

Via Email Only

Ms Lisa Blackler
Health Service Chief Executive
Central Queensland Hospital and Health Service
COHSCE@health.qld.gov.au
PTSS-Rockhampton@health.qld.gov.au

Mr Matthew Cooke
Board Chair
Central Queensland Hospital and Health Service
CQHHS_Board@health.qld.gov.au

Dr David Rosengren
Director-General
Queensland Health
dg_correspondence@health.qld.gov.au

The Honourable Tim Nicholls MP
Minister for Health and Ambulance Services
health@ministerial.qld.gov.au

Ms Janet Anderson PSM
Health Ombudsman
Office of the Health Ombudsman
complaints@oho.qld.gov.au

CC:

Ms Donna Kirkland MP
Member for Rockhampton and Assistant Minister for Mental Health, Drug and Alcohol Treatment,
Families and Seniors and Central Queensland
rockhampton@parliament.qld.gov.au

**Re: Rockhampton Hospital Maternity Unit, Birth Suite and Special Care Nursery
Unsafe staffing and skill mix, failure of the workload escalation process, clinical incident
under-reporting, and the persistence of the failures identified by the Office of the Health
Ombudsman in 2019**

Dear Ms Blackler, Mr Cooke, Dr Rosengren, Minister Nicholls and Ms Anderson,

We write on behalf of nurses and midwives employed in the Maternity Unit, Birth Suite, Special Care Nursery and associated maternity services at Rockhampton Hospital, and on behalf of their colleagues across the Rockhampton campus.

In August and September 2026 the Nurses' Professional Association of Australia surveyed nursing and midwifery staff at Rockhampton Hospital. The survey was anonymous and voluntary, and no respondent was asked to identify a patient.

The results are set out below in full. We do not ask you to accept our characterisation of them. We ask you to read the figures, and the words of your own staff, and to respond to them.

Every internal mechanism available to these staff has already been used, and has not produced change. The Business Planning Framework has been escalated. Workload concern forms have been lodged in volume. RiskMan reports have been submitted. Audits have been completed. Concerns have been raised with line managers, with the Acting Midwifery Unit Manager, director of midwifery and now acting director of midwifery, after hours duty nurse manages and the hospital executive on call and above. Our members' assessment, expressed in numbers below that admit of no ambiguity, is that none of it has worked and there is no foreseeable change in the immediate future.

We are also aware that on 3 September 2026 the Queensland Nurses and Midwives' Union gave formal notification of a Stage 3 workload concern for Maternity Services at Rockhampton Hospital, under clause 39.3(b) of the *Nurses and Midwives (Queensland Health) Award State 2015*, and that a maternity action group has since been convened by the Health Service with a meeting held on 11 September 2026. NPAA does not seek to duplicate that process and supports any genuine attempt to resolve these matters.

1. This Health Service has been here before

In February 2016 an independent review was announced into the maternity ward at Rockhampton Base Hospital following the death of one baby and injury to three others. In April 2016 midwives passed a vote of no confidence in the senior management of this Health Service over its handling of long-term staffing and training issues, and the Chief Executive resigned. In June 2016 the review was released and the then Chief Executive apologised publicly, stating that *"our systems and processes have contributed to the poor outcomes in all four cases"*.

That review made 35 recommendations. They included;

- filling staffing and training gaps,
- improved leadership from management,
- better auditing, and
- increased staff-to-patient ratios during labour and birth.

This Health Service advised that all 35 were implemented by January 2017.

The review itself has never been made public. The Office of the Health Ombudsman records, at footnote 60 of its 2019 investigation report, that the review "was commissioned under section 124 of the HHB Act and as such is confidential" and that this Health Service "released a public version of the review recommendations". Ten years on, this Health Service cannot be measured against a text nobody outside it has read.

In June 2019 the Office of the Health Ombudsman ('OHO') published its systemic investigation, [Safety and quality of maternity services across Central Queensland Hospital and Health Service](#). In 2026, the staff of that same service reported to us, in numbers, that the specific failures the Ombudsman identified across this Health Service are present at Rockhampton now.

2. Staffing and skill mix

Of the nurses and midwives who responded:

- 61 per cent say their ward or unit starts a shift below its planned or rostered staffing numbers every shift or almost every shift.
- A further 27 per cent say several times a week.
- Six respondents in total said it happens once a week or less.
- 70 per cent say the skill mix on their shift is unsafe for the acuity of the patients every shift or almost every shift.
- 85 per cent have finished a shift believing they were not able to deliver safe care to their patients because of staffing, at least weekly.
- Thirty-nine per cent say every shift or almost every shift.

Asked what drives the unsafe skill mix:

- 62 per cent identified too few experienced staff on the shift,
- 52 per cent too many junior or newly graduated staff at once, and
- 45 per cent agency or float staff unfamiliar with the ward.

Asked to name the biggest issues in their workplace:

- 76 per cent named unsafe skill mix,
- 63 per cent not enough staff rostered,
- 61 per cent missed breaks and fatigue, and
- 51 per cent the loss of experienced staff with no one left to learn from.

Some of the comments left were;

"With current staffing levels, acuity, junior heavy staff and lack of experienced staff, heavy reliance on agency there will be a serious adverse incident where a patient will be seriously harmed. Clinical facilitators consistently pulled to team lead, leaving junior staff without support."

Experienced Registered Midwife, Maternity

"Someone is going to die/adverse outcome (staff or patient) if staffing is not fixed immediately."

Experienced Registered Nurse/Registered Midwife

"The ward has been an unhappy place for quite some time, years. It has become over medicalised... Now, what's left, is a dangerous ward not fit for patient care. A major lack of staff, 24 EFT short, skill shortage and experienced midwives tearing their hair out. The average career

lifespan of a midwife today is 3 to 4yrs. This speaks volumes. Rocky maternity is in trouble, and it's only going in one direction, to the coroner's."

