Queensland Health

Clinical **Excellence** Queensland

Queensland Paediatric Quality Council

Triennial Report
September 2020

Improvement | Transparency | Patient Safety | Clinician Leadership | Innovation

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 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 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; 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 in 2015. 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. The QPQC established a Steering Committee in 2018 to assist the council with governance and planning future work. The role of these committees is outlined below:

Privacy Policy of the council:

The QPQC's Privacy Policy governs the following

- The ways 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.
- The copying and destroying of information.

QPQC Steering Committee:

Prior to November 2017, the QPQC quarterly meeting comprised representatives from the Infant Mortality and Clinical Incident subcommittees. However, as the work of the council has progressed, it became apparent that there was a need for the overseeing committee to have a more strategic and governance role.

A new QPQC Steering Committee was established in November 2018. The steering committee is chaired by the Chair of the QPQC, meets 3 times a year and acts as a governing body for the QPQC with 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.

Evolving priorities to address inequities in health outcomes:

Through the work of both subcommittees it is increasingly obvious that all Queensland children do not achieve the same health and survival outcomes. Whether the topic is infant mortality or clinical incidents in hospital settings, younger infants and young children, those from Aboriginal and or Torres Strait Islander backgrounds, those who live in rural and remote settings, and those who live in areas of social disadvantage, are disproportionately disadvantaged. These inequitable outcomes have driven deeper exploration and analysis by both subcommittees in an effort to identify opportunities for prevention universally as well as proportionately addressing the needs of priority population groups.

Clinical Incident Subcommittee (CISC):

A clinical incident is an unexpected event arising as an outcome of health care which causes or may cause unintended harm. Within Queensland Health, clinical incidents are categorized using a severity assessment code (SAC) with the most serious incidents (those resulting in death or permanent harm to the patient) classified as SAC 1 events. Clinical incident reviews are completed on all SAC 1 events (usually a Root Cause Analysis). These provide factual descriptions, identify contributory factors and make recommendations to prevent recurrence.

The Clinical Incident Subcommittee (CISC) has responsibility for investigating statewide themes, recommendations and the quality of serious SAC 1 clinical incident analyses involving children and young people under 18 years of age in Queensland. The terms of reference include:

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

Where key themes are identified, the committee undertakes themed analysis and targeted review, for example testicular torsion, plaster cast care or sepsis. This can include reviews of themed SAC 2 clinical incidents (those resulting in temporary patient harm).

In keeping with the resolve to address vulnerable groups in the paediatric population, planning is currently underway to develop a mechanism to review a broader range of deaths and serious injury of younger paediatric patients to identify statewide themes and priorities for action.

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 (IMSC) 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, 2014 and 2015 have been reviewed. Deaths occurring in 2016 are currently being analysed. The IMSC also responds to issues as they arise in the reviews with a focus particularly in the areas of prevention, response and investigation of SUDI with a number of key collaborative projects currently underway in these areas.

Summary of Progress of both subcommittees since last Triennial Report:

2018

2018 saw the culmination of the previous years detailed investigations and research into several key publications and actions (a detailed list is provided at the end of the document). The QPQC launched its new newsletter "Paediatric Matters" in late 2018. This is one of the primary mechanisms through which the QPQC shares key learnings and resources with all HHSs arising from the outcomes of our CISC and IMSC reviews. Between 2018 and August 2020 a total of 5 editions have been released.

The CISC and IMSC committee released Queensland State Summaries of their research findings in September 2018. The CISC report detailed key themes and learnings from a review of 2012-2014 SAC 1 clinical incidents involving children under 18 years in Queensland. The IMSC report summarized the statewide findings from review of 96 post neonatal deaths which occurred 2013. Key messages in the areas of prevention, investigation and support for families were explored.

The CISC and IMSC committees both continued their case reviews, with targeted work also being undertaken where key statewide themes and issues were identified. The QPQC continued to identify opportunities for sharing learnings across the state through presentations to key government bodies, networks and committees and through identified information sharing forums (such as the patient safety educations sessions and CHQ Grand Rounds).

