IN-CAMERA **PROCEEDINGS BEFORE**[1]

JOINT SELECT COMMITTEE ON THE ROYAL NORTH SHORE HOSPITAL

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

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At Sydney on Thursday 22 November 2007

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The Committee met at 9.00 a.m.

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PRESENT

Reverend the Hon. F. J. Nile (Chair)

Legislative Council	**Legislative Assembly**
The Hon. A. R. Fazio	Mr. M. J. Daley
The Hon. J. A. Gardiner	Mr P. R. Draper
	Dr A. D. McDonald
	Mrs J. G. Skinner
	Ms C. M. Tebbutt

[1] Published by resolution of the Committee 22 November 2007.

ALICIA JACKSON, Registered Nurse, Royal North Shore Hospital, and

SAMANTHA FLEW, Nursing Unit Manager, Emergency Department, Royal North Shore Hospital, and

MICHELLE BEETS, Nurse Manager, Emergency Department, Royal North Shore Hospital, affirmed and examined:

CHAIR: Thank you for agreeing to give evidence today. We appreciate your attendance. I ask each of you in what capacity are you appearing before the Committee?

Ms JACKSON: I am a registered nurse at Royal North Shore Hospital.

Ms FLEW: Nursing Unit Manager of the Emergency Department.

Ms BEETS: Nurse Manager of the Emergency Department, Royal North Shore Hospital.

CHAIR: We are pleased to have Susan Pearce present as a support person, not as a witness. Do any of you want to make an opening statement?

Ms BEETS: Yes, I would like to. I have handouts for the Committee of things I am going to discuss today. If you wish to have copies they are available. I wanted to thank you for giving us the opportunity to present today and to give you a nursing perspective on our positions at the hospital. Although I have to say I was a bit disappointed that we were not asked at the outset to appear and there did not appear to be much of a nursing presence at this Committee. The issues that we wish to discuss today are related to the nursing workforce, nursing education, overcrowding in the emergency department, lack of acute mental health beds and bullying and harassment. Basically I wanted to get the message over today that the nursing workforce we have today—which has been supplied at the back of my statement as a graph of our skill mix and our nursing base at the hospital—has shifted over the years from an experienced R8 nurse down to a second year nurse who is virtually one year out of the university. We have lost a lot of our senior skill cover due to some of the conditions that we have to work with in the emergency department, which is overcrowding and it is very stressful. A lot of our senior workforce has now gone part-time or has left the profession totally. It is a huge concern to all of us.

In relation to nursing education, because these nurses who have come out of the university are fairly inexperienced—and it is no-fault of their own—they do not have the skills or the knowledge base to look after critically ill people. We require a few more clinical nurse educators to support them in their role to allow them to fulfil their career and to attract some personnel because this has an impact on the nursing care they are able to give. Currently we have only two full-time clinical nurse educators for a staff base of 86.46 full-time equivalents nursing staff. One of those positions has been vacant for the best part of this year. So literally we have had one clinical nurse educator trying to teach the nurses the basic skills of how to look after critically ill people. Therefore, obviously, I would not mind some increased resources for a clinical nurse educator, a system with their professional development. The increasing levels of overcrowding in the emergency department [ED], which I am sure you have heard about during this process,

results in increased adverse events towards patients, increased sick leave amongst staff, poor morale and increased length of stay for patients in the ED. It is also vital that this overcrowding is reduced, otherwise we will not have any more nurses left in the system.

The other issue that I want to talk about is the triage nurse, which is quite vital to our role in the emergency department. Often the triage nurse is the first point of contact for anyone entering an emergency department. The triage nurse is often the target of much abuse, sometimes physical. The triage nurse has an enormous workload in assessing patients, competing with multiple priorities, many interruptions and pressures to offload ambulances when people can often walk in off the street with a high clinical need to be prioritised in the system. The pressure for us to offload ambulances is phenomenal because of the KPIs that we are requested to meet. It becomes very difficult for us to be able to do that when we do not have any beds in the ED. The triage nurse is often the target of abuse due to patients presenting because the ones in the wait room are very irate, sick and injured. I noticed some of the comments made earlier in the processes that the nurses were cold, uncaring and mechanical. But nurses are under extreme pressure and working in triage is very difficult.

