2026 (No. 37)

PARLIAMENT OF TASMANIA

PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS

North West Regional Hospital Upgrade – Emergency Department and Ambulance Drop Off Redevelopment

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

MEMBERS OF THE COMMITTEE

Legislative Council	House of Assembly
Ms *Rattray (Deputy Chair)*	Ms *Butler (Chair)*
Mr *Hiscutt* from 26 May 2026	Ms *Burnet*
	Mr *Shelton*

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1 INTRODUCTION

To Her Excellency the Honourable Caroline Wells, 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:-

North West Regional Hospital Upgrade – Emergency Department and Ambulance Drop Off Redevelopment

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

2 BACKGROUND

2.1 This reference recommended the Committee approve the expansion and reconfiguration of the North West Regional Hospital (NWRH) Emergency Department (ED), as well as the redevelopment of the ambulance entry and drop-off area.

2.2 The objective of the proposed works is to improve safety and security for all users of the ED, including ED staff, paramedics, patients, and carers. The proposed works form part of the NWRH Masterplan Stage 1 as well as a broader effort to address capacity, functionality and safety challenges within emergency departments, as identified in the Independent Review of Emergency Department Security.

2.3 The site of the proposed works is within the NWRH campus at 23 Brickport Road, Burnie, at the existing ED entry and ambulance bay, accessed via Hospital Street. The proposed works' footprint is situated within a highly constrained and active clinical setting, requiring careful integration with existing buildings, services, and circulation networks.

2.4 The proposed works will include the following:

- A reconfigured ED entry and triage interface, improving visibility, patient processing and operational control;
- A new and upgraded ambulance arrival and transfer environment, including secure access, dedicated write-up and decontamination facilities, and improved separation between ambulance and public domains;
- Zoned waiting environments, including low-stimulation and mental health areas, supporting a range of patient cohorts and behaviours;
- The introduction of interview, assessment, and hold spaces located to support both clinical care and safe management of higher-risk presentations; and

- Reconfigured staff, support, and administrative areas, improving workflow efficiency, staff amenity, and operational adjacency.

3 PROJECT COSTS

3.1 Pursuant to the Message from Her Excellency the Governor-in-Council, the estimated cost of the work is $14.5 million.

The following table details the current cost estimates for the project[1]:

	Budget
Base Project Cost Estimate (Construction plus Consultants and Design costs)	$11,075,000
Design and Construction Contingency	$1,300,000
Design and Construction Sub Total	**$12,375,000**
Furniture, Fittings and Equipment	$350,000
Professional and Authority Permits, Fees and Charges	$495,000
ICT Infrastructure and Equipment	$335,000
Art in Public Buildings	$80,000
Client Cost and Fees Sub Total	**$1,260,000**
General Project Contingency	$365,000
Decanting Allowance	$500,000
Total Project Cost Estimate	**$14,500,000**

[1] *North West Regional Hospital Upgrade – Emergency Department and Ambulance Drop Off Redevelopment,* Submission to the Parliamentary Standing Committee on Public Works, Department of Health, p. 7.

4 EVIDENCE

4.1 The Committee commenced its inquiry on Monday 11 May 2026 with an inspection of the site of the proposed works. The Committee then returned to the Function Room, Cradle Coast Authority, 1-3 Spring Street, Burnie, whereupon the following witnesses appeared, made the Statutory Declaration and were examined by the Committee in public:-

- Paula Hyland, Chief Executive Hospitals North West, Department of Health;
- Casey Stark-Allen, Director, Regional Operations North West, Ambulance Tasmania, Department of Health;
- Simon Dunne, Director Programming and Delivery, Infrastructure Services, Department of Health; and
- Andrew Goelst, Project Manager, Programming and Delivery, Infrastructure Services, Department of Health.

The following Committee Members were present:-

- Ms Jen Butler MP (Chair);
- Hon. Tania Rattray MLC (Deputy Chair);
- Ms Helen Burnet MP; and
- Mr Mark Shelton MP.

Overview

4.2 Mr Simon Dunne provided an overview of the proposed works:

> ***Mr DUNNE*** *- … The North West Regional Hospital is a critical component of Tasmania's health system and provides emergency care to a large and geographically diverse population across the north-west coast. Its emergency department plays a vital role in delivering urgent and complex care and has been operating under consistently high demand for a number of years. This redevelopment responds directly to the demand and to identified shortcomings in the existing physical environment that impact safety, efficiency and access to care. The overarching purpose of the project is to significantly improve the safety and security of all users of the emergency department, including staff, patients, carers, visitors and paramedics. The redevelopment will address physical constraints and environmental risks within the existing department, improve lines of sight, separation of clinical and public spaces, and provide safer and more functional environments for emergency care delivery.*
>
> *In parallel, the project seeks to improve the overall physical environment to the emergency department. Modernising and reconfiguring the space will create a more supportive and efficient working environment for clinical and operational staff, while also providing patients with a facility that is better suited to the delivery of contemporary emergency health care. Improving the quality, functionality and condition of the built environment is central to supporting workforce wellbeing, retention and the delivery of high-quality patient care.*

The redevelopment also responds directly to the outcomes of the independent review of Tasmania's major hospital emergency departments. The project will improve patient flow within the emergency department, address congestion and bottlenecks and support more effective triage processes, including for mental health consumers. Importantly, it will also enable better care for patients with low acuity needs who arrive by ambulance, ensuring they are received in a safe, dignified and appropriate manner without compromising care for higher acuity patients.

A key focus of the project is inclusivity and accessibility. The redesigned emergency department will be better equipped to meet the needs of patients who are neurodiverse, experiencing a mental health condition, living with disability or have experienced sexual assault. Design decisions have been informed by the need to support privacy, reduce sensory stress, improve safety and provide trauma-informed care environments that recognise the diverse needs of the community served by the hospital.