The QPQC also collaborated with our key partners to progress priority areas of interest. A collaborative workshop was held with the Statewide Child and Youth Network in Townsville: "Experience, Expectations and Equity: Can we do more to Prevent Sudden and Unexpected Infant Deaths?" for Health Professionals working with infants and their families, July 2018. CISC members participated in a multi-incident review of suspected suicides, January-June 2018 coordinated by the Mental Health Alcohol and Other Drugs Branch (Queensland Health) and contributed learnings from a review of sepsis SAC 1 incidents to support the introduction of the new Paediatric Sepsis Pathway initiative.

In 2018, the QPQC also established a new Steering Committee to provide oversight and strategic direction to the QPQC.

2019

In 2019, CISC finalized its review of 2015-2017 SAC1 clinical incidents involving children under 18 years in Queensland. Themed work was also undertaken in the following areas:

1. Testicular torsion. The CISC committee worked collaboratively with CHQ Paediatric Surgeons to review SAC 1 clinical incidents involving testicular torsion. Resources were developed to share our five key learnings including a patient safety communique, education poster targeting teenage boys and a fact sheet for families and carers.

2. Retrieval of critically ill children. The QPQC worked collaboratively with Clinical Excellence Queensland (CEQ) to share learnings from our 2012-2014 review of clinical incidents involving the retrieval of critical ill children and to identify recommendations for improving patient safety and care. CEQ published the findings of this "Paediatric Patient Safety Review" in mid-2019.

CISC also worked collaboratively with the Queensland Children's Critical Incident Panel (QCCIP) to share feedback on the quality of clinical incidents being developed across Queensland Health. This included presentations at the new "Quality Improvement Roadshows" being coordinated by QCCIP across Queensland Health.

The IMSC continued their review of Queensland's post-neonatal infant deaths that occurred in 2014 and 2015 with a particular focus on Sudden and Unexpected Deaths in Infants (SUDI). Three key areas for change were identified: prevention, response and investigation. Key collaborations and projects were developed to support the QPQC's role in facilitating change in these areas. Three key project areas were:

- Grant submissions completed in an attempt to provide funding to update Queensland Health's outdated Safe Sleep Guidelines for infants.
- Obtaining funding from Clinical Excellence Queensland to conduct an evaluation of the effectiveness of the Pēpi-Pod® Program in reducing infant mortality in Queensland.
- Key connections were made within The Queensland Coroner's Court, Queensland Police Service and Forensic and Scientific Services and a meeting was held to explore the possibility of an improved investigation model in Queensland for Sudden and Unexpected Deaths in Infants

In 2019 the QPQC Chairs and Coordinators also participated in newly established Queensland Quality Assurance Committee's collaborative designed to share learnings and best practice across all Queensland Health quality assurance councils.

2020

In 2020, CISC commenced reviews of 2018-2019 SAC 1 clinical incidents involving children under 18 years of age in Queensland. Themed reviews were also undertaken on SAC 1 and 2 clinical incidents involving the care of children in plaster casts +/- splints in collaboration with CHQ plaster technicians, physiotherapists and orthopedic surgeons. Our five key learnings were shared through Paediatric Matters in early 2020. Discussions have commenced on our next priority area "Vascular Access Devices" with content experts across Queensland Health.

CISC continues to collaborate with CEQ on the implementation of the Paediatric Patient Safety Review Project. Work is also continuing on a peer reviewed publication outlining the findings of a themed review of 2012-2017 clinical incidents involving children with a diagnosis of sepsis.

The IMSC committee commenced the review of 2016 SUDI deaths and was able to maintain this review process despite workplace changes with the assistance of Microsoft Teams. There have been several key achievements on key projects in 2020 to date:

- The QPQC was able to obtain a small parcel of funding for a halftime project officer for two months to develop two *short*Guides for safe sleep in infants. These short guides are a succinct and action focused version of the lengthy guidelines which can replace sections of the outdated safe sleep guidelines. To date three *short*Guides have been drafted in consultation with key clinical leads and Queensland Clinical Guidelines and will be submitted for statewide consultation by the end of 2020.

- The State Coroner of Queensland has endorsed the trial of a multiagency meeting following SUDI deaths in Queensland. The Terms of Reference have been developed and formal processes are now being developed with other agencies. The IMSC have taken a lead role in developing the format, agenda and evaluation process for this trial. It is hoped that one trial review can be conducted before the end of 2020.