Another huge issue that we have is lack of mental health beds for acute mentally ill patients. Our presentations have increased. I have put some figures on the second page of my statement. For the first six months of 2006 we saw 888 patients presenting with mental health issues. For the same period this year we have seen over 1,000. The delay for mental health patient separation from the ED is primarily due to the unavailability of acute mental health beds, not due to the delay in treatment processes. These patients are very disruptive. They increase the workload for the clinicians and their length of stay in the ED is not uncommon from three to five days. Often we request individual patient specials for these patients, and they are not always supplied. We have a high level of nursing vacancies. I have attached a graph on a page at the back comparing last year to this year. Our recruitment and retention factor has been pretty poor at Royal North Shore over the last year and the bad press that we have been receiving has not been very helpful.

Then we go on to harassment and bullying of the staff, which is a systemic problem by senior nursing administration at Royal North Shore. This is due to the constant demands and pressures to meet key performance indicators. These key performance indicators have been set down to monitor and achieve quality outcomes for patients. They have been mostly unachievable for 2007. These are very clearly out of the control of the ED. When the patient occupancy is greater than 85 per cent, which I know you have heard about, the hospital becomes very inefficient, elective surgery is cancelled and emergency patients build up in the ED, which results in increased stress for the staff. I think there is very much a lack of professional recognition for nurses, who are undervalued, especially by the general public and their peers. Childcare facilities in the hospital workplace for nursing staff who wish to return to the workforce are not available. Parking, of course, is difficult for staff and we need reduced parking rates. That is a minor thing in the scheme of things. That is roughly what I had to talk about.

CHAIR: Thank you, Ms Beets, for sharing that with us. We appreciate it. Do any of the other nurses wish to make a statement?

Ms JACKSON: I would like to make a statement. I do not think it is just isolated to the emergency department. It is throughout the whole hospital that nurses are

constantly under pressure to move patients to accommodate emergency patients coming up to the wards. So they are quite stressed as well. They are getting burnout. A lot of people are leaving and positions are being filled with agency staff or enrolled nurses or assistant in nursing positions who do not have the expertise in the areas of high dependency, orthopaedic wards and spinal units. So they are feeling the pressure as well. It is throughout the whole hospital, unfortunately.

Ms FLEW: I would just like to add that I think the hospital has lost focus on the one reason why we all take oaths to be nurses and to work in hospitals, and it is patients. There seems to be no direct focus on patient safety and there is a lot of patient compromise in order to meet benchmarks to get people up to the wards. It is clearly simple, you know. The emergency department can process patients and get the best treatment we can give with the resources that are available to us, if we can get the patients out of the emergency department. It is simple maths but no-one seems to be listening to us.

Every day we are under enormous stress to give the best care we can to the patients who come in to the Royal North Shore Hospital emergency department, who believe and want to get the best care that they believe, and truly they do, deserve. But every day we struggle to meet the benchmarks. I think the pressure to move the patients to the wards when they are not well enough to go and the pressure to get people off ambulance trolleys because the matrix system that has been brought in clearly is not working really affect the staff because they are asking us to make decisions and to cut corners when clearly we will not do them. I think there needs to be a focus on patient safety and the stresses that the staff are having to undertake to, you know, meet benchmarks.

CHAIR: Thank you very much for sharing that. We will have some questions, now if you do not mind answering those from the Committee members.

Mrs JILLIAN SKINNER: Thank you very, very much indeed, all of you, for coming in. Can I say that we value enormously your contribution here, but also your work in the hospital. I would like to ask you about the question of morale, which you have touched upon, perhaps, Michelle.

Ms BEETS: Yes.

Mrs JILLIAN SKINNER: This has been an ongoing problem for some time.

Ms BEETS: Yes.

Mrs JILLIAN SKINNER: Has it not?

Ms BEETS: I think so. I think this year has to be decidedly the worst year. I have actually been 22 years working at the Royal North Shore Hospital. I have been a nurse for 37—way too long, but anyway—and it is actually a great job. Nursing is fantastic, but the conditions that we have been meeting over the years are declining, and I think personally we are at rock bottom at the moment.

Mrs JILLIAN SKINNER: While the recent media publicity has not helped at all—

Ms BEETS: No, not at all.

Mrs JILLIAN SKINNER: —would you say that there is some hope that at least bringing this out now and having this inquiry actually can provide some answers.

