Queensland Health

Clinical **Excellence** Queensland

Triennial Report
(Including 2023 Annual Activity Statement)

Queensland Paediatric Quality Council 2023

Improvement | Transparency | **Patient Safety** | Clinician Leadership | Innovation

Queensland Government

Queensland Paediatric Quality Council Triennial Report

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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 Deputy Director General on standards and quality indicators of paediatric clinical care, to enable health providers in Queensland to improve safety and quality. 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 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).

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

To address these functions two subcommittees, the Infant Mortality Subcommittee and the Clinical Incident Subcommittee were established. These subcommittees undertake in depth case reviews in their area of interest, cluster analysis, collaboration with experts and other agencies, communication of findings through various forums and targeted action with partners as needed.

Privacy Policy

The QPQC's Privacy Policy governs the following:

- the way the QPQC, a member of the QPQC and a relevant person can acquire and compile information;
- how the QPQC stores information in compliance with its disclosure obligations under the *Hospital and Health Boards Act 2011*;
- how information can be disclosed; and
- the copying and destroying of information.

A full copy of the Privacy Policy is included in Appendix 1.

QPQC Committees

Steering Committee

The QPQC Steering Committee was established in 2018 to provide a strategic and governance role for the QPQC. It is chaired by the Chair of the QPQC and has responsibility for:

- Providing strategic direction and endorsement for the work of the QPQC and its subcommittees;
- Oversight of subcommittee projects;
- Monitoring the QPQC budget and supporting grant applications;
- Advocating for the work of the QPQC and its subcommittees and providing linkages with other stakeholders as required;
- Oversight of research, ethics, data and integrity; and
- Responding to and actioning QPQC related correspondence.

It is comprised of senior representatives from across Queensland Health and our partner networks and agencies, as well as consumer and General Practitioner representatives.

Clinical Incident subcommittee

The Clinical Incident Subcommittee (CISC) has responsibility for investigating statewide themes, recommendations and the quality of serious clinical incident analysis reports involving children and young people under 18 years of age in Queensland. The terms of reference include:

- Comprehensively identify/describe factors that contribute to death/permanent paediatric patient harm and opportunities for prevention and health promotion;
- Analyse the quality of paediatric clinical incident reports; and
- Analyse the strength of recommendations made in paediatric clinical incident reviews.

Our committee is comprised of members with knowledge and expertise in the areas of paediatrics/child health, paediatric nursing, paediatric intensivists, patient safety, retrieval services, surgical and human/system factors.

Infant Mortality subcommittee

The Infant Mortality Subcommittee (IMSC) is a panel of Queensland Health and external agency experts brought together by the QPQC to review Sudden and Unexpected Deaths in Infancy (SUDI) and examine opportunities for prevention. When death circumstances were reviewed three key areas for change were identified: prevention, response, investigation. The subcommittee contribute to the Council's work in these three areas.

Summary of Progress: Sept 2020- August 2023

Clinical Incident Subcommittee (CISC)

Case reviews

The CISC committee completed reviews of all SAC1 paediatric clinical incident reports for the period 2018 to 2021. Work has recently commenced on the 2022 SAC1 clinical incident reviews. We have worked with the Patient Safety and Quality Improvement Service to streamline data collection processes, with information now available for review up to December 2022. Ethics approval for ongoing clinical incident reviews (2021 – onwards) was granted in February 2022.

Summary Report

A summary report entitled *"Multi-incident Analysis of SAC1 Clinical Incident Reports involving Children 2015-2019"* was prepared and released by CISC in February 2023. This report shares findings from our reviews of 2015-2019 SAC1 clinical incidents, including a profile of clinical incidents by patient and facility; the statewide themes and learnings identified; as well as providing feedback to Queensland Health Hospital and Health Services (HHS) on the overall quality of clinical incident reports received. It builds on a previous QPQC review of 2012-2014 paediatric SAC 1 clinical incident reports, the findings of which were released in July 2018.

The report was distributed widely across Queensland Health Hospital and Health Services and is available on our QPQC website. The QPQC team have also shared the findings of this review through targeted presentations across a range of forums including the Queensland Child and Youth Clinical Network Forum, the Clinical Incident Management Collaborative, and the Paediatric Sepsis Pathway team.

Themed Reviews

The CISC committee undertook themed reviews in three statewide areas of interest. These included:

- Sepsis: A diagnosis of sepsis continued to represent a significant diagnostic cluster comprising 29% of the 2015-2019 clinical incidents reviewed. CISC members undertook a themed review on a subset of 2012-2017 sepsis clinical incidents in children (n=28). Members of the Queensland Health Paediatric Sepsis team provided expert advice/feedback. A report of the findings from this review was prepared and published in the Journal of Paediatric and Child Health in September 2021. This paper explored statewide themes, contributing factors and recommendations for improving the care of children with sepsis in Queensland.

- Vascular Access Devices: In late 2020, CISC undertook a themed review of 3 SAC1 & 40 SAC 2 paediatric clinical incident reports involving complications from vascular access devices in Queensland (2017 to 2019). This review was undertaken in consultation with Tricia Kleidon from the Children's Health Queensland Vascular Access Management Service. A total of five statewide themes/learnings were identified. These were shared in Paediatric Matters Edition 7 which was released in May 2021.

- Diagnostic Error: In September 2021, CISC commenced a themed review of 20 SAC 1 paediatric clinical incident reports (2018-2019) in which diagnostic error was identified as a contributing factor (n=20 incidents). This included 15 incidents involving delayed diagnosis and 5 incidents involving wrong/missed diagnosis. A complex array of contributing factors was identified including patient, system, cognitive and unmodifiable factors. A total of 10 statewide lessons were identified and shared in Editions 8 and 9 of Paediatric Matters released in May and July 2022, and through presentations to key Queensland Health forums and groups. Meetings were also held with the Queensland Health Primary Clinical Care team to explore opportunities to embed these learnings within the Primary Clinical Care Manual.

CISC continued to identify opportunities for sharing learnings across key stakeholder groups. CISC successfully submitted posters and presentations at various national and international conferences covering topics such as our themed reviews of vascular access devices, diagnostic error, plaster casts and our CISC methodology. The committee won a Poster Award: Best local (Australian) poster at the International Society for Quality in Healthcare Conference in October 2022 for our work on Vascular Access Devices.

Infant Mortality Subcommittee (IMSC)

Case reviews

The IMSC Committee has continued to focus on the review of Sudden Unexpected Death in Infancy (SUDI). The review of cases in the 2013 to 2016 cohort was finalised. The committee, with the support of the Steering Committee, then opted to move to more contemporary case reviews and data for 2019 to 2021 deaths was obtained. IMSC has completed the review of 2019 deaths and is close to completing the 2020 SUDI death reviews. Data from the 2013-16 cohort is currently being collated for reporting and will be compared to the 2019-2021 cohort once completed.

Safer Infant Sleep Clinical guidelines.

Production of the Safe Infant Sleep Clinical *short*Guides were shared for review with the Queensland Clinical Guidelines (QCG) in early 2021. QCG determined that these four guides were comprehensive enough to be combined into a complete Clinical Guideline for Infant Safe Sleeping. The QPQC continued working closely with Queensland Clinical Guidelines and the established statewide working group to develop the Safer Infant Sleep Guideline. The working group consisted of over 100 participants and included clinicians, consumers, and peak body representatives. Feedback from the working party was incorporated in November/December 2021 which resulted in a restructure of the document to ensure better continuity. A flow diagram reflecting priorities was also developed and this then went back to the working group and for statewide consultation in March 2022. The Safer Infant Sleep Guideline was endorsed and published in August 2022. The QPQC along with Professor Jeanine Young from the University of the Sunshine Coast have presented the guideline at numerous forums to spread the message. Paediatric Matters Editions 10 and 11 are dedicated to presenting the risk minimisation approach to safer shared sleeping with infants and are in final drafts for release shortly.