- The Pēpi-Pod® Program evaluation project has completed analysis of all the data collected and preliminary results have been shared with key stakeholders. The final report is currently being prepared for release in the next two months.

- Continued collaborative work with Townsville HHS on the development and trial of a SUDI Health History Protocol for use in Emergency Departments.

The QPQC team have also recruited both consumer and general practitioner representatives for the QPQC Steering Committee in 2020.

QPQC Meetings Dates, Objectives and Outcomes

Dates	Objectives	Achieved
QPQC Steering Committee		
2018-2020 ** 6 meetings.	Oversee QPQC grant funding, planning, membership and staff recruitment. Monitor progress of the IMSC and CISC subcommittees. Oversight of legal advice re publication in peer review journals Developing future workplans and directions for the QPQC and steering committees Endorsing key outputs of the subcommittees	New Steering Committee established QPQC workplan endorsed Legal advice incorporated in terms of reference Terms of reference endorsed. Key outputs endorsed for CISC and IMSC Consumer and GP reps recruited.
Clinical Incident subcommittee		
2018 – 10 meetings 2019 – 9 meetings 2020 – ** 5 meetings (to date)	Commenced 2015-2017 clinical incident reviews Themed meetings: Adverse Procedural Events, Retrievals. Continuation of 2015-2017 clinical incident reviews. Themed reviews: Sepsis, Plaster Casts Commenced 2018-2019 clinical incident reviews. Themed discussions held re vascular access devices.	All 2015-2017 clinical incident reviews completed (n=47) Newsletters, education packages and reports released in key themed areas of sepsis, retrieval, testicular torsion, plaster casts (see outputs below) Report into findings of 2012-2014 clinical incident reviews released.
Infant Mortality subcommittee		
2018 – 10 meetings 2019 – 10 meetings 2020 – ** 7 meetings (to date)	Review of 2014 cases Review of 2015 cases Commencement of review of 2016 cases Feedback on safe sleep guides	All 2014-2015 cases reviewed. 2016 SUDI death reviews commenced. Review and endorsement of all publications, grant submissions and project material described above and below
*** In the second quarter of 2020, the COVID pandemic disrupted many QPQC activities as subcommittee members, most of whom are frontline health care workers, attended to COVID priorities and QPQC staff working from home set up new mechanisms to continue council work, and lent assistance to progress QCYCN COVID-related priorities. As at September 2020, QPQC staff continue to conduct all activities including meetings via electronic and virtual processes.*		

Details of Key Activities and Outputs:

"Paediatric Matters" Newsletter:

Edition 1: Sepsis: Detect early. Could this be Sepsis?
https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/qpqc/QPQC-Paediatric-Matters-edition-1-2018.pdf

Edition 2: Testicular Torsion – A time critical condition
https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/qpqc/QPQC-Paediatric-Matters-edition-2-2018.pdf

Edition 3: Sudden Unexpected Deaths in Infancy (SUDI) – Part 1
https://www.childrens.health.qld.gov.au/wp-content/uploads/2019/04/QPQC-Paediatric-Matters-SUDI-edition-3-2019.pdf

Edition 4: Sudden Unexpected Deaths in Infancy (SUDI) – Part 2
https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/qpqc/QPQC-Paediatric-Matters-SUDI-edition-4-2019.pdf

Edition 5: Tips and Tricks: Reducing cast related harm in children
https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/qpqc/QPQC-Paediatric-Matters-edition-5-2020.pdf

Hospital and Health Service Reports:

Clinical Incident subcommittee*. Multi-incident Analysis of SAC 1 Paediatric Clinical Incidents 2012-2014: Queensland State Summary Report*. Queensland Paediatric Quality Council, July 2018.
https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/qpqc/Multi-incident-Analysis-of-SAC-1-Paediatric-Clinical-Incidents-2012-2014.pdf

Infant Mortality subcommittee*. Review of 2013 Queensland Post-Neonatal Infant Deaths: Queensland State Summary Report.* Queensland Paediatric Quality Council, September 2018.
https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/qpqc/Review-of-2013-Queensland-Post-Neonatal-Infant-Deaths.pdf

