



QPQC

Queensland Paediatric
Quality Council

Multi-Incident Analysis of SAC1 Clinical Incident Reports involving Children 2015–2019

Prepared by the Clinical Incident Subcommittee,
Queensland Paediatric Quality Council
February, 2023



Queensland
Government

Acknowledgements

The Queensland Paediatric Quality Council (QPQC) would like to acknowledge the children and families who have experienced harm or death as an unexpected outcome during their health care. We acknowledge the distress and suffering experienced by families as a result of these events. We also acknowledge the impact that these unexpected patient outcomes have on health care workers who work hard to provide the best possible care, and who are also affected by these events.

The QPQC gratefully acknowledges the contribution of our volunteer Clinical Incident Sub-Committee (Appendix 1) for their invaluable time, knowledge, and assistance in completing these reviews. We also acknowledge the Patient Safety and Quality Improvement Service, Queensland Health Hospital and Health Services (HHSs), HHS patient safety and clinical teams who undertake in-depth reviews of these events, and the Coroner's Court of Queensland for providing documentation in support of this research.

We thank our expert advisors: Ms Tricia Kleidon, Dr David Bade, Professor Kellie Stockton, Mr Scott Coventry, Dr Amanda Harley, Dr Adam Irwin, Associate Professor Paula Lister, Dr Bhavesh Patel and Associate Professor Craig McBride for their assistance with the themed reviews in their areas of subject matter expertise. We gratefully acknowledge the support and guidance of the QPQC Steering Committee and Dr Diane Cruice (Co-coordinator, QPQC) during this analysis, and the record keeping and report drafting by Ms Melissa Schmiede (Administrative Support, QPQC).

This report has been written by Mrs Jodie Osborne (Co-coordinator, QPQC), Dr Sharon Anne McAuley and Associate Prof. Julie McEniery (Co-Chairs, QPQC) and members of the Clinical Incident Subcommittee.

1. Background

The Queensland Paediatric Quality Council (QPQC) is a quality assurance committee established under the *Hospital and Health Boards Act, 2011*. Its purpose is to collect and analyse clinical information relating to paediatric mortality and morbidity in Queensland and to make recommendations to improve patient safety and care. A key area of research involves statewide multi-incident analysis of Queensland Health (QH) clinical incident reports involving children, where the QPQC goal is to identify opportunities for prevention that are applicable state-wide.

A clinical incident is an unexpected event associated with health care which causes, or may cause, unintended harm to the patient. A Severity Assessment Code (SAC) is used by QH to classify clinical incidents, with the most serious (those leading to death or likely permanent harm) classified as SAC1, or temporary harm, SAC2.⁽¹⁾ Clinical incident reviews undertaken in response to serious adverse events (e.g., Root Cause Analyses (RCAs) or Human Error and Patient Safety reviews (HEAPS)) provide a valuable mechanism for identifying factors that contributed to the incident at the local level, and recommendations for improving patient safety and care. However, the findings and recommendations from these reviews are rarely shared outside the Hospital and Health Service (HHS) that commissioned the review.

Multi-incident analysis is a process in which groups of clinical incident review reports are examined together, to identify opportunities for broader, system-wide improvements to patient safety.⁽²⁾ The purpose is not to reinvestigate the incident, but to look for common themes, contributing factors and learnings and to translate these learnings into broader statewide improvements to patient safety and care.

The QPQC undertook a retrospective multi-incident analysis of SAC1 clinical incident reports involving children under 18 years in Queensland, that occurred between January 2015 and December 2019. This report shares the findings from this review including: a profile of clinical incidents by patient and facility; the statewide themes and learnings identified (including resources for further information); as well as providing feedback to HHSs on the quality of QH clinical incident reports received. It builds on a previous QPQC review of 2012–2014 clinical incidents reports involving children, the [findings](#) of which were released in July 2018.

2. Methodology

The Childrens Health Queensland (CHQ) Health Research Ethics Committee approved this work as a quality assurance activity. Reviews were undertaken by an expert panel (the Clinical Incident Subcommittee, CISC) with membership representing HHSs from across Queensland and with clinical expertise in child health, paediatrics, paediatric subspecialties, surgery, nursing, patient safety and human/system factors (Appendix 1).