Pēpi-Pod® Program Reports and Projects

Evaluation Report

Over the last four years the QPQC in collaboration with the University of the Sunshine Coast and the University of Auckland conducted the project: *"Measuring the effectiveness of the Pēpi-Pod® Program in reducing infant mortality in Queensland".* The final report for this project was officially released in July 2022. The report was sent to the Minister for Health and Ambulance Services, Director-General Queensland Health, Commissioner Queensland Ambulance Services, Attorney-General and Minister for Justice, Women, and Prevention of Domestic and Family Violence, Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director General along with all Hospital and Health Service Chief Executives in Queensland. The research team are now preparing a manuscript for a peer-reviewed journal.

Queensland Technologies Future Fund Grant project - "Enabling Queensland Implementation of the Pēpi Pod® program (EQuIPP) Project".

The QPQC conducted and completed this project in 2021- 2022. An advisory group was formed with members from around the state to provide strategic information, advice, and direction to support the work of the project. The strategy adopted was to learn from, and build on, what is already known about implementing the Queensland Pēpi-Pod® Program. The group identified that the hub and spoke model was the best way to implement the program into routine use state-wide. We employed a Hub Coordinator who began her role in early 2022. Two pilot sites were chosen for their considerable interest in our program and high priority populations, Bundaberg Hospital and Community Health Service and Caboolture Hospital and Community Health Service. Formal program training commenced in March to available midwives, nursing staff and community health workers. Although the project is completed these two pilot sites continue to use the program with great results reported by staff and families.

HHS Chief Executives Forum Brief

Following the completion of the EQUIPP project the QPQC worked in collaboration with Patient Safety to develop a brief to support the statewide roll out of the Pēpi-Pod® Program with the goal of presenting this to the Chief Executive forum. The brief was presented in March 2023 with all Chief Executives supporting the roll out and agreeing to fund the sleep spaces (Pods) in their HHS. The brief included a small amount of funding from Clinical Excellence Queensland to fund one position, based at Children's Health Queensland, to begin the statewide roll out process. QPQC continues to be involved with this as part of the governance/advisory group.

Coroners Court of Queensland – SUDI Multiagency Advisory Meeting Pilot.

In 2020 The State Coroner of Queensland endorsed the pilot of a multiagency meeting following SUDI deaths in Queensland. The IMSC have taken a lead role in developing the format, agenda, and evaluation process for this trial. The pilot commenced in March 2021 and concluded in November 2021.

Several side projects have resulted from this pilot which are still being actioned. The coroner supported the QPQC presenting at the meeting of all Queensland Coroners in August 2022. The QPQC has had ongoing conversations with the State Coroner and Deputy State Coroner about documenting the expected pathway of investigation for SUDI deaths.

Other QPQC Activities

The QPQC co-chairs and coordinators have contributed as active members and contributors on a range of Queensland Health projects and committees including:

- Queensland Paediatric Critical Care Pathway Project
- Strategy, Children and Families Unit: Child Death Injury and Review Model
- Paediatric Sepsis Executive Committee
- Paediatric Patient Safety Review Project
- Queensland Maternity and Perinatal Quality Council

The QPQC team have worked with Steering Committee to examine an expanded paediatric review model for the QPQC, including a proposal to extend reviews to include Sudden Unexpected Death in Childhood (SUDC). Discussions about scope and relevancy are ongoing.

The QPQC team is in the early stages of exploring ways to better support members' emotional safety and well-being due to the confronting nature of some of the reviews we conduct, particularly where members are directly involved in the care of the infants or children.

QPQC Membership and Resourcing

In 2021, the QPQC steering committee endorsed changes to the leadership roles within QPQC from Chair/Deputy Chair to Co-Chair Positions. The co-chair role continued to be filled by Dr Julie McEniery and Dr Sharon Anne McAuley.

In June 2023, our founding and longstanding Chair Dr Julie McEniery resigned from the QPQC Co- Chair role. The QPQC team and Steering Committee acknowledged Dr McEniery's enormous contribution to the QPQC and paediatric health care in Queensland at her final Steering Committee meeting in June. Dr McEniery will continue her work with the QPQC in an honorary role as Chair of IMSC.

Recruitment for a new co-chair will commence in 2024. In the interim, Dr Sharon Anne McAuley will fulfill the co-chair roles until recruitment is completed.

There have also been recruitment drives across the three years including new consumer representatives for the Steering Committee, General Practitioner representatives for the CISC and IMSC committees and a major recruitment of new members for CISC and IMSC in 2023.

Our four-year funding cycle was completed in June 2023. An interim one-year funding arrangement is now in place, pending the implementation of recommendations from a Queensland Health review of Quality Assurance Committees.

QPQC Meeting Dates, Objectives and Outcomes

Dates	Activities
Steering Committee	
2020-2023: 9 meetings **Meeting Dates since last Annual Activity Statement** 12/7/22, 4/10/22, 7/3/23, 6/6/23, 5/9/23	Monitored progress of the IMSC and CISC subcommittees Provided oversight of QPQC grant funding, planning, membership recruitment and Chair succession planning Contributed to the development/identification of workplans and directions for the QPQC and steering committees, including discussion around expanded Paediatric Mortality reviews Reviewed and endorsed key outputs for the subcommittees.
Clinical Incident Subcommittee	
2020 (Sept- Dec): 3 Meetings – 3 Cases reviewed & 40 cases as part of a themed review. **2021:** 8 meetings - 15 Cases reviewed & 22 cases as part of a themed review. **2022:** 9 meetings – 25 Cases reviewed **2023:** 7 meetings to date – 20 Cases reviewed **Meeting Dates since last Annual Activity Statement** 23/8/22, 25/20/22, 22/11/22, 28/2/23, 28/3/23, 2/5/23, 23/5/23, 27/6/23, 25/7/23, 22/8/23	Review of 2018 - 2019 incidents completed Review of 2020 - 2021 incidents completed Commenced 2022 clinical incident reviews Themed meetings: • Vascular Access Devices • Diagnostic Error Feedback on CISC activities including: • Paediatric Matters Editions 7, 8 and 9 • Sepsis Publication • Poster presentations
Infant Mortality Subcommittee	
2020: (Sept- Dec): 3 meetings – 11 Cases reviewed **2021:** 8 meetings: – 21 Cases reviewed **2022:** 7 meetings: – 20 Cases reviewed **2023:** 7 meetings to date – 22 Cases reviewed **Meeting Dates since last Annual Activity Statement** 16/8/22, 19/10/22, 15/11/22, 21/2/23, 21/3/23, 18/4, 23, 16/5/23, 20/6/23, 18/7/23, 15/8/23	Review of 2016 cases completed Review of 2019 cases completed Review of 2020 cases commenced Feedback on IMSC activities such: • Safer Infant Sleep Guidelines • Working Wonders Grant application 2021- for safer sleep education • Pēpi pod® Program report and project • SUDI Map project • Paediatric Matters Editions 6, 10 & 11

Key Activities and Outputs

Paediatric Matters

Edition 6 – Infant Reflux and Inclined Sleep: ***Why is this a SUDI risk?***

Edition 7 – Plan for Success: ***Reducing Vascular Access Device Injuries***

Edition 8 – Diagnostic Error Part 1: ***Getting to the correct diagnosis faster***

Edition 9 – Diagnostic Error Part 2: ***Cognitive factors and clinical reasoning***

Government Reports/Guidelines

Clinical Incident Subcommittee**. *Multi-Incident Analysis of SAC1 Clinical Incident Reports involving Children 2015-2019*.** Queensland Paediatric Quality Council, February 2023

McEniery J.A., Young J., Cruice D.C., Archer J., Thompson J.M.D (2022*)* ***Measuring the effectiveness of the Pepi-Pod Program in reducing infant mortality in Queensland*** Safer Infant Sleep, Queensland Clinical Guidelines

Queensland Clinical Guidelines. ***Safer infant sleeping***. Guideline No. MN22.71-V1-R27. Queensland Health. 2022. Available from: http://www.health.qld.gov.au/qcg

Evaluation/Implementation Report. ***Enabling Queensland Implementation of the Pepi-Pod Program established in 2010 as 'little (EQuIPP) Project.*** Queensland Technology Future Fund (QTFF). September 2022.