Government Publications:

Chapter Section QFCC Annual Report*: Case study: Themes from an expert panel review of SUID cases in 2013 (71-74)* Queensland Family and Child Commission. Annual Report: Deaths of children and young people, Queensland, 2016-2017. Queensland Government 2017.
https://www.qfcc.qld.gov.au/sites/default/files/child-deaths-annual-report2016-17/FINAL%20QFCC%20AnnualReport%201617_word.pdf

Chapter Section QFCC Annual Report*: Case Study: Expert panel review of SUDI cases 2013–2014 – recommendations and actions (71-73)* Queensland Family and Child Commission. Annual Report: Deaths of children and young people, Queensland, 2018-2019. Queensland Government 2019.
https://www.qfcc.qld.gov.au/sites/default/files/2020-01Chapter_8_Sudden_unexpected_deaths_in_infancy.pdf

Chapter Section Clinical Excellence Queensland's Paediatric Patient Safety Review Report*: Priority Two: Retrieval of the critically ill child (19-22).* Paediatric Patient Safety Review: Report of the review of adverse paediatric events involving critically ill children in Queensland (2016 and 2017), State of Queensland (Queensland Health) 2019 https://qheps.health.qld.gov.au/psu/paediatric-patient-safety-review-report

Peer Reviewed Publications and Posters:

Young, J, McEniery J and Cruice D. *SUDI: Infant Sleeping Position is still not reliably reported* (PDF, 711kB). Oral Presentation. International Conference for Still Birth, SIDS and Baby Survival, Glasgow, June 2018.

McEniery, J and Cruice, D. *Sudden Unexpected Death in Infancy: Comparison of neonatal and post-neonatal deaths Queensland Australia* (PDF, 176kB). Poster Presentation, Perinatal Society of Australia and New Zealand Conference, Auckland, March 2018.

McEniery J and Cruice D. *The Voice of the Infant. Cause of death coding does not always reflect what really mattered in the life of the infant who died suddenly and unexpectedly* (PDF, 178kB). Poster Presentation, Perinatal Society of Australia and New Zealand Conference, Auckland, March 2018.

Hamilton, M.J., McEniery, J.A., Osborne, J.M., & Coulthard, M.G. (2018). *Implementation and strength of root cause analysis recommendations following serious adverse events involving paediatric patients in the Queensland public health system between 2012 and 2014.* J Paediatr Child Health,55:1070-1076. doi:10.1111/jpc.14344

Osborne J, McAuley, SA and McEniery, J. *Multi-incident analysis of testicular torsion clinical incidents in Queensland 2010 - 2015.* Poster Presentation. International Forum on Quality and Safety in Healthcare, Melbourne, September 2018.

McAuley, SA, Osborne, JM and McEniery, J. *Multi Incident analysis of clinical incidents involving cases in Queensland (2014-2019).* Prepared for Australian Institute of Clinical Governance (AICG) Patient Safety and Quality Care Symposium, Melbourne (postponed)

Osborne, JM, McAuley, SA and McEniery, J. *Multi Incident analysis of serious paediatric clinical incidents in Queensland (2012-2017)*. Prepared for Australian Institute of Clinical Governance (AICG) Patient Safety and Quality Care Symposium, Melbourne (postponed)

Resources:

Testicular Torsion Education Poster, Queensland Paediatric Quality Council, August 2019.

Testicular Torsion fact sheet, Children's Health Queensland Hospital and Health Service March 2019

Current Council Membership (September 2020)

