

Queensland Paediatric Quality Council

Triennial Report

AUGUST 2023 – AUGUST 2026



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Report prepared by the QPQC Team

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Introduction

The Queensland Paediatric Quality Council (QPQC) is a quality assurance committee established under the *Hospital and Health's Board Act, 2011*. It was originally gazetted on 14 September 2001, deactivated in 2006 and reconvened in 2012.

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;
- 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.

This report provides a summary of the QPQC's activities from August 2023 to July 2026. It shares key learnings, recommendations and outputs from the QPQC and its subcommittees, focused on prevention and improving paediatric patient safety and care.

Functions

The QPQC's functions, with respect to paediatric mortality and morbidity, include to:

1. Investigate and monitor trends in the incidence and causes of paediatric mortality and morbidity to identify issues that need action and/or further study.
2. Provide recommendations to the Deputy Director General for Health on ways to reduce preventable incidents.
3. Work collaboratively with organisations statewide, nationally and internationally. These may include but are not limited to:
 - a. Clinical Excellence Queensland, Queensland Health
 - b. Queensland Child and Youth Clinical Network
 - c. Statistical Services Branch, Queensland Health
 - d. Other Quality Assurance Councils
 - e. Patient Safety and Quality, Queensland Health
 - f. Queensland Family and Child Commission (QFCC)
 - g. Office of the Health Ombudsman (OHO)
 - h. Paediatric councils with like functions in other Australian jurisdictions
 - i. Office of the State Coroner
 - j. Queensland Children's Clinical Incident Panel (QCCIP), Queensland Health
 - k. Clinical Excellence Commission, New South Wales, Safer Care Victoria.
4. To disseminate findings and recommendations of the Council in such a way as to improve the quality and safety of care to children and young people and minimise preventable childhood mortality and morbidity.

QPQC Committees and Priority Areas of Activity

Steering Committee

The QPQC Steering Committee was established in 2018 to provide a strategic and governance role for the QPQC. It 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 primary health care representatives.

Subcommittees

Since its re-establishment in 2012, the Council's work has focused on two priority areas of activity:

- post-neonatal infant death review, to understand the excess infant mortality in Queensland and seek opportunities for prevention.
- multi-incident reviews of serious paediatric clinical incident reports to identify common themes, contributing factors and opportunities for improvements to patient safety and care.

Work across these areas has been progressed through the Infant Mortality and Clinical Incident Subcommittees of the QPQC.

a. Infant Mortality Subcommittee

The Infant Mortality Subcommittee (IMSC) is a specialist multidisciplinary subcommittee of the QPQC, comprising Queensland Health and external agency experts. Historically, the IMSC has undertaken multidisciplinary reviews of sudden and unexpected deaths in infancy (SUDI) to identify recurrent themes, contributory and modifiable factors, system-level issues and opportunities for improvement. Findings from these reviews contribute to the QPQC's work across three key areas—*prevention, response and investigation*—and inform broader clinical and system-level quality improvement.

b. Clinical Incident Subcommittee

The Clinical Incident Subcommittee (CISC) reviews serious clinical incidents involving children and young people under 18 years of age in Queensland, identifying statewide themes and recommendations; and assessing the quality of incident analysis reports. The 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.

The IMSC and CISC subcommittees conduct detailed case reviews, cluster analyses, collaborative reviews with experts and other agencies, communicates findings through various forums and supports targeted action to improve outcomes.

In 2025/2026, following strategic discussions with our partner agencies, the QPQC decided to discontinue these two areas of activity, bringing to a close more than a decade of case review work. Whilst the work of these committees will be finalised in late 2026/early 2027, the QPQC will continue to provide broad oversight of infant and clinical incident mortality and morbidity data, to identify key themes and priority areas of activity as needed.

This year, the QPQC expanded its focus to include reviews of two additional paediatric mortality and morbidity concerns:

- Deaths of children aged 28 days to <18 years in Queensland with severe nutritional deficiency (2020 - 2025).
- Sudden unexpected deaths in children aged 1 year to <3 years occurring in Queensland between 2020 and 2024 (inclusive).

This has resulted in the creation of a new Nutritional Deficiencies Subcommittee and a transition in the role of the Infant Mortality Subcommittee.

c. Nutritional Deficiencies Subcommittee

The Nutritional Deficiencies Subcommittee is a panel of Queensland Health and external agency experts with responsibility for quantifying and characterizing micronutrient deficiency related morbidity and mortality in Queensland children (with a focus on Iron, Vitamin A and Vitamin C deficiency). The committee will seek to identify system level contributing factors, missed opportunities for detection/prevention and inform statewide safety and quality improvement. Members have knowledge and experience in areas such as paediatrics, diet and nutrition, general practice, emergency care, ophthalmology, haematology, population health and child death reviews.

d. Sudden and Unexpected Deaths in Children Pilot Review: Infant Mortality Subcommittee

The Sudden Unexpected Deaths in Children (SUDC) Pilot Review builds on the established methodology used by the Infant Mortality Subcommittee to review sudden and unexpected deaths in children aged one to under three years - an age group for which the circumstances and contributory factors associated with sudden unexpected death are less systematically understood. The Pilot will involve reviews of SUDC cases identified in Queensland between 2020 and 2024, with a view to refine the project methodology, and undertake preliminary identification of recurring themes, contributory and potentially modifiable factors, and opportunities for prevention and system improvement.

Summary of the Activities Performed and Outcomes Achieved: August 2023 – August 2026

Clinical Incident Subcommittee (CISC)

Year	Activity Summary	Outcomes
2023 – 2026	Case reviews CISC continued its ongoing reviews of all paediatric SAC1 clinical incident reports for the timeframe 2021-2023. All incidents were reviewed using a multi-incident analysis tool which identified demographic, facility, incident type, human and system factors for each event. Cases were reviewed individually and jointly by two CISC reviewers and presented at a CISC meeting for discussion and consensus.	Sept 23 – Aug 24: 19 clinical incidents reviewed Sept 24 – Aug 25: 21 clinical incidents reviewed Sept 25 – March 26: 10 clinical incidents reviewed The CISC review process ended in March 2026. Future reviews of SAC1 paediatric clinical incidents will be undertaken as priority themes are identified. A report will be released in late 2026 documenting findings from 2020-2023 clinical incident reviews. The report will share a profile of clinical incidents; statewide themes and recommendations; and identify opportunities for enhancing the clinical incident review process.
2023-2024	CISC Themed Review: Children's Early Warning Tool (CEWT) The CEWT is used across Queensland Health to recognize and respond to deterioration in hospitalised children. CISC completed a themed review of 17 paediatric SAC 1 clinical incidents involving children (0<18 yrs) in which issues were identified with the way the CEWT was being used (2017 - June 2022). Reviews were undertaken across October and November 2023 with two expert advisors, Shaune Gifford and Lynette Adams, Patient Safety Queensland.	The committee identified 4 recommendations to better support the use of the CEWT across Queensland Health: 1. Emergency departments be a priority for education, training & resources to support the use of the CEWT. 2. Training and resources include a focus on supporting the correct documentation/calculation of CEWT scores and appropriate clinical responses. 3. Statewide communication or guidelines to be released, including requirement for measuring blood pressure on the CEWT and how to overcome barriers. 4. Greater inclusion of CEWT charts in clinical incident review reports to assist in identifying concerns and supporting improvements in care. The recommendations were forwarded to Patient Safety and Quality, Clinical Excellence Queensland, who have oversight of the CEWT across Queensland Health. PSQ have implemented the following strategies: 1. The Recognising and Responding to Acute Deterioration Steering Committee (RRAD-SC) endorsed changes to the Emergency Department CEWT charts, including: • The inclusion of the Patient Escalation of Concern for Kids (PECK) Question (Paediatric Patient Safety Review Team). • The addition of a prompt within the Primary Survey to include the risk of battery/magnet ingestion or insertion. • The addition of a Primary survey prompt to include immediate medical notification if parents have an unplanned re-presentation of their child to an emergency department.