Queensland Family and Child Commission Annual Report, Chapter Section QFCC Annual Report: Queensland Paediatric Quality Council Update: ***Measuring the effectiveness of the Pépi-Pod® Program in reducing infant mortality in Queensland (55).*** Chapter 7 Sudden unexpected deaths in infancy (48-55) Queensland Family and Child Commission, Annual Report: Deaths of children and young people. Queensland, 2020-2021. Queensland Government 2021.

The State of Queensland (Queensland Paediatric Quality Council on behalf of Queensland Child Death Review Board) Issues Paper: ***Sudden unexpected death in infancy among vulnerable families in Queensland, 2021.***

Peer reviewed Publications

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".*** Journal of Paediatrics and Child Health, 58(3), 497-503.

Key Activities and Outputs

Oral Presentations

Osborne, J.M., and McAuley, S.A. (on behalf of the Clinical Incident Subcommittee**). "*Multi-incident Reviews of SAC1 Paediatric Clinical Incident Reports 2015-2019: Learnings Across the First 2000 Days".*** Queensland Child and Youth Clinical Network Forum, May 2023.

McCaffery, K. (on behalf of the Clinical Incident Subcommittee**). "*Diagnostic Error: Contributing Factors and Lessons Learnt from Serious Clinical Incidents in Children".*** Children's Health Queensland Grand Rounds Presentation, March 2023.

McAuley, S.A (on behalf of the Clinical Incident Subcommittee). ***"Getting Better at Getting to the Correct Diagnosis Faster".*** Don't Forget the Bubbles Conference. August 2022.

McAuley, S.A., Osborne, J.M., and McEniery, J.A. (on behalf of the Clinical Incident Subcommittee). ***"Multi-incident Analysis of Serious Paediatric Clinical Incidents Reviews involving Diagnostic Error in Queensland (2018-2019)".*** Presented at the ANZA-SIDM 2022 Improving Diagnosis Conference, April 2022.

Osborne, J.M., McAuley, S.A. and McEniery, J.A. (on behalf of the Clinical Incident Subcommittee**. "*Multi-incident Analysis of Paediatric Clinical Incidents involving Casts/Splints in Queensland 2014-2019".*** Australian Institute of Clinical Governance Patient Safety and Quality Care Symposium 2021.

Julie McEniery, Diane Cruice, Terry Ryan, Jordan Cotter. ***QPQC / Coroners Court of Queensland SUDI Multiagency Advisory Pilot (SUDI MAP) A Collaborative Co-design Approach to Process and System Change.*** Oral Presentation, ISA - ISPID 2021 International Conference – Driving Change in Stillbirth, SIDS and Infant Death, November 2021

Diane Cruice, Jeanine Young, Julie McEniery. ***The Queensland Safer Infant Sleeping Guidelines: A Tiered Response and Risk Minimisation Approach***. Oral Presentation, ISA - ISPID 2021 International Conference – Driving Change in Stillbirth, SIDS and Infant Death, November 2021

Diane Cruice, Julie McEniery, Jeanine Young***. 'Inclined, Elevated, Propped Up' A Review of SUDI Where the Infant Was Not Placed Flat and Level at Sleep Time***. Oral Presentation, ISA - ISPID 2021 International Conference – Driving Change in Stillbirth, SIDS and Infant Death, November 2021

Julie McEniery, Jeanine Young, Diane Cruice, John Thompson. ***Measuring the Effectiveness of the Pēpi-Pod® Program in Reducing Infant Mortality in Queensland***. Oral Presentation, ISA - ISPID 2021 International Conference – Driving Change in Stillbirth, SIDS and Infant Death, November 2021

Key Activities and Outputs

Oral Presentations cont.

Jeanine Young, Diane Cruice, Julie McEniery. ***When Does Baby Really Need to Sleep Inclined? Contemporary Safe Sleep Guidelines to Inform Optimal Decision-Making for Each Infant.*** Oral presentation, ISA - ISPID 2021 International Conference – Driving Change in Stillbirth, SIDS and Infant Death, November 2021

Jeanine Young, Diane Cruice, Julie McEniery, Jaime Blackburn, Josie Wilson. ***Cross-agency Collaboration in Queensland Child Death Review: Counting Lives, Informing Change*****.** Oral Presentation, ISA - ISPID 2021 International Conference – Driving Change in Stillbirth, SIDS and Infant Death, November 2021

Young J, Cole R, Thompson JMD, Cruice D, McEniery J. (2022) ***Addressing Caregiver Challenges with Inconsistent and Unrealistic Safe Sleep Messaging: A Safer Sleep Guideline informed by Risk Minimisation.*** Australian College of Midwives, 2022 24th ACM National Conference 2022, Cairns, 13-15th September 2022.

Young J, Cole R, McEniery J, Cruice D. (2022) ***Safer Infant Sleep informed by Risk Minimisation: Embracing Diversity and Supporting Parents with Realistic Advice*****.** CAPEA Conference Childbirth and Parenting Education: Riding the Wave of Change in Childbirth and Parenting Education. Sunshine Coast, 12-15th October 2022

Jeanine Young, Diane Cruice, Lee-Anne O'Keefe, Julie McEniery. ***Partnering with Families to Keep Babies Close and Safe, the Journey of the Queensland Pēpi-Pod® Program So Far*****.** Webinar presentation, Australian College of Children and Young People's Nurses (ACCYPN), August 2022.

Poster Presentations

McAuley SA, Osborne J.M, and McEniery J.A (on behalf of the Clinical Incident Subcommittee). ***"Quality Improvement Learnings from a Multi-Incident Analysis of Queensland Paediatric Vascular Access Device Clinical Incidents".*** International Society for Quality in Health Care, Brisbane, October 2022

Osborne, J.M., McAuley, SA., and McEniery, J.A. (on behalf of the Clinical Incident Subcommittee) 2021**.** ***"Multi-Incident Analysis of Paediatric Clinical Incidents involving Casts/Splints in Queensland (2014-2019)".*** Australasian Institute of Clinical Governance (AICG) Patient Safety and Quality Care Symposium (online) 2021.

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

Current Council Membership

Steering Committee

Name	Qualification	Summary of Experience
Dr Sharon Anne McAuley **Chair QPQC** **Co-Chair CISC**	Chief of Critical Care, CHQHHS Senior Medical Officer, Emergency Medicine, Queensland Children's Hospital, Children's Health Queensland Hospital and Health Service MB BCh BAO DCH MSc FRACP FRCPCH AFRACMA	Sharon Anne is a Senior Staff Specialist Emergency Paediatrician and works in the Children's Emergency Department at the Queensland 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 Julie McEniery **Chair IMSC**	Paediatric Intensive Care Specialist MBBS MPH FRACP FCICM DrPH	Julie specialized in Paediatric Intensive Care, working at the Children's Hospitals in Brisbane for three decades. A commitment to address preventable paediatric mortality in Queensland informed her MPH dissertation (2005, UQ, "A Review of In-Hospital Paediatric Mortality in Queensland in 2001") and her DrPH thesis (2022, UNSW, "Towards Understanding QLD's Excess Infant Mortality"). Her ongoing roles include clinician education, and international medical volunteering for "Operation Smile", the Cleft Lip and Palate Charity.
Jaime Blackburn	Executive Director Research and Child Death Prevention Queensland Family & Child Commission	Jaime is the Executive Director - Research and Child Death Prevention at the Queensland Family and Child Commission - a senior executive and qualified accountant with extensive experience in both the public and private sector, in Queensland and in the UK. Jaime previously worked for the Department of the Premier and Cabinet and held roles in corporate governance, risk management and internal audit services.
Associate Professor Steven McTaggart	Executive Director, Medical Services Queensland Children's Hospital Children's Health Queensland Hospital and Health Service MBBS, FRACP, PhD	Steven is the Executive Director, Medical Services, Children's Health Queensland. Steven has worked in Brisbane as a paediatric nephrologist for 20 years and is passionate about person-centered care; patient safety and quality; clinical excellence; and supporting the workforce to deliver continuous improvement. Steve's leadership has been pivotal in the development of Children's Health Queensland's Clinical Excellence Framework through a collaborative, co-design process with staff and consumers.