Scope of the works includes the extension and remodelling of the ambulance drop-off bay to improve safety and functionality for Ambulance Tasmania crew and patients. This will enhance patient transfer, reduce operational risk and support smoother handover into the emergency department. A new pedestrian pathway along Hospital Street will also provide safer and more accessible entry to the emergency department, improving separation between vehicles and pedestrian traffic. [2]

Presentations to the Emergency Department

4.3 The Committee received evidence on the total presentations to the NWRH ED, as well as the categories of patients:

***Ms BURNET** - Can you describe the makeup of who accesses the emergency department and can you describe how that is likely to change? What's envisaged though the next five to 10 years?*

…

***Ms HYLAND** - North West Regional Hospital Emergency Department has on average 30,000 presentations in total per year. Just in the last 10 months alone, we've had 23,725, so we're on track to hit the 30,000 by the end of June.*

The second largest makeup is the category 4 and 5s. They are patients who potentially could have been seen in either an urgent care centre or a GP practice. That was 8915 in the last 10 months.

Category 3s are our biggest, so 10,732. That's that mid-range, and many of those would go on to be admitted. Category 2s are 3845 and cat 1s are 233.

***Ms BURNET** - And what's cat 1 versus cat 2?*

***Ms HYLAND** - In terms of the more serious nature?*

***Ms BURNET** - Yes.*

[2] Transcript of Evidence, 11 May 2026, Department of Health, pp. 2-3.

Ms HYLAND *-Category 1: they're very serious, either traumas, things that need emergency - they need to be seen almost within 0 minutes and they're taken into resus bays and treated in that way. Category 2s will get into the ED very quickly; they're urgent, but not needing a full team to see them immediately. They can be triaged within a certain period of time…* [3]

4.4 In response to matters taken on notice dated 23 June 2026, the proponent provided further data on the presentations to the ED. In terms of overall activity, the ED saw 29,381 presentations in 2025 and 12,058 from January to June 2026. [4] Their response further stated:

- *Age group distribution (2025 + 2026 YTD combined)*
  - *65 years and above: 10,726 (largest cohort)*
  - *25-44 years: 9,500*
  - *45-64 years: 8,335*
  - *15-24 years: 5,848*
  - *1-14 years: 5,935*
  - *Under 1 year: 1,095*
- *Key observations*
  - *Demand is highest among older populations (65+), followed by working-age groups (25-64).*
  - *Presentations among children and young people (under 15) remain comparatively lower, though still represent a consistent portion of activity.*
  - *The overall age distribution pattern remains consistent between 2025 and 2026 YTD, with no major shifts in cohort proportions.*
  - *While 2026 activity is trending lower, it is broadly aligned with 2025 when considering the partial-year timeframe.* [5]

Staff Retention and Recruitment

4.5 The Committee received evidence on the staff retention and recruitment for the ED:

Ms BURNET *- What is the retention and recruitment of staff like for this department?*

Ms HYLAND *- From a medical workforce point of view, we have actually just achieved our accreditation with ACEM up to a level 2. We were level 3 and we've actually gone up to a level 2, which means we can have registrars trained for two years instead of one, which is a great recruitment and retention activity. A lot of work's gone into that by that department.*

We do have a reliance on locum staff, but that team has also been instrumental in working on a model where we can actually have staff on contracts that can actually fly in and fly out so that they're not actually locums; they're actually employed by us. We have actually offered, I think, two contracts so far to people who want to be long-term with us, but still want to maintain whatever their life is somewhere else. That's

[3] Transcript of Evidence, 11 May 2026, Department of Health, pp. 12-13.
[4] Additional Information in Response to Questions on Notice, Department of Health, dated 23 June 2026, p. 1.
[5] Additional Information in Response to Questions on Notice, Department of Health, dated 23 June 2026, p. 2.

a model that we're certainly looking at because it's advantageous for us. We get recurrent people who are well known.

Nursing-wise, we do reasonably well. We have had some agency staffing in that area, I can't tell you the degree right at this current time, but we are attempting to maintain our benchmarks so that we stay properly staffed. [6]

4.6 The proponent provided further evidence on the staffing arrangements of the ED in their response to matters taken on notice. As at 12 June 2026, the ED employed 22.39 full time equivalent (FTE) agency nurses and 8.33 FTE locum medical staff. [7] The following table[8] was also provided that shows the current established positions within the Department, broken down by profession and award group. The proponent advised that many of the vacancies within the table are currently in recruitment processes:

North

Classification and role	Sum of Position FTE	Sum of FTE Occupied	Vacancies
Health & Human Services Award Band 1 - 9	**7.01**	**6.19**	**0.83**
Administration Officer	0.45	0.45	0.00
Emergency Department Communications Clerk	2.96	2.53	0.44
Emergency Department Triage Clerk	2.50	2.50	0.00
Emergency Department Triage Clerk (Casual/Relief)	0.50	0.11	0.39
EMET Program Support Officer	0.60	0.60	0.00
Health & Human Services Award OHO 1 - 3	**12.29**	**10.00**	**2.29**
Emergency Department Support Officer	9.07	8.79	0.28
Emergency Department Support Officer (Casual/Relief)	2.03	0.00	2.03
Emergency Department Support Officer (Relief)	0.01	0.05	-0.04
Hospital Aide	1.17	1.16	0.01
Nurses	**76.65**	**54.28**	**22.37**
Associate Nurse Unit Manager (ANUM)	5.28	5.11	0.17
Clinical Nurse Educator	1.00	1.00	0.00
Enrolled Nurse	11.11	4.32	6.79
Nurse Unit Manager (NUM) - Emergency Department	1.00	1.00	0.00
Project Nurse - Safety and Security	1.00	0.00	1.00
Registered Nurse	49.22	36.77	12.45
Registered Nurse - Clinical Facilitator	3.69	3.53	0.16
Registered Nurse - Clinical Facilitator (Casual)	0.86	0.00	0.86
Registered Nurse - Transition to Practice	1.68	2.53	-0.84
Registered Nurse (Relief)	0.40	0.00	0.40
Registered Nurse Relief	1.41	0.04	1.37
Salaried Medical Practitioners	**36.00**	**21.99**	**14.01**
Clinical Director - Emergency Medicine	1.00	0.25	0.75
Clinical Lead - Emergency Medicine (NWRH)	1.00	1.00	0.00
Intern	1.00	1.00	0.00
Medical Intern	1.00	1.00	0.00
Registrar - Emergency Medicine	8.50	7.74	0.76
Registrar - Emergency Medicine (Relief)	2.19	0.00	2.19
Registrar (DEM/Anaesthetics)	2.00	1.00	1.00
Registrar (Emergency Medicine) (STP-TMSDT)	1.00	0.00	1.00
Resident Medical Officer	9.00	3.00	6.00
Resident Medical Officer - Specialist College Trainee	1.00	1.00	0.00
Staff Specialist - Emergency Medicine	7.08	6.00	1.08
Staff Specialist - Emergency Medicine (Relief)	1.23	0.00	1.23
Grand Total	**131.95**	**92.46**	**39.50**

