



PARLIAMENT OF TASMANIA

PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS

North West Regional Hospital Mental Health Precinct

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

MEMBERS OF THE COMMITTEE

Legislative Council

Mr Harriss (Deputy Chair) until 2 May 2026
Mr Hiscutt from 26 May 2026
Ms Rattray (Deputy Chair from 11 May 2026)

House of Assembly

Ms Butler (Chair)
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 Mental Health Precinct

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 construction of a new, purpose-built mental health facility at the North West Regional Hospital (NWRH). The North West Regional Hospital Mental Health Precinct (the Precinct) will replace the existing Spencer Clinic with a contemporary, recovery-oriented facility that will support best practice models of care.
- 2.2 The Precinct is part of Stage 1 of the NWRH Masterplan, and is part of the Government's response to the 2018 recommendations from the Mental Health Integration Taskforce and the Tasmanian Department of Health's Strategic Priorities for 2021-2023.
- 2.3 The site of the proposed works is classified as greenfield, meaning it has not been previously developed. While there are no existing buildings on the site of the proposed works, there are adjacent accommodation buildings which will need to be considered and remain in use throughout the construction period.
- 2.4 The site of the proposed works is separated from the main hospital which introduces the risk of operational needs not adequately being met. In response to this risk, a future pedestrian link bridge has been proposed and forms part of Stage 1 of the NWRH Masterplan.
- 2.5 Key design features of the proposed works include single-bed rooms with ensuites, sensory modulation spaces, dedicated courtyards for high and low care units, and a dedicated de-escalation courtyard. The design prioritises dignity, privacy, and connection to nature, and aims to promote a non-institutional atmosphere.
- 2.6 The design of the Precinct also provides for modern staff facilities to attract and retain the workforce. These features include a combination of clinical, consultation, and office spaces, an open-plan environment, efficient access to storage, and flexible use areas to maximise opportunities and overcome service delivery constraints. The Precinct will also allow for the development of and adjustment to new operational workflows and models of care.

3 PROJECT COSTS

3.1 Pursuant to the Message from Her Excellency the Governor-in-Council, the estimated cost of the work is \$40 million.

The following table details the current cost estimates for the project:

	COST ESTIMATE (\$)
Base Project Cost Estimate (Construction plus Consultants and Design costs)	34,462,028
Design and Construction Contingency	6,079,838
Design and Construction Sub-Total	40,541,866
Professional and Consultant Fees (inc. project management, contract management etc.)	1,655,594
Permits, Fees and Charges	952,029
ICT Infrastructure and Equipment	745,000
Furniture, Fittings and Equipment (FFE)	3,000,000
Art in Public Buildings	80,000
Client Cost and Fees Sub-Total	6,432,624
Total Project Cost Estimate	46,974,490

4 EVIDENCE

4.1 The Committee commenced its inquiry on Wednesday, 11 March 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:-

- Jarrod Bannon, Group Director – Mental Health Services North/North West, Tasmanian Health Service, Department of Health;
- Cameron Burbridge, Architect, Lead Consultant, ARTAS;
- Rachael Dobson, Senior Project Manager, Infrastructure Services, Department of Health;
- Simon Dunne, Director Programming and Delivery, Department of Health;
- Catherine Schofield, Executive Director of Nursing (Director of Services), Tasmanian Health Service, Department of Health; and
- Dee-Ann Simmons, Project Manager, Infrastructure Services, Department of Health.

The following Committee Members were present:-

- Ms Jen Butler MP (Chair);
- Hon. Dean Harriss MLC (Deputy Chair);
- Ms Helen Burnet MP; and
- Hon. Tania Rattray MLC.

Overview

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

Mr DUNNE - ... The Department of Health is progressing this important development to deliver a modern, purpose-built mental health facility on the North West Regional Hospital campus in Burnie. This is a state-funded investment and a major component of Stage 1 of the North West Regional Hospital Masterplan.

This project responds directly to longstanding community need and statewide mental health reform. It replaces the ageing Spencer Clinic with a contemporary, 22-bed inpatient facility that meets modern standards, supports recovery-orientated care and provides the capacity and the flexibility required for the region's growing population. The precinct has been carefully designed to provide a safe, therapeutic and dignified environment for consumers and high-quality workspace for staff. It includes single bedrooms with private ensuites, sensory modulation spaces and multiple therapeutic outdoor areas that support calm, privacy and healing.