Experienced Registered Midwife

We draw your attention to what the comparison within our own data shows. 84 per cent of respondents work in maternity, birth suite or the special care nursery. Among maternity respondents, 82 per cent say skill mix is unsafe every or almost every shift. Among respondents from the rest of the hospital, the figure is 9 per cent. On the question of whether they can deliver safe care, the figures are 96 per cent and 27 per cent. On whether the Business Planning Framework allocation is sufficient, 84 per cent and 18 per cent.

The gap is not small. These services are an outlier inside their own hospital, measured on an instrument that asked every respondent the same questions.

Nor is this the view of an inexperienced workforce. Among the respondents with eleven or more years in nursing or midwifery:

- 61 per cent say skill mix is unsafe every or almost every shift,
- 71 per cent would not want a member of their own family to be a patient on their ward, and
- 90 per cent do not trust the Executive and Board of this Health Service to act on staff safety concerns.

3. The Business Planning Framework

73 per cent of respondents consider the allocated staffing for their ward or unit insufficient or seriously insufficient to staff it safely. Forty-six per cent chose "*seriously insufficient*", the strongest option available.

Only 25 per cent know they have access to their unit's Business Planning Framework. A framework that is the agreed mechanism for determining safe nursing and midwifery staffing is, for three quarters of the workforce it governs, a document they cannot see.

On workload data, 27 per cent of respondents have no visibility of their ward's TrendCare or workload data at all, and a further 16 per cent do not know whether they do. Of those who do have visibility, most say the data shows the ward to be understaffed, either consistently or frequently. Respondents also say TrendCare does not reflect the ward accurately, because time pressure and the need to put patient care ahead of data entry mean it is not always completed properly.

We are advised by members that they feel the full-time equivalent allocation for the maternity service has not been uplifted in approximately ten years, despite increases in both births and patient acuity, and that a request for uplift currently sits with the Executive and has not been recognised as urgent.

We understand that position is not in dispute. We understand the Health Service has itself advised that a program of Business Planning Framework reviews was undertaken in the last year for the first time in approximately eight years. If that is correct, the establishment on which this maternity service has been run was, on the Health Service's own account, unexamined for close to a decade.

"The BPF has gone unchanged for years. The unit is in desperate need of staffing uplift. The BPF is sitting with executive team and CE and has not been recognised as urgent. We have just lost our Director, our Executive Director of Nursing and Midwifery, general manager and Chief operating officer. The hospital is in complete dysfunction."

RN Midwife, Maternity

"The current funding of maternity service and structure with failure of appropriate timely approval BPF has grossly contributed to the issues within maternity services. Last there has been no real increase in funding or FTE over the last ten years despite the increase in births and patient acuity."

Registered Nurse, Maternity

We further draw your attention to the treatment of newborns in the workload calculation. We are advised that babies on the postnatal ward are not counted as patients for the purposes of staffing at Rockhampton, while they are counted at other Queensland hospitals. Members describe caring for fifteen women and their babies with the babies invisible to the staffing model, while performing blood tests, observations and, where required, resuscitation on those babies. Often with one midwife and one student midwife or registered nurse, which makes the midwife responsible for 15 women and 15 babies, 30 patients.

That account is not ours alone. In its Stage 3 notification of 3 September 2026 the Queensland Nurses and Midwives' Union recorded members reporting one midwife caring for approximately 15 maternity patients, and the ward operating with up to 15 women and 11 babies with only one midwife available to provide care and observations. More and more frequently they are saying they are having a student midwife and a pool RN only, on the ward.

Our members have stated:

"Babies are also not included in the acuity which they should be as we perform blood test, vital signs, resuscitation and more on these babies."

Registered Midwife, Maternity

"Safe patient/staff ratios to include the babies!!"

Registered Nurse/Registered Midwife, Maternity Unit

We also draw attention to the governing principle of the framework itself. *Business Planning Framework: the methodology for nursing and midwifery workload management* (6th edition, 2021) provides that the nursing resources required for safe care delivery are to determine funding requirements, that service demand should be reduced where resources are insufficient, and that financial considerations should support, not dictate, decisions about the nursing resources needed for patient safety and safe, quality care.

We note that Queensland has legislated midwife-to-patient ratios of one to six, including babies as patients, in postnatal wards, phased in from 1 September 2025, and that those ratios apply only to the Royal Brisbane and Women's, Townsville, Cairns, Gold Coast University, Logan and Sunshine Coast University hospitals. Rockhampton is not among them. The Office of the Health Ombudsman

recorded in 2019 that “in Queensland, there are no set ratios for midwives working in the maternity service”. That remains true at Rockhampton in 2026.

4. One team leader, four clinical areas

We are advised that a single team leader on each shift is responsible for the 15-bed maternity ward, the five-room birth suite with three procedure rooms, the maternity assessment unit, the special care nursery, and that the team leader is regularly required to carry a patient load at the same time.

We ask you to read that against the Ombudsman's own case study of Patient A at Rockhampton in 2015, in which the senior midwife on the morning shift “*was unable to check-in with the midwife in birth suite, in part because the senior midwife was covering multiple roles*”, and in which the Ombudsman found that “*a lack of clarity between roles, responsibilities and escalating care meant that staff did not have sufficient capacity to review Patient A's presentation and make a fulsome assessment of her risk status and the care she required. This resulted in a prolonged labour and a poor outcome for the baby.*”

That is the same failure mode, in the same unit, eleven years later.

“Include more than one Team leader (who currently oversees the inpatient ward, SCN, birth suite, MAU).”

Experienced Registered Nurse/Registered Midwife, Maternity Unit

“There is only one Team Leader in the entire maternity unit experienced in neonatal nursing that SCN staff can escalate to for advice and direction regarding clinical care at the time of this survey. This is not only unsafe for our most vulnerable patients, unwell and/or compromised babies, but also unsafe for staff.”

