Triennial Report

Queensland Paediatric Quality Council

August 2017

Queensland Government

Gazettal:

The Queensland Paediatric Quality Council (QPQC) was gazetted on 14 September 2001. It was deactivated in 2006 and reconvened in 2012.

Purpose:

The purpose of the QPQC is to:

Collect and analyse clinical information regarding paediatric mortality and morbidity in Queensland to identify state-wide and facility-specific trends; and

Make recommendations to the Minister for Health on standards and quality indicators of paediatric clinical care, to enable health providers in Queensland to improve safety and quality; and

Assist with the adoption of such standards in both public and private sectors.

Background to Council organisation:

In 2012, the newly reconvened QPQC agreed on proposed work to address areas of concern in childhood mortality in Queensland (Qld), with a philosophy of not duplicating work done by other organisations. It was considered that the Qld childhood death numbers and rates, and particularly deaths from injury ("external cause") were well described in the annual report by the then Commission for Children, Young People and the Child Guardian (CCYPCG), and this continues in the reporting by the new Queensland Family and Child Commission (QFCC). In a similar vein, the Queensland Maternal and Perinatal Quality Council (QMPQC) carefully reviews perinatal mortality, which includes neonatal mortality.

After consideration, QPQC identified two areas of concern where death review utilising clinical content expertise and access to health documents could make a new and needed contribution. These were:

- a review of childhood death from disease ("morbid conditions"), to understand deaths in hospital, events in hospital, and death certification, with a focus on prevention.

- post-neonatal infant death review, to understand the excess infant mortality in Queensland and seek opportunities for prevention.

To address these functions, the QPQC convened two subcommittees, the Infant Mortality Subcommittee and the Clinical Incident Review Subcommittee. The role of these subcommittees is outlined below:

Clinical Incident Review (RCA) Subcommittee:

The RCA Subcommittee is undertaking a detailed analysis of paediatric Root Cause Analyses (RCAs) conducted for SAC1 (the most serious Severity Assessment Code) events in the three year period (2012 to 2014). The terms of reference include:

1) Comprehensively identify/describe factors that contribute to death/permanent paediatric patient harm; and

2) Analyse the quality of paediatric RCAs, with a focus on whether improvements in quality can be seen either over time, or in RCAs in which the Queensland Children's Critical Incident Panel (QCCIP) has provided assistance (since February 2014); and

3) Analyse the strength of recommendations made in paediatric RCAs

The Clinical Incident Review Subcommittee is also undertaking 'mini projects' into Testicular Torsion and High Flow Nasal Cannula (HFNC) Oxygen use among paediatric patients.

The Infant Mortality Subcommittee (IMSC):

The QPQC identified an excess in infant mortality in Queensland. Between 2007 and 2012, Queensland's infant death rate was 36% higher than the rest of Australia, with a higher rate than all other jurisdictions except for the Northern Territory. The largest mortality gap occurs among post-neonatal infants, with Qld's post-neonatal death rate 41% higher than the rest of Australia. Deaths in the post-neonatal period are largely described as Sudden Unexpected Deaths in Infancy (SUDI) – due to SIDS and other undetermined causes - as well identified causes such as infection and injuries.

Many infant deaths have associated modifiable risk factors, which if reduced or eliminated, could have prevented the death from occurring. For this reason, post-neonatal mortality is an important measure of the effectiveness and availability of health services for mothers and children. The QPQC considers Queensland's excess infant mortality to be unacceptable. Accordingly, a key priority area is the analysis of infant deaths. The Infant Mortality Subcommittee undertakes a detailed review of the circumstances and events surrounding infant deaths, as well as the infant's clinical records, in an effort to comprehensively identify the factors associated with infant deaths (age range: infants who have left hospital to one [1] year). Modifiable risk factors are a particular focus. Deaths that occurred in 2013 are currently being analysed.

The QPQC Committee:

The Council meets three times per year. Its membership includes representatives from both subcommittees, and other members representing a diversity of paediatric professional disciplines and expertise (see membership below). The meetings provide opportunity for oversight of the subcommittees and information sharing.