Year	Activity Summary	Outcomes
		2. Extensive statewide online education has been provided regarding these changes, emphasising the critical importance of calculating CEWT scores and escalating appropriately within the Emergency Department. 3. Work on the development of a CEWT user guide, which will be completed by the end of 2026. 4. Customised support continues to be offered to HHS staff following serious clinical incident reviews where issues with the CEWT tool use are identified. 5. An update to the Clinical Incident Templates and Clinical Incident Management Report Writing e-learning module to prompt inclusion of sections of statewide forms/tools/pathways 6. PSQ have been working with the Paediatric Patient Safety Review team on a draft "Paediatric Infection Related Clinical Incident template which includes a focus on deterioration and representations and use of the CEWT, including a prompt to include any statewide form/tool/pathway. QPQC Publication: Learnings were shared through Paediatric Matters Edition (12) <u>Recognising Deterioration: Children's Early Warning Tool</u> released in June 2024
2025-2026	CISC Themed Review: Re-presentations CISC completed a themed review of 21 paediatric SAC 1 clinical incidents involving children (0 to <18 yrs) who re-presented to an Emergency Department for the same, evolving or related condition. Reviews were undertaken across February and March 2025. Key themes from the review focused on diagnosis and clinical reasoning, and safety netting and discharge processes.	CISC identified 5 system-wide recommendations for improving care for children who re-present to Queensland Health facilities. 1. Develop statewide tools, procedures and education focused on normalising and supporting clinicians to manage diagnostic uncertainty and effectively communicate this to families. 2. HHSs to consider a "one-up" rule for the management of re-presentations- requiring review by a more senior clinician on subsequent presentations. 3. Development of a standardised discharge process for paediatric patients 4. Investigate alternatives that could be implemented at a Statewide level to replace "No Caller ID" with one that identifies service. 5. Improvements to clinical incident review processes to promote exploration of clinical reasoning, the local environment and multi-agency reviews. QPQC Publications - Learnings were shared through two editions of Paediatric Matters: • July 2025: Paediatric Matters Edition (13): <u>Ticked the Box or Closed the Loop: Reframing Safety Netting in Paediatric Emergency Departments</u> • Nov 2025: Paediatric Matters (14): <u>Re-presentations: Detecting Change, Rethinking the Differential</u>

Year	Activity Summary	Outcomes
		The QPQC is liaising with action partners to progress these recommendations. Early activities include: • E-Health Queensland (as part of a pre-established project) are undertaking a Caller Line Identification and CNAME pilot. • PSQ updated the benefits section of the Multi-Health Service and Cross Agency Clinical Incident Review Factsheet to include improved visibility of patient's full episode of care and shared understanding of contributory factors across services. • PSQ are undertaking a review of the Contributing Factors Framework which includes workforce issues and a specific section to include factors such as cognitive biases, differential diagnosis, delays or missed diagnosis, second opinion/escalation, clinical reasoning • PSQ and the Paediatric Patient Safety Review team are developing a Paediatric Infection Related Clinical Incident template, including a focus on deterioration and re-presentations. • The QPQC presented the above findings at a "Paediatric Small Steps Big Impact" Education Session in June 2026 resulting in a re-presentation prompt being added to the primary survey section of Queensland Health early warning tools.
2023-2026 Presentations The CISC committee actively worked to share learnings from its general and themed clinical incident reviews through presentations at Queensland Health forums, national and international conferences.		• May 2024: Australian & New Zealand Child Death Review & Prevention Group Conference: Multi-Incident Reviews of Serious Paediatric Clinical Incidents in Qld 2015-2019 • Sept 2025: Clinical Incident Management Forum: "Paediatric Matters: Sharing Learnings from Clinical Incident Reviews" • October 2025: Queensland Child and Youth Clinical Network Forum: "Shaping tomorrow's care through multi-incident reviews of serious paediatric clinical incidents: Re-presentations" • Nov 2025: Poster presentation International Forum on Quality and Safety in Healthcare in Canberra: System-wide learnings on the Children's Early Warning Tool following a Multi-Incident Analysis of Serious Paediatric Clinical Incidents in Queensland (2017 -June 2022). • June 2026: Paediatric Small Steps, Big Impact Education Sessions: "Re-presentations: Detecting Change, Rethinking the Differential". • June 2026: Clinical Incident Management Collaborative: "Learnings from Statewide Paediatric SAC1 Clinical Incident Reviews: Re-presentations"
2024-2025 Collaborations CISC partnered with the Paediatric Patient Safety and Review team, PSQ, on the Paediatric Patient Safety Review 2024. This project involved reviews of SAC1 clinical incident reports involving critically ill children in Qld between July 2021 and June 2023; as well as a review of progress against recommendations made under the initial Paediatric Patient Safety Review Report 2019.		Work was overseen by a Paediatric Patient Safety Advisory Group who provided expert advice and guidance on the review. The committee included inter-disciplinary clinical specialists and Queensland Health network representatives. The Paediatric Patient Safety Review team released a report in November 2025, sharing findings and recommendations from the review. Consistent with QPQC reviews, the report identified issues with the recognition and response to critical illness, as well as the incident analysis process. The report identified eight recommendations to promote system-wide improvement in the care of critically ill children across Queensland, incorporating QPQC recommendations.

Year	Activity Summary	Outcomes
2025-2026	Queensland Maternity and Perinatal Quality Council (QMPQC) review of serious clinical incidents involving delayed detection of neonatal jaundice in dark-skinned babies.	The QMPQC coordinated this review, with the QPQC sharing key themes from our previous SAC1 reviews of clinical incidents involving neonatal jaundice. The QPQC also participated in discussions regarding recommendations and learnings from the review (ongoing). Outputs to-date include the release of a patient safety communique and education poster.

Infant Mortality Subcommittee (IMSC)

Year	Activity Summary	Outcomes
2023 – 2025	Case Reviews IMSC continued its ongoing reviews of sudden and unexpected deaths in infants (SUDI) focusing on 2020-2021 cases. The SUDI Project uses a statewide, multi-source review approach, drawing on population data; Births, Deaths and Marriages registry data; coronial records and Queensland Health records. These data sources are reviewed collectively by a multi-disciplinary committee to support a more comprehensive understanding of the circumstances surrounding each death and to identify recurring patterns and potentially modifiable factors.	August 2023 – July 2024: 23 SUDI deaths reviewed August 2024 – July 2025: 26 SUDI deaths reviewed August 2025 - Sept 2025: Cluster review of 7 SUDI deaths in a de-identified Hospital and Health Service The committee completed its reviews of all 2019-2021 SUDI deaths in September 2025. A summary report sharing learnings from these reviews is currently being developed.
2024-2025	Report: Sudden Unexpected Deaths in Infancy (SUDI) (2013-2016) Data analysis, preparation and publication of a report sharing learnings from reviews of SUDI infant deaths from 2013-2016.	IMSC released a report <u>“Sudden and Unexpected Infant Deaths During Sleep in Queensland 2013-2016”</u> in April 2025. The report identified several priorities for prevention and system improvement: • Promote updated safer infant sleep guidelines, supporting consistent, contemporary safer sleep messaging across health and community settings. • Strengthen safer infant sleep education for families, with a focus on supporting the practical application of safer sleep advice in a range of caregiving circumstances. • Strengthen support for families experiencing vulnerability through improved integration and continuity of care across maternity, child health and family support services. • Expand targeted prevention and support initiatives, including sustained home visiting programs and the Pēpi-Pod® Program, particularly for families experiencing increased vulnerability. • Strengthen SUDI investigation processes and bereavement support, supporting consistent investigation following sudden unexpected infant deaths and appropriate, coordinated support for bereaved families.