Experienced Registered Nurse, Maternity and Special Care Nursery

We note, and report honestly, that one-to-one midwifery care for a woman in established labour is reported as usually or always achieved by the substantial majority of birth suite respondents. Our members' consistent account is that this is achieved by drawing staff away from the maternity ward and the special care nursery and team leaders taking a patient load. The standard is being met in one area by removing cover from the others.

Rockhampton Maternity is a 24 hour service without 24 hour support. Administrative staff, cleaners and assistants in nursing are not rostered across all shifts, so clinical staff absorb that work alongside a clinical load.

Women presenting acutely to the birth suite, in the way a patient would present to an emergency department, are being placed in the waiting room, ward kitchenette, to wait, untriaged, with waits reported sometimes in excess of three hours before assessment. We are advised that following an earlier poor outcome at this hospital, that area was not to be used for waiting patients. If that is correct, a control put in place after a previous poor outcome has been abandoned. We ask you to read

that against the Ombudsman's finding set out above, that staff did not have sufficient capacity to review Patient A's presentation and make a fulsome assessment of her risk status.

The birth suite, the maternity assessment unit and the maternity ward are frequently bed blocked. Where birth suite rooms are occupied by women who are not in labour and the ward cannot accept transfers, women presenting in labour are held in the assessment unit or kept waiting, and the same midwives cover more areas at once.

Staff have recently been asked, verbally, to carry out inductions of labour around the clock, which means artificial rupture of membranes taking place late at night. We are not aware of any written change to the model of care, any risk assessment, or any change to the roster to support it. Staff do not consider it safe, or appropriate for the women in their care.

5. The Special Care Nursery

This is the matter on which we ask for the most urgent attention.

The OHO recorded in 2019 that the staffing standard for the Rockhampton special care nursery is one nurse or midwife to one baby who is unstable or on assisted ventilation, one to two babies who are stable on CPAP, and one to four babies who are clinically stable. The Ombudsman recorded the nursery as having six cots.

Of the respondents who work in the special care nursery, 68 per cent say that rostered staffing meets those ratios only sometimes, rarely or never. On whether two trained neonatal nurses are rostered per shift, 50 per cent say rarely or never.

Asked the highest number of babies they had personally been responsible for at one time in the last six months, respondents answered 13, 12, 12 “*had non trained staff to help*”, 11, 11, 10 “*admitted neonates one on CPAP only trained neonatal nurse*”, 10, 9 “*with myself and an EEN*”, 9 and 8.

We are further advised that the nursery is now funded for eight cots and has recently been running at nine and ten.

We understand a briefing note seeking uplift for the Special Care Nursery is presently with the Chief Operating Officer and remains undetermined, and that the nursery's Business Planning Framework identifies a requirement for additional registered nurse full-time equivalent, the extent of which depends on whether the nursery is to be established at eight or twelve cots. We ask for the date by which that decision will be made, and for the decision itself.

“I was placed in a situation where I was responsible for a baby requiring CPAP despite not being CPAP competent. At the same time, I was responsible for five other babies. The second nurse working with me was a graduate RN with no previous Special Care Nursery experience, and there were no senior SCN staff available on the shift to provide support or guidance. I felt as though I had no choice but to manage the situation because there was simply no one else available who knew what to do, including the maternity Team Leader..... raise my concerns, but I never received any acknowledgement, follow-up or response.”

Registered Nurse, Special Care Nursery

“When staffing is addressed, we get bodies, we don't get competent staff... As there are usually only 2 or 3 people working in the nursery, there is usually only 1 nursery trained person within the 2 or 3 workers. This ultimately causes a lot of stress for the competent worker and puts babies/mums/patients in unsafe situations. It's starting to get really concerning. It's not a matter of if something bad will happen, it's when due to the constant understaffing.”

Registered Nurse, Special Care Nursery

“Neonatal nursing is a highly specialised skillset equivalent to ICU/PICU and the staff working within the special care nursery should be trained and have the appropriate skillset. These neonates are vulnerable patients unable to advocate for themselves... A midwife or midwifery student or grad nurse without lengthy training is not appropriate, safe staffing and puts extra pressure on the trained staff member and increases risk of harm to patients.”

Experienced Registered Nurse, Special Care Nursery

“I have over (decades) Midwifery and Neonatal Nursing experience. I am at times (often) left to care for 10-12 babies with insufficient staff to meet that ratio, or with inexperienced and untrained staff that have never worked in a Special Care Nursery. Some of these staff have never even held or fed a baby prior to the shift.”

Experienced Registered Nurse/Midwife, Special Care Nursery

Contemporaneous accounts from the nursery

NPAA holds several contemporaneous written accounts, provided by multiple different staff, of shifts in the Special Care Nursery during 2026. We set out the pattern they describe rather than any single shift, and we have removed details that could identify the staff involved, the babies concerned, or the dates.

The accounts describe shifts on which the nursery was staffed by one nurse with neonatal competence working alongside an agency or redeployed staff member with no special care nursery experience, while the nursery was at or above its funded capacity and taking new admissions requiring respiratory support, neurological monitoring, or management of hypoglycaemia and hypothermia. In each case the shift coordinator was aware that the second staff member lacked nursery experience, and any additional help available was similarly inexperienced.

The consequences recorded across these accounts include:

- a nationally advised treatment timeframe for a neonate not being met;
- cares and feeds delayed, and observations missed;
- a baby subject to a child protection process not receiving the level of monitoring required;
- a mother not receiving the feeding education required before a complex discharge;
- the same nurse simultaneously holding the neonatal resuscitation role for the unit;
- nurses being made responsible for babies on CPAP while not CPAP competent, on multiple occasions despite repeated concerns being raised.

- The SCN senior staff member was unable to attend resuscitation on the birth suite or CAT1 EMC/S as was unable to leave to the SCN babies with untrained assistants.