Summary of Progress since last Triennial Report:

The resourcing of the QPQC Chair and Coordinator role in 2015 provided increased productivity. Literature reviews for post neonatal infant death and for Root Cause Analysis (RCA) were conducted to inform the proposed case review work. The majority of 2015 was dedicated to convening the Infant Mortality and Clinical Incident Subcommittees, setting up agreements with document and data providers, and requesting and collating case documents. The sub-committees are made up of a panel of experts in each area (see membership below) and met monthly to assist the Chair and Coordinator to develop the review methodologies, and develop data collection forms and processes.

2016 saw the further development and staffing of the IMSC and RCA subcommittees. The QPQC submitted successful applications for funding to the Clinical Excellence Division and Health Care Improvement Unit to support the IMSC and RCA projects respectively, allowing the recruitment of two part time principal project officers and a project administrative officer. The IMSC and RCA subcommittee review process, review tools and meeting processes were refined. By late 2016, both projects had moved to secure online data entry and data transfer systems. During 2016, the QPQC engaged a University of Queensland (UQ) medical honours student to undertake research on the strength of RCA recommendations. Specific projects were completed for testicular torsion and high flow nasal cannula oxygen use among paediatric patients resulting in the release of two patient safety communiques.

In 2017, both subcommittees to the QPQC have focused on finalising ethics agreements, case reviews, data collection and entry, and data analysis. The focus has also been on sharing learnings from our reviews through conference submissions, presentations, grants submissions and patient safety communiques. The QPQC has worked to partner with key stakeholders including Child and Youth Mental Health, Oral Health Services, Queensland Family and Child Commission and Queensland Maternity and Perinatal Quality Council. A new Sepsis collaborative offers further opportunity for partnership. Funding was secured for a 0.1 Deputy Chair position to support the work of the committee and promote succession planning.

Presentation of findings will be the focus for the remainder of 2017. Feedback to Hospital and Health Services who provided RCA and infant records is a priority, particularly sharing identified themes and recommendations.

QPQC Meetings Dates, Objectives and Outcomes

2015: 3rd March, 11 November

2016: 1st March, 12th July, 6 September, 6th December

2017: 15th March, 25th July, 28th November

Dates	Objectives	Achieved
QPQC		
2015-2017 9 meetings.	Establish and monitor progress of the IMSC and RCA subcommittees. Oversee QPQC grant funding, planning, membership and staff recruitment. Oversee testicular torsion and high flow nasal cannula (HFNC) oxygen use projects. Collaborate with UQ honours medical student on strength of RCA recommendations research. Invite presentation/collaborations with external stakeholders i.e.: Pēpi-Pod® Program researchers, QMPQC, QFCC. Contribute to external reviews i.e. NHPA Review of the Performance and Accountability Framework Indicators.	• IMSC and RCA projects established. • Testicular Torsion and HFNC projects completed. • UQ honours project near completion. • QPQC project team recruited • QPQC input into QFCC Child Death report • QPQC presentations on IMSC and RCA findings conducted. • Grant applications submitted for Pēpi-Pod® Program outcome research
Clinical Incident Review Subcommittee		
2015 – 6 meetings 2016 – 8 meetings 2017 – 7 meetings (to date)	Development of review methodology and tool. Commence RCA case discussions. Review methodology refined. Continuation of RCA case discussions. Themed meetings on testicular torsion and retrieval. Finalisation of RCA case discussions. Themed meetings on Sepsis and Wrong tooth procedures.	• Secure on-line case review tool developed. • 2012-2014 RCA case reviews completed (N= 52) • Patient safety communique on testicular torsion released
Infant Mortality Subcommittee		
2015 – 6 meetings 2016 – 10 meetings 2017 – 7 meetings (to date)	Development of review methodology and tool. Commence infant death case review. Majority of SUDI cases discussed, review methodology further refined. Completion of SUDI cases and majority of non SUDI cases reviewed.	• Secure on-line case review tool developed • All 2013 SUDI cases reviewed

Details of Key Activities and Outputs:

2015

- Agreement with Patient Safety Unit for data sharing for Severity Assessment Code One (SAC1) paediatric events in hospitals in QLD. Review plan set for multi incident analysis of 2012-2014 RCAs in QLD. Commenced writing to each HHS for records for infants who had died in 2013, and for RCA documents for the triennium 2012-2014.