West Regional Hospital Masterplan

[6] Transcript of Evidence, 11 May 2026, Department of Health, p. 19.
[7] Additional Information in Response to Questions on Notice, Department of Health, dated 23 June 2026, p. 2.
[8] Additional Information in Response to Questions on Notice, Department of Health, dated 23 June 2026, p. 3.

4.7 Evidence heard by the Committee stated that the proposed works form part of the implementation of Stage 1 of the North West Regional Hospital Masterplan. Mr Andrew Goeslt expanded on this and discussed future upgrades to Emergency Department:

> ***CHAIR*** *- … on page 4 it says the project budget is for $14.5 million. It's fully funded by the Tasmanian state government. How does this fit into the North West hospital's master plan, and do you think the $14.5 million for the refit and refurb is achievable?*
>
> ***Mr GOELST*** *- As part of stage 1 of the master plan, there are other projects that are part of that which I understand the committee has already reviewed in the North West Mental Health Precinct that will be on top of the hill, the link bridge, the new inpatient unit, the moving of renal from Parkside up to the hospital and also a transit lounge is part of that. Those projects will fully close out stage 1. This upgrade to the emergency department is an integral part of delivering stage 1 of the master plan, noting that stage 7 will deliver the larger upgrade for full futureproofing off into the future.*
>
> *We have rigorously worked with the design team and an independent quantity surveyor to check our budget. We have had three checks on the cost of the project under the budget and we continue to have an appropriate contingency available to us to address market factors that have also been taken into account by the quantity surveyor, such as the Iran war and the like, and then local contractor pressures. We believe that we understand the north-west contracting market and that we have very strong tender interest to ensure that we get a competitive tender. For those reasons, I believe the budget is appropriate and adequate.*
>
> *…*
>
> *… stage 7 of the master plan makes the dramatic difference to the area. For stage 7 to become possible, the helipad needs to be moved. The location of the helipad really does constrain what is possible within the footprint of the emergency department. For $14.5 million, you could not completely move the emergency department or incorporate the relocation of the helipad, but that is really mapped out very clearly and strongly within the master plan. For myself, as a project professional with 30 years of experience of delivering government infrastructure, I see this as very good value for money for what it is going to achieve and the outcomes for the stated project aims that it is going to cover. I think we are covering a lot of square metres within what would normally be an expensive hospital environment and so I do believe, even though I have not come with facts and figures for it, my professional judgment is that we are getting very good value for money for the impact that we are delivering.* [9]

4.8 The Committee sought further evidence on the impact of the current location of the hospital's helipad:

> ***CHAIR*** *- Can you explain why the helipad is an inhibitor…?*
>
> ***Mr GOELST*** *- What we would have liked to have achieved… is a different way for ambulances to access and egress from the site. It would have been nicer to achieve a*

[9] Transcript of Evidence, 11 May 2026, Department of Health, pp. 3-4.

drive-in/drive-out for the ambulances in a more refined way. We need to realign what is called Hospital Street out there, which is the main road that traverses the site. That street cannot be appropriately realigned until the helipad is moved in accordance with the master plan. It is very much the three-dimensional nature of the site. The sheer level change and level differences that we have to incorporate means that you need space to overcome level and dimensional changes. The helipad puts an incredibly solid bookend with its large concrete columns, its bridge and just the structure itself to be able to give any cost-effective flexibility to address that. [10]

4.9 Mr Goelst also provided evidence on the staging of the Masterplan and the decision to move the helipad at a later stage:

> ***Ms RATTRAY*** *- You just talked about the helipad - the removal or relocation of that piece of infrastructure. Would it have been more prudent to have done that first and then come to this? I don't want to scare anyone who's obviously put a lot of work into this, but is there some synergy around that or is it just not practical to wait for that?*
>
> ***Mr GOELST -*** *My reading of the master plan is that the move of the helipad is best done when construction and decantings are occurring in the area as to where the helipad will go. So, it's really until those steps are taken. I think there is an inherent logic to the way that the master plan has been laid out. Whilst I've described it as a challenge for this project, because we just don't have any room to move, I think that the master plan is very sound in the logic of its flow on how the site is renewed for the future.* [11]

Project Budget

4.10 The Committee sought confirmation from the proponent that the proposed works would be completed within the allocated budget:

> ***Ms RATTRAY*** *- … I've moved to page 7… it talks about further cost savings being addressed through design development and tender costs are expected to be below the $14.5 million budget. I know that at our site visit, I asked a question around the design and construction contingency and was advised that design has already come in on budget. That means that the current contingency is the construction contingency only… does that mean that you'll be able to get those extra additional upgrades done in the current budget? I know it's an expectation, but given what's been said here is, is that almost a definite?*
>
> ***Mr GOELST -*** *I believe that we have a very good chance. What we mean by the tender costs below $14.5 million is that the tender costs will come in to not put pressure on having to exceed the $14.5 million budget and that we will be able to defend what is an appropriate construction contingency for the complexity of the project and the need to keep everything operating 24/7 including: the helipad, including AT, including the entire emergency department and the surrounding areas, medical imaging and the like.*
>
> *Whilst the design phase is now complete and that third check from the quantity surveyor is complete - it was completed in the time from when this was submitted to*