Current Council Membership

Steering Committee

Name	Qualification	Summary of Experience
Ainslie Kirkegaard	Queensland Coronial Registrar Coroners Court of Queensland Department of Justice and Attorney-General	Ainslie Kirkegaard is the inaugural Coronial Registrar of the Coroners Court of Queensland. This is a unique judicial registrar role designed to triage deaths reported daily across Queensland. Ainslie has held this role since early 2012 and previously held the positions of Counsel Assisting the Deputy State Coroner and Director, Office of the State Coroner. Ainslie became a part of the Queensland coronial system in 2008, bringing more than 15 years' experience in policy and legislation development in the Health, Education, and Justice portfolios, with specialist expertise in coronial and health regulatory law and policy. Having been appointed as an Acting Magistrate since April 2015, Ainslie now also relieves as Coroner when required
Dr Neil Archer	Clinical Director of Paediatrics Cairns and Hinterland Hospital and Health Service MBChB FRCPH FRACP	Neil is the Clinical Director of Paediatrics for CHHHS and has been practicing Paediatrics for over 20 years. He completed specialist training in Australia and the UK. He has specific training and special interest in respiratory medicine, allergy, and paediatric rheumatology. Neil has a keen interest in system approaches to improving service provision in terms of effectiveness and equity for all children in regional Australia, communication and safety.
Kirstine Sketcher-Baker	Executive Director, Patient Safety and Quality Improvement Service Clinical Excellence Queensland, Department of Health	Kirstine is the Executive Director of the Patient Safety and Quality Improvement Service and is responsible for monitoring and supporting Hospital and Health Services to minimise patient harm, reduce unwarranted variation in health care and achieve high-quality patient-centered care. Kirstine has a statistical background with a longstanding interest in monitoring patient safety and quality of care in hospitals.
Dr Ka-Kiu Cheung	General Practitioner, Broadbeach Medical Centre General Practitioner with special interest, Gold Coast University Hospital Developmental Paediatric Clinic/Antenatal Clinic B. Pharm MBBS (Hons) DRANZCOG MPH FRACGP	KK works as a GP in private practice and publicly as a GP with Special Interest in obstetric and developmental paediatric clinics through the Gold Coast University Hospital. KK has over 15 years' experience with a focus on antenatal and paediatric care and more recently in organisational governance and public health with roles on health boards, models of care development and establishing new tertiary clinics. She has a strong interest in clinical governance and strategic direction of health services as evidenced by KK's involvement as a board director of the Gold Coast Primary Health Network and General Practice Gold Coast

Current Council Membership

Steering Committee

Name	Qualification	Summary of Experience
Dominic Tait	Executive Director, Clinical Services Queensland Children's Hospital Children's Health Queensland Hospital and Health Service BPhty MBA	Dominic is a highly experienced healthcare manager and Allied Health professional who is passionate about designing, as well as leading patient and family-centered healthcare services. Prior to his appointment of Executive Director Clinical Services Dominic was the hospital's Divisional Director of Clinical Support for 3 years. He also served in Operation Manager roles across multiple divisions such as Critical Care, Surgery and Clinical Support at the former Royal Children's Hospital.
Dr Clare Thomas	Director of Paediatrics, Sunshine Coast University Hospital Queensland Co-Chair Qld Child and Youth Clinical Network (QCYCN) MBBS FRACP	Clare is Director of Paediatrics at Sunshine Coast Hospital and Health Service and Co-Chair of the QCYCN. Clare is a General Paediatrician, a supervisor of trainee Paediatricians, and National Examiner for the Royal Australian College of Physicians. She is experienced in leading health systems and process re-design and is committed to guiding and empowering clinicians to strive to deliver high quality care through health system improvement for care of children and young people. She is enrolled in a PhD, evaluating a standardised workflow designed to improve the safety and quality of non-critical paediatric inter-hospital transfers. Clare chairs the Paediatric Improvement Collaborative Steering Committee
Frank Tracey	Health Service Chief Executive Queensland Children's Hospital Children's Health Queensland Hospital and Health Service	Frank is the Health Service Chief Executive, Children's Health Queensland Hospital and Health Service. With more than 30 years' experience working in health systems, Frank has a background in nursing and holds advanced qualifications in both health and management. His extensive experience in health commissioning and provision in clinical and community settings is complemented by strong managerial and leadership skills, and an applied interest in translational health research.
Professor Leonie Callaway	Co-Chair Queensland Maternal and Perinatal Quality Council Director of Research, Women's Obstetrics and Gynecology, RBWH MNHHS MBBS (Hons I) FRACP PhD GC Lead GAICD	Leonie is a General and Obstetric Physician, with a strong track record in clinical research relating to gestational diabetes, hypertension in pregnancy, medical disorders of pregnancy, clinical trials, clinical studies, and epidemiology. Leonie holds roles including Director of Research within Women's and Newborn Services at the RBWH, Executive Director of the Women and Children and Families Stream for Metro North HHS District and is Co-Chair of the Queensland Maternal and Perinatal Quality Council.

Current Council Membership

Steering Committee

Name	Qualification	Summary of Experience
Dr Rachael Beswick	Queensland Child and Youth Clinical Network (QCYCN) Co-Chair Director, Models of Care Children's Health Queensland, Hospital and Health Service PhD Audiology/Audiologist MBA	Rachael is the Director of Queensland's newborn screening program, Healthy Hearing and Co-Chair of the QCYCN. Rachael has established and maintained extensive sector partnerships at a local, state, and national level, including development of the inaugural Childhood Hearing Collaborative. She is also currently leading the Australasian Newborn Hearing Screening sub-committee which is developing a national consensus statement for detection of hearing loss beyond the newborn period.
Zehnab Vayani	Consumer Representative	Zee is passionate about paediatric and integrated health care. She has supported and listened to families who struggle to access timely and family centered care in rural and remote parts of Queensland. Zee is a member of the Gold Coast Health Consumer Advisory Group and sits on several diverse health centered committees bringing her knowledge and experience as a consumer into consideration for future growth and development of the Queensland Health Service.
Dr Melissa (Meg) Cairns	General Practitioner General Practice Liaison Officer, Women Children and Families Clinical Stream, Metro North Hospital and Health Service Member Queensland Maternal and Perinatal Quality Council (QMPQC) MBBS FRACGP GAICD	Meg is a Specialist General Practitioner with over 25 years' experience, currently practicing in Brisbane. Prior to that, she worked in Queensland Health Hospitals in Brisbane and regional Queensland, and in General Practice in Toowoomba. Meg is also a GP Liaison Officer with Metro North Health, Chair of the Brisbane North Primary Health Network (PHN) Clinicians' Advisory Group, a Member of the Brisbane North PHN Clinical Council and a Member of the Queensland Maternal and Perinatal Quality Council.
Angela Young	Director Aboriginal & Torres Strait Islander Engagement Queensland Children's Hospital Children's Health Queensland Hospital and Health Service LLB	Angela is the Executive Director, Aboriginal and Torres Strait Islander Engagement. Prior to her current appointment, Angela was the General Manager, Policy and Research for the QLD Aboriginal and Islander Health Council, where she was a strong advocate for the health advancement of Aboriginal and Torres Strait Islander peoples. Angela is committed to creating a more innovative, culturally safe and engaging healthcare pathway for Aboriginal and Torres Strait Islander children, young people and their families.