The accounts state, in substance, that staffing on those shifts was severely inadequate in both number and skill mix for the activity and acuity; that this compromised timely and appropriate patient care and created substantial risk to both patients and staff; and that these circumstances are not exceptional but recur regularly, frequently leaving one nurse alone with no experienced colleague to escalate to.

We ask the Health Service to identify the clinical governance mechanism that permits a treatment timeframe for a neonate to be missed for want of staffing, and to advise how many shifts in the Special Care Nursery over the last six months have been rostered without a staff member competent in the management of a neonate on CPAP.

6. The workload escalation process has failed

Clause 7.2(a) of the *Nurses and Midwives (Queensland Health and Department of Education) Certified Agreement (EB12) 2025* provides that “nurses and midwives must have safe workloads”, that “minimum safe staffing and skill mix is essential for safe workloads in nursing and midwifery practice”, and that “nurses and midwives have a process in place within the organisation to escalate workload issues”.

That process exists at Rockhampton. Our members have used it. These are the results.

We note first that the process has now been taken to its final internal stage. On 3 September 2026 the Queensland Nurses and Midwives' Union notified a Stage 3 workload concern under clause 39.3(b) of the Award, recording that concerns have been raised repeatedly by staff across Birth Suite, the Maternity Ward, Special Care Nursery, Maternity Assessment Unit, Midwifery Group Practice and Outpatient clinics, and that these are no longer isolated concerns but a systemic failure to provide safe staffing and sustainable workloads. That notification also records that its members are reluctant to submit workload forms, because they fear adverse consequences and because, in their experience, nothing changes when they do. It records the same underlying concerns: time constraints, missed meal breaks, fatigue and unpaid overtime. Our survey quantifies the same thing.

Fifty-seven per cent of respondents have lodged at least one electronic workload concern form in the last twelve months.

Of those who lodged a form:

- 25 per cent report that overtime was authorised but the underlying problem remained;
- 18 per cent received a response but nothing changed;
- 16 per cent received no response at all;
- 13 per cent received a templated or generic response; and
- 7 per cent were discouraged from lodging it or experienced a negative consequence for doing so.

A further 37 per cent of all respondents wanted to lodge a workload concern and did not.

Seventy-eight per cent of respondents disagree or strongly disagree with the statement “concerns raised by staff are acted on”.

We understand the Health Service's own audit of the maternity service over the last twelve months records 184 instances in which staff were unable to take a meal break, and 2,143 hours of overtime.

We ask that those figures be read alongside the finding that 37 per cent of staff wanted to lodge a workload concern and did not. A low volume of workload concern forms is not evidence of a safe workload where staff have told us, in these proportions, that lodging one achieves nothing.

“I have reported workload concerns before as I have been asked to work outside of my contracted duty or where staffing has been unsafe and I have negative experiences from this, I have documented evidence of the same. I attempted to lodge a formal grievance and did not receive a response to this. I exhausted all escalation attempts. I faced reprisal for speaking up on my experience.”

Experienced Registered Nurse, Maternity and Special Care Nursery

“We are tired of management gaslighting us when we come to them and ask for help and their response was 'oh well', 'there is nothing we can do', 'I'm not going to call everyone on the roster', 'what do you expect the director of nursing to do?', 'You are going to have to figure it out, I can't help you'. Or not having any response at all and ignored when calling management and DON for support.”

Experienced Registered Nurse/Registered Midwife, Maternity

We further understand that the Health Service has recently accepted, in its own forum, that escalations made after hours have not been treated seriously, including an instance in which a midwife escalated three times, asked for the matter to be taken to the person in charge of the hospital, and lodged a workload concern form, and received no response. We ask what has changed in the after-hours escalation pathway since that was accepted, and on what date.

7. Clinical incidents are not reaching the system

Fifty-seven per cent of respondents have witnessed or been involved in an incident in the last six months where a patient was harmed, or nearly harmed, and staffing levels or skill mix were a contributing factor. Nineteen per cent report more than five such incidents.

Of those respondents, 39 per cent report that some or all of those incidents were not reported in RiskMan. The reasons given, in order of frequency, are that there was no time to complete a report, that the respondent did not believe anything would come of it, and that the respondent was concerned about being blamed or feared the consequences.

“No there's no time on the shift and we're not paid to stay back to fill a riskman out.”

Survey respondent

“Due to how busy my work area (SCN) is, consistently finishing after my shift ends UNPAID and past experience of completing them, I do not.”

"I was told I categorised it incorrectly and felt like they blamed me for filing the risk management instead of asking what could be done to prevent it."

Survey respondent

"Consistently had them ignored."

Survey respondent

"Yes it was several months ago and I am still waiting for it to be acknowledged."

Survey respondent

Members also report that adverse outcomes are being downgraded.

The governance consequence is the point. If two in five staff who witness staffing-related harm do not report it, the incident data on which this Board relies understates the true rate by design. We understand 217 clinical incidents have been recorded for this service since 1 January 2026. On our members' evidence that figure is a floor, not a measure. Any assurance the Board has received about the safety of this service, drawn from RiskMan or from Safety and Quality Committee reporting, rests on a denominator that our members tell us is wrong.

We note the Ombudsman's own finding in 2019 that across this Health Service, of 170 recommendations and lessons learnt arising from 14 serious clinical incident analyses, only 17 per cent were assessed as high effect, and that at Gladstone in April 2018 a review identified 55 outstanding SAC 1 recommendations of which 26 *"had not been progressed, despite years having passed since the incidents"*, which the Ombudsman described as *"unacceptable"*. The Ombudsman also recorded that *"across all of the visits to the various CQHHS facilities, staff from this office routinely heard that clinicians feel separated from the development of recommendations during the incident analysis process"*.