[10] Transcript of Evidence, 11 May 2026, Department of Health, p. 4.
[11] Transcript of Evidence, 11 May 2026, Department of Health, p. 5.

today - I'm just able to give the committee the very latest information. A lot of hard work went into that and we certainly have looked for cost savings where possible. [12]

4.11 Mr Goeslt also discussed the impact of the war in the Middle East on the proposed work's budget:

> ***Ms BURNET*** *- … I'm curious to know, with the impacts of the war in the Persian Gulf and supply of materials in particular, how does that impact this budget?*
>
> ***Mr GOELST*** *- The material types that we're using in this project have probably had the least cost escalation versus other infrastructure projects that are out there. We have very minimal roadworks, so a very small amount of bulk earthworks or the like that are moved by heavy machinery and trucks. We're doing very little sort of under the ground where all sorts of different types of pipes have had ridiculous amounts of cost escalation in a short period of time. Then we're not using very much steelwork or that much concrete either.*
>
> *It's very much we are refurbishing internal spaces, which is paint, floor coverings, plaster, stud walls, those sorts of things, which have had probably the lowest amounts of cost escalation in this season. So, a fortunate project to be delivering when there's a major Middle East crisis.* [13]

Design and Safety Improvements

4.12 The Committee heard evidence on how the design of the proposed works would improve the security for users of the Emergency Department:

> ***CHAIR*** *- … your submission on page 6 alludes to a 2023 security incident on the site, in that particular site. Without providing too much detailed information, for the record, could you give us a broader understanding of that particular incident and how the new design of this proposed project or refurb would mean that incidents as such could be lessened?*
>
> ***Ms HYLAND*** *- In 2023, a contracted staff member of the North West Regional Hospital was unfortunately stabbed outside of the doors of the emergency department just directly in front of those where I think you walked this morning. That led to quite a significant review for the whole of the Department of Health, but specifically the North West Regional Hospital and led to things like standby security now 24 hours a day, seven days a week at the emergency department and that is still in place while these things are happening.*
>
> *The design here has really indicated, and I think you referred to it as the rabbit warren in the back there, that staff areas were actually not secured. One of the key changes is that those staff areas - and we've even changed office layouts and moved doors so that they will all open into the staff area, with swipe card access, so that patients and visitors can't inadvertently walk through that space. We've changed the flow as well. There is now only one in and out, whereas we actually have two or three in and outs, that will make that easier to monitor. All the visitors and patients in reception in the waiting area will only go in and out through one door, rather than in and out multiple doors. There's more ability. The new security office is located with doors to go*

[12] Transcript of Evidence, 11 May 2026, Department of Health, p. 5.
[13] Transcript of Evidence, 11 May 2026, Department of Health, p. 6.

straight into the waiting area and straight back into the ED for additional security. We also have our patient safety officers that were employed after that time that also circulate within the emergency department and the waiting room to support safety. [14]

4.13 The Committee heard further evidence on the safety upgrades to the drop-off zone and footpaths outside of the area of the proposed works:

> ***Ms BURNET*** *- … It's not very iterative getting from the car park. In fact, we saw examples of pedestrian crossings which were in car parks, in the actual car park. You are either having a car parking on that pedestrian crossing - certainly very difficult to safely get around. I understand those might be issues for management as well. Can you just describe how, for patients arriving by car… Can we hear for the record how people would arrive and how that is more iterative?*
>
> ***Ms HYLAND*** *- We've gone from - we have one drop-off zone for patients and families who might be dropping off so there's less walking distance. That will go to two drop-off zones in this change, and -*
>
> ***Ms BURNET*** *- Sorry to interrupt, but most people would walk from the car park, would they not?*
>
> ***Ms HYLAND*** *- No, if someone's coming to the emergency department who actually has either injured themselves or needs assistance with a wheelchair, they will go to the drop-off zone, which is right adjacent to the walkway where you would have been this morning. The walkway move is a big change for the North West Regional Hospital. Human beings go from the quickest point from A to B. They don't cross roads and then cross roads back again, which is unfortunately the current design, so this is a major change for us to have the walkway on the same side as the hospital, which will prevent - and we would have staff and patients and visitors walking on the road every day at the current point in time.*
>
> *…*
>
> ***Mr GOELST*** *- Look, I really think that is an important change. We did see that onsite. We saw at least close to a dozen people walking up the road today. The footpath being part of this project really is a critical safety improvement and a critical improvement to assist access and egress and then certainly for carers to come as well, go grab a coffee safely. Those sorts of things. Very important outcomes.* [15]

4.14 Mr Casey Stark-Allen provided the Committee with his perspective on the design improvements to the Ambulance Bay:

> ***Mr STARK-ALLEN*** *- In comparison from what occurs now to the future design, besides the entrance moving, I don't think there's any real change to the flow. There's greater capacity within the transfer holding bay, which allows us to maintain clinical care while experiencing transfer care delays or provide care to acute patients while being triaged through the ED system. I don't think there's a huge amount of change besides the egress and exit. I don't think there's going to be a huge amount of difference for*

[14] Transcript of Evidence, 11 May 2026, Department of Health, pp. 7-8.
[15] Transcript of Evidence, 11 May 2026, Department of Health, pp 8-9.

the flow of our patients between what occurs now and the future design. Effectively, the entrance is just relocated slightly and then the transfer and hold area is increased.