Current Council Membership

Clinical Incident subcommittee

Name	Qualification	Summary of Experience
Dr Kevin McCaffery **Co-Chair CISC**	Paediatric Intensivist Queensland Children's Hospital, Children's Health Queensland Hospital and Health Service 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.
Dr Mark Coulthard	Staff Specialist in Paediatric Intensive Care Queensland Children's Hospital, Children's Health Queensland Hospital and Health Service MB BS PhD FRACP FCICM	Mark has practiced as a paediatric intensive care specialist in Brisbane since 1996, following training in Melbourne and Dallas, Texas. Mark's research interests include medical education, telemedicine, and the basic science of vascular endothelial permeability in sepsis and critical illness.
Professor **Marcus Watson**	Professor, The School of Psychology, University of Queensland Enterprise Senior Fellow - MedTech, Faculty of Engineering and Information Technology, University of Melbourne BSc (Hons) MSc GDip CS PhD	Marcus has expertise in human factors and complex systems and a range of experience in medical, nursing, and allied health education and in particular, expertise in the design of safety systems.
A/Prof Ben Lawton	Senior Staff Specialist Paediatric Emergency Physician – Logan Paediatric and Neonatal Retrieval Consultant – MedSTAR Kids (South Australia Ambulance Service) Simulation Consultant – STORK, Children's Health Queensland Medical Advisor to the Patient Safety and Quality Service (QCH) MBChB BSc(hons) FRACP (PEM) MPH	Ben is a paediatric emergency physician practicing in Logan ED, where he was formerly the Deputy Director and Clinical Lead for paediatrics. He also works as a retrieval consultant for MedSTAR Kids, the paediatric and neonatal retrieval branch of South Australia Ambulance Service. He is a simulation consultant and former director of Children's Health Queensland's Stimulation Training Optimising Resuscitation for Kids team and is currently serving as a medical advisor to the Patient Safety and Quality Service at Queensland Children's Hospital. Ben is an Associate Professor in Griffith University's Faculty of Medicine.

Current Council Membership

Clinical Incident subcommittee

Name	Qualification	Summary of Experience
Professor Craig McBride	Senior Staff Specialist Paediatric Surgeon, Queensland Children's Hospital Children's Health Queensland Hospital and Health Service PhD FRACS, FACS	Craig is a consultant in Paediatric Surgery, Neonatal Surgery, Urology, Burns and Trauma at the Queensland Children's Hospital. He is also the Deputy Director of Clinical Training (Surgical) for the hospital. He is a member of both the Clinical Ethics Consulting Service and the Human Research Ethics Committee. He is a Professor at the University of Queensland, with academic appointments also at Griffith University (Associate Professor) and Queen Mary University of London (Honorary Senior Lecturer).
Tammy Doyle	Clinical Nurse Consultant, Safety Improvement Officer Women's and Family Service, Sunshine Coast University Hospital BACH	Tammy works as a Safety Improvement Officer at the SCUH. She is an RCA trainer/ consultant for the Eastern Seaboard. Tammy designs and delivers Quality and Safety training programs both locally and statewide on Root Cause Analysis, Human Factors and Clinical Incident Management. She is passionate about strengthening the quality improvement cycle and promoting safety cultures within multidisciplinary teams.
Dr Christopher Edwards	Staff Specialist in Paediatrics, Bundaberg Base Hospital, Wide Bay Hospital and Health Service MBBS FRACP	Chris works as a staff specialist at the Bundaberg Hospital. He provides clinical direction and quality improvement in the operation of the neonatal nursery and coordinates paediatric education in the Emergency Department. Chris is also Chair of the Special Care Nursery Business Meeting and is a member of the Paediatric and Perinatal monthly Morbidity and Mortality Meetings
Dr Daniel Carroll	Staff Specialist, Paediatric Surgery The Townsville Hospital, Townsville Hospital and Health Service MBBS FRACS BM BCh MRCS	Daniel works as a Senior Staff Specialist in Paediatric Surgery at The Townsville Hospital and served as Director of Paediatric Surgery from 2014 until December 2019. Daniel is currently the clinical lead for childhood trauma and the Queensland representative for ANZAPS.
Sarah Busuttil	Clinical Nurse- Child Health, Toowoomba Hospital, Darling Downs Hospital and Health Service BNurse GCCh&FHlth	Sarah works as a Registered Nurse in the Darling Downs across the areas of Acute Paediatrics, Child and Family Health and the Child Protection Unit. This experience allows Sarah to bring a wide view and perspective from a regional health service.

Current Council Membership

Clinical Incident subcommittee

Name	Qualification	Summary of Experience
Andrea Hetherington	Nurse Practitioner, Children's Emergency Department, The Prince Charles Hospital, Metro North Hospital and Health Service BACH MSN	Andrea is a Nurse Practitioner in the Emergency Department (Adult & Children's) at The Prince Charles Hospital in Brisbane. With a background in Paediatric Intensive Care and Emergency, her clinical work mainly focuses on caring for sick children who present to the Children's Emergency Department.
Dr Lauren Kromoloff (Membership commenced 20/4/23)	Consultant Paediatrician Integrated Medicine, Emergency, Child and Youth Services Cairns and Hinterland Hospital and Health Service MBBS DCH FRACP	Lauren is a Consultant Paediatrician at the Cairns Hospital. She provides paediatric outpatient consultation and child protection advice. Lauren has regular participation and presentation teaching sessions, MDT meetings with allied health, Education Queensland and Child and Youth Mental Health Services.
Dr Maree Crawford	SMO General Paediatric Medicine, Queensland Children's Hospital Childrens Health Queensland Hospital and Health Service MBBS, Fellowship of the Royal Australasian College of Physicians	Maree is a Senior Staff Specialist at Queensland Children's Hospital and provides acute inpatient care and outpatient paediatric medicine. She is a Senior Lecturer with Paediatrics and Child Health University of Queensland. She has interests in developmental and behavioural paediatrics with a long background in child protection and forensic medicine.
Dr Clare Thomas	Director of Paediatrics, Sunshine Coast University Hospital Queensland Co-Chair Qld Child and Youth Clinical Network (QCYCN) MBBS FRACP	Clare is Director of Paediatrics at Sunshine Coast Hospital and Health Service and Co-Chair of the QCYCN. Clare is a General Paediatrician, a supervisor of trainee Paediatricians, and National examiner for the Royal Australian College of Physicians. She is experienced in leading health systems and process re-design and is committed to guiding and empowering clinicians to strive to deliver high quality care through health system improvement for care of children and young people. She is enrolled in a PhD, evaluating a standardised workflow designed to improve the safety and quality of non-critical paediatric inter-hospital transfers. Clare chairs the Paediatric Improvement Collaborative steering committee