Ms BEETS: Yes. We are looking to you for the hope.

Mrs JILLIAN SKINNER: Would it not surprise you to know that I have been approached by many, many of your colleagues who are saying, "This is our hope, and we want this inquiry because we have to have some resolution"?

Ms BEETS: Yes. I am sure that some good will come out of this. If we can even just get the hospital back to 85 per cent occupancy, then everybody's daily life will be so much easier to manage and things will work and processes will happen, and the pressure will not be there, and the morale will lift, and everybody will be able to do a great job.

Mrs JILLIAN SKINNER: When you talk about the focus on achieving the benchmarks—

Ms BEETS: Yes.

Mrs JILLIAN SKINNER: —I am taking it that none of you has a problem per se with the benchmarks, but it is that you do not have the resources to meet them. I see nods all round.

Ms BEETS: Yes. It is hard to meet the benchmarks when the hospital is at greater than 85 per cent occupancy. There is no way we can offload an ambulance in 30 minutes, especially when six or eight arrive simultaneously, and then we also have people walking in off the street who might have chest pain and who are also considered a high priority. So you are trying to balance. We are under pressure to get the ambulance patients in so we can meet the target, but then the person who is waiting out the front with their chest pain, or potential infarct, they might have to wait that bit longer because of these pressures. So we try to balance it. We would rather get the person in with the chest pain, which we probably would do, therefore the ambulance gets to wait, and not every ambulance needs to be offloaded immediately.

Ms FLEW: Can I just add that puts extra stress on the triage nurse because they are experienced clinicians who recognise when a patient needs to be seen by a doctor or needs to be in a bed, and we do not have the resources. When we do not have the resources to provide that service because there is the expectation to offload an ambulance beforehand, again it lowers morale. We have nurses—our emergency nurses do not want to triage. It is the most important position in our department and our senior nurses do not want to go out there. It is very difficult. That is how bad the morale is at the moment. We need to look to this inquiry to find some solutions. We can offer some and hopefully it will be better.

Mrs JILLIAN SKINNER: Just about every clinician who has given evidence here has talked about beds.

Ms BEETS: Yes.

Mrs JILLIAN SKINNER: And nurses to look after patients in those beds.

Ms BEETS: Yes.

Mrs JILLIAN SKINNER: Because it is not just a matter of going and finding the beds: they are all there, are they not?

Ms BEETS: Yes.

Mrs JILLIAN SKINNER: It is a matter of addressing this nursing shortage.

Ms BEETS: Yes.

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Ms FLEW: Yes.

Ms JACKSON: Yes, and also, you know, when the patients are sorted out in emergency and packaged up and are ready to go to the ward area, most of the time there are no beds available because those wards are shut.

Mrs JILLIAN SKINNER: I was astonished at the number of wards that have been closed—

Ms BEETS: Yes.

Mrs JILLIAN SKINNER: —over recent years. Is that something that needs to be addressed?

Ms BEETS: I think years ago they reduced a lot of hospital-length-of-stay for patients, so they did need to cut back some beds. But I think perhaps five years ago, we might have been just a tiny bit more ruthless in the cutting back of the beds and that is coming now, we can see that happening now.

Mrs JILLIAN SKINNER: So it is like a pendulum has swung the other way.

Ms BEETS: Yes. I mean, obviously opening more beds will be a solution, but we also need the workforce to mind these patients.

Mr MICHAEL DALEY: That is right.

Ms BEETS: And, you know, to balance these books, nurses, I have to say, will not want to come back to the workforce if we have to keep up with these conditions that we are working under. I think we need adequate remuneration as well because I do not think that in general we are a valued workforce. Also for most of our nursing staff, the average age of the nurse is in their mid-40s. Give them another five years and they will have left the system. The girls who are coming or the people who are coming out of university now, there are two second-year nurses who are very motivated, decidedly keen, but do not always have the knowledge base and that is not their fault. They are tired of it already and they have only been out of university one year. They travel, go abroad or take another degree from a different university, so we are not retaining the workforce.

Mrs JILLIAN SKINNER: Earlier I think it was Matthew Daly who gave evidence about the numbers of nurse educators. It was commended by this Committee, one member in particular. It is a very commendable initiative, but if you say you have only one—

Ms BEETS: We have one at the moment.

Mrs JILLIAN SKINNER: How many do you need?