The QPQC developed a multi-incident analysis data tool to summarise demographic, patient, facility, incident type, human and system factors associated with the adverse events; as well as quality indicators relating to the comprehensiveness of the review and strength of recommendations made. This tool has been refined over a number of years, having started with an adaptation of unpublished documents from the QH Patient Safety and Quality Improvement Service, the New South Wales Clinical Excellence Commission's 'Clinical Management – Children and Young Person RCA Review Committee Taxonomy Dictionary'⁽³⁾ as well as the Department of Veterans Affairs National Centre of Patient Safety Recommended Hierarchy of Actions tool.⁽⁴⁾ A summary of the process is provided below.



3. Profile of SAC 1 Clinical Incidents in Children 2015 – 2019

A total of 174 SAC1 clinical incidents in children (0 to <18 years) were identified from the Riskman database for the time period January 2015–December 2019. Of these, 101 incidents were not included in this review as they fell within the scope of other Quality Assurance Committees (i.e.: mental health or birth events); occurred outside the hospital setting; were subject to Statutory Authority reviews; had SAC level downgrades; or involved a duplicate of the same case.

Clinical incident reports relating to the remaining 73 incidents were requested from the commissioning HHS. Of the 73 clinical incidents reviewed, 50 were RCAs, 15 HEAPS reviews, six Clinical Review Reports, one Case Review Report, and a Morbidity and Mortality Review. The proportion of full RCAs undertaken, as a percentage of all reviews in this series, has fallen from 82% in 2012–2014 to 69% across 2015–2019.

The frequency of clinical incidents varied over time, with the mean number of incidents per year being 15 (range 9 to 18 incidents).

3.1 Facility Profile

Incidents were distributed unevenly across 13 of the 16 HHSs (Figure 1) with the mean number of incidents per HHS being 5. For the 13 HHSs where a clinical incident was reported, the number of incidents ranged from 1 to 12 incidents per HHS.

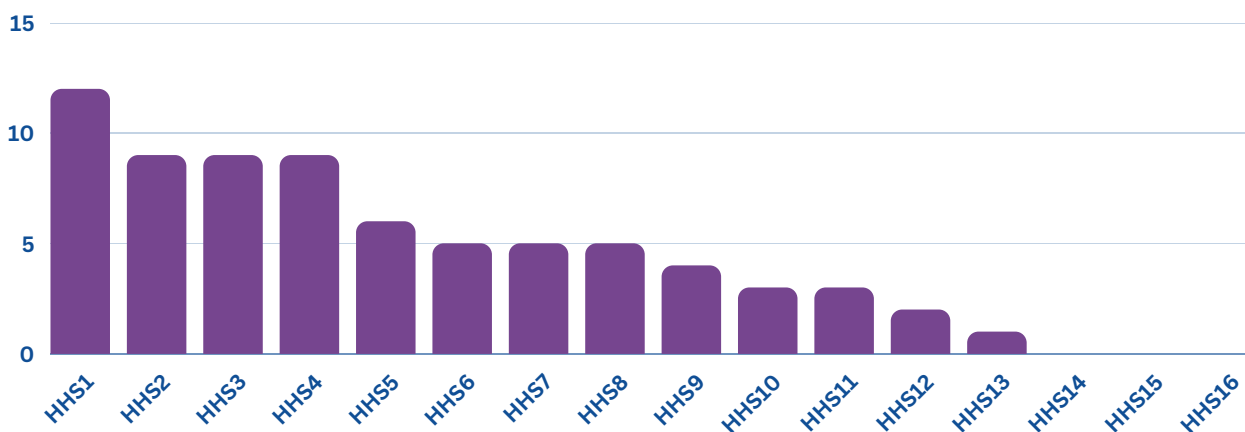


Figure 1: Distribution of clinical incidents in children across de-identified HHSs

Figure 2 compares the frequency of clinical incidents (by HHS location) with the 2019 distribution of Queensland’s child population (age 0 to 17 years), using the Accessibility and Remoteness Index of Australia (ARIA).^(6,7) The proportion of clinical incidents in children in the combined Outer Regional, Remote and Very Remote areas (32%) is over-represented when compared with estimates of the child population for those areas (16%).