- Development of database of 2013 infant death data obtained from Health Statistics Unit, (infant deaths, perinatal data collection, emergency presentations and admissions).

- Meetings with Coroner and Acting Commissioner of the new QFCC to develop agreement for data sharing (coronial documents, coded deaths). Commenced collection and collation of infant documents.

- Partnerships also formed with CHQHHS Queensland Children's Critical Incident Panel (QCCIP).

- Presentation to Children's Health Queensland HHS (CHQHHS) Board and SCYCN regarding QPQC activities.

- Convening of the IMSC and RCA Subcommittees to plan case review methodology. Chair and Coordinator developed data collection forms, databases, and committees commenced case review.

- Successful Grant application from Networks Project Funding for RCA project coordinator.

- Unsuccessful grant application to Children's Hospital Foundation Research Grants for 2016 for project officer for Infant Mortality review project.

2016

- IMSC began reviewing 2013 infant deaths and the RCA Sub Committee continued RCA case reviews for 2012-2014.

- Successful application to Clinical Excellence Division for project officer for IMSC review project.

- Staff recruitment:
  Part-time temporary Administrative officer commenced in May;
  0.5 FTE Project officer RCA project commenced in June;
  0.5 FTE Coordinator commenced in July; and
  0.5FTE IMSC project officer commenced in October.

- The new project coordinators reviewed data collection tools for both subcommittees and developed "REDCap™" databases for data entry and analysis. Secure File Transfer protocol used to provide case documents to subcommittee members.

- Attended NSW Clinical Excellence Commission (CEC) meeting in Sydney to observe process to review RCAs and establish partnerships with the CEC.

- New processes for research partnership developed in response to approach from UQ student. Resulted in QPQC collaboration with Honours Student's on a project to review the strength and implementation of RCA recommendations.

- RCA subcommittee undertook research, in partnership with a CHQ surgeon, on the key themes and issues identified in SAC1 RCA's involving testicular torsion. A patient safety communique, outlining the key lessons learnt was prepared by the QPQC in partnership with the Patient Safety and Quality Improvement Service (PSQIS). The communique was endorsed by the Royal Australasian College of Surgeons and released in early 2017.

- The QPQC in collaboration with PSQIS undertook research into High Flow Nasal Cannula (HFNC) Oxygen use among paediatric patients (not involved in a clinical trial). A patient safety communique was prepared and released in early 2017 outlining recommendations to enhance the safety of HFNC in this age group.

2017

- Ethics waivers for the IMSC and RCA subcommittees submitted and approved.

- Finalisation of reviews of RCA dataset for 2012-2014 and Post-neonatal Infant Deaths for 2013.

- Establishment of a new research partnership with CHQ Paediatric Surgeons to develop a peer reviewed publication on acute scrotal presentations and key lessons learnt.

- Collaboration with Child and Youth Mental Health Services, Oral Health Services and Queensland Perinatal and Maternity Quality Council on RCAs involving youth suicide, wrong tooth procedures and neonatal and maternity case reviews.

- Meeting with QFCC resulted in plan for contribution of 2013 SUDI case series produced by QPQC into the 2017 QFCC Child Death Report.

- Collaboration with the Statewide Paediatric Sepsis Forum outlining key themes and issues identified in the RCA review.

- Presentations at the PSQIS Patient Safety Education Session (re: QPQC and Testicular Torsion) and Queensland Child and Youth Clinical Network Learning Set (re: Sudden and Unexpected Deaths in Infancy),

- Abstract submitted on findings of the RCA project to the APAC Forum 2017 and CHQ Patient Safety Symposium.

- Application submitted to the Children's Hospital Foundation, Health Services Grant (2017) regarding the Utility of the Pēpi-Pod® Program as a strategy to reduce infant mortality in Queensland. The application reached interview stage but was not successful this round.