Ms BEETS: I would like three or four because you need to be able to work them after hours and do a rotating roster so they are there on the weekend or they are there at 10 o'clock at night to support the nurses. Everyone works office hours and goes home, but the workload is generally in the evening and the support mechanism is not there. So I really do need an increase, only because the nursing staff, if you look at my graph, is very free down this end of the scale. There is a lot of people here, but they are mostly part time. They do about two days per week and they are the R8 senior workforce. There is not much in the middle and then we are looking at the people just coming out of university, first and second years. They do not have the knowledge base. It comes with experience. They will get it, but they need help to get it.

Dr ANDREW McDONALD: Referring to this graph, which shows that the 18.48 full-time equivalents [FTEs] are R8s.

Ms BEETS: Yes.

Dr ANDREW McDONALD: And you have a lot more R1s to R4s.

Ms BEETS: Yes.

Dr ANDREW McDONALD: When is a nurse able to require minimal supervision?

Ms BEETS: I think personally, from my years of experience, around the sort of year 4, year 5, mark because they have got a bit of solid grounding and they have built on some of their skills. I think around about R4 you expect a bit more of them and they are usually good at coping at that, but R2s, they really are very limited in their knowledge base. They are good nurses, but they just do not have it yet. They will get it, if they get the support and the experience.

Ms FLEW: I think most R2s have only just finished their year graduate rotations so their experience is extremely limited.

Dr ANDREW McDONALD: The Committee has been told that professional practice units are being set up in the area and headed by Mary Dowling—

Ms BEETS: Yes.

Dr ANDREW McDONALD: —to investigate patient complaints and staff grievances such as your own. Have you had any contact with the Professional Practice Unit [PPU] as yet, Michelle?

Ms BEETS: Well, unfortunately when all this happened, this incident that has brought us to this inquiry, I was actually on seven weeks leave. So about that time they did at bit of an investigation at the hospital to do with bullying and harassment, but I was not actually there and never got to speak to any of the people involved. The bullying and harassment is just generally a systemic problem across the whole hospital. It sort of starts at the top and it filters down to the people at the coalface and it is due to the pressures that everybody is under. It is no specific issue. It is just a general, everyday workload, and it still happened this week but in a different way. They are still asked questions, "Why have you not offloaded the ambulances?"

This week we have come very unstuck with beds. Nothing really has improved since I have been back. I have been back five weeks now from my holiday. Leading into my holiday, it was a complete nightmare and it has been consistently bad since about April. We are talking November and not much has changed despite what happened several months ago with the incident that has brought us here. We had a little bit of a lull initially but I think it is that patients did not present to the hospital because of the bad press. Now it is starting to pick up again, and again there are very few beds available. Earlier this week we had hardly any beds left in the hospital.

Ms JACKSON: Plus the acuity of the patients that do present is quite high. It is not that you can treat them and send them home. They need lots of work, lots of investigation and admission to hospital, basically. So they are not people that you can send back to see their general practitioner [GP]. That is another problem too.

The Hon. AMANDA FAZIO: I have a couple of issues. One is just in relation to bullying and harassment. I wonder whether Ms Flew or Ms Jackson have any comments to make about the recent reports into bullying and harassment at Royal North Shore?

Ms JACKSON: I feel that there is bullying and harassment evident but it does come from the senior management in nursing at the Royal North Shore. But these people are under constant pressure themselves, like Michelle mentioned, to meet key performance indicators [KPIs] that are totally impossible to keep to, due to the high acuity of patients and no access to beds, wards being closed and no nursing staff to look after these patients. I guess they are very frustrated in their positions and that impacts on everybody else. It just brings everybody down and it fractures right down the line to the coalface.

Ms FLEW: I think, unfortunately with those pressures, sometimes the direct clinical staff on the floor also receive that—

Ms JACKSON: We are the ones that cop it, basically.

Ms FLEW: —harassment, basically. As managers, we try to sort of take the brunt of it for them, but it is very hard when you have got junior staff trying to do their job and they are being harassed by people they do not even know to get patients to wards when it is not safe to do so. And it is rampant in the hospital, unfortunately.

The Hon. AMANDA FAZIO: We hear a lot about access block and we have heard a little bit about exit block, which is getting people out of the hospital who should

not be there. Have you any comments to make on how that contributes to the problems that you face in your day-to-day work?