Name	QPQC Role	Qualification	Summary of Experience
Associate Professor Julie McEniery	Chair, QPQC Chair, Infant Mortality sub committee Clinical Incident Review subcommittee member	Paediatric Intensivist, Queensland Children's Hospital, CHQHHS Associate Professor, University of Queensland MB BS MPH FRACP FCICM	Julie is a Paediatric Intensive Care specialist working at the Queensland Children's Hospital in Brisbane. Her MPH dissertation, 2005 (UQ), was a review of in-hospital paediatric mortality in Queensland in 2001. This remains a significant public health and research interest and she is currently completing a DrPH (UNSW) examining Queensland's infant mortality. Julie is a national examiner for the CICM and RACP colleges, instructs on APLS courses Australia-wide, and volunteers on international medical missions for "Operation Smile", the Cleft Lip and Palate Charity based in Brisbane.
Dr Sharon Anne McAuley	Deputy Chair, QPQC Clinical Incident Review subcommittee member	Senior Medical Officer, Emergency Medicine, Queensland Children's Hospital, CHQHHS MBBCH BAO DCH MSC FRCPCH FRACP 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. Sharon Anne is the Chair of the Queensland Children's Critical Incident Panel.
Frank Tracey	QPQC Steering Committee member	Health Service Chief Executive Children's Health Queensland Hospital and Health Service	Frank has more than 30 years' experience working in health systems. This experience includes most recently holding the position of General Manager Operations and Acting Director, Clinical Support Services at the Auckland District Health Board. 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. While working in both government and non-government roles Frank has focused on delivering sustainable health strategies that serve the best interests of patients, health professionals, the broader health system and the community.
Ainslie Kirkegaard	QPQC Steering Committee member	Queensland Coronial Registrar Coroners Court of Queensland Department of Justice and Attorney-General	Ms Ainslie Kirkegaard was appointed as the inaugural Queensland Coronial Registrar in 2013. Prior to undertaking this role, Ms Kirkegaard had previously held the positions of Counsel Assisting the Deputy State Coroner and Director of the OSC. Ms Kirkegaard joined the OSC in 2008, bringing over 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.

Name	QPQC Role	Qualification	Summary of Experience
Jaime Blackburn	QPQC Steering Committee member	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.
Dr John Waugh	QPQC Steering Committee member	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 Judy Williams	QPQC Steering Committee member CISC committee member	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 Kerri-Lyn Webb	QPQC Steering Committee member	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
Kirstine Sketcher-Baker	QPQC Steering Committee member	Executive Director, Patient Safety and Quality Improvement Service Clinical Excellence Queensland, Department of Health	Kirstine Sketcher-Baker 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-centred care. Kirstine has a statistical background with a longstanding interest in monitoring patient safety and quality of care in hospitals.
Associate Professor Steven McTaggart	QPQC Steering Committee member	A/Executive Director, Medical Services Children's Health Queensland Hospital and Health Service (CHQHHS) MBBS, FRACP, PhD	Steven is currently acting as the Executive Director of Medical Services CHQ HHS, with a substantive position as the Divisional Director of Medicine at the Queensland Children's Hospital. He has worked in Brisbane as a paediatric nephrologist for almost 20 years and he maintains a strong passion for clinical medicine and improving the care of children and families.

Name	QPQC Role	Qualification	Summary of Experience
Professor Leonie Callaway	QPQC Steering Committee member	Conjoint position as Head, UQ's Northside Clinical School Cluster, and Senior Specialist in Obstetric and Internal Medicine at the Royal Brisbane and Women's Hospital. MBBS (Hons I) FRACP PhD GC Lead GAICD	Professor Leonie Callaway is a General and Obstetric Physician and is Co-Chair of the Queensland Maternal and Perinatal Quality Council. Her ongoing research interests include obesity and inflammation in pregnancy, the role of the maternal metabolism on fetal programming and neonatal body composition, lifestyle interventions in pregnancy, the role of pregnancy in unmasking the risks of future chronic disease and probiotics for the prevention of gestational diabetes mellitus. She has internationally regarded expertise in the areas of diabetes, hypertension and metabolism before, during and after pregnancy. She was President, and then Chair of the Board of the Australasian Diabetes in Pregnancy Society. She has extensive experience in providing complex preconception care and provides expert clinical management of the most high-risk pregnancies.
Dr Melissa (Meg) Cairns	QPQC Steering Committee member	General Practice Liaison Officer GP Alignment Maternity and Gynecology Metro North Hospital and Health Service MBBS, FRACGP RACGP	Meg has worked in Queensland Health Hospitals in Brisbane and regional Queensland for a number of years after which she started General Practice in Toowoomba and Brisbane. Meg is also a Clinical Advisor to Brisbane North Primary Health Network, Metro North Hospital and Health Service and Queensland Health, Chairs the Clinicians' Advisory Group and is also a member of the Queensland Maternal and Perinatal Quality Council
Dr Ka-Kiu Cheung	QPQC Steering Committee member	General Practitioner with General Interest Gold Coast University Hospital Developmental Paediatric Clinic Antenatal Clinic GCHHS General Practitioner Broadbeach Medical Centre B.Pharm, MBBS (Hons), DRANZCOG, MPH, FRACGP	KK works as a GP in private practice and publicly as a GP with Special Interest (GPwSI) in obstetric and developmental paediatric clinics through the Gold Coast University Hospital. Her role as a GPwSI includes the ability to work in a team environment, communicate effectively, liaise and facilitate transfer of care between private-public and primary-tertiary health systems. KK's experience in both prenatal and postnatal care aligns well with the purpose of QPQC to develop and monitor indicators and trends impacting on paediatric morbidity and mortality. KK also is a board director for the Gold Coast Primary Health Network.
Carolyn Wharton	QPQC Steering Committee member	Consumer Representative	Carolyn joins 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. Through her consumer representative work, she has contributed to changes that improve the care for health consumers.

