Toowoomba Hospital Maternity Assurance Review Summary Report

August 2026

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FINDINGS

Based on staff interviews, direct feedback from Darling Downs Hospital and Health Service (DDHHS) and documents provided to the Reviewers, substantial reform activity is currently underway across Toowoomba Hospital Maternity Services. These reform efforts are broad in scope and span multiple domains, reflecting the scale of the issues identified in earlier reviews.

Four main initiatives underpin the current reform agenda:

- ensuring adequate staffing;
- improving the provision of women-centred, safe and evidence-based maternity care;
- contemporising models of care to better meet the needs of women and families across DDHHS; and
- improving workplace culture towards a more collaborative maternity care model.

Alongside governance reform, there has been a strong emphasis on rebuilding clinical governance capability. This includes the development of data tracking systems, audit processes, and mechanisms for monitoring key performance indicators. Structured clinical review forums, including multidisciplinary processes, have been introduced, along with more standardised documentation and reporting tools. These initiatives represent a significant shift.

Many of these systems remain newly implemented or are still under development. Data collection processes are not yet consistently applied or fully integrated into decision-making, and the service is still transitioning from a reactive model of governance to a more proactive, evidence-based approach.

Overall, while reform activity is comprehensive and appropriately targeted to the issues identified, it remains early in its lifecycle. These initiatives are not yet embedded into routine practice and remain dependent on continued leadership focus, resourcing, and staff engagement.

There remains a significant risk that the specific intent of recommendations arising from individual Reviews may be inadvertently overlooked given some of the Recommendations have been bundled together in the Master Action Plan and oversight is centred on the summary Master Action Plan.

In summary, based on the material available to the Reviewers and the interviews conducted, DDHHS's implementation of recommendations across the five review reports appears variable. A summary of each review report is set out below.

Report 1: Intrauterine Fetal Death Review Report

In relation to Report 1: Intrauterine Fetal Death Review Report, implementation seems uneven. Some recommendations concerning rural maternity services appear to be well established and capable of ongoing operation, whereas implementation at Toowoomba Base Hospital appears to remain in progress.

Across a number of recommendations, the Reviewers were unable to identify clear governance, monitoring arrangements or auditable evidence sufficient to assess sustainability with confidence. The overall position suggested by the material and interviews conducted is that DDHHS has commenced work in several areas, but that implementation remains incomplete in a number of respects.

Report 2: RANZCOG Accreditation Report

In relation to Report 2: RANZCOG Accreditation Report, DDHHS appears to have made the strongest overall progress. A number of recommendations and conditions relating to training, supervision, roster management, education, trainee participation and access to learning opportunities appear to have been completed or substantially advanced.

However, the evidence does not yet suggest that all cultural and structural conditions have been implemented in a manner that demonstrates fully sustainable change, particularly where the recommendation requires broader organisation reform or cultural rebuilding. Accordingly, while this Report reflects the most developed implementation response, sustainability appears missed across the more complex recommendations.

Report 3: Office of Chief Midwife Collaborative Clinical Review Report

In relation to Report 3: Office of Chief Midwife Collaborative Clinical Review Report, there are indications of some important structural progress, particularly in relation to governance reform and the creation of committees intended to improve maternity oversight across DDHHS.

Nevertheless, many recommendations appear still to be in progress, and the evidence does not consistently demonstrate that new processes are yet embedded or operating to a sustainable standard.

In several areas, the Reviewers were unable to identify clear governance and monitoring arrangement for ongoing implementation. The material therefore suggests partial advancement, with sustainability still dependent upon further consolidation and consistent execution.

Report 4: Independent Workplace Culture Review

In relation to Report 4: Independent Workplace Culture Review, implementation activities have commenced and are ongoing. The maturity of implementation is not yet sufficient to permit a comprehensive assessment of whether these changes are sustainable or embedded.

The issues identified in that review are cultural and behavioural in nature and are therefore unlikely to be resolved by procedural change alone. Sustainable implementation is likely to depend upon consistent leadership, accountability, workforce stability, staff engagement and evidence that expected cultural standards are being embedded in day-to-day practice.

Report 5: Internal Maternity Services Review Report

In relation to Report 5: Internal Maternity Services Review Report, DDHHS appears to have progressed some actions over time, but the implementation remains mixed and a number of longstanding issues have not yet been fully embedded or resolved.

In particular, where recommendations depend upon enduring changes to models of care, interprofessional practice, policy alignment, complaints responsiveness and service culture, the evidence of sustainability remains limited. Overall, incremental progress is being made rather than a fully mature implementation state.

The Reviewers are concerned that this report was commissioned in August 2018 and was received by the Chief Executive in October 2025.

Master Action Plan

DDHHS created an action plan for each individual Review Report and these were provided to the Review Team. DDHHS also prepared a Master Action Plan to incorporate each of the 117 recommendations arising from the individual Review Reports into 16 overarching action items. This was intended to provide a single point of reference for implementation oversight.

At least some individual action plans arising from Review Reports do not appear to be 'living documents', with action items listed as 'transferred to the Master Action Plan'. However, the Master Action Plan provided to the Reviewers does not appear to explicitly cross reference all 117 recommendations contained in the individual action plans.