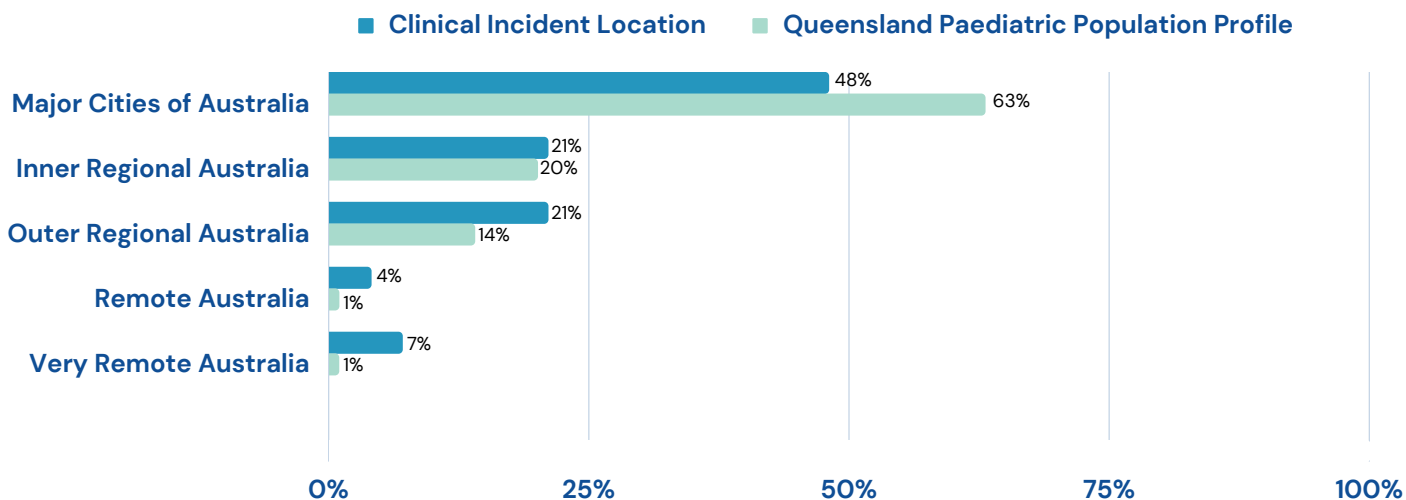


Figure 2: Comparison of the spread of clinical incidents in children against 2019 child population (age 0-17 years) estimates by remoteness of residence.

Seventy-seven percent of clinical incidents occurred in a health facility with a Clinical Services Capability Framework level (Children’s Medical Services)⁽⁸⁾ of 4 and above. Twenty-one percent of facilities were classified under the Rural and Remote Health Facility Classification⁽⁹⁾ as either a District Hospital, Rural Hospital, Community Hospital or Community Clinic.

3.2 Patient Profile

Incidents involved males (51%) and females (49%) almost equally. Figure 3 compares the age categories of children involved in clinical incidents with 2016 Queensland child population estimates (0 to 19 years).⁽¹⁰⁾ Children aged 0 to 4 years were overrepresented, being involved in 63% of clinical incidents despite comprising only 25% of Queensland’s child population. Compared with 2012–2014 clinical incidents, the proportion of children 0 to 4 years of age involved in childhood SAC1 clinical incidents has risen by 16%.