Ms BEETS: I think that there is a bit of exit block obviously happening because there is a reduction in the rehabilitation beds. Alicia has been very much involved in trauma patients. They have a lot of patients that need rehabilitation post their injuries. There is a lack of access to those kinds of beds. I am sure that nursing homes are a bit of a problem. I do not know how big a problem that is because I am more in the emergency department, so even though we are responsible for the whole hospital, I do not always have enough facts to contribute on that, I am sorry.

Ms JACKSON: I can comment a little or speak to that question on exit block. I am seeing trauma patients right around the whole hospital at Royal North Shore and that includes aged care trauma patients. It might be decided that this patient is not safe to go home any more or that they need a nursing home placement. That becomes a huge issue. There are no beds, or funding means that we may not be financially viable to get these patients into nursing homes, so they tend to stay in hospital for extended periods of time.

Trying to get people with severe brain injury to a brain injury unit is difficult. There are not enough rehabilitation beds in New South Wales, especially brain injury rehabilitation beds. We are a major spinal injury hospital, as you know, and severe burns unit, as well as a trauma centre, and trying to get these patients through rehabilitation is very, very difficult. Therefore they stay in acute care beds or in an acute care hospital for extended periods because there are no beds available.

CHAIR: Following up on your report, Ms Beets—which is very good—you mentioned that you were at Royal North Shore Hospital for 23 years.

Ms BEETS: Yes.

CHAIR: We have been trying to work out what went wrong with Royal North Shore Hospital when it was so high in its standards and reputation. Did you notice at some point this occupancy issue or overcrowding at the hospital?

Ms BEETS: I think in the last five years it has generally deteriorated, but this year has to be the worst year. I do not think it has helped in some ways having changes in general managers as frequently as we did many years ago. We have gone to about eight of them within 10 years because things have not been fixed, so the solution is to dismiss that person and bring in another person. Quite frankly, I do not think it is their fault. Constantly changing these people is not going to make the system right. You need to keep someone there, even though it is bad, and let them work through the issues and make it better again. If it is bad, you are out, next one in, sort of thing. I think that has not helped.

The changes in management structure within the hospital have been very ad hoc. We had an unsettling period last year with the divisional nurse manager structure. I think that started to begin the decline, to be honest. I cannot pinpoint anything. Whether our patients are more acute and over the years they have decreased a few more beds so you did not notice another five missing, or another 10 missing. When I started at Royal North Shore it was possibly 900 and possibly 99 beds, and now it is just under the 500 mark, if not just above 400. We are not really sure exactly how many beds are there. They

talk about lots of beds, but I think if reality came to it and you actually counted them there are probably 400 and something. So the hospital has technically halved since I started, which is significant considering we are a big tertiary hospital and we take referrals from everywhere.

CHAIR: A couple of you spoke about the key performance indicators [KPIs] and said they are unachievable. What actually happens? If you have to get someone in an ambulance in half an hour, does someone question you, or do you note it down? How does anyone know how long it took?

Ms BEETS: I do not feel that we should earn that KPI personally, because the ambulance service has the jurisdiction of pushing the off-stretcher button to put the KPI in place. They might stop and have a chat to somebody, go around to the local coffee shop and buy a coffee, then go back to the car and push the button. So the information is decidedly inaccurate. We do not have control over the button. They go back to their ambulance and they are ready for the next job.

CHAIR: The ambulance people are the ones who make that record?

Ms BEETS: That is right.

CHAIR: Which evaluates you?

Ms BEETS: Yes, exactly, and it is very inaccurate. We have asked to have control over it but for some reason it has not happened. At the moment we have been a little bit more meeting of the benchmark, but I think for a good seven months this year we were the worst hospital in the State, I am led to believe. Everything was: You are the worst at this, you are the worst at that—you are the worst at everything. But to be honest, we actually provide a very good service. And I could not do it without the rest of the nursing staff or the medical staff.

CHAIR: Do you think those key performance indicators are unrealistic?

Ms BEETS: Certainly not the off-stretcher button. Getting the patients out of the department within eight hours to a ward bed should be very feasible, but at times that is not met either because we cannot move the patients to the wards due to there being no beds in the hospital or we are waiting on people to be discharged. Even this week we have had mental health patients in our department, probably five at a time. We have had two of them there for three days and one person there for five days, already this week.

