RiskMan Data Release Notes

QH-RITM15840158 (RTI 6713) All SAC1 Incidents by HHS

Important Information

1. The legislative provision under which the RiskMan data is being disclosed falls under section 150(a) of the *Hospital and Health Boards Act 2011* (Qld) for the purpose of evaluating, managing, monitoring or planning health services.
2. The legislative provision under which the RiskMan data is being disclosed falls under section 153 of the Hospital and Health Boards Act 2011 (Qld) where a designated person may disclose confidential information if the disclosure is to an Act official and the confidential information is relevant to the functions being performed by the Act official.
3. The RiskMan data is being disclosed to the applicant in accordance with the applicant's request and in accordance with its terms.
4. Only Minimum Data Set field are eligible to be reported on where subject affected equal "Patient / Client".

Purpose of report

RTI / IP application #6713/24

Data Source

- The RiskMan information system is designed to enable reporting, investigation and management of clinical incidents and consumer feedback reported/received by Hospital and Health Service (HHS) staff.
- Any data presented was extracted from RiskMan posted data on the 16 May 2025 and is self-reported by HHS staff and is subject to change;

Search Criteria

Clinical Incidents:

- HHS: All
- Date range: 1 August 2023 to 30 August 2024 (Incident date)
- Subject Affected: Patient / client
- Confirmed Outcome: SAC1

Search Methodology

- RiskMan data was extracted and checked by Systems team, Patient Safety and Quality, Clinical Excellence Queensland.
- The search was run in the RiskMan application using the requested search criteria.

Results

Clinical incidents - Subject affected (Patient / client)

- QH-RITM15840158 (RTI #6713/24) – All SAC 1 Incidents by HHS - includes all clinical incidents using search criteria above, reported in RiskMan between 01-08-2023 and 30-08-2024.
  555 rows were returned for clinical incidents based on the report criteria.

Count of reported SAC1 clinical incidents (Death & Likely Permanent harm) by HHS Statewide

Hospital and Health Service	Death	Harm – likely permanent	Grand Total
CAIRNS AND HINTERLAND	25	12	37
CENTRAL QUEENSLAND	32	20	52
CENTRAL WEST		1	1
CHILDREN'S HEALTH QUEENSLAND	2	9	11
DARLING DOWNS	22	13	35
DEPARTMENT OF HEALTH		1	1
GOLD COAST	34	19	53
MACKAY	19	3	22
METRO NORTH	82	41	123
METRO SOUTH	46	53	99
NORTH WEST	2	1	3
SOUTH WEST	2	2	4
SUNSHINE COAST	12	11	23
TORRES AND CAPE	1	1	2
TOWNSVILLE	21	13	34
WEST MORETON	21	10	31
WIDE BAY	15	9	24
Grand Total	**336**	**219**	**555**

Interpretation Notes

The vast majority of care delivered in hospitals and by other health services in Queensland is very safe and effective. However, despite excellent skills and best intentions of our staff, occasionally things do not go as expected. When this happens, it is distressing for patients, families and staff, particularly when the consequence is severe. Publicity around these events can also cause the community to lose trust in their healthcare system.

Queensland Health has worked hard to develop a patient safety culture that actively encourages staff to report clinical incidents and see these as opportunities to learn about and fix problems. The analysis of these incidents helps us better understand the factors that contribute to patient incidents, and implement changes aimed at improving safety. While some people may interpret reports of clinical incidents as a sign of poor safety, we view incident reporting as an indicator of a good patient safety culture that ultimately leads to better patient care i.e. staff are willing to report incidents to actively pursue implementation of actions in order to minimise the potential for the reoccurrence of a similar incident in the future.