The building integrates biophilic design principles, draws inspiration from the north west coast landscape and avoids an institutional feel, ensuring that the facility is welcoming to patients, families and the wider community. The design also delivers

strong operational functionality. It separates public, clinical and service flows; enhances staff visibility and safety; offers flexible clinical zones; and incorporates sustainability features, such as LED lighting, double glazing and a light-coloured roof to reduce heat gain. The facility will connect into existing hospital infrastructure, and this is designed with universal access and inclusive wayfinding throughout.

...

We intend to procure a head contractor through an open tender process to drive competitiveness and value for money. Planning approval was submitted in November 2025, with the construction scheduled to commence in September 2026 and operational readiness expected in early 2028. This project represents a critical investment in the mental health infrastructure of north west Tasmania. It will significantly enhance access to care, improve patient outcomes, support staff attraction and retention, and deliver a modern facility aligned with contemporary models of care. We look forward to working with the community to ensure strong oversight and successful delivery of this essential project for the Tasmanian community.

Need for the Proposed Works

4.3 Mr Jarrod Bannon provided evidence on the need for the proposed works:

Ms BURNET - ... I have questions concerning the need in the north west for acute mental health facilities. What are the needs?

Mr BANNON - ... At the moment we have the 19-bed Spencer Clinic, which has an average occupancy rate at the moment of, well, around 100 per cent. There is absolutely a need to increase our capacity to meet that demand. That is not the only area where we're considering the need to expand and grow. We're obviously looking at community-based services in support of that. There's been the recently commenced and commissioned mental health emergency response service, which has had significant improvement in being able to support consumers to avoid unnecessary emergency department presentations and subsequent admissions. There absolutely is a need and a demand. I don't think that we could sit here and say comfortably that those 23 beds are going to meet the potential future demand. We will need to continue to explore other opportunities that could be an alternative to hospitals and state-based services.

4.4 The Committee heard evidence on the average length of stay, and discharge process, for those requiring inpatient mental health services in the north west:

Ms BURNET - ... somebody who requires high needs... how long do they usually stay in that part of the facility now?

Mr BANNON - The KPI that we attempt to achieve is around 12 to 14 days. I think across the state at the moment we're sitting closer to around 16 days as the average length of stay across all of our bed-based services.

Ms SCHOFIELD - It exceeds that in the north west, but that's often to do with the fact that people live farther away from services. They're possibly kept longer to ensure that they're more stable when they're actually discharged.

Ms BURNET - In relation to discharge, does everybody have a place to go when they're discharged from the psychiatric ward?

Mr BANNON - It is extremely rare across adult mental health services in the north and north west for us to discharge a consumer to no fixed abode. That isn't a common practice. We do make all attempts and efforts to ensure that people have suitable and stable accommodation or at least a time-limited safe space until we can arrange and we rely heavily on our multidisciplinary team, particularly our social workers, to support that discharge planning process.

4.5 Ms Dee-Ann Simmons then provided evidence on how the proposed works would respond to challenges that exist in the current Spencer Clinic:

CHAIR - It is important for it to be on the public record, the briefest explanation about the current state of the existing facility, and that's not to take anything away from the amazing work that the workforce is doing within that facility. I'm not sure, it might be best put to you, Ms Simmons, to explain the confines and whether the current site is appropriate for assisting people to a good recovery?

Ms SIMMONS - I can answer it in terms of what we're providing in this proposed project. It has certainly taken a lot of what is currently there and conceived, what's not functioning so that we've been able to bring it into the brief of this new project. Things like - you saw that the lunchroom is also the activity room and the - it's all in the one space. It's also the media room. In this new project, we've divided up all these spaces. Rather than every room be a multipurpose as it currently is, the new facility will have purpose-focused rooms for each activity. There are the consult rooms, interview rooms, group activity, indoor exercise rooms, sensory modulation and all these kinds of things that actually support healing and recovery.

Yes, certainly the current conditions at Spencer Clinic have provided us with a really good insight of what's not working and what we can improve on in the new facility.

4.6 In response to matters taken on notice, the Department of Health provided data of the growing demand for inpatient mental health services in the north west:

Occupancy rates for beds at NWRH over the past five years have grown from 85 per cent in 2021 to 100 per cent in 2025. Mental Health related presentations at the NWRH have grown from 1882 in 2021 to 1954 in 2025 and admissions have grown from 415 to 457 in the same period. The data would indicate a similar continued trend for growing demand.