63%
involved children
0-4yrs of age

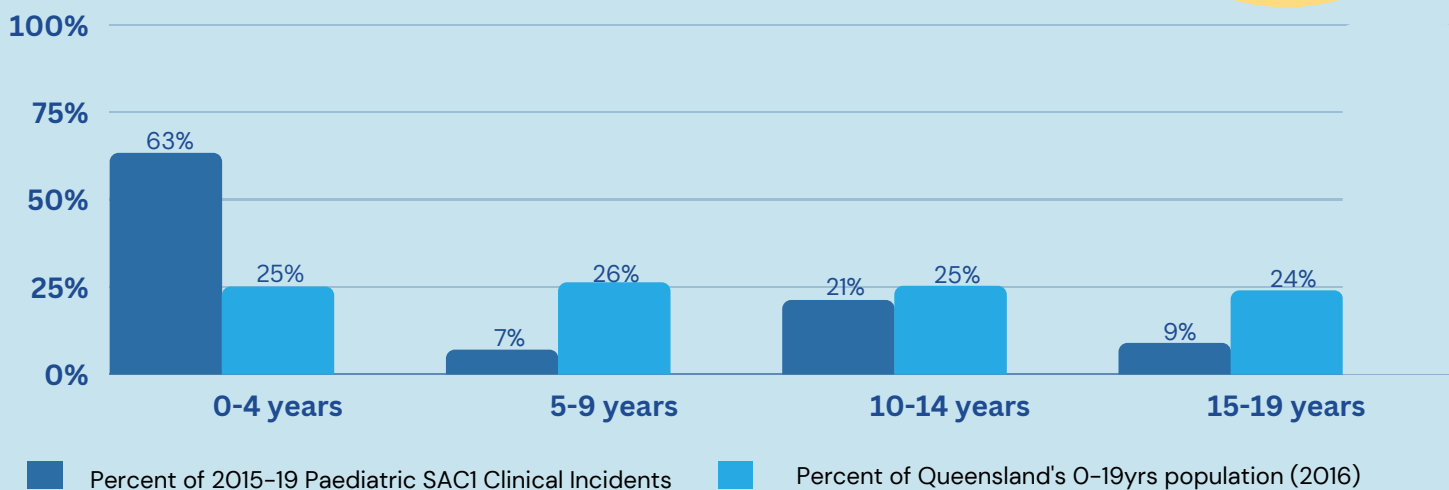



Figure 3: Percentage of children involved in SAC1 paediatric clinical incidents (by age) vs 2016 Queensland Paediatric Population Estimates (0 to 19 years)⁽¹⁰⁾

Twenty five percent of clinical incidents involved children who were identified as being of Aboriginal and/or Torres Strait Islander background, three times higher than population estimates of Aboriginal and/or Torres Strait Islander children aged 0 to 19 years living in Queensland (7%).⁽¹¹⁾ This figure is also 11% higher than the proportion of children who were identified as Aboriginal and/or Torres Strait Islander in 2012–14 SAC1 paediatric clinical incidents (14%).

25%
were children from
Aboriginal and/or Torres
Strait Islander background

Outcome for the child was identified as likely permanent harm in 50 incidents (68%) or death in 23 incidents (32%). The coroner was notified in 19 of 23 incidents involving the death of a child, with 14 investigated as a coronial case.



Facility and Patient Summary

Young infants and children aged less than 4 years, Aboriginal and/or Torres Strait Islander children, and children treated in remote and very remote facilities appear to be vulnerable to serious clinical incidents when compared to population estimates. Clinicians should use local processes for escalation to senior clinical review if there are any concerns identified during the care of the patient.

4. Statewide Themes

4.1 Diagnostic Error (Themed review: 20 SAC1 incidents; Jan 2018–Dec 2019)

Diagnostic error was identified as a contributing factor in 74% (n=54) of the 2015–2019 clinical incidents reviewed. CISC completed a themed review on a subset of 20 of these incidents covering the time period 2018–2019. This included 15 incidents involving delayed diagnosis and 5 incidents of missed/wrong diagnosis. A complex array of contributing factors was identified including patient, system, cognitive and unmodifiable factors. These findings, including ten statewide lessons learnt and resources for clinicians, were shared in Editions 8 and 9 of the QPQC newsletter “Paediatric Matters” released in May and July 2022 (see section 6 for details).

4.2 Sepsis (Themed review: 28 SAC1 incidents; Jan 2012–Dec 2017)

A diagnosis of sepsis continued to represent a significant diagnostic cluster comprising 29% (n=21) of the 2015–2019 clinical incidents reviewed. CISC members undertook a themed review of the subset of 2012–2017 sepsis clinical incidents in children (n=28). Contributing factors included delays in recognising and responding to the deteriorating patient, inadequate management/treatment, diagnostic error (mainly diagnostic delays), escalation delays/failures, problems with the use of early warning tools, and communication issues. Key findings and statewide learnings were shared in a peer reviewed publication released in September 2021 (see section 6 for details). Expert advice/feedback was provided by members of the Queensland Paediatric Sepsis team including Dr Amanda Harley, Dr Adam Irwin and Assoc. Prof Paula Lister.

4.3 Vascular Access Devices (Themed review: 43 incidents SAC1 (n=3) and SAC2 (n=40); 2017–2019)

CISC reviewed 43 SAC1 and SAC2 clinical incidents involving complications from vascular access devices in children between January 2017 to December 2019. Expert advice was provided by Tricia Kleidon, Nurse Practitioner, CHQ Vascular Assessment and Management Service. Recurrent themes included: 67% occurred in infants (<12 months old); 65% involved peripheral IV cannulas (PIVCs) and 51% resulted in infiltration/extravasation injuries.

In the 22 incidents where infiltration/extravasation injuries occurred, contributing factors included issues with the frequency/adequacy/documentation of IV site checks (59%), inadequate securement (41%), medications used (36%) and insertion (23%). Statewide learnings were identified and shared through Edition 7 of Paediatric Matters released in May 2021 (see section 6 for details).