Interpreting numbers of clinical incidents, comparing the number of clinical incidents between HHSs, or using the number of clinical incidents as indicators of performance is not advised due to:

- a degree of clinical subjectivity in deciding whether an adverse outcome is a clinical incident i.e. what is reasonably expected is different from one clinician to the next, as well as what is expected by the patient/family. For example, a death may not have been reasonably expected and therefore met the definition of a SAC1 incident, but is later determined to have been the result of an underlying condition. Consistent with best practice across the world, it is important to us to have a reporting system that captures a broad scope of adverse patient outcomes that *could* be potentially preventable so that we can continue to learn and improve.
- Classification of an adverse patient outcome as a clinical incident does not describe 'negligence' or 'fault' on behalf of our staff or systems.
- Not all clinical incidents are preventable.
- Higher incident reporting rates are generally accepted as an indicator of a positive and transparent safety culture, rather than a marker of less safety care.
- Reporting of SAC 1 clinical incidents is mandatory.

Assessment Code (SAC) Definitions (Clinical Incidents)

SAC 1 - Death or likely permanent harm which is not reasonably expected as an outcome of healthcare

RTI 6713/24

Riskman SAC1 data

Distinct Count of Incident ID	Column Labels		
Row Labels	Death	Harm - permanent	Grand Total
CAIRNS AND HINTERLAND	25	12	37
CENTRAL QUEENSLAND	32	20	52
CENTRAL WEST		1	1
CHILDREN'S HEALTH QUEENSLAND	2	9	11
DARLING DOWNS	22	13	35
DEPARTMENT OF HEALTH		1	1
GOLD COAST	34	19	53
MACKAY	19	3	22
METRO NORTH	82	41	123
METRO SOUTH	46	53	99
NORTH WEST	2	1	3
SOUTH WEST	2	2	4
SUNSHINE COAST	12	11	23
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Hot Issues Brief

Cluster of Intrauterine Fetal Deaths (IUFD) North West Hospital and Health Service

01/07/2024

Issue

- In December 2023, North West Hospital and Health Service (HHS) engaged an external expert case review team to collaborate with the local content experts, to undertake a multidisciplinary peer clinical review due to an identified cluster of stillbirths.
- On completion of the review, the review team concurred all eleven (11) cases did not meet the SAC 1 clinical incident severity rating criteria. The review team agreed it was reassuring that the standard of care reviewed in all cases was of a high standard. The team acknowledged the challenges in delivering care to pregnant women across the NWHHS and was impressed with the consistency of service and adherence to the Queensland Clinical Guidelines for Maternity and Neonatal care.
- The Perinatal Mortality Cluster Review report and associated recommendations were approved on 22 May 2024.

Background

- North West HHS identified eight (8) women and their families across the Health Service, who experienced a stillbirth, between the 1st May 2023 and the 30th November 2023. This was an increase compared to previous years and national data.
- The potential cluster was reported via a hot issue brief and external support was sought from the Queensland Maternity and Perinatal Quality Council (QMPQC) and Clinical Excellence Queensland (CEQ) to conduct an in-depth review.
- In all, the eight (8) cases were reviewed along with the addition of three (3) historical stillbirths that had been reported within the North West HHS.
- The purpose of the review was to:
  - determine if a true stillbirth cluster occurred between 1st May 2023 – 30th November 2023
  - assess the safety and quality of the clinical care provided
  - identify and theme any contributing factors
  - identify any omissions in care
  - assist in the development of recommendations, if appropriate, to improve the quality and accessibility of care in the North West HHS
  - review and support the perinatal M & M review processes at North West HHS.
- The team reviewed each case to determine what, if any, contributing factors were present. Each relevant factor was then evaluated to determine the degree to which it contributed to the death. All aspects of antenatal and intrapartum care were reviewed. The Australian Perinatal Mortality Clinical Audit Tool was used to review each case to assist in identifying contributing factors.
- The contributing factors were classified as either:
  - organisation and or management factors e.g., inadequate supervision of staff, lack of appropriate clinical management protocols, lack of communication between services.

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Date: 01/07/2024

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Date: 01/07/2024

- personnel factors e.g., staff factors relating to professional care and service provision.
- barriers for the pregnant women accessing or engaging with recommended antenatal care e.g., no, infrequent, or late booking or antenatal care, women declining treatment or advice.