NWRH Spencer Clinic	2021	2022	2023	2024	2025
NWRH - Spencer Clinic (19 Beds)	85%	90%	96%	90%	100%
Total admissions	415	372	374	454	457
NWRH ED - Mental health related presentations	1882	1844	1979	1915	1954
NWRH ED - Mental health related presentations ALOS (hours)	5.9	6.8	7.7	8.8	10.4
Average wait for inpatient mental health bed from ED	3.8	6	10.4	12.2	16.5

...

Separations data for the NWRH Spencer Clinic indicate a sustained level of inpatient mental health activity, with an average of 37 separations per month over the most recent two year period. While the largest proportion of separations relate to short term admissions of 1-7 days LOS (18 per month), a substantial number of patients experience longer stays, with an average of 7 separations per month for stays of 8-14 days and 12 separations per month for stays exceeding 14 days LOS.

Separations - Monthly average (2 year period)	Short term 1-7 days LOS	Medium 8-14 days LOS	Long >14 days LOS	Total
NWRH - Spencer Clinic	18	7	12	37

1

Model of Care for the Proposed Works

4.7 The Committee heard evidence on how the design of the proposed works will promote best practice models of care:

CHAIR - Can you run us through... the care model which would be used in the new facility and - there are two questions - how the design in the proposed project complements that model?

Ms SCHOFIELD - We've done an awful lot of work in regards to the future, I suppose, in relation to the model of care that will be introduced. Obviously, a lot of the same elements will be maintained from, I suppose, the philosophy that the staff bring to the work that they do such as trauma-informed care, least-restrictive, and all the principles that govern the work that they undertake.

In the way that the new facility will be designed, there will be capacity to have a very intensive, I suppose, high-dependency unit where your truly acute admissions will be able to be looked after in an environment that will encourage and support recovery and, I suppose, tranquilly in some ways rather than some of the chaotic nature that exists currently within Spencer Clinic because of the number of people who are just existing within a very small footprint. There will be that capacity with the open spaces, the ability to look out and to have rest and relaxation as well as clinical therapy and treatment and be able to provide for that in a step-down model.

In each of those sort of pods, if we're looking at that from a pod perspective, there will be high-intensity care that will then step down. It will be sort of like a transition from the highest intensity to the lowest intensity through to discharge. That will be enabled by the design of the new facility, whereas at the moment that's all sort of like mixed into the same - I know there's the separation of the high-dependency unit, but in recent times because of the demand, we haven't been able to run a separate high-dependency unit in Spencer Clinic. It's sort of very much an open unit where you're making the best of the environment - the situation.

...

Mr BURBRIDGE - A few of the big points that we looked at during the design is every individual bedroom with private en-suites, whereas Spencer Clinic doesn't have that currently; giving that dignity back to the consumers; making sure all the bedrooms have an outlook, whether it be onto the landscape or towards the back of the site or

¹ Parliamentary Standing Committee on Public Works Hearing – North West Regional Hospital Mental Health Precinct – Questions on Notice, Department of Health response to PWC request for additional information, 16 April 2026, pp. 3-4.

down over the front of the site to the ocean, also separating the back-of-house services from the inpatient unit. Currently, in Spencer Clinic, if you're delivering some stores to store rooms or stuff like that, you need to actually go physically into the unit. We're trying to - all those people who don't need to be in there, we're trying to keep them out. Big central back-of-house corridor that can access off the backside of the lift. People delivering stores, medication, whatever can do that without having to go into the unit itself; again, with all the maintenance of plant and equipment, doing that outside of the unit; just trying to reduce the amount of people that don't need to be in the unit.

Also looking at lighting, making sure there's lots of natural light into the unit itself. The acoustics was another big one. As you saw today, it was quite loud and a lot of stuff going on in the lounge areas, so working heavily with the acoustic engineer to make sure the environment is acoustically nice, and not loud and noises going off everywhere. That was a big one, and then also giving choice to consumers, so having the multiple little lounges around the place; so if someone doesn't like what's on TV, they can take themselves off to another little lounge and get away. Someone's annoying them, they can remove themselves. And the sensory modulation rooms as well; if you want to go in and make it pitch black or colourful lights or music or whatever, you have a space to go and do that.

CHAIR - I gather from the design, with the care model, there's also different work areas. At the moment you have Centrelink people coming in to meet in an office which is shared by four different people: that was an example that was given this morning, or a social worker trying to negotiate quite private conversations with a client whilst having to share a workspace. Can you talk through what the new workspaces would look like for the staff?