Year	Activity Summary	Outcomes
2023-2026	IMSC Collaborations and Activities IMSC was involved in a range of collaborations and work arising in response to discussions and priorities identified in the Summary Report and case review meetings.	- October 2023: IMSC provided feedback on the SUDI section of Police Form 1 to enhance data collected by police in reviews of SUDI deaths. These suggestions were incorporated into the revised form now being used by the Queensland Police Service. 2023-2025: Establishment of a genetic testing working group to undertake a national survey of work occurring across other jurisdictions and drafting of a flow chart of genetic testing. 2023-2025: Collaboration with the Queensland Family and Child Commission and Queensland Paediatric Sepsis Program on the development of a draft Child and Family Health questionnaire 2024: Collaboration with the Reform Office First 2000 Days Team to assist with the set-up of the Pepi Pod Program for statewide rollout. 2026: IMSC Inter-Agency Submission: Review of the Coroners Act 2003 (Qld). The Queensland Government commenced a review of the Coroners Act 2003 to consider opportunities to strengthen Queensland's coronial framework. The QPQC prepared a submission informed by its experience in reviewing sudden unexpected deaths in infancy and childhood, with a particular focus on opportunities to strengthen investigation, multidisciplinary review, support for bereaved families and system-level learning. Five priority areas were identified in the QPQC submission: - Comprehensive child and family medical history assessment and documentation - Clear and consistent pathways for genetic assessment and referral - Multidisciplinary review and interagency coordination - Bereavement support and coordination for families - System learning and prevention opportunities
2025	Cluster Review of SUDI deaths in a de-identified Hospital and Health Service The SUDI review and Queensland Child and Family Commission highlighted a significantly higher-than-expected number of SUDI deaths in a de-identified Hospital and Health Service (HHS-A) region between January and June 2025. IMSC completed a cluster review of these deaths at our August and September 2025 IMSC meetings, to identify preventable risk factors and opportunities for prevention.	A total of 7 SUDI deaths were reviewed. Preventable risk factors and missed intervention opportunities were identified, highlighting the need for stronger local and system-wide prevention strategies. A report sharing recommendations from the review was developed and shared with HHS-A. A de-identified report was also developed and sent to the Queensland Family and Child Commission, the State Coroner and Queensland Police Service. Recommendations included: Strengthening Safer Infant Sleep Planning with Families: Strengthen safer infant sleep education and planning by moving beyond a standardised discharge-based approach to provide tailored, repeated and culturally responsive education that reflects families' lived experiences, including situations that are out-of-routine or involve substance use, fatigue and multiple caregivers. Additional support should be provided for infants identified as being at increased risk of SUDI, alongside broader population-level safer sleep messaging delivered across health, community and interagency settings. Improving Vulnerability and SUDI Risk Identification: Strengthen systems for the early identification, assessment and support of vulnerable families and infants at increased risk of SUDI, including reliable administration and scoring of the Edinburgh Postnatal Depression Scale (EPDS), and review of processes for identifying and responding to domestic and family violence.

Year	Activity Summary	Outcomes
2023-2026	Publications/Presentations IMSC shared learnings from its SUDI reviews through publications and presentations at Queensland Health, national and international forums.	• Strengthening Continuity of Care and System Collaboration: Improve continuity of care and sharing across maternity, child and family health services, particularly for families and infants identified as being at increased risk. This should include review of communication pathways between Queensland Health and other maternity and child and family healthcare providers, including GP shared-care models, to support timely and effective sharing of relevant information. <u>Paediatric Matters:</u> • September 2023: Paediatric Matters Edition 10: “Our Baby Sleeps in Our Bed. Part 1. Safer shared sleep with infants: SUDI risk identified as low” • September 2023: Paediatric Matters Edition 11: “It was easier to bring him into our bed to sleep. Part 2: Safer shared sleep with infants: Multiple SUDI risks identified” • March 2026: Paediatric Matters Edition (15): “Seeing the Same Patterns: Lessons from Sudden Infant Death Reviews” <u>Presentations</u> • August 2023: Annual Workshop for Child Protection Liaison Officers and Advisors: <i>Understanding Relationship between SUDI, Social Vulnerability and Suffocation.</i> • May 2025: Australian & New Zealand Child Death Review & Prevention Group Conference: <i>Sudden and Unexpected Infant Deaths During Sleep in Queensland 2013-2016: Risk Factors and Opportunities for Prevention</i> • October 2025: Qld Child & Youth Clinical Network Forum: <i>Shaping tomorrow’s care through infant mortality reviews</i> • June 2025: General Practice Liaison Officer Forum: <i>Sudden Unexpected Death in Infancy: Insights from Case Reviews and the Role of Primary Care in Prevention.</i> <u>Queensland Family and Child Commission (QFCC) Annual Report: Deaths of Children and Young People in Queensland</u> • 2023/2024 Annual Report: IMSC contributed two sections: “Clinical Guidelines: Safer Infant Sleep” (page 61) and “Infant Maturity and Development and Risk of SUDI (page 64-66) within Chapter 8: Sudden Unexpected Deaths in Infancy (SUDI) • 2024/2025 Annual Report: IMSC contributed two sections: “Clinical Guidelines: Safer infant sleep” (page 85) and “Findings from the review of Queensland Sudden Unexpected Death in Infancy (SUDI) cases between 2013–2016” (page 89) within Chapter 8: Sudden Unexpected Deaths in Infancy (SUDI)

Year	Activity Summary	Outcomes
2026	Sudden Unexpected Deaths in Children (SUDC) Pilot Review The SUDC Pilot Review is a retrospective, multidisciplinary case review of sudden and unexplained deaths in children aged 1 to <3 years in Queensland (2020-2024). The aim of the pilot will be to refine the project methodology, and undertake preliminary identification of recurring themes, contributory and potentially modifiable factors, and opportunities for prevention and system improvement.	IMSC commenced work on the pilot project in late 2025. A scoping exercise was undertaken as part of a pre-pilot review by an expert working group, to identify case characteristics, demographic patterns, emerging themes and to test and refine the methodology and processes.

Nutritional Deficiencies Subcommittee

Year	Activity Summary	Outcomes
2026	The QPQC was approached by the Queensland Family and Child Commission and Qld Health clinicians, regarding a cluster of incidents involving the deaths of children with severe nutritional deficiencies in Queensland. The QPQC established a subcommittee to undertake an in-depth review of these incidents; and to collate data on Health service usage via Queensland Health data collections and clinician surveys. The aim is to quantify and characterize micronutrient deficiency related morbidity/mortality in Queensland children (with a focus on Iron, Vitamin A and Vitamin C deficiency). It will identify system-level contributing factors, missed opportunities for detection/ prevention and opportunities for statewide safety and quality improvement.	A subcommittee was established in April 2026 with representatives from across Queensland Health and partner agencies, including dietitians/nutritionists, paediatricians, ophthalmologists, haematologists, population health professionals, mortality and morbidity review experts and general practitioners. 6 case reviews were completed in August 2026. Data requests have been submitted to Pathology Queensland and Statistical Services Branch. Final report anticipated early 2027.

QPQC General Activities

Year	Activity Summary	Outcomes
2023-2025	Recruitment The QPQC team completed recruitment drives to expand the membership of the IMSC and CISC committees; engage new consumers on the Steering Committee and to recruit new Chairs/Deputy Chairs.	A total of 11 new members were recruited across the sub-committees and two new consumers for the Steering Committees. Dr Claire Thomas was recruited as Deputy Chair in 2024, before being appointed QPQC Chair in 2025. Dr Ianthe Mills was subsequently recruited in the Deputy Chair role in 2025.
2023-2025	Member Wellbeing A priority focus for the QPQC has been to develop strategies to support the psychosocial wellbeing of our members. This is in recognition of the potential impact that undertaking reviews of infant and healthcare related deaths can have on members over time.	The QPQC liaised with the Coroner Court of Queensland to learn more about the tools and support they provide for their staff. Two funding grants were submitted to the CE Imagination fund in 2024 and 2025 to support the QPQC to develop a wellbeing package for health professionals who review clinical incidents and mortality and morbidity documentation. These grants were unsuccessful in acquiring funding for the project. Interim measures were adopted, including providing statements on the importance of wellbeing and educating members on support options.
2025-2026	QPQC Review In late 2025, the QPQC completed a strategic review of its structure, functions and priority areas of work to ensure its activities remained responsive to emerging issues in paediatric mortality and morbidity. The review further supported alignment with the recommendations from the Deloitte review of Queensland Health Quality Assurance Committees conducted for Clinical Excellence Queensland.	Meetings were held with strategic partner agencies in October and November 2025. A new work plan was identified for 2026 focusing on the finalization of IMSC and CISC, and the establishment of the SUDC Pilot and Nutritional Deficiencies Project. Communication strategy on new directions completed. QPQC Privacy Policy updated (ongoing).