Actions to date

- The review team concurred all eleven (11) cases did not meet the SAC 1 clinical incident severity rating criteria and the incidents were downgraded to the appropriate severity rating.
- While the cluster of stillbirths is concerning, the review team did not identify any blame-worthy acts and no themes or factors related to care given were significant contributors to the stillbirths or neonatal death. Whilst there were several contributing factors identified, it was noted that these were common factors attributed to perinatal mortality outcomes in other public maternity services in Queensland.
- One (1) patient complaint was received from the 11 incidents which has been managed and closed.
- The review team noted overall, the level of care provided to pregnant and birthing women in the North West HHS is of a high standard despite some recognised challenges in relationships between the Obstetric, Midwifery Group Practice (MGP) and Core Maternity Service.
- Recommendations from Review Team:
  1. The NWHHS Obstetric team to incorporate the use of the QMPQC resources below during the Mortality and Morbidity (M and M) review of maternity care provided by the NWHHS:
     - Intrauterine Fetal Death (IUFD) and Stillbirth triage checklist.
     - The Australian Perinatal Mortality Clinical Audit Tool.
     - Continue to add data to the CEQ Perinatal Mortality NWHHS Audit spreadsheet commenced for this review; and
     - Review the QMPQC perinatal mortality training videos which support the implementation of the published resources into M & M reviews.
  2. Utilise the multidisciplinary M & M process to involve all teams to improve transparency, support continuous learning, and build relationships.
  3. All Maternity service providers will initiate the “Discussion and Partnership Care Plan: Declining Recommended Maternity Care” State-wide form SW985 with all women declining recommended care. The midwife will support women at appointments with an Obstetrician to allow the Obstetric team the opportunity to discuss care options and obtain informed consent.
  4. Urgent review of all open and in-progress clinical incident recommendations to determine the necessary resources for progression of recommendation implementation. Specifically, the review team identified open recommendations from August 2020 that are yet to be completed.
  5. North West HHS Director of Healthcare Standard Unit liaise with Patient Safety Nurse Manager to conduct a review and benchmarking process against other health services for the triage of unconfirmed SAC 1 and 2 events and CIVT process, Clinical Incident Management procedure/processes and management of recommendations to align local process with best practice. This includes local content experts be involved in the all SAC 1 reviews and consulted during the

development of the recommendations before commissioning authority sign-off. The Obstetric and Midwifery teams be actively involved in the CIVT process when a SAC 1 is reported/identified. This will ensure that the correct severity rating and type of review, team membership, staff support and Open Disclosure is discussed.

6. CTG equipment availability in Level 2 facilities across the North West HHS should be considered by the Executive Leadership Team for appropriateness, implications for training, and cost of purchase and ongoing maintenance.
7. The review team agreed internal efforts should be undertaken to improve communication amongst the broader team with a view to a more collegiate team culture and patient-centred approach for our patients. A more structured approach utilising external expertise may be required once internal avenues have been shown not to be successful.
8. The Executive Leadership Team considers funding the appropriate staff resourcing to implement the recommendations in this review, as well as open, in-progress, and pending recommendations related to MGP, Maternity, and Obstetric Care.

- Progress against the above recommendations is as follows:
  1. The triage checklist, Australian Perinatal Morality clinical audit tool and Perinatal audit spreadsheet is in use. The clinical areas have been made aware of available training videos with implementation into the M&M reviews to occur.
  2. M & M multidisciplinary approach is established in the NWHHS, enhancements to this process outlined in recommendation one is underway.
  3. This form is being utilised by all team members where a woman or family are declining recommended care.
  4. A Comprehensive review of clinical recommendations commenced on 22 April 2024 focused on Obstetrics and Maternity recommendations. Historical, open, in-progress and new recommendations were included in the review. The review aims to identify common themes, duplicate or similar recommendations, and recurrent recommendations. The review has been completed and a brief prepared for the Executive Leadership team to be provided in the next 2 weeks. This includes proposed solutions to minimise duplicate recommendations while maintaining transparency and governance containing information relevant to making strategic decisions regarding current recommendations and future resourcing. Focused work has also occurred with the relevant assigned staff to assist with overdue recommendations from 2020.
  5. This has commenced with significant progress made, further work to be completed prior to receiving stakeholder feedback and endorsement.
  6. To be commenced.
  7. Although work in this area has been done prior to the cluster review, this recommendation is to be commenced.
  8. The Executive Leadership Team have approved initial funding to support the staff resourcing to assist for 3 months. Further funding requests will be submitted outside of NWHHS internal funding sources.
- Although the review team did not identify any specific inadequacy in care in relation to culturally appropriate First Nations women's antenatal care, North West HHS is awaiting two recommendations reports from the Queensland Health Maternity Models of Care Appraisal to support First Nations women in Rural and Regional areas.
- The Connected Community Pathways funding for Keeping First Nations Mums and Bubs on Country continues to support the delivery of care in the North West HHS.
- The North West HHS is currently working on a submission for growing deadly family initiative to support first nations women and remote maternity services.