***Ms BURNET** - Where does the journey for paramedics end? Do you go into the emergency area? What happens?*

***Mr STARK-ALLEN** - The end of the journey is a bit fluid depending on the clinical presentation and the collegial care that continues with the patients. Effectively when transfer of care occurs is when a handover has been provided to a member of the ED staff, whether a nurse or doctor, and the ED takes over care. The paramedics will then go and finish their patient care record and ready their vehicle for either returning to station to stand by or to respond to another case in the community.*

…

***Ms BURNET** - … The ambulance bay will have a glass door that will open automatically and then close automatically. Does that improve safety or the patient experience, if you like?*

***Mr STARK-ALLEN** - Absolutely. We will get a rapid roller door, very similar to what the Launceston General Hospital has in their ambulance bay, which will increase privacy for patients, which is a big concern for patient care and also safety for our paramedics so that we don't get members of the public just wandering in and looking for the entrance to the ED department while clinical care is being provided in the transition. It is also a better working environment. Within the new ED design, we're looking at creating a write-up space for paramedics. Currently they do that in the triage bay, which makes it a very noisy and busy environment. This will allow them to have their own space, which is away from the elements.* [16]

4.15 Witnesses provided evidence on the upgrades to the duress system for both ED and Ambulance Tasmania staff:

***CHAIR** - …. Can you give us a run-through of what the current duress systems are in that area, including the ambulance station area as well, because you're very exposed, and how the duress systems may be improved in this refurb?*

***Mr GOELST** - … I'd suggest that right now it's not uniform and is a little bit ad hoc and would require a fair bit of knowledge of the area to really respond to that. The project will make the duress and security responses uniform. The same type of buttons, same-coloured buttons, same throughout the entire department. Access through doors and the like will be made uniform as well.*

We are also putting them in places that will make them far more accessible and within arm's length in critical areas or within a few steps. That has been done in very close consultation with frontline staff. Then also I've put aside what's called a provisional sum within the contract because you can't expect frontline staff to fully assess the limited 2D plans and 3D things that we've shown them. We also have some finance put aside to respond to the frontline staff. They go, 'Gee, we wish you'd thought about putting it there', and there'll be money to put that extra additional in. We've really tried to cover that off from all angles because that really is a critical thing of

[16] Transcript of Evidence, 11 May 2026, Department of Health, pp. 9-10.

what we've done by going and doing the consultation we've done to date, setting up with the AT staff in the superstation. They came up with, 'We need a duress button here.' That's something that came from detailed staff consultation. We believe we've done a lot to capture good outcomes there.

***Ms HYLAND** - We did have a security review of the design. That's included.*

***Mr GOELST** - Appendix C of the report, that specialist security consultant with international experience, has been part of every step of the way. They have been checking every iteration of the plans and will also support us through construction.*

***CHAIR** - Anything to add to that, Casey, from the ambulance point of view with the bay?*

***Mr STARK-ALLEN** - The only thing is this upgrade will enhance the security duress features within the ambulance bay, which I don't believe there are any currently. Our paramedics wear a radio with a duress button on it. It's not linked to the hospital system. It's linked to our comms cen from the statewide operations centre who liaise with Tas Pol, so this will be a welcome addition to the ambulance bay.* [17]

Ambulance Drop Off

4.16 The Committee heard further evidence on the proposed works specific to the Ambulance Drop Off Area. Ms Hyland responded to a question regarding transfer of care delays:

***CHAIR** - … it's my understanding that part of this refurb is the creation of additional space for ambulances to transfer patients before they can then be actually placed into the hospital or admitted into the hospital. Is a part of this refurb part of that policy to address the ban on ramping, which is how it was referred to?*

***Ms HYLAND** - … The North West Regional Hospital has an extremely good relationship with Ambulance Tasmania and has very, very good transfer-of-care times. Patients do not sit on a bed generally in that holding area. While the area itself might be slightly larger, it's still not intended for beds to stay there for any length of time. Our model of care will remain the same - for quick transfers. It's more for ease of flow and access around if someone does happen to be in a bed there. It is not an intention to change our flow; we will continue to have rapid offloads.* [18]

4.17 Mr Stark-Allen provided evidence on the proposed works' compliance with Infection Prevention and Control requirements:

***CHAIR** - When we were on our tour this morning, Casey, you were referring to the Infection Prevention and Control (IPC). Could you run us through the IPC requirements of that ambulance area and how were you complying with the IPC requirements?*

***Mr STARK-ALLEN** - I think there are a number of things. Having the rapid roller door will make it a little bit more concealed from the environment. Additionally, we noted*

[17] Transcript of Evidence, 11 May 2026, Department of Health, pp. 15-16.
[18] Transcript of Evidence, 11 May 2026, Department of Health, p. 10.

this morning that there were a lot of bins that are stored there that are being relocated as part of this reason.

…

The removal of the waste bins will aid towards IPC standards. Additionally, a new storeroom and write-up area will allow for better ventilation and better storage of some of our critical equipment, allowing our crews to remain response capable.

We still maintain the same Personal Protective Equipment (PPE) on-ing and offing area as well as decontamination sinks and equipment to decontaminate the ambulance. Additionally, there is a dedicated decontamination shower for patients or crew that end up going to an incident that requires them to decontaminate before onward journey. [19]

4.18 He also discussed the additional space being provided for Ambulance Tasmania staff:

CHAIR *- There is additional write-up and support areas, is that right, for ambulance?*

Mr STARK-ALLEN *- Correct. Once the patient has been transferred to the care of the ED department, or during that process, one of the paramedics will either continue or start writing up their clinical notes for the case. Having a dedicated write-up area allows them to do that without encroaching on the ED staff space, which, as you could see this morning, is quite confined by the footprint.*

Additionally, after a critical incident, a lot of crews, given that North West Regional Hospital is the major catchment for high-acuity cases in the region, they will facilitate a debrief, and at the moment that occurs ad hoc, either in the garage if the environment is correct or sometimes occurring in the triage bay, which creates more ambient noise. Having their own dedicated space to facilitate this is excellent. [20]

Emergency Department

4.19 The Committee heard evidence specific to the proposed upgrades to the Emergency Department. Ms Hyland provided evidence on the introduction of a flexible room to be used as a waiting area for vulnerable patients:

CHAIR *- …I would like to ask you a question around the dedicated sexual assault service area, and if you can compare what the experience is now with the current care arrangements compared to what this project will be able to provide to patients.*

Ms HYLAND *- Thank you. Currently, victim/survivors who might come into the ED for an examination will remain within the waiting area; they might be directed to a slightly quieter spot, but there is no separate waiting area. The new design provides for a flexible room that can be used as a waiting area for that person that is actually out of sight of the rest of the ED. As you can imagine, it is a small place and everyone tends to know everyone and so having that privacy is really essential.*

[19] Transcript of Evidence, 11 May 2026, Department of Health, pp. 10-11.
[20] Transcript of Evidence, 11 May 2026, Department of Health, p. 11.