Committee Membership – Current members

Steering Committee



CHAIR

Name	Qualification	Summary of Experience
Dr Clare Thomas Chair QPQC	Director of Paediatrics, Sunshine Coast University Hospital, Sunshine Coast Health MBBS FRACP	Clare is a Consultant Paediatrician and the Director of Paediatrics at Sunshine Coast Health. She is the Queensland Paediatric Clinical Lead for the Australian Paediatric Clinical Practice Guidelines program. Clare is 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 deliver high quality care through health system improvement. She is currently undertaking a PhD with Griffith University, evaluating a standardised inter-facility transfer workflow designed to improve the safety and quality of non-critical paediatric inter-hospital transfers.



DEPUTY CHAIR

Dr Ianthe Mills Deputy Chair QPQC	General and Developmental Paediatrician Sunshine Coast University Hospital, Sunshine Coast Health MBBS. FRACP, PhD	Ianthe is a General and Developmental Paediatrician working at Sunshine Coast Health. She works with the local child development service and is currently conducting research with Griffith University on diagnosis of Foetal Alcohol Syndrome Disorder. Ianthe is the Sunshine Coast clinical lead for paediatric quality improvement, case reviews and simulation education. Ianthe is an Advanced Paediatric Life Support instructor and is passionate about education of medical students and doctors in training.
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MEMBER

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.
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MEMBER

Name	Qualification	Summary of Experience
Dr Neil Archer	Consultant Paediatrician, Cairns Hospital, Cairns and Hinterland Hospital and Health Service MBChB FRCPH FRACP	Neil 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.
Brendan Hoad	Chief Operating Officer Queensland Children's Hospital, Children's Health Queensland Hospital and Health Service	Brendan brings more than two decades of experience in Queensland Health. An operating theatre nurse by background, Brendan has been part of the Queensland Children's Hospital since its inception and previously served at the Royal Children's Hospital. Throughout his career, Brendan has held several senior leadership roles within the Division of Surgery. Since 2019, he has served as the Divisional Director for Surgery, where he has played a pivotal role in advancing safe, high-quality surgical care for children and young people across Queensland.
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 FAICD	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
Associate Professor Steven McTaggart	Executive Director, Medical Services Queensland Children's Hospital, Children's Health Queensland Hospital and Health Service Paediatric Medical Lead, Patient Safety & Quality, Queensland Health MBBS, FRACP, PhD	Steven is the Executive Director, Medical Services, CHQHHS and the Paediatric Medical Lead, Patient Safety & Quality, Queensland Health. He 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.



MEMBER



MEMBER

Name	Qualification	Summary of Experience
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, Metro North Hospital and Health Service 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.
Dr Penny Larcome	Paediatric Senior Staff Specialist Gold Coast University Hospital, Gold Coast Hospital and Health Service. Co-Chair Queensland Child and Youth Clinical Network BSc, MBBS, MPH, MMed (Pain Management), FRACP	Penny is a Senior Staff Specialist GCUH– Adolescent Young Adult Medicine She also is Co-Chair Queensland Child Youth Clinical Network, Medical Lead, Adolescent Young Adult Service and Member of the Children's Services Operational and Governance Committee
Naomi Flenady	Nursing Director - Clinical Lead, Better Hospital Flow Project , Digital Health Branch Co-Chair, QCYCN, Assistant DON, Patient Flow & 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 currently is the Nursing Director - Clinical Lead for the BHF Project, Co-Chair of the Queensland Child & Youth Clinical Network and is the Assistant Director Of Nursing, Patient Flow & Catch at QCH. Naomi is also an endorsed Nurse Practitioner, credentialed for Paediatric Emergency at QCH.



MEMBER



MEMBER

Name	Qualification	Summary of Experience
Kirstine Sketcher-Baker	Executive Director, Patient Safety and Quality Improvement Clinical Excellence Queensland, Department 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.



MEMBER

Libby Doney	A/ Chief Operating Officer Queensland Family and Child Commission	Libby Doney is the acting Chief Operating Officer, joining the Commission in November 2025. Libby is a strategic and values-driven executive leader with more than a decade of experience shaping public sector reform and workforce transformation across government agencies. Most recently holding senior executive roles with the Northern Territory Department of Education and Training, Libby has led large multidisciplinary teams delivering corporate, inclusion, wellbeing and client engagement services and initiatives.
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MEMBER

Adele Fahey	Consumer Representative	Member of the Family advisory Committee, Children's Health Queensland Hospital and Health Service Educator, specialising in Neuro-affirming
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MEMBER

Zehrab 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.
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MEMBER

Leah Hardiman	Consumer Representative	Research Assistant, Macquarie University Consumer Lead – Metro North Women's and Children's Clinical Stream Neoresq, Obsresq and Women's and Newborns Research
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MEMBER

Name	Qualification	Summary of Experience
Dr Diane Cruice	Principal Project Officer, Healthy Pregnancy, Kids and Families, Prevention Strategy Branch, Population Health Division, Department of Health BSpPath PhD	Diane has a background in Speech Pathology, a PhD in Public Health, and extensive experience in paediatrics. Her current work addresses social determinants of health to improve children's well-being and development, with a focus on safer infant sleep, including the statewide Pēpi-Pod® Program rollout.

Clinical Incident Subcommittee



CHAIR

Name	Qualification	Summary of Experience
Dr Clare Thomas Chair QPQC	Director of Paediatrics, Sunshine Coast University Hospital, Sunshine Coast Health MBBS FRACP	Clare is a Consultant Paediatrician and the Director of Paediatrics at Sunshine Coast Health. She is the Queensland Paediatric Clinical Lead for the Australian Paediatric Clinical Practice Guidelines program. Clare is 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 deliver high quality care through health system improvement. She is currently undertaking a PhD with Griffith University, evaluating a standardised inter-facility transfer workflow designed to improve the safety and quality of non-critical paediatric inter-hospital transfers.



CO-CHAIR

A/Prof Ben Lawton	Senior Staff Specialist Paediatric Emergency Physician – Logan Hospital, Metro South Hospital and Health Service, Simulation Consultant – STORK, Children’s Health Queensland 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. Ben is an Associate Professor in Griffith University’s Faculty of Medicine.
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MEMBER

Dr Christopher Edwards	Director Medical Services, 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
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MEMBER

Dr Julia Wills	General Paediatrician Logan Hospital, Metro South Hospital and Health Service MBBS BAdvMedSc	Julia is a Senior Registrar, Paediatrics at the Logan Hospital. She has a passion for quality and system improvements including the flow through the paediatric inpatient unit. Julia has been working towards several quality improvement initiatives and is involved in preparing and presenting cases for Morbidity & Mortality.
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MEMBER

Name

Dr Brett Hoggard

Qualification

Medical Director, Retrieval Services
Queensland, QAS, Department of Health.
MB ChB FACEM

Summary of Experience

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 several other quality assurance and improvement committees



MEMBER

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.



MEMBER

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).



MEMBER

Tammy Doyle

Clinical Nurse Consultant, Safety Improvement
Officer Women's and Family Service, Sunshine
Coast University Hospital, Sunshine Coast
Hospital and Health Service
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.



MEMBER

Name

Dr Lauren Kromoloff

Qualification

Staff Specialist Paediatrics Consultant
Cairns Hospital, Cairns and Hinterland Hospital
and Health Service
MBBS DCH FRACP

Summary of Experience

Lauren is a Consultant Paediatrician at Cairns Hospital. She provides paediatric outpatient consultations and child protection advice, as well as caring for inpatient and acutely unwell children and neonates.