4.4 Plaster Cast/Splints (Themed review: 29 incidents: 5 SAC1 and 24 SAC2; June 2014–April 2019)

Complications from plaster casts/splints comprised 7% (n=5) of the 2015–2019 SAC1 clinical incidents reviewed. CISC members extended their themed review to include both SAC1 and SAC2 clinical incidents (n=29) for the time period 2014–2019. Expert advice was provided by Dr David Bade, Professor Kellie Stockton and Scott Coventry from the Queensland Children’s Hospital. Pressure injuries were the most prevalent complication, identified in 66% of incidents. Contributing factors included problems with cast application (79%), cast management (76%) and cast removal (21%). Findings from this review, including statewide lessons learnt, clinical red flags and patient risk factors were shared through Paediatric Matters Edition 5 released in March 2020 (see section 6 for details).

4.5 Testicular Torsion (Themed review: 11 SAC 1 Incidents; Jan 2010– Dec 2017)

Clinical incidents involving testicular torsion were identified as a priority in our 2012–2014 summary report, resulting in the release of a Patient Safety Communique in April 2017.⁽¹²⁾As part of the QPQC’s ongoing monitoring of identified themes, CISC completed a themed review of 11 paediatric testicular torsion incidents (2010–2017) resulting in loss of testis. Contributing factors included: ultrasounds falsely reassuring/delaying treatment; boys having vague symptoms/late presentations; the process to actively exclude testicular torsion not being followed; delays in treatment associated with patient transfer; and testicular torsion being misdiagnosed as epididymo-orchitis. Key findings and statewide lessons learnt were shared in Paediatric Matters Edition 2 released in 2018. CISC also developed resources for patients and families in collaboration with CHQ paediatric surgeons Associate Professor Craig McBride and Dr Bhavesh Patel, and the CHQ Marketing and Communication team (see section 6 for details).

5. Quality of Clinical Incident Reviews

CISC members completed an evaluation of clinical incident review documentation against a number of quality indicators. The purpose of these reviews was to identify both strengths in clinical incident review methodology, as well as opportunities for improvement. This is important, as clinical incident reviews that are of a high quality, comprehensive and incorporate a range of stakeholder views, are more likely to identify both the underlying root causes/contributing factors; and include recommendations that make a real improvement to patient safety and care. Quality indicators assessed in this review included:

- Did the RCA provide a comprehensive sequence of events?** (Icon: Gear with numbers 1, 2, 3)
- Are the contributing factors identified and clearly documented?** (Icon: Document with pencil)
- Are the root causes identified?** (Icon: Question mark with arrows)
- Do recommendations/lessons learnt address the root causes/contributing factors?** (Icon: Hand holding speech bubble)
- Were patients/families' views included in the review?** (Icon: People holding hands)

It should be noted that two of the items: “comprehensive sequence of events” and “are the root causes identified” were only assessed when a full RCA had been undertaken (n=50/73), in line with the specific requirements of these reviews.

RCA reports were generally well written, with 62% providing a comprehensive sequence of events (Figure 4). CISC considered that contributing factors were fully identified in 48% of all clinical incident review reports and partially identified in a further 34% of reviews. In full RCA's, 32% were considered to have identified all root causes, with a further 24% partially identifying the root cause of the incident. In addition, 32% of all clinical incident reviews were considered to have recommendations/lessons learnt which addressed all the root causes and contributing factors, with a further 52% partially addressing these. Finally, only 32% provided evidence that patients/families views had been considered, making this an opportunity for improvement.