Mr BURBRIDGE - Within the unit itself, there's one consult room and three interview rooms, so two interview rooms in low care and one in high care: interview rooms for exactly that. If you have a staff member who needs to be with the consumer, a nice quiet space to go and do it. We have a family room in the front-of-house lobby upstairs, so if staff members want to meet with family members to talk about something, there's a nice quiet space for that to happen. Dedicated tribunal room for TASCAT, dedicated meeting room for the staff members to do the handovers and all that sort of stuff. Then we have four offices, a mix of one-person and two-person offices, reception and then two lots of open-plan workstations for the staff members and then a dedicated staff room, which is purely a staff room. It won't have computers or anything in it, like their current facility does.

...

Ms SCHOFIELD - The other thing that I'd just like to say, going back to that model, the model as well as the infrastructure was developed with consumers and carers. Their lived experience was at the beginning of those conversations and then being with us all the way through those conversations. I think it is important that a lot of this has come from what they have experienced and seen, and have said that they would like to see, in future development.

The other thing to say is that some of the model will look at how we use those resources more, perhaps, prudently as to where we need the experience in those high-care settings, and using peer workers more in the softer spaces that don't

require so much clinical intervention, because the plans have already been developed and can be undertaken by others.

- 4.8 The Committee also heard evidence on the decision to reduce the bed number for the proposed works due to the removal of a short-stay unit, as well as the models of care required for a short-stay unit compared with a typical inpatient unit:

CHAIR - ... Regarding the decision to have 22 beds in the facility, it's our understanding from this morning's evidence that a 27-bed facility was initially discussed. Why was the 22-bed facility mark landed on?

Ms SIMMONS - Originally there was the five-bed, short-stay included in the design. Ultimately, it came down to available funding; we had to design within the funding envelope. The 22 beds of acute inpatient was what's needed. The five beds for short-stay, it's probably worth noting as well, it wouldn't just be an additional five beds for short-stays, it's a different model of care, so it would require a whole different, essentially, facility added onto the current 22 beds. So, it would have its own additional admin facilities, its own reception and it would be a whole different look and feel as well. Patients can come and go from short-stays, so it would have to have its own entry. It's not just an additional five beds; it would have been a whole additional unit, essentially, that would have been added. It came down to we needed to deliver the project, and 22 beds is what we could deliver within the funding.

CHAIR - Can I ask, what the difference between short-stay assistance - or short-stay opposed to a longer stay is, insofar as patient care?

...

Mr BANNON - ... to put it quite simply: the short-stay unit really is intended for people who are experiencing a time-limited episode of distress. Often, they are attached to a sister service, such as a safe haven, so a consumer would present in either situational or suicidal distress. It would be deemed that they're not safe to return back into the community for the evening. We would seek an admission to a short-stay unit for a time-limited period to put a safety plan in place for that individual before transferring them back out into the community, as opposed to a typical acute inpatient admission where the average length of stay is around 12 to 14 days which would not be clinically indicated for the cohort of consumers who would require a short-stay admission.

CHAIR - Do we know hypothetically what the additional funding requirements or cost requirements would have been for the five short-stay or that section - on top of the cost?

Ms SIMMONS - We had a design done up including the short-stay and associated services to support that. That came in at around \$83 million -

CHAIR - On top of the original cost or overall?

Ms SIMMONS - Overall.

- 4.9 The Committee heard further evidence on how the proposed works and model of care will attract and retain staff:

Ms RATTRAY - ... the model of care that will be used in this new proposed facility appears to me will need additional staffing, and we heard this morning that staffing for such a specialised service of medical care is difficult on the coast. It's difficult everywhere, but it's even more challenging on the coast... what's the thinking around that additional staffing needs?

Mr BANNON - Definitely. I think we've reached a point in the project now, getting closer to reaching the tender stage, where we're commencing what the workforce planning will look like. We know that it will result in an increase in need for FTE, not just of existing FTE, but also as an opportunity to create new positions. We've recently introduced lived-experience workers to our inpatient units, which has been a first in Tasmania, and we're also looking at roles such as Aboriginal health liaison positions, but I think the most important drawcard for us is going to be, with our recruitment and retention - is that this is a new purpose-built, truly contemporary facility.

We know that the environment that staff work in does have a significant impact on how they feel, and I think Spencer has done some incredible work in improving its recruitment strategy. We've gone from having, on average, around 10 agency nurses at any given time to now at around two, so there's been a significant improvement in being able to recruit and retain, and we think that bringing this piece of infrastructure online should only improve that.