Name	QPQC Role	Qualification	Summary of Experience
Hamza Vayani	QPQC Steering Committee member	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.
Professor Jeanine Young	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 breast feeding 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.
Dr Diane Payton	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 Lucy Cooke	Infant Mortality subcommittee member	Medical Director Neonatology RESQ Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service MBBS FRACP	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.
Dr Nadine Forde	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	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.

Name	QPQC Role	Qualification	Summary of Experience
Dr Susan Ireland	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-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.
Dr Robyn Penny	Infant Mortality subcommittee member	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.
Dr Elisabeth Hoehn	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 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, 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.
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.
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.

Name	QPQC Role	Qualification	Summary of Experience
Catherine McCosker	Infant Mortality subcommittee member	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 Chamanthi Nanayakkara	Infant Mortality subcommittee member	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 Wei Wei Chan	Infant Mortality subcommittee member	Paediatrician, Gold Coast University Hospital Gold Coast Hospital and Health Service MBBS RCPCH RACP	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. Wei Wei has active participation in departmental meetings such as Paediatric Quality and Safety, Paediatric Management and Paediatric Ambulatory Care. Currently attends committee meetings such as Paediatric Slow Growth, Paediatric Tube Weaning and Paediatric Guidelines along with coordinating and chairing the quarterly Paediatric Mortality and Morbidity Meetings.
Fiona Boorman	Infant Mortality subcommittee member	Manager, Child Death Prevention, Family and Child Research Queensland Family & Child Commission (QFCC)	Fiona has had experience in the Commonwealth and Queensland state governments with a specialisation in data analysis mainly in the areas of child protection, health, crime and justice statistics. Her foundational study in the areas of physics and mathematics laid the basis for her strong analysis and critical thinking skills. In recent years Fiona has held management positions leading research and policy teams in the areas of child death prevention, children's rights, welfare and protection. For the last six years Fiona has led the team responsible for maintaining the Queensland Child Death Register and producing the annual report on child deaths in Queensland.

Name	QPQC Role	Qualification	Summary of Experience
Dr Peter Stevenson	Infant Mortality subcommittee member	Acting Director of Medical Services Fraser Coast Clinical director of Paediatric, Fraser Coast Wide Bay Hospital and Health Service MBBS FRACP	Peter is very focused on child safety in the community, involved in many committees and groups representing and advocating for regional and rural QLD. Always looking to improve the patient and families experience. Has a wealth of knowledge working throughout Australia and a couple of years in the United Kingdom.
Lee-Anne O'Keefe	Infant Mortality subcommittee member	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	Infant Mortality subcommittee member	Director Queensland Injury Surveillance Unit, Mater Health Services Queensland. Senior Medical Officer, Emergency Medicine, Queensland Children's Hospital, CHQHHS 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.
Kate Pausina	Infant Mortality subcommittee member	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.
Catherine McCosker	Infant Mortality subcommittee member	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.