Council Membership:

Name	QPQC Role	Qualification	Summary of Experience
Dr Julie McEniery	Chair, QPQC Chair, Infant Mortality sub committee Clinical Incident Review subcommittee member	Divisional and Medical Director, Division of Critical Care, Lady Cilento Children's Hospital (LCCH) Paediatric Intensivist, Lady Cilento Children's Hospital, CHQHHS MB BS MPH FRACP FCICM	Julie is a Paediatric Intensive Care specialist working at the Lady Cilento Children's Hospital in Brisbane. In addition she is the Director of the Division of Critical Care. Her MPH dissertation, awarded in 2005, was a review of in-hospital paediatric mortality in Queensland in 2001 and this remains a significant public health and research interest. Julie is a national examiner for the CICM and RACP colleges.
Dr Sharon Anne McAuley	Deputy Chair, QPQC Clinical Incident Review subcommittee member	Senior Medical Officer, Emergency Medicine, Lady Cilento Children's Hospital, CHQHHS MBBCH BAO DCH MSC FRCPCH FRACP	Sharon Anne is a Staff Specialist Emergency Paediatrician and works in the Children's Emergency Department at the Lady Cilento Children's Hospital, Brisbane. She is also a Senior Lecturer at UQ. She undertook her specialist training mainly in Cambridge and London, UK. In addition to her clinical role, Sharon Anne has a particular interest in Patent Safety and Quality.
Dr Kevin McCaffery	Chair, Clinical Incident Review subcommittee QPQC member	Paediatric Intensivist QPICS, Lady Cilento Children's Hospital, CHQHHS MB ChB MRCP (UK) FCICM	Kevin trained as a paediatrician with subspecialty paediatric intensive care accreditation in the United Kingdom. He has experience nationally and internationally in PICU. He currently has strong clinical and research interest in the problem of recognition and management of the deteriorating child and was involved in the development of the Children's Early Warning Tool.
Katie Robinson	QPQC member	Nurse Manager Safety and Quality, Child and Youth Community Health, CHQHHS Graduate certificates in Sexual Health and Forensic Nursing and a Masters of Public Health	Kate's current role as the Quality and Safety Manger for Child and Youth Community Health (CYCHS) exposes her to a number of different aspects of quality and safety in paediatric care, both community and acute. She is a member of the CHQ Morbidity and Mortality Committee, the Queensland Children's Critical Incident Panel as well as the Children's Health Australasian Special Interest Group for Quality and Safety.
Kay Ahern	QPQC member	Principal Project Officer, Patient Safety Unit, Department of Health Master of Emergency Nursing Graduate Certificate of Management	Kay's current role forms a valuable link between the QPQC and the Patient Safety Unit. Kay is an experienced Registered Nurse with an extensive background in emergency nursing management, a background in in the public and private sectors and more recently working in the corporate sector of heath. Her current portfolio includes surveillance and review of SAC1 for paediatrics, maternity and neonates.