8. Speaking up, reprisal and trust in this Health Service

Of the respondents:

- 48 per cent do not feel safe to raise patient safety concerns in their workplace.
- 61 per cent disagree or strongly disagree that they can raise concerns without fear of reprisal.
- 81 per cent do not trust the Executive and Board of this Health Service to act on staff safety concerns. Fifty-one per cent selected "strongly disagree", the highest single response to any question in the survey.
- 72 per cent would not be happy for a member of their own family to be a patient on their ward; and
- 60 per cent would not recommend Rockhampton Hospital as a place to work.

In the last twelve months, respondents report personally experiencing intimidation (46 per cent), being yelled at or sworn at (36 per cent), rostering, hours or leave used punitively (31 per cent), bullying (25 per cent), being told their concerns were exaggerated or not real (24 per cent), being publicly

criticised or humiliated (22 per cent), and threats to their registration, employment or career (10 per cent).

“Multiple CQHHS CEs have been made aware of the issues in maternity including a previous OHO investigation identifying similar issues. Staff do not feel safe as other staff who have spoken up faced adverse action and disappeared from the workplace.”

Experienced Midwife

“There is so much fear of retribution to speak up, concerns not met and staffing awful.”

Registered Nurse/Registered Midwife, Maternity

“If you don't fix the staffing, workload and culture at Rockhampton soon you will find there will be no one left who wants to stay. The very toxic blame culture in that place is why I will probably never return.”

Experienced Registered Nurse/Registered Midwife, Rockhampton Maternity

These figures are not a measure of morale. They describe a psychosocial hazard, and this Health Service carries a legal duty in respect of it.

Under the *Work Health and Safety Act 2011 (Qld)*, Central Queensland Hospital and Health Service must ensure, so far as is reasonably practicable, the health and safety of the workers it engages. Health includes psychological health. The *Work Health and Safety Regulation 2011 (Qld)* requires psychosocial risks to be eliminated so far as is reasonably practicable and, where they cannot be eliminated, minimised so far as is reasonably practicable.

That duty is not discharged by inviting staff to speak up. It is discharged by making it safe for them to do so, and by acting on what they say. On our members' evidence, neither is currently being met. A workplace in which three staff in five cannot raise a concern without fearing the consequences, and four in five do not trust the Executive and Board to act on it, is not a psychologically safe workplace.

We ask the Health Service to treat the findings in this section as a work health and safety matter requiring assessment and control, and to advise what steps it will take, so far as is reasonably practicable, to provide a workplace in which the nurses and midwives of the Rockhampton maternity service can raise a concern about the safety of a woman or a baby without fear.

We ask the Board in particular to sit with one figure. Ninety per cent of the most experienced nurses and midwives who responded, those with eleven or more years in the profession, do not trust you to act on their safety concerns. That is not a communication problem.

9. The harm being done to the workforce

In the last twelve months, as a result of work:

- 79 per cent have taken sick leave for stress, anxiety or burnout.
- 79 per cent have considered leaving Rockhampton Hospital.
- 57 per cent have considered leaving nursing or midwifery altogether.
- 49 per cent have felt unsafe driving home after a shift because of fatigue.

- 39 per cent have sought psychological support or counselling.
- 21 per cent have reduced their hours.

Twenty-eight per cent say they are unlikely or very unlikely to still be working at Rockhampton Hospital in twelve months' time. A further 30 per cent are unsure.

"Staff are mentally breaking from the staffing issues. Numerous brilliant experienced staff have left and many are considering leaving. Bullying, Inaction, Gaslighting and intimidation are simply not ok. This is people's and their children's lives at risk. You all have families."

Experienced Registered Nurse/Registered Midwife, Special Care Nursery

"I don't know how much longer I (nor my fellow colleagues) can go on working in these conditions as I am already taking antidepressants to keep functioning on a daily basis. The Rockhampton area women and families deserve excellent care, which we feel we are not able to give under current conditions."

Experienced Registered Midwife, Maternity

"I am often in tears in my car before and after shifts... Due to this I largely feel unsafe to escalate my professional concerns for workloads in the Rockhampton Hospital due to above evidenced reprisal."

Special Care Nursery

We are advised that more than six staff have been absent on workers' compensation or leave from the maternity workplace due to extreme distress.

On retention, we ask you to consider the graduate cohort. We are advised that of twelve graduate midwives who completed their graduate year in February 2026, two remain. We are advised that of eight graduates taken on at the beginning of this year, one left within a week. We are advised that the Clinical Coach position was vacant for most of 2025 due to stress leave and that the incumbent subsequently resigned for the same reason, that three new clinical facilitator positions were created and one has already resigned, and that clinical facilitators are pulled to the team leader or clinical role on at least half of their shifts.

That practice appears to be contrary to clause 71.3 of the certified agreement, which provides that clinical facilitators, coaches and educators are not to be used to fill roster vacancies or leave except in exceptional circumstances agreed through the Nursing and Midwifery Implementation Group, and that such circumstances must be out of the ordinary and unpredictable in nature, and almost always short term. On our members' account the practice at Rockhampton is being used to fill long-term gaps. We ask whether any exceptional circumstance has been agreed through NaMIG, and if so, when and on what terms.

We further understand the Health Service's own separation data shows that, across the last twelve months, the maternity service is in approximately the same position it was in a year ago, with starters offsetting finishers. That is not recovery. It is a service running to stand still while the experience of those who leave is not replaced.

10. The absence of a line of escalation

Our members' capacity to escalate depends on there being someone to escalate to. We are advised that at the time of writing:

- The substantive Director of Nursing and Midwifery position is vacant. It was filled in an acting capacity for approximately twelve months, then backfilled on a twelve-week contract by the Clinical Midwifery Consultant from the maternity unit, who was the only applicant to an internally advertised expression of interest and who has no operational management experience.
- The General Manager for Rockhampton, Capricorn Coast and Mount Morgan resigned after less than nine months in the role.
- The Chief Operating Officer was stood down after approximately six months and subsequently terminated.
- The Executive Director of Nursing and Midwifery departed after approximately twelve months and the position has been backfilled on a temporary basis.
- The acting Midwifery Unit Manager is on leave.