We already have an existing SAMS room, but this is actually an upgrade essentially for what we will have and with the addition of the waiting area. It is in a quiet space; we think that it will be well accepted. We have talked to the Arch Centre for sexual harm and support, and we will be taking over the same colours as they use at Arch so that we can have the exact same sort of process, so that if victim/survivors are using both services, which we strongly encourage, they will have a seamless transition between services.

***Ms RATTRAY** - They will have an ensuite as well?*

***Ms HYLAND** - Yes.*

***Ms RATTRAY** - So that will be a much more appropriate?*

***Ms HYLAND** - Yes.*

***CHAIR -** Is there a risk that that area being separate, being devil's advocate here, that visibility and safety could actually be a concern to that person whilst they are waiting in that section? Is there some form of monitoring or an ability to still be able to keep an eye on.*

***Ms HYLAND** - While it is a quiet area, it is certainly not outside of the ED and so it is a through-traffic, and there are doors there that go in and out that staff would use. There would be regular flow; they would just have a private space within that. So, I don't think that it would pose difficulty from that perspective.* [21]

4.20 The Committee sought further evidence on the experience of those presenting to the ED with mental health concerns:

***CHAIR** -… if you can talk us through people with mental ill health that are presenting in the emergency section, what that journey would look like for them? Are there any separate areas for them or would they have a different entry point as well.*

***Ms HYLAND** - Currently, you may still enter through the emergency department or you may be brought in by police, or you may be brought in by ambulance. You would enter the department. We have one existing, what we're now calling low stimulation or mental health space, which has low ligature areas and no equipment that can be used to hurt themselves or others, which is monitored - which is quite up near the doors. The issue we have is that we were going to have a second space, but we're recognising that it's not just for people with mental ill health issues and we do think it's necessary for our neurodivergent population to have a quieter place to be.*

It does depend on clinical need. So if you do still require quite high level of clinical support, you will be in the main area and you may even be in a resus bay, which is quite difficult. But where we can support it, we will have access now to two low-stimulation rooms to support many different types of our population to have a better experience. The design of the second low-simulation room came out of an anti-discrimination case that we worked with a complainant on and included them in the consultation for this.

[21] Transcript of Evidence, 11 May 2026, Department of Health, pp. 11-12.

CHAIR *- Just for the record, there isn't a separate entry point for people who are feeling mentally unwell at that time?*

Ms HYLAND *- No. The model of care is that they need to be clinically assessed to ensure that there isn't something clinically that's impacting them into ill health, whether that might be sepsis or other types of infection or some other issue. When the new mental health precinct comes on board on the hill, there is the intent that that could be the second entry point for those clearly not with a clinical issue.* [22]

4.21 The Committee heard evidence on how the proponent was futureproofing as part of the proposed works:

Ms HYLAND *- So the majority of our patients would actually come in and go within the same admission. There's not that many who actually go on to further admission within the hospital.*

I think what we've done, even though we focus mainly on security in the design, is that we have actually managed to change or enlarge the footprint of the ambulatory care area, which is where most of our category 3s, 4s and 5s would be treated initially.

We have added for futureproofing - we only currently have one triage room; we will now have access to three. Two will be fully compliant assessment rooms, and one will be a procedure/assessment room and they lead directly back out to the waiting area so that people would come in, access treatment and go back to the waiting area as needed. That's a huge change for us and should help the flow of our ambulatory care patients to get treated quickly and go again. [23]

4.22 The Committee heard further evidence on the upgrades to the triage area to improve safety both for staff and paediatric patients:

Ms BURNET *- I suppose it was quite clear from the current layout that there are a lot of blind spots, so very difficult to see around corners to really surveil the waiting area and access is easy for any member of the public to go to areas which are staff areas. Can you just describe how you've addressed some of those issues?*

Mr GOELST *- I think the moving of the triage area is absolutely critical to that. As you would have seen on the walk, the triage area probably has 120-degree view currently, and then over a fairly short distance into some solid walls. What we're opening up is an almost 360-degree view where they can see externally, because at the moment they really cannot see externally, so they can see externally, they can more easily see the ambulance bay, then they can see through the entire area. We also form a single line of security where only a tiny section of floor is not visible to the triage area, so in the moving of the public toilets and the reglazing, so every solid wall in that space is demolished and returned with glazing. Then we have in the entire area tripled the number of security cameras as well.*

We've got backup on backup in that regard, so the change in sight distances is considerable.

[22] Transcript of Evidence, 11 May 2026, Department of Health, p. 12.
[23] Transcript of Evidence, 11 May 2026, Department of Health, p. 13.

Ms BURNET *- Was there consideration of a physically separated area for paediatric patients?*

Mr GOELST *- We have the fully physically separated waiting space there beside the red-wait mental health space, so that can be fully enclosed and acoustically sealed off and also has incorporated a television with a different feed on it for children's programs to be on that television. That is the appropriate response Australia-wide for emergency departments at this time, so we're certainly having current standards met through that space.* [24]

4.23 Witnesses also raised the upgrades to staff and storage areas:

Ms BURNET *- … We've just talked a little bit about the improvements in staff facilities. Can you just also describe what other things are - I mean, clearly the layout, the safety issues, any sort of breakout spaces for staff and the training facilities?*

Ms HYLAND *- Within the design, the staff currently has a lunch room that's actually cut off in half, so they have two spaces they can access if there's too many. This now means that they can have one full space so that they can access as a larger group, but they've also still provided enough space for a staff training area that's a breakout for them. They have regular senior staff meetings that will be used for that as well. There's additional office space that they don't currently have. All of that will be within the swipe card access area so that there won't be walk-ins or accidental walk-ins by other visitors or patients.*