Dr Andrew Hallahan	QPQC member	Executive Director, Medical Services, Lady Cilento Children's Hospital, CHQHHS MBBS (Hons) BSc (Med) Dip Paeds FRACP	Dr Andrew Hallahan is the Executive Director Medical Services (EDMS) for Children's Health Queensland and the Paediatric Lead for the Clinical Excellence Division Patient Safety and Quality Improvement Service. He has worked in children's healthcare for more than 20 years with a focus on systems improvement. Andrew established the Queensland Children's Critical Incident Panel, as a state-wide resource to support expert review of children's patient safety events.
Dr Catherine Skellern	QPQC member Infant Mortality subcommittee member	Eminent Staff Specialist, Child Protection and Forensic Medicine Service, Lady Cilento Children's Hospital, CHQHHS BHB; MBChB; FRACP; MPH; MForensMed; FCFM (RCPA)	Catherine brings a wealth of experience in child protection and forensic medicine to QPQC and in particular the IMSC case reviews. She is a Paediatrician on the SCAN team, Pine Rivers and RCH (Core Member) and is part of the Child Advocacy Service Clinic, RCH. Her clinical role includes the medical, developmental and forensic assessment of children in hospital and the community.
Professor Jeanine Young	QPQC member Infant Mortality subcommittee member	Professor of Nursing, School of Nursing, Midwifery and Paramedicine, University of the Sunshine Coast. PhD (Faculty of Medicine, University of Bristol), BSc (Hons) Nursing (University of the West of England), Adv. Dip Nursing Care (UWE), Registered Nurse, Registered Midwife, Neonatal Nurse (English National Board 405 Special and Intensive Care of the Newborn)	Jeanine has a special interest in infant care practices; in particular breastfeeding and parent-infant bed-sharing, which formed the basis of her doctoral studies. Jeanine has established a research program to investigate Queensland's infant mortality rate, with a focus on evidence-based strategies and educational resources to assist health professionals in delivering Safe Sleeping messages to families with young infants and to reduce Aboriginal and Torres Strait Islander infant mortality. In collaboration with Change for our Children New Zealand, Jeanine is the Australian lead for the Pēpi-Pod Program.
Kate Cogill	QPQC member Infant Mortality subcommittee member	Nurse Unit Manager of Ward 9B (Medical/Babies Inpatient Unit), Lady Cilento Children's Hospital, CHQHHS RN BN GCert Nurs (Neonatal care)	Kate is a registered nurse with over 20 years experience in a variety of clinical settings. She is a Nurse Unit Manager of Medical/Babies ward in the LCCH. She has advanced level practice demonstrated by caring for complex infants and families.
Dr Diane Payton	QPQC member Infant Mortality subcommittee member	Anatomical Pathologist, Pathology Queensland, Department of Health MBBS FRCPA	Diane has extensive experience in neonatal, infant and paediatric pathology. She has contributed to many publications in the field of infant mortality and pathology.
Dr Elisabeth Hoehn	QPQC member Infant Mortality subcommittee member	Medical Director, Queensland Centre for Perinatal and Infant Mental Health MBBS, FRANZCP, Certificate in Child and Adolescent Psychiatry	Elizabeth provides leadership in the area of perinatal and infant mental health across Queensland. She also provides consultant child psychiatry services to child and youth mental health service across North Brisbane.

Dr Lucy Cooke	QPQC member Infant Mortality subcommittee member	Staff Specialist, Neonatology Mater Health Service MBBS FRACP	Lucy's experience in Neonatology and current role as a Staff Specialist in Neonatology is invaluable in the review of infant deaths and developing publications in the area.
Dr Nadine Forde	QPQC member Infant Mortality subcommittee member	Forensic Pathologist, Queensland Forensic and Scientific Services, John Tonge Centre Brisbane BAappSc, MBBS, FRCPA	Nadine is an experienced Forensic Pathologist and currently works at the John Tonge Centre performing and reviewing infant and paediatric autopsies. She is also a member of another mortality review committee.
Dr Otilie Tork	QPQC member Infant Mortality subcommittee member	Senior Staff Specialist Paediatrician and Child Protection Adviser, CPFMS BSc (Med); MBBS; Dip Paed; FRACP	Otilie is an experienced Forensic Paediatrician providing forensic medical assessments for children with suspected exposure to physical/sexual abuse and neglect. She also and provides consultation and liaison in relation to inpatient and other child protection matters.
Dr Susan Ireland	QPQC member Infant Mortality subcommittee member	Senior Staff Specialist Neonatologist, The Townsville Hospital MB ChB FRACP FRCPCH	Susan has experience as a paediatric specialist prior to sub-specializing in neonatology. Susan is a member of the Children's' Hospital critical incident panel and has an interest in neonatal and paediatric morbidity and mortality. Susan also brings a regional and rural perspective to the QPQC and IMSC.
Dr Janene Davies	Infant Mortality subcommittee member	Staff Specialist in anatomical Pathology, Pathology Queensland FRCPA, FRACGP, MBBS, Certificate General Practice psychiatry Monash university	Janene has a wide range of experience in the area of paediatric anatomical Pathology. She works across both paediatric and maternity settings.
Johanna Neville	Infant Mortality subcommittee member	Team Leader, Maternal Child Health Team, North Cape Apunipima Cape York Health Council Certificate of General Nursing, Certificate of Acute Illness in Children, Certificate of Mental Health Nursing in Rural Communities, Graduate Diploma Midwifery, Post-graduate Certificate: Business, Post-graduate Certificate in Clinical Specialization, Post Graduate Certificate in Midwifery prescribing and Ultrasound ordering.	Johanna works within the field of indigenous maternal/ family primary health care services in Cape York. Johanna brings a valuable perspective on indigenous maternal/family care in isolated and remote communities.
Rebecca Shipstone	Infant Mortality subcommittee member	PhD Candidate, School of Nursing, Midwifery and Paramedicine, University of the Sunshine Coast BSocSci; GradDipArts(Phil)	Rebecca worked for 10 years for the former Commission for Children and Young People (now QFCC) and Child Guardian reviewing child deaths. She is currently undertaking doctoral research into SUDI (the Qld SUDI Study) which will review all cases of SUDI that occurred between 2004 and 2014, with a focus on socially vulnerable families.