The consequence our members describe is that there is currently no clear line of escalation or approval between the Midwifery Unit Managers and the Executive Director of Nursing and Midwifery, including for recruitment.

We are also advised that none of these positions has been openly advertised and that incumbents have been directly appointed. We do not make an allegation about any appointment. We ask the Board to satisfy itself on the point, and to note that the perception among the workforce is itself corrosive, as the survey responses show.

"The CMC was stepping into the DONM role and neither was backfilled, the system breaking down. No senior leadership, it feels like. Everyone is struggling at the moment, so much pressure."

Maternity

11. Investment decisions across the Health Service

We raise this because our members raise it, repeatedly and without prompting.

Rockhampton is the higher-capability referral hub for maternity and neonatal services across Central Queensland.

The Service Agreement 2025/26 to 2027/28 between the Department of Health and this Health Service records operational funding for the reinstatement of maternity services at Biloela of \$1,688,000 in 2025-26, \$1,410,000 in 2026-27 and \$1,470,000 in 2027-28, and \$5,460,000 for a modular facility at Gladstone Hospital while capital works are undertaken. We are advised that the Biloela service is expected to deliver between ten and twenty births annually under low-risk criteria, and that a substantial further capital investment has been made in a new maternity ward at Gladstone.

Over the same period, the Rockhampton maternity service has received no uplift to its Business Planning Framework allocation, and 73 per cent of our respondents consider its staffing allocation insufficient or seriously insufficient to run it safely.

"It's wonderful you are getting birthing back at Biloela but they have so many midwives for what the service will provide and we are the main hub that is suffering so bad."

Experienced Registered Midwife

"We never see any honest action or accountability relayed to us as to why we work so understaffed, why are other hospitals receiving such upgraded areas and we don't, why do we feel like we just have to put up with bad conditions."

Registered Nurse/Registered Midwife, Maternity

We do not say those investments are wrong. We ask how a Health Service justifies them while its only Level 4 maternity service, which takes the complex women and babies for the entire district, operates over capacity on a staffing allocation set a decade ago.

12. The 2019 findings, measured against 2026

The OHO's 2019 investigation identified, across this Health Service, failures in staffing and skill mix, in the recognition and escalation of risk, in clinical incident management and the implementation of recommendations, and in workplace culture including the capacity of staff to speak up without fear.

We set out below what our members report in each of those four domains in 2026.

- **Staffing and skill mix.** Seventy per cent report unsafe skill mix every or almost every shift. Seventy-three per cent consider the Business Planning Framework allocation insufficient. The special care nursery ratios recorded by the Ombudsman in 2019 are met only sometimes, rarely or never for 68 per cent of nursery staff.
- **Escalation of risk.** A single team leader covers four clinical areas, replicating the precise failure identified in the Ombudsman's Patient A case study. Members report a nationally advised neonatal treatment timeframe missed for want of staffing.
- **Incident management.** Thirty-nine per cent of those who witnessed staffing-related harm report that some or all of it was not entered in RiskMan. Members report reports unacknowledged for months, closed without feedback, and in one case a reporter who felt blamed for making the report.
- **Culture and speaking up.** Sixty-one per cent cannot raise concerns without fear of reprisal, against an Ombudsman finding in 2019 that there was "still work to be done to rebuild trust and safety between clinicians when speaking up".

We further note Recommendation 8 of the 2019 investigation, which required this Health Service within three months to develop a procedure for the transfer of a woman's care when her Midwifery Group Practice midwife departs the service, the Ombudsman having found that "*there are no set expectations or consistent procedures in relation to managing the transfer of an MGP midwife's caseload if they were to depart the service*". We are advised that the Rockhampton Midwifery Group

Practice has not expanded since the report and has contracted, that two recent resignations have left five midwives, and that caseloads have again been transferred to other MGP midwives or to the core midwifery team.

We ask the Director-General, the Minister and the Health Ombudsman to note the sequence. A confidential review in 2016 produced 35 recommendations which this Health Service reported as fully implemented within twelve months. A systemic investigation in 2019 directed no recommendation to Rockhampton, in recognition of the change efforts there. In 2026 the staff of Rockhampton service reported that many of the same failures which led to the 2016 review have re-emerged.

13. Work health and safety obligations

Central Queensland Hospital and Health Service has duties under the *Work Health and Safety Act 2011 (Qld)* to ensure, so far as is reasonably practicable, the health and safety of its workers, and “health” under that Act includes psychological health.

Queensland's framework deals expressly with psychosocial hazards. The *Work Health and Safety Regulation 2011 (Qld)* imposes a duty to manage psychosocial risks and requires a person conducting a business or undertaking to have regard, among other things, to the design of work including job demands. The Managing the risk of psychosocial hazards at work Code of Practice 2022 is approved and in force, and identifies high job demands, exposure to traumatic events and poor support as psychosocial hazards.

The survey results in section 9 of this letter, taken together with the reports of missed breaks, unpaid overtime, recall on rostered days off, and the accounts of staff being required to work outside their demonstrated competence, describe a psychosocial risk that in our submission is neither identified nor controlled.

We ask what psychosocial risk assessment has been undertaken in respect of the Rockhampton maternity service, and what control measures have been implemented.

14. Obligations this Health Service has already accepted

The matters in this letter are not only a question of resourcing. On our members' evidence they place this Health Service outside obligations it has accepted in writing.

The Service Agreement 2025/26 to 2027/28 requires that “HHSs must operate clinical service delivery consistent with the National Safety and Quality Health Service Standards”, that “the HHS holds responsibility for the health, safety and wellbeing of all workers, including... injury prevention and management”, and that “the HHS will maintain accreditation to the standards required by the department”. It also requires the Health Service to prepare and submit a Leadership Engagement Framework demonstrating how “hospital executives will maintain a visible, active and accessible presence on the frontline”, and to report against it at Performance Review Meetings. Our members report that senior executives are not seen in the maternity service.