…

Ms BURNET *- … Storage space, obviously, storage in a facility is problematic. How have you addressed some of those issues?*

Mr GOELST *- I can talk to that. We put a storeroom into the ambulance bay extension without compromising, I believe, the other needs of that extension. In moving the public toilets to a far better place for better outcomes, we are turning the existing toilets into a new store for the emergency department, improved linen storage as well. Then in the removal of the plaster room we have provided appropriate storage to replace that and turn the plaster room into a trolley to get better use of spaces. We have included a dedicated cleaner space within the department; otherwise that is on trolleys in corridors as well. That decongests that space and provides improved toileting for patients. We have looked for opportunities for better joinery and the like within refurbished spaces as well, which would help to decongest items. We have negotiated with other parts of the hospital to move some items that are currently stored within the emergency department, particularly what we're converting into the low-stimulus room, to be stored there and then being brought on the infrequent ad hoc basis that those items are needed down to the ED. We have worked very hard to maximise the storage that is there.* [25]

[24] Transcript of Evidence, 11 May 2026, Department of Health, pp. 17-18.
[25] Transcript of Evidence, 11 May 2026, Department of Health, p. 20.

Staging of the Proposed Works

4.24 In acknowledging the challenges of upgrading the ED and Ambulance Bay while requiring continual operation and accessibility, the Committee heard evidence on the staging of the proposed works:

> ***Ms RATTRAY*** *- On page 11, it indicates the architectural responses and talks about recognising the complexity of construction within a fully operational emergency department. I'm interested in having some understanding of how you see that working in the practical sense - should this project proceed to that - because it's going to be quite disruptive to an already really busy, high-traffic area and there'll be lots of contractors, or potentially lots of contractors, around and there's not much parking. Actually, there's very little parking, but that's unique to all hospitals, I think; just some indication of how that is going to be managed, and particularly that interface between construction and clinical environments.*
>
> ***Ms HYLAND*** *- … We've got significant staging within the project in order to do that. The biggest impact will be to the waiting area at different times, but we would have that zoned off and we have the capacity to move things in order to zone in order to actually undertake that. We had extensive conversation about access and entry to the ED and we've managed to stage that so that while we'll change the access and entry, we'll maintain it at the ED instead of having to go through another part of the hospital.*
>
> *We've explored all sorts of different options in order to make that less intrusive. Again, if it is an area that's going to be disrupted, they're quite used to that type of approach. It's not their first redevelopment either, and so they're quite keen in order for the project to go ahead to get the outcomes that they're looking for. They understand that it'll be a short-term-pain-for-long-term-gain kind of approach.* [26]

4.25 Witnesses expanded on the staging of the project when discussing the timeline and duration of the proposed works:

> ***CHAIR*** *- … I have a question on page 20 about the timeline. You've got design and contract documentation complete in April 2026, so that's complete. Construction contractor appointment, which will be in about another two months from now, but your construction commencement is August 2026 with a practical completion by December 2027. It seems like quite a long duration for that, because it is really, in essence - and I know there's a lot in it - it's a renovation of sorts, isn't it?*
>
> ***Mr GOELST*** *- The reason for the duration is the need to keep everything operating 24/7. Rather than being able to do large areas all at once, this is a bite size. That's the reason for the length of time that is going to be needed. I actually believe that the proposed duration at the moment is actually going to be incredibly tight. The contractor is going to work very hard to achieve that.*
>
> ***CHAIR*** *- Will you be decanting one area into another area?*
>
> ***Mr GOELST*** *- That's largely what we're doing. We're building the ambulance extension first, so that we have areas to decant to, to move the Tetris pieces around to make it*

[26] Transcript of Evidence, 11 May 2026, Department of Health, pp. 14-15.

all happen. For example, you saw today where the public toilets will eventually be; that'll have to be a red wait room for a time and those sorts of things. To keep it 24/7, we've had to go very slowly through the space.

…

Very detailed consultations occurred on the construction staging. We've had well north of a dozen meetings on that, spent many hours with the infection prevention control clinical nurse consultant in getting all that signed off as well. We've got some recent learnings from very difficult projects that have been delivered at Launceston General Hospital to make sure we've got the very best air quality control in behind the hoardings and the spaces as we're working in some very difficult areas. We make sure that the hoardings are also hardened so that it's safe for both the contractors and the staff. We've talked about locking down tools so they can't be gotten to and stolen. We have turned it upside down, looked at in a lot of different ways with a lot of different individuals, including the key frontline staff, doctors and nurses, orderlies, clerks, cleaners. We have 12 major stages plus, the roadworks is a 13th stage. All those stages have multiple sub-stages and we have gone over it with a fine-tooth comb. [27]

Stakeholder Engagement

4.26 Mr Dunne provided an overview of the stakeholder engagement undertaken for the proposed works:

> ***Mr DUNNE -*** *… Stakeholder engagement has been integral to shaping the project. During the concept design in September 2025, the department undertook consultation with emergency department staff, Ambulance Tasmania, Tasmania Police and consumer advocates. Feedback was received on layout, functionality and safety considerations, and key themes included the location of the sexual assault medical services room, security and privacy of staff areas, mental health patient safety, ambulance drop-off design, neurodiverse patient needs and the safety and security requirements for Tasmania Police. These insights have been carefully incorporated into the schematic design to ensure the redevelopment is practical, responsive and fit for purpose. Consultation on the schematic design phase was undertaken in February 2026, which influenced the outcome of the detailed design and the subsequent tender documents.* [28]

4.27 Mr Goelst provided further detail on the outcome of feedback received from various stakeholder groups:

> ***CHAIR -*** *… I know that disability and vision impairment advocates have been consulted, we've already stated that, domestic and sexual violence support reps including Laurel House and for emergency department staff and paramedics with the lived operational experience, can you talk us through mental health advocacy groups and some of the feedback that they've provided to your group and some of the advice that you took from them within this design?*
>
> ***Mr GOELST*** *- The design has been heavily influenced by both internal departmental staff and external advocates who we've spoken with.*

[27] Transcript of Evidence, 11 May 2026, Department of Health, pp. 21-22.
[28] Transcript of Evidence, 11 May 2026, Department of Health, p. 3.