Current Council Membership

Clinical Incident subcommittee

Name	Qualification	Summary of Experience
Dr Brett Hoggard	Medical Director, Retrieval Services Queensland, QAS, Department of Health. MB ChB FACEM	Brett is an Emergency Specialist and Retrieval Physician. His experience in, and passion for, emergency medicine, prehospital and retrieval medicine, and as Medical Director for Retrieval Services Queensland has paralleled his dedication to a strong safety and quality system across all patient demographics and aeromedical systems in Australasia. This commitment is demonstrated in his role as Chair of the Statewide Integrated Group Quality Assurance Committee (STIG), and membership on and contributions to a number of other quality assurance and improvement committees
Nicola Sanders	Patient Safety Quality Manager PSQS, Queensland Children's Hospital, Children's Health Queensland Hospital and Health Service. RN Diploma Higher Education in Child Branch Nursing BTEC National Diploma in Science and Health Studies	Nicola is a paediatric nurse with over 20 years' experience of nursing across England and Australia paediatric acute care settings. This covered specialties ranging from paediatric general medical, surgical, and adolescent care, later developing a special interest area and expertise across nursing care in a tertiary paediatric emergency and trauma department in Brisbane (Former Royal Children's Hospital and then transitioning to Queensland Children's Hospital). Nicola is a passionate safety and quality professional with extensive expertise in safety and quality management including clinical incident management and quality improvement with extensive knowledge and expertise of applying the National Safety and Quality Health Service Standards (NSQHSS) to best practice every day within a tertiary paediatric hospital and health service as a Patient Safety and Quality Manager for the past eight years.
Dr Emily Moody (Membership commenced 26/4/22)	A/Co-Clinical Director, West Moreton Rural Services Senior Medical Officer, Boonah Health Service Queensland Rural & Remote Clinical Network Co-Chair National Clinical Educator, ACRRM Fellowship Education Program Senior Lecturer, University of Queensland MBBS FRACGP FARGP FACRRM MPHTM AFRACMA JCCA Accredited (Anaesthetics) CEQ HIU Fellow	Originally from Cairns, Emily is a rural generalist with advanced skills in Anaesthetics, who has practiced in several rural locations throughout Queensland in both private and public sectors, caring for adult and paediatric patients. She is the National Clinical Educator of the ACRRM Fellowship Education Program, and a local supervisor at Boonah Hospital, where she works as a Senior Medical Officer. She is currently acting as Co-Clinical Director West Moreton Rural Services. Emily recently undertook a Healthcare Improvement Fellowship to enable her to take a holistic systems approach to improving the health and wellbeing of rural and remote Queenslanders in her role as the Queensland Rural and Remote Clinical Network Co-Chair.

Current Council Membership

Clinical Incident subcommittee

Name	Qualification	Summary of Experience
Dr Toni Weller (Membership commenced 18/5/23)	General Practice Liaison Officer, (QGPL) Co-Chair Townsville Hospital Townsville Hospital and Health Service FRACGP MBBS LLB (HONS) B.COM GAICD AICGG	Toni is a General Practitioner, Co-Chair of the Queensland General Practice Liaison Network, and the Senior Medical Lead GPLO for the Townsville Hospital and Health Service. In her liaison work she heads a multidisciplinary collaboration of clinicians who provide expert advice and work on matters that identify and address services gaps between primary and secondary/tertiary care. Toni works in collaboration with multiple stakeholders in her role as GPLO to improve quality of processes and systems that improve patient safety and health outcomes for the THHS. In her role as a GP, Toni provides her patients with holistic clinical health care across life spectrum.
Margaret-Ann Knowles (Membership commenced 30/8/22)	Clinical Nurse, Logan Hospital Children's Inpatient Unit Metro South Hospital and Health Service BNursing	Maggie works at the Logan Hospital in the Children's Inpatient Unit as a Clinical Nurse. She supports a multidisciplinary team managing the care to medical and surgical paediatric patients. Maggie has a passion for nursing and has proven leadership skills by acting as the Clinical Nurse Consultant in the past 2 years. She has been responsible for reviewing clinical incidents and implementing change when required.
Naomi Flenady (Membership commenced 6/2/23)	Assistant Director of Nursing, Patient Flow and CATCH, Queensland Children's Hospital Children's Health Queensland Hospital and Health Service BNursing, MNNP GradCertACNg (Paediatrics) GradCertPallCare	Naomi has over 10 years' experience in providing advanced clinical care and leadership within the paediatric specialty. She works as the Assistant Director of Nursing for Patient Flow & CATCH at QCH and uses her advanced level of professional, clinical, operational and change management experience to lead the broader patient flow, clinical safety, staffing and CATCH teams and develop models/pathways of care in accordance with current best practice. Naomi is an endorsed Nurse Practitioner, credentialled for Paediatric Emergency at QCH.
Dr Benjamin Beckwith	Senior Staff Specialist Paediatrician Children's Services, The Prince Charles Hospital, Metro North Hospital and Health Service MBBS FRACP	Ben is a Senior Staff Specialist Paediatrician at The Prince Charles Hospital, Chermside with many years of experience on various quality committees. Ben sits on The Prince Charles Hospital Serious Incident, Complex Case and Mortality committee and has been a member on various quality and safety committees over the past 12 years.

Current Council Membership

Infant Mortality subcommittee

Name	Qualification	Summary of Experience
Dr Chamanthi Nanayakkara	Staff Specialist Paediatrics/Child Protection Advisor Toowoomba Hospital, Darling Downs Hospital and Health Service MBBS FRACP FRCPCH MRCPCh UK CCST BSc (Hons) - Biochemistry MSc Clinical Paediatrics University of London	Chamanthi works as a General Paediatrician and Child Protection Advisor at Toowoomba Hospital. She is the Discipline Lead for Paediatrics for the UQ Rural Clinical School medical students. Chamanthi is involved in the medical student teaching area, teaching of junior staff, education of nursing staff and regular neonatal resuscitation programmes. Chamanthi is also involved in perinatal mortality meetings and in the multi-disciplinary rounds and journal club at Toowoomba Hospital.
Dr Otilie Tork	Senior Staff Specialist Paediatrician Acting Medical Director CPFMS, Queensland Children's Hospital Children's Health Queensland Hospital and Health Service BSc (Med) MBBS Dip Paed FRACP AFRACMA	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 Sue Ireland	Senior Staff Specialist Neonatologist, The Townsville Hospital MB ChB FRACP FRCPCH	Susan has experience as a Paediatric specialist prior to sub-specialising 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.
Professor Jeanine Young AM	Professor of Nursing, School of Health, University of the Sunshine Coast, Queensland, Australia Honorary Professor, Centre for Health Services Research, University of Queensland Ministerial Appointment, QLD Child Death Review Board Member, Queensland Paediatric Quality Council IMSC ISPID Co-Chair, Child Death Review and Epidemiology Working Groups PhD, BSc (Hons-1st class) Nursing, Adv. Diploma of Nursing Care, RGN, Reg Midwife, Neonatal Nurse (ENB 405 Special and Intensive Care of the Newborn)	Jeanine has established a research program to investigate Queensland's infant mortality rate and associated infant care practices. Program foci include evidence-based strategies and educational resources to assist health professionals in raising awareness for families with young infants; and the development of co-designed community-based interventions designed to address social vulnerabilities associated with infant mortality in priority populations. In collaboration with Change for our Children, Jeanine is the Australian lead for the Pēpi-Pod® Program.

Current Council Membership

Infant Mortality subcommittee

Name	Qualification	Summary of Experience
Dr Janene Davies	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.
Detective Inspector Chris Hansel (Membership commenced 19/5/22)	Detective Inspector, Operating Manager Child Trauma & Sexual Crime Unit, Crime & Intelligence Command, Queensland Police Service	Chris is a Detective Inspector with the Queensland Police Service who manages the Child Trauma Unit. He has been a long serving member of the QPS and dedicates his time to protect and serve the Children of Queensland.
Cathy McCosker	Child Health Nurse Warwick Child and Family Health Darling Downs Hospital and Health Service Graduate Diploma Psychological Studies – with Distinction (USQ) Bachelor Applied Science – Nursing (QUT) Child Health Certificate Midwifery Certificate	Cathy works as a Child Health Nurse at the Warwick Child and Family Health Service. Her role includes supporting family in the community and at their homes. Cathy provides support for parents and care givers regarding infants and young children's growth and development. Education re: breast feeding, children's behaviour issues, parenting issues and other well baby issues, Intensive home visiting program for at risk families amongst many other specialties that the Child Health Nurses engage in for the community.
Dr Wei Wei Chan	Paediatrician, Gold Coast University Hospital Gold Coast Hospital and Health Service MBBCh BAO MRCPCH FRACP	Wei Wei provides high quality patient care which is family focused and evidence based in her role as Paediatrician at the Gold Coast University Hospital. She teaches and supervises junior medical staff and medical students and currently is a Senior Lecturer at Griffith University.
Dr Lucy Cooke	Medical Director Neonatology RESQ Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service MBBS FRACP	Lucy has 20+ years of Neonatal intensive care experience. Current role coordinates more than 600 transfers of acutely unwell newborns from around the whole of Queensland. Provides a unique insight into the challenges faced by rural and regional Queensland in accessing tertiary care for their babies after birth.