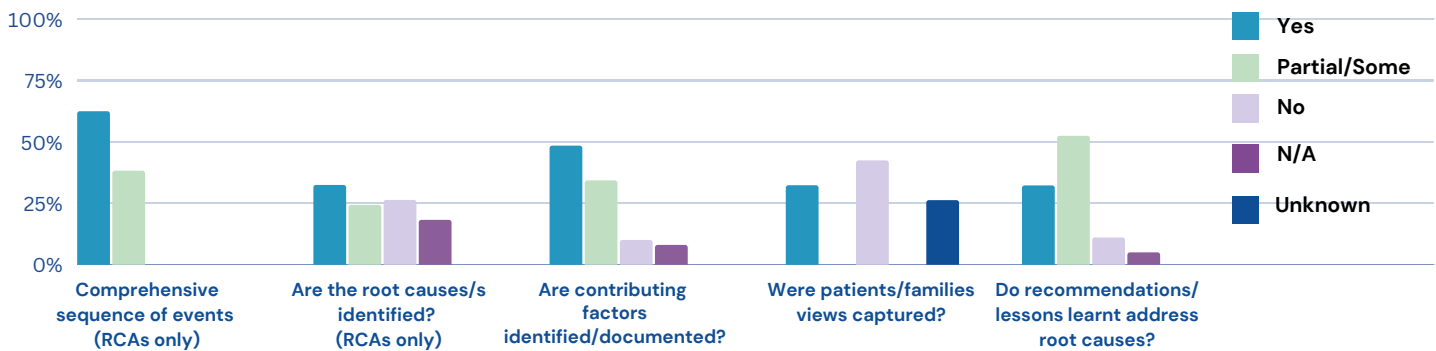
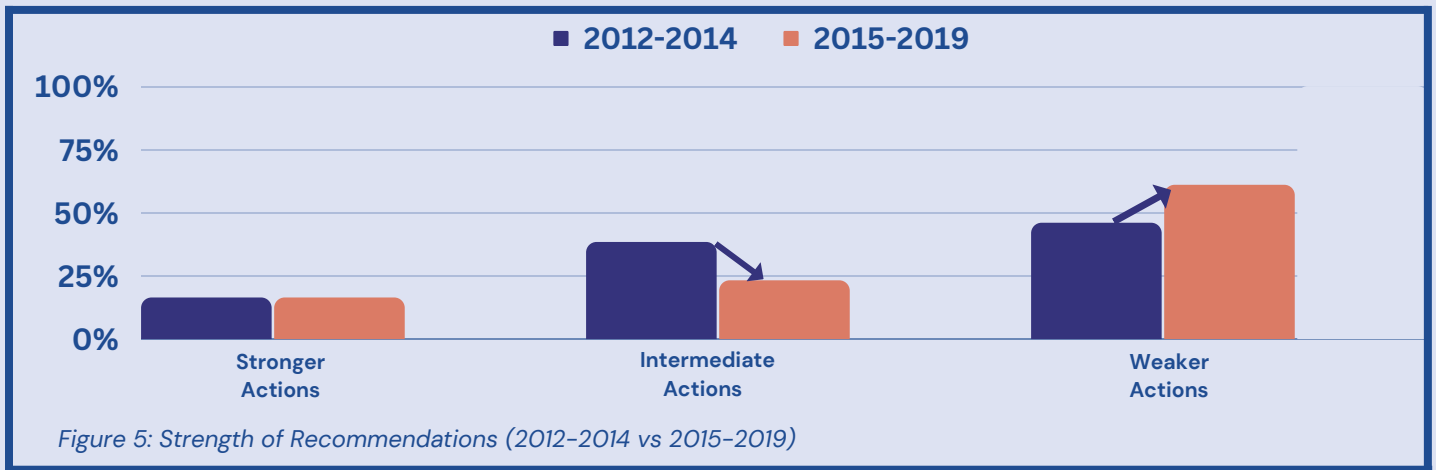


Figure 4: Indicators of the quality of 2015–19 clinical incident reviews

5.1 Strength of Recommendations

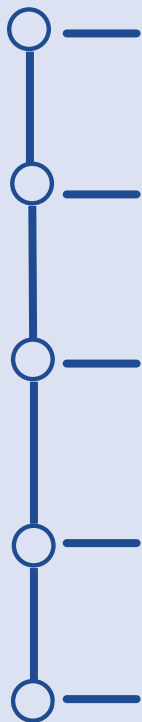
Across the 73 clinical incident reports received, there was a total of 324 recommendations (including lessons learnt), ranging from 0–17 recommendations (average of 4) per report. The strength of recommendations was analysed using the Department of Veterans Affairs National Centre of Patient Safety Recommended Hierarchy of Actions tool⁽⁴⁾ which classifies actions as “stronger, intermediate or weaker” in terms of their potential to reduce patient harm. Using this scale, 61% of recommendations were classified as weaker, 23% intermediate and 16% as stronger actions (see Figure 5).

When compared to the findings of our 2012–2014 clinical incident reviews, there has been no movement in the numbers of stronger actions used. Whilst strong recommendations are less frequently applicable in health care (compared with other industries), it is concerning to note a rise in the number of weaker actions identified and a reduction in the number of intermediate actions by 15%.



5.2 Enhancing the Quality of Clinical Incident Reviews

CISC members have identified a number of opportunities for improving the quality and effectiveness of our clinical incident reviews. These recommendations include



INCREASED LINKAGE WITH ALL SERVICES INVOLVED IN THE CARE OF THE PATIENT at the time of the incident review, i.e. inviting contributions from other service providers who may have had direct involvement with the case.