Karen Hose	Infant Mortality subcommittee member	Neonatal Nurse Practitioner, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service Master of Nursing (Nurse Practitioner); Graduate Certificate Neonatal Care; Bachelor of Nursing	Karen is a Neonatal Nurse Practitioner with over 20 years experience in a variety of clinical settings, including hospital and non-government organisations. She currently works in the Intensive Care Nursery at RBWH.
Robyn Penny	Infant Mortality subcommittee member	Clinical Nurse Consultant Child Health Liaison, Community Child Health Services Bachelor of Health Science (Nursing) Master of Family and Community Health PhD - Queensland University of Technology	Robyn has over 30 years' experience in child health and maternity settings throughout Queensland with a focus on community and primary care settings. She also has extensive experience in integrating the patient/client journey and exploring opportunities for improvement around communication and service transitions.
Dr Fiona Macfarlane	Clinical Incident Review subcommittee member QPQC member	Director Anaesthesia and Pain Management, Lady Cilento Children's Hospital, CHQHHS MBBS FRCA FANZCA	Fiona is Director of Anaesthesia and Pain Management at LCCH. She has a long history of safety and quality experience, involvement in RCAs and Mortality and Morbidity committees.
Dr John Gavranich	Clinical Incident Review subcommittee member QPQC member	Director of Paediatrics, Ipswich Hospital, West Moreton Hospital and Health Service MBBS FRACP GCert Health Studies	John is Director of Paediatrics at Ipswich Hospital. He brings a wealth of experience in services to children in hospital and community settings.
Dr Judy Williams	Clinical Incident Review subcommittee member QPQC member	Clinical Director Paediatrics, Bundaberg Hospital, Wide Bay Hospital and Health Service MBBS QLD, FRACP (Paediatrics)	Judy is Clinical Director of Paediatrics Bundaberg with extensive experience in regional and rural paediatric care. She has a particular interest in patient quality and safety and is a member of the Queensland Paediatric Critical Incident panel. Judy has provided leadership in RCA development at a local level.
Lynette Adams	Clinical Incident Review subcommittee member QPQC member	Principal Project Officer, Patient Safety Unit, Department of Health BN BEd(Prim) GCert Nurs(Paed)	Lynette has a back ground in paediatric nursing and currently works as a Principal Project Officer, Patient Safety and Quality Improvement Service. She has extensive experience in developing, implementing and providing support for State-wide paediatric patient quality and safety initiatives.