Ms RATTRAY - You see the aesthetics of working in a new environment, and it's going to be a strong attraction for those specialised services to come to Burnie.

Mr BANNON - Not just the aesthetic, but the fact that it is purpose built. At the moment, our greatest asset at Spencer Clinic is our staff and our workforce. We cannot rely on the environment to support recovery and de-escalation. We're going to be moving to a facility that allows tools and resources to a workforce to be able to do the important work that they enter mental health services to do, that we're currently not able to support them to do in the current environment.

...

Ms SCHOFIELD - We have a number of strategies that we're employing, I suppose, across the state. One is the peer workforce strategy that Jarrod has talked about. The other is increasing sort of right supports to the TTPs, the transition-to-practice, and looking at more effectively recruiting transition-to-practice graduates into mental health who come from the north west, and match need with demand, in terms of growing our own.

... and then ensuring that the staff feel supported to support that workforce coming through. As well, we now have a new strategy around allied health practitioners - again, bringing in novice practitioners, or early-career practitioners, I should say, and growing our own is a very strong strategy that we have. We're not relying on interstate, but gaining that interstate experience where we need experience, but actually looking at supporting and growing our own as a culture. I think that's gone some way to increasing and decreasing our reliance on agency staff. In fact, we've had a number of agency staff who've joined our ranks permanently. In some ways it has surprised us because Spencer would be not the best thing to advertise, as it currently stands from an infrastructure perspective.

Staffing for the Proposed Works

- 4.10 Having heard evidence on the proponent's strategies for attracting and retaining staff for the Precinct, the Committee sought further evidence on the breakdown of staff required for the facility:

Ms BURNET - Just the clinical mix of allied health professionals, psychiatrists and so forth for that kind of size facility, ideally.

Mr BANNON - It isn't going to be too dissimilar from a medical perspective from what we've currently got. It is only an increase in three beds, so that will be a small increase in FTEs. At the moment, we've currently got two SMPs [specialist medical practitioners] who are our psychiatrists. Supporting them, we've got two registrars and a rotational RMO [resident medical officer], who is a junior medical officer. From a nursing perspective, on-shift, we currently work off nursing hours per patient day, which somewhat translates to around one registered nurse per four consumers. We'd be looking at around eight nurses per morning shift; afternoon shift would be the same and slightly less on an evening. That's the nursing disposition.

Ms BURNET - They're RNs [registered nurses]?

Mr BANNON - They're a mix of RNs and ENs [enrolled nurses]. We have around 30 per cent of ENs on any given shift that make up that nursing workforce. They're supported by what we currently refer to as attendants or healthcare assistants, who support on the unit, and then our allied health workforce is currently made up of one social worker with a part-time psychologist.

In no way do we consider that the current disposition of MDT [multidisciplinary team] is adequate. We would be looking to advocate for an increase in MDT disposition moving forward. There are a range of other supports onsite daily supporting. We've got a senior nurse, who is titled specifically as a discharge planner who you might have met today. We also have a RUSON which is a Registered Undergraduate Student Of Nursing. Again -

Ms SCHOFIELD - We're looking at expanding those.

Mr BANNON - ... we would be advocating for an increase in some of those auxiliary supports, particularly in the Aboriginal health liaison space and lived-experience workforce.

Transition from the Existing Facility to the Proposed Works

- 4.11 The Committee heard evidence on the plans to transition staff and consumers from the existing Spencer Clinic to the Precinct:

CHAIR - From a clinical perspective, can you give us a really brief insight into the move from the current facility to the proposed facility and decanting both, and what that may look like?

Mr BANNON - We're really fortunate that this is a new build on a greenfield site, so there's no need to stagger or phase that transition. We will be procuring an entirely new suite of furniture and furnishing, so I guess Cat and I as executive leaders would be looking at the implementation and transition process, and developing a really robust plan with additional resources from an internal project perspective to

facilitate what that looks like. We imagine that will be over a period of time, particularly given the need to have some familiarisation with a lot of new functionality and technology that we've not currently got access to. We would have a full and complete orientation and onboarding to this new facility.

CHAIR - And to maintain that continuity of care as you're moving from one to the other.

Mr BANNON - Absolutely. There will be a need for a strong piece of consumer engagement there to support the consumers with what would be quite a confusing transition, if you're in a period of unwellness, to be in one facility in one moment and then supported to a new facility. We will certainly engage with our lived-experience workforce to support with that.