Mr MICHAEL DALEY: In the emergency department?

Ms BEETS: Yes, in the emergency department, which is a noisy environment, the lights are on 24/7, and they are not really getting any mental health support. They are getting their medications, and hopefully we are looking after them. But they are there for a reason, because their mental health is unstable, but they do not have that input because they are in the emergency department, visited once or twice a day by the registrars or the consultant.

Ms FLEW: And taking up beds for acute patients that are queuing out the front.

Ms BEETS: On Monday there were five of them there. We have had a huge increase in mental health patients.

Mr MICHAEL DALEY: Are they people with mental health problems, or are they people with drug-related problems?

Ms BEETS: A bit of both. Some of them have personality disorders that are hard to treat anyway. But some people stop taking the medication because they think they feel better and then you have to get them back on track again. There are lots of reasons.

Ms JACKSON: They can be quite disruptive patients, obviously through no fault of their own. If you have a patient in the bed next to them who is having a stroke, it is not very pleasant for that patient and their relatives. These people are uninhibited; they go running around, some of them naked, and cursing and swearing. It is terrible for everybody.

CHAIR: They are not really a patient in the sense that they need to be in a bed, are they?

Ms BEETS: No. But it is not good to leave them there for five days; they do need a bed.

CHAIR: Do you strap them down?

Ms BEETS: No, we do not strap them down. We might use increased sedation on these patients—which is not always ideal in these patients either but it is only to make it easier to manage them within the emergency department. We do not tie patients down any more. We use chemical restraints; it is easier.

Mr PETER DRAPER: We really appreciate your attendance today. During the hearing there has been a lot talk about attracting the experienced nurses back. Do you think we can? How are we going to make it attractive to get people who have chosen to leave to come back?

Ms BEETS: I have quite a few mothers working with me at the moment who are in the R8 zone. They would pick up extra shifts but they cannot always work after hours because the child care at the hospital closes at 5 o'clock. If the child care could be extended to at least 10 or 11 o'clock at night, if one of the family members or some single parents do not have the backup, there would be an opportunity to perhaps get some of those people back into the workforce. I think we need to be recognised professionally. Nurses are nurses, but nurses are really important people in the scheme of things, and I think we need to be financially remunerated. I am managing a workforce of more than 100 people and I think my counterparts in the public-private sector probably earn twice the wage that I get, for less hassle.

Mr PETER DRAPER: There has also been a lot of faith put in the Committee to come up with recommendations. We are due to report before Christmas. If that reporting were to be delayed, would that have an impact on morale, do you think?

Ms BEETS: No, I do not think so. We need some very quick wins and then some long-term gains. So if it is going to make it better in the end, I would rather wait another two or three weeks. Have your nice Christmas holiday, come back, and give us something to look forward to. I want to get the message out that overcrowding is the hugest problem. Occupancy greater than 85 per cent is really the challenge, I know, but it will make a difference. Also, we really do a good job.

CHAIR: Your submission is very valuable. The Committee would like to include it in the evidence but we need to have you agree to put your names to it.

Ms BEETS: I am happy to put it out there.

CHAIR: There is no name on the submission. It could be done confidentially. However, we would like to publish it.

Ms BEETS: I will put my name to it. I have been a nurse for a long time, and I guess it is time to retire.

Ms FLEW: I am happy to put my name to it also.

Ms JACKSON: I am happy to put my name to it as well.

CHAIR: Are you happy for the evidence you have given this morning to be published?

Ms BEETS: I have no problem with that, if it is going to help. I know the nurses have had a very small voice in the scheme of things. I think it is important that we speak up for our profession.

CHAIR: You have certainly done that today.

Ms BEETS: Thank you very much.

CHAIR: The three of you are happy for your evidence to be published?

Ms BEETS: Yes.

Ms FLEW: Yes.

Ms JACKSON: Yes. Getting back to your question about where it all went wrong, we are very passionate about our profession but we are also very passionate about our patients and their families. We feel like Royal North Shore is slowly haemorrhaging to death at the moment, and we want to stop that haemorrhaging and make it better. Hopefully this inquiry will do that.

Motion agreed to:

That the evidence and submission of the witnesses be published.

(The witnesses withdrew)

(Conclusion of evidence in camera)

(Public hearing resumed)