- The Perinatal Cluster Review report has been provided to the relevant Quality Assurance Committee, the Queensland Maternal and Perinatal Quality Council for their review and learnings.

Media response

☐ A media holding statement has been prepared and copy submitted with this HIB.
☒ A media holding statement is not required.
☐ A proactive media release is scheduled to occur on

Confidential

- One (1) patient complaint was received from the 11 incidents which has been managed and closed.
- The patient made a verbal complaint to s.47(3)(b) [redacted]
- Open disclosure occurred on s.47(3)(b) [redacted] with the acting Chief Operating Officer Dr Theodore Chamberlain, Indigenous Liaison Officer Louise Butler, Indigenous Liaison Officer Team Leader Regina Mullins, the patient's midwife, Health Worker Vanessa, and acting Executive Director Nursing Midwifery Clinical Governance Troy Lane.
- s.47(3)(b) [redacted]

Clinical Incident Summary

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Date:	12/03/2024
Patient:	Perinatal cluster review
Specialty:	Obstetrics & Gynecology and Midwifery Services
Brief description of incident:	North West HHS identified eight (8) women and their families across the Health Service, who experienced a stillbirth, between the 1st May 2023 and the 30th November 2023. This was an increase compared to previous years and national data.

Coroner Advice:	Nil.
Legal matter status:	Nil.

Contact person

Sean Birgan, Health Service Chief Executive

Queensland Health

Hot Issues Brief

Cluster of Intra-Uterine Foetal Deaths

17 November 2023

Issue

- A cluster of perinatal mortality cases have occurred in the previous six months within the North West Hospital and Health Service (NWHHS).

Background

- A total of seven intra-uterine foetal deaths have occurred within the health service since May 2023.
- Each of these have been individually reviewed and assessed and referred for appropriate investigation.
- Gestational age ranges from 26 to 39 weeks.
- Three cases have occurred within recent weeks prompting close review.
- On preliminary analysis, this exceeds the expected number of cases when compared with national data.

Actions to date

- Each case has gone through a clinical incident evaluation and referred for appropriate individual further review.
- A summary of the cases does not immediately identify a particular red flag, although several cases involve maternal diabetes.
    - A gap analysis to review diabetic services between Mount Isa and remote sites will be undertaken.
- As an extra-ordinary cluster has been identified, NWHHS is proceeding with an external review process.
- NWHHS will contact The Queensland Maternity and Perinatal Quality Council to assist and consider undertaking a review process.
- Contact has been made with Children's Health Queensland Patient Safety and Quality Service.
- NWHHS will commence the utilisation of the Queensland Perinatal Quality Council, Perinatal mortality HHS Audit template to track NWHHS specific cases.

Media response

☒ A media holding statement is not required.

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Date: 17/11/2023

DLT Member / HSCE: Sean Birgan
Position: HSCE
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Date: 17/11/2023

Confidential

- Of the cluster of seven, four identify as First Nations.
- s.47(3)(b) [redacted]

Clinical Incident Summary

- Cohort of cases with varied clinical details. No obvious unifying features.

Date:	November 2022-November 2023
Specialty:	Specialty incident relates to obstetrics and gynaecology

Contact

Dr Anthea Woodcock, A/Executive Director Medical Services and Clinical Services, North West Hospital and Health Service, 07 4744 4840.