The improvements to the high-dependency room: to increase the size of that room; for that room to have a dedicated mental health space as well. We have also dramatically improved, say, odour control in that space as well, which is a which is a really good outcome.

Bays 11 and 12 are nominated to have glazing on the front of them and are in a quieter part of the department, so they have been communicated to be spaces that would be prioritised for neurodiverse patients to be able to be placed into, for them to be lower-stimulus spaces.

The creation of the second, equivalent room to the high-dependency room, but not quite as hardened as what it is, mainly around doors, but that space is in a quieter corner of the department. It also has a dedicated ensuite associated with that as well.

The use of the multiple assessment rooms assists with departmental staff having options for patients and then the nomination of the red-wait area, when there isn't an infectious patient in there, to also be used for patients who need lower stimulus as well.

It could be argued that from two touch points, we've got over half a dozen touch points in that space. Then the floor plans, the wall layouts, the colours will still also be informed by those groups as well.

The current feedback from those groups is that they are really impressed with the amount of codesign that's occurred in that space and the listening that the design team has done to get some dramatically improved outcomes. [29]

4.28 The Committee sought further evidence on the negative feedback that had been received:

***Ms RATTRAY** - I did note that further on the report it talks about feedback survey summary and it says that, 'the consultation was generally positive'. Then it goes on to say 'while most feedback received was positive'. So were there some matters that were raised through the feedback and the consultation that haven't been able to be addressed in this particular proposed redevelopment and upgrade?*

***Mr GOELST** - I can talk to that problem. One of the ones was there was a small amount of doctors who really wanted to maximise the floor metres, the square metres inside the emergency department and see the forensic sexual assault space moved to another location. We did genuinely explore that and examine that possibility. It's also not something that is impossible for the future; it's just not possible at the moment. That would be probably the main item that was raised.*

I think, elsewhere, on a sort of lesser priority, is obviously we would love to significantly increase the size of the staff spaces as well and perhaps provide - some staff from different streams of staffing would have liked a separate area for them, whereas they really want to try to keep the staff together and to explore a holistic team. Issues like that were raised. What we've done is ensured that we've communicated back to the whys and why-nots, but the listening we've done - it's overwhelmingly positive because they really have stretched the design team. There were three things that were raised. Paula's already raised one with the procedure

[29] Transcript of Evidence, 11 May 2026, Department of Health, p.18.

assessment room, where I just thought would be impossible to achieve, but they kept asking for it, we kept on looking and we got a great outcome. Paula also had some input that allowed us to get the third assessment room in place. We've achieved some really great outcomes in the codesign process.

***Ms RATTRAY** - But there are some reasonable upgrades for staffing areas, as well. It certainly wasn't completely dismissed out of hand. It was addressed in some way, not perhaps all the way?*

***Ms HYLAND** - We can't always do everything that everyone asks for. I think we've had a good balance of actually meeting most needs and taking on board that there might be some changes in the future, but the sexual assault medical service room has to remain where it is. I think the staff has acknowledged that with the meeting room and the family room and where the waiting area is that's now separate, that that will actually be a better change. [30]*

Does the Project Meet the Requirements of the Public Works Committee Act?

4.29 In assessing any proposed public work, the Committee seeks an assurance that each project meets the criteria detailed in Clause 15(2) of the Public Works Committee Act 1914. Broadly, and in simple terms, these relate to the purpose of the works, the need for and advisability of undertaking the works, and whether the works are a good use of public funds and provide value for money to the community . The Committee questioned the witnesses who provided the following confirmation:

***CHAIR** - …Does the proposed works meet an identified need or need or solve a recognised problem?*

***WITNESSES** -Yes.*

***CHAIR** - Are the proposed works the best solution to meet identified needs or solve a recognised problem within the allocated budget?*

***WITNESSES** -Yes.*

***CHAIR** - Are the proposed works fit for purpose?*

***WITNESSES** -Yes.*

***CHAIR** - Do the proposed works provide value for money?*

***WITNESSES** -Yes.*

***CHAIR** - And are the proposed works a good use of public funds?*

***WITNESSES** -Yes. [31]*

[30] Transcript of Evidence, 11 May 2026, Department of Health, pp. 18-19.

[31] Transcript of Evidence, 11 May 2026, Department of Health, p. 26.

5 DOCUMENTS TAKEN INTO EVIDENCE

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

- *North West Regional Hospital Upgrade – Emergency Department and Ambulance Drop Off Redevelopment,* Submission to the Parliamentary Standing Committee on Public Works, Department of Health; and
- Department of Health response to matters taken on notice, dated 23 June 2026.

6 CONCLUSION AND RECOMMENDATION

6.1 The Committee is satisfied that the need for the proposed works has been established. Once completed, the NWRH ED and Ambulance Drop Off will be expanded and reconfigured to improve security and capacity for all its users.

6.2 The proposed works will address current limitations within both areas of the hospital. For both the ED and Ambulance Drop Off area, there will be improved separation between staff and public domains to improve safety and workflow efficiencies.

6.3 The Ambulance Drop Off upgrades will improve patient arrival and transfer procedures, and provide staff with dedicated write-up and decontamination facilities.

6.4 The works proposed for the ED include the reconfiguration of staff, support, and administrative areas, zoned waiting environments, including low-stimulation and mental health areas, and the introduction of interview, assessment, and hold spaces.

6.5 Accordingly, the Committee recommends the North West Regional Hospital Upgrades – Emergency Department and Ambulance Drop Off Redevelopment, at an estimated cost of $14.5 million, in accordance with the documentation submitted.

Parliament House
Hobart
7 July 2026

Jen Butler MP
Chair