The Clinical Governance Standard requires workforce systems that ensure staff have the skills and competence for their roles, with appropriate supervision and within scope of practice. On our members' evidence, staff without neonatal competence are rostered to care for neonates requiring respiratory support, staff without CPAP competence are made responsible for babies on CPAP, and the competencies that would remedy this cannot be completed because staff are pulled to clinical duties on their training days. Members also report incidents lodged in respect of women and babies accepted or retained beyond the clinical services capability of this service, the Clinical Services Capability Framework being a further requirement of the Service Agreement.

SAC1 completion rates and sentinel events in maternity and neonates are indicators against which this Health Service reports to the Department. Those indicators cannot be accurate when 39 per cent of staff who witnessed staffing-related harm report that some or all of it never entered RiskMan.

We ask this Health Service to confirm, for clinical incidents recorded in the maternity service and special care nursery over the last twelve months, in how many the legislated reporting requirement, regulatory notification, open disclosure and recommendation fields were completed, and in how many an incident analysis was undertaken.

We put this to the Board and the Director-General directly. This Health Service has given the Department written undertakings on clinical standards, accreditation, worker health and safety, and executive presence on the frontline, and reports against maternity and neonatal safety indicators under the same agreement. The evidence in this letter, drawn from its own nurses and midwives and from its own incident system, indicates those undertakings are not being met. We ask what assurance the Department has received to the contrary, and on what basis.

15. What NPAA asks of the Office of the Health Ombudsman

We write to the Health Ombudsman because the Office has examined this service before, and because what we set out above is, in substance, a report that the matters it examined have not been resolved.

In its June 2019 investigation the Office directed no recommendation to the Rockhampton maternity service, recording that it had "made significant strides over the last three years, and is no longer the same service that it was in 2016 when the external review was completed", and concluding: "In recognition of the change efforts at Rockhampton Hospital, I do not consider it necessary to make any recommendations." Four of the Office's eleven recommendations were directed to Central Queensland Hospital and Health Service as a whole and so applied to Rockhampton, including Recommendation 8 concerning the transfer of a woman's care when her Midwifery Group Practice midwife departs the service.

That conclusion appears to have partly rested on an on-site visit in October 2018 and, in significant part, on information provided by the Health Service.

The evidence in this letter, drawn from the nursing and midwifery workforce of that service in 2026, indicates that the four domains the Office examined, being staffing and skill mix, the recognition and

escalation of risk, clinical incident management, and a culture in which staff can speak up, are not presently being met at Rockhampton.

NPAA asks the Health Ombudsman to consider:

1. whether to commence an investigation, including on the Office's own initiative, into the safety and quality of the maternity, birthing and neonatal services at Rockhampton Hospital, covering the period since the Office's 2019 investigation;
2. whether the matters identified in the Office's 2019 investigation in respect of Central Queensland Hospital and Health Service have been sustained.
3. A thorough review of submitted riskmans and workload grievance forms as well as patient and visitor complaints.
4. the reported fear of reprisal among staff, and what protections would allow them to give evidence candidly to any investigation.

What NPAA asks

We ask the Health Service to:

1. immediately review the staffing and skill mix of the Special Care Nursery, birth suite, maternity ward and outpatient department, and confirm in writing that no shift in the Special Care Nursery will be rostered without at least two staff competent in neonatal care, including one competent in the management of a neonate on CPAP, and that at least two registered midwives are rostered to the birth suite and to the ward at all times;
2. immediately review the team leader model in the maternity service, having regard to the single team leader currently covering the maternity ward, birth suite, maternity assessment unit and special care nursery;
3. advise the date by which the Business Planning Framework review of the maternity service and Special Care Nursery will be completed, and provide its outcome to staff;
4. advise the date by which the briefing note seeking uplift for the Special Care Nursery will be determined, and whether the nursery is to be established at eight or at twelve cots;
5. count newborn babies as patients for the purposes of nursing and midwifery workload calculation at Rockhampton, consistent with the practice at other Queensland hospitals;
6. advise what change has been made to the after-hours escalation pathway since the Health Service accepted that escalations were not being treated seriously, and on what date;
7. approve agency and relief staffing to the full extent of the calculated roster gap, rather than to a lesser number, until the establishment is corrected;
8. audit all electronic workload concern forms and Riskmans lodged in the maternity service in the last twelve months, and report to the Board on how many were resolved, how many resulted in a change to the roster or the staffing profile, and how many were escalated to the Nursing and Midwifery Director;

9. undertake and provide a psychosocial risk assessment of the maternity service under the Work Health and Safety Regulation 2011 (Qld);
10. offer permanent positions to final-year student midwives who have trained in this service, before the February commencement date;
11. fill the substantive Director of Nursing and Midwifery position through open advertisement, and in the interim confirm in writing to maternity staff the current line of escalation and approval;
12. convene the maternity action group fortnightly rather than monthly, and provide a written update after each meeting to all maternity staff rather than to attendees alone; and
13. attend the unit. Members report that senior executives are not seen on the floor. We would encourage that irrespective of anything else in this letter.
14. advise whether, if the Business Planning Framework establishment for the maternity service is not to be funded to the level safe care requires, the Health Service will reduce service demand in accordance with the framework, and if so which services will be reduced; and
15. confirm whether any exceptional circumstance has been agreed through the Nursing and Midwifery Implementation Group permitting clinical facilitators, coaches and educators to fill roster vacancies, as required by clause 71.3.
16. confirm whether inductions of labour are now being conducted around the clock in this service, on whose authority, whether that change was risk assessed, and what change to the roster accompanies it; Staff believe this is not a safe or woman friendly practice.
17. confirm the triage arrangements for women presenting acutely to the birth suite, including where they wait and how long they wait before assessment, and explain why women are being held untriaged in the ward kitchenette when, following an earlier poor outcome at this hospital, that practice was to cease;
18. advise what staffing is provided for medical terminations of pregnancy managed in the birth suite and on the maternity ward, and whether that activity is counted in the workload calculation; and
19. confirm what non-clinical support is rostered across all shifts, and whether the administrative position supporting the unit will continue beyond the expiry of the current contract. As a ward unit providing a 24/7 service why is there not 24hr admin and cleaning/AIN support?
20. advise how often the birth suite, maternity assessment unit and maternity ward have been bed blocked in the last 12 months, what escalation applies when a woman presents in labour and no birth suite room is available, and where she is cared for while she waits.