GREATER INCLUSION OF PATIENT/FAMILY VIEWS in clinical incident reviews. Patients and families can provide invaluable insights into contributing factors from the patient's perspective, resulting in a more comprehensive understanding of the incident and stronger recommendations.

INCREASED EXPLORATION OF PATIENT/FAMILY DEMOGRAPHICS, CULTURAL ISSUES AND HEALTH STATUS in clinical incident analysis reports. This is particularly significant in light of the important role social determinants play in health outcomes for children.

DETAILED EXPLORATION OF CLINICAL DECISION-MAKING PROCESSES (in real time) would add value to clinical incident reviews, including consideration and refinement of differential diagnoses and sources of potential diagnostic bias. This would also reduce the issue of hindsight bias by the review team.

There was a missed opportunity, in some incidents, to examine the **LOCAL CONTEXT, CULTURE AND ENVIRONMENT** in which clinical incidents occurred, particularly where external reviews had been undertaken with limited contributions from involved staff.

To date, feedback on clinical incident reviews has been shared through the Queensland Children's Critical Incident Panel's (QCCIP) "Clinical Incident Roadshows" held in Bundaberg and on the Sunshine Coast in 2019. The QPQC also collaborated with Monique Hamilton, an honours student from the University of Queensland to review the implementation and strength of recommendations in 2012-2014 root cause analyses in Queensland Public Hospitals. A peer reviewed publication outlining the findings from this review was released in 2019 (see section 6 for full details). CISC will continue to explore opportunities for sharing these learnings with HHSs.

6. Publications & Resources

Diagnostic Error

Paediatric Matters (Edition 8): [Diagnostic Error Part 1: Getting to the Correct Diagnosis Faster \(May, 22\)](#)

Paediatric Matters (Edition 9): [Diagnostic Error Part 2: Cognitive Factors and Clinical Reasoning \(July, 22\)](#)

Presentation: [Multi-Incident Analysis of Serious Paediatric Clinical Incident Reviews Involving Diagnostic Error In Queensland \(2018-2019\)](#). ANZA-SIDM 2022 Improving Diagnosis Conference (April 2022)

Sepsis

Coulthard, M.G., Osborne, J.M., McCaffery, K., McAuley, S.A. and McEniery, J.A. (2021). [Multi-incident analysis of reviews of serious adverse clinical events in children with serious bacterial infection and/or sepsis in Queensland, Australia between 2012 and 2017](#). J Paediatric Child Health. 58: 497 – 503. <https://doi.org/10.1111/jpc.15759>

Paediatric Matters (Edition 1): [Sepsis: Detect Early – Could this be sepsis?](#) (2018)

Vascular Access Devices

Paediatric Matters (Edition 7): [Plan for Success: Reducing Vascular Access Device Injuries](#) (May 21)

Plaster Casts/Splints

Paediatric Matters (Edition 5): [Tips and Tricks: Reducing Cast Related Harm in Children](#) (March 20)

Osborne, J.M., McAuley, S.A. and McEniery, J.A. [Multi-incident Analysis of Paediatric Clinical Incidents involving Casts/Splints in Queensland 2014-2019 \(video\)](#). Australian Institute of Clinical Governance Patient Safety and Quality Care Symposium 2021.

Testicular Torsion

Paediatric Matters (Edition 2): [Testicular Torsion – A Time Critical Condition \(2018\)](#)

Osborne J, McAuley SA and McEniery J. [Multi-incident analysis of testicular torsion clinical incidents in Queensland 2010 – 2015](#). Poster Presentation, International Forum on Quality and Safety in Healthcare Conference, Melbourne, 2018.

[Testicular Torsion Education Poster](#), Queensland Paediatric Quality Council (Aug, 2019)

[Testicular Torsion Factsheet](#)

Quality of Clinical Incidents

Hamilton, M. J., McEniery, J. A., Osborne, J. M. and Coulthard, M. G. (2019), [Implementation and strength of root cause analysis recommendations following serious adverse events involving paediatric patients in the Queensland public health system between 2012 and 2014](#). J Paediatric Child Health, 55: 1070-1076. doi:10.1111/jpc.14344

CISC Methodology

Osborne, J.M., McAuley, S.A. and McEniery, J.A. [Multi-incident Analysis of Paediatric Clinical Incidents. Turning Local Reviews into Statewide Learnings](#). International Forum on Quality and Safety in Healthcare, Australasia, September 2021.