Current Council Membership

Infant Mortality subcommittee

Name	Qualification	Summary of Experience
Kate Cogill	Clinical Nurse Consultant, SCN Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service BN RN Grad Cert Neonatal Care	Kate is the Clinical Nurse Consultant in the Neonatal Unit at the Royal Brisbane and Women's Hospital.
Lee-Anne O'Keefe	Nurse Unit Manager, Child and Youth Community Health Service, Caboolture, Metro North Hospital and Health Service BACH	Lee-Anne is a Nurse and Endorsed Midwife with over 27 years of expertise in the areas of Midwifery, neonatology and most recently Maternal and Child Health. She is currently the Nurse Unit Manager of Caboolture Child Health Service Lee-Anne has a passion for participating in the development and promotion of a research culture as evidenced by accepting roles in the Early Years Centre Caboolture partnership and Clinical Lead for the Aboriginal and Torres Strait Islander Intensive Home Visiting Project.
Dr Ruth Barker	Director Queensland Injury Surveillance Unit, Mater Health Services Queensland. Senior Medical Officer, Emergency Medicine, Queensland Children's Hospital, Children's Health Queensland Hospital and Health Service MBBS FRACP	Ruth works as an Emergency Paediatrician at the Queensland Children's Hospital and is the Director of the Queensland Injury Surveillance Unit based at the Mater Medical Research Institute. Ruth has worked in injury prevention since 2003 and during this time developed an extensive network of contacts within the injury prevention community, including industry, media, Standards, government, and non-government groups.
Fiona Boorman	Manager Child Death Prevention Queensland Family & Child Commission (QFCC) BSc (Hons) - Physics	Fiona is the Manager Child Death Prevention at the QFCC and leads the team responsible for maintaining the Queensland Child Death Register, producing the annual report on child deaths in Queensland, and the child death prevention research activities under the Safer Pathways Through Childhood framework.

Current Council Membership

Infant Mortality subcommittee

Name	Qualification	Summary of Experience
Shelley Duffy (Membership commenced 11/5/22)	Nurse Unit Manager Primary School Nurse Health Readiness Program Child, Youth and Community Health Service, Children's Health Queensland Hospital and Health Service BN GC-CAHNU	Shelley is a Nurse Unit Manager for the Child, Youth and Community Health Service CHQHHS. She currently leads 16 Nurse Navigators in the Navigate Your Health Program which provides specialist health systems navigation for children in out of home care and young people subject to Youth Justice Orders. Shelley is a Registered Nurse, Midwife and Child Health Nurse with a 30 history of supporting infants, children and young families and is dedicated to building capacity within families to make informed health choices.
Dr Rebecca Shipstone	Principal Research and Special Projects Officer Child Death Prevention Queensland Family and Child Commission BSocSci; GradDipArts (Phil) PhD	Rebecca is the Principal Research and Special Projects Officer in the Child Death Prevention team at the QFCC. She is a public health sociologist with experience in research and health promotion within government and the tertiary sector. Rebecca recently completed her doctoral research into SUDI (the Qld SUDI Study) which reviewed all cases of SUDI that occurred between 2010 and 2014, with a focus on deaths in Aboriginal and Torres Strait Islander families and families experiencing social vulnerabilities.
Dr Diane Payton	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.
Kaye Byrnes	Senior Social Worker Division of Family & Community, Hervey Bay Hospital, Wide Bay Hospital and Health Service	Kaye works as a Senior Social Worker in the Women and Children's Units at Hervey Bay Hospital.

Retired Members
(2021 – 2023)

Name	Qualification	Summary of Experience
Dr Peter Stevenson *IMSC subcommittee*	Senior Staff Specialist, Emergency Medicine, The Prince Charles Hospital, Metro North Hospital and Health Service MD Dip ABEM FRACP	Peter has trained and worked as a consultant in both combined and separate Adult and Children's Emergency Departments for more than 15 years. He has been a member of Morbidity and Mortality committees at departmental, hospital, and now state-wide level for the last 13 years and is the coordinator for safety, quality, and performance at TPCH ED.
Kate Pausina *IMSC subcommittee*	Detective Senior Sergeant, Domestic and Family Violence Death Review Unit Coronial Support Unit, Forensic Services Group	Kate is the representative from Queensland Police Service. She possesses extensive experience in juvenile justice, child sex -offences, Coroner's Office, intelligence and strategy, road safety and, most recently, acting officer-in-charge at Albany Creek Police Station. Kate is invaluable to the work of the committee and brings a non-clinical unbiased point of view to the review of cases.
Johanna Neville *IMSC subcommittee*	Team Leader, Maternal Child Health Team, North Cape Apunipima Cape York Health Council Certificate of General Nursing, Acute Illness in Children, Mental Health Nursing in Rural Communities, Graduate Diploma Midwifery	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.
Katie Robinson *IMSC subcommittee*	Nurse Manager Safety and Quality, Child and Youth Community Health, CHQHHS Graduate certificates in Sexual Health and Forensic Nursing and a Master 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.

Retired Members
(2021 – 2023)

Name	Qualification	Summary of Experience
Dr Judy Williams *CISC subcommittee*	Clinical Director Paediatrics, Bundaberg Hospital, Wide Bay Hospital and Health Service MBBS 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.
Dr John Waugh *Steering Committee*	Director of Paediatrics Caboolture Hospital MNHHS MBBS RACMA	In his role as Director of Paediatrics at the Caboolture Hospital, John provides clinical leadership and direction to members of staff. John is dedicated to the improvement of quality of care for Paediatrics patients.
Dr Kerri-Lyn Webb *Steering Committee*	Senior Staff Specialist in Developmental/Behavioural Paediatrics Children's Health Queensland (CHQHHS) Co-Chair Queensland's Child and Youth Clinical Network (QCYCN) MBBS	Dr Kerri-Lyn Webb is a Senior Staff Specialist with Children's Health Queensland (CHQ), and Co-chair of Clinical Excellence Queensland's Child & Youth Clinical Network (QCYCN). She has a graduate diploma in Public Health and is the medical lead – Evaluation, for Health Services and Systems Research CHQ. Kerri-Lyn's clinical background is in Child Development and Community Paediatrics, and she has had a lead role in shaping child development service provision across Queensland since 2009. She is skilled in transdisciplinary practice and family centred care and works with clinicians, consumers of healthcare and researchers to progress quality, safety, and integrated care initiatives both locally and state-wide.
Hamza Vayani *Steering Committee*	Consumer Representative	Hamza joins the QPQC Steering committee as a consumer representative. He has experienced the challenges in paediatric care due to his personal circumstances. His high-level health literacy and experience of serving on strategic health related committees cements his understanding of the health system from a consumer perspective. Hamza has recently completed a four-year term as a member of the inaugural Health Consumers Queensland Collaborative and works part time for the child and Youth Mental Health service as a consumer and carer engagement coordinator.