Sustainability Strategies

4.12 The Committee heard evidence on the sustainability strategies being implemented for the proposed works:

Ms BURNET - ... In relation to sustainability strategies to be adopted, you talk about a 60 per cent reduction target across departments by 2050. Can you describe what fundamental things you're going to be putting in as part of this project?

Mr BURBRIDGE - The first one is solar panels on the roof to help reduce energy consumption. LED lights throughout and insulation to meet all the section J requirements for walls, ceilings, and under floor. Double glazing, if not triple glazing. Basically, all the consumer bedrooms, all the areas consumers can be left alone in, they have actually ended up being triple-glazed windows. We can conceal the blinds behind a window so the consumers can't get to the blinds. Instead of double, it becomes triple glazing, which helps with the thermal there as well. Double glazing everywhere else. Light-coloured roof to help reflect and stop the hot solar heat gain into the building. The selection of all the plants, the air-con units, mechanical units, hot water, and all that sort of stuff.

...

Ms SIMMONS - Things like the mechanicals - it's more about the zoning and the efficiency in terms of the different zones -

Mr BURBRIDGE - Yes, not having an air-con zone that spans across the whole width of the building, for instance, so you don't have half the zone on the southern side and half the zone on the northern side because the air-con will be fighting itself constantly. Zoning them appropriately around the building to work with orientations and work with how the pods and all that sort of stuff work to make sure they're efficient as possible.

...

Ms RATTRAY - If you have triple glazing, why would you need awnings to external windows?

Mr BURBRIDGE - To stop some of the sun coming in as well, so it's more for -

Ms RATTRAY - You have blinds on the inside and triple glazing and then you're having awnings to external windows?

Mr BURBRIDGE - Yes, you can have your blind open and still look outside but you don't necessarily have direct sunlight coming into your bedroom.

Ms RATTRAY - Would you say that it is over the top?

Mr BURBRIDGE - No, I wouldn't like to be looking through a blind all day if there's sun coming through my window without a blind or without an awning on the outside. I prefer to have the awning on the outside and not be looking through grey blinds.

Mr DUNNE - The best practice to manage shading is to do it externally first before you treat the glazing. Always external is the priority first and then you work your way in within the building, so it's always a benefit to treating and controlling the shading externally.

Mr BURBRIDGE - It also gives the consumer the maximum amount of control. Some consumers might want to have the blind down or blind up. We give them the options.

Car Parking

4.13 The witnesses provided evidence on the increase in car parking included in the proposed works, as well as part of the NWRH Masterplan:

Ms BURNET - I have another question around the consolidation of car parking over the site. There was going to be more car parking below the building, but what's the overall plan?

...

Ms SIMMONS - Car parking for the Masterplan is in various stages, is my understanding. There will be additional car parking delivered as part of Stage 1 as well. Then, I think there's an additional three or four more car parking spots as part of the Masterplan. I think it's important to note that, for this building, we are providing additional spaces to service this building.

...

Ms BURNET - While we're on parking, just in relation to futureproofing and EV [electric vehicle] parking, is there any likelihood that this has been considered in this part of the development or beyond, in the master plan?

Ms DOBSON - We currently have a project that is delivering two EV spaces for each of the hospitals, or four different hospitals, around the state, including North West Regional, so that would be available. Any future multistorey or car park-specific projects will have EVs. There's a project happening in the multistorey in Launceston that has multiple EV points as well. So, yes, it's a different part of the design and delivery.

Mr BURBRIDGE - There will be no EV parking underneath this building, because if you do that, it increases a lot of fire requirements. It has a lot more requirements for fire sprinklers and detectors, and a cost impact with that as well. If there were EVs for this one, it would be located in the car parks outside.

- 4.14 In response to matters taken on notice, the Department of Health provided further evidence on the increase in car parking for the proposed works and the broader NWRH site:

32 carparking spaces will be added to current available parking at North West Regional Hospital as part of this project. This number includes 2 accessible carparks. An additional bay will also be added for drop offs.

o Approximately 630 additional car parks are expected to be delivered across the 20-year North West Hospitals Masterplan.

o To date, 43 additional car parks have been provided at the North West Regional Hospital through various improvements to parking.

o The intention is that the additional car parks will be provided in basements and under crofts of new buildings where possible, and through the creation of car parks at ground level. ²