Even where specific cross-references were noted, the planned actions did not always fully address the substance of the individual recommendations. The Review Team also noted differences in the completion dates, accountable and responsible staff members, reported in the individual action plans and the Master Action Plan.

As part of the procedural fairness afforded to DDHHS, the Reviewers conducted further inquiries with DDHHS about recommendations that were not readily apparent to the Reviewers in the Master Action Plan. Following further consultation with DDHHS, some additional amendments were made to this Report referencing the Master Action Plan. However, there remains a significant risk that the specific details of each of the recommendations arising from the individual Reviews may be inadvertently overlooked where they are broadly summarised in the Master Action Plan. Consideration should therefore be given to ensure each recommendation, is clearly identified in the Master Action Plan.

Consumer Complaints

Detailed consideration was made of:

- DDHHS's processes for responding to consumer complaints;
- the adequacy of the complaints process at DDHHS, particularly as it relates to concerns raised by consumers into maternity outcomes in the period since 1 January 2025;
- a review of methods and past practices of how consumer complaints have been raised, received and responded to since 1 January 2025; and
- any opportunities to strengthen the complaints process, including the extent to which matters raised in the public forum may be responded to, in order to support community confidence in clinical service outcomes.

In summary, DDHHS has an established consumer complaints framework supported by policy, legislation and governance mechanisms. Complaints may be made through multiple channels, including verbal complaints to staff, written correspondence, email, online forms, post and feedback boxes. Complaints are intended to be recorded in RiskMan (Queensland Health's digital incident, hazard and risk management program), triaged according to a severity framework, acknowledged within 5 days and generally resolved within 35 days. Additional pathways exist for Ryan's Rule, open disclosure, Aboriginal and Torres Strait Islander consumer complaints, and complaints received through external bodies such as the Office of the Health Ombudsman and ministerial offices. A weekly Clinical Incident Management meeting has also provided a forum for escalation and oversight of high-risk complaints, clinical incidents and open disclosure matters.

Notwithstanding that framework, the adequacy of the complaints process as it relates to maternity outcomes since 1 January 2025 is mixed. On one view, DDHHS has met the statewide KPI, with 84% of closed maternity complaints resolved within 35 days and a reduction in longstanding open complaints since the announcement of this Review. However, a review of the processes applied in

these complaints identified some issues related to inappropriate severity classification, missed opportunities for quality improvement and premature closure. Also, consumer evidence demonstrates that the process is not consistently experienced as accessible, responsive or effective. Survey responses and interviews described barriers to raising concerns, poor visibility of complaint pathways, dissatisfaction with responses, poor communication, lack of follow-up, and a perception that complaints did not lead to meaningful resolution or change. In particular, concerns raised in real time during care were sometimes experienced as dismissed, minimised or redirected into formal processes without meaningful response.

The review of methods and past practices since 1 January 2025 indicates that maternity complaints have generally been raised and managed through generic complaints channels rather than maternity-specific pathways. DDHHS has no dedicated maternity complaints service, and complaint information in facilities is generic rather than specific to maternity consumers. While the introduction of the Midwife Guide role in February 2026 reflects a responsive attempt to provide a more accessible point of contact for women and families, the role currently sits outside the formal complaints framework and is not clearly embedded in policy or procedure. This creates risks of incomplete complaint capture, inconsistent handling of concerns, gaps in accountability, and reduced confidence if consumers assume concerns raised with the Midwife Guide will automatically be formally actioned. The Review also identified the absence of any documented process for managing concerns raised in public forums, such as social media or community meetings, where no direct complaint has been lodged.

There are clear opportunities to strengthen the complaints process and support community confidence in clinical service outcomes. These include better supporting women after unexpected maternity outcomes through timely consultant-led debriefing and follow-up; formally integrating the Midwife Guide role into the complaints governance framework; adopting a “no wrong door” approach so concerns are captured and actioned regardless of how they are raised; improving visibility of complaint and escalation options; clarifying how concerns raised in public forums should be triaged and addressed; and improving the quality of complaint responses, including through clearer written response requirements for more serious complaints.

The numbers of complaints, the process and length of time for their acknowledgement and resolution should be a standing agenda item for the Safe Care Committee’s meetings.

More broadly, the Review Panel considers that stronger transparency, more compassionate and accountable communication, and more visible evidence that complaints lead to clinical improvement in delivery of service and outcomes will be necessary to improve community confidence in DDHHS maternity services.

Hospital and Health Boards Act 2011 (HHB Act)

In summary, the HHB Act imposes strict confidentiality obligations that significantly limit DDHHS’s ability to publicly respond to concerns about individual clinical outcomes.

Part 7 of the HHB Act protects identifiable patient information and imposes serious penalties for unauthorised disclosure.

Section 160 of the HHB Act provides only a narrow public interest exception, requiring written authorisation by the chief executive and setting a high threshold for disclosure. That exception does not authorise DDHHS to routinely rebut public criticism or media reporting about individual cases. As a result, even where reporting is incomplete, inaccurate or misleading, DDHHS may be legally unable to correct the record if doing so would identify a patient. This creates a tension between patient confidentiality and maintaining public confidence in maternity services.

If Hospital and Health Services are to be able to correct misinformation in limited circumstances, legislative amendment to the HHB Act would likely be required.