MEMBER

Dr Toni Weller

Clinical Director, Hospital and General
Practice Liaison Services, Townsville Hospital,
Townsville Hospital and Health Service
FRACGP MBBS LLB (HONS) B.COM GAICD CHIA

Toni is a General Practitioner by trade who currently holds clinical director and board roles across Queensland's public health and primary care sectors. Her expertise and interest is in clinical quality & safety, stakeholder engagement, and system-wide reform. Toni works in collaboration with multiple stakeholders in her role in General Practice Liaison to improve integration between the primary and tertiary care systems for Townsville Hospital and Health Service (THHS).



MEMBER

Margaret-Ann Knowles

Clinical Nurse Consultant, 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.



MEMBER

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.



MEMBER

Name	Qualification	Summary of Experience
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 of various quality and safety committees over the past 12 years.
Dr Mark Coulthard	Staff Specialist in Paediatric Intensive Care (ret), Children's Health Queensland Hospital and Health Service. Honorary Associate Prof. The University of Queensland MB BS PhD FRACP FCICM	Mark practiced as a paediatric intensive care specialist for 30 years up until 2023. He Currently works as a clinical academic tutor for the University of Queensland and continues basic research in retrieval medicine & vascular endothelial permeability in sepsis and critical illness.
Brendan O'Connor	Consultant Paediatric Surgeon, Townsville University Hospital, Townsville Hospital and Health Service BSc(Hons), MB BCh BAO (Hons), DOHNS DCH MRCSI MCh (Hons) FRCSI (Paed.Surg)	Consultant Paediatric Surgeon, THHS QLD Health Digital Informed Consent Project Clinical Advisory Group Member QLD Health Patient Safety Net Champion
Dr Maree Crawford	Senior Medical Officer, 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 Chathu Herath	Director of Paediatrics Gladstone Base Hospital, Central Queensland Hospital and Health Service BHB, MBChB (UoA), DipPaed, PID (Oxon) FRACP MPH (LSTHM)	Chathu is a Specialist Paediatrician & Clinical Director of Paediatrics at Gladstone Hospital. Chathu has recently stepped into a role as Senior Lecturer and Year 3 site Coordinator at Gladstone for the Rural clinical Medical school with the University of Queensland and is passionate about supporting education across all levels. She is a local examiner with the RACP. She is the current Chair of the CQHHS Sepsis working group, and has been a member of the Qld statewide Paediatric Sepsis CAG since 2019.



MEMBER



MEMBER

Name	Qualification	Summary of Experience
Dr Emily Moody	Senior Medical Officer, Boonah Health Service National Clinical Educator, ACRRM Fellowship Education Program MBBS FRACGP-RG FRACGP FARGP FACRRM ARST-EM DRGA MPHTM A/FACMA	Emily is a Rural Generalist with advanced skills in anaesthetics and emergency medicine and currently practises as a Senior Medical Officer at Boonah Health Service within West Moreton Health, with extensive experience across rural hospitals and general practice settings throughout Queensland. Emily is Chair of the Queensland Clinical Network Executive and previously served as Co-Chair of the Queensland Rural and Remote Clinical Network. She is also a Rural Generalist Pathway Advisor with the Queensland Rural Generalist Pathway and National Clinical Educator for the Australian College of Rural and Remote Medicine's Fellowship Education Program.
Dr Sebastian Rimpau	Senior Medical Officer, PICU Queensland Children's Hospital, Children's Health Queensland Hospital and Health Service FCICM MBBS	Sebastian is a Paediatric intensivist at the Queensland Children's Hospital. His philosophy centres on delivering thorough, compassionate care with a strong emphasis on the prevention, early identification, and management of ICU- and illness-related complications. I am deeply committed to fostering a culture of psychological safety, learning and improvement, where the focus is on understanding systemic contributors to clinical incidents rather than attributing blame to individuals. Sebastian assumed the Safety and Quality portfolio within the QCH Paediatric Intensive care unit in 2025
Clare Page	CNC Quality and Patient Safety Paediatrics, Logan Hospital, Metro South Hospital and Health Service BNurs GradCert Paediatric Child and Youth Health Nursing	Clare is Clinical Nurse Consultant at the Logan Hospital, specialising in Quality and Safety Paediatrics and Neonates.
Samantha Tenison-Woods	Clinical Nurse Consultant, Statewide Paediatric Sepsis Program, Queensland Children's Hospital Children's Health Queensland Hospital and Health Service BACH MN	Sam is a Clinical Nurse Consultant for the Statewide Paediatric Sepsis Program. She has a passion for Quality Improvement and Clinical Incident Management. Sam provides leadership and education within multidisciplinary teams and promotes quality and safety as per nursing standards.



MEMBER



MEMBER

Name	Qualification	Summary of Experience
Dr Christine Smith	Paediatric Emergency Physician, Emergency Department, Queensland Children's Hospital, Children's Health Queensland Hospital and Health Service Medical Advisor to Patient Safety and Quality Service Chair - QCCIP BSc MBBS FRACP	Christine is a Paediatric Emergency Physician at Queensland Children's Hospital (QCH), She brings extensive experience in the critical care management of children with diverse medical and psychosocial needs. Her role involves close collaboration with multidisciplinary teams and stakeholders across various specialties and health services. Christine also serves as a Medical Advisor for Patient Safety and Quality at QCH, where she is chair of the Queensland Children's Clinical Incident Panel (QCCIP).
A/Prof Paula Lister	Paediatric Intensivist, Director PCCU Sunshine Coast University Hospital, Sunshine Coast Hospital and Health Service, Medical Co-Chair Queensland Paediatric Sepsis Program MBBCh FCICM, FFICM, FRCPCH, MRCP, PhD	Paula is a Senior Medical Officer and Director of the Paediatric Critical Care Unit at the Sunshine Coast University Hospital. She is also the intensivist on the Paediatric Sepsis Program
Dr Samantha Fairless	Emergency Staff Specialist & Clinical Lead of Paediatrics Ipswich Hospital, West Moreton Hospital and Health Service MBBS FACEM PEM B AppSC B BehSc	Samantha is a Paediatric Emergency Medicine Physician at the Ipswich Hospital she is also a member of the Emergency Care of Children Network where they review state-wide clinical guidelines, patient, and nursing education as well as the development of educational resources.
Dr Siobhan O'Sullivan	General Paediatrician, Cairns Hospital, Cairns and Hinterland Hospital and Health Service FRACP RACP MBBS (hons)	Siobhan is a Consultant Paediatrician at Cairns Hospital. She provides regular paediatric inpatient and outpatient consultation. Siobhan has a special interest in quality improvement and is involved with preparing and presenting cases for paediatric morbidity and mortality meetings.



MEMBER

Infant Mortality subcommittee



CHAIR

Name	Qualification	Summary of Experience
Dr Julie McEniery	Paediatric Intensive Care Specialist, Emeritus Doctor, Children's Health Queensland Hospital and Health Service MBBS MPH FRACP FCICM DrPH	Julie specialised 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.
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 provides consultation and liaison in relation to inpatient and other child protection matters.
Dr Sue Ireland	Senior Staff Specialist Neonatologist, The Townsville Hospital, Townsville Hospital and Health Service 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.



MEMBER



MEMBER



MEMBER



MEMBER



MEMBER



MEMBER



MEMBER



MEMBER

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.
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	Paediatric Staff Specialist, 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.
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.



MEMBER

Name	Qualification	Summary of Experience
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.
Lee-Anne O'Keefe	Director of Nursing & Midwifery CY&FH, Longreach Hospital, Central West 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 Director of Nursing and Midwifery at Longreach Hospital. 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.
Professor Jeanine Young AM	Professor of Nursing School of Health, University of the Sunshine Coast FACN, FACCYNP, PhD, BSc (Hons) Nursing, Adv. Dip Nursing Care RGN, Reg Midwife, Neonatal Nurse (ENB 405 Special & 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
Lindy Tews	Acting Detective Senior Sergeant Operations Leader	Operations Leader – Child Trauma Unit, Crime and Intelligence Command Queensland Police Service
Dr Diane Payton	Anatomical Pathologist, Queensland Children's Hospital, 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.