Name	QPQC Role	Qualification	Summary of Experience
Katie Robinson	Infant Mortality subcommittee member	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.
Dr Kevin McCaffery	Chair, Clinical Incident Review subcommittee	Paediatric Intensivist QPICS, Queensland 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.
Dr Mark Coulthard	Clinical Incident subcommittee member	Staff Specialist in Paediatric Intensive Care Course Coordinator, Academic Discipline of Paediatrics and Child Health MB BS PhD FRACP FCICM	Dr Mark G Coulthard has practised as a paediatric intensive care specialist in Brisbane since 1996, following training in Melbourne and Dallas, Texas. He is the course coordinator for the Academic Discipline of Paediatrics and Child Health. Mark's research interests include medical education, telemedicine in intensive care and the basic science of vascular endothelial permeability in sepsis and critical illness.
Lissa McLoughlin	Clinical Incident subcommittee member	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.
Dr Clare Thomas	Clinical Incident subcommittee member	Senior Medical Officer Paediatrics, Women's and Family Services, Sunshine Coast Hospital and Health Service Senior Lecturer – School of Clinical Medicine, The University of Queensland MBBS, FRACP	Clare is a Paediatrician working in clinics for General Paediatrics, Infant Clinic and Child Development Service. As part of her role she is responsible for Acute Paediatric and Neonatal resuscitation education to medical and nursing staff. Clare is the Chair of Paediatric Morbidity and Mortality Meetings Member of Morbidity and Mortality oversight Committee (SCHHS) Member of MEAC – Medical Emergency Advisory Committee (SCHHS)
Dr Peter Rizzo	Clinical Incident subcommittee member	Senior Staff Specialist, Emergency Medicine, The Prince Charles Hospital, Metro North Hospital and Health Service MD; Dip ABEM; FACEM	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.

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Dr Maree Crawford	Clinical Incident 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 QCH. 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 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 and a range of experience in medical, nursing and allied health education and in particular, expertise in the design of safety systems.
Dr Ben Lawton	Clinical Incident subcommittee member	Deputy Director (Paediatrics) Logan Emergency Department Paediatric Emergency Physician Simulation Consultant – STORK, Children's Health Queensland MBChB BSc (Hons) FRACP (PEM)	Ben is a paediatric emergency physician working as deputy director (Paediatrics) of Logan ED and as a simulation consultant with Simulation Training Optimising Resuscitation for Kids (SToRK). He is a member of the Paediatric Research in Emergency Departments International Collaborative (PREDICT) and currently involved in studies looking at procedural sedation, adolescent mental health and cervical spine injuries.
Andrea Hetherington	Clinical Incident subcommittee member	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. She has a keen interest in improving service access and efficiency for patients who present to the ED and has been involved in multiple local projects focusing on this. Andrea is an instructor for Advanced Paediatric Life Support and enjoys travelling to the rural and remote locations to share her knowledge and skills in caring for sick children.
Dr Brett Hoggard	Clinical Incident subcommittee member	Statewide Medical Director, Retrieval Services Queensland, ADRMB, Prevention Division 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 Statewide 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 including the QPQC Clinical Incident Subcommittee. He places enormous importance on trying to ensure regional, rural and remote clinicians are supported in providing access to best care for their patients

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Dr Craig McBride	Clinical Incident subcommittee member	Senior Staff Specialist Paediatric Surgeon, Queensland Children's Hospital, CHQHHS BHB MBChB FRACS (Paed Surg)	Craig is a consultant in Paediatric Surgery, Neonatal Surgery, Urology, Burns and Trauma at the Queensland Children's Hospital. He is also the Supervisor of Training for six accredited trainees in surgery each year, and 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 Senior Lecturer in the Academic Discipline of Paediatrics and Child Health at the University of Queensland, and an Adjunct Research Fellow at Griffith University.
Lynette Adams	Clinical Incident subcommittee member	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.
Dr Andrew Hutchinson	Clinical Incident subcommittee member	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.
Dr Fiona Macfarlane	Clinical Incident subcommittee member	Director Anesthesia and Pain Management, Queensland Children's Hospital, CHQHHS MBBS FRCA FANZCA	Fiona is Director of Anaesthesia and Pain Management at QCH. She has a long history of safety and quality experience, involvement in RCAs and Mortality and Morbidity committees.
Sarah Busuttil	Clinical Incident subcommittee member	Clinical Nurse- Child Health, Toowoomba Hospital, Darling Downs Hospital and Health Service BNurse	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.
Tammy Doyle	Clinical Incident subcommittee member	CNC Safety Improvement Officer, Women's and Family Service, Sunshine Coast University Hospital BACH	Tammy works in the Safety, Quality and Innovation Unit as a CNC Safety Improvement Support Officer where she leads the review of paediatric clinical incidents Since 2017, she has been a faculty member of the Australian Council of Health Care Standards (ACHS), Improvement Academy, facilitating Root Cause Analysis (RCA) public and custom workshops. In addition to, she has experience in designing and delivering local and state (QLD) Quality and Safety (Q&S) training programs, including Human Factors, Open Disclosure, and Clinical Incident Management.