Dr Mark Coulthard	Clinical Incident Review subcommittee member QPQC member	Staff Specialist in Paediatric Intensive Care Course Coordinator, Academic Discipline of Paediatrics and Child Health MB BS PhD FRACP FCICM	Mark has had 25 years of paediatric ICU experience and previous involvement with Queensland Infant and Child Mortality committee. He has also had a previous PICU portfolio in Quality & Safety.
Andrea Hetherington	Clinical Incident Review subcommittee member	Nurse Practitioner, Children's Emergency Department, The Prince Charles Hospital, Metro North Hospital and Health Service Masters of Nursing Science (Nurse Practitioner), Master of Nursing (Paediatric, Child and Youth Health Nursing). Graduate Certificate in Paediatric Intensive Care Nursing, Bachelor of Nursing	Andrea is a Nurse Practitioner, Children's Emergency Department at the Prince Charles Hospital. She brings a wealth of knowledge and experience in the area of paediatric emergency critical care nursing. Andrea is involved in clinical reviews of neonates and children across the health service,
Dr Michael Williams	Clinical Incident Review subcommittee member QPQC member	SMO Child and Adolescent Health, Mackay Base Hospital, Mackay HHS MB BS FRACP MMedSci	Michael is a senior regional general paediatrician and ex-director of Child & Adolescent Health Mackay; He has had long experience in rural and regional children's health care and in telehealth consultation.
Lissa McLoughlin	Clinical Incident Review subcommittee member	Director of Nursing and Midwifery, Mount Isa Hospital, North West HHS Registered Nurse Certification Registered Midwife Certification	Lissa has worked in all areas of Paediatrics, Maternity and Special Care Nursery from Tertiary Centres through to the rural and remote settings. She also has a specific interest in the development and enhancement of Registered Nurses post graduate education specializing in Paediatrics and Indigenous health in the Rural and Remote settings.
Michael Lewczuk	Clinical Incident Review subcommittee member	Operations Manager, Department of Critical Care, Lady Cilento Children's Hospital, CHQHHS Bachelor of Nursing, Graduate Certificate in PICU, Master in Nursing Leadership	Michael has extensive critical care nursing skills and is an experienced retrieval nurse and coordinator. Michael has been involved in reviewing and implementing changes to reduce clinical incidences as well as a great deal of work to develop safe reliable systems to improve care in paediatrics.
Dr Christa Bell	Clinical Incident Review subcommittee member	Staff Specialist Emergency Medicine, Gold Coast University Hospital, GCHHS MBBS, MRCP, FRACP, FACEM	Christa is a Staff Specialist, Emergency Physician and Children's Critical Care Paediatrician at the Gold Coast University Hospital.

Dr Peter Rizzo	Clinical Incident Review subcommittee member	Senior Staff Specialist, Emergency Medicine, The Prince Charles Hospital, Metro North Hospital and Health Service MD; Dip ABEM; FACEM	Peter trained and worked as a consultant in both combined and separate Adult and Children's Emergency Departments for more than 15 years. He is a member of Morbidity and Mortality committees at departmental, hospital, and now state-wide level for last 13 years. Currently coordinator for safety, quality, and performance at TPCH ED.
Dr Maree Crawford	Clinical Incident Review subcommittee member	SMO Child Protection & Forensic Medical Services, CHQHHS MBBS Fellowship of the Royal Australasian College of Physicians	Maree provides acute inpatient care and outpatient paediatric medicine at LCCH. Her role with in in the Child Protection and Forensic Medical Service (CPFMS) is to provide acute forensic assessments for children with physical and sexual abuse; interagency management via SCAN (suspected child abuse and neglect) teams; health, development and behavioural assessment of children in the child protection system.
Associate Professor Marcus Watson	Clinical Incident Review subcommittee member	Associate Professor The School of Psychology, University of Queensland BSc(Hons) MSc GDip CS, PhD	Marcus has expertise in human factors and complex systems. A range of experience in medical, nursing and allied health education and particular expertise in the design of safety systems.
Catherine McCosker	Clinical Incident Review subcommittee member	Registered Nurse – Child Health, Warwick, Darling Downs HHS B. App Science (Nursing) Certificate Midwifery Certificate Child Health Grad Dip Psychological Studies	Catherine has worked a child health nurse for many years. She currently works within a regional Child Health team to deliver quality services to the community, and also work and liaise with other community agencies such as Head Space, and mental health services to provide programs for vulnerable families.