We ask the Board to:

1. satisfy itself as to whether the assurance it has received about the safety of the Rockhampton maternity service is consistent with the account given by its own nurses and midwives; and
2. release the 2016 independent review of the Rockhampton Base Hospital maternity service in full, or state publicly the reason it will not.

We ask the Director-General and the Minister to:

1. commission a Health Service Investigation into the Rockhampton maternity, birthing and special care nursery services under Part 9 of the Hospital and Health Boards Act 2011 (Qld), with terms of reference extending to staffing and skill mix, the operation of the Business Planning Framework, the workload concern process, clinical incident reporting and culture, and covering the period since the 2019 investigation by the Office of the Health Ombudsman; and
2. extend the legislated midwife-to-patient ratios under the Hospital and Health Boards Act 2011 (Qld) to Rockhampton Hospital, and commence work on ratios for birth suites and special care nurseries, which are currently prescribed at no Queensland hospital.

Documents requested

1. the current Business Planning Framework service profile for the Rockhampton maternity service, birth suite and special care nursery, the profiles for each of the preceding ten years, and the date of the last completed review prior to the current one;
2. any Business Planning Framework submission for uplift lodged by the maternity service in the last 24 months, and the record of its consideration, including the briefing note presently with the Chief Operating Officer;
3. TrendCare or equivalent workload data for the maternity service and special care nursery for the last 24 months, expressed against funded hours;
4. the number of electronic workload concern forms lodged in the maternity service in each of the last 24 months, with their recorded outcomes;
5. the audit of overtime and missed meal breaks in the maternity service for the last twelve months;
6. the number of clinical incidents recorded for the maternity service and special care nursery in the last 24 months, by SAC rating, and the number in which staffing or skill mix was recorded as a contributing factor;
7. the special care nursery's funded cot capacity and its actual daily occupancy for the last 12 months;
8. the rostered skill mix for the special care nursery for the last 12 months, showing for each shift the number of staff holding a neonatal qualification;
9. the maternity service's vacancy rate, separations, agency usage and overtime expenditure for the last 24 months;
10. any psychosocial risk assessment undertaken in respect of the maternity service;
11. the implementation status of each of the 35 recommendations of the 2016 independent review, and the evidence relied upon to close each;
12. the implementation status of Recommendation 8 of the 2019 investigation by the Office of the Health Ombudsman, being the Midwifery Group Practice transfer of care procedure;
13. the action list and minutes of the maternity action group, and any written update provided to staff;

14. the Leadership Engagement Framework prepared under the Service Agreement 2025/26 to 2027/28, and the most recent report made to the Department against it;
15. the most recent National Safety and Quality Health Service Standards assessment outcome for the Rockhampton maternity, birthing and neonatal services, and any recommendations or conditions arising and their implementation status;
16. the roster audits completed at the conclusion of each roster publication in 2026.

Conclusion

NPAA raises this matter to resolve it. Our members are not asking to be left alone and they are not refusing scrutiny. They have used every process this Health Service provides. They have lodged the workload forms, filed the RiskMans, escalated to their managers, and answered a survey at some personal risk in order to say the same thing collectively that they have been saying individually for years.

What they are telling you is that the maternity, birthing and neonatal services at Rockhampton are being held together by a very dedicated and exhausted small number of experienced staff who are leaving, and that the arithmetic runs out.

| *"It's not a matter of if something bad will happen, it's when."*

Registered Nurse, Special Care Nursery

This Health Service received that warning in 2015 and 2016, and four families paid for it. It received a second warning from the Office of the Health Ombudsman in 2019. The staff of the service are giving you a third, in writing, in advance, and with the evidence.

We ask you to consider Toowoomba.

Since 2018 the maternity service at Toowoomba Hospital has been the subject of five separate reviews and investigations, producing 117 recommendations. An independent assurance review released on 7 September 2026 found that 40 of those 117 had not been implemented. It found implementation uneven and incomplete, with some changes lacking clear governance, monitoring or auditable evidence, and it warned that the health service's own action plan, which compressed 117 recommendations into 16 broader items, risked burying the detail and intent of individual findings. An internal maternity services review commissioned in August 2018 was not received by that health service's chief executive until October 2025.

The same review recorded that "concerns raised in real time during care were sometimes experienced as dismissed, minimised or redirected into formal processes without meaningful response". That sentence describes, with precision, what the nurses and midwives of Rockhampton have told us about workload concern forms and RiskMan reports in this letter.

Over the same period Toowoomba recorded three rare placental abruptions in eighteen months. Two babies died and a third was born with a disability. A further death is the subject of a Severity

Assessment Code 1 investigation. Requests for a Part 9 investigation, made by a consumer organisation and by the Opposition, were answered with an assurance review. The chief executive of that health service has since acknowledged that progress "has not been consistent enough".

We draw no equivalence between the two services, and we make no claim about clinical outcomes at Rockhampton. We draw the process parallel, and we ask you to draw it with us. Reviews were conducted. Recommendations were made. Recommendations were reported as actioned. The problems persisted, and families paid for it. What Toowoomba demonstrates is that an internal process, however well intentioned, is not a substitute for independent scrutiny, and that the cost of discovering this late is not borne by the health service.

Given the matters raised in this letter, we ask for a response within 14 days.

Yours sincerely,

Kara Thomas

President

Nurses' Professional Association of Australia