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Dr Daniel Carroll	Clinical Incident subcommittee member	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.
Dr Christopher Edwards	Clinical Incident subcommittee member	Staff Specialist in Paediatrics, Bundaberg Base Hospital, Wide Bay Hospital and Health Service MBChB FRACP	Chris works as a staff specialist at the Bundaberg Hospital. He provides clinical direction and quality improvement in the operation of the Special Care 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
Ann-Maree Brady	Clinical Incident subcommittee member	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.
Nicola Sanders	Clinical Incident subcommittee member	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 registered nurse who originally trained in the United Kingdom and has been working in Australia for the past eleven years at the former Royal Children's Hospital Brisbane and now Queensland Children's Hospital. She has worked across general paediatrics, adolescent and general surgical specialities over the years and most recently in Paediatric Emergency and Trauma Nursing. She has extensive experience in patient safety and clinical incident management including experience in Root Cause Analyses at CHQ.
Dr Benjamin Beckwith	Clinical Incident subcommittee member	Acting Clinical Director, Senior Staff Specialist Paediatrician Children's Services, The Prince Charles Hospital, MNHHS MBBS FRACP	Ben is currently 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.
Kimberley Pigram	Clinical Incident subcommittee member	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.

Retired Members (Sep 2017 – Sep 2020)

Name	QPQC Role	Qualification	Retirement date
Sandy Ellis	Infant Mortality subcommittee member	Detective A/ Snr Sgt; Secretariat, Coronial Services Governance Board Queensland Police Service	August 2020
Jordana Rigby	Infant Mortality subcommittee member	Advanced Social Worker – Clinical Specialist Child Development Services, Queensland Health BSW (Hons) MMH (FT)	July 2020
Dr Andrew Hallahan	QPQC Steering Committee	Executive Director Medical Services Children's Health Queensland, Hospital and Health Service	July 2020
Ben Freedman	Clinical Incident subcommittee member	Senior Project Officer, The Townsville Hospital, TTHHHS BA Social Work, Masters of Conflict Management and Resolution	June 2020
Kate Cogill	Infant Mortality subcommittee member	Clinical Nurse Consultant Special Care Nursery, Royal Brisbane and Women's Hospital MNHHS RN BN GCert Nurs (Neonatal care)	April 2019
Michael Lewczuk	Clinical Incident subcommittee member	Operations Manager, Department of Critical Care, Queensland Children's Hospital, CHQHHS Bachelor of Nursing, Graduate Certificate in PICU, master's in nursing leadership	March 2019

(Continued) Retired Members (Sep 2017 – Sep 2020)

Name	QPQC Role	Qualification	Retirement date
Kay Ahern	QPQC	Principal Project Officer, Patient Safety Unit, Department of Health Master of Emergency Nursing Graduate Certificate of Management	February 2018
Dr Michael Williams	Clinical Incident subcommittee member	SMO Child and Adolescent Health, Mackay Base Hospital, Mackay HHS MB BS FRACP MMedSci	February 2018
Dr Christa Bell	Clinical Incident subcommittee member	Staff Specialist Emergency Medicine, Gold Coast University Hospital, GCHHS MBBS, MRCP, FRACP, FACEM	February 2018
Dr Catherine Skellern	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)	February 2018
Dr John Gavranich	Clinical Incident subcommittee member	Director of Paediatrics, Ipswich Hospital, West Moreton Hospital and Health Service MBBS FRACP GCert Health Studies	October 2017