Collaborations

[Paediatric Patient Safety Review](#): Report on the review of adverse paediatric events involving critically ill children in Queensland (2016 and 2017), State of Queensland (Queensland Health), June 2019

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Appendix 1: Clinical Incident Subcommittee members

Dr Sharon Anne McAuley

Co-chair, Clinical Incident Subcommittee

A/Chief of Critical Care, CHQHHS; Senior Medical Officer, Emergency Medicine, Queensland Children's Hospital, CHQHHS; Co-Chair, QPQC

Dr Kevin McCaffery

Co-chair, Clinical Incident Subcommittee

Staff Specialist in Paediatric Intensive Care, Paediatric Intensive Care Unit, Queensland Children's Hospital Children's Health Queensland HHS

Andrea Hetherington

Nurse Practitioner, Children's Emergency Department, The Prince Charles Hospital, Metro North HHS

Ann-Maree Brady

Clinical Nurse Consultant, Children's Health Queensland Retrieval Service

Dr Ben Lawton

Paediatric Emergency Physician, Logan Hospital, Metro South HHS. Simulation Consultant, STORK. Retrieval Consultant, MedSTAR Kids.

Dr Ben Beckwith

Staff Specialist Paediatrician Children's Services, The Prince Charles Hospital, Metro North HHS

Dr Brett Hoggard

Statewide Medical Director, Retrieval Services Queensland

Dr Christopher Edwards

Staff Specialist, Paediatrics, Bundaberg Base Hospital, Wide Bay HHS

Dr Clare Thomas

Director of Paediatrics, Sunshine Coast University Hospital, Sunshine Coast HHS

Assoc. Prof. Craig McBride

Senior Staff Specialist Paediatric Surgeon, Queensland Children's Hospital, Children's Health Queensland HHS

Dr Daniel Carroll

Staff Specialist, Paediatric Surgery, The Townsville Hospital, Townsville HHS

Dr Emily Moody

Senior Medical Officer, Laidley Hospital, West Moreton HHS

Lissa McLoughlin

Nurse Unit Manager, Caloundra Hospital, Sunshine Coast HHS

Assoc. Prof. Julie McEniery

Paediatric Intensive Care Specialist, Queensland Children's Hospital, Children's Health Queensland HHS Co-Chair, QPQC

Lynette Adams

Principal Project Manager, Paediatric Critical Care Pathway Project, Children's Health Queensland HHS

Margaret-Ann Knowles

Clinical Nurse, Logan Hospital, Metro South Hospital and Health Service

Assoc. Professor Marcus Watson

Associate Professor, The School of Psychology, University of Queensland

Dr Maree Crawford

Senior Medical Officer, Child Protection & Forensic Medical Services, Children's Health Queensland HHS

Dr Mark Coulthard

Staff Specialist in Paediatric Intensive Care, Paediatric Intensive Care Unit, Queensland Children's Hospital, Children's Health Queensland HHS

Naomi Flenady

Clinical Nurse Consultant, Bayside Health Service, Metro South HHS

Nicola Sanders

Patient Safety Quality Manager, Patient Safety and Quality Service, Queensland Children's Hospital, Children's Health Queensland HHS

Sarah Busuttil

Clinical Nurse, Child Health, Toowoomba Hospital Darling Downs HHS

Dr Siobhan O'Sullivan

General Paediatrician, Cairns and Hinterland HHS

Tammy Doyle

Clinical Nurse Consultant, Safety Improvement Officer, Sunshine Coast University Hospital, Sunshine Coast HHS

Jodie Osborne

Coordinator, Clinical Incident Subcommittee, QPQC

Melissa Schmiede

Administrative Project Officer, QPQC

Retired members

Dr Andrew Hutchinson

Staff Specialist Paediatrician, Ipswich Hospital, West Moreton HHS

Ben Freedman

Senior Project Officer, The Townsville Hospital, Townsville HHS

Dr Fiona Macfarlane

Director, Anaesthesia and Pain Management, Queensland Children's Hospital, CHQHHS

Dr Peter Rizzo

Senior Staff Specialist, Emergency Medicine, The Prince Charles Hospital, Metro North HHS

Dr Judy Williams

Clinical Director Paediatrics, Bundaberg Hospital, Wide Bay HHS

Kimberley Pigram

Clinical Nurse, Redlands Hospital, Metro South HHS

Dr Clinton Gibbs

Clinical Director – Northern Operations, Retrieval Services Queensland

Contact

Queensland Paediatric Quality Council
Centre for Children's Health Research
Level 7, 62 Graham Street, South Brisbane, QLD 4101

E: qpqc@health.qld.gov.au

W: www.children.health.qld.gov.au/chq/health-professionals/qpqc/