Pedestrian Link Bridge

- 4.15 The witnesses provided the Committee with evidence on the proposed pedestrian link bridge that will connect the Precinct with the main hospital:

Ms RATTRAY - ... *My understanding is that that's quite crucial to the functionality of the new proposed facility. Do we have some indication of what sort of timeframe that will be and not having to use the trolleys with some warming devices to get food and supplies up to the new facility...*

Ms DOBSON - ... *The link bridge that will connect the Masterplan Stage 1, which includes the mental health precinct, to the current hospital will come in at or just above the current main entry to the hospital and that is part of Stage 1 delivery as part of the Masterplan. That's what's in the design phase at the moment. The funding model for that, the state is seeking to match federal funding, so it hasn't been sourced as far as the delivery, the funding for delivery of that, but the design is in process, and the mental health precinct has been designed to allow for the link bridge connection to that.*

- 4.16 The Committee heard further evidence on the risk of the Precinct being disconnected from the main hospital:

Ms BURNET - ... *I have a question for you, Ms Schofield: in relation to code blues and for emergency purposes for staff safety and so forth, so code blacks, what kind of risks have been considered in relation to that and this build?*

Ms SCHOFIELD - *I would say quite significant risks have been considered, which is why we lobbied very heavily to ensure there was linkage, because we were acutely aware of the risks of not being connected. It is unfortunate that we have to mitigate, from the completion of this build to the completion of what we see as part of an essential component - from managing, as you say, the code blues and code blacks. We are looking at mitigation strategies and ways of working to accommodate that once this*

² *Parliamentary Standing Committee on Public Works Hearing – North West Regional Hospital Mental Health Precinct – Questions on Notice, Department of Health response to PWC request for additional information, 16 April 2026, p. 3*

building is commissioned, knowing that we will get a better solution at some point in the future.

Ms BURNET - Do you have an ideal width for a link bridge, as well? I'm curious to know: are there intrinsic risks with a corridor such as this, in relation to safety and so forth, the likely width, as well as any of those other things to consider?

Ms SCHOFIELD - Can I just say that some of the infrastructure, in terms of width, must be prescribed in the same way through the guidelines, the same way as rooms would be prescribed in terms of what's required. Other facilities operate very well with a link bridge with a separate facility and we visited one, or your team visited one in Melbourne where they have a very nice separate mental health facility but linked to the acute-care hospital. So it does work; it does mitigate some of those safety issues. With the transport of any consumer there comes a risk when you're moving somebody from one area to another, but we can't avoid that because of how the health system is set up that people are assessed in one place and then taken somewhere else. We will endeavour to do as many, I think, direct admissions to this facility. That will be a major component of the model of care. At the moment, the majority of admissions come through the emergency department. We will endeavour to ensure that's minimised...

Project Risks

- 4.17 The Committee sought evidence on the risk of the close proximity between the proposed works and the NWRH's helipad:

CHAIR - Talking about the Masterplan, we learnt today that firstly the helipad has been contentious because of the closeness of that to the proposed facility. It's my understanding in the Masterplan that that helipad may be moved at some stage in the future. Can you talk us through that and then also mitigation around the noise and the reverberation from the helicopter and how you can lessen the impact of that on the proposed facility?

Ms DOBSON - I will talk to the location. Part of the Masterplan is to relocate the helipad to on top of the current ED. I think it's Stage 5, but I might need to come back and check. That doesn't pose an issue as far as flight path currently by leaving it to the final stage. The constructability: we will have to make considerations and work with Ambulance Tasmania during construction because there will be cranes etc. We have precedent to enable that and stand down the cranes to allow for incoming and outgoing flights. I will pass on to Cam.

Mr BURBRIDGE - The current building is outside the obstacle limitation area of the helipad. But as Rachael just said, during construction, there will be cranes and trucks and stuff that potentially will be in that opposite limitation area, so just need to be ongoing consultation with the helicopter operator during construction. It is the same thing that ARTAS did for the Mersey Hospital when they were building that. The construction compound was actually underneath the helipad there, and there was a stern protocol in place that when the helicopter was coming in to land, the builder would have to do various steps to make sure it was secure before they could land and they get notified a certain time before the helicopter was coming in. I imagine it'd be the same.

Ms RATTRAY - Wouldn't the Mersey helipad be just as close as what the one here is? So what's the problem?

Ms DOBSON - It's more the sound and the vibration needs to be assessed for incoming and outgoing and the uplift to the air when flights come and go. It is a considerable amount of planning that goes in to determine what the flight path is.

