that there are features of the current hospital that are not conducive to meeting today's standards in modern health practice, as I said in the submission. The current building has been satisfactory and the community hasn't generally called for anything better. I believe that whether you have a new building or use the old building is just really a matter of economics and cost to a large degree and I don't know what documents are around. I haven't seen any that have been extensively costed to say, 'To redevelop this is going to cost \$10 million; to build a new one is going to be \$7 million'. I think it should be taken a stage further than it has been and from your committee's questions that would seem to be appropriate from your points of view as well.*

*In respect to that, I believe that within the costing of a new one you have to include the costing of the demolition of this one. ... I think the pulling of this down and turning it into parklands should be budgeted into the cost.*

*Maybe the nursing home would have some commercial value because it has been built as accommodation premises, and that may be continued. As far as this building is concerned, I wouldn't see much value in it at all. It could be a burden on the community or other people further down the track, and it shouldn't be.*

*In the submission I made, Mr Chairman, one of my main concerns is the health status of Queenstown people ... there are two issues in regard to this that I would allude to. One is, as you perhaps were concerned about, Mr Chairman, whether the health status of this community is being taken into account in the planning of the new hospital in terms of simply the quantum of support that is needed in these situations with an ageing population. There are still a lot of retired people in Queenstown who may have difficulties.*

*The other area which I have been more specific about is the need for the most sophisticated and advanced technological level of air-conditioning in the new hospital. In fact, the new hospital is in a far worse site than this hospital in terms of wood-smoke pollution ...*

*When I went to get further information on the air-conditioning just this last week, I was advised that the service drawings had not been completed ...*

The Committee questioned Mr Schulze as to what he understood were the concerns of the mining industry in relation to health services on the West Coast. Mr Schulze responded:-

*... there is an indication that they feel with the mining industry here there is always a fear that there will be a major accident and they wonder whether the facilities are good enough to support that ... I think there was a general concern about the health services generally being adequate without even regard to dealing with emergency services.*

*I talked to the department about dealing with emergency services - if, say, there was a sudden emergency with a bus over a bank - and the department gave similar answers to me as they gave your committee which, I felt, were quite reasonable.*

Mr Ray Shea appeared before the Committee and detailed the history of the concept to replace the hospital, which he said was a longstanding proposal, he made the following submission:-

*... I am a long-term resident of Queenstown, and in particular I have been a long-term servant of the Health department. In that sphere I have been a member of the Queenstown Hospital Board, West Coast District Hospital Board, Sick and Accident Fund, and also a member of the North West Regional Hospital Board from 1991 to 1997.*

*I am very concerned with the comments being raised within the community without full consultation. ... there are a lot of people in this town who want to see this hospital proceed and proceed on the site that has been identified and removed from here.*

The Mayor of the West Coast Council, Darryl Gerrity made the following submission:

*Council twice has supported unanimously the relocation of the hospital into a new hospital in the town. We analysed all the information we had at the time and we did a lot of consulting and, as I said, twice we have reiterated our position that we support it. There have also been two public meetings. As you are aware, there has been a lot of information going out. This hospital issue has been around for 15 years or so at least, probably longer according to Ray Shea, who would be more of an authority on it than me. The information has come out all through the community, through two surveys carried out by Di Hollister: health needs assessment programs for the northern part of the west coast and for the southern part of the west coast. The professional officers have also put out a report and supported the hospital.*

*I would like to put on record that council fully supports the relocation and the rebuilding of the new hospital. There will be some issues discussed. Mr Schulze brought up airconditioning, sunlight et cetera. These will go through normal council procedures such as planning, building, plumbing inspectors et cetera*

*and we will ensure that the best possible conditions are available to the residents who use that facility. Rest assured, we will be very diligent in our examination of the planning and building permission when it is sought.*

*There are another couple of small issues I might make the committee aware of. There is a disaster plan for the west coast; it is now being reworked. On the helicopter issue, there was an accident 10 kilometres south of Strahan. A chap injured his ankle and was taken directly to Hobart - not to Strahan or Queenstown but directly to Hobart. Most of these search and rescue helicopters issues now can land anywhere that the pilot deems safe. It can be on the road, on the water or on the recreation grounds. They do not normally bring them here to the west coast, unless it is for necessary patient stability. Everything goes to Hobart, Burnie or Launceston.*

The Committee questioned Mr Gerrity as to the status of the hall. He responded:-

*... It was actually a picture theatre that became a roller rink and a basketball stadium. We all like to preserve our heritage. It would have to go through a community process but my gut reaction is that they would rather see it go for the benefit of the asset that is going to be built there, rather than keep it. Maybe the facade can stay there and the roof flattened. I can't predict what council would say, but I feel they would agree that it is not true heritage. As long as the hospital didn't intrude into the streetscape or demolish the streetscape that was there but in fact complemented it, which they are intending to do, I don't think the building would stand up. However, heritage councils are funny to deal with.*

*... It was listed in the plan; it went through a process. Godden Mackay did the heritage study in Queenstown, and it is listed through that study. I think a case ought to be put up for its removal. I don't know how severely that case would be fought by residents; I don't think it would be fought too much if it's going to bring a benefit. And one of the other issues is that it doesn't stuff up the streetscape, because it is an historic main street, and we want to keep that historic streetscape.*

### **Additional information requested**

Following the initial meeting, the Committee sought the following additional information from the Department of Health and Human Services:-

- Details of air conditioning options for the proposed development to take into account smoke pollution issues.
- Clarification of heritage issues in relation to Gaiety Hall.
- Cost comparison between 'greenfield' development and current proposal.
- Cost of demolition of the existing hospital.