MEMBER



MEMBER



MEMBER



MEMBER



MEMBER

Name	Qualification	Summary of Experience
Shelley Duffy	ADON Early Years, CYCHS Nursing Children's Health Queensland Hospital and Health Service BN GC-CAHNU	Shelley is the ADON 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.
Angie Reece	Clinical Midwifery Consultant Neonatal Ipswich Hospital, West Moreton Hospital and Health Service BNursing MNP	Angie has over 13yrs experience as a Nurse and Midwife. Her current role has a particular focus on the identification of safety and risk in the neonatal population and their families. Angie uses her highly developed skills to engage with stakeholders and collaborate extensively within multidisciplinary teams to achieve best outcomes in this vulnerable population.
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.
Dr Nicole White	General Practitioner Neighbourhood Medical (incl GP 4 Kids) Bardon BPhty MBBS (Hons) DCH FRACGP	Dr Nicole White is a General Practitioner with special interest in Paediatrics. She manages a wide array of paediatric health issues and is actively involved in the evaluation and management of children with behavioural and learning difficulties. Nicole's extensive experience within the paediatric healthcare field has fostered an understanding of the broader issues that influence this demographic and their families.
Cheryl Glidden	Clinical Nurse Consultant/CPLO Logan Hospital Child Protection Unit, Metro South Hospital and Health Service BNursing GradCertPaedNsgStd MNLeadership	Cheryl works as a CNC at the Logan Hospital Child Protection Unit. She holds portfolio responsibility for coordinating and undertaking MSH Child Death and Serious Injury review.



MEMBER



MEMBER



MEMBER



MEMBER



MEMBER

Name	Qualification	Summary of Experience
Dr Christopher Edwards	Director Medical Services, Staff Specialist in Paediatrics, Bundaberg Base Hospital, Wide Bay Hospital and Health Service MBBS FRACP	Chris is the Director of Medical Services 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 Diane Cruice	Principal Project Officer, Healthy Pregnancy, Kids and Families, Prevention Strategy Branch, Population Health Division, Department of Health BSpPath	Diane has a background in Speech Pathology, a PhD in Public Health, and extensive experience in paediatrics. Her current work addresses social determinants of health to improve children's well-being and development, with a focus on safer infant sleep, including the statewide Pēpi-Pod® Program rollout.
Georgie Collins	Principal Review Officer, Child Death Review Board Secretariat, Queensland Family and Child Commission MForSc, BASc, BAppSc (Biochem)	QFCC Child Death Review Board Secretariat, Forensic and Scientific Services
Marissa McDonald	Clinical Nurse Consultant, Emerald Child and Family Health Emerald Community Health, Central Queensland Hospital and Health Service BNursing GradCertMid IBCLC	In her current role as CNC Emerald Child, Youth and Family Health Marissa provides education and clinical leadership through the sharing of advanced clinical knowledge, skills, and competency in the fields of breastfeeding, child health and development assessments and immunisation to the Emerald Child Health team, in particular to a number of Child Health nurse beginner practitioners.
Mark Davidson	SMO, Forensic Paediatrician Child Protection and Forensic Medical Services Queensland Children's Hospital, Children's Health Queensland Hospital and Health Service MBBS MSc FRACP	Mark is an experienced Senior Medical Officer, Forensic Paediatrician at the Queensland Children's Hospital and a member of the Child Protection Paediatric Society of Australia (CPPSA). Mark has completed training in General Paediatrics through Sydney Children's Hospital and The Children's Hospital at Westmead. He has also taken training in Neuroprotective Developmental Care through the NDC Institute (Possums), including management of infant cry-fuss problems, sleep, feeding, growth, and nutrition.



MEMBER



MEMBER



MEMBER



MEMBER



MEMBER

Name	Qualification	Summary of Experience
Dr Samantha Fairless	Emergency Staff Specialist Clinical Lead of Paediatrics, Ipswich Hospital, West Moreton Hospital and Health Service MBBS FACEM Fellowship ACEM, Dual Fellowship Paediatric Emergency Medicine PEM	Samantha has been working as a FACEM (Fellowship of Australian College of Emergency Medicine) PEM (Paediatric Emergency Medicine Physician) for six years and currently works as the Paediatric Emergency Department clinical lead at Ipswich Hospital. Samantha has had the opportunity to be involved in many clinical incident reviews, including monthly Morbidity & Mortality meetings and several critical incidents for the hospital. This work has also included incident reviews for patients under the care of the Department of Child Safety. In her current role, Samantha has a close working relationship with the inpatient paediatric team, and together we ensure that we continue to provide safe and consistent care to the paediatric population of West Moreton.
Samantha Lewis	Patient Safety & Quality Officer, Clinical Nurse Consultant, Cairns Hospital, Cairns and Hinterland Hospital and Health Service BNSc GradCertCFHN GDipMid MNLeadership	Samantha works at the Cairns Hospital as a Patient Safety and Quality officer where she manages and provides analysis of Severity Assessment Code and High risks near miss clinical incidents. Prior to this role Samantha worked for an Aboriginal Community Controlled Health Organisation in a home visit program for first time mothers.
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.
Brittany Kreis	Registered Nurse/ Child Health Nurse, Ellen Barron Family Centre, Childrens Health Queensland Hospital and Health Service BNursing	Brittany is a Child Health Nurse working at the Ellen Barron Family Centre which is Queensland's only tertiary-level residential specialist child health service. Brittany supports families from a wide variety of cultural and socioeconomic backgrounds who have been referred to participate in a 5-day parenting education and support program.



MEMBER

Nutritional Deficiencies subcommittee



CHAIR

Name	Qualification	Summary of Experience
Dr Clare Thomas	Director of Paediatrics, Sunshine Coast University Hospital, Sunshine Coast Health MBBS FRACP	Clare is a Consultant Paediatrician and the Director of Paediatrics at Sunshine Coast Health. She is the Queensland Paediatric Clinical Lead for the Australian Paediatric Clinical Practice Guidelines program. Clare is 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 deliver high quality care through health system improvement. She is currently undertaking a PhD with Griffith University, evaluating a standardised inter-facility transfer workflow designed to improve the safety and quality of non-critical paediatric inter-hospital transfers.



MEMBER

Dr Sally Campbell	Senior Medical Officer, Haematology, Queensland Children's Hospital, Children's Health Queensland Hospital and Health Service MBBS B.Sc PhD	Sally is a clinical haematologist and haematopathologist based in Queensland at QCH, RBWH and Pathology Queensland. Her research background is in haemostasis/thrombosis, with particular areas of interest being inherited and acquired bleeding disorders and thrombosis.
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MEMBER

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).
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MEMBER

Professor Danielle Gallegos	Professor of Nutrition and Dietetics, Queensland University of Technology FDA GAICD B.Sc	Danielle has made a significant contribution to public health nutrition research in particular in the areas of food security, food literacy and early infant feeding. Her research focuses on real world "wicked" problems that require interdisciplinary and transdisciplinary solutions. Danielle has led major implementation projects in the area of food, nutrition and early childhood education and care with significant outcomes leading to practice change.
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MEMBER



MEMBER



MEMBER



MEMBER



MEMBER

Name	Qualification	Summary of Experience
Dr Matt Wakeley	Director of Paediatrics, Bundaberg Hospital, Wide Bay Hospital and Health Service. QLD Directors of Paediatrics Forum Co-Chair MBBS FRACP	Matt is the Clinical Director of Paediatrics for the Wide Bay Hospital and Health Service and Co-chairs the QLD Directors of Paediatrics Forum Co-Chair
Kate Wilson	Senior Dietitian, Child Development Service North CYCHS, Children's Health Queensland Hospital and Health Service MNutrDiet	Kate is a Senior Dietitian working within the Child Development Service, Children's Health Queensland Hospital and Health Service
Dr Diane Cruice	Principal Project Officer, Healthy Pregnancy, Kids and Families, Prevention Strategy Branch, Population Health Division, Department of Health BSpPath	Diane has a background in Speech Pathology, a PhD in Public Health, and extensive experience in paediatrics. Her current work addresses social determinants of health to improve children's well-being and development, with a focus on safer infant sleep, including the statewide Pēpi-Pod® Program rollout.
Dr Kristie Bell	Director of Dietetics & Food Services, Children's Health Queensland Hospital and Health Service BSc (Nutr&Diet), PhD	Kristie is an Accredited Practising Dietitian with over 25 years of experience in paediatric nutrition across tertiary, acute, and community settings, with extensive expertise in nutritional deficiencies and malnutrition in high-risk infants and children.
Dr Monique Dade	Senior Staff Specialist Paediatrician General Paediatrics, Queensland Children's Hospital, Children's Health Queensland Hospital and Health Service MBBS FRACP	Monique is a Senior Medical Officer, General Paediatrics working at the Queensland Children's Hospital.