CHAIR - Is it also potentially problematic because of the nature of the facility being close to a helipad landing and that that may be stressful? Can that be mitigated with design?

Mr BURBRIDGE - Yes, we're working with the acoustic engineer the whole way along the process to both make sure the internal sound reverberation in the space is nice and the sound between different areas is limited and the sound from outside - the helicopter - is limited as much as possible. It is a bit difficult to design out helicopter noise because it's not a static point. It's over there, then it's 200 metres away. We have been working with an acoustic engineer to try to mitigate that as much as possible.

4.18 The Committee also heard evidence on the current project cost estimate and the risk of exceeding the project budget:

Ms RATTRAY - ... There's a very small buffer in what's presented to the Committee and the money that's been provided, the \$47 million. I'm interested in what happens - because this is not the final cost estimate, if that is my understanding. Do you want to help me work through that and how you will get to what you will be able to accept tender-wise? I don't need a figure; I just need to know what happens if it doesn't meet this cost.

Ms SIMMONS - I can speak from project perspective for that. The cost plan that we had at the time of this paper was a schematic design cost plan. We have since worked through detailed design, so we know exactly what's going on with the walls, where the windows will be, door handles, right down to very small details. From that cost plan to this cost plan, I'm personally quite confident that we're on budget in that we haven't crept the scope at all. The footprint has remained the same from schematic design through to end-of-detail design.

The schematic design cost plan has the contingencies for any details that might cost more than expected, but I'm fairly confident that the design team has done an excellent job of containing the scope within what we have in that schematic budget. So, confidence is high that we'll be on budget at the detailed design cost plan, which we will be receiving next week, hopefully. Then from there, from detailed design to pre-tender - the pre-tender estimates are more just a double-check that once the team has completed the contract documents, everything is as what we thought in the detailed design. It's rare, and it would be unexpected, that that cost would then increase significantly or there be any major surprises from detailed design cost plan to pre-tender, and then we hope that the contract's pricing is as expected.

Community Consultation

4.19 Mr Dunne provided the Committee with an overview of the consultation undertaken by the proponent:

Mr DUNNE - ... The project has undergone two substantial rounds of stakeholder and community consultation, first in March 2025 and, again, following design refinement, in October and November 2025. Feedback has been consistently supportive of the project's intent with constructive input on building access, parking, visual amenity and service capacity. This feedback directly informed the final design.

4.20 Ms Simmons advised the Committee that feedback had been received from the community regarding concerns about the building height, which led to its reduction during the design stage. The Committee then asked whether there had been any other concerns raised during the proponent's community consultation process:

Ms RATTRAY - ... I note that one of the risks is community and local stakeholders, and you've already indicated that they weren't necessarily too happy about the original build height. Is that all? There is no more negative public input, or is that not quite the case? ...

Ms SIMMONS - There's always potential, but we take means to try to mitigate that. We've had two major rounds of community consultation. In our last round we didn't receive any negative feedback, and as we head into construction, we will then implement the next round of engagement. We actually have the personal contact with those residents along Bridport Road there, so we know them by name, and we will give them tailored personal communication along with broader community information as we head into construction.

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

4.21 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 needs 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 - Are the proposed works a good use of public funds?

WITNESSES - Yes.

5 DOCUMENTS TAKEN INTO EVIDENCE

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

- *North West Regional Hospital Mental Health Precinct*, Submission to the Parliamentary Standing Committee on Public Works, Infrastructure Services, Department of Health, 19 February 2026; and
- Department of Health response to matters taken on notice, 16 April 2026.

6 CONCLUSION AND RECOMMENDATION

- 6.1 The Committee is satisfied that the need for the proposed works has been established. Once completed, the proposed works will provide a fit-for-purpose facility that is contemporary and recovery-oriented.
- 6.2 The proposed works will support best practice models of care and provide calm environments, therapeutic outdoor spaces, and modern staff facilities to attract and retain staff. The design prioritises dignity, privacy, and connection to nature, and promotes a non-institutional atmosphere.
- 6.3 The Precinct will respond to the need for increased capacity and flexibility for the north west's growing population, in conjunction with further opportunities to meet this demand, such as community-based services and the Mental Health Emergency Response Service.
- 6.4 Accordingly, the Committee recommends North West Regional Mental Health Precinct, at an estimated cost of \$40 million, in accordance with the documentation submitted.



**Parliament House
Hobart
18 June 2026**

**Jen Butler MP
Chair**