Such information was received and the Committee reconvened on 9 December in Launceston to further consider the project. The following witnesses appeared:-

- Philip Morris, State Manager, Aged Rural and Community Health
- Scott Curran, Project Architect, Artas Architects and Planners
- Peter Alexander, Manager Facilities Management Branch
- Bill Cochrane, Senior Project Manager Capital Works
- Lisa Nelson, Heritage Consultant
- David Orpin, Kingston & Associates, Mechanical Sub Consultants
- Alan Coote, Kingston & Associates, Mechanical Sub Consultants
- Gordon Sutton, Chairman, Health West Action Group

## Woodsmoke pollution

Mr Alexander made the following submission in relation to the concerns raised by residents concerning the issue of wood smoke pollution:-

*... 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.*

*... There is information relating to the health profile of the west coast and there is information relating to the effects of wood smoke. ... 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 added:

*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 Coote added:-

*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 out 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.*

*An 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 Orpin gave further clarification in relation to the issues of air filtration and air temperature:

*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.*

## **Fire safety**

The Committee questioned the witnesses regarding the concerns expressed by some that the location of the aged care facility above plant and gas equipment was a fire risk. Mr Curran responded:

*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 is that we 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.*

Further to that submission, the Committee questioned the witnesses as to the evacuation of clients from the building. The witnesses responded:-

*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.*

## **Gaiety Theatre**

The Committee questioned the witnesses further in relation to the heritage significance of the Gaiety Theatre. Ms Nelson responded:-

*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 Godden 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.*

The Committee questioned Ms Nelson as to what was the likely involvement of the Heritage Council in relation to the theatre and what would be the issues should the West Coast Council delete it from the planning scheme. Ms Nelson responded:-

*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.*

The Committee questioned Ms Nelson as to the feasibility of altering the roof profile. She responded:-

*I think that the roof form, pitch and height is actually integral 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, 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.*

The Committee questioned Ms Nelson as to whether the Council was bound to consult with the Heritage Council, Ms Nelson responded:-

*... 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.*

The Committee enquired as to whether there was any appeal process to decisions of the Heritage Council. Ms Nelson responded:-

*Yes. ... 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'.*

Mr Alexander added:-

*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.*

Ms Nelson added:-

*I have to say that the chances of demolishing 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.*

### **Smoke and updraft issues**

The Committee recalled Mr Curran to address concerns expressed by local residents in relation to smoke protection measures. Mr Curran responded:-

*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.*

*... 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.*

*Where 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.*

Mr Cochrane added:-

*... 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 overridden 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.*

## DOCUMENTS TAKEN INTO EVIDENCE

The following documents were taken into evidence and considered by the Committee:

- Department of Health and Human Services
- Peter Schulze, undated
- Health West Action Group, undated
- Mohammed El-Said, dated November 24, 2004
- Bryan Fisher, dated 24 November 2004
- Maureen MacDonald, dated 24 November 2004
- Ross Hannigan, dated 24<sup>th</sup> November 2004
- Trevor Stebbings, dated 23<sup>rd</sup> November 2004
- William A. Suitor, dated 24.11.04
- Trudi Pricop, dated 23 Nov. 04
- Sandra M. Suitor, dated 23<sup>rd</sup> November 2004
- Zill Gorman, dated 23 Nov. 04
- Claude Williams, dated 24 Nov 04
- Cliff Lovell, dated 24 Nov 04
- Gordon Sutton, dated 24 Nov 04
- Bernie Bradshaw, dated 25<sup>th</sup> November 2004

- Department of Health and Human Services – correspondence dated 7 December 2004 with supporting documents
- Trevor Stringer – submission dated 1 December 2004
- Gordon Sutton – photographs

## CONCLUSION AND RECOMMENDATION

The Committee was satisfied that the need to provide the Queenstown community with a new integrated multi-purpose health facility to provide for current and future needs was clearly established.

The reinforced concrete construction of the existing hospital, much of which is over sixty years old, does not lend itself readily to upgrading, particularly the installation of new services. The buildings are inflexible and not easily adapted to facilitate the delivery of modern health services.

The Committee sees the incorporation of the former Gaiety Theatre as being a regrettable concession to heritage considerations, as the evidence received by the Committee was that there was little local support for its retention. Whilst this building will receive external cosmetic treatment, its retention impacts negatively on the amenity of the new building particularly for aged care residents.

Notwithstanding this unfortunate aspect, the overall design of the proposed facility lends itself to creating a ‘home like’ environment for patients and visitors whilst allowing for the delivery of the full range of contemporary health services.

The Committee is satisfied, on the evidence that it received, that a redevelopment on the existing site is not a feasible proposition in comparison to the opportunity to construct a new facility in an appropriate location. The proposed new hospital, residential aged care and community health services development will be a major improvement in the provision of health services to Queenstown and the West Coast.

The Committee notes the wish of many members of the Community that the old hospital facilities be demolished if there are no financially prudent proposals for its redevelopment. There is a wish in the community that the old hospital not remain as another derelict building in Queenstown. The cost for demolition was indicated at \$1,000,000.

Accordingly, the Committee recommends the project, in accordance with the documentation submitted, at an estimated total cost of \$6,600,000.

Parliament House  
HOBART  
24 January 2005

Hon. A. P. Harriss M.L.C.  
CHAIRMAN