MEMBER

Name	Qualification	Summary of Experience
Dr Julie McEniery	Paediatric Intensive Care Specialist, Emeritus Doctor, Children's Health Queensland Hospital and Health Service MBBS MPH FRACP FCICM DrPH	Julie specialised 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.
A/Prof Susan de Jersey	Assistant Director, Prevention Strategy Branch, Population Health Division Queensland Health. Advanced Dietitian, Dietetics and Food Services, RBWH Metro North Hospital and Health Service. BNutrDiet BHumanMvt MPH PhD	Associate Professor Susan De Jersey is an advanced accredited Practicing Dietitian and Credentialed Diabetes Educator at RBWH. Susan also holds the position of Assistant Director for the Prevention Strategy Branch, Queensland Health
Professor Shuan Dai	Director of Ophthalmology Queensland Children's Hospital, Children's Health Queensland Hospital and Health Service MBBS MSc FRANZCO	Professor Dai is the Director of Ophthalmology at Children's Health Queensland Hospital and Health Services and the Queensland Children's Hospital in Brisbane, Australia. He currently serves as the Chair of the Royal Australian and New Zealand Strabismus Society. Additionally, he is the Paediatrics and Strabismus Section Editor for the RANZCO journal, Clinical and Experimental Ophthalmology.
Dr Nicolas Smoll	Senior Medical Officer, Staff Specialist Public Health, Sunshine Coast University Hospital, Sunshine Coast Hospital and Health Service MB BS MCLinChi B.A.Sc. PhD in Epidemiology and Biostatistics	Nicolas is a Public Health Senior Medical Officer at the Sunshine Coast Hospital and Health Service. Nicolas has over 15 years' experience as a Medical Epidemiologist and support impactful projects in immunisation innovation and outbreak management. His expertise includes outbreak analytics and vaccine efficacy estimation, supporting data-driven public health interventions.



MEMBER



MEMBER

Name	Qualification	Summary of Experience
Dr Toni Weller	Clinical Director, Hospital and General Practice Liaison Services, Townsville Hospital Townsville Hospital and Health Service (QGPL) Co-Chair 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.
Dr Chathu Herath	Clinical Director of Paediatrics Gladstone Base Hospital, Central Queensland Hospital and Health Service BHB, MBChB (UoA), DipPaed, PID (Oxon), FRACP, MPH (LSTHM)	Chathu is a Specialist Paediatrician & Clinical Director of Paediatrics at Gladstone Hospital. Chathu has recently stepped into a role as Senior Lecturer and Year 3 site Coordinator at Gladstone for the Rural clinical Medical school with the University of Queensland and is passionate about supporting education across all levels. She is a local examiner with the RACP. She is the current Chair of the CQHHS Sepsis working group, and has been a member of the Qld statewide Paediatric Sepsis CAG since 2019.



MEMBER

Former committee members

The QPQC would like to acknowledge the contribution of former committee members who ceased membership during the reporting period

Full name	Committee	Date commenced	Position of employment	Date Ceased
Jaimie Blackburn	Steering committee	26 th February 2019	Chief Operating Officer, Queensland Family & Child Commission	6 th February 2024
Dr Ravi Bala	Infant Mortality subcommittee	18 th July 2023	Staff Specialist Paediatrician, Gold Coast University Hospital	9 th May 2024
Alycia Thorpe	Clinical Indent subcommittee	20 September 2023	Registered Nurse, Weipa Integrated Health Service	20 August 2024
Angela young	Steering committee	21 st April 2021	Executive Director Aboriginal & Torres Strait Islander Engagement, Queensland Children's Hospital	9 th August 2024
Dan Carroll	Clinical Incident subcommittee	4 th August 2020	Senior Staff Specialist, Paediatric Surgery, Townsville University Hospital	11 th December 2024
Chris Hansel	Infant Mortality subcommittee	19 th May 2022	Detective Inspector, Queensland Police Service	26 th June 2024
Dominic Tait	Steering Committee	28 th May 2021	Executive Director Clinical Services, Queensland Children's Hospital	20 th June 2025
Sue Scott	Infant Mortality subcommittee	26 th June 2024	Detective Acting Senior Sergeant, Queensland Police Service	6 th February 2025
Ji Jin Lim	Steering Committee	12 th September 2024	QCYCN, Co-Chair, Staff Specialist Redcliffe Hospital	24 th June 2025
Dr Sharon Anne McAuley	QPQC, Steering, CISC	9 June 2015	Chair of the QPQC, Director of Critical Care, Queensland Children's Hospital	30 th June 2025
Rebecca Shipstone	Infant Mortality subcommittee	3 rd April 2017	Principal Project Officer, Queensland Family and Child Commission	8 th July 2025

Full Name	Committee	Date Commenced	Position of Employment	Date Ceased
Christopher Smith	Steering Committee	4 th March 2024	Executive Director, Government Relations and Corporate Services, Queensland Family and Child Commission	10 th July 2025
Kevin McCaffery	Co-Chair Clinical Incident subcommittee	6 th February 2012	Paediatric Intensivist, Queensland Children's Hospital	27 th July 2025
Ainslie Kirkegaard	Steering Committee	23 rd April 2019	Coroner, Department of Justice and Attorney-General, Coroners Court of Queensland	24 th October 2025
Chelsea Wallace	Infant Mortality subcommittee	12 th July 2023	Group Practice Midwife, Birawan MGP, Sunshine Coast University Hospital	9 th November 2025
Nicola Mainwaring	Clinical Incident subcommittee	4 th August 2020	Patient Safety Quality Manager, Queensland Children's Hospital	26 th November 2025
Emma White	Steering Committee	14 th July 2025	Chief Operating Officer, Queensland Family and Child Commission	19 th January 2026
Rachael Beswick	Steering Committee/Nutritional Deficiencies subcommittee	30 th August 2021	Director, First 2000 Days, Reform Office, Department of Health	28 th June 2026
Andrea Hetherington	Clinical Incident subcommittee	27 th September 2016	Nurse Practitioner, Emergency Department, The Prince Charles Hospital	1 April 2026

Privacy Policy

The Committee's Terms of Reference is attached as Appendix 1.

Queensland Paediatric Quality Council (QPQC)

Privacy Policy

Purpose

This policy aims to ensure the Queensland Paediatric Quality Council (QPQC, the Council), its members and relevant persons understand their responsibilities regarding the adoption of a privacy policy in accordance with the Hospital and Health Boards Regulation 2023 (the Regulation). The policy outlines how the Council acquires and compiles relevant information, stores relevant information, discloses relevant information and asks an individual for consent to disclose the individual's identity and meets the requirements of the Hospital and Health Boards Act 2011 (the Act).

Scope

This Privacy Policy applies to:

- the Council (including its Subcommittees)¹
- members of the Council (including its Subcommittees)²
- a person authorised by the Council as a Relevant Person to assist, including persons who:
 - provide administrative or secretarial services to the Council
 - advise the Council about the performance of its functions
 - are engaged to collect, collate, analyse or manage information for the Council
 - provide clinical, technical, epidemiological, legal or other expert advice, including subject matter clinical advisors or expert reviewers
 - review and prepare reports and other information for the council
 - any other person formally authorised by the Council to assist in carrying out its functions.