Retired Members
(2021 – 2023)

Name	Qualification	Summary of Experience
Kimberley Pigram *CISC subcommittee*	Clinical Nurse, Lamb Ward, Redlands Hospital, Metro South Hospital and Health Service BACH MN B.App.Sc (Ex.&Sp.Sc.)	Kimberley is a Clinical Nurse on Lamb Ward, the paediatric inpatient unit at Redlands Hospital. She has years of experience in the care of children and their families in the acute care, critical care, hospice, and community environments including both metropolitan and rural and remote contexts. Her experience is broad and diverse which gives insight into the many contexts and intricacies of paediatric care provided throughout Queensland. Kimberley also is a Clinical Nurse facilitator at Hummingbird House Children's Hospice.
Karen Hose *IMSC subcommittee*	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.
Andrew Hutchinson *CISC subcommittee*	Staff Specialist Paediatrician, Women, Children and Family. Ipswich Hospital, West Moreton Hospital and Health Service MBBS	Andrew is a general paediatrician working at Ipswich Hospital with clinical interests in neonatology and child protection. He is passionate about regional healthcare and ensuring that children and families have access to safe, effective, and equitable health services. Andrew has extensive training and experience in clinical governance and Clinical management.
Ann-Maree Brady *CISC subcommittee* (Membership ceased 15/4/23)	Clinical Nurse Consultant, Children's Health Queensland Retrieval Service BACH MN B.Sc.	Ann-Maree has extensive experience in both Paediatric Intensive Care and Paediatric Retrievals, having worked in these areas internationally and nationally. She has been fortunate to have held a variety of roles in these areas which has enabled Ann-Maree to develop her clinical knowledge and understanding of systems within healthcare settings.

Retired Members
(2021 – 2023)

Name	Qualification	Summary of Experience
Lissa McLoughlin *CISC subcommittee* (Membership ceased 30/6/23)	Nurse Unit Manager Diabetes, Caloundra Hospital, Sunshine Coast University Hospital BACH	Lissa has worked in all areas of Paediatrics, Maternity and Special Care Nursery from tertiary Centre's through to rural and remote settings. She has a specific interest in the development and enhancement of registered nurses post graduate education, specialising in paediatrics and indigenous health in rural and remote settings.
Lynette Adams *CISC subcommittee* (Membership ceased 24/5/23)	Principal Project Manager, Paediatric Critical Care Pathway Project, Children's Health Queensland Hospital and Health Service BN BEd(Prim) GCert Nurs(Paed)	Lynette has a background in paediatric nursing and currently works as a Principal Project Manager for the Paediatric Critical Care Pathway Project. She has extensive experience in developing, implementing, and providing support for State-wide paediatric patient quality and safety initiatives.
Carolyn Wharton *Steering Committee* (Membership ceased 27/4/23)	Consumer Representative	Carolyn joined the QPQC Steering committee as a consumer representative. She has personally accessed and utilised the Queensland Hospital and Health Service for over 15 years. Carolyn has a strong interest and passion in paediatric and critical care due to her personal experience with the care of her daughter. Over the years Carolyn has developed a broad understanding of Queensland Health paediatric services and has been a consumer representative on various working groups, advisory committees, and projects across paediatrics.
Dr Robyn Penny *IMSC subcommittee* (Membership ceased 6/5/23)	Clinical Nurse Consultant Child Health Liaison, Community Child Health Services BSN, 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.

Appendix 1

QPQC Privacy Policy

1. Policy Statement

Members of the Queensland Paediatric Quality Council (QPQC), 'Relevant Persons' detailed in the Terms of Reference of the QPQC, and those staff working on matters assigned by the QPQC must maintain the confidentiality of information they acquire or come into contact with, during the course of their work.

2. Outcome Standard

Patient information acquired during the course of work undertaken by or on behalf of the QPQC is maintained in a totally confidential manner, and is only disclosed between members of the Council, 'Relevant Persons', and staff working on matters assigned by the QPQC in accordance with the *Hospital and Health Boards Act 2011*, Part 6, Division 1, the Terms of Reference of the QPQC and this policy.

3. Evaluation method

QPQC to review the specific breaches if any at their regular meetings.

4. Objectives

- To ensure all patient information/data is maintained in a totally confidential manner and not divulged to any other person.
- To ensure QPQC members, 'Relevant Persons' and those staff who are working at the direction of the QPQC, do so in accordance with this policy.
- To ensure the QPQC complies with the *Hospital and Health Boards Act 2011,* Part 6, Division 1 and the *Hospital and Health Boards Regulation 2012*, Part 5, Divisions 1-6.

5. Procedures

All QPQC members, 'Relevant Persons' and staff who are working at the direction of the QPQC must sign the Queensland Health Confidentiality Agreement (QPQC Terms of Reference Appendix 4) and these will be maintained by the QPQC Secretariat.

This policy encompasses the following:

- Acquisition and compilation of relevant data/information
- Secure storage of information
- Disclosure of information
- Consent for disclosure
- Copying and destruction of information.

5.1 Data Collection

The QPQC will source data/information from the Health Statistics Unit (HSU). It will receive paediatric death data in electronic database format. This data will include but is not limited to, information contained within the MR63D Perinatal Data form, Cause of Death (Form 9), Birth and Death Registration Forms, admitted patient dataset and patient clinical records

The QPQC will source data/information from the Patient Safety Unit. Data/information will be received in electronic PDF format.

Where additional information is required, the QPQC will seek Confidential Case Summary and patient clinical records, from the Health Statistics Unit, individual Hospital and Health Services, or private health providers.

In addition to the data held by Queensland Health, the QPQC may seek data from the Office of the State Coroner, Local Coroners and the Registry of Births, Deaths and Marriages. Coronial data may include the Police Report of Death to a Coroner (Form 1), autopsy and toxicology reports, coronial findings and other coronial investigation documents.

5.2 Storage

All information electronically stored by the QPQC will be maintained on an internal data storage system, protected by password and only accessible by staff assigned to assist the QPQC. Printed documentation will be securely maintained in a locked cabinet. Access to all documentation is limited to QPQC members, 'Relevant Persons' detailed in the Terms of Reference of the QPQC, and/or staff undertaking functions on behalf of the QPQC. Authorisation for access to the internal data storage system will be in writing by the Chair of the QPQC.

The functions of the QPQC, its minutes and supporting documentation are required to be maintained in a secure environment for a period of 10 years as per the Queensland Health Disposal and Retention Schedule for Clinical Records. All documentation generated electronically by the QPQC will be clearly identified as confidential.

Information/documentation will only be handled by authorised persons, e.g., members of the QPQC, Relevant Persons detailed in the Terms of Reference of the QPQC, or staff working on behalf of the QPQC. All reasonable measures will be taken to ensure the information/data remains confidential. On receipt of the information/data, the QPQC member/s must maintain the information in a secure manner e.g., in a locked cabinet.

5.3 Disclosure of information

The QPQC members, Relevant Persons detailed in the Terms of Reference of the QPQC, and staff undertaking work on behalf of the QPQC will not publish, divulge or communicate to someone else any information that will identify an individual without their written consent.

Reports generated by the QPQC will contain aggregate and de-identified data and address matters in a general manner which will, as a far as practical, maintain the confidentiality of the recipient of the health service or the individual provider.

5.4 Consent for disclosure

The members of the QPQC, Relevant Persons detailed in the Terms of Reference of the QPQC, or staff undertaking functions on behalf of the QPQC, will not divulge or communicate to someone else information about an individual without the written consent of the individual be they a patient or staff member, or in the case the person has died, consent from the most available senior next-of-kin.

5.5 Copying and destroying information

Copying of information will be limited and only performed to enable QPQC members to participate in discussions at meetings. All documentation of the QPQC will be maintained and/or destroyed in accordance with Queensland Health Retention and Disposal of Clinical Records Policy 2005, Qld Health (Clinical Records) Retention and Disposal Schedule: QDAN 546 v.3, and the Queensland Government General Retention and Disposal Schedule for Administrative Records v.2.1.

Following the completion of a review of a paediatric death, all documentation shall be returned to the QPQC which will ensure all confidential information is destroyed in a secure manner.

5.6 Documentation

Refers to all data forms: hard/printed copy, electronic copy stored on computers or back up storage devices. Examples could include CDs, x-ray/microfilm data, photographs, etc.

5.7 Responsibilities

Responsibilities contained within this Privacy Policy relate to all QPQC members, Relevant Persons detailed in the Terms of Reference of the QPQC, and those staff who are working on behalf of the QPQC.

5.8 References

Queensland Hospital and Health Boards Act 2011

Queensland Hospital and Health Boards Regulation 2012

Queensland Paediatric Quality Council Terms of Reference 2015