Acquiring and compiling relevant information

The Council, all members and relevant persons³ must meet specific confidentiality obligations when acquiring and compiling relevant information. The Regulation explains relevant information *means acquired or compiled by the Council in the performance of its functions.*⁴

¹ The Council was established pursuant to s.82 of the HHB Act.

² Note the confidentiality obligations apply to former members; see section 84(1) of the HHB Act.

³ Relevant Persons are individuals authorised by the Council as defined in the scope of the privacy policy.

⁴ s32(4) Hospital and Health Boards Regulation 2024

The Council, members and relevant persons helping the Council, may acquire and compile relevant information including from the following sources:

- Public and private sector health facilities (including Root Cause Analysis (RCA) reports, as well as RCA relevant documents), professional associations, national and international entities, including professional colleges, commonwealth departments and non-government organisations.
- Confidential case summaries and patient clinical records, as well as other related information.
- Office of the State Coroner and the Registry of Births Deaths Marriages and Divorces. Coronial data may include the report of a death to a coroner, police reports, autopsy and toxicology reports, coronial findings and other coronial investigation documents.

Securely storing relevant information.

The Council has a range of mechanisms in place to ensure relevant information is securely stored in accordance with *Public Records Act 2002* and the [Queensland State Archives, General Retention and Disposal Schedule](#) (GRDS).

These mechanisms include

- Including a reference in the QPQC's Terms of Reference, to the responsibility for recordkeeping activities by the secretariat
- Using record keep systems which are secure from misuse, loss and unauthorised access, modification or disclosure and ensuring records are created, stored and maintained systematically.
- Access to the QPQC internal data storage system is restricted to members of the QPQC team. Confidential data is protected by password and any printed material stored in a locked cabinet.
- Ensuring confidential information is shared with all QPQC members and relevant persons via a secure file transfer system (Kiteworks) when required to fulfill the functions of the Council.
- Marking relevant documentation generated electronically by the Council as *Confidential and Not for further disclosure* when distributing.
- Ensuring all Council members and relevant persons receive a copy of the Quality Assurance Committee (QAC) Guideline, this Policy and complete the Confidentiality Form prior to participating in QAC activities.

Disclosing relevant information.

The Council may disclose relevant information, however certain restrictions apply under section 83 and 84 of the Act, these include ensuring:

- a report furnished, or information made available by the Council, is de-identified, unless the provider or recipient of the health service has consented in writing to the disclosure⁵
- if a report identifies a provider, a copy of the report is given to the provider to enable the provider to comment on the report⁶.
- a person who is or was a member of the Council does not disclose to someone else, information acquired by the person as a member of the Council, other than:
 - for the purpose of exercising the functions of a member of the Council
 - to members of another QAC if the information is relevant to the functions of the other QAC
 - to a prescribed patient safety entity under section 85 of the Act

⁵ s.153 of the HHB Act – A designated person may disclose confidential information if the disclosure is to an Act official and the confidential information is relevant to the functions being performed by the Act official.

⁶ Section 85A has limited application; health professionals working in a HHS, and health executives and senior health service employees appointed by a hospital and health service (including Visiting Medical Officers and Senior Medical Officers) are excluded. Further amendments are being considered

- to a relevant Chief Executive in relation to health professionals working in the department (Director-General), a Hospital and Health Service (Health Service Chief Executive), or private health facility (licensee of the facility), to prevent serious risk of harm under section 85A of the Act⁶
- if the person is a registered health practitioner⁷ - for notifying the Office of the Health Ombudsman about information in relation to a reasonable belief of the person that another registered health practitioner has behaved in a way that constitutes public risk notifiable conduct⁸
- to comply with a requirement of an inspector⁹ made of the person under the Act, if the requirement relates to an offence under Part 6, Division 1 of the Act
- under a regulation made under section 91 of the Act.

The Council has processes in place to ensure current and past Council members and relevant persons, are aware and comply with their legislative responsibilities and restrictions in relation to disclosing information, this includes:

- Ensuring all Council members and relevant persons receive a copy of the QAC Guideline, this Policy, the [Factsheet: Disclosing Information](#), and complete and sign the Confidentiality Form prior to participating in QAC activities.

Obtaining consent to disclose an individual's identity

The Council will only disclose information about a provider or recipient of health services, when written consent has been formally sought and obtained in writing.

The Council will firstly seek to ensure the appropriate person has been identified to provide consent. If there is an issue regarding decision making capacity (including in relation to the age of the individual) or the authority of an authorised representative, the Council will seek legal advice to clarify its position.

When seeking written consent to disclose an individual's identity, the Council will provide written advice to the individual explaining:

- the type of personal information being disclosed
- the purpose of the disclosure
- who will be receiving the information and what it will be used for by the recipient/s
- any foreseeable consequences of agreeing to the disclosure
- the right to withdraw consent and the steps involved to do this (ensuring this is a simple and straightforward process).

The Council will not seek broader consent than is necessary for the purpose and will have a clear understanding of the intended use of the information and request for consent accordingly.

Copying information

The copying of information is only permitted for the purpose of exercising the functions of the Council.

Destroying information

The Council will ensure prior to the disposal of QAC records, the secretariat will seek written endorsement from the Director-General of Queensland Health via Clinical Excellence Queensland.

The secretariat will maintain a disposal schedule in accordance with Queensland Health's General Retention and Disposal Schedules (GRDS) and at a minimum, will include:

⁷ Registered health practitioner is defined in Schedule 2 of the HHB Act

⁸ Public risk notifiable conduct is defined in Schedule 2 of the HHB Act

⁹ Inspector is defined in Schedule 2 of the HHB Act

- evidence of disposal authorisation in the schedule current at the time of disposal
- a description of the records and date range
- evidence the disposal was properly approved
- if the records are destroyed, evidence of how this occurred, for example, a certificate specifying the method, place and date of destruction and details of the staff or contractor who carried out the destruction.

When destroying records, the Council should assess the sensitivity of the records and, where appropriate, use methods that completely destroy the records beyond any possible reconstruction¹⁰.

Breach of confidentiality

Pursuant to the Act, the Council is bound by confidentiality obligations which are outlined in the Confidentiality Form, completed annually by each member and relevant persons when they are engaged by the Council.

In circumstances where the Council becomes aware of, or is notified of a suspected breach of confidentiality, the Council will take the following steps:

1. Review the material available to understand and consider what is alleged to have occurred.
2. Review the obligations of the Council under Part 6, Division 1 of the Act and relevant documents such as the Terms of Reference and any QAC policies.
3. Identify what section/s of the Act, or other Council documents and/or processes are alleged to have been breached.
4. Identify if the Council has any other procedures that govern the steps to be taken in the circumstances.
5. The Council will consider the nature of the alleged breach and seek legal advice to determine the appropriate process for managing the breach.
6. Notify the Department as soon as the Council becomes aware of the alleged breach by emailing quality-assurance-committee@health.qld.gov.au¹¹.

Relevant legislation

- *Hospital and Health Boards Act 2011*
- *Hospital and Health Boards Regulation 2023*
- *Information Privacy Act 2009*
- *Public Records Act 2002*

Supporting documents

Queensland State Archives, General Retention and Disposal Schedule authorised under section 26 of the *Public Records Act 2002*, for the disposal of common and administrative public records created by all Queensland Government agencies.

Interpreting the legislation – *Information Privacy Act 2009*, Key Privacy Concepts – agreement and consent – Office of the Information Commissioner, Queensland

¹⁰ Refer to: [Records governance policy](#),

¹¹ Required to ensure compliance with the Department's Legislative Compliance Management Framework

Approval and implementation

Policy Custodian	Policy Contact Details	Approval Date	Approver
Principal Project Officer/Coordinator Queensland Paediatric Quality Council	qpqc@health.qld.gov.au	12 June 2026	Chair, Queensland Paediatric Quality Council

Version control (Insert details of any changes made to this document. Date to be written in full)

Version	Date	Comments	Approver
1	12 June 2026	QPQC privacy policy updated using new PSQ template.	